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EDITORIAL

Target population for the screening of human papillomavirus (HPV) and anal carcinoma precursor lesions – Results from a pilot study in HIV-infected males with sexual risk factors

Ninety-five percent of precursor lesions –high-grade squamous intraepithelial lesions (HSIL) and anal intraepithelial neoplasms (AIN)– and their progression to squamous anal cancer (AC) are induced by high-risk HPV (HR-HPV) serotypes 16 and 18. Their incidence is higher particularly in HIV-infected male patients who have sex with other males (HIV-MSM) (144/100,000/patients/year) (1-4).

Screening programs for cervical cancer, initiated during the 1950s in the USA, have shown positive results in reducing the incidence of HR-HPV infection among the general population. It is because of this that the study this editorial refers to, published in the present issue of *Revista Española de Enfermedades Digestivas (The Spanish Journal of Gastroenterology)* by Iribarren-Díaz et al. is particularly interesting (5). By implementing a screening program using anal cytology and high-resolution anoscopy (HRA) in a reference hospital for a target population of HIV-MSM patients, the authors identified a high prevalence of HR-HPV infection by high-risk serotypes 16 and 18, as well as AC precursor lesions.

Their paper also reveals several aspects to be considered for the successful setup of such screening programs. First, multidisciplinary care is crucial (infectologist, coloproctologist, specialist nurse, pathologist, microbiologist). Secondly, a clinical management path is to be established for referred patients. All patients must undergo history-taking, proctological assessment, digital anorectal examination, and anal cytology first. Those with cytologic changes and/or positive for HPV 16-18 must undergo HRA. Those with lesions categorized as HSIL (AIN-2 and 3) must be referred for ablative and/or surgical treatment. Thirdly, a follow-up protocol should be established. Thus, the authors suggest that follow-up should consist of yearly brush samplings for patients with prior negative cytology, annual HRAs for patients with low-grade ILs (LSIL, AIN-1), and an HRA every 6 months for patients with precursor HSILs (AIN-2 and 3). HRA must be carried out in reference institutions, whereas cytology may ideally take place in specialized outpatient clinics.

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