



Your Health and Wellness: Cervical Cancer



It is fitting every January (National Cervical Awareness month) to review current trends in cervical cancer detection and prevention.

Human papillomavirus (HPV) is the most common sexually transmitted viral disease in the United States and has affected 20 million individuals to date with 5.5 million new cases annually. At least 50% sexually active men and women will have been exposed to HPV at some point and 50% of women by age 50. This would make HPV exposure the norm rather than the exception. This has not happened without great economic, social, medical, and individual impact.

Studies have estimated annual costs for screening, care, and treatment for HPV at 180 million US dollars versus life time costs for cervical carcinoma at up to 3.5 billion. These figures cannot represent the often unrecognized quality of life issues including anxiety, shame, guilt, and loss of self image. To bring the real costs into focus the CDC places HPV fourth behind HIV, nosocomial infections, and food borne infections.

Since June of 2006, a quadrivalent vaccine (Gardasil) has been FDA approved. This followed a five year ½ million dose international study without major problems. The vaccine protects against “high risk” HPV genotypes 16 & 18 (known to be responsible for CIN I and CIN II (pre-malignant cervical histological changes). It also protects against genotypes 6 & 11 (responsible for condyloma acuminata, genital warts). Genotypes 16 & 18 are responsible for approximately 70% of cervical carcinomas. Genotypes 6 & 11 are responsible for 90% of genital warts.

Both ACIP (Advisory committee on Immunization Practices) and ACOG (American College of Obstetricians and Gynecologists) have made similar recommendations. Vaccinate all women between the ages of 11 & 26. Ideally this would be done before she becomes sexually active. There is some consideration being given to vaccinating all sexually active women even those 26 and older. Though they may have been exposed to some of the four genotypes, it is unlikely that they have been exposed to all four (0.1% only). There is no recommendation on this at the present. Nor is there any recommendation for men at the present.

The above applies to all women whether they have had abnormal pap smears or genital warts before. There is no need to screen for HPV or await a pap result. The vaccine is a non-live vaccine and may be used in the immunodeficient or women who are breast feeding. It is not approved for use in pregnancy.

Vaccine is 100% effective in prevention of CIN (cervical intra-epithelial neoplasia) and condyloma acuminata in women who are previously uninfected. It remains unclear if booster



vaccination will be necessary after five years. Vaccination is given in 3 parts at 0, 2, & 6 months. Prior approval with patient's insurance is advised. Vaccination may be available cost free for certain Medicaid patients, Native Americans and those of federally funded rural health centers.

Though the initial cost may be high (more than \$750), the long term economics, utilization of medical resources and quality of life issues undeniably favor vaccination. Studies have shown that though we may expect a certain amount of resistance to vaccinating an adolescent for a STD, 80% of mothers would vaccinate their daughters. Some where between a patient's care with her pediatrician, family practitioner or gynecologist this invaluable tool should be made available.

Assuredly this is a situation where we should “vaccinate early” and “vaccinate often”.

Thomas Feigman, MD

The Women's Place