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# HPV detection patterns in young women from the PAPCLEAR longitudinal study: implications for HPV screening policies.

Thomas Beneteau<sup>1,\*</sup>, Soraya Groc<sup>2</sup>, Carmen Lia Murall<sup>3</sup>, Vanina Boué<sup>1</sup>, Baptiste Elie<sup>1</sup>,  
Nicolas Tessandier<sup>4</sup>, Claire Bernat<sup>1,5</sup>, Marine Bonneau<sup>6</sup>, Vincent Foulongne<sup>2</sup>, Christelle Graf<sup>6</sup>,  
Sophie Grasset<sup>1</sup>, Massilva Rahmoun<sup>1</sup>, Michel Segondy<sup>2</sup>, Vincent Tribout<sup>7</sup>, Jacques Reynes<sup>8</sup>,  
Christian Selinger<sup>1,9</sup>, Nathalie Boule<sup>6</sup>, Ignacio G. Bravo<sup>1</sup>, Mircea T. Sofonea<sup>2,10</sup>, Samuel Alizon<sup>1,4,\*</sup>

<sup>1</sup> MIVEGEC, Univ Montpellier, CNRS, IRD, France

<sup>2</sup> PCCEI, Univ Montpellier, Inserm, EFS, Montpellier, France

<sup>3</sup> Department of Biological Sciences, Université de Montréal, Montréal, Canada

<sup>4</sup> Center for Interdisciplinary Research in Biology (CIRB), Collège de France, CNRS, INSERM, Université PSL, Paris, France

<sup>5</sup> Institut de Génomique Fonctionnelle, Université de Montpellier, CNRS, INSERM, Montpellier, France

<sup>6</sup> Department of Obstetrics and Gynaecology, Centre Hospitalier Universitaire de Montpellier, Montpellier, France

<sup>7</sup> Center for Free Information, Screening and Diagnosis (CeGIDD), Centre Hospitalier Universitaire de Montpellier, Montpellier, France

<sup>8</sup> Department of Infectious and Tropical Diseases, Centre Hospitalier Universitaire de Montpellier, Montpellier, France

<sup>9</sup> Swiss Tropical and Public Health Institute, Basel, Switzerland

<sup>10</sup> CHU de Nîmes, Nîmes, France.

\* Corresponding authors: [thomas.beneteau@ird.fr](mailto:thomas.beneteau@ird.fr) and [samuel.alizon@cnrs.fr](mailto:samuel.alizon@cnrs.fr)

## Abstract

**Objectives.** HPV infections are ubiquitous. For most infections, we lose track of the presence of the virus in host in less than three years after the start of infection. The mechanisms regulating the persistence of HPV infection are still partially understood. In this work, we focus on incident HPV detection in young women and we characterise the dynamics of these infections and evaluate the effect of genotype and host socio-economic factors on the duration of HPV detection and time between detection.

**Methods.** We investigated human papillomavirus (HPV) genotype detection patterns in 182 young women in Montpellier, France. We relied on SPF<sub>10</sub>-LiPA25 screening assay for the simultaneous detection of 25 HPV genotypes. We used survival analysis tools with frailty effects to investigate the contribution of viral and host factors to variations in the time of HPV detectability, time of first incident detection, and time before re-detection.

**Results.** Women of the PAPCLEAR cohort experienced numerous positive HPV events, including frequent redetection of the same genotype. We retrieve classical results that HR-genotypes are detected for longer duration than LR-genotypes. HR-genotypes were also more likely to be detected than LR-genotypes during the follow-up. The number of lifetime sexual partner was strongly associated with increased risk of new positive detection while vaccination was related to a lower risk of displaying incident infections. Covariates related to socio-economic difficulties were associated with longer duration of HPV positivity.

**Conclusions.** Young women display numerous event of HPV detection, with frequent codetections of multiple genotypes at the same time and redetection of the same type after periods of no detection. These new detection are almost certainly the result of new acquisition from sexual partners, with little evidence of re-emergence of latent infections. A better characterisation of transient infections might help unveil doubts and misconception on HPV physiopathology, favouring adherence to preventive policies.

## Keywords

Papillomaviruses ; Vaccination ; Epidemiology ; Public Health

28 Human Papillomaviruses (HPV) are the most oncogenic viruses known to infect humans, accounting  
29 for more than 600,000 deaths worldwide each year [1]. They are also one of the most common sexually  
30 transmitted infections, with estimates suggesting that by 45yo, more than 80% of the people are or  
31 have already been infected by an HPV [2]. It is generally accepted that the initial HPV infection is  
32 acquired during the first sexual exposures, with the prevalence peaking after sexual debut, and that the  
33 risk of contracting a new HPV infection increases with the number of sexual partners [3]. HPV presence  
34 generally goes undetected within the first three years, an event generally referred as HPV clearance [4].  
35 This clearance, however, may not necessarily imply true immune clearance. The interpretation of re-  
36 detection events is delicate as they might originate from various sources: true new infection, transient  
37 deposition from a sexual partner, or detection of latent infection [5].

38 Most certainly, HPV detection is a combination of these different pathways. Deciphering the cause  
39 of new HPV detection is still a major challenge. Answering this question is crucial in the optimisation  
40 of future public health policies, to evaluate the effectiveness of catch-up vaccination or organise the age  
41 stratification of vaccination policies.

42 Longitudinal studies are valuable data both in terms of density and length of follow-up. Extracting  
43 full potential of such raw material is challenging and require the use of rigorous statistical tools. In this  
44 work, we used the PAPCLEAR cohort which of samples collected every 8 weeks in 132 young women,  
45 aged 18-25, for which we test the presence of 25 HPV genotypes using the SPF10-LiPA25 technique [6].  
46 In particular, we evaluated viral genotypes and host factors involved with attention to frailty effects at  
47 the patient level and accounting for the censoring in the data to maximize the quality of the analysis.

## 48 **Materials and methods**

### 49 **Study design and participants**

50 The PAPCLEAR cohort has been detailed elsewhere [7]. In short, this monocentric longitudinal study  
51 included 189 women, who were between 18 and 25 years old at inclusion, lived in the area of Montpellier  
52 (France) and reported having at least one new sexual partner over the last 12 months. Women with  
53 a history of HPV-associated pathology were excluded from the study. Pregnant women or women who  
54 were planning a pregnancy within the first year of inclusion were also excluded from the study. A graphic  
55 summarising the inclusion protocol can be found in the Supplementary materials S4. A total of 150 women  
56 were followed longitudinally for up to 2 years between 2016 and 2020. The additional 39 participants  
57 were part of a cross-sectional analysis, that was prematurely suspended due to the pandemic. On-site  
58 visits of infected participants took place every 8 weeks with a gynaecologist or a midwife, who performed a  
59 cervical smear. Except for inclusion, participants were told to avoid sexual contact the day before the visit  
60 took place to avoid unwanted transient sexual deposition from the partner. At inclusion, the participants  
61 self-completed an extensive questionnaire related to demographic, socioeconomic, and behavioural risk  
62 factors. For the next visits, the participants also filled in follow-up questionnaires to notify changes in  
63 their habits. All participants provided written informed consent.

### 64 **Genotyping**

65 We first tested for the presence of alpha papillomaviruses in the cervical smears using the DEIA assay  
66 [8]. DEIA-positive samples were genotyped using the LiPA25 assay, which was chosen for its sensitivity  
67 and can detect up to 25 different HPV genotypes [6]. Among these, we refer to high-risk (HR) genotypes  
68 for HPV16, 18, 31, 33, 35, 39, 45, 51, 52, 56, 58, 59, 66, 68 [9] and to low-risk (LR) for the remaining  
69 12 (HPV6, 11, 34, 40, 42, 43, 44, 53, 54, 70, 74). If the LiPA25 test was negative, the genotype was  
70 determined using the PGMY PCR amplification [10] and Sanger sequencing of the PCR product. If the  
71 sequencing did not yield a clear result, samples were labelled as 'non-typable'.

## 72 **Statistical analyses**

73 All statistical analyses were conducted using R 4.2.2 with additional packages listed in Supplementary  
74 materials A6.

75 We excluded all the women with less than three visits, meaning all the cross-sectional group and  
76 18 participants from the longitudinal group (1 participant quit the study, 4 were seen once, and 13  
77 were seen only twice). All analyses were genotype-specific, with the unit of observation being the HPV  
78 genotype. Therefore, each participant could contribute to multiple observations. Following earlier studies,  
79 we assumed the dynamics of each genotype to be independent at the participant level and between  
80 participants [11]. If not specified, the results were pooled across all genotypes.

81 As used in previous works [12], we defined an HPV genotype as ‘prevalent’ if detected at inclusion.  
82 We also defined a genotype as ‘incident’ if detected at posterior visits but not at inclusion. Patterns of  
83 positive detection separated by only one negative visit, sometimes referred to as ‘intermittent detection’  
84 [12], are handled differently between studies and there does not appear to be consensus on the way to deal  
85 with such data. In the main analysis, we considered the two episodes as separated but we also conducted  
86 analysis with merged intermittent patterns (Supplementary materials A5).

87 Model selection was performed using the corrected Akaike Information Criterion (AICc) as a metric  
88 for the penalised goodness of fit [13] We evaluated the goodness of fit for all sub-models of the maximum  
89 model (i.e. with all the covariates) and estimated the hazard ratios of the Cox regression using a full  
90 averaging procedure on the best models. Thorough details are available in the Supplementary materials  
91 A4. To test for differences between the two populations, we used Fisher’s exact test for qualitative  
92 variables and Wilcoxon-Mann-Whitney’s test for quantitative variables. We displayed the raw  $p$ -values  
93 in the results Tables and Figures. In the following, a  $p$ -value  $< 0.05$  is considered significant.

## 94 Survival analyses

95 For each genotype and each participant, we analysed the duration of HPV detectability, the duration  
96 between HPV-positive episodes, and the time to incident HPV infection. Survival functions for these  
97 quantities were computed using the non-parametric Nelson-Aalen estimator [14, 15]. For the time until the  
98 first incident detection, we fitted a Weibull distribution to the survival function to predict the cumulative  
99 risk of incident detection at 5 years since inclusion (see the Supplementary materials A7 for more details).

100 For a given episode, we defined the time of HPV detectability as the duration between the midpoint at  
101 the start of the episode and the midpoint at the end of the episode. We included all incident episodes, even  
102 the shortest episodes that were only detected during one visit, elsewhere referred to ‘transient’ infections,  
103 but hereafter called ‘singletons’, and the right-censored observations. The latter corresponds to patients  
104 who tested positive for HPV at their last scheduled visit. We also included prevalent episodes whose  
105 start is unknown and for which the duration of HPV detectability is right-censored. Similarly, the time  
106 between consecutive positive episodes was computed as the duration between the midpoint at the end of  
107 the expired episodes and the midpoint at the start of the new episodes. The time until the first incident  
108 infection here corresponds to the time from inclusion to the midpoint at the start of the first incident  
109 detection. Extensive information can be found in Supplementary Methods A3.

110 We checked for differences in HPV detectability and time to first incident detection between HR-  
111 genotypes and LR-genotypes using log-rank tests [16, 17]. To evaluate the effect of non-viral variables,  
112 we used Cox proportional hazards models [18]. We stratified the Cox regression with different baseline  
113 hazard functions for genotypes not detected, first detection, first redetection, and second redetection. We  
114 assumed no interaction between the strata. For all Cox regression analyses, we checked the validity of the  
115 proportional hazards (PH) assumption using Schoenfeld’s residuals [19]. The covariates included in the  
116 analysis are the number of lifetime sexual partners (LTSP), the BMI at baseline, the self-declared ethnic  
117 origin (Caucasian vs. non-caucasian or mixed-origin), the HPV vaccination status, the sexual affinity,  
118 the use of condom or contraceptive pills, an indicator of financial difficulties (participant had to decline

119 medical care because of financial reasons), the number of years between inclusion and first menstruation,  
120 the number of years between inclusion and first sexual intercourse and the smoking stats (past, current  
121 or never). The numbers for each category can be found in Table 1.

122 We considered here that the unit of observation was the HPV genotype at the patient level. Thus as  
123 one participant would experience codetection of multiple genotypes, this could induce some correlations  
124 between the observations. To account for correlations between observations of the same cluster (i.e. a  
125 participant), we add shared frailty effects at the patient level in the Cox regression [20]. We tested for the  
126 relevance of adding the frailty at the patient level using a likelihood ratio test with one degree of freedom  
127 between the two models (with and without the frailty effect).

## 128 Results

### 129 Descriptive analysis

130 The 150 participants of the PAPCLEAR cohort came for 6 visits on average (Poisson 95% CI: 5.63 - 6.43).  
131 For the 132 women included in the analysis, the follow-up duration was on average 311 days (IQR: 182 -  
132 431), this accounted for a total of 1543 months of follow-up. The PAPCLEAR participants included in  
133 the analysis were on average aged 21.3yo (IQR: 20 - 23) at inclusion and around half of them (62/132)  
134 were vaccinated against HPV (56 with Gardasil and 6 with Cervarix). Baseline characteristics for the 132  
135 women included can be found in Table 1.

136 In about 74% of the women included in the analysis (98/132), we detected at least one episode during  
137 their follow-up and 47% (62/132) experienced codetections (i.e. the simultaneous detections by more than  
138 one genotype). Overall, we detected 342 distinct episodes, 186 incident (including 137 first detections, 44  
139 redetections and 5 second redetections) and 156 prevalent, including 211 from HR types and 114 from LR  
140 types. For 17 episodes, we could not determine the genotype detected. The three most frequent detected  
141 types in descending order were HPV51, HPV53, and HPV66, in agreement with previous results on the  
142 PAPCLEAR cohort [7]. A total of 83 (62.9%) participants were positively detected for at least one HPV



143 genotype.

144 An average of 2.6 (Poisson 95% CI: 2.32-2.88) episodes per woman were detected during the whole  
145 follow-up, which yielded an average attack rate of 2.99 HPV episodes detected per person-year.

#### 146 **Detection of first incident HPV episode**

147 Overall, we detected 137 first incident detection for all detectable genotypes and all participants. At  
148 one year, we estimated a 4.80% (log-log 95% CI: 3.99 - 5.77) cumulative proportion of first incident  
149 HPV detection pooled across all genotypes. After two years of follow-up, the proportion of first incident  
150 infection detection increased to 7.26% (log-log 95% CI: 5.84 - 9.02). To assess the variation after 5 years,  
151 we used the Weibull fit and predicted the proportion to reach 16.56% (95% CI: 7.37 - 29.73). Information  
152 regarding the Weibull fit can be found in the Supplementary materials A7.

153 We assessed the rate of incident detection by oncogenic risk. We found that HR-HPV were more  
154 likely to be detected than LR-HPV over the whole follow-up (log-rank p-value < 0.01). We, however,  
155 lacked statistical power to verify that the difference in survival functions between HR genotypes and LR  
156 genotypes was consistent for redetection or second redetection.

#### 157 **Risk factors for the time between consecutive detection**

158 In addition to the 137 observed first incident detection (3271 right-censored), we detected 156 preva-  
159 lent episodes, 44 observed redetection (213 right-censored) and 5 second redetection (36 right-censored).  
160 Among the redetection, 33 consecutive episodes were only separated by one negative visit, pattern else-  
161 where referred to as ‘intermittent’ detection[12]. Compared to participants reporting 1 or 2 LTSP, women  
162 who reported 3-10 LTSP had increased risk of experiencing new detection(hazard ratio: 2.40 ; 95% CI:1.07  
163 - 5.39), first incident or redetection. We observed a similar trend for participants reporting more than 10  
164 LTSP, compared to the reference of 1 or 2 LTSP. However, we lacked statistical power to report significant  
165 association (hazard ratio: 2.15 ; 95% CI:0.94 - 4.93). Merging intermittent patterns (Figure S2) yielded  
166 similar results, this time with a significant association for the group reporting more than 10 LTSP. We

Table 1: **Baseline description of the PAPCLEAR cohort for participants included in the analysis (> 2 visits).** Except for the vaccine used not included in the analysis, the first level display for all categorical variables is the reference level used in the Cox analysis. Missing observations were removed from the analysis.

Covariates	States/mean [IQR]	# women	% women
Age at inclusion	21.27 [20 - 24]	132	100
Age of first menstruation	12.85 [12 - 14]	131	99.24
Years between 1st menstruation and inclusion	8.42 [7 - 10]	131	99.24
Age of first sexual intercourse	16.39 [15 - 17]	132	100
Years between 1st intercourse and inclusion	4.89 [3 - 7]	132	100
Vaccination	Unvaccinated	66	50.00
	Vaccinated	66	50.00
Vaccine used	Cervarix	6	9.09
	Gardasil	56	84.18
	Non-specified	4	6.06
Self-declared ethnicity	Mixed or other	27	20.45
	Caucasian	105	79.55
Self-declared sexual affinity	Bi-/Homosexual	12	9.09
	Heterosexual	120	90.90
Smoking	Never	61	46.21
	Past	19	14.39
	Current	52	39.39
Contraceptive pills †	Not using	64	48.48
	User	68	51.51
Male condoms	Not using	56	42.42
	User	76	57.57
Number of lifetime sexual partner	1;2	20	15.15
	3;10	63	47.72
	11+	48	36.36
	missing	1	0.76
Financial difficulties *	No experience	117	88.64
	Experienced in the last 12mo	15	11.36

† emergency pills not included

\* defined as a participant who declined medical care because of financial reasons

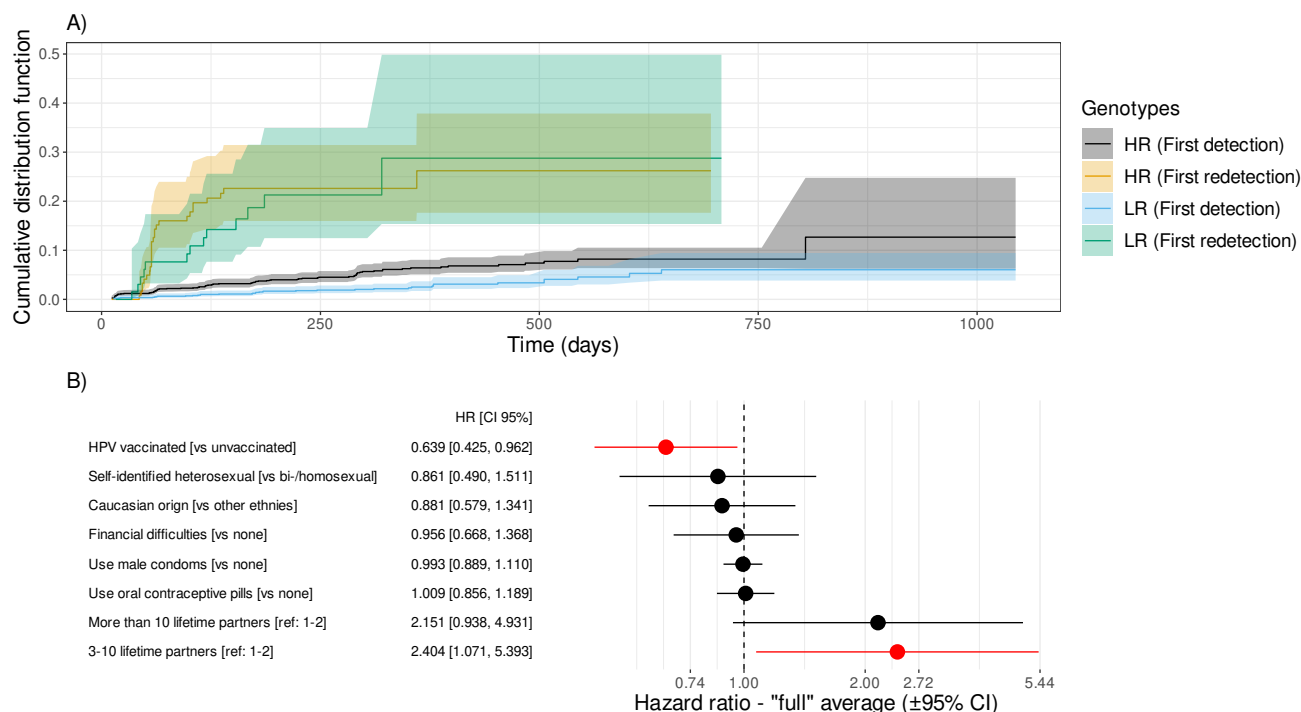


Figure 1: **Cumulative distribution functions for the time to first incident detection and time to first genotype redetection stratified by HR/LR genotypes and effects of host covariates on these estimates.** A) Cumulative distribution function (CDF) of the time to first incident HPV detection since inclusion and the time to the first redetection, stratified by HPV genotype status (HR and LR). B) Hazard ratio for the best models selected by Cox regression with frailty at the patient level. Significant covariates are in red and hazard ratios greater than 1 indicate the covariate is associated with an increased risk of detection, hence lower duration between consecutive episodes.

167 also found that vaccinated participants were less likely to display new incident detection or redetection  
 168 compared to unvaccinated participants (hazard ratio: 0.64 ; 95% CI: 0.43-0.96). Thorough results of the  
 169 Cox analysis for the time between consecutive episodes are displayed in Figure 1.

## 170 Loss of HPV detection

171 On the total of 342 detected episodes, 156 were prevalent HPV detection and for 40 episodes we did not  
 172 observe the loss of detectability. For 17 episodes, the participants entered positive to a genotype and left  
 173 the follow-up still positive for that same genotype, without any negative visit in-between. The majority  
 174 of the episodes were positive for only one visit (198/342 ; 57.9%), but a significant proportion of them are  
 175 censored observations (86/198 ; 43.4%) and thus potentially just a glimpse of a longer event. We estimated  
 176 a median period of HPV detectability of 113 days (log-log 95% CI: 92.5 - 124). Our results suggest that

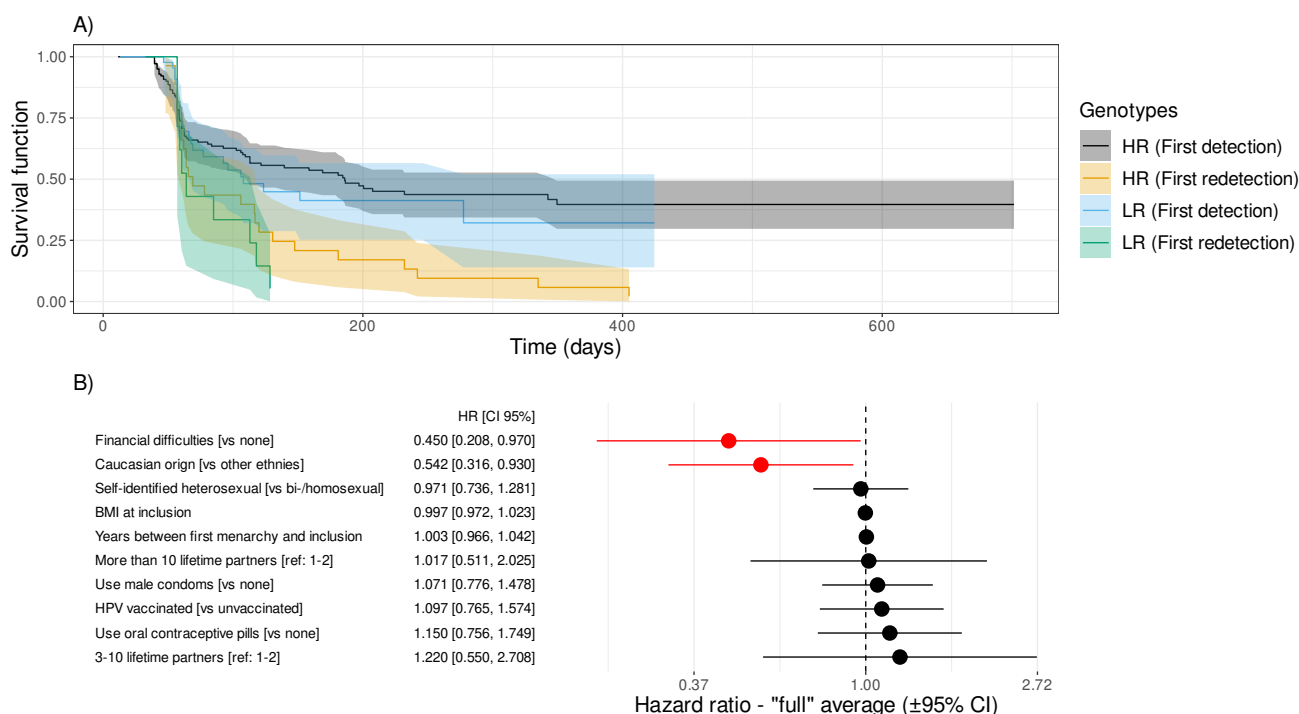


Figure 2: **Survival function for the time of HPV detectability stratified by HR/LR genotypes and effects of host covariates on this estimate.** A) Survival functions stratified by the genotype (HR/LR) for the time to loss of HPV detection. B) Hazard ratios for the host factors. Significant factors are in red and a hazard ratio lower than one indicates that the trait is associated with a decreased rate of loss of HPV DNA detection, hence longer survival functions. The reference level is indicated in the bracket for the qualitative variables (see Methods for details).

177 around 23.5% (log-log 95% CI: 16.5 - 31.4) of the HPV episodes were still detectable after 700 day of  
 178 follow-up. We found that HR-HPV types were detected significantly longer than LR-HPV infections  
 179 (log-rank p-value < 0.05), the survival functions are displayed in Figure 2. The median duration of  
 180 detectability was 130 days (log -log 95% CI 106 - 186) for HR genotypes and 96 days (log-log 95% CI 67.5  
 181 - 113) for LR genotypes.

182 Finally, we investigated the effect of key host factors (listed in Table 1) on the duration of HPV  
 183 detectability using LiPA assays. Our analysis showed that HPV was detected for a significantly longer  
 184 duration in participants who experienced financial difficulties (defined as a participant who declined  
 185 medical care because of financial reasons) in the last 12mo before inclusion compared to participants who  
 186 did not experience it (Hazard ratio: 0.45 ; 95% CI: 0.21 - 0.97). Infections were also detected longer in  
 187 participants who identified themselves solely as 'Caucasians' (Hazard ratio: 0.54 ; 95% CI: 0.32 - 0.96)

188 compared to participants who identified themselves as non-Caucasian or mixed-origin (Figure 2). These  
189 results were similar when merging intermittent patterns (Figure S3).

## 190 Discussion

191 In this work, we analysed the HPV detection patterns of 132 young women from the PAPCLEAR cohort.  
192 We estimated a cumulative probability of first incident HPV detection since baseline, pooled across all  
193 genotypes, of 4.80% (log-log 95% CI: 3.99 - 5.77) at one year and predicted it to reach 16.56% (95% CI:  
194 7.37 - 29.73) at five year. While we used convenient denominations such as ‘first incident detection’ or  
195 ‘first redetection’ following previous works, these expressions surely not bare the same relevance in terms  
196 of natural history. It is very unlikely for most of the investigated participants that a first detection during  
197 the follow-up corresponds to a true first exposure, only 11.36% participants declared having had their first  
198 sexual partner in the last 12 months. Besides, these definitions are dependent of the sampling frequency,  
199 as the probability of documenting a short period between redetections increases with the sampling rate.  
200 Thus, it is not straightforward to compare our results with other studies. Our results for first detection  
201 are very similar to results for first redetection but quite discordant with estimates for first incident detection  
202 from other studies [12]. Those differences might first come from the difference in the cohort design, as  
203 the sampling rate for the Ludwig-McGill cohort was about every 6 months. Besides, the two populations  
204 were quite different. Participants here are all between 18-25 years old at inclusion. In the latter, there  
205 is a wider age diversity among the women, with around 80% of the women being older than 25 years  
206 old. Sexual activity is negatively correlated with age after sexual debut, thus our population might be  
207 more exposed to HPV due to increased sexual activity [21]. Additionally, the Ludwig-McGill cohort was  
208 sampled from low-income families from Brazil, while we included women without income criteria.

209 We found that the participants experienced numerous detected episodes (2.99 per women-year), most  
210 of them being positively detected for only one visit (198/374 singletons, 86/198 censored). In a quarter  
211 of the participants included in the analysis (34/132), no alphapapillomaviruses was detected, while for 18  
212 women we detected more than 5 episodes during the follow-up. Redetection, were not uncommon as in  
213 about a third of women displaying at least one HPV positive visit we detected redetections of the same  
214 genotype. The frequency of codetections is similarly high (47%) and is consistent with previous studies

215 [22].

216 To date, except for some specific populations (e.g. abstinent women [23]), it is quite difficult to settle  
217 on the origin of new HPV detection in humans. In our cohort, the number of lifetime partners was  
218 negatively associated with the duration between episodes. We found that in participants reporting a  
219 number of lifetime partners higher than 3, the time between episodes was significantly shorter than for  
220 women with 1 or 2 reported LTSP at inclusion, with little difference between participants reporting 3 to 10  
221 LTSP and those reporting more than 11 LTSP. The number of LTSP was not associated with the number  
222 of years between first intercourse and inclusion. Besides, women reporting a higher number of LTSP  
223 at inclusion were also more likely to report intercourse with new partner during the follow-up. Taken  
224 together, our results suggest that new detection and redetection observed here are more likely to be new  
225 acquisition than re-emergence of latent infection. Additionally, we recall that only women who declared  
226 having sex with a new partner in the last 12 months were included in the cohort [7]. It was noted elsewhere  
227 that in the setting of new sexual partners, true incident infection was the preferential explanation [24, 25].  
228 Compared to unvaccinated participants were less at risk of displaying incident infections. These results  
229 are consistent with observations in a dozen country [26].

230 We found that HR-HPV types were more likely to be detected for a longer period than LR-HPV types,  
231 which corroborates earlier studies [27]. Conversely, we found that the time between HPV positive events  
232 was shorter for HR-HPV types compared to LR-HPV types, consistent with other work [22].

233 The mean duration of HPV detectability was globally lower than previous studies [12, 22, 23, 27]. This  
234 can be partially explained by the difference in sampling rates with compared to studies (8 weeks compared  
235 to 6 months) and the inclusion of all positive episodes, including the singletons, sometimes excluded from  
236 analysis [23]. Participants that experienced financial difficulties (defined as a participant who declined  
237 medical care because of financial reasons) in past 12 months prior to inclusion displayed longer periods  
238 of HPV detectability compared to participants that did not declared suffering from financial struggles.  
239 People in situations of poverty generally tend to live in areas with low medical coverage, thus also limiting

240 their access to medical care [28]. While there was no significant difference in vaccination uptake between  
241 participants who faced financial difficulties and those who did not, taken together, our results suggest that  
242 people with financial difficulties might be less prone to seek medical guidance, especially since specialists  
243 are not fully reimbursed in France, thus putting them more at risk of genital infections and complications.  
244 Our results also suggest that self-declared Caucasian participants experienced longer periods of HPV  
245 detection. However, we lacked information to assess if that trend originated from genetic origin or socio-  
246 demographic/behavioural differences between the two groups. Besides, our population is relatively limited  
247 in number (132 women, 27 mixed origin or non-Caucasian origin, 105 Caucasian origin) and restricted to  
248 a specific region in France. It does not reflect the French population diversity, and thus might just be the  
249 results of selection bias.

250 Clarifying the dynamic of HPV infection, especially regarding the distinction between re-detection  
251 and new acquisition is decisive to inform public health policies. Efficient screening policies and prevention  
252 have been implemented to limit progression towards cancer with good compliance to these measures  
253 [29]. While most HPV infections are generally benign, testing positive during HPV screening can cause  
254 psychological stress and anxiety [30], especially if self-sampling becomes widespread [31].

255 We believe a better characterisation of HPV infections, especially regarding the link between infection  
256 status and detection data, will help unveil doubts and misconception on HPV physiopathology, favouring  
257 adherence to preventive measures [32].

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## 267 **Declaration of Competing Interest**

268 J. R. reports personal fees from Gilead (consulting and payment or honoraria for lectures, presentations,  
269 speaker’s bureaus, manuscript writing, or educational events), Janssen (payment or honoraria for lec-  
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276 any conflict of interest or personal relationships that could have appeared to influence the work reported  
277 in this paper.

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## 391 Supplementary Materials

### 392 A1 Ethics

393 The PAPCLEAR trial was promoted by the Centre Hospitalier Universitaire de Montpellier and ap-  
 394 proved by the *Comité de Protection des Personnes (CPP) Sud Méditerranée I* on 11 May 2016 (CPP  
 395 number 16 42, reference number ID RCB 2016A00712-49); by the *Comité Consultatif sur le Traite-  
 396 ment de l'Information en matière de Recherche dans le domaine de la Santé* on 12 July 2016 (reference  
 397 number 16.504); and by the *Commission Nationale Informatique et Libertés* on 16 December 2016 (ref-  
 398 erence number MMS/ABD/AR1612278, decision number DR-2016488). This trial was authorised by  
 399 the *Agence Nationale de Sécurité du Médicament et des Produits de Santé* on 20 July 2016 (reference  
 400 20160072000007). The ClinicalTrials.gov identifier is NCT02946346. All participants provided written  
 401 informed consent.

### 402 A2 Protocol of PAPCLEAR study

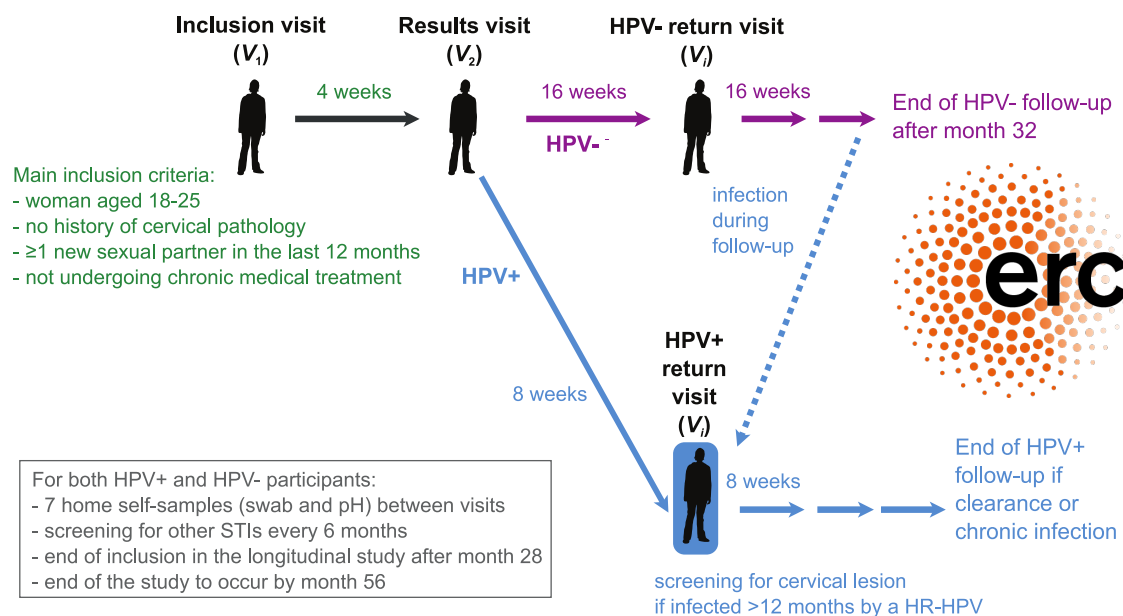


Figure S1: General structure of the PAPCLEAR study. [7]

### 403 **A3 Defining events and durations**

404 Results from the DEIA and LiPA25 assays yielded dated binary vectors. For each infectious event, we only  
405 know the intervals during which the infection started and ended, which means the data is ‘doubly interval  
406 censored’ and usually cumbersome to analyse [33]. To simplify the problem, we computed duration using  
407 the conventional midpoint methodology. For this, we defined the start of an infection as the midpoint  
408 between the last negative test before and the first positive test of the infection. Likewise, we defined the  
409 end of an infection as the midpoint between the last positive test of the infection and the first negative  
410 test after the infection). For incomplete data, we assume the start to be at inclusion for left-censored  
411 observation and we assumed the end to be at last visit for right-censored observation. The bias associated  
412 with this simpler method is expected to be limited since our sampling scheme is regular and short-spaced  
413 [34].

414 To study the time to HPV infection clearance, we defined as an ‘event’ or ‘episode’ a series of at least  
415 one positive LiPA25 detection for a given HPV type and a given participant. During the follow-up, we  
416 often detected several events per participant (sometimes even by the same genotype). We assumed that  
417 two consecutive episodes were independent even if only separated by one negative visit. Such patterns,  
418 also called intermittent [12], are sometimes merged to form a longer episode instead of two separate  
419 entities [23]. We evaluated the changes in the estimates using this methodology below XXXX.

420 To estimate the time of HPV detectability, i.e. the time of positive HPV detection, we computed the  
421 duration between the midpoint at the start of an infection and the midpoint at the end of the infection. If  
422 one or both of the endpoints were censored, we assumed the duration to be right-censored. We assumed  
423 the events to be independent [11] and, therefore, defined the time between episodes to be independent  
424 events. For the time to first incident infection, we excluded prevalent infection and computed the time  
425 from inclusion to the midpoint at start of first incident detection for a genotype and a participant. If the  
426 genotype is not detected during follow-up, we used a right-censored observation whose duration equals  
427 the time of follow-up of the participant. When analysing the time between positive episodes, we included



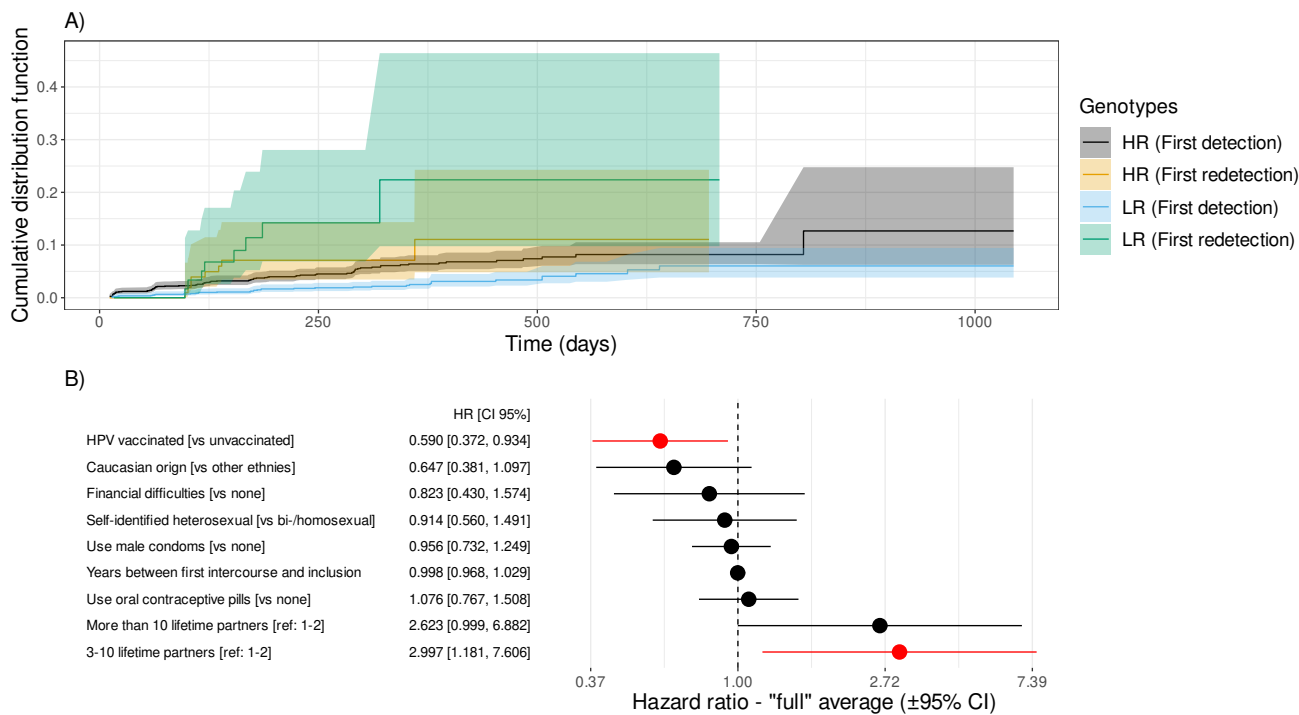
428 all events and computed the time as the duration between the midpoint at start of expired episodes and  
429 the midpoint at start of the new episodes. There is in general, a lower number of data of redetection than  
430 expected because some participant were still positive for a genotype at end of follow-up, thus preventing  
431 us from computing a time of redetection. In both cases, the cumulative distribution functions (CDF) or  
432 survival functions were computed using the Nelson-Aalen estimator of the cumulative hazard rate function  
433 [14, 15, 35].

## 434 **A4 Model comparison**

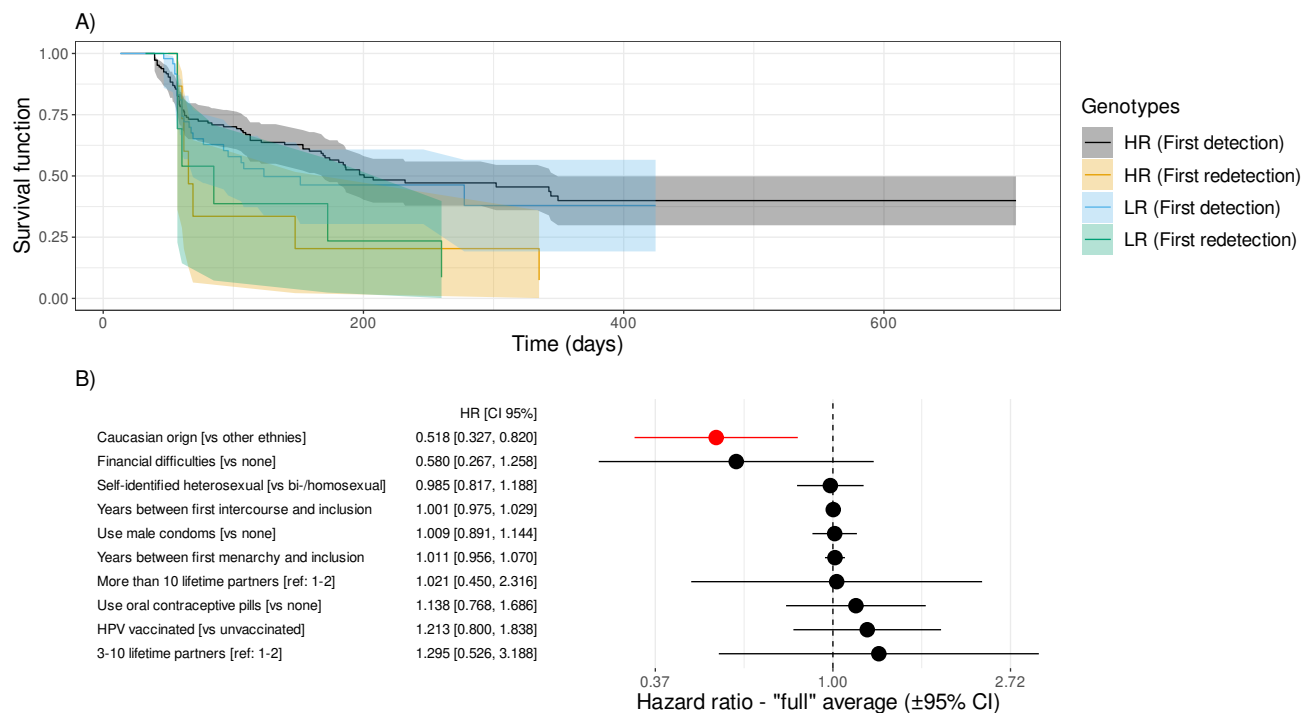
435 We compared the models using the corrected Akaike Information Criterion (AICc) as a metric for the  
436 penalised goodness of fit [13]. Briefly, we first generated the maximum model with all the variables chosen  
437 for the Cox regression and then performed the model selection by subsetting all possible combinations  
438 from the maximum model and evaluating their respective AICc. We kept the models with an AICc smaller  
439 than the minimum AICc+2, following standard practice [36]. We then averaged the coefficients of the  
440 remaining models using a full averaging procedure to avoid artificial departure from 0. This was necessary  
441 because we averaged on all the selected models, not just on the ones with the variable whose coefficient  
442 was computed [37]. Finally, we computed the hazard ratio by taking the exponential of these averaged  
443 coefficients.

## 444 **A5 Merging intermittent patterns**

445 Following previous notations, intermittent patterns corresponds to successive positive HPV detection  
446 episodes separated only by one negative visit. Merging intermittent patterns modifies the data used for  
447 analysis, diminishing the number of events, making them last longer in average. In total, we detect 33  
448 intermittent patterns. Merging the patterns decreased the number of positive detectable events by the  
449 same amount. However, it did not change much the results of the Cox regression. While the degree of  
450 significance varies between the two datasets, the same trends were observed between the two cases.



**Figure S2: Cumulative distribution functions for the time to first incident detection and time to first genotype redetection stratified by HR/LR genotypes and effects of host covariates on these estimates for merged intermittent patterns.** A) Cumulative distribution function (CDF) of the time to first incident HPV detection since inclusion and the time to the first redetection, stratified by HPV genotype status (HR and LR). B) Hazard ratio for the best models selected by Cox regression with frailty at the patient level. Significant covariates are in red and hazard ratios greater than 1 indicate the covariate is associated with a increased risk of detection, hence lower duration between consecutive episodes.



**Figure S3: Survival function for the time of HPV detectability stratified by HR/LR genotypes and effects of host covariates on this estimate for merged intermittent patterns.** A) Survival functions stratified by the genotype (HR/LR) for the time to loss of HPV detection. B) Hazard ratios for the host factors. Significant factors are in red and a hazard ratio lower than one indicates that the trait is associated with an decreased rate of loss of HPV DNA detection, hence longer survival functions. The reference level is indicated in the bracket for the qualitative variables (see Methods for details).

## 451 **A6 R packages**

- 452 – SURVIVAL: non-parametric and parametric estimators of the survival function and Cox regression
- 453 [38] ; version 3.5-3.
- 454 – MUMIN: model selection and model averaging [39] ; version 1.46.0.
- 455 – COXME: adding frailty effects to the hazard function as a centred Gaussian distribution [40] ; version
- 456 2.2-17.

## 457 **A7 Graphical Weibull fit**

Let  $\lambda > 0$  be the scale parameter and  $k > 0$  be the shape parameter, for all  $t \in \mathcal{R}^+$ , we can define the survival function of the Weibull distribution as:

$$S(t) = e^{-\left(\frac{t}{\lambda}\right)^k} \Leftrightarrow \log(-\log(S(t))) = k(\log(t) - \log(\lambda)) \quad (\text{S1})$$

458 Thus using the  $\log(-\log(\cdot))$  transformation of the survival function, estimated using non-parametric  
459 estimators like Nelson-Aalen or Kaplan-Meier, and plotting it versus the natural logarithm of the event  
460 times, we can assess if a Weibull distribution is an appropriate model to describe the data by evaluating  
461 the goodness of the fit as a linear model [41]. Clearly, for the time to first incident detection pooled across  
462 all genotypes, and for both HR genotypes and LR genotypes grouping, the Weibull was relevant (panel  
463 A in Figure S4). However, for the time to loss of HPV detection, we see a clear non-linear trend between  
464 the  $\log(-\log(\cdot))$  transformation of the survival function and the  $\log(\text{time})$  (panel B in Figure S4), thus  
465 discouraging us for trying to fit a Weibull distributions to this data. The parameter estimates of the  
466 Weibull distribution for the time to first incident detection are displayed in Table S1.

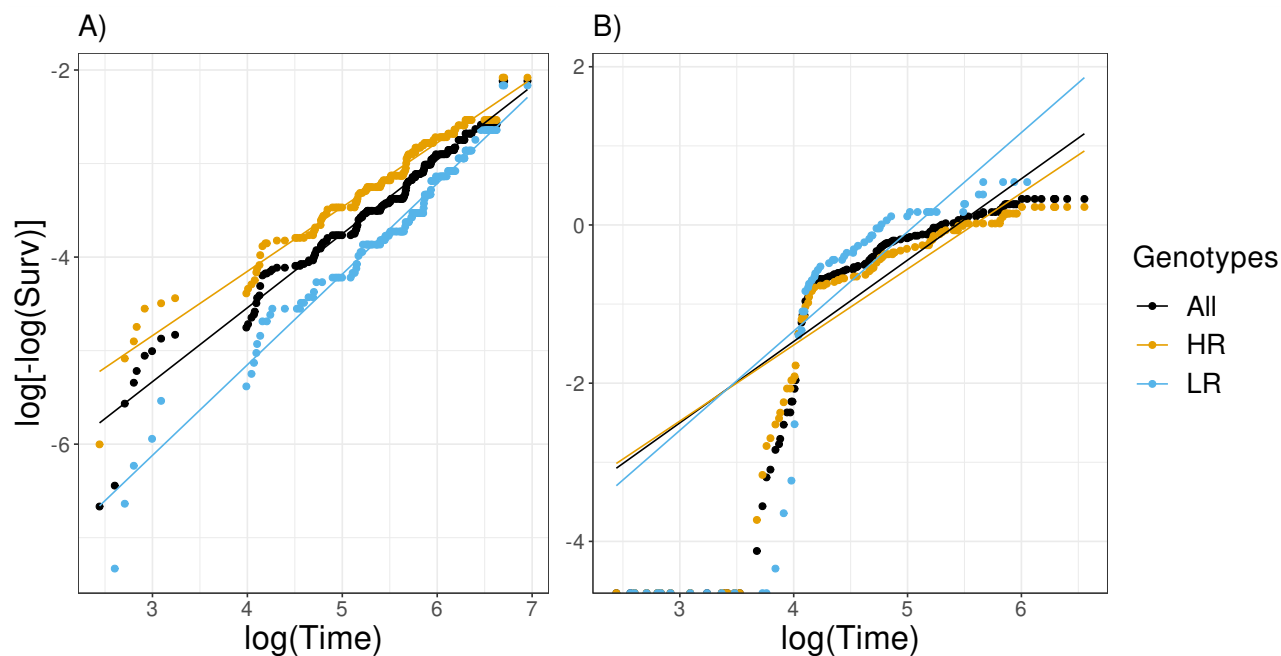


Figure S4: **Graphical assessment for the goodness of Weibull fit.** On panel A) we displayed the  $\log(-\log(\cdot))$  transformation of the survival function for the time to first incident detection versus the  $\log(\text{Time})$  and on panel B) the same transformation for the survival functions of the time to loss of HPV detection. For panel A) the linear fit is acceptable while for panel B) there is a clear non-linear trend.

Table S1: **Estimates for the Weibull parameters (shape and scale) for the time to first incident detection.**

	scale ( $\lambda$ )	shape ( $k$ )
All genotypes	$1.43 [0.79; 2.58] \times 10^4$	0.832 [0.713; 0.970]
HR genotypes	$1.12 [0.63; 2.01] \times 10^4$	0.832 [0.714; 0.971]
LR genotypes	$1.93 [1.27; 2.94] \times 10^4$	0.832 [0.714; 0.971]