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# POCKET GUIDE: HPV INFECTION IN PATIENTS WITH HIV

NYSDOH AIDS INSTITUTE HIV CLINICAL GUIDELINE

JANUARY 2021

## ALL RECOMMENDATIONS



### Screening

- Clinicians should continue to perform cervical and anal Pap smears as recommended for individuals with HIV, regardless of their HPV vaccination status (see the AI guidelines on *Cervical Screening for Dysplasia and Cancer* and *Screening for Anal Dysplasia and Cancer in Patients with HIV*). (A2)
- Clinicians should examine the neovagina in transgender women who have undergone vaginoplasty to assess for visible HPV lesions at baseline and during the annual comprehensive physical examination. Examination can be done using an anoscope, a small vaginal speculum, or nasal speculum. (A3)

### Transmission and Prevention

- Clinicians should recommend the 9-valent human papillomavirus (HPV) vaccine 3-dose series at 0, 2, and 6 months to all individuals who are 9 to 26 years of age 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)

### Obtaining a Sexual History

- Clinicians should ask all patients about sexual behaviors and new sex partners at each routine monitoring visit to assess for risk behaviors that require repeat or ongoing screening. (A3)

Continued on P.2 →

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



### Presentation and Diagnosis

- Clinicians with limited expertise should refer individuals with abnormal anogenital physical findings, such as warts, hypopigmented or hyper-pigmented plaques/lesions, lesions that bleed, or any other lesions of uncertain etiology for expert evaluation. This evaluation may include colposcopy, high-resolution anoscopy, and/or biopsy. (A3)
- Clinicians should maintain a low threshold for obtaining biopsies of lesions that are atypical in appearance, condylomatous, that are hyper- or hypo-pigmented or variegated, or that fail to respond to standard treatment. (A3)
- Clinicians should refer for or perform colposcopy for individuals with HIV who have abnormal cervical cytology (including persistent atypical squamous cells of undetermined significance) and high-risk HPV (see the AI guideline on *Cervical Screening for Dysplasia and Cancer*). (A2)
- Clinicians should refer for or perform high-resolution anoscopy for individuals with HIV who have abnormal anal cytology, who have visible anal lesions, or if palpable lesions are elicited on digital anorectal examination. (A2)
- Clinicians should refer individuals with visible urethral lesions to a urologist experienced in HPV biopsy and diagnosis. (A3)
- Clinicians should diagnose, treat, and follow-up HPV-related lesions in patients with HIV in consultation with a clinician experienced in the management of HPV and HIV. (A3)

### Treatment

- Clinicians should use the same therapeutic modalities in patients with and without HIV when treating HPV, with the exception of sinecatechin use; sinecatechins should not be used in immune-compromised individuals. (A3)
- Clinicians should obtain a biopsy to exclude dysplasia or cancer for condyloma that have not responded to treatment. (A3)
- Clinicians should switch treatment modalities if biopsy-confirmed warts/condyloma have not improved substantially within 4 months of therapy. (A3)

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



### Treatment *continued*

- Clinicians should refer patients with lesions that are resistant to topical therapies; that change in appearance; that have ulceration, irregular shape, or variegated pigmentation; or with biopsy-proven dysplasia to clinicians experienced in the management of HPV and HIV. (A3)
- Clinicians should refer patients with visible urethral lesions to a urologist for treatment. (A3)
- Clinicians should refer patients with HIV who have anogenital cancer to an oncologist for treatment. (A3)
- Clinicians should avoid imiquimod during pregnancy unless the benefits outweigh the risk. (A3)
- Clinicians should not use sinecatechins, podophyllin, or podofilox (podophyllotoxin) in pregnant individuals. (A3) *See the Centers for Disease Control and Prevention's guideline on Anogenital Warts.*

### Sex Partner Exposure to HPV and HIV

- **REQUIREMENT:** NYS Public Health Law requires that medical providers talk with individuals with HIV about their options for informing their sex partners that they may have been exposed to HIV, including the free, confidential partner notification assistance offered by New York State Department of Health and New York City Department of Health and Mental Hygiene.
- When a patient with HIV is diagnosed with HPV, clinicians should advise the patient to encourage sex partners to seek evaluation for possible exposure to both HPV and HIV. (A3)

## KEY POINTS

### Transmission and Prevention

- In individuals with HIV, the 9-valent HPV vaccine is administered in 3 doses at months 0, 2, and 6.
- 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

- Assessment for visible HPV lesions in individuals with HIV can be accomplished through baseline and then annual examination of the peri-urethral and anogenital areas in the vagina and cervix.
- Individuals who have received HPV vaccination should still be screened for cervical and anal disease according to the recommended schedules (for more information, see the AI guidelines on *Cervical Screening for Dysplasia and Cancer* and *Screening for Anal Dysplasia and Cancer in Patients with HIV*).

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**KEY POINTS** *(continued from opposite side)*

### Presentation and Diagnosis

- Cervical and anogenital symptoms of HPV-associated disease include itching, bleeding, pain, or spotting after sexual intercourse. HPV-associated disease should be considered in the differential diagnosis when symptoms are present.
- Failure to correctly diagnosis precancerous or cancerous HPV-related disease in a timely manner can cause delay of appropriate therapy and possible mortality. Therefore, clinicians should maintain a low threshold for obtaining biopsies of lesions that are atypical in appearance, condylomatous, have variegated pigmentation, or that fail to respond to standard treatment.

### Partner Exposure to HIV and HPV

- When a patient with HIV is diagnosed with a new STI, the clinician should inform the patient about the implications of the diagnosis for his/her sex partner(s):
  - A new STI diagnosis signals that the patient was engaging in sexual behaviors that place sex partners at increased risk of acquiring HIV infection.
  - The local health department may contact a sex partner confidentially about the potential exposure and treatment options.
- Clinicians should provide patients with information and counseling about notifying partners, risk reduction, and safer sex practices.

**Available Treatment Options for Anogenital Condyloma for Patients with HIV** (see full guideline for references)

| Condyloma Type | Treatment | Comments |
|---|---|---|
| Anogenital Condyloma | • Cryotherapy<br>• Podophyllin resin 10%–25% in a compound tincture of benzoin*<br>• Surgical excision<br>• Trichloroacetic acid (TCA) or bichloracetic acid (BCA) 80%–90%*<br>**Patient self-administered treatments:**<br>• Imiquimod 3.75% or 5% cream (may decrease likelihood of recurrences)<br>• Podofilox 0.5% solution or gel* | • Extra-genital warts, including warts on penis, groin, scrotum, vulva, perineum, external anus, and peri-anus<br>• Weakens condoms and vaginal diaphragms |
| Urethral Meatus Condyloma | • Cryotherapy with liquid nitrogen<br>• Surgical excision | — |
| Vaginal Condyloma | • Cryotherapy with liquid nitrogen<br>• Surgical excision | — |
| Cervical Condyloma | • Cryotherapy with liquid nitrogen<br>• Surgical excision<br>• TCA or BCA 80%–90% solution | • Management of cervical warts should include consultation with a specialist<br>• For those who have exophytic cervical warts, a biopsy evaluation to exclude high-grade squamous intraepithelial must be performed before treatment is initiated |
| Neovaginal Condyloma | • Cryotherapy<br>• Imiquimod 3.75% or 5% cream (may decrease likelihood of recurrences)<br>• Podofilox 0.5% solution or gel*<br>• Podophyllin resin 10%–25% in a compound tincture of benzoin*<br>• Sinecatechins 15% ointment*<br>• Surgical excision<br>• TCA or BCA 80%-90%* | • Weakens condoms and vaginal diaphragms |

* Imiquimod, podophyllin, and podofilox (podophyllotoxin) should not be used in pregnant individuals. TCA or BCA can be used to treat small external warts during pregnancy but may not be as effective. Sinecatechins should not be used in any individual with HIV because safety and efficacy data do not exist.

**← 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 *HPV Infection in Patients with HIV*. The full guideline is available at www.hivguidelines.org.**