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Anal intraepitelial neoplasia: how and for who do we perform a screening program?

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Dear Editor,

In reference to the interesting article published by Silva et al. (1), we believe it is important to comment on some aspects related to anal cytology as a tool for the screening of anal intraepithelial neoplasia (AIN) in at risk patients.

Our group started an AIN screening program in 2005 (2). Since December 2014, a total of 1,916 HIV-infected patients participated in this program (3). During the first ten years of follow-up, the accumulated incidence of invasive anal cancer in the patients who participated in our program was 0.1%, compared to 0.6% in the group of patients who did not want to participate ($p = 0.023$). Thus, the annual incidence rate was of 20 and 90 per 100,000 person/year, respectively ($p = 0.151$).

The group of Silva et al. (1) suggests that anal cytology is not the best method as a first screening approach. This opinion goes against our program and that of other groups. Our protocol is based on an initial altered anal cytology (ASCUS, LSIL, HSIL), followed by high-resolution anoscopy (HRA) for diagnosis and treatment with infrared coagulation of high-grade anal dysplasia (AIN II-III) confirmed histologically.

At the moment, we do not have scientific evidence for the best management. We are waiting for the final results of an ongoing clinical trial in order to evaluate if the implementation of an anal cancer screening protocol is justified in at risk patients, which will probably be crucial to establish the best guidelines for daily clinical practice (4). In the meantime, most groups are performing screening programs focused only in men who have sex with men (MSM) with an HIV infection. A HRA and biopsy of suspected AIN is performed in these cases, without a prior anal cytology.

Our group supports an algorithm based on the detection of cases to perform HRA by means of pathology anal cytology. This can have a positive impact on the decline of invasive anal cancer in the participating population. In addition, it is likely to be more efficient from a health economics point of view (3).

We would also like to emphasize that women and probably MSM patients (without HIV infection) should also be considered as at risk and be included in these screening protocols, according to our clinical experience and that of other groups (5).

There is no doubt that the data provided by the ANCHOR trial (4) will probably help us answer many of these questions with more scientific evidence.

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