HIV CLINICAL RESOURCE ¼-FOLDED GUIDE

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SCREENING FOR ANAL DYSPLASIA AND CANCER IN PATIENTS WITH HIV

NYSDOH AIDS INSTITUTE HIV CLINICAL GUIDELINE MARCH 2020

ALL RECOMMENDATIONS P.1

Transmission and Prevention of HPV

- Clinicians should recommend the 9-valent human papillomavirus (HPV) vaccine 3-dose series at 0, 2, and 6 months to all individuals aged 9 to 26 years [a] with HIV regardless of CD4 cell count, prior cervical or anal cytology (Pap test) results, HPV test results, HPV-related cytologic changes, or other history of HPV-related lesions. (A3)
- Clinicians should engage patients who are 27 to 45 years of age in shared decision-making regarding HPV vaccination. (A3)

Screening

- For all patients with HIV ≥35 years old, regardless of HPV vaccine status, clinicians should:
  - Inquire annually about anal symptoms, such as itching, bleeding, palpable masses or nodules, pain, tenesmus, or a feeling of rectal fullness. (A2)
  - Perform a visual inspection of the perianal [b] region. (A3)
  - Provide information about anal cancer screening and engage the patient in shared decision-making regarding screening, including anal cytology prior to digital anorectal examination (DARE). (A3)
  - Perform DARE if anal symptoms are present. (A*)
- Clinicians should promote smoking cessation for all patients with HIV and especially for those at increased risk of anal cancer. (A3)
- For all patients with HIV ≥35 years old, clinicians should recommend and perform annual DARE to screen for anal pathology. (B3)
- Clinicians should evaluate any patient with HIV who is ≥35 years old and presents with signs or symptoms that suggest anal dysplasia. (A3)

ALL RECOMMENDATIONS *(continued from P.1)* P.2

Screening *continued*

- Clinicians should conduct or refer for high resolution anoscopy (HRA) and histology (via biopsy) any patient with abnormal anal cytology. (A2)
- Clinicians should refer patients with suspected anal cancer determined by DARE or histology to an experienced specialist for evaluation and management. (A3)

Follow-up of Abnormal Anal Cytology Results

- Clinicians should refer patients with abnormal anal cytology results to a care provider with experience performing HRA and follow up as indicated in Figure 1. (A3)
- Clinicians should perform a cervical cytology test (Pap test) for any individual with abnormal anal cytology results who has not had negative cervical screening results within the past year. (A3)

Treatment and Follow-Up

- Clinicians should perform post-treatment HRA at 6 months in patients who have been successfully treated for anal HSIL or should refer patients for this follow-up. (A3)
- Clinicians should base follow-up after a patient's first post-treatment HRA and biopsy based on the most recent histopathology findings (see Figure 1). (A3)
- Clinicians should immediately refer patients with a diagnosis of anal cancer to an oncologist or surgeon trained in the management of anal cancer. (A2)
- Clinicians should closely monitor patients with anal cancer in collaboration with the oncologist after definitive treatment for cancer. (A3)

Notes:

a. In October 2018, the FDA changed its HPV vaccination recommendations to include ages 26 to 45. There was no specific mention of HIV.

b. The perianal area is a 5 cm radius from the anal verge. In women the vulvar and perianal areas overlap.

SELECTED KEY POINTS

Burden and Implications of HPV-Related Anal Disease in Individuals With HIV

- Infection with more than 1 HPV type occurs more frequently among individuals with HIV, and such individuals can be at risk for cervical, vulvar, and perianal or anal SIL.

Smoking

- Smoking is strongly associated with anal cancer and with increased risk for anal cancer recurrence. Smoking cessation should be promoted for all patients with HIV, especially those at increased risk for anal cancer.

Transmission and Prevention of HPV

- HPV testing is not recommended before administration of the HPV vaccine.
- It is important that clinicians inform patients with HIV about the risk of acquiring HPV and other STIs from close physical contact with the external genitalia, anus, cervix, vagina, urethra, mouth and oral cavity, or any other location where HPV lesions are present.
- Consistent and correct condom use remains an effective way to prevent the transmission of most STIs, including HPV. However, it is important that clinicians inform patients that barrier protection such as condoms and dental dams may not fully protect against HPV.

Screening

- The utility of HPV typing for the management of anal disease is unknown.
- In individuals with HIV, assessment for visible anogenital HPV lesions, including in the urethra, is part of the annual physical examination.
- If a DARE is performed with anal cytology or HRA, clinicians should obtain the cytologic sample first, before lubrication is introduced into the anal canal. Lubrication may affect the ability to obtain an adequate cytologic sample. DARE may also cause bleeding, which can contaminate the cytologic sample.

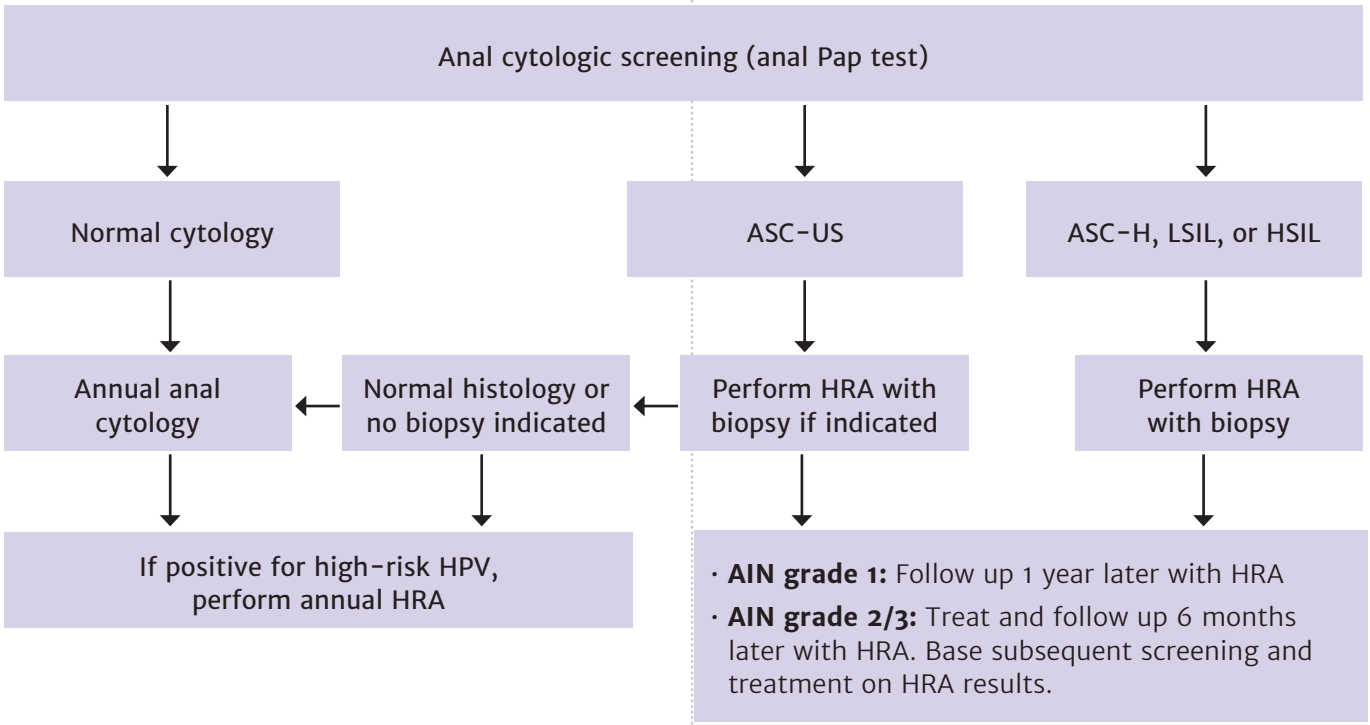
PERFORMING AN ANAL PAP TEST

- Perform an anal Pap test before using swabs for other STI testing, using lubricant, or performing a DARE.
- A moistened nylon or polyester swab may be used to obtain an anal cytology sample according to the laboratory authority's collection instructions (cotton swabs should not be used). See *University of California San Francisco Anal Cancer Information > Obtaining a specimen for anal cytology* for detailed instructions.
- Instruct patients to refrain from performing an anal enema or douche, engaging in anal sex, or inserting any objects into the anus for 24 hours prior to cytologic screening.

← Use this code with your phone's QR code reader to go directly to a mobile-friendly version of the guideline.

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

Figure 1. Follow-up of Anal Cytologic Screening Results



Key: AIN, anal intraepithelial neoplasia; ASC-US, atypical squamous cells of undetermined significance; ASC-H, atypical squamous cells cannot exclude HSIL; HPV, human papillomavirus; HRA, high resolution anoscopy; HSIL, high-grade squamous intraepithelial lesion; LSIL, low-grade squamous intraepithelial lesion.