AETC AIDS Education & Training Center Program Southeast

Beyond Love: A Review of STI and HIV Testing Guidelines

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Agenda

- Epidemiology/Sexual history taking
- “Good” screening tests
- HIV screening recommendations
- STI screening recommendations
- Summary/Questions

The STATE of STDs in the United States

in 2016

STDS TIGHTEN THEIR GRIP ON THE NATION'S HEALTH AS RATES INCREASE FOR A THIRD YEAR

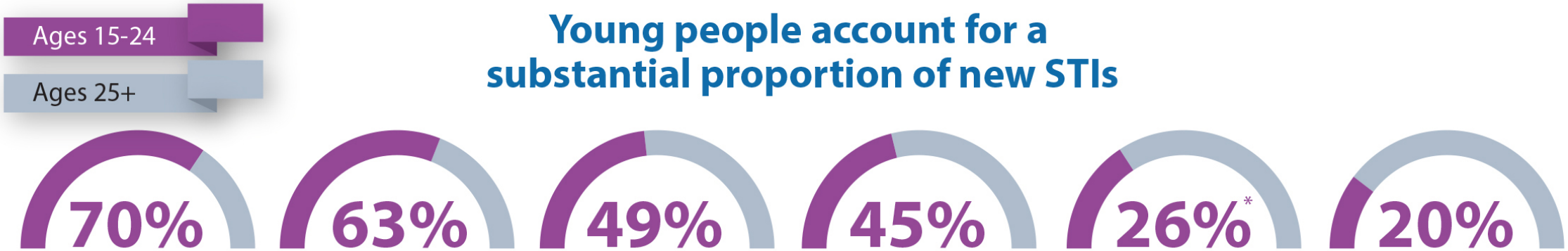
1.59 million
CASES OF CHLAMYDIA
4.7% increase since 2015

468,514
CASES OF GONORRHEA
18.5% increase since 2015

27,814
CASES OF SYPHILIS
17.6% increase since 2015

LEARN MORE AT: www.cdc.gov/std/

Young people account for a substantial proportion of new STIs



Case # 1 – James is a 29 yo male who comes to your clinic for a sexual health evaluation. What is the best way to start the sexual history?

A. Hi James, I'm Dr. _____. How often do you engage in anal sex?

B. Do you think you are at risk for STIs or HIV?

C. I'm going to ask you some sensitive questions now…

D. When was the last time you had sex?

E. You feel comfortable talking about your sexual health now?

Acknowledgement of Clinical Context

- 15 minute visit
- Building trust quickly
- Competing clinical priorities
- More screening required
- Interruptions
- “BY THE WAY…”

HOW DO YOU BEGIN THE SEXUAL HEALTH/HISTORY CONVERSATION?

DISCUSSING SEXUAL HISTORY

- Leave your baggage at home
- Create a comfortable environment
- Ask general questions first
- Normalize the process
- Don’t judge – FIX YOUR FACE!!
- Try disclaimers:
  - “I’m gonna get in your business now”
  - “I need to ask some very personal questions”
  - “These are standard questions we ask everyone”
  - “If you feel uncomfortable”

Be careful what you ask…

SEXUAL BEHAVIOR – 5 key questions

1. Are you currently having sex? With women, men or both?
2. How many sexual partners have you had in the past 3 months?
3. Are you in a relationship currently?
4. How often do you use condoms with ____ sex? Always, sometimes, never?
5. Any other sexual partners?
6. Ask about body parts and orifices – if transgender or gender non-conforming

*CONTINUE TO REVISIST FOR BOTH HIV+ AND HIV-

SEXUAL IDENTITY VS. BEHAVIOR

SEXUAL IDENTITY VS. BEHAVIOR

So what's the difference?

- **Sexual identity** – how one thinks of oneself in terms of to whom one is sexually or romantically attracted
  - Heterosexual, "gay," bisexual, asexual, etc.
- **Sexual behavior** – what you DO
  - Oral, vaginal, anal
  - Insertive, receptive

SEXUAL IDENTITY VS. BEHAVIOR

Focus on behaviors, not identities

- Do you engage in oral sex, vaginal sex, anal sex?
- For MSM: Are you a “Top” (insertive), ”Bottom” (receptive) or “Versatile”?
- What prevention strategies do you use?
- Toys? Lubricants? Enemas? Douching?

Provider Barriers to Conducting a Risk Assessment/Sexual History

- Inexperience or discomfort asking questions
- Limited time is available
- Discomfort responding to issues that arise
- Incorrect assumptions about sexual behavior and risk
- Patient perception of stigma from a medical care provider
- Fear of offending the patient

The Five “Ps” - CDC

Sexual Risk Assessment[2, 3]

The Centers for Disease Control and Prevention (CDC) has developed a simple categorization of sexual history questions that may help providers, or other members of the clinical care team, remember which topics to cover. These are called the Five P's:

What's the Missing "P"?

PLEASURE

Risk group history

- History of the “4 H’s”
  - Homosexuals
  - Hemophiliacs
  - Heroin users (IV)
  - Haitians
- Target on who you are, not what you do
- Risk for worsening stigma
- Balance of acknowledging current EPI and sensitivity/stigma

SHIFT FOCUS

1. Assess safer sex practices
2. Describe geographic risk
3. Discuss sexual networks
4. Offer help, not judgment

Potential affirming approaches

1. Making sexual history taking normalized
2. Including other medical staff members
3. Spreading the responsibility
4. Institutional help: Fliers, videos for patients
5. Patient empowerment

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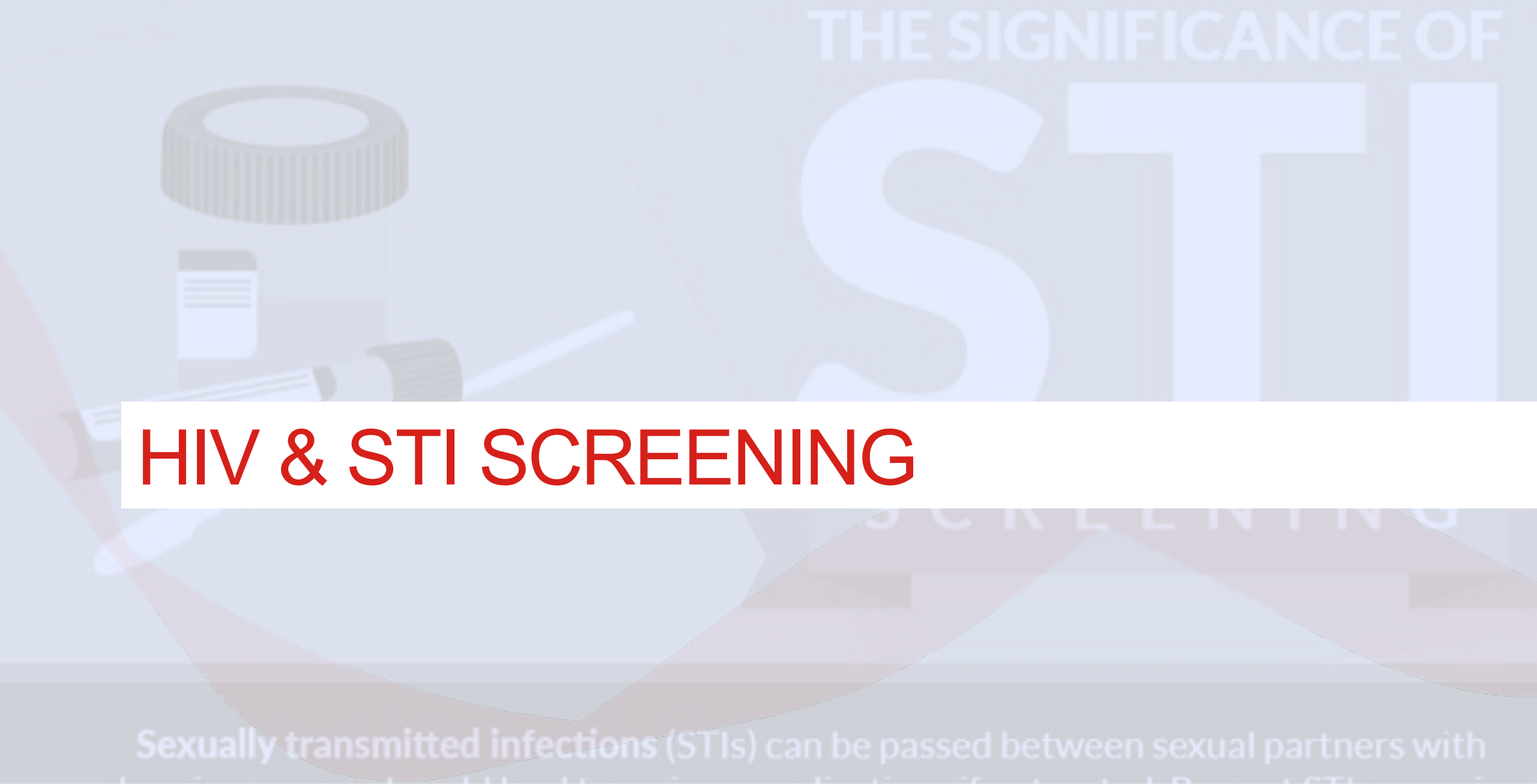
The take home on sexual history taking?

- Sexual history-taking is an art form
- There is not “right way” to do it
- What you ask and how you ask it can establish trust
- The only bad question is the question not asked



HIV & STI SCREENING

Case # 2 – Diane is a 37 yo woman who is single, sexually active with a steady boyfriend, but occasionally has sex with women. She uses condoms "sometimes," and comes to you for a "full" STI check – she is asymptomatic. What do you tell her?

A. What sexual behaviors have you done that concern you about STIs?
B. Don't worry, your risk for HIV is really low – you have a steady boyfriend and you can't get HIV from women!
C. Send her for the following tests: HIV Ag/Ab, RPR, urine GC/CT/trich
D. Send her for the following tests: HIV Ag/Ab, RPR, urine GC/CT/trich, HSV Abs ½
E. A & C

What makes a good screening test?

- Reasonably priced
- Relatively non-invasive
- Must identify a disease, that, if untreated, will cause significant morbidity and mortality
- Must be for a disease that has a preclinical phase, a presymptomatic phase during which disease is detectable
- Must have an acceptable treatment course

U.S. Preventive Services Task Force (USPSTF) – HIV screening

- Adolescents and adults between 15 and 65
- Testing for all at least once in their lifetime. Test more frequently according to clinical history
- Men who have sex with men (MSM) – consider testing more frequently
- Some recommend annual screening for all

Reasoning behind recommendations?

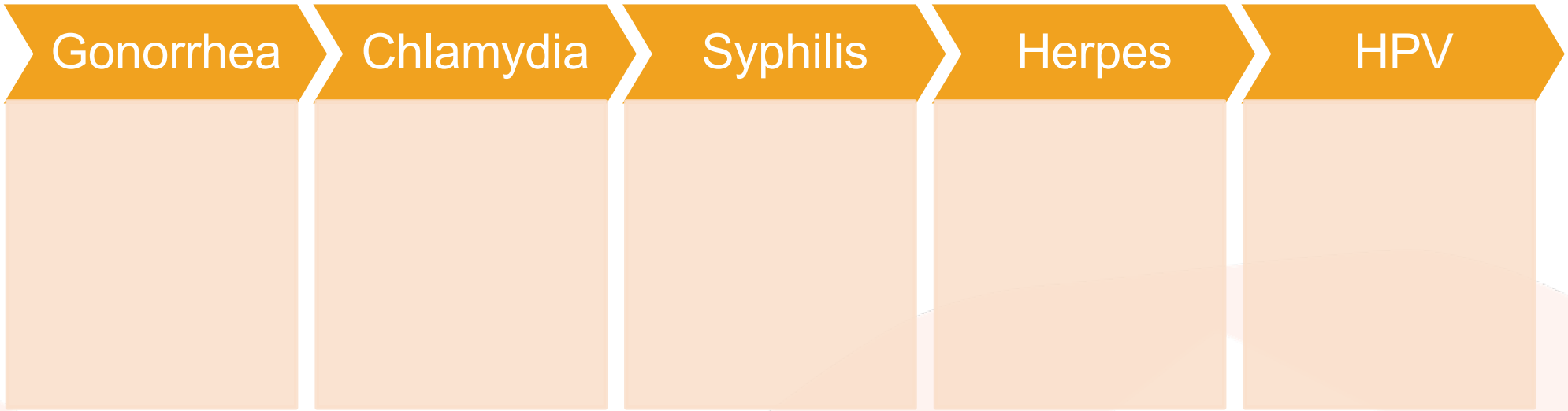
- Risk group and risk behavior stratification hasn't worked
- New infections plateaued until recently
- Patients may not be forthcoming with behavior
- Importance of Treatment as Prevention (TasP)

Sequence of HIV testing

- Fourth generation HIV test (testing for p24 viral antigen)
- If negative – nothing more to do
- If positive – HIV immunoassay that differentiates between HIV1 and HIV 2
- If positive 4th generation and positive immunoassay – confirms + status
- If positive 4th generation but negative or indeterminate immunoassay – obtain HIV nucleic acid testing (NAAT) OR HIV RNA PCR

BUT WHAT ABOUT THE OTHER STIS?

STI screening recommendations

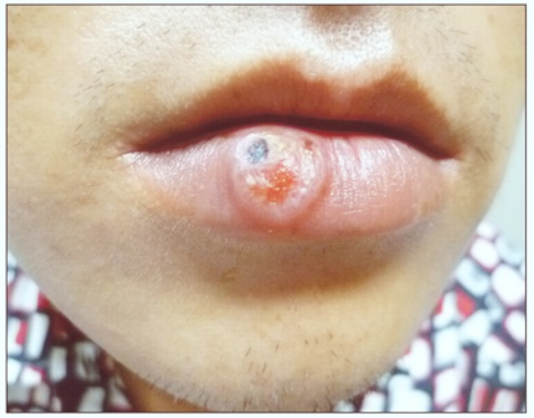


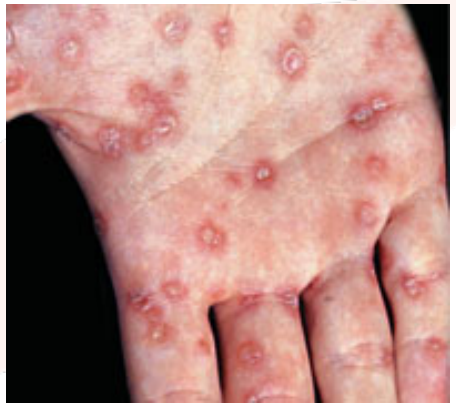
Gonorrhea/Chlamydia

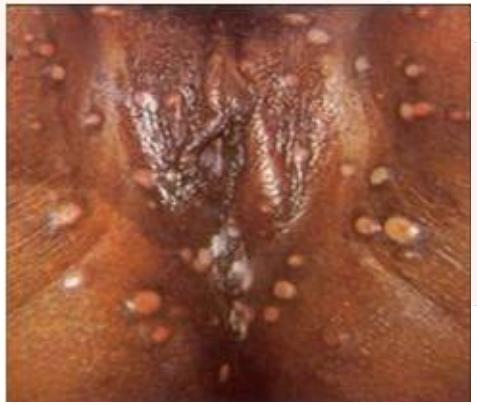
- Women – sexually active under 25
- Pregnant women
- Men - those in high prevalence areas
- MSM – at least yearly, more frequently if needed (every 3-6 months)
  - Triple site testing: urine, oral, rectal
- HIV positive – first evaluation, yearly, then as clinically indicated

Syphilis

- MSM – at least annually
- Pregnant women –
  - Initial prenatal visit
  - Early in third trimester and at delivery IF high risk
- HIV+ patients – initial screen, then at least annually

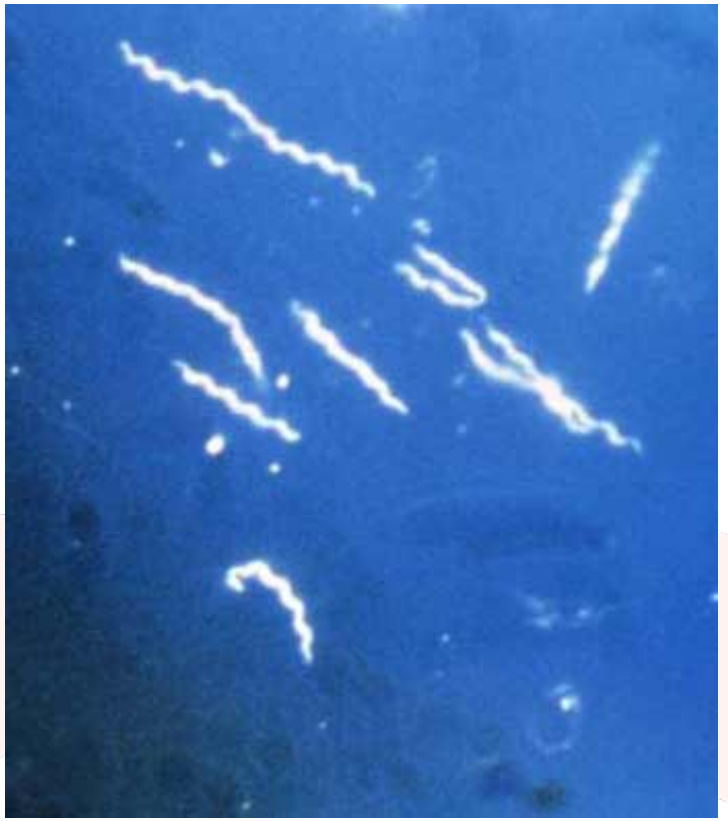






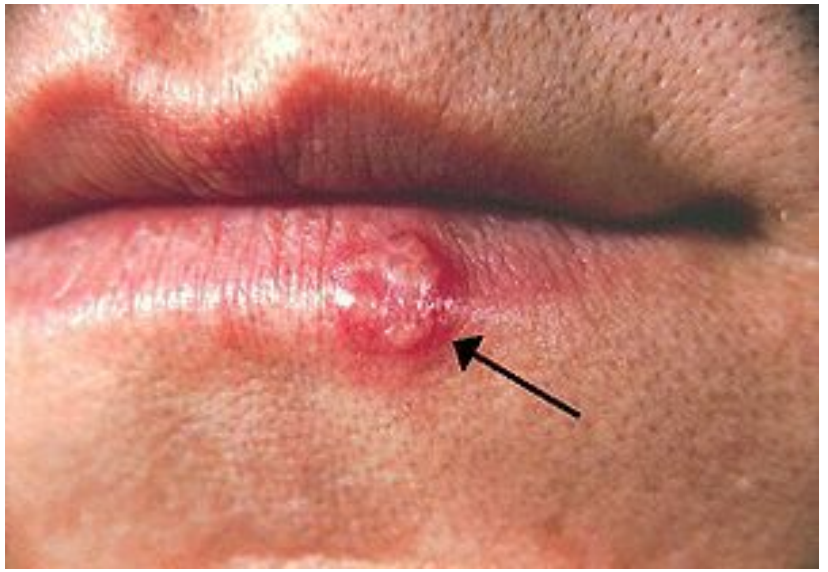
Syphilis serology

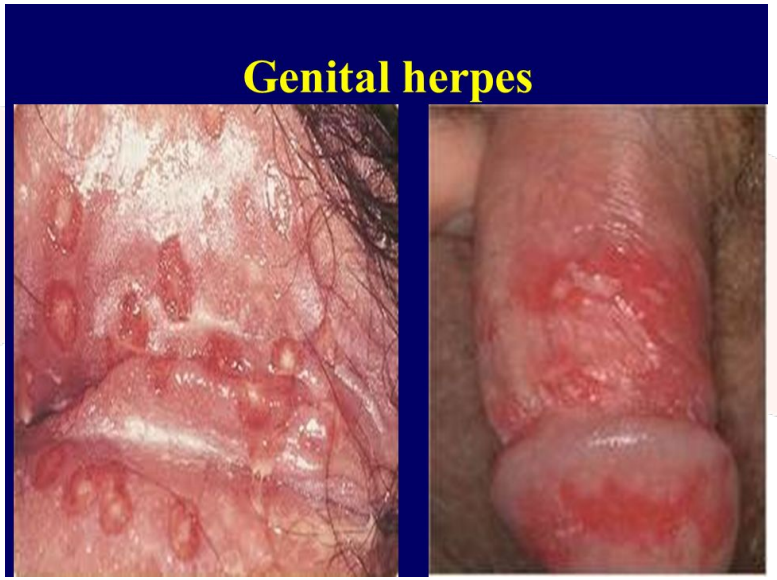
- **Non-treponemal tests (Screening test)**
  - Relies on reactivity of serum antibodies against a cardiolipin-lecithin-cholesterol antigen (**RPR, VDRL**)
  - Not highly specific; can have false positives
  - Insensitive in primary and late syphilis: check a treponemal test
  - Titers of 1:8 or higher are unusual for false positives
  - 4-fold decline in titer is considered an adequate response
- **Treponemal tests: antibody to *T. pallidum* (TPPA, FTA-Abs)**
  - **Confirmatory test**
  - May remain positive for extended periods, possibly for life, even after adequate treatment of syphilis
  - A persistently reactive treponemal test does NOT indicate inadequate treatment, relapse, or re-infection



Herpes (HSV1/2)

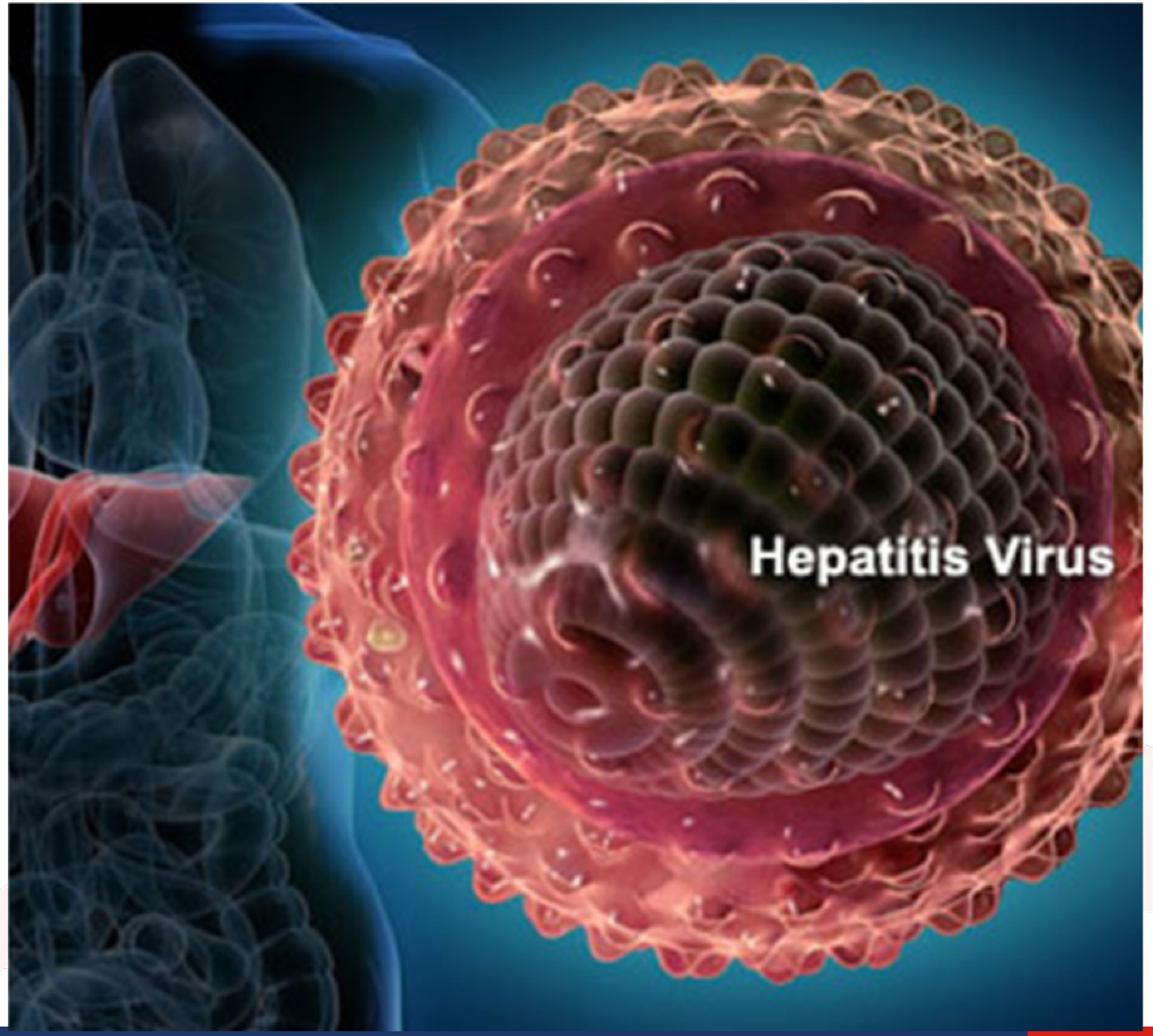
- No specific screening recommendations for HSV antibody screening (IgG) – WHY?
- Consider type-specific antibody screening for patients presenting for STI evaluation
- Consider in high risk pregnant women
- Different from testing when symptomatic





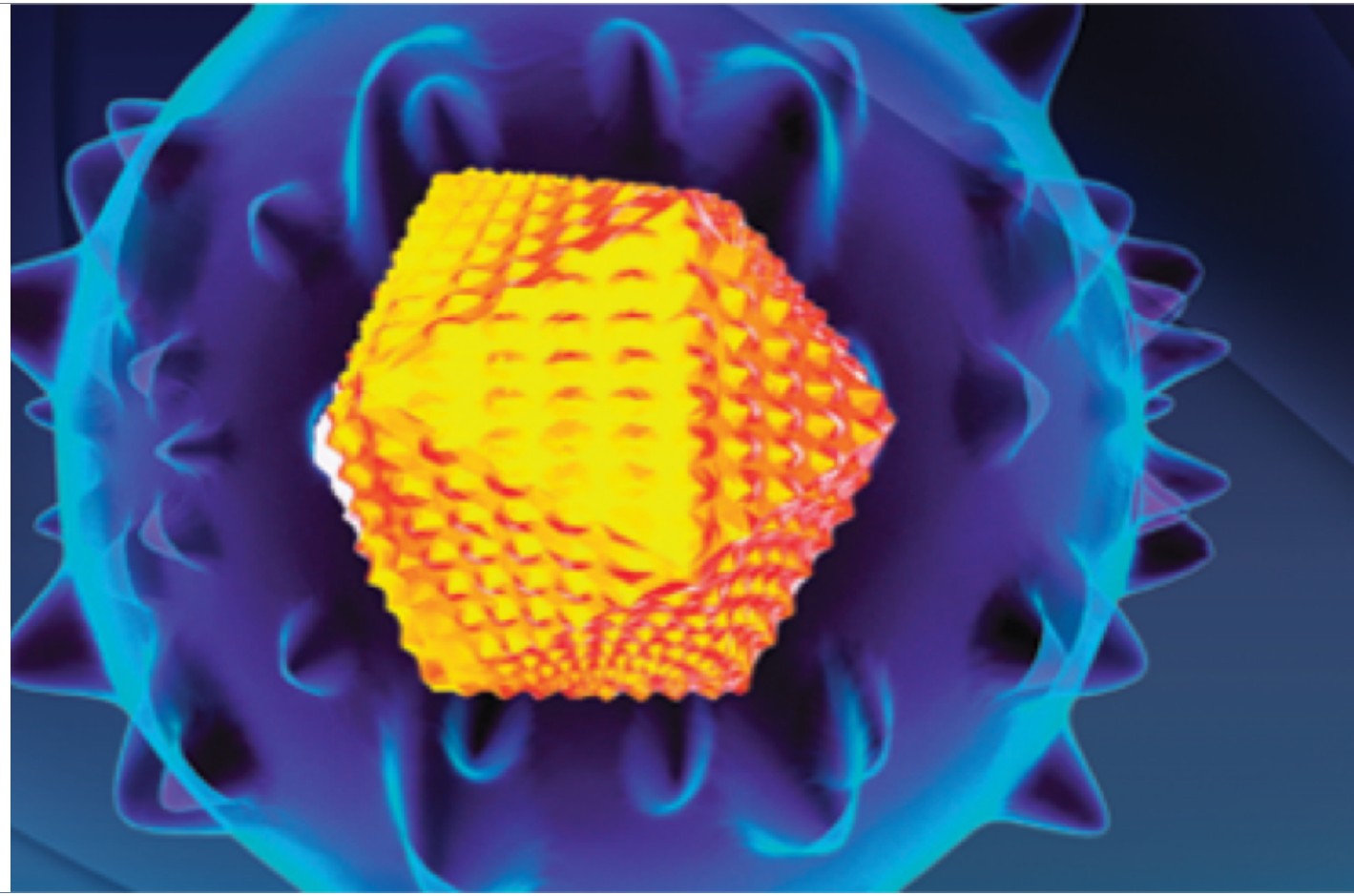
Hepatitis B

- Who to screen?
  - MSM
  - IVDU
  - Pregnant women
  - HIV+ patients
- Everyone else IF increased risk
- Test for Hepatitis B surface Antigen



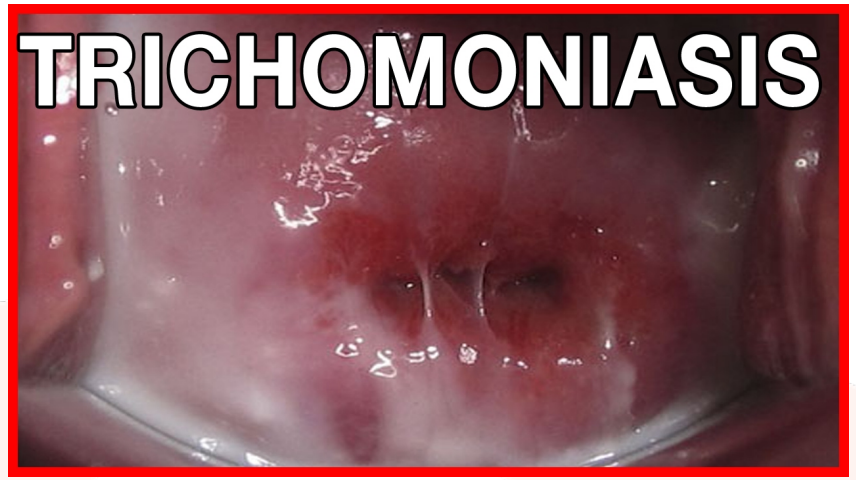
Hepatitis C

- Screen anyone born between 1945 – 1965
  - Hepatitis C antibody
- Annual testing for HIV+ patients
- Other patients IF additional risk factors
  - Multiple sex partners
  - IVDU
  - Multiple STI

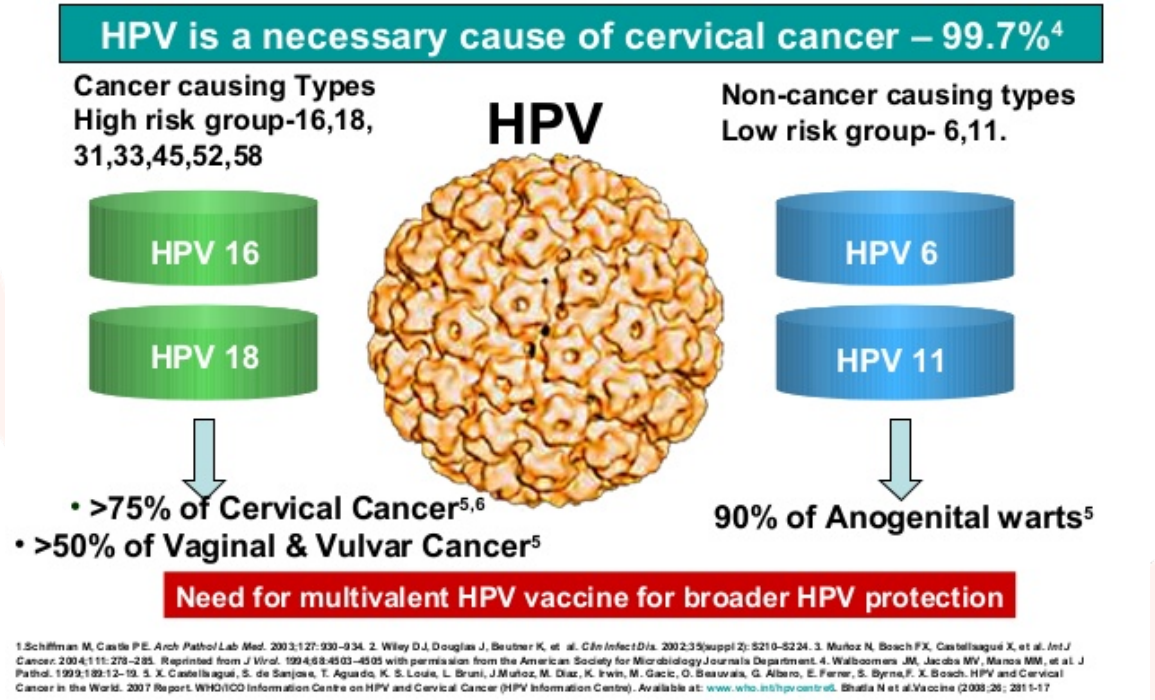


Trichomoniasis

- Consider screening:
  - Women in high risk settings
  - Women at higher risk
- HIV + women:
  - Entry screening
  - Annual screening thereafter



Human Papillomavirus (HPV)

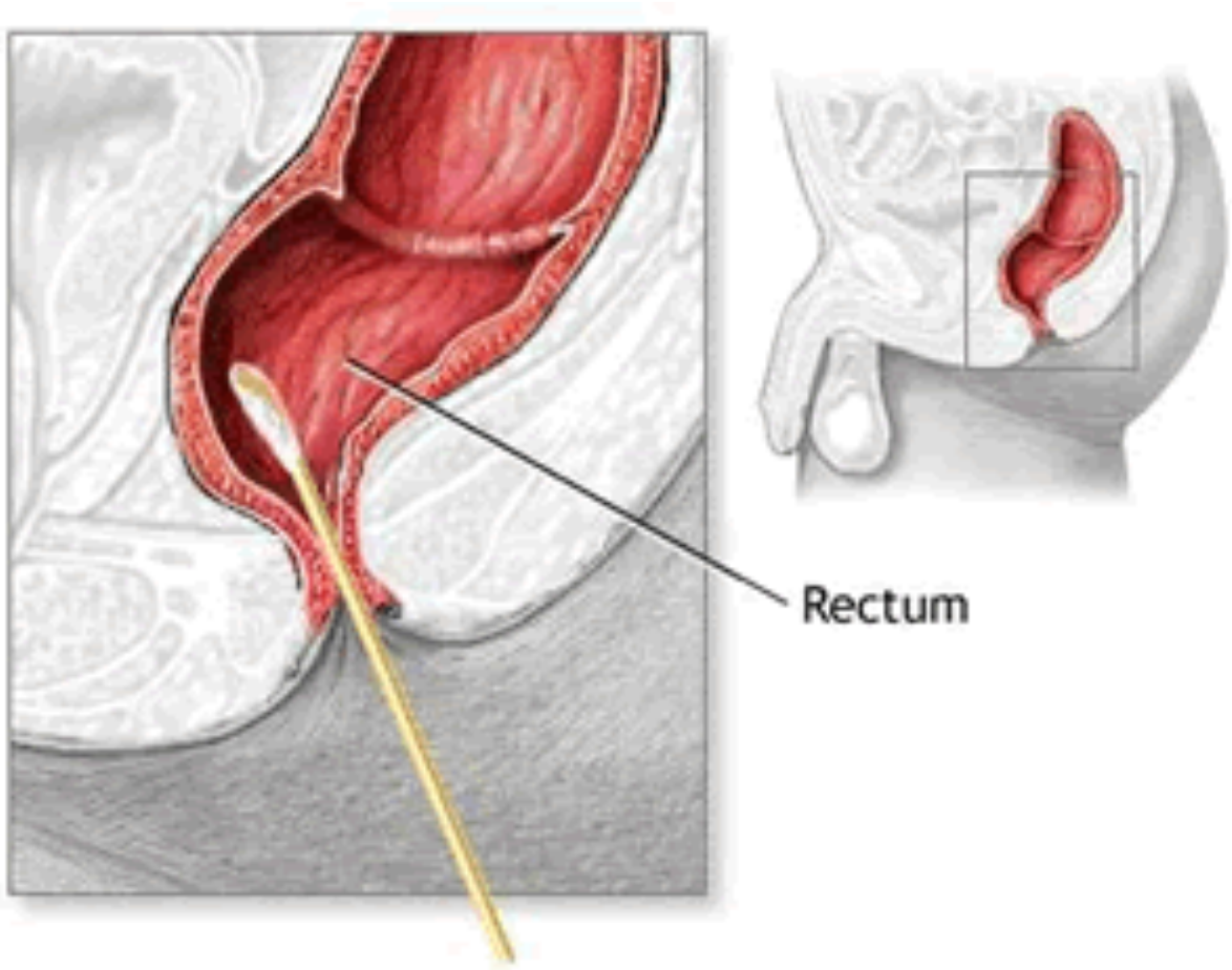


1.Schiffman M, Castle PE. *Arch Pathol Lab Med.* 2003;127:930–934. 2. Wiley DJ, Douglas J, Beutner K, et al. *Clin Infect Dis.* 2002;35(suppl 2):S210–S224. 3. Muñoz N, Bosch FX, Castellsagué X, et al. *Int J Cancer.* 2004;111:278–285. Reprinted from *J Virol.* 1994;68:4503–4505 with permission from the American Society for Microbiology Journals Department. 4. Walboomers JM, Jacobs MV, Manos MM, et al. J Pathol. 1999;189:12–19. 5. X. Castellsagué, S. de Sanjose, T. Aguado, K. S. Louie, L. Bruni, J.Muñoz, M. Diaz, K. Irwin, M. Gacic, O. Beauvais, G. Albero, E. Ferrer, S. Byrne,F. X. Bosch. HPV and Cervical Cancer in the World. 2007 Report. WHO/ICO Information Centre on HPV and Cervical Cancer (HPV Information Centre). Available at: www.who.int/hpvcentre6. Bhatla N et al.Vaccine (2008;26; 2811-17

HPV SCREENING?

Cervical Cancer

- Recommendations are age-based
  - < 21: not recommended
  - 21 – 29: every three years cytology
  - 30 – 65:
    - Every three years cytology OR
    - Every five years cytology + HPV testing
  - > 65: can discontinue unless history of CIN2/3 or adenocarcinoma in situ



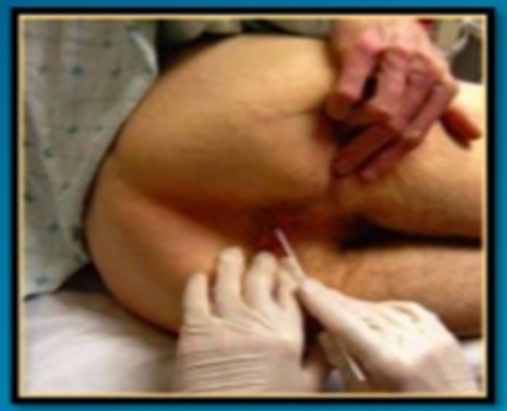
NO COMPARABLE UNIVERSAL HPV SCREENING RECOMMENDATIONS FOR MEN

Prevention & Screening

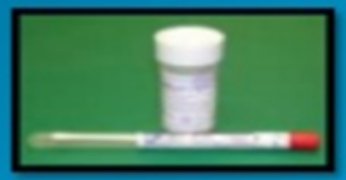
Who? What? When? Where?

Screening Methods

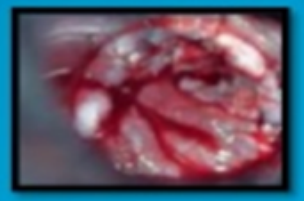
- Physical Examination
  - Anal Exam
  - DRE
  - Anoscopy



- Anal pap smears



- High resolution anoscopy
  - 5% acetic acid



NYS Department of Health Guidelines: Recommendations for Anal Pap Smears

- At baseline and as part of the annual physical examination for all HIV-infected adults, regardless of age, clinicians should:
  - Inquire about anal symptoms, such as itching, bleeding, diarrhea, or pain
  - Perform a visual inspection of the perianal region
  - Perform a digital rectal examination
- Clinicians should refer women with cervical HSIL and any patient with abnormal anal physical findings for high-resolution anoscopy and/or examination with biopsy of abnormal tissue
- Clinicians should obtain anal cytology at baseline and annually in the following HIV-infected populations
  - Men who have sex with men
  - Any patient with a history of anogenital condylomas
  - Women with abnormal cervical and/or vulvar histology

Current Guidelines Related to Anal Cancer Screening

Agency	Population	Recommendations
New York State Dept. of HIV AIDS Institute (2007)	High risk HIV infected patients; MSM, history of anogenital warts, history of HPV related cervical dx	Annual DARE and visual inspection for all HIV patients. Annual anal pap for high risk patients
Northwest Pennsylvania Rural AIDS Alliance (2008)	All HIV-infected men and women. MSM considered high risk	Baseline anal pap for all patients. Annual pap for MSM; every 6 -9 mths for CD4 count < 500
CDC (2009)	All HIV infected men and women	Visual inspection with DARE annually. If anal pap done abnormals must be followed with HRA
US Dept. Veterans Affairs (2009)	All HIV infected adults; target high risk individuals	Baseline and annual anal pap. Abnormals must be followed with HRA
National Guideline Clearing House (2011)	HIV infected men and women	Baseline and annual anal pap
Canadian Medical Advisory Secretariat (2007)	HIV infected men and women	Anal pap test should parallel the same approach for cervical pap testing
British HIV Association (2008)	HIV infected patients	All HIV units should have guidelines established for anal Cancer. No specific guidelines on account of lack of evidence

Source: Wells JS et al, 2014; AIDS Patient Care and STDs; 28 (7) 350 - 357

Anal pap smear guidelines?

Case # 2 – Diane is a 37 yo woman who is single, sexually active with a steady boyfriend, but occasionally has sex with women. She uses condoms "sometimes," and comes to you for a "full" STI check – she is asymptomatic. What do you tell her?

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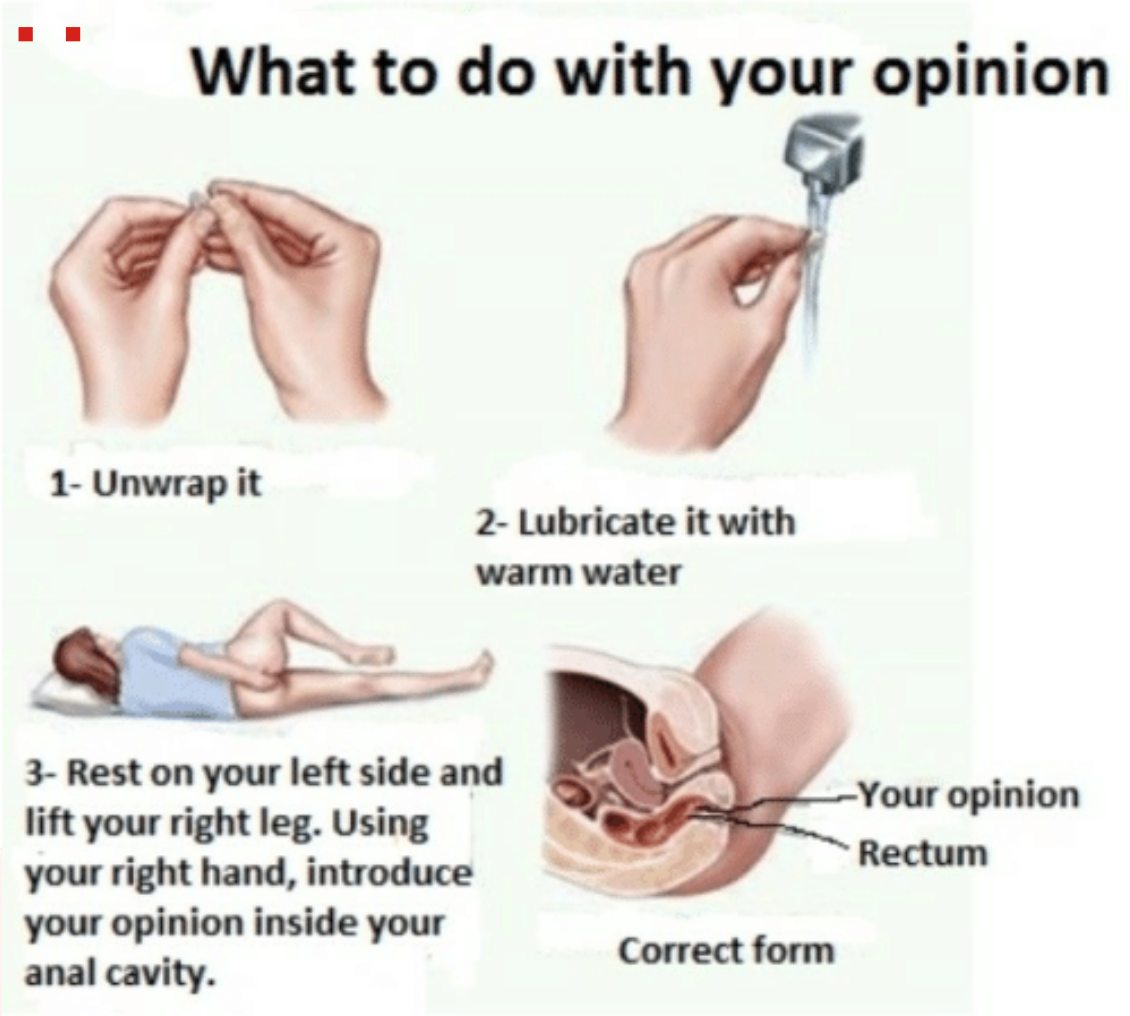
D. Send her for the following tests: HIV Ag/Ab, RPR, urine GC/CT/trich, HSV Abs ½
E. A & C

REMEMBER…

- GUIDELINES ARE GUIDELINES
- NOTHING REPLACES CLINICAL JUDGMENT
- DO A THOROUGH HISTORY AND EXAM

Opinions are like…



In summary…

- HIV screening for adults 15 – 65
- Don’t forget STI screening
- Pay attention to special populations
  - MSM
  - Pregnant woman
  - HIV+ individuals
- Use your clinical judgment

Questions?