Name: Megan Smith
Position & Affiliation: Associate Professor and Principal Research Fellow, Cancer Elimination Collaboration, Sydney School of Public Health, University of Sydney
Conference/Meeting Name: International Papillomavirus Society conference (IPVS) 2025
Location: Bangkok, Thailand.
Dates: 23rd –26th October 2025
Presentation Type (invited keynote, oral, poster): 1 x full-length (10 minute) oral presentation; 1 x flash (3 minute) oral presentation; 1 x oral poster presentation.
Full References (including all authors (presenter in bold) & title):

1. **Smith M**, Killen J, Rimalos K, Hall M, Louw D, Canfell K. "*Clinical impact and cost-effectiveness of HPV screening in vaccinated populations: modelled evaluation for the UK National Screening Committee (NSC).*" [oral presentation]
2. **Smith M**, Killen J, Rimalos K, Codde J, Brotherton J, Butler T, Canfell K, Cohen P, Hawkes D, Saville M, Steel N, Watts J, Whop L, Powell A. "*Health and cost benefits of HPV point-of-care testing in a remote Indigenous community: modelled analysis for the PREVENT project.*" [flash (3 minute) oral presentation]
3. **Smith M**, Nisha M, Liang Y, Bateson D, Saville M, Canfell K. "*Timeliness of follow-up of participants treated for high-grade lesions: findings from the Australian National Cervical Screening Program.*" [oral poster presentation].

In October 2025, I attended the 37th conference of the International Papillomavirus Society, which brought together more than 1,000 international colleagues working in basic science, clinical science, epidemiology, public health, and implementation. The theme of IPVS 2025 was "Research toward the global elimination of HPV-related diseases and cancers". In addition to the presentations on cutting edge science, there were dynamic debates on "hot topics", awareness sessions, a range of workshops, and interactive poster presentations. Key topics included equity in cervical cancer elimination, emerging information about AI and its role, and experiences implementing HPV prevention activities in the context of a global call for action to eliminate cervical cancer.



Local performers at the conference opening ceremony

My highlights included:

- Hearing about vaccination and cervical screening implementation experiences from a range of settings, with a common theme that successful delivery required co-design with communities. This was summarised well by one speaker who noted: we have the tools to prevent cervical cancer (and HIV, HCV) - but it is the community who brings these evidence-based tools to the people and who are key to achieving health equity
- The "hot topic" debates on who should be the priority for secondary target groups for HPV immunization in LMICs, whether it is possible to completely clear persistent HPV infection, whether a point of care HPV test costing <$5 is feasible within the next 3 years, and how AI

might transform access to treatment in LMICs. A clear findings from one of these debate topics were that vaccinating more girls and women is much more effective, efficient, and likely also more equitable than vaccinating boys, and arguments that vaccinating boys improves equity do not have any strong evidence to support them (with the exception that they could improve equity for men who have sex with men). A clear conclusion from another debate topic was that there is good reason to believe that low-cost point-of-care HPV tests will be available soon. This will facilitate the scale-up of HPV screening in a range of settings especially low-income countries.

- Hearing about global financing for HPV and HPV-related cancer research and cervical cancer prevention, the impact of recent US policy changes, and new initiatives
- The future focus of the U.S. President's Emergency Plan for AIDS Relief (PEPFAR)
- An update on screening/ early detection of oropharyngeal cancer
- Insight into AI algorithms, including how they are developed and insights into reliability.
- Also - visiting some temples (the Temple of the Emerald Buddha, Wat Arun and Wat Phra) and delicious dinners (at The Local and Oranuch Thai Dining).

I gave three presentations at the conference, two related to cervical screening in Australia, and one based on commissioned work for the UK on how best to approach cervical screening in vaccinated populations (see reference list for details). My Cancer Elimination Collaboration colleagues also presented on a range of topics, including the implications of USAID cutbacks on HIV and cervical cancer; the relationship between armed conflict and premature cancer mortality; factors associated with switching to cervical screening using self-collection; community awareness and experiences of being offered choice and/or using self-collection in Australia since this became a universal option in July 2022; modelling supporting the updated WHO cervical screening guidelines; outcomes; estimates of the impact to date of HPV vaccination in 78 LMICs based on the Cervical Cancer Elimination Planning Tool; and findings from the Compass trial on the whether long-term CIN3+ risks by HPV screening status differ in younger women according to whether they have been vaccinated.

Thank you to Sydney Cancer Partners for supporting my travel and this fantastic learning and networking experience.



Members of our Cancer Elimination Collaboration team at the 2025 International Papillomavirus Society meeting in Bangkok

Health and cost benefits of HPV point-of-care testing in a remote Indigenous community: modelled analysis for the PREVENT project

Megan Smith[1], James Killen[1], Kay Rimalos[1], Jim Codde[2], Julia Brotherton[3], Tamara Butler[4], Karen Canfell[1], Paul Cohen[5], David Hawkes[6], Marion Saville[6], Nerida Steel[7], Jared Watts[8,9], Lisa Whop[4], Aime Powell[2,4].

HPV screening in remote Indigenous communities

Usual care

Clinician-collected sample sent to lab for HPV testing

⇩

Reflex LBC (if HPV+)

⇩

Travel to regional centre for colposcopy

Low follow-up completion

PREVENT model

Point-of-care HPV test on self-collected sample

⇩

Same day LBC & colposcopy (if HPV+)

High follow-up completion

- ✓ Designed in collaboration with communities
- ✓ Prioritised cultural safety, trust building, family-inclusive engagement, integration with existing services
- ✓ Small group education sessions:
  - nature and prevalence of HPV
  - importance of cervical screening
  - available treatment options

? How do costs and benefits compare?



A more efficient model: outcomes per 1,000 screened

	Usual care	PREVENT	
Completed follow-up*	51%	86%	✓
HGAs detected	9	27	✓
Cost	$ 107,350 – $ 588,415	$ 136,923 – $ 354,941	**40% lower to 28% higher**
Cost per HGA	$ 11,404 – $ 62,472	$ 5,096 – $ 13,207	✓ **55-79% lower**
NNS to detect one HGA	106	37	✓ **65% lower**

* completed all recommended follow-up, including treatment, if indicated.
HGA = high-grade abnormality. NNS = number needed to screen to detect one HGA
Range in costs reflects uncertainty in attendance rates for treatment, as travel to a larger regional centre is required (range considered: 39.44-100%). Treatment attendance assumed to be the same for PREVENT and usual care.

Conclusions

PREVENT :

- ✓ is more efficient
- ✓ detects more HGA → prevents more cancer longer term
- ✓ supports national cervical cancer elimination goals

Likely increase in participation would increase benefits further

Find out more about PREVENT

Powell *et al*, Lancet Public Health 2025; 10(9):e732-e740

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1. Sydney School of Public Health, University of Sydney. 2. Institute of Health Research, University of Notre Dame. 3. Melbourne School of Population and Global Health, University of Melbourne. 4. Yardhura Walani, Australian National University. 5. Medical School, University of Western Australia. 6. Australian Centre for the Prevention of Cervical Cancer. 7. Western Australia Cervical Cancer Prevention Program. 8. Rural Clinical School, University of Western Australia. 9. WA Country Health Service.

Timeliness of follow-up of participants treated for high-grade lesions: findings from the Australian National Cervical Screening Program

Megan Smith[1], Monjura Nisha[1], Ya-Lun Liang[1], Deborah Bateson[2], Marion Saville[3], Karen Canfell[1].

1. Sydney School of Public Health, The University of Sydney, Australia. 2. Sydney Medical School, The University of Sydney, Australia.
3. Australian Centre for the Prevention of Cervical Cancer, Melbourne, Australia

Introduction

Women treated for high-grade squamous intraepithelial lesions (HSIL) and adenocarcinoma in situ (AIS) remain at elevated risk of recurrence and invasive cervical cancer post-treatment.

To ensure a safe return to routine screening, Australian guidelines (Jul 2005-Mar 2025) recommended co-testing (HPV + LBC testing) at 12 months post-treatment and annually thereafter.

We assessed the timeliness of post-treatment surveillance.

Materials and methods

We used data from the National Cancer Screening Register (Dec 2017–Jul 2024) to identify participants treated for HSIL or AIS (between 1 Dec 2017-31 Dec 2022) with ≥9 months follow-up time post-treatment, and measured the proportion with:

- a 1st co-test 9-15 months post-treatment;
- a 2nd co-test 9-15 months later;
- negative co-test results.

Analyses were stratified by socio-demographic characteristics.

Kaplan-Meier analyses were conducted to calculate time-to-event for the 1st co-test.

Results

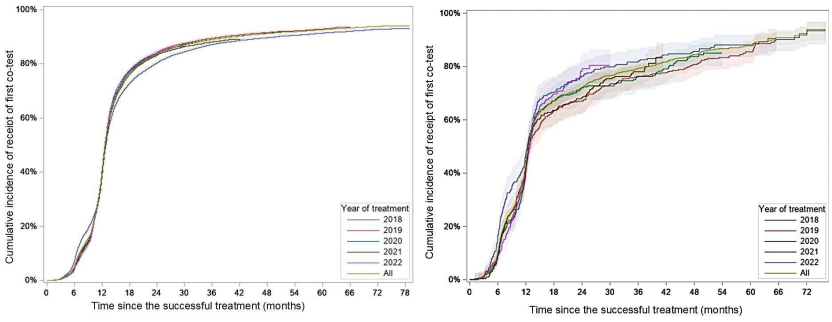
Among 51,846 screening participants treated for HSIL, 58.1% received their 1st co-test 9-15 months after successful treatment (improving from 53.6% to 60.5% for those treated in 2018 and 2022, respectively).

The proportion of those 1,432 screening participants treated for AIS who received their 1st co-test 9-15 months after successful treatment was somewhat lower (47.2%; improving from 45.5% to 53.7% for those treated in 2018 and 2022, respectively).

Cumulative incidence of 1st co-test reached ~84% by 24 months and ~89% by 36 months post-treatment for those with HSIL, and ~72% and ~79% for AIS at the corresponding timeframes (**Figure 1**).

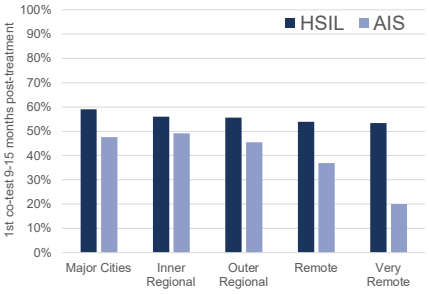
Figure 1 Cumulative incidence of receipt of 1st post-treatment co-test

a) HSIL b) AIS



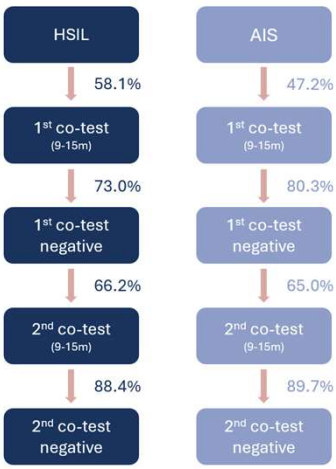
Timely receipt of 1st co-test was relatively lower among those living in remote or very remote areas (**Figure 2**), and Aboriginal and Torres Strait Islander women (data not shown).

Figure 2 Proportion receiving 1st post-treatment co-test in recommended timeframes, by remoteness



Of those who received their 1st co-test 9-15 months post-treatment, 73.0% of those treated for HSIL and 80.3% of those treated for AIS were co-test negative (**Figure 3**). Approximately two thirds of those who were co-test negative had a 2nd co-test 9-15 months later, at which approximately 88% were again co-test-negative.

Figure 3 Management after successful treatment for HG abnormalities



Conclusions

Our analysis suggests that those who start post-treatment surveillance typically do so close to 12 months post-treatment.

However, ~40% of those treated for HSIL and ~50% of those treated for AIS over this period did not receive a 1st co-test within recommended timeframes, and ~10-20% still have no test recorded 3 years after treatment. There was further drop-off between the 1st co-test and timely attendance for the 2nd co-test.

Among those with a second co-test, a very high proportion (approaching 90%) had a second negative co-test.

The recent change to recommend HPV tests, rather than co-tests, for post-treatment follow-up after HSIL enables testing on a self-collected sample. This may improve timeliness of follow-up, and thereby safety and equitable outcomes in cervical cancer prevention.

Further information

Contact

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Acknowledgments

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