RISCC

1. HPV DNA testing should be used as a primary test

Large, randomised trials from the RISCC consortium and from other research groups have documented **large differences in cancer risk among women receiving normal cytology results** and women receiving a negative HPV test. **The combination of HPV testing and cytology is inefficient** because the risk of women who co-test as negative is only a little lower than HPV testing alone while co-testing is substantially more expensive. **In regions where screening is still based on cytology, we recommend changing to screening with HPV testing only.** The effectiveness and efficiency of cytology triage for HPV-positive women (the most applied triage method in current HPV-based screening programmes) should be carefully monitored.

2. Gender-neutral vaccination accelerates HPV elimination

When the HPV vaccine is offered **to boys and girls** (gender-neutral vaccination), **HPV is eliminated more quickly**. In populations in which HPV is eliminated or nearly eliminated, more effective screening programs can be used.

3. HPV test can determine your cervical cancer risk

The HPV test provides much more information than just positive/negative. Depending on the type of virus and if it is a new or old infection, the risk may differ several hundred-fold. Thus, a simple HPV screening history can determine a woman's risk profile and her need for further screening.

4. Management of lesions in vaccinated populations

Most **cervical lesions in HPV-vaccinated populations** contain non-vaccine HPV types that have a **low risk of progression to cancer**. In such cases, a conservative approach (monitoring/follow-up) can be used instead of immediate treatment.

risk-based screening for cervical cancer

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5. Screening intensity in vaccinated populations

Vaccination reduces the risk of cervical cancer as well as of developing precursor lesions with high progressive potential. Thus, in vaccinated populations, it should be possible to switch from the **"one size fits all" screening** where everyone in a population is offered screening at regular intervals (regardless if needed or not) and instead use **risk-based screening** in which the cancer risk of the woman is determined based on her age, screening history, and other relevant factors.

6. Risk-based screening

Simple consideration of the results of previous screening tests and of the HPV prevalence in the population (if not known, the coverage of HPV vaccination or individual HPV vaccination status can be used to infer how much HPV is left) can be used to **tailor personalised, more effective screening programmes**. For example, RISCC investigators found that a majority of cervical cancers arise from just 3% of the women in the population, implying that effective targeting of these women with HPV screening should provide a more effective and less costly screening program.

7. Self-sampling

HPV self-sampling tests have a similar performance to samples collected by healthcare professionals, both regarding the sensitivity to detect cervical precancer but also in the specificity of identifying women without cervical lesions, under the condition of using validated PCR-based HPV assays. Standardised procedures should be followed with respect to collection, transport, storage, and handling of self-samples in the laboratory. **Self-sampling helps to increase the proportion of the screened population** (also in remote or underserved areas), is less costly, and is more convenient for the women being tested. **Screening programmes should set up pilots** before general roll-out of self-sampling strategies to select effective systems.

RISCC

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For more information about the project, visit our website:

www.riscc-h2020.eu