



IX JORNADAS DOCENTES

Viernes 22 y sábado 23 de septiembre de 2023

Comorbilidades en personas con VIH:
Impacto y Prevención

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Taller práctico de cáncer: Intervenciones de cribado en
población VIH

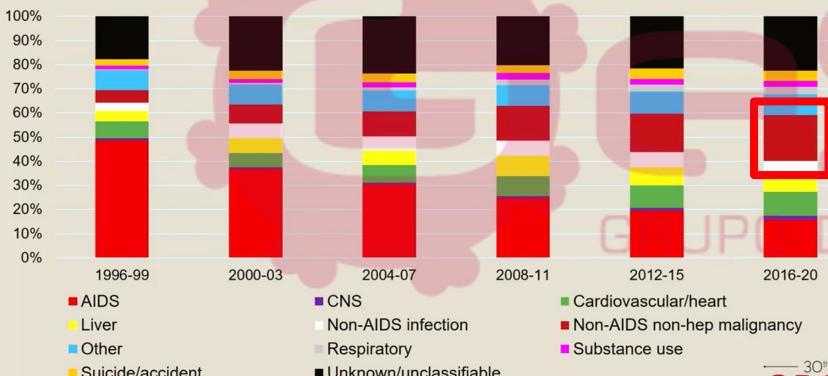




Introducción

Las neoplasias no SIDA son la principal causa de mortalidad en PVVIH

Percentages of categorised causes of death, by calendar year period of death



	Mortality rate per 10 000 person-years (95% CI)	Observed deaths	Expected deaths*	Standardised mortality ratio (95% CI)
People diagnosed with HIV	448 839 person-years			
All-cause mortality	118 (115-121)	5302	938	5.7 (5.5-5.8)
Non-AIDS deaths	44.9 (43.0-46.9)	2017	923	2.2 (2.1-2.3)
Non-AIDS infections	8.0 (7.2-8.9)	358	33	10.8 (9.8-12.0)
Non-AIDS cancers	8.6 (7.8-9.5)	388	300	1.3 (1.2-1.4)
Cardiovascular disease and stroke	8.4 (7.6-9.3)	378	223	1.7 (1.5-1.9)
Liver disease	5.2 (4.6-5.9)	234	63	3.7 (3.3-4.2)
Accident	2.1 (1.7-2.6)	94	68	1.4 (1.2-1.7)
Suicide	2.1 (1.8-2.6)	96	48	2.0 (1.6-2.4)
Substance misuse	2.7 (2.3-3.2)	121	47	2.6 (2.1-3.1)
Other causes	7.8 (7.0-8.6)	348	141	2.5 (2.2-2.7)

Rates of Key Death Causes With HIV Falling in Europe/America. Deaths Due to Comorbidities 30th CROI, Conference on Retroviruses and Opportunistic Infections, February 19-22, 2023, Seattle Mark Mascolini

Croxford S, Kitching A, Desai S, et al. Mortality and causes of death in people diagnosed with HIV in the era of highly active antiretroviral therapy compared with the general population: an analysis of a national observational cohort. Lancet Public Health. 2017 Jan;2(1):e35-e46. doi: 10.1016/S2468-2667(16)30020-2. Epub 2016 Dec 15. PMID: 29249478.





Introducción

Ensayos clínicos demuestran reducción de la mortalidad en la mayoría de las neoplasias en población general ^{1,2}

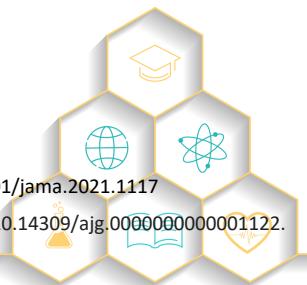
Cribado de cáncer implementado en PVVIH deriva del de población general ³

GRUPO DE ESTUDIO DEL SIDA-SEIMC

1.US Preventive Services Task Force. Screening for Lung Cancer: US Preventive Services Task Force Recommendation Statement. *JAMA*. 2021;325(10):962-970. doi:10.1001/jama.2021.1117

2.Shaukat A, Kahi CJ, Burke CA, Rabeneck L, Sauer BG, Rex DK. ACG Clinical Guidelines: Colorectal Cancer Screening 2021. *Am J Gastroenterol*. 2021;116(3):458-479. doi: 10.14309/ajg.00000000000001122.

3.European AIDS Clinical Society Guidelines. Version 11.1, October 2022. Accessed May 2023.





Cancer: Screening Methods⁽ⁱ⁾ **EACS GUIDELINES, October 2022**

Problem	Persons	Procedure	Evidence of benefit	Screening interval	Additional comments
Anal cancer	MSM and persons with HPV-associated dysplasia*	Digital rectal exam ± anal cytology	Unknown; advocated by some experts	1-3 years	If anal cytology abnormal, anoscopy
Breast cancer	Women 50-74 years ⁽ⁱⁱ⁾	Mammography	↓ Breast cancer mortality	1-3 years	
Cervical cancer	Women > 21 years	PAP smear or liquid based cervical cytology test	↓ Cervical cancer mortality	1-3 years	HPV genotype testing may aid PAP/liquid based cervical screening
Colorectal cancer	Persons 50-75 years or with a life expectancy > 10 years	According to local screening programme practice. Colonoscopy every 10 years if willing/able. If unable, annual faecal immunochemistry test (FIT) for occult blood, or multitarget stool DNA (MT-sDNA) testing every 3 years, or computed tomography colonography (CTC) every 5 years	↓ Colorectal cancer mortality	Depending on screening method used	
HepatoCellular Carcinoma (HCC)	HCC screening should follow current EASL guidelines* see pages 8, 81 and 115 ^(iv)	Ultrasound (and alpha-fetoprotein)	Earlier diagnosis allowing for improved ability for surgical eradication	Every 6 months	* Risk factors for HCC in this population include family history of HCC, ethnicity (Asians, Africans), HDV and age > 45 years. EASL guidelines propose using the PAGE-B score in Caucasians to assess the HCC risk, however this score has not been validated in persons with HIV
Prostate cancer	Men > 50 years with a life expectancy >10 years	PSA ^(v)	Use of PSA is controversial	1-2 years	Pros: ↑ early diagnosis and modest ↓ prostate cancer specific mortality. Cons: overtreatment, adverse effects of treatment on quality of life
Lung Cancer	Age 50-80 years old who are at high risk of lung cancer (at least a 20 pack-year smoking history, and are either current smokers or former smokers having quit within the past 15 years)	Low-dose helical CT (where local screening programs are available)	↓ Lung cancer related mortality	Every year	Evidence confirmed in large RCT, but persons with HIV not included and there may be a higher false positive rate among people with HIV

**GUÍA DE PRÁCTICA CLÍNICA SOBRE LOS
TUMORES NO DEFINITORIOS DE SIDA E
INFECCIÓN POR EL VIH**

(ACTUALIZACIÓN MARZO 2019)

PANEL DE EXPERTOS DE GeSIDA



Escenarios clínicos para aplicar cribado

Cáncer cérvix

Estimates of the global burden of cervical cancer associated with HIV

Dominik Stelzle*, Luana F Tanaka*, Kuan Ken Lee, Ahmadaye Ibrahim Khalil, Iacopo Baussano, Anoop S V Shah, David A McAllister, Sami L Gottlieb, Stefanie J Klug, Andrea S Winkler, Freddie Bray, Rachel Baggaley, Gary M Clifford, Nathalie Broutet, Shona Dalal

6 veces más frecuente en mujeres con VIH

Stelzle D, Tanaka LF, Lee KK, et al. Estimates of the global burden of cervical cancer associated with HIV. *Lancet Glob Health.* 2021;9(2):e161-e169. doi: 10.1016/S2214-109X(20)30459-9.

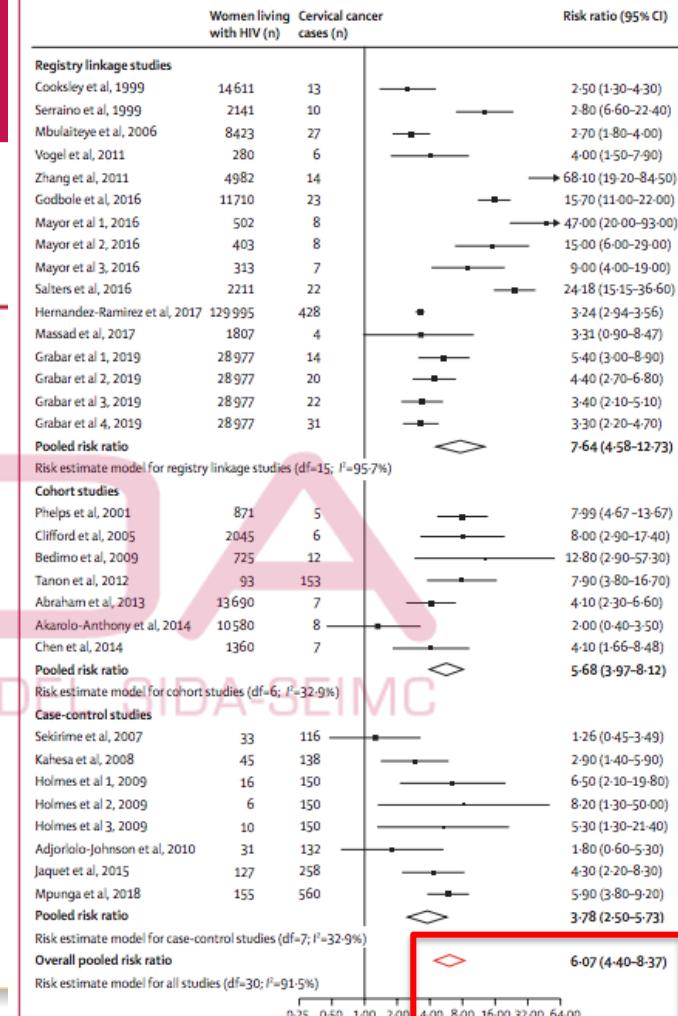


Figure 1: Risk of developing cervical cancer among women living with HIV, by type of study



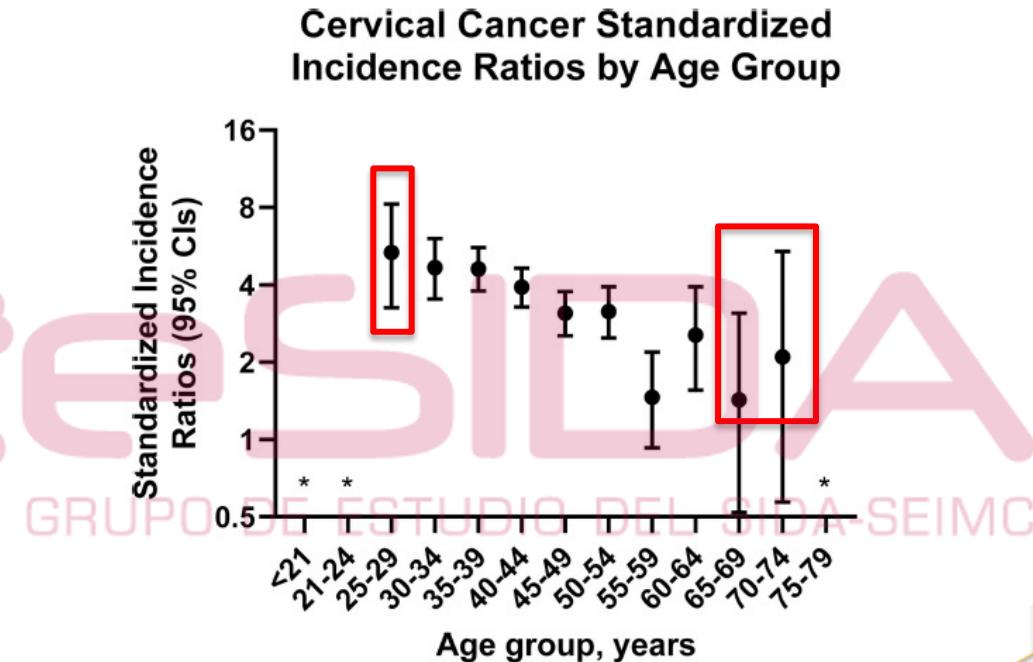
Cáncer cérvix

- Citología cérvix

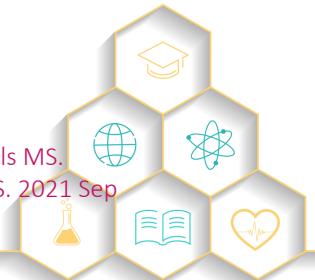
IRR 6

Entre 25-29 años, 6 veces más
incidencia de cáncer de cérvix.
LA MÁS ELEVADA

Duración del cribado de
cérvix: toda la vida



Stier EA, Engels E, Horner MJ, Robinson WT, Qiao B, Hayes J, Bayakly R, Anderson BJ, Gonsalves L, Pawlish KS, Zavala D, Monterosso A, Shiels MS. Cervical cancer incidence stratified by age in women with HIV compared with the general population in the United States, 2002-2016. AIDS. 2021 Sep 1;35(11):1851-1856. doi: 10.1097/QAD.0000000000002962. PMID: 34049357; PMCID: PMC8373779.

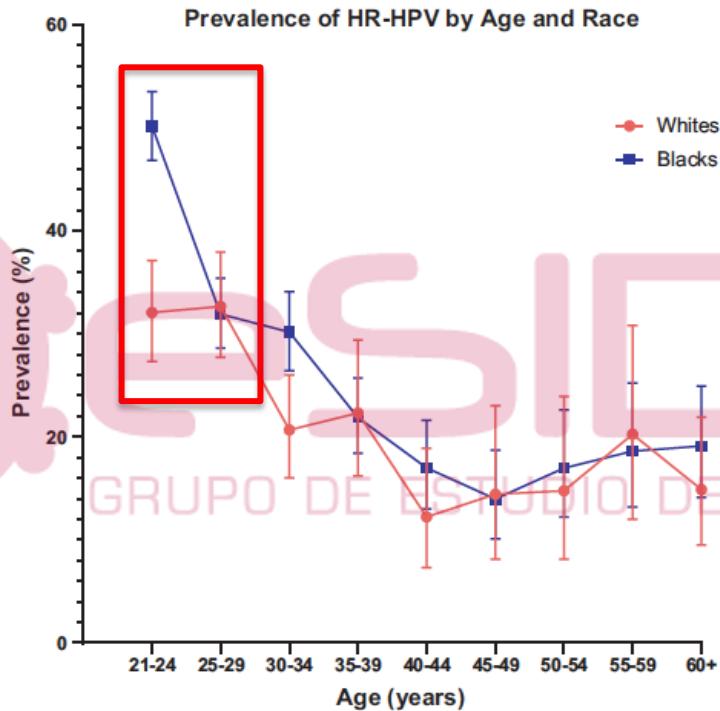




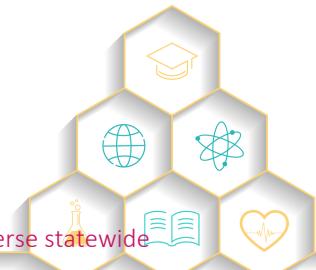
Cáncer cérvix

- VPH

Prevalencia muy elevada
de VPH hasta los 30
años



Clarke MA, Risley C, Stewart MW, et al. Age-specific prevalence of human papillomavirus and abnormal cytology at baseline in a diverse statewide prospective cohort of individuals undergoing cervical cancer screening in Mississippi. *Cancer Med.* 2021 Dec;10(23):8641-8650. doi: 10.1002/cam4.4340. Epub 2021 Nov 3. PMID: 34734483; PMCID: PMC8633239.



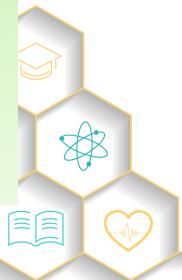


Cáncer cérvix

Cervical cancer	Women > 21 years	PAP smear or liquid based cervical cytology test	↓ Cervical cancer mortality	1-3 years
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Mujer joven: cribado cáncer de cérvix desde los 21 años (o tras 1^a relación) con citología anual (3 primeros años) y posteriormente cada 3 años, toda la vida.

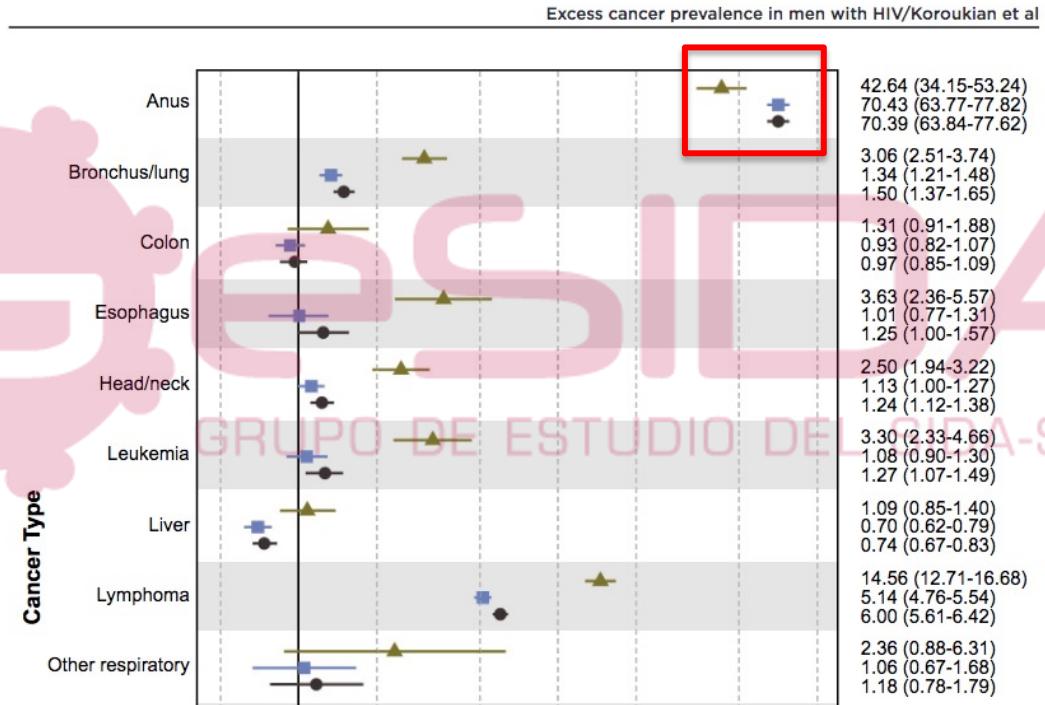
Estudio de VPH más rentable a partir de los 30 años





Cáncer anal

Es la neoplasia no SIDA con mayor exceso de incidencia y mortalidad





Cáncer anal

Es la tercera, tras pulmón e hígado, con mayor mortalidad
 Es la primera con más años de vida perdidos

Table 2. Cancer-attributable Mortality Among People Living With Human Immunodeficiency Virus from 10 States, 2001–2015, by Cancer Site

Cancer Site	Number of Cancers	Proportion of Deaths Preceded by Cancer, p_g (95% CI)	Adjusted Hazard Ratio (95% CI)	Population-attributable Fraction (95% CI)	Cancer-attributable Mortality Rate
All sites combined	31 611	17.5% (17.3%–17.8%)	5.79 (5.69–5.89)	14.5% (13.6%–15.4%)	386.9
AIDS-defining cancers	12 315	6.5% (6.4%–6.7%)	4.28 (4.17–4.40)	5.0% (4.4%–5.6%)	134.1
Kaposi sarcoma	4485	1.9% (1.8%–2.0%)	2.99 (2.86–3.14)	1.3% (0.9%–1.6%)	34.0
Non-Hodgkin lymphoma	7072	4.3% (4.1%–4.4%)	5.35 (5.18–5.52)	3.5% (3.0%–3.9%)	92.6
Cervical	758	.4% (.3%–.4%)	2.56 (2.31–2.85)	.2% (.1%–.4%)	5.9
Non-AIDS-defining cancers	19 296	11.0% (10.8%–11.2%)	6.21 (6.08–6.34)	9.2% (8.5%–9.9%)	245.7
Anus	1729	.8% (.7%–.9%)	4.02 (3.74–4.31)	.6% (.4%–.8%)	16.1
Liver	1331	1.1% (1.1%–1.2%)	19.0 (17.9–20.2)	1.1% (0.8%–1.3%)	28.4
Hodgkin lymphoma	1420	.6% (.5%–.6%)	3.47 (3.20–3.77)	.4% (.2%–.6%)	11.3
Breast	1110	.4% (.4%–.5%)	2.97 (2.70–3.27)	.3% (.1%–.4%)	7.8
Prostate	2252	.5% (.5%–.6%)	1.21 (1.11–1.32)	.1% (−.1%–.2%)	2.3
Lung	2878	2.5% (2.4%–2.6%)	16.3 (15.7–17.0)	2.4% (2.0%–2.7%)	63.0
Colorectal	1272	.6% (.6%–.7%)	4.00 (3.69–4.34)	.5% (.3%–.7%)	12.6
Other	7304	4.3% (4.2%–4.5%)	6.25 (6.06–6.45)	3.6% (3.2%–4.1%)	97.4

Horner MJ, Shiels MS, Pfeiffer RM, Engels EA. Deaths attributable to cancer in the US HIV population during 2001–2015. *J Acquir Immune Defic Syndr* 2022;90(2):184–192. doi: 10.1097/QAI.0000000000002930.

Luo Q, Pfeiffer RM, Noone AM, et al. Years of life lost to cancer among the United States HIV population, 2006–2015. *AIDS*. 2022;36(9):1279–1286. doi: 10.1097/QAD.0000000000003249.

Table 2. Total years of life lost to cancer by subgroups, and by cancer types in the total United States population of people with HIV between 2006 and 2015.

Subgroup	TYLL to cancer	Percentage of TYLL to any cancer
Overall	135 000	100.0
Age		
20–39	23 400	17.3
40–59	91 200	67.5
60+	20 400	15.1
Race		
Non-Hispanic white	37 200	27.5
Non-Hispanic black	72 600	53.8
Hispanic	21 700	16.1
Risk group		
MSM, non-PWID	73 400	54.4
PWID	14 600	10.8
All other	46 900	34.7
Cancer type		
AIDS-defined cancer		
Non-Hodgkin lymphoma	27 800	20.5
Kaposi sarcoma	12 800	9.5
Cervix Uteri	2600	1.9
Non-AIDS-defined cancer		
Anal	9700	7.2
Lung and bronchus	9000	6.6
Colon and rectum	6000	4.4
Hodgkin Lymphoma	5000	3.7
Liver	4500	3.3
Breast	3800	2.8
Prostate	2600	1.9
Other	35 000	25.9

PWID, persons who inject drugs; TYLL, total years of life lost.



Cáncer anal

Dxo previo de SIDA
como FR más
importante que la edad

Table 1. Cumulative incidence of anal cancer among people with HIV and among those with AIDS at 10 years from HIV or AIDS diagnosis and between 10 and 20 years from diagnosis^a

Sex/risk group stratified by age at HIV/AIDS diagnosis	Cumulative incidence, % (95% confidence interval)			
	HIV, 0-10 y	AIDS, 0-10 y	HIV, 10-20 y	AIDS, 10-20 y
MSM				
<30 y	0.17 (0.13 to 0.20)	0.35 (0.28 to 0.41)	0.88 (0.75 to 1.01)	1.23 (1.05 to 1.40)
30-34 y	0.22 (0.18 to 0.26)	0.42 (0.35 to 0.48)	0.86 (0.75 to 0.98)	1.26 (1.10 to 1.42)
35-39 y	0.27 (0.23 to 0.31)	0.51 (0.43 to 0.58)	0.76 (0.66 to 0.86)	1.17 (1.00 to 1.33)
40-44 y	0.27 (0.22 to 0.31)	0.55 (0.46 to 0.64)	0.68 (0.58 to 0.78)	1.12 (0.93 to 1.32)
45-59 y	0.24 (0.21 to 0.28)	0.60 (0.51 to 0.68)	0.63 (0.55 to 0.71)	0.96 (0.78 to 1.14)
≥60 y	0.32 (0.20 to 0.43)	0.63 (0.37 to 0.90)	0.38 (0.22 to 0.54)	0.44 (0.05 to 0.84)
Other men				
<30 y	0.04 (0.02 to 0.06)	0.09 (0.04 to 0.13)	0.22 (0.14 to 0.29)	0.35 (0.22 to 0.48)
30-34 y	0.12 (0.07 to 0.16)	0.20 (0.13 to 0.27)	0.36 (0.25 to 0.47)	0.51 (0.36 to 0.67)
35-39 y	0.11 (0.08 to 0.15)	0.18 (0.12 to 0.23)	0.35 (0.26 to 0.44)	0.37 (0.26 to 0.49)
40-44 y	0.09 (0.06 to 0.12)	0.20 (0.15 to 0.26)	0.30 (0.22 to 0.37)	0.38 (0.26 to 0.49)
45-59 y	0.09 (0.07 to 0.11)	0.17 (0.13 to 0.22)	0.21 (0.16 to 0.26)	0.35 (0.24 to 0.47)
≥60 y	0.08 (0.03 to 0.13)	0.10 (0.02 to 0.18)	0.19 (0.07 to 0.31)	0.33 (0.03 to 0.63)
Women				
<30 y	0.03 (0.01 to 0.04)	0.09 (0.05 to 0.13)	0.25 (0.19 to 0.31)	0.47 (0.33 to 0.60)
30-34 y	0.06 (0.03 to 0.09)	0.11 (0.06 to 0.16)	0.20 (0.13 to 0.26)	0.41 (0.27 to 0.54)
35-39 y	0.07 (0.04 to 0.10)	0.17 (0.11 to 0.22)	0.24 (0.17 to 0.31)	0.40 (0.27 to 0.53)
40-44 y	0.06 (0.03 to 0.09)	0.13 (0.08 to 0.19)	0.31 (0.22 to 0.39)	0.36 (0.21 to 0.51)
45-59 y	0.09 (0.06 to 0.12)	0.20 (0.14 to 0.26)	0.22 (0.15 to 0.28)	0.34 (0.21 to 0.48)
≥60 y	0.04 (0.00 to 0.09)	0.08 (0.00 to 0.17)	0.14 (0.00 to 0.29)	0.07 (0.00 to 0.21)

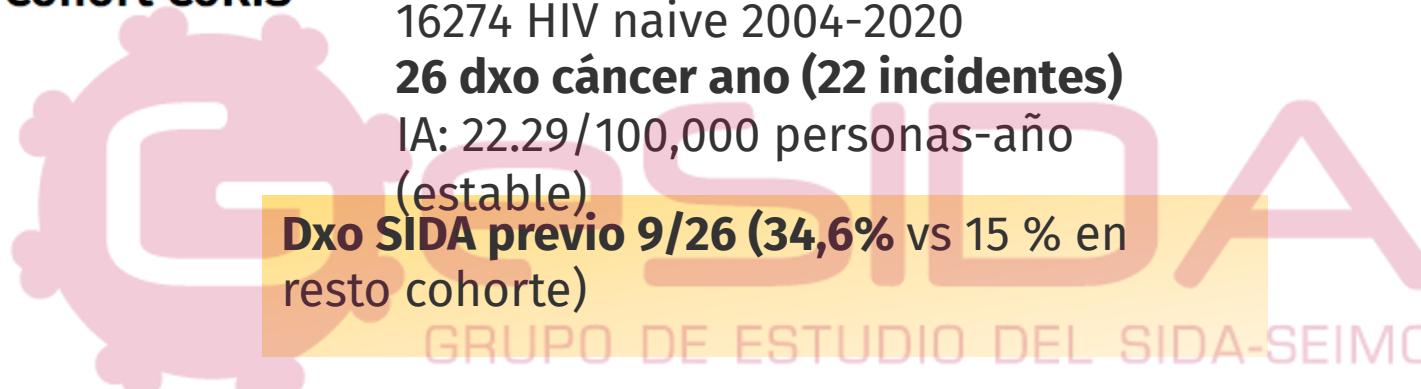
^a Age is in years and was measured at AIDS diagnosis (for people with AIDS) or HIV report (for people with HIV only). Cumulative incidence estimates for people with HIV do not censor at the onset of AIDS. MSM, men who have sex with men.





ORIGINAL CONTRIBUTION

Incidence of Anal Cancer and Related Risk Factors in HIV-Infected Patients Enrolled in the National Prospective Spanish Cohort CoRIS



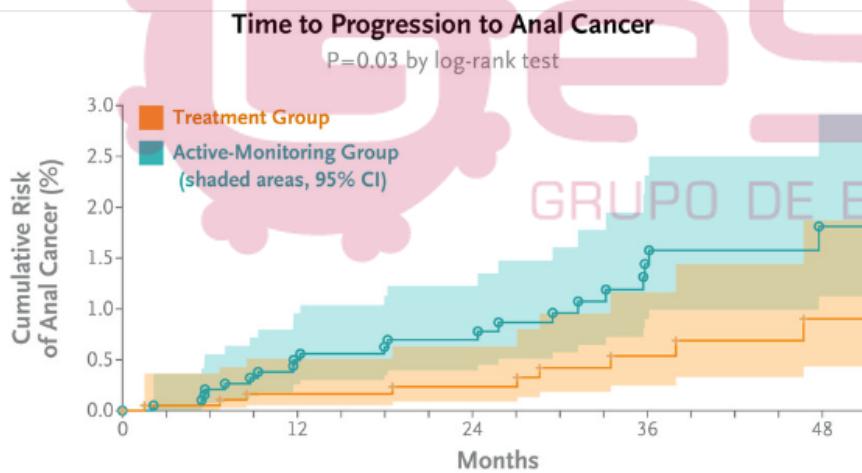
Riesgo cáncer anal:
Dxo previo de SIDA: x 2,7 veces

Recuento CD4:  28%/100 CD4 adicionales



Cáncer anal

Tto HSIL: Reducción del riesgo de progresión a cáncer del 57%

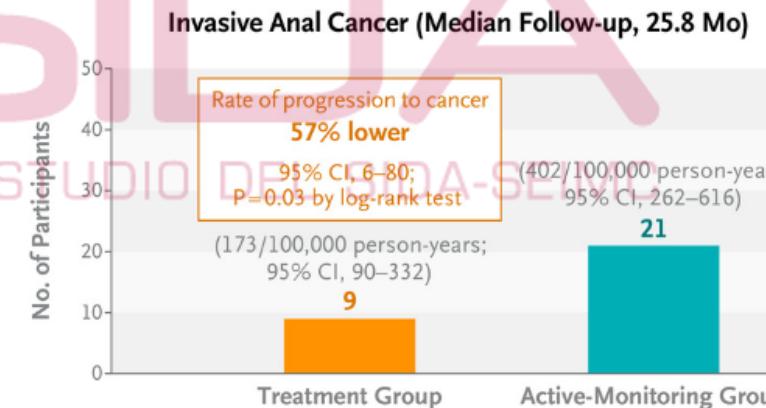


ORIGINAL ARTICLE

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

ANCHOR

J.M. Palefsky, J.Y. Lee, N. Jay, S.E. Goldstone, T.M. Darragh, H.A. Dunlevy,



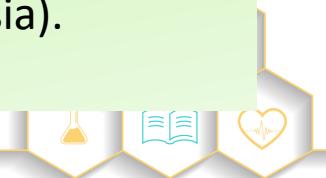


Cáncer anal

Anal cancer	MSM and persons with HPV-associated dysplasia ^(II)	Digital rectal exam ± anal cytology	Unknown; advocated by some experts	1-3 years
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Hombre HSH joven (sobre todo con dxo previo SIDA): cribado cáncer anal con examen digital y citología anal anual +- estudio VPH.

Si citología alterada, AAR con biopsia y tratamiento de lesiones HSIL (biopsia). Repetir AAR 2 al año tras tto de HSIL.



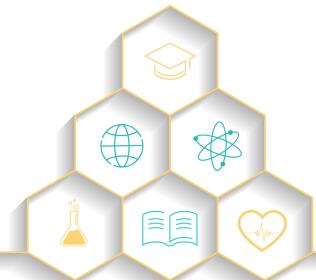
Spectrum and Incidence Trends of AIDS- and Non-AIDS-Defining Cancers between 2010 and 2015 in the French Dat'AIDS Cohort

Cáncer pulmón

Table 3. Global incidence rates overall and by sex of ADCs and selected NADCs in the French Dat'AIDS cohort between 2010 and 2015.

	Overall		Men		Women	
	N ^a	Incidence/100,000 PY (95% CI)	N ^a	Incidence/100,000 PY (95% CI)	N ^a	Incidence/100,000 PY (95% CI)
ADCs	345	191.4 (172.3-212.7)	289	232.9 (207.6-261.4)	56	99.7 (76.8-129.6)
Kaposi sarcoma	137	76.0 (64.3-89.9)	127	102.4 (86.0-121.8)	10	17.8 (9.6-33.1)
NHL	191	106.0 (92.0-122.1)	160	129.0 (110.5-150.6)	31	55.2 (38.8-78.5)
NHL (ICD-10: C83 and C85)	169	93.8 (80.7-109.0)	141	113.7 (96.4-134.1)	28	49.9 (34.4-72.2)
ICC					16	28.5 (17.5-46.5)
NADCs	989	548.8 (515.6-584.1)	746	601.3 (559.7-646.0)	234	432.8 (381.6-490.7)
Lung cancer	98	54.4 (44.6-66.3)	76	61.3 (48.9-76.7)	22	39.2 (25.8-59.5)
Liver cancer	96	53.3 (43.6-65.1)	76	61.3 (48.9-76.7)	20	35.6 (23.0-55.2)
HL	82	45.5 (36.6-56.5)	73	58.8 (46.8-74.0)	9	16.0 (8.3-30.8)
HNC	54	30.0 (23.0-39.1)	42	33.9 (25.0-45.8)	12	21.4 (12.1-37.6)
Anus cancer	57	31.6 (24.4-41.0)	43	34.7 (25.7-46.7)	14	24.9 (14.8-42.1)
Colon and rectum cancer	45	25.0 (18.6-33.4)	35	28.2 (20.3-39.3)	10	17.8 (9.6-33.1)
Anus/colon/rectum cancer ^b	96	53.3 (43.6-65.1)	74	59.6 (47.5-74.9)		39.2 (25.8-59.5)
Urinary bladder cancer	25	13.9 (9.4-20.5)	23	18.5 (12.3-27.9)	2	3.6 (0.9-14.2)
Breast cancer					51	90.8 (69.0-119.5)
Prostate cancer			113	91.1 (75.7-109.5)		

Es la neoplasia no SIDA con mayor incidencia





Cáncer pulmón

B. Non-infection related cancers

Mesothelial and soft tissue	3.50 (2.10-5.81)
Multiple myeloma	3.41 (2.44-4.77)
Biliary tract	3.19 (0.78-13.02)
Bone and joints	2.94 (1.53-5.64)
Trachea, bronchus, and lung	2.48 (1.94-3.16)
Leukaemia	2.81 (2.18-3.62)
Brain and central nervous system	2.80 (1.80-4.37)
Small intestine	2.53 (1.15-5.54)
Ovary	2.40 (1.53-3.77)
Thymus, heart, mediastinum, and pleura	2.17 (0.90-5.21)
Testis	2.10 (1.43-3.11)
Pancreas	1.99 (1.32-3.01)
Kidney and renal pelvis	1.47 (0.98-2.21)
Gallbladder	1.39 (1.01-1.90)
Melanoma of skin	1.19 (0.89-1.61)
Bladder	1.18 (0.82-1.68)
Colon and rectum	1.09 (0.79-1.51)
Thyroid	0.98 (0.60-1.59)
Breast	0.91 (0.68-1.20)
Prostate	0.81 (0.63-1.05)



2,5 veces mayor incidencia que en población general



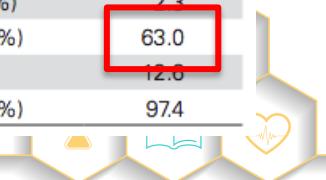


Cáncer pulmón

Es la neoplasia no SIDA con mayor mortalidad

Table 2. Cancer-attributable Mortality Among People Living With Human Immunodeficiency Virus from 10 States, 2001–2015, by Cancer Site

Cancer Site	Number of Cancers	Proportion of Deaths Preceded by Cancer, p_d (95% CI)	Adjusted Hazard Ratio (95% CI)	Population-attributable Fraction (95% CI)	Cancer-attributable Mortality Rate
All sites combined	31 611	17.5% (17.3%–17.8%)	5.79 (5.69–5.89)	14.5% (13.6%–15.4%)	386.9
AIDS-defining cancers	12 315	6.5% (6.4%–6.7%)	4.28 (4.17–4.40)	5.0% (4.4%–5.6%)	134.1
Kaposi sarcoma	4485	1.9% (1.8%–2.0%)	2.99 (2.86–3.14)	1.3% (.9%–1.6%)	34.0
Non-Hodgkin lymphoma	7072	4.3% (4.1%–4.4%)	5.35 (5.18–5.52)	3.5% (3.0%–3.9%)	92.6
Cervical	758	.4% (.3%–.4%)	2.56 (2.31–2.85)	.2% (.1%–.4%)	5.9
Non-AIDS-defining cancers	19 296	11.0% (10.8%–11.2%)	6.21 (6.08–6.34)	9.2% (8.5%–9.9%)	245.7
Anus	1729	.8% (.7%–.9%)	4.02 (3.74–4.31)	.6% (.4%–.8%)	16.1
Liver	1331	1.1% (1.1%–1.2%)	19.0 (17.9–20.2)	1.1% (.8%–1.3%)	28.4
Hodgkin lymphoma	1420	.6% (.5%–.6%)	3.47 (3.20–3.77)	.4% (.2%–.6%)	11.3
Breast	1110	.4% (.4%–.5%)	2.97 (2.70–3.27)	.3% (.1%–.4%)	7.8
Prostate	2252	.5% (.5%–.6%)	1.21 (1.11–1.32)	.1% (−.1%–.2%)	2.3
Lung	2878	2.5% (2.4%–2.6%)	16.3 (15.7–17.0)	2.4% (2.0%–2.7%)	63.0
Colorectal	1272	.6% (.6%–.7%)	4.00 (3.69–4.34)	.5% (.3%–.7%)	12.0
Other	7304	4.3% (4.2%–4.5%)	6.25 (6.06–6.45)	3.6% (3.2%–4.1%)	97.4



Younger age at cancer diagnosis in people living with HIV

Table 2. Comparison of Median Ages at Diagnosis Between HIV-Infected People in the North American AIDS Cohort Collaboration on Research and Design (NA-ACCORD) and the General Population, After Weighting the General Population to the Age Structure of NA-ACCORD

Cancer	Observed in HIV-Infected Individuals		Median Age, y	General Population After Weighting ^a	PValue
	Cases	Median Age, y			
Lung	644	54	68	58	<.0001
Prostate	504	58	66	59	.43
Anus	291	47	57	51	<.0001
Liver	226	54	62	54	.50
Oral cavity and pharynx	173	51	60	53	.04
Hodgkin lymphoma	171	44	39	45	.98
Colon	111	55	67	56	.55
Kidney	109	52	62	54	.0003
Larynx	86	53	63	56	.09
Melanoma (whites only)	77	49	56	51	.18
Breast	56	48	58	47	.27
Pancreas	55	53.5	67	57	.14
Myeloma	49	52	66	56	.008





Cáncer pulmón

JAMA | US Preventive Services Task Force | RECOMMENDATION STATEMENT

Screening for Lung Cancer

US Preventive Services Task Force Recommendation Statement

Summary of Recommendation

Adults aged 50 to 80 years who have a 20 pack-year smoking history and currently smoke or have quit within the past 15 years	The USPSTF recommends annual screening for lung cancer with low-dose computed tomography (LDCT) in adults aged 50 to 80 years who have a 20 pack-year smoking history and currently smoke or have quit within the past 15 years. Screening should be discontinued once a person has not smoked for 15 years or develops a health problem that substantially limits life expectancy or the ability or willingness to have curative lung surgery.	B
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Cáncer pulmón

EACS GUIDELINES 2022

Lung Cancer	Age 50-80 years old who are at high risk of lung cancer (at least a 20 pack-year smoking history, and are either current smokers or former smokers having quit within the past 15 years)	Low-dose helical CT (where local screening programs are available)	↓ Lung cancer related mortality	Every year
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Cáncer colon

B. Non-infection related cancers

Mesothelial and soft tissue	3.50 (2.10-5.81)
Multiple myeloma	3.41 (2.44-4.77)
Biliary tract	3.19 (0.78-13.02)
Bone and joints	2.94 (1.53-5.64)
Trachea, bronchus, and lung	2.48 (1.94-3.16)
Leukaemia	2.81 (2.18-3.62)
Brain and central nervous system	2.80 (1.80-4.37)
Small intestine	2.53 (1.15-5.54)
Ovary	2.40 (1.53-3.77)
Thymus, heart, mediastinum, and pleura	2.17 (0.90-5.21)
Testis	2.10 (1.43-3.11)
Pancreas	1.99 (1.32-3.01)
Kidney and renal pelvis	1.47 (0.98-2.21)
Gallbladder	1.39 (1.01-1.90)
Melanoma of skin	1.19 (0.89-1.61)
Bladder	1.18 (0.82-1.68)
Colon and rectum	1.09 (0.79-1.51)
Thyroid	0.98 (0.60-1.59)
Breast	0.91 (0.68-1.20)
Prostate	0.81 (0.63-1.05)



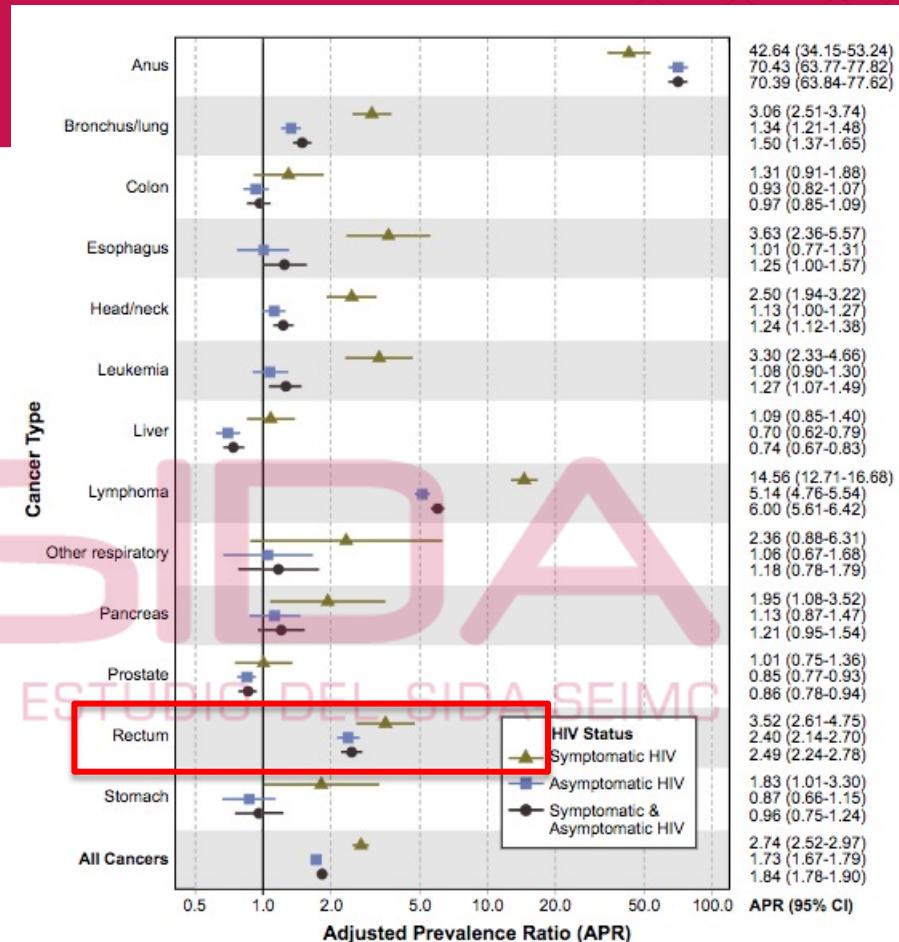
Similar incidencia a población general

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Cáncer de recto

Mayor prevalencia de cáncer rectal,
sobre todo el escamoso relacionado con
VPH





Cáncer colo-rectal

Colorectal cancer	Persons 50-75 years or with a life expectancy > 10 years	According to local screening programme practice. Colonoscopy every 10 years if willing/able. If unable, annual faecal immunochemistry test (FIT) for occult blood, or multitarget stool DNA (MT-sDNA) testing every 3 years, or computed tomography colonography (CTC) every 5 years	↓ Colorectal cancer mortality	Depending on screening method used
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Cáncer próstata

¿Cribado con evidencia?
Ofrecerlo

Prostate cancer	Men > 50 years with a life expectancy >10 years	PSA ^(M)	Use of PSA is controversial	1-2 years
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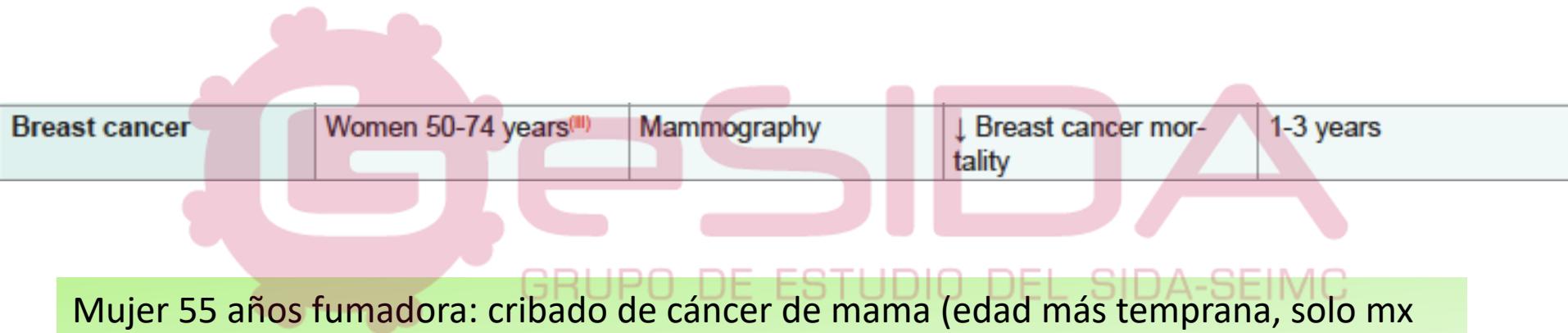
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Hombre 55 años fumador y HSH: cribado de cáncer de pulmón (TC; es la ppal causa de muerte y a edades más tempranas), colo-rectal (similar a PG excepto >recto), anal (dxo previo SIDA, condilomas) y ofrecer de próstata (2030 el más frecuente).





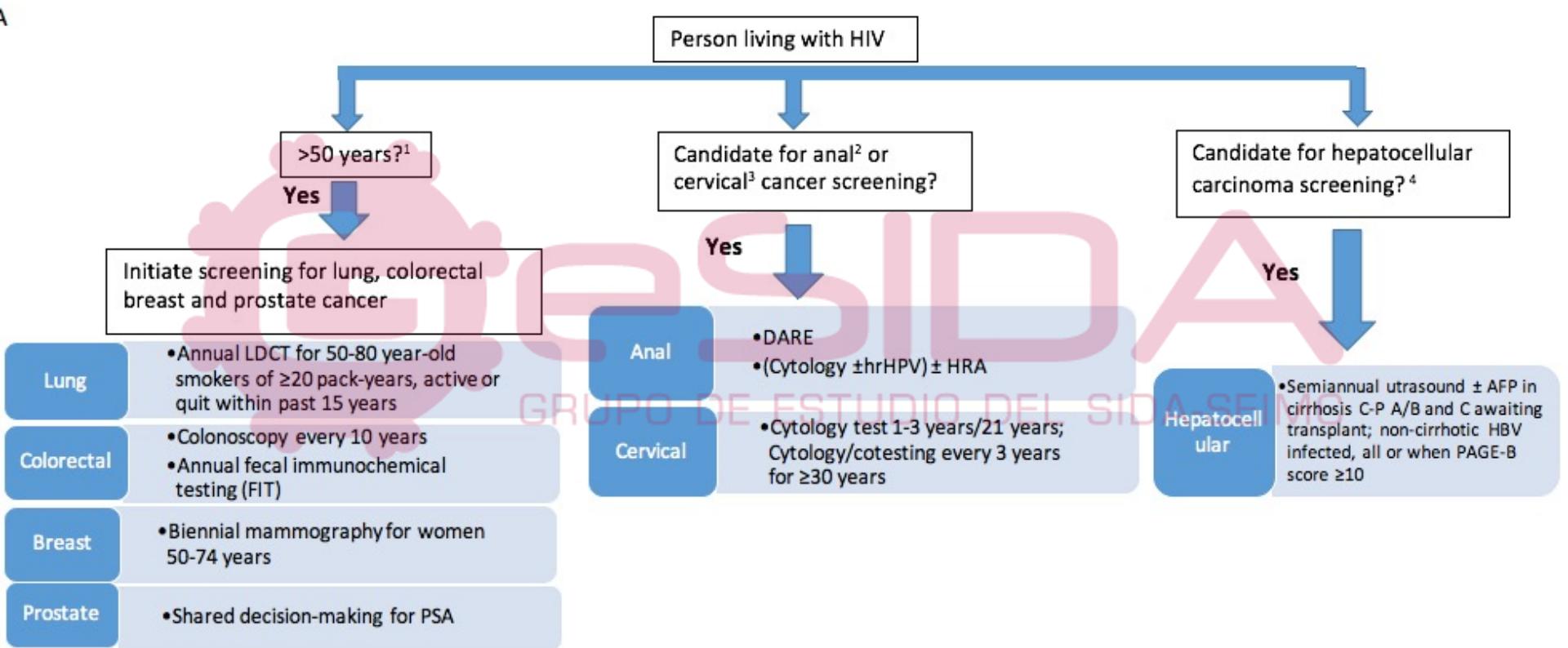
Cáncer mama



Mujer 55 años fumadora: cribado de cáncer de mama (edad más temprana, solo mx cada 2 años?), pulmón (TC menos sensibilidad, valorar edades más tempranas), colo-rectal (similar a PG), anal (si sexo anal o VPH genital).

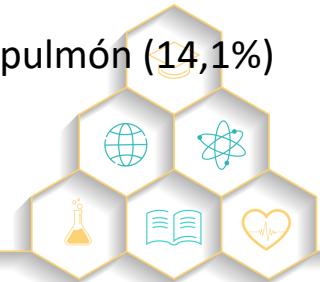
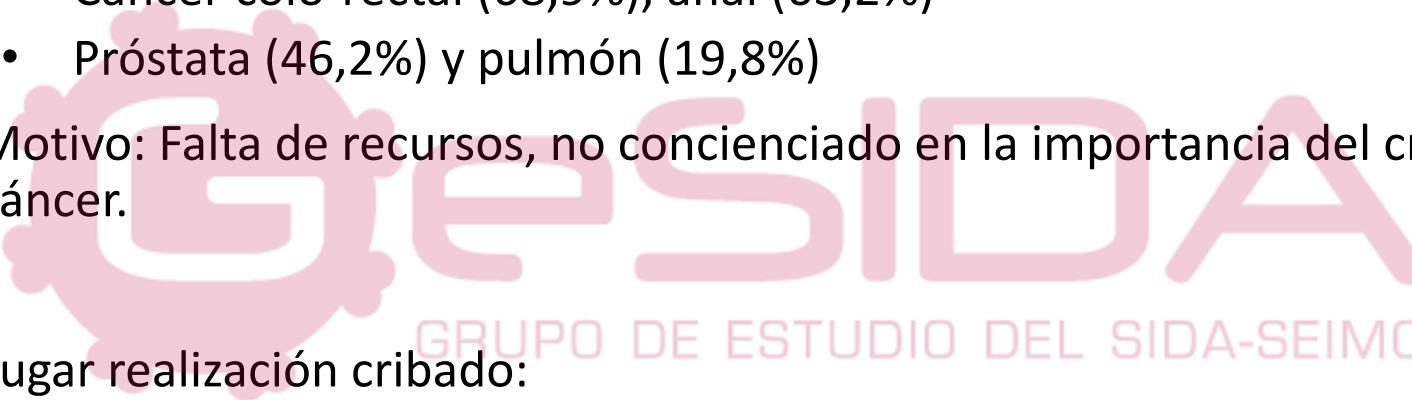


Recomendaciones actuales



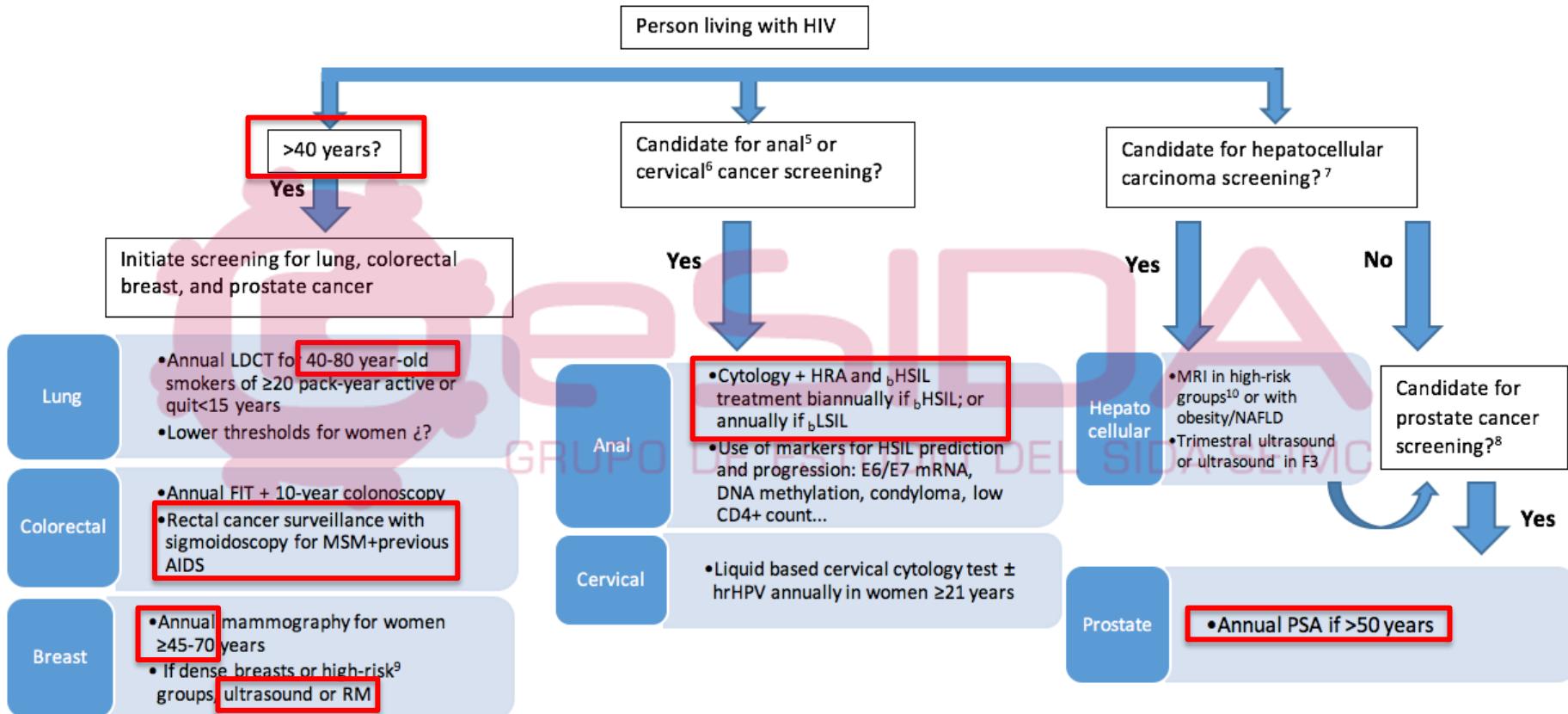
Encuestas entre especialistas UEI

- 106 cuestionarios --- 12 CC.AA
 - Cáncer hepático (94,3%), cérvix (93,2%) y mama (85,8%).
 - Cáncer colo-rectal (68,9%), anal (63,2%)
 - Próstata (46,2%) y pulmón (19,8%)
- Motivo: Falta de recursos, no concienciado en la importancia del cribado de cáncer.
- Lugar realización cribado:
 - UEI → hígado (86,8%), cérvix (50,5%), próstata (46,2%), ano (43,4%) y pulmón (14,1%)
 - Salud Pública → cáncer colo-rectal y de mama
- Variabilidad entre hospitales y CCAA





Nuestra propuesta



IMPC-NEO



PI18/01861



STUDY PROTOCOL

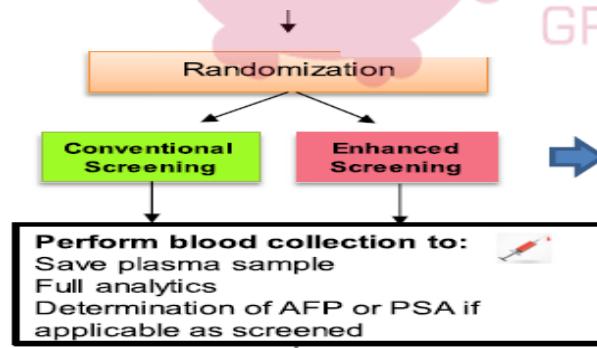
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Impact of an enhanced screening program on the detection of non-AIDS neoplasias in patients with human immunodeficiency virus infection

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IMpacto de un Programa Ampliado de Cribado en la detección de NEOplasias no-sida en pacientes con infección por el VIH



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Screening options to which the patient is susceptible according to Age/Sex/Study Arm:

SEX	AGE (years)	CONVENTIONAL		ENHANCED		
WOMAN	18-39		Anal		Anal	
	40-44		Hepatic		Hepatic	
	45-49	Breast	Colon	Cervix	Colon Lung	Skin
	50-70					
MAN	40-49	Prostate	Colon	Anal	Colon	Skin
	50-70	Hepatic		Hepatic	Lung	

2 estrategias de cribado

para la detección precoz de neoplasias anales, de cérvix, pulmón, mama, próstata, colorrectales, hepáticas y de piel

Convencional vs ampliado



Conclusiones

- Las neoplasias no SIDA son la principal causa de mortalidad en PVVIH
- El exceso de incidencia y de mortalidad de muchas de estas neoplasias respecto a la población general implica que el cribado de cáncer es primordial en PVVIH
- Necesidad de adaptar los cribados a PVVIH y generar evidencia sobre la estrategia idónea de cribado y estratificación del riesgo en PVVIH

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MUCHAS GRACIAS

