An overview of early investigational drugs for the treatment of human papilloma virus infection and associated dysplasia.

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Abstract

Introduction: High-risk HPV (HR-HPV) related invasive cervical cancer (ICC) causes >270,000 deaths per annum world-wide with over 85% of these occurring in low-resource countries. Ablative and excisional treatment modalities are restricted for use with high-grade pre-cancerous cervical disease with HPV infection and low-grade dysplasia mostly managed by a watch-and-wait policy.

Areas Covered: Various pharmacological approaches have been investigated as non-destructive alternatives for the treatment of HR-HPV infection and associated dysplasia. These are discussed dealing with efficacy, ease-of-use (physician or self-applied), systemic or locally applied, side-effects, cost and risks. The main focus will be the perceived impact on current clinical practice of a self-applied, effective and safe pharmacological anti-HPV treatment.

Expert Opinion: Current prophylactic HPV vaccines are expensive, HPV type restricted and have little effect in already infected women. Therapeutic vaccines are under development but are also HPV type-restricted. At present, the developed nations use national cytology screening and surgical procedures to treat only women identified with HPV-related high-grade dysplastic disease. However, since HPV testing is rapidly replacing cytology as the test-of-choice, a suitable topically-applied and low-cost antiviral treatment could be an ideal solution for treatment of HPV infection per se with test-of-cure carried out by repeat HPV testing. Cytology would only then be necessary for women who remained HPV positive. Although of significant benefit in the developed countries, combining such a treatment with self-sampled HPV testing could revolutionise the management of this disease in the developing nations which lack both the infrastructure and resources to establish national cytology screening programs.
1. Introduction

Infection with high-risk (HR) types of HPV is now well established as the main aetiological agent for invasive cervical cancer (ICC)\(^1-^3\) and globally there are >270,000 deaths from this disease per annum with over 85% of these occurring in low resource settings where it comprises >23% of all female malignancies\(^4,^5\). The development of ICC can take 10-20 years and is preceded by oncogenic HPV related pre-invasive pathologies which are characterised as either low-grade (CIN1) or high-grade cervical intraepithelial neoplasia (CIN2/3)\(^1\). Such lesions can be screen detected by cervical cytology testing where they are diagnosed as either borderline atypical squamous cells of undetermined significance (ASCUS), low-grade squamous intraepithelial lesions (LSIL) or high-grade squamous intraepithelial lesions (HSIL)\(^6\) (See Figure 1). If cervical cytology is abnormal, screening programmes recommend diagnostic and management guidelines. Diagnosis involves colposcopy and when the diagnosis of high grade CIN grade is confirmed by biopsy, treatment is mandated.

The reduction in ICC related mortality in the developed world has been largely dependent on organised cytology screening and similar trends in cervical cancer mortality have been achieved by the practice of organised single screen and treat in low resource settings \(^7\). However, in the majority of the poorer nations, lack of resources and health education means that most pre-invasive cervical disease remains undiagnosed and untreated. Thus, where resources are limited, low-cost screening and alternative treatment options are clearly a high priority.

Current treatments in clinical practice are either by ablative (destructive) or excisional modalities which have similar success rates but have different morbidities \(^8\). In the developed nations, Large Loop Excision of the Transformation Zone (LLETZ) (aka loop electrosurgical excision procedure – LEEP \(^9\)) is used in the majority of colposcopy clinics. Over 80% of these procedures are performed under local analgesia and the whole of the transformation zone is available for subsequent histological examination. Although highly effective (80-95%), this procedure is associated with a risk of primary/secondary haemorrhage, prolonged vaginal discharge, infection and a risk of preterm delivery in subsequent pregnancies which can be problematic in low resource countries \(^10,^11\). Ablative cold coagulation and cryotherapy are often advocated for use in these settings since these are low cost, require minimal infrastructure and can be carried out by trained non-medical health professionals. However, some studies have suggested that these treatments have a higher failure rate when compared to other
Ablative and destructive approaches to treatment have their limitations and in the small minority of cases can lead to persistent disease requiring more radical treatment which might ultimately require hysterectomy. Furthermore, implementation of these procedures requires appropriately trained medical staff and facilities which are often not available in low-resource settings. Moreover, any treatment associated complications are also much more difficult to manage in such locations.

Prevention is an obvious solution to these problems and the two currently available prophylactic vaccines Cervarix® and Gardasil® have now been implemented in many of the developed nations. Although these do provide some cross type protection, in general, their limitations are HR-HPV 16/18 type restriction and high cost. A prophylactic nonavalent vaccine has just been approved in the USA and Europe which should provide broader protection although it is still likely to be expensive. Furthermore, since these are prophylactics, an effective pharmacotherapy for HPV infection, and any associated underlying dysplasia, would be an ideal solution for women already infected with HPV. Thus implementation of a well-tolerated and safe non-destructive treatment modality would permit this to be used against HPV infection per se, in addition to low-grade disease, for which there are currently limited treatment options. This would be particularly advantageous in low resource settings where low-cost HPV tests, such as Care HPV (Qiagen), combined with self-sampling, could provide an alternative to cytology for the basis of treatment decisions with test-of-cure carried out by follow-up repeat HPV testing. Those women with persistent HPV infection could then either be re-treated or referred for conventional colposcopy followed by surgery if this was deemed necessary. However, for such a “catch all” pharmacological treatment to be implemented, it would clearly need to be reasonably priced and have comparable success rates to current surgical procedures.

There are a variety of non-surgical approaches which have been evaluated in clinical trials for the treatment of HPV related cervical dysplasia although in 2004 these were not recommended due to side-effects and limited efficacy. However, recent improvements in their application combined with the development of new modalities means some of these approaches have now “come-of-age” and these will now be discussed with respect to their ability to fulfil the aforementioned criteria.
2. Photodynamic Therapy (PDT)

PDT is a minimally invasive procedure which uses either topical or systemic treatment with a photo-sensitiser followed by exposure to light of an appropriate wavelength and it has been used to treat both low and high grade cervical dysplasia with varying degrees of success. Systemic photo-sensitisers, such as Photfrin®, can cause problems with non-specific dermal photosensitisation. A recent small series using the topical photo-sensitiser hexaminolevulinate, has reported high success rates of 95% clearance of CIN lesions with 83% (5/6 patients) clearance of HPV16/18. These findings clearly indicate that this procedure has considerable potential to provide an effective non-surgical treatment for both low and high-grade HPV related dysplasia, if proven in larger studies. However, since it is physician applied, with the attendant equipment and cost implications, it is very unlikely to be used for the treatment of HPV infection or disease in low resource settings.

3. Cidofovir

The antiviral drug cidofovir is currently licensed for the treatment HIV related CMV retinitis and it has been used extensively off-licence for the treatment of low-risk (LR) HPV laryngeal warts. It has also been used to treat HR-HPV related cervical dysplasia and more recently with some success where 14/23 (>60%) of women with pre-treatment biopsy confirmed CIN2 were found to be histologically normal following 3 physician-applied local applications of cidofovir. Regarding mode-of-action, cidofovir is incorporated in viral DNA and preferentially inhibits CMV DNA polymerase but has no such selectivity against HPV since this utilizes the host DNA polymerase. Thus, its anti-HPV activity has been shown to rely on the reduced capacity of HPV positive cells to repair DNA damage. However, since this drug is both mutagenic and carcinogenic in animals, its use for the treatment of HPV related benign and pre-malignant pathologies has proved controversial. Given these concerns, it is not likely that the use of locally applied cidofovir would be approved for the treatment of cervical HPV infection. Furthermore, at a cost of approximately $1000 for a 5 ml vial of 75 mg/ml it is also expensive which would limit its use in resource constrained settings.

4. Imiquimod
The immune activator imiquimod does not have direct antiviral activity but activates cytokines which subsequently promote immunological clearance of virus. Although local application of this agent has been used extensively to treat LR-HPV related genital warts, its efficacy was found to be questionable in a recent systematic review. In a study carried out in Taiwan, women who had been treated with surgery for cervical and vaginal dysplasia, but had persistent HPV infection both with and without dysplasia, were treated with locally applied 5% imiquimod cream for 6 weeks which showed 65% clearance of HPV infection. Moreover, >60% clearance of cervical dysplasia was also reported but only in 4/6 patients. A very similar study, also carried out in Taiwan, used 5% imiquimod cream for 8 weeks and showed a 76% clearance of HPV presumably due to the longer treatment period. However, a comparison of imiquimod therapy to standard surgical intervention for CIN treatment concluded that disease recurrence was the same in both groups and yet side effects such as fever, fatigue, headache, myalgia, nausea, chills and vaginal discharge were considerably worse in women treated with imiquimod. Compared to cidofovir, imiquimod is reasonably priced and there is no doubt that it is effective in some women. Furthermore, it can be self-applied although its efficacy is not better than surgical procedures and it can produce unpleasant side-effects for the duration of treatment limiting compliance. To illustrate, 39 out of 84 women treated with 5% imiquimod for HPV-related vulval intraepithelial neoplasia (VIN), reported grade 3 or 4 adverse events.

5. 5-Flurouracil (5-FU)
5-FU is pyrimidine analogue cytotoxic agent used in the treatment of cancer and topical application of a 5% solution of this drug for 8 weeks over a 16 week period has been used to treat CIN2. This produced regression of disease in 96% of patients after 6 months follow up although only 50% had normal pathology and were also negative for HPV. It is well known that 5-FU has very significant toxic side-effects associated with both local and systemic use and these effects can be difficult to predict demonstrating marked variations between individuals. Since 5-FU is so toxic, its application to the cervix was physician-applied and its reported efficacy against CIN2 and HPV was no better than current surgical procedures. Given these observations and safety concerns, it is very clear that this drug would not be approved for the treatment of HPV infection per se or even low-grade disease in the general population.
6. Interferon

Ten intra-lesional injections of 3mIU of the endogenous human antiviral protein interferon-alpha over 3-4 weeks were used to treat 45 cases of CIN1-3 and 30 of carcinoma in situ (CIS) \(^{34}\). All women returned to normal cytology and were HPV negative which was maintained during a six year follow-up period. This study was a simple proof-of-concept with no control arm and yet, given the marked efficacy observed, it is curious that there have been no further more robust phase 2 studies carried out on this indication. This could be related to the need for direct intra-lesional injection and with interferon-alpha being a biological, it is very expensive. Furthermore, systemic interferon does cause significant side-effects such as flu like symptoms and low mood. However, there are now microencapsulated forms of this drug available which can be used for direct topical application although it is very likely that cost will still be an issue \(^{35}\).

7. Therapeutic Vaccines

Although not strictly pharmacotherapy, to date, 12 different therapeutic HPV vaccines have been produced which are at various stages of clinical development \(^{36}\). These can be roughly grouped into 5 different categories depending on the immunogen which can be protein, peptide or DNA and the delivery system which can be viral or dendritic cell based. The majority of therapeutic vaccines target E6 and/or E7 from HPV16 with or without HPV18. Exceptions to these are the live vaccinia virus recombinants MVA-2, which targets bovine papilloma virus (BPV) E2, and MVA-1 which targets HPV16 E1. The activity and current status of all these different vaccines is summarised in a review by Rosales and Rosales \(^{36}\). One of the most interesting of these is the MVA-E2 vaccine which was initially tested in Mexico. Out of 78 women diagnosed with either CIN1, 2 or 3, 36 received direct intrauterine injection of the vaccine once weekly for 6 weeks and 42 were treated with cryotherapy although the latter group only consisted of women with CIN1 or 2. MVA-2 produced a return to normal cytology in 85% of patients and HPV DNA was still present in 50% of those treated. Cryosurgery produced a return to normal histology in 100% of patients and yet 67% were still positive for HPV DNA \(^{37}\). The same authors carried out a more comprehensive study of the efficacy of MVA-E2 on HPV related dysplastic lesions in 1176 women and 180 men by direct injection of the vaccine into the uterus, vulva, urethra or anus \(^{38}\). Inclusion criteria were aged between 29 and 49 years and positive
for either LR or HR-HPV. Female patients all had associated cervical dysplasia (CIN1, 2, 3) or condyloma whereas male patients had either anal dysplasia (AIN) or urethral condylomas. The outcome was elimination of HPV DNA is 83% of patients treated with 89% of women and 100% of men showing normal histology post-treatment. Although these results are very encouraging, there are clearly safety issues concerning the use of live vaccinia recombinant vaccines. Even though these authors used the attenuated Ankara strain of vaccinia\textsuperscript{39} and stated the treatment was well tolerated with no adverse reactions, there are real concerns surrounding the release of such recombinant live virus vectors into the general population.

More recently, a DNA-based HPV vaccine VGX-3100 has been developed which was delivered by 5 intramuscular injections combined with \textit{in vivo} electroporation. This was initially used to treat 18 women with persistent CIN2/3 which demonstrated a convincing immune response although efficacy was not reported in this study\textsuperscript{40}. A phase 2 trial has also been carried out using the same vaccine to treat a total of 148 women with CIN2/3 and CIN3 (Trial ID No. NCT01304524) although this has not yet reported.

8. Pre-Clinical and Clinical Trials Carried out on Natural Products

In addition to the previously discussed synthetic small-molecule, protein and vaccine based therapies, a variety of natural products have also been investigated for anti-HPV activity\textsuperscript{41}. Examples of these are, ferulic acid\textsuperscript{42}, artemisinin\textsuperscript{43-45}, withaferin A\textsuperscript{46}, resveratrol\textsuperscript{47}, (-)-epigallocatechin-3-gallate\textsuperscript{48}, ursolic acid\textsuperscript{49}, berberine\textsuperscript{50}, jaceosidin\textsuperscript{51}, curcumin\textsuperscript{52} and indole-3-carbinol\textsuperscript{53}. Although all these products have shown activity against cultured HPV positive cervical carcinoma cell lines, very few have been tried in the clinic. Notable exceptions were:-

Oral administration of the artemisinin derivative Arteminol R for 28 days was shown to improve both clinical symptoms and disease marker expression in 10 women with advanced cervical cancer with no serious adverse events\textsuperscript{45}.

Ninety eight women were recruited for a phase 2 randomised trial of placebo or 800 mgs of orally administered green tea polyphenol (-)-epigallocatechin-3-gallate once daily for 4 months which showed no difference in CIN or HPV status between placebo or test\textsuperscript{48}.

Two hundred and eighty two HPV positive women with no dysplasia were treated with either curcumin containing formulations or placebo controls for 30 days.
which showed a modest improvement in HPV clearance (87% Test Vs 73% placebo).  

Thirty women with biopsy confirmed CIN2/3 were randomised to receive 200 mg or 400mg of indole-3-carbinol or placebo orally once a day for 12 weeks. Although there was a statistically significant regression of dysplasia in the test group, there was no detectable clearance of HPV when compared to placebo 53.

9. Human Immunodeficiency Virus Protease Inhibitors (HIV PI’s)

Most HIV PI’s are small molecule, peptide mimetic drugs which target the HIV aspartyl protease that is essential for the production of infectious virions and these agents have been shown to have pleiotropic effects against viral replication at various stages of the virus life cycle 54. Furthermore, it was also shown that selective off-target effects of these drugs on the mammalian proteasome contributes to their activity against HIV 55-57. Since HPV, and many other viruses, are known to deregulate the proteasome 58, it was considered that HIV PIs may have broader activity against other viruses. Preclinical studies demonstrated this against HPV which showed lopinavir to be the most active HIV PI against cultured HPV positive cervical carcinoma cell lines 59. However, although lopinavir was the most effective HIV PI against HPV in vitro, this was at higher concentrations than can be achieved from normal oral dosing for HIV therapy 60. Indeed a recent comparison of non-PI and PI-based highly active antiretroviral therapy (HAART) both with and without oral lopinavir, was carried out in HIV positive women which showed no effect on the prevalence of cervical HPV infection 61. Nevertheless, previous in vitro studies have defined at least part of the mode-of-action of lopinavir against HPV 62 and several HIV PI’s are now well known to have both anticancer and antiviral properties 63-67. Moreover, lopinavir has also been shown to have activity against severe acute respiratory syndrome (SARS) and, more recently, middle eastern respiratory syndrome (MERS) coronaviruses 68-70. Lopinavir is normally prescribed as a 4:1 mixture with ritonavir (Kaletra®) and earlier in vitro studies suggested that the presence of ritonavir may actually be detrimental to the anti HPV activity of this compound 59. Ritonavir as a mono-therapy has been shown to have anti-invasive and anti-proliferative activity against cells derived from pre-invasive CINs but little activity against cells derived from more advanced cervical carcinomas 71.
With regard to clinical trials carried out on treatment of HPV related cervical dysplasia with HIV PI’s, the University of Texas is currently recruiting for a phase II single-arm intervention trial of oral nelfinavir in patients with CIB 2/3 or 3\(^72\) (Trial Id. No. NCT01925378) which is expected to complete in December 2016. A phase 1 single-arm, proof-of-concept trial of topically applied Lopimune (Generic Kaletra, CIPLA) has also been carried out. Standard Lopimune soft-gelatin capsules (133.3mg Lopinvir + 33.3mg Ritonavir) were given twice daily as a vaginal pessary for 2 weeks to 23 Kenyan women diagnosed with HPV positive HSIL\(^73\). Follow up of these women at 3 months showed 60% had regained normal pathology with 18% regressing to low-grade disease producing a combined positive response in 78% with clearance of HPV seen in 50% of these women. Clearly, these observations support further investigation on the ability of HIV PI’s to treat HPV infection per se in addition to any associated dysplasia.

10. Conclusion
Out of the various pharmacotherapies and vaccines discussed it is very clear that for reasons of efficacy, side-effects, ease-of-use, safety, HPV type restriction and cost the majority of these will not provide a viable “catch all” alternative to current surgical modalities for the treatment of HPV related dysplasia. However, there are some notable exceptions which may prove suitable following further validation in appropriate clinical trials.

11. Expert Opinion
There is no clinically approved effective pharmacological treatment for HPV infection or associated cervical dysplasia and it is clear that excisional surgery or ablative procedures will continue to be the recommended treatment within opportunistic or organised screening programmes for pre-invasive disease as illustrated in Figure 1. A potential new approach would be a ‘mass’ conservative medical effective treatment for HPV and associated disease. HPV infection is very common, often producing no abnormal pathology and has a high rate of spontaneous clearance, particularly in low grade lesions and in younger women\(^74\). In view of this, a watch and wait policy is considered to be best clinical practice for the management of HPV infection and associated low-grade dysplasia (LSIL or CIN1) since excisional and ablative methods are necessarily destructive with the added risk of treatment associated side-effects and
morbidity. Of particular concern is that in countries that do not have prophylactic vaccination or cytology screening, women and their partners who acquire, albeit transient, HR-HPV infection will constitute a reservoir of infectious virus which clearly enhances dissemination to other individuals. The majority will clear the virus but the minority who develop persistent HPV infection are at increased risk of developing associated dysplasia. A potential solution to this problem would be a “catch-all” pharmacological antiviral treatment which also proved effective against dysplasia which may or may not be present. Such a treatment could then be prescribed on the basis of a positive test for HR-HPV with test-of-cure by repeat HPV testing. However, the rate of spontaneous clearance of HPV16/18 in placebo control groups can be >70% within six weeks which implies that such a pharmacotherapy would necessarily have to be extremely well tolerated with minimal risk of complications. This raises the question, are any of the previously discussed treatments suitable?

Locally applied PDT, Cidofovir, Imiquimod, 5FU and Interferon all showed significant efficacy against dysplastic lesions although, all but Imiquimod, were physician applied. Since there are also issues of safety, side-effects and cost it is unlikely that any of these modalities will ever be used for the treatment of HPV or pre-invasive disease.

With regard to therapeutic vaccines, as previously discussed, there are quite a number of these at various stages of development. Furthermore there is no doubt that the physician applied vaccinia recombinant MVA-E2 proved extremely effective although there are very real safety concerns with this type of treatment which will undoubtedly limit its use. The DNA based vaccine VGX-3100 could provide the means to treat HPV infection and dysplasia although its efficacy is not yet known. In addition, like most HPV vaccines, it is type-restricted and is a systemic treatment with associated risks plus the cost is currently unknown.

A variety of preclinical studies have been carried out on the activity of different phytochemicals in HPV positive cervical carcinoma cell lines although most of these do not translate into useful clinical efficacy. The possible exception to this could be Arteminol although this was only used to treat 10 women with advanced disease and clearly needs more thorough investigation.

Finally, as regards off-licence use of HIV PI’s, the proof-of-concept trial on self-applied topical lopinavir (Kaletra) is a very promising indication but clearly needs larger phase 2 trials to establish efficacy. Most significantly, since Kaletra is
currently licensed for the long-term systemic treatment of HIV positive pregnant women and children it is comparatively safe when compared to the other previously discussed topical agents. As regards cost, the generic form of Kaletra (Lopimune) was approximately £10 per patient treated as purchased from a Kenyan pharmacy.

In summary, in order for a pharmacological treatment for HR-HPV and associated dysplasia to be implemented widely it would need to satisfy the following criteria: Self-applied; Non-destructive; Minimal side-effects, Short duration; Non-mutagenic; Effective as traditional treatments and Affordable.
Of the previously discussed modalities, it is our opinion that topical application of the HIV protease inhibitor Kaletra would provide the most promising candidate to date.

References
* Evaluation of the low-cost self-sampled careHPV test.
* Comparison of pharmacotherapies used to treat HPV related disease in 2004
* A small study showing good efficacy of PDT for the treatment of CIN
* Demonstrates 60% clearance of abnormal CIN lesions treated with cidofovir.
* Toxicity of cidofovir in HPV+ve cells depends on their reduced DNA repair capacity.
* Describes perspectives on safety issues surrounding the off licence use of cidofovir.
* Shows imiquimod has equivalent efficacy to surgery for the treatment of CIN but has worse side-effects.
* Illustrates the issue of patient non-complinace associated with side-effects of imiquimod
* Only study reporting the use of direct intralesional injection of interferon-α as treatment for CIN.
** Very thorough review of the current status of immune therapies for HPV related disease.
* Shows the potential of vaccinia virus based therapeutic vaccine MVA-2 for the treatment of CIN.
* Larger study confirming the activity of the MVA-2 against a variety of HPV related pathologies.

* Shows early results on activity of the DNA-based therapeutic HPV vaccine VGX-3100.


* Clinical trial of curcumin as a treatment for HPV infection suggests modest activity.

* Illustrates the off-target effects of HIV protease inhibitors.


* Illustrates the off-target effects of HIV protease inhibitors.


** First preclinical report of the activity of HIV protease inhibitors against HPV.


* Provides evidence that the concentration of lopinavir produced by oral administration is insufficient for anti HPV activity.


** Describes information on the mode-of-action of lopinavir against HPV and the concentration required for this effect in vitro.


* Speculates on prospective use and rationale underlying the off-target effects of HIV protease inhibitors against HPV.


* Reports off-target activity of lopinavir against SARS virus.

* Identifies lopinavir as having activity against MERS virus in vitro.


** Clinical trial of oral nelfinavir as a treatment for CIN - Not yet reported.

73. Hampson I. Lopinavir as a Topical Treatment (LOTT) trial for HPV-related cervical dysplasia in HIV negative women. 2014 [cited; Available from: http://www.controlled-trials.com/ISRCTN48776874

** Proof-of-concept clinical trial of self-applied topical Kaletra (Lopimune) as a treatment for CIN2/3 - Manuscript revision currently under consideration.


Figure Legend

Figure 1. The Stages of HPV Related Cervical Carcinogenesis.
Article Highlights

• Globally HPV-related cervical cancer is a leading cause of women’s cancer deaths with the vast majority of these occurring in the poorer nations.
• Cytology is rapidly being replaced by HPV testing as the primary test-of-choice for cervical smears and yet treatment options for HPV infection per se, or associated low-grade disease, are very limited.
• Surgical/ablative treatments for HPV-related cervical dysplasia are effective but are only advocated for use with high-grade disease which largely restricts their use to wealthier nations which possess the resources required for screening, diagnosis and treatment.
• An effective, safe, non-destructive, low-cost and self-applied pharmacological therapy with minimal side-effects, has the potential to revolutionise the treatment of HPV infection and related dysplasia by providing a “catch all” medical treatment for HPV infection per se and all grades of dysplasia.
• A variety of pharmacotherapies and therapeutic vaccines have been evaluated for this purpose although currently none of these are licensed for the treatment of HPV-related dysplasia.
• Most do not satisfy the above criteria for one or more reasons such as limited efficacy, unacceptable side-effects, HPV type restriction, physician-applied, risk-of-complications, length of treatment required and high cost.
• Out of all the prospective pharmacological treatments evaluated to date, only topical application of the HIV protease Kaletra (Lopimune) has the potential to satisfy all of the preceding requirements although it is currently at the proof-of-concept stage.
CIN1 CIN2
Mild Dysplasia
CIN3
Moderate Dysplasia
Severe Dysplasia
Carcinoma In Situ
Invasive Cancer
Normal
Cervical Epithelium
Basal Cells
Rate of Spontaneous Clearance of HPV and Associated Dysplasia
HR-HPV Infection (10-20 yrs)