U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Public Health Service

Centers for Disease Control
and Prevention (CDC)
Atlanta GA 30329-4027

Responses to Peer Reviewer Comments

Recommendations for HIV Screening of Gay, Bisexual, and Other Men Who Have Sex with Men – Clinical Settings, United States, 2017

In compliance with the Peer Review Plan (available at https://www.cdc.gov/hiv/pdf/policies/msm_hiv_test_gl_peer_review_plan_b.pdf), we provided a draft of the document listed above to selected independent peer reviewers.

Peer Reviewers' Comments

1. Provide an evaluation of the updated recommendations overall and their applicability for screening MSM with HIV

Overall, reviewers thought the documents were well written and the literature review overall appeared to be sound. Some specific comments received: "no technical comments. The literature review was done in accordance with usual standards, the process of synthesizing the literature seemed comprehensive and fair, and I know of no papers that were missed in the review." Reviewer B said "they are well organized chronologically and well documented including differences between different CDC recommendations by divisions versus the USPTF." Reviewer C said "The documents you sent are clearly written, and I think that the CDC team did a good job in reviewing the evidence and developing the guidelines based on the approach described." However, reviewer C had major concerns about the conclusions drawn, described in detail below.

2. Evaluate the appropriateness of the methods used to develop these recommendations and the strength of the authors' inferences

Reviewer B had concerns regarding the way the evidence was rated. "The conclusions of this review should adopt the rating system for prevention and treatment recommendations as employed by CDC in the rating of strategies to prevent and treat opportunistic infections in persons living with HIV (please see page A-5 in https://aidsinfo.nih.gov/contentfiles/lvguidelines/adult_oi.pdf). Another use of this

type of rating approach can be found in Marrazzo, et al JAMA. 2014;312(4):390-409." The reviewer noted this "might give the clinician a bit more realistic guidance."

CDC response: We agree that the rating of the recommendations is not evident in the Methods section in document, and appreciate you noting this important oversight. The methods used in this guidelines adapt the Community Guide approach which designates three levels of rating the recommendation used by the Task Force: Recommended, Recommended Against, and Insufficient Evidence. Changing the methodology to a different rating scale i.e., similar to the OI treatment guidelines, etc., will involve a reevaluation of the evidence and reconvening of all consultants / work group members who weighed in on the previous evidence framework and recommendation rating scale. We feel confident in the current methods employed here but do think for future revisions of this guideline, your great suggestion can be considered. As a result of this feedback, we edited the papers to highlight that providers were encouraged to consider more frequent screening: "*Clinicians can also consider the potential benefits of more frequent HIV screening (e.g., every 3 or 6 months)* for some asymptomatic sexually active MSM based on their individual risk factors, local HIV epidemiology, and local testing policies."

Reviewer C had concerns about the attention on the benefit to the individual: "Second, insofar as the group focused on frequent testing as an intervention to benefit the patient tested, I don't think the review considers all the relevant issues. Frequent testing will lead to earlier HIV diagnoses."

CDC Response: We agree that a recommendation based solely on benefits to the individual would miss many of the benefits from more frequent testing. That is why we considered four domains to screen literature for our evidence base: Societal and individual benefits, harms, acceptability, and feasibility. "Societal benefits" was defined as benefits accruing not to the individual, but rather to the society as a whole on the basis of reduction of HIV transmission to others. Most of the evidence was actually measuring the societal benefits, specifically, reducing onward transmission or cost effectiveness of more frequent testing. The models did find that more frequent screening would be cost effective, or that it could lead to reduction in HIV transmission: but not all the models found very strong associations. The expert consultants agreed the effect was "moderate" but called for additional models or other studies to conclude that testing more frequently along should be strongly recommended. On the basis of this comment, CDC edited the papers to emphasize the four domains that were used in the evaluation, in particular the societal benefits.

Reviewer C also had concerns about the methods used for the review. "I do not think the approach adopted in this review is consistent with traditional CDC standards or with USPSTF guidelines." "As someone involved in the CDC STD Treatment Guidelines, I can assure you that we did not have strong evidence for the recommendation to treat gonorrhea with both ceftriaxone and azithromycin, a recommendation based primarily on the group's belief that two drugs might retard the development and transmission of

antimicrobial resistant gonorrhea. So I guess I would ask, why the change? Why is the standard here so much higher?"

CDC Response: We adapted the Community Guide for this review. The Community Guide has been utilized by many workgroups at CDC to evaluate the evidence of interventions and make public health recommendations. The USPSTF standards are arguably even more rigorous, as they use GRADE and would very likely arrive at the same conclusion. We think the Community Guide is an appropriate platform for our current recommendations and takes a realistic approach to evidence based methods. In terms of what other CDC working groups have done to revise or make recommendations: there is an emphasis, growing in the last few years/decade, to use evidence-based practices for guidelines and move away from only using expert opinion to make recommendations.

3. Point out any omissions or oversights in the literature cited as the evidence base for these recommendations

None noted

4. Identify any biases, oversights, omissions, or inconsistencies in the interpretations, findings, and conclusions

Reviewer A mentioned an omission about the benefits of HIV testing: "it is also a critical first step for high risk MSM who test negative to be linked to PrEP and other prevention services. I think this part is missing and may be helpful to include as it will provide guidance to clinicians about next steps after MSM test negative regardless of the frequency."

CDC Response: We agree that testing is critical for PrEP, and we revised the documents to incorporate this benefit more clearly.

A concern was noted by reviewer B regarding excluding non-clinical settings from the recommendations.

"This exclusion is not reflecting the reality of how people monitor their HIV serostatus in 2016. I think more and more people are utilizing some combination of clinical and non-clinical testing opportunities to assess their HIV serostatus over time."

CDC response: We agree that men may choose to get tested at frequent intervals outside of a clinical setting. However, we made the decision to focus on clinical settings for this recommendation for several reasons. One, we were updating the 2006 guidelines for HIV testing in health care settings, and the work group felt it was appropriate to be narrowly focused on that setting. Second, we believe that the non-clinical setting is truly different and should be evaluated separately from clinical settings. It is true that young

men in particular might not have a regular place for care, and therefore might find it more convenient to be tested by a CBO or other outreach facility. However, clinical settings are still the largest source of tests for MSM, and are better prepared to diagnose recent or acute infection because of the presence of laboratory testing algorithms. Clinical settings are also preferable because linkage to care for MSM testing HIV-positive is more streamlined (and likely to be successful), as is the prescribing of PrEP for those who are HIV-negative. Further, our recommendations are relevant for gay-oriented clinics (e.g., Whitman Walker, Howard Brown, LA Gay and Lesbian Center, etc.) where many MSM go for medical care.

CDC recently issued program guidance for HIV testing providers called *Implementing HIV Testing in Nonclinical Settings: A Guide for HIV Testing Providers*. The purpose of the guide is to familiarize providers with key programmatic issues and updates that impact HIV testing service delivery in nonclinical settings. While the guidance did not address frequency of testing, it does help staff with challenges unique to testing in non-clinical settings.

Reviewer C noted an oversight: "Starting people on ART before lab results come back is not the standard of care in most places, but treating everyone with acute HIV probably is. Insofar as the review is focuses on individual level benefits, you might consider addressing this issue."

CDC Response: we agree that this was overlooked. We added this potential benefit to the discussion.

5. Provide advice on the reasonableness of judgments made from the scientific evidence

Reviewer A asked about a portion of the paper where CDC discussed potential groups of MSM who might not benefit from more frequent screening, including those who live in communities where clinicians don't routinely screen MSM for HIV: "I don't think that this should be a consideration for no benefit from more frequent testing. MSM may be educated and empowered by these recommendations to seek more frequent than annual HIV screening and request it from providers that may or may not routinely ask about sexual histories."

CDC Response: We agree and removed the sentence from the paper.

Reviewer C said "Is this guideline consistent with the care continuum initiative? Does it really make sense to try to accelerate linkage to care and initiation of ART, but not accelerate HIV diagnoses in the population most affected by HIV infection?"

CDC Response: We think the emphasis on at least yearly testing, with the addition that more frequent screening is also reasonable under some yet unknown circumstances, is

appropriate when making recommendations across the US. During the expert consultation we heard concerns that some communities do not have resources to test all MSM more frequently. We also heard concerns that some communities wouldn't see a large benefit to frequent screening because they don't yet have infrastructure to link patients quickly to medical care, and get them virally suppressed. The experts believe that that frequent testing is beneficial mostly in places where linkage and retention are strong, like in Seattle. Based on the feedback, CDC edited the documents to specifically emphasize the possibility that frequent screening probably yields the most benefit in communities where linkage and retention are supported.

6. Ensure that scientific uncertainties are clearly identified and characterized, that the potential implications of any uncertainties for the proposed recommendations are clear

None noted

7. Assess whether the authors sufficiently acknowledge limitations in the evidence used to develop the recommendations and any limitations of the recommendations themselves for the intended purpose of screening MSM for HIV infection.

Reviewers B and C had concerns about the conclusion drawn by the CDC Workgroup. Reviewer B said the conclusion might lead "clinicians, health systems, and perhaps insurance companies and others might think that there is no strong reason to provide testing more than once per year." Reviewer C had concerns about use of these recommendations for practice. "If you directed a local health department HIV/STD control program, what would you recommend? I think you need to ask yourselves, will a new guidelines saying that frequent HIV/STD testing is not clearly indicated in MSM help clinicians, local health departments and other HIV prevention agencies get their work done? I think it won't. I think it will have a deleterious effect."

CDC Response: We did not intend to suggest that more frequent than annual screening was not beneficial in some circumstances, only that we don't have all the information we need right now to say under which circumstances it might be beneficial. We do think there is enough evidence to say that there are some situations in which it could be cost effective and help decrease onward transmission. We call for more studies will be done to provide the evidence that will support that theory. Further, not all health departments have the same opinion as may be the case in your community. During the expert consultations some health departments did raise concerns that they did not have the resources to support frequent testing and would need to take from other, more (or equally) beneficial HIV prevention programs. Finally, we don't have studies showing whether there could be harm to MSM if they are required to be tested more frequently than annually, due to cost of other factors. As you know, Insurers now must cover

evidence-based services for adults that have a rating of “A” or “B” in the current recommendations of the United States Preventive Services Task Force (USPSTF). Since the USPSTF recommendation for MSM is to screen annually, it is possible that some health care facilities may charge MSM for additional tests. This could constitute a harm. For these reasons, without more evidence, we do not know what the balance of benefits and harms are, and thus we do not know whether as you say, not strongly recommending more frequent testing will be deleterious. On the basis of this feedback, CDC revised the papers to emphasize the fact that there is support for more frequent screening and that clinicians are free to consider it when treating patients. We also reiterated the success of health departments that have supported more frequent screening. Finally, we emphasize the “at least” annual testing because many men are still not testing annually.

Reviewer C also said: “I think the best option would be for CDC to reconsider the evidentiary standard used for these guidelines and issue new guidelines that make it easier for local public health to promote frequent testing. If that is not possible, I think it would be better not to issue any guideline document at all, particularly if the group cannot clearly define the evidentiary threshold for coming up with a recommendation to test MSM more frequently, including a study design that is feasible.”

CDC Response: We believe we used the correct evidentiary standard and have called for more data and analyses for future research, at which time we can investigate the research question again. We will make more clear that if additional modeling studies are conducted, using different methods, that show decreases in new infections and/or HIV transmissions, then we can make stronger recommendations.

ISI/HISA Dissemination:

https://www.cdc.gov/hiv/programresources/planning.html
https://www.cdc.gov/od/science/quality/support/peer-review.htm

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