Spectrum
COMMUNITY HEALTH CIC
a spectrum of care and recovery

BEST meeting
ISH Barnsley

Dr Sylvia Bates

19th May 2021



Topics

- Clinic services during C19
- PrEP
- U=U
- Other HIV related update
- Mycoplasma Genitalium



Clinic services during C19

- Telephone consultations
  - Morning list – wait for call back.
    - Number of slots depends on staffing
    - Once full –reception triage. 6 urgent appts then clinical staff triage
  - Afternoon booked slots
- Postal / collection medication
- Self testing
  - On site. Book slot to attend – no need for phone consultation if just CT GC screening. Can book for STS HIV if telephone consultation.
  - Preventx – postal CT GC STS HIV kits



- Face to face
  - Symptomatic individuals
  - LARC / depo
  - Use of HCA teams for BP, BMI, extended self screening (eg Mgen / HVS)



Suspended services

- Walk in and wait – including young peoples walk in
  - Plans for after school call backs
  - Will re-introduce YP walk in as soon as possible
  - Undertaking patient survey regards delivery of other services
- Some treatments
  - LN2 for warts



FSRH guidance

- Extended use
  - Mirena / Levosert 6 years
  - 10 year Cu coil extended to 12 years
- Longer prescriptions
  - COCP – if BP / BMI documented in last 12 months can issue 1 year. Self reported BP/BMI acceptable at times of high C19 risk
  - POP – 1 year prescriptions
- No extended use
  - Jaydess 3 years , Kyleena 5 years, 5 year Cu coil, Depo




HIV
PrEP

Pre-exposure Prophylaxis (PrEP)

- HIV negative individuals take HIV medication before having sex to reduce the risk of acquiring HIV
- Medication = tenofovir disoproxil 245mg / emtricitabine 200 mg
- Can be taken as daily, or event based (on demand)

Dosing

Daily

- Heterosexual men and women / Trans men and women
- 7 day lead in
- Take 7 days after last sex

Event based

- MSM
- Take 2 tablets 2-24 hours before sex, then one tablet daily until 48 hours after last sex

- T's and S's – 4 doses a week is enough to offer 90% protection (vs 99% with daily)

Suitability

- Eligibility
- Any symptoms of HIV seroconversion in the last 4 weeks
- Any PrEP already taken

- Medical history
  - Renal disease (diabetes, hypertension, >40, nephrotoxic drugs)
  - Bone risk (>50 – esp . women, meds eg steroids, low weight, smoking, excess alcohol)
  - Psychiatric / mental health history
  - Hepatitis B (? Vaccinated)

- Drug use / Chem sex



Follow up

3 monthly

- Sexual health screening
  - CT GC
  - STS HIV
  - Hep Bs Ag if not immune
- Review of risk /health promotion
- U+E if indicated
- Urinalysis

Annual

- U+E



What evidence is there to support the use of PrEP?

- Double-blind placebo-controlled RCT (iPrEx) and Phase 3 open-label RCT (PROUD) reported the efficacy of daily oral PrEP with TDF-FTC in preventing HIV infection in MSM at 44% and 86%, respectively. PROUD – number to treat over 1 year to prevent 1 infection =13

- Double-blind placebo-controlled RCT (IPERGAY) reported the efficacy of on demand PrEP with TDF-FTC in preventing HIV infection in MSM at 86%.

- iPrEx Open-label Extension (iPrEx-OLE) reported no HIV seroconversions when drug levels were compatible with taking four or more pills per week

- IPERGAY Open-label Extension (IPERGAY-OLE) demonstrated a 97% reduction in HIV transmission risk compared to the placebo arm of the IPERGAY randomised phase.



Eligibility

iwantprepnow.co.uk



Eligibility

- On-demand or daily oral TD-FTC should be offered to HIV-negative MSM / daily oral TD-FTC should be offered to trans-women who are identified as being at elevated risk of HIV acquisition through condomless anal sex in the previous 6 months and ongoing condomless anal sex. (1A)*

- Daily oral TD-FTC should be offered to HIV-negative MSM, trans men and women and heterosexual men and women having condomless sex with partners who are HIV positive, unless the partner has been on ART for at least 6 months and their plasma viral load is <200 copies/mL. (1A). In the case of MSM, event based dosing may also be used

- PrEP with daily oral TD-FTC should be offered on a case-by-case basis to heterosexual men and women with current factors that may put them at increased risk of HIV acquisition.

Eligibility summary

- People having ongoing unprotected sex and are at risk of HIV through:
  - Having a partner known to be HIV positive who is not yet undetectable on treatment
  - Having a partner in a high risk group for HIV of unknown status

- Event based dosing only recommended for those having exclusively anal sex



Safety

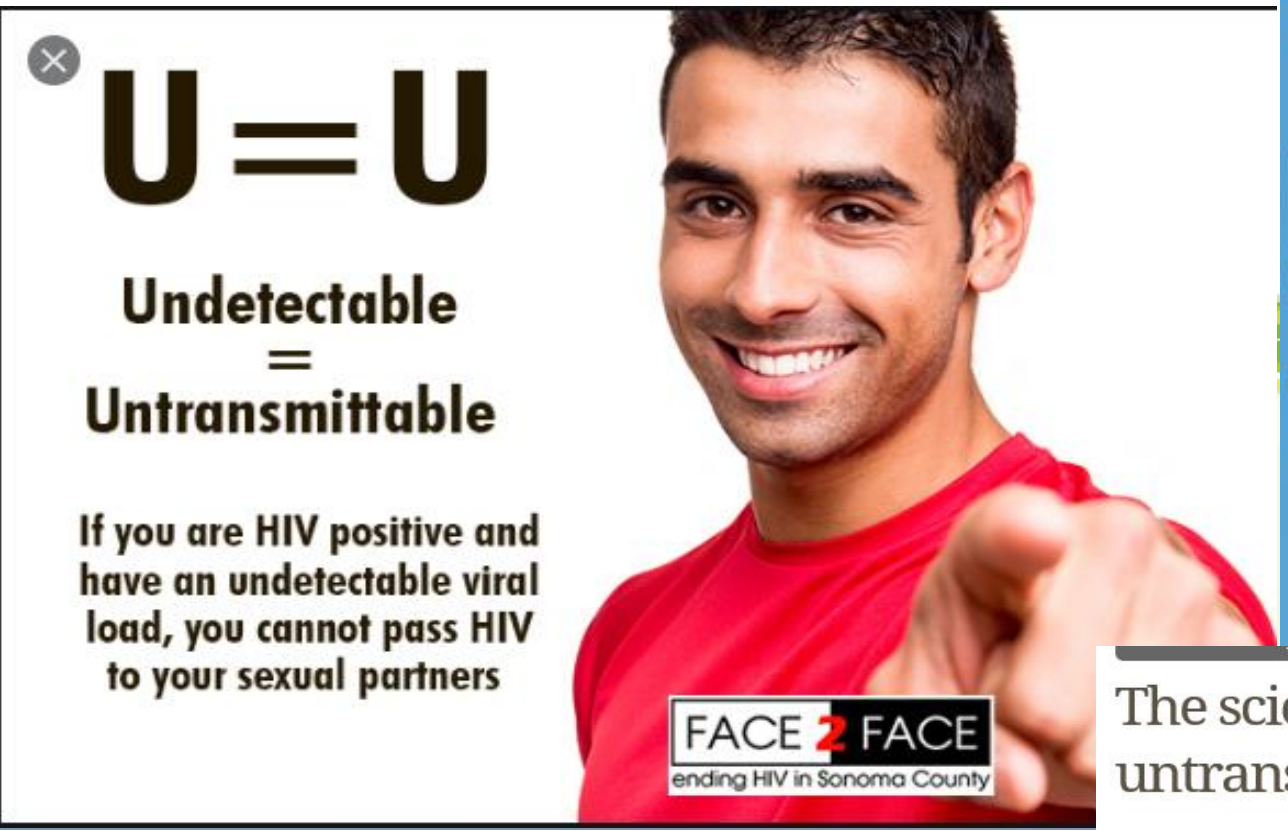
- Side effects: headache, nausea, GI upset
- Good safety data
- Where kidney function has been affected it is usually mild, non-progressive and reversible decrease in creatinine clearance
- Age >40 years or having Cr Cl < 90 at base line have been independently associated with having a fall in Cr CL to < 60
- No long term detrimental effects on bone health or increased fracture risk, although small net reduction in BMD

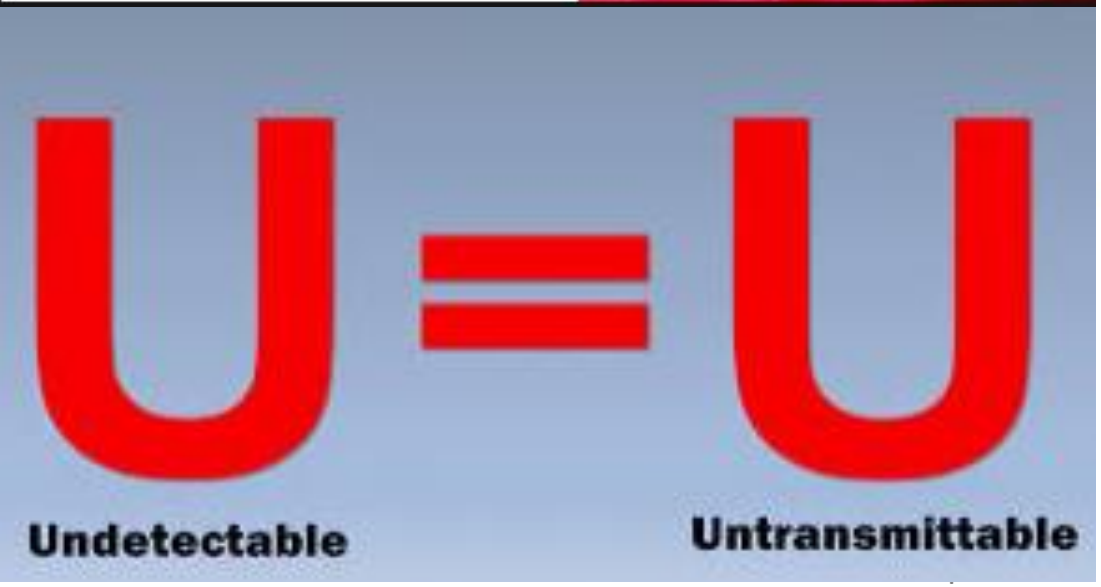


Barriers to taking

- Knowledge of PrEP
- Availability / access to PrEP
- Lack of ability to differentiate between treatment and prevention
- Cultural – mistrust of medicines







The science is clear: with HIV, undetectable equals untransmittable

NIH officials discuss scientific evidence and principles underlying the U=U concept.

WHAT:

In recent years, an overwhelming body of clinical evidence has firmly established the HIV Undetectable = Untransmittable (U=U) concept as scientifically sound, say officials from the National Institutes of Health. U=U means that people living with HIV who achieve and maintain an undetectable viral load—the amount of HIV in the blood—by taking and adhering to antiretroviral therapy (ART) as prescribed cannot sexually transmit the virus to others. Writing in *JAMA*, officials from NIH's National Institute of Allergy and Infectious Diseases (NIAID) review the scientific evidence underlying U=U and discuss the implications of widespread acceptance of the message.

Antiretroviral drugs to treat HIV infection spill out of a pill

BHIVA endorses 'Undetectable equals Untransmittable' (U=U) consensus statement

Wednesday 12 July 2017

The British HIV Association (BHIVA), today announces its endorsement for the 'Undetectable Equals Untransmittable' (U=U) Consensus Statement produced by the Prevention Access Campaign.

BHIVA Chair, Professor Chloe Orkin, said: "As the UK's leading voice for HIV health professionals, our backing for U=U is unequivocal. There should be no doubt about the clear and simple message that a person with sustained, undetectable levels of HIV virus in their blood cannot transmit HIV to their sexual partners.

"This fact is a testament to the preventive impact of effective HIV treatment and highlights the need to maximise access to treatment in order to minimise and ultimately eradicate HIV transmission. Spreading the U=U message is also an important way to help reduce the stigma experienced by people living with HIV, whose sexual partners may fear infection unnecessarily."

The U=U statement is based on evidence from the PARTNER study (published in the Journal of the American Medical Association, 12 July 2016).

Partner study

- 1166 couples, gay and straight – covering 58,000 episodes of sex without condoms
- No linked HIV transmissions from the HIV positive to the negative partner.
- To be included in the results, viral load had to be undetectable at the most recent test. Undetectable in this study was defined as being less than 200 copies/mL.



Partner 2 study

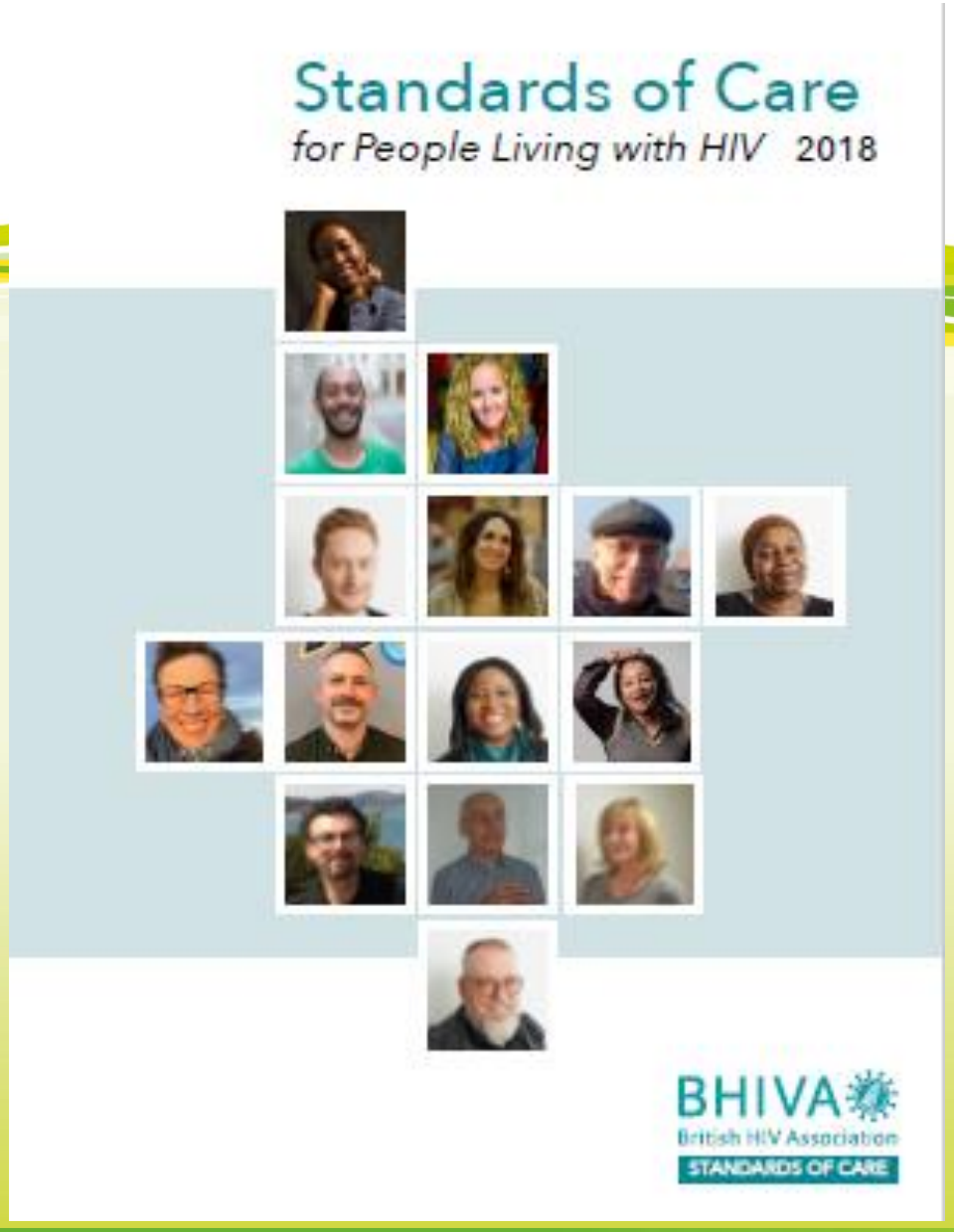
- 972 gay male couples
  - 88% were white, Median age was about 40 years
  - 97% had viral loads <50 copies/mL at enrolment
- 2,072 couple-years of follow-up and approximately 76,000 episodes of condomless sex
- Approximately 25% reported an STI during the most recent follow-up period
- 15 incident HIV infections detected, none of which were linked phylogenetically to the partner with HIV
  - estimated risk of transmission of zero
  - a maximum risk of one transmission of HIV per 435 years of condomless anal sex

Without virologic suppression due to ART, 472 within-couple transmissions would have been expected.




IT'S
A
SIN


CONDOMS
HERPES
AIDS
"AIDS IS A WHITE MAN'S DISEASE"



2. Person-centred care

2a. Stigma – equitable and non-discriminatory care .....
2b. Self-management and peer support.....
2c. Participation of people with HIV in their care .....
2d. Well-being .....

Person centred care

Person-centred care means that services consciously adopt the perspectives of individuals, families and communities to respond to their needs and preferences in humane and holistic ways; the person is a participant, not just a beneficiary of the health system.



Stigma – equitable and non-discriminatory care

All people living with HIV should be provided with equitable and non-discriminatory care across all healthcare settings including those outside sexual health and reproductive services.

Fear of stigma and discrimination is a leading contributor to poor health outcomes for people living with or affected by HIV. This stigma may be in addition to pre-existing stigma based on actual or perceived membership of different social groups (e.g. gender identity, religion, age, class, ethnicity, sexuality).



The People Living with HIV Stigma Survey UK 2015

- in the preceding 12 months, one in seven (13%) reported hearing negative comments from a healthcare worker about themselves or other people living with HIV.
- Approx one-third worried about being treated differently to other patients at their general or dental practice, and 5% felt treatment was refused or delayed across all healthcare settings because of their HIV status.

As a woman living with HIV, I find that stigma and self-stigma are sometimes more of an issue than the HIV itself.

People living with HIV should be made aware of how they can raise concerns if they are unhappy with their care or have experienced stigma and should be supported in doing so. They should be reassured this will not affect access to or the standard of their care.

Healthcare services should ensure that staff members are aware of the confidential nature of people's medical records, including their HIV status



NICE National Institute for Health and Care Excellence

Public Health England

NICE guideline

HIV testing: increasing uptake among people who may have undiagnosed HIV

NICE guideline
Published: 1 December 2016
www.nice.org.uk/guidance/ng60



HIV testing - GP surgeries

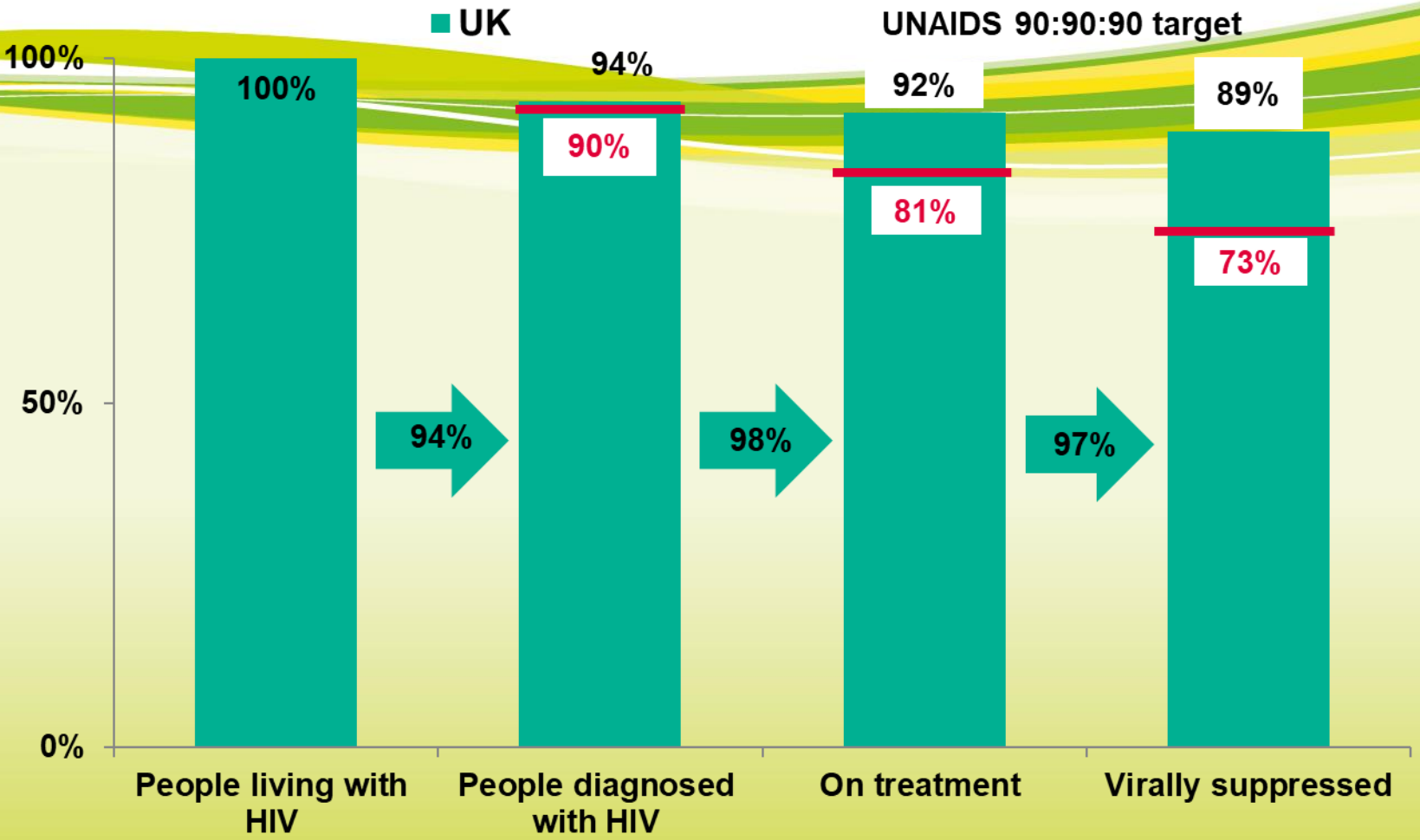
- In all areas, offer and recommend HIV testing to everyone who has not previously been diagnosed with HIV and who:
  - has symptoms that may indicate HIV or HIV is part of the differential diagnosis (for example, infectious mononucleosis-like syndrome), in line with HIV in Europe's HIV in indicator conditions
  - is known to be from a country or group with a high rate of HIV infection (see recommendation 1.1.1)
  - if male, discloses that they have sex with men, or is known to have sex with men, and has not had an HIV test in the previous year
  - is a trans woman who has sex with men and has not had an HIV test in the previous year
  - reports sexual contact (either abroad or in the UK) with someone from a country with a high rate of HIV
  - discloses high-risk sexual practices, for example the practice known as 'chemsex'
  - is diagnosed with, or requests testing for, a sexually transmitted infection
  - reports a history of injecting drug use
  - discloses that they are the sexual partner of someone known to be HIV positive, or of someone at high risk of HIV (for example, female sexual contacts of men who have sex with men).



- In areas of high and extremely high prevalence, also offer and recommend HIV testing to everyone who has not previously been diagnosed with HIV and who:
  - registers with the practice or
  - is undergoing blood tests for another reason and has not had an HIV test in the previous year.
- Additionally, in areas of extremely high prevalence, consider HIV testing opportunistically at each consultation (whether bloods are being taken for another reason or not), based on clinical judgement.
- If a venous blood sample is declined, offer a less invasive form of specimen collection, such as a mouth swab or finger-prick.



Continuum of HIV care in the UK: 2019



Clinical case
22 yr old female

- June 2020
  - Fever, central stabbing LAP, dysuria, nausea, discharge, irreg bleeding (depo)
  - PMH – PID (Chlamydia +ve) Dec 19, IBS – different pain
  - On Fluoxetine and IBS meds
  - CT +ve with GP – prescribed azithromycin same day as contacted us
  - RBF 6 / 52 – condoms always. Ex RBF Last SI 4 months previously,
  - Tender uterus, Cx motion tenderness, mild adnexal discomfort. Occ PC on slde. Clinical PID – doxycycline and metronidazole.
  - Gonorrhoea, M Genitalium Not detected
  - Felt a lot better after Rx



- July 2020
  - Return of LAP , discharge (candida), dysuria – pain esp. severe after micturition, irreg bleeding (ref to gynae by GP)
  - New partner for last 1/12
  - CMT, No adnexal pain/mass
  - USS requested
  - Recurrent HSV and candida
- Aug 2020
  - Marcolide resistant Mycoplasma genitalium
  - Rx Moxifloxacin 400 mg OD for 14 days



- Sept 2020
  - Mgen det – resistant
  - Had UPSI so retreated with moxifloxacin 400 mg OD for 10 days
- Dec 2020
  - Mgen +ve . Resistant
  - No sex
  - Rx minocycline
  - Other Rx options explored – IV moxifloxacin, pristinamycin



- Feb 2021
  - Mgen negative
  - BUT – RBF not cleared his Mgen
- April 2021
  - M gen negative
  - Ongoing problems with LAP – awaiting laparoscopy



Mycoplasma Genitalium

Isolated 1981 – Mollicute

Evades immune system

- intra-cellular infection
- antigenic and phase variation of its surface proteins
- infection may persist for months or years

Disease

Host immune response

Toxic to cilia cells

- Similar population to chlamydia
- General population 1-2 % men and women
- STI clinic attenders 4-38%
- Risk of transmission per coital act is likely to be less than for chlamydia
- Incubation period unknown



- Most cases are asymptomatic
- M. genitalium infection is unequivocally and strongly associated with NGU in men
  - M. genitalium in 15–25% NGU, 10-35% non-chlamydial non-gonococcal urethritis (NCNGU)
  - 1–2% in the general population
  - M. genitalium is also associated with persistent and recurrent urethritis - 40%
- In women
  - M. genitalium infection associated with post coital bleeding, cervicitis, endometritis and PID (cause of 10 -13 % PID) Not yet confirmed to cause tubal factor infertility



Signs and symptoms

- Symptoms men
  - Asymptomatic (possibly 90%)
  - Urethral discharge, Dysuria, Penile irritation, Urethral discomfort, Urethritis (acute, persistent, recurrent), Balanoposthitis
- Symptoms women
  - Asymptomatic (likely > 95%)
  - Dysuria, PCB, Painful inter-menstrual bleeding, Cervicitis, Lower abdominal pain
- Complications men
  - Sexually acquired reactive arthritis, Epididymo-orchitis
- Complications women
  - PID, Tubal factor infertility (uncertain association), Sexually acquired reactive arthritis, Pre-term delivery



BASHH recommend M gen testing for those :

- With non-gonococcal urethritis
- With signs and symptoms suggestive of pelvic inflammatory disease
- Who are contact of M gen infection

Consider testing for M. genitalium infection in those with:

- signs or symptoms of mucopurulent cervicitis, particularly post-coital bleeding
- people with epididymo-orchitis
- people with sexually-acquired proctitis



Resistance

- 40% Macrolide resistance

- Doxycycline 100 mg bd for seven days followed by azithromycin 1 g orally as a single dose then 500 mg orally once daily for two days* where the organism is known to be macrolide-sensitive or where resistance status is unknown (1D).
- Moxifloxacin 400 mg orally once daily for ten days if organism is known to be macrolide resistant or where treatment with azithromycin has failed



Second line treatment

- Doxycycline 100 mg bd for seven days* then pristinamycin 1 g orally four times daily for ten days
- Pristinamycin 1 g orally four times daily for 10 days
- Doxycycline 100 mg orally twice daily for 14 days
- Minocycline 100 mg orally twice daily for 14 days



Spectrum COMMUNITY HEALTH CIC
a spectrum of care and recovery

Thank you for listening

Any questions?