

Transcript Details

This is a transcript of a continuing medical education (CME) activity. Additional media formats for the activity and full activity details (including sponsor and supporter, disclosures, and instructions for claiming credit) are available by visiting:

<https://reachmd.com/programs/cme/hpv-vaccination-rates-in-mid-adult-and-high-risk-patients-strategies-for-improvement/15430/>

Time needed to complete: 15 minutes

ReachMD

www.reachmd.com

info@reachmd.com

(866) 423-7849

HPV Vaccination Rates in Mid-Adult and High-Risk Patients: Strategies for Improvement

Announcer:

Welcome to CME on ReachMD. This activity, titled "HPV Vaccination Rates in Mid-Adult and High-Risk Patients: Strategies for Improvement" is provided by Prova Education.

Prior to beginning the activity, please be sure to review the faculty and commercial support disclosure statements as well as the learning objectives.

Dr. Giuliano:

As many of you remember, the 4-valent HPV [human papillomavirus] vaccine was first licensed and introduced into public health practice in 2006. And since then, there's been all this incredible data on the safety and the effectiveness of the 4-valent vaccine. As we would have it, research has progressed and the vaccine we now have is the 9-valent HPV vaccine, which provides protection against an additional 5 HPV types that can cause cancer. Now this 9-valent vaccine was approved in 2014. Since then, the CDC guidelines have changed several times, most recently in 2019, regarding vaccination of mid-adult-aged men and women. Although the ACIP [Advisory Committee on Immunization Practices] guidelines broaden the age range for those eligible for vaccination and coverage, the coverage has been slowly increasing, but the prevalence of HPV among adults remains high and vaccination rates remain suboptimal. They are well below our national goals of 80% of age-eligible patients completing the vaccine series. So today, we're going to discuss the updates to the guidelines and offer strategies to apply them in your practice.

This is CME reach MD and I'm Dr. Anna Giuliano.

Dr. Heidelbaugh:

And I'm Dr. Joel Heidelbaugh.

Dr. Giuliano:

So, Dr. Heidelbaugh, why is HPV vaccination in adults important, and who are those that face the greatest burden from HPV-related diseases?

Dr. Heidelbaugh:

So generally, when we think about the burden of HPV disease, we should be thinking about that burden really being related to cancer. And so HPV prevention is really cancer prevention. And right now in the US, men actually have the highest burden of HPV-related cancers, and that's related to oropharyngeal cancer, where the incidence is 5 times higher in men than in women. And historically, we've thought of HPV-related cancers relative to cervical cancer in women, and that's actually the next most common cancer. It's important to remember that HPV causes 10s of millions of cases of cervical dysplasia among both young and middle-aged women, year over year.

So men and women remain susceptible to acquiring HPV throughout their lifetime. And we need to be thinking about specifically people aged 27 to 45 years. And so the only way to really prevent oral pharyngeal cancer, which mainly affects men, is through a vaccination against HPV. All HPV vaccines have roughly 100% efficacy for the prevention of HPV vaccine type-related persistent infection and a variety of other types of cancers including cervical, vulvar, and vaginal, as well as anal.

So the take home point here is HPV vaccination has been shown to prevent cancer in both men and women. And the myth of HPV-

associated disease is that it's just a women's issue, and it's certainly not.

So, Dr. Giuliano, with that information as background, let's now focus on updates that were made in 2019 to the ACIP, the Advisory Committee on Immunization Practices, HPV vaccination recommendations.

Dr. Giuliano:

So from the very start in 2006, the ACIP recommended routine vaccination of 9- to 26-year-olds. Now some of you will remember the target age for vaccination has always been those adolescents ages 11 and 12. And that remains the target for a variety of reasons; it's the optimal time to vaccinate. And more recently, we are recommending to go as low as age 9 to help spread out the number of vaccines adolescents are receiving in any 1 clinical visit. So why the 18 to 26? Well, we need to catch up, you know, we would be missing generations if we didn't have catch-up and we only vaccinated those adolescents. So since the start, the recommendation has routine vaccination of 9- to 26-year-olds. Now what is new is the ACIP guidance on vaccination of mid-adult-aged men and women. And again, those are individuals ages 27 to 45. Now why is that important? Well, you've just heard from Dr. Heidelbaugh that one of the most important cancers and the largest burden is oropharyngeal cancer. This actually occurs in a median age of around 60 or 61. So if we can actually reach those individuals that still remain at risk for infection that causes cancer, that is the age range 27 to 45, we have an opportunity to reduce that cancer burden in the future.

So right now, CDC estimates that approximately 9.1 million women and 13.9 million men aged 19 to 26 remain unvaccinated. And unfortunately, very few Americans ages 27 to 45 have ever been vaccinated despite being at risk for new infections and as I said, potentially progression to cancer. So the recommendation is for these unvaccinated adults to catch up their vaccination, and catch-up vaccination is with the standard 3-dose schedule for all persons through age 26. Now after age 26, it's a case-by-case basis on a discussion between the provider and their patient. And they are to use shared clinical decision-making, which we'll come back to later.

So, Dr. Heidelbaugh, what can you tell us about other HPV-associated cancers?

Dr. Heidelbaugh:

Again, we've talked about how we tend to think HPV-related cancer is limited to cervical cancer, and now we're talking about how oropharyngeal cancer is very prevalent. There are other HPV-associated cancers that we need to be aware of, and these include anal cancers or anorectal cancers, vaginal cancers, vulvar cancers, and penile cancers. And we need to understand the prevalence; we need to appropriately screen for them. We know both oropharyngeal and anal cancers are significantly increasing in incidence. And the only way to really definitively prevent these is through vaccination.

Dr. Giuliano:

That's absolutely correct. Now fortunately, cervical cancer incidence, due to screening, has been decreasing in the United States, but it has hit what we call a plateau. And the only way to overcome that plateau and really get to cervical cancer elimination is going to be through vaccination.

And the other thing that's really interesting is if you look at the median age at which women acquire a cervical HPV infection, it's around 24. So what does that mean? That means half of all women acquire the infection that causes the disease after the age of 24, which really supports the concept of vaccinating even in the 20s and early 30s, and so on for women. And for men, what we have found is that men continue to be susceptible to acquiring a new HPV infection throughout their lifetime. So as you've just heard, the only way to prevent those infections and diseases that are increasing in incidence among men is through vaccination.

For those who are just tuning in, you're listening to CME on ReachMD. I'm Dr. Anna Giuliano, and here with me today is Dr. Joel Heidelbaugh. We're just about to delve further into our discussion of strategies for improving HPV vaccine uptake across a series of different patient populations, including how and when we should be using shared clinical decision-making.

Dr. Heidelbaugh:

Dr. Giuliano, we touched on this briefly, but why has the CDC provided a permissive recommendation for HPV vaccination in adults aged 27 to 45 years.

Dr. Giuliano:

So one of the things we're going to talk about is the difference between a routine recommendation and a permissive one. But first, I just want to tell you who remains at risk in that older age group. And there are many as I just mentioned earlier, very few individuals in the United States above the age of 26 have received vaccination, even the 18- to 26-year-old age group are not fully covered, and very far from being fully covered. So that's the general population, and then there are individuals who are at increased risk, and those include active-duty servicemembers, gay and bisexual men, men who have sex with men, transgender woman, people living with HIV, and any population that is immunosuppressed.

And so although we have a large population in the US that has been vaccinated, we have a larger one over the age of 26 that has not. However, if you look at the relative effectiveness of the vaccine, it's not as effective in the older ages, ages 27 to 45, as we've seen in the adolescents and the young adults. And again, this is why we say the target age for population is the adolescent population. However, there is very much so clinical benefit. Now because there is clinical benefit, but effectiveness is not quite as high, the ACIP then strongly recommends everybody receive that vaccine earlier. But if they haven't, on a case-by-case basis, to have that discussion with their provider if they're in the 27- to 45-year age range. And it really is one of a clinical protocol versus a public health protocol. The routine recommendation is a public health recommendation. And the shared decision-making is a clinical decision that occurs on a case-by-case basis.

After the guidelines were updated for vaccination for adults ages 27 to 45 and this whole concept of shared clinical decision-making or SCDM was recommended, there was increased uptake partially attributed to this older age group having a permissive recommendation. So I wonder, Dr. Heidelbaugh, how do you start this discussion that hopefully leads to a patient's acceptance of HPV vaccination in this slightly older age group?

Dr. Heidelbaugh:

Following a shared decision-making model, it's important to provide that education so that a patient can make an informed consent about this, but also understanding that each individual patient – and in this particular scenario that we're talking about, men between 27 and 45 years of age – they really can play a role in cancer prevention, not only for themselves but on a broader level for their for their communities. For many men, this discussion is often a very foreign concept.

So a great place to start with that really is the sexual health assessment. Certainly, asking about partners and understanding practices, understanding how they view the role of protection from STIs [sexually transmitted infections], their own past history of STIs, and relationship status or plans for a potential pregnancy with their partner in the near or potentially distant future.

So I think the sexual health assessment is certainly a great place to start. But it really takes time in our practices. You know, I think many men are going to view this as not a male issue, like we talked about, and really assessing that their own individual risk may be a very low one. So I think talking about current statistics, like you mentioned, certainly incidence is certainly really important.

Dr. Giuliano:

Well, thank you, Dr. Heidelbaugh. And now before we close this topic, there's one really important question that continues to come up. And that is: should a patient who is unvaccinated and has had a positive HPV test either, you know, a PAP cytology or primary HPV test that was positive, should they be vaccinated?

Dr. Heidelbaugh:

Unequivocally, yes, people who test positive for HPV aren't necessarily positive for all of the genotypes that are targeted by the vaccine. So what we know is the vaccine can help protect against various genotypes that a patient may not have been exposed to but certainly could be exposed to, including those high-risk genotypes 16 and 18, which are so prevalent in oropharyngeal cancers and penile cancers, anorectal cancers, and all the other ones that we've discussed today.

Dr. Giuliano:

Absolutely.

Well unfortunately, that's all the time we have today, so I want to thank our audience for listening in and thank you Dr. Joel Heidelbaugh, for sharing your clinical expertise and insight. It was an absolute pleasure speaking with you today.

Dr. Heidelbaugh:

And thank you Dr. Anna Giuliano, it was my pleasure to be part of this today and have this very robust dialogue with you.

Announcer:

You have been listening to CME on ReachMD. This activity is provided by Prova Education.

To receive your free CME credit, or to download this activity, go to ReachMD.com/Prova. Thank you for listening.