

# *Enhancing Early Detection: The Latest in Cancer Screening*

Wednesday 12th March 2025

*The content in this session is valid at date of presentation*



Australian Centre  
for the Prevention of  
Cervical Cancer



**Cancer  
Council**

## *Acknowledgement of Country*

North Western Melbourne Primary Health Network would like to acknowledge the Traditional Custodians of the land on which our work takes place, The Wurundjeri Woi Wurrung People, The Boon Wurrung People and The Wathaurong People.

We pay respects to Elders past, present and emerging as well as pay respects to any Aboriginal and Torres Strait Islander people in the session with us today.



# *Victorian Cancer Screening Framework Initiative*



Australian Centre  
for the Prevention of  
Cervical Cancer



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**phn**  
VICTORIAN-TASMANIAN  
ALLIANCE

An Australian Government Initiative



This webinar was supported by the Victorian Government.

# Housekeeping – Zoom Webinar

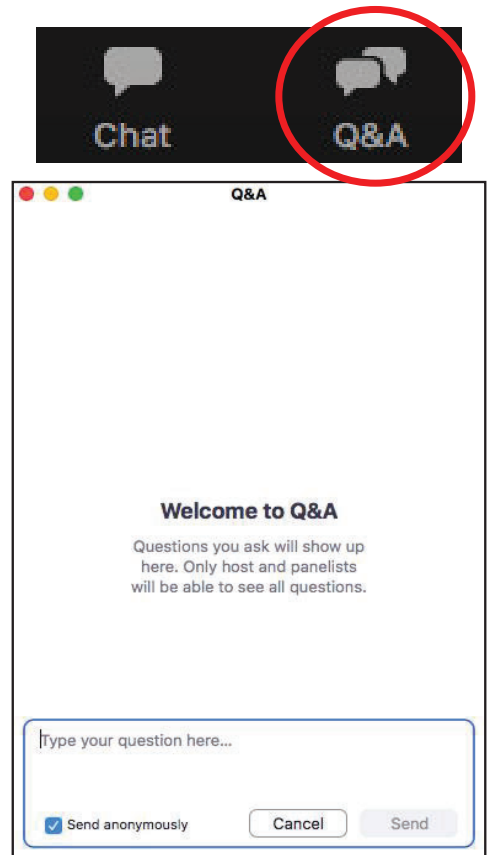
All attendees are muted

Please ask questions via the Q&A box only

Q&A will be at the end of the presentation

This session is being recorded, you will receive a link to this recording and copy of slides in post session correspondence.

Questions will be asked anonymously to protect your privacy



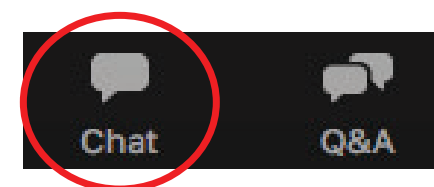
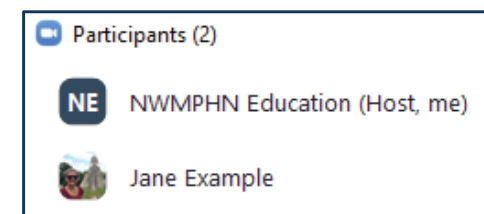


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If you are not sure if your name matches, please send a Chat message to 'NWMPHN Education' to identify yourself.



## Speakers

### *Professor Marion Saville, Australian Centre for the Prevention of Cervical Cancer*

**Professor Marion Saville** is an anatomical pathologist and has been Executive Director of the Australian Centre for the Prevention of Cervical Cancer since 2000. She currently chairs the working group to review Australia's Guidelines for the management of screen-detected abnormalities in the National Cervical Screening Program. Marion was appointed as a member of the Order of Australia on Australia Day 2020 for her significant service to women's health through cervical screening initiatives.

### *A/Prof Justin Tse, University of Melbourne*

**Associate Professor Justin Tse** is a practicing general practitioner at Doctors of Ivanhoe and an academic specialist in the Department of General Practice and Primary Care at the University of Melbourne. He also holds appointments with the Victorian Comprehensive Cancer Centre and Cancer Council Victoria. Justin completed his research degree in prostate cancer and is involved in research with the Cancer in Primary Care Team at the University of Melbourne. He has a specific focus on bowel cancer screening, prevention and early detection.

### *Mr John Lee, Telstra Health*

**John Lee** is the Head of Engagement and Communications for the National Cancer Screening Register at Telstra Health. He joined the team in 2018, bringing over 10 years' experience in the field of cancer screening health promotion and engagement in the UK and Australia. John is passionate about improving participation in cancer screening programs and integrating the broader health care ecosystem to help improve outcomes for Australians.

# UPDATES TO THE NCSP GUIDELINES

## Changes relevant for General Practice

Prof Marion Saville AM | Executive Director

Australian Centre for the Prevention of Cervical Cancer

12<sup>th</sup> March 2025



Australian Centre for  
the Prevention of  
Cervical Cancer



VCS  
Pathology



Population  
Health



Digital  
Health



# ACKNOWLEDGEMENT OF TRADITIONAL OWNERS



# SUMMARY OF THE AUSTRALIAN NATIONAL CERVICAL SCREENING PROGRAM



## START

Age 25 years

## SCREENING INTERVAL

5 yearly

## EXIT

Age 70 to 74 years

Primary HPV test with partial genotyping (16/18) + reflex Liquid Based Cytology (LBC) triage

All sexually active women or people with a cervix - HPV vaccinated or not

Cervical  
Screening Test  
(CST)

## Option of self-collection

Invitation & reminders to screen:  
National Cancer Screening Register

# EXPANDED CERVICAL SCREENING OPTIONS



Since 1 July 2022, all routine screening participants can choose to screen using either:

## Practitioner-Collected Cervical Screening Test

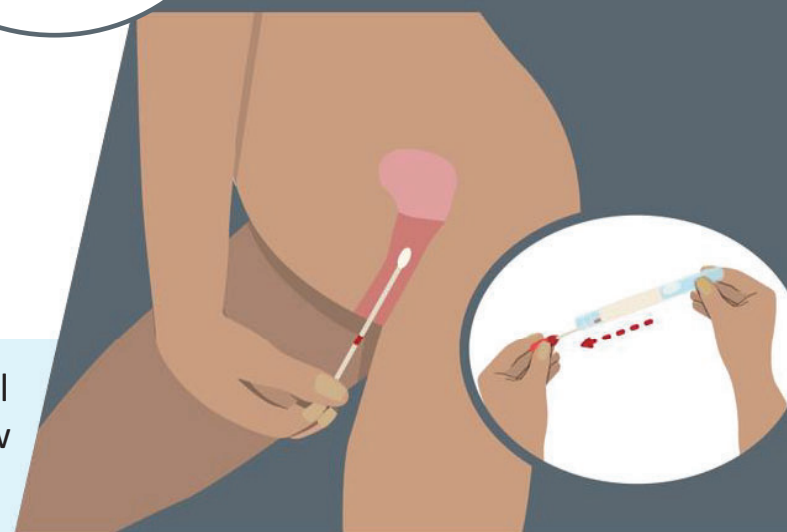


**Option 1**  
a clinician-collected  
sample from the  
cervix taken using a  
speculum

Those who choose self-collection still access cervical screening through their healthcare provider, to allow for education, engagement and follow-up of results

**Option 2**  
a self-collected  
vaginal sample

## HPV Self-collection





Accurate

Safe

## SELF-COLLECTION

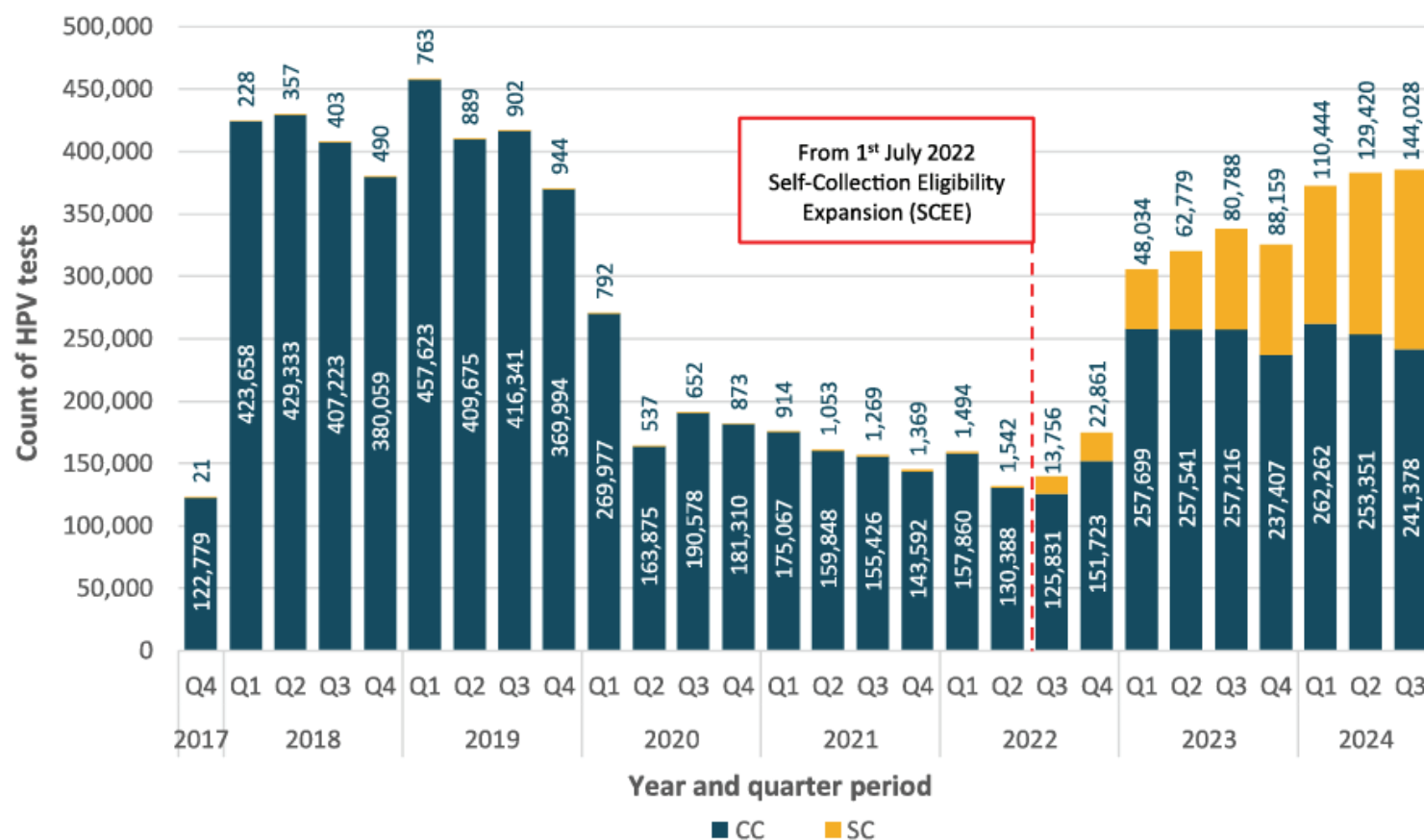


Acceptable

Easy



# SELF-COLLECTION TEST VOLUMES



HPV screening tests reported as self-collected and clinician-collected in each quarter Q4 2017 – Q3 2024

Source: NCSP Cervical Screening Test self-collection uptake report. 2024.

# UPCOMING GUIDELINE UPDATES

April 14<sup>th</sup> 2025



New Cervical Screening Clinical Guidelines are expected to come into effect on 14 April 2025.



**Access the cervical screening guidelines via the Cancer Council Australia website, or directly via the MAGICapp platform:**

[www.cancer.org.au/clinical-guidelines/cervical-cancer/cervical-cancer-screening](http://www.cancer.org.au/clinical-guidelines/cervical-cancer/cervical-cancer-screening)



# SUMMARY OF CHANGES IN 2025

## National Cervical Screening Guidelines



1

Guidelines shifted to MagicAPP platform, creating a more user-friendly experience

2

New chapter 'Cervical screening in clinical practice' which includes links to resources

3

Changes to post-treatment management for people who have been treated for HSIL

4

Categories of people considered immune-deficient clarified and expanded

5

Change in recommendation for screening participants with HPV (not 16/18) detected on a self-collected sample who do not return for cytology until 9 months or more after the HPV test

6

Screening after total hysterectomy (where indicated) simplified to annual testing

7

Changes to surveillance following treatment of AIS

# 1. CHANGE TO MAGICAPP PLATFORM



- Improved structure and format to support ease of navigation for healthcare providers
- MAGICapp supports many clinical guidelines both in Australia and globally
- You can still access this through the existing Cancer Council Australia website link. Make sure to bookmark it!

<https://www.cancer.org.au/clinical-guidelines/cervical-cancer/cervical-cancer-screening>



## Clinical Guidelines

About Guidelines

Home / Cervical cancer / Cervical cancer screen...

### CERVICAL CANCER SCREENING

## National cervical screening program



### National Cervical Screening Program Guidelines

v1.17 published on 10/8/2024

#### Sections

- 1 Summary of guidelines >
- 2 Introduction >
- 3 How to use these guidelines >
- 4 Terminology, classification systems and report preparation >
- 5 Cervical screening in clinical practice >
- 6 Management of HPV test results >

References 470 Evidence 0 Recommendations 199

Filter by: ☐ Unresolved feedback

## 1 Summary of guidelines

### 1.1 Summary of changes in 1 July 2024 edition

#### Introduction

As 5 years have passed since Australia's National Cervical Screening Program (NCSP) transition to a screening strategy based on human papillomavirus (HPV) testing, the National Cervical Screening Guidelines have undergone a review and update. The scope of the review was informed by the N...

[More >](#)

# NAVIGATING THE MAGICAPP PLATFORM



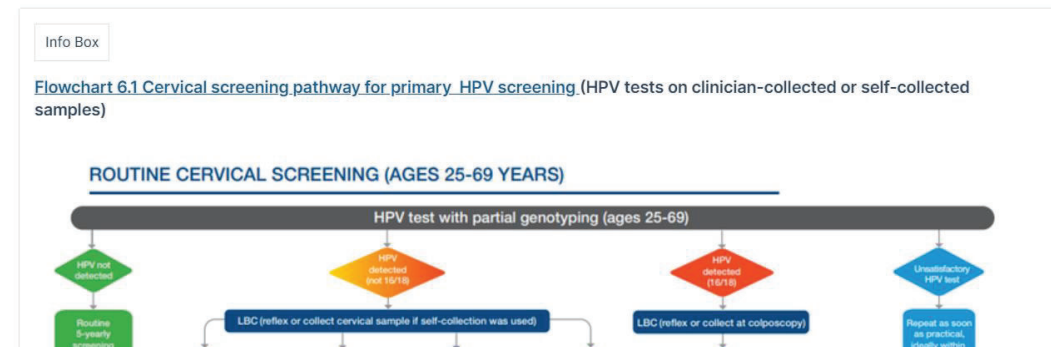
MAGICapp Layers of Information enables an online multilayered format, designed to allow end-users to find the most relevant information first and then drill down to find more detail:

- **All Recommendations, Good Practice Statements and Decision Flowcharts are displayed on the front page (first layer) of each chapter.**

## 6 Management of HPV test results <sup>1</sup>

Cervical screening pathways according to primary human papillomavirus (HPV) screening result are summarised in Flowchart 6.1.

[More >](#)



## 2. NEW SECTION

### Chapter 5: Cervical screening in clinical practice

- Brings together into one location the most important concepts and information for those performing cervical screening, particularly in the primary care setting.
- Also links to other specific sections, such as 'Management of HPV test results' and 'Screening and management in specific populations',
- Also links to NCSP and other updated resources including the NCSP [Healthcare provider toolkit](#), which supports healthcare providers in engaging under-screened and never-screened people in cervical screening.

5	Cervical screening in clinical practice	▼
5.1	Understanding the role of HPV and explaining it to participants	
5.2	National Cervical Screening Program (NCSP)	
5.3	National Cancer Screening Register (NCSR) – its role and how to access information	
5.4	Supporting informed choice > between a clinician-collected or self-collected CST sample	
5.5	Pathology request forms	
5.6	Supporting participation of under-screened and never-screened people	>
5.7	People who have experienced early sexual contact	
5.8	Exit testing in people aged 70–74	
5.9	Screening in people aged 75 and older	
5.10	Pregnancy	
5.11	Immune-deficient people	



### 3. SCREENING OF PEOPLE WITH IMMUNE DEFICIENCY



**‘Immune-deficiency’:** groups with severe acquired or congenital immune deficiency deemed to have or be at substantially higher risk of cervical precancer and cancer

Most evidence references transplant patients and PLHIV; advice on other conditions extrapolated from these studies

Immune-deficient participants assessed as being at substantially increased cervical cancer risk:

- should be screened every 3 years
- should be referred for colposcopy by an experienced colposcopist or in a tertiary centre if HPV (any type) is detected





# SCREENING OF PEOPLE WITH IMMUNE DEFICIENCY



Categories have been clarified and expanded. The following list of examples is not exhaustive:

## 3-YEARLY SCREENING

### Recommended

- Living with HIV
- Solid organ transplant with immunosuppressive therapy
- Active haematological malignancy
- Haematopoietic stem cell transplant recipients
- Primary immunodeficiency

### Should be highly considered

- Long term haemodialysis (>6 m)
- Long-term treatment (>6 m) with highly immunosuppressive therapies
  - high-dose corticosteroid treatment
  - selected conventional and targeted synthetic disease-modifying anti-rheumatic drugs
  - biologic therapies that deplete T cells
  - multiple immunosuppressants

## 4. CHANGES TO TEST OF CURE



### Test of Cure refresher

The risk of recurrence and invasive cervical cancer remains elevated for 10–25 years in people who have been treated for HSIL [CIN2/3]

Post-treatment surveillance ('Test of cure') is important to detect residual or recurrent disease

'Test of cure' following treatment for HSIL involves annual testing, until:

2 x negative tests

1 year apart (consecutive tests)

Before they are considered 'baseline' risk and can return to 5 yearly screening

# CHANGES TO TEST OF CURE



Following treatment for HSIL

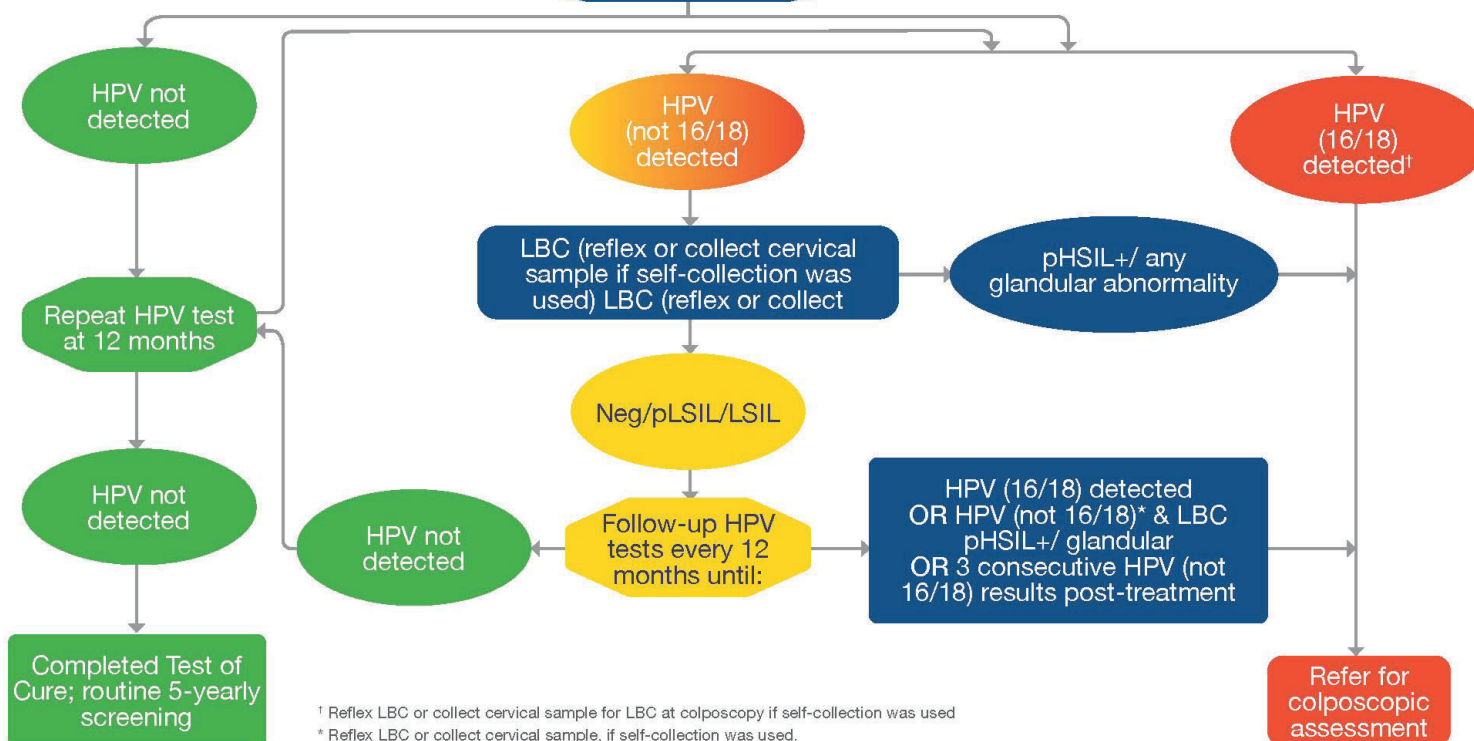
	2024 (CURRENT)	2025 (NEW GUIDELINES)
Recommendation	Annual <b>co-tests</b> until 2 x consecutive negative tests (negative HPV and LBC)	Annual <b>HPV tests</b> until 2 x consecutive test with HPV not detected
Self-collection an option?	✗	✓

## TEST OF CURE FOLLOWING TREATMENT FOR HIGH-GRADE SQUAMOUS ABNORMALITIES



### Treatment for HSIL (CIN2/3)

HPV test (commence at  
12 months post-treatment)



### REC 9.17

**Abnormal Test of Cure results:  
HPV (not 16/18) detected with  
LBC negative, pLSIL or LSIL**

- continue annual HPV tests until HPV not detected at two consecutive tests.
- if HPV (not 16/18) detected (LBC negative or pLSIL/LSIL) on three consecutive annual tests → refer for colposcopy.

Suggested citation: Cancer Council Australia Cervical Cancer Screening Working Party. Clinical pathway: Test of Cure following treatment for high-grade squamous abnormalities. National Cervical Screening Program: Guidelines for the management of screen detected abnormalities, screening in specific populations and investigation of abnormal vaginal bleeding. CCA 2024. Accessible from [http://wiki.cancer.org.au/australia/Guidelines/Cervical\\_cancer/screening](http://wiki.cancer.org.au/australia/Guidelines/Cervical_cancer/screening)

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## 5. REPEAT SELF-COLLECT AT 9 MONTHS



If have not returned for cytology after HPV (not 16/18) detected

LBC must be performed when HPV (not 16/18) detected to determine risk and further management

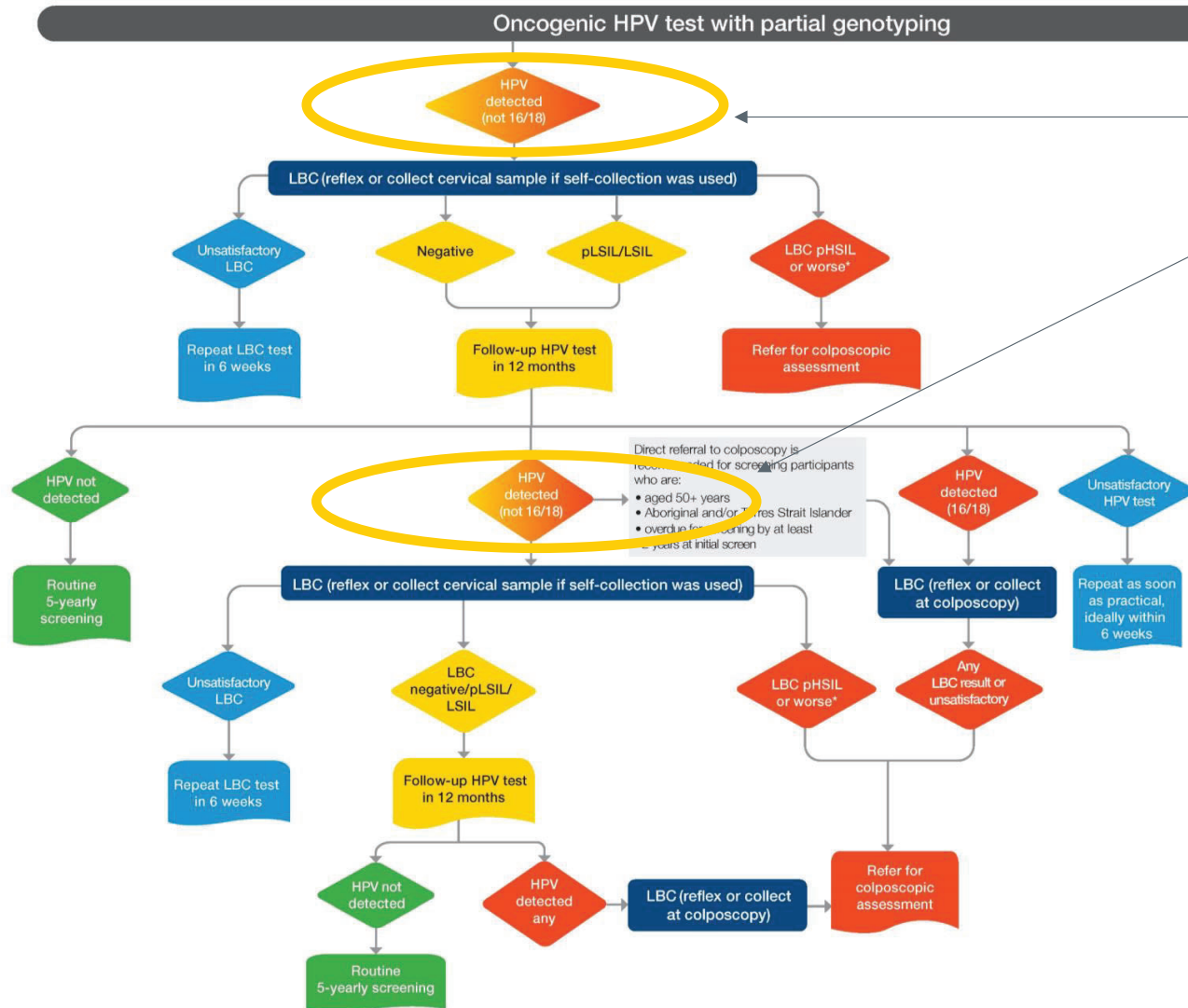
If self-collected → return within 6 weeks for LBC

However, for those **who do not return until 9 months** or more after the HPV test:

offer a follow-up self-collected HPV test, rather than LBC

this will determine if the HPV infection has now been cleared and the person can return to routine screening

## CERVICAL SCREENING PATHWAY (CLINICIAN COLLECTED OR SELF-COLLECTED)



For those who do not return until 9 months or more after the self-collected HPV test:

offer a follow-up self-collected HPV test, rather than LBC

this will determine if the HPV infection has now been cleared and the person can return to routine screening

Cancer Council Australia Cervical Cancer Screening Working Party. Clinical pathway: Cervical screening pathway. National Cervical Screening Program Guidelines for the management of screen detected abnormalities, screening in specific populations and investigation of abnormal vaginal bleeding. Accessible from [http://wiki.cancer.org.au/australia/GuidelinesCervical\\_cancer/Screening](http://wiki.cancer.org.au/australia/GuidelinesCervical_cancer/Screening). Updated Dec 2020.

# CASE STUDY



Samiha is  
35 years old  
and booked  
her first ever  
CST

Her results  
have returned  
HPV (not  
16/18)

Follow-up appointment  
within 6 weeks for LBC

Samiha does not return for  
the follow-up appointment

Samiha returns 10 months  
later, at which:

**LBC must  
be taken**

**Samiha can  
collect her own  
sample again**



## 6. SCREENING AFTER HYSTERECTOMY



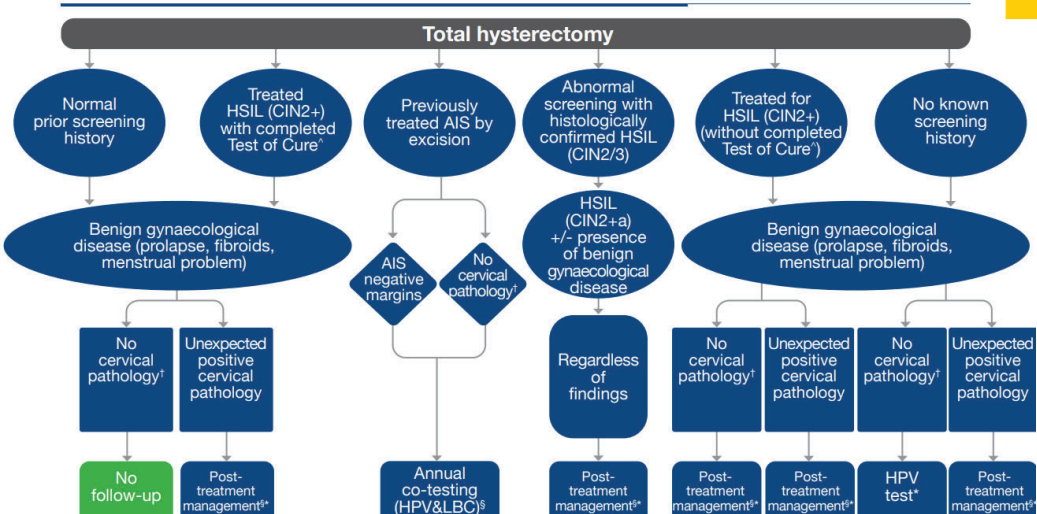
- Simplified to **annual testing**
- co-test or HPV test depending on cervical pathology and history

- until 2 x negative tests on 2 x consecutive occasions

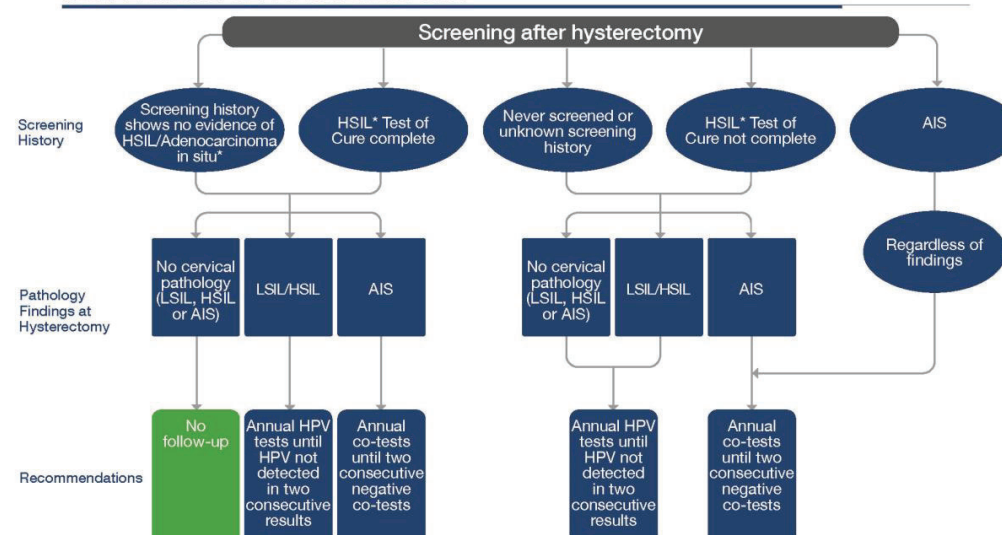
# SCREENING AFTER TOTAL HYSTERECTOMY



## VAGINAL SCREENING AFTER TOTAL HYSTERECTOMY



## SCREENING AFTER HYSTERECTOMY



<sup>\*</sup> completed Test of Cure, either with two consecutive annual rounds of negative co-tests or two consecutive annual rounds of negative HPV tests

<sup>†</sup> No cervical pathology (LSIL, HSIL or AIS) found on examination of the cervix

<sup>§</sup> Post-treatment management for AIS in people with a hysterectomy: annual co-testing on a vaginal vault specimen is recommended, commencing 12 months after treatment until the person has tested negative on both tests (HPV and LBC) on 2 consecutive occasions, after which they do not need further testing

<sup>\*</sup> Post-treatment management for HSIL, or where no known screening history HPV test to be taken from the vaginal vault 12 months after treatment & annually thereafter until the person has tested negative on 2 consecutive occasions, after which they do not need further testing

Suggested citation: Cancer Council Australia Cervical Cancer Screening Working Party. Clinical pathway: Vaginal screening after total hysterectomy. National Cervical Screening Program: Guidelines for the management of screen detected abnormalities, screening in specific populations and investigation of abnormal vaginal bleeding. COA 2016. Accessible from [http://helix.cancer.org.au/australia/Guidelines/Cervical\\_cancer\\_screening](http://helix.cancer.org.au/australia/Guidelines/Cervical_cancer_screening)

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<sup>\*</sup> Histologically confirmed

LSIL = Low-grade squamous intraepithelial lesion

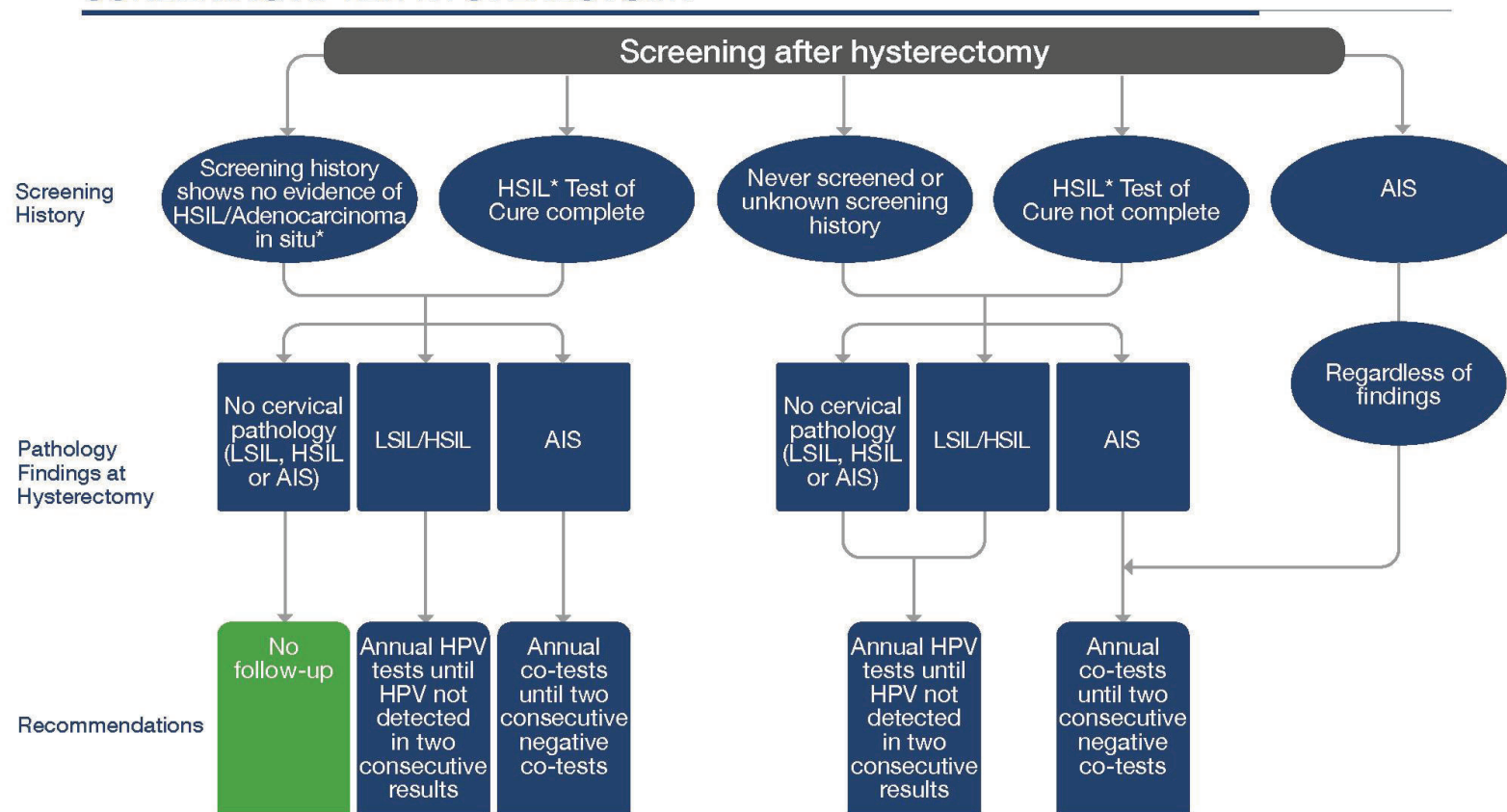
HSIL = High-grade squamous intraepithelial lesion

AIS = Adenocarcinoma in situ

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## SCREENING AFTER HYSTERECTOMY



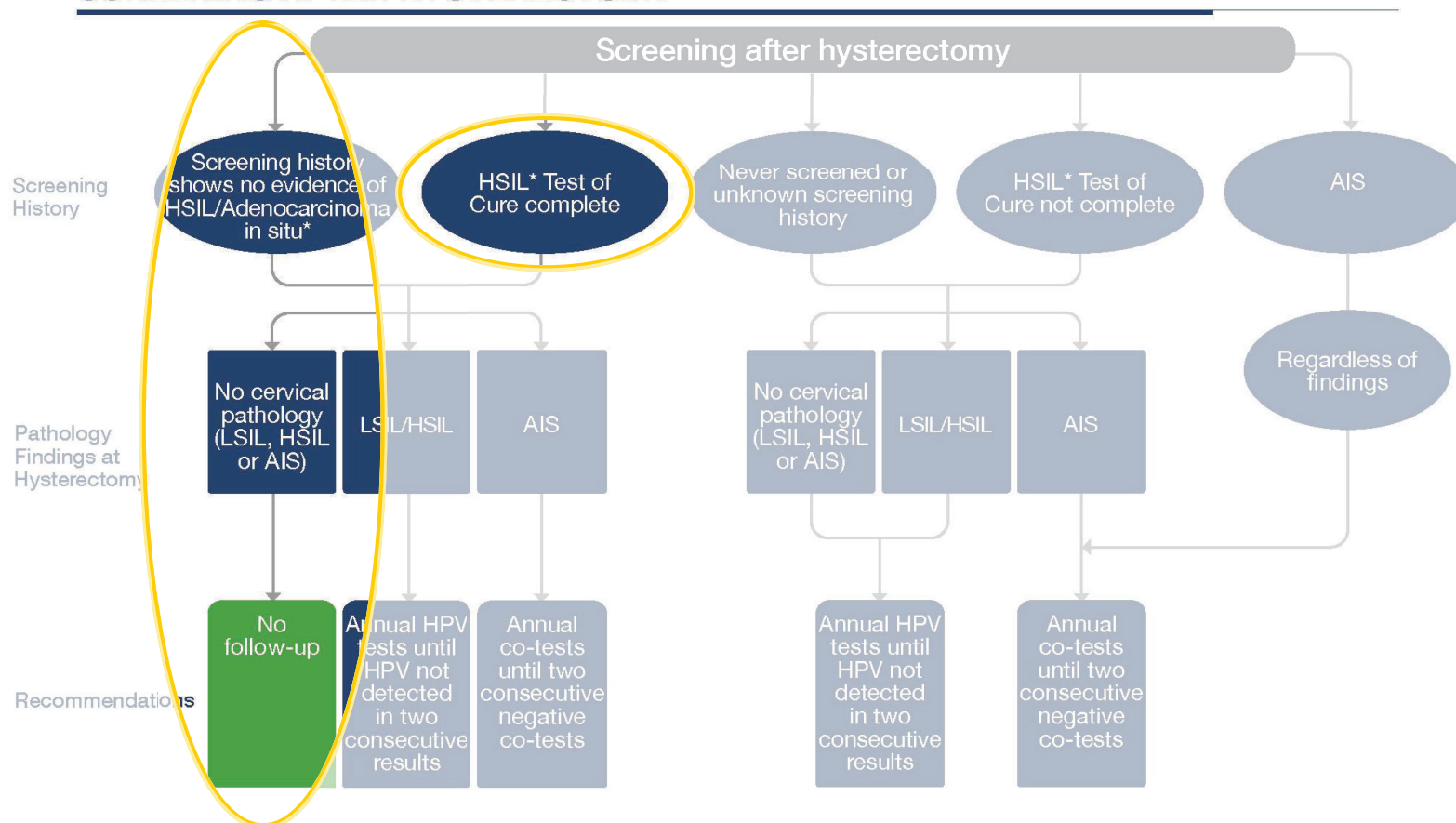
\* Histologically confirmed

LSIL = Low-grade squamous intraepithelial lesion

HSIL = High-grade squamous intraepithelial lesion

AIS = Adenocarcinoma in situ

## SCREENING AFTER HYSTERECTOMY

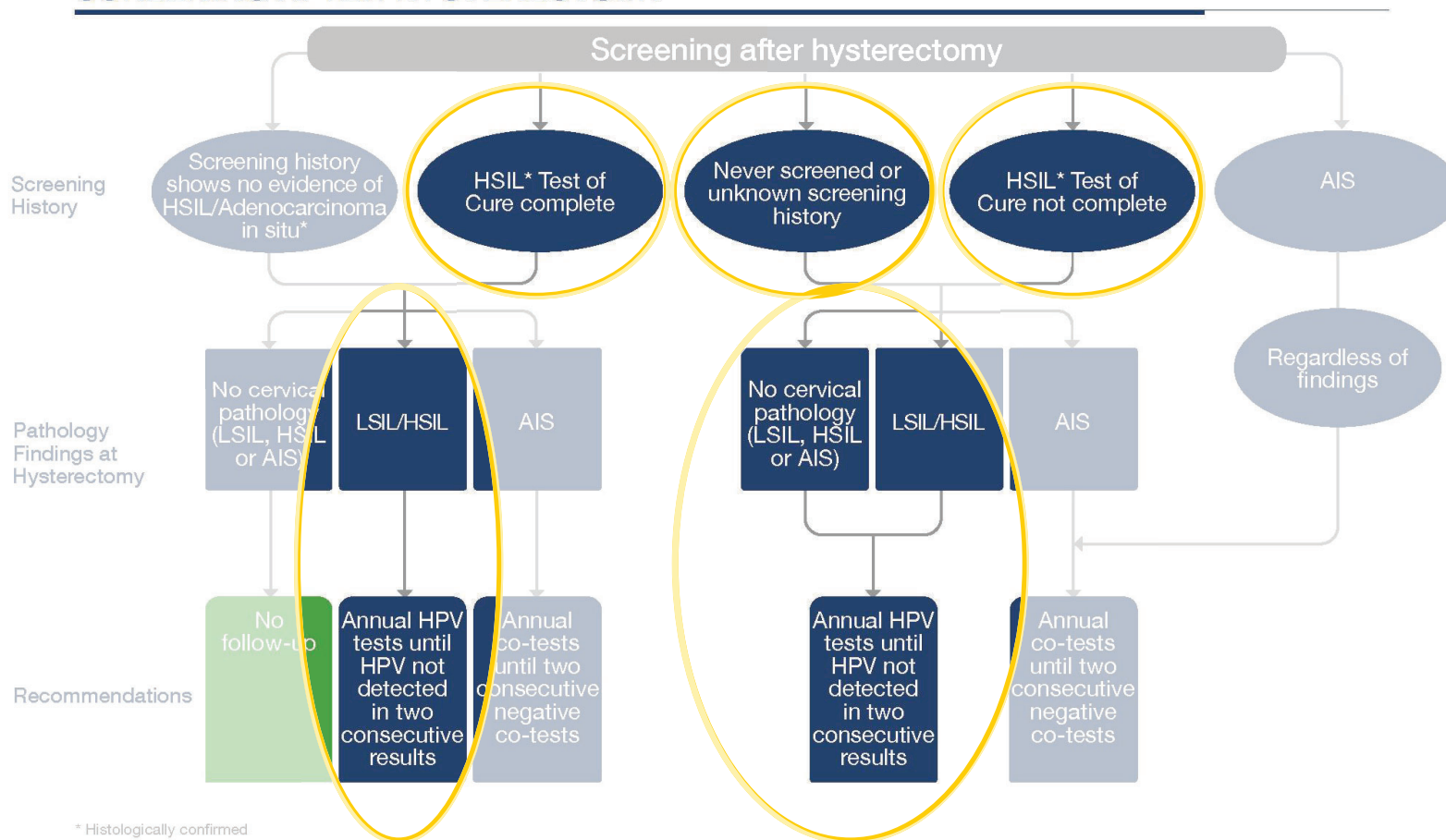


\* Histologically confirmed  
 LSIL = Low-grade squamous intraepithelial lesion  
 HSIL = High-grade squamous intraepithelial lesion  
 AIS = Adenocarcinoma in situ

### No follow-up follow-up required if:

1. No history of HSIL / AIS and no cervical pathology findings at hysterectomy
2. History of HSIL with Test of Cure complete and no cervical pathology findings at hysterectomy

## SCREENING AFTER HYSTERECTOMY



\* Histologically confirmed  
 LSIL = Low-grade squamous intraepithelial lesion  
 HSIL = High-grade squamous intraepithelial lesion  
 AIS = Adenocarcinoma in situ

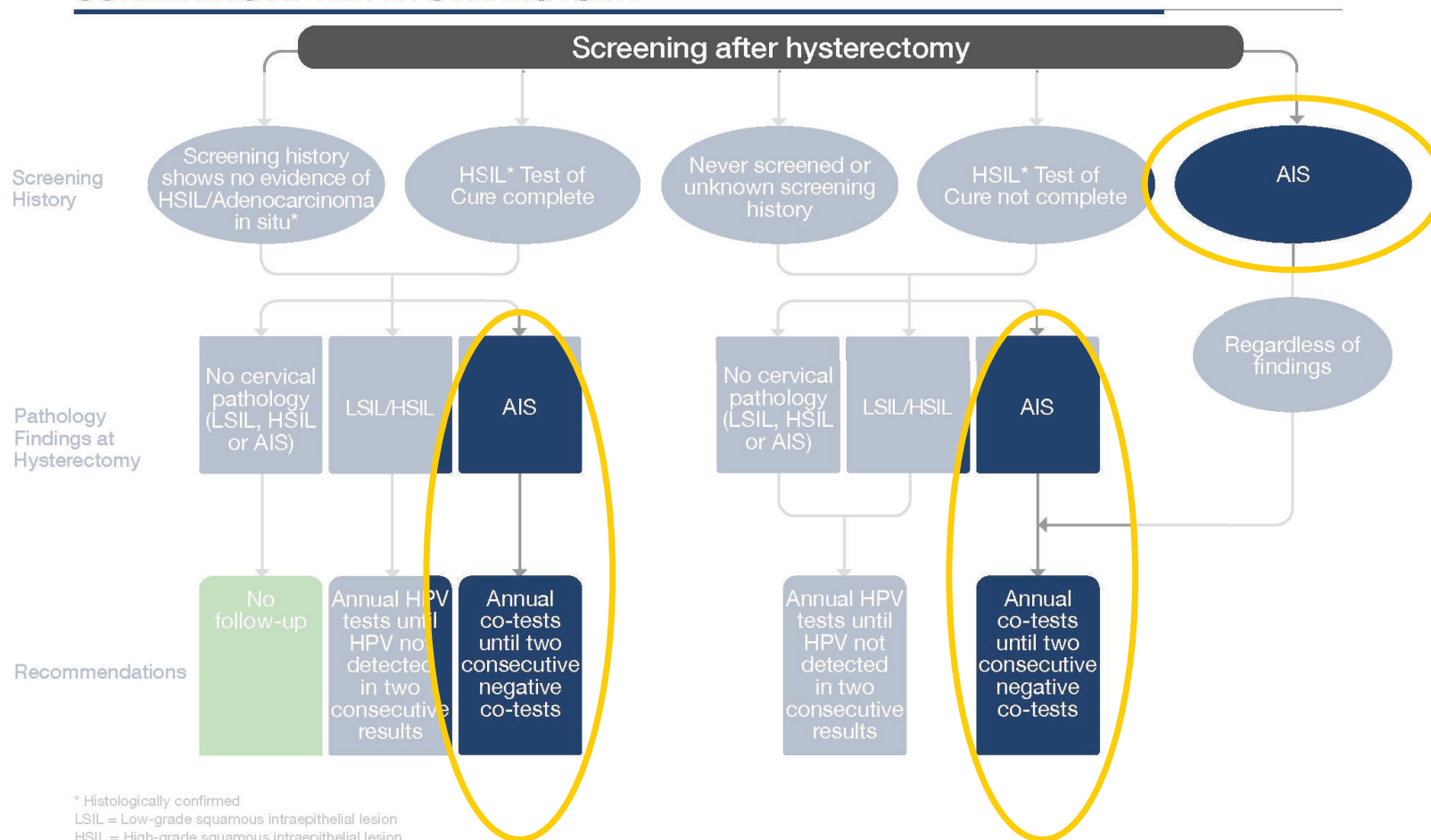
### Annual HPV tests if:

P/Hx of HSIL, Test of Cure complete but LSIL/HSIL pathology findings at hysterectomy

P/Hx of HSIL with Test of Cure incomplete, regardless of pathology findings

Or if never screened or unknown screening history, regardless of pathology findings

## SCREENING AFTER HYSTERECTOMY



**Annual co-tests tests if:**

Pathology findings AIS

PHx of AIS

Testing can cease when co-tests are negative on two consecutive occasions



# 7. CHANGES TO SURVEILLANCE FOLLOWING TREATMENT OF AIS



## AIS refresher

Adenocarcinoma in situ (AIS) is an HPV-associated precancerous lesion of the glandular cells of the endocervix and the precursor to endocervical adenocarcinoma.

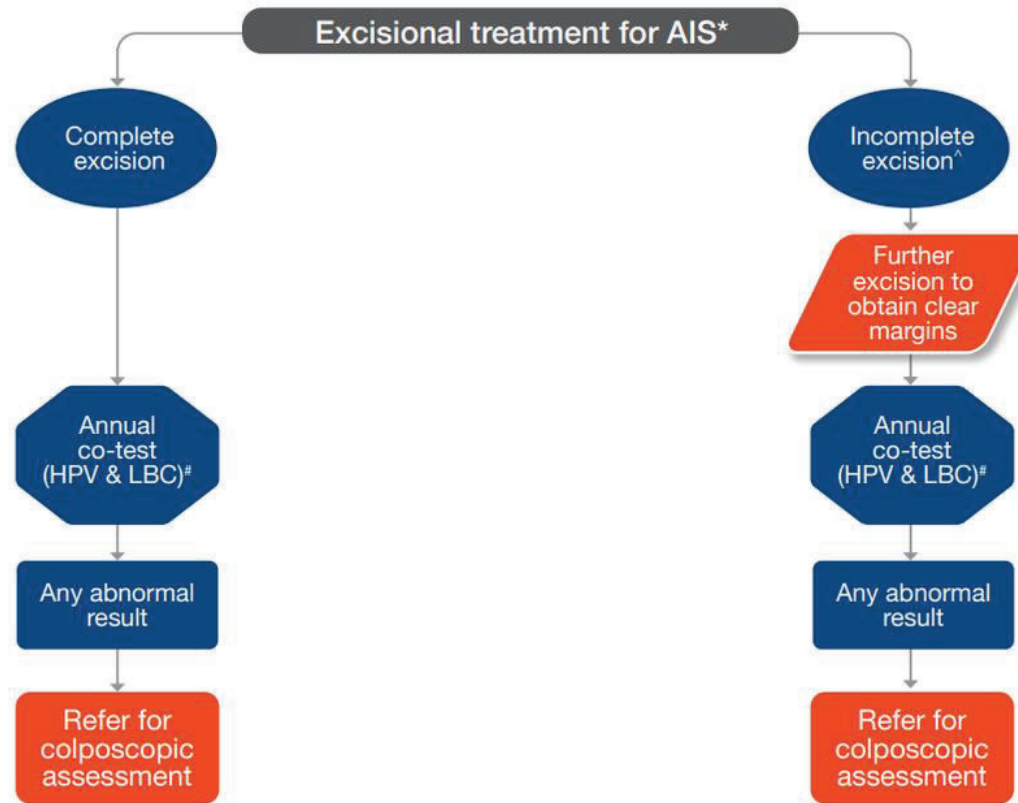
Histological confirmation of adenocarcinoma in situ (AIS) lesions often occurs as the result of a diagnostic excisional biopsy, usually a cold knife cone biopsy, which may or may not have completely excised the lesion.

Current guidelines (prior to 14 April) require  
**annual co-tests indefinitely**





## FOLLOW-UP AFTER EXCISIONAL TREATMENT FOR AIS



\* AIS = Adenocarcinoma in situ

^\# If all testing has been negative for 5 years, surveillance testing can be extended to every 3 years. If surveillance tests have been done for 25 years or more since the time of treatment and all tests are negative, people can be returned to routine screening. If they have already had a negative co-test when aged 70 years or older they can exit screening.

^ If margins are equivocal, review at MDT

Suggested citation: Cancer Council Australia Cervical Cancer Screening Working Party. Clinical pathway: Follow-up after excisional treatment for AIS. National Cervical Screening Program: Guidelines for the management of screen detected abnormalities, screening in specific populations and investigation of abnormal vaginal bleeding. CCA 2024. Accessible from [http://wiki.cancer.org.au/australia/Guidelines/Cervical\\_cancer/Screening](http://wiki.cancer.org.au/australia/Guidelines/Cervical_cancer/Screening)

### Annual co-tests

Refer for colposcopy if any abnormal result

Interval can be extended to **3 years** if **all co-tests negative for 5 years**

If all tests negative for 25 years:

- return to routine screening (if <70yo)
- exit the program (if >70yo)

# COLPOSCOPY RELEVANT CHANGES



- Option to **defer re-referral** for those with HPV (16/18) detected, LBC report of negative, and normal colposcopy, if 12-month follow-up results are again HPV (16/18) detected and negative LBC
  - Repeat HPV test in another 12-months, rather than immediate referral to colposcopy
- 
- Laboratories should recommend that patients be referred to colposcopy
  - Colposcopists who wish to defer return to colposcopy will need to advise the NCSR

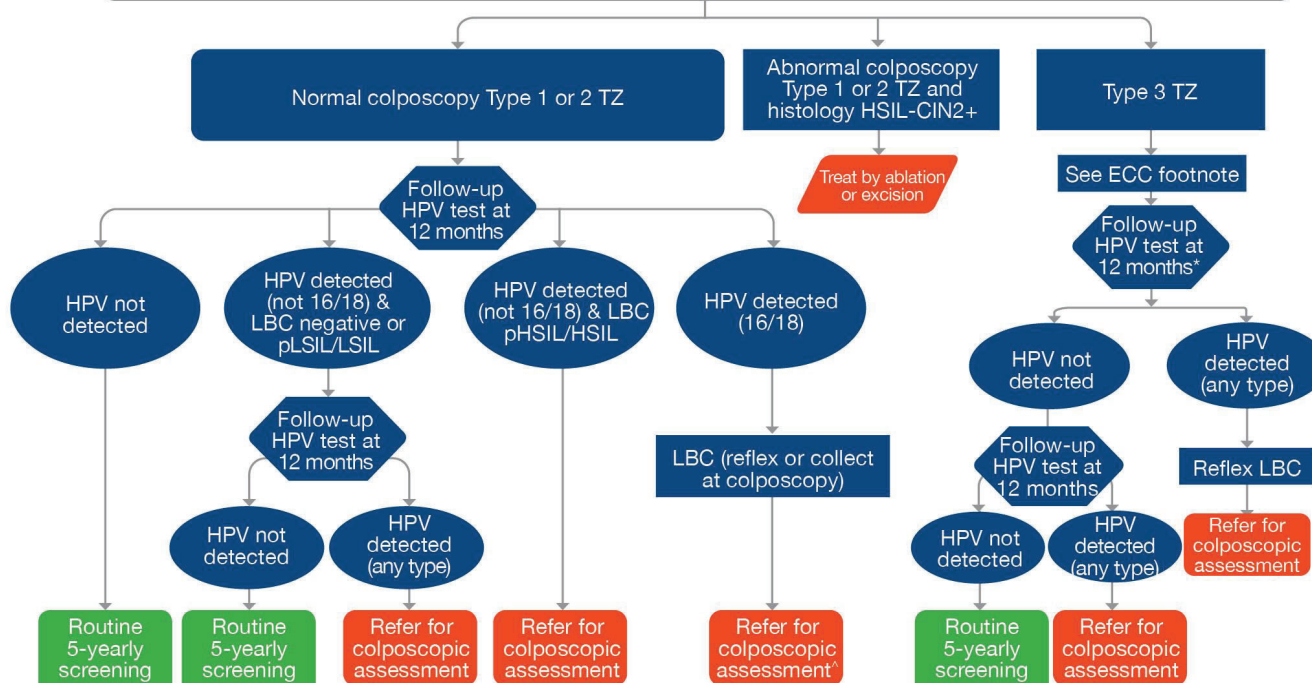
See NCSP Guidelines section 8.21 for more information

# COLPOSCOPY RELEVANT CHANGES



## 8.3: COLPOSCOPY MANAGEMENT AFTER LBC PREDICTION OF NEGATIVE, pLSIL OR LSIL

Colposcopy after LBC prediction of Negative, pLSIL or LSIL following detection of HPV (any type)



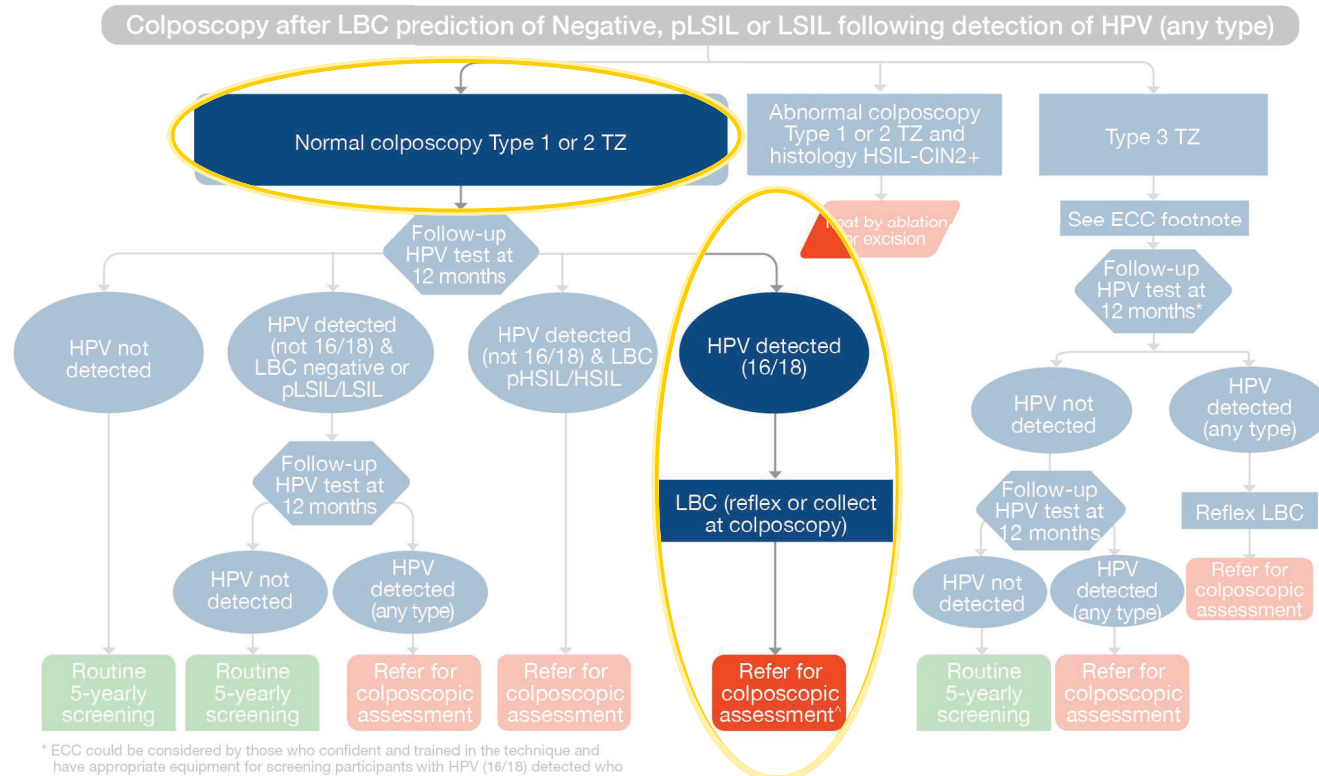
\* ECC could be considered by those who confident and trained in the technique and have appropriate equipment for screening participants with HPV (16/18) detected who have never been screened before (and are aged 26+)

<sup>^</sup> If LBC is performed prior to colposcopy, and is negative, then the HPV test could be repeated in another 12 months before re-referral to colposcopy.

# COLPOSCOPY RELEVANT CHANGES



## 8.3: COLPOSCOPY MANAGEMENT AFTER LBC PREDICTION OF NEGATIVE, pLSIL OR LSIL



\* ECC could be considered by those who confident and trained in the technique and have appropriate equipment for screening participants with HPV (16/18) detected who

^ If LBC is performed prior to colposcopy, and is negative, then the HPV test could be repeated in another 12 months before re-referral to colposcopy.

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If LBC is performed prior to colposcopy, and is negative, then the HPV test could be repeated in another 12 months before re-referral to colposcopy

# NEW RESOURCE AVAILABLE

Summary of the guideline updates



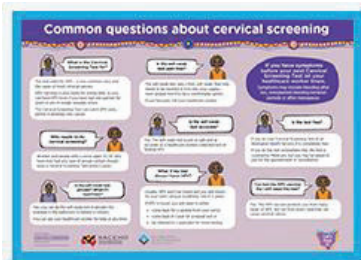
New resource is now available  
summarising the updated  
guidelines. Download a copy for  
your clinic today!

<https://acpcc.org.au/wp-content/uploads/2025/02/updated-CS-guidlines-April-2025.pdf>

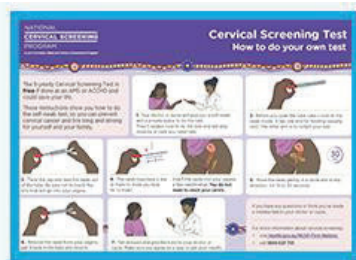


# NEW AND UPDATED RESOURCES AVAILABLE

on the ACPCC resource hub



Common Questions



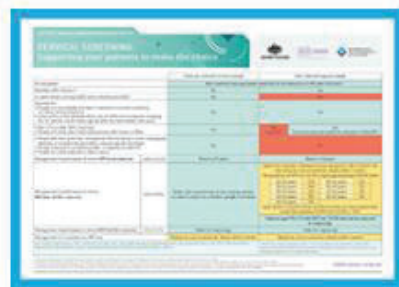
How to take your own cervical screening test



Information for your next Cervical Screening Test



How to take your own cervical screening test – English



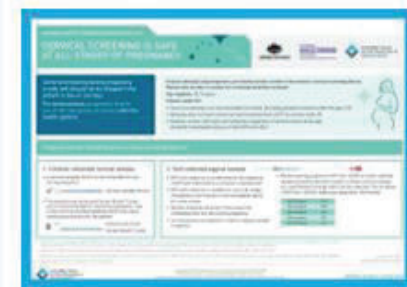
Supporting your patients to make the choice



National Cervical Screening Program Quick Reference



HPV and cervical screening resource

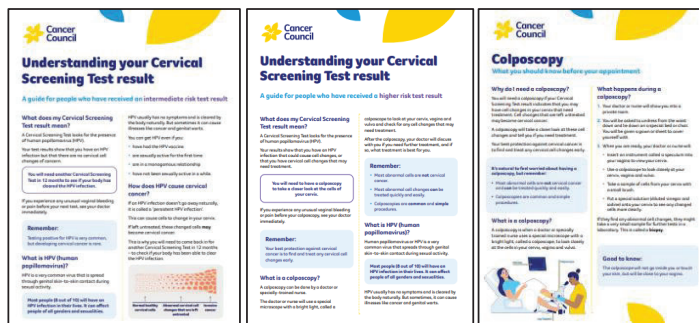


Cervical screening during pregnancy

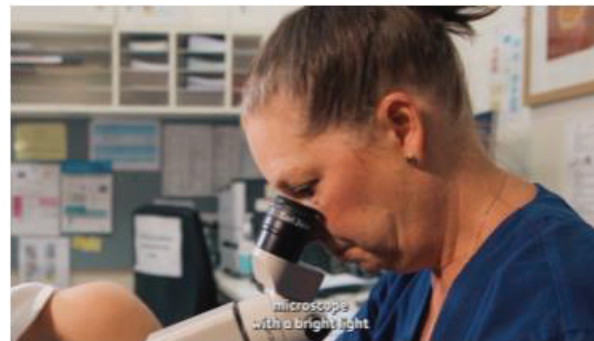
# CANCER COUNCIL VICTORIA RESOURCES FOR PATIENTS



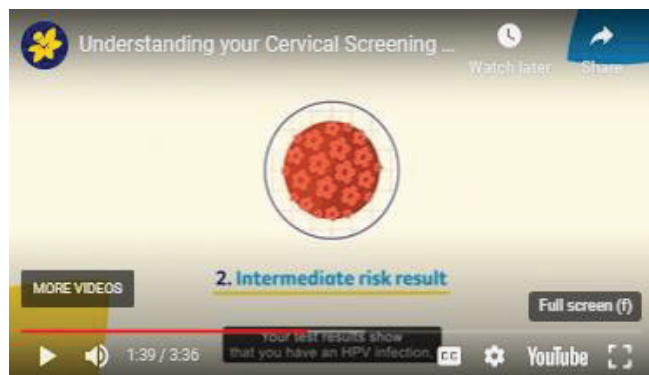
## Fact sheets



## Patient education video about colposcopy



## Animation – Understanding your CST results



## Patient stories

### Lucinda, 31



In 2019, Lucinda went to her local GP for her routine **Cervical Screening Test** – her first in Australia since having recently moved from Ireland.

When her test came back as abnormal, Lucinda was advised to come back in 12 months to have another Cervical Screening Test. The follow-up test again came back abnormal, and Lucinda was referred to have a colposcopy.

As a midwife, Lucinda was familiar with the procedure, but this didn't stop her feeling

### Daniella, 53



After experiencing some unusual vaginal bleeding at age 30, Daniella went to see her local doctor to get it checked out.

Her doctor completed a Pap test (now called the **Cervical Screening Test**), which came back with abnormal results. When the second test came back abnormal again, Daniella was referred to see a Gynaecologist to have a colposcopy.

Never having heard of a colposcopy before, Daniella said she was worried but that she knew it was an important step she needed to take for her health.



# CONTACT US FOR FURTHER SUPPORT

We're here to help!



[education@acpcc.org.au](mailto:education@acpcc.org.au)

Clinical advisory service  
Phone: (03) 9250 0309

# THANK YOU!



Australian Centre for  
the Prevention of  
Cervical Cancer



VCS  
Pathology



Population  
Health



Digital  
Health



NHMRC  
Centre of Research  
Excellence in  
Cervical Cancer  
Control





# Enhancing Early Detection: The Latest in Cancer Screening

*12 March 2025*

**Pathways are written by GP clinical editors with support from local GPs, hospital-based specialists and other subject matter experts**



- 
- **clear and concise, evidence-based medical advice**
  - **Reduce variation in care**
  - **how to refer to the most appropriate hospital, community health service or allied health provider.**
  - **what services are available to my patients**

# HealthPathways- Cancer Screening Pathways

Melbourne

Public Health

Specific Populations

Surgical

Women's Health

Breastfeeding

Contraception and Sterilisation

Gynaecology

Perineal Tear Follow-up

Cervical Cancer

Cervical Polyps

Cervical Screening

Recurrent or Chronic Vulvovaginal Candidiasis

Dysmenorrhoea

Endometrial Cancer

Female Genital Cutting/Mutilation (FGC/M)

Fibroids

Heavy Menstrual Bleeding

Hysteroscopy

Intermenstrual Bleeding

Search: Cervical screening

AT A

## Melbourne HEALTHPATHWAYS

### Latest News

24 February

**Health.vic**

[Health alerts and advisories](#)

---

24 February

**Paracetamol pack size restrictions are now in effect**

From 1 Feb 2025, general sale packs of paracetamol have been reduced to 16 tablets, pharmacy packs (without supervision) to 50 tablets, and larger packs (up to 100 tablets) are available only under pharmacist supervision. [Read more...](#)

---

19 February

**Criteria Led Discharge (CLD) Toolkit**

The CLD Toolkit is now available. Developed by the Department of Health & Safer Care Victoria, it supports safe, timely discharge

### Pathway Updates

Updated - 28 February  
[Guide to MBS Items](#)

Updated - 21 February  
[Ankylosing Spondylitis](#)

Updated - 21 February  
[Varicella \(Chickenpox\) and Pregnancy](#)

Updated - 13 February  
[Herpes Zoster \(Shingles\)](#)

Updated - 13 February  
[Immunisation - Adults](#)

- ABOUT HEALTH
- BETTER HEALTH
- RACGP RED BOOK
- USEFUL WEBSITES &
- MBS ONLINE
- NPS MEDICINEWISE
- PBS

[SEND FEEDBACK](#)

Click 'Send Feedback' to add comments and questions about this pathway.



# HealthPathways- Cancer Screening Pathways

**Cervical Screening**

Red flags

- Visible suspicious cervical mass

**Background**

About cervical screening

**Assessment**

**Practice point**

**Arrange further assessment if symptomatic**  
Arrange further assessment for a patient with symptoms (e.g., abnormal vaginal bleeding) or abnormal examination, even if they have a negative cervical screening result.

- Ask the patient "are you of Aboriginal or Torres Strait Islander origin?". Consider the specific cultural and spiritual needs of each patient.
- Take a history:
  - Menstrual and gynaecological, particularly abnormal bleeding or discharge
  - Previous cervical screening history. If required, obtain previous results from the National Cancer Screening Register (NCSR).
- Consider additional support for patients who are under-screened or never-screened, including:
  - Aboriginal and Torres Strait Islander patients
  - LGBTIQ+ patients with a cervix
  - patients with a history of female genital cutting
  - patients who have experienced sexual abuse or assault.
  - patients with a disability.
  - patients who have cervical or vaginal atrophy or vaginal dryness e.g., due to breastfeeding or menopause.
- Check the routine screening recommendations and consider additional screening recommendations for specific patient populations:
  - Patients who experienced sexual activity at a young age (< 14 years) who did not receive the HPV vaccination before sexual activity
  - immune-deficient patients
  - Diethylstilbestrol-exposed patients

**National Bowel Cancer Screening Program (NBCSP)**

Clinical editor's note

From 1 July 2024, the National Bowel Cancer Screening Program (NBCSP) lowered the eligible screening age from 50 years to 45 years.

**Background**

About the National Bowel Cancer Screening Program (NBCSP)

**Assessment**

**Practice point**

**Do not use NBCSP for high-risk testing**  
The NBCSP is not designed to replace targeted testing and screening of higher-risk population groups e.g., patients with symptoms, positive family history and/or previous bowel polyps.

**The faecal occult blood test (iFOBT) for screening**

- Check:
  - patient's eligibility for the NBCSP
  - any contraindications
  - any cultural factors – advise the patient about the test and if necessary provide translated information
- Encourage screening by a faecal occult blood test (iFOBT) which will be posted to eligible patients by the NBCSP, within 4 weeks of their milestone birthdays.
- Arrange follow-up if indicated.

**Patient access to iFOBT kits**

There are two models to help increase screening participation:

- Mail-out model – the NBCSP posts test kits to adults who hold a Medicare or Department of Veterans' Affairs (DVA) card within 4 weeks of their eligible milestone birthdays.
- Alternative access to kits model – healthcare providers give kits directly to eligible people, and explain the test and how to do it. See Australian Department of Health and Aged Care – Alternative Access to Bowel Screening Kits Guide.

## HealthPathways – Relevant and Related Pathways

### Cervical cancer screening relevant and related pathways

- [Cervical Screening](#)
- [Women's Health](#)
- [Cervical Cancer](#)
- [Cervical Polyps](#)
- [Gynaecology](#)
- [Endometrial Cancer](#)
- [Ovarian Cancer – Established](#)
- [Ovarian Cancer Follow-up](#)
- [Colposcopy Referral](#)
- [Fertility Specialised Referral](#)
- [Acute Gynaecology Referral or Admission \(Same-day\)](#)
- [Non-acute Gynaecology Referral \(> 24 hours\)](#)

### Other related Pathways

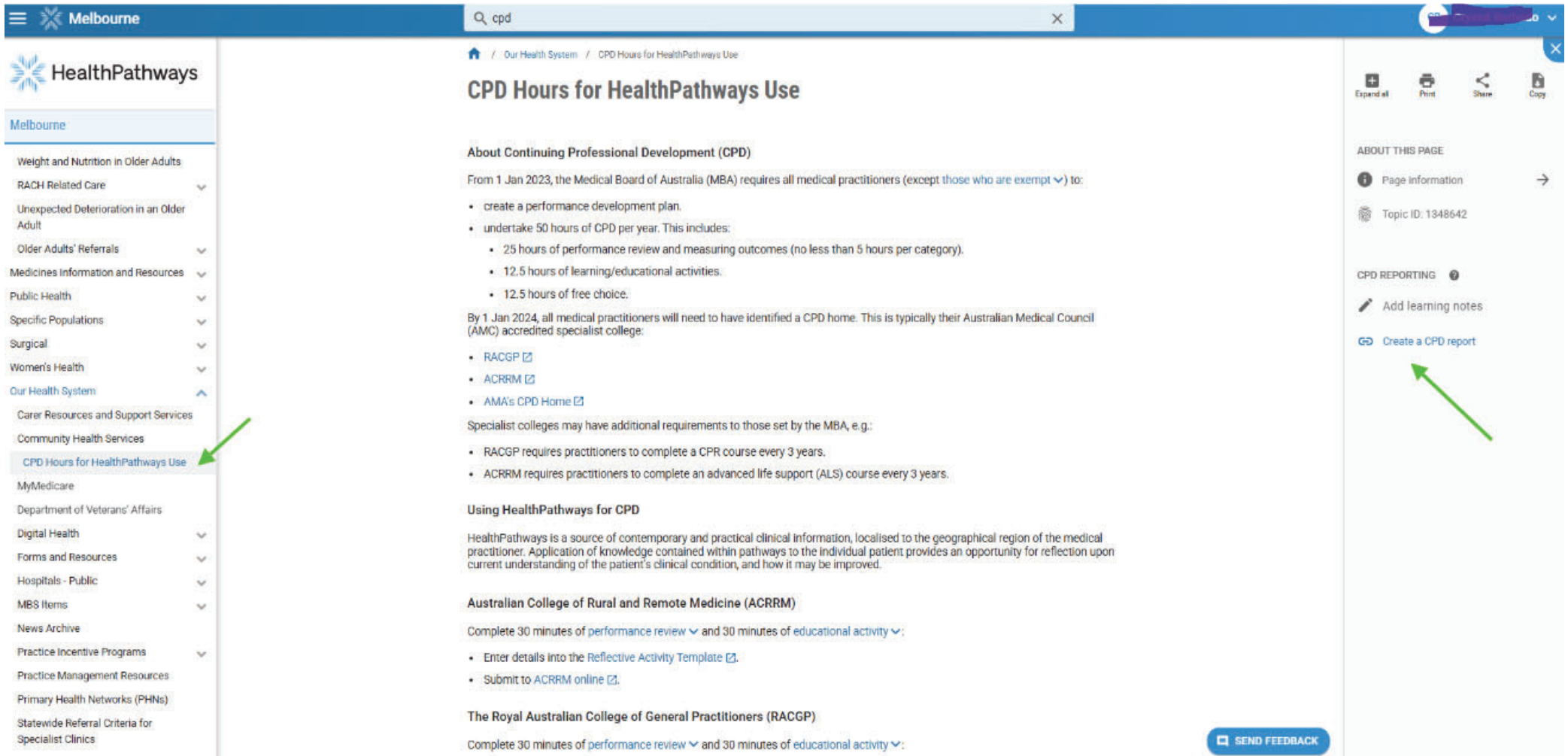
- [Guide to MBS Items](#)
- [Statewide Referral Criteria for Specialist Clinics](#)
- [CPD Hours for HealthPathways Use](#)

### Bowel cancer screening-relevant and related pathways

- [National Bowel Cancer Screening Program \(NBCSP\)](#)
- [Bowel Cancer](#)
- [Bowel Cancer Risk Categories and Screening](#)
- [Colorectal Symptoms - Suspected Colorectal Cancer](#)
- [Past Colorectal Cancer Colonoscopy Surveillance](#)
- [Positive Faecal Occult Blood Test \(FOBT\)](#)
- [Colorectal Symptoms – Suspected Colorectal Cancer](#)
- [Gastrointestinal Investigations](#)
- [Acute Gastroenterology Referral or Admission \(Same-day\)](#)
- [Non-acute Gastroenterology Referral \(> 24 hours\)](#)
- [Acute Colorectal Surgery Referral or Admission \(Same-day\)](#)
- [Non-acute Colorectal Surgery Referral \(> 24 hours\)](#)



# HealthPathways – CPD Hours for HealthPathways Use



**Melbourne**

HealthPathways

Melbourne

- Weight and Nutrition in Older Adults
- RACH Related Care
- Unexpected Deterioration in an Older Adult
- Older Adults' Referrals
- Medicines Information and Resources
- Public Health
- Specific Populations
- Surgical
- Women's Health
- Our Health System
- Carer Resources and Support Services
- Community Health Services
- CPD Hours for HealthPathways Use**
- MyMedicare
- Department of Veterans' Affairs
- Digital Health
- Forms and Resources
- Hospitals - Public
- MBS Items
- News Archive
- Practice Incentive Programs
- Practice Management Resources
- Primary Health Networks (PHNs)
- Statewide Referral Criteria for Specialist Clinics

Search: cpd

Home / Our Health System / CPD Hours for HealthPathways Use

## CPD Hours for HealthPathways Use

### About Continuing Professional Development (CPD)

From 1 Jan 2023, the Medical Board of Australia (MBA) requires all medical practitioners (except those who are exempt) to:

- create a performance development plan.
- undertake 50 hours of CPD per year. This includes:
  - 25 hours of performance review and measuring outcomes (no less than 5 hours per category).
  - 12.5 hours of learning/educational activities.
  - 12.5 hours of free choice.

By 1 Jan 2024, all medical practitioners will need to have identified a CPD home. This is typically their Australian Medical Council (AMC) accredited specialist college:

- [RACGP](#)
- [ACRRM](#)
- [AMA's CPD Home](#)

Specialist colleges may have additional requirements to those set by the MBA, e.g.:

- RACGP requires practitioners to complete a CPR course every 3 years.
- ACRRM requires practitioners to complete an advanced life support (ALS) course every 3 years.

### Using HealthPathways for CPD

HealthPathways is a source of contemporary and practical clinical information, localised to the geographical region of the medical practitioner. Application of knowledge contained within pathways to the individual patient provides an opportunity for reflection upon current understanding of the patient's clinical condition, and how it may be improved.

### Australian College of Rural and Remote Medicine (ACRRM)

Complete 30 minutes of performance review and 30 minutes of educational activity:

- Enter details into the [Reflective Activity Template](#).
- Submit to [ACRRM online](#).

### The Royal Australian College of General Practitioners (RACGP)

Complete 30 minutes of performance review and 30 minutes of educational activity:

Expand all Print Share Copy

ABOUT THIS PAGE

- Page information
- Topic ID: 1348642

CPD REPORTING

- Add learning notes
- [Create a CPD report](#)

SEND FEEDBACK

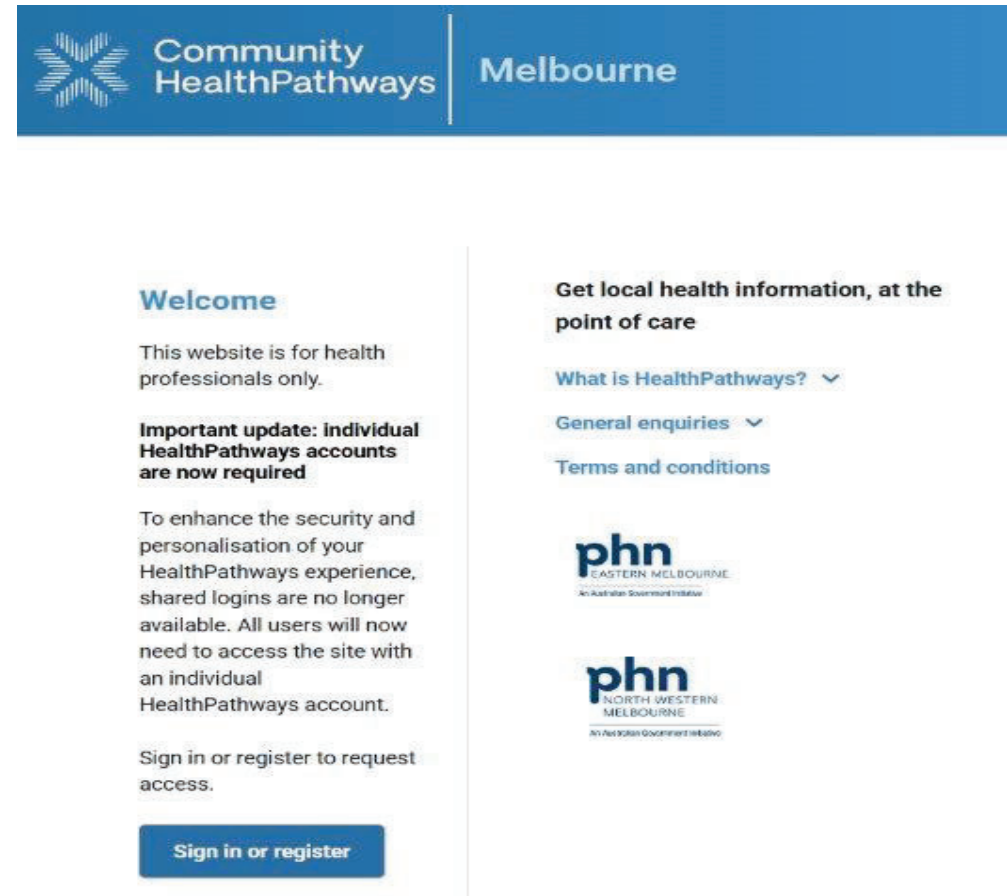
# Accessing HealthPathways

Please click on the **Sign in or register** button to create your individual account or scan the QR code below.

If you have any questions, please email the team [info@healthpathwaysmelbourne.org.au](mailto:info@healthpathwaysmelbourne.org.au).



 [melbourne.healthpathways.org.au](http://melbourne.healthpathways.org.au)

A screenshot of the HealthPathways Melbourne website. The header is blue with the "Community HealthPathways Melbourne" logo. The main content area is white and contains a "Welcome" message, a notice about individual accounts, and a "Sign in or register" button. The right sidebar is blue and contains links for "What is HealthPathways?", "General enquiries", and "Terms and conditions", along with logos for "phn EASTERN MELBOURNE" and "phn NORTH WESTERN MELBOURNE".

**Community HealthPathways Melbourne**

**Welcome**

This website is for health professionals only.

**Important update: individual HealthPathways accounts are now required**

To enhance the security and personalisation of your HealthPathways experience, shared logins are no longer available. All users will now need to access the site with an individual HealthPathways account.

Sign in or register to request access.

**Sign in or register**

**Get local health information, at the point of care**

**What is HealthPathways?** ▾

**General enquiries** ▾

**Terms and conditions**

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EASTERN MELBOURNE  
An Australian Government initiative

**phn**  
NORTH WESTERN MELBOURNE  
An Australian Government initiative



THE UNIVERSITY OF  
MELBOURNE

# PHN Cancer Screening Webinar

National Bowel Cancer Screening  
Program

A/Prof Justin Tse  
Melbourne Medical School







# Acknowledgement of Country

*We acknowledge the Wurundjeri people who are the traditional custodians of the land on which we meet today and acknowledge and pay our respects to their Elders past and present.*

*We acknowledge those who are meeting on other first nation lands and pay respect to their Elders past and present.*





# Cancer Screening Webinar – Colorectal Cancer

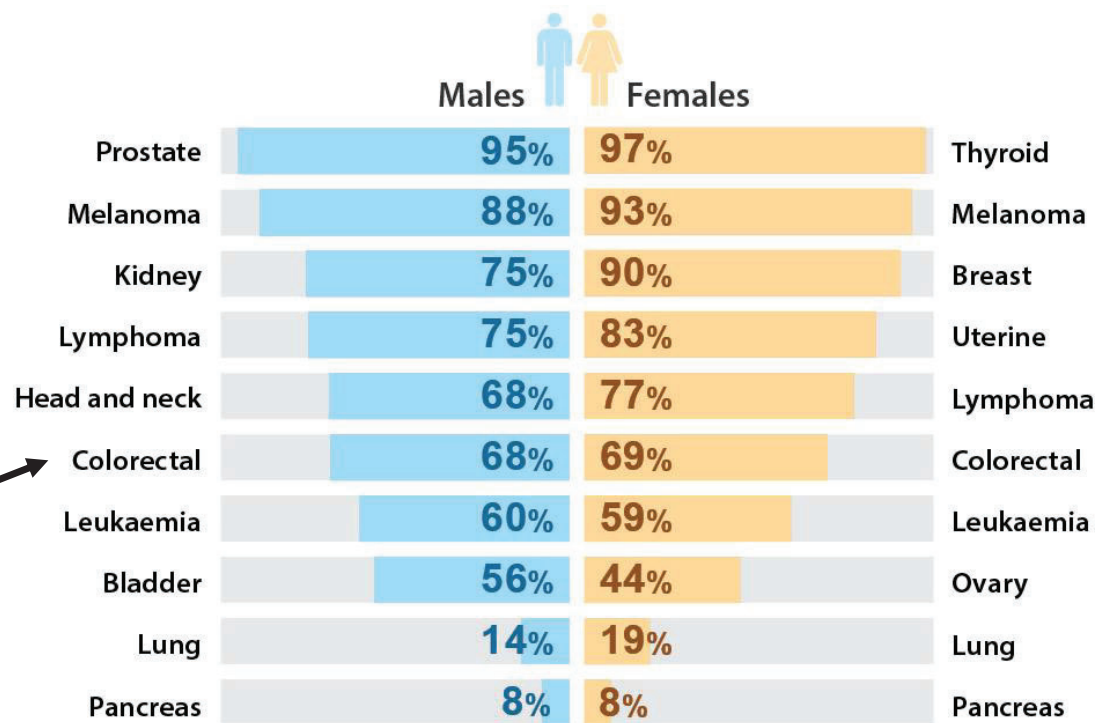
## Objective 1

Identify changes to the National Bowel Cancer Screening Program Guidelines and evidence supporting them

## Objective 2

Discuss changes required in clinical practice as a result of cervical and bowel screening guideline updates

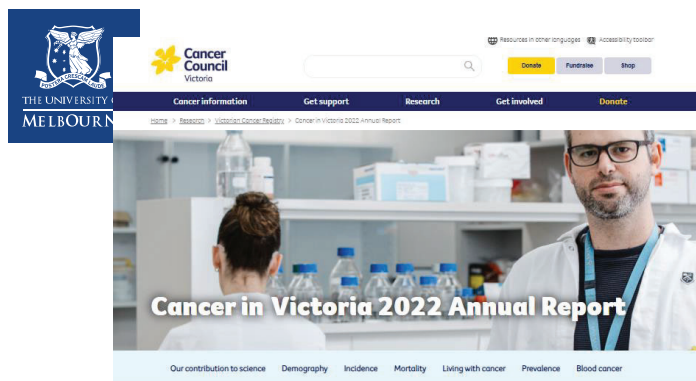
# Cancer in Australia = 5-year survival rates



**Victoria – 2023**  
**Bowel Cancer – Stage 1**  
**diagnosis – over 90%**  
**(5-year survival rate)**

**Overall 5-year survival**  
**rate – now at 73% for**  
**Bowel Cancer**

Source: AIHW Australian Cancer Database 2013.



**The Victorian Cancer Registry: Our contribution to science**

**Cancer Council of Victoria – Registry report 2022 - link**

**Relative survival rate – high for Breast, Prostate, Melanoma and Bowel Cancer**

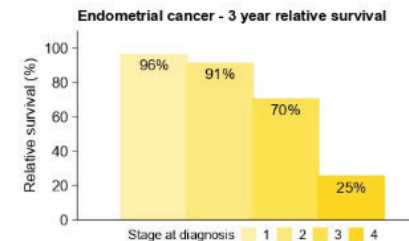
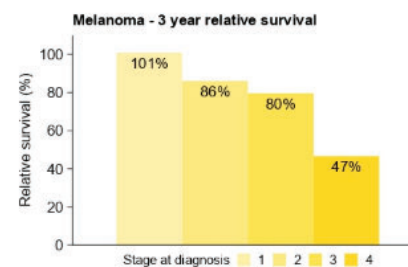
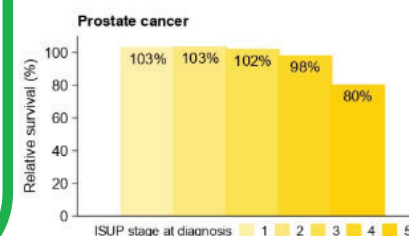
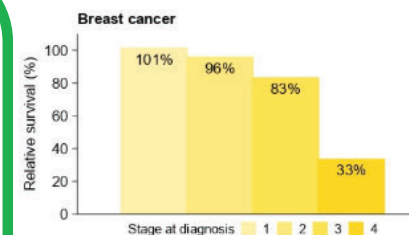
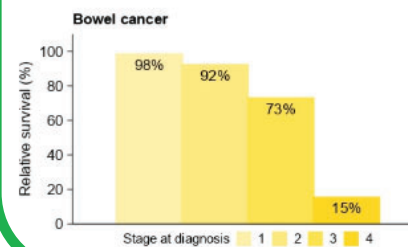
## Living with cancer

### A snapshot of cancer survival in Victoria in 2022:

- The 5-year survival rate for Victorians diagnosed with cancer has increased 48% over the past 30 years.
- Across all cancers, the 5-year survival rate is 73% for females and 70% for males.
- Survival rates vary significantly across cancer types and are also impacted by a person's age, whether they identify as Aboriginal or Torres Strait Islander, where they live, and the stage of cancer at diagnosis.

Five-year relative survival for breast, bowel and prostate cancer, one-year relative survival for melanoma and three-year relative survival for endometrial cancer by stage of disease at diagnosis, Victoria 2021 (Figure 44)

The stage at which cancer is diagnosed significantly impacts survival rates. Early-stage diagnosis, particularly in breast, prostate, and melanoma cases, shows a relative survival rate exceeding 100%. This suggests potential associations with factors like socioeconomic status, improved healthcare access, or lifestyle changes post-diagnosis that enhance survival rates.







# The symptomatic patient

**Screening programs for CRC are targeted for *asymptomatic* patients**

- If a patient presents with *symptoms or signs*, the *Optimal Care Pathways* suggest the following ->

Current colorectal cancer OCP guidance for Step 2: Presentation, initial investigations and referral

The following signs, symptoms and results should be investigated

- Positive iFOBT
- Passage of blood with or without mucus in faeces
- Unexplained iron deficiency anaemia
- Change in bowel habit (loose stools or constipation), especially a recent one
- Undiagnosed abdominal pain or tenderness
- Unexplained rectal or abdominal mass
- Unexplained weight loss
- Lethargy

Initial investigations include

- Detailed family history for patients presenting with possible symptoms of colorectal cancer
- Physical examination
- Digital rectal examination
- Full blood examination and iron studies

Referral options

At the referral stage, the patient's GP or other referring doctor should advise the patient about their options for referral, waiting periods, expertise, if there are likely to be out-of-pocket costs and the range of services available. This will enable patients to make an informed choice of specialist and health service.

Communication

The GP's responsibilities include:

- explaining to the patient and/or carer who they are being referred to and why
- supporting the patient and/or carer while waiting for specialist appointments informing the patient and/or carer that they can contact Cancer Council on 13 11 20.

Timeframe

Test results should be provided to the patient within 1 week of testing. If symptoms suggest colorectal cancer, patients should be referred and colonoscopy completed within 4 weeks. Patients should see a surgeon within 2 weeks of GP referral following a positive diagnosis of colorectal cancer via colonoscopy.

# The RACGP Red Book Guidelines



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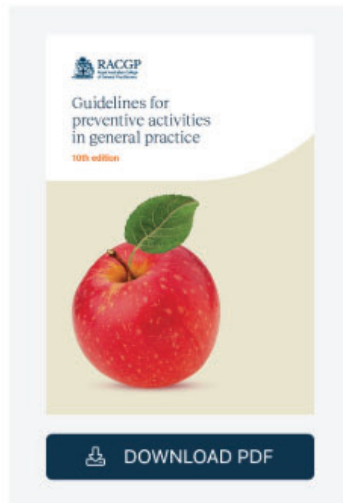


Table of contents
Table of Abbreviations
About the Red Book
<b>Screening, case finding and prevention principles</b>
Structure of the Red Book

Search guideline



## Cancer | Colorectal cancer

### Screening age bar (average risk)

0-9	10-14	15-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75-79	≥80
-----	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-----

#### > Prevalence and context of the condition

#### ✓ Table of recommendations

#### Screening

Recommended as of: 28/06/2024

Screening			
Recommendation	Grade	How often	References
Immunochemical faecal occult blood testing (iFOBT) every 2 years is recommended starting at age 45 years and continuing to age 74 years for those at average risk of colorectal cancer.	Conditionally recommended	Every 2 years	5
Colonoscopy is not generally recommended for screening people at average or slightly increased risk according to their family history.	Generally not recommended	N/A	6,7,8





# The National Bowel Cancer Screening Program

National program – started in 2006 with expansion of age range in 2014 to 50–74-year-old

2024 – new age range 45–74-year-old

The rationale ->

- Evidence that early detection improves 5-year survival rate iFOBT. Safe and reliable test. Easy to use.
- iFOBT can reduce deaths from the disease by 36 per cent
- Still low uptake rate – 40% of eligible population
- Completed every two years



The screenshot shows the top navigation bar of the Cancer Council Australia website. It includes the Cancer Council logo, a search bar, a location selector, and a 'Donate' button. Below the navigation bar is a breadcrumb trail: Home / About us / Policy and advocacy / Early Detection Policy / Bowel cancer / Policy context. The main heading is 'Policy context' for 'Bowel Cancer Early Detection Policy'. A sidebar on the left lists 'On this page:' with a link to '1. National Bowel Cancer Screening Program'. A right sidebar contains a 'BOWEL CANCER OVERVIEW' section.

## Cost-effectiveness

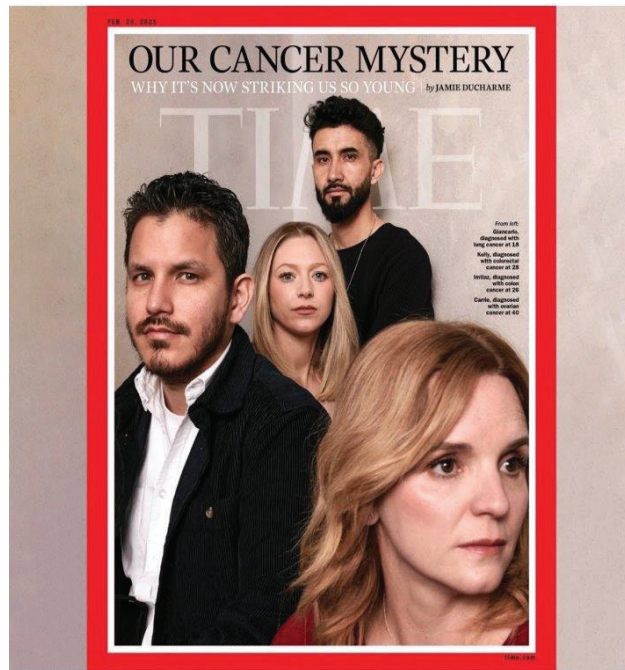
A range of studies have found population-based bowel cancer screening with iFOBT once every 2 years in people aged 50-74 years is cost-effective as discussed below.

A preliminary cost-effectiveness study of the NBCSP found that, over the lifetime and relative to no screening, the program was predicted to save 1,265 life years, prevent 225 bowel cancer cases and cost an additional \$48.3 million, equivalent to a cost-effectiveness of \$38,217 per life-year gained (LYG) at current participation levels. An analysis assuming full participation improved this to \$23,395 LYG.<sup>[14]</sup>




A 2017 cost-effectiveness study of the NBCSP found that biennial iFOBT screening is highly cost-effective and was predicted to be associated with a cost-effectiveness ratio of \$2,693-\$3,048 per life-year saved compared with no screening.<sup>[15]</sup> The fully implemented NBCSP is estimated to reduce bowel cancer incidence by 23% and mortality by 36%.<sup>[15]</sup> A subsequent study concluded that in comparison to other screening approaches (including no screening, colonoscopy, computed tomographic colonography, faecal DNA test, plasma DNA test and flexible sigmoidoscopy), the biennial iFOBT is highly cost-effective and the most cost-effective approach of all the screening scenarios considered.<sup>[16]</sup>



# Dan Buchanan – VCCC Monday Lunch Live ([link](#))



**13th Feb issue - TIME** ([link](#))



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ome > Why is bowel cancer in young Australians increasing?

## Why is bowel cancer in young Australians increasing?


Published on Mon, 06/03/2024 - 14:15

### Monday Lunch Live

3 June 2024

In this webinar, A/Prof Dan Buchanan presents on the alarming rise of colorectal cancer in Australians under the age of 50 years. He shares the latest information on bowel cancer in Australia, and his research on the causes of young-onset bowel cancer.

Young-onset colorectal cancer (bowel cancer) is now the leading cause of cancer-related deaths in Australians under the age of 50 years. The number of people diagnosed with young-onset colorectal cancer is increasing in Australia, but the questions remains, why? A/Prof Dan Buchanan's research uses different approaches to understand the cause of young-onset colorectal cancer: including the



[Source Details](#)



# Dan Buchanan – VCCC Monday Lunch Live [\(link\)](#)



Why is bowel cancer in young Australians increasing?



## Early-onset Colorectal Cancer is now a global problem

Incidence of EOCRC is increasing in US<sup>1</sup> and high-income countries<sup>2</sup>.

>10% of all new CRC diagnoses are EOCRC

11% of colon cancers and 23% of rectal cancers by 2030<sup>2</sup>

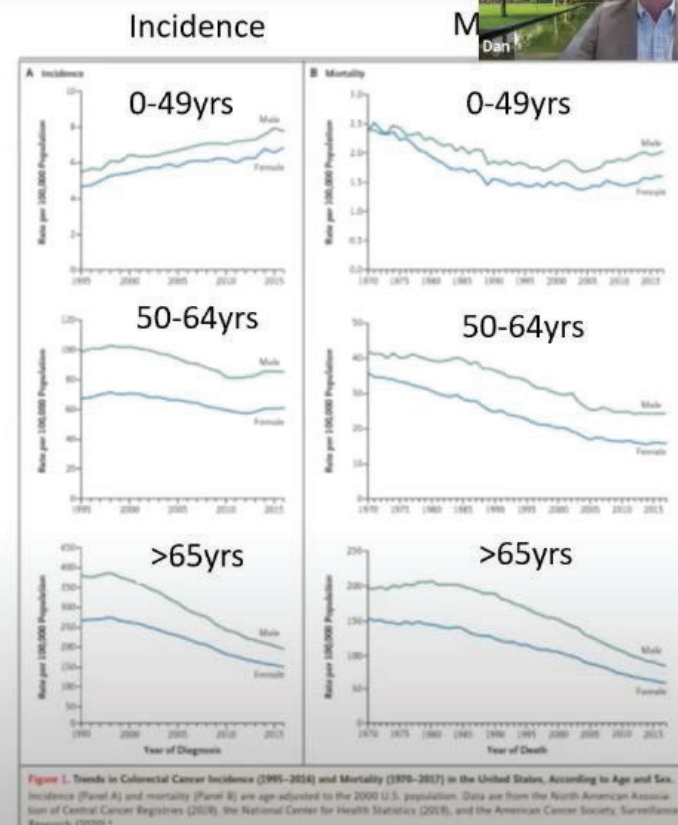
EOCRC is #1 cause of cancer-related death in US in men and #2 in women<sup>1</sup>

EOCRCs have more advanced stage at presentation and more cancer in distal (left-sided) colon and rectum<sup>1,2</sup>

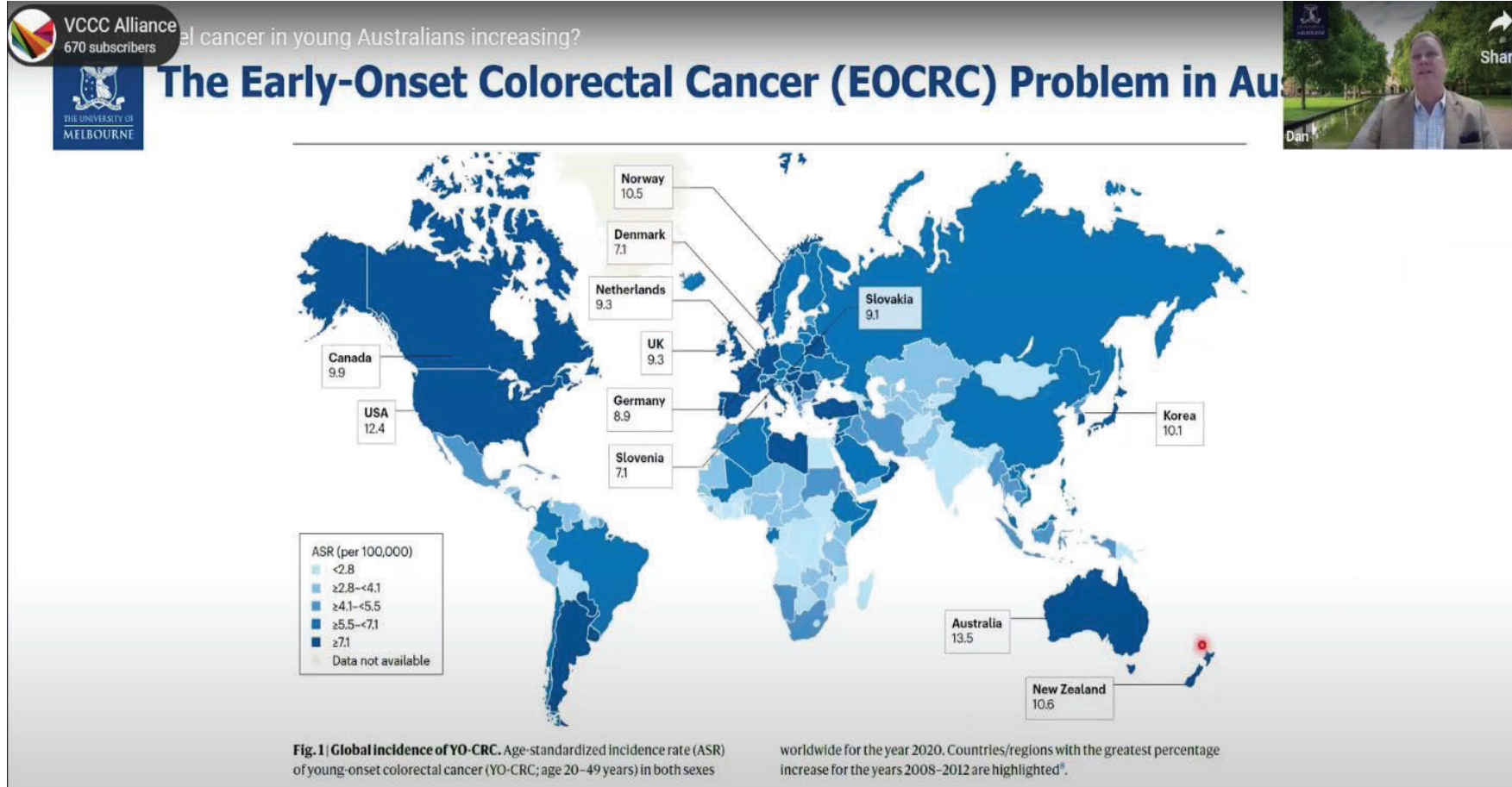
The cause of the increasing incidence is unknown...

➤ Birth cohort effect from 1950s

MORE VIDEOS



# Dan Buchanan – VCCC Monday Lunch Live [\(link\)](#)







## New age range – 45 to 74 years old

National Bowel Cancer  
Screening Program |  
Australian Government  
Department of Health and  
Aged Care - link

- Phone 1800627701 / web-form
- 45–49-year-old – must call up

### National Bowel Cancer Screening Program

This program aims to reduce deaths from bowel cancer by detecting early signs of the disease. If found early, more than 90% of cases can be successfully treated. Eligible Australians aged 45 to 74 can do a free test at home every 2 years. Learn about the program and how to do the test.

#### Learn about the program

Understand why it's important to have regular bowel screening tests.



#### Doing a bowel screening test

Find out what's involved in doing a bowel screening test.



#### Understand what your result means

Learn what your bowel screening result means and what happens next.



#### Kit access for healthcare providers

Healthcare providers can now bulk order kits to issue to eligible patients.



#### Lowered eligible age for bowel screening

From 1 July 2024, people aged 45 to 49 can join the program and screen for free. You can request your first free kit by [submitting a webform](#) or calling 1800 627 701. All eligible people aged 45 to 74 can also ask their doctor about getting a kit.

[Learn more about the change >](#)



Aged 45 to 49 and want a kit? Overdue for screening, need a replacement kit or form?

[Request your kit](#)

[Download a participant details form](#)



## Pause

### Reflection

As a primary care doctor

- Are we proactive in cancer screening in all cancers including colorectal cancer?
- If the participation rate is 40%, what can my clinic do to increase this participation rate?
- How can we encourage prevention and early detection in the 40–50-year-old age group of cancer and other conditions?

Fact – Cancer Council of Victoria states there will be 30,000 undiagnosed cancers by 2028 in Victoria due to a fall in screening rates post COVID pandemic



# General Practice pack - online access to information



Australian Government  
Department of Health and Aged Care

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## Guidance for patient screening

Australia's 3 national cancer screening programs aim to prevent cancer through regular testing and early detection. Learn about the programs and how you as a healthcare provider can play an important role in our breast, bowel and cervical screening programs.

### On this page

[General practice packs](#)

[Your role in encouraging cancer screening](#)

[Clinical and screening guidelines](#)

[Stay up to date](#)

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[More cancer screening information](#)

### Cancer

[About cancer](#)



[Screening for cancer](#)

[Guidance for patient screening](#)

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[Guidance for patient screening | Australian Government Department of Health and Aged Care \(LINK\)](#)

