Cost-effectiveness of cervical cancer screening with primary human papillomavirus testing in Norway

The Harvard community has made this article openly available. Please share how this access benefits you. Your story matters

Citation

Published Version
doi:10.1038/bjc.2012.94

Citable link
http://nrs.harvard.edu/urn-3:HUL.InstRepos:11365847

Terms of Use
This article was downloaded from Harvard University’s DASH repository, and is made available under the terms and conditions applicable to Other Posted Material, as set forth at http://nrs.harvard.edu/urn-3:HUL.InstRepos:dash.current.terms-of-use#LAA
Cytology-based screening programmes that have achieved comprehensive coverage have been credited with significant reductions in incidence of and mortality from invasive cervical cancer through early detection and treatment (Hakama and Hristova, 1997; Peto et al, 2004; Bray et al, 2005). Despite successful screening, cervical cancer is still among the three most frequent cancers for women 25–49 years of age in Norway, where incidence and mortality rates are 9.5 and 1.7 per 100,000 women-years, respectively (Cancer Registry of Norway, 2011). Since 1995, the Norwegian Coordinated Cervical Cancer Screening Program has invited women to cytology-based screening every 3 years. Recent clinical studies have reported that human papillomavirus (HPV) DNA testing has a higher sensitivity for detecting high-grade precancerous lesions (Arbyn et al, 2006), possibly resulting in more opportunities for early detection and treatment. In addition, data combined from six European countries suggests that the primary screening interval may be safely extended by using HPV DNA testing (Dillner et al, 2008).

In the autumn of 2009, vaccination against HPV was introduced as part of the childhood immunisation programme for preadolescent girls, free of charge. The HPV vaccine protects against two carcinogenic HPV types, 16 and 18, that cause ~70% of cervical cancers in Norway, as well as two non-carcinogenic types, 6 and 11, that cause the majority of genital warts. HPV vaccination of older women has not been implemented, and screening will continue to remain the main source of prevention against cervical cancer for the current population of Norwegian women who are past the vaccination target age, as well as those who do not receive the vaccine in adolescence. Importantly, screening will also continue to be critical among those vaccinated to prevent the 30% of cancer cases that are not attributable to the vaccine types.

Given the availability of HPV vaccines and highly sensitive HPV DNA tests (Franco, 2003; Arbyn et al, 2006a, b), countries around the world are evaluating new screening algorithms that use HPV DNA testing for primary screening; however, determining the optimal approach to cervical cancer prevention is quite complex and involves multiple tradeoffs. For example, despite the higher sensitivity of the HPV DNA test for high-grade cervical intraepithelial neoplasia (CIN), health officials have concerns with regard to the low clinical specificity of the test, which may result in over referrals (i.e., excess burden for women and health services). This limitation may be minimised by an algorithm that relies more heavily on identifying HPV persistence rather than immediately subjecting women directly to colposcopy/biopsy, a diagnostic procedure that may be associated with
increased anxiety compared with routine testing. The use of decision-analytic methods to synthesise and extrapolate clinical, epidemiological, and economic evidence beyond the capacity of empirical trials, may aid decisions regarding the optimal secondary prevention strategies under various scenarios of uncertainty (Goldie, 2003). Such models can estimate the lifetime risk of dying from cervical cancer, life expectancy, and lifetime costs related to screening and treatment of cervical cancer. These data are then used to estimate the additional costs and life years saved of a particular screening strategy, compared the current recommended strategy. In Norway, the health benefit of an intervention or strategy is considered to be good value for money if the additional life year costs < 500 000 Norwegian Kroner (NOK; \( \approx \$83,000 \)). In this study, we use a decision-analytic model to assess the impact of adopting recently proposed cervical cancer prevention strategies involving primary HPV DNA testing (Cancer Registry of Norway, 2011) in order to inform policy recommendations in Norway. Specifically, our analysis addresses whether women who have been vaccinated against HPV can be screened efficiently using primary HPV DNA testing and whether the optimal strategy may differ for those women who have not been vaccinated.

MATERIALS AND METHODS

Analytic approach

We adapted an existing mathematical model to reflect the natural history of HPV-induced cervical cancer in Norway (Goldhaber-Fiebert et al., 2007; Kim et al., 2007; Kim and Goldie, 2008). The model was adjusted to the Norwegian context using primary clinical and cost data from Norway to project the health and economic outcomes associated with different scenarios of screening. We compared the currently recommended cytology-based programme with alternative screening strategies that use HPV DNA testing for women who have been either vaccinated or not vaccinated against HPV-16 and HPV-18 in pre-adolescence. Outcomes included lifetime risk of cancer, life expectancy, and lifetime costs. Incremental cost-effectiveness ratios (ICERs), calculated as the additional dollar ($) for each additional year of life saved (YLS) of a strategy compared with the next most costly strategy, was used as a performance indicator. Strategies that were more costly and less effective (dominated) or less costly and less cost-effective (weakly dominated) were removed from the cost-effectiveness calculations. The ‘most cost-effective’ intervention is not necessarily the one that has the lowest ratio as society may be willing to pay more for health benefit. We used the proposed willingness-to-pay threshold of 500 000 NOK (\( \approx \$83,000 \)) per YLS to signify the amount below which an intervention would be considered ‘good value for money’ (Norwegian Directorate of Health, 2007). We adopted a societal prospective, including all costs and benefits regardless to whom they accrue, and discounted costs and benefits by 4% per year, as recommended in Norway (Norwegian Finance Department, 2005). Uncertain parameters and scenarios were explored extensively in sensitivity analysis.

Model overview

The individual-based stochastic model has been previously described (Goldhaber-Fiebert et al., 2007; Kim et al., 2007; Kim and Goldie, 2008). The model simulates the natural history of HPV-induced cervical cancer in a series of mutually exclusive, collectively exhaustive health states. A cohort of females enters the model and can transition between health states in monthly intervals until death. Transition probabilities are a function of HPV type, history of prior HPV infection (i.e., natural immunity), and age. The model is static in that HPV incidence changes as a function of age, but does not change as a function of sexual activity or HPV prevalence in the population over time. Indirect effects of vaccination on risk of HPV infection (i.e., herd immunity) were explored in a sensitivity analysis by reducing HPV incidence in unvaccinated women. Health states were stratified according to HPV infection (no infection, high-risk type 16, high-risk type 18, other high-risk types and low-risk types (Munoz et al., 2003)), CIN grade 1 (CIN1), CIN grade 2, 3 (CIN23), invasive cancer (local, regional or distant), and death. Women with cancer can be identified either through screening or from symptoms, or they may remain undetected and progress to more advanced stages of cancer. Women with cancer face stage-specific survival rates; all women face competing mortality risks from other causes based on Norwegian life tables (Statistics Norway, 2011).

Epidemiologic data

Baseline transition parameter values describing the natural history of disease were based on the best available empirical data and assume that the underlying mechanism of cervical carcinogenesis does not vary across epidemiological settings. However, risk factors, such as sexual behaviour, and cervical cancer incidence rates differ between countries; therefore, country-specific data are needed to adjust baseline inputs to account for variations in progression and regression rates. We leveraged empirical data from Norway and used a likelihood-based algorithm to identify candidate sets of parameter values that achieve good-fit to epidemiological outcomes observed in the Norwegian population. Specifically, Norwegian data used for calibration included age-specific prevalence of HPV-16, HPV-18 (Mari Nygaard, personal communication) and of CIN2 in Norwegian women (Molden et al., 2005, 2006); the relative contributions of HPV-16, HPV-18 and other high-risk HPV types in CIN23 and cervical cancer (Steinar Thoresen, personal communication), and pre-screening (1953–1969) cancer incidence rates were obtained from the Cancer Registry of Norway. The parameterisation and likelihood-based calibration process have been described previously (Goldhaber-Fiebert et al., 2007; Kim et al., 2007; Kim and Goldie, 2008); details of the Norwegian-specific calibration for the current analysis are included in the Supplementary Appendix. All analyses were conducted with 50 statistically indistinguishable (i.e., good-fitting) parameter sets to incorporate the effect of uncertainty surrounding the natural history of cervical cancer. Results were reported as the mean of outcomes across the 50 parameter sets, and ICERs were calculated as the incremental mean costs divided by the incremental mean effects of two strategies (Stinnett and Paltiel, 1997). Screening test characteristics (i.e., sensitivity and specificity) were based on published studies and varied in sensitivity analyses (Franco, 2003; Sherman, 2003; Solomon, 2003; Arbyn et al., 2006; Cuzick et al., 2006a,b).

Cost data

Direct medical and non-medical costs associated with screening, vaccination, and treatment were estimated using a combination of official Norwegian guidelines (Norwegian Medical Association, 2010a) and expert opinion. All costs were measured in 2010 NOK and converted to US dollars (US $) using the average annual 2010 exchange rate (US $1 = NOK6.05) (Federal Reserve, 2011). Direct medical costs for screening, diagnosis, and treatment of dysplasia and invasive cervical cancer were based on Norwegian Diagnosis Related Groups (DRGs) and the Fee Schedules for General Practitioners and Specialists (Norwegian Directorate of Health, 2010; Norwegian Medical Association, 2010b,c; Table 1). Screening laboratory costs were adjusted to reflect potential discrepancies between published reimbursement rates and true economic costs (additional details in the Supplementary Appendix). We based HPV vaccination costs on a published report from the Norwegian
Screening HPV DNA performance for detection of CIN
Significance or worse. Local: stage Ia – IIa; Regional: stage IIb – IIIb; Distant: IVa – IVb.

Treatment, CIN treatment, screening test, colposcopy, and office found in the Supplementary Appendix. The costs of cancer

The current Norwegian screening strategy involves triennial cytologic evaluation of cervical cells (i.e., cytology) followed by repeat cytology in combination with HPV testing for atypical squamous cells of undetermined significance or low-grade squamous intraepithelial lesion (LSIL) 6 months later (herein referred to as ‘cytology-based screening’). Women with high-grade squamous intraepithelial lesions are referred directly to colposcopy/biopsy. The proposed strategy involves switching older women (age ≥ 34 years) from the current strategy to primary HPV DNA testing with liquid-based cytology (LBC) triage for women found to be positive for hrHPV types (herein referred to as ‘HPV with reflex LBC’). For women who are HPV-positive and cytology-negative (HPV+/Cyt−), the strategy uses a period of intensified screening to identify women who are persistently HPV+/Cyt−, requiring three additional HPV+/Cyt− results each with 12 months apart before receiving a referral for colposcopy/biopsy.

Our primary analysis included 24 variations of the strategy specified by the Norwegian proposal and immediately relevant for Norwegian policy decisions (Figure 1). We compared variations of the strategy that differed by routine screening interval, the number of persistent HPV+/Cyt− results, and the month interval between repeat testing required prompting colposcopy. We then conducted a secondary analysis, which included the same strategies but allowed the age at which women switch from cytology to primary HPV testing (i.e., 31 or 34 years) to vary. In addition, we allowed younger women with LSIL to be referred directly to colposcopy, as recommended in other settings (Wright et al, 2007). The secondary analysis also included a strategy of pre-adolescent vaccination only without screening. For all analyses, we held the screening start and stop ages constant and maintained the 3-year screening interval for younger women (pre-switch). We evaluated the optimal strategies for two sub-groups of women: those who had been vaccinated and those who had not been vaccinated in pre-adolescence.

Screening compliance was assumed to be 100% to allow comparison of the maximum benefit for each strategy; however, this assumption was varied in sensitivity analysis. For this variation, we assumed that the risk is equally distributed across attenders and non-attenders and there was no change in future screening behaviour. For strategies that incorporate vaccination, we assumed that: (1) the vaccination is given to sexually naive girls at the age of 12 years; (2) all girls receive the recommended three doses of the vaccine; (3) vaccination is 100% effective in preventing HPV-16, HPV-18, but does not give any protection against contracting other high-risk HPV types (i.e., no cross-protection); and (4) duration of vaccine immunity is lifelong (see Supplementary Appendix for additional assumptions).

In addition to varying costs, we varied the test characteristics of cervical cytology and evaluated the impact of uncertainty around herd immunity, vaccine efficacy, and waning vaccine protection in sensitivity analyses. To explore the impact of screening coverage, we applied a distribution of screening frequencies across the cohort. For this we assumed 15% were non-screeners, 70% complied with the specified interval, and the remaining 15% were screened less frequently (1 year delay each screening round). Although simplified, these assumptions are consistent with estimates documented by the Norwegian Cancer Registry (Cancer Registry of Norway, 2009). Last, we conducted a probabilistic sensitivity analysis by using the 50 good-fitting parameter sets.

RESULTS
Analysis including currently proposed Norwegian strategies only

In the primary analysis and regardless of vaccination status, the current cytology-based screening strategy was less effective and
more costly (i.e., strongly dominated) than proposed strategies that involve switching to primary HPV testing at 34 years of age. For unvaccinated women, the optimal (cost-effective) strategy involves switching at age 34 years to primary HPV DNA testing with a 4-year screening interval. For women HPV+/Cytdominant management involves three additional persistent HPV+/Cytrepeats 6 months apart, before colposcopy referral. This strategy is associated with a cost-effectiveness ratio of $83 000 per YLS, compared with the next best strategy and yields an expected reduction in lifetime cervical cancer risk of 65%, compared with no screening (Figure 2A). By comparison, the current cytology-based screening programme gives an expected cancer risk reduction of \(~55\%\).

For vaccinated women, the preferred screening strategy involves extension of the screening interval to every 6 years after the switch-age of 34 years with the same follow-up of HPV+/Cytreduce risk for hrHPV types; with women abnormal cytology are then referred directly to colposcopy with biopsy. We compared variations of the strategy, which differed by screening interval (3–6 years), the number of persistent HPV+/Cytreasons (e.g., 1, 2, or 3 persistent result(s)), and the month interval between repeat testing (e.g., 6- or 12-month follow-up intervals) required to prompt colposcopy. In the base case, the switch-age of screening was 34 years; in a secondary analysis, we allowed women to switch at an earlier age (31 years). Abbreviations: CIN = cervical intraepithelial neoplasia; Colpo/biopsy = colposcopy with biopsy; hrHPV = high-risk human papillomavirus; HPV+/Cytr = HPV-positive and cytology-negative result; LBC = liquid-based cytology.

## Analysis including additional strategies

Switching unvaccinated women to primary HPV DNA testing at age 31 years was always preferred over strategies that involved switching at the proposed age of 34 years. Switching at a younger age provided equal or greater reductions in cervical cancer and could cost up to 24% less over a woman’s lifetime compared with the current screening strategy (Table 2). The optimal strategy, with an ICER of $76 000 per YLS, entails switching at age 31 years to primary HPV DNA testing every 4 years with reflex LBC (Table 2; top panel). This strategy requires women who are HPV+/Cytr to have three persistent results 12 months apart, before colposcopy referral. This strategy compared with the optimal strategy, identified by our primary analysis has similar benefits, but would be expected to cost \(~5\%\) less per woman over her lifetime. Variants of this screening strategy were less attractive. If a 3-year screening interval was maintained for older women using HPV DNA testing and the most intensive follow-up of HPV+/Cytr women, we estimated that it provides nominal life expectancy gains at a cost of approximately $513 000 per YLS, compared with the next best strategy.

For women vaccinated during adolescence, switching at an earlier age to HPV DNA testing may also provide similar benefit at a lower cost per woman compared with switching at age 34 years. The optimal strategy involved a 6-year screening interval after the switch-age of 31 years and requires two additional HPV+/Cytreasons 12 months apart, before colposcopy referral (Table 2; bottom panel). Compared with switching women to 6-yearly HPV screening at age 34 years and the current cytology-based programme, vaccinated women may achieve similar cancer risk reductions by switching at the earlier age but could reduce the cost per woman over her lifetime by an additional 5% and 18%, respectively.

## Sensitivity analysis

Overall results were not sensitive to cancer and CIN treatment costs or the imperfect screening compliance scenarios. Results
Figure 2  Efficiency frontiers showing the trade-off of costs and benefits. Discounted life expectancy, lifetime costs, reduction in lifetime risk of cancer, and ICERs for alternate cervical cancer screening strategies for women 34 years and older from the ‘primary analysis’ (see the Results for details) for either unvaccinated (A) or vaccinated (B) women. Strategies lying on the efficiency curve are either less costly and more effective (i.e., strongly dominant) or more costly but more cost-effective (i.e., weakly dominant) than those lying to the right of the curve. The slope of the efficiency curve (also the inverse of the ICER) will be steeper when the net gain in the life expectancy per dollar is greater. Abbreviations: HPV = human papillomavirus; HPV+/Cyt− = HPV-positive and cytology-negative result; ICER = incremental cost-effectiveness ratio; LBC = liquid-based cytology.

were moderately influenced by screening costs, colposcopy costs, and vaccine efficacy. For example, if the cost of a colposcopy/biopsy doubled ($674 rather than the $337 assumed in the base case), the optimal primary screening interval for vaccinated women remained constant, but the follow-up strategy requires biopsy doubled ($674 rather than the $337 assumed in the base analysis are cost-effective according the Norwegian cost-effectiveness threshold. For unvaccinated women 34 years or older, switching to primary HPV DNA testing with a 4-year screening interval was found optimal in the majority of the simulations (58%), whereas a 6-year screening interval was never preferred. The analogous results for vaccinated women indicated that a 6-year screening interval was optimal in 94% of the simulations and a 5-year screening interval was optimal in 6% of the simulations.

DISCUSSION

With the advent of new HPV diagnostics, secondary preventative strategies have the potential to further reduce the burden of
cervical cancer. For countries that have implemented the HPV vaccination, two distinct risk groups will emerge as cohorts of vaccinated girls become eligible for screening. Model-based vaccination, two distinct risk groups will emerge as cohorts of cervical cancer. For countries that have implemented the HPV vaccination, two distinct risk groups will emerge as cohorts of vaccinated girls become eligible for screening. Model-based analyses that look at primary HPV DNA testing in developed countries (Goldie et al., 2004, 2006; Sherlaw-Johnson and Philips, 2004; Kim et al., 2005; Bidus et al., 2006; Kulasingam et al., 2006; Goldhaber-Fiebert et al., 2008) to include new alternative triage strategies for women who are not vaccinated, our primary analysis projected that the optimal strategy for primary screening involves cytology for younger women and HPV DNA testing with reflex LBC every 4 years for women aged 34 years and older. The algorithm requires three additional persistent HPV+/Cyt− results 6 months apart, before colposcopy referral. For vaccinated women, the primary screening interval for older women could be extended to 6 years with the same follow-up for HPV+/Cyt− women. Our expanded secondary analysis concluded warned the same primary screening intervals by allowing that switching at an earlier age could further reduce lifetime costs while maintaining a similar reduction in the risk of cancer. We also found that it was rarely attractive to refer younger women with LSIL directly to colposcopy.

To our knowledge, this is the first analysis to evaluate the cost-effectiveness of alternate screening strategies to prevent cervical cancer in Norway. We expand upon previous modelling studies, which look at primary HPV DNA testing in developed countries (Goldie et al., 2004, 2006; Sherlaw-Johnson and Philips, 2004; Kim et al., 2005; Bidus et al., 2006; Kulasingam et al., 2006; Goldhaber-Fiebert et al., 2008) to include new alternative triage strategies for older women who are HPV-positive, but cytology-negative. There is no consensus regarding how to optimally manage HPV-positive results to avoid over referral and unwarranted stress for women (Cuzick et al., 2006a) and the choice of management strategy for HPV+/Cyt− women may depend on other factors such as colposcopy resource constraints and preference to minimise false-positive results. The proposed management approach attempts to minimise the potential excess burden on resources and use a risk management strategy that identifies only the women at increased risk (i.e., those with persistent HPV infection) who have not developed dysplasia detectable by cytology. As we varied follow-up intervals of 6 or 12 months and number of persistent HPV+/Cyt− results required to prompt colposcopy, while holding all else constant, yielded relatively minimal changes to cancer risk reduction; our analysis suggests that it is rarely attractive to refer women to colposcopy after one additional HPV+/Cyt− result. We found that switching to primary HPV DNA testing at age 31 dominated switching at age 34, one screening episode earlier than suggested by the Norwegian proposal. This is likely because the prevalence of high-risk HPV does not substantially change from 31 to 34 years, allowing women to capitalise on the additional benefit of HPV testing without the system incurring excess costs from a large number of transient infections. Determining the optimal switch age is inherently dependent on the natural history of HPV in older women.

Our analysis has clear limitations, many of which have been described previously (Goldhaber-Fiebert et al., 2007; Kim et al., 2007; Kim and Goldie, 2008). We chose to use a detailed simulation model that accommodates complex screening strategies and individual history at the expense of explicitly modelling herd immunity. In sensitivity analysis, we tried to simulate the indirect effects (herd immunity) that HPV vaccination may have on the incidence HPV-16, HPV-18 among unvaccinated women. We also chose not to include other HPV-related diseases. It would be expected that by preventing additional non-cervical cancers, we would see improved cost-effectiveness. We acknowledge the benefit of including quality-adjusted life years; however, cervical cancer health state utilities have not been published in Norway, and we therefore elected to express our results as cost per YLS. Cost per quality-adjusted life year ratios would likely yield more.

### Table 2: Cost-effectiveness results for the analysis including additional strategies

<table>
<thead>
<tr>
<th>Screening start age</th>
<th>Screening frequency, pre-switch (years)</th>
<th>Screening switch age</th>
<th>Screening frequency, post-switch (years)</th>
<th>Primary screening test, post-switch</th>
<th>Wait time for rescreen HPV+/Cyt−/C0 (months)</th>
<th>No. of additional HPV+/Cyt− results to colposcopy</th>
<th>Vaccine</th>
<th>Absolute reduction in cancer (%)</th>
<th>Total cost per woman ($)</th>
<th>Total LE$ ($/YLS)</th>
<th>ICER ($/YLS)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unvaccinated women</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>25</td>
<td>3</td>
<td>Cytologya</td>
<td>None</td>
<td>None</td>
<td>6a</td>
<td>1a</td>
<td>No</td>
<td>55.45</td>
<td>1001</td>
<td>32.9526</td>
<td>—</td>
</tr>
<tr>
<td>25</td>
<td>3</td>
<td>Cytologya</td>
<td>31</td>
<td>6</td>
<td>HPV</td>
<td>12</td>
<td>3</td>
<td>No</td>
<td>55.59</td>
<td>76.00</td>
<td>29.00</td>
</tr>
<tr>
<td>25</td>
<td>3</td>
<td>Cytologya</td>
<td>31</td>
<td>5</td>
<td>HPV</td>
<td>12</td>
<td>3</td>
<td>No</td>
<td>58.82</td>
<td>822.00</td>
<td>57.00</td>
</tr>
<tr>
<td>25</td>
<td>3</td>
<td>Cytologya</td>
<td>31</td>
<td>4</td>
<td>HPV</td>
<td>12</td>
<td>3</td>
<td>No</td>
<td>63.44</td>
<td>922.00</td>
<td>76.00</td>
</tr>
<tr>
<td>25</td>
<td>3</td>
<td>Cytologya</td>
<td>31</td>
<td>4</td>
<td>HPV</td>
<td>6</td>
<td>3</td>
<td>No</td>
<td>65.26</td>
<td>971.00</td>
<td>98.00</td>
</tr>
<tr>
<td>25</td>
<td>3</td>
<td>Cytologya</td>
<td>31</td>
<td>4</td>
<td>HPV</td>
<td>3</td>
<td>3</td>
<td>No</td>
<td>65.39</td>
<td>982.00</td>
<td>121.00</td>
</tr>
<tr>
<td>25</td>
<td>3</td>
<td>Cytologya</td>
<td>31</td>
<td>3</td>
<td>HPV</td>
<td>3</td>
<td>3</td>
<td>No</td>
<td>70.22</td>
<td>1160.00</td>
<td>144.00</td>
</tr>
<tr>
<td>25</td>
<td>3</td>
<td>Cytologya</td>
<td>31</td>
<td>3</td>
<td>HPV</td>
<td>6</td>
<td>1</td>
<td>No</td>
<td>70.49</td>
<td>1200.00</td>
<td>153.00</td>
</tr>
<tr>
<td>Vaccinated women</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>25</td>
<td>3</td>
<td>Cytologya</td>
<td>None</td>
<td>None</td>
<td>6a</td>
<td>1a</td>
<td>Yes</td>
<td>63.54</td>
<td>464.00</td>
<td>32.9490</td>
<td>17.00</td>
</tr>
<tr>
<td>25</td>
<td>3</td>
<td>Cytologya</td>
<td>31</td>
<td>6</td>
<td>HPV</td>
<td>12</td>
<td>2</td>
<td>Yes</td>
<td>85.38</td>
<td>1267.00</td>
<td>80.00</td>
</tr>
<tr>
<td>25</td>
<td>3</td>
<td>Cytologya</td>
<td>31</td>
<td>6</td>
<td>HPV</td>
<td>6</td>
<td>3</td>
<td>Yes</td>
<td>85.81</td>
<td>1279.00</td>
<td>92.00</td>
</tr>
<tr>
<td>25</td>
<td>3</td>
<td>Cytologya</td>
<td>31</td>
<td>5</td>
<td>HPV</td>
<td>6</td>
<td>3</td>
<td>Yes</td>
<td>86.89</td>
<td>1339.00</td>
<td>185.00</td>
</tr>
<tr>
<td>25</td>
<td>3</td>
<td>Cytologya</td>
<td>31</td>
<td>4</td>
<td>HPV</td>
<td>6</td>
<td>3</td>
<td>Yes</td>
<td>88.48</td>
<td>1439.00</td>
<td>229.00</td>
</tr>
<tr>
<td>25</td>
<td>3</td>
<td>Cytologya</td>
<td>31</td>
<td>4</td>
<td>HPV</td>
<td>6</td>
<td>2</td>
<td>Yes</td>
<td>88.50</td>
<td>1442.00</td>
<td>290.00</td>
</tr>
<tr>
<td>25</td>
<td>3</td>
<td>Cytologya</td>
<td>31</td>
<td>3</td>
<td>HPV</td>
<td>6</td>
<td>3</td>
<td>Yes</td>
<td>90.25</td>
<td>1609.00</td>
<td>418.00</td>
</tr>
<tr>
<td>25</td>
<td>3</td>
<td>Cytologya</td>
<td>31</td>
<td>3</td>
<td>HPV</td>
<td>6</td>
<td>1</td>
<td>Yes</td>
<td>90.36</td>
<td>1625.00</td>
<td>544.00</td>
</tr>
<tr>
<td>25</td>
<td>3</td>
<td>Cytologya</td>
<td>31</td>
<td>3</td>
<td>HPV</td>
<td>6</td>
<td>1</td>
<td>Yes</td>
<td>90.39</td>
<td>1636.00</td>
<td>707.00</td>
</tr>
</tbody>
</table>

**Abbreviations:** HPV = human papillomavirus; LE = discounted life expectancy; ICER = incremental cost-effectiveness ratio; HPV+/Cyt− = HPV-positive, cytology-negative result.

1 Discounted at 4% per year. All costs are expressed in 2010 US dollars ($US = NOK6.05).
2 Combo test triage (HPV/cytology) 6 months later for atypical squamous cells of undetermined significance (ASCUS) and low-grade squamous intraepithelial lesion results.
3 Held constant for all combo strategies for younger women.
4 Combo test triage (HPV/cytology) 6 months later for ASCUS results only.
attractive ICERs and, therefore, we expect our cost per YLS to be a more conservative estimate.

Our cost estimates differed from those used for a previous analysis assessing the cost-effectiveness of the HPV vaccination in the context of the current screening programme in Norway (Dasbach et al, 2008). There have been certain disease-specific DRG updates (i.e., gynaecological brachytherapy; Norwegian Directorate of Health, 2010) since the publication, which help explain much of the difference in cancer treatment costs. The rank ordering of the results were stable when we varied the cancer treatment costs in our model from 50 to 200% of their base case values. We have also chosen to include direct non-medical costs, such as transportation and productivity loss directly attributable to screening and treatment. Norwegian wages are among the highest in the world and significantly contribute to the economic costs associated with screening and treatment. Through sensitivity analyses, we found that our main conclusion, with respect to screening interval for vaccinated and unvaccinated women, were robust to most cost assumptions; results were influenced only when doubling the costs associated with the primary office visit.

One limitation of the proposed strategy, which requires repeated follow-up of HPV +/– Cyt– women before colposcopy referral, is the potential for loss-to-follow-up. Norwegian women are more likely to ignore recommendations to follow-up equivocal and low-grade results compared with those indicating a high-grade lesion (Nygard et al, 2006). If the importance of continuing to follow-up an HPV +/– Cyt– negative result is not communicated adequately to women, the additional sensitivity of HPV testing could be eroded. We did not evaluate whether this affects the optimal strategy, but it should be considered as a potential drawback of this particular screening algorithm.

The optimal strategies identified by this analysis will require a comprehensive and dynamic system, which can alert women according to their individual screening needs. More complex and tailored screening algorithms will be more difficult to understand, not only for women, but also for clinicians, who are responsible for explaining and implementing strategies. Extensive monitoring of the coverage, compliance, resource use, and outcome variables is also crucial in order to allow the public health officials to identify caveats and areas that are in need of improvement. Models can never replace true-life evaluation and as data accumulate, our model can be refined and revised.

CONCLUSION

Our objective was to provide quantitative insight to policy makers about the trade-offs between different screening strategies, which use new screening technology in the context of HPV vaccination. We highlight the importance of alternative screening strategies that are conditional on vaccination status and age. The optimal strategies for vaccinated women determined by this analysis are very similar to the strategy that has been proposed for pilot testing in Norway (Cancer Registry of Norway, 2011). We shed light on the potential benefits of switching to HPV DNA testing at an earlier age and considering different screening recommendations for those women who have not been vaccinated. Given a cost-effectiveness threshold of $83,000, it may be more efficient to screen unvaccinated women, more frequently than those women who were vaccinated during adolescents. We conclude that in Norway, strategies involving a switch to primary HPV testing in older women is expected to be cost-effective compared with the current cytology-based screening programme.

ACKNOWLEDGEMENTS

We are grateful for the contributions of Mari Nygaard, Steinar Thoresen, Leena Kiviluoto, Stephen Resch, Gry Skare, The Norwegian Cancer Registry, and the entire cervical cancer prevention team at the Center for Health Decision Science (Harvard School of Public Health). This work was supported in part by the University of Oslo, The Norwegian Cancer Society (nr: 634201-2010); JDO, SS, and JJK are funded in part by the US National Cancer Institute (RO1 CA93435) and the Bill and Melinda Gates Foundation (30505) for related work in developing countries.

Disclaimer

Our work was independent of the funders and the funding sources had no involvement in the study design or conduct of the study; collection, management, analysis or interpretation of the data; or preparation, review or approval of the manuscript.

Supplementary Information accompanies the paper on British Journal of Cancer website (http://www.nature.com/bjc)

REFERENCES


This work is published under the standard license to publish agreement. After 12 months the work will become freely available and the license terms will switch to a Creative Commons Attribution-NonCommercial-Share Alike 3.0 Unported License.