The absence of high-risk HPV in the anal canal is associated with a low risk of high-grade dysplasia and anal cancer.

Missed opportunities for screening and prevention have been documented. Lower rates of anal cancer screening for people of color have been described and represent inequities in health care.

Infection with more than 1 HPV type occurs more frequently among individuals with HIV, and such individuals can be at risk for cervical, vulvar, and perianal or anal SILs.

The absence of HPV-related cervical disease in the genital tract does not eliminate the need to screen for anal dysplasia in women with HIV who are ≥35 years old.

It is important that clinicians inform patients with HIV about the risk of acquiring HPV and other sexually transmitted infections (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, including HPV. However, it is important that clinicians inform patients that barrier protection, such as condoms and dental dams, may not fully protect against HPV.

Informed patients about the objective of anal cancer screening and risk prevention. It is important to discuss the specifics of the screening procedure and identify patient preferences to support informed decision-making about screening.

Lower rates of anal cancer screening for people of color have been documented in 44% of individuals with anal cancer.

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FIGURE: Follow-Up of Anal Cytologic Screening Results [a]

Anal cytologic screening (anal Pap test and clinical assessment) [b]

Normal cytology

Annual anal cytology

ASC-US

Reflex high-risk HPV testing, if available, on ASC-US specimen

OR

Perform anal HPV testing on follow-up visit within 6 months

HPV (-) or not available

HPV (+)

Perform HRA with biopsy

Normal histology or no biopsy indicated.

Follow up 1 year later with HRA

LSIL: Follow up 1 year later with HRA. Stop HRA after 2 normal results and continue with annual assessment and anal cytology

HSIL: Treat and follow up every 6 months with HRA. Stop HRA after 2 normal results and continue with annual assessment and anal cytology

Abbreviations: ASC-US, atypical squamous cells of undetermined significance; HPV, human papillomavirus; HRA, high resolution anoscopy; HSIL, high-grade squamous intraepithelial lesion; LSIL, low-grade squamous intraepithelial lesion.

Notes:
a. The figure describes recommended screening and follow-up for the following individuals with HIV who are ≥35 years old: men who have sex with men, women, transgender men, and transgender women.
b. Continued annual clinical assessment and anal cytology, with annual HRA, is recommended for patients with a history of HSILs as long as life expectancy exceeds 10 years.

← Use this code with your phone’s QR code reader to go directly to a mobile-friendly version of the guideline.

This 1/4-Folded Guide is a companion to the New York State Department of Health AIDS Institute guideline Screening for Anal Dysplasia and Cancer in Patients With HIV. The full guideline is available at www.hivguidelines.org.