Partial update: NCSP-CCA cervical cancer screening guideline

Public consultation submission register

20–30 August 2020

Contents

Public consultation of the partial update was held between 20–30 August 2020. Submissions were received online (using the wiki comment function) and via emails to guidelines(at)cancer.org.au.

Where it is noted throughout this register as “Text revised”, unless otherwise stated, the reader should be aware text was revised within the section at which the comment is listed.

We thank all individuals and organisations for their considered feedback and positive engagement with the Public Consultation process to assist with the development of these guidelines.

Cancer Council Australia

Consultation Submissions Received

List of parties that made a submission are noted below. There were 11 parties responding in total and 28 comments received. Comments have been de-identified.

Submissions register	
Individual/organisation	**Confidentiality**
Dr Tracey Lu, Capital Pathology, ACT	**None**
Anonymous	**Yes**
Dr Ganendra Raj Kader Ali on behalf of WA Cancer and Palliative Care Network (WACPCN)	**None**
Anonymous	**Yes**
Anonymous	**Yes**
Sullivan Nicolaides Cytology	**None**
Dr Ayman Shenouda (Acting President) on behalf of Royal Australian College of General Practitioners	**None**
Dr Vanessa Obers, Pathologist | Anatomical Pathology Department, Director, Cytopathology. Histopathologist/Cytopathologist, Melbourne Pathology	**None**
Dr Debra Graves, Chief Executive Officer, Royal College of Pathologists of Australasia	**None**
Rossemarie Ramirez-Avalos, A/Medical Scientist in Charge, Cytopathology, QEII Medical Centre	**None**
Dr. Jeffrey Tan, Royal Women's Hospital	**None**

Public Consultation Submissions

General comments

#	Submission	Working Party consideration	Outcome
B1	As a representative of the WA Cancer and Palliative Care Network (WACPCN) I would like to say we fully support the changes being made in the National Cervical Screening Guidelines. It is clear that the working committee is making these changes based on the data extracted from the recent Australian experience.	Noted with thanks	None
C1	**General comments regarding proposed intermediate pathway changes** As a general comment, whilst in principle this appears to be a beneficial change, it is believed that these amendments will lead to an increase in complexity, workload and risk, with greater opportunity for deviation from the recommended pathway.	Noted with thanks	Implementation issues highlighted here will be addressed in *"Health system implications of these recommendations"*
G1	While the laboratory is in favour of the updated guidelines which will safely alleviate the pressure on the colposcopy services, a significant concern regarding this update lies with the NCSR and their ability to adequately effect and negotiate these amended recommendations within their algorithms. Currently there are still deficiencies in the NCSR with backlogs of several months for colposcopy data which affects the laboratory's ability to give the appropriate recommendations. They have also demonstrated poor agility and adaptability with a user portal that is almost 2 years overdue which results in considerable frustration for clinicians who are not able to access screening histories and therefore order inappropriate tests. This further leads to women incurring out of pocket costs and downstream accounting problems for the laboratories for tests performed outside of the guidelines and is a significant impost on the laboratory with a large amount of time consumed by staff chasing up the current guideline exceptions and variations. Unless these concerns are adequately addressed, the ability of the laboratory to deliver an effective service will be impacted and the current shortcomings of the NCSP and NCSR and will be compounded.	Noted with thanks. Comments concerning the operation of the NCSR will be passed along to the DoH.	Implementation issues highlighted here will be addressed in *"Health system implications of these recommendations"*
G3	Another concern is regarding the education of doctors, women and laboratories. This needs to be real time education and not merely via a website. The renewed cervical screening program is almost 2 years old and there are a number of clinicians who remain confused as to which test to order and when to order a rebateable test. The onus of education does not principally lie with the laboratory. Any patient and doctor education issued by the laboratory should be complementary to that issued by the Department of Health.	This is a dissemination and implementation activity.	Implementation issues highlighted here will be addressed in *"Health system implications of these recommendations" and comments passed to the DoH*

Specific comments

Oncogenic HPV types not 16/18

Authors: Marion Saville, Karen Canfell, Megan Smith

#	Sub section within page	Comment	Working Party consideration	Outcome
A5	Review of NCSP data	**Comment on decision regarding age (<50 vs >50)** It is surprising and a little disturbing to see evidence presented and then immediately discounted. Data from our own new program (in Table 6.3) shows that women over 50 years of age have lower rates of HSIL and cancer after two 'intermediate' risk CST results, than do women under 50. Further, there is also published evidence from our program to support this. Please see: Farnsworth et al 'Detection of high-grade cervical disease among women referred directly to colposcopy following a positive HPV screening test varies with age and cytology findings', International Journal of Cancer 2020. https://doi.org/10.1002/ijc.33128 If the program is to be based on evidence, this age differential should not be part of the guidelines.	Review of data from the Farnsworth paper against NCSR data has been undertaken. This decision to continue to refer women aged 50+ related to concern that given the difficulty in visualising the entire TZ in this age group, the cross sectional assessment carried out, using NCSR data, may be underestimating the true rate of disease.	Review of data from Farnsworth paper against NCSR data undertaken.
C2	Evidence update (non-systematic review) New flowchart	The inclusion of women who identify as being of Aboriginal or Torres Strait Islander descent as a group of women that may be at higher risk of harbouring a high-grade abnormality does not appear to be supported by evidence. Consideration should be given as to whether the inclusion of this group is targeted and discriminatory. In the absence of evidence, it's suggested that this group be removed from the 'higher risk' classification.	There is evidence that women who identify as being of Aboriginal or Torres Strait Islander descent bear a disproportionate burden of cervical cancer incidence and mortality (AIHW), are at higher risk of having a high-grade abnormality detected (Whop et al, Cancer 2016) and are less likely to received colposcopy in the recommended timeframe following a recommendation in the pre-renewal program (Whop et al). This has been cited to strengthen the basis for inclusion as a group at higher risk of high-grade abnormality within '*Review of NCSP data*'.	Text revised and additional evidence cited to support inclusion as a group at higher risk of high-grade.
D2	Evidence update (non-systematic review) New flowchart / Recommendations / Tables	**Persisting HPV (not 16/18)/Intermediate pathway - overall comments** Regarding new **REC 6.B**: • This list of exceptions adds yet another layer of difficulty and complexity for reporting laboratories. Should this be made official, the NSCP guidelines must stipulate who is responsible (i.e. referrers or reporting labs) for ensuring this pathway is followed accurately, particularly as clinical information may be incomplete. Is the NCSR capable of knowing when a patient is currently immunocompromised, for example, if this hasn't been provided to the laboratory by the referrer?	Beyond the scope of the guideline, comment is related to issues with NCSR.	Implementation issues highlighted here will be addressed in *"Health system implications of these recommendations"*

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		• The data provided in **table 6.3** indicates that women over 50 under these circumstances are actually at lower risk that patients under 50, so the reasoning for this is unclear. We also note that patients over 70 that may form part of this population (? - unpublished data) will still be referred to colposcopy when HPV (not 16/18) positive (**REC6.17**).	This decision related to concern that given the difficulty in visualising the entire TZ in this age group, the cross sectional assessment carried out, using NCSR data, may be underestimating the true rate of disease. This has been made clearer in sections *'Evidence update (non-systematic review)*' and '*Review of NCSP data*'.	Text revised. Guidelines explicitly note groups of women who fall outside these guidelines and link to the specific chapters for them.
		• DES exposed patients are still recommended to have a colposcopy every year (**REC 17.1**) and are referred to colposcopy for any abnormality anyway (**REC 17.2**) , so including them into a new and more complex pathway may not be of much benefit.	Thanks for bringing this to our attention, agreed The exception has been removed from updated flowchart 6.1.	Flowchart revised.
		• Immuno-suppressed patients are already referred to colposcopy for a positive HPV (not 16/18) test (**REC 16.2**).	Thanks for bringing this to our attention, agreed. The exception has been removed from updated flowchart 6.1.	Flowchart revised.
D1	Evidence update (non-systematic review) New flowchart	**<u>Persisting HPV (not 16/18)/Intermediate pathway - overall comments</u>** Recommendations in general for persisting HPV (not 16/18) and/or p/LSIL - clarification is required in other situations: • Persisting HPV (not 16/18) in test-of-cure patients: The first line of the NCSP wiki section on the test-of-cure protocol states that women who have been treated for HSIL 'have an elevated risk of recurrence for 10-25 years', yet the guidelines for persisting HPV non 16/18 in these patients recommend only offering colposcopy for 'anxious' patients with fluctuating results (**REC10.10**). If these patients have an 'elevated risk' – should (new) **REC6.C** or something similar also apply to these patients after three positive tests?	We agree, that there are inconsistencies between the recommendations in this section (prior to and after the changes) with recommendations for women currently undergoing test-of-cure (**Rec 10.10 and 10.11**). We also note that management of women with recent histologically-confirmed LSIL who have equivalent test results (non-16/18 positive, LBC neg/pLSIL/LSIL) is not clear in **Rec 9.1**. Updates to those sections of the guidelines are out of scope for this update, but we will raise these issues with DoH.	Issue to be raised with DoH. Revision of Rec10.10 and clarification of Rec9.1 to be considered to align with changes to this section.
		• Patients with no oncogenic HPV detected but p/LSIL on LBC: Guidance is needed for reporting CSTs on these patients, as so many LBCs are now being performed for reasons other than a positive HPV result. Should recommendations for these be as for persisting HPV (not 16/18)? Should patients returning after HPV (not 16/18) detection with a follow-up HPV test that is negative but where a co-test was performed (for symptoms, for example) and that now have p/LSIL be referred to colposcopy? • Guidance is also needed for laboratories on the recommendations that should be given when patients do not go to colposcopy, or no colposcopy	Beyond the scope of the guideline. Management of women who present with symptoms is dealt with in section 18 of the guideline. Management of women with a co-test for another reason (eg test of cure) is also described elsewhere and out of scope for this update. Women returning after HPV (not 16/18) detection, initially classified as intermediate risk and with no other indication for co-testing (within scope of this	Comments have been shared with the Department of Health.

#	Sub section within page	Comment	Working Party consideration	Outcome
		results are available, no histology appears to be performed, and they return with a negative follow up HPV test.	section) are recommended to be managed on the basis of the negative HPV test (**Rec 6.9**).	
F1	New flowchart	The algorithm that is outlined in this update is a complicated tool to follow and there is, therefore, a risk that mistakes could be made and some women at higher risk may be overlooked. It may be more effective if the algorithm were simplified and all women with persistent HPV oncogenic types (not 16/18) on their 12 month-repeat test be referred for colposcopy. While this is likely to result in slightly more colposcopies, this may be balanced out against the risk that some women at higher risk 'fall through the cracks' because of information gaps or errors in interpreting the algorithm. If not already done so, we recommend the Cancer Council give the above serious consideration.	Clinical feedback [strongly/significantly?] indicated that the current pathway is overwhelming colposcopy demand for very little benefit in terms of CIN2+/AIS detection. Following feedback from other **[public consultation submissions?]**, the removal of the exception for immune-deficient women and DES exposed women is appropriate and will give some relief from the complexity of the pathway. Further the NCSR is expected to support the changed pathway, acting as a safety net, to minimise the risk of women "falling through the cracks"	Guidelines updated to note and refer to specific separate guidelines for some women and clarify that this section of the guidelines does not apply to them, reducing complexity here. (see response to comment D2)
G2	New flowchart	The updated intermediate risk guidelines are too complex with too many exceptions and are very likely to result in further erroneous follow up letters from the NCSR. Erroneous follow up letters are already issued for patients who have achieved a pre-renewal test of cure, in many instances in excess of 20 years with subsequent negative and adequate screening history, an issue acknowledged by the NCSR as a fault within their algorithms.	Clinical feedback [strongly/significantly] indicated that the current pathway is overwhelming colposcopy demand for very little benefit in terms of CIN2+/AIS detection. Following feedback from other [public consultation submissions?], the removal of the exception for immune-deficient women and DES exposed women is appropriate and will give some relief from the complexity of the pathway. Further the NCSR is expected to support the changed pathway, acting as a safety net, to minimise the risk of women "falling through the cracks"	Feedback to DoH regarding erroneous follow-up letters. Complexity has been reduced here by updating guidelines to note and refer to specific separate guidelines for some women previously listed as exceptions here and clarify that this section of the guidelines does not apply to them. (see response to comment D2)
H2	New flowchart	Identifications of clients as being of Aboriginal or Torres Strait Islander poses a difficult task for laboratories as data is not always provided by clinicians. This will only create more demands into the current existing workloads with the possibility of incorrect recommendations for our clients.	Laboratories are required to provide Aboriginal/ Torres Strait Islander identity information to the NCSR, where this is available. This exception in the changed pathway requires laboratories to act on the information available to them from laboratory request forms, it does not require laboratories to contact practitioners for "missing" information.	No change.

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J1	Recommendations	NEW REC6.A: I have no concern with the recommendation for waiting an extra 12-months except for the triage LSIL. [see comment J2]	n/a	n/a
J2	Tables	**Table 6.1** I think your CIN3+ rate is a little low. Your CIN2+ rate for HPV16/18 is ~12%, Farnsworth 2020 for HGA is 18%. This tells me that your criteria for counting CIN2+/CIN3+ may not be catching all of them. **Table 6.2** Moreover, if we are looking at the 2nd CST after an intermediate risk CST, then most would be discounted in 2018 and leave you with 2019. And assuming that overall, an estimated 67% of infections resolve by 12 months (from your wiki statement), then the absolute numbers for you to come up with those CIN3+ rate will be quite a small cohort. What we have seen in our clinic is a much, much higher CIN3+ rate of over 4% for triage LSIL, albeit not all originate from a previous intermediate risk CST as most women seen in 2018 would have an abnormal pap prior. I do not know what % of CIN3+ you use as a criteria for requiring colposcopy, the ASCCP(USA) use 4% threshold. Our data is unpublished and I have asked my Department head to decide if the data can be forwarded to this public consultation.	Thank you for bringing this to our attention. Review of data from the Farnsworth paper against NCSR data has been undertaken, and NCSR data were re-extracted to ensure the most up-to-date and complete outcome data. Table 6.1: The CIN2+ rate for HPV16/18 (18.7-19.5%) is now consistent with what is described here for Farnsworth 2020. Table 6.2: Based on the re-extracted data, the CIN3+ rate for non-16/18+ LBC neg/pLSIL/LSIL is 3.1-3.4%, based on outcome data for approximately 21,000 women. This is still lower than for the groups where colposcopy is recommended. Among women who are 16/18+ at baseline, the subgroup who are LBC negative have a similar risk of CIN3+ as women with two consecutive results of HPV+ (not 16/18) LBC neg/pLSIL/LSIL, women who are 16/18+ LBC negative have a risk of cancer that is more than 10 times higher.The USA (ASCCP) has a lower threshold for colposcopy referral than Australia, as US cytology screening guidelines refer women with a primary cytology result of LSIL to colposcopy. In Australia's cytology program, women with a result of LSIL were referred for 12m follow-up, unless they were aged 30+ and had no recent negative cytology result, in which case there was an option for 6m follow-up or immediate colposcopy. Note that the data from this laboratory would have been included within the updated extract from the NCSR.	Review of data from Farnsworth paper against NCSR data undertaken. NCSR data have been re-extracted to ensure data completeness. Tables 6.1 and 6.2 have been updated; however, implications for management pathway are unaffected.
K1	Recommendations	**Oncogenic HPV types not 16/18 - Comments for HPV non 16/18 pathway review** We support the introduction of **REC 6A** based on the feedback we have received from our local gynaecological groups. Colposcopy clinics are overwhelmed and many patient in this category are experiencing considerable delays in getting colposcopic reviews.	Following feedback from **other [public consultation submissions?]**, the removal of the exception for immune-deficient women and DES exposed women is appropriate and will give some relief from the complexity of the pathway.	Feedback shared with DoH regarding issues with the quality of NCSR data.

#	Sub section within page	Comment	Working Party consideration	Outcome
		However, we have a major concern with the implementation of this new recommendation. **REC 6B** lists a number of exceptions, and this will place a significant burden on laboratory staff to ascertain these details for each patient. It is difficult to obtain this information from either the referring clinician or from the NCSR, and this will result in a significant increase in administration from the laboratory. Our experience shows that when there are exceptions to a recommendation it creates a lot of confusion especially in an already complicated system. There is also increased chance for a patient getting an erroneous recommendation. In order for this to be successful, we would need to rely heavily on the data held by the NCSR. We have significant concerns with the NCSR being able to do this. There are still issues with incomplete histories in the NCSR either with unmatched patient histories or potentially some laboratories not sending all histories into the registry.	Laboratories are required to provide Aboriginal/ Torres Strait Islander identity information to the NCSR, where this is available. This exception in the changed pathway requires laboratories to act on the information available to them from laboratory request forms, it does not require laboratories to contact practitioners for "missing" information. Further the NCSR is expected to support the changed pathway, acting as a safety net, to minimise the risk of women "falling through the cracks".	Guidelines updated to note and refer to specific separate guidelines for some women and clarify that this section of the guidelines does not apply to them, reducing complexity here. (see response to comment D2)
H1	Health systems implications	NCSR data is often incomplete, when obtaining colposcopy results the result is partial. Clinicians do not always provide the most updated data, particularly when clients change clinicians. Inaccurate and partial data pose a risk for incorrect recommendations.	Beyond the scope of the guideline, comment is related to issues with NCSR.	Feedback shared with DoH regarding issues with the quality of NCSR data.
A1	Health systems implications	**Response to intermediate pathway changes - broad comments** We understand the impetus for this change, the evidence behind it and the potential benefits such a change may bring. However we believe there are many factors which have not been addressed and must be acknowledged prior to any implementation. In broad terms, this change will lead to an increase in complexity, workload (especially for laboratories) and opportunity for errors (with potential harm to women) in a program which is still struggling with implementation of the original Renewal changes 2 ½ years after its commencement. Laboratories are truly the 'engine rooms' of the cervical screening program and our concerns should be addressed before major changes are made. In particular, the timeline for this change should be determined in close consultation with pathologists, to enable notification of and discussion with referring practitioners.	Beyond the scope of the guideline; this is a dissemination and implementation activity to be determined by the Department of Health.	Implementation issues highlighted here will be addressed in *"Health system implications of these recommendations"*
A2	Health systems implications	**The following are what we see as the main problems:** For referrers: • There has been little government-led education for GPs regarding the changes of the 'renewed' program. Pathologists have largely filled this void, partly out of a sense that this is a component of our remit and partly out of necessity. Such a change will increase our burden in the education sphere. • Referrers frequently require assistance with individual case management. They rely on us [pathologists] to interpret (often limited) patient histories, the guidelines (which do not cover every clinical scenario) and the inconsistent recommendations produced by the NCSR. A considerable amount of a	Comment noted, Guidelines cannot cover all clinical scenarios but commonly arising scenarios that are not covered could be raised with NCSP for consideration by Guideline review group. Comment regarding inconsistent recommendations from NCSR noted.	Comments have been shared with the Department of Health.

#	Sub section within page	Comment	Working Party consideration	Outcome
		pathologist's daily workload is spent in conversation with GPs about specific cases. Cont. comment A3		
A3	Health systems implications	*(The following are what we see as the main problems:)* A. For laboratories: • Formulating appropriate recommendations for each woman screened is one of our [pathologist's] core tasks and accuracy of each recommendation is vital for the program to function well and for women to be protected. We already struggle with limited and sometimes inaccurate patient histories. Requiring us to obtain accurate information about women's ATSI status, DES exposure and immune status (for example) will add to our workload and create opportunities for discrepant/incorrect recommendations and possible harm to women. • Further to the above, there is a risk that inadvertent errors in recommendations will lead to undermining of referrers' confidence in pathologists and laboratory reports. Cont. comment A4	Laboratories are expected to take account information available to them. There is not an expectation that potentially "missing" information is chased down.	Guidelines updated to note and refer to specific separate guidelines for some women and clarify that this section of the guidelines does not apply to them, reducing complexity here. (see response to comment D2) No other change.
A4	Health systems implications	*(The following are what we see as the main problems:)* B. For the NCSR: • Data collection and data provision, which are the two key functions of the NCSR, are still not occurring at the expected level. If the NCSR is not able to fulfill its functions 2 ½ after the commencement of the program, it is unrealistic to assume there will be no problems if further demands are made of it. Interpretation of guidelines is also an NCSR function. At times when the reporting laboratory and the NCSR interpret the guidelines differently and make different recommendations for individual patients, referrers and women become confused and their confidence in the program falls. This is already occurring - examples include decisions regarding when 'test of cure' is complete after treatment of HSIL and whether a woman with 'intermediate risk' result in the test of cure pathway is ever referred back to colposcopy. Resources could be better utilised fixing the current problems in the NCSR, rather than adding to the problems.	The comments relating to difficulties with the NCSR are noted. Nevertheless, the issues with overwhelming colposcopy demand for very limited benefit require adjustment to the pathway based on emerging evidence after more than 2 years of the renewed NCSP.	No change. Feedback shared with DoH regarding issues with NCSR.
C3	Health systems implications	Further to this [comment C2, pg 3, re: inclusion of women who identify as being of Aboriginal or Torres Strait Islander descent], the collection and recording of Indigenous status and immune deficiency information in general practice, pathology laboratory information systems and the NCSR is not mandated and is therefore inconsistently reported.	All parties, primary care, laboratories and the NCSR have a role to play in improving the identification of women who identify as Aboriginal or Torres Strait Islander in the NCSP in order to support continuous improvement in the availability and acceptability of screening, follow-up and treatment. In turn it would be hoped that will	No change.

#	Sub section within page	Comment	Working Party consideration	Outcome
		Consideration should be given on how this impacts the ability of these services to align and make appropriate recommendations in support of patient management and optimal care pathways.	support closing of the gap in cervical cancer incidence and mortality Laboratories are required to provide Aboriginal/ Torres Strait Islander identity information to the NCSR, where this is available. This exception in the changed pathway requires laboratories to act on the information available to them from laboratory request forms, it does not require laboratories to contact practitioners for "missing" information.	
D3	Health systems implications	**<u>Persisting HPV (not 16/18)/Intermediate pathway - overall comments</u>** We agree with recommendations 6.A and 6.C in principle, but have concerns regarding implementation: • NCSR data is often incomplete and it is virtually impossible to obtain reliable colposcopy data. Without having accurate data, there is a risk of both over-referral and under-referral for colposcopy. Assurance is needed that the NCSR has the ability to identify and follow up these higher risk women who will now have had persisting HPV for longer before being referred. • Education of clinicians is of paramount importance to ensure they refer directly to colposcopy if there is a known relevant history. Even nearly three years into the new program, referrers are still calling our laboratory daily with questions regarding the guidelines and correct follow up. A huge amount of misunderstanding still exists, particularly for low-grade abnormalities (many referrers still request co-tests when following these up, and/or think these patients require the test-of-cure protocol). • Education for referrers is also necessary to ensure they are aware of and understand how to use the new NCSR portal when it becomes available. Many issues arise when patients visit new doctors and verbally give them incorrect (or no) information. Referrers also need to be encouraged to include all relevant clinical information on request forms, especially colposcopy results.	Noted, with thanks.	Implementation issues highlighted here will be addressed in *"Health system implications of these recommendations"*
K2	Health systems implications	The lack of colposcopy data is also a major problem. Until these issues with the NCSR are resolved, it will be very difficult to manage these patients effectively. We also already have problems with the NCSR sending letters to patients for repeat CST collections that are not consistent with the laboratories' recommendations, and upon investigation do not follow the current recommendations laboratories and clinicians are working with, particularly in the areas of test of cure and follow up after colposcopy ie **REC 9.1.** Contact with the NCSR indicates there are issues with the algorithms (which also don't allow for clinical interpretations) the NSCR uses in these	Beyond the scope of the guideline, comment is related to issues with NCSR.	No change. Comments relating to NCSR will be passed to DoH

#	Sub section within page	Comment	Working Party consideration	Outcome
		scenarios. These incongruities between the laboratory and NCSR recommendations is creating a situation where the result from the laboratory is undermined and clinicians and patients ultimately lose confidence in the cervical screening program when they are not sure which recommendation to follow. Again, we are not confident the NSCR is going to be able to be able to cope with more changes to recommendations when we are already experiencing so many issues.		
K3	Health systems implications	Education of GPs and specialists would also need to happen before these changes come into effect, and how would this occur? So far the education of clinicians has fallen to the laboratories, however this needs to be a much more coordinated and central function by the probably the RACGP &/or RANZCOG. The program guidelines are so complicated that a number of clinicians are still confused even 2 ½ years after implementation. Any further changes need to be thoroughly communicated, and educational sessions run, to ensure the success of any future change.	Noted, with thanks. Beyond the scope of the guideline, this is a dissemination and implementation activity.	Implementation issues highlighted here will be addressed in *"Health system implications of these recommendations"*

Self-collected vaginal samples

Authors: Marion Saville, Karen Canfell, Megan Smith

#	Sub section within page	Comment	Working Party consideration [response from CCA/lead author]	Outcome
F2	General	Self-collected samples should not be restricted to particular groups and should be the patient's choice. Follow up sampling for patients who test positive for HPV should preferably be physician collected. A self-collected sample would be satisfactory to use if physician collection is not available. However, this may mean the patient is more likely to require a colposcopy.	This change is the subject of a separate policy review being undertaken by the Commonwealth.	No change.

Editorial comments

#	Sub section within page	Comment	Outcome
1	General	Suggest replacing 'National Cervical Screening Register' with 'National Cancer Screening Register'.	Typo corrected.
C3	General	It's suggested that a clear definition of 'immune deficient' (in the context of the clinical guidelines) be added to relevant chapters as well as the glossary.	This section of the guidelines has been updated to note that management of immune-deficient women is described in a separate section, users are referred to the relevant section (18), which includes a definition of immune-deficient.