HIV CLINICAL RESOURCE ¼-FOLDED GUIDE

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CERVICAL SCREENING FOR DYSPLASIA AND CANCER IN THE SETTING OF HIV INFECTION

NYSDOH AIDS INSTITUTE HIV CLINICAL GUIDELINE 1/2018

☐ KEY POINTS

Who to screen:

- Screening for cervical cancer in the setting of HIV should be performed as detailed in this guideline for eligible individuals, including cisgender women, transgender men, and nonbinary individuals assigned female at birth. Transgender men who have an intact vagina or cervix remain at risk of human papilloma virus (HPV) infection, vaginal or cervical dysplasia, and cervical cancer.
- Throughout this guideline, the term transgender men refers to individuals assigned female at birth but who identify as males. Approximately one-third of transgender or gender nonconforming individuals who were assigned female at birth identify as neither male nor female (i.e., nonbinary). For a list of common transgender and nonbinary terms and definitions, see, for instance, UCSF Center of Excellence for Transgender Health.
- This committee encourages care providers to discuss the need for cervical cancer screening with transgender men and nonbinary individuals to help ensure appropriate care for these individuals.

Risk in people with HIV infection:

- Recent data demonstrate increased risk of anal dysplasia and rising rates of anal cancer in females with HIV infection. Although anal squamous intraepithelial lesions have been associated with concurrent CSIL, they also occur independently of CSIL. Therefore, anal cytology should be performed on all cisgender females with HIV infection with and without cervical abnormalities according to guidelines for adults with HIV infection. In addition, it is important that digital examination of the anus for anal cancer and dysplasia continue at the recommended intervals, regardless of Pap test results. Although there are no data available on screening in transgender or nonbinary individuals with HIV infection, it would be logical to also perform anal screening for these populations.
- Regardless of Pap test results, it is important that routine screening for STIs continues to be performed to assess for risk behaviors that require repeat or ongoing screening.
- It is important that clinicians continue to perform visualization of the external genitalia and a digital pelvic examination as part of the annual physical examination.

Continued next panel

☐ KEY POINTS *Continued*

- Because testosterone use can induce vaginal atrophy and affect specimen adequacy for a cervical Pap test, the Pap test requisition for transgender men should note both testosterone use and the presence of amenorrhea to assist the accurate interpretation of cell morphology. Asking patients about all gender-reassignment and gynecologic surgical procedures is essential to determine the need for cervical or vaginal screening.

HPV co-testing:

- HPV co-testing is *not* recommended for individuals who are younger than 30 years.

ALL RECOMMENDATIONS p.1

PREVENTING CERVICAL CANCER AND PRECANCEROUS LESIONS

- Clinicians should recommend the 9-valent HPV vaccine 3-dose series at 0, 2, and 6 months to all individuals aged 9 to 26 years with HIV regardless of CD4 cell count, prior cervical or anal Pap test results, HPV-related cytologic changes, or history of HPV lesions. (A3)
- Clinicians should perform a cervical Pap test for all individuals assigned female at birth who have HIV infection at the following time intervals:
  - Within 2 years of the onset of sexual activity or by age 21 years. (A2)
  - Annually until 2 tests in a row screen negative, then every 3 years. (A2)
  - At 6 months after treatment for an abnormal result and then annually until 2 tests in a row screen negative, then every 3 years. (A3)
- Clinicians should perform cervical cytologic screening for individuals who have undergone a supracervical hysterectomy (cervix left in situ). (A1)
- After total hysterectomy (uterus and cervix removed), clinicians should perform *vaginal* Pap testing at least annually until negative for 2 tests in a row, then every 3 years. (A2)
- Clinicians should repeat cervical cytologic tests after 2 months but within 4 months after a result of "insufficient specimen for analysis." (A3)
- Clinicians should perform HPV co-testing (cervical cytologic test with a concurrent HPV test) only for individuals who are older than 30 years. (A2)

FOLLOW-UP OF ABNORMAL PAP TEST RESULTS

- For individuals younger than age 30 years with a Pap test result of ASC-US, clinicians should ensure that a reflex HPV test is performed. (A reflex HPV test is performed in response to, not concurrent with, an abnormal Pap test.)
  - If the reflex HPV test result is positive, clinicians should refer the patient for colposcopy. (A2)
  - If the reflex HPV test is negative, clinicians should perform both a repeat Pap test and an HPV test at 1 year. (A2)
    - If both tests are negative at 1 year, then the clinician should resume standard Pap testing (every 3 years). (A2)

ALL RECOMMENDATIONS p.2

- For individuals 30 years or older, an HPV co-test is routinely performed along with a cervical Pap test; however, if the HPV co-test was not performed in a patient who has a Pap test result of ASC-US, then clinicians should perform HPV reflex testing.
  - If the HPV test result is positive, clinicians should refer the patient for colposcopy. (A2)
  - If the HPV test result is negative, clinicians should perform both a repeat Pap test and an HPV test at 1 year:
    - If either test result is positive, clinicians should refer the patient for colposcopy. (A2)
    - If both test results are negative, then the clinician should resume standard Pap testing (every 3 years). (A2)
- For individuals of all ages, clinicians should refer for or perform colposcopy in response to the following Pap test results:
  - Atypical squamous cells, high-grade squamous intraepithelial lesion cannot be excluded (ASC-H). (A1)
  - Low-grade squamous intraepithelial lesion (LSIL). (A1)
  - High-grade squamous intraepithelial lesion (HSIL). (A1)
  - Atypical glandular cells (AGS). (A1)
- Colposcopy is not indicated as an initial screening test. Clinicians should limit colposcopy for use as a follow-up to abnormal screening on either PEP test or high-risk HPV test. (A2)
- After a patient has completed treatment for an abnormal cervical biopsy test, clinicians should repeat cytologic tests at 6 months then annually until 2 tests in a row screen negative, then every 3 years. (A3)

DIAGNOSED CERVICAL CANCER

- Clinicians should *immediately* refer patients with HIV infection and a diagnosis of cervical cancer to a gynecologic oncologist or surgeon trained in the management of cervical cancer. (A2)
- Clinicians should closely monitor patients with cervical cancer in close collaboration with the gynecologic oncologist after definitive treatment for cancer. (A3)

CERVICAL PAP TEST RESULTS

Pap test cytology screening currently uses the Bethesda Classification System as standard nomenclature for describing abnormal results that may require further follow-up. The Bethesda Classification System and other naming conventions describe the degree of neoplastic change found on biopsy and may still be seen in some Pap test pathology reports and in the scientific literature. These naming conventions are not interchangeable. Pap test results may include both cytological and histological nomenclature.

Table 2. Cytological and Histological Classification of Cervical Dysplasia

Bethesda Classification System (2014) (describes cytology obtained at cervical Pap)	
ASC-US	Atypical squamous cells of undetermined significance
ASC-H	Atypical squamous cells, HSIL cannot be excluded
AGC	Atypical glandular cells
AGC-NOS	Atypical glandular cells not otherwise specified
AGC-FN	Atypical glandular cells favoring neoplasia
LSIL	Low-grade squamous intraepithelial lesion
HSIL	High-grade squamous intraepithelial lesion
Cancer	—
Cervical Intraepithelial Lesion (or neoplasia [CIN]) (describes histology obtained at biopsy)	
Atypia	—
CIN I	Low-grade cervical intraepithelial neoplasia
CIN II	Moderate-grade cervical intraepithelial neoplasia; may be a low-grade or high-grade lesion
CIN III	High-grade cervical intraepithelial neoplasia
CIS	Carcinoma *in situ*
Cancer	—

Adapted from Nayar R, Wilbur DC. The Pap test and Bethesda 2014. Cancer Cytopathol 2015;123(5):271-81. [PMID: 25931431]

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This ¼-Folded Guide is a companion to the New York State Department of Health AIDS Institute guideline *Cervical Screening for Dysplasia and Cancer in the Setting of HIV Infection*. The full guideline is available at www.hivguidelines.org.