Treat Your Cervix Well

August 1, 2000 By Sue Rochman

Brenda was 25 years old and six months pregnant when she learned she had HIV in December 1996. Two months later, she felt a bump on her outer labia and underwent a complete gynecological exam. “As part of the exam, I had a Pap test done,” recalls the Los Angeles native, now 29. The bump was a genital wart that could easily be burned off. But the results of the Pap test were more serious. “Because the Pap was positive, my physician sent me to a special clinic for a colposcopy. I remember this so clearly, because I had no idea what was going on. I just knew that it was abnormal. So, I asked one of the nurses why they were doing the colposcopy. She told me it was to see if I had cancer.”
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The news left Brenda dazed. “I came out of there with my big belly, all depressed because I had just learned I had HIV, and now I thought that I had cancer. I felt like I was dying,” she says.

The test results were reassuring: Brenda didn’t have cancer. In fact, for the moment, she didn’t need any treatment at all. She, like many other women, had a positive Pap test because she had some telltale cell abnormalities caused by the human papillomavirus, or HPV.

HPV is present in virtually all cervical cancer and is especially common in HIV positive women. But it doesn’t always lead to cancer. And with vigilant care, it almost never will.

HPV, with more than 70 strains, is one of the most common sexually transmitted diseases. Some strains are harmless; others lead to genital warts or cause abnormal cells to grow on or near the cervix or anus. About 13 have the potential to become cancerous. This is why Brenda’s Pap test was so important. Half of the women diagnosed with invasive cervical cancer have never had a Pap smear, and another 10 percent have not had one done in the past five years. Lack of screening is the key factor in the 5,000 cervical cancer deaths that occur in the United States each year.

Once, physicians thought the only link between HIV and HPV was that women who engaged in unprotected sexual activity were easily exposed to both viruses. Now they know that there’s a biological connection.

One of the largest studies of HIV and HPV was conducted by Joel Palefsky, MD, professor of medicine at the University of California at San Francisco, and published in 1999. Using information culled from the Women's Interagency HIV Study, an ongoing federal study of 2,056 HIV positive and 569 high-risk HIV negative women, Palefsky found that the positive women had a higher prevalence of HPV infection than the negative women did—a sign that HIV may have affected the women's ability to fight off HPV. Women whose immune systems were the most damaged by HIV showed the highest rate of HPV infection.

Other studies have found that HIV positive women have more types of HPV in their genital tract and are more likely to have persistent HPV infection than HIV negative women. (While some women are temporarily infected with HPV but throw it off, in others the virus remains in the body as a "persistent infection.") HIV positive women with low CD4 cell counts, high viral loads, concurrent STDs or multiple sex partners are most at risk for persistent HPV infection. Women who smoke may also be at higher risk as there may be a relationship between tobacco carcinogens and persistent HPV infection. Howard Minkoff, MD, a researcher in the department of obstetrics and gynecology at the State University of New York, says, "An estimated 25 percent of the attributable risk of cervical cancer in the United States is due to smoking, because smoking kills off the Langerhans [immune] cells that are needed to kill off HPV."

Despite these higher rates of HPV infection, HIV positive women haven't had high rates of cervical cancer. This finding has taken many by surprise—especially the women's health activists who fought long and hard in the early 1990s to have the federal government adopt cervical cancer as an AIDS-defining condition.

One reason may be that it can take decades for HPV to develop into cervical cancer, says Kenneth Mayer, MD, a professor of medicine and community health at Brown University and director of the university's AIDS program. It may also be, Mayer says, that the immune systems of HIV positive women with disease-causing strains of HPV are able to keep it somewhat under control, limiting its effects to dysplasia (abnormal cell growth) rather than cancer. Or it could be that women are getting proper screening and treating abnormal growths in time.

Studies are now being conducted on whether HAART helps keep HPV in check, as it has other AIDS-related diseases. "If you look at Kaposi's sarcoma," Palefsky says, "you'll see that it is tens of thousands of times more common in HIV positive people than in the general population. This implies that people with normal immunity can handle that virus [HHV-8] very well. But since HPV is so common in the general population, that means a lot of people have immune systems that can't handle HPV. So, if you take a person who is HIV positive and put them on HAART, the best you can hope for is that they will approach the level of HPV control we see in an HIV negative person. And an HIV negative person can easily get HPV." Still, says Palefsky, "the treatment for HPV lesions might get a little easier once the HIV is under control."

An abstract presented at last February's Retroviruses Conference, authored by Minkoff, Palefsky and others, also suggests that HAART helps some women keep HPV-related cell abnormalities from progressing.

Brenda now has a Pap smear every six months, the recommended pace for women with HIV (see "Smear No Evil," POZ, July 2000). Health practitioners use a long cotton swab to remove cells from in and around the cervix, to be examined for abnormalities under a microscope. The most common finding is "atypical squamous cells of undetermined significance" (ASCUS), which means the technician has found a few abnormal cells. This could be due to HPV infection, some other vaginal infection or the use of oral contraceptives. A second Pap test should be done three months after an ASCUS diagnosis, to see whether the condition has cleared up or whether there is a persistent infection that requires treatment.

If many of the cervical cells look abnormal, or the abnormalities are more severe, a woman will be diagnosed with a cervical dysplasia. Dysplasia is not cancer, but it may be a precancerous condition. Depending on the location, number and severity of the abnormal cells, a woman will be told she has a low- or high-grade squamous intraepithelial lesion (LSIL or HSIL) or a grade 1, 2 or 3 cervical intraepithelial neoplasia (CIN)—two systems for classifying cell changes. An HSIL (or CIN 3) indicates the presence of severely abnormal cells, but since they are only on the cervix, they are almost always easily treatable with surgery. (Doctors may call a severe HSIL a carcinoma-in-situ, but don't panic; surgery at this stage is urgent, but still extremely effective.)

For HIV positive women, an abnormal result should always be followed up with a colposcopy. This test, done by a specialist, entails inserting a tube with a magnifying lens into the vagina for a full examination of the cervix. Often the specialist will also perform a biopsy (the collection of a small tissue sample) to more closely gauge the severity of the dysplasia. Some physicians may additionally recommend an HPV DNA test prior to colposcopy, which will show whether the ASCUS result was due to HPV or some other infection. Though it could help clarify your follow-up strategy, it's no substitute for a colposcopy, and physicians are still debating its value.

An increasing number of health care facilities now use a Pap Plus Speculoscopy (PPS) as an alternative to colposcopy. The speculoscopy entails putting a vinegar wash on the cervix and then using a chemical light called a Speculite, which makes abnormal cells appear white. The test may not be as sensitive in detecting abnormal cells as a colposcopy, but is more reliable than the standard Pap in diagnosing dysplasia.

Dysplasia is treated by removing the abnormal cells. This can be done with a cone biopsy (cutting out a cone-shaped piece of tissue around the abnormal cells), electrocautery (burning the cells off with electricity), a chemical application or laser treatment. Cryotherapy, which freezes and thus destroys the abnormal cells, is now done less frequently. To remove all the abnormal cells, HIV positive women may require two successive treatments, such as a cone biopsy followed by laser treatment. If the HPV has moved from a precancerous to a cancerous state, a test will be done to

determine whether the cancer is contained within the cervix or has moved to the uterus or other areas of the body. Cancer treatment may entail a hysterectomy or a hysterectomy plus radiation—well worth avoiding with regular preventive care.

According to just-released data from the Swedish Family-Cancer Database, invasive cervical cancer in women is associated with anal cancer in their husbands. So if you are diagnosed with cell abnormalities, it’s probably wise to encourage your male partners to get an anal Pap smear.

All HIV positive women should have a comprehensive gynecological exam, including a Pap test, as part of their initial evaluation, and get a Pap test done twice in the first year after an HIV diagnosis. If results are normal, the Pap should be done at least once, preferably twice, a year from then on. If the results are abnormal, a colposcopy should be performed. To receive the most accurate Pap test possible, doctors recommend scheduling a Pap during the middle of the menstrual cycle (your cycle begins the first day of your period). If you have your period on the day of a Pap, reschedule your appointment.

The Pap test has saved the lives of many women. But it’s not perfect. Fifteen to 30 percent of women whose Pap tests are reported as normal actually have abnormal cells that went undetected. This is why frequent Paps are necessary; it is uncommon to have abnormal cells go undetected twice. In addition, 5 to 10 percent of women who receive an ASCUS diagnosis actually have an underlying high-grade lesion, which means that keeping follow-up appointments is critical, too.

A vaccine for cancer-causing strains of HPV is on the horizon. Be here for it.

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