The Case for PAP-HPV Co-testing: A Conservative Approach is Warranted and More

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A recent study of cervical cancer screening among 256,648 women has supported the superiority of Pap HPV testing [3]. Of the 526 cancers detected, HPV testing alone would have missed 18.6% and cytology alone 12.2%. Although this study involved Digene Hybrid Capture and not the Roche Cobas test, there were a surprising number of false negative HPV tests are sufficiently common to undermine its role as a primary testing method. The practice implications of these recent studies is that cotesting is the more sensitive approach overall.

Beyond these issues, this controversy is reflective of a recent trend in laboratory medicine. When new technologies are developed, there is often a rush to implement a more expensive test for a somewhat limited increased patient benefit, but with great benefit to venture capital investors. The original benefit of the conventional Pap smear was its low cost and the ease of screening large populations. Thin layer technology has improved screening practice both by clearing an obscuring background and drying artifact and providing a platform for HPV and other STD testing. Automated screening adds additional costs which are balanced by increased "through put" by cytotechnologists under commercial pressure to increase profits. In recent years even cytotechnologists and pathologists have even invested in these new biotech companies, clearly a potential conflict of interest.

Much of this is done in the name of decreasing health care costs and the morbidity of unnecessary colposcopy. While these are desirable goals, cotesting remains the most sensitive screening approach at the present time and is likely to remain so until an HPV vaccine covering all oncogenic types is developed.

What is lost in this discussion is the fact that the best way to increase early detection of cervical precancer and cancer in the United States is the extension of the simple Pap test to those women at high risk in underserved populations. While it is appropriate to increase the sensitivity of any cancer screening test, twenty per cent of American women are not being screened at all! The increase of the age of initial screening to 25 across the board ignores the fact that invasive cancer does occur in women in their early 20s in high risk populations. Similarly, the increase in the screening interval from one to three or even five years assumes universal health care where all women are covered and reliably followed as in the United Kingdom and the Netherlands. In underserved US populations coverage is often haphazard and the abolition of the annual Pap test will probably mean that women are screened less often than even three years. Although Obamacare has greatly reduced the number of the uninsured, true universal health care remains elusive in the US. It is sad that there is so much investment in refining screening methods for the insured while high risk uninsured women are not screened. Federal regulators and health care policy makers need to keep their eye on the prize which is the health and welfare of the all American women.

References