HIV/Sexual Health Clinical Education Session

http://courses.ashm.org.au/HIV/hiv-sexual-health-clinical-education-session/

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Sexually Transmitted Infections (STI)

BMJ Journals

Dec 2017-March 2018

Volume 93-94

Impact factor 3.212 (2016)

"world's longest running international journal on sexual health"

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Acute hepatitis A infection after hepatitis A immunity in a HIV positive individual

Authors - Ming Jie Lee, Sam Douthwaite, Ranjababu Kulasegaram
February 2018 Vol 94-1

Background -

- 55 year old Eastern European MSM
- HIV positive, diagnosed 2 years prior. Latest CD4 470, UDVL
- Hx of hip osteoarthritis and treated secondary syphilis.

Presentation –

- 2/52 Hx of fevers, poor appetite, nausea and increasing jaundice.
- Client reported unprotected oral and protected RAI with CMP's in saunas in the UK.
- Also travelled to Hungary where client participated in unprotected oral and protected RAI with CMP's.

Acute hepatitis A infection after hepatitis A immunity in a HIV positive individual

Investigations –

- The clients liver function was deranged with conjugated hyperbilirubinaemia, elevated liver enzymes, with normal full blood counts, renal coagulation and inflammatory markers.
- HAV IgM and IgG antibodies were positive
- No active Hepatitis C or E, Immune to Hepatitis B

Management –

- With the use of conservative management and the resolution of his jaundice the client improved.

Possible explanations –

- The client may have had an incomplete vaccination course.
- The initial detectable HAV serology may have been a false positive due to assay performance, sample contamination or mislabelling.

NSW GOVERNMENT Health South Eastern Sydney Local Health District

Routine enquiry for domestic violence and abuse in sexual health settings.

Authors - Lucy Lyus, Tracey Masters
March 2018 Volume 94 Issue 2

- Domestic Violence and Abuse (DVA) takes a heavy toll on the mental and physical health of survivors and their families.
- On average DVA is fatal for 2 women/week.
- It is the use of power and control to deprive survivors of the right to their own bodies and futures.
- Survivors are more likely to experience STI's, HIV, UTI's and untended pregnancy to name a few examples.
- Sexual health professionals receive little training in the area of DVA
- An intervention known as IRIS – Identification and Referral to Improve Safety was adapted from an existing model used in General Practice in the UK.

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Routine enquiry for domestic violence and abuse in sexual health settings.

The outcomes of IRIS –

- In a randomised controlled trial IRIS helped to identify 3 times as many women and lead to 6 times as many referrals compared with usual practice.
- This increase enquiry rate went from 10% to 61% when it was made mandatory to document whether or not DVA had been asked about.
- Sexual Health practitioners are particularly adept at working with diverse populations and with vulnerable groups and are thus well placed to identify and support survivors of DVA.

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Macrolide and quinolone-resistant Mycoplasma genitalium in a man with persistent urethritis: the tip of the British iceberg?

Authors – Suneeta Soni, Andy Parkhouse, Gillian Dean
December 2017 Volume 93 Issue 8

Presentation –

- 40 year old white British MSW
- 3/12 Hx of persistent dysuria and clear urethral discharge
- Previous Rx included 1 day, 5 day and 7 day courses of antibiotics (client unable to recall the names) with worsening symptoms
- 16/7 prior to onset of symptoms the client had CLVI with a Thai CFP in Thailand.
- 6/7 prior had protected VI with a British CFP
- FPU sample –ve for CT and GC, +ve MG

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Macrolide and quinolone-resistant Mycoplasma genitalium in a man with persistent urethritis: the tip of the British iceberg?

Management -

- Initial, Unknown 1,5 and 7 day courses of ABs
- Moxifloxacin 400mg daily 14 days
- Pristinamycin 1g QID with Doxycycline 100mg BD for 10/7.
- Urine sample was sequenced and found to have 23S rRNA gene mutation A2059G conferring resistance to macrolides and parC S831 mutation causing high level Moxifloxacin resistance.
- This client strain is hypothesised to have been transmitted from the partner in South-East Asia were quinolone resistance is widespread.

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A phase II clinical study to assess the feasibility of self and partner anal examinations to detect anal canal abnormalities including anal cancer.

Authors – Alan G Nyitray, Joseph T Hicks, Lu-Yu Hwang, Sarah Baraniuk, Margaret White, Stefanos Millas, Nkechi Onwuka, Xiaotao Zhang, Eric L Brown, Michael W Ross, Elizabeth Y Chiao.
December 2018 Volume 94 Issue 2

- Study was conducted in Harris County, Texas USA
- Recruited for during 2015-2016
- 200 MSM aged between 27-78 years were taught self-anal examination (SAE) or partner anal examination (PAE)
- Inclusion criteria - English speaking, MSM, aged between 27-80 years, with no current Doctor's diagnosis of anal condylomas, haemorrhoids, fissures or anal cancer.
- Men were excluded if they reported a Digital anorectal examination (DARE) in the prior 3/12.

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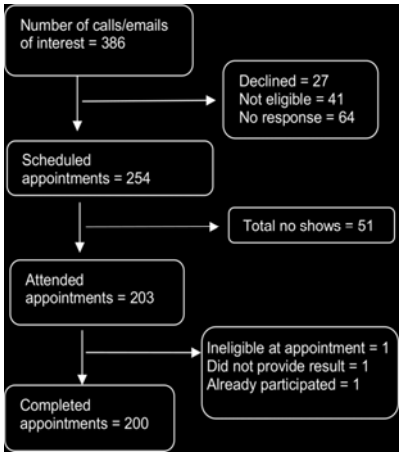
A phase II clinical study to assess the feasibility of self and partner anal examinations to detect anal canal abnormalities including anal cancer.



Of the 200 participants;

46.5% Caucasian
42.5% African American
17.5% Latino

Just under 2/3 of the men were overweight/obese

60.5% reported HIV infection

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A phase II clinical study to assess the feasibility of self and partner anal examinations to detect anal canal abnormalities including anal cancer.

Method –

- All recruits attended a single clinic visit for
  - SAE/PAE training
  - DARE performed by a clinician
  - SAE/PAE performed by ones self or a partner
  - Survey on completion

The goal was to be able to detect any palpable abnormality regardless of type.

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A phase II clinical study to assess the feasibility of self and partner anal examinations to detect anal canal abnormalities including anal cancer.

Results –

- A total of 93% of the men classified the health of their anal canal correctly.
- 88.5% agreed with the clinician's observation of no abnormality (true negatives)
- 6% or 12 of the men had a palpable abnormality observed by the clinician with 9 of these also being reported by the men themselves (true positives)
- 11 men reported an abnormality not detected by the clinician (false positive)
- 93% of participants stated that now after being taught how to perform self and partner examinations they would plan to do another in the future.
- 92.5% reported that they would see a Doctor if they detected an anus abnormality.

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Places and people: the perceptions of men who have sex with men concerning STI testing: a qualitative study

Datta J, Reid D, Hughes G, et al. Sex Transm Infec 2018;94:46-50

• Objective: to explore experiences and views of MSM on attending sexual health services and their preferences regarding service characteristics; develop a risk assessment tool for use in sexual health clinics (not described)

• Method: participants recruited by community organisations, social media and an app through completing an online questionnaire to assess eligibility (16<, male/trans male, ever had sex with a man, and sexually attracted to men). Total of 330 accessed the website; 133 completed the survey; 3 ineligible and 130 were attempted contact via email or mobile.

• Eight focus group discussions subsequently held with 61 MSM in four English cities (London, Birmingham, Leeds and Manchester) in July/August 2015 and participants reimbursed £40

•Groups were audio-recorded and transcribed, with each individual participant identified by voice and assigned a code number, the data was open-coded (thematic analysis)

Places and people: the perceptions of men who have sex with men concerning STI testing: a qualitative study

Attending a sexual health clinic

- Two main motivations: concern they had acquired an STI, or as part of a routine check-up
- Marked by anxiety re: outcome of tests and what treatment might involve
- Young men in particular uncomfortable about disclosure and discussing behaviour in an unfamiliar environment (apprehension++ at first attendance), minorities were particularly aware of being identified and in some locations participants' felt it was more difficult to maintain anonymity in small towns

"I think one of my fears is the fear of seeing another black person taking care of me there. I think I prefer to be treated by a white person than black. Simply because…it's a matter of trust. I think: 'what if this black person maybe knows someone I know?'" (44yrs, Birmingham, HIV negative)

Places and people: the perceptions of men who have sex with men concerning STI testing: a qualitative study

Material/Social aspects of space

- Participants often felt self-conscious about being seen going in, and an obvious entrance could be discourage people attending:

"So sometimes it can feel like the walk of shame itself, to get to the clinic" (39, Birmingham, HIV negative)

- An open waiting room can result in awkward social encounters, and there are concerns re: confidentiality:

"[the HIV unit] was a separate door where people would come out and call people in. So you'd know anybody called who went through that door was HIV positive" (29, Birmingham, HIV positive)

- Some men continued to attend a familiar clinic even if it was not convenient, as they wanted to avoid the potential discomfort of locating and entering a different one

- There was no obvious preference for types of services – some prefer more generic services (e.g. GP) as there is greater anonymity, others prefer specialist services and felt out of place in general clinics
- It was common to feel uncomfortable in non-specialist settings e.g. hospital phlebotomy department or pharmacy hosting SH clinic

Places and people: the perceptions of men who have sex with men concerning STI testing: a qualitative study

Interaction with staff

"I think the staff are the thing that makes a clinic… their attitude towards you, their professionalism, their knowledge base. Basically everything" (44, London, HIV positive)

• Participants wanted staff to be friendly (but not TOO friendly!), professional, discreet and knowledgeable.

• Some felt susceptible to implied criticism even though there were no overt behaviours implying this from staff (self-criticism compounds discomfort) Regarding judgement *"…they kind of do, you can just see it on their faces"*

"I think if you are going into a clinic you are feeling quite vulnerable…so the staff need generally to be ultra-sensitive to what you need and kind of talk you through the experience" (28, London, HIV negative)

"I think it makes a difference when you know the person who's testing you is gay, you don't feel like you're having to educate" (24, Leeds, HIV negative)

• Negative experiences were more common when younger. Many expressed strong feelings about being asked numbers of sexual partners – some felt it was intrinsically judgemental.

What is the overlap between HIV and shigellosis epidemics in England: further evidence of MSM transmission?

Mohan K, Hibbert M, Rooney G, et al. Sex Transm Infect 2018;94:67-71

- *Shigellosis* is a highly infectious bacterial infection spread by faecal-oral route
- Symptoms include diarrhoea, sometimes with mucus, pus or blood, fever, nausea, vomiting, tenesmus and stomach cramps
- Sexual behaviour now considered an important risk factor for *shigella* and sometimes also linked to travel (outbreaks in London and Berlin in 2006 coincided with MSM who had travelled between two cities)
- Evidence suggests sexual transmission has replaced foreign travel as the predominant mode of *shigella* transmission in England
- All *shigella* cases reported to Public Health England (PHE) and the HIV/AIDS reporting system between 2004 and 2015 were matched using code, DOB and gender
- 88 664 people living with HIV and 10 269 *shigella* cases reported (5 975 *shigella* cases unable to be included due to inadequate data to allow matching – these were more likely to have a travel history, no gender difference)

What is the overlap between HIV and shigellosis epidemics in England: further evidence of MSM transmission?

- 8% (873/10269) of all *shigella* cases were living with HIV (93% men)
- 15% of male *shigella* cases (815/5533) were living with HIV; 21% of non-travel male *shigella* cases were living with HIV (720/3481) – 91% were reported MSM in the HIV dataset (likely higher)
- 2% of non-travel female *shigella* cases were living with HIV (31/1946)
- *Shigella* preceded HIV diagnosis in 14% (100/720) of cases – *shigella* is therefore an indicator for HIV testing

- Year on year increases in *shigella* incidence in men living with HIV, more pronounced among MSM living with HIV. Likely an underestimation of how *shigella* and HIV has overlapped due to data issues
- Simultaneous increases in incidence of gonorrhoea, LGV and other STIs with MSM, especially MSM living with HIV. This is consistent with increases in high-risk sexual behaviours.

- Suggested three drivers for *shigella* transmission: sex parties/chemsex; social media apps; and increased acceptability of sexual behaviours leading to faecal-oral contact

Detection of Chlamydia trachomatis in rectal specimens in women and its association with anal intercourse: a systematic review and meta-analysis

Chandra NL, Broad C, Folkard K, et al. Sex Transm Infect Epub ahead of print [03 Feb 2018]

- Clinical significance of rectal CT in women is unclear – undiagnosed and untreated rectal CT may be a potential reservoir which could impede effective treatment and transmission prevention
- Systematic review and four meta-analyses using random effects modelling to review studies on women in high-income countries to **estimate the prevalence of rectal chlamydia, concurrency with urogenital chlamydia and associations with reported anal intercourse**. Also assessed for risk of bias appraising internal/external validity i.e. study methods and how generalisable they are

- Articles published Jan 1997- Oct 2017 (data from 1995-2014)
- Included studies reporting rectal CT positivity in heterosexual women >15 yrs in high-income countries. Studies must have used NAAT testing and reported total number tested and positivity of rectal CT.
- 14 eligible studies among diverse populations, all at sexual health services
- Authors assumed positive rectal CT swab represents active and established infection (van Liere, 2015: convenience sample of rectal CT+ swabs showed similar bacterial load between MSM and women with concurrent infection reporting AI. Bacterial load significantly lower among women reporting no anal sex)

Detection of Chlamydia trachomatis in rectal specimens in women and its association with anal intercourse: a systematic review and meta-analysis

Results

- **All studies rectal CT positivity 1.7% - 77.3%**
- Summary positivity = 6% (95% CI 3.2-8.9%) for routine clinic-attending women (ie. not 'high risk')
- Summary concurrent rectal and urogenital CT positive = 68.1% (CI 56.6-79.6%)
- Rectal CT positive but urogenital CT negative = 2.2% (CI 0-5.2%)
- Reported anal intercourse was NOT associated with rectal CT (risk ratio 0.90 (CI 0.75-1.10))

- Insufficient evidence to use reported AI as an indicator for rectal CT testing
- Among studies with available data, 13% of rectal CT+ was among women reporting AI (87% no reported AI)

- All studies were from women attending sexual health services, not generalisable
- No consistent definition of 'history of AI' or 'high-risk' women, high heterogeneity, high risk of bias
- Extra-genital infections are common in women, but what are the implications?
- Suggest if positive repeat urogenital CT test 3/12 later, could consider rectal CT test OR rx with doxycycline