Cervical Screening
GP Update, 2025

Frequently Asked Questions, with Dr Simone Gonzo

Q: How will I know when "no further screening" is required?
A: The NCSR will show "screening complete/no further screening required" where appropriate, and your PMS NCSR alert will clear. For ≥70s, discuss optional ongoing screening despite formal exit.

Q: My patient received a letter 1–2 months early. If I screen now, will they be billed?
A: Potentially, yes. Letters have occasionally arrived early. Check NCSR, and if truly early, either (a) set recall for the correct date, or (b) hand them a labelled self-collect kit with the "earliest date" written on it. That avoids out-of-pocket billing.

Q: The patient is symptomatic (bleeding/discharge) but not yet due. Is it still funded?
A: Yes. That becomes diagnostic testing, not screening. Mark the request "symptomatic" and describe the clinical scenario to ensure appropriate funding.

Q: Do HPV-vaccinated patients follow different rules?
A: No. Screening pathways are the same regardless of vaccination. Vaccination reduces population risk, but we still test for HPV presence first, then act.

Q: Should I recommend Gardasil after a positive CST?
A: Usually no meaningful benefit at that point (and likely not funded). Consider immunocompromised adults without prior vaccination on a case-by-case basis.

Q: Is self-collection as good as clinician-collection?
A: For HPV detection, yes — equivalent accuracy when the sample is collected according to the instructions. If HPV is detected, the lab/clinician can add LBC as needed.

Q: Patient didn't come back for LBC after HPV (not 16/18) on self-collect. What now?
A: At 9 months, a self-collect can be used to check for clearance. If it's negative, the patient is returned to routine interval; if positive, continue per algorithm or refer as indicated.

Q: What exactly changed in Test-of-Cure after HSIL?
A: Use annual HPV test only (self-collect acceptable). Three consecutive annual HPV-positive results → colposcopy. Mark pathology request forms "test-of-cure".

Q: How do I follow AIS after treatment (with or without hysterectomy)?
A: Annual co-test; any abnormality → colposcopy. After 5 years of annual negatives → 3-yearly. After 25 years of negatives (<70) → routine / (≥70) may exit.

Q: Post-hysterectomy surveillance — simple rule?
A: *Prior AIS:* Annual co-test until 2 negatives, then stop for that indication.
No HSIL/AIS and normal histology: No further testing needed.

Q: Who is "immunodeficient" for the shorter interval?
A: HIV, solid organ or stem-cell transplant, active haematological malignancy, primary immunodeficiency; consider those on high-dose steroids/DMARDs/biologics. Screen 3-yearly; any HPV → colposcopy.

Q: When do I refer for colposcopy right away?
A: HPV 16/18 (regardless of cytology); abnormal cytology; persistent HPV on three annual TOC tests; any HPV in immunodeficient patients.

Q: Patients ≥70 asking to continue — okay?
A: Yes. Although eligible to exit, they can continue 5-yearly screening if preferred. Discuss utility vs burden; still funded within program rules.

Where to next

For further learning, explore...
🎓 Our short CPD **Micro-Course** in cervical screening;
🎓 Or dive deeper with our university-assured, structured **Certificate Course** pathway in Women's Health.
🌐 **www.healthcert.com/wom**