Letter to the Editor

Dear sir/madam


We congratulate the authors on their work which extrapolates data from 4,846 adult subjects who had oral rinses examined for the presence of any HPV type to the first nationally representative estimates of oral HPV prevalence in the United States adult population. However, we feel it important to point out several issues which may otherwise result in over-interpretation of the significance of the data, especially from a health care providers’ point of view.

1. Firstly, in the title of the paper, use of the word ‘infection’ may give an impression that the population with detectable virus in their oral samples showed clinically observable manifestations attributable to HPV. Strictly, the word infection means the presence of a potential pathogen and of disease caused by that presumptive pathogen. A distinction between an infected individual and a carrier must be made. Furthermore, carriage and shedding of HPVs may be transient.


In the present study, samples were evaluated for HPV using polymerase chain reaction (PCR) and DNA sequencing with a view to identifying HPV types. This shows only the presence of the virus with no indication of genomic change. Genomic integration occurs at low frequency, so the mere presence of HPV in saliva does not necessarily place an individual at a greater risk of developing cancer in the upper aero-digestive tract (Mark Lingen 2010).

3. Thought also needs to be given to mode of transmission. The literature on cervical cancer and HPV-related ano-genital cancer points to the fact that transmission of virus is primarily through “skin to skin” contact during sexual intercourse. [zur Hausen H 1994; zur Hausen H 2002, IARC 2007]. With regard to the association of HPV to oropharyngeal cancer, there is good indirect evidence that oral carriage is acquired through direct oral-genital contact (Anaya-Saavedra G, Ramirez Amador V, Irgoyen-Camacho ME, Garcia-Cuellar CM, Guido-Jimenez M, Mendez-Martinez R et al 2008). HPV does not replicate in saliva. It requires terminally differentiated squamous epithelial cells to
replicate: it is in these cells that the virus retains a high copy number, where viral genes are
expressed, progeny viruses are produced and shed, in this case into oral fluids. There is as yet no
evidence that saliva acts as an HPV transmission vehicle for oral or genital contamination, though
given the presence of shed epithelium in oral fluids this is quite possible.

4. Finally, it is important to distinguish between a marker or an indicator of disease and a true
risk factor. A risk factor should be directly part of the causal chain of disease, whereas a risk
indicator or risk marker is associated with the disease and may or may not be causal. ( Johnson NW
2003). In carcinogenesis, not all known risk factors have a direct aetiological role: Some may be
contributory or predisposing factors [such as diets poor in antioxidants or trace elements]. Simply
detecting HPV in tumour cells or detecting serum antibody markers of past or present HPV carriage
does not necessarily demonstrate the direct involvement of HPV in the development of a given
tumour (Snijders PJ, van den Brule AJ and Meijer CJ 2003). In our opinion it is premature to draw
conclusions such as “there would be a 4.7% reduction in incidence rate of head and neck cancer in
the United States if oncogenic HPV infection could be prevented”!

5. In conclusion, whilst it makes sense to promote good hygiene in sexual behaviour, as in oral
or food hygiene, for the maintenance of health, we submit that current knowledge does not permit
the quantitative conclusions proffered in this interesting paper.

Yours faithfully,

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