1. For patients with an abnormal Pap, the Pap Tracking nurse will contact the patient by telephone per Ob/Gyn policy and follow-up with a tailored letter unless the patient is less than age 18, in which case she will be contacted by phone.

2. The timing of her appointment will depend on the severity of her Pap. In addition, if she has been colposcoped previously in the department and repeat colposcopy is indicated, the appointment will be scheduled with the same provider to promote continuity.

3. Patients who have a Pap showing atypical squamous cells of undetermined significance (ASC-US) will have a reflex HC-HPV test run (assuming concurrent collection with original Pap). If Hybrid Capture HPV shows a high risk type, then the patient will be contacted (see #1) and mailed the colposcopy letter (G.1.6) and colpo info sheet (G.1.7).

4. **Colposcopy** is recommended for the following subset of patients with ASCUS:
   a. Patients with ASCUS with “ASC-H” noted.
   b. Patients who are **HIV** positive.
   c. Patients who have a **grossly visible cervix lesion** at speculum exam.

5. Patients with Pap smears showing a **squamous intraepithelial lesion** - (LGSIL or worse) should be scheduled for colposcopic evaluation per Ob/Gyn policy and colpo letter mailed (G.1.6), (G.1.7). For most patients this should include an ECC and 4 quadrant biopsies. This holds regardless of the patient’s age, menstrual status and hysterectomy status. Individualization is, however, warranted in cases of patients with concomitant life-threatening illnesses.

6. Patients with a Pap smear showing atypical glands of undetermined significance (AGCUS) should be scheduled for colposcopy and routine ECC per Ob/Gyn policy and colpo letter mailed (G.1.6). EMB should be done in all women > 35 and in younger women who have unexplained vaginal bleeding. Consider ultrasound to rule out adnexal mass if pelvic exam limited.

7. If a Pap smear indicates **negative for intraepithelial lesion or malignancy** and fungal organisms morphologically consistent with Candida species or Trichomonas vaginalis, and if the patient was not treated since the Pap smear was taken, consider vaginitis evaluation/treatment.

8. If Pap smear reports **negative for intraepithelial lesion or malignancy** and a shift in flora suggestive of bacterial vaginosis and patient has not been treated
for bacterial vaginosis since Pap smear was taken, consider evaluation and treatment for bacterial vaginosis if patient is symptomatic.

9. If Pap report indicates endometrial cells, benign in a post menopausal woman and she is not on estrogen, this may indicate endometrial polyps, hyperplasia or carcinoma. If the patient is not taking estrogen she should undergo colposcopy and endometrial sampling.

10. Patients whose Pap shows histiocytes, hyperkeratosis or hyperparakeratosis as the only abnormality do not need any further evaluation.

11. Pap smears which lack endocervical cells, if performed with a brush/spatula, do not need to be repeated.

FOLLOW-UP:

12. **Pap: Normal and HPV positive**: If penultimate Pap was NEGATIVE, repeat Pap and HPV (co-testing) in one year and, if both negative and assuming no prior indication for annual Paps, she can resume Paps three years apart and should be contacted and letter mailed (G.1.4). If penultimate Pap was ABNORMAL and/or HPV POSITIVE: follow-up colposcopy.

13. **Pap: ASC-US and HPV negative**: If penultimate Pap NEGATIVE, repeat Pap and HPV (co-testing) in one year and, if negative and assuming no prior indication for annual Paps, she can resume Paps three years apart and should be notified by mail accordingly (G.1.4). If penultimate Pap ABNORMAL and/or HPV POSITIVE, follow-up colposcopy.

14. **Pap: AGC and all biopsies negative**: If HPV is positive, consider additional work-up (LEEP, pelvic ultrasound). Otherwise, do Pap and HPV co-testing at 6 and 24 months and ECC, possible EMB. If all studies negative, may return to q.3.yr. screening. If any test is abnormal, repeat evaluation including colposcopy.

15. **Biopsy shows CIN-I**. Most cases will resolve spontaneously. Treatment should, therefore, be avoided for most cases. Do Pap and HPV co-testing at 12 and 24 months. If all studies negative, may return to q.3.yr. screening. If any test is abnormal, repeat colposcopy.

16. **Biopsy shows CIN II-III**. Treat appropriately. Pap and HPV co-testing at 6 and 24 months. If all studies negative, may return to q.3.yr. screening. If any test is abnormal, repeat colposcopy.