

Guidance for STD Clinical Preventive Services for Persons Infected With HIV

CALIFORNIA STD CONTROLLERS ASSOCIATION AND
CALIFORNIA COALITION OF LOCAL AIDS DIRECTORS

A CONSIDERABLE AMOUNT of epidemiologic data has accumulated over the last decade showing that sexually transmitted diseases (STDs) such as syphilis, chancroid, herpes, gonorrhea, chlamydia, and trichomoniasis and abnormalities of the vaginal ecosystem (i.e., bacterial vaginosis) facilitate HIV transmission (two- to fivefold with ulcerative STDs increasing the risk the most). Clinical research has shown that symptomatic STDs increase HIV shedding among persons infected with HIV and it is likely that asymptomatic infections also produce some inflammation with resultant increased HIV shedding. One randomized trial in an African community showed that improving community level STD control decreased HIV incidence by 40%.

After reviewing available data, the CDC Advisory Committee for HIV/STD Prevention released recommendations (MMWR Morb Mortal Wkly Rpt July 1998; 47:RR-12) concluding that STDs facilitate HIV transmission and that controlling STDs should be added to behavioral change as a primary HIV prevention intervention. In the United States the attributable fraction of HIV transmission facilitated by STDs has not been determined. Studies to quantitate the contribution of STDs, both symptomatic and asymptomatic, in HIV transmission are difficult to conduct and it will be many years before such data will be available. However, the

committee commented that the effect of STD control on HIV prevention should be most apparent in populations with a high STD prevalence. Given all the evidence, the committee recommended that STD prevention and control be incorporated as an explicit component in HIV prevention plans.

Even though the role of asymptomatic STDs and genital tract inflammation from non-STD organisms in increasing HIV shedding has not yet been clearly quantified, the committee recommended that persons infected with HIV (potential transmitters) be screened for STDs as part of clinical preventive services. It follows that these services could be most easily delivered (from the client's point of view) during their initial HIV medical evaluation and during periodic medical care visits. If unsafe sexual behavior is occurring, and is likely to continue, risk reduction counseling should be provided and STD screening should be repeated as necessary (see Appendix B). Ryan White resources (HIV Care) are available to cover STD screening (such as urine-based chlamydia and gonorrhea nucleic acid amplification tests, and a pelvic examination to identify trichomoniasis and bacterial vaginosis). The cost for these STD tests compared with the cost of failure to prevent HIV transmission warrants STD screening as a means of HIV prevention.

Since symptomatic STDs have been clearly shown to increase HIV shedding, counseling patients infected with HIV about STD symptom recognition and the importance of refraining from sexual activity until effective treatment is completed is important. Patients should know where they can receive prompt diagnosis and treatment of STDs. STD clinics can provide a backup service for diagnosis and treatment when necessary.

Clinicians are urged to conduct a sexual risk assessment that includes an STD history and to discuss strategies with the patient that will facilitate adoption of risk-reducing behavior that the patient believes he/she can perform. These data should be recorded in the medical record. Preprinted forms with standardized questions can help to assure that all the basic risk behavior issues and STD history are covered, and can serve as

This document was developed by infectious disease experts of the California STD Controllers Association (CSTDCA), the California Conference of Local AIDS Directors (CCLAD), the STD Control Branch and the Office of AIDS, California Department of Health Services. Evidence reviewed in this process included local STD prevalence data among persons with HIV or in at-risk groups. The Guidance was written by Robert A. Gunn, MD, MPH, Past Chair, CSTDCA, and STD Control Officer, Office of Public Health, Health and Human Services Agency, San Diego, CA; Jeffrey D. Klausner, MD, MPH STD Control Officer, Department of Public Health, San Francisco, CA; and Alice Gandelman, MPH, Director, California STD/HIV Prevention Training Center, Berkeley, CA. The membership of both the CSTDCA and CCLAD approved the final document.

Correspondence: Robert A. Gunn, MD, MPH, STD Control Officer, 3851 Rosecrans Street, San Diego, CA 92110. E-mail: rgunnxhe@co.san-diego.ca.us

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TABLE 1. STD Clinical Preventive Services and Screening Recommendations for HIV-Infected Persons on Initial Visit and Whenever Sexual Exposure Indicates Repeat Screening

All patients	
Gonorrhea	Amplification*—urine or urethral/endocervical specimen or Culture
Chlamydia	Amplification*—urine or urethral/endocervical specimen
Syphilis serology	RPR or VDRL [†]
Herpes history or HSV-2 serology	Counsel about herpes symptom recognition and increased HIV viral shedding during symptomatic phase [‡]
Hepatitis B vaccination [§]	
Oral or rectal exposure (last 3 months)	
Gonorrhea	Rectal/pharyngeal culture
Injection drug use	
Ever	Hepatitis C serology, [¶] hepatitis B serology
Current	Hepatitis A vaccination
Fecal contact—insertive rectal/oral-anal	Hepatitis A vaccination
Women	
Pelvic examination	Examination of vaginal fluid and pH determination for trichomoniasis and bacterial vaginosis

*Amplification of nucleic acid most sensitive test; nonamplified DNA tests (GenProbe) are not recommended.

[†]Syphilis serology—quantitative RPR (preferred) or VDRL. If reactive, follow with a confirmatory test—TPPA or FTA.

[‡]Optional test—May be useful in clinical management and may help identify HSV-2 symptoms that patient did not recognize. HIV shedding is increased during genital HSV symptoms. HSV-1 serology may also be helpful in some cases since 20–40% of genital herpes is caused by HSV-1.

[§]Hepatitis B serology is indicated among high-risk clients such as injecting drug users and men who have sex with men to determine immune status and identify chronic HBV infection. Persons with chronic HBV infection need evaluation of liver function and counseling about how to prevent transmission. Sex and needle/drug equipment sharing partners should undergo HBV screening and vaccination.

^{||}Nucleic Acid Amplification Tests for these sites (rectum/pharynx), while not FDA approved, are sensitive and specific and are in clinical use at certain locations (after appropriate validation studies are completed by the test performing laboratory per CLIA guidelines).

[¶]Hepatitis C serology also indicated for persons who received blood transfusions before July 1992.

RPR = rapid plasma reagin; HSV = herpes simplex virus.

a record to monitor behavior and intervisit STD symptoms and STDs.

Specific Recommendations

Risk Assessment and Health Education

Obtain a sexual and injection drug use risk assessment and record in the medical chart (e.g., number of sex partners in last 3 months, location of partner meeting, known versus anonymous partners, condom use, drug/alcohol use around sexual activity).

Obtain an STD history (disease/infection, number of times, approximate dates) and record in medical chart.

Provide educational material about STD symptoms and advise about the importance of refraining from sexual activity until a diagnosis is made and treatment is completed.

Provide advice on how to obtain STD diagnostic and treatment services (if not readily available from HIV care provider, use a local STD clinic).

Assess the patient's perception of their risk for STDs.

Identify risk-reduction activities that the patient believes can be accomplished.

Develop and record a risk reduction plan.

Provide referral to risk-reduction programs as needed.

Discuss the need for partner HIV counseling and testing and, if patient is infected with an STD, discuss the need for partner STD treatment and testing. Local HIV/STD prevention programs may be able to provide assistance in delivering partner management services.

Clinical Preventive Services and Screening Tests

Specific STD clinical preventive services for persons infected with HIV are listed in Table 1. We recommend that clinicians caring for persons infected with HIV provide these services at the initial medical evaluation and at least once for patients in on-going care, especially for persons who report ever having had an STD or have a lifestyle indicating unsafe sexual behavior; repeat periodically based on the client's sexual behavior. For persons who have been practicing unsafe sex and are likely to continue these practices, providing risk-reduction client-centered counseling (refer to risk reduction counseling program—Appendix C) and periodic STD screening should be strongly considered (e.g., prevention case management). Likewise, clients infected with HIV who have an STD diagnosed at the initial exam should have a repeat STD screening every 3 to 6 months, since data show that the risk of having another STD in the near future is increased.

Repeat tests can be obtained during follow-up medical evaluations. Some testing, such as urine-based chlamydia and gonorrhea tests, could also be obtained at counseling sessions. In some instances, medical care providers could share the delivery of prevention services with early HIV intervention programs and STD clinics.

Appendix A: Diagnostic/Treatment Issues

1. Chlamydial and gonococcal nucleic acid amplification tests are sensitive and specific for urethral or endocer-

vical chlamydial or gonococcal infection. Urine-based screening is easy and highly acceptable for both males and females. However, swab specimens can also be used. Less sensitive nucleic acid probes or antigen detection (EIA) chlamydia tests are not recommended.

2. Herpes simplex virus type 2 (HSV-2) serologic tests that identify HSV-2 antibody are now available. A positive test indicates prior infection even though a patient may not have ever recognized symptoms of HSV-2 infection. Careful questioning may elicit recognition of symptoms such as tingling, itching, redness, or discharge. HIV shedding is increased when HSV-2 symptoms are present.
3. Hepatitis B vaccination is recommended for all patients; however, those with a history of ever injecting drugs (IDU), persons who were sex partners of IDUs, or men who have sex with men (MSM) should have a hepatitis B core antibody test (Anti-HBc) to determine previous infection and if negative, HBV vaccine should be given. If positive, HBV surface antigen (HBsAg) test should be performed to determine if the person is chronically infected. Current sex or needle sharing partners of persons with chronic HBV infection should also be offered HBV testing and vaccination.
4. Bacterial vaginosis (BV) and trichomoniasis can be diagnosed by light microscopy (wet mount examination) and pH of vaginal secretions during pelvic exam. An examination card diagnostic methodology (FemExam Test Card, Litmus Concepts, Inc, Santa Clara, CA – gives a pH and amine reading) is also available to diagnose bacterial vaginosis as well as a BV Blue Test (Gryphon Diagnostics, Atlanta, GA) which uses a single swab 10 minute enzyme test for BV diagnosis. Trichomoniasis can also be diagnosed by culture (InPouch TV; Biomed Diagnostics, Abbott Park, IL).
5. STD-infected patients should inform their partners of the need for STD treatment and evaluation. As of Jan 1, 2001, California law allows clinicians to provide a prescription/medication for a sex partner exposed to chlamydia without examining the partner as an adjunct to the recommended medical evaluation of all potentially exposed sex partners. For HIV transmission prevention, sex and needle-sharing partners should be informed about their potential HIV exposure and encouraged to receive HIV counseling and testing and STD screening. If the relationship is ongoing, periodic examinations for STDs and other conditions (i.e., BV, nongonococcal urethritis [NGU]) that alter genital tract host defenses should be considered. STD-infected patients who are unwilling or unable to notify their sex partners should be referred to local health department communicable disease inves-

tigators who can assist with this process in a professional and confidential manner.

Appendix B: MMWR Statement (MMWR Morb Mortal Wkly Rpt 1998; 47:14)

Persons already infected with HIV should be screened routinely for STDs. Early STD detection and treatment in this subpopulation could be particularly effective and cost-beneficial in reducing HIV transmission for three reasons: most STDs promote increased shedding of HIV; the number of HIV-infected persons is smaller than the number of persons at risk for becoming infected; and HIV-infected persons often are receiving regular medical care.

Specifically, all HIV-infected persons who might be at risk for STD acquisition should be screened regularly for curable STDs, including gonorrhea, chlamydial infection, syphilis, and—among women—trichomoniasis. In addition, persons with HIV/AIDS should be assessed for genital herpes, educated about symptoms of herpes, and counseled to particularly avoid sex during periods with symptoms of reactivation of genital herpes, which are associated with higher rates of HIV viral shedding. Screening frequency should depend on the person's risk behavior, the potential risk behavior of the person's partner(s), and the incidence of STDs in the local population, but generally should occur at least yearly if any potential risk exists for STD acquisition. It should be performed more frequently if any incident STDs are detected by symptoms or screening. These services should be provided as part of and at the site of routine, quality HIV care.

Appendix C: Client-Centered Risk-Reduction Counseling for STD/HIV Prevention

Guiding Principles

Client-centered counseling (CCC) for STD/HIV prevention is an interactive process between clinician/counselor and patient/client. The goals are to identify behaviors that put the client at increased risk for STDs and HIV, and develop a plan that can be carried out to reduce those risks. Key components of CCC are listed below:

- Establish client rapport/develop trust
- Maintain non-judgmental attitude
- Ask open-ended questions
- Maintain confidentiality
- Facilitate risk reduction on patient/client's terms (i.e., what they can realistically do)
- Limit information to essential facts that reduce misinformation
- Encourage patient/client to actively participate in the session

Protocol and Suggested Open-ended Questions for Risk Assessment/Risk Reduction Session:

A. Risk assessment/sexual history: Identify,

1. Number of current and past sexual partners
2. Types of sexual practices
3. Barrier contraceptives used
4. Past STD history
5. Intentions for becoming pregnant
6. Current STD/HIV /pregnancy risk

Suggested open-ended questions:

- Tell me a little about why you came to the clinic today.
- When was the last time you were tested for HIV or other STDs?
- What would you like to know before you leave here today?
- How many different people do you have sex with?
- How many different people are they having sex with?
- When do you have sex without a condom?
- What types of sex do you have (i.e., anal, oral, vaginal)?
- What are the situations in which you're most likely to put yourself at risk for STDs?
- How often do you use drugs or alcohol? How does this influence your STD risk behaviors?
- If you were infected, how do you think you may have become infected?

B. Assess patient/clinic perception of risk and readiness for change—

1. Establish an accurate perception of STD/HIV risk.
2. Determine knowledge and awareness regarding transmission.
3. Identify risk-reducing activities that patient/client believes they can accomplish to reduce current risk.

Suggested open-ended questions:

- What do you know about STDs (i.e., chlamydia, gonorrhea, herpes) and HIV?
- How do you think (specific STD, HIV, etc.) is passed from one person to another?
- What kinds of conversations have you had with your sex partners (or friends) about STDs and/or HIV?
- How often do you use condoms with your steady partners?
- How often do you use condoms with partners who you don't know very well?
- How at risk do you think you are for getting STD/HIV?

- What would you want to do to help you reduce that risk?

C. Develop realistic risk reduction plan—

1. Identify current risk reduction efforts and support behavior changes already made (i.e., it's great that you've made that effort; are here; recognize your risks, etc.).
2. Determine patient/client barriers to risk reduction behaviors (i.e., accurate perception of risk, difficulties using/getting partner to use condoms, power differences in relationship, social or cultural barriers making risk reduction difficult, access to appropriate health care, other concerns of higher priority, etc.).
3. Facilitate risk reduction plan based on above factors, that patient/client believes they can do (possible strategies: monogamy/partner testing, reduce number of sex partners, increase condom use with main and/or non-main partners, abstinence, sexual activities that don't involve exchange of blood, semen, or vaginal secretions, discussion with partner(s), reduce alcohol/drug use, get regular check-ups, etc.).

Suggested open-ended questions:

- Tell me about when you use condoms, how has that worked?
- Who do you use condoms with? How often?
- When you used condoms (talked to your partners, had fewer partners, etc.) what was happening that made that possible?
- How is that working for you now?
- When are you least likely to use condoms (talk to your partner about condoms, etc.)?
- Tell me about the times when it has been (or, what do you think will be) the most difficult to reduce your risk.
- What one thing do you think you can do to reduce your risk right now?
- What will you need to do differently?
- How/when are you going to bring up condoms/risk reduction options with your sex partners?
- What will be the most difficult part of this for you?
- When do you think you'll have the opportunity to try this behavior (discussion, etc.)?

D. Referrals to other programs and services, if needed:

- Partner services
- Couples counseling
- Other needs identified by clinician and/or patient