Keep Your Spurs Sharp:

Prevention Across the Cancer Continuum

1:45 PM – 2:50 PM

American Cancer Society®

NATIONAL HPV VACCINATION ROUNDTABLE

American Cancer Society®

NATIONAL ROUNDTABLE ON CERVICAL CANCER

Keep Your Spurs Sharp:
Prevention Across the Cancer Continuum

Michelle Fiscus, MD
Association of Immunization Managers

Sarah Temkin, MD
American Cancer Society

Amy Wiser, MD, FAAFP, IBCLC, MSCP
University of Iowa

Thank You

A Living Landscape: Cervical Cancer Screening

Amy Wiser, MD, FAAFP, IBCLC, MSCP

ACS NRTCC, Interim Chair

Associate Professor; University of Iowa
Department of Family & Community Medicine

American Cancer Society®

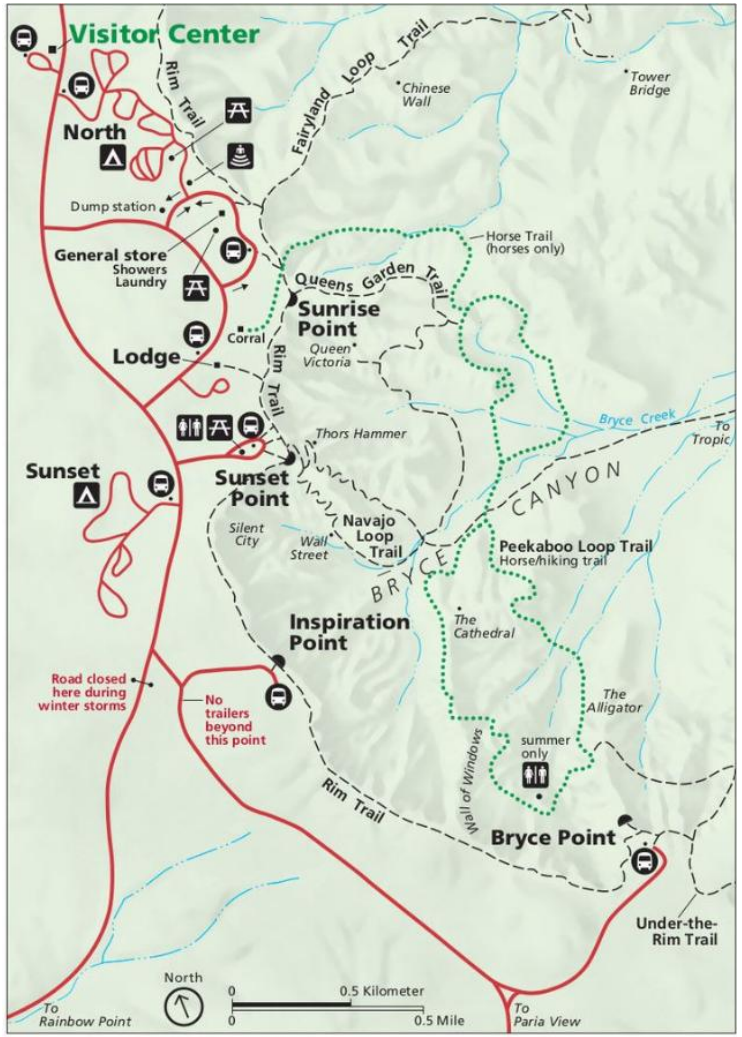
NATIONAL ROUNDTABLE ON CERVICAL CANCER

June 9, 2026

Disclosures

I have no disclosures to report.

Approaching the Landscape



- Where we have been
- Where we are now
- Where we are going

Cervical Cancer Screening

Where we have been (recent history)

Liquid-based cytology

- Opportunity for HPV testing → reflex testing
- Clinician collected cervical specimen

→ HPV testing

- Triage or reflex test for cytology results
- HPV testing is *not supported for individuals aged less than 25*
  - Transient HPV infections are common
  - Rarely contribute to carcinogenic outcomes.

Cervical Cancer Screening

Where we have been (recent history)

Co-testing

- Concurrent cytology *and* HPV testing
- Increased sensitivity and long term negative predictive value of CIN detection compared to cytology
- Clinician collected cervical specimen

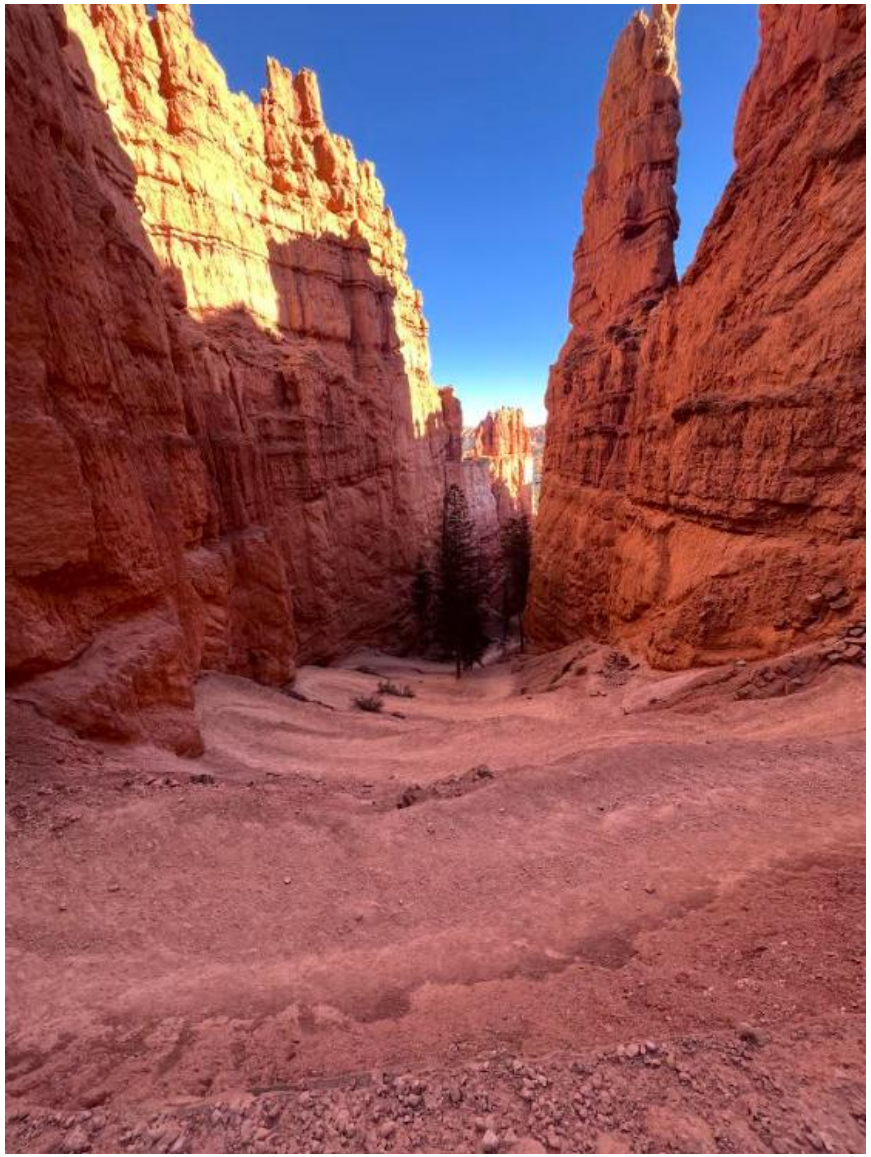
Cervical Cancer Screening

Where we have been/are (recent history)

Primary HPV screening

- Reports positive based on detection
  - hrHPV mRNA E6/E7 proteins
  - hrHPV DNA
- Sensitivity exceeds cytology alone
- Specificity exceeds co-testing and cytology
- Opportunity for cytology → reflex testing

Clinician collected cervical specimen… *and*



Cervical Cancer Screening

Where we are now

Primary HPV screening: *Self collection in the CLINIC setting*

When:
- if not possible or desirable for the clinician to collect a cervical specimen

Who:
- Asymptomatic patients -No abnormal bleeding
- No history: cervical cancer, HIV infection, DES exposure
- No active menstrual bleeding, or use of vaginal products in the previous two days

How:
- Molecular testing (HPV RNA or DNA) via vaginal collection.
- Cervical specimen is *not* collected by this screening method.

Cervical Cancer Screening

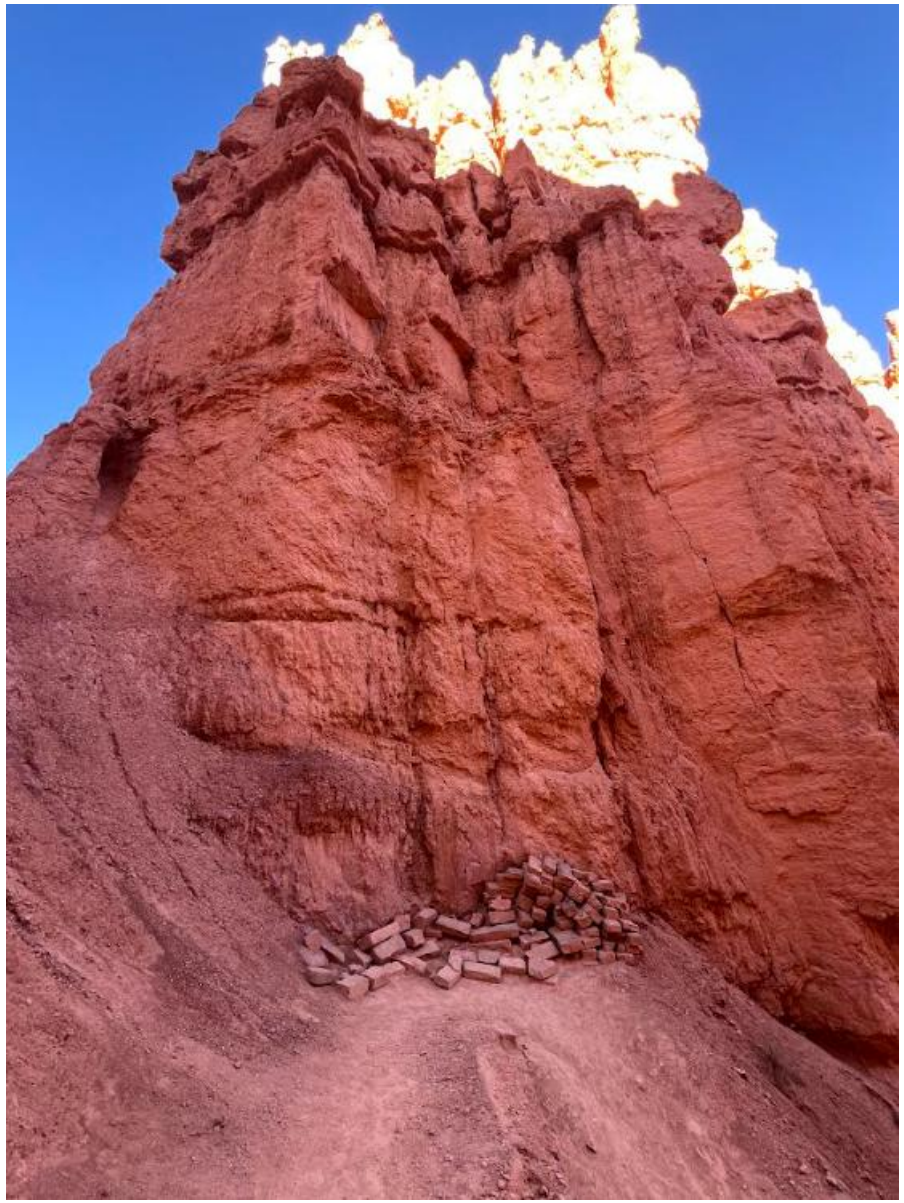
Where we are now/going

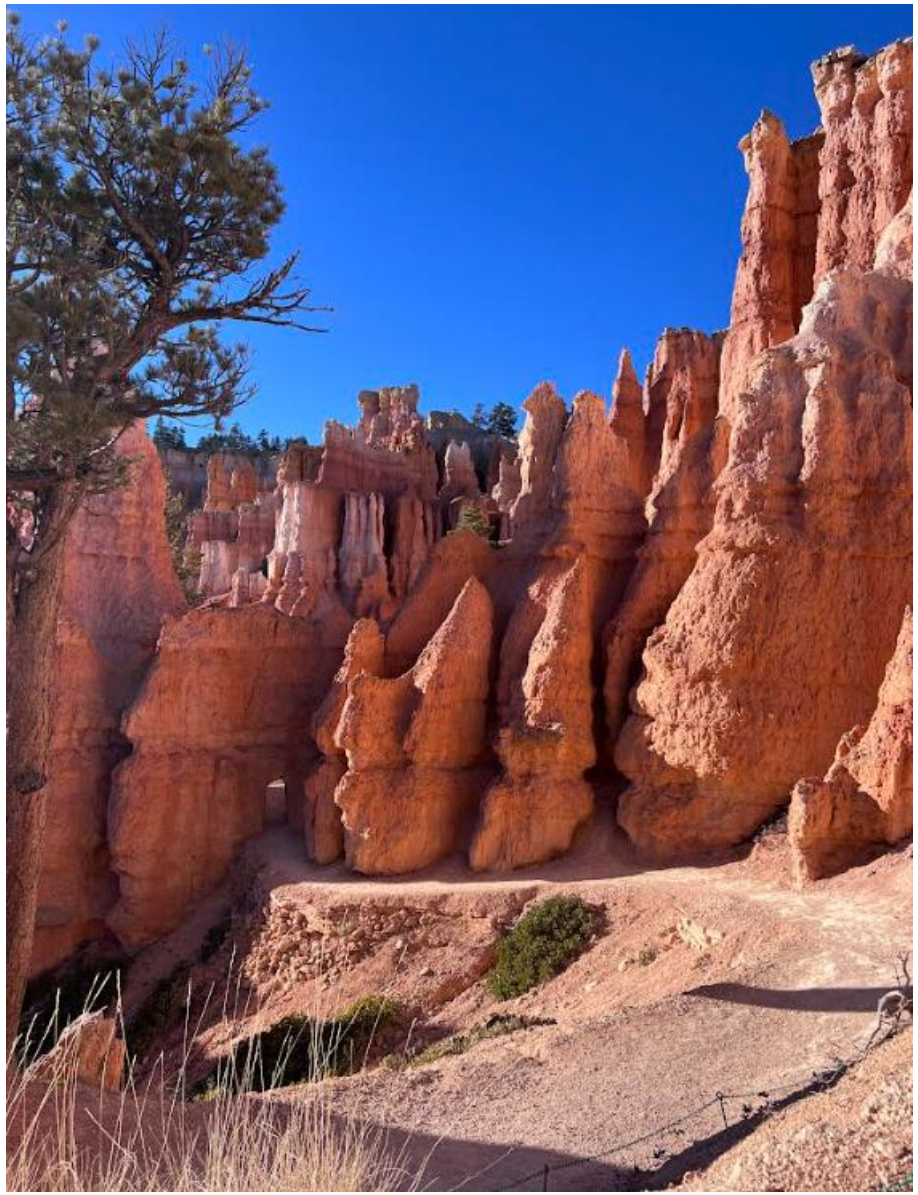
Primary HPV screening: *Self collection in the HOME setting*

- Concept similar to Clinic setting
  - Specific software collection requirements

- Evidence for the utilization and validity
- FDA approval occurring

Cervical Cancer Screening





Comparison of Screening Guidelines for Individuals at Average Risk for Cervical Cancer

Age	2024 USPSTF (draft recommendation)	2020 American Cancer Society and 2026 update
< 21 years	Recommends against screening	No screening is recommended
21-24 years	Cytology alone every 3 years	No screening is recommended
25-29 years	Cytology alone every 3 years	Primary HPV testing every 5 years with clinician-collected sample or every 3 years with self-collected sample Cotesting* every 5 years or cytology alone every 3 years are acceptable options if primary HPV screening is limited or not available
30-65 years	Primary HPV screening every 5 years with clinician- or patient-collected sample Cotesting* every 5 years or cytology alone every 3 years is an alternative to primary HPV screening	Primary HPV screening every 5 years with clinician-collected sample or every 3 years with self-collected sample Cotesting* every 5 years or cytology alone every 3 years is acceptable if primary HPV testing is limited or not available
> 65 years	Recommends against screening in those who have had adequate screening and are not otherwise at high risk for cervical cancer	Discontinue screening if negative primary HPV screening (preferred) or negative cotesting (acceptable) at 60 and 65 years of age, or three consecutive negative cytology tests performed at the recommended screening interval with last test at age 65 years (acceptable) Self-collected primary HPV vaginal specimens should follow 3-year testing interval
After hysterectomy	Recommends against screening after hysterectomy with removal of the cervix and no history of CIN2+ or cervical cancer	Individuals without a cervix and without a history of CIN2+ in the past 25 years or any history of cervical cancer should not be screened

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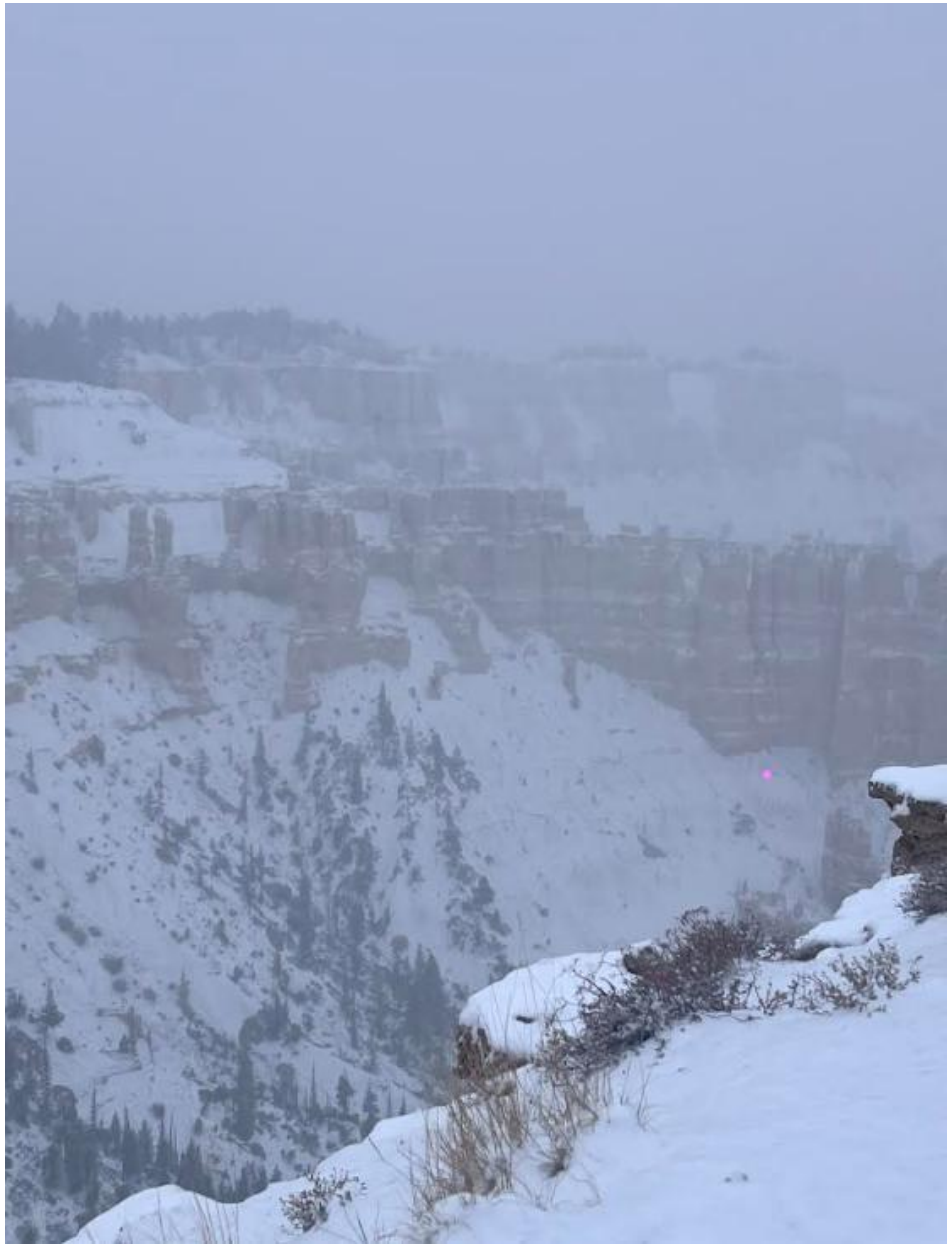
Table. HRSA Cervical Cancer Screening Guidelines

Cervical cancer screening guidelines issued in 2016 (effective with plan years beginning in 2018)	Cervical cancer screening guidelines issued in 2025 (effective with plan years beginning in 2027)
The Women's Preventive Services Initiative recommends cervical cancer screening for average-risk women aged 21 to 65 years. For women aged 21 to 29 years, the Women's Preventive Services Initiative recommends cervical cancer screening using cervical cytology (Pap test) every 3 years. Cotesting with cytology and human papillomavirus testing is not recommended for women younger than 30 years. Women aged 30 to 65 years should be screened with cytology and human papillomavirus testing every 5 years or cytology alone every 3 years. Women who are at average risk should not be screened more than once every 3 years.	The Women's Preventive Services Initiative recommends cervical cancer screening for average-risk women aged 21 to 65 years. For women aged 21 to 29 years, cervical cancer screening using cervical cytology (Pap test) every 3 years is recommended. Co-testing with cytology and human papillomavirus (hrHPV) testing is not recommended for women younger than 30 years. Women aged 30 to 65 years should be screened with primary hrHPV testing every 5 years (preferred) or cytology and hrHPV testing (co-testing) every 5 years. If hrHPV testing is not available, continue screening with cytology alone every 3 years. Women who are at average risk should not be screened more than once every 3 years. Patient-collected hrHPV testing is an appropriate method and should be offered as an option for cervical cancer screening in women aged 30 to 65 years at average risk. Additional testing may be required to complete the screening process and follow-up findings on the initial screening. If additional testing (eg, cytology, biopsy, colposcopy, extended genotyping, dual stain) and pathologic evaluation are indicated, these services also are recommended to complete the screening process for malignancies.

Abbreviations: hrHPV, high-risk human papillomavirus; HRSA, Health Resources and Services Administration; Pap, Papanicolaou.

A Living Landscape



Cervical Cancer Screening

Where are we going

- Education – patient and provider
- IT/EHR
- Stigma
- Access
- Cost/Coverage
- **Self Collection**

The *impact* of these work groups continues.

ACS NRTCC Self-Collection Work Group

Accomplishments

Creation of on-line resources:

Preparing for Self-Collection: Clinician Communication Guide

Cervical Cancer Screening with the HPV Self-Collection Test for women and people with a cervix

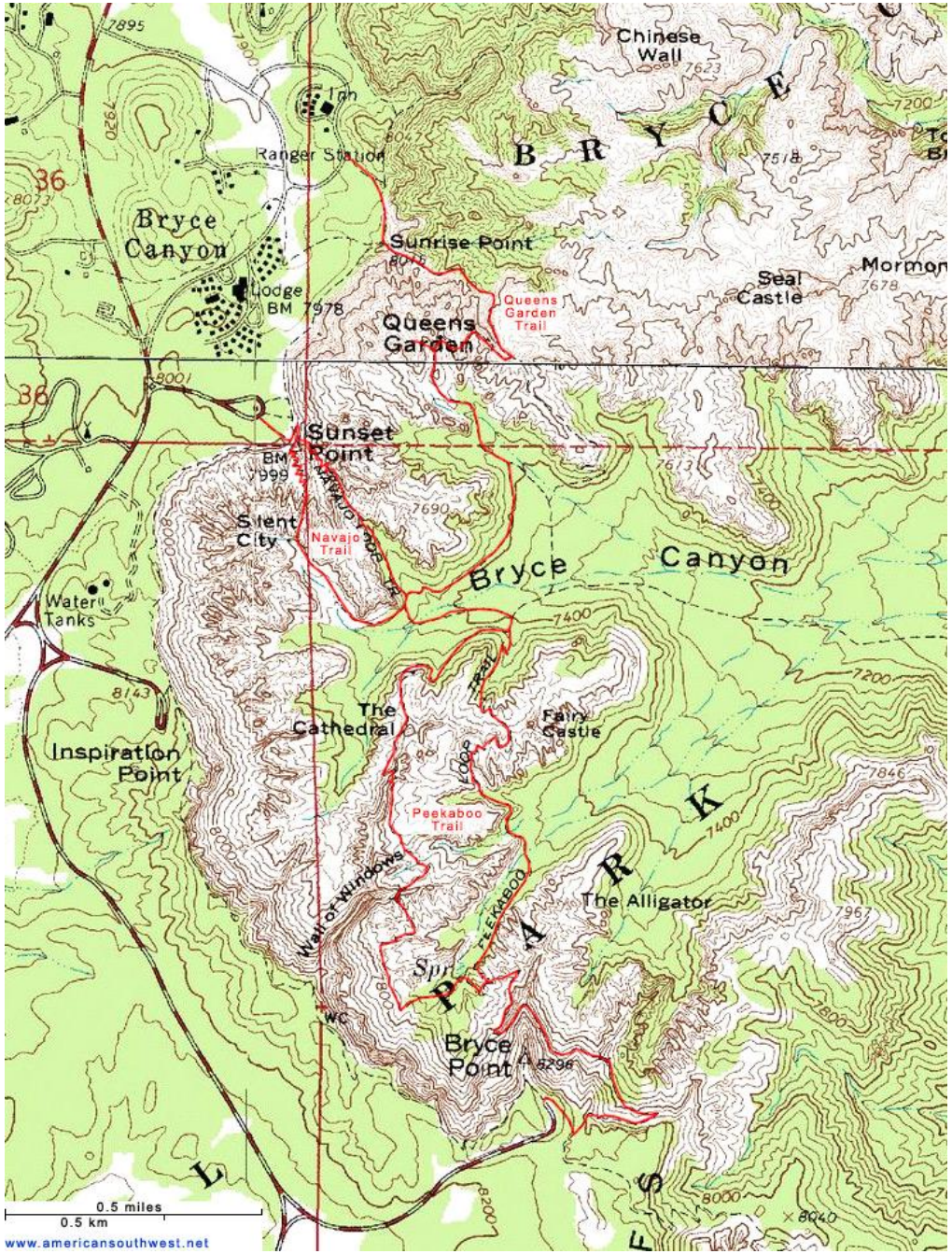
- webinar series targeted for FQHCs and other safety net settings

Current work

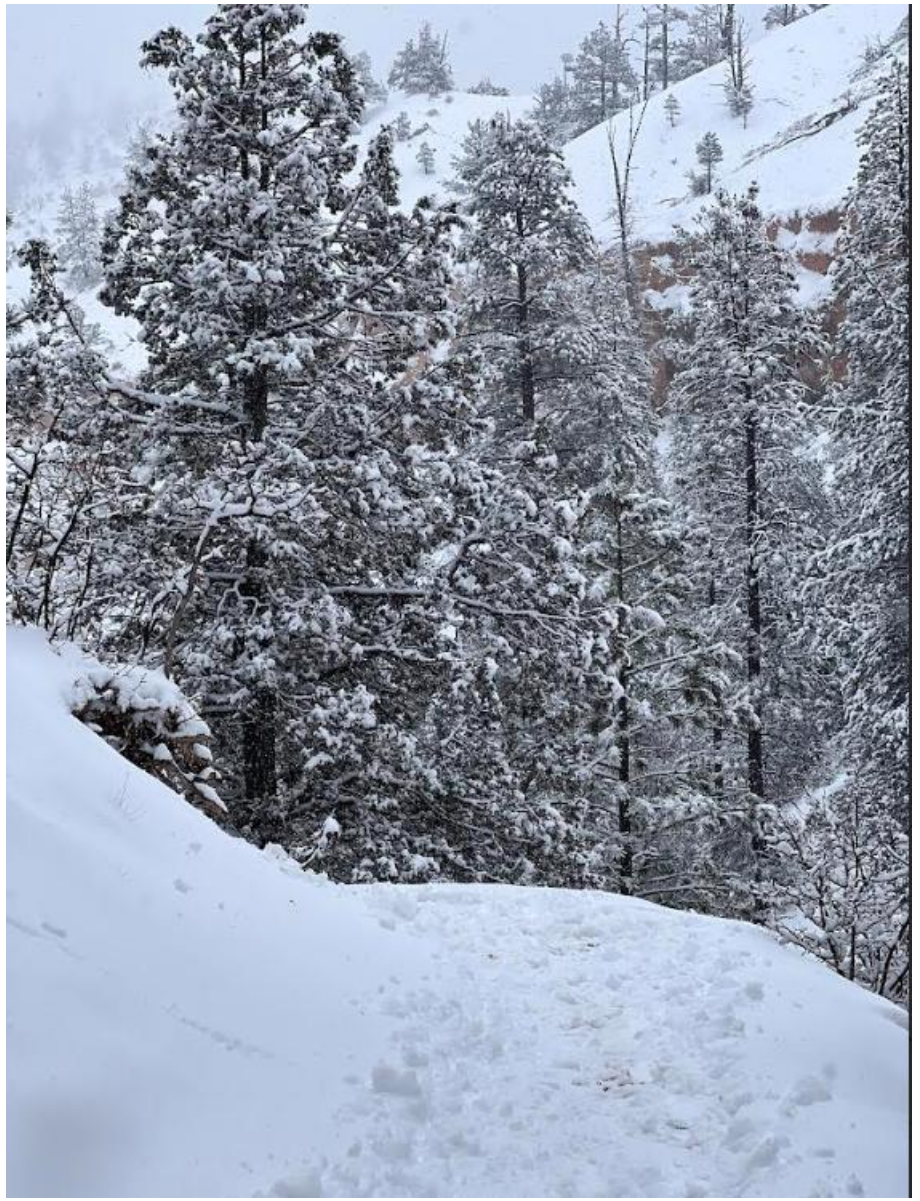
Development of a **mapping dashboard** that tracks uptake by clinics/systems to:

- monitor and communicate trends
- enable health systems to easily connect

Navigation Plan



Finding the trail



References

- *Cervical Cancer Screening: IARC Handbooks of Cancer Prevention*. Vol 18. IARC Publications; 2022. Accessed January 16, 2025. https://publications.iarc.fr/Book-And-Report-Series/Iarc-Handbooks-Of-Cancer-Prevention/Cervical-Cancer-Screening-2022
- Chor J, Davis AM, Rusiecki JM. Cervical Cancer Screening Guideline for Individuals at Average Risk. *JAMA.* 2021;326(21):2193–2194.
- Practice Bulletin No. 168: Cervical Cancer Screening and Prevention. *Obstet Gynecol.* 2016 Oct;128(4):e111-e130.
- Fontham ETH, Wolf AMD, Church TR, et al. Cervical cancer screening for individuals at average risk: 2020 guideline update from the American Cancer Society. *CA Cancer J Clin.* 2020 Sep;70(5):321-346.
- Center for Disease Control and Prevention: Human Papillomavirus (HPV): Clinical Overview. Updated July 9, 2024. Accessed January 16, 2025. https://www.cdc.gov/hpv/hcp/clinical-overview/index.html#cdc_clinical_overview_pat_coun-patient-counseling
- Perkins RB, Wentzensen N, Guido RS, et al. Cervical Cancer Screening: A Review. *JAMA*. 2023 Aug 8;330(6):547-558.
- Wright TC Jr, Schiffman M. Adding a test for human papillomavirus DNA to cervical-cancer screening. *N Engl J Med*. 2003 Feb 6;348(6):489-90.
- Rozemeijer K, Naber SK, Penning C, et al. Cervical cancer incidence after normal cytological sample in routine screening using SurePath, ThinPrep, and conventional cytology: population based study. *BMJ*. 2017 Feb 14;356:j504.
- US Preventive Services Task Force. Public Comment on Draft Recommendation Statement, Draft Evidence Review, and Draft Modeling Report: Screening for Cervical Cancer. Updated. December 10,2024. Accessed December 18, 2024. https://www.uspreventiveservicestaskforce.org/uspstf/announcements/public-comment-draft-recommendation-statement-draft-evidence-review-and-draft-modeling-report-screening-cervical-cancer.
- Christine B, Bush M, Thurakal A, Sheehy AM. New Cervical Cancer Screening Guidelines From the US Department of Health and Human Services: Strengthening Women's Preventive Health. *JAMA.* 2026;335(8):661–662. doi:10.1001/jama.2025.26456
- Perkins RB, Wolf AMD, Church TR, Elkin EB, Skates SJ, Etzioni RD, Guerra CE, Herzig A, Hoffman RM, Oeffinger KC, Raoof S, Shih YT, Walter LC, Zeigler-Johnson C, Manassaram-Baptiste D, Smith RA. Self-collected vaginal specimens for human papillomavirus testing and guidance on screening exit: An update to the American Cancer Society cervical cancer screening guideline. CA Cancer J Clin. 2026 Jan-Feb;76(1):e70041. doi: 10.3322/caac.70041. Erratum in: CA Cancer J Clin. 2026 Jan-Feb;76(1):e70066.
- Wentzensen N, Clarke MA. Cervical cancer screening—past, present, and future. *Cancer Epidemiol Biomarkers Prev*. 2021;30(3):432-434.
- Nayar R. Cervical cancer prevention in the United States-where we've been and where we're going: The American Cancer Society Primary HPV Screening Initiative. *Cancer Cytopathol*. 2023 Dec;131(12):747-750.
- Arbyn M, Smith SB, Temin S, et al. Collaboration on Self-Sampling and HPV Testing. Detecting cervical precancer and reaching underscreened women by using HPV testing on self samples: updated meta-analyses. *BMJ*. 2018 Dec 5;363:k4823
- FDA News Release. FDA Roundup: May 17, 2024. Accessed December 18, 2024. https://www.r.gov/news-events/press-announcements/fda-roundup-may-17-2024
- Crane L, Fitzpatrick MB, Sutton, E, et al. Evaluation of a Self-collected Device for Human Papillomavirus Screening to Increase Cervical Cancer Screening. J Low Genit Tract Dis. 2025 Jan 1;29(1):1-5.
- Nishimura H, Yeh PT, Oguntade H, et al. HPV self-sampling for cervical cancer screening: a systematic review of values and preferences. *BMJ Glob Health*. 2021 May;6(5):e003743.
- Madzima TR, Vahabi M, Lofters A. Emerging role of HPV self-sampling in cervical cancer screening for hard-to-reach women: Focused literature review. *Can Fam Physician.* 2017 Aug;63(8):597-601.
- National Cancer Institute. NCI Last Mile Initiative. Accessed January 27, 2025. https://prevention.cancer.gov/major-programs/nci-cervical-cancer-last-mile-initiative
- National Cancer Institute. FDA Approves HPV Tests That Allow for Self-Collection in a Health Care Setting. Updated July 24, 2024. Accessed January 27, 2025. https://www.cancer.gov/news-events/cancer-currents-blog/2024/fda-hpv-test-self-collection-health-care-setting#:~:text=Health%20Care%20Setting-,FDA%20Approves%20HPV%20Tests%20That%20Allow%20for%20Self,in%20a%20Health%20Care%20Setting&text=For%20now%2C%20the%20option%20to,in%20a%20health%20care%20setting.
- National Cancer Institute. Self-collection for HPV Testing to Improve Cervical Cancer Prevention (SHIP) Trial (LMI-001-A-S02). Accessed January 27, 2025. https://www.cancer.gov/research/participate/clinical-trials-search/v?id=NCI-2024-07726

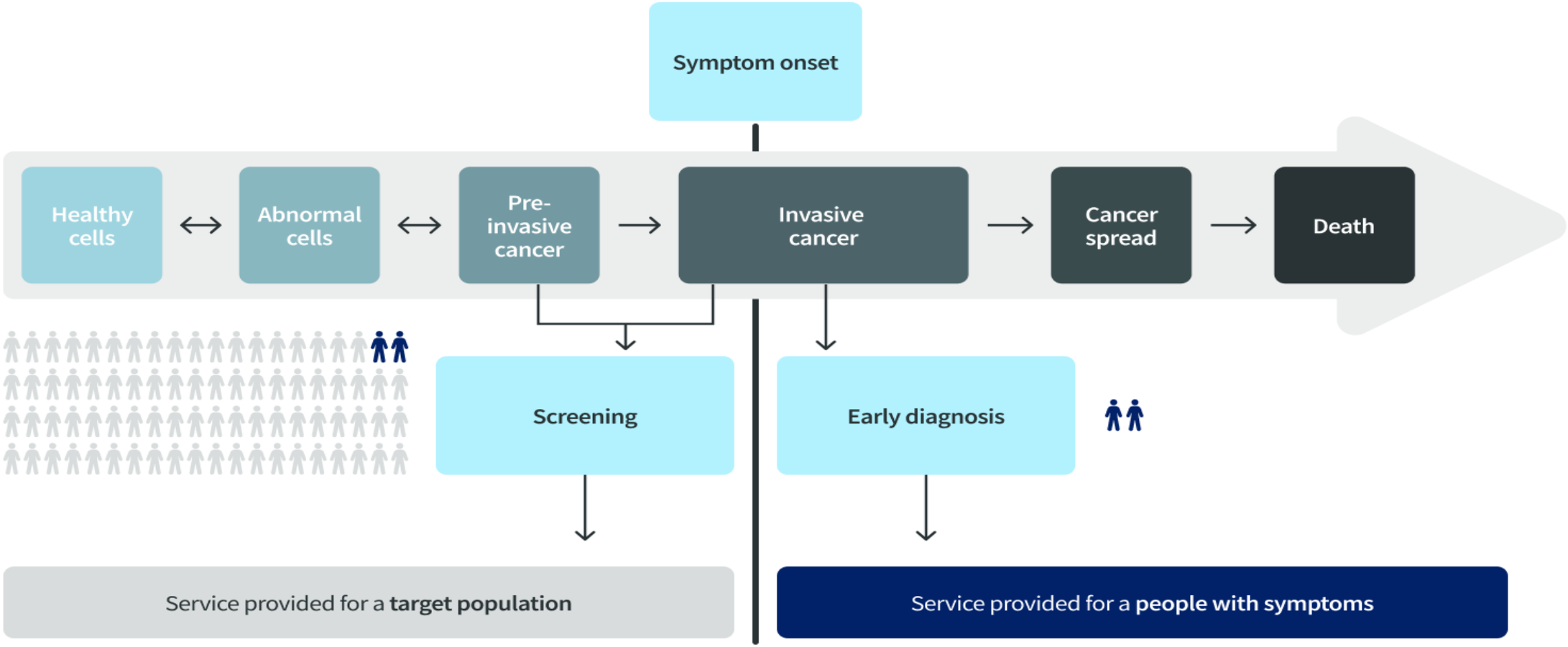
Thank You

Treatment of HPV Associated Cancers

ACS HPVRT & ACS NRTCC National Meeting

Sarah M. Temkin, MD, FACS

The Goal of Prevention is Improving Cancer Outcomes

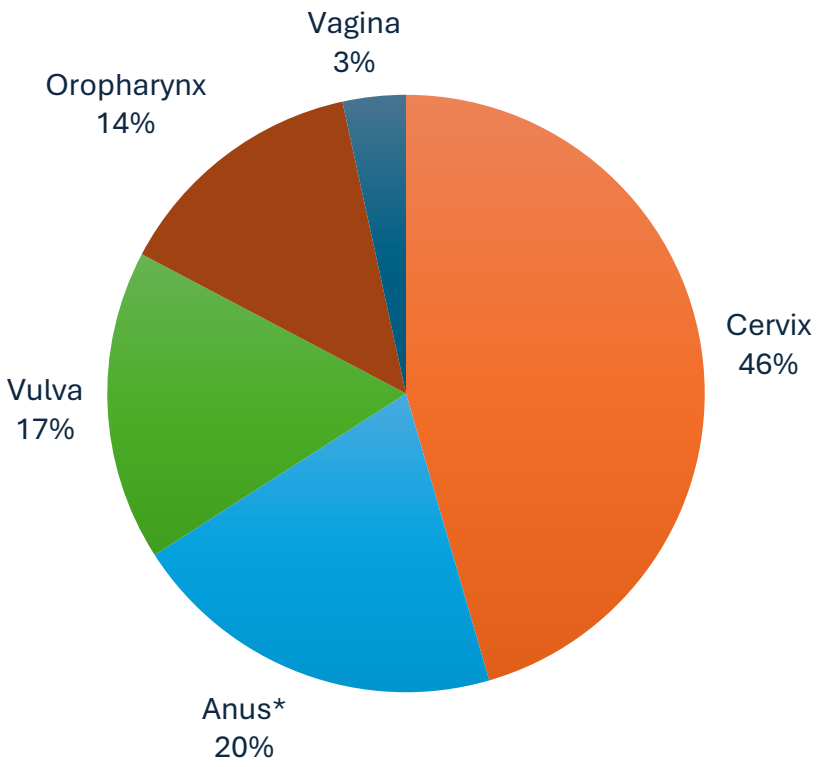


IMPROVED CANCER OUTCOMES
(Fewer deaths, less treatment and toxicity)

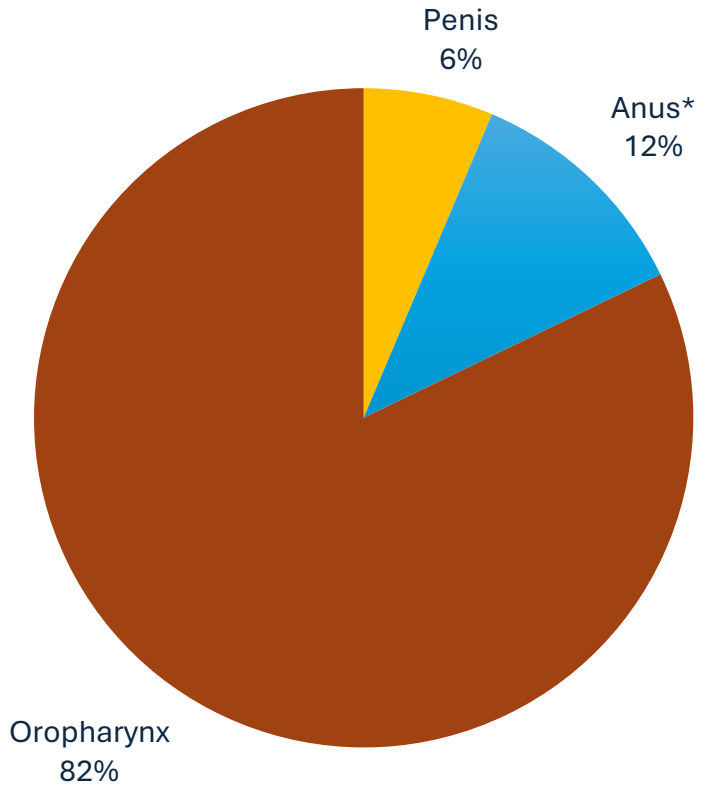
https://canceratlas.cancer.org/

HPV-associated Cancer Diagnoses (2018-2022)

Annual Female Cases (n=26,280)

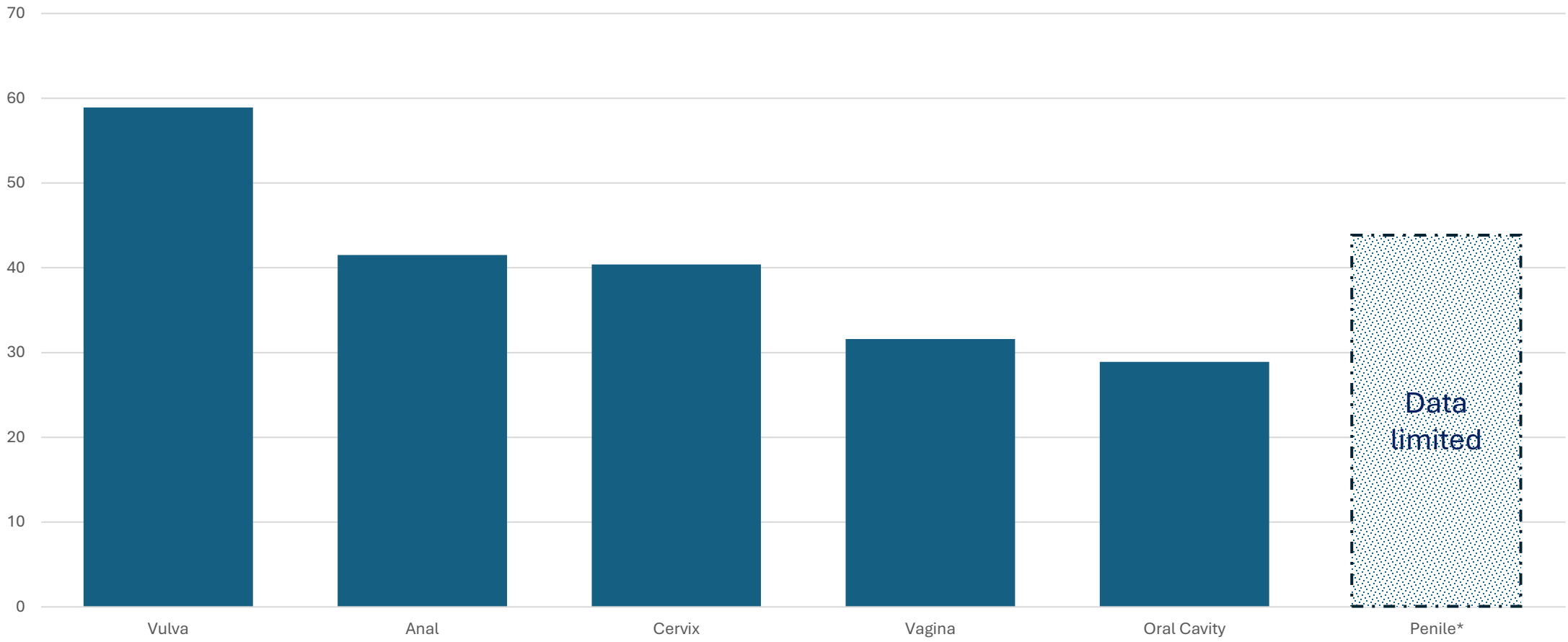


Annual Male Cases (n=21,704)



https://www.cdc.gov/united-states-cancer-statistics/publications/hpv-associated-cancers.html

HPV Cancers Localized at Diagnosis



https://seer.cancer.gov/statistics-network/https://schs.dph.ncdhhs.gov/schs/pdf/CCRPenileCancerFactSheet102920.pdf

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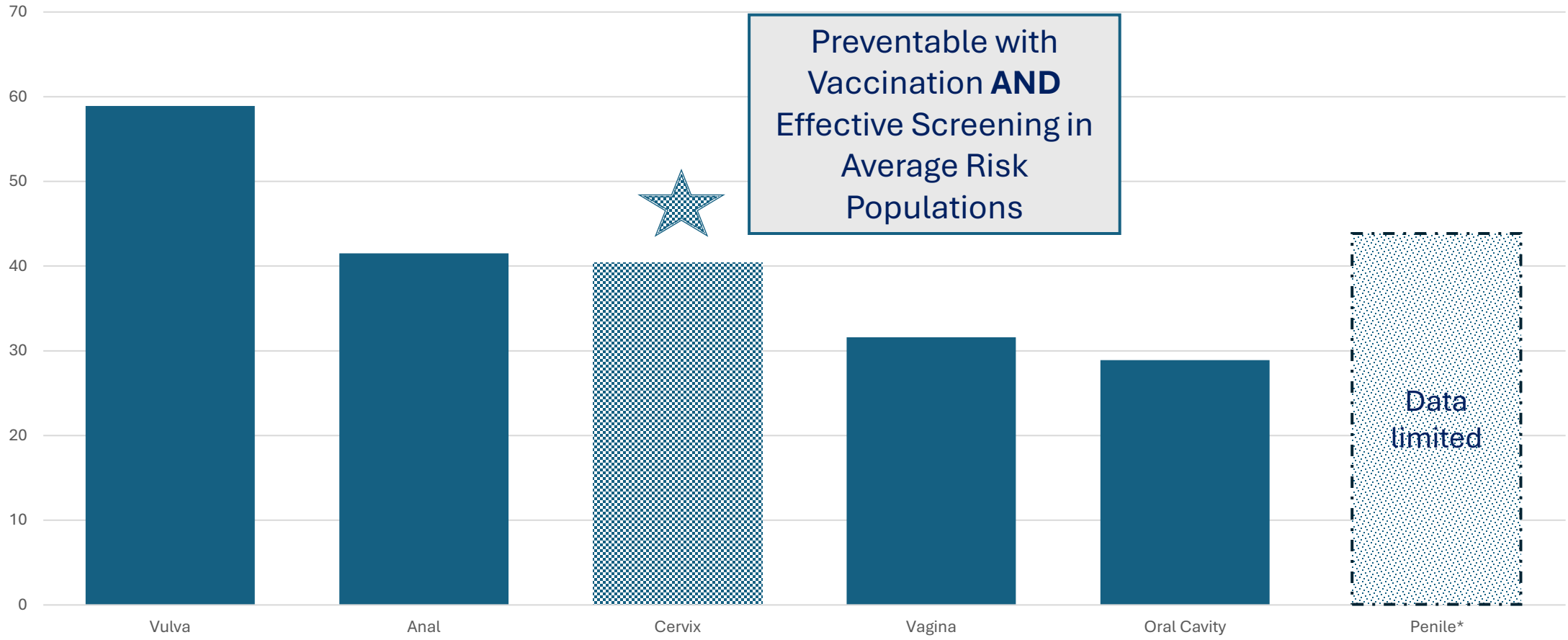

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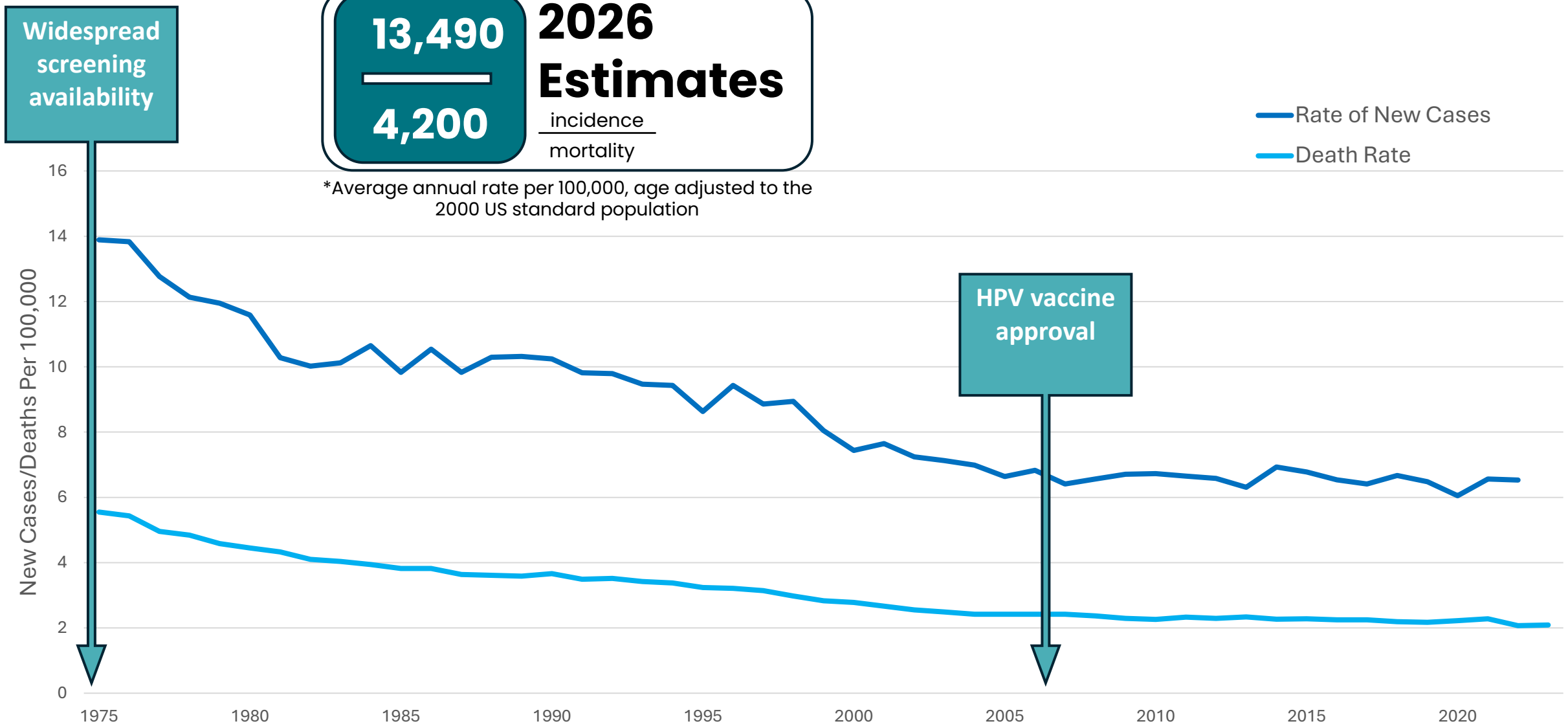
Cervical Cancer Incidence and Mortality

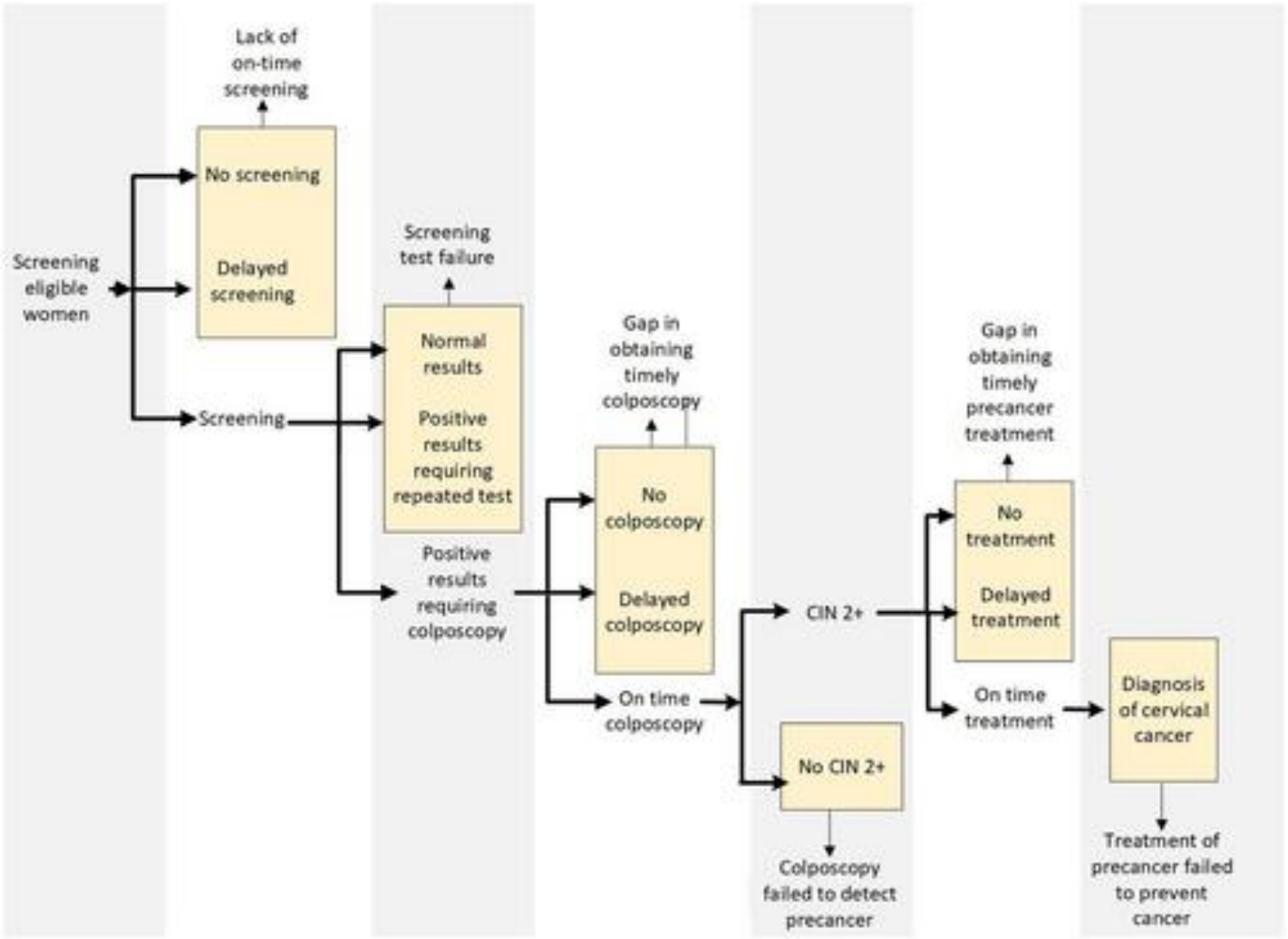
13,490 / **4,200** — **2026 Estimates** (incidence / mortality)

*Average annual rate per 100,000, age adjusted to the 2000 US standard population



https://cancerstatisticscenter.cancer.org/

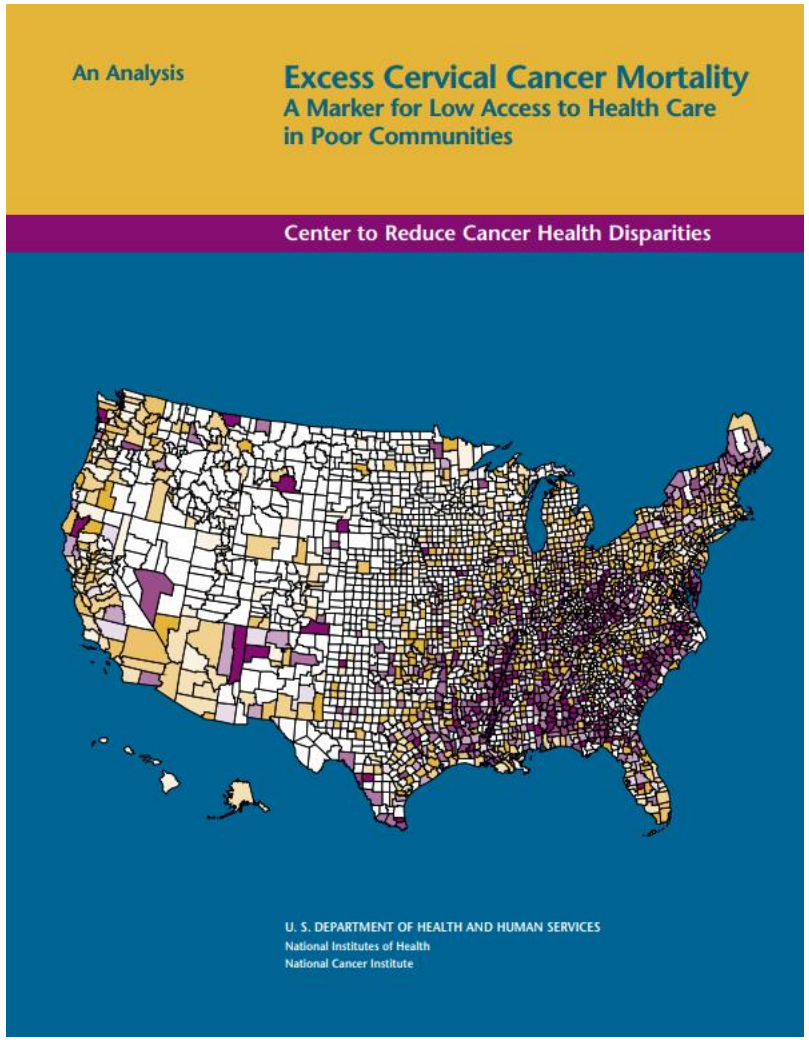
Cervical Cancer Results from Care Gaps

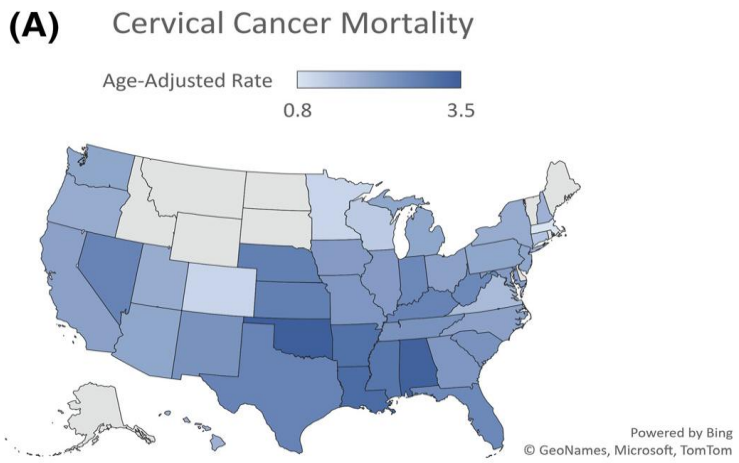


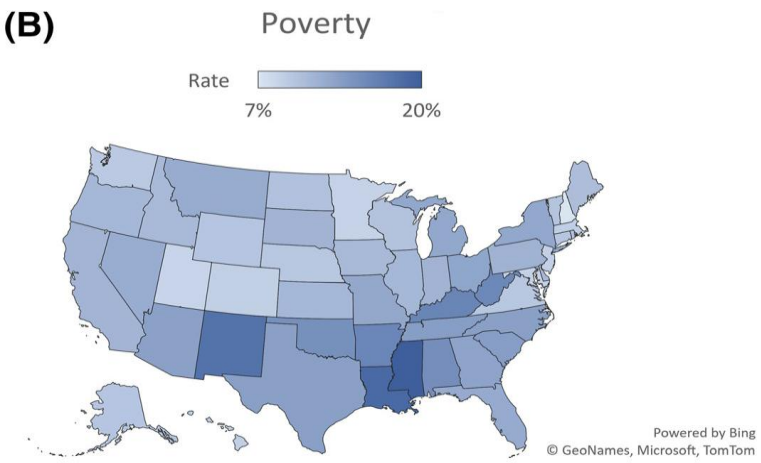
Care gap types in the screening history among women diagnosed with cervical cancer	
Lack a screening test	46.3%
Screening test failure	31.2%
Diagnostic/treatment care gap	22.2%
No clear care gap	**0.2%**

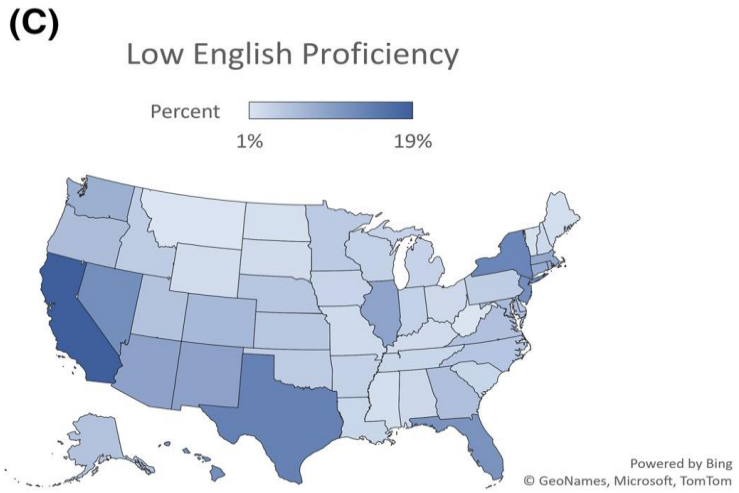
Chao CR, etal. Cancer Med. 2023; 12: 3705-3717. doi: 10.1002/cam4.5226

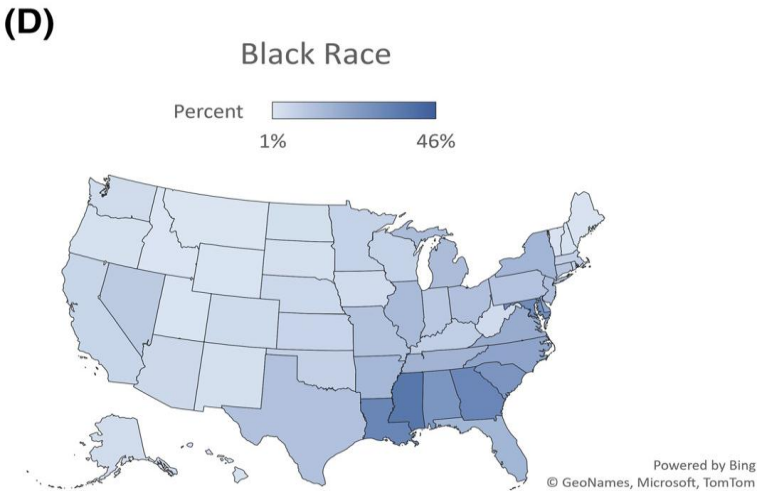
Care Gaps Persist After Diagnosis









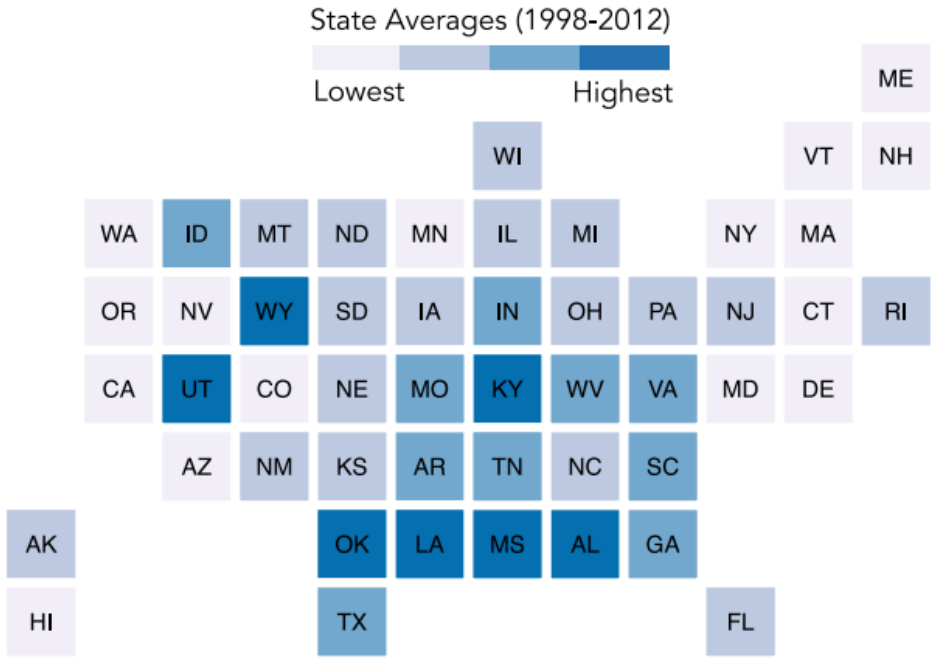


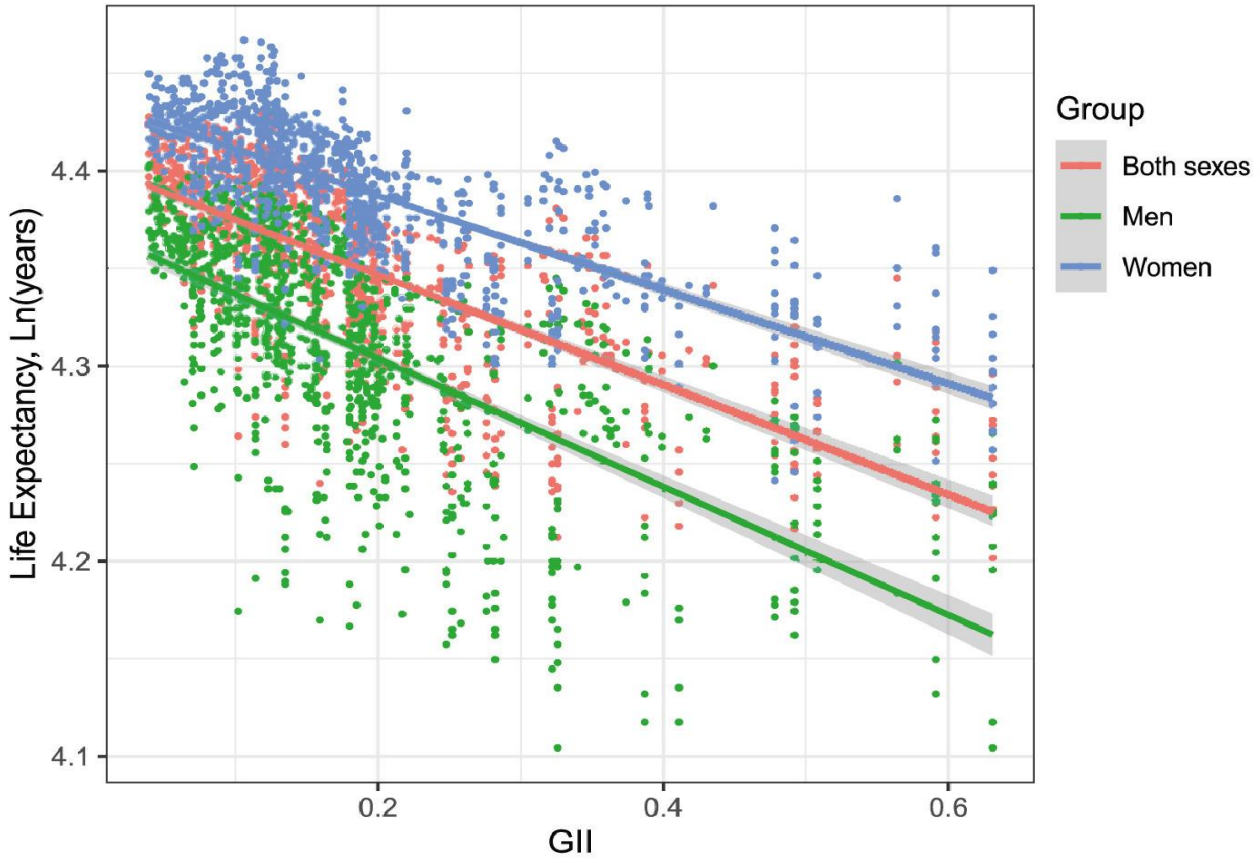
https://www.cancer.gov/about-nci/organization/crchd/about-health-disparities/resources/excess-cervical-cancer-mortality.pdf
Cancer, Volume: 128, Issue: 23, Pages: 4063-4073, First published: 14 October 2022, DOI: (10.1002/cncr.34487)

Social Factors Influence the Health of Women

Veas C, etal. EClinicalMedicine. 2021 Jul 31;39:101051. doi: 10.1016/j.eclinm.2021.101051. PMID: 34386759;

Social Factors That Influence Health Outcomes For Women



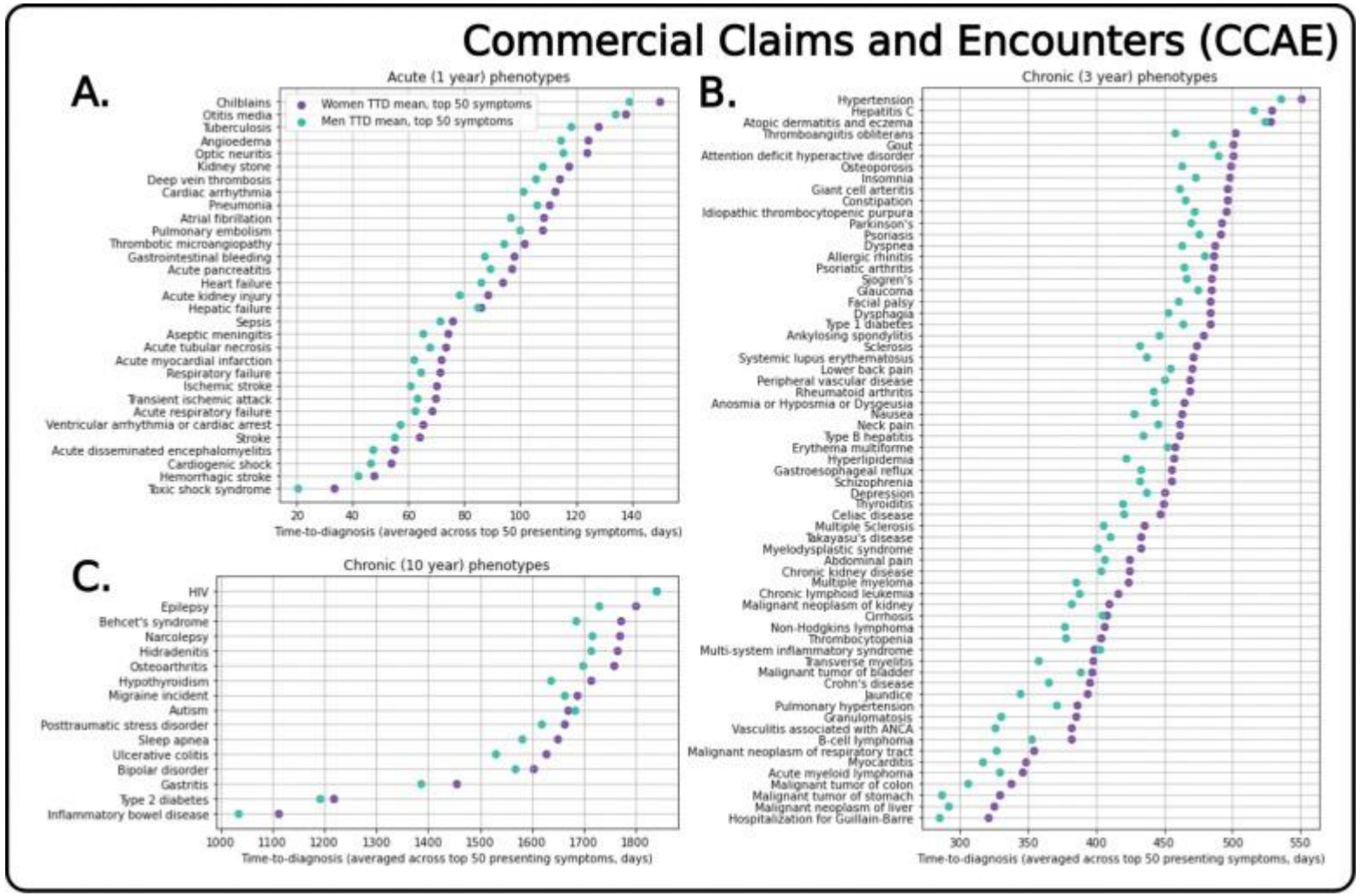


Structural sexism – "systematic gender inequality in power and resources in a given gender system"

Homan, P. *American Sociological Review* 84.3 (2019): 486-516.

Veas, C et al. eClinicalMedicine, Volume 39, 101051. DOI: 10.1016/j.eclinm.2021.101051

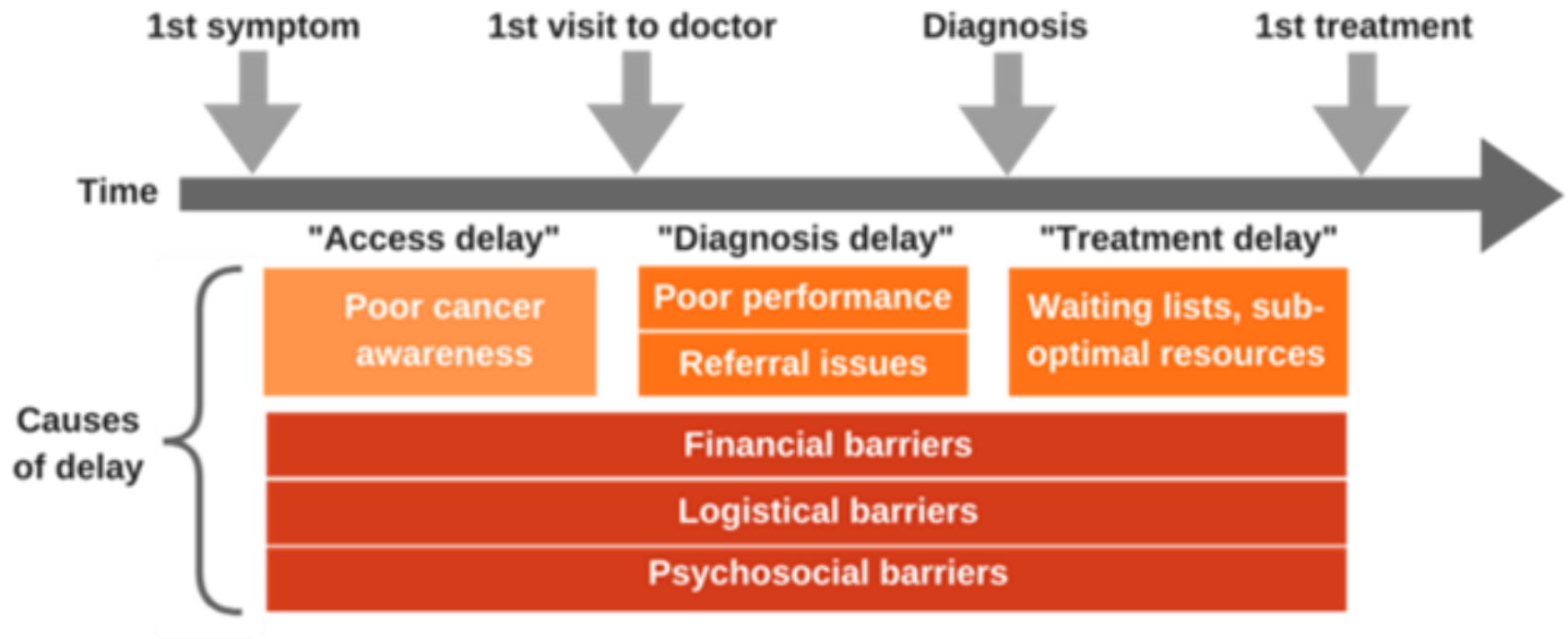
Delays in Diagnosis Are More Common Amongst Women



Women wait 21, 63, and 134 days longer than men after their first presentation with any relevant symptom for the acute, mid-length chronic, and long-term chronic phenotypes respectively

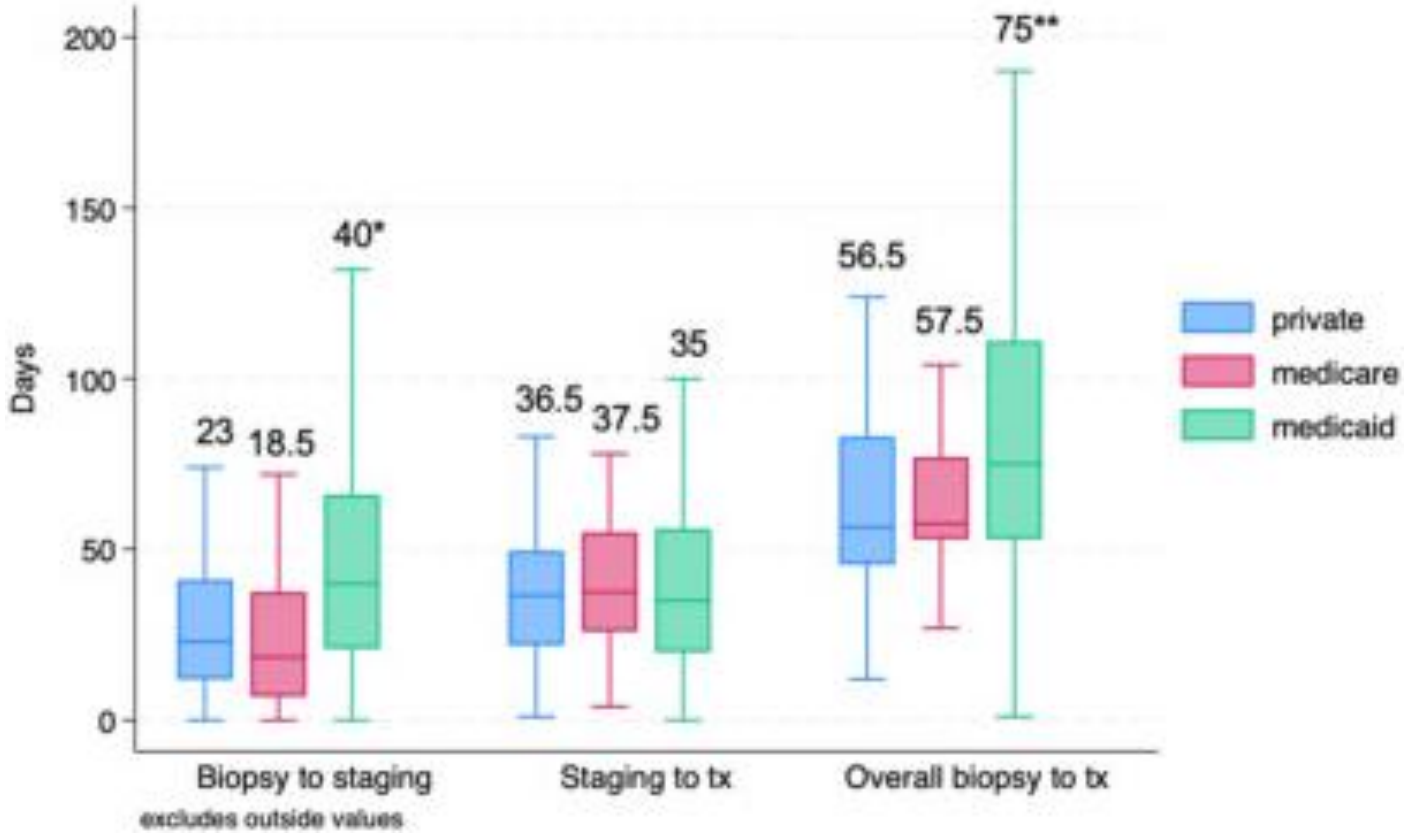
Sun TY, et al. medRxiv. 2023 Oct 16:2023.10.12.23296976. doi: 10.1101/2023.10.12.23296976.

Delays to Treatment Negatively Influence Cancer Outcomes



https://www.who.int/europe/news-room/fact-sheets/item/cancer-screening-and-early-detection-of-cancer

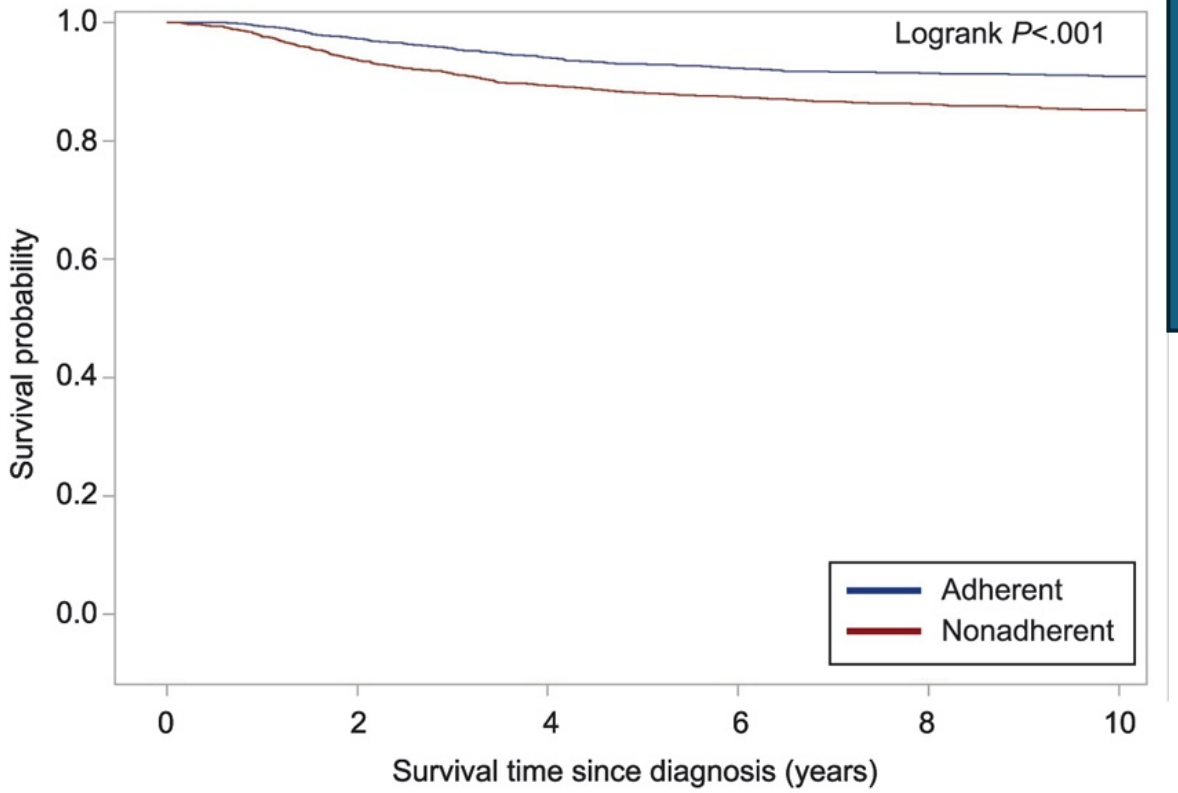
Most Cervical Cancer Patients Experience Delays To Treatment



37% of patients received timely treatment initiation

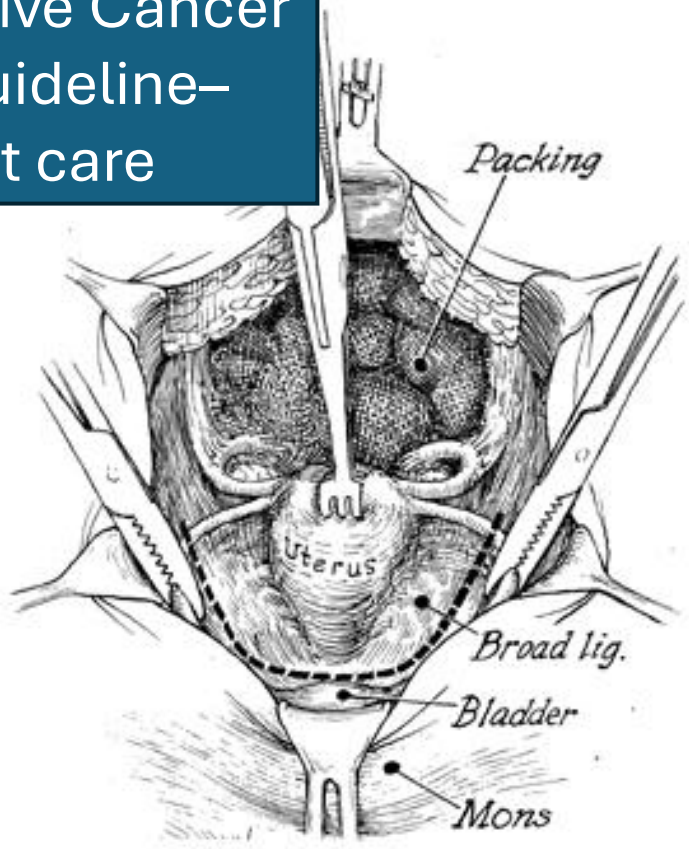
Liang J, et al. American Journal of Obstetrics & Gynecology, 2025; 233, 186.e1-186.e9 DOI: 10.1016/j.ajog.2025.02.032

Less Than Half Of Patients with Early Staged Disease Receive Guideline Concordant Care



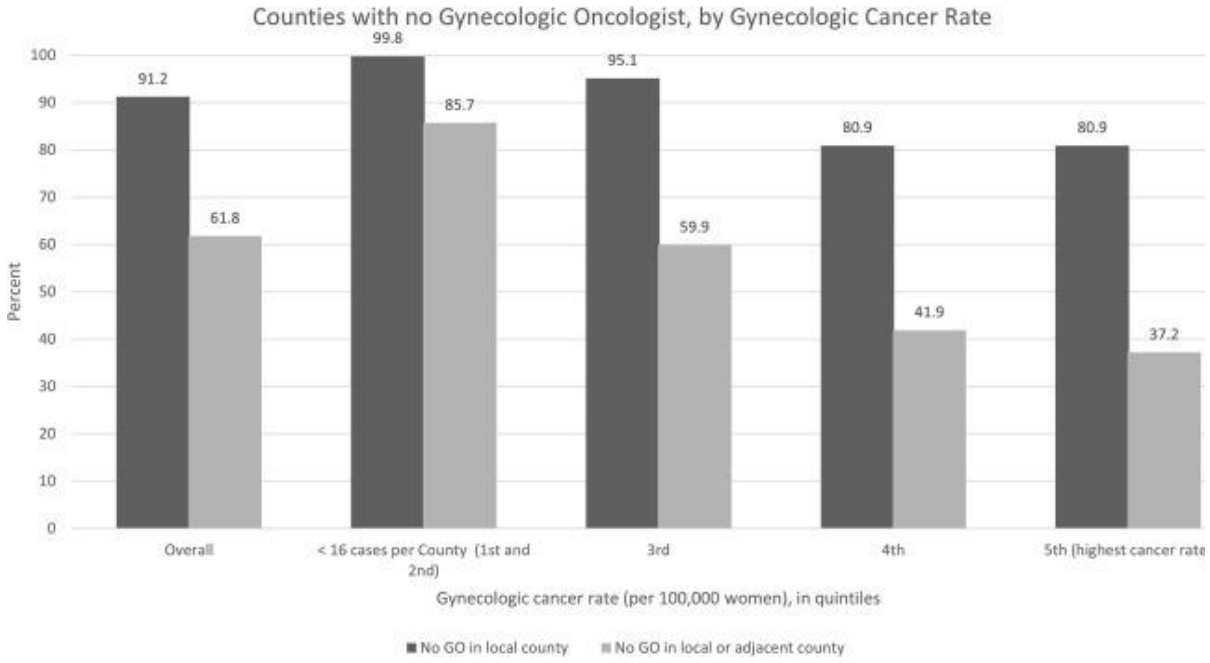
Adherent	2,818	2,610	2,390	2,051	1,683	1,348
Nonadherent	3,219	2,822	2,508	2,065	1,598	1,242

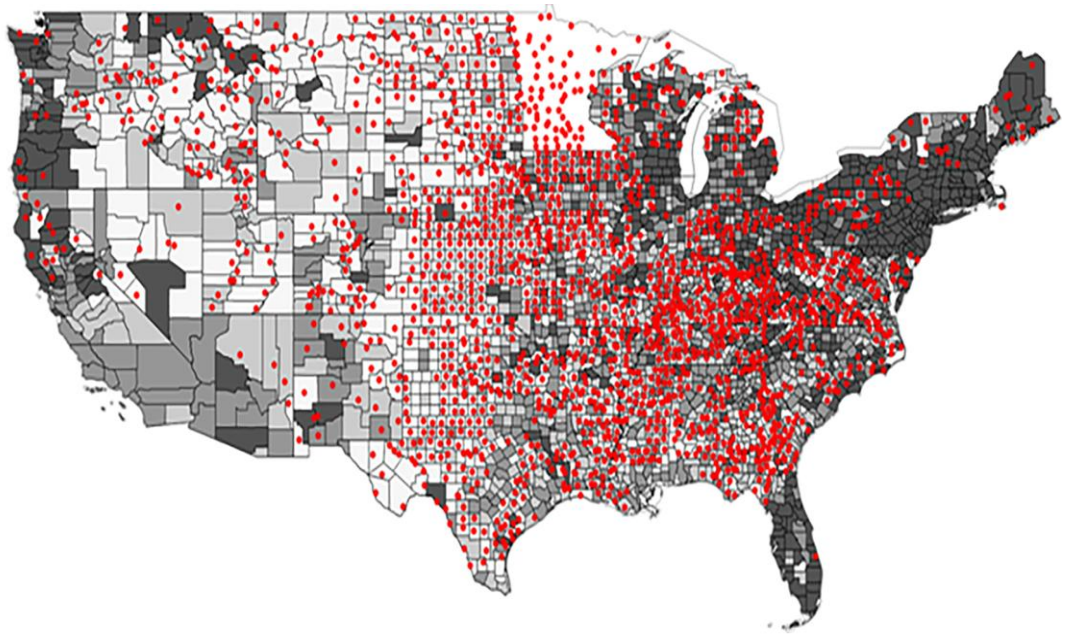
46.7% of patients received National Comprehensive Cancer Network guideline–adherent care



Pfaendler KS, et al. Obstetrics & Gynecology 131(5):p 899-908, May 2018. | DOI: 10.1097/AOG.0000000000002591

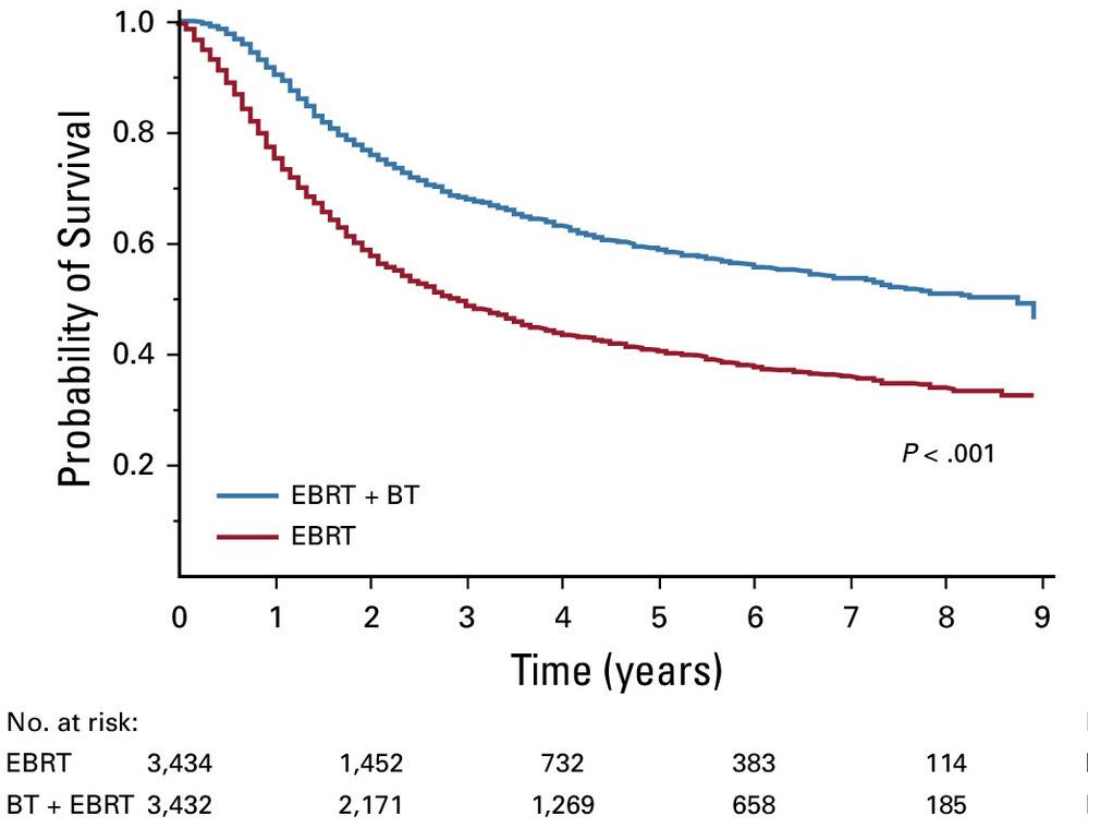
Most Counties Have No Gynecologic Oncologist





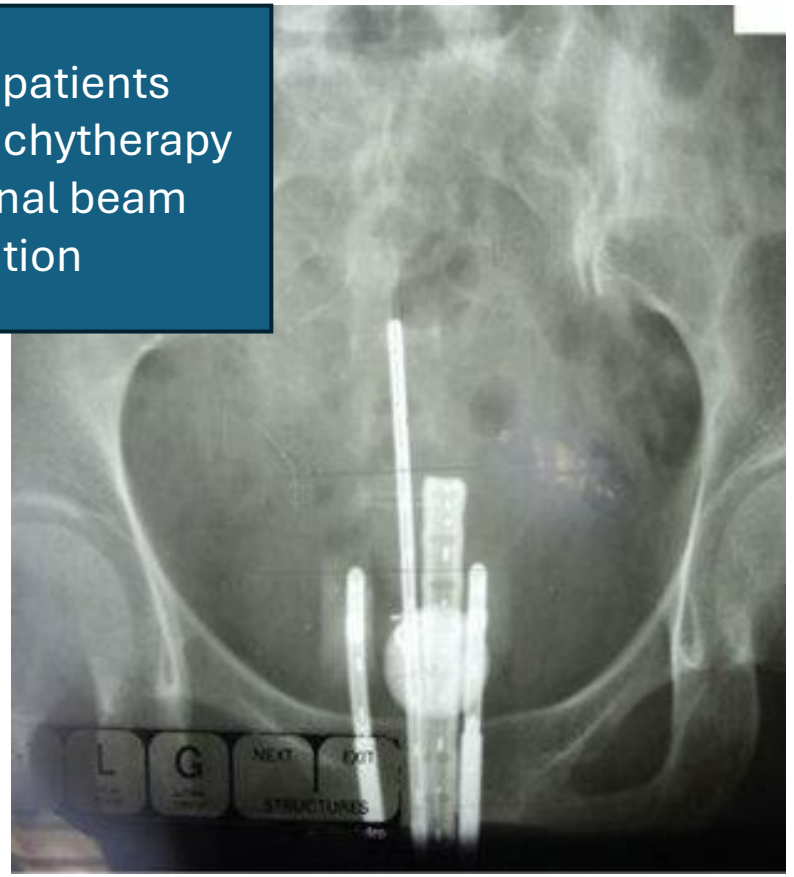
Ackroyd SA, et al. Gynecol Oncol. 2021 Nov;163(2):229-236. doi: 10.1016/j.ygyno.2021.08.013.

Less Than Half Of Patients with Locally Advanced Disease Receive Brachytherapy



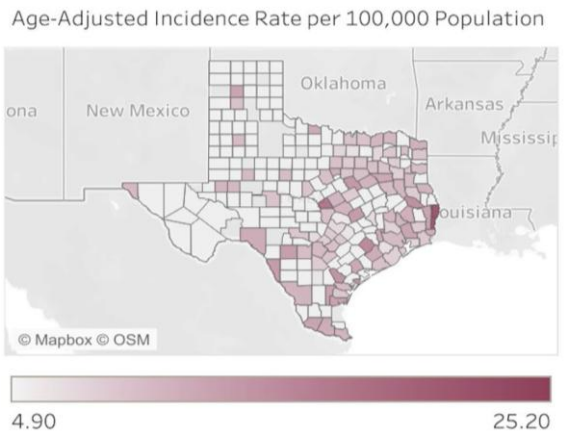
No. at risk:					
EBRT	3,434	1,452	732	383	114
BT + EBRT	3,432	2,171	1,269	658	185

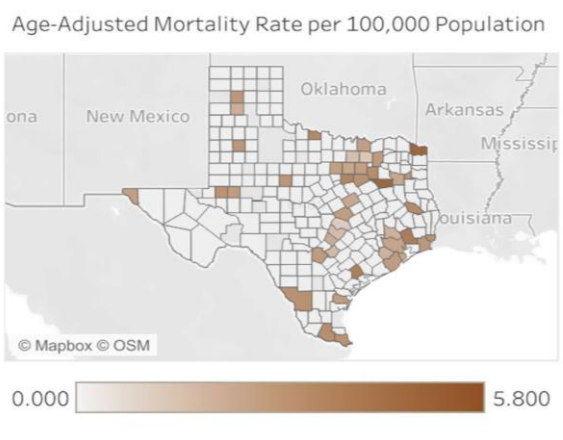
47.3% of patients received brachytherapy with external beam radiation

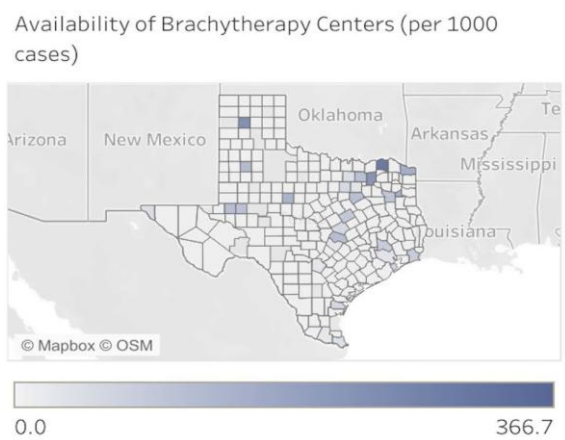


Boyce-Fappiano D, et al. JCO Oncol Pract 17, e1958-e1967(2021) Volume 17, Number 12. DOI: 10.1200/OP.21.00291

Availability of Radiation Does not Map to Areas of High Need

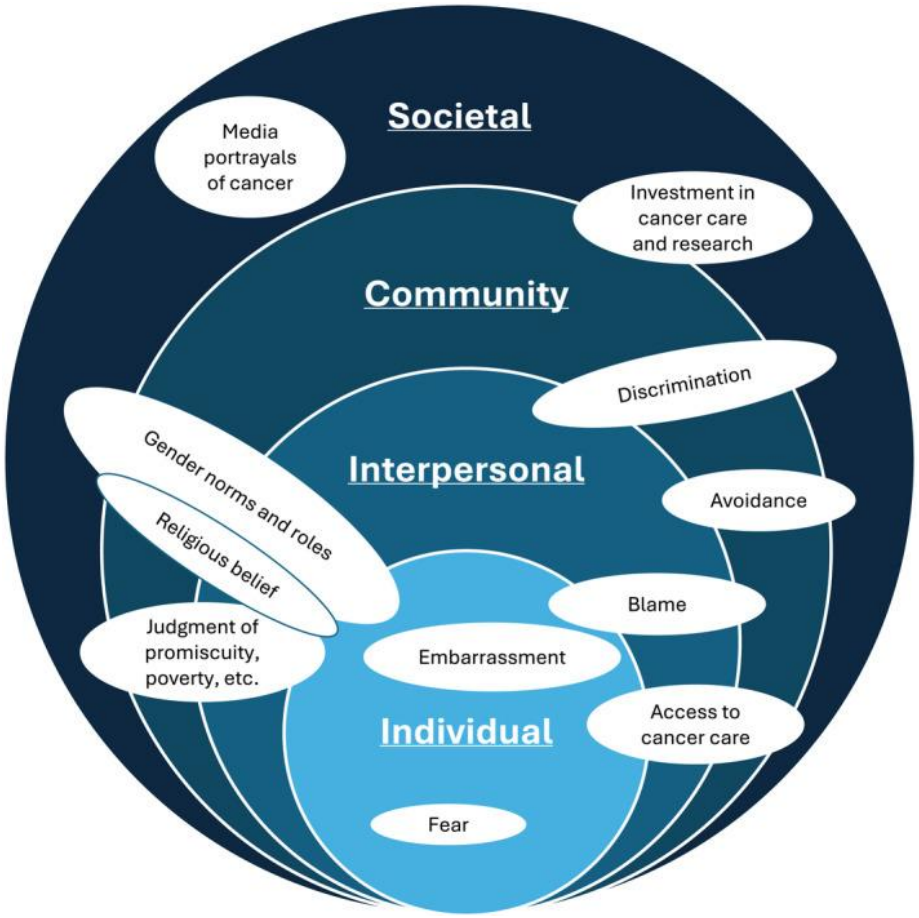






Jhavar S, et al. *Brachytherapy*. 2026 Jan-Feb;25(1):221-228. doi: 10.1016/j.brachy.2025.09.010.

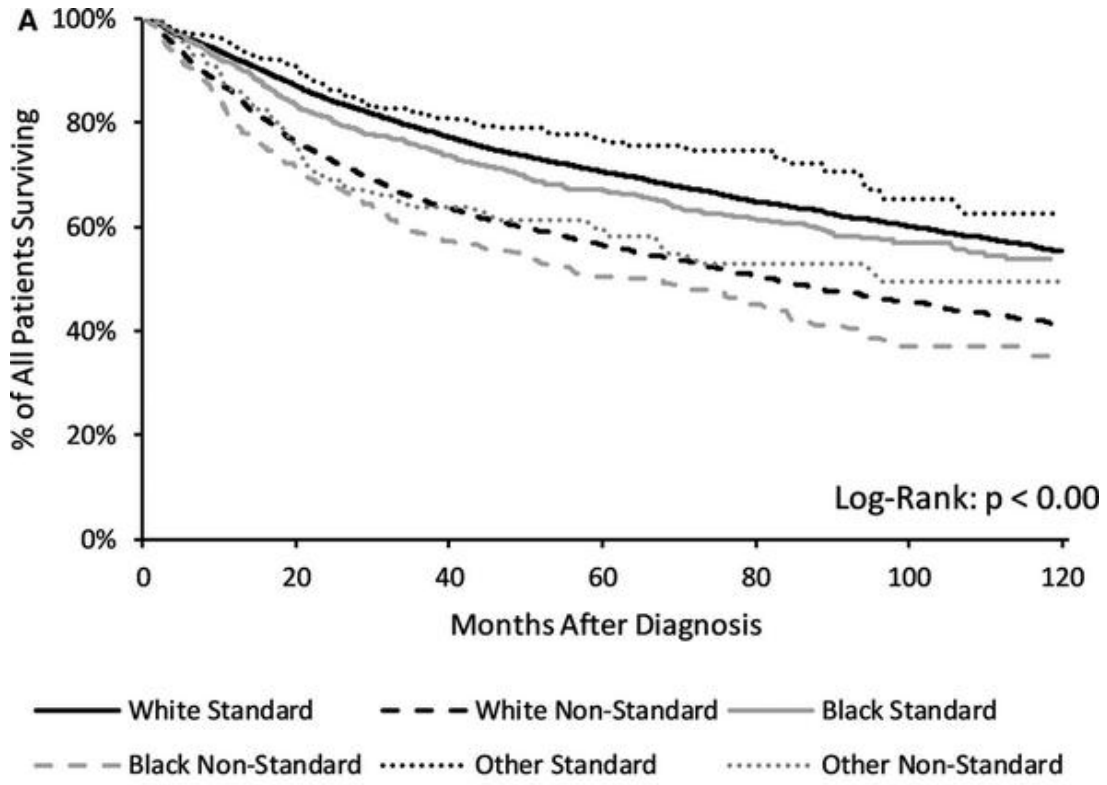
Stigma Influences the Cancer Journey



STIGMA: a powerful social process involving negative labeling and stereotyping of certain human characteristics as socially undesirable, remains a significant but often overlooked barrier to cervical cancer prevention efforts

Link BG, Phelan JC. Conceptualizing stigma. Annu Rev Sociol. 2001;27(1):363-385. doi: 10.1146/annurev.soc.27.1.363
Bae HS, Temkin SM. Cervical cancer stigma - A silent barrier to the elimination of cervical cancer. Cancer. 2025 Mar 1;131(5):e35776. doi: 10.1002/cncr.35776.

Disparities in Other HPV-Associated Cancers: Anal Cancer

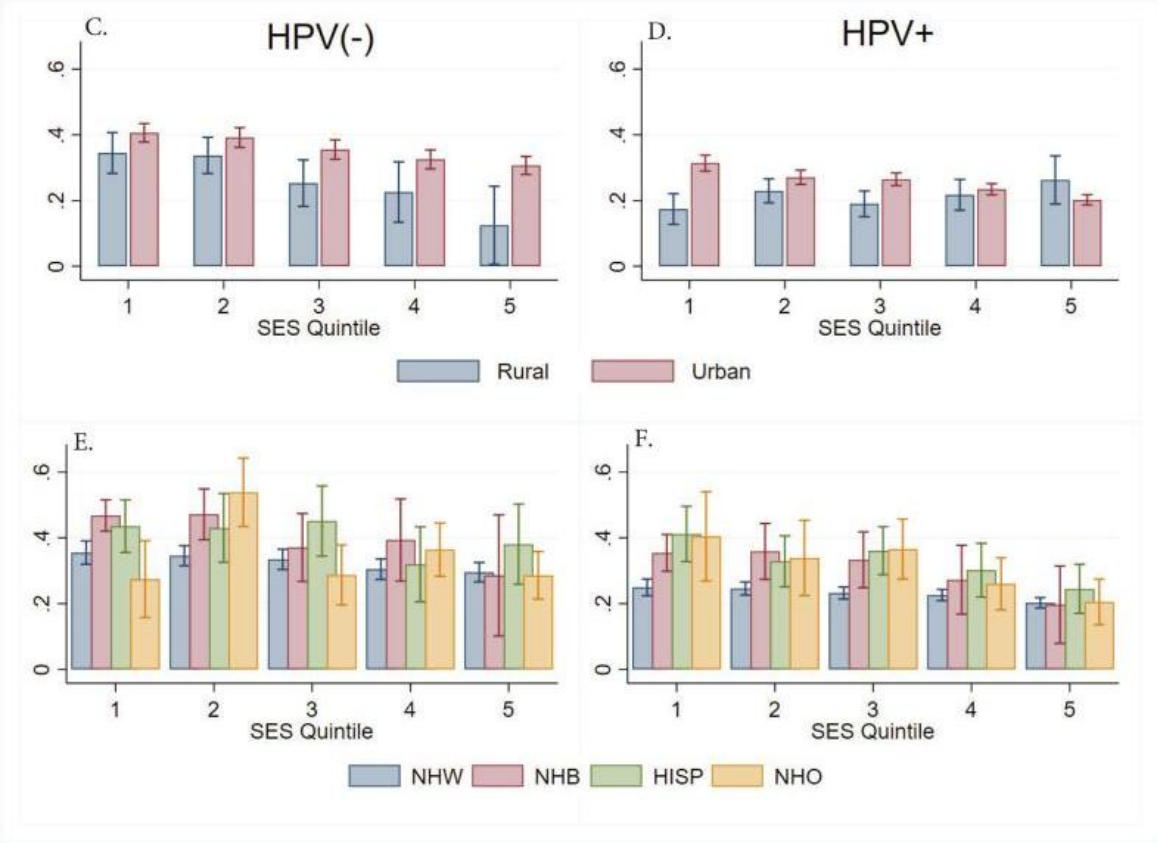


White and Privately Insured Patients are More Likely to Receive Standard of Care Treatment

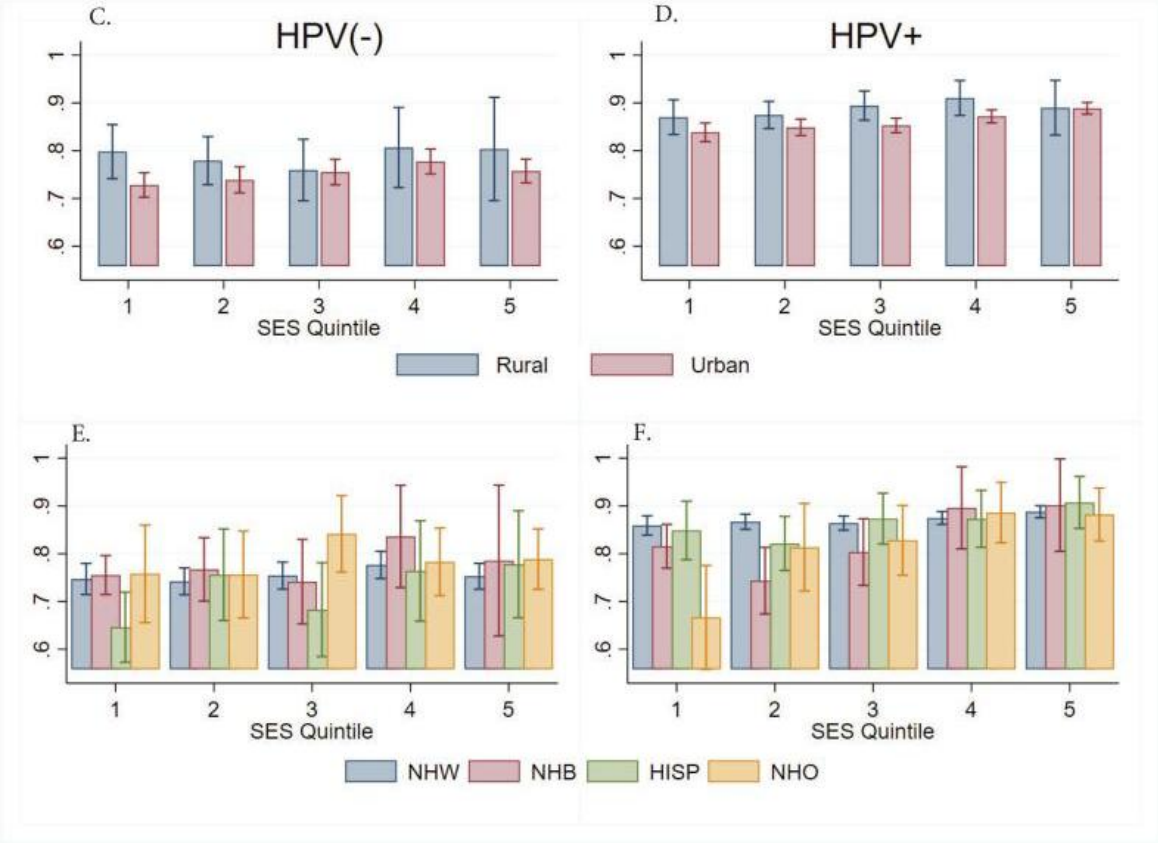
Chen, D., et al. (2021). Cancer Medicine, 10(2), 575–585. https://doi.org/10.1002/cam4.3625

Disparities in Oropharyngeal Cancer Care

Treatment delays of two or more months after diagnosis



Receipt of radiation



Semprini J, Williams JC. Tech Innov Patient Support Radiat Oncol. 2023 Mar 21;26:100205. doi: 10.1016/j.tipsro.2023.100205.

Strategies to eliminate cancer health disparities

- Emphasize studying the causes of disparities in the number of cancer cases and deaths.
- Tackle factors that prevent successful outcomes in underserved populations at each step of cancer care, from prevention through survivorship.
- Engage communities in cancer education and promote structural changes that increase prevention and early detection.
- Improve health literacy by developing culturally relevant education programs that encourage community wellness.
- Ensure that every person benefits from cancer research and clinical advancements.
- Support strategic efforts to increase representation of all populations in cancer research.

https://nationalcancerplan.cancer.gov/goals/eliminate-cancer-health-disparities

National Cancer Plan

Thank You

Questions?