US states shun HPV vaccination

Uptake of the HPV vaccine in the US appears to have stalled, with only two states making the vaccination a requirement, researchers have warned.

The latest figures from the US Centers for Disease Control and Prevention (CDC) show that only 37·6% of adolescent girls and 13·9% of adolescent boys had received all three doses of the vaccine in 2013.

In this latest study, Jason Schwartz and Laurel Easterling of Princeton University (Princeton, NJ, USA) examined the presence and timing of state requirements for vaccines with particular relevance to adolescent health and compared those findings with the implementation of HPV vaccines.

When comparing other vaccination regimens at corresponding points in their rollout histories—ie, 8 years after publication of an Advisory Committee on Immunization Practices report, they showed that vaccination requirements were more common for varicella vaccine (38 states and DC), hepatitis B vaccine (36 states and DC), and meningococcal conjugate vaccine (21 states and DC) than for HPV vaccine (one state and DC). Rhode Island is expected to become the third state to require it in August, 2015.

Lead author Schwartz said: "State requirements have repeatedly been shown to be highly effective in promoting and sustaining high vaccination rates in the US. The thought is that a strong, unambiguous recommendation from health-care providers to parents in support of HPV vaccination for their son and daughter is often absent, in contrast to how other routine vaccinations are presented and discussed."

Debbie Saslow, from the American Cancer Society (Atlanta, GA, USA), said: "Unfortunately, the vaccination programme didn't get off to a good start as it was framed as a vaccine against a sexually transmitted disease rather than a vaccine against cancer. This has hindered uptake. Although Virginia and DC are the only US states to make HPV vaccination a requirement, they have included generous opt-out policies. As a result, it makes very little difference to uptake rates", warned Saslow.

Litjen Tan, of Immunization Action Coalition (Saint Paul, MN, USA) added: "If the uptake rate is hovering at about 40%, mandates may not be the best way to get those rates up to 90%, as there is not enough support for the vaccine".

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Published **Online**
July 17, 2015
http://dx.doi.org/10.1016/S1470-2045(15)00157-6

For the **study by Schwartz and Easterling** see *JAMA* 2015; **314:** 185–86

Active surveillance preferred for low-risk prostate cancer

Active surveillance or watchful waiting has increased in the USA during 2010–13 for patients with low-risk prostate cancer, a new study by Matthew Cooperberg and Peter Carroll (University of California, San Francisco, CA, USA) suggests.

During the same time period, the rates of appropriate and potentially curative local treatment—rather than only androgen deprivation therapy—increased significantly, in patients with prostate cancer aged below 75 years, who had high-risk disease.

The investigators examined 10 472 men with a mean age of 65·7 (SD 8·8) years, from the Cancer of the Prostate Strategic Urologic Research Endeavor (CaPSURE), a national registry of patients with prostate cancer at 45 urology practices in the USA. Their analysis included men with prostate tumours (stage cT3aN0M0 or lower) who were treated (during 1990–2013) with prostatectomy, radiotherapy, androgen deprivation monotherapy, or active surveillance or watchful waiting. The risk of prostate cancer was classified by the Cancer of the Prostate Risk Assessment (CAPRA) score (median score of 2 [IQR 1–4]).

Cooperberg and Carroll noted that during 1990–2009, use of surveillance in low-risk prostate cancer (CAPRA score: 0–2) remained low, between 6·7% (95% CI 5·8–7·6) to 14·3% (10·3–18·3); but it increased significantly during 2010–13 to 40·4% (34·9–45·9; p<0·001). For high-risk prostate tumours, the rates of androgen deprivation monotherapy increased steadily to 29·8% (23·3–36·4), but decreased during 2010–13 to 24·0% (14·1–33·9). However, in men 75 years and older with high-risk tumours, androgen deprivation therapy still accounted for 66·7% (95% CI 39·6–93·7) of treatment.

"The study [has] found that after years of overtreatment of low-risk prostate cancer—and under-treatment of high-risk tumours—we are finally seeing rapid progress toward appropriately risk-adapted management decisions for both low- and high-risk tumours at the national level", Cooperberg said. Ralph de Vere White (UC Davis Comprehensive Cancer Center, Sacramento, CA, USA) commented, "the rise in acceptance of active surveillance over the time period supports the contention that if the vast majority of urologists are shown convincing data, namely here, on the appropriate use of active surveillance, they will follow it. The hope is that the next time period will see an even further adoption of the correct treatment of this disease, namely active surveillance."

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Published **Online**
July 17, 2015
http://dx.doi.org/10.1016/S1470-2045(15)00155-2

For the **study by Cooperberg and Carroll** see *JAMA* 2015; **314:** 80–82