This mass was a paraganglioma. Dopamine is metabolized by catechol-O-methyltransferase into methoxytyramine within head and neck paragangliomas (HNPGL). Urinary dopamine derives from renal extraction and decarboxylation of circulating L-dopa (1). Sixty-nine percent of HNPGL are benign, and 5%–16% secrete catecholamines. Isolated secretion of methoxytyramine is limited to 8%–13% of HNPGL (2, 3). Unlike norepinephrine- and epinephrine-secreting tumors, dopamine-secreting tumors lack symptoms of catecholamine excess. Methoxytyramine is the best biochemical marker to monitor the relapse of dopamine-producing HNPGL.

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References


US Preventive Services Task Force HIV Screening Guidelines: A Laboratory Perspective

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The US Preventive Services Task Force (USPSTF)3 released guidelines that assign a grade A recommendation for screening the general population for HIV (1) (http://www.uspreventiveservicestaskforce.org). The CDC first published HIV testing guidelines that advocated for routine HIV screening in 2006. Shifting the HIV screening strategy from targeting high-risk populations to “universal” screening transformed the paradigm and was controversial at the time. The CDC recommended that testing be conducted under opt-out protocols and eliminated aspects that were perceived as cumbersome barriers to testing, such as pretest counseling and separate consent forms. The change in guidelines was prompted by evidence that 20%–25% of individuals infected with HIV are unaware of their status (2). Undiagnosed individuals cannot benefit from treatment and continue to contribute to disease transmission.

Since then many professional organizations, including the American College of Physicians and the Infectious Diseases Society of America, have expressed support for routine HIV testing. At first glance this recent move by the USPSTF appears to be just the latest and perhaps an overdue endorsement of the CDC recommendations. However, it is believed that the USPSTF policy change will have a significant impact on making the 2006 CDC guidelines a reality, because private and state health plans use this organization’s recommendations to determine reimbursement and define local policy on HIV testing. Furthermore, in the context of the Affordable Care Act (ACA), a grade A recommendation for preventive services mandates that health plans, both private and public, will provide coverage without out-of-pocket expenses or copayments for the patient. Practical considerations such as reim-

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Nonstandard abbreviations: USPSTF, US Preventive Services Task Force; ACA, Affordable Care Act.
bursement have a profound effect on the extent to which guidelines are adopted in clinical practice. Removing financial barriers for screening is a critical first step. Equally important is the projection that because of the ACA the number of uninsured persons will be reduced and therefore patients diagnosed with HIV will have better access to treatment.

The new recommendations are undoubtedly going to facilitate HIV screening and increase both the number of individuals screened for HIV infection and the number of persons diagnosed with HIV infection. Laboratories will need to expand their capacity to accommodate the anticipated rise in demand for all laboratory tests associated with HIV screening, diagnosis, and monitoring. There are several point-of-care tests currently available and widely used for HIV screening, including the first over-the-counter, rapid HIV test for home use. Screening immunoassays can also be performed on a number of automated platforms with extensive test menus, which can be easily integrated into the laboratory of a primary care facility. In addition, a new CDC HIV diagnostic algorithm has been proposed that replaces confirmation of HIV infection by Western blot with an assay that has a rapid test format and can be easily performed in a nonspecialized laboratory. Technological advances, combined with novel HIV diagnostic algorithms, adequate reimbursement, and increased volume, are likely to further shift HIV testing to hospital laboratories. Diagnosis through universal screening is poised to become the accepted standard of care and be integrated into routine clinical laboratory practice.

Universal screening that is available at no cost to the patient and is accessible and rapid will likely lead to increased acceptance of testing by individuals. The fact remains that despite the 2006 CDC recommendations, the CDC reported that 41% of individuals who were diagnosed with HIV between 2006 and 2009 had no history of previous HIV testing (3). The hope is that the recent developments in HIV screening will translate into substantial progress in identifying HIV infected persons and the effort to reduce HIV disease transmission. Accurate and timely diagnosis by the laboratory will play a key role in this endeavor.

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