Sexually Transmitted Infections
&
HIV in Primary Care

Dr S Bates

Gateway Clinic, Sackville street

Our Service

- July 2015 – HIV and Sexual health care delivered from Gateway Clinic
- HIV care provided by Barnsley Hospital
- Contraception and STI care provided by Spectrum CIC

GUM Services

- Confidential
- Non judgemental
- Open access
- Onsite diagnosis
- Free treatment

"Ah, Mr Bond, I've been expecting you..."

Services delivered

Contraceptive pills
Contraceptive patches
Coils
Implants
Assessment and referral for abortion
Psychosexual counselling
Youth clinic

Non-contraceptive use of IUS

Non-invasive screening (asymptomatic)
Chlamydia screening
Point of care tests for HIV
Diagnosis and treatment of STI
Biopsy to confirm diagnosis
Motivational interviewing
Contact tracing
Hepatitis B vaccination (sexual risk)

Genital dematoses
Non-STI causes of vaginal discharge
Cervical cytology

How to refer

- Allow patients to self refer and contact the clinic directly
  - Patient may not make contact

- ‘Phone the clinic to make an appointment.
  - Ask for health advisors if confirmed STI or complex

- Refer by letter
  - delay of receiving an appointment.

Contact details

Gateway Clinic

Gateway Plaza

Sackville Street

Barnsley

S70 2RD

Tel: 0800 055 6442

STIs- general principles

- Accurate diagnosis
- Prompt, appropriate and simple treatment regimens
- Contact tracing
- Test of cure where appropriate

Infection screening

When to think about Screening

- PCB / IMB
- Cervicitis
- Abnormal vaginal discharge
- Genital ulceration
- Dysuria
- Rectal / anal pain / discharge
- Skin rashes
- Evidence on a co-existing STI
- Recent partner change or high risk group / partner

Tests – CT GC NAAT

- Men
  - 1st void urine (must have held urine for 1 hour)

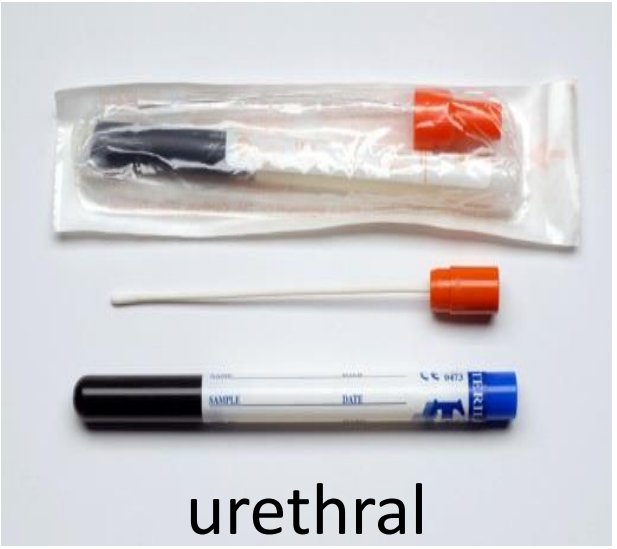
- Women
  - Endo-cervical swab
  - Self or physician taken vulvo vaginal swabs

Local NAAT tests for chlamydia

Endo-cervical swab, rectal swab

First void urine sample

Gonorrhoea - testing



<u>Caution</u>

- A positive test does NOT mean an individual has gonorrhoea
- Patients with a positive NAAT test must have culture tests to confirm diagnosis
- Preferably should be referred to GUM

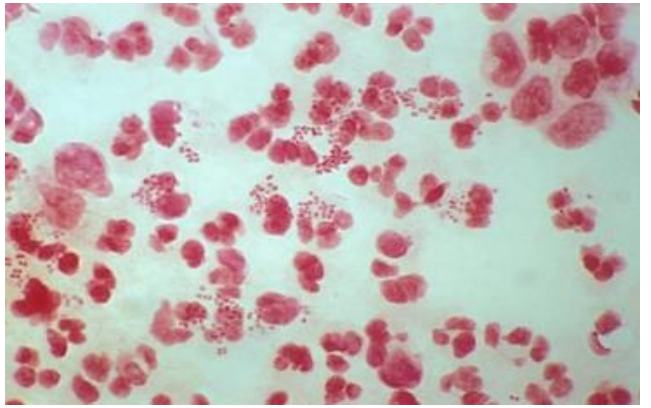
GC culture plate

Chlamydia and gonorrhoea – Treatment

Chlamydia

- Azithromycin 1 gr PO single dose
- Doxycycline 100mg bd 1/52 for rectal chlamydia

Consider referral to GUM for contact tracing



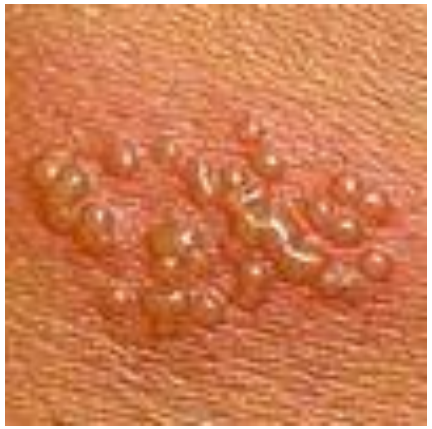
Gonorrhoea

Refer to GUM

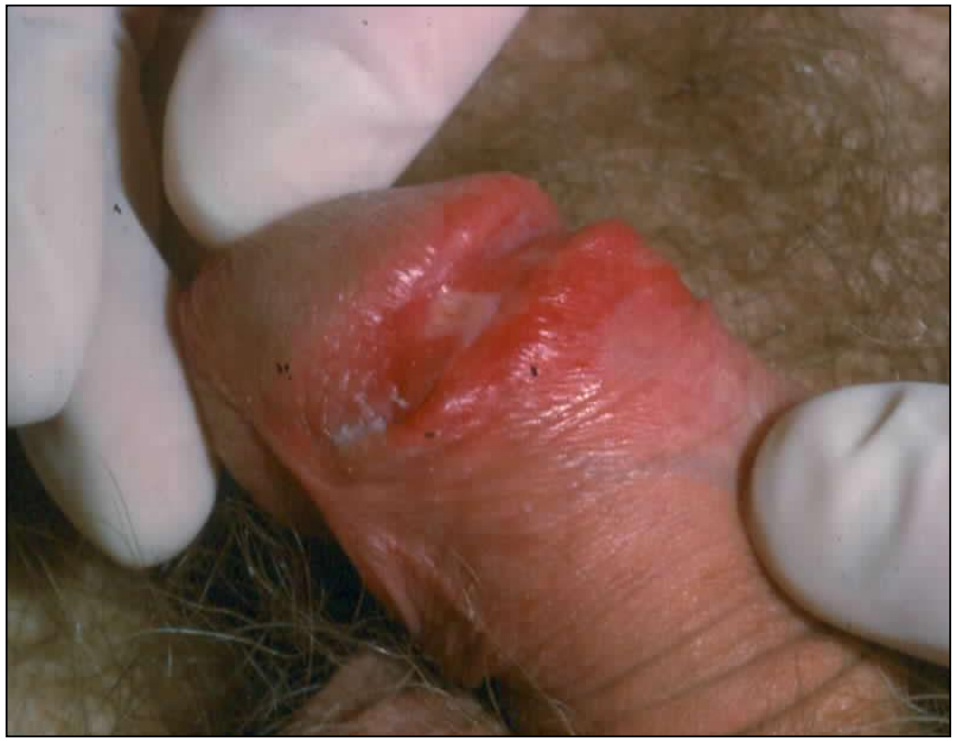
- Ceftriaxone 500mg IM single dose with azithromycin 1 gram PO single dose

Genital blisters / ulcers

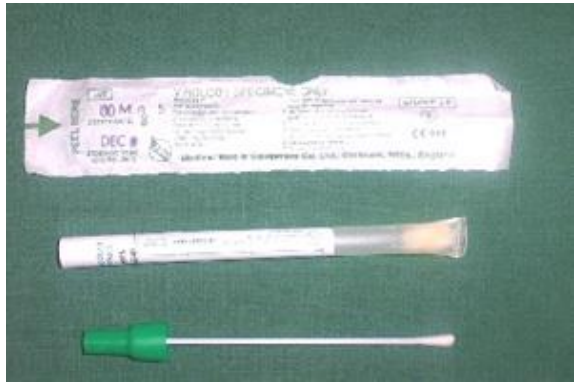
HSV

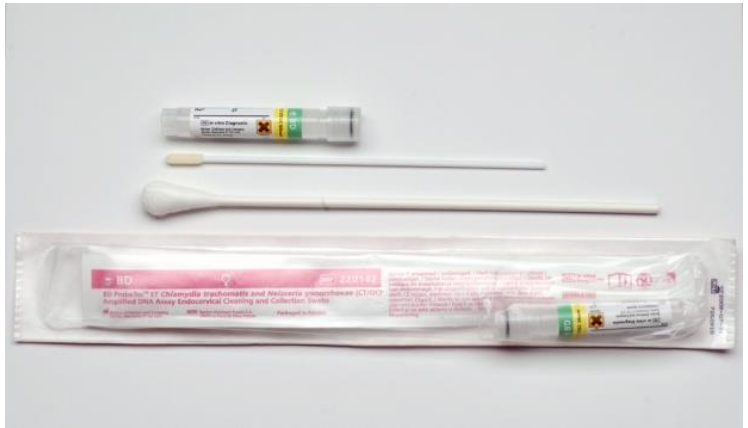


Treatment:
Valaciclovir
500mg BD 5/7
Refer to GUM



Tests:
HSV PCR from lesion



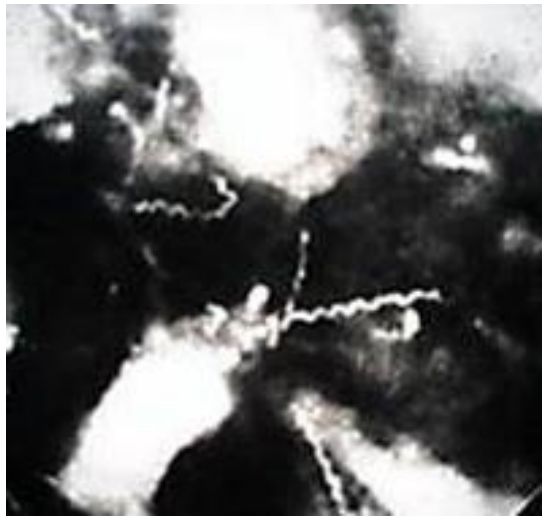


Syphilis

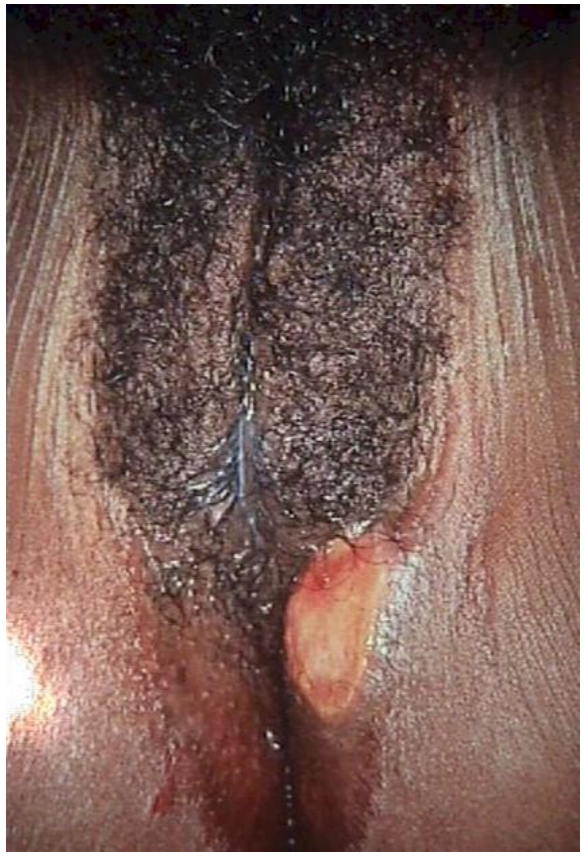
If suspicious of syphilis refer to GUM

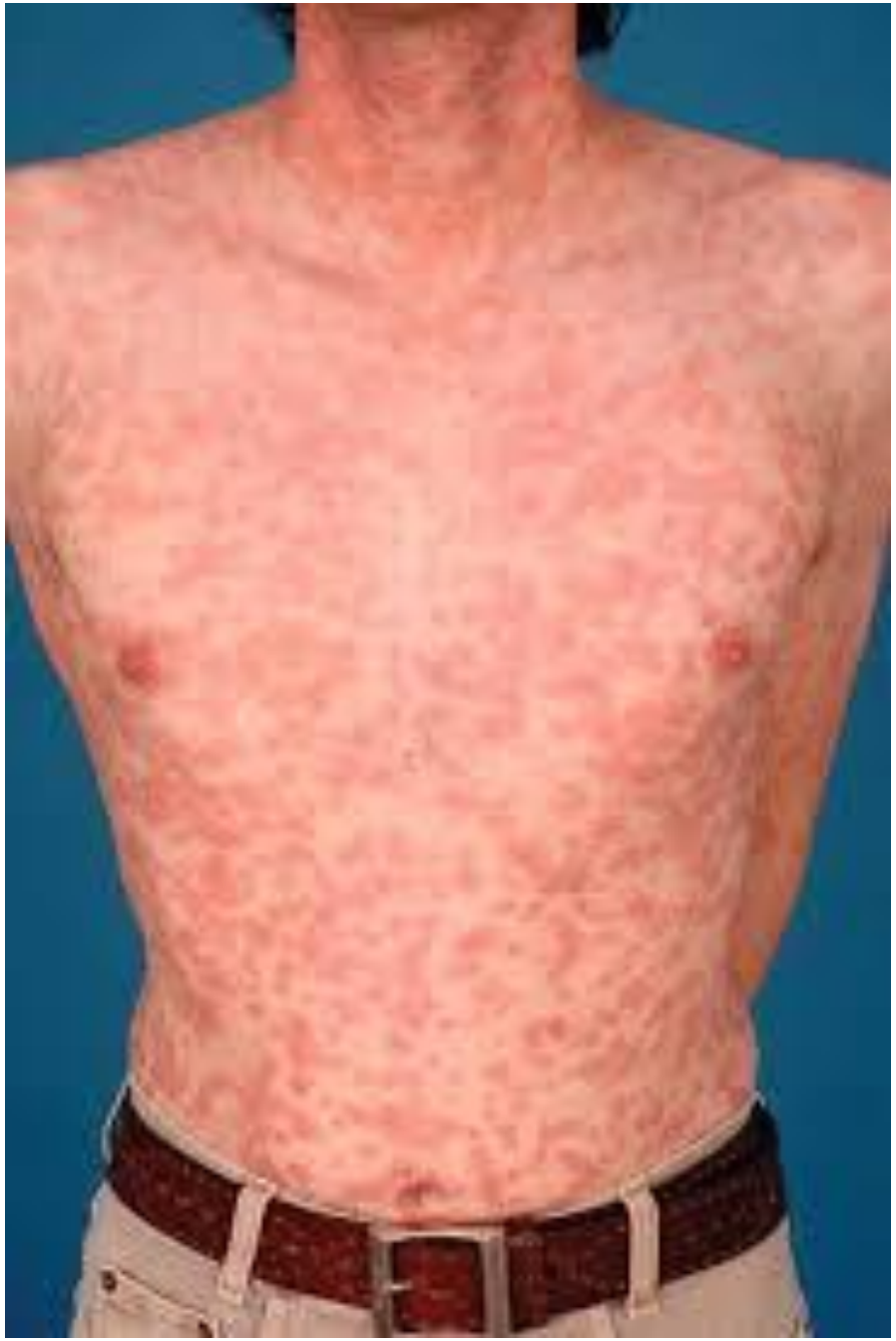
Treatment: Benzathine penicillin
2.4MU IM for primary

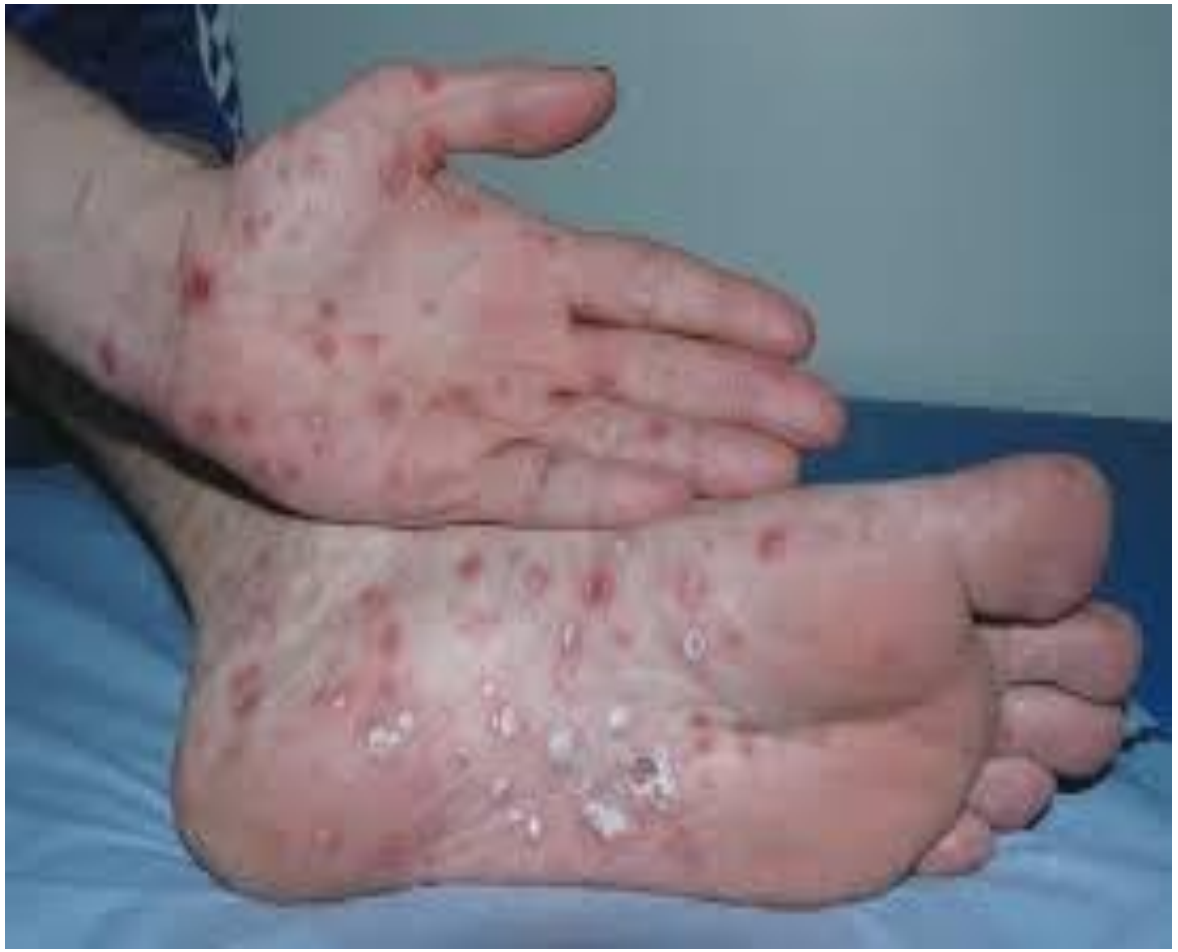
STS - Serological tests for syphilis ** may be negative in early disease



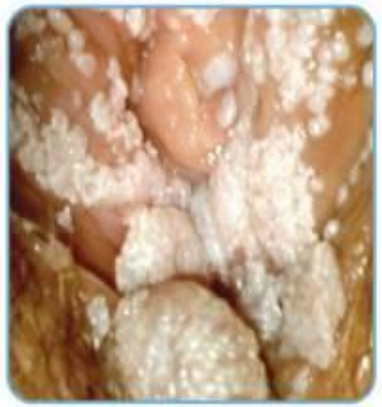
Dark ground microscopy

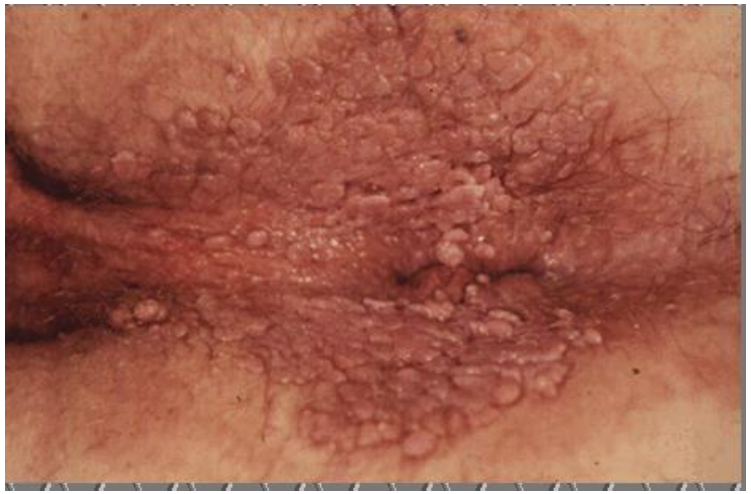






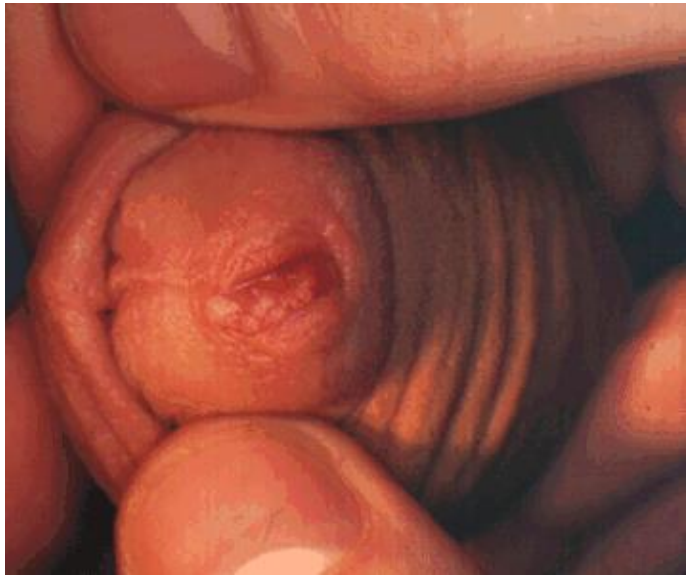
Genital warts





HPV Types 6 & 11 account for 90% of genital warts

HPV 6 & 11 infections are usually asymptomatic and resolve spontaneously - 90% within two years.



Treatment

- Destructive methods
  - LN2
  - podophylotoxin
  - Surgery
  - Diathermy
  - Curettage

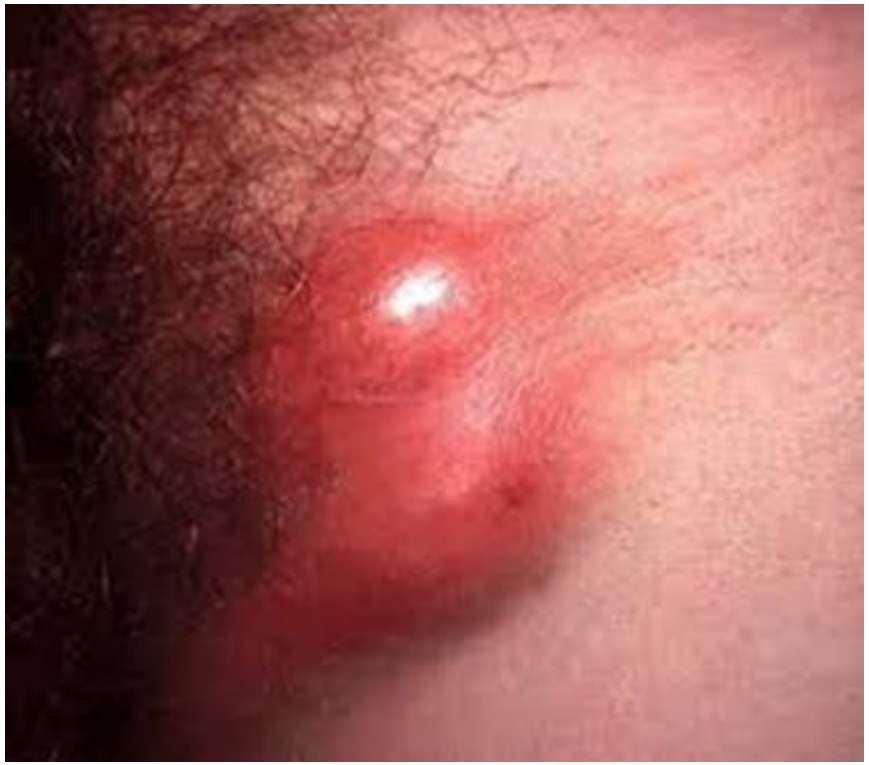
- Immune response modifiers
  - Imiquimod

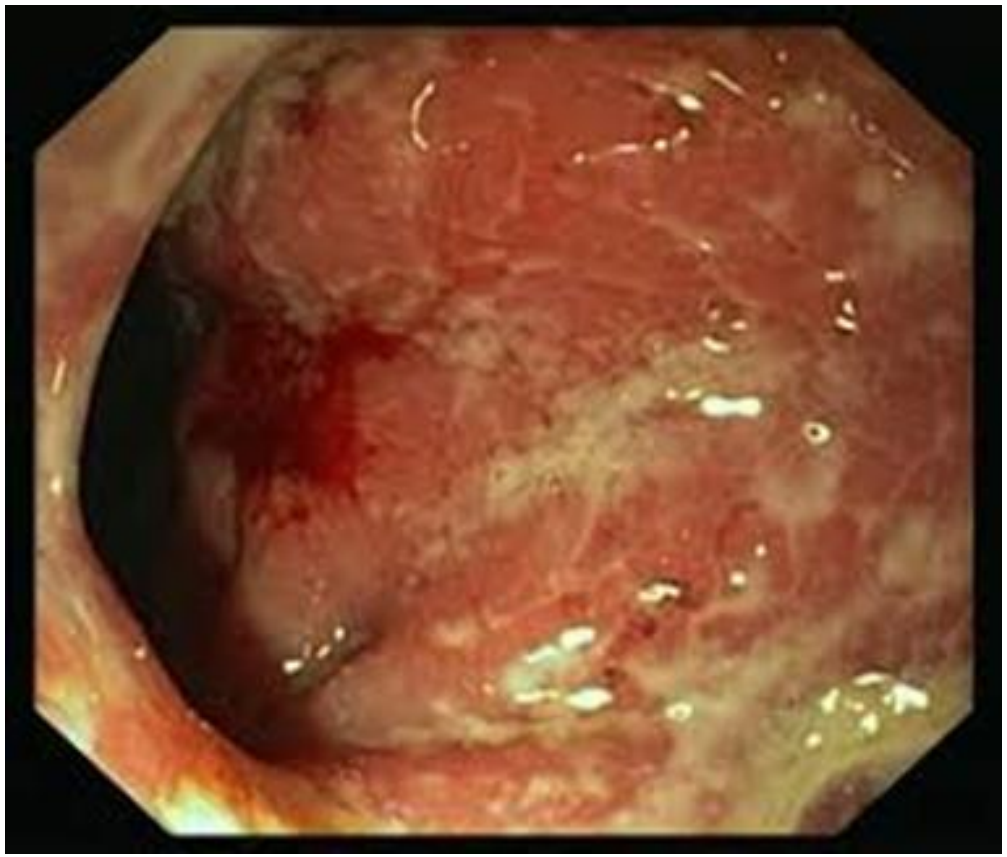
What’s new?

- Resistant GC
- Chem sex
- LGV
- Hepatitis C

LGV

- Chlamydia – invasive serovars L1,L2,L3
  - 80 cases per quarter
  - UK – highest global rates in MSM
  - 77% London, Brighton, Manchester
- Symptoms
  - Primary
    - Painless papule / pustule – may persist for weeks
    - Proctitis (96%) – blood/pus/pain
  - Secondary
    - Lymphadenopathy / bubo formation, usually unilateral ‘groove’ sign
    - Fever, arthritis, pneumonitis, hepatitis
  - Tertiary
    - Chronic inflammation, tissue destruction eg scarring, fibrosis, fistulae





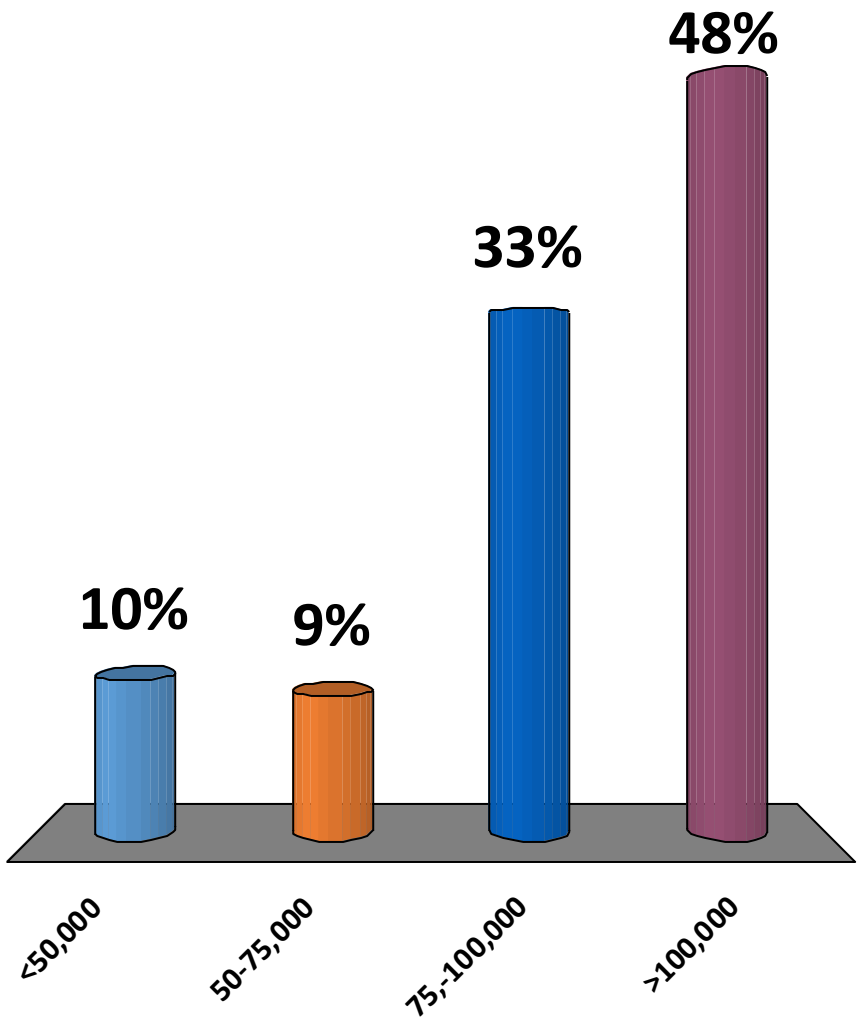
- Diagnosis
  - NAAT testing for CT, if positive test for LGV serovars at Colindale
- Treatment
  - 3 weeks of doxycycline 100 mg BD (or erythromycin / azithromycin)

HIV

Disease process, Epidemiology & Treatment

1. How many people are estimated to be living with HIV in the UK?

A. <50,000
B. 50-75,000
C. 75,-100,000
D. >100,000

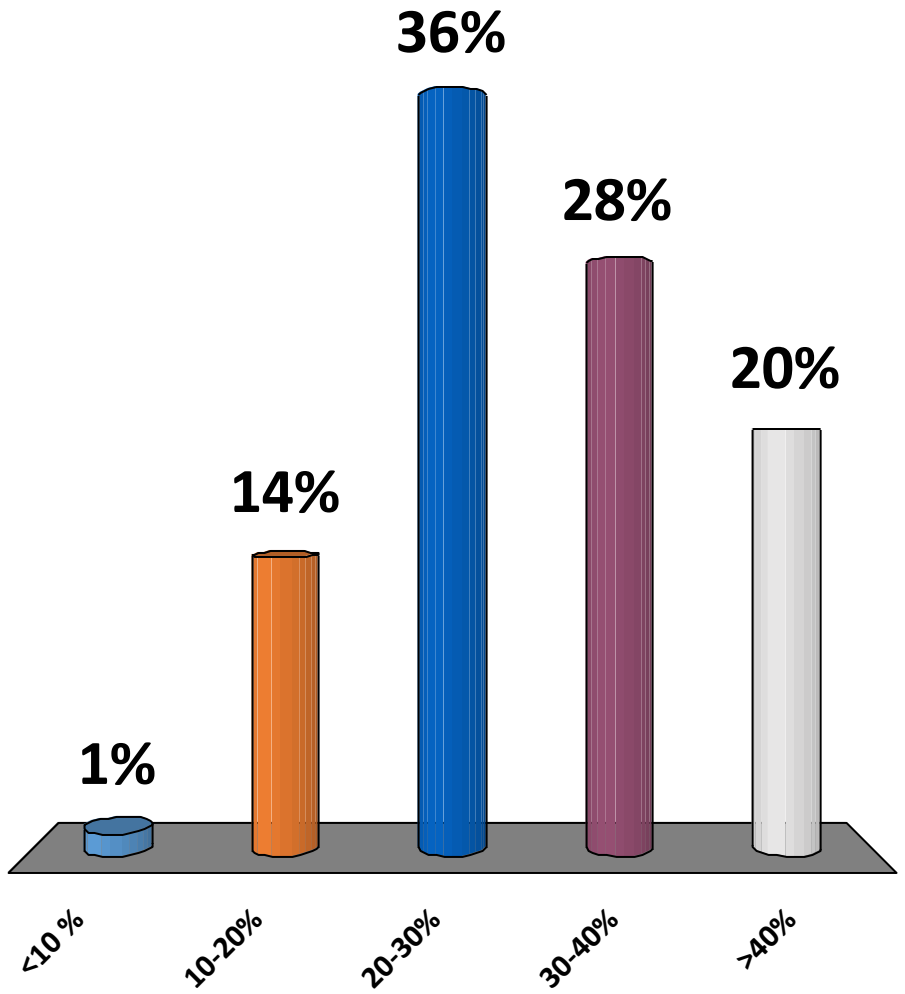


How many people are estimated to be living with HIV in the UK?

A. <50,000
B. 50 - 75,000
C. 75- 100,000 ✓
D. >100,000

2. What proportion of people with HIV remain undiagnosed?

A. <10 %
B. 10-20%
C. 20-30%
D. 30-40%
E. >40%

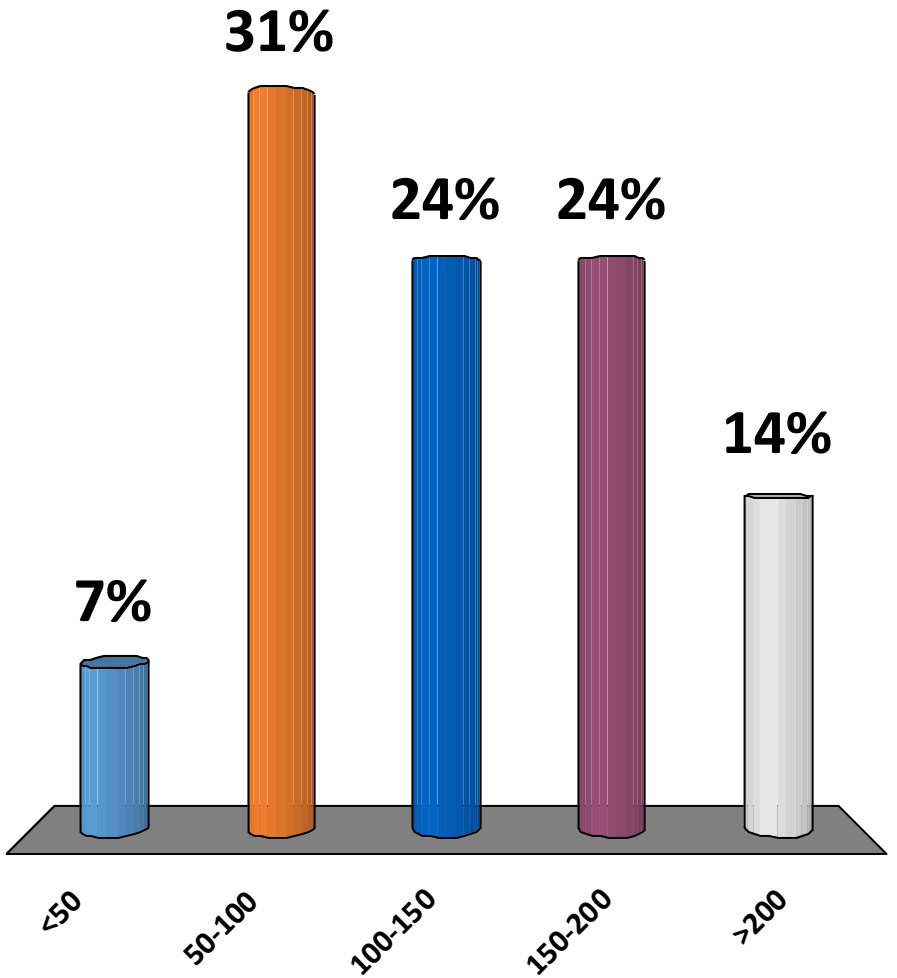


What proportion of people with HIV remain undiagnosed?

A. <10 %
B. 10-20%
C. 20-30% ✓
D. 30-40%
E. >40%

3. How many people living with HIV are accessing services in Barnsley?

A. <50
B. 50-100
C. 100-150
D. 150-200
E. >200

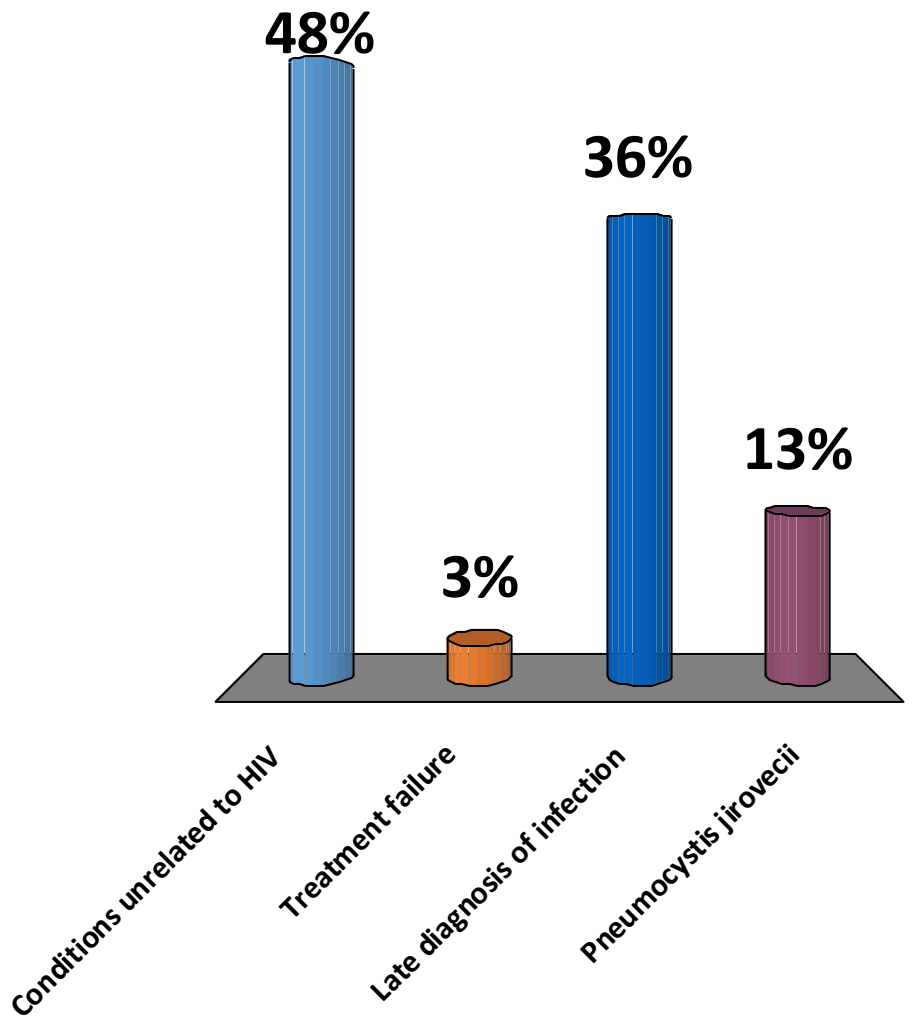


How many people living with HIV are accessing services in Barnsley?

A. <50
B. 50-100
C. 100-150
D. 150-200
E. >200

4. What is the main cause of death in people living with HIV?

A. Conditions unrelated to HIV
B. Treatment failure
C. Late diagnosis of infection
D. Pneumocystis jirovecii



What is the main cause of death in people living with HIV?

A. Conditions unrelated to HIV
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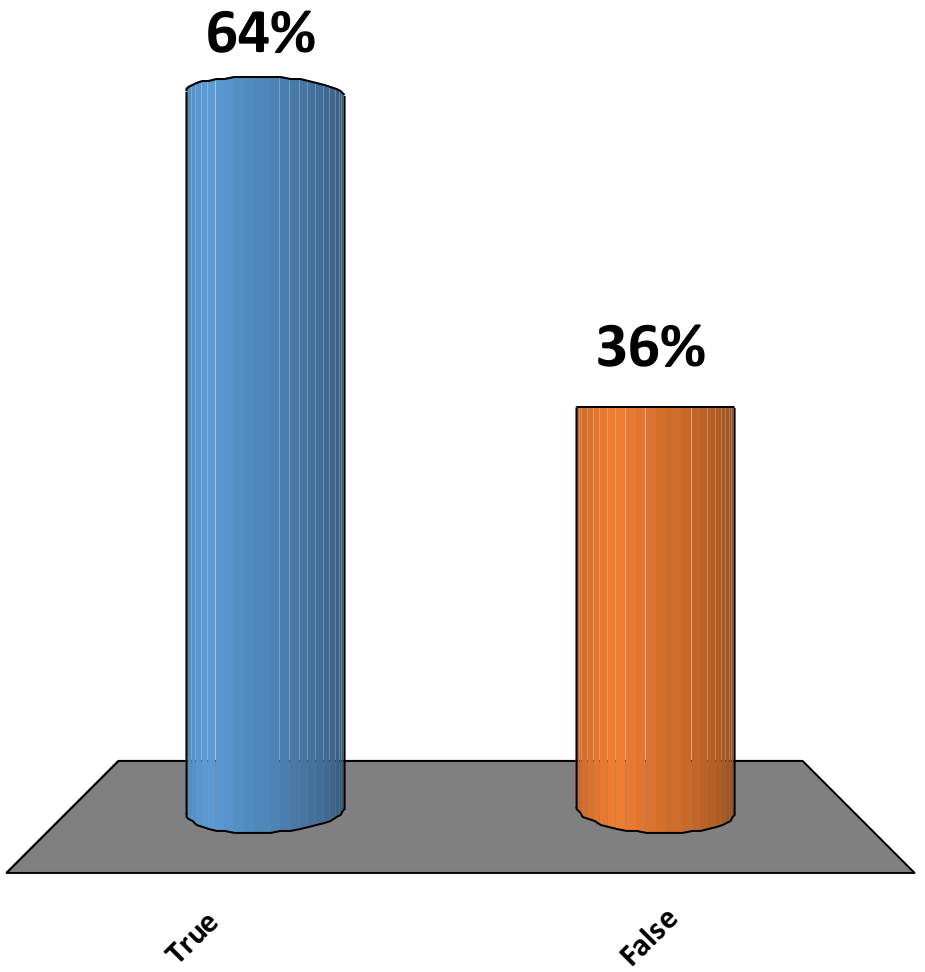
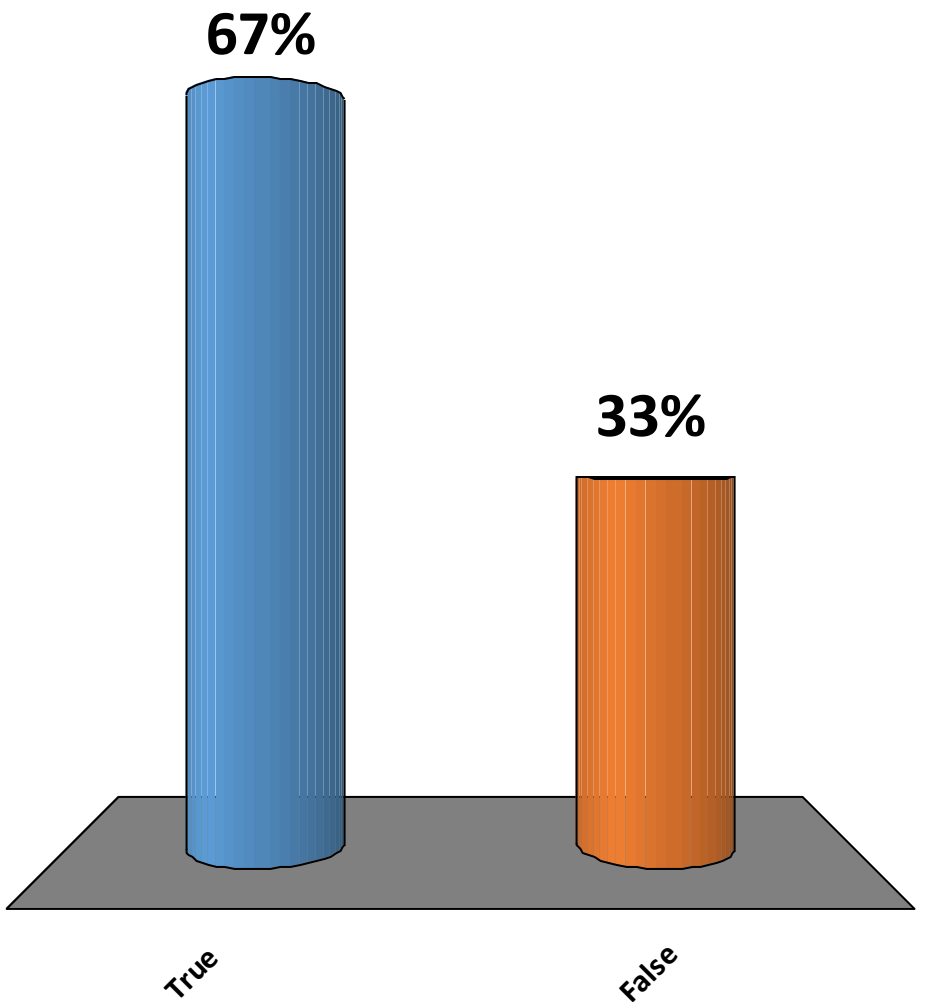
5. In order to do an HIV tests, pre-test counselling has to be undertaken

A. True
B. False



6. It takes 3 months following exposure for HIV to be reliably diagnosed on a blood test

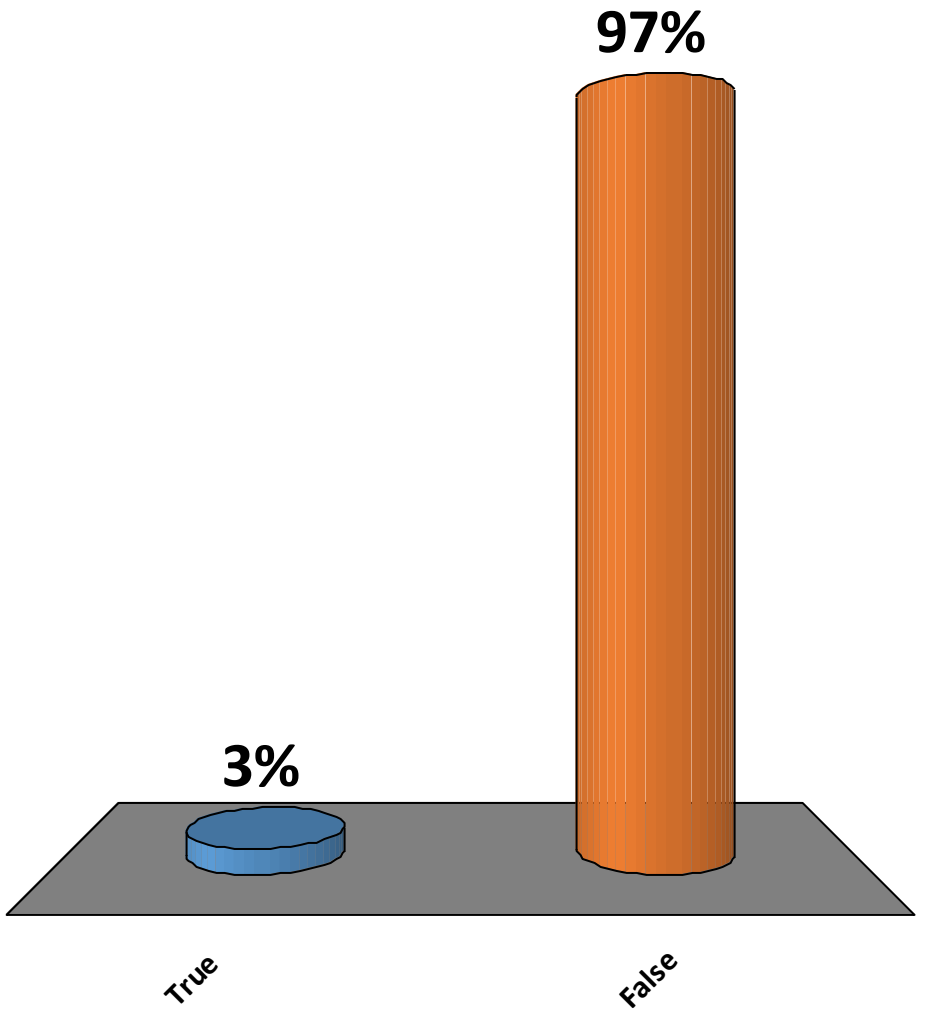
A. True
B. False



7. HIV tests should only be requested by practitioners with experience in sexual health issues

A. True

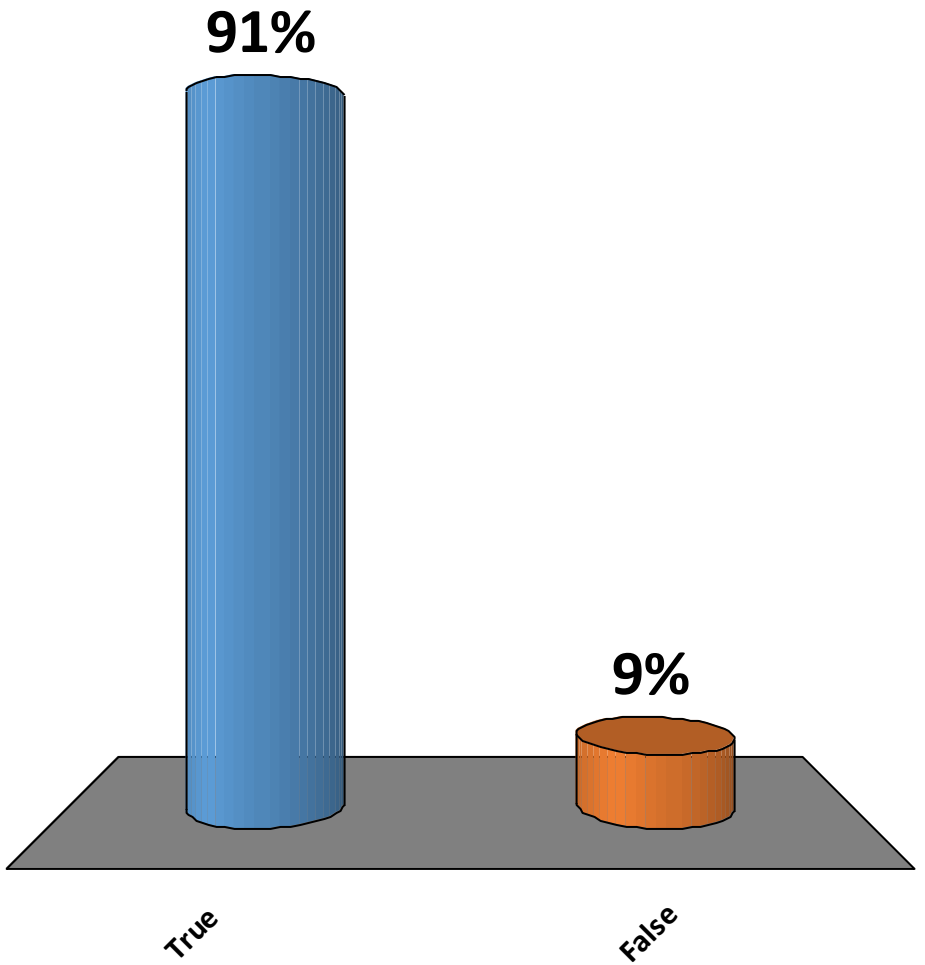
B. False



8. Any practitioner can request an HIV test, with verbal consent from the patient.

A. True

B. False



Which of the following statements is true?

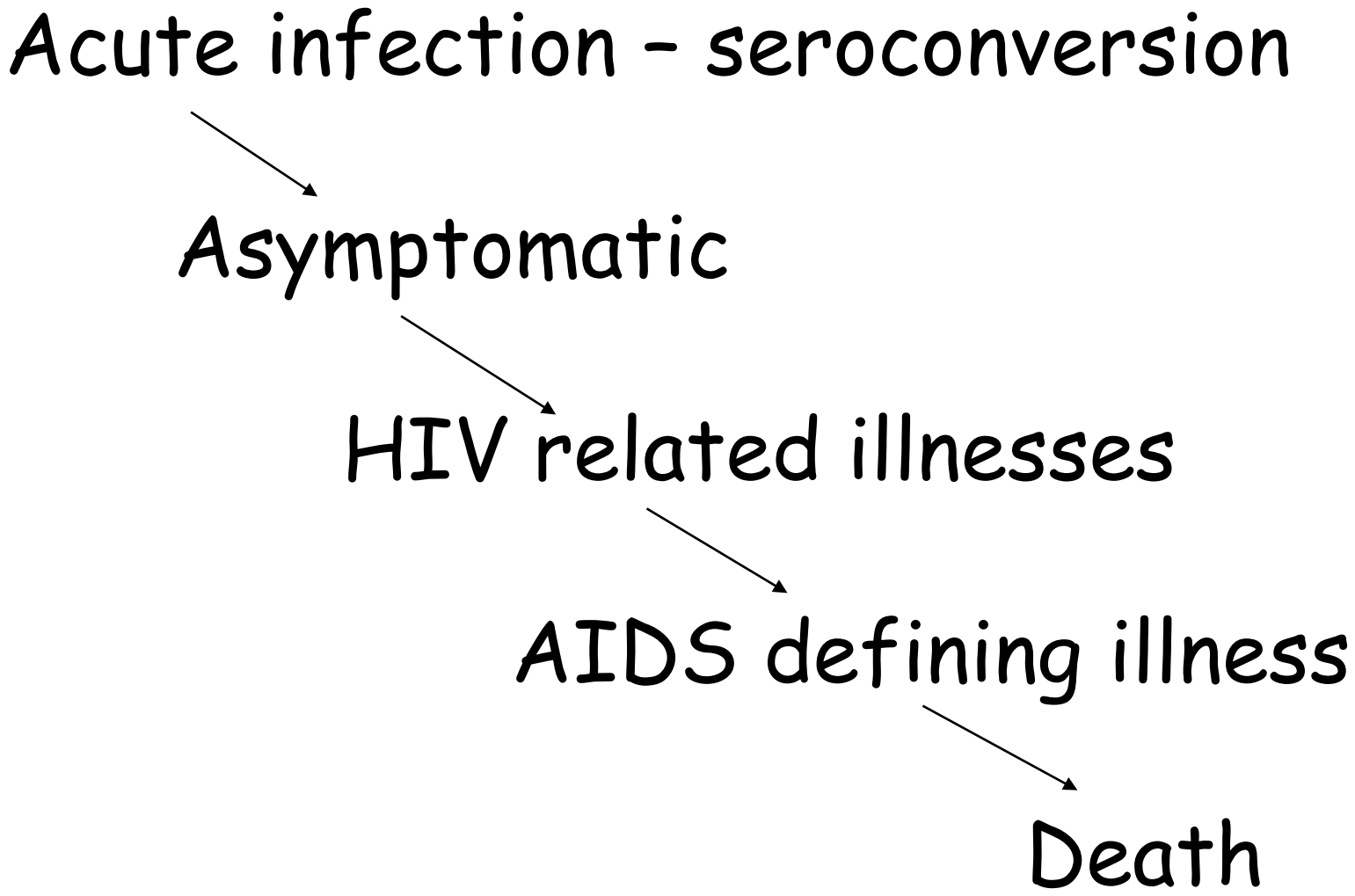
A. In order to do an HIV tests, pre-test counselling has to be undertaken
B. It takes 3 months following exposure for HIV to be reliably diagnosed on a blood test
C. HIV tests should only be requested by practitioners with experience in sexual health issues
D. Any practitioner can request an HIV test, with verbal consent from the patient.

HIV
- the basics

Acquisition

- Sex
- Vertical transmission
- Injecting drug use
- Blood transfusions with infected blood
- Percutaneous injury – needle stick

HIV infection



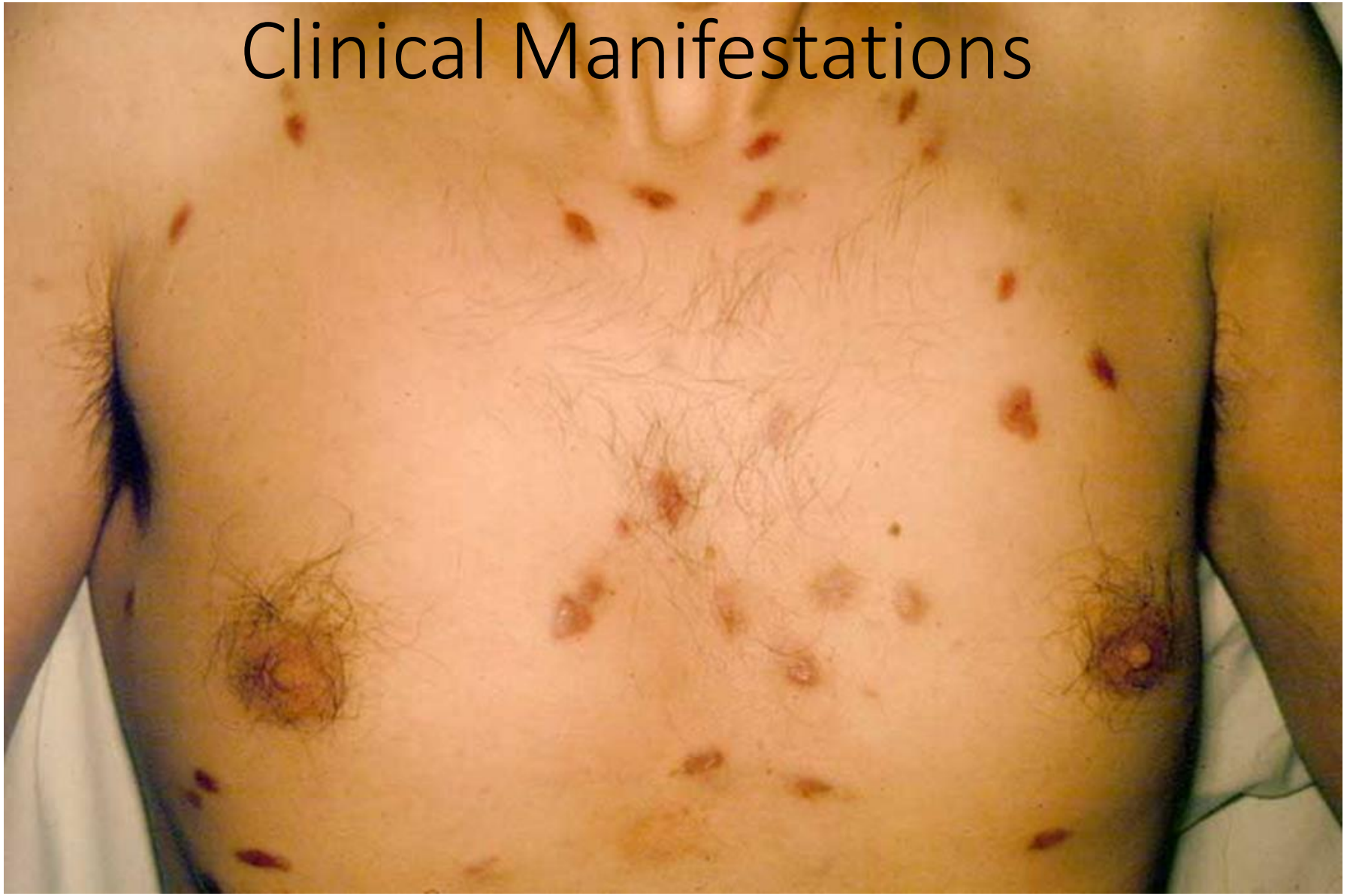
Sero-conversion	CD4 > 500	CD4 500 - 200	CD4 <200
○Fever ○Myalgia ○Arthralgia ○Adenopathy ○Malaise ○Rash ○Meningo-encephalitis	○Guillain-Barre syndrome ○Bell's palsy ○Polymyositis ○Chronic demyelinating neuropathy ○Idiopathic thrombo-cytopaenia ○Tinea	○Seborrhoeic dermatitis ○Gingivitis ○Warts ○Molluscum ○TB ○Herpes Zoster/ Simplex ○Oral candida ○KS ○CIN ○Primary CNS lymphoma	○Cryptosporidiosis ○PCP ○Toxoplasmosis ○Cryptococcal meningitis ○CMV ○MAC

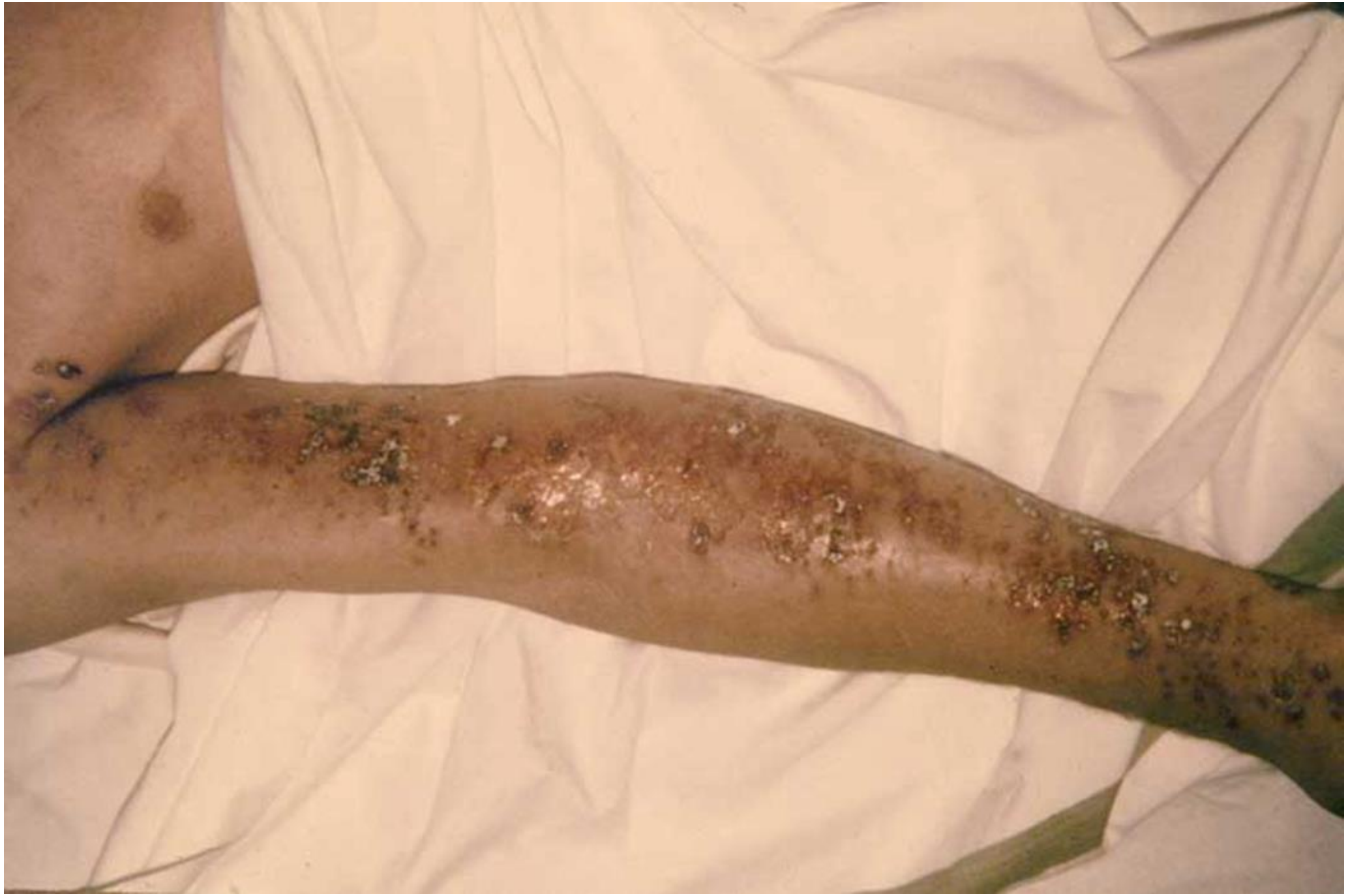
Primary HIV infection

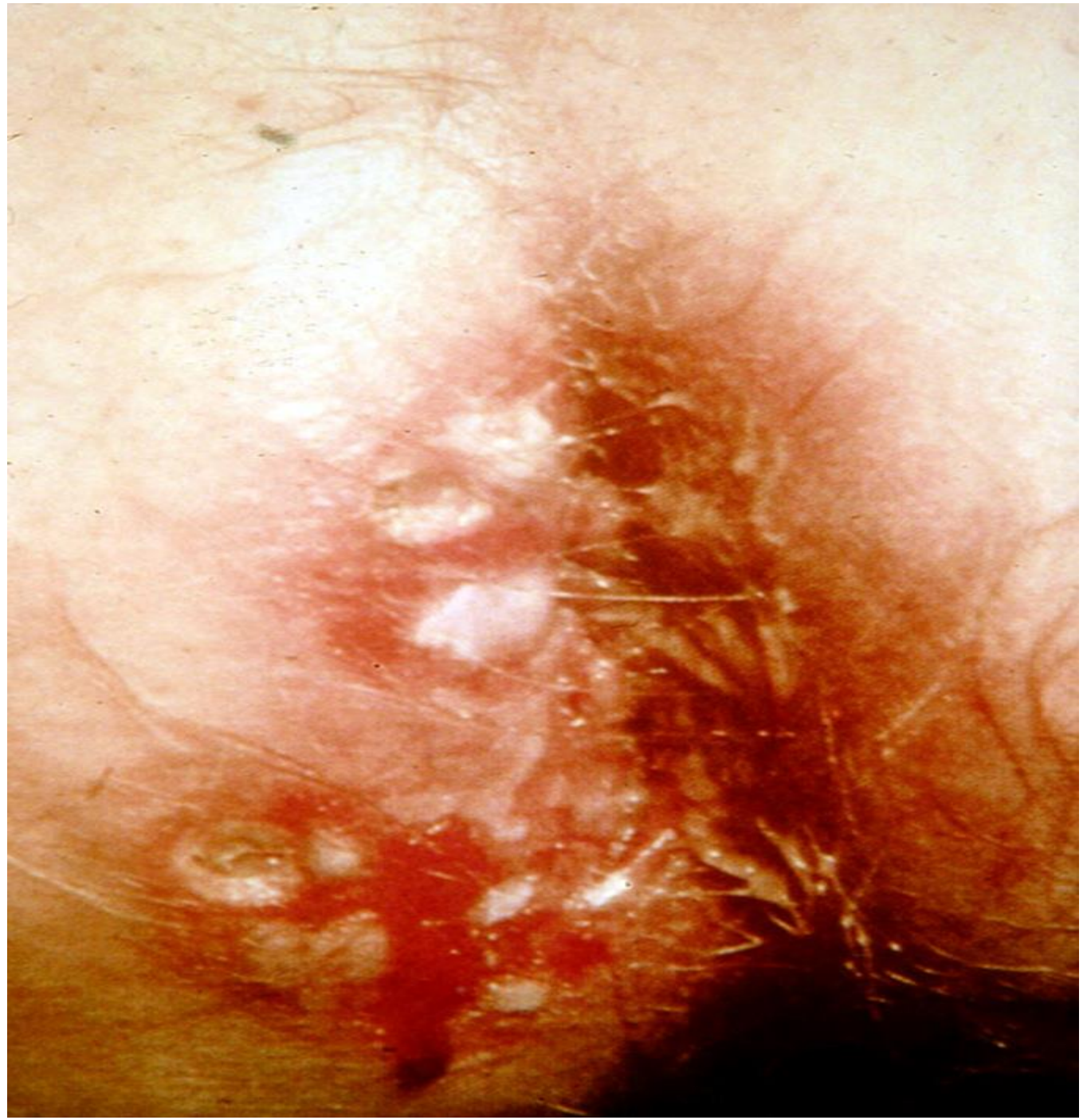
Classical triad of:

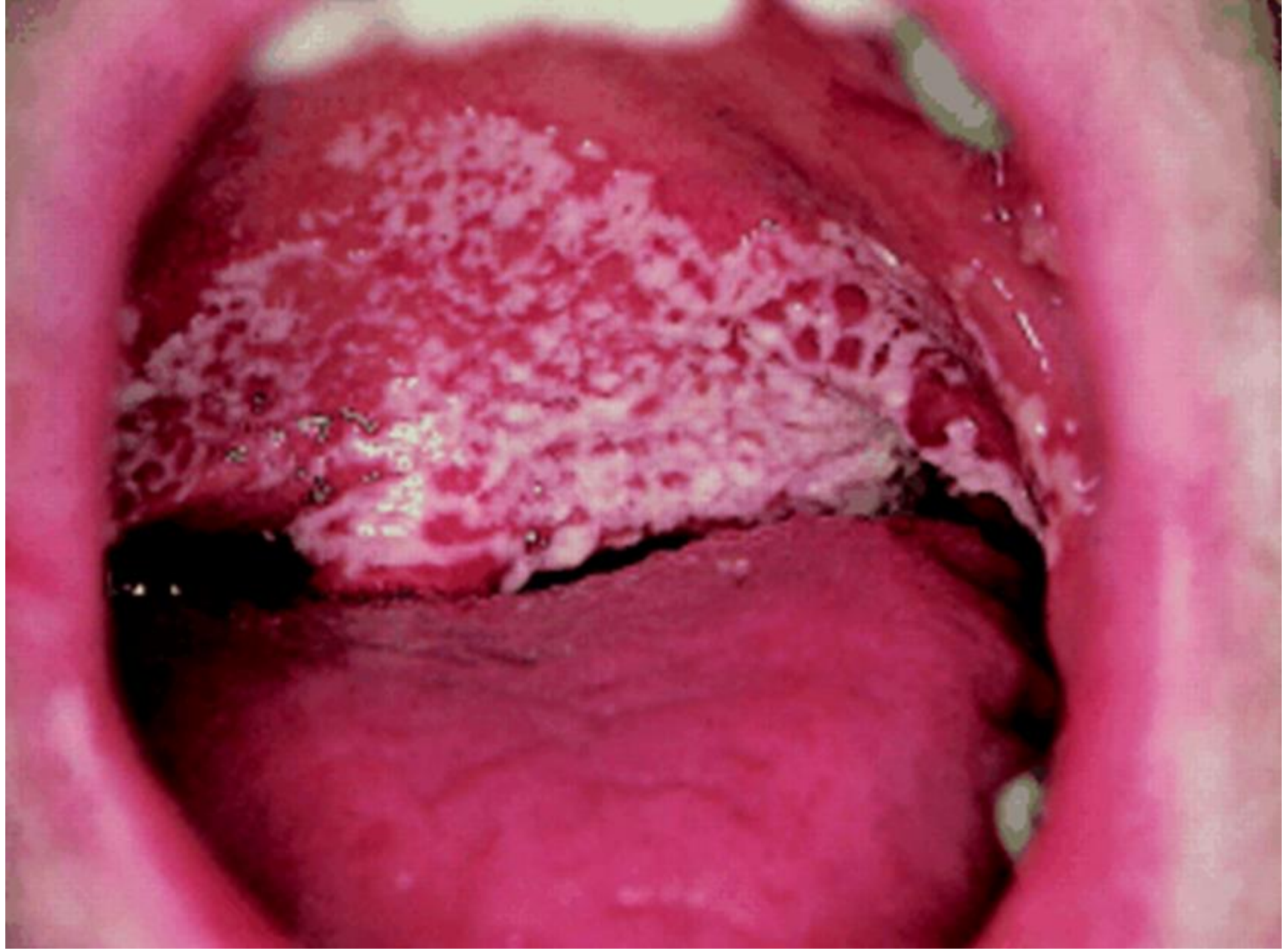
-Pharyngitis
-Rash
-Fever

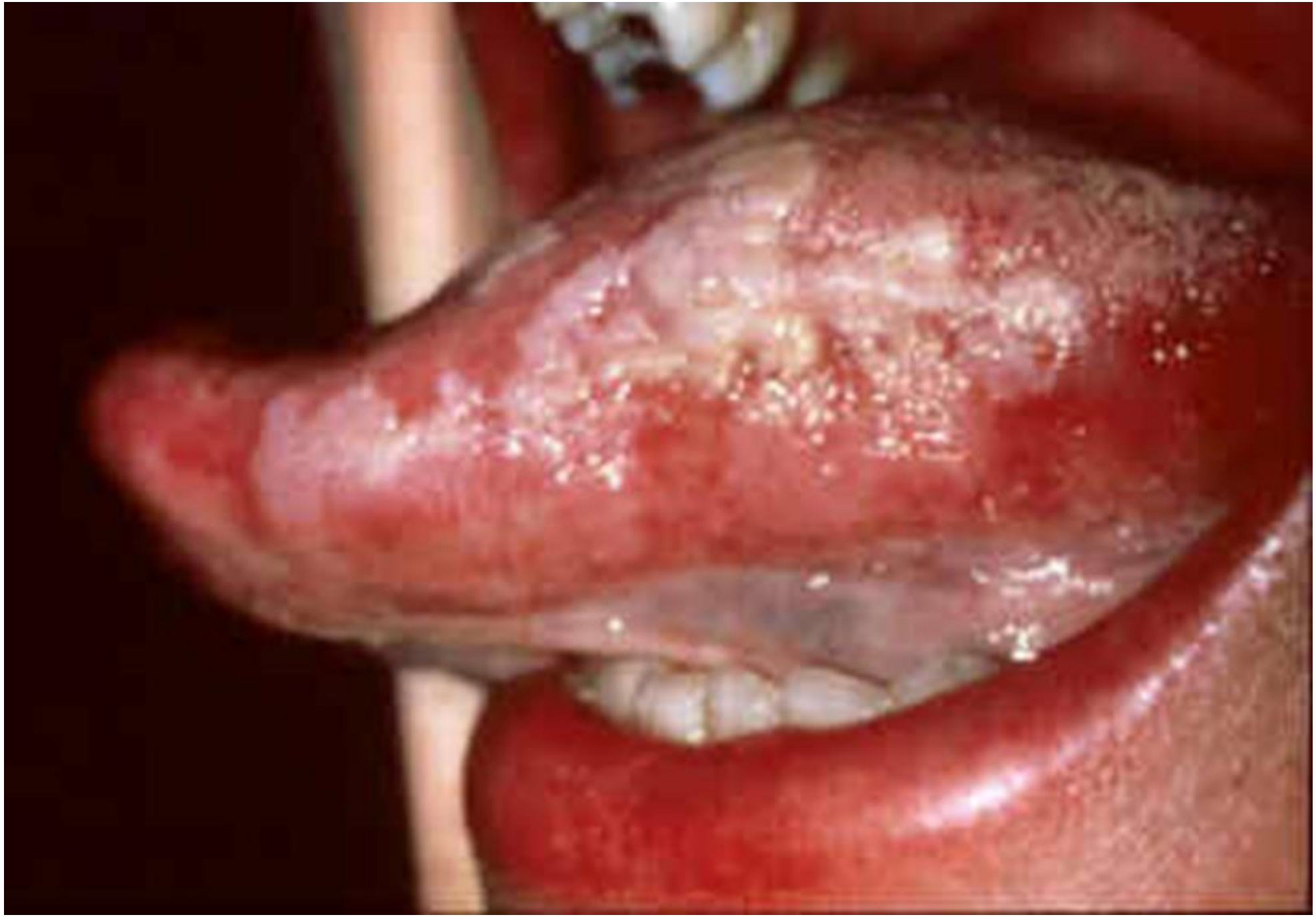
Clinical Manifestations

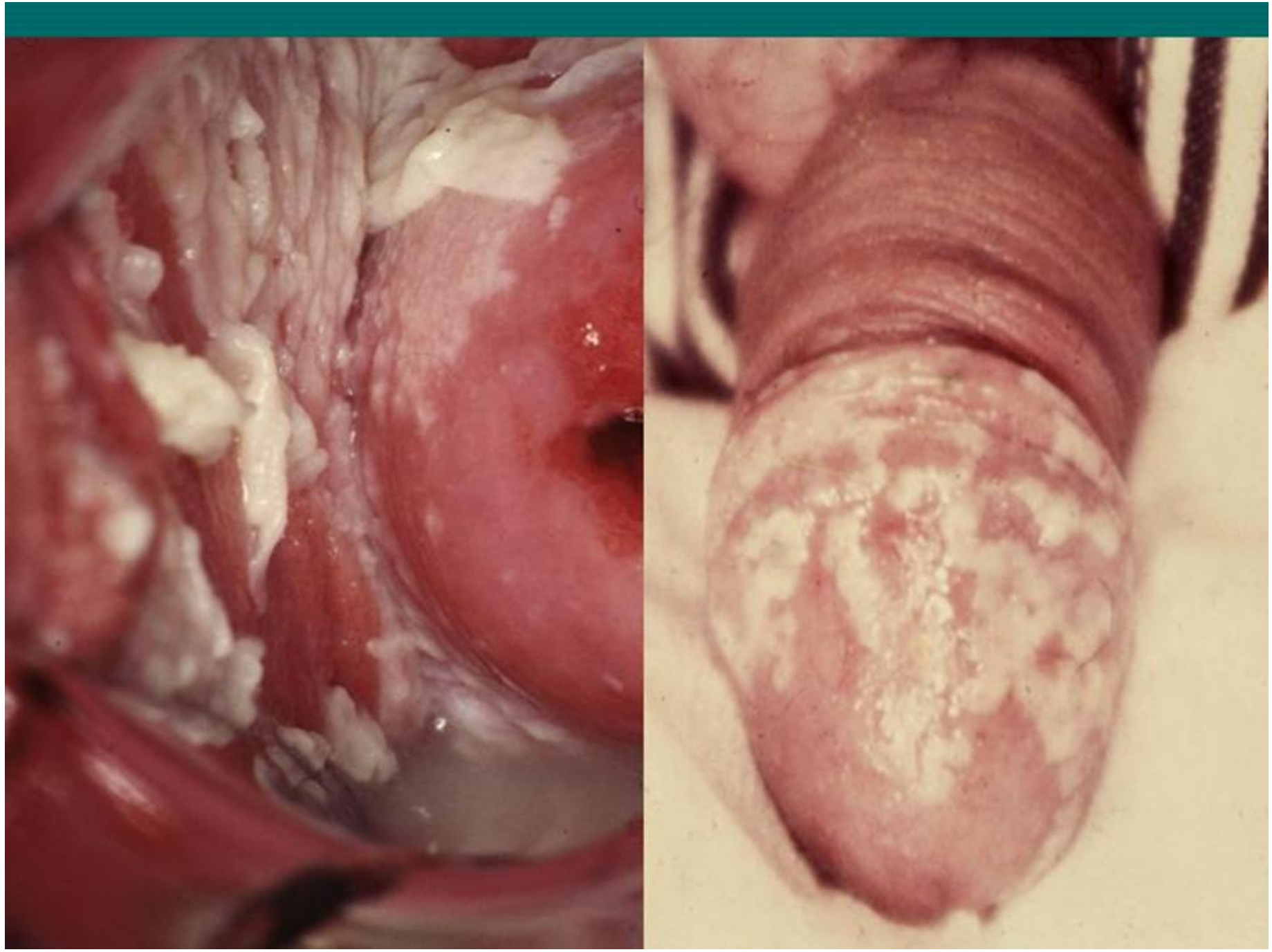


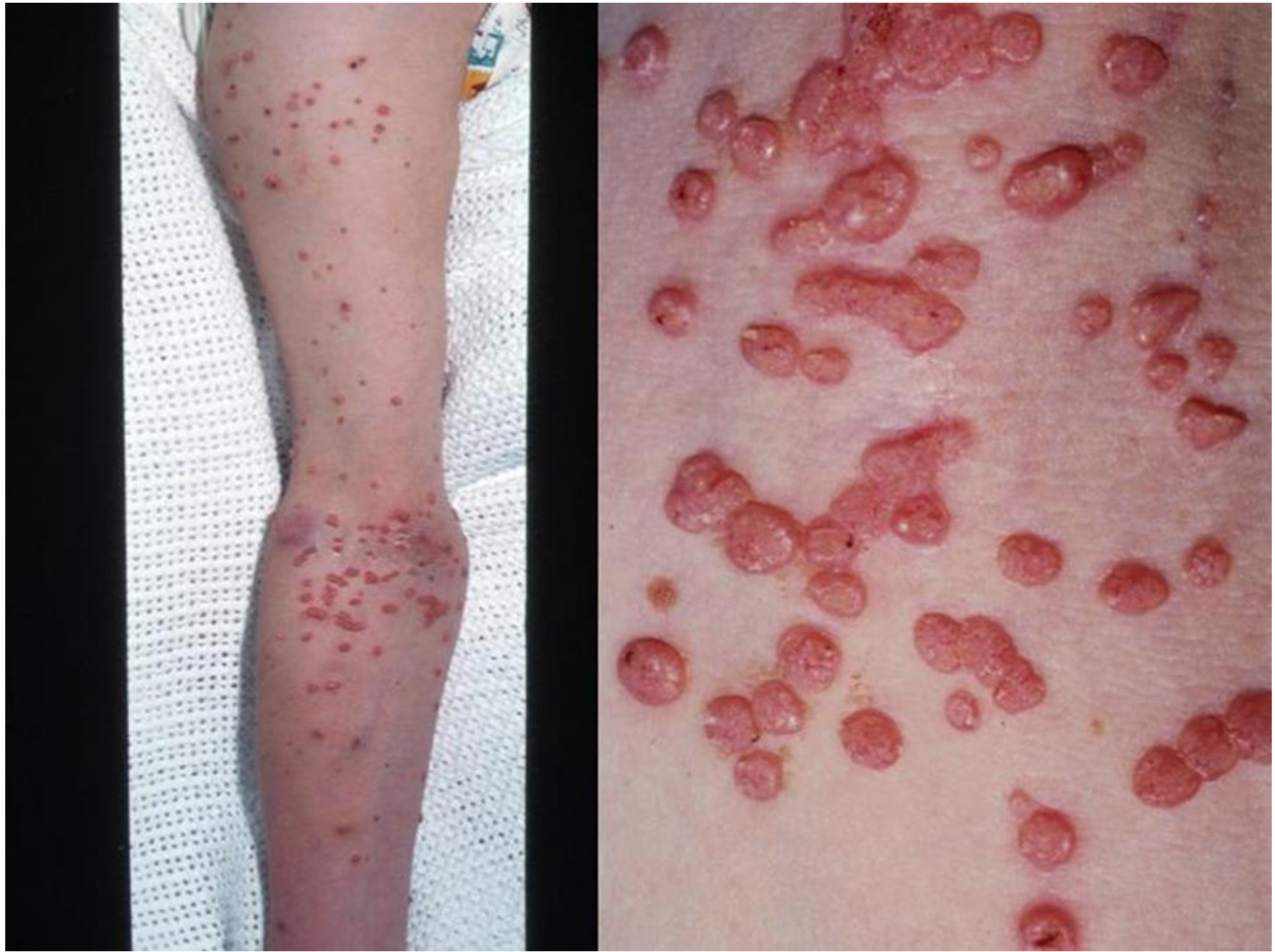


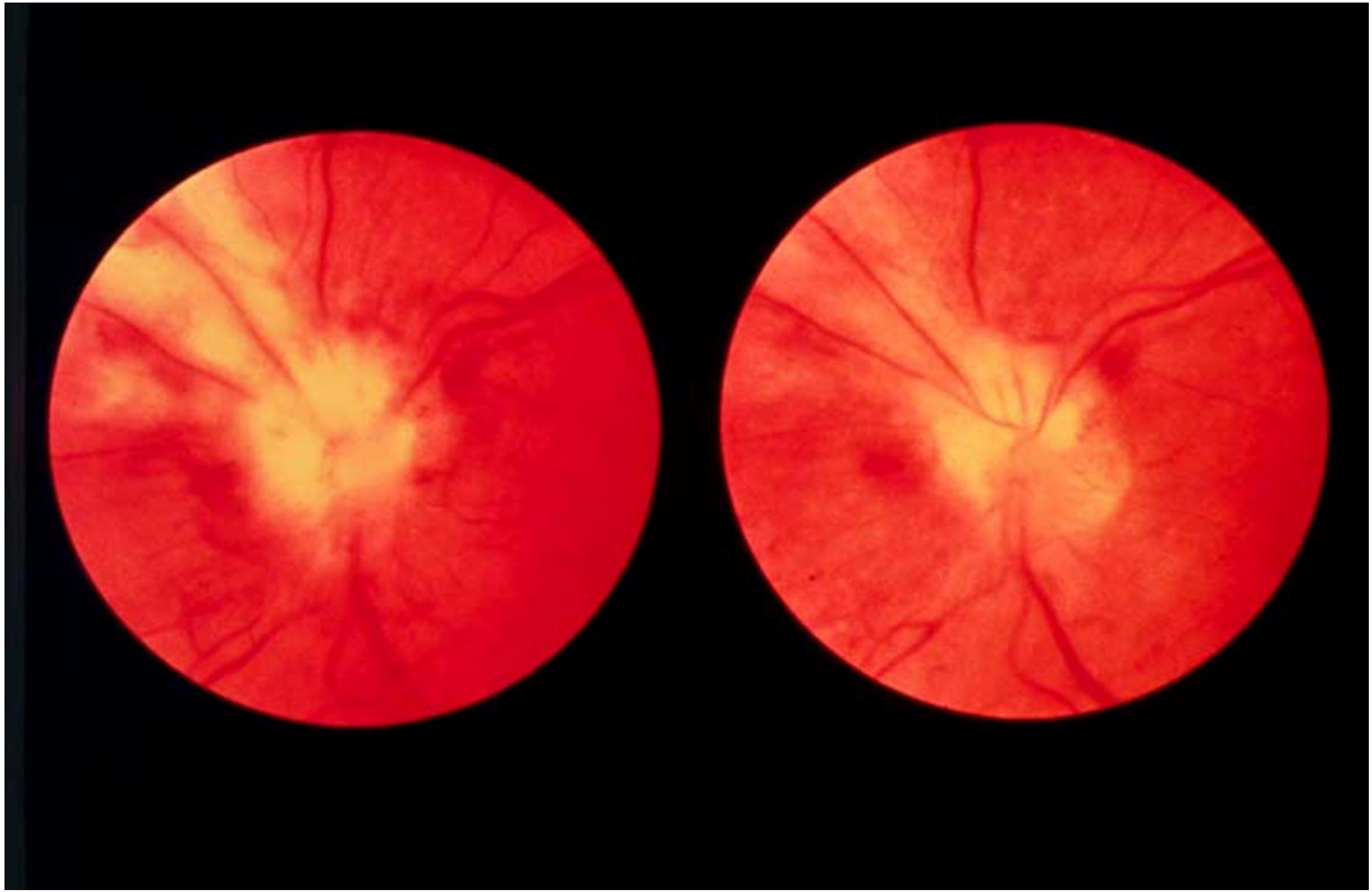










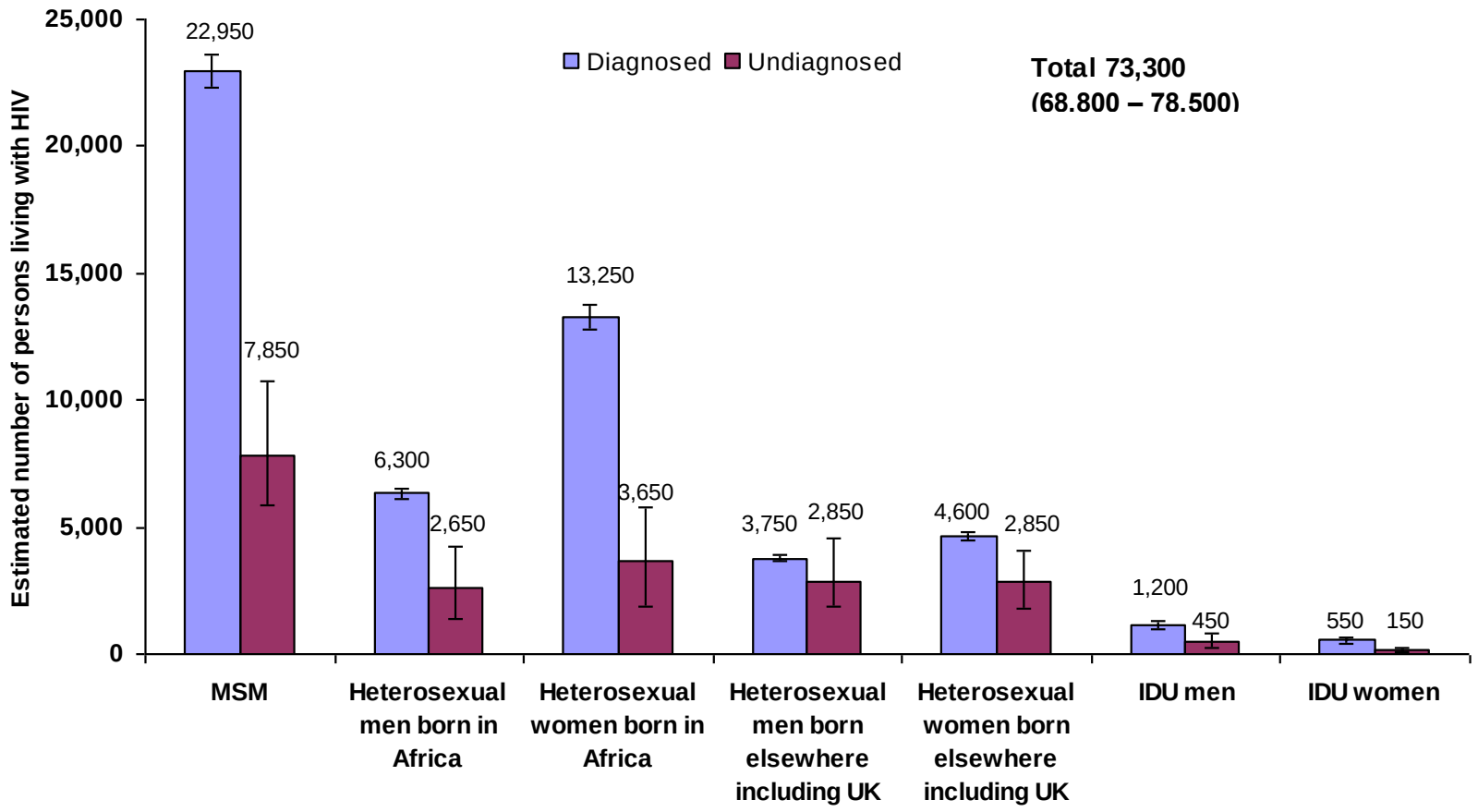


HIV in the UK

- There are currently an estimated 96,000 people with HIV in the UK.
- 24% of those infected (>23,000) remain undiagnosed – HPA 2011
- 47% of new HIV diagnoses are diagnosed late (CD4 < 350). 56% of women are diagnosed late.
- 35% of HIV-related deaths attributable to late diagnosis – BHIVA audit 2006
- Effective treatments greatly reduce morbidity
- Better response to treatment if started early
- Fully suppressed viral loads reduce onward transmission

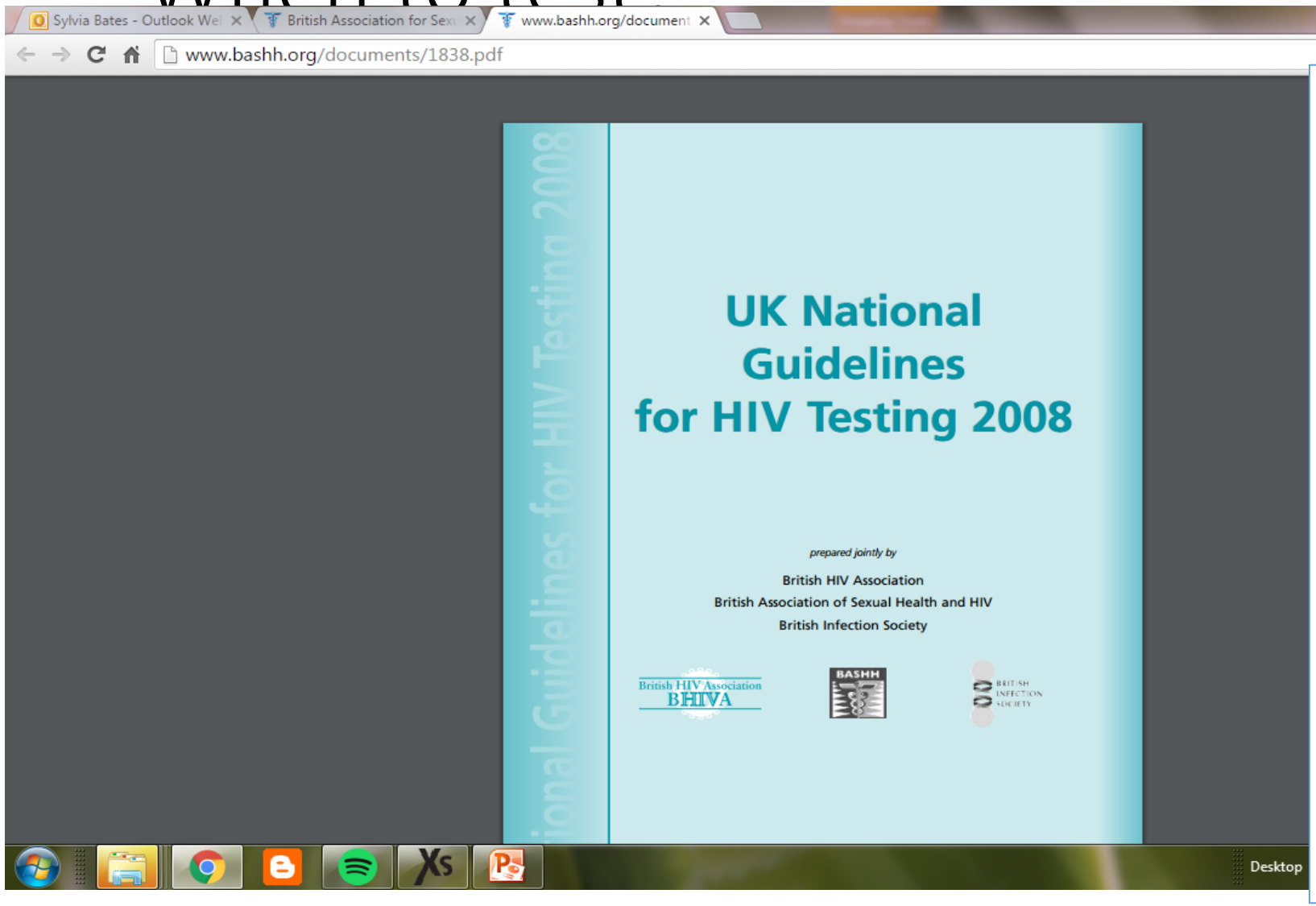
British HIV Association. Mortality Audit 2005-6.
www.bhiva.org/documents/ClinicalAudit/FindingsandReports/MortalityAudit.ppt

Estimated number of adults (15 to 59 years) living with HIV (both diagnosed and undiagnosed) in the UK: 2007



MPES

When to test?



TOP 3

1. TB
2. BBV – Hep B / C
3. Lymphoma

B. An HIV test should be considered in the following settings where diagnosed HIV prevalence in the local population (PCT/LA) exceeds 2 in 1000 population (see local PCT data[†]):

1. all men and women registering in general practice
2. all general medical admissions.

The introduction of universal HIV testing in these settings should be thoroughly evaluated for acceptability and feasibility and the resultant data made available to better inform the ongoing implementation of these guidelines.

C. HIV testing should be also routinely offered and recommended to the following patients:

1. all patients presenting for healthcare where HIV, including primary HIV infection, enters the differential diagnosis (*see* table of indicator diseases and section on primary HIV infection)
2. all patients diagnosed with a sexually transmitted infection
3. all sexual partners of men and women known to be HIV positive
4. all men who have disclosed sexual contact with other men
5. all female sexual contacts of men who have sex with men
6. all patients reporting a history of injecting drug use
7. all men and women known to be from a country of high HIV prevalence (>1%*)
8. all men and women who report sexual contact abroad or in the UK with individuals from countries of high HIV prevalence.*

* for an up to date list *see*

UK National Guidelines for HIV Testing 2008

Table 1: Clinical indicator diseases for adult HIV infection

	AIDS-defining conditions	Other conditions where HIV testing should be offered
Respiratory	Tuberculosis Pneumocystis	Bacterial pneumonia Aspergillosis
Neurology	Cerebral toxoplasmosis Primary cerebral lymphoma Cryptococcal meningitis Progressive multifocal leucoencephalopathy	Aseptic meningitis/encephalitis Cerebral abscess Space occupying lesion of unknown cause Guillain–Barré syndrome Transverse myelitis Peripheral neuropathy Dementia Leucoencephalopathy
Dermatology	Kaposi's sarcoma	Severe or recalcitrant seborrhoeic dermatitis Severe or recalcitrant psoriasis Multidermatomal or recurrent herpes zoster

Gastroenterology	Persistent cryptosporidiosis	Oral candidiasis Oral hairy leukoplakia Chronic diarrhoea of unknown cause Weight loss of unknown cause Salmonella, shigella or campylobacter Hepatitis B infection Hepatitis C infection
Oncology	Non-Hodgkin's lymphoma	Anal cancer or anal intraepithelial dysplasia Lung cancer Seminoma Head and neck cancer Hodgkin's lymphoma Castleman's disease
Gynaecology	Cervical cancer	Vaginal intraepithelial neoplasia Cervical intraepithelial neoplasia Grade 2 or above
Haematology		Any unexplained blood dyscrasia including: • thrombocytopenia • neutropenia • lymphopenia
Ophthalmology	Cytomegalovirus retinitis	Infective retinal diseases including herpesviruses and toxoplasma

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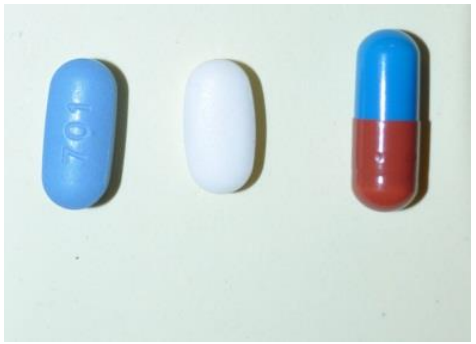
Ophthalmology	Cytomegalovirus retinitis	Infective retinal diseases including herpesviruses and toxoplasma Any unexplained retinopathy
ENT		Lymphadenopathy of unknown cause Chronic parotitis Lymphoepithelial parotid cysts
Other		Mononucleosis-like syndrome (primary HIV infection) Pyrexia of unknown origin Any lymphadenopathy of unknown cause Any sexually transmitted infection

HAART

- At least 4 useful, widely available single tablet regimens
- ‘Cleaner’ drugs – fewer side effects
- Newer drug groups with fewer drug-drug interactions
- Compliance is the key to successful treatment

ART is for life - *Never* advise a patient to stop

ART without advice from HIV unit



Benefits of treatment

- Preservation of immune function
- Improved life expectancy
- Reduced onward transmission
- Reduction of mother to baby transmission
- Fewer hospital admissions

What to watch out for in Primary Care

- A few patients still choose not to disclose

- Watch out for drug interactions. Common culprits:
  - Statins
  - Omeprazole

www.hiv-druginteractions.org

- Live vaccinations

How to do an HIV test

You need one of these....

……verbal consent and a standard microbiology form – simply request HIV test!

You do not need….

Formal pre test counselling*, written consent, cat 3 stickers (unless other risk), special permission!

** If patient identified as being at high risk of infection GUM health advisors will come and see patient*


DAVID SCHARF / PHOTO RESEARCHERS INC.