Follow-Up of Abnormal Cervical Cytology Results, continued

• Clinicians should perform cervical cytology screening for pregnant patients, ideally within 6 weeks postpartum. (A2)

• After a patient has undergone cervical excision, clinicians should perform reflex HPV testing. (A2)

• When cervical dysplasia is diagnosed, clinicians should ensure that patients understand the potential risks and benefits and engage pregnant patients in the decision-making process. (A2)

• If at 1 year the cervical cytology result indicates ASC-US and the HPV test result is negative, the clinician should repeat both the cervical cytology and HPV test. (A2)

• If the reflex HPV test result is positive, the clinician should refer the patient for colposcopy. (A2)

• If the reflex HPV test result is negative, the clinician should continue cervical screening as noted. (A2)

• If at 1 year the cervical cytology result is negative and the HPV test result is positive, clinicians should perform reflex HPV testing. (A2)

Note: Cervical cytology with concomitant HPV testing (i.e., cotesting) is recommended for patients with HIV who are ≥30 years old. For individuals <30 years old, a reflex HPV test is performed in response to an abnormal cytology result and not concurrently with cervical cytology.

Management of Cervical Cancer

• Clinicians should immediately refer patients with HIV and a diagnosis of cervical cancer to a gynecologic oncologist or surgeon trained in the management of cervical cancer. (A*)

• Clinicians should closely monitor patients with a history of cervical cancer with possible consultation with a gynecologic oncologist after definitive treatment for cancer, which may include surgery, radiation, and chemotherapy. (A3)

Abbreviations: AGC, atypical glandular cells; AIS, adenosarcoma in situ; ASC-H, atypical squamous cells, high-grade squamous intraepithelial lesion; ASC-US, atypical squamous cells of undetermined significance; ART, antiretroviral therapy; CIN, cervical intraepithelial neoplasia; HPV, human papillomavirus; HSIL, high-grade squamous intraepithelial lesion; LSIL, low-grade squamous intraepithelial lesion; STI, sexually transmitted infection.

ALL RECOMMENDATIONS (continued from P.3)
**FIGURE 1: Follow-Up for Abnormal Cervical Cytology Results in Patients With HIV**

- Cervical cytology results obtained with HPV testing as recommended [a]
  - Result: ASC-US + HPV negative
    - Repeat cervical cytology and HPV test in 1 year
  - Result: ASC-US positive and HPV negative
    - Resume routine cervical cytology every 3 years
  - Result: ASC-US positive and HPV positive
    - Consider repeat cytology and HPV cotest at 1 year or refer for colposcopy
  - Result: ASC-US negative and HPV negative
    - Perform or refer for colposcopy

- Result: ASC-US + HPV positive or ASC-H, LSIL, or HSIL regardless of HPV status
  - Manage as per recommendations of ASCCP: 2019 ASCCP Risk-Based Management Consensus Guidelines for Abnormal Cervical Cancer Screening Tests and Precursors [e]

**Abbreviations:** ASC-H, atypical squamous cells; ASC-US, atypical squamous cells of undetermined significance; ASCCP, American Society for Colposcopy and Cervical Pathology; CIN, cervical intraepithelial neoplasia; HPV, human papillomavirus; HSIL, high-grade squamous intraepithelial lesion; LSIL, low-grade squamous intraepithelial lesion.

**Notes:**
- a. In patients <30 years old, HPV reflex testing should be performed in patients with a positive cervical cytology result; in patients ≥30 years old, HPV cotesting is recommended.
- b. If cotesting was not performed, then HPV reflex testing is indicated following an abnormal cytology result.
- c. For non–high-grade CIN, refer to ASCCP recommendations for management of LSIL (CIN 1) preceded by ASC–H or HSIL cytology.
- d. In patients <25 years old, immediate excision is not recommended; in nonpregnant patients ≥25 years old, the decision regarding expedited treatment versus colposcopy with biopsy should be based on shared decision-making between the patient and clinician.

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**SELECTED KEY POINTS**

**HPV Prevention**
- HPV vaccination status does not change the schedule of cervical cancer screening.
- HPV testing is not recommended before administration of the HPV vaccine.
- 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 reduce the risk of transmission of most STIs. Inform patients that barrier protection such as condoms and dental dams may not fully protect against HPV.

**Screening for Cervical Abnormalities**
- Compassionate engagement in shared decision-making is crucial when navigating extended screening intervals or discontinuation of screening based on a patient’s lifetime prognosis. Consider duration of HIV infection, viral load and CD4 cell count over time, and history of abnormal Pap test results and anogenital HPV lesions.
- Cervical screening every 5 years may benefit virally suppressed patients adherent to HIV and primary care with negative cytology and HPV test results, no genital or pelvic complaints, no tobacco use, and no other cervical cancer risk factors.
- Inclusive and culturally sensitive healthcare includes a safe and welcoming environment that acknowledges the needs of transgender, transmasculine, transfeminine, and nonbinary patients.
- Ask about all gender-affirming and gynecologic surgical procedures to help inform screening for HPV–related cancers.
- To facilitate accurate interpretation of cell morphology, note testosterone use and the presence of amenorrhea in the requisition for cervical cytology in transgender men.

**Follow-Up of Abnormal Cervical Cytology Results**
- Any cervical cytology result of AGC requires immediate follow-up with colposcopy and further evaluation. This committee strongly encourages all facilities that provide medical care for patients with HIV to develop a clinical pathway for the screening, diagnosis, and treatment of abnormal anal cytology results.

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**FIGURE 2: Follow-Up for Cervical Cytology Result of AGC in Patients With HIV [a]**

- Cervical cytology result: AGC
  - All subcategories except atypical endometrial cells, regardless of HPV test result
    - Nonpregnant individuals <35 years old: Perform or refer for colposcopy with endocervical sampling. If at risk for endometrial neoplasia, include endometrial sampling [b]
  - Atypical endometrial cells
    - Nonpregnant individuals ≥35 years old: Perform or refer for colposcopy with endocervical and endometrial sampling
    - Perform or refer for endometrial and endocervical sampling. Colposcopy may also be performed

**Abbreviations:** AGC, atypical glandular cells; ASCCP, American Society for Colposcopy and Cervical Pathology; HPV, human papillomavirus.

**Notes:**
- b. Conditions that increase risk for endometrial neoplasia include abnormal uterine bleeding, obesity, or conditions suggesting chronic anovulation.