

HPV Vaccination Programme – The Nurses' Role

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I am currently reading a fascinating book about someone for whom I have the greatest admiration – Benjamin Franklin: printer, scientist, philosopher, fund-raiser, a key person in that remarkable event, the formation of the United States of America. Franklin was raised in Boston, where one of the major influencers on public opinion at the time, was a clergyman, who among other things, promoted the practice of “inoculation against smallpox”. The same issues which prevailed then, are the very ones we face today. Benjamin Franklin quite quickly supported the practice of inoculation – he could see with his own eyes the difference between outcomes when a smallpox epidemic swept through, but not all agreed.

Things are a little more complex today, and we have opportunities to vaccinate for conditions Franklin never heard of. But the debate continues between those who support vaccination generally, and those who do not, and between those who support a vaccination programme for HPV, and those who do not. The issues here are very subtle, and worth teasing apart for the purposes of constructive debate.

Human Papilloma Virus, or HPV as it is more commonly known, is simply, the wart virus. There are many types – about 80 that affect the genital area have been identified. Some of them result in the cauliflower-type warts which are visible on the internal and external genitalia. Usually they are an issue because of cosmetic concerns. Most types of HPV are invisible to the naked eye, and while many are quite harmless, there are two types, 16 & 18, which are the most common, can cause cervical cancer.

As a nurse who has worked 20 years in sexual health, I have to say that the news of Gardasil, a vaccine which prevents types 16 & 18, and two other strains of HPV, those that cause external genital warts you can see, was one of the most exciting pieces of news I have had since I began this work. Like every nurse working in sexual health, we have received plenty of information when the vaccine was first announced, and we have been watching every policy move to get Gardasil on the vaccination schedule so that it would be subsidised. But we weren't just waiting for policy change! We have been actively promoting Gardasil to parents and anyone in our sphere of influence, even though the vaccine cost about \$500 per child. Most of those in the sexual health world, have already been vaccinating for over a year.

The reason for our enthusiasm is simple: on almost daily basis, we see young men and women who have HPV infection. Most of the women will not go on to develop cervical cancer, but they do face the prospect of annual cervical smears, and have a higher risk of having to have a colposcopy at some stage in their lives. They are almost always devastated when the reality of the HPV diagnosis is explained. At the very beginning of their sexual experiences, they are consigned to a life-time of genital examinations, which, no matter how kindly and sensitively done, are an unwanted invasion. They have to confront the reality of the impact of this diagnosis on their future sexual relationships. They are often over-whelmed with feelings of being dirty, and that no-one will ever want to have sex with them again. There is considerable emotional pain when anyone is diagnosed with HPV, and significant resources go into supporting each one of these people young and older. The HPV vaccine is not just about preventing cervical cancer, it is also about preventing the ongoing consequences of having acquired an HPV infection which results in an abnormal smear.

But a vaccination programme does not involve just sexual health nurses. There are many other nurses working in the primary care sector, who are not on the mailing and contact lists we are and so news of HPV vaccine was not a high priority as they faced many other pressing issues in a busy practice. A significant number of these nurses have never or rarely conducted a sexual health consultation with their young patients and feel, quite rightly, unskilled in this area. They do need to have access to an education programme where their concerns can be addressed.

The overall debate over whether the HPV Vaccine is safe and effective, and for how long it is effective, has continued through a College Discussion Group. There are some who feel that there is still debate about side-effects, and debate about how the length of time for which the HPV vaccine is effective. One commentary which encapsulates much of the dispute about the safety and efficacy of the vaccine is in a paper presented at a recent Womens Health Action Group workshop: "Gardasil - Cartwright's Daughter?": <http://www.womens-health.org.nz>

Safety is certainly an issue – we never again want to see the days when New Zealand women are, without consent, used as the research base for practices and medications. But to compare Gardasil and the HPV vaccination programme with the events which led to the Cartwright report is, in my view, absurd and serves the debate no useful purpose. There is plenty of information already freely available for those looking for it.

In this instance, we are not world leaders. Indeed, the reverse is true - we are, once again, dragging behind. I was recently in Australia, and found that people were astounded to hear that we have neither HPV vaccination nor Implanon (a form of contraception – but that's another article!). There is a very strong body of research which attests to the safety, and discomfort of the vaccine. Side-effects are an issue – most will have a sore injection site, and young women have already had unpleasant experiences with Menz B, which many young people are saying was a much worse injection than Gardasil. Look back to my earlier description of what happens when young women are diagnosed with HPV : they have a choice: three injections with some discomfort or potentially annual smears? It is truly a no-brainer and should be very, very easy to promote to young women!

In 20 years of sexual health practice, in which our team have done several thousands of cervical smears, we have had one case of cervical cancer diagnosed. Every week, we re-call several women who have to have annual smears because of their history of HPV causing abnormal smears. The vaccine may not be perfect, the information available may not be acceptable to every person, future vaccinations may be required to sustain immunity, there are clearly nurses who are not sufficiently skilled or knowledgeable to be an active part of the vaccination programme, but there is plenty that we do know: this vaccine is very successful at preventing four of the most troublesome strains of HPV that account for about 70% of genital HPV disease, it has been given to a large number of people and has not been found to have significantly problematic levels of serious adverse reaction. There are a large number of sexual health nurses who have the knowledge and the skills to manage the nursing implications of the vaccination programme right now. This is the first chance we have had of preventing HPV infection, and thereby, reducing the suffering that goes with it.

Do we know everything about this vaccine? No – we don't know the length of time for which it will be efficacious – that knowledge will come from the passage of time. But can we wait until every single question is answered? If we hold off from promoting this vaccine, we are, in the meantime, actively denying a vaccine to some who may most benefit. The issue of denying young women the HPV vaccination right now, is not part of any debate I've seen, yet it must be considered.

Let me return briefly to my hero – the utterly amazing Benjamin Franklin. He and his wife only had one son who was often a sickly child, and Franklin was a very busy man. Between finding the time, and waiting for Francis to get stronger, Franklin never got around to inoculating him. When the smallpox epidemic went through Philadelphia in 1738, Francis's fifth year, it took him too. Franklin was devastated, but still considered it his civic duty, as a known supporter of inoculations, to print public articles stating his son did not die by inoculation, but because of failure to inoculate. Fifty years later, Franklin wrote "I long regretted bitterly and still regret that I had not given it to him by inoculation". Their only other child was a daughter, whom Franklin ensured was inoculated when she was still a baby. What would Franklin, the scientist say about HPV vaccine I wonder? He would consider the evidence very thoroughly, and on balance, I would be more than surprised if did anything other than say that we should do all we can to make this programme work for the benefit of all.

References

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