CATEGORY: BEST PRACTICE

The Royal Australian and New Zealand College of Obstetricians and Gynaecologists
Excellence in Women's Health

Vaginal screening after hysterectomy in Australia

This statement has been developed and reviewed by the Women's Health Committee and approved by the RANZCOG Board and Council.

A list of Women's Health Committee Members can be found in Appendix A.

Disclosure statements have been received from all members of this committee.

Disclaimer This information is intended to provide general advice to practitioners. This information should not be relied on as a substitute for proper assessment with respect to the particular circumstances of each case and the needs of any patient. This document reflects emerging clinical and scientific advances as of the date issued and is subject to change. The document has been prepared having regard to general circumstances.

First endorsed by RANZCOG: November 2010
Current: March 2020
Review due: March 2023

Objectives: To provide advice on vaginal screening after hysterectomy.

Target audience: Health professionals providing gynaecological care.

Values: The evidence was reviewed by the Women's Health Committee (RANZCOG), and applied to local factors relating to Australia.

Background: This statement was first developed by Women's Health Committee in November 2010 and reviewed in March 2020.

Funding: This statement was developed by RANZCOG and there are no relevant financial disclosures.

1. Introduction

In December 2017, the National Cervical Screening Program in Australia changed from 2 yearly cervical cytology testing to 5 yearly primary HPV screening with reflex liquid-based cytology for those women in whom oncogenic HPV is detected in women aged 25–74 years.

New Zealand has not yet transitioned to primary HPV screening. Guidance for New Zealand practice is provided in a separate document informed by the Ministry of Health's Guidelines for Cervical Screening in New Zealand[2]. Once HPV screening is adopted RANZCOG will review the screening guidelines with the aim of producing a single guideline covering both New Zealand and Australia.

Recommendations on vaginal screening after hysterectomy for the Australian population have largely been informed by data based on cytology obtained from the vaginal vault and from limited data on co-testing with HPV partial genotyping and vaginal vault cytology.

The Australian National Cervical Screening Program provides guidance on the role of vaginal screening after hysterectomy that are available via the following link https://wiki.cancer.org.au/australia/Clinical_question:Screening_after_total_hysterectomy

A summary of recommendations from these guidelines is listed below.

2. Summary of recommendations

2a. Following total hysterectomy [1]

Recommendation 1	Grade
Total hysterectomy for benign disease Women with a normal cervical screening history, who have undergone hysterectomy for benign disease (e.g. menorrhagia, uterine fibroids or utero-vaginal prolapse), and have no cervical pathology at the time of hysterectomy, do not require further screening or follow up.	Consensus-based recommendation
Recommendation 2	**Grade**
Total hysterectomy after completed Test of Cure Women who have had a total hysterectomy with no evidence of cervical pathology, have previously been successfully treated for histologically confirmed HSIL and have completed Test of Cure, do not require further follow-up. These women should be considered as having the same risk for vaginal neoplasia as the general population who have never had histologically confirmed HSIL and have a total hysterectomy. If unexpected LSIL or HSIL is identified in the cervix at the time of hysterectomy, then these women require follow-up with an annual co-test on a specimen from the vaginal vault until they have a negative co-test on two consecutive occasions.	Consensus-based recommendation

Recommendation 3	Grade
Total hysterectomy after adenocarcinoma in situ (AIS) Women who have had a total hysterectomy, have been treated for AIS, and are under surveillance, should have a co-test on a specimen from the vaginal vault at 12 months and annually thereafter, indefinitely.† Women who have a total hysterectomy, as completion therapy or following incomplete excision of AIS at cold-knife cone biopsy or diathermy excision, should have a co-test on a specimen from the vaginal vault at 12 months and annually thereafter, indefinitely. † Until sufficient data become available to support cessation of testing	Consensus-based recommendation
Recommendation 4	**Grade**
Total hysterectomy for treatment of high-grade CIN in the presence of benign gynaecological disease Women who have had a total hysterectomy as definitive treatment for histologically confirmed HSIL in the presence of benign gynaecological disease, irrespective of cervical margins, should have a co-test on a specimen from the vaginal vault at 12 months after treatment and annually thereafter until the woman has tested negative by both tests on two consecutive occasions. After two annual consecutive negative co-tests, the woman can be advised that no further testing is required.	Consensus-based recommendation
Recommendation 5	**Grade**
Total hysterectomy after histologically confirmed HSIL without Test of Cure Women who have been treated for histologically confirmed HSIL, are under surveillance or have returned to routine screening without Test of Cure, and have had a total hysterectomy with no evidence of cervical pathology, should have a co-test on a specimen from the vaginal vault at 12 months and annually until the woman has tested negative on two consecutive occasions. After two annual consecutive negative co-tests, the woman can be advised that no further testing is required.	Consensus-based recommendation
Recommendation 6	**Grade**
Total hysterectomy and no screening history Women who have had a total hysterectomy with no evidence of cervical pathology, and whose cervical screening history is not available, should have a HPV test on a specimen from the vaginal vault at 12 months and annually thereafter until they have a negative HPV test on two consecutive occasions. After two annual consecutive negative HPV tests, women can be advised that no further testing is required.	Consensus-based recommendation

Recommendation 7	Grade
Colposcopy referral for any positive co-test result following total hysterectomy Women who have had a total hysterectomy and are under surveillance with co-testing, and have a positive oncogenic HPV (any type) test result and/or any cytological abnormality, should be referred for colposcopic assessment.	Consensus-based recommendation
Recommendation 8	**Grade**
Vaginal bleeding following total hysterectomy Women who have vaginal bleeding† following total hysterectomy should be assessed by their GP or gynaecologist, regardless of the results of any surveillance tests. †Vaginal bleeding is quite common in the early weeks following hysterectomy and, where appropriate, should be investigated by the treating gynaecologist.	Consensus-based recommendation
Recommendation 9	**Grade**
Total hysterectomy after genital tract cancer Women who have been treated for cervical or endometrial cancer are at risk of recurrent cancer in the vaginal vault. These women should be under ongoing surveillance from a gynaecological oncologist. Therefore, they will be guided by their specialist regarding appropriate surveillance and this is outside the scope of these guidelines.	Consensus-based recommendation

2b. Following Subtotal hysterectomy

Recommendation 10	Grade
Subtotal hysterectomy Women who have undergone subtotal hysterectomy (the cervix is not removed) should be invited to have 5-yearly HPV testing in accordance with the recommendation for the general population. Any detected abnormality should be managed according to these guidelines.	Consensus-based recommendation

3. References

1. Cancer Council Australia, Chapter 13. Screening after total hysterectomy https://wiki.cancer.org.au/australia/Clinical_question:Screening_after_total_hysterectomy

2. Ministry of Health's Guidelines for Cervical Screening in New Zealand. https://www.nsu.govt.nz/system/files/resources/guidelines_for_cervical_screening_in_new_zealand-may19.pdf

4. Links to other College statements

Cervical Cancer Screening in Australia (C-Gyn 19)
https://www.ranzcog.edu.au/RANZCOG_SITE/media/RANZCOG-MEDIA/Women%27s%20Health/Statement%20and%20guidelines/Clinical%20-%20Gynaecology/Cervical-Cancer-Screening-in-Australia-(C-Gyn-19)-Jul-2014.pdf?ext=.pdf

Guidelines for referral of investigation of intermenstrual and postcoital bleeding (C-Gyn 06)
https://ranzcog.edu.au/RANZCOG_SITE/media/RANZCOG-MEDIA/Women%27s%20Health/Statement%20and%20guidelines/Clinical%20-%20Gynaecology/Investigation-of-intermenstrual-and-postcoital-bleeding(C-Gyn-6)-March-2018.pdf?ext=.pdf

Evidence-based Medicine, Obstetrics and Gynaecology (C-Gen 15)
https://www.ranzcog.edu.au/RANZCOG_SITE/media/RANZCOG-MEDIA/Women%27s%20Health/Statement%20and%20guidelines/Clinical%20-%20General/Evidence-based-medicine,-Obstetrics-and-Gynaecology-(C-Gen-15)-Review-March-2016.pdf?ext=.pdf

5. Patient information

A range of RANZCOG Patient Information Pamphlets can be ordered via:

http://www.ranzcog.edu.au/publication/womens-health-publications/patient-information pamphlets.html

Appendices

Appendix A Women's Health Committee Membership

Name	Position on Committee
Professor Yee Leung	Chair and Board Member
Dr Gillian Gibson	Deputy Chair, Gynaecology
Dr Scott White	Deputy Chair, Obstetrics and Subspecialties Representative
Associate Professor Ian Pettigrew	Member and EAC Representative
Dr Kristy Milward	Member and Councillor
Dr Will Milford	Member and Councillor
Dr Frank O'Keeffe	Member and Councillor
Professor Steve Robson	Member
Professor Sue Walker	Member
Dr Roy Watson	Member and Councillor
Dr Susan Fleming	Member and Councillor
Dr Sue Belgrave	Member and Councillor
Dr Marilyn Clarke	ATSI Representative
Associate Professor Kirsten Black	Member
Dr Thangeswaran Rudra	Member
Dr Nisha Khot	Member and SIMG Representative
Dr Judith Gardiner	Diplomate Representative
Dr Angela Brown	Midwifery Representative, Australia
Ms Adrienne Priday	Midwifery Representative, New Zealand
Ms Ann Jorgensen	Community Representative
Dr Rebecca Mackenzie-Proctor	Trainee Representative
Dr Leigh Duncan	Maori Representative
Prof Caroline De Costa	Co-opted member (ANZJOG member)
Dr Christine Sammartino	Observer

Appendix B Overview of the development and review process for this statement

i. Steps in developing and updating this statement

This statement was originally developed in November 2010 and was most recently reviewed in March 2020. The Women's Health Committee carried out the following steps in reviewing this statement:

- Declarations of interest were sought from all members prior to reviewing this statement.
- Structured clinical questions were developed and agreed upon.
- An updated literature search to answer the clinical questions was undertaken.
- At the November 2019 face-to-face meeting, the existing consensus-based recommendations were reviewed and updated (where appropriate) based on the available body of evidence and clinical expertise. Recommendations were graded as set out below in Appendix B part iii)

ii. Declaration of interest process and management

Declaring interests is essential in order to prevent any potential conflict between the private interests of members, and their duties as part of the Women's Health Committee.

A declaration of interest form specific to guidelines and statements was developed by RANZCOG and approved by the RANZCOG Board in September 2012. The Women's Health Committee members were required to declare their relevant interests in writing on this form prior to participating in the review of this statement.

Members were required to update their information as soon as they become aware of any changes to their interests and there was also a standing agenda item at each meeting where declarations of interest were called for and recorded as part of the meeting minutes.

There were no significant real or perceived conflicts of interest that required management during the process of updating this statement.

iii. Grading of recommendations

Each recommendation in this College statement is given an overall grade as per the table below, based on the National Health and Medical Research Council (NHMRC) Levels of Evidence and Grades of Recommendations for Developers of Guidelines. Where no robust evidence was available but there was sufficient consensus within the Women's Health Committee, consensus-based recommendations were developed or existing ones updated and are identifiable as such. Consensus-based recommendations were agreed to by the entire committee. Good Practice Notes are highlighted throughout and provide practical guidance to facilitate implementation. These were also developed through consensus of the entire committee.

Recommendation category		Description
Evidence-based	A	Body of evidence can be trusted to guide practice
	B	Body of evidence can be trusted to guide practice in most situations
	C	Body of evidence provides some support for recommendation(s) but care should be taken in its application
	D	The body of evidence is weak and the recommendation must be applied with caution
Consensus-based		Recommendation based on clinical opinion and expertise as insufficient evidence available
Good Practice Note		Practical advice and information based on clinical opinion and expertise

Appendix C Full Disclaimer

This information is intended to provide general advice to practitioners, and should not be relied on as a substitute for proper assessment with respect to the particular circumstances of each case and the needs of any patient.

This information has been prepared having regard to general circumstances. It is the responsibility of each practitioner to have regard to the particular circumstances of each case. Clinical management should be responsive to the needs of the individual patient and the particular circumstances of each case.

This information has been prepared having regard to the information available at the time of its preparation, and each practitioner should have regard to relevant information, research or material which may have been published or become available subsequently.

Whilst the College endeavours to ensure that information is accurate and current at the time of preparation, it takes no responsibility for matters arising from changed circumstances or information or material that may have become subsequently available.