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By Salina Chang and Pelin Batur, MD Cleveland Clinic is a nonprofit academic medical center. Advertising on our website helps support our mission. We do not support the non-Cleveland Clinic Products or Services Policy Vaccination Problems Effective counseling of patients and families is essential. Although the first HPV vaccine was approved in 2006, only 34.9% of American adolescents were fully vaccinated by 2015. This was partly due to the fact that suppliers had not recommended it, were not familiar with it or had concerns about its safety, and partly because some parents had abandoned it. The doctor should eliminate any myths about HPV vaccination and make sure that parents and patients understand that the HPV vaccine is safe and effective. Studies have shown that thanks to high-quality recommendations (i.e., a health care provider strongly endorses the HPV vaccine, encourages same-day vaccination and discusses cancer prevention), patients are nine times more likely to start a HPV vaccination schedule and three times more likely to follow follow doses.<sup>13</sup> Ensuring good family and patient education does not necessarily require more consultation. A recent study found that spending less time discussing an HPV vaccine could lead to improved vaccine coverage.<sup>14</sup> The study compared parental methods of advising the HPV vaccine and found that simply informing patients and their families that the HPV vaccine should have been associated with a higher rate of vaccine acceptance than invitation talk about it.<sup>14</sup> When providers announced that a vaccine should be linked to a higher rate of vaccine acceptance than invitation to talk about it.<sup>14</sup> When providers announced that a vaccine should be available. Assuming that parents were ready for vaccination, there was a 5.4% increase in HPV vaccination coverage.<sup>14</sup> Conversely, doctors who engage parents in open discussions about the HPV vaccine did not improve HPV vaccination coverage.<sup>14</sup> The authors suggested to providers the HPV vaccination approach as if they were advising patients and families on the need to avoid second-hand smoke or the need to use car seats. If parents or patients resist the intended ad approach, it is appropriate to expand counseling and joint decision-making. This includes eliminating misconceptions that parents and patients may have about the HPV vaccine. The American Cancer Society lists 8 facts for reference.<sup>15</sup> Secondary Prevention: Cervical Cancer Screening Since the introduction of the Papanicolaou (Pap) test, rates of cervical cancer in the U.S. have decreased by more than 60%.<sup>16</sup> Because almost all cervical cancer can be prevented with proper screening, all women between the ages of 21 and 65 should be screened. Currently, there are three options for cervical cancer screening: only for dads, a dad-HPV test and a high-risk HPV test. The last two variants detect high-risk HPV genotypes. Some organizations have screening algorithms that recommend when to use these tests, but 3 that form today's standard of care in Cancer screenings come from the American College of Obstetricians and Gynecologists (ACOG), the American Society for Colposcopy and Cervical Pathology (ASCCP), and the U.S. Preventive Services Task Force (USPSTF).<sup>17-19</sup> Pap only testing is conducted every 3 years to test for cervical neoplasia, which may indicate preinvasive. Pap-HPV cotesting is performed every 5 years in women over 30 years with past normal screening. Until 2018, all three organizations have recommended cotesting as the preferred screening algorithm for women aged 30 to 65.<sup>17-19</sup> Patients with a history of abnormal test results requiring more frequent testing, as recommended by ASCCP.<sup>18</sup> High risk HPV only the test uses real-time polymerase chain reaction to detect HPV 16, HPV 18, and 12 other HPV types. Only two tests are approved by the FDA as standalone cervical cancer screening tests - the Roche Cobas HPV test, approved in 2014, and Beckton Dickinson's ONclarity HPV analysis approved in 2018. Other HPV tests that are used in testing strategies should not be used for high-risk HPV testing only because their performance characteristics may differ. In 2015, a study, Solving the Advanced Diagnosis of HPV (ATHENA) found that that round 1 screening only for high-risk HPV for women over 25 was more sensitive than just dad or cotesting for stage 3 intraepithelial cervical neoplasia or more severe disease (after 3 years of follow-up).<sup>20</sup> Current guidelines from ASCCP<sup>18</sup> and ACOG<sup>17</sup> will state that a high-risk HPV test can be repeated every 3 years (when used for verification itself) if the woman is over 25 years old and had a normal test result. If the result of the HPV test is positive for HIGH-risk HPV 16 or 18 genotypes, then a colposcopy is immediately indicated; Women who test positive for one of the other 12 high-risk subtypes will need to take a Pap smear test to determine the appropriate follow-up.<sup>18,21</sup> In 2018 the USPSTF updated its recommendations, mentioning that for women between the ages of 30 and 65, dads are only testing every 3 years, cotesting every 5 years, or high risk HPV only testing every 5 years all relevant screening strategies With Pap-only or high-risk HPV-only screenings are preferred.<sup>19</sup> This is unlike the ACOG and ASCCP recommendations for joint testing every 5 years, with alternatives Papa only or HPV-only testing is conducted every 3 years.<sup>17,18</sup> Links Bruni L, with alternatives Papa only or HPV-only testing is conducted every 3 years.<sup>17,18</sup> Links Bruni L, with alternative variants of Papa only or HPV-only testing conducted 3 years.<sup>17,18</sup> Help Bruni L, with alternatives Papa only or HPV-only testing is conducted every 3 years.<sup>17,18</sup> Help Bruni L, With alternative variants Papa only or HPV-only testing is conducted every 3 years.<sup>17,18</sup> References Bruni L, Diaz M., Castelsagua X, Ferrer E., Bosch FX, de Sanjos S. 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