Increasing HIV and STI testing in Primary Care

Dr David Mummery
GP North End Medical Centre
Epidemiology of HIV in UK

- 2007 – estimated 77,400 living with HIV
- 2009/10 – estimated 86,500
- 2011/12 - >100,000 living with HIV in UK
- Large proportion in London
- Worldwide >33 million majority in Sub-Saharan Africa
Epidemiology of HIV

- Estimated that 25% - 33% are UNAWARE of their HIV infection (>25,000 people)
- Also number of new diagnoses increasing most years (>8000/yr)
- Number of new diagnoses higher in heterosexual population for last 7 years
Primary Care involvement

• Many of these individuals who have HIV but are unaware of it are accessing Primary Care but not GU services
• May be asymptomatic or may have indicators of HIV infection
• Traditionally very few HIV tests have been performed in Primary Care
Role of Primary Care

- Direct management of HIV likely to remain within secondary care.
- Primary Care:
  - Recognise undiagnosed HIV infection and offer HIV testing or onward referral
  - Manage complications of HIV therapy in a shared care arrangement with HIV services
  - Manage the Primary Care needs of the HIV positive population as HIV becomes increasingly a chronic disease in an ageing population
Increasing HIV testing

- NICE guidelines March 2011
- BHIVA recommends that GPs in areas where >2/1000 (15-59) diagnosed HIV should consider offering an HIV test to everyone at registration and to people having a blood test for any reason.
- Especially from communities areas of the world with high HIV prevalence and MSM
NICE guidelines

- Also anyone who may have possible symptoms of HIV infection.
- 37 PCTs in England diagnosed HIV >2/1000
- All of London >2/1000 (H&F 8.1/1000) of 15 - 59
- A good argument for HIV screening in adults based on CDC data.
- Clinically and economically justified
- Try and reduce number of “late presenters” of HIV infection
- 8 pilot projects in England have shown HIV testing in Primary care to be acceptable and feasible
NICE guidelines

• Emphasise needs for discussion/explanation of HIV infection – people still may have different knowledge and experience of HIV and treatment – Benefits of knowing HIV status

• Clear referral pathways and method for giving results.

• Need for complete confidentiality

• If diagnosis made immediate referral to HIV clinic for assessment
Pre-test discussion

- Up until recently long questionnaire 20-30 minutes? still needed
- Brief pre-test discussion:
  - Window period 3/12
  - Quick risk assessment, Benefits of testing, Confidentiality, Consent (verbal), How result will be given....
- Confidentiality: A NEGATIVE test does NOT have implications for mortgages or life insurance. If asked if a patient has ever had an HIV test – refuse to answer
- Long pre-test discussion may have actually have been putting people off testing
- NORMALISING and DE-STIGMATISING HIV and HIV TESTING essential say: “we offer it to everyone”
Barriers in Primary Care – for Primary Care Team

- Knowledge/expertise
- Confidentiality
- Time constraints
- Poor communication with GU
- Fear of broaching sexuality
- Historically alienated
- Previous lack of guidelines
- Prejudice
- Communication/cultural issues
Barriers for patients

- Confidentiality/disclosure – members of family/friends at same practice. May know people who work at the practice
- Family orientated
- Less anonymous – may prefer GU
- Fear of discrimination/homophobia/racism
- Worries re: insurance/mortgage reports
- Fear of lack of knowledge of GP
- Previous bad experiences at GP “We don’t do those tests here”
- Worries about who else at practice may know diagnosis
NHS consortia changes

• Emphasis on money saving
• By diagnosing “late presenters” and stopping going to ITU with PCP – huge financial savings as well as benefits for patients
• More and more HIV care may be transferred to GP as now chronic disease
How to Test?

- Blood test
- Many blood tests done in Primary Care
- See high risk patients for results personally
- 4th generation test – may come back as “Reactive” and also P24 antigen test
- Majority of people with seroconvert within 6 weeks but may be up to 3 months
How to Test?

- Point of Care (POCT) testing
- Commonly done in GU clinics
- A couple of GP pilots – may take extra time/resources
- Excellent sensitivity/specificity but should always be confirmed with blood test
How to Test?

• Saliva tests
• HINTS study >1000 tests in Primary Care Arm 16-65 (Also A&E arm and Dermatology)
• False positive rate 1-2/1000
• Uptake 74%
• Easy to do and non intrusive
• Text messaging/recall system
• Very high acceptability
• Should be published this summer
Who to test?

• If >2/1000 prevalence – offer all adults
• Often HIV infection ASYMPTOMATIC
• However in many people diagnosed with HIV have had clinical/biochemical clues/markers months/years prior to diagnosis
• Important to be aware of these
Primary HIV infection – seroconversion

- Very important to spot as HIGHLY infectious
- Easily overlooked
- 80% have symptoms and 80% seek medical advice
- Typically 2-4 weeks after exposure but can be up to 3 months
Seroconversion

- Flu-like illness (fever, myalgia, headache, lymphadenopathy)
- Maculopapular rash
- Pharyngitis/oral ulceration
- Concomitant STIs
- Lymphopaenia, thrombocytopenia, raised ALT/AST
- Aseptic meningitis/encephalitis
Seroconversion

- HIV antibody tests may be –ve.
- 4th generation tests check P24 antigen or HIV RNA
- Put “HIV seroconversion” on form
- If high suspicion liase with local HIV team as diagnosis of Primary Infection enables partner notification/screening for other STIs etc and for screening for co-infection
- Eg 10% HIV individuals in Europe co-infected with Hep B
Gastroenterological

Oral/oesophageal disease:
Oral hairy leukoplakia
Oral candidiasis
Kaposi’s Sarcoma
Oesophageal thrush
CMV oesophagitis
HSV oesophagitis
Diarrhoea and Weight Loss (common!)

- Campylobacter/Salmonella/Shigella
- C.Difficile
- Cryptosporidium/Microsporidium
- Giardia
- Lymphoma (abdominal pains)
- CMV colitis
- KS
Perianal Disease

- HSV
- HPV
- AIN
- Syphilis
- LGV
Dermatological presentations

- Seborrheic dermatitis
- Herpes Zoster
- Molluscum Contagiosum
- Kaposi’s Sarcoma
- Psoriasis
- Angular Chelitis
- Primary/Secondary Syphilis
- Eosinophilic folliculitis
- Acute HIV infection
Neurological presentations

- Toxoplasmosis
- HSV encephalitis
- Primary Cerebral Lymphoma
- AIDS dementia complex (HIV test should be part of dementia screen)
- Cryptococcal meningitis
- Tuberculous meningitis
Respiratory

- Recurrent chest infections/SOB
- Dry cough (PCP)
- TB (ALL should have HIV test)
- Haemoptysis
- Lymphadenopathy
Blood tests

- Raised ESR/CRP
- Low WCC/neutrophils
- Raised LFTs in seroconversion

- Other STIs: HPV/HSV/chlamydia/syphilis/LGV/Gc if one STI diagnosed always offer HIV test
Antenatal Care

• Routine HIV antenatal testing – extremely successful intervention

• Try and do same for Primary Care through blood/POCT/salivary tests...

• Make tests ROUTINE part of health check up
• Do not discriminate who offer tests to eg elderly
• De-stigmatise HIV testing
Future......

- More early HIV diagnoses and hopefully less transmission.
- Routine HIV testing for adults offered by GPs in London
- Stronger links with GUM
- More routine care for HIV patients in Primary Care
- Primary Care needs increased knowledge of HIV/medications/interactions/interactions/common HIV related problems /confidentiality & disclosure
Other STI testing

- Routine asymptomatic STI testing does NOT need to be done at hospital.
- Traditionally GPs sent may patients to GU clinic for Screens – *much* more expensive and not necessary and duplication of time & effort.
- Symptomatic patients on case by case basis – may need GU input commonly.
Chlamydia

- Commonest STI: >50% asymptomatic
- Chlamydia screening programme 16-24
  ?future of programme uncertain
- Urine testing
- Low vaginal swabs
- Results/Treatment/Contact Tracing
- Azithromycin 1g stat NO SI 1 week
Gonorrhoea

- Commonly symptomatic
- Urine testing (not good sensitivity especially in women)
- Low vaginal swab
- Likely to need GU input
- Oral Cefixime/IM ceftriaxone
Syphilis

- Easy to check on blood screen
- Clinical symptoms –
  - Primary Chancre -> GU
  - Secondary: maculopapular rash; soles/hands commonly affected; malaise, sore throat, arthralgia, iritis, raised LNs, condylomata lata

If serology (TPHA/VDRL) positive and NO tmt needs to go to GU.
Treatment syphilis

- Highly infectious
- Needs rigorous contact tracing
- Syphilis increases risk of transmission of HIV
- IM benzathine benzylpenicillin
- Best done at GU clinic
- Jarisch-Herxheimer reaction
HPV

- Clinical diagnosis
- Cryotherapy

- Treatment: Warticon/Aldara/Cryotherapy

- Severe HPV – GU/surgeons
Herpes Simplex Virus

- Often clinical Hx
- Viral swabs
- May need to see GU
- Can be diagnostic uncertainty
- Blood testing not very useful
Trichomonas

• Green frothy discharge in women
• Can be confused with BV
• If suspicious of TV best seen by GU – needs microscopy and rigorous contact tracing
LGV

- Chlamydial infection
- Recent increase in cases
- Buboes. Rectal pain, proctitis, discharge, diarrhoea, systemic symptoms
- Rectal chlamydia swab
Summary

• Much HIV and STI testing can be easily done in Primary Care
• If uncertain can contact GU – try develop closer links
• Asymptomatic screens especially suitable to be done in Primary Care
• Brings up many issues eg confidentiality
• Some patients may prefer GU setting
ALWAYS THINK ABOUT HIV AS A DIFFERENTIAL DIAGNOSIS AND OFFER TESTING ROUTINELY!!
Mr and Mrs D have arrived 6 months ago as refugees from Zimbabwe. They have 2 children: a girl aged 6 (B) and boy aged 12 (S). On routine blood tests performed by their GP both Mr and Mrs D have been found to be HIV positive and both have been informed about this and been referred to the local HIV clinic. They had never previously had HIV tests. Both parents do not want either of their children to have HIV tests as they think that they are “too young” and it is best to wait until they are older and can understand more. Both parents come to see you for advice........
Clinical Scenarios

Dr N is 58 years old and has a senior position at his local hospital. On a recent STI screen 3 weeks ago he was found to be HIV positive and he has been informed of the results. His last HIV test was 5 years ago and was negative. He is married with 2 children who are both currently at university. In his sexual history he has said that he has had several casual relationships with men over the last 10 years. He is yet to inform anyone else of the recent test results and has come to see you in a highly anxious and agitated state regarding the results........