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ID CONSULT

Screen Sexually Active Teens for HIV

Screening for HIV should be routine for all sexually active adolescents.

In September 2006, the Centers for

Disease Control and Prevention issued new recommendations calling for annual routine HIV screening in health care settings for all patients aged 13-64 years, regardless of perceived risk status. The guidelines are notable in that they call for a policy of "opt-out" screening rather than requiring written informed consent, and they allow for screening to occur without pre-test counseling in situations where such a requirement would present a barrier (MMWR 2006;55:RR-14).

The CDC believes—and I agree—that these changes are necessary. Our current practice of screening only those individuals perceived to be at high risk isn't working. There are about 1 million HIV-infected people in the United States, as many as 25% of whom are undiagnosed. Not only are they missing out on the potential benefits of antiretroviral therapy, but their sexual activity represents a threat for transmission to others. Current HIV testing programs identify approximately 40,000 new cases every year, a number that has not changed in nearly a decade.

Teenagers are among those at risk. The CDC guidelines note that in the 2005 national Youth Risk Behavior Survey, 47% of high school students reported having had sexual intercourse at least once, and 37% of those who were sexually active had not used a condom during their most recent act of sexual intercourse. In 2005, according to the CDC, heterosexual intercourse overall accounted for 15% of HIV transmission in males and 80% in females. (Male-to-male sexual contact made up 67% of transmission among males.)

I strongly support routine screening for our adolescent patients but with certain modifications to the CDC's stated policy. While the idea of eliminating all risk profiling makes sense for the adult community, in adolescents I think it boils down to one question: Are you sexually active? If the answer is yes, no matter what the circumstances, screening is indicated. Clearly, this is an issue for every physician who treats adolescents.

I also think that, contrary to the guideline for adults, adolescents do need counseling about HIV before and after testing. Simply telling a teenager that you plan to test them for HIV unless they opt out is not adequate. At a minimum, we need to tell teens that sexual activity is a risk factor for the transmission of HIV, and for that reason we believe they should be tested. Just because a teen is monogamous doesn't mean her or his partner is. We

must impress upon them that even if they're sure their partner is "safe," they can't be confident that the same applied to their partner's previous partners.

We also should explain that the testing is a two-step process. The initial step (ELISA) identifies HIV-specific antibodies but sometimes is falsely positive. If the ELISA is positive, a Western blot test is done for confirmation. No matter what the result, a second visit is highly recommended. If the adolescent is HIV positive, this visit should be used to assess how the teen is handling the diagnosis emotionally, to determine the best course of action for treatment and to refer the teen for other support services.

If the test comes back negative, the primary care physician should still use the opportunity to remind teens that if they're sexually active and not using condoms, they're always at risk. The test was only a snapshot in time.

It's also important to explain beforehand what a positive test means: It indicates that there is an HIV infection, but it gives no information about what stage of the disease they're in. They could be very early in the course of disease, or very late in the course of disease and already have AIDS.

Just as the CDC recommends for adults, I believe that physicians should use every medical encounter with an adolescent, be it a sports physical or an acute illness visit, to do HIV counseling and screening.

The issue of parental consent is still

problematic and a potential barrier. Ideally, of course, the teenager is willing to have his or her parent or guardian consent to testing. But if not, the laws concerning consent and confidentiality vary by state. In general, public health statute and legal precedent allow for evaluation and treatment of minors for sexually transmitted diseases without parental knowledge or consent. The Guttmacher Institute's Web site is an excellent resource for specific state-by-state information on laws governing minors' consent to medical care, access to STD services, and sex and STD/HIV education (www.guttmacher.org, click on "adolescents" on the left).

Most state laws, however, don't yet address the issue of consent for screening for HIV in asymptomatic adolescents. The American Academy of Pediatrics advises that physicians obtain advice regarding the disposition of laws in their state addressing consent or other legal obligations from their attorney or another trusted local source, such as their hospital's office of legal compliance. The AAP Committee on Pediatric AIDS is expected to issue a statement in response to the CDC guidelines sometime in 2007. ■

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Cancer Society Backs HPV Vaccine for Girls 11, 12 Years

BY ELIZABETH MECHCATIE
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The American Cancer Society advocated routine vaccination against human papillomavirus for 11- and 12-year-old girls but cautioned that the potential impact of universal vaccination on cervical cancer rates can only be realized if those underserved populations at greatest risk have access to the vaccine, according to new guidelines released by the Society on Jan. 19.

The guidelines also recommended that girls as young as age 9 years can receive the human papillomavirus (HPV) vaccine and that females 13-18 years old should be vaccinated to catch up on missed vaccine or to complete the number of required injections.

"The vaccine holds remarkable potential, but unless the same populations of women who right now do not have access to or do not seek regular Pap tests get this vaccine, it will have limited impact," Dr. Harmon J. Eyre, chief medical officer of the Society, said in a statement announcing the new guidelines on the use of the prophylactic HPV vaccination to prevent cervical cancer

and cervical intraepithelial neoplasia (CIN).

The guidelines emphasized that whether or not a woman has been vaccinated, she should continue to be screened for CIN and for cancer. "As HPV vaccination for the prevention of cervical cancer is introduced and promoted, it remains critical that women undergo regular screening even if they have been vaccinated,"

Dr. Eyre said in the statement.

The guidelines were based on a formal review of the available data on HPV vaccination conducted by an expert panel convened by the ACS and are published in *CA: A Cancer Journal for Clinicians* (CA Cancer J. Clin. 2007;57:7-28).

The currently available vaccine is Gardasil, approved by the Food and Drug Administration in June 2006 for females aged 9-26 years to prevent conditions caused by HPV types 6, 11, 16, and 18, the HPV types covered in the vaccine (cervical cancer, condyloma acuminatum, cervical adenocarcinoma in situ, vulvar intraepithelial neoplasia grades 2 and 3, vaginal intraepithelial neoplasia

grades 2 and 3, and CIN grades 1, 2, and 3). HPV types 16 and 18 cause about 70% of cervical cancers, and HPV types 6 and 11 cause about 90% of genital warts.

The guidelines concluded that there are not enough data to recommend either for or against universal vaccination of females aged 19-26 years in the general population. But deciding

The three-dose series of HPV vaccine is recommended for girls aged 11-12 but can be started at age 9; catch-up vaccination is recommended for girls and women 13-26 years old.

whether a woman in this age group should be vaccinated "should be based on an informed discussion between the woman and her health care provider regarding her risk of previous HPV exposure and potential benefit from vaccination." Since the potential benefits are likely to lessen as a woman's number of lifetime sexual partners increases, women should "ideally" be vaccinated before potential exposure to genital HPV through sexual intercourse, the guidelines said.

The guidelines do not recommend HPV vaccination currently for women over age 26 or for men.

This year, the Society estimates that 11,150 women will be diagnosed with invasive cervical cancer in the United States, and that 3,670 women will die from cervical cancer. Most cervical cancers are caused by HPV infections, with about 70% caused by HPV types 16 and 18, which are included in Gardasil. Approximately 500,000 precancerous lesions are diagnosed annually in the United States, of which about 50%-60% can be attributed to HPV 16 and HPV 18.

A substantial, long-term impact of the vaccine on cervical cancer rates is not expected to be evident until the young girls being vaccinated reach the age of 48, the median age at which women are diagnosed with cervical cancer, the guidelines said. Ultimately, the impact on cervical cancer will be affected by factors that include coverage in at-risk populations and durability of protection. But in the short term, vaccination could potentially have a beneficial impact in terms of lower

numbers of HPV infections leading to a reduced number of women with abnormal Pap smears that require a work-up and treatment, fewer abnormal Pap results, and fewer referrals for colposcopy, cervical biopsy, and genital warts (HPV 16, 11, 6, and 18 cause about 40% of histologically confirmed CIN).

The guidelines focus on Gardasil but will be updated as new vaccines become available and are approved. A second HPV vaccine, Cervarix, is not yet approved.

HPV vaccination was included for the first time in the 2007 recommended immunization schedule for children and adolescents, released earlier in January by the Centers for Disease Control and Prevention, the American Academy of Pediatrics, and the American Academy of Family Physicians. The three-dose series of HPV vaccine is recommended for girls aged 11-12 but can be started at age 9; catch-up vaccination is recommended for girls and women 13-26 years old who have not been vaccinated or have not received all three injections. ■

The full text of the ACS guidelines is available at <http://CAonline.AmCancerSoc.org>.