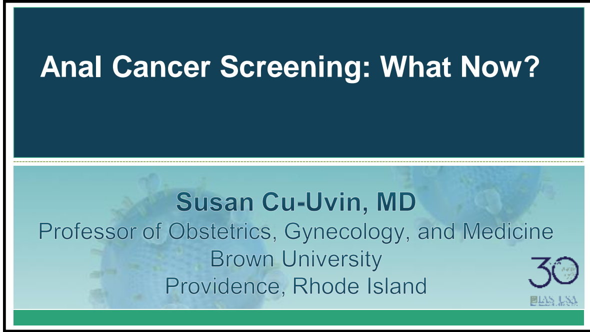

1

Financial Relationships With Ineligible Companies (Formerly Described as Commercial Interests by the ACCME) Within the Last 2 Years:

Dr Cu-Uvin has no relationships with ineligible companies to disclose. (12/05/22)

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Learning Objectives

After attending this presentation, learners will be able to:

- Describe the impact of the HIV epidemic on the incidence and progression to anal cancer and the risk factors among people with HIV (PWH) in the United States
- List the recommendations for anal cancer screening and their limitations among PWH
- Describe the recommended treatment for anal high grade squamous epithelial lesions to prevent anal cancer

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Case 1:

- 45 y.o. PWH and identifies as MSM
- CD4 count of 200
- PVL undetectable on combination antiretroviral therapy (cART)
- No diagnosis of sexually transmitted infection in the past 2 years
- He says "he always uses a condom with sexual activity"

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Case 1:

- The incidence of anal cancer among MSM with HIV is high and is estimated to be 89 per 100,000 person-years. (1,2)
- Among women with HIV, the incidence ranges from 18.6 to 35.6 per 100,000 person years. (2)
- In comparison, the incidence of anal cancer in the general population is 1.6 per 100,000 person-years. (3)
- In a meta-analysis, the risk of progression from anal HSIL to cancer was estimated to be 265 per 100,000 person-years among MSM with HIV. (4)
- Danish data show a 5-year incidence of progression to cancer of 14.1% among persons with HIV with anal intraepithelial neoplasia. (5,6)

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Case 2:

- 35 y.o. transgender female with HIV who is asymptomatic
- CD4 count of 150
- PVL undetectable on cART
- She wants to know if she should be screened for anal cancer

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Recommendations for Anal Cancer Screening:

- **For MSM and transgender women age 35 and older; Women with HIV (WWH) and all other PWH age 45 and older:**

- ***Anal Cytology Testing Only***

- If screening with anal cytology only, PWH in whom screening has been initiated should have an anal cytology testing every 12 months **(BIII).** If the results of three consecutive anal cytology tests are normal, follow-up anal cytology tests should be every 3 years **(BIII).** Persons with any abnormal cytology (≥ASC-US) should be referred for HRA **(BIII).**

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Recommendations for Anal Cancer Screening:

- ***Normal Anal Cytology with HPV Co-Testing***

- If co-testing with anal cytology and anal high-risk HPV testing is performed, then persons who co-test negative (i.e., a normal anal cytology and negative HPV test) can have their next anal cancer screening in 3 years **(BIII).**

- If the initial anal high risk HPV testing results identify HPV16 or HPV16/18, referral to HRA is recommended (regardless of cytology result) **(BIII).**

- If anal cytology is normal and the high-risk HPV testing is positive, but the genotype-specific testing for HPV16 or HPV16/18 is negative, then repeat co-testing in one year is recommended. If either of the co-tests at one year is abnormal (i.e., abnormal anal cytology or positive high-risk HPV), referral to HRA is recommended **(BIII).**

- If the initial high-risk HPV test is positive but that test does not specifically identify HPV 16 or 18 genotypes, then repeat cytology and HPV co-testing is recommended in 6 months. Referral for HRA is recommended if either test is positive at 6 months **(BIII).**

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Recommendations for Anal Cancer Screening:

- ***Abnormal Anal Cytology and HPV Co-testing***

- If ASC-US on anal cytology, and high-risk HPV testing is negative, then repeat co-testing (cytology and high-risk HPV testing) in 1 year is recommended. If either of the co-tests at one year is abnormal (i.e., abnormal anal cytology or positive high-risk HPV test) referral to HRA is recommended **(BIII).** If ASC-US on cytology and high-risk HPV testing is positive, then referral for HRA is recommended.

- For LSIL, ASC-H or HSIL on anal cytology, referral to HRA is recommended (regardless of high-risk HPV test result) **(BIII).**

- Within the above guidelines, if the number of people who need HRA is exceeding HRA capacity, providers may consider prioritizing for referral to HRA: older PWH; those known to be living with HIV for the longest period of time; those with higher grade of cytologic abnormality; those with HPV 16 or 18 on HPV testing; and current smokers. All other PWH meeting the criteria specified above should be referred for HRA as soon as feasible **(BIII).**

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Case 3:

- 50 y.o. MSM with HIV, diagnosed with anal high grade squamous epithelial lesion by HRA and biopsy.

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Anchor Study (7)

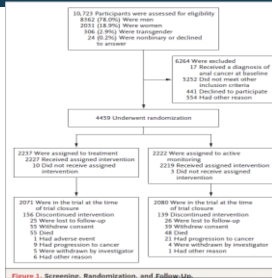

Figure 1. Screening, Randomization, and Follow-Up.

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ANCHOR Study

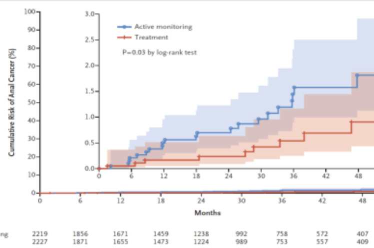

Figure 2. Kaplan–Meier Curve of the Time to Progression to Anal Cancer.
The inset shows the data on an expanded y axis. The shaded areas represent 95% confidence intervals.

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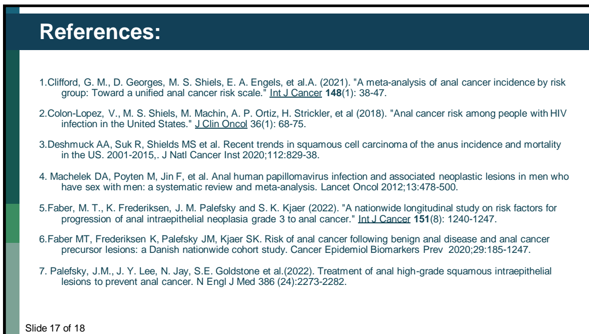

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