Guidelines for HPV vaccine

This statement has been developed and reviewed by the Women’s Health Committee and approved by the RANZCOG Board and Council.

A list of Women’s Health Committee Members can be found in Appendix A.

Disclosure statements have been received from all members of this committee.

Disclaimer: This information is intended to provide general advice to practitioners. This information should not be relied on as a substitute for proper assessment with respect to the particular circumstances of each case and the needs of any patient. This document reflects emerging clinical and scientific advances as of the date issued and is subject to change. The document has been prepared having regard to general circumstances.

First endorsed by RANZCOG: November 2006
Current: March 2019
Review Due: March 2022

Values: The evidence was reviewed by the Women’s Health Committee (RANZCOG), and applied to local factors relating to Australia and New Zealand.

Background: This statement was first developed by Women’s Health Committee in November 2006 and reviewed in March 2019.

Funding: The development and review of this statement was funded by RANZCOG.
Table of contents

1. Plain language summary ........................................................................................................... 3
2. Summary of recommendations ................................................................................................... 3
3. The National HPV Vaccination Program .................................................................................. 3
4. HPV Vaccines ........................................................................................................................... 4
   4.1 Dosage ................................................................................................................................ . 4
   4.2 Safety and Clinical Efficacy ...................................................................................................... 4
   4.3 Target populations ................................................................................................................. 5
   4.4 Ongoing screening ................................................................................................................. 5
   4.5 Other considerations .............................................................................................................. 5
5. References ................................................................................................................................ 6
6. Other suggested reading ........................................................................................................... 6
7. Useful Links .............................................................................................................................. 6
8. Links to other College statements ........................................................................................... 7
9. Patient information .................................................................................................................... 7

Appendix A Women’s Health Committee Membership .................................................................... 8
Appendix B Overview of the development and review process for this statement ....................... 8
Appendix C Full Disclaimer .......................................................................................................... 10
1. **Plain language summary**

Vaccination against the human papillomavirus (HPV) is available in Australia and New Zealand. Infection with high-risk types of HPV has been linked to a number of adverse health outcomes for both women and men, including cervical cancer. HPV vaccination has been shown to be safe and effective, and is recommended for all eligible young women and men.

Further plain language information can be found at: [https://www.ranzcog.edu.au/Womens-Health/Patient-Information-Guides/Patient-Information-Pamphlets](https://www.ranzcog.edu.au/Womens-Health/Patient-Information-Guides/Patient-Information-Pamphlets)

2. **Summary of recommendations**

<table>
<thead>
<tr>
<th>Recommendation 1</th>
<th>Grade</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participation in the HPV Vaccination Program should be encouraged for all eligible boys and girls in the National programs in Australia and New Zealand.</td>
<td>Consensus-based recommendation</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Recommendation 2</th>
<th>Grade</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current cervical screening recommendations in Australia and New Zealand should be followed regardless of vaccination status.</td>
<td>Consensus-based recommendation</td>
</tr>
</tbody>
</table>

3. **The National HPV Vaccination Program**

Cervical cancer remains a significant cause of cancer morbidity and mortality in women throughout the world. Persistent infection with oncogenic Human Papilloma Virus (HPV) is associated with the development of cervical cancer. Infection with oncogenic HPV types is also implicated in the development of other cancers, including vulva, vagina, anus, penis, as well as some head and neck cancers. Of the oncogenic HPVs, types 16 and 18 account for about 70% of cervical cancers. Non-oncogenic HPV types 6 and 11 cause genital warts. HPV infection is common with an estimated 70-80% of sexually active women worldwide becoming infected at some stage in their life. The use of HPV vaccines prevents infection with vaccine-related HPV types, and has been shown to reduce the incidence of precursor (pre-malignant) lesions and, potentially, malignant cervical cancer.

In Australia, the National HPV Vaccination Program was established by legislation in 2007 and implemented in 2008. The Program now funds the routine school based vaccination of boys and girls in first year of high school (age 12 – 13). Girls and boys aged 9 years to under 27 years are eligible to participate in New Zealand’s HPV immunisation programme.

The National HPV Vaccination Program Register in Australia was established in early 2008 to support the National HPV Vaccination Program. The 2016 report on 3 dose vaccination coverage for all females turning 15 years was 79% nationally. For males turning 15 years of age in 2016, the coverage was 73% nationally.
4. HPV Vaccines

The HPV vaccines are made from Virus Like Proteins (VLP) that do not contain live, attenuated or killed virus. Given by intramuscular injection the VLP induces an antibody response. If the vaccinated individual is exposed to live HPV, the antibody response protects that individual from infection.

None of the available HPV vaccines are therapeutic and therefore do not treat existing lesions.

The National programs in Australia and New Zealand use the Gardasil 9 vaccine (9 valent or containing 9 types of HPV).

Gardasil 9 contains HPV types 6,11,16,18,31,33,45,52,58 which potentially prevents 90% of the cervical cancers. Trials demonstrated 95-100% efficacy against HPV types in the vaccine and therefore increased potential for cancer prevention (cervix, vulva, vagina, anal, oropharynx, penile).^9^

4.1 Dosage
The National HPV Vaccination Programs recommend two doses given by intramuscular injection scheduled at 0 and 5-13 months. If immunocompromised or older than 15 years, 3 doses is recommended at 0, 2, 6 months.\(^10^\)

4.2 Safety and Clinical Efficacy
Breastfeeding women can be vaccinated without risk for the infant or mother.

Vaccination during pregnancy is not recommended. However monitoring of women who have inadvertently received Gardasil during pregnancy has not identified any risks for the fetus or mother.

Anaphylaxis after HPV vaccination occurs about 1–3 times in every one million vaccine doses. No other serious responses to the vaccine have been identified. Most adverse reactions after vaccination are minor (injection site reactions, fever, headaches, dizziness, muscle pain).

Gardasil 9 can be administered concurrently with other vaccines but separate syringes and different injection sites should be used.

In clinical trials Gardasil vaccine demonstrated high efficacy against all included HPV types in both males and females. Efficacy was initially assessed in 14,215 women aged 16 to 26 years in a double-blind, phase IIb/III trial. Three doses of either Gardasil (4 valent) or Gardasil 9 (9 valent) were administered at 0, 2 and 6 months. HPV 9 efficacy was 97%. Many studies have now been completed confirming the high efficacy of Gardasil 9.\(^11-13^\)

Effectiveness is optimal when the vaccine is given under 15 years of age, and prior to onset of sexual intercourse.

In countries with high HPV vaccine coverage, such as Australia and Denmark, there has been a profound reduction in the number of genital wart cases. Data from Australia suggest elimination of genital warts is possible.\(^14^\)

Data collected by the Victorian Cervical Screening Register indicates a reduction in the incidence histologically confirmed high-grade cervical abnormalities since the introduction of the HPV vaccine in women aged under 20, and 20-24, and that this decrease is now becoming manifest in the 25-29 age group. In young women, there has been a decline in incidence of almost 75%.\(^15^\)
4.3 Target populations
- Females aged 9 to 45 years and males aged 9 to of 26 years can receive the HPV vaccine.\textsuperscript{14}
- Women with a history of previous HPV infection will most likely benefit from protection against disease caused by the other HPV vaccine genotypes with which they have not been infected.
- The vaccine can be given to patients with previous cervical intraepithelial neoplasia, but the benefits will be limited to future HPV exposure. Cervical screening and corresponding management based on National guidelines and RANZCOG recommendations must continue.
- Gardasil 9 is classified as pregnancy category B2. The vaccine is not recommended for use in pregnancy. No adverse effects have been identified, but caution is advised.\textsuperscript{14}
- Women who become pregnant during the course of vaccination should defer the subsequent doses until the completion of pregnancy, regardless of timing. Vaccination should resume at the appropriate dose interval. There is no need to recommence the complete vaccination program. For example, women who have received one or two doses should receive the second and/or third dose at the completion of the pregnancy\textsuperscript{14}.
- The presence of immunosuppression, either medically or in patients with HIV infection, is not a contraindication for Gardasil 9. However, the immune response may be smaller in the immunocompromised patient than in immunocompetent patients.\textsuperscript{14}

4.4 Ongoing screening
- Current cervical screening recommendations should be followed regardless of vaccination status.
- The need for continued cervical screening according to recommended national policies should be emphasised.

4.5 Other considerations
Participation in the cervical screening program has declined among young women since the introduction of the National HPV Vaccination program. The need for continued cervical screening according to recommended national policies should be emphasised.
5. References


6. Other suggested reading


7. Useful Links

Human Papillomavirus (HPV) Immunise Australia Program, Department of Health

Cervical Cancer Vaccine, Ministry of Health, New Zealand

National Cervical Screening Program: Guidelines for the management of screen-detected abnormalities, screening in specific populations and investigation of abnormal vaginal bleeding (Australia)
Primary HPV screening from 1st December 2017

8. Links to other College statements

Cervical Cancer Screening in Australia (C-Gyn 19)

Evidence-based Medicine, Obstetrics and Gynaecology (C-Gen 15)

9. Patient information

A range of RANZCOG Patient Information Pamphlets can be ordered via:
https://www.ranzcog.edu.au/Womens-Health/Patient-Information-Guides/Patient-Information-Pamphlets
Appendices

Appendix A Women’s Health Committee Membership

<table>
<thead>
<tr>
<th>Name</th>
<th>Position on Committee</th>
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<tbody>
<tr>
<td>Professor Yee Leung</td>
<td>Chair and Board Member</td>
</tr>
<tr>
<td>Dr Gillian Gibson</td>
<td>Deputy Chair, Gynaecology</td>
</tr>
<tr>
<td>Dr Scott White</td>
<td>Deputy Chair, Obstetrics and Subspecialties Representative</td>
</tr>
<tr>
<td>Associate Professor Ian Pettigrew</td>
<td>Member and EAC Representative</td>
</tr>
<tr>
<td>Dr Kristy Milward</td>
<td>Member and Councillor</td>
</tr>
<tr>
<td>Dr Will Milford</td>
<td>Member and Councillor</td>
</tr>
<tr>
<td>Dr Frank O’Keefe</td>
<td>Member and Councillor</td>
</tr>
<tr>
<td>Professor Sue Walker</td>
<td>Member</td>
</tr>
<tr>
<td>Dr Roy Watson</td>
<td>Member and Councillor</td>
</tr>
<tr>
<td>Dr Susan Fleming</td>
<td>Member and Councillor</td>
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<tr>
<td>Dr Sue Belgrave</td>
<td>Member and Councillor</td>
</tr>
<tr>
<td>Dr Marilyn Clarke</td>
<td>ATSI Representative</td>
</tr>
<tr>
<td>Associate Professor Kirsten Black</td>
<td>Member</td>
</tr>
<tr>
<td>Dr Thangeswaran Rudra</td>
<td>Member</td>
</tr>
<tr>
<td>Dr Nisha Khot</td>
<td>Member and SIMG Representative</td>
</tr>
<tr>
<td>Dr Judith Gardiner</td>
<td>Diplomate Representative</td>
</tr>
<tr>
<td>Dr Angela Brown</td>
<td>Midwifery Representative</td>
</tr>
<tr>
<td>Ms Ann Jorgensen</td>
<td>Community Representative</td>
</tr>
<tr>
<td>Dr Rebecca Mackenzie-Proctor</td>
<td>Trainee Representative</td>
</tr>
<tr>
<td>Prof Caroline De Costa</td>
<td>Co-opted member (ANZJOG member)</td>
</tr>
<tr>
<td>Dr Christine Sammartino</td>
<td>Observer</td>
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</table>

Appendix B Overview of the development and review process for this statement

i. Steps in developing and updating this statement

This statement was originally developed in November 2006 and was most recently reviewed in March 2019. The Women’s Health Committee carried out the following steps in reviewing this statement:

- Declarations of interest were sought from all members prior to reviewing this statement.
- Structured clinical questions were developed and agreed upon.
- An updated literature search to answer the clinical questions was undertaken.
- At the November 2018 face-to-face committee meeting, the existing consensus-based recommendations were reviewed and updated (where appropriate) based on the available body of evidence and clinical expertise. Recommendations were graded as set out below in Appendix B part iii)

ii. Declaration of interest process and management

Declaring interests is essential in order to prevent any potential conflict between the private interests of members, and their duties as part of the Women’s Health Committee.
A declaration of interest form specific to guidelines and statements was developed by RANZCOG and approved by the RANZCOG Board in September 2012. The Women’s Health Committee members were required to declare their relevant interests in writing on this form prior to participating in the review of this statement.

Members were required to update their information as soon as they become aware of any changes to their interests and there was a standing agenda item at each meeting where declarations of interest were called for and recorded as part of the meeting minutes.

There were no significant, real or perceived conflicts of interest that required management during the process of updating this statement.

### iii. Grading of recommendations

Each recommendation in this College statement is given an overall grade as per the table below, based on the National Health and Medical Research Council (NHMRC) Levels of Evidence and Grades of Recommendations for Developers of Guidelines. Where no robust evidence was available but there was sufficient consensus within the Women’s Health Committee, consensus-based recommendations were developed or existing ones updated and are identifiable as such. Consensus-based recommendations were agreed to by the entire committee. Good Practice Notes are highlighted throughout and provide practical guidance to facilitate implementation. These were also developed through consensus of the entire committee.

<table>
<thead>
<tr>
<th>Recommendation category</th>
<th>Description</th>
</tr>
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<tbody>
<tr>
<td>Evidence-based</td>
<td></td>
</tr>
<tr>
<td>A</td>
<td>Body of evidence can be trusted to guide practice</td>
</tr>
<tr>
<td>B</td>
<td>Body of evidence can be trusted to guide practice in most situations</td>
</tr>
<tr>
<td>C</td>
<td>Body of evidence provides some support for recommendation(s) but care should be taken in its application</td>
</tr>
<tr>
<td>D</td>
<td>The body of evidence is weak and the recommendation must be applied with caution</td>
</tr>
<tr>
<td>Consensus-based</td>
<td>Recommendation based on clinical opinion and expertise as insufficient evidence available</td>
</tr>
<tr>
<td>Good Practice Note</td>
<td>Practical advice and information based on clinical opinion and expertise</td>
</tr>
</tbody>
</table>
Appendix C Full Disclaimer

This information is intended to provide general advice to practitioners, and should not be relied on as a substitute for proper assessment with respect to the particular circumstances of each case and the needs of any patient.

This information has been prepared having regard to general circumstances. It is the responsibility of each practitioner to have regard to the particular circumstances of each case. Clinical management should be responsive to the needs of the individual patient and the particular circumstances of each case.

This information has been prepared having regard to the information available at the time of its preparation, and each practitioner should have regard to relevant information, research or material which may have been published or become available subsequently.

Whilst the College endeavours to ensure that information is accurate and current at the time of preparation, it takes no responsibility for matters arising from changed circumstances or information or material that may have become subsequently available.