Key findings 2018-19

- **71.9% of eligible women aged 25-64 adequately screened**
  - 0.5 percentage point increase on the previous year, when coverage was 71.4%

- **4.41 million women aged 25-64 invited for screening**
  - A decrease of 1.0% on the previous year when 4.46 million women were invited

- **3.43 million women aged 25-64 tested**
  - An increase of 7.7% on the previous year when 3.18 million women were tested
The United Kingdom Statistics Authority has designated these statistics as National Statistics, in accordance with the Statistics Registration Service Act 2007 and signifying compliance with the Code of Practice for Statistics.

Designation can be broadly interpreted to mean that the statistics:

- meet identified user needs;
- are well explained and readily accessible;
- are produced according to sound methods; and
- are managed impartially and objectively in the public interest.

Once statistics have been designated as National Statistics it is a statutory requirement that the Code of Practice shall continue to be observed.

Find out more about the Code of Practice for Statistics at: https://www.statisticsauthority.gov.uk/code-of-practice/

The statistics in this report are used to inform policy and to monitor the quality and effectiveness of screening services.

They are derived from information that is routinely collected by Public Health England (PHE) for the operation of the screening programme, including quality assurance and performance management purposes.

We would like to acknowledge the key contributions made by members in PHE Screening who provided a significant contribution to the collection and interpretation of data, as well as acting as subject matter experts informing the production of this report.
Programme summary

This publication presents information about the NHS Cervical Screening Programme ('the programme') in England in 2018-19. It reports on women aged 25-64 who are invited for regular screening under the call and recall programme, the screening samples examined by pathology laboratories and subsequent referrals to colposcopy clinics. Women outside of this age group may also be assessed by the programme.

Women between the ages of 25* and 64 are invited for regular cervical screening under the programme, the intent of which is to detect abnormalities within the cervix that could, if undetected and untreated, develop into cervical cancer.

The statistics presented cover the following topic areas:

• Call and recall
• Cervical cytology
• Colposcopy

The associated data tables, interactive visualisation, appendices and quality statement are available on the main publication page:

https://digital.nhs.uk/pubs/cervical1819

*Women receive their first invite at/from age 24.5 years.

Call & recall
In 2018-19:
Age-appropriate coverage was 71.9%
(ages 25-64 years)

Cervical cytology
In 2018-19:
3.57 million samples were examined.
(all ages)

Colposcopy
In 2018-19:
182,304 women were referred for colposcopy
(all ages)
Publication resources

Report bulletin (this document)

• Presents a detailed summary of the findings from the 2018-19 data collection.

• Further information on the data presented within this report is available in the additional publication resources outlined here.

Interactive dashboard

• The main report is accompanied by an interactive data dashboard. Data are presented in maps and charts. This allows comparison between areas as well as showing changes over time.

• The geographic breakdowns included in the dashboard are upper tier local authority, region and country.


Data tables

• Contain all relevant statistics for 2018-19.

• Available in Excel and csv formats.

Appendices

• Further detail on a number of topics including:
  • Publication context
  • Coverage definitions
  • Changes to the programme
  • Data collection

Quality statement:

• Contextual information to aid understanding and presentation of the data including the methods used to compile the statistics and other background information that users may find useful.

All resources are available from the publication page:

Changes in 2018-19

Implementation of HPV (Human Papillomavirus) primary screening

• HPV primary screening continues to be implemented¹.

• In 2018-19, screening samples may have been processed using either the HPV triage or HPV primary screening protocols.

• The way in which samples are processed differs under the HPV triage and HPV primary screening methods (see page 20 for details of the pathways), resulting in changes in volume in certain pathways because of the new process.

• The datasets collected for the 2018-19 report, do not distinguish between individuals who were screened using either HPV triage or HPV primary screening.

Turnaround time (VSA15)

• Time from sample to receipt of result (known as turnaround time), is a key performance indicator for the programme.

• The lack of capacity in laboratories has impacted on turnaround times for cytology screening since 2017-18. See Appendix J for more information on this issue. See page 19 for the current figures.

Cervical Screening Saves Lives campaign

• Launched by PHE on 5 March 2019, the ‘Cervical Screening Saves Lives’ campaign is intended to increase awareness of screening and encourage women to attend for regular screening².

• The campaign launched in March 2019 and so will have some effect on the statistics for 2018-19. However, the campaign's main effect is expected to be captured in next year’s statistics (data for 2019-20).

Invites incident in 2018

• In 2018, an incident was identified relating to invitation letters sent³. The incident, which covered the period January to June 2018, affects equivalent to less than 1% of women invited in either 2017-18 or 2018-19.

• This incident was reported in the 2017-18 report, published November 2018. See Appendix F for more information.


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Section 1 - Call and recall - Programme overview

Coverage:
Defined as the percentage of women in a population eligible for screening at a given point in time who were screened adequately within a specified period.

Acceptable performance is defined as achieving coverage levels of 80% or greater.

The main coverage definition used in the report is age-appropriate coverage.

Women eligible for regular screening:
Age 25 to 64 years
(First invitation sent at 24.5 years)

Standard recall interval between screens:
Ages 25 to 49: three years
Ages 50 to 64: five years

Additional screens:
Women aged 65+ may be invited if they have a recent or previous abnormal test result OR have not had a cervical screening test since 50 and request one.

Key terms:
Call: invitation for previously unscreened women.
Recall: invitation for subsequent screens.

Detailed overview of programme:
https://www.nhs.uk/conditions/cervical-screening/

Age-appropriate coverage
(used for headline coverage figures, available since 2011)
25 to 49 = screened within the last 3.5 years on 31 March
50 to 64 = screened within the last 5.5 years on 31 March
25 to 64 = screened within the last 3.5 or 5.5 years (depending on age) on 31 March

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5. In a small proportion of cases the pathology laboratory is unable to assess the cells to give a result and the test is considered inadequate.

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Call and recall - Age-appropriate coverage
National and regional

National coverage as at 31 March, 2011 to 2019

- On 31 March 2019, coverage for women aged 25-64 was 71.9%, an increase of 0.5 percentage points from the previous year.
  - Coverage in the lower age cohort (25-49) increased to 69.8%, from 69.1% in 2018
  - Coverage in the upper age cohort (50-64) remained at 76.2%, the same as in 2018.

Regional coverage as at 31 March, 2018 and 2019

- In 2019, coverage ranged from 64.6% in London to 75.1% in the East Midlands.
- All screening regions, except for London, reported an increase in coverage in 2019 when compared with 2018.

Age-appropriate coverage at 31 March 2013 excludes some women from a small number of local authorities. Source: PHOF, Open Exeter, NHS Digital. See Data Table 1.

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LA coverage as at 31 March 2019, for women aged 25-64 years

- 101 of 149 LAs had coverage levels of 70% and above, an increase of two compared to 2018.

- Coverage ranged from 50.3% in Kensington and Chelsea (London) to 79.5% in Derbyshire (East Midlands).

- No LAs achieved the acceptable performance level of 80%.

An interactive version of this map is available in the visualisation:

National KC53 coverage as at 31 March 2018 and 2019

- In the 25-49 age cohort, coverage was lowest in the youngest age group (25-29) and highest in the oldest age group (45-49).
- In the 50-64 age cohort, coverage was lowest in the oldest age group (60-64) and highest in the youngest age group (50-54).
- In 2019, women aged 50-54 had the highest reported coverage at 78.4%.

**KC53 coverage**
(Historic definition providing more detailed age breakdowns)
25 to 49 = screened within the last 3.5 years on 31 March
50 to 64 = screened within the last 5 years on 31 March

The key difference to age-appropriate coverage is the time since last screening for the older age cohort (50 to 64); 5 years rather than 5.5 years.

Until a more detailed breakdown of age-appropriate coverage is available, the KC53 remains a useful resource for more detailed age group comparisons.

Source: KC53, NHS Digital. See Data Table 1a.
Call and recall – Coverage in UK countries
March 2019, ages 25-64 years

Cervical screening programmes in the UK countries have different target age groups and screening frequencies. When comparing coverage among UK countries, these differences should be considered.

- For England, Scotland and Wales, coverage is calculated within the past 3.5 years (age 25-49) or 5.5 years (age 50-64).
- For Northern Ireland, coverage is calculated within the past 5 years (age 25-64).

<table>
<thead>
<tr>
<th>Country</th>
<th>Number of eligible women (thousands)</th>
<th>Number of women screened within specified target period (thousands)</th>
<th>Coverage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>England</td>
<td>15,190.7</td>
<td>10,922.0</td>
<td>71.9</td>
</tr>
<tr>
<td>Northern Ireland</td>
<td>498.2</td>
<td>381.0</td>
<td>76.5</td>
</tr>
<tr>
<td>Scotland</td>
<td>1,410.4</td>
<td>1,030.7</td>
<td>73.1</td>
</tr>
<tr>
<td>Wales</td>
<td>776.7</td>
<td>568.1</td>
<td>73.2</td>
</tr>
</tbody>
</table>

Source for England: PHOF, Open Exeter, NHS Digital. See Data Tables 1 and 13.
Source for Northern Ireland: http://www.cancerscreening.hscni.net/statistics/wstats05.html#P-4_0
Source for Scotland: http://www.isdscotland.org/Publications/index.asp
Source for Wales: http://www.cervicalscreeningwales.wales.nhs.uk/statistical-reports
Women are invited for screening by the programme either as part of routine screening or because of a repeat screen being required. More detailed information about invitation types can be found on the next page.

The programme targets women aged 25-64, with women receiving their first invitation from age 24 years and 6 months.

- In 2018-19, 4.41 million women aged 25-64 were invited for screening, most of whom were aged 25-49 (3.39 million).

- The number of women aged 25-64 years invited for screening in 2018-19 decreased slightly to 4.41 million compared with the previous year (4.46 million in 2017-18).

- The peak in 2011-12 may be associated with the death and diagnosis of the high profile media personality Jade Goody. 

7. An unexpected increase in women tested in 2008-09 has been associated with the diagnosis and death from cervical cancer of the high profile media personality, Jade Goody (Lancucki et al, 2012). Research published in the Journal of Medical Screening reported that her diagnosis and death, which were well publicised, “…were marked by a substantial increase in attendances in the cervical screening programme in England….(Although the) increase in screening attendances was observed at all ages…..the magnitude was greater for women aged under 50” (Lancucki et al, 2012, p4) [https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3385661/]

Source: KC53, NHS Digital. See Data Tables 1 and 4
## Call and recall – Invitations for screening

### Types of invitation

Women in the programme may receive an invite to screen in one of five scenarios:

<table>
<thead>
<tr>
<th>Routine</th>
<th>(1) Call</th>
<th>Invites for previously unscreened women.</th>
<th>(2) Recall</th>
<th>Invites for subsequent screens following:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Previous negative cytology result or</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Previous negative HPV test and recalled after the usual interval (3 or 5 years).</td>
</tr>
</tbody>
</table>

| Early       | (3) Surveillance | Previous abnormal screening result. | (4) Abnormality | Last sample showed some abnormality and a repeat was advised. | (5) Inadequate | Last sample was inadequate. |
|repeat recall|               |                                          |               |                                                           |
|             |               | • Following treatment for cervical abnormalities. |             |                                                           |
|             |               | • Previous positive HPV test.              |             |                                                           |

Invites for screening by type of invitation, England 2017-18 and 2018-19, women aged 25-64

<table>
<thead>
<tr>
<th>Year</th>
<th>Total invites</th>
<th>Routine</th>
<th>Early repeat recall in less than 3 years for reasons of</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Call %</td>
<td>Recall %</td>
</tr>
<tr>
<td>2017-18</td>
<td>4,457,953</td>
<td>19.6</td>
<td>68.3</td>
</tr>
<tr>
<td>2018-19</td>
<td>4,412,229</td>
<td>20.5</td>
<td>68.3</td>
</tr>
</tbody>
</table>

Sum of components may not equal 100% due to rounding.

Source: KC53, NHS Digital. See Data Table 4.
Call and recall – Women tested

Women who attend a cervical screening appointment will have their sample taken and it will then be sent to a cytology screening laboratory for assessment. Women may be tested following an invitation from the programme, or screened opportunistically, i.e. if a test is overdue (not prompted by the programme) when visiting a GP or other health service.

National testing, 2008-09 to 2018-19

- In 2018-19, 3.43 million women aged 25-64 were tested, an increase of 0.25 million from the previous year.

- The peaks in 2008-09 and 2011-12, have been associated with the death and diagnosis of the high profile media personality Jade Goody.

National testing by source, 2014-15 to 2018-19

- In 2018-19, 82.6% of women aged 25-64 were tested following an invitation from the screening programme.

---

8. Research published in the Journal of Medical Screening reported that her diagnosis and death, which were well publicised, "...were marked by a substantial increase in attendances in the cervical screening programme in England...(Although the) increase in screening attendances was observed at all ages.....the magnitude was greater for women aged under 50" (Lancucki et al, 2012, p4) https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3385661/
Call and recall – Test results overview

In 2018-19, 3.43 million women (25-64) were tested, generating 3.55 million tests. 9.

97.6% of test results were adequate. (3.47 million tests)

2.4% of tests resulted in an inadequate sample. (86.2 thousand tests)

In instances where a repeat invitation was sent as a result of this inadequate sample, the results were as follows:

89.6% of test results were adequate. (73.0 thousand tests)

10.4% of tests resulted in an inadequate sample. (8.5 thousand tests)

Where a woman receives multiple tests, their final result will be the most severe result recorded in the year (see table below).

Of all final results:

- 5.6% showed an abnormality (non-negative)
- 1.1% showed a high-grade abnormality

<table>
<thead>
<tr>
<th>Result of test (most severe in year)</th>
<th>2017-18</th>
<th>2018-19</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total adequate test results</td>
<td>3,133,646</td>
<td>3,383,307</td>
</tr>
<tr>
<td>%</td>
<td>97.6%</td>
<td>97.6%</td>
</tr>
<tr>
<td>Negative</td>
<td>94.4</td>
<td>94.4</td>
</tr>
<tr>
<td>Borderline changes</td>
<td>2.3</td>
<td>2.2</td>
</tr>
<tr>
<td>Low-grade dyskaryosis</td>
<td>2.2</td>
<td>2.2</td>
</tr>
<tr>
<td>High-grade dyskaryosis (moderate)</td>
<td>0.5</td>
<td>0.5</td>
</tr>
<tr>
<td>High-grade dyskaryosis (severe)</td>
<td>0.6</td>
<td>0.6</td>
</tr>
<tr>
<td>High-grade dyskaryosis/?invasive carcinoma*</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>?Glandular neoplasia**</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>Total</td>
<td>100.0</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Source: KC53, NHS Digital. See Data Table 8.
For detailed explanations of the different types of cytology see Appendix D.
*?invasive carcinoma means ‘suspected invasive carcinoma’
**?glandular neoplasia means ‘suspected glandular neoplasia of endocervical type’

9. NB. Some women may receive multiple tests in a year for clinical reasons such as a previous inadequate sample or the need for a repeat test due to a previous abnormality (with or without treatment)
Call and recall – Abnormal test results

Tests showing a high-grade abnormality, England, 2018-19

The percentage of results showing a high-grade abnormality decreased with age; 2.2% for women aged 25-29, falling to 0.3% for women aged 60-64.

Tests with an abnormal result, by LA, 2018-19

Ages 25-64 years

Source: KC53, NHS Digital. See Data Table 8.
NB. The percentages are aggregates of four test result groups; high-grade dyskaryosis (moderate), high-grade dyskaryosis (severe), high-grade dyskaryosis (severe)/invasive carcinoma and glandular neoplasia (endocervical type)

119 of 149 LAs had between 4% and 8% of tests with an abnormal result. The maximum percentage of tests with an abnormal result was 10.4%.

Source: KC53, NHS Digital. See Data Table 12.
NB. The percentages are aggregates of six test result groups; high-grade dyskaryosis (moderate), high-grade dyskaryosis (severe), high-grade dyskaryosis (severe)/invasive carcinoma and glandular neoplasia (endocervical type)
Call and recall – Time from screening to receipt of results

National policy states that all women should receive their cervical screening test result within two weeks of the sample being taken.

The Key Performance Indicator (KPI) for this delivery is 98%.

Key definitions
The two week period is defined as the interval between the date the sample was taken and the date a woman received her result letter.

It is measured using an expected delivery date based on the date of letter printing and the postage class used by the screening department.

Key outcomes in 2018-19

• 48.4% of letters were received within 2 weeks, a decrease of 10.3 percentage points from the previous year.

The time taken to implement HPV primary screening across England has had an unintended impact on the cytology workforce and reduced cytology screening capacity. This has led to an increase in the turnaround times of cervical screening samples since 2016-17\(^{10}\) (see Appendix J for more information). Actions to address increases in turnaround-time have been put in place\(^{11}\). HPV primary screening is planned to be fully implemented across England by December 2019.

Source: VSA15, NHS Digital ‘Open Exeter’ system. See Data Tables 9 and 9a. NB. Figures prior to 2013-14 are derived from the PCO dataset. See Appendix B.


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Call and recall – Time from screening to receipt of results
Regional – Results within 14 days

Regional performance, 2017-18 and 2018-19, ages 25-64 years

- In 2018-19, no region met the KPI value of 98% of letters returned within 14 days.
- The North West reported the highest percentage of letters received within two weeks at 71.4%.
- Yorkshire and the Humber reported the lowest percentage of letters received within two weeks at 21.4%.
- Three regions had increased performance compared to the previous year (North East, North West and the East of England).

A LA breakdown of this output is available both in the Data Tables and the interactive visualisation:


Source: VSA15, NHS Digital ‘Open Exeter’ system. See Data Tables 9 and 9a.
Call and recall – Recall status

Following screening/testing, there are three types of recall status within the programme; normal recall (action code A), repeat recall (action code R), and suspend recall (action code S). This page describes the recall pathways for cytology screening with HPV triage and HPV primary screening.

**Normal recall status**

(Requires a further test which is earlier than a routine recall)

**Pathway:** Cytology screening with HPV triage

Normal recall status given following a test result of:
- negative cytology OR
- when there are borderline changes or low-grade dyskaryosis and the high risk HPV (hrHPV) test is negative

**Pathway:** HPV primary screening

A normal recall status will be given when the hrHPV test is negative.

**Repeat recall status**

(Requires a further test which is earlier than a routine recall)

**Pathway:** Cytology screening with HPV triage

Repeat recall required where the test result is:
- inadequate cytology OR
- borderline change when the hrHPV test result is unavailable

**Pathway:** HPV primary screening

Repeat recall required where the test result is:
- hrHPV unavailable
- hrHPV positive with inadequate cytology

An early recall of 12 months will be given if the result is hrHPV positive with negative cytology.

**Suspend recall status**

(Recall suspended due to referral to colposcopy)

**Pathway:** Cytology screening with HPV triage

Only allowable status following a test result of high-grade dyskaryosis (moderate) or worse.

Also used following negative cytology, borderline or low-grade dyskaryosis when the hrHPV test result is positive OR a series of inadequate cytology test results.

**Pathway:** HPV primary screening

Only allowable status following a test result that is positive for hrHPV with abnormal cytology.

Also required after testing positive for hrHPV and negative for cytology three times in a row OR a series of HPV unavailable or hrHPV positive with inadequate cytology test results.

Also used when individual remains under hospital care, regardless of test result in both screening pathways.

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### Call and recall – Recall status by most severe screening result

<table>
<thead>
<tr>
<th>Test result (2018-19)</th>
<th>Total number</th>
<th>Normal (A)</th>
<th>Repeat (R)</th>
<th>Suspend (S)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inadequate</td>
<td>77,869</td>
<td>-</td>
<td>97.5</td>
<td>2.5</td>
</tr>
<tr>
<td>Negative</td>
<td>3,161,293</td>
<td>94.6</td>
<td>4.5</td>
<td>0.9</td>
</tr>
<tr>
<td>Borderline changes</td>
<td>75,343</td>
<td>47.8</td>
<td>3.2</td>
<td>49.0</td>
</tr>
<tr>
<td>Low-grade dyskaryosis</td>
<td>75,724</td>
<td>21.2</td>
<td>1.3</td>
<td>77.5</td>
</tr>
<tr>
<td>High-grade dyskaryosis (moderate)</td>
<td>15,699</td>
<td>-</td>
<td>-</td>
<td>100.0</td>
</tr>
<tr>
<td>High-grade dyskaryosis (severe)</td>
<td>19,285</td>
<td>-</td>
<td>-</td>
<td>100.0</td>
</tr>
<tr>
<td>High-grade dyskaryosis/?invasive carcinoma*</td>
<td>792</td>
<td>-</td>
<td>-</td>
<td>100.0</td>
</tr>
<tr>
<td>?Glandular neoplasia (endocervical)*</td>
<td>1,246</td>
<td>-</td>
<td>-</td>
<td>100.0</td>
</tr>
</tbody>
</table>

- = recall status not applicable for this result

**?invasive carcinoma means ‘suspected invasive carcinoma’, ?glandular neoplasia (endocervical) means ‘suspected glandular neoplasia of endocervical type’

NB. The sum of components may not equal totals due to rounding.

Source: KC53, NHS Digital. See Data Table 10.

- Of women with only a negative result:
  - 94.6% of women were given a normal recall status.
  - 4.5% were given a repeat recall status as they were under surveillance or follow up.
  - 0.9% were given a suspend recall status as they were under hospital care\(^{12}\).
  - 97.5% of women with an inadequate screening result were given a repeat recall status.

---

12. Those with a negative result and suspend recall status could include some who were referred to colposcopy for symptoms noted at the time of testing.

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Call and recall - Impact of HPV triage testing on recall status

Borderline and low-grade results

Recall status for borderline screening results, 2008-09 to 2018-19

- Prior to HPV testing as triage and test of cure (from March 2012) most women with a first borderline screening result would have been assigned a repeat recall status.

- Where HPV testing has been implemented, women with a borderline result are tested for high risk HPV and depending on the result either returned to ‘normal’ routine recall or referred to colposcopy and given a suspend recall status. In 2018-19, comparatively few women (3.2%) were given repeat recall status.

Recall status for low-grade screening results, 2008-09 to 2018-19

- The change following the introduction of HPV testing in March 2012 is less pronounced for women with low-grade dyskaryosis screening results. However, the increase in the proportion of women with a normal recall status and the fall in the proportion with a repeat recall status is still evident.

NB. Figures prior to 2013-14 are derived from the PCO dataset. See Appendix B. Source: KC53, NHS Digital. See Data Table 10.

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Changes to cervical screening policy

- In May 2013 a HPV primary screening pilot was launched whereby cervical samples are first tested for HPV.
- This differs from the existing process where samples are examined under a microscope by a cytologist for signs of abnormality.
- If a sample is found to be HPV negative, the woman is returned to routine recall.
- If a sample is found to be HPV positive, a slide is prepared from the same sample and examined by a cytologist.
- Women who have a HPV positive screen with a cytology negative result, will be recalled in 12 months for a further screen.
- Women who have a HPV positive screen with an abnormal cytology result are referred to colposcopy.
- If results are unavailable following three tests then a referral to colposcopy is made.
- For further details see the Quality Statement.
Women who have an inadequate sample either have to be tested again or referred to colposcopy following a third consecutive inadequate result.

- The proportion of inadequate samples has fallen since the introduction of Liquid Based Cytology (LBC) in 2004-05.
- Before the introduction of LBC technology, rates of inadequate samples submitted by GP and NHS Community Clinics (NHSCC) for women aged 25-64 were between 9% and 10% each year.

Source: KC61. NHS Digital. See Data Tables 1 and 15.
Cervical cytology – inadequate samples (GP & NHS Community Clinics)

Inadequate samples by age, 2018-19

- 2.3% of all samples were inadequate, similar to previous years.
- The proportion of inadequate samples is higher in older age bands, 55 years and above.

Inadequate samples by laboratory, 2018-19

Ages 25-64 years

- Five laboratories had inadequate rates over 4%, with most (41 of 48) recording rates over 1% but less than 4%.

Source: KC61. NHS Digital. See Data Table 15.

Source: KC61, NHS Digital. See Data Table 19.
Cervical cytology – adequate samples (GP & NHS Community Clinics)
England 2018-19, ages 25-64 years

Adequate sample testing outcomes 2018-19

<table>
<thead>
<tr>
<th>Test result</th>
<th>Number</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Negative</td>
<td>3,061,823</td>
<td>95.0</td>
</tr>
<tr>
<td>Borderline changes</td>
<td>66,655</td>
<td>2.1</td>
</tr>
<tr>
<td>Low-grade dyskaryosis</td>
<td>63,822</td>
<td>2.0</td>
</tr>
<tr>
<td>High-grade dyskaryosis (moderate)</td>
<td>13,236</td>
<td>0.4</td>
</tr>
<tr>
<td>High-grade dyskaryosis (severe)</td>
<td>17,005</td>
<td>0.5</td>
</tr>
<tr>
<td>High-grade dyskaryosis/?invasive carcinoma*</td>
<td>621</td>
<td>0.0</td>
</tr>
<tr>
<td>?Glandular neoplasia (endocervical)*</td>
<td>1,129</td>
<td>0.0</td>
</tr>
<tr>
<td><strong>Total adequate samples</strong></td>
<td><strong>3,224,291</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>

- 95.0% of samples were reported as being negative.
- 2.0% of tests were reported as low-grade dyskaryosis.
- 2.1% of tests were found to have borderline change.
- Women below the age of 30 were amongst those most likely to have an abnormal test result (see Data Table 15).


NB. The sum of components may not equal totals due to rounding.
Source: KC61, NHS Digital. See Data Table 15.
Cervical cytology – time from receipt of sample to authorisation of laboratory report

England, 2008-09 to 2018-19, all ages

- The percentage of laboratory tests authorised (test confirmed) within two weeks fell from 72.6% in 2017-18 to 61.9% in 2018-19.
- Prior to 2016-17 the percentage authorised within 2 weeks had been above 90% since 2010-11.
- The increase in time to authorisation of reports in recent years is attributable to the time taken to implement HPV primary screening. This has affected capacity in laboratories due to reduced workforce. Further details can be found in Appendix J.
- Data for the 3.72 million samples authorised in 2018-19 is broken down further in the chart below.

Source: KC61, NHS Digital. See Data Tables 16 and 16a.

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Cervical cytology – Outcome of colposcopy referrals

There are two main colposcopy referral groups:

1. **Women referred after non-negative samples**

   **Prior to roll out of HPV testing:**
   Women with ‘persistent’ non-negative results (most significant result either inadequate, borderline change or low grade dyskaryosis).

   **After roll out of HPV testing as triage**
   Women with a first test result showing borderline change or low-grade dyskaryosis where they also test positive for HPV. Or persistent inadequate results.

2. **Women referred after a single occurrence of a potentially significant abnormality**

Outcomes where the most significant result was either a high-grade dyskaryosis (moderate), high-grade dyskaryosis (severe)/invasive carcinoma or glandular neoplasia (endocervical).

**Outcome of referrals, April to June 2018**

- Referrals following a potential significant abnormality were found to have the most severe conditions of cervical cancer; cervical intraepithelial neoplasia (CIN3) or adenocarcinoma in situ (60.5%).

- This compares to 5.2% for referrals following non-negative samples.

**Chart:**

- **Percent**
- **Women referred following:**
  - Persistent non-negative sample / positive HPV
  - Single occurrence of potentially significant abnormality

**NB:** The sum of components may not equal totals due to rounding. Chart excludes a very small number of cases with a non-cervical cancer outcome.

*Other includes: HPV only, no CIN/no HPV, seen in colposcopy: result not known, inadequate biopsy, see in colposcopy: no abnormality detected/no biopsy taken

Source: KC61, NHS Digital. See Data Table 18a
Cervical cytology – Achievable standards for laboratory reporting

Overview

The distribution of individual laboratory results is used by the programme for quality assurance purposes in monitoring performance. Where laboratories fall outside specified ranges (standards) there is a requirement to investigate the reason(s) for this.

The standards which laboratories are required to adhere to are outlined in ‘Achievable standards, Benchmarks for reporting and Criteria for evaluating cervical cytopathology’[^13]. The standards are set from the 5th and 95th percentiles of the distributions of Key Performance Indicators (KPIs).

There are three key values used in this quality assurance which are summarised on the right with further detail available in Appendix B. Values should be considered alongside other information rather than in isolation.

<table>
<thead>
<tr>
<th>Value</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>PPV</td>
<td>Positive Predictive Value</td>
</tr>
<tr>
<td></td>
<td>A performance indicator measuring the percentage of women referred with high-grade cytology or worse, whose biopsy is reported as CIN2 or worse.</td>
</tr>
<tr>
<td>APV</td>
<td>Abnormal Predictive Value</td>
</tr>
<tr>
<td></td>
<td>The percentage of samples reported as borderline or low grade that led to a referral and subsequent histological diagnosis of CIN2 or worse.</td>
</tr>
<tr>
<td>RV</td>
<td>Referral Value</td>
</tr>
<tr>
<td></td>
<td>The number of women referred to colposcopy per detection of one CIN2 or worse legion (excluding inadequate referrals).</td>
</tr>
</tbody>
</table>

The percentile ranges for the PPV, RV and APV indicators are calculated using data from the previous year (KC61, Part C2). For example, the PPV for 2018-19 is based on data from 2017-18.

See Appendix B for definitions of PPV, RV and APV and see Appendix E on Outcomes of Gynaecological Referrals for further information about cervical intra-epithelial neoplasia (CIN).

* Based on results for women aged 25-64 tested in GP and NHS community clinics only.

NB: Women with negative cytology but who test positive for HPV and are referred to colposcopy are not currently included in the calculation of referral value. See Appendix B – Definitions for more information.

Source: KC61, NHS Digital. See Data Tables 19 and 19a.
Section 3 - Colposcopy – Overview

What is a colposcopy?
A simple procedure used to look at the cervix to:
• Determine whether the cells are abnormal and
• Determine whether treatment is needed

When would a woman be referred for colposcopy?
• Some of the cells in their screening sample are abnormal
• The nurse or doctor who carried out the screening test thought their cervix didn’t look as healthy as it should
• It wasn’t possible to provide a woman with a clear result after several screening tests.
• Following persistent positive tests for high risk HPV

Further information
• Biopsies of tissue may be taken or treatment may be provided during a colposcopy
• https://www.nhs.uk/conditions/colposcopy/

Key referral figures 2018-19:
• 182,304 referrals to colposcopy were reported in 2018-19, an increase of 3.6% from 2017-18 (175,995).
• 65.1% of referrals were reported as being triggered by a screening test.
• 27.1% of referrals were clinically indicated (women referred because they had symptoms of a cervical abnormality).
• The proportion of referrals for ‘other’ reasons decreased from 8.4% in 2017-18 to 7.8% in 2018-19.

For further information see Data Table 20.

Note
This section includes women who were referred from outside the screening programme. (i.e. women referred directly to colposcopy, without a screening test, by a health service due to potential cervical cancer symptoms)

Colposcopy – time from referral to first offered appointment

England 2018-19

Time from referral to first offered appointment is defined as the time between the date on the referral letter and the first offered outpatient appointment, regardless of whether the appointment was attended or not.

- 38.1% of women were offered an appointment within 2 weeks of referral. This compares to 40.6% in the previous year.
- 65.6% of women were offered an appointment within 4 weeks of referral. This compares to 69.3% in the previous year.
- 94.9% of women with a referral type of ‘High-grade dyskaryosis moderate/severe’ were offered an appointment within 2 weeks. This meets the programme standard for at least 93% of women to be offered an appointment within 2 weeks.
- In 0.4% of cases, the time from referral to first offered appointment was over 12 weeks.

<table>
<thead>
<tr>
<th>Waiting time</th>
<th>All referrals</th>
<th>2017-18</th>
<th>2018-19</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;= 2 weeks</td>
<td>40.6</td>
<td>38.1</td>
<td></td>
</tr>
<tr>
<td>&lt;= 4 weeks</td>
<td>69.3</td>
<td>65.6</td>
<td></td>
</tr>
<tr>
<td>&lt;= 8 weeks</td>
<td>98.5</td>
<td>98.5</td>
<td></td>
</tr>
<tr>
<td>&lt;= 12 weeks</td>
<td>99.4</td>
<td>99.6</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Waiting time</th>
<th>High-grade dyskaryosis (moderate or severe)</th>
<th>2017-18</th>
<th>2018-19</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;= 2 weeks</td>
<td>95.9</td>
<td>94.9</td>
<td></td>
</tr>
<tr>
<td>&lt;= 4 weeks</td>
<td>99.5</td>
<td>99.4</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Waiting time</th>
<th>High-grade dyskaryosis / invasive carcinoma*</th>
<th>2017-18</th>
<th>2018-19</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;= 2 weeks</td>
<td>99.0</td>
<td>98.2</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Waiting time</th>
<th>Glandular neoplasia*</th>
<th>2017-18</th>
<th>2018-19</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;= 2 weeks</td>
<td>98.7</td>
<td>97.0</td>
<td></td>
</tr>
</tbody>
</table>


Source: KC65, NHS Digital. See Data Tables 20 and 21.
# Colposcopy – appointment attendance status by type

**England 2018-19**

- 71.2% of all appointments were attended
- 2.3% of appointments were cancelled by patients on the day
- 7.8% of appointments involved the patient not attending with no advance warning
- The lowest attendance was seen for follow up appointments (64.1%)

<table>
<thead>
<tr>
<th>Total appointments</th>
<th>New appointments</th>
<th>Return for treatment</th>
<th>Follow up</th>
<th>All appointments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attendance status</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Attended</td>
<td>74.4%</td>
<td>78.7%</td>
<td>64.1%</td>
<td>71.2%</td>
</tr>
<tr>
<td>Cancelled by patient - in advance</td>
<td>13.6%</td>
<td>12.7%</td>
<td>14.9%</td>
<td>14.0%</td>
</tr>
<tr>
<td>Cancelled by patient - on the day</td>
<td>2.1%</td>
<td>2.0%</td>
<td>2.7%</td>
<td>2.3%</td>
</tr>
<tr>
<td>Cancelled by clinic</td>
<td>3.0%</td>
<td>2.7%</td>
<td>7.9%</td>
<td>4.7%</td>
</tr>
<tr>
<td>Did not attend - no advance warning</td>
<td>6.8%</td>
<td>3.9%</td>
<td>10.3%</td>
<td>7.8%</td>
</tr>
<tr>
<td>Did not attend - arrived late</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Did not attend - left without being seen</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
</tr>
</tbody>
</table>

NB. The sum of components may not equal totals due to rounding.
Source: KC65, NHS Digital. See Data Table 22.

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Colposcopy (first attendances)\(^\text{17}\) – type of procedure\(^\text{18}\) and referral indication

**England 2018-19**

- 57.3% of all women attending for the first time had some treatment or procedure.
- For all referrals, the most common treatment or procedure was diagnostic biopsy (44.8%).
- The most common treatment differed between referrals for borderline or low-grade abnormalities (diagnostic biopsy – 58.6%) and high-grade abnormalities (excision – 51.0%).


<table>
<thead>
<tr>
<th>Referral indication</th>
<th>Total first attendances</th>
<th>All referrals*</th>
<th>Inadequate</th>
<th>Borderline changes or low-grade dyskaryosis</th>
<th>High-grade dyskaryosis or worse**</th>
<th>Clinical indication (urgent)</th>
<th>Clinical indication (non-urgent)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Treatment</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>No procedure</td>
<td>42.7</td>
<td>72.1</td>
<td>39.8</td>
<td>12.3</td>
<td>58.1</td>
<td>62.0</td>
<td></td>
</tr>
<tr>
<td>Procedure used</td>
<td>57.3</td>
<td>27.9</td>
<td>60.2</td>
<td>87.7</td>
<td>41.9</td>
<td>38.0</td>
<td></td>
</tr>
<tr>
<td>Diagnostic biopsy</td>
<td>44.8</td>
<td>25.4</td>
<td>58.6</td>
<td>36.6</td>
<td>34.8</td>
<td>31.1</td>
<td></td>
</tr>
<tr>
<td>Excision</td>
<td>10.6</td>
<td>0.7</td>
<td>1.2</td>
<td>51.0</td>
<td>1.6</td>
<td>1.1</td>
<td></td>
</tr>
<tr>
<td>Ablation without biopsy</td>
<td>0.3</td>
<td>0.2</td>
<td>0.0</td>
<td>0.0</td>
<td>0.4</td>
<td>1.1</td>
<td></td>
</tr>
<tr>
<td>Ablation with biopsy</td>
<td>0.1</td>
<td>-</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.2</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>1.5</td>
<td>1.5</td>
<td>0.3</td>
<td>0.1</td>
<td>5.0</td>
<td>4.5</td>
<td></td>
</tr>
</tbody>
</table>

**NB:** The sum of components may not equal totals due to rounding.

* Includes ‘other’ referral indications that cannot be broken down into a specific category.
** Includes ‘invasive carcinoma which means ‘suspected invasive carcinoma, and ‘glandular neoplasia which means ‘suspected glandular neoplasia of endocervical type’.

Source: KC65, NHS Digital. See Data Table 23.

17. Most first attendances will relate to a referral in that year, although some women attending may have been referred in a previous year and some of the women referred in 2017-18 will attend in the next year.
18. The data collected relate only to procedures undertaken the first time a woman attends. In the case of deferred treatment the woman will be recorded as having no treatment at her first attendance.

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Colposcopy (first attendances)\textsuperscript{19} – procedure usage\textsuperscript{20} by region

<table>
<thead>
<tr>
<th>Reporting region and sub-region*</th>
<th>Procedure used</th>
<th>No procedure</th>
</tr>
</thead>
<tbody>
<tr>
<td>England</td>
<td>57.3</td>
<td>42.7</td>
</tr>
<tr>
<td>NEYH</td>
<td>60.9</td>
<td>39.1</td>
</tr>
<tr>
<td>North East</td>
<td>67.2</td>
<td>32.8</td>
</tr>
<tr>
<td>Yorkshire and the Humber</td>
<td>58.0</td>
<td>42.0</td>
</tr>
<tr>
<td>North West</td>
<td>50.4</td>
<td>49.6</td>
</tr>
<tr>
<td>East Midlands</td>
<td>68.0</td>
<td>32.0</td>
</tr>
<tr>
<td>West Midlands</td>
<td>51.9</td>
<td>48.1</td>
</tr>
<tr>
<td>East of England</td>
<td>52.6</td>
<td>47.4</td>
</tr>
<tr>
<td>London</td>
<td>51.1</td>
<td>48.9</td>
</tr>
<tr>
<td>South</td>
<td>66.4</td>
<td>33.6</td>
</tr>
<tr>
<td>South East</td>
<td>63.9</td>
<td>36.1</td>
</tr>
<tr>
<td>South West</td>
<td>67.9</td>
<td>32.1</td>
</tr>
</tbody>
</table>

*The North East Yorkshire and Humber (NEYH) reporting region is broken down into Yorkshire and the Humber and the North East sub-regions. The South reporting region is broken down to show the South East and South West sub-regions.

Source: KC65, NHS Digital. See Data Table 23.

\textsuperscript{19} Most first attendances will relate to a referral in that year, although some women attending may have been referred in a previous year and some of the women referred in 2017-18 will attend in the next year.

\textsuperscript{20} The data collected relate only to procedures undertaken the first time a woman attends. In the case of deferred treatment the woman will be recorded as having no treatment at her first attendance.

- The percentage of all women receiving some treatment or undergoing a procedure ranged from 50.4% in the North West to 68.0% in the East Midlands.

- Diagnostic biopsy was the most common procedure used across all regions, ranging from 34.8% of attendances in the North West to 54.0% in the North East.

- Excision was the next most common procedure, ranging from 1.2% in London to 14.1% in the South West.

- See Table 23 in the Data Tables for a full breakdown of the data by region, type of procedure and referral indication.
Colposcopy – Time from biopsy until patient informed of result\textsuperscript{21}
England, 2018-19 (4 month sample\textsuperscript{22})

- In 2018-19, 48,223 biopsies with a time to result recorded, were reported by clinics in the four sample months.

- The woman was informed of her result within 2 weeks in 39.4% of all cases, and in 46.2% of cases, women were informed within 2 to 4 weeks.

- In 0.5% of cases, women had not been informed of their results within 12 weeks. This figure includes cases where the result had not yet been reported to the clinic.

\textsuperscript{21} This is the time between the date on which the biopsy was taken and the date on the letter that is sent to the patient informing her of her result.
\textsuperscript{22} In order to allow time for follow up of results, the data relates only to those biopsies taken in the first month of each quarter. The data include all biopsies taken, not just those taken from women on first attendance. It is possible that more than one biopsy may be taken from the same woman.

Source: KC65, NHS Digital. See Data Table 24.
Colposcopy – non-diagnostic biopsies by outcome
England, 2017-18 and 2018-19 (4 month sample\textsuperscript{23})

Of all biopsies reported in 2018-19 with an outcome recorded (48,220), 68.4% were diagnostic and the remaining 31.6% were classed as non-diagnostic (excisional – 29.9%, other non-diagnostic – 1.7%)

- Excisional biopsies represent treatment to remove abnormal cells from the cervix. The outcome of most of these is therefore expected to be CIN1 or worse.

- Of all known non-diagnostic biopsy outcomes, 84.8% showed CIN1 or worse\textsuperscript{24}. This is a decrease from 2017-18, when the equivalent proportion was 85.4%.

<table>
<thead>
<tr>
<th>Outcome</th>
<th>2017-18</th>
<th>2018-19</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of biopsies reported</td>
<td>14,617</td>
<td>15,258</td>
</tr>
<tr>
<td>Biopsies with unknown result</td>
<td>17</td>
<td>27</td>
</tr>
<tr>
<td>Biopsies with known result (=100%)</td>
<td>14,600</td>
<td>15,231</td>
</tr>
<tr>
<td>Cancer</td>
<td>2.0</td>
<td>2.3</td>
</tr>
<tr>
<td>Adenocarcinoma in situ</td>
<td>2.7</td>
<td>2.8</td>
</tr>
<tr>
<td>CIN3</td>
<td>43.7</td>
<td>43.6</td>
</tr>
<tr>
<td>CIN2</td>
<td>24.9</td>
<td>24.9</td>
</tr>
<tr>
<td>CIN1</td>
<td>12.1</td>
<td>11.1</td>
</tr>
<tr>
<td>HPV / Cervicitis only</td>
<td>5.3</td>
<td>5.1</td>
</tr>
<tr>
<td>No CIN / No HPV</td>
<td>9.0</td>
<td>10.0</td>
</tr>
<tr>
<td>Inadequate / unsatisfactory biopsy</td>
<td>0.2</td>
<td>0.2</td>
</tr>
<tr>
<td><strong>Total showing CIN or worse</strong></td>
<td><strong>85.4</strong></td>
<td><strong>84.8</strong></td>
</tr>
</tbody>
</table>

\textsuperscript{23} In order to allow time for follow up of results, the data relates only to those biopsies taken in the first month of each quarter. The data include all biopsies taken, not just those taken from women on first attendance. It is possible that more than one biopsy may be taken from the same woman.

\textsuperscript{24} This covers CIN1, CIN2, CIN3, adenocarcinoma in situ and cancer.

NB: The sum of components may not equal totals due to rounding.
Source: KC65, NHS Digital. See Data Table 25.
## Section 4 - Clinical terminology definitions

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
<th>Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ablation</td>
<td>A treatment that destroys tissue rather than removes it.</td>
<td></td>
</tr>
<tr>
<td>Biopsy</td>
<td>A medical procedure that involves taking a small sample of tissue so that it can be examined under a microscope.</td>
<td><a href="http://www.nhs.uk/conditions/biopsy/pages/introduction.aspx">http://www.nhs.uk/conditions/biopsy/pages/introduction.aspx</a></td>
</tr>
<tr>
<td>Carcinoma in situ (CIS)</td>
<td>An early form of carcinoma. These are cancerous cells in the cervix but they have not started to grow beyond the small area where they started.</td>
<td><a href="http://www.nhs.uk/Conditions/Cancer-of-the-cervix/Pages/Diagnosis.aspx">http://www.nhs.uk/Conditions/Cancer-of-the-cervix/Pages/Diagnosis.aspx</a></td>
</tr>
<tr>
<td>Cervical Glandular Intraepithelial Neoplasia (CGIN)</td>
<td>An abnormality of the glandular tissue in the endocervix (the inside of the cervix or cervical canal).</td>
<td></td>
</tr>
<tr>
<td>Cervical Intra-epithelial Neoplasia (CIN)</td>
<td>Sub-divided into CIN1, CIN2, CIN3. See Appendix E for further information.</td>
<td></td>
</tr>
<tr>
<td>Clinical indication</td>
<td>A woman who has been referred because she had symptoms of a cervical abnormality and not because of a screening test.</td>
<td></td>
</tr>
</tbody>
</table>
# Clinical terminology definitions

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Colposcope</td>
<td>A specially designed and lighted microscope which allows a doctor or specialist nurse to look more closely at the cells lining the cervix.</td>
</tr>
<tr>
<td>Colposcopy</td>
<td>A detailed examination of the cervix (neck of the womb).</td>
</tr>
<tr>
<td></td>
<td><a href="http://www.nhs.uk/conditions/colposcopy/Pages/Introduction.aspx">http://www.nhs.uk/conditions/colposcopy/Pages/Introduction.aspx</a></td>
</tr>
<tr>
<td>Cytology</td>
<td>The medical and scientific study of cells. Cervical cytology refers to a specific branch of pathology, the medical specialty dealing with making diagnoses of cervical dysplasia.</td>
</tr>
<tr>
<td>Diagnostic biopsy</td>
<td>A biopsy taken to make a diagnosis.</td>
</tr>
<tr>
<td>Dyskaryosis</td>
<td>Small changes that are found in the cells of the cervix. The nuclear change which is seen in cells derived from lesions histologically described as CIN.</td>
</tr>
<tr>
<td>Dysplasia</td>
<td>An abnormality of development. Cervical dysplasia refers to abnormal changes in cells from the surface of the cervix which, if left untreated, could lead to cervical cancer.</td>
</tr>
<tr>
<td>Endocervical cells</td>
<td>Cells located in the inside of the cervix (cervical canal).</td>
</tr>
<tr>
<td>Excision biopsy</td>
<td>Surgery is used to remove a larger area of tissue, such as a lump, for closer examination.</td>
</tr>
</tbody>
</table>
# Clinical terminology definitions

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Glandular neoplasia of endocervical type</td>
<td>Samples showing cytological features suggestive of CGIN or endocervical adenocarcinoma. Appears as glandular neoplasia (endocervical) in this report.</td>
</tr>
<tr>
<td>Glandular neoplasia (non cervical)</td>
<td>Samples where no cervical abnormalities are found but the sample contained features suggesting a diagnosis of endometrial, ovarian, or metastatic lesions from beyond the genital tract.</td>
</tr>
<tr>
<td>Human Papillomavirus (HPV)</td>
<td>A family of viruses that affect the skin and the moist membranes that line the body, such as those in the cervix, anus, mouth and throat. Infection of the cervix with high risk HPV types can cause abnormal tissue growth and other changes to cells, which can lead to cervical cancer.</td>
</tr>
<tr>
<td>HPV Primary Screening</td>
<td>Used in six pilot sites and is starting to be implemented as the preferred method of cervical screening. Cervical samples are tested for HPV as the primary test and only those samples where high risk HPV is detected will have a cytological screen. Those with abnormal cells will be referred to colposcopy and those with no abnormal cells will be recalled within 12 months to repeat screening.</td>
</tr>
<tr>
<td>HPV Triage screening</td>
<td>Used on cervical samples that have first had a cytology test result of ‘borderline’ or ‘low grade dyskaryosis’. The sample is further tested for the presence of HPV and, if positive, indicates the woman should be referred for colposcopy.</td>
</tr>
</tbody>
</table>
## Clinical terminology definitions

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Invasive squamous carcinoma</td>
<td>Known as ‘suspected invasive squamous carcinoma’ or cancer. Appears as ?invasive carcinoma in this report.</td>
</tr>
<tr>
<td>Koilocytosis</td>
<td>A type of change to cervical cells caused by HPV infection.</td>
</tr>
<tr>
<td>Non-diagnostic biopsy</td>
<td>A biopsy taken with the intention of excising/treating the cervical abnormality.</td>
</tr>
<tr>
<td>Screened</td>
<td>A woman has been screened if she has had an adequate cervical screening test result. A woman who has only had an inadequate test has not been classed as screened.</td>
</tr>
<tr>
<td>Squamous cells</td>
<td>Cells that cover the surface of the ectocervix (the outer surface of the cervix).</td>
</tr>
<tr>
<td>Tested</td>
<td>A woman has been tested if she has had a cervical screening test, regardless of the result.</td>
</tr>
</tbody>
</table>
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