USPSTF Recommends HIV Screening for All Pregnant Women

BY MARY ELLEN SCHNEIDER
Senior Writer

Physicians should screen all pregnant women for HIV infection, according to updated recommendations from the U.S. Preventive Services Task Force.

The task force—an independent panel of experts in prevention and primary care—recommended in 1996 that physicians routinely screen and counsel pregnant women at high risk for HIV and those living in communities with high numbers of HIV-infected newborns.

At that time, the task force did not find sufficient evidence to recommend for or against routine screening for pregnant women without identified risk factors for HIV.

The updated recommendation is based on "good evidence" that both standard and rapid screening tests can accurately detect HIV infection in pregnant women and "fair evidence" that the universal prenatal counseling and voluntary testing increases the proportion of HIV-infected women who are diagnosed and treated before delivery (Ann. Intern. Med. 2005;143:32-7).

The task force also determined that there is "good evidence" that treatments such as highly active antiretroviral therapy (HAART) can lead to significantly reduced rates of HIV transmission from mother to child.

"Early identification of maternal HIV seropositivity allows early antiretroviral treatment to prevent mother-to-child transmission, allows providers to avoid obstetric practices that may increase the risk for transmission, and allows an opportunity to counsel the mother against breast-feeding," the task force said.

About 40,000 people are infected with HIV each year in the United States; this number includes about 300 cases of mother-to-child transmission, the task force reported.

The recommendation for universal screening of pregnant women is "sensible," said Doug Campos-Outcalt, M.D., chair of the American Academy of Family Physicians Commission on Clinical Policies and Research.

Many physicians are already following this recommendation, he said, and for those who are screening high-risk patients only, the switch to routine screening should be an easy one. "It is becoming more of a common practice," said Dr. Campos-Outcalt, who is also associate chair of the department of family medicine at the University of Arizona, Phoenix.

The American College of Obstetricians and Gynecologists, the American Academy of Pediatrics, and the Centers for Disease Control and Prevention all recommend that HIV testing be part of a routine battery of prenatal blood tests unless declined by the patient.

The CDC and ACOG also recommend that women in their third trimester be retested if they are known to be at high risk for acquiring HIV and that rapid HIV testing be done during labor in women whose HIV status is undocumented.

A system in which women are informed of the screening and given the chance to opt out has been shown to produce higher screening rates than opt-in approaches for which specific informed consent is required, according to ACOG.

"Given the enormous advances in HIV prophylaxis for pregnant women and newborns, it is clear that early identification and treatment of all pregnant women with HIV is the best way to prevent neonatal disease," ACOG's Committee on Obstetric Practice wrote in a November 2004 committee opinion.

The USPSTF also recommended that physicians screen all adolescents and adults at increased risk for HIV infection. Patients are considered to be at increased risk for HIV if they have one or more individual risk factors or receive health care in a high-prevalence or high-risk clinical setting such as an STD clinic or correctional facility.

The task force did not make a recommendation for routine screening for HIV among adolescents and adults who are not at increased risk. ■

The task force recommendations are available online at www.ahrq.gov/clinic/uspstf/uspshivi.htm.

Perinatal HIV Consultation Service

The National HIV/AIDS Clinicians' Consultation Center at the University of California, San Francisco, offers a perinatal HIV consultation and referral hotline. The service offers around-the-clock advice from experts on the indications for and the interpretations of HIV testing as well as consultation on treating HIV-infected pregnant women and their infants. To reach this service, call 888-448-8765.

Vulvar Diseases More Frequent And Severe in HIV-Positive Women

BY ELIZABETH MECHCATIE
Senior Writer

BETHESDA, MD. — HIV-infected women shed more human papilloma virus, have higher rates of high grade cervical intraepithelial neoplasia, and are diagnosed more frequently with vulvar intraepithelial neoplasia (VIN) than are women who are not infected, Thomas C. Wright Jr., M.D., said at a conference on vulvovaginal diseases.

Women infected with HIV have an increased rate of human papilloma virus (HPV) shedding that is generally estimated at about four times that of HIV-negative women, said Dr. Wright, director of obstetrics, gynecology, and pathology at Columbia University College of Physicians and Surgeons, New York.

Among HPV-infected women, those who are also infected with HIV have more HPV types than do women without HIV. In one study conducted in New York City, 31% of HIV-positive women had more than one HPV type, vs. 9% of HIV-negative women. A total of 16% and 14% had HPV 16 and HPV 18, respectively, in the HIV-positive group vs. 6% and 3%, respectively, in HIV-negative women.

Vulvar condylomas in this population are numerous and multifocal, and tend to respond poorly to standard treatments.

Studies conducted in the 1990s determined that the distribution of HPV types in women without cervical intraepithelial neoplasia (CIN) tend to be the same in those who are HIV positive and those who are HIV negative. But women with biopsy-confirmed CIN 2,3 who are HIV positive "tend to be more heterogenous for high risk [HPV] types" he said.

Types 16 and 18, which tend to be the most common high-risk HPV types in the general population and appear to be more aggressive than other high-risk HPV types, are found in considerable numbers of CIN 2,3 cases in both HIV-infected and uninfected women. However, in HIV-infected women, the other HPV types that can cause cancer "may become a little more pathogenic" as the immune system deteriorates, Dr. Wright noted.

Viral load and CD4 counts have both been found to be markers for patients who shed HPV: The Women's Interagency HIV Study (WIHS) published in 1999 found that HPV was detected more frequently in women with low (under 200) CD4 counts, regardless of their HIV viral load. Similarly, women with a high HIV viral load, even with a higher CD4 count, will have high rates of HPV shedding, Dr. Wright said at the conference, sponsored by the American Society for Colposcopy and Cervical Pathology.

For more than a decade, it has been clear that the prevalence of CIN among HIV-positive women is high, estimated at two to four times higher than among noninfected women. He referred to four large prospective follow-up studies, including one he and his associates conducted in New York City, which found that the rates of abnormal cytology in HIV-positive women ranged from 30% to 40%, vs. 8% to 20% among HIV-negative women.

In his study, 7% of the HIV-positive women had high-grade CIN (CIN 2,3), vs. 1% of the HIV-negative women. Over a 3-year follow-up, 20% of the HIV-positive women developed biopsy-confirmed CIN, increasing to 30% over 6 years. Predictably, a woman with low CD4 counts is more likely to develop CIN, Dr. Wright said, adding that a woman with low CD4 counts who is followed for 48 months has a 40% chance of developing biopsy-confirmed CIN.

In HIV-infected women, condylomas are very common. Vulvar condylomas in this population are numerous and multifocal, and tend to respond poorly to standard treatments, he said. Although VIN is less common than is CIN, VIN is much more common in HIV-infected women compared with uninfected women.

In a study published this year of 1,778 HIV-infected women and 500 HIV-negative women followed for 8 years, incident condylomas were detected in 23% of HIV-positive women vs. 7% of HIV-negative women. In the WIHS study published this year, risk factors for condylomas identified among HIV-positive women were cytologic abnormalities, HPV, smoking, no HAART (highly active antiretroviral therapy), and a low CD4 count, he said.

Now that HAART is used so widely, there is much less cervical and vulvar disease in HIV-infected patients, Dr. Wright observed. At one point, a large proportion of the patients he saw at the Columbia colposcopy clinic were HIV positive, but those numbers have markedly dropped now that most are on HAART, which has been shown to reduce the incidence of condylomas.

VIN, however, is clearly an increasing problem in this population, he said. Because women in the HIV clinic are well screened and treated with loop electrosurgical excision procedure when CIN is detected, cervical cancer is less common. In contrast, "we continue to identify vulvar cancers," since screening and treating for VIN lesions is not as thorough.

In a study that followed cervical disease in HIV-positive and -negative women, he and his coinvestigators have found that about 4% of HIV-positive women developed biopsy-confirmed VIN over 60 months vs. less than 1% of HIV-negative women. And, as with cervical disease, the risk was higher with lower CD4 counts, where almost 20% of those with CD4 counts under 200 developed biopsy-confirmed VIN.

In the WIHS study, incident VIN 2,3 was detected in 8% of HIV-positive women during follow-up and 2% of HIV-negative women, "a relatively high attack rate" of 1.52 per 100 person years among HIV-positive women, vs. 0.36 per 100 person years for HIV-negative women. This indicates that about 1% of HIV-positive women will develop biopsy-confirmed VIN every year, Dr. Wright pointed out.

In the WIHS study, the risk of VIN 2,3 was increased in women with cytologic abnormalities and high-risk HPV types. However, HAART use and CD4 counts did not have a significant impact on incidence, so while HAART is effective in reducing condylomas and CIN, "we're not seeing the same dramatic impact of HAART on VIN incidence, in the studies that have been reported."

Based on these findings, he recommended a high level of awareness of vulvar disease in HIV-infected patients. ■