

Follow CIN Closely in HIV-Positive Women

Treatment of CIN I has a high failure rate in these women, but it has a relatively low rate of progression.

BY ROBERT FINN
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SAN FRANCISCO — Women who are HIV positive are at enhanced risk of cervical intraepithelial neoplasia and must be followed closely, according to Meg Newman, M.D.

Furthermore, treatment of squamous intraepithelial lesions (SIL) or cervical intraepithelial neoplasia (CIN) is less effective, and there's a very high risk of recurrence in women with the virus. HIV-positive women should be warned of this possibility, so they'll be prepared for any necessary retreatment, she said at a meeting on HIV management sponsored by the University of California, San Francisco.

Despite the risk of SIL/CIN recurrence

in HIV-positive women, it is possible to avoid invasive cervical carcinoma, said Dr. Newman of the University of California, San Francisco, and San Francisco General Hospital. She said her hospital has developed the following treatment guidelines for SIL/CIN in patients with HIV infection:

► While treatment of CIN I (mild dysplasia) has a high failure rate in HIV-positive women, it appears to have a relatively low rate of progression. At San Francisco General Hospital, women with CD4 counts more than 200 cells/μL who

can commit to follow-up are treated only with close observation.

► Cryotherapy is appropriate for a woman with CIN I if her CD4 count is less than 200 cells/μL or if she has a higher CD4 count but is likely to be lost to follow-up.

► Appropriate treatment for HIV-infected women with CIN II (moderate to marked dysplasia) or CIN III (severe dysplasia) requires an ablative or excisional procedure.

► Cryotherapy is appropriate for CIN II or III if there is a satisfactory colposcopy; the patient has had

no previous cervical treatment; and the lesion is completely visible, less than 2 cm in diameter, and affects only one or two quadrants.

► Laser ablation is better when the lesion

is greater than 2 cm in diameter or involves three or four quadrants.

► The loop electrosurgical excision procedure (LEEP) is helpful when cryotherapy is inappropriate due to lesion size, or if the lesion is located high in the endocervix.

► LEEP can't be done when the cervical architecture is disrupted secondary to a prior LEEP or to a cone biopsy.

► A cold-knife cone biopsy requires an operating room. This procedure is best used for a high-grade lesion when malignancy is detected on Pap smear and microinvasive disease or a glandular lesion is present.

► After excisional or ablative treatment of CIN II or III, topical 5-fluorouracil appears to be useful as an adjunctive treatment.

Finally, Dr. Newman noted that cigarette smoking is one behavior that may play an important role in the acquisition and recurrence of SIL/CIN, and women should be counseled to quit. ■

Despite the risk of SIL/CIN recurrence in women infected with HIV, it is possible to avoid the development of invasive cervical carcinoma.

New CDC Guidelines for Nonoccupational HIV Prophylaxis

BY ROBERT FINN
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For the first time, the federal government has issued guidelines on attempting to avoid HIV infection after accidental exposure to the virus outside of the health care workplace.

The Centers for Disease Control and Prevention—issued guidelines call for a 28-day course of a three-drug regimen of highly active antiretroviral therapy, but only if a high-risk exposure occurred within 72 hours of treatment initiation (MMWR 2005;54[RR02]:1-20).

The guidelines define high-risk exposures as those that occur through unprotected sex, condom breakage or slippage, sexual assault, the sharing of injection-drug equipment, or an accident with a source known to be HIV-infected.

If the HIV status of the source is unknown, physicians and patients should make decisions on nonoccupational postexposure prophylaxis (nPEP) on a case-by-case basis, taking into account the specific circumstances of the possible exposure and the risk of infection.

nPEP is not recommended for negligible exposure risks or for exposures that occurred more than 72 hours prior to treatment.

Prophylaxis is also not recommended for people whose behaviors result in frequent, recurrent exposures to HIV, such as those who often have unprotected sex with HIV-infected partners, or injection drug users who often share equipment.

nPEP is intended to be a "safety net," similar to the prophylaxis that has long been available to health care workers and others who have been exposed to HIV in an occupational setting, Ronald O. Valdis-

erri, M.D., said during a press teleconference sponsored by the Centers for Disease Control and Prevention.

"It is clearly not a morning-after pill," he said, pointing out the exacting nature of the 28-day regimen and its potential side effects.

The CDC guidelines are supported by a number of studies, including a recent feasibility study of 700 patients who were evaluated 12 weeks after nPEP was initiated. Of the 700, 7 individuals seroconverted, investigator Michelle Roland, M.D., reported.

Six of the seven seroconverters reported other high-risk encounters in the 6 months before nPEP; three of the seven reported ongoing high-risk behavior even after starting nPEP, suggesting that the failure of nPEP in these patients may not have been entirely due to medication failure.

Adherence to the treatment was fairly good, Dr. Roland said. During week 1, 84% of patients reported no missed doses during the prior 4 days; 78% reported no missed doses during week 2 and week 4.

While stating that no specific multidrug regimen has been shown to be superior to any other in the nPEP population, the guidelines list two preferred regimens and nine alternatives.

The drugs in the preferred nonnucleoside reverse transcriptase inhibitor (NNRTI)-based regimen are efavirenz plus either lamivudine or emtricitabine plus either zidovudine or tenofovir. Efavirenz should be avoided in pregnant women or women of childbearing potential.

The drugs in the preferred protease-inhibitor (PI)-based regimen are lopinavir and ritonavir (coformulated as Kaletra) plus zidovudine plus either lamivudine or emtricitabine.

The 28-day regimen will cost approximately \$600-\$1,000 depending on the specific drugs prescribed, according to Dr. Valdiserri, deputy director of CDC's National Center for HIV, STD, and TB Prevention.

The federal guidelines come well after some states—including California, Massachusetts, and Rhode Island—instituted their own nPEP guidelines. But Dr. Valdiserri rejected the notion that the federal government has been dragging its feet on issuing guidelines.

He noted that the CDC convened an expert panel in 1998, and the panel con-

cluded that, at that time, there was insufficient evidence on the effectiveness of nPEP.

A second expert panel in 2001 did recommend nPEP based on new data from human and animal studies, but it has taken several more years for the guidelines to make their way through the bureaucracy. ■

The full set of recommendations, including dosages, side effects, and other prescribing information for 20 antiretroviral drugs and combination formulations, can be found at www.cdc.gov/mmwr/mmwr_rr.html.

