PrEP & infezione da HPV: esperienza di un centro MTS

Luigi Pisano

Azienda USL Toscana centro
Servizio Sanitario della Toscana

CENTRO MTS
S.C. DERMATOLOGIA
OSPEDALE PIERO PALAGI,
FIRENZE

CENTRI MTS

- Counseling
- Diagnosi
- Trattamento
- Sorveglianza epidemiologica

} delle infezioni / malattie a trasmissione sessuale

SISTEMA DI SORVEGLIANZA SENTINELLA DELLE INFEZIONI SESSUALMENTE TRASMISSIBILI

CENTRO MTS FIRENZE

c/o S.C. Dermatologia – Ospedale Piero Palagi, Firenze

- … prime visite / anno; … visite / anno
- ACCESSO DIRETTO (senza necessità di prenotazione né di richiesta medica) dal LUN al VEN – h. 8,00-11,00
- Possibilità di eseguire subito, contestualmente alla visita, prelievi ematici e tamponi microbiologici
- Test per HIV e sifilide GRATUITI (esenzione DO1)
- Possibilità di somministrare subito, contestualmente alla diagnosi, terapia antibiotica iniettiva per gonorrea e sifilide ("***TEST & TREAT***")
- Programmazione di biopsie a scopo diagnostico; interventi di escissione chirurgica/DTC/laser di condilomi o altre lesioni preneoplastiche/neoplastiche sospette
- Attivazione di ***percorsi ad hoc*** in base alla patologia e alla storia del paziente, in collaborazione con l'equipe delle Malattie Infettive, della Ginecologia e della Proctologia della USL Toscana Centro

Centro Operativo AIDS
COA

ISTITUTO SUPERIORE DI SANITÀ

SCREENING CANCRO ANALE HPV-CORRELATO

LA NOSTRA ESPERIENZA

2013:

Inizio della collaborazione tra centro MTS di Firenze e ISPRO per un progetto di studio sulla citologia anale in maschi a rischio (**striscio convenzionale**)

2015:

Prosegue la collaborazione con ISPRO per uno studio di confronto della citologia anale in **fase liquida** con la metodica convenzionale

Aprile 2017:

«Istituzionalizzazione» del **Pap test anale in strato sottile** ed estensione dello screening anche alle donne

Maggio 2017:

Inizio della collaborazione con la Proctologia dell'Ospedale Palagi di Firenze e istituzione di un **ambulatorio dedicato «dermo-proctologico»**

Centro MTS
(accesso diretto)

ISPRO
Istituto per lo studio, la prevenzione e la rete oncologica

AMBULATORIO DERMO-PROCTOLOGICO

Screening per la prevenzione del carcinoma anale HPV-correlato con **Pap test + HPV test anale**

RIVOLTO A:

- **MASCHI OMO-/BI-SESSUALI o con storia di condilomatosi peri-/endo-anale**
- **HIV+**
- **DONNE**

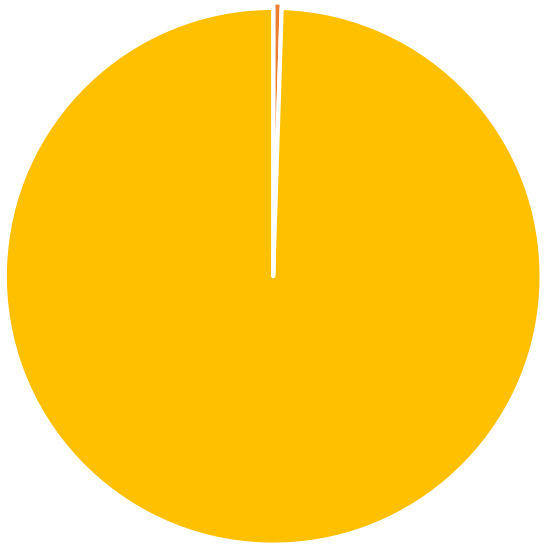
- Anoscopia ad alta risoluzione (H.R.A.)
- Eventuale biopsia mirata
- Trattamento

VACCINAZIONE

WHAT WE KNOW

	Common Types of Cancer	Estimated New Cases 2022	Estimated Deaths 2022
1.	Breast Cancer (Female)	287,850	43,250
2.	Prostate Cancer	268,490	34,500
3.	Lung and Bronchus Cancer	236,740	130,180
4.	Colorectal Cancer	151,030	52,580
5.	Melanoma of the Skin	99,780	7,650
6.	Bladder Cancer	81,180	17,100
7.	Non-Hodgkin Lymphoma	80,470	20,250
8.	Kidney and Renal Pelvis Cancer	79,000	13,920
9.	Uterine Cancer	65,950	12,550
10.	Pancreatic Cancer	62,210	49,830
	-	-	-
25.	**Anal Cancer**	**9,440**	**1,670**

ANAL CANCER



0.5% of all new cancer cases in the U.S.

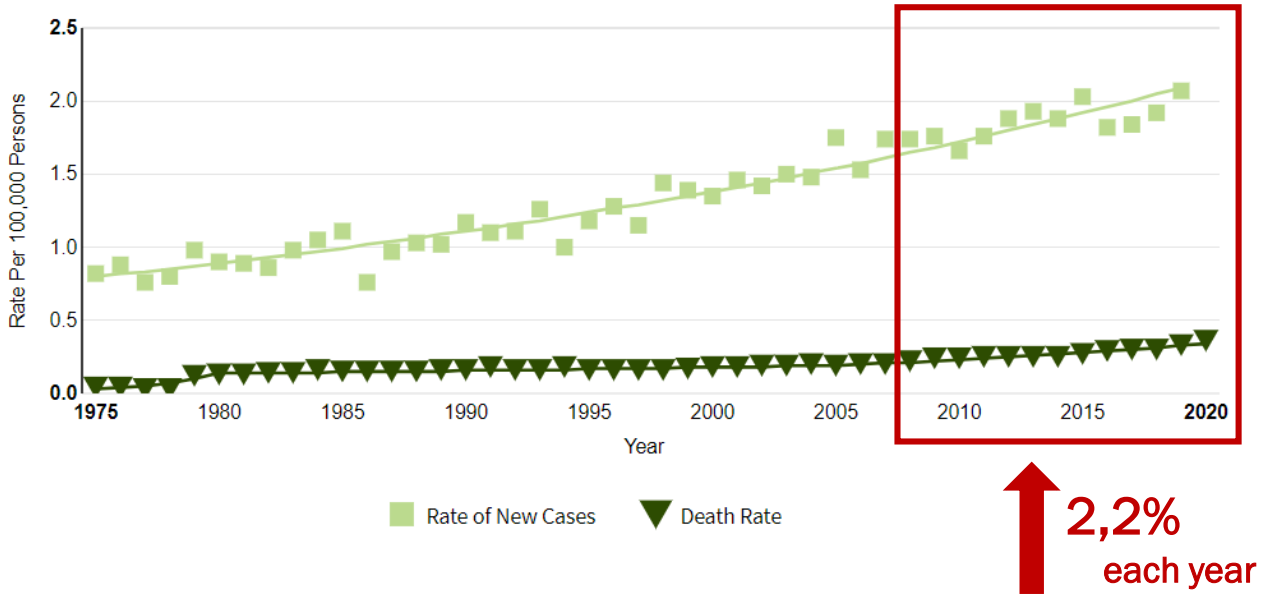
WHAT WE KNOW

Estimated New Cases in 2022	9,440
% of All New Cancer Cases	0.5%

Estimated Deaths in 2022	1,670
% of All Cancer Deaths	0.3%

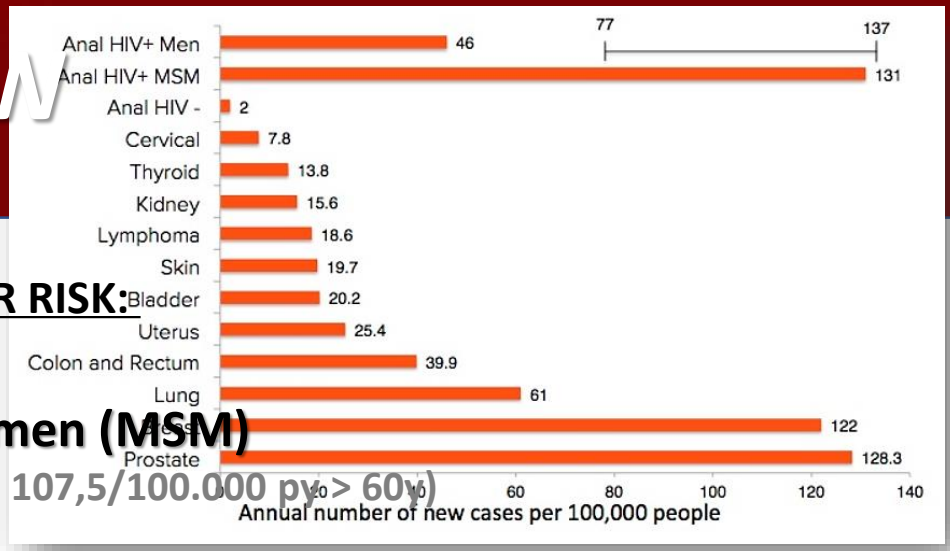
5-Year Relative Survival
70.1%
2012–2018

- The rate of new cases of anal cancer was 1.9 per 100,000 men and women per year.
- Approximately 0.2% of men and women will be diagnosed with anal cancer at some point during their lifetime.
- In 2019, there were an estimated 74,752 people living with anal cancer in the United States.



NIH NATIONAL CANCER INSTITUTE

WHAT WE KNOW



DIFFERENT LEVELS OF ANAL CANCER RISK:

1) HIV-positive men who have sex with men (MSM)

Incidence: 85/100.000 person-years (16,8/100.000 py < 30 y; 107,5/100.000 py > 60y)

2) HIV-positive men who have sex with women (MSW)

Incidence: 32/100.000 py

3) HIV-positive women

Incidence: 22/100.000 py

4) HIV-negative MSM

Incidence: 19/100.000 py

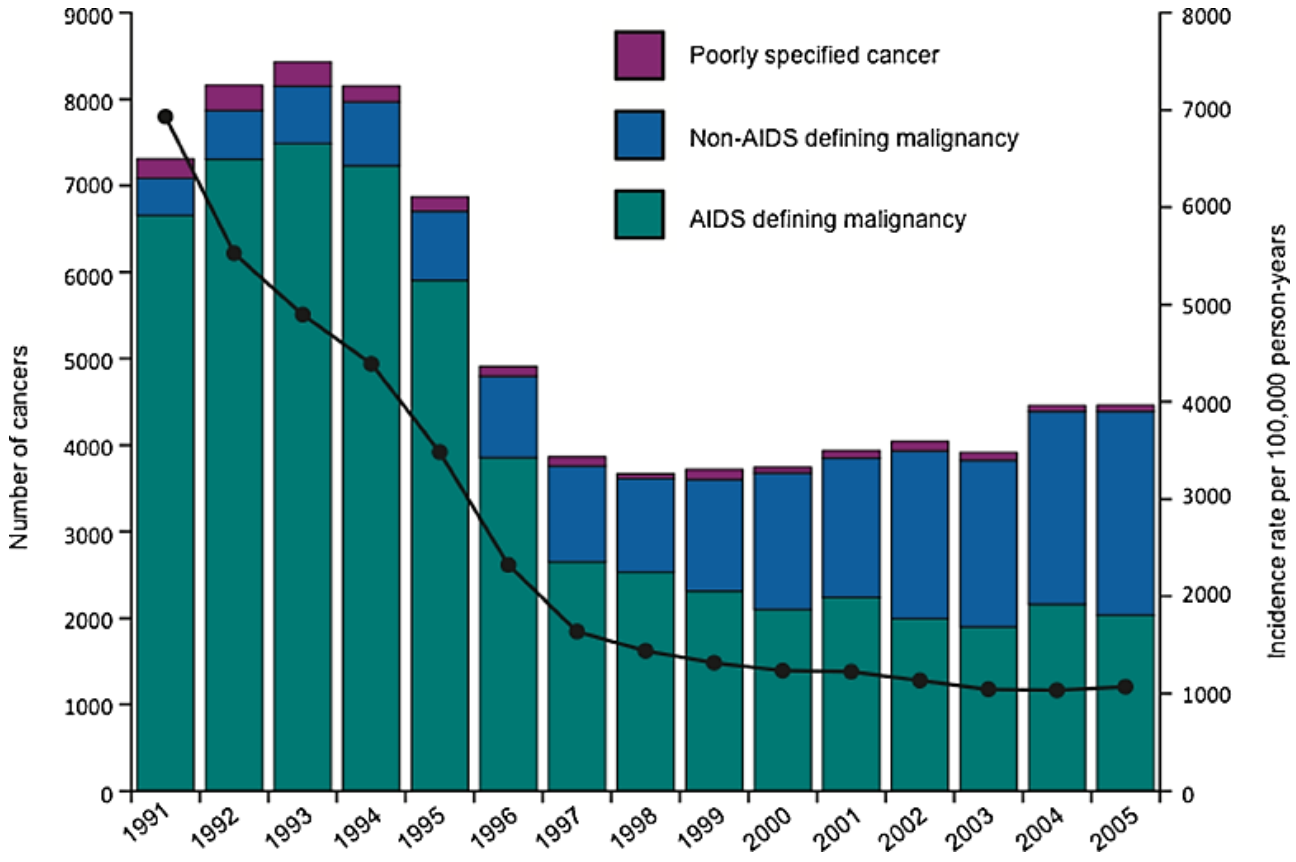
5) HIV-negative women with prior HPV-related genital cancer or dysplasia (+++ vulvar cancer, cervical cancer, CIN3)

6) Other immunocompromised patients without HIV infection (+++ solid organ transplant recipients)

A meta-analysis of anal cancer incidence by risk group: Toward a unified anal cancer risk scale

Gary M. Clifford[1] | Damien Georges[1] | Meredith S. Shiels[2] | Eric A. Engels[2] | Andreia Albuquerque[3,4] | Isobel Mary Poynten[5] | Alexandra de Pokomandy[6] | Alexandra M. Easson[7] | Elizabeth A. Stier[8]

WHAT WE KNOW



- A 2015 meta-analysis of observational studies evaluating the incidence of malignancies before and after the introduction of highly active antiretroviral therapy (HAART) reported that **the risk of anal cancer was four times higher in the post-HAART period than in the pre-HAART period.**

- In the post-HAART period, increased survival times in people living with HIV might be associated with an increase in the incidence of anal and other non-AIDS-defining cancers.

Assessing the impact of HAART on the incidence of defining and non-defining AIDS cancers among patients with HIV/AIDS: A systematic review

Ricardo Ney Oliveira Cobucci[a,b,*], Paulo Henrique Lima[a], Pollyana Carvalho de Souza[b], Vanessa Viana Costa[b], Maria da Conceição de Mesquita Cornetta[d], José Veríssimo Fernandes[c], Ana Katherine Gonçalves[d]

WHAT'S NEW

- People living with HIV who receive ART have a decreased prevalence of high-risk HPV, and those with undetectable HIV viral load have decreased risk of high-grade lesion (HSIL-AIN2+) prevalence.
- Overall, ART was not found to be associated with anal cancer risk, but the subgroup of ART users with sustained undetectable HIV viral load had a 44% reduced risk of anal cancer.
- Furthermore, an increase in nadir CD4 cell counts of 100 cells per µL was associated with a 40% reduction in anal cancer incidence.
- **ART use, when started early and with HIV viral control achieved over a prolonged period, was effective at lowering anal cancer risk.**

The current recommendations of encouraging earlier ART initiation, coupled with a focus on rapid virological control and sustained adherence, are likely to lead to an earlier and possibly more functionally complete mucosal immune reconstitution, in turn leading to clearance of anal high-risk HPV and control of associated anal lesion development.
This study points to yet one more reason to emphasize early diagnosis of HIV infection and immediate initiation of effective ART in populations at increased risk of anal cancer.

Association of antiretroviral therapy with anal high-risk human papillomavirus, anal intraepithelial neoplasia, and anal cancer in people living with HIV: a systematic review and meta-analysis

Helen Kelly, Admire Chikandiwa, Laia Alemany Vilches, Joel M Palefsky, Silvia de Sanjose, Philippe Mayaud *Lancet HIV 2018; 5: e45-58*

WHAT WE KNOW

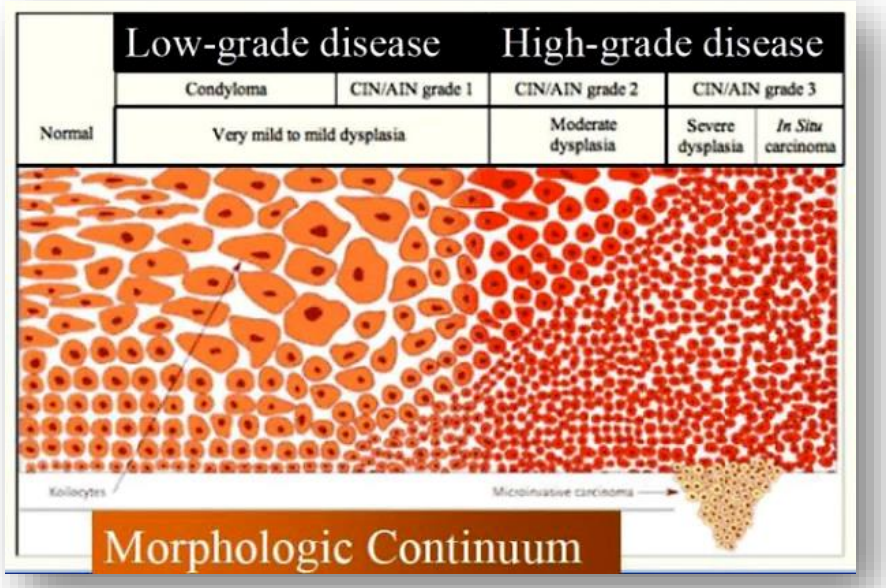
1. Success of cervical cancer screening programs

2. Causation by oncogenic HPVs

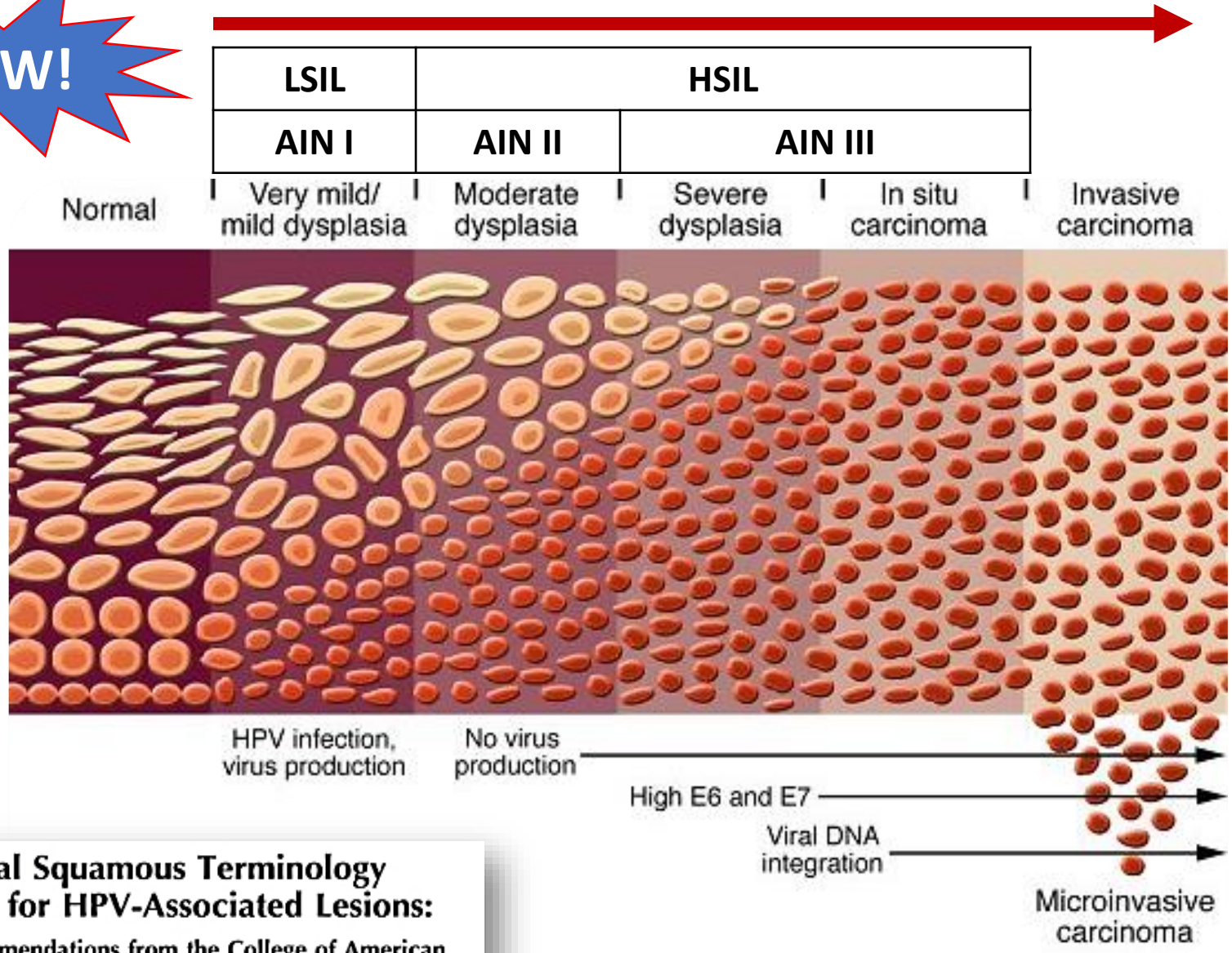
HPV: nuova classificazione (IARC 2011)

HR-*clade*	Gruppo 1	Cancerogeni per l'uomo	16, 18, 31, 33, 35, 39, 45, 51, 52, 56, 58, 59
	Gruppo 2A	Probabilmente cancerogeni per l'uomo	68
	Gruppo 2B	Possibilmente cancerogeni per l'uomo	26, 30, 34, 53, 66, 67, 69, 70, 73, 82, 85, 97
LR	Gruppo 3	Non classificabili come cancerogeni per l'uomo	6, 11, 28, 32, 40, 42, 43, 44, 54, 55, 57, 61, 62, 71, 72, 74, 81, 83, 84, 86, 87, 89

3. CIN = AIN



NEW!



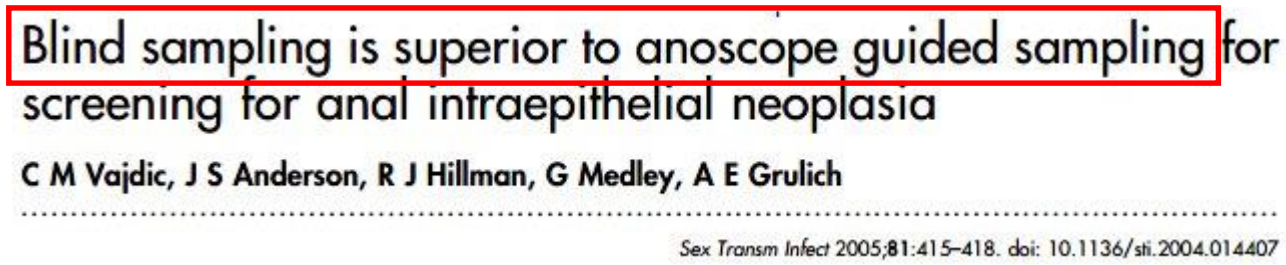
The Lower Anogenital Squamous Terminology Standardization Project for HPV-Associated Lesions:

Background and Consensus Recommendations from the College of American Pathologists and the American Society for Colposcopy and Cervical Pathology

Teresa M. Darragh, MD;[1] Terence J. Colgan, MD;[2] J. Thomas Cox, MD;[3] Debra S. Heller, MD;[4] Michael R. Henry, MD;[4] Ronald D. Luff, MD;[5,6] Timothy McCalmont, MD;[1] Ritu Nayar, MD;[7] Joel M. Palefsky, MD;[1] Mark H. Stoler, MD;[8] Edward J. Wilkinson, MD;[9] Richard J. Zaino, MD;[10] David C. Wilbur, MD,[11] for members of the LAST Project Work Groups

PAP TEST ANALE: REGOLE GENERALI

- **NON** è necessaria alcuna preparazione.
- I pazienti NON devono aver effettuato clisteri NÉ devono aver avuto rapporti anali di tipo ricettivo nelle 24 h precedenti.
- Il paziente dovrebbe essere posto in decubito laterale sinistro ("**posizione fetale**") ma anche altre posizioni sono accettate (**decubito prono**, **posizione genu-pettorale**).
- Se in combinazione con la citologia viene realizzato anche un esame digitale anorettale o una HRA, la **citologia** deve essere eseguita **sempre prima**, in quanto il lubrificante utilizzato per l'esplorazione rettale o per l'HRA può alterare la qualità del campione citologico.
- Il prelievo citologico anale, a differenza di quello cervicale, viene solitamente realizzato «**alla cieca**», senza la diretta visualizzazione del canale anale e della giunzione squamo-colonnare ano-rettale.



Blind sampling is superior to anoscope guided sampling for screening for anal intraepithelial neoplasia

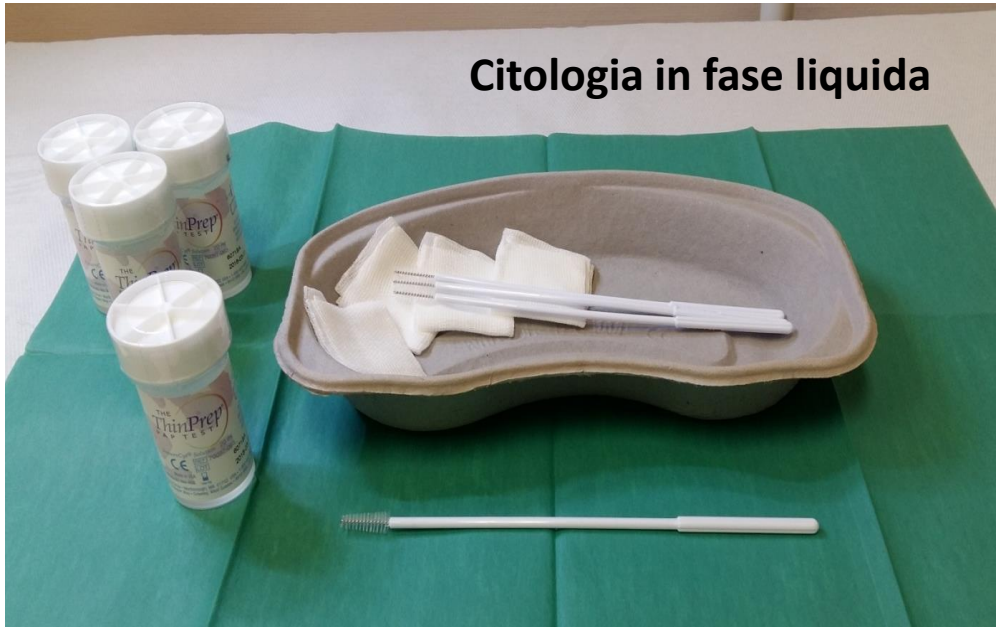
C M Vajdic, J S Anderson, R J Hillman, G Medley, A E Grulich

Sex Transm Infect 2005;**81**:415–418. doi: 10.1136/sti.2004.014407

CITOLOGIA CONVENZIONALE vs LBC

✓ Sensibilità maggiore rispetto al Pap test convenzionale
✓ Minor percentuale di inadeguati
✓ Maggiore riproducibilità interpretativa tra operatori differenti
✓ Possibilità di applicazione sullo stesso campione di metodiche molecolari ancillari per la ricerca e tipizzazione del virus HPV e di marcatori di progressione con tecniche di immunocitochimica

✓ Preparati citologici di alta qualità in monostrato (strato sottile) senza interferenze, cioè liberi da «fattori oscuranti» come sangue, muco, feci, batteri, cellule infiammatorie, e da strati di materiale sovrapposto che talvolta ostacolano una corretta interpretazione.



HIGH RESOLUTION ANOSCOPY (H.R.A.)

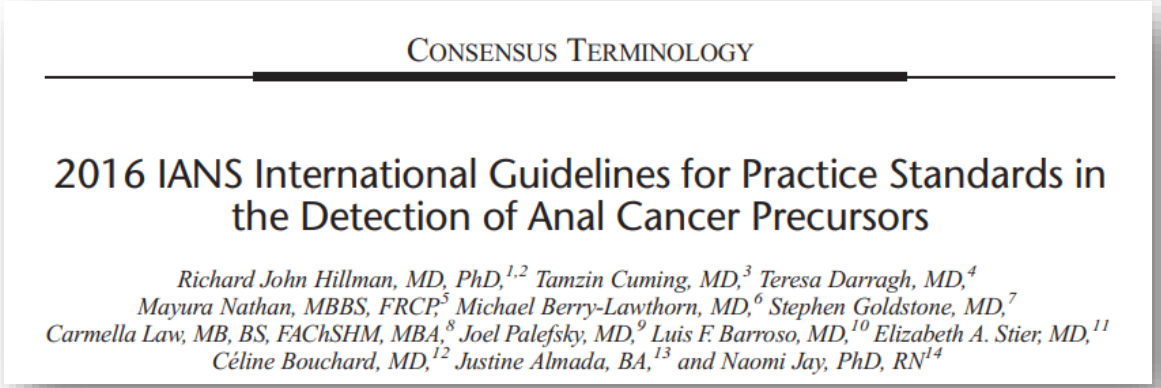
✓ *Examination of the anus, anal canal and perianus using a **colposcope** for lighting and magnification, after application of **5% acetic acid** and **Lugol iodine solution** to identify anal lesions.*

✓ Office-based procedure

✓ Adapted from gynecologic colposcopy

✓ Similar terminology and descriptors

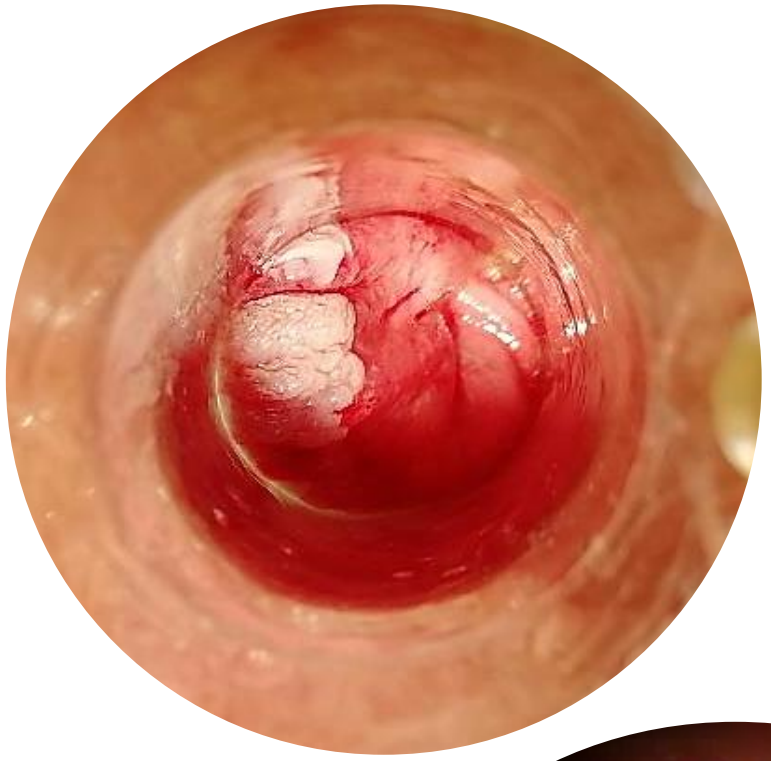
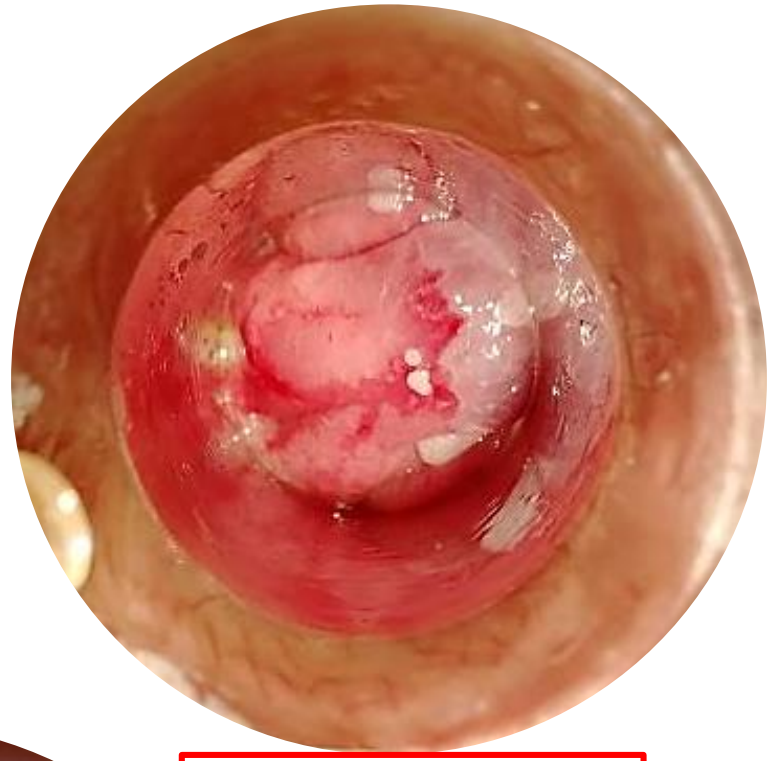
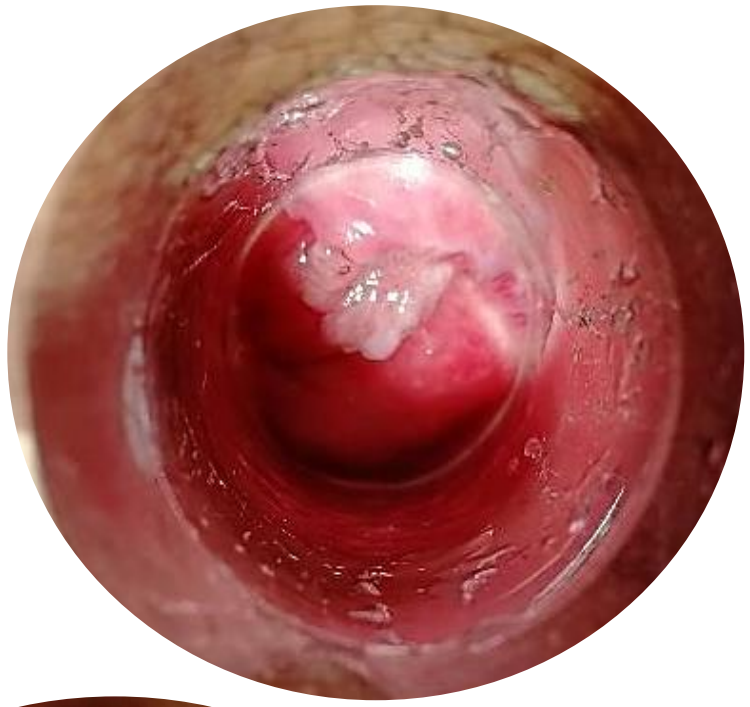
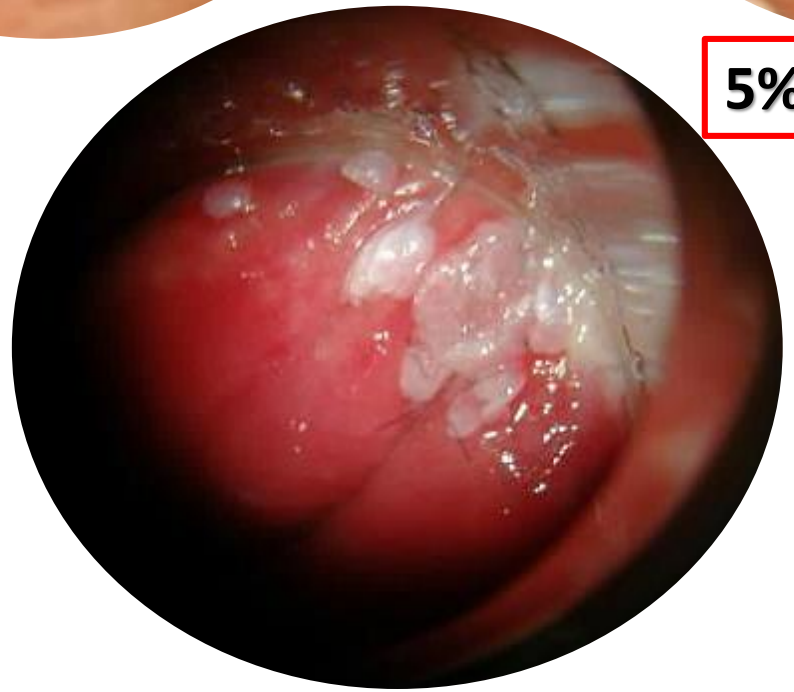
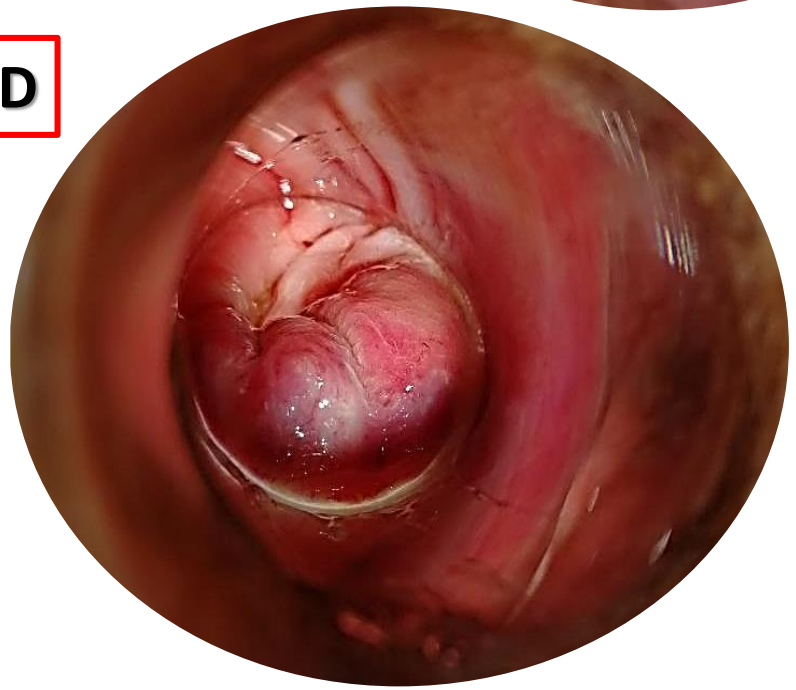
✓ Validated for anal canal



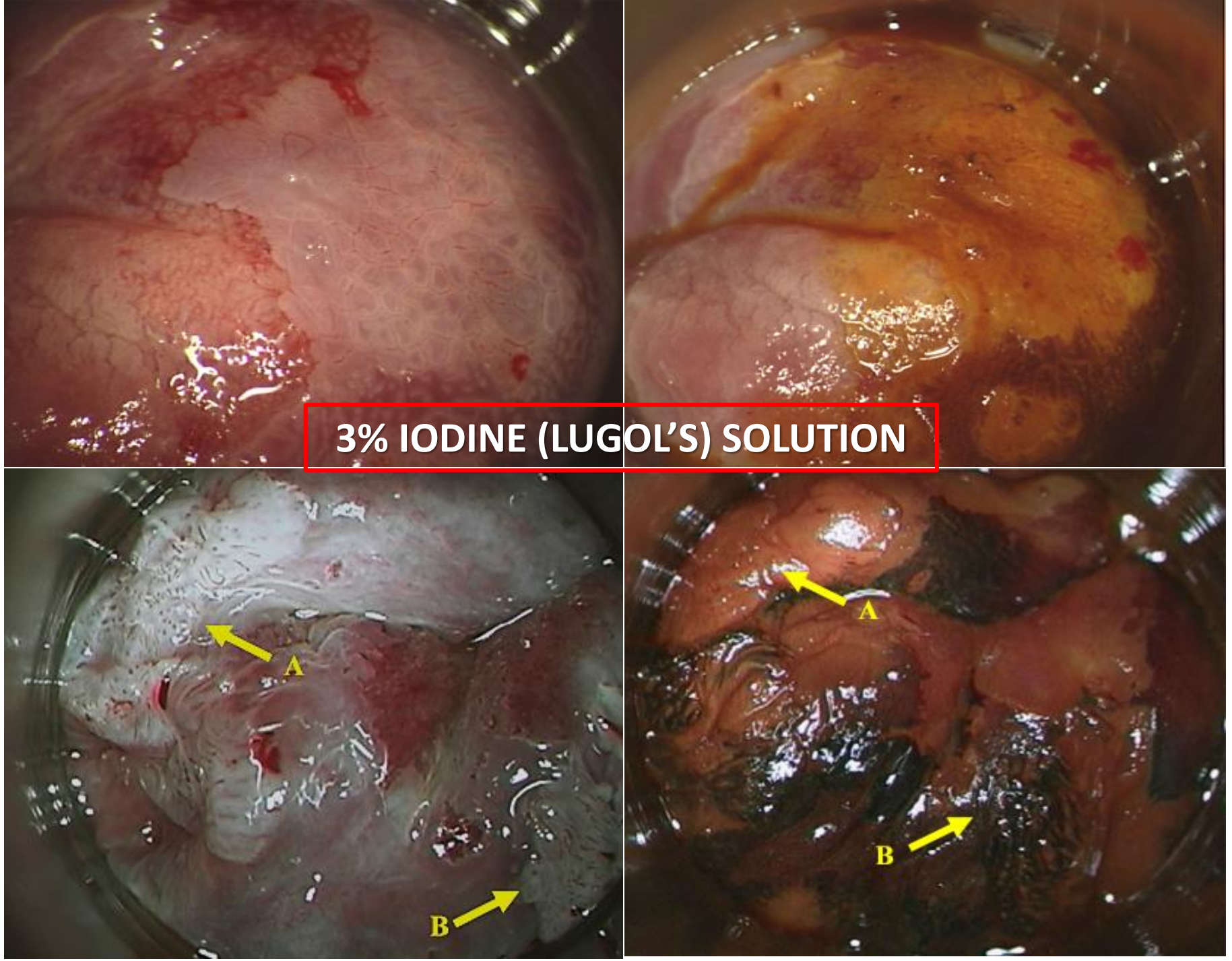
CONSENSUS TERMINOLOGY

2016 IANS International Guidelines for Practice Standards in the Detection of Anal Cancer Precursors

Richard John Hillman, MD, PhD,[1,2] Tamzin Cuming, MD,[3] Teresa Darragh, MD,[4] Mayura Nathan, MBBS, FRCP,[5] Michael Berry-Lawthorn, MD,[6] Stephen Goldstone, MD,[7] Carmella Law, MB, BS, FAChSHM, MBA,[8] Joel Palefsky, MD,[9] Luis F. Barroso, MD,[10] Elizabeth A. Stier, MD,[11] Céline Bouchard, MD,[12] Justine Almada, BA,[13] and Naomi Jay, PhD, RN[14]

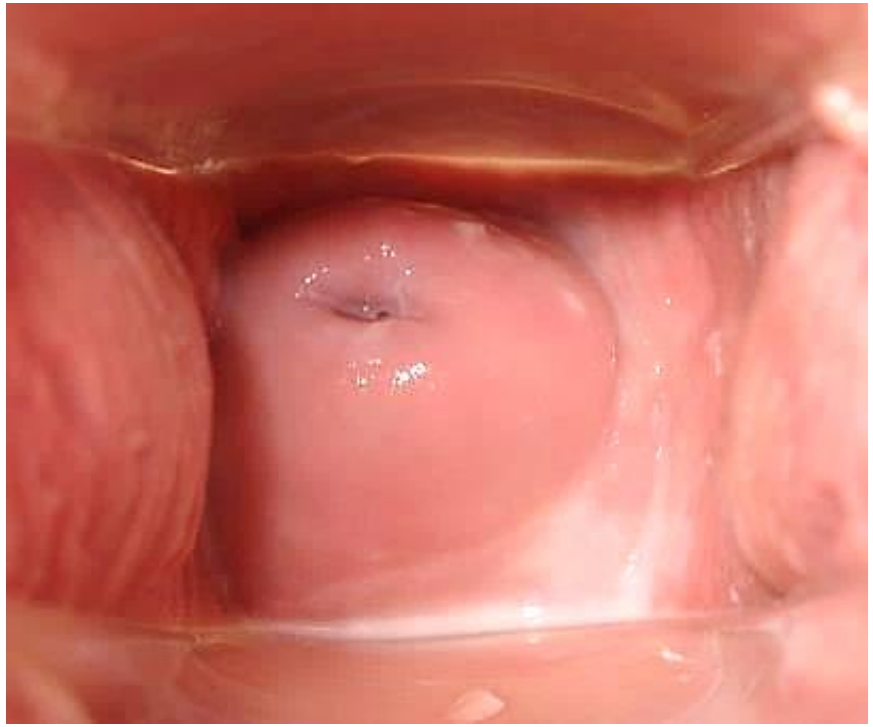






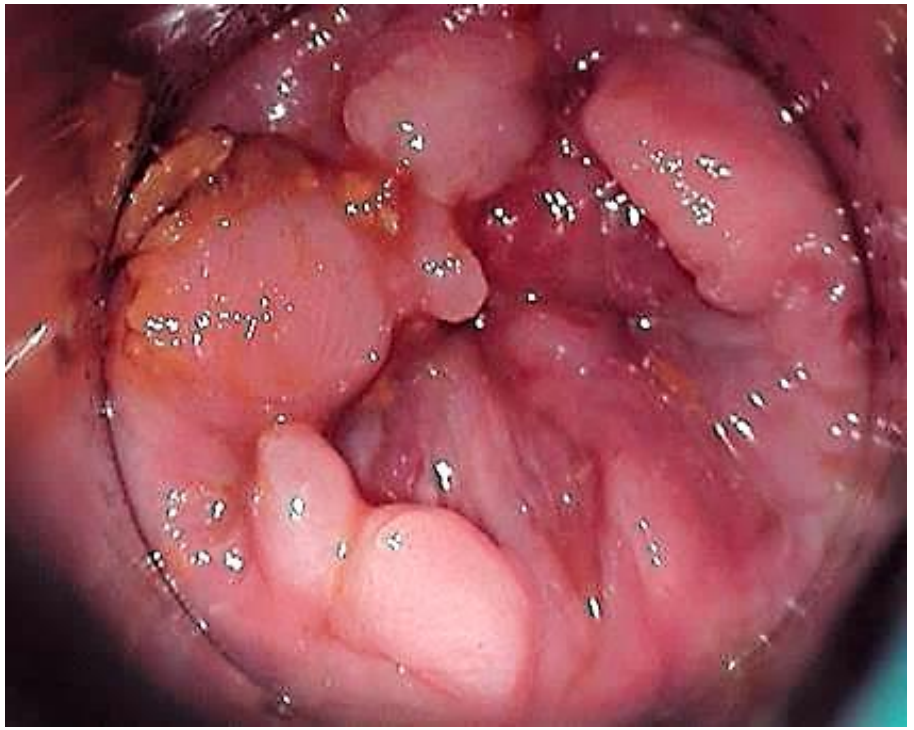
5% ACETIC ACID


3% IODINE (LUGOL'S) SOLUTION
A
B
A
B

CERVICAL COLPOSCOPY vs H.R.A. : SOME DIFFERENCES…

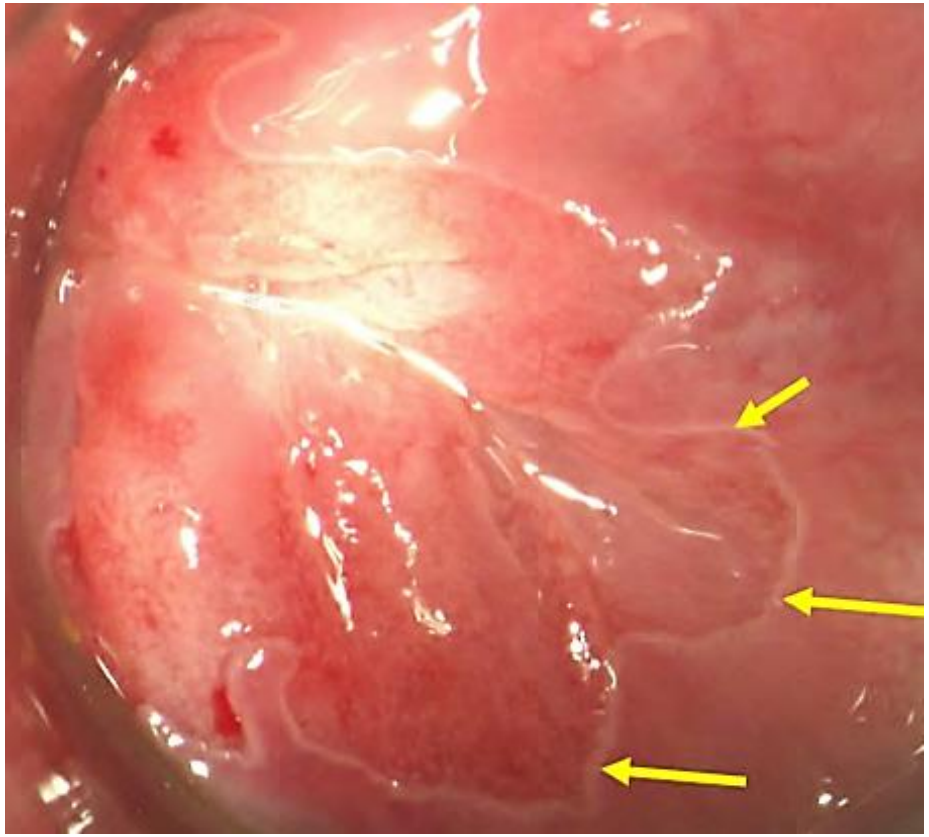
- In the evaluation of CIN lesions, an **overview image of the complete cervix** can be obtained, allowing the evaluation of suspected lesions in 1 picture.
- In contrast, in the evaluation of AIN lesions, an overview of the complete transformation zone in the anal canal cannot be obtained, because of the **folded nature of the anal mucosa** and the presence of **anatomical obstacles** such as *papillae*. Consequently, the anal transformation zone has to be evaluated in **consecutive images** to get a full picture of possible AIN involvement. The clinician must hold the anoscope in position throughout the examination, adjusting where necessary, to fully visualize the entire AnTZ, including the SCJ, while refocusing and repositioning the colposcope as needed.

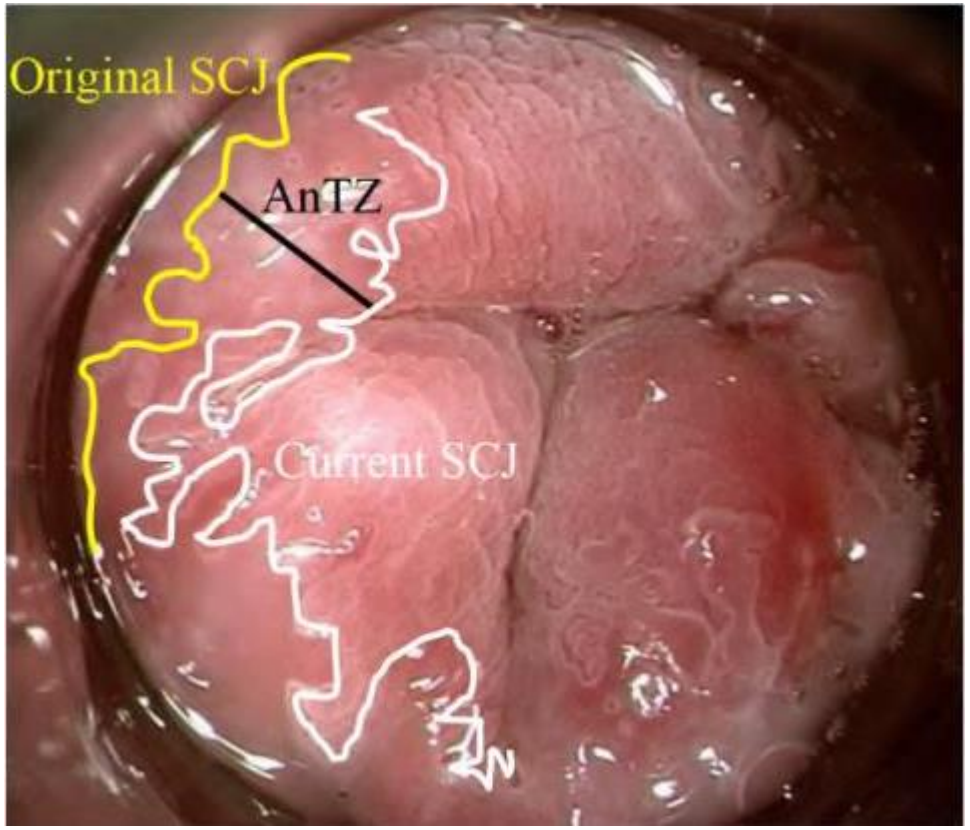




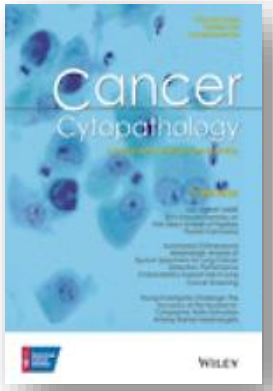
- In the anal canal, we found a **larger TZ** compared to the endocervix. Most lesions are found in this larger area of metaplastic changes overlying columnar epithelium. Widespread, the multifocal disease is often present.

- Microscopic features helping to identify anal HSIL may be subtle, requiring higher magnification and more acetic acid compared with the cervix, and can differ from those seen on the cervix.





H.R.A. is technically complex and requires training and experience to perform adequate examinations!



Cancer Cytopathology
Volume 123, Issue 9
Sep 2015

Screening to Prevent Anal Cancer: Current Thinking and Future Directions

Joel M. Palefsky, MD, CM, FRCP(C), Professor of Medicine, University of California San Francisco

WHY ROUTINE ANAL SCREENING OF AT-RISK POPULATIONS IS NOT RECOMMENDED:

- **Treatment of anal HSIL is not yet proven to reduce the incidence of anal cancer**: this is the primary reason for lack of guidelines recommending screening for HSIL. In this era of Evidence-Based Medicine, evidence of the efficacy of anal screening to reduce incidence of anal cancer is needed.
- **Treatment of anal HSIL is not yet optimized**: individuals in population at highest risk often have large and multifocal lesions, rendering total clearance difficult.
- **Screening approaches to identify anal HSIL are not yet optimized**: the most specific test to identify HSIL is HRA, but HRA is too expensive to be used as a screening tool, and there is also a paucity of clinicians well trained in HRA. Therefore, as in many cervical cancer screening programs, the initial step in screening is citology, that has high sensitivity but poor specificity. The grade of disease is often underestimated on cytology compared with HRA-guided biopsy.

WHAT'S NEW

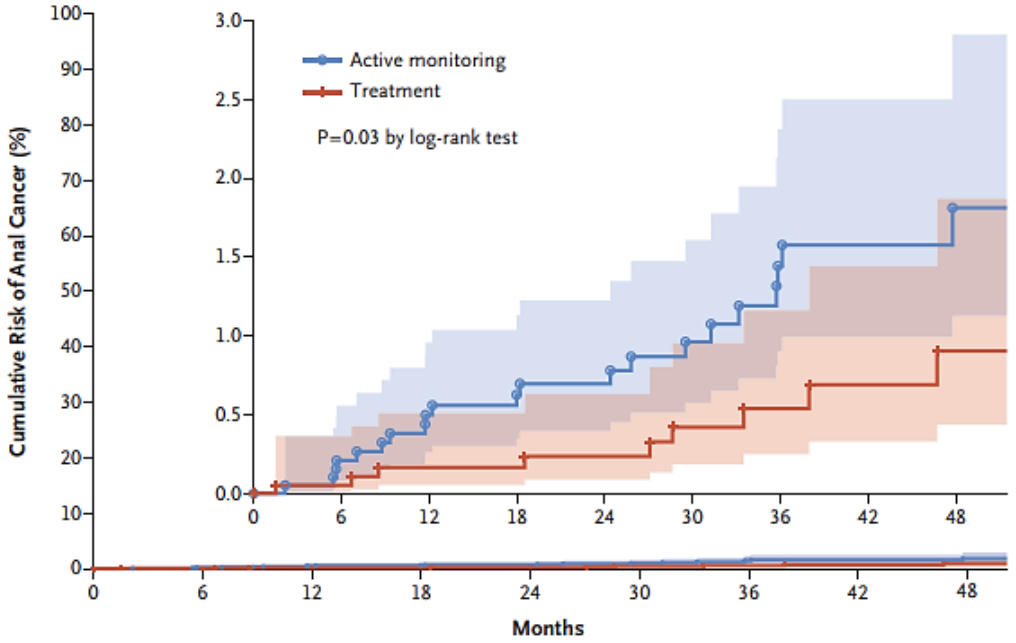
June 2022

The NEW ENGLAND JOURNAL of MEDICINE

ORIGINAL ARTICLE

Treatment of Anal High-Grade Squamous Intraepithelial Lesions to Prevent Anal Cancer

J.M. Palefsky, J.Y. Lee, N. Jay, S.E. Goldstone, T.M. Darragh, H.A. Dunlevy, I. Rosa-Cunha, A. Arons, J.C. Pugliese, D. Vena, J.A. Sparano, T.J. Wilkin, G. Bucher, E.A. Stier, M. Tirado Gomez, L. Flowers, L.F. Barroso, R.T. Mitsuyasu, S.Y. Lensing, J. Logan, D.M. Aboulafia, J.T. Schouten, J. de la Ossa, R. Levine, J.D. Korman, M. Hagensee, T.M. Atkinson, M.H. Einstein, B.M. Cracchiolo, D. Wiley, G.B. Ellsworth, C. Brickman, and J.M. Berry-Lawhorn, for the ANCHOR Investigators Group*



- **Participants who had undergone treatment for anal HSIL had a rate of progression to anal cancer that was nearly 60% lower than those who had undergone active monitoring and not received treatment.**
- **These data provide support for the use of screening and treatment for anal HSIL as the standard of care for persons living with HIV who are 35 years of age or older.**
- **These data may also be relevant for other groups at increased risk for anal cancer.**

WHAT'S NEW

Received: 3 November 2023 | Revised: 17 December 2023 | Accepted: 21 December 2023
DOI: 10.1002/ijc.34850

IJC INTERNATIONAL JOURNAL of CANCER

SPECIAL REPORT

International Anal Neoplasia Society's consensus guidelines for anal cancer screening

Elizabeth A. Stier[1] | Megan A. Clarke[2] | Ashish A. Deshmukh[3,4] | Nicolas Wentzensen[2] | Yuxin Liu[5] | I. Mary Poynten[6] | Eugenio Nelson Cavallari[7] | Valeria Fink[8] | Luis F. Barroso[9] | Gary M. Clifford[10] | Tamzin Cuming[11] | Stephen E. Goldstone[12] | Richard J. Hillman[6,13] | Isabela Rosa-Cunha[14] | Luciana La Rosa[15,16] | Joel M. Palefsky[17] | Rosalyn Plotzker[18] | Jennifer M. Roberts[19] | Naomi Jay[17]

Population—Risk category	When	Anal cancer incidence[2,5] per 100,000 person-years
Risk Category A (incidence ≥ 10-fold compared to the general population)		
MSM and TW with HIV	Age 35	>70/100,000 age 30–44 >100/100,000 age 45+
Women with HIV	Age 45	>25/100,00 age 45+
MSW with HIV	Age 45	>40/100,000 age 45+
MSM and TW not with HIV	Age 45	>18/100,000 age 45–59 >34/100,000 age 60+
History of vulvar HSIL or cancer	Within 1 year of diagnosis	>40/100,000
Solid organ transplant recipient	10 years post-transplant	>25/100,000
Risk Category B (incidence up to 10-fold higher compared to the general population)		
Cervical/vaginal cancer	Shared decision age 45[a]	9/100,000
Cervical/vaginal HSIL	Shared decision age 45[a]	8/100,000
Perianal warts (male or female)	Shared decision age 45[a]	Unknown
Persistent cervical HPV 16 (>1 year)	Shared decision age 45[a]	Unknown
Other immunosuppression (e.g., Rheumatoid arthritis, Lupus, Crohn's, Ulcerative colitis, on systemic steroid therapy)	Shared decision age 45[a]	6/100,000
Incidence among the general population: 1.7 per 100,000[8]		

WHAT'S NEW

Primary screening test	Triage test	Level of evidence	Special considerations
Cytology	None	BII	Anal cytology is the most widely used and evaluated test for anal cancer screening. Providers may consider using different thresholds for referral to HRA depending on capacity (see Table 3).
	hrHPV (with or without genotyping)	CII	hrHPV testing to triage ASC-US cytology (or other results, see Table 3) could be used to reduce HRA referral rates. This strategy has not been widely evaluated in the literature.
hrHPV (with or without genotyping)	None	BII	The efficiency of primary testing with a pooled hrHPV test is limited in populations with high HPV prevalence (e.g., MSM with HIV). This strategy could be considered in settings with no cytology infrastructure, or to reduce HRA (for patients testing hrHPV negative) in practices providing HRA on all patients. In most settings, additional triage will be needed for individuals who test hrHPV positive. Use of hrHPV genotyping, specifically for HPV16, may help identify patients with high risk of HSIL or cancer. Performance does not seem to improve with the addition of HPV18.[4] hrHPV testing may not be available in many settings.
	Cytology	CII	Triage of hrHPV-positive results with cytology (e.g., at an ASC-US or worse threshold) can improve specificity of hrHPV-testing and reduce HRA referral. However, observational data on this approach are lacking in the literature.
Cytology/hrHPV co-test (with or without genotyping)	None	BII	Current available data suggest that anal co-testing does not provide any benefit over primary hrHPV testing for anal HSIL. However, anal co-testing may be especially beneficial for its negative predictive value. Co-testing may be less efficient in populations with high hrHPV prevalence.
Digital anal rectal exam (DARE)	None	BII	All populations at-risk for anal cancer receive DARE at time of screening tests (or in lieu of screening tests in absence of HRA availability).

- Based on findings from the systematic review and meta-analysis of diagnostic studies, conducted primarily among PWH, **anal cytology**, **hrHPV testing** (including genotyping for HPV16), and **hrHPV-cytology co-testing** are all strategies currently used for anal cancer screening and show acceptable performance.
- These screening strategies are intended for populations with access to HRA.

- In the absence of HRA availability, screening should be limited to **digital anal rectal exam** (**DARE**) for detection of anal cancer.

Received: 3 November 2023 | Revised: 17 December 2023 | Accepted: 21 December 2023
DOI: 10.1002/ijc.34850

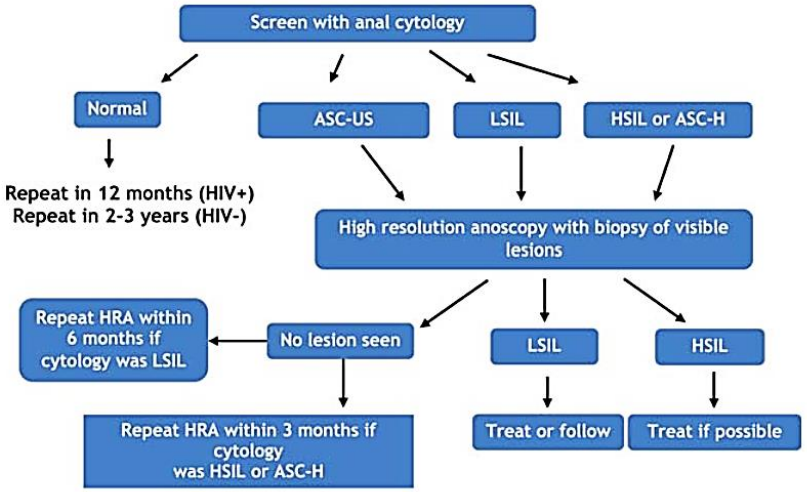
SPECIAL REPORT

IJC INTERNATIONAL JOURNAL of CANCER

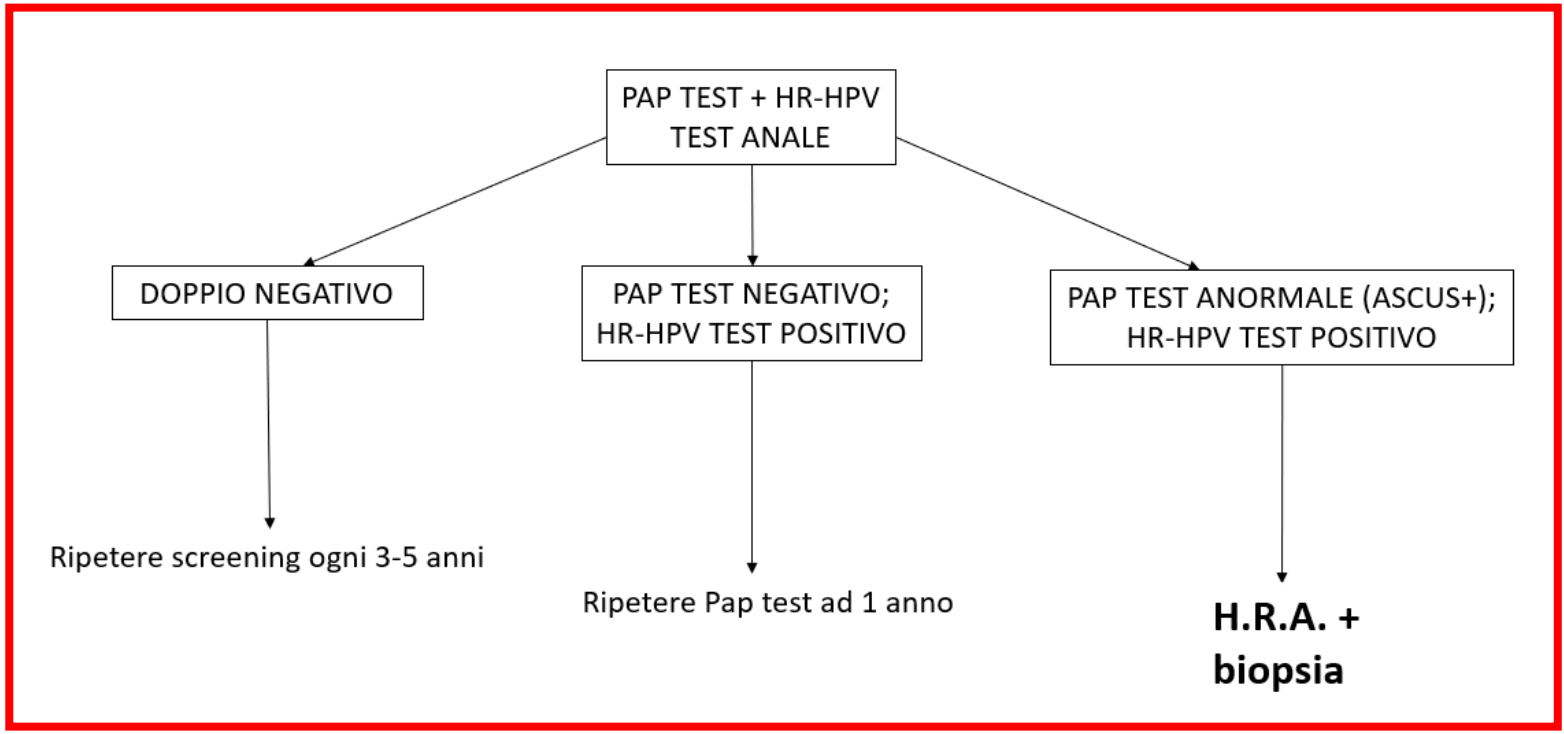
International Anal Neoplasia Society's consensus guidelines for anal cancer screening

On the basis of our experience..

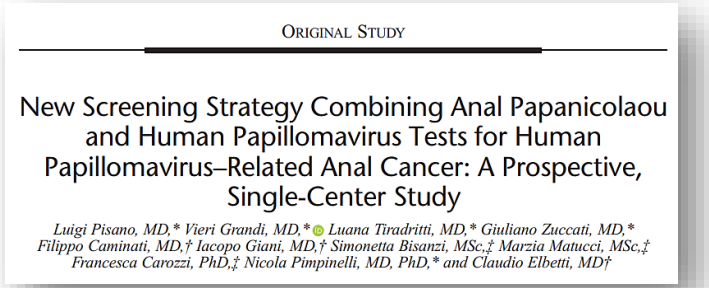
SCREENING ALGORITHM FOR ANAL HIGH-GRADE SQUAMOUS INTRAEPITHELIAL LESIONS



University Of California San Francisco Anal Neoplasia Clinic, Research, and Education Center



Centro MTS, S.C. Dermatologia, Università degli Studi di Firenze



ORIGINAL STUDY

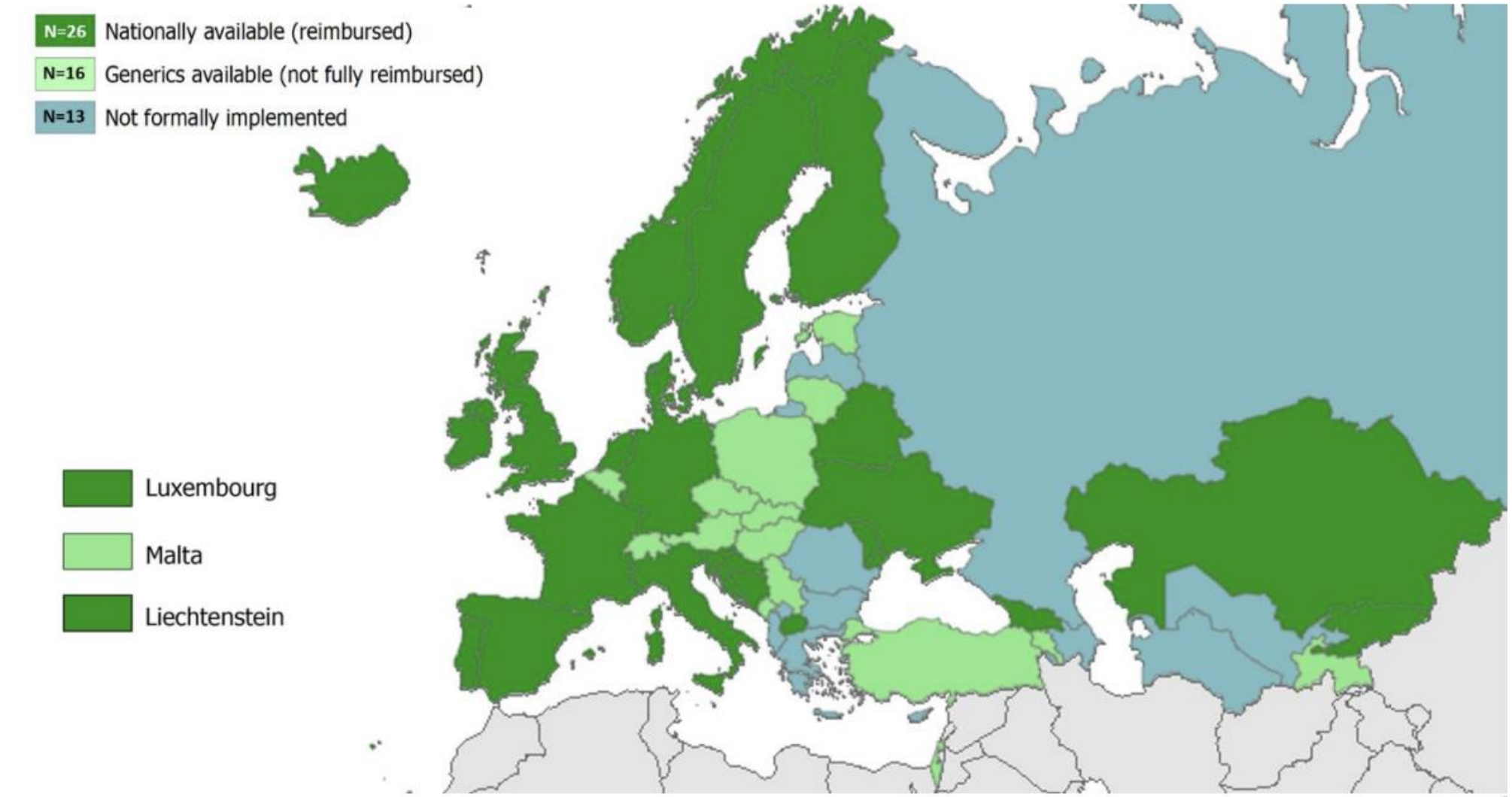
New Screening Strategy Combining Anal Papanicolaou and Human Papillomavirus Tests for Human Papillomavirus–Related Anal Cancer: A Prospective, Single-Center Study

Luigi Pisano, MD, Vieri Grandi, MD,* Luana Tiradritti, MD,* Giuliano Zuccati, MD,* Filippo Caminati, MD,† Iacopo Giani, MD,† Simonetta Bisanzi, MSc,‡ Marzia Matucci, MSc,‡ Francesca Carozzi, PhD,‡ Nicola Pimpinelli, MD, PhD,* and Claudio Elbetti, MD†*

PROFILASSI PRE-ESPOSIZIONE (PrEP)

PrEP IN EUROPA

Figure 1. Status of PrEP implementation in Europe and Central Asia, 2023 (n=55)



PrEP IN ITALIA

- *Agosto 2016*: l'EMA rilascia l'autorizzazione all'immissione in commercio nei 28 Paesi dell'UE per **Truvada®** come PrEP.

- *Marzo 2018*: l' EMA autorizza l'utilizzo di **medicinali generici** «*emtricitabina/tenofovir disoproxil*» (TDF/FTC) come PrEP. Alcuni di questi farmaci generici sono iscritti nel nostro Paese in **fascia C (NON RIMBORSATI DAL SSN)**, soggetti a prescrizione da parte di uno specialista in Malattie Infettive. Costo inferiore rispetto a Truvada®.

- *26 aprile 2023*: l'AIFA autorizza la rimborsabilità dell'associazione Emtricitabina/Tenofovir Disoproxil per la «Profilassi pre-esposizione (PrEP)» al fine di ridurre il rischio di infezione da HIV-1 sessualmente trasmessa in adulti e adolescenti ad alto rischio. **CLASSE DI RIMBORSABILITA': H**

- Solo lo **specialista infettivologo** può teoricamente prescrivere la terapia, subordinandola alla compilazione di un PT. Da questo momento in poi, la distribuzione del trattamento avviene unicamente da parte delle **farmacie ospedaliere**.

PROFILASSI PRE-ESPOSIZIONE (PrEP)

LA NOSTRA ESPERIENZA

Settembre 2021:

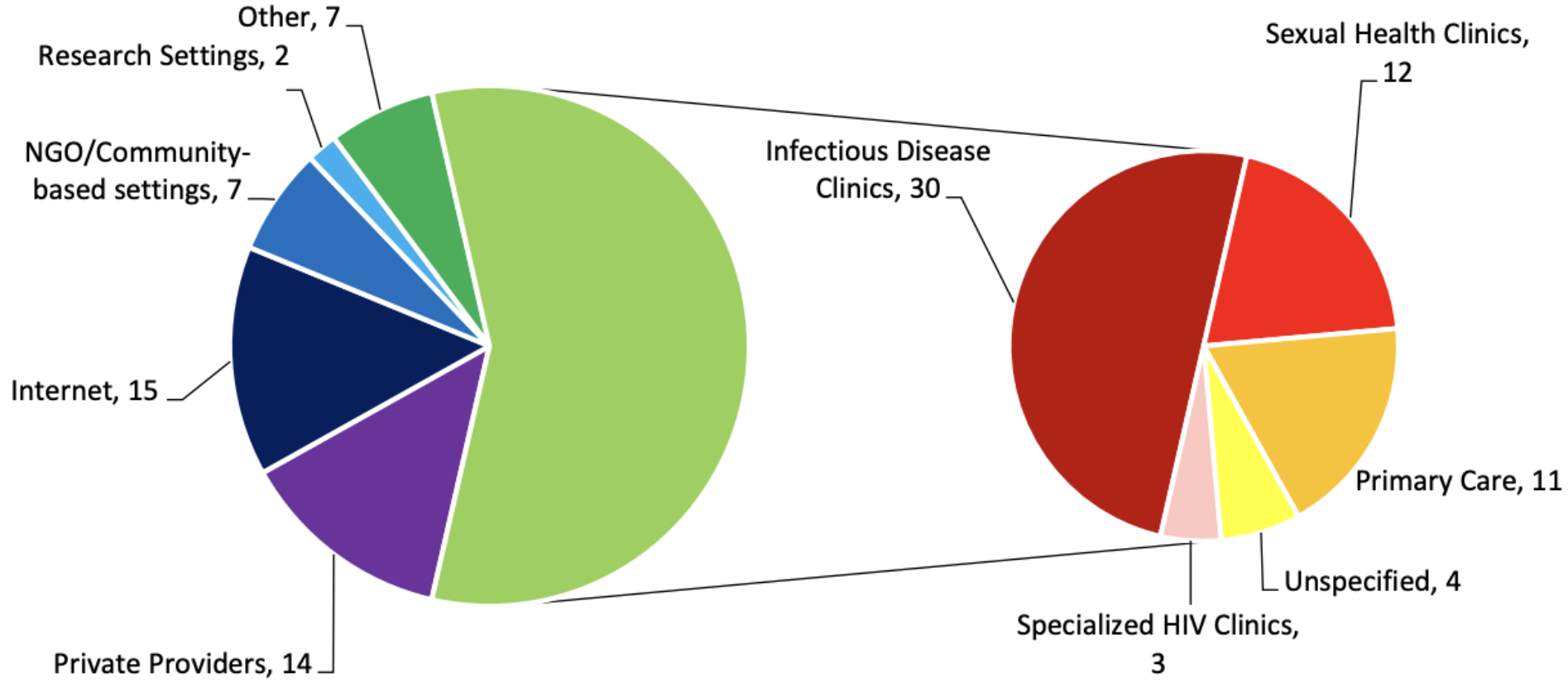
Attivazione di un punto PrEP presso il centro MTS della S.C. Dermatologia del P.O. Palagi di Firenze

Maggio 2023:

Erogazione gratuita della PrEP

WHO CAN PRESCRIBE PrEP?

Figure 4. Settings in which PrEP is available across Europe and Central Asia (n=50)



IL RUOLO DEL DERMATOLOGO-VENEREOLOGO…?

JEADV JOURNAL OF THE EUROPEAN ACADEMY OF DERMATOLOGY & VENEREOLOGY

LETTER TO THE EDITOR

The potential role of derma-venereologists in prescribing and managing pre-exposure prophylaxis in Italy

L. Pisano, G. Ciccarese, R. Balestri, V. Gaspari, S. Ramoni, L. Atzori, M. Papini

First published: 06 August 2024 | https://doi.org/10.1111/jdv.20278

- Having the opportunity to offer PrEP **at the same time as the diagnosis and treatment of STDs** allows us to significantly reduce the likelihood of HIV transmission.
- STD centres have the potential to reach persons at risk of HIV who are interested in accessing PrEP programmes through such centres.
- The possibility of prescribing PrEP by dermato-venereologists directly within their STD centres would also facilitate the periodic serological and microbiological screening.
- The final objective would be to **make PrEP more accessible** to everyone **while guaranteeing the necessary periodic screening for HIV and other STDs**.

PrEP & MTS

- Dall'introduzione della PrEP si sono diffuse **preoccupazioni** sul rischio di aumento dei rapporti senza condom e conseguente aumento di tutte le altre MTS.
- In realtà, la ***«risk compensation»*** in corso di PrEP è molto dibattuta in letteratura, con studi che indicano sia aumenti, sia nessun cambiamento nei rapporti non protetti e nell'incidenza delle MTS.
- La PrEP non deve essere considerata un compromesso tra la prevenzione dell'HIV e la prevenzione delle altre MTS, ma piuttosto come una **opportunità per ridurre le MTS nelle popolazioni ad alto rischio**, attraverso l'esecuzione di più frequenti test di screening e conseguenti diagnosi più precoci e trattamenti più tempestivi, con conseguente interruzione della catena dei contagi (***TEST & TREAT STRATEGY***).
- Alcuni modelli matematici suggeriscono che, se un gruppo di soggetti a rischio sia di HIV che di altre MTS fossero iscritti ai programmi PrEP, i frequenti test che ne dovrebbero risultare potrebbero portare ad un calo sostanziale dell'incidenza di tutte le MTS.

PRIMA PRESCRIZIONE DI TDF/FTC PER UN SOLO MESE, POI PER UN PERIODO NON SUPERIORE A 3 MESI

Tempo 0

- Test HIV Ab/Ag (4° gen.),
- Sierologie per epatite A/B/C
- **Screening MTS** (sierologia lue; tampone orofaringeo, anorettale e raccolta urine I mitto per NG e CT)
- Creatinina sierica e stima GFR
- [Test di gravidanza]

1 mese

- Test HIV Ab/Ag (4° gen.)
- [Test di gravidanza]

3 mesi

- Test HIV Ab/Ag (4° gen.),
- **Screening MTS** (sierologia lue; tampone orofaringeo, anorettale e raccolta urine I mitto per NG e CT)
- [Test di gravidanza]

6 mesi

- Test HIV Ab/Ag (4° gen.),
- Sierologie per epatite A/B/C
- **Screening MTS** (sierologia lue; tampone orofaringeo, anorettale e raccolta urine I mitto per NG e CT)
- Creatinina sierica e stima GFR
- [Test di gravidanza]

- **AD OGNI FOLLOW-UP: COUNSELLING PER LA RIDUZIONE DEL RISCHIO SESSUALE/INIETTIVO, NONCHE' PER LA MASSIMIZZAZIONE DELL' ADERENZA E LA VALUTAZIONE DI EVENTUALI EFFETTI COLLATERALI.**
- **SUGGERIRE NECESSITA' DI VACCINAZIONI SPECIFICHE (HAV, HPV…)**

PrEP & MTS

LA NOSTRA CASISTICA (dati preliminari)

- 156 M
- 139 MSM; 2 MSW; 15 MSMW
- 12 «daily»; 144 «on demand»

Screening preliminare:

- 18 NG (2 uretriti, 6 proctiti, 10 faringiti)
- 12 CT (3 uretriti, 7 proctiti, 2 faringiti)
- 10 MG (6 uretriti, 4 proctiti)

40/156 (25,6%):
infezione batterica asintomatica

In corso di PrEP:

- 3 condilomi
- 3 HSV2
- 2 sifilidi
- 33 NG (4 uretriti, 15 proctiti, 14 faringiti)
- 23 CT (6 uretriti, 16 proctiti, 1 faringite)
- 18 MG (8 uretriti, 7 proctiti, 3 faringiti)

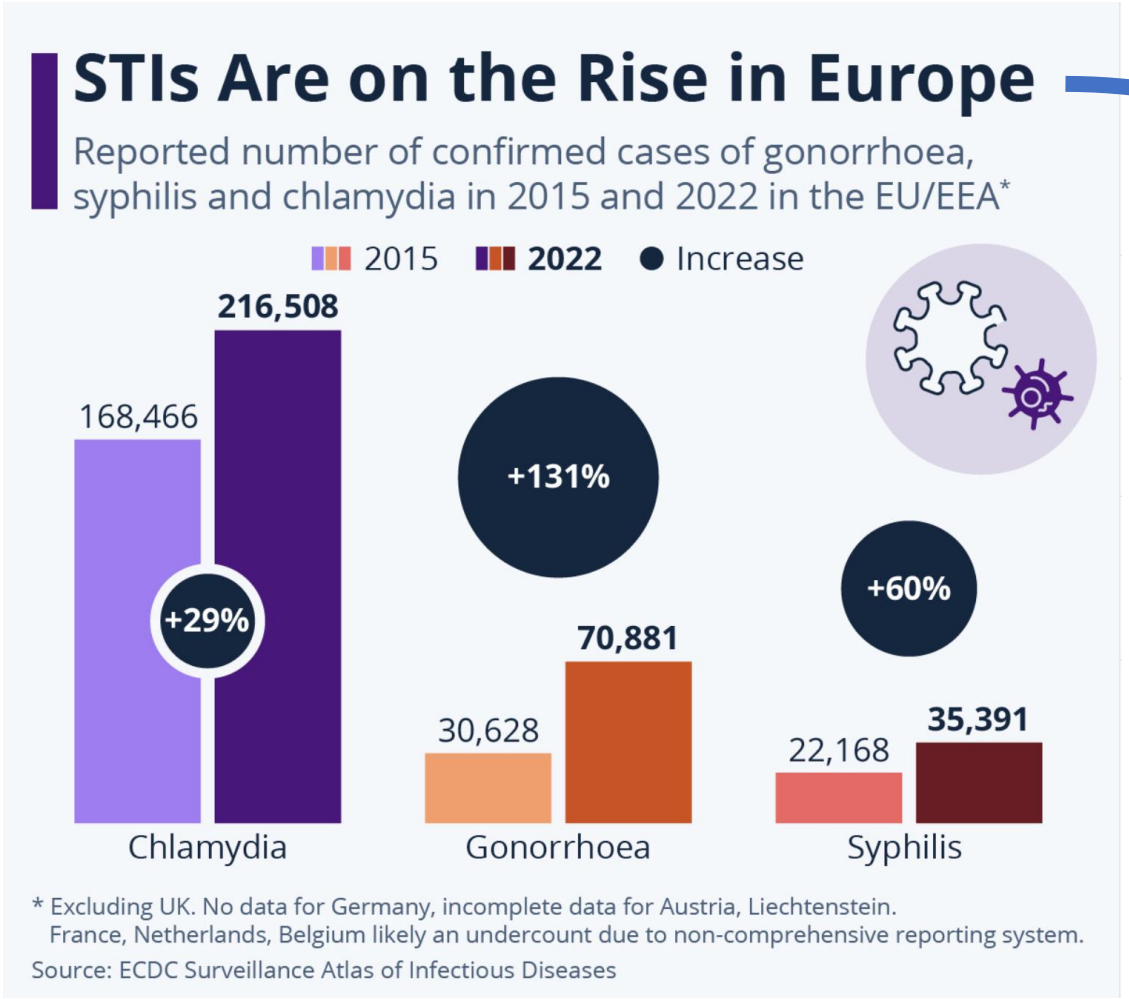
2 U. sintomatiche extra screening trim.

1 U. e 1 P. sintomatiche extra screening trim.

2 U. sintomatiche extra screening trim.

74/156 (47,4%):
infezione batterica PER LO PIU' asintomatica

PrEP & MTS



This rise is mostly driven by ASYMPTOMATIC INFECTIONS

JOURNAL ARTICLE

High Rate of Asymptomatic Bacterial Sexually Transmitted Infections (STIs) in Men who Have Sex with Men on Pre Exposure Prophylaxis (PrEP)

Lucas La Fata, MD, Laurent Cotte, MD, Matthieu Godinot, MD, Aymeric Pansu, MD, Carole Groslafeige, MD, Djamila Makhloufi, MD, Andre Boibieux, MD, Tristan Ferry, MD, Christian Chidiac, MD Author Notes

Open Forum Infectious Diseases, Volume 4, Issue suppl_1, Fall 2017, Page S669,

- 80.3% of incident STIs: asymptomatic

PrEP & MTS

Sexually Transmitted Infections

Management of asymptomatic sexually transmitted infections in Europe: towards a differentiated, evidence-based approach

Chris Kenyon,[a,] Björn Herrmann,[b] Gwenda Hughes,[c] and Henry J. C. de Vries[d,e,f,g]*

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[b]Section of Clinical Microbiology, Department of Medical Sciences, Uppsala University, Uppsala, Sweden
[c]Department of Infectious Disease Epidemiology, London School of Hygiene & Tropical Medicine, UK
[d]Department of Dermatology, Amsterdam UMC Location University of Amsterdam, Meibergdreef 9, Amsterdam, the Netherlands
[e]Amsterdam Institute for Infection and Immunity, Infectious Diseases, Amsterdam, the Netherlands
[f]Center for Sexual Health, Department of Infectious Diseases, Public Health Service Amsterdam, the Netherlands
[g]Amsterdam Institute for Global Health and Development, Amsterdam, the Netherlands

Summary

Most sexually transmitted infections (STIs) can be accurately diagnosed and treated during asymptomatic carriage. Widespread screening for these STIs is therefore assumed to be an effective way to reduce their prevalence and associated disease. In this review, we provide evidence that this is the case for HIV and syphilis. However, for other STIs such as *Neisseria gonorrhoeae* and *Chlamydia trachomatis*, our review reveals that the evidence that screening reduces infection prevalence and associated disease is weak. There is also growing evidence of harms from screening that might outweigh any benefits. The harms include the increased consumption of antimicrobials that follows frequent screening and increased detection of asymptomatic STIs in key populations, such as men who have sex with men taking HIV pre-exposure prophylaxis, and associated risk of antimicrobial resistance in target and non-target organisms. There may also be psycho-social harm associated with an STI diagnosis. We conclude that in the absence of symptoms, in high STI prevalence populations frequent STI screening should be limited to HIV and syphilis.

The Lancet Regional Health - Europe 2023;34: 100743

Published Online 26 October 2023
https://doi.org/10.1016/j.lanepe.2023.100743

For gonorrhoea and chlamydia, the harms of screening may outweigh any benefits

PrEP & MTS

QUESTIONI APERTE:

- Dobbiamo continuare a screenare i pazienti in PrEP (per NG, CT, MG) **ogni 3 mesi**?
- Dobbiamo trattare **tutte** le infezioni asintomatiche che diagnostichiamo ?
- Se abbiamo paura dell'over-treatment conseguente all'over-screening, come dobbiamo comportarci con la Doxy-PEP?

… ma fino a che punto???

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Grazie per l'attenzione