Meeting of 2 July 2016 at the Hotel Ibis Bastille Opera in Paris, under the auspices of UPIGO

Introduction by Guy SCHLAEDER, Strasbourg, Past President of UPIGO

As decided at our previous meeting on October 2015, today we shall hold a roundtable discussion on cervical cancer prevention. The second topic will be primary care for women. The UPIGO Annual General Assembly will be held at the end of the afternoon.

MAIN THEME : CERVICAL CANCER PREVENTION

Coordinator : Jean-Jacques BALDAUF (Strasbourg).

The reports were very detailed. Each participant was asked to summarise and outline desired improvements.

1- CERVICAL CANCER AND CERVICAL CANCER PREVENTION IN SWITZERLAND

André KIND (Basel)

Switzerland has one of the lowest cervical cancer incidence and mortality rates in the world and the lowest in Europe: the age-standardized incidence rate is 3.6 / 100 000 and the age-standardized mortality rate is 1.1 / 100 000. 240 women are diagnosed with and 94 women die from cervical cancer each year. Nevertheless these rates differ between regions within Switzerland. Rural areas have higher rates compared to urban ones. This is a pattern which is seen throughout the world.

Switzerland is a small country with a high level of economic wealth. The World Bank ranks Switzerland as number 4 in the list of countries with the highest gross domestic product in the world. Nevertheless, socioeconomic status and education have an impact on the incidence and mortality of women with cervical cancer, even in a system where prevention measures and treatment of cervical cancer are free. Women with a low level of education have a 50% higher risk of dying from cervical cancer compared to women with a high level of education.

The incidence rate of cervical cancer has dropped since the late 1960s by 50-60% and it is so low now that other disease associated with Human Papilloma Virus (HPV) such as Anal, Vulva and Oropharyngeal Cancers are gaining more importance.

It is not completely understood why the cervical cancer rate is so low in Switzerland. There is no national screening programme for cervical cancer. Screening is opportunistic and cytology based. The Swiss Society of Obstetrics and Gynaecology recommends cervical cytology screening every 2 years between 21 and 29 years and every 3 years between 30 and 70 years. Insurance companies pay for theses examinations. There is no good data on attendance at screening, but existing data suggest rates of around 70% every 3 years, with differences between women getting screened every year and about 10-15% women never getting screened.

As no good data is available, we do not know how many precancerous lesions are diagnosed and treated, how many colposcopies are performed, how many adverse outcomes such as

preterm labour are due to the treatment of precancerous lesions occurring, and what sort of psychological impact our screening has. We have no good estimates of the costs of our cervical cancer screening, but know that it is one of the most expensive worldwide.

New guidelines are currently being developed by a working group within the Swiss Society of Obstetrics and Gynaecology. One option is to have HPV-based screening included above 30 years of age.

Bi- and quadrivalent HPV-vaccines are available in Switzerland. The nonavalent vaccine has not yet been licenced. The national vaccination programme suggests HPV-vaccination at 11-14 years with a free catch up at 26 years. Vaccination is not mandatory in Switzerland and vaccination rates remain below 60%.

Conclusion

Switzerland has a very low rate of cervical cancer, but even so, 240 women are diagnosed with and 94 women die of cervical cancer. To reduce these rates, it will be necessary to introduce a national screening programme with a call/re-call system and quality assurance measures. HPV-vaccination rates need to be increased substantially. This is not only important for the primary prevention of cervical cancer, but also for the prevention of other HPV-related cancers such as anal cancer, for which no screening methods have been established.

2- CERVICAL CANCER PREVENTION – DATA ON GREECE: Athanasios CHIONIS (Athens)

- In Greece there is no organized population-based cervical cancer screening program.
- The existing program is opportunistic.
- Eligible age is 20+ or one year after the initiation of sexual activity.
- Interval period is one year.
- There is no registry concerning the total amount of pap smears of Hellenic territory.

Unfortunately in Greece there is no official screening program monitoring Pap smear records. From public health records, it can be concluded that there is a slight decline in the number of Pap smears performed annually from 49.524 in 2012 to 45.940 in 2014 even though Pap smears are available free of charge in the public sector. This can be attributed to the period of austerity and high rates of unemployment during the same period in Greece.

The same trend concerning the decline of the number of Pap smears can be noted in a random private hospital in Athens during the same time period.

What is of great importance, based on the IMS Data (March 2016), is an increase in the vaccination coverage from 20% in 2010 to 40% in 2015. Lately, the high vaccination coverage rates can also be partly attributed to the announcement that the HPV vaccine will stop being publically funded in women older than 18 years of age from 2017.

3 - INCIDENCE AND PREVENTION OF CERVICAL CANCER IN ALBANIA:

Gjergji THEODOSI (Tirana)

From the data of the University Hospital of Tirana, the incidence of cervical carcinoma in Albania during the years 2004-2013, were diagnosed about 9.3 cases for 100.000 women. They were treated using, surgery, chemo and radiotherapy, but still the women's mortality is very high.

The most of cases were from 45 to 64 years of age, more from the north-east regions.

The main directions of cervical carcinoma prevention were considered:

a. The careful treatment of all small, benign, pathologies of the uterine cervix, like polyps, ectropions, etc

b. The careful treatment of every type of inflamatory cervical process, till the normal aspect.

c. The current use of specific recommended examinations, like: Papanicolaou Test, every 1-2 years,

The Pap- Smear results were mostly normal, and about 6-8% considered with histopathologic features like: ASCUS; HSIL or LSIL. When considered necessary, we used colposcopic of cervical biopsy and the treatment was later based on the examens results..

The use of Anti HPV vaccine is not regular, and not financially covered.

The molecular biology laboratory of the Public Health Institute, is using currently, the examens for HPV types testing, The number of exams, is every year higher. (about 2500 examens for 5 years)

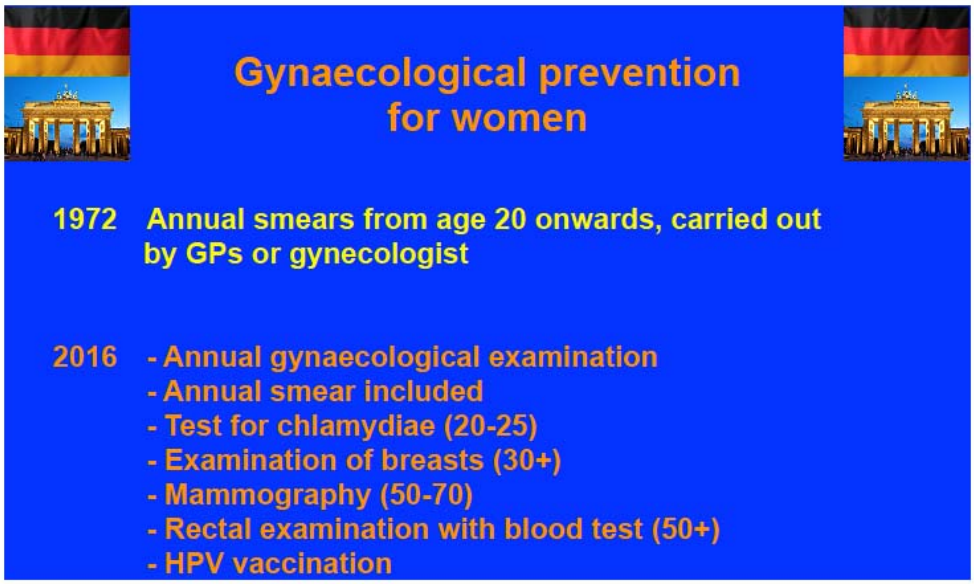
Up to now, there is not a National Screening Programme concerning genital carcinoma and not an organized vaccination using anti HPV vaccines.

4 - Ideas for screening in the future: Michael MENTON (Reutlingen, Germany)

In the future, when 80-90% of the population is vaccinated and the effectiveness of vaccination is proved, screening may be reduced.

Currently this condition has not been met in Central Europe.

The practice in Germany is as follows:



Diagnosis based on high quality cytology test is good enough for screening cervical cancer. The PPV (positive predictive value) is very high (90-95% for a smear indicating a major dyplasia). However, the PPV of the HPV test is 10%. Therefore there is a clear and significant danger of over-treatment.

A cytology test gauges the size of the lesion. It is possible to find cancers of the body of the uterus which are HPV negative. Furthermore, adenocarcinomas of the cervix are on the increase. There is evidence that the HPV-test is often not reliable and negative where a cervical adenocancer is present.

Commentaire [S1]: Importance or seriousness

The HPV test has a high sensitivity rate (85-90%) for the detection of HPV infection. Only 10% of positive cases reveal a dangerous lesion requiring treatment.

The HPV test should be added to the cytology test for older women (over 35 or 40). This would have two advantages. First, there is less risk of over-treatment because most women are no longer taking family planning measures. Secondly, cytology tests do not always make it possible to make a diagnosis in cases of atrophy. The combination could lead to increased sensitivity and specificity.

For women over 40, sensible screening would include a smear every two or three years and an HPV test every six years.

If an HPV test is positive, it is completed by a colposcopy, cytology and possibly biopsy.

The US industry is promoting “triage”.

This is inacceptable for several reasons:

- It is contradictory to first ask for a test with a higher sensitivity and then sort using this method, which is not considered sufficient.
- If a test is positive, the patient has a right to a proper examination, i.e. a colposcopy, cytology and histology depending on the situation.
- Industrial triage is not sufficient.
- Triage is a military process for when there insufficient resources (disasters, accidents or in war). In Europe, we currently have neither war nor a shortage of gynaecologists. This military method cannot be accepted in civil circumstances.

5 - Prevention of cervical cancer in Mali

1 °) Screening and treatment of precancerous cervical lesions in Mali using visual inspection methods further to application of acetic acid and Lugol's solution, by Toure Moustapha, Traoré Alassane, Binta Keita, Tegueté Ibrahim, Traoré Cheick and Traoré Youssouf.

Cervical cancer is the second most common cancer among women in the world with 452,000 new cases per year. In Mali it is the most common cancer among women. According to a study conducted in 2008, its rate of occurrence is 27 per 100,000 women per year. Cervical cancer mortality and morbidity rates are growing. In Mali, as in most developing countries, three-quarters of the cases are diagnosed at a late stage. It is a real public health problem in Mali.

Visual tests after application of acetic acid and Lugol's solution were used with the following results:

The study was conducted throughout the country, under the aegis of the National Directorate of Health and the Malian Society of Gynaecology Obstetrics and with the participation of 28 physicians, 52 midwives and 3 health technicians, between February 2001 and April 2010. 26,164 women were screened. 2,093 (8%) tested positive and 24,070 (92%) tested negative. The age range was between 25 and 59 years, with an average of 39.6 years plus or minus 7. 38% were illiterate.

The number of pregnancies varied from 0 to 20, with an average of 5.25 (the fertility rate is about 6 children per woman).

The histological diagnosis was as follows: 489 cases of cervicitis; 332 condylomas, 680 dysplasias and 261 cancers, observed mostly at a late stage.

Treatment methods included cryotherapy, loop diathermy treatment (in about 40% of cases), conisation and surgery.

In conclusion: screening for precancerous lesions of the cervix by acetic acid and Lugol's solution offers an alternative to vaginal cervical smears for countries with limited resources and insufficient qualified personnel. It can be used at low cost, is easy to organise with staff in basic centres. Rapid availability of results allows immediate treatment of lesions.

2) Vaccination against the papilloma virus in Mali, by Toure Moustapha, Diallo Fanta Siby and Traoré Alassane

Like other countries in the epidemiological area of West Africa, Mali has embarked on a new process to strengthen its expanded routine vaccination programme by introducing vaccination against the papilloma virus. This is in line with commitments under the Global Vaccine Action Plan as part of efforts to meet the Millennium Development Goals.

According to a study carried out in Mali in 2008, the occurrence of cervical cancer is estimated to be 27 per 100,000 women per year; with 89.7% of cervical cancer cases associated with HPV.

A pilot study was undertaken under the aegis of the National Health Directorate's National Vaccination Centre, in two urban and rural areas covering 416 villages and 38 neighbourhoods, with 231 vaccinators, 4 national supervisors and 8 district supervisors. It produced the following results.

In rural areas, the target population was estimated at 7,373 10-year-old girls, of whom 5,335 were enrolled at school and 2,038 were in the community. 100% were vaccinated during their first visit.

In urban areas, the target population was estimated at 3,668 10-year-old girls, of whom 3,235 were enrolled at school and 169 were in the community. 93% were vaccinated

Conclusion: The results of this pilot study (100% of the vaccination rate in rural areas and 93% in urban areas) revealed that HPV vaccination is possible in our country. It is hoped that it will be possible to roll the programme out across the whole of Mali. The results of the second visit should be received soon.

Mali is keen to cooperate with UPIGO cooperation in various sectors, particularly in the field of training and research.

6 - Cervical cancer prevention in France, Jean-Jacques Baldauf, Strasbourg

In France there are still nearly 3,000 new cases of cervical cancer each year, causing 900 to 1,000 deaths. Screening for cervical cancer is opportunistic except in 13 *départements*, which are experimenting with organised screening. The highly improved effectiveness of organised screening is due both to the increased participation of women, especially older women, and the better quality of samples, the interpretation of smears and the follow-up of women showing abnormal results. As a result, a ministerial order has been issued to designate regional organisations responsible for rolling out organised screening for cervical cancer on the basis of terms of reference drawn up by the National Cancer Institute (INCa). The aim is to have organised screening rolled out across the country in 2018. The main recommendations are:

- systematic sending of invitations letters/reminders to women who haven't participated in screening,
- monitoring of all women who test positive (whether they have participated spontaneously or have been invited to participate in screening by post);
- the diversification of ways of taking samples involving GPs, midwives and other healthcare professionals by providing training and offering quality assurance for samples and information measures for professionals and women.

In parallel, vaccination in France is both non-organized and non-systematic. Nine years after the introduction and reimbursement of HPV vaccination in France, vaccination coverage is inadequate, with less than 20% of 16-year-old girls receiving three doses. In addition, since 2010, vaccination coverage has been decreasing among girls aged 14-16. In response to these poor vaccination coverage figures, the French High Council for Public Health changed

its recommendations on HPV vaccination in 2013 by targeting the vaccination of girls aged 11 to 14, that is, before they become sexually active, with a catch up between 15 and 19. This new target age range target involves both GPs and paediatricians, and it already entails a vaccination appointment. Moreover, it “desexualizes” the vaccine and produces a better immune response, as it permits a schedule where two doses are administered with a six-month interval. The 31% increase in the number of doses of vaccines sold in 2013 compared to 2012 reflected the larger target group but has not led to an increase in vaccination coverage over the medium and long term. However, the lowering of the target age (girls aged 11 to 14) should help increase the proportion of uninfected girls at the time of vaccination because they will not have become sexually active. It must be noted that vaccination coverage in France is too low to obtain a significant impact which would make a change in screening strategy possible.

7 - Prevention of cervical cancer in Slovakia: Martin Rocheda, Bratislava

Cervical screening is carried out for women between the age of 23 and 64 years in the form of a conventional Pap smear, taken by a gynaecologist. Laboratories are certified and recognised on condition that they have a sufficient number of smears each year.

The incidence of cervical cancer is among the highest in Europe, at about 17.2%.

Only 30% of eligible women are enrolled on the screening programme. Participation is better in cities than in rural areas.

Planned: a National Centre for Cervical Screening to guarantee the quality of screening. A recall system is planned to improve participation in screening.

HPV vaccination

In Slovakia: Gardasil, Cervarix and Gardasil 9 are available. Despite the efforts of various expert associations, HPV vaccination is not offered in the national vaccination programme financed by the national health authorities.

8 - Prevention of Cervical Cancer in Luxembourg: Annik Conzemius (Luxembourg)

This summary should be considered provisional and subject to future modifications. Cervical screening is done in an opportunistic manner via annual checks. The participation rate is 72%.

A working group at the Ministry of Health is planning to improve the current system.

It is hoped to improve the vaccination rate of girls aged 11 to 14. There is currently a high degree of reluctance among both parents and doctors.

The vaccine currently used is Cervarix, with 2 injections between 11 and 14 years and 3 injections if the vaccine is used later.

Planned:

- between the age of 20 and 30: a single, annual cytology test.

- between the age of 30 and 60: joint HPV test and cytology test, repeated every 3 years if negative, more frequent tests if positive with colposcopy and biopsy according to the case,

- after 60: back to normal.

The working group has not yet completed its work. It is hoped that approval will be given in the autumn.

9 - Prevention of cervical cancer In Italy: Pier Francesco Tropea, Calabria Region

Cervical screening is free on the Health Service for women aged 25 to 64, with a smear every three years. Participation is better in northern Italy, at 90 %, compared to 60% in southern Italy

When cytology is positive, an examination takes place in hospital.

With colposcopy, biopsy and sometimes HPV test.

HPV vaccination

12-year-old girls are vaccinated (regional governments cover the cost) with a second dose after two months and a third dose after six months. Some regions even vaccinate for free between the ages of 15 and 18.

The percentage of vaccinees is 76 to 86%, in the north of the country, depending on the region, and 62 to 74% in the south.

Type of vaccine: most often bivalent (types 16 and 18), sometimes quadrivalent (16, 18.6 and 11).

Comments: Italian epidemiologists aim to vaccinate 95% of 12-year-old girls.

The HPV test is used in some areas in further to abnormal cytology results.

10 - In Europe: Jean-Jacques BALDAUF (Strasbourg)

Cervical cancer is well suited for screening. Its natural development is characterised by the long-term presence of pre-cancerous lesions which can be detected by a smear and then treated effectively.

The lack of screening is the biggest risk factor for cervical cancer in all countries. Experts from the World Health Organisation and the International Agency for Research on Cancer agree that the best solution is organisation, with a system where women are invited for screening.

Organised screening is the most appropriate way to combat lower participation caused by socio-economic inequalities. The introduction of well-organised cytological screening for cervical cancer in certain Nordic countries (Denmark, Finland, Iceland, Norway and Sweden) has reduced the occurrence of this cancer and mortality rates by up to 80%. In Europe, screening methods vary. Fourteen countries have a national organised screening programme. Seven others, including France, are developing regional programmes, covering between 4 and 72% of the population. Eleven countries only have voluntary screening at people's own initiative. This group includes Switzerland, where smears are carried out annually and yet cervical cancer rates are among the lowest recorded in Europe, probably thanks to the significant resources made available.

In countries where HPV vaccine coverage is high, we are currently obtaining initial results that show a significant decrease in precancerous cervical lesions among the vaccinated population. In Europe there are different ways of organising vaccination programmes (school campaigns, vaccination centres, private provision, tender processes), and vaccination is either free or reimbursed to varying degrees depending on the country. The target age range

for vaccination is broadly identical. Coverage rates vary between 17% and 86%, with France at the low end of this range.

Conclusion

The organisation of screening is essential to ensure quality of care and the limitation of bad practices, especially with regard to the involvement of health professionals other than gynaecologists and obstetricians, the use of screening processes requiring triage and even the development of specific strategies for particular target groups (women under 30, vaccinated women, etc.). Without waiting for the impact of vaccination to be seen, it is appropriate to replace individual screening with organised screening. This ensures increased safety and fairer treatment for patients, reduced costs for society and invaluable assistance for health professionals in dealing with anomalies in the recommended manner. This approach is a prerequisite for possible screening using the HPV test, which requires essential triage procedures.

97% of cervical cancers could be avoided by the optimal implementation of the two preventive measures.

Jean-Jacques BALDAUF (Strasbourg)

HEALTH CHECK-UPS FOR WOMEN AT THE DOCTOR'S OFFICE

Which examinations are really useful and effective?

by Guy Schlaeder* and Jean-Marie Mossard** (Strasbourg).

Preliminary remark: this update on primary care for women has been produced under the aegis of UPIGO (International Professional Union of Gynaecologists and Obstetricians). It was presented at the annual meeting on 2 July 2016 in Paris. UPIGO is an INGO which enjoys participative status with the Council of Europe. It has on this basis contributed to the McCafferty report on 'The European strategy for sexual and reproductive health and rights' and the Maury-Pasquier report on 'Preventive health policies in the Member States of the Council of Europe'. Initially aimed at gynaecologists, this update is also intended to be of use to general practitioners in their dealings with female patients.

This work is published with the two annexes and the detailed bibliography in "Medecine Therapeutique". The reference to quote is:

Schlaeder G, Mossard JM. Le bilan de santé périodique chez la femme au cabinet médical. MT 2017 ;23 (2) : 66-73 doi :10.1684/met.2017.0618

Gynaecologists are often the only doctors consulted by women on a regular basis. In the USA, almost half of primary care consultations are with a gynaecologist; the remainder being with a general practitioner. In Europe, for example in France, Germany or Switzerland, primary care appears more often to be provided by general practitioners. However it is important that gynaecologists are aware of the latest developments in preventive medicine in the field of women's health. It therefore appeared to us to be useful to bring together in this article the current arguments in favour of detailed and regular health check-ups for women. In addition to 'health check-ups', we are also talking about primary care, annual health examinations, preventive care or screening. It should be noted that large-scale systematic screening programmes are essentially aimed at people who do not actually show any symptoms.

WHICH TESTS SHOULD BE PART OF REGULAR HEALTH CHECKS FOR ADULT WOMEN?

A large number of tests are often suggested; however, testing should be limited to those tests which are actually useful and effective. An American group of experts in preventive medicine (US Preventive Services Task Force-USPSTF) has put together a set of recommendations drawn from a wide group of experts and learned societies. The tests have been classified in order of pertinence: to be offered or provided (grade A or B), to be offered in certain cases (grade C), to be discouraged or avoided (grade D), insufficient evidence as to their benefits or harms (grade I).

Our recommendations are based essentially on those of the Task Force. However, we have added some relevant points from other sources, mainly from France. The Task Force's recommendations have been widely reproduced by a number of European or Canadian authorities. What follows is an outline of the screening tests currently recommended for adult women.

LIFESTYLE: diet, alcohol intake, smoking and physical activity should be assessed at each regular health check. If there are any concerns, the patient should be referred to an appropriate structure.

Concerning **alcohol intake,** the recommendations are to check for alcohol abuse in adults over the age of 18 and to offer advice to anyone who appears to be 'at risk' (grade B). There are no recommendations concerning adolescents (grade I, insufficient data).

It is useful to find out whether and how much adults over the age of 18 **smoke** and if possible offer advice about methods to help them give up smoking (grade A). For pregnant women, additional help should be offered (grade A).

It is worth noting that in France smoking and alcohol abuse are the causes of approximately 73,000 and 49,000 deaths each year respectively. Drug abuse receives a lot of publicity, but it is apparently the cause of only about 300 deaths each year. (Observatoire Français des Drogues et des Toxicomanies, 2015).

Healthy eating and physical exercise: in an adult population presenting no known cardiovascular risk factors (HTA, diabetes, hyperlipidemia, cardiovascular disease), the effectiveness of general measures, advice promoting healthy eating and physical activity, has not been formally demonstrated (grade C). Each individual case needs to be examined in the light of other risk factors identified.

The psychological profile of the patient should be assessed at each consultation. Here, active listening, intuition and a benevolent attitude on the part of the doctor are better than any systematic questionnaire. If a climate of trust can be established with the patient, it will be easier to get them to accept the need for further tests or treatment.

WEIGHT PROBLEMS are assessed using Body Mass Index. BMI = weight (in kg) divided by the square of the height in metres. If a person's BMI is higher than 25, they are in the overweight range. If it is higher than 30, they are in the obese range and should be referred for specialist treatment to a dietician or nutritionist or for group therapy, etc. (grade B).

Systematic testing for DIABETES is recommended for asymptomatic adults with a TA consistently higher than 135/80 (grade B). If TA is lower than 135/80 the data are insufficient (grade I). Screening for diabetes can be done by fasting or random blood sugar tests, or HbA1C test. The American Diabetes Association recommends fasting blood sugar tests and talks of diabetes if the level is equivalent to or higher than 1.26 G/L. In Switzerland testing for diabetes is recommended if BMI is higher than 25 in an adult aged 40 or over. In Quebec, screening for diabetes is recommended every three years for those over the age of 40, and also for adults under 40 if risk factors are observed.

In France, the Haute Autorité de Santé (HAS), the advisory body on health, recommended in 2015 using an approved questionnaire, such as the relatively detailed FINDRISK (FINish Diabetes Risk score), to identify adults at risk. In the same report, the HAS lists the various primary preventive measures that are effective and provides very practical basic advice on nutrition.

BLOOD PRESSURE should be measured at each consultation, for all adults, in order to test for high blood pressure: TA of 140/90 or higher (grade A). Depending on the systolic and diastolic readings, it will be useful to check blood pressure again after one or two years. The technique for taking blood pressure needs to be rigorous: according to HAS, the patient should be in a sitting or lying down position, at rest for at least three to five minutes; an approved electronic device should be used; a reading should be taken first on both arms and the highest systolic reading noted; for the initial measure, orthostatic or postural hypotension should be checked for by taking a reading at least one to three minutes after the patient has stood up.

There is no systematic routine testing for DYSLIPIDEMIA IN ADULTS. The Task Force considers that, in the absence of risk factors, there are no sound arguments either for or

against routine testing for dyslipidemia (grade C). If risk factors are present (diabetes, a personal history of cardiac or arterial problems, family history of cardio-vascular disease, smoking, high blood pressure, or obesity with a BMI of 30 or higher) a lipid profile is recommended for women over the age of 20 and especially for women over the age of 45, with a full cholesterol test (HDL and LDL).

A number of countries have adapted the recommendations of the US Task Force. Quebec for example recommends a lipid profile every three to five years for all women between the ages of 50 and 75. In Switzerland, the recommendation is for a lipid profile every five years for women over 45.

CORONARY HEART DISEASE

The Task Force considers that there is no indication for either a resting or an exercise ECG for an adult with no symptoms or at low risk of coronary disease (grade D). For a patient with medium or high risk, the usefulness has not been demonstrated; there is not sufficient data to make a recommendation (grade I).

AORTIC ANEURISMS

Screening by abdominal ultrasound is not indicated for women (grade D). On the other hand, it is indicated for men aged between 65 and 75 who are ex-smokers (grade B). No specific recommendation is made for men who have never smoked (grade C).

OSTEOPOROSIS

A bone mineral density test is recommended for women over the age of 65 in the absence of risk factors (grade B). For women under 65, a bone mineral density test is recommended if there are risk factors. Risk factors include: a course of corticoid treatment for longer than three months, prolonged oestrogenoprivation, fragility fractures, thinness with a BMC lower than 19, falls in patients over 65, or concerns about any of the following lifestyle factors: smoking, alcohol intake, physical exercise or healthy eating.

HEPATITIS B

The US Task Force recommends screening of all pregnant women (grade A).

The recommendations of the Haute Autorité de Santé (HAS) in France are for screening of all pregnant women, any non-vaccinated person who could be at risk either because they

have travelled to an endemic area, or have been in contact with an infected person, people with a history of either intravenous or intranasal drug abuse, those who have had a tattoo or body piercing or have previously undergone massive or repeated blood transfusions. People who are at risk and are not immune must be vaccinated.

HEPATITIS C

Screening is recommended in the presence of risk factors: essentially intravenous drug users, but also people who received blood transfusions before systematic screening of transfused blood was introduced (in 1992), people who have had tattoos, body piercings or acupuncture in conditions of other than stringent hygiene, and for children born of hepatitis C positive mothers (grade B).

HIV INFECTION

All adolescents and adults aged between 15 and 65 and all pregnant women should be tested for HIV infection. The HIV serology of any person with known risk factors should be monitored (grade A).

In France, l'Institut National Pour la Prévention et l'Education à la Santé (INPES) has put together a detailed document on HIV prevention and testing.

SEXUALLY TRANSMITTED INFECTIONS (STI)

It is important to offer careful and detailed preventive advice to all sexually active adolescents and to all adults at risk of sexually transmitted infections (grade B).

In France INPES details the risk factors and screening indications for various STIs: chlamydia, gonorrhoea, hepatitis B, hepatitis C, HIV, syphilis, human papillomavirus (HPV).

In France serological testing for syphilis and hepatitis B is mandatory for pregnant women, and HIV testing is offered systematically.

CONTRACEPTION

We recommend that women of reproductive age who do not wish to become pregnant should take contraceptive measures. Terminating a pregnancy is a traumatic experience for any women, and especially for teenage girls.

THE MENOPAUSE

The US Task Force does not consider combination therapy (combined doses of estrogen and progesterone) to be effective in preventing ailments (Grade D).

According to the Task Force, the benefits are outweighed by the adverse side-effects, which include strokes, breast cancer, hepatobiliary diseases, deep-vein thrombosis and pulmonary embolism. This is especially so in the case of the combination therapy using equine estrogen 0.625mg/day and medroxyprogesterone acetate 2.5 mg/day.

In France the Haute Autorité de Santé (HAS) takes a more nuanced approach. Hormonal treatment during the menopause is still recommended for menopausal women suffering from functional disorders linked to the menopause and which have a detrimental effect on their quality of life. The HAS recognises that the known risks associated with these treatments are being confirmed, and recommends the prescription of minimal doses for a limited duration, with an assessment once a year at least.

Note that in France natural estrogens (17 beta E2) have existed and been prescribed for decades whereas in North America for a long time only equine estrogens were available. It would appear that natural estrogens are better tolerated.

VACCINATIONS

The Task Force refers to the schedule published by the US health authorities, specifically by the *Centers for Disease Control and Prevention*, usually known as CDC. Vaccination against polio is no longer mandatory in the USA, but it is in France. Each country adopts its own schedule, in line with its priorities.

Doctors should look for any indications that any women of reproductive age may be a victim of DOMESTIC VIOLENCE. If there any concerns, the woman should be referred for professional help to a doctor, nurse, social worker or psychotherapist (grade B).

The Task Force recommends systematic screening (annual low-dose CT scan) for LUNG CANCER in heavy smokers (30-pack year) aged between 50 and 80. The screening may be stopped once the person has stopped smoking for 15 years or more. The French health authorities do not recommend this procedure; they consider it is not efficient and that there is a risk of radiation.

SKIN CANCER

Advice on the prevention of skin cancer should be given before the age of 24 and from the age of 10 upwards (grade B). There are no recommendations for adults over 24 (grade I, insufficient data).

Screening for COLO-RECTAL CANCER should be carried out between the ages of 50 and 75, either by FOBT (faecal occult blood test) every two years or by colonoscopy every 10 years (grade A).

CERVICAL CANCER

The US Task Force recommends a pap smear every three years for women between the ages of 21 and 65 (grade A). Between the ages of 30 and 65 screening can be done every five years by combining the pap smear with an HPV test (grade A).

In France a pap smear is recommended every three years for women between the ages of 25 and 65 and the importance of organised screening, with quality control, is stressed. This makes the screening more efficient and reduces the costs.

In Europe most organised screening programmes start at around the age of 25 and run until the age of 65 with a pap smear every three years; in some cases only every five years. Some countries use the HPV test, in general in conjunction with a pap smear.

In France, the Haut Conseil de la Santé Publique (HAS) recommends that all teenage girls should receive anti-HPV vaccination between the ages of 11 and 14, i.e. before they become sexually active. This is given in two doses, the second one six months after the first. Older teens and young women between the ages of 15 and 19 (or even up to 26 according to the CDC) can still be vaccinated but will need three doses.

BREAST CANCER

The US Task Force recommends that women between the ages of 50 and 74 have a mammogram every two years (grade B). For women between the ages of 40 and 49 this is decided on a case-by-case basis (grade C).

In France, women between the ages of 50 and 74 are advised to have a mammogram every two years, ideally as part of an organised screening programme with quality control.

Some European countries stop screening at 69; some start between 40 and 49 especially if there are identified risk factors. Sweden recommends a mammogram between 40 and 74 and the test has been free since 1 July 2016.

If there is a family history of breast cancer, a genetic consultation is recommended and may also be followed by a BRCA test. Specific monitoring is necessary where there is a personal history of breast cancer and/or if the patient has received high level radiation therapy as a treatment for Hodgkin's disease.

OVARIAN CANCER

According to the experts of the US Task Force, there is no need for systematic screening of patients who show no symptoms and where there is no gene mutation which would increase the risk of ovarian cancer (grade D).

CONCLUSION

This completes our review of the systematic regular examinations to be carried out for asymptomatic women. Our review is deliberately selective; we have limited it to the tests we consider to be the most useful. Further details may be found in the numerous specialised articles and in particular the remarkable work of the US Task Force.

TWO FINAL COMMENTS

> Given the large number of tests recommended for women at different ages, it is a good idea to keep a track of them in some kind of document, of which the patient also has a copy. Women should be motivated to feel personally involved in the management of their own health. Empathy on the part of the doctor is a key factor in fostering communication with the patient and thus making her more receptive to the various recommended tests.

> Detailed questioning concerning the patient's medical history, the assessment of risk factors, checking that the patient is up to date with vaccinations, a clinical examination, requests for further tests if necessary, and the provision of appropriate advice for each female patient, require the doctor to spend more time with each patient. We believe there are legitimate grounds for adapting the medical nomenclature and reviewing the reimbursement of such additional medical acts in order to take account of this additional time required.

ANNEXES:

1) Fiche prévention clinique du Québec, 2015

2) Calendrier des vaccinations, Ministère de la santé France et INPES.2016

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Recommandations suisses pour le bilan de santé au cabinet médical, Jacques Cornuz et coll. Revue Médicale Suisse, 1936-1942, 2015.

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20 - UPIGO STATUTORY GENERAL ASSEMBLY

AGOFPRI, the Association of French Gynaecologists and Obstetricians for International Relations, was admitted to UPIGO in place of SYNGOF.

Report by the Treasurer G. Schlaeder. The budgetary situation is currently satisfactory and the association has a positive account balance. The General Assembly gave discharge to the Treasurer.

Elections. The following people were elected further to discussions and elections:

President: Athenosios Chionis, Greece

Secretary General: Moustapha Toure, Mali

Past President and treasurer: Guy Schlaeder, France

Scientific adviser: Jean-Jacques Baldauf, France

The next AGM will take place in Athens, at the invitation of President Chionis, on 23 and 24 June 2017. Topics will include the latest developments in cervical cancer prevention (coordination: JJ Baldauf) and the role of midwives (coordination Moustapha Toure).

Participants at the AGM: Raymond Belaiche, Jean-Jacques Baldauf and Guy Schlaeder for France, Athanasios Chionis for Greece, Moustapha Touré for Mali, and Gjergji Theodosi for Albania. Jan Stencl from Slovakia and Aissata Bal-Sall from Mauritania gave their proxy votes Guy Schlaeder, in accordance with the statutes.

Conclusions: We had fruitful exchanges during this meeting in Paris. Most of our deliberations will be available on the website (www.upigo.org), where possible in French and English. After a period of instability, UPIGO has been given a new lease of life. Each of us will endeavour to bring young colleagues in to join us.

Redaction Toure and Schlaeder 2016

The end