Comparison of careHPV and Hybrid Capture 2 Assays for Detection of High-Risk Human Papillomavirus DNA in Cervical Samples from HIV-1-Infected African Women

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The careHPV and HC2 assays were compared for high-risk human papillomavirus (HR-HPV) DNA detection in cervical samples from 149 HIV-1-infected African women. The HR-HPV DNA detection rates were 37.6% and 34.9% for careHPV and HC2, respectively. Agreement between the two tests was 94.6% (95% confidence interval [CI], 89.7% to 97.7%) with a kappa value of 0.88 (95% CI, 0.81 to 0.96), indicating an excellent agreement. careHPV may be considered as suitable as HC2 for cervical cancer screening among HIV-infected African women.

Cervical cancer is the third-most-common cancer in women worldwide, with more than 500,000 annual cases, and the fourth-most-common cause of cancer death in women, with about 275,000 annual deaths. However, more than 85% of cases and deaths occur in developing countries, cervical cancer being the commonest cancer and the leading cause of cancer death in African women (Globocan 2008 [http://globocan.iarc.fr]). The high mortality rate observed in Africa is due mainly to the absence of cervical cancer screening, resulting in diagnosis of advanced and often untreatable disease (1).

Virtually all cases of cervical cancer result from persistent infection with carcinogenic genotypes of human papillomavirus (HPV) (2). It is now well established that detection of these high-risk HPV (HR-HPV) genotypes in cervical samples allows identification of women at risk of precancerous or cancerous cervical lesions, and HR-HPV DNA testing has been proposed as a primary screening test for cervical cancer prevention (3, 4).

The incidence of HR-HPV infection and of high-grade cervical lesions is significantly increased in women infected with HIV-1 (5–7). Therefore, a screening strategy based on HR-HPV testing in African women infected with HIV-1 may play an important role in cervical cancer prevention.

The Hybrid Capture 2 (HC2) assay (Qiagen Corporation, Gaithersburg, MD) is a Food and Drug Administration (FDA)-approved test for cervical cancer screening. This assay is based on HR-HPV detection using a cocktail of RNA probes targeting 13 HR-HPV types, namely, HPV16, HPV18, HPV31, HPV33, HPV35, HPV39, HPV45, HPV51, HPV52, HPV56, HPV58, HPV59, and HPV68. The careHPV assay (Qiagen) is a new signal amplification assay adapted from HC2. This assay, which is designed to be simpler and more rapid to use and more affordable than HC2 in resource-poor settings, targets 14 HR-HPV types, HPV66 being included in the probe cocktail in addition to the 13 HR-HPV types targeted by the HC2 assay (8, 9). There has been no published evaluation of the direct comparison between the two assays.

We compared the careHPV assay with the HC2 assay for a subset of women enrolled in the HARP (HPV in Africa Research Partnership) study, which is conducted in two sub-Saharan African countries, South Africa and Burkina Faso, with the aim to evaluate cervical cancer screening and treatment approaches for the prevention of cervical neoplasia in HIV-1-infected African women. More than 1,200 consenting HIV-1-seropositive women ages 25 to 50, of whom two-thirds were on antiretroviral therapy (ART), were enrolled in the HARP study between November 2011 and October 2012, and this cohort was followed up every 6 months. The study was approved by the research ethics committees of the University of the Witwatersrand in South Africa, the Ministry of Health in Burkina Faso, and the London School of Hygiene & Tropical Medicine.

The comparison was done with samples collected from 149 unselected consecutive HARP study participants (75 in Johannesburg, South Africa and 74 in Ouagadougou, Burkina Faso) attending their regular research clinic appointment 12 months after enrollment, between February and April 2013. At baseline visit, 68 (46%) women were 25 to 34 years old and 81 (54%) were 35 to 50 years old; 48 (32%) had a CD4 T cell count of ≤350 cells/μL.

### TABLE 1 Agreement between careHPV and HC2 assays for 149 HIV-positive women from Burkina Faso and South Africa

<table>
<thead>
<tr>
<th>HC2 result</th>
<th>No. (%) of samples with careHPV result</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Positive</td>
</tr>
<tr>
<td>Positive</td>
<td>50 (33.6)</td>
</tr>
<tr>
<td>Negative</td>
<td>6 (4.0)</td>
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</tbody>
</table>

aP < 0.0001 (McNemar’s test).

FIGURE 1 Comparison of high-risk human papillomavirus (HR-HPV) DNA detection rates of the careHPV assay and the HC2 assay among HIV-1-infected women enrolled in the HARP study (South Africa and Burkina Faso). Number of samples showing positive or negative HR-HPV detection by the two tests are indicated. doi:10.1128/JCM.02144-13

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Two cervical samples were consecutively taken for each woman. The first sample was collected using the careHPV sample collection device, consisting of a careBrush and a vial of careHPV collection medium. The second sample was collected using the Digene cervical sampler, consisting of a cervical brush and specimen transport medium. careHPV tests were performed at the respective sites by medical scientists specifically trained by a Qiagen scientist, and the HC2 tests were performed in Montpellier, France, with samples stored at −80°C and shipped in dry ice. The assays were performed according to the manufacturer’s instructions. The HC2 assay was considered positive when the relative light unit/cutoff (RU/CO) ratio was ≥ 1. The positive or negative result of the careHPV assay was displayed by the careHPV test controller without additional specification of the luminescent signal intensity. Samples for which a discrepant result between the two assays was observed were tested for HPV detection and typing using the INNO-LiPA HPV genotyping Extra assay (Innogenetics, Courtaboeuf, France). In cases of nontypeable HPV as identified by the INNO-LiPA HPV genotyping Extra assay, genotyping was performed by sequencing as previously described (10).

The HR-HPV prevalence was 37.6% (95% CI, 29.8% to 45.9%) by careHPV and 34.9% (95% CI, 27.3% to 43.1%) by HC2. In South Africa, the prevalence of HR-HPV was 37.3% as detected by careHPV and 33.3% by HC2, whereas in Burkina Faso, this prevalence was 37.8% by careHPV and 36.5% by HC2. The overall agreement between tests was 94.6% (141/149; 95% CI, 89.7% to 97.7%) (Table 1). Agreement was 96.0% (72/75; 95% CI, 88.8% to 99.2%) in South Africa and 93.2% (69/74; 95% CI, 84.9% to 97.8%) in Burkina Faso. The kappa test value of 0.88 (95% CI, 0.81 to 0.96) indicated an excellent agreement. The results obtained for the discrepant samples are shown in Table 2. All the discrepant samples were positive for HPV detection by the INNO-LiPA HPV genotyping Extra assay. Among the six samples positive by careHPV and negative by HC2, five were positive for HR-HPV types targeted by HC2 probes and one was positive for HPV25, a non-HR-HPV type. Among the two samples negative by careHPV and positive by HC2, one was positive for the HR-type HPV51 and the other was positive only for the low-risk type HPV6.

Taken together, these results indicate an excellent agreement between the careHPV and HC2 assays. The few cases of discrepancy observed may be due to amounts of HR-HPV DNA at the limit of detectability or to cross-reactivity with non-HR-HPV types (11). Moreover, the fact that the two assays were performed not with the same sample but with consecutive samples collected in the assay-specific collection medium may have been a cause of discrepancy independently from the performances of the assays themselves. Results from this study indicate that careHPV may be considered as suitable as HC2 for cervical cancer screening among HIV-infected women in resource-constrained settings.

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