Sexual Health Update

ashm

Developing a sustainable HIV, viral hepatitis, and sexual health workforce

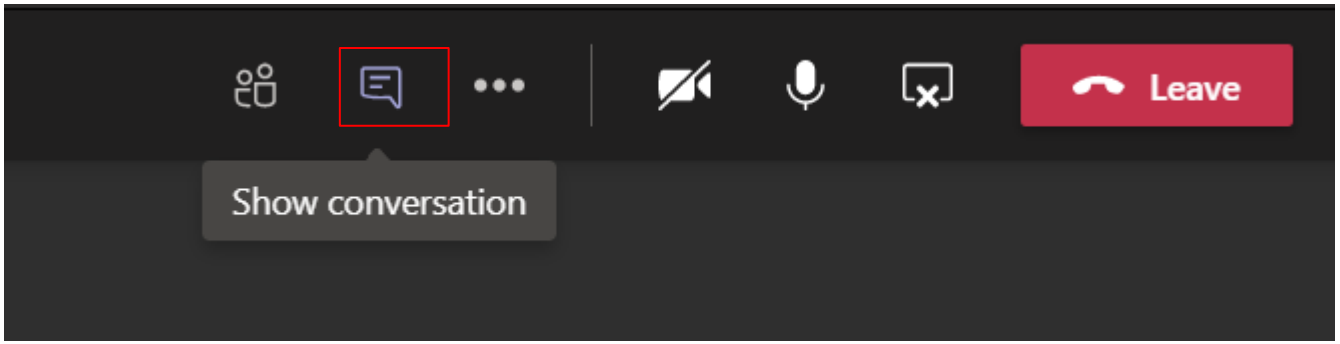
Supported by:

Queensland Government
Queensland Health

ASHM is a signatory to the ACFID Code of Conduct and is committed to the principles of the Ottawa Charter for health promotion and the Jakarta Declaration on health promotion.

Acknowledgement of country

Microsoft Team Chat Function



About ASHM

ashm

Australasian Society for HIV, Viral Hepatitis and Sexual Health Medicine

ASHM supports development of the HIV, viral hepatitis and sexual health workforce through education and training, resources and policy.

Acknowledgements

Original PPT written in 2013 by Dr Craig Rodgers

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VHHITAL

Melbourne

Presented by:

Dr Clare Heal
Professor in the Department of General Practice and Rural Medicine, James Cook University School of Medicine

This webinar is supported by

Queensland Government
Queensland Health

Mackay Sexual Health Service
12-14 Nelson Street Mackay

- Screening, testing, treatment for STIs
- HIV rapid testing (results in 20 minutes)
- HIV post-exposure prophylaxis (PEP)
- HIV pre-exposure prophylaxis (PrEP)
- Management HIV ,Hepatitis B and C
- Transgender care
- Sexual dysfunction
- Genital skin conditions
- Free condoms and lube
- Training, education,health promotion
- Termination of pregnancy information

Contact:
P (07) 4968 3919

Opening Times:
Monday to Friday
8.00am to 4.30pm

Learning Outcomes

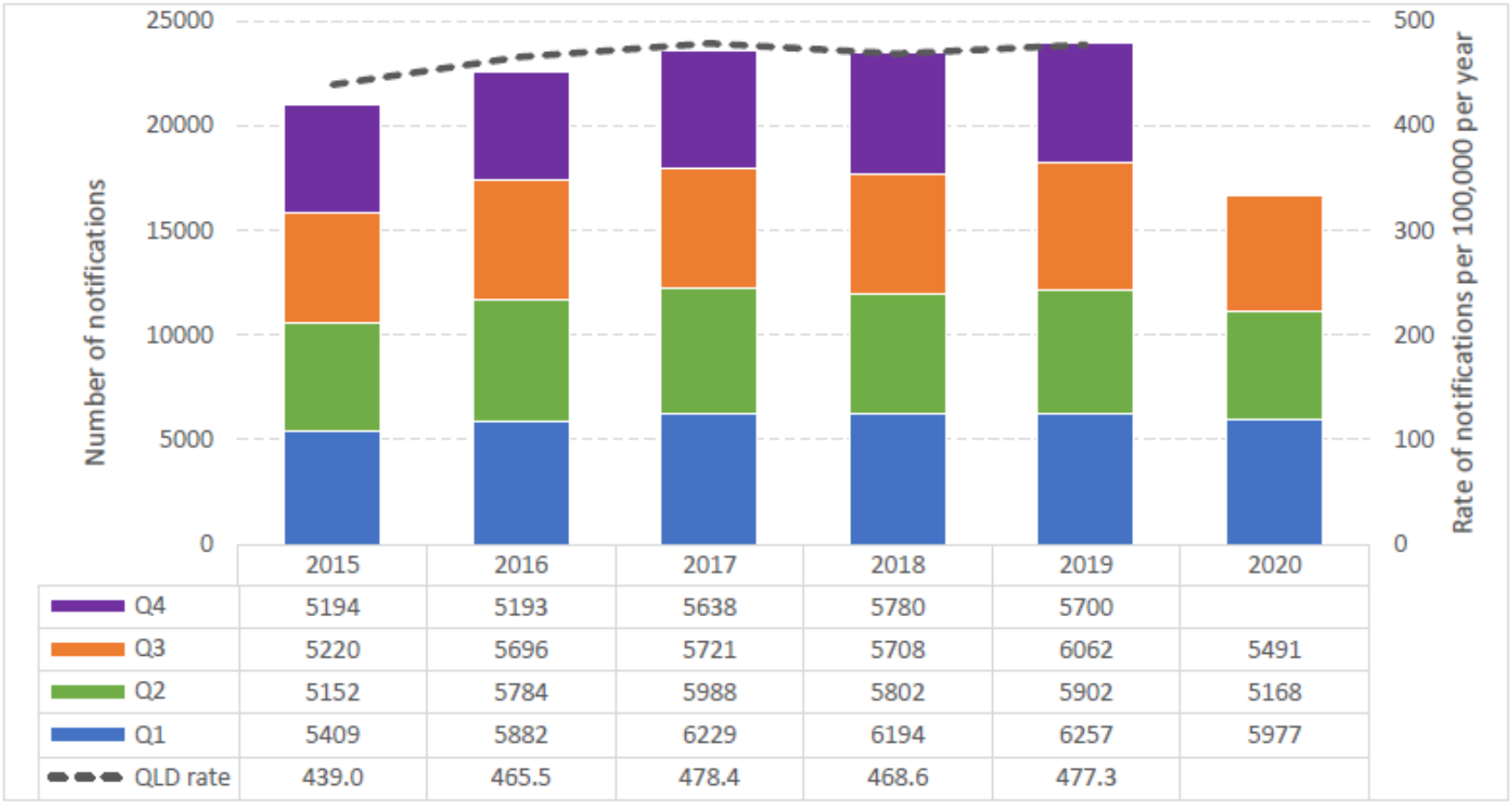
- Demonstrate confidence in discussing sexual health
- Explain the importance of screening/testing for STIs
- Describe contact tracing and its key role in managing STIs
- Understand diagnosis and management of gonorrhea and syphilis
- GP topical issues: PREP, MTOP, Mycoplasma, Transgender

What is your role and where are you joining from tonight?

Tell us via the chat box

Epidemiology (Local)

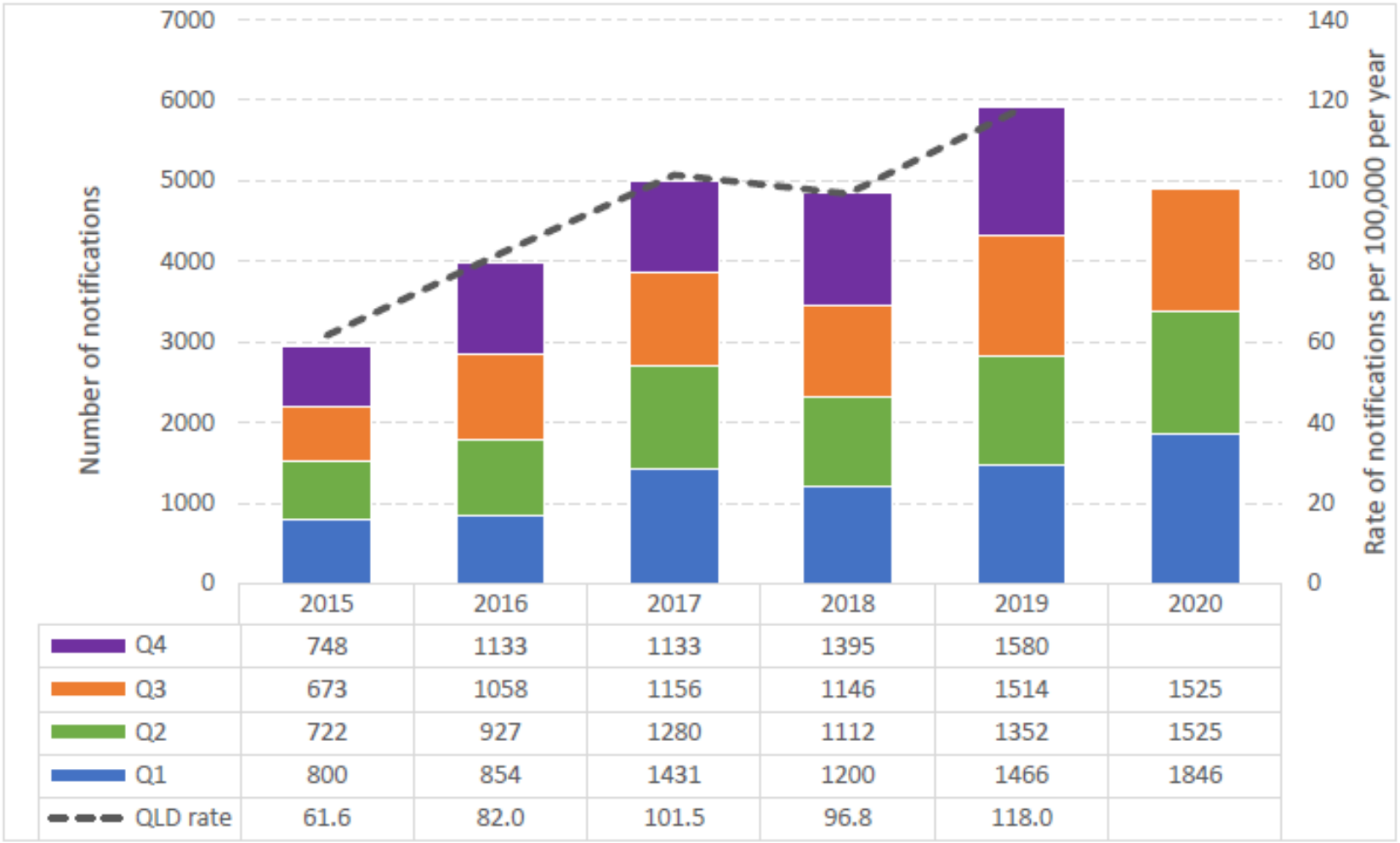
Chlamydia notification counts in Queensland, by quarter, 1 January 2015–30 September 2020, and annual notification rates (per 100,000 population per year).



	2015	2016	2017	2018	2019	2020
Q4	5194	5193	5638	5780	5700	
Q3	5220	5696	5721	5708	6062	5491
Q2	5152	5784	5988	5802	5902	5168
Q1	5409	5882	6229	6194	6257	5977
QLD rate	439.0	465.5	478.4	468.6	477.3	

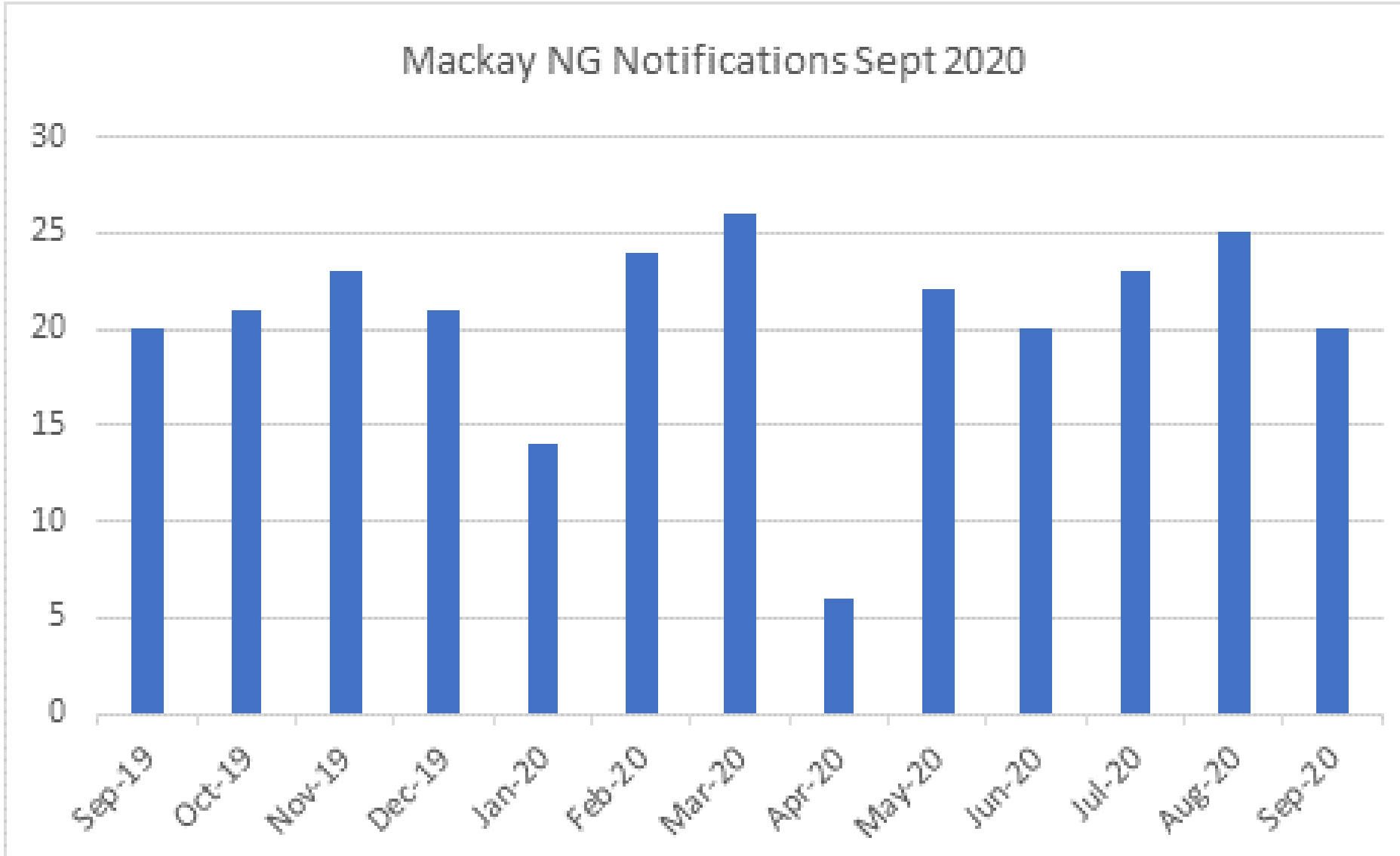
Resource: Notifications of BBVSTIs in Queensland: 1 Jan–30 Sep 2020

Gonorrhoea notification counts in Queensland, by quarter, 1 January 2015–30 September 2020, and annual notification rates (per 100,000 population per year).

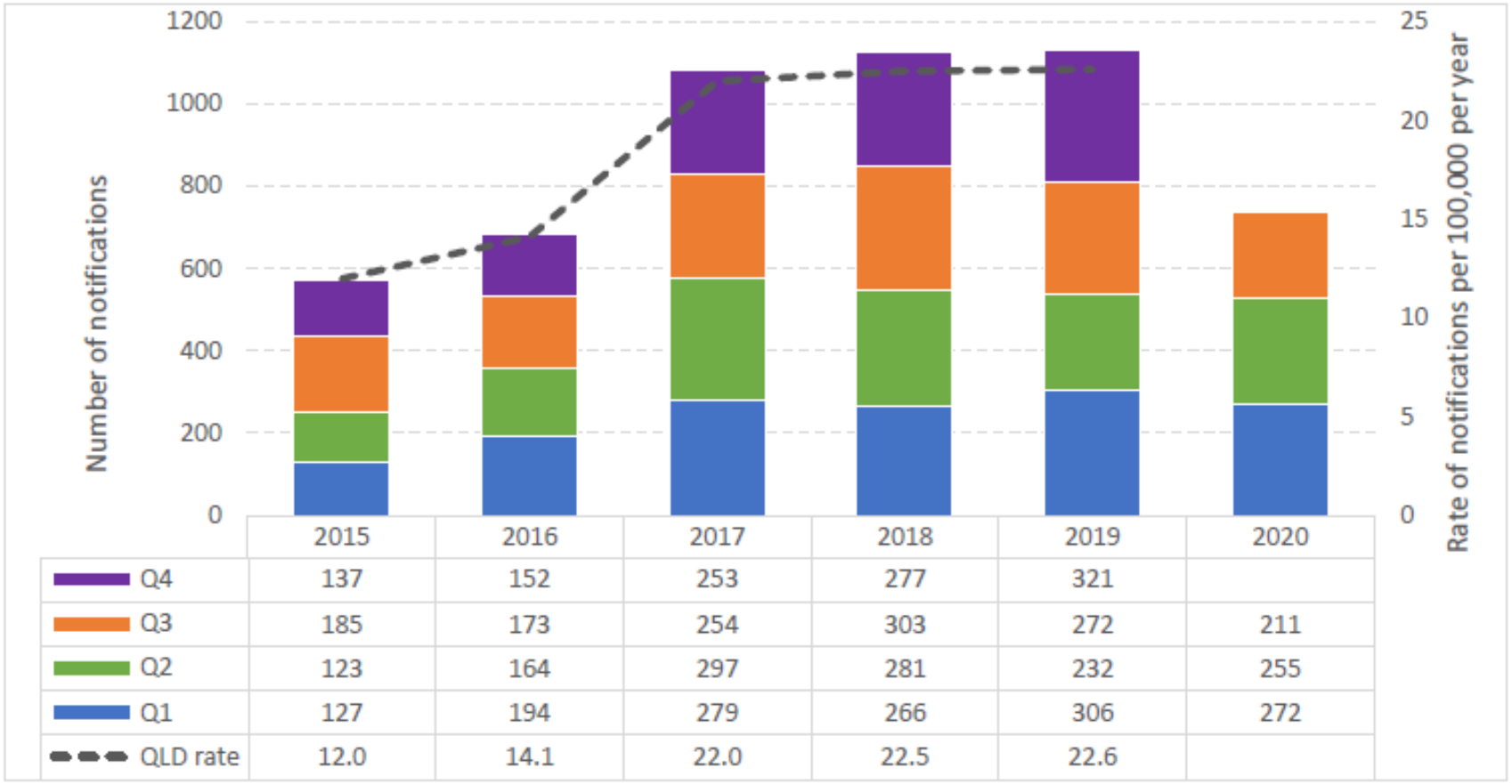


	2015	2016	2017	2018	2019	2020
Q4	748	1133	1133	1395	1580	
Q3	673	1058	1156	1146	1514	1525
Q2	722	927	1280	1112	1352	1525
Q1	800	854	1431	1200	1466	1846
QLD rate	61.6	82.0	101.5	96.8	118.0	

Resource: Notifications of BBVSTIs in Queensland: 1 Jan–30 Sep 2020


Mackay NG Notifications Sept 2020
30
25
20
15
10
5
0
Sep-19
Oct-19
Nov-19
Dec-19
Jan-20
Feb-20
Mar-20
Apr-20
May-20
Jun-20
Jul-20
Aug-20
Sep-20

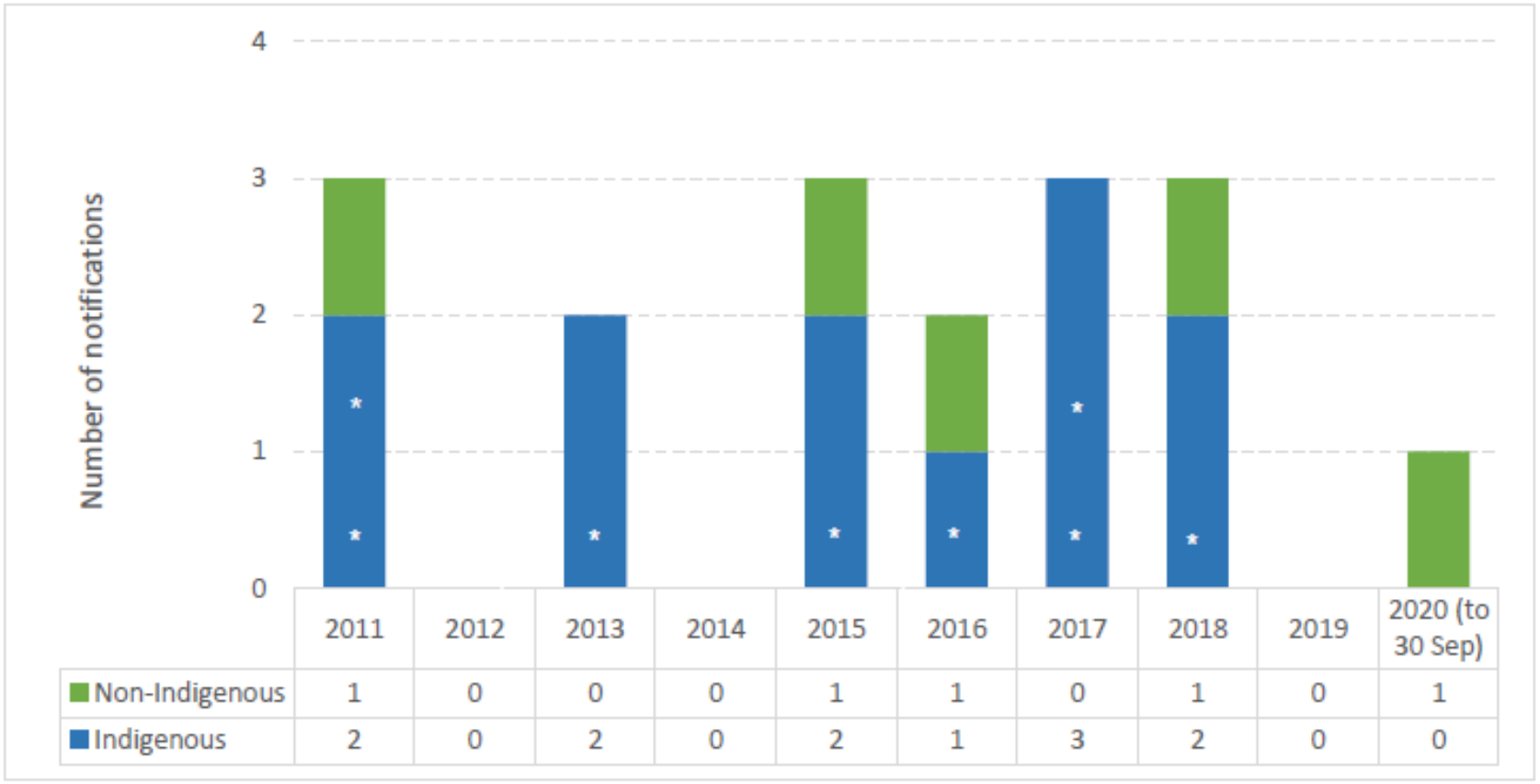
Infectious syphilis notification counts in Queensland, by quarter, 1 January 2015–30 September 2020, and annual notification rates (per 100,000 population per year).



	2015	2016	2017	2018	2019	2020
Q4	137	152	253	277	321	
Q3	185	173	254	303	272	211
Q2	123	164	297	281	232	255
Q1	127	194	279	266	306	272
QLD rate	12.0	14.1	22.0	22.5	22.6	

Resource: Notifications of BBVSTIs in Queensland: 1 Jan–30 Sep 2020

Congenital syphilis notification counts in Queensland, by Indigenous status, 1 January 2011–30 September 2020



	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020 (to 30 Sep)
Non-Indigenous	1	0	0	0	1	1	0	1	0	1
Indigenous	2	0	2	0	2	1	3	2	0	0

Resource: Notifications of BBVSTIs in Queensland: 1 Jan–30 Sep 2020

Broaching the subject

When would you start a conversation about sexual health testing?

Tell us via the chat box

Starting a conversation about sexual health testing

Bring the subject up opportunistically

Use a “hook”

As part of a reproductive health consultation

Because the patient requests a “checkup” for STIs

The basics – sexual history

WHEN did you have sex?

When did you most recently have sex?

WHO are you having sex with

Are you having sex / sleeping with men, women or both?

WHAT types of sex are you having sex?

What type of sex are you having - vaginal / anal / oral sex?

Why are these questions so important?

Questions?

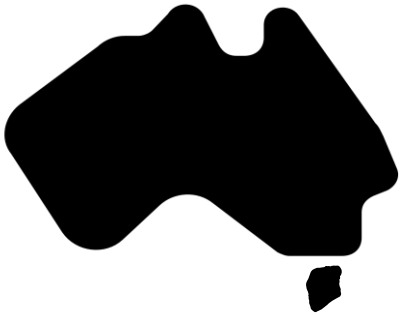
Screening & Testing

Who to screen for STIs?

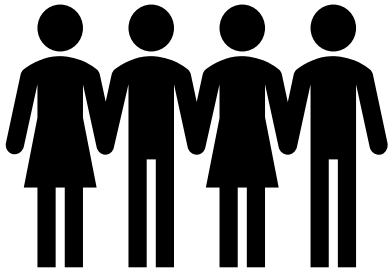
Who/what are high risk groups for STI screening?

Tell us via the chat box

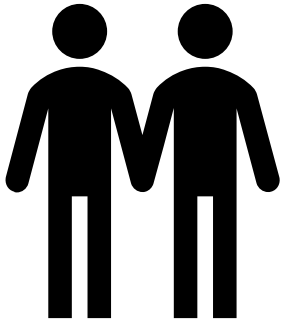
Priority populations for STI screening



Aboriginal and Torres Strait Islander peoples



Young people 15-29 years of age



Men who have sex with men

Sex workers

Who else??

- ✓ **Patient requests testing (explore concerns)**
- ✓ **Sexual history indicates need for testing**
- ✓ **Symptoms & signs of infection or immunosuppression**
- ✓ **Exclude co-infection in patients hep B or C or TB**
- ✓ **Diagnosed with another STI**

The Australasian STI Management Guidelines

Everything you need to know: http://www.sti.guidelines.org.au/

STI/BBV Testing tool for asymptomatic people

STI/BBV Testing Tool for Asymptomatic People: https://stoptherise.initiatives.qld.gov.au/sites/default/files/wysiwyg-files/QH1214_STI-BBV_TestingTool_Screen.pdf

STI/BBV Testing tool for asymptomatic people

STEP 2 STI/BBV testing – who to test and how often

Recommendations from the *Australian STI Management Guidelines*[1] (unless otherwise stated)

WHO Is the patient?	WHAT Infection?	HOW OFTEN Should you test?
Young people (15–29 years)	CHLAMYDIA	Annually
	HEPATITIS B	Once. First confirm HBV immune status (history of prior vaccination or serology) and vaccinate if not immune
	SYPHILIS HIV	Consider according to sexual history and local STI and HIV prevalence
Asymptomatic people requesting STI/HIV testing	CHLAMYDIA	Annually or more often according to sexual history
	HEPATITIS B	Confirm HBV immune status (history of prior vaccination or serology) and vaccinate if not immune
	HIV	Offer to everyone requesting testing for HIV[2]
Aboriginal and/or Torres Strait Islander people	CHLAMYDIA GONORRHOEA SYPHILIS	Annually or more often according to sexual history or local STI prevalence. Regular testing for chlamydia, syphilis and HIV is recommended, as per the Standard Asymptomatic Check-up guideline.
	HEPATITIS C HIV* TRICHOMONIASIS**	A sexual history can be difficult to obtain in certain settings so consider offering BBV/STI testing liberally to this population. * Especially in the presence of other STIs ** For those from rural/regional/remote areas
	HEPATITIS B	Confirm HBV immune status (history of prior vaccination or serology) and vaccinate if not immune[6]
Men who have sex with men (MSM) (ref: STIGMA Guidelines[3])	CHLAMYDIA GONORRHOEA SYPHILIS HIV	At least annually, up to 4 times per year for MSM who fall into one or more of the following categories: • Have any unprotected anal sex • Have ≥10 sexual partners in the last 6 months • Participate in group sex • Use recreational drugs during sex • Are HIV positive
	HEPATITIS A	Serological testing is not recommended before routine administration of hepatitis vaccine. Vaccinate as per recommendations in the Australian Immunisation Handbook.
	HEPATITIS B	Confirm HBV immune status (history of prior vaccination or serology) and vaccinate if not immune[7]
	HEPATITIS C	If HIV positive or have history of injecting drug use. If antibody positive, test for hepatitis C NAAT to determine if patient has chronic hepatitis C.
Sex workers (see 'MSM' for male sex workers)	CHLAMYDIA GONORRHOEA SYPHILIS HIV	Testing should be based on local STI prevalence, symptoms, diagnosed or suspected STI in contact and clinical findings. Frequency based on sexual history (private and professional life), if condom use is <100% (including history of condom breakages/slippages) or at patient request.
	HEPATITIS A	Serological testing is not recommended before routine administration of hepatitis vaccine. Vaccinate as per recommendations in the Australian Immunisation Handbook.
	HEPATITIS B	Confirm HBV immune status (history of prior vaccination or serology) and vaccinate if not immune[7]
	HEPATITIS C	If antibody positive, test for hepatitis C NAAT to determine if patient has chronic hepatitis C.
People who inject drugs	CHLAMYDIA GONORRHOEA SYPHILIS	Annually or more often according to sexual history.
	HEPATITIS A	Serological testing is not recommended before routine administration of hepatitis vaccine. Vaccinate as per recommendations in the Australian Immunisation Handbook.
	HEPATITIS B	Confirm HBV immune status (history of prior vaccination or serology) and vaccinate if not immune[7]
	HIV HEPATITIS C	According to sexual history and annually with an ongoing history of injecting drugs. If antibody positive, test for hepatitis C NAAT to determine if patient has chronic hepatitis C.
Pregnant women (ref: RACGP[4] and Australian Government Department of Health[5])	CHLAMYDIA	Consider in pregnant women aged 15–29 years and those at higher risk
	HEPATITIS B	All pregnant women should be screened using the HBsAg test. Vaccinate susceptible women who are at increased risk
	HIV SYPHILIS	Every pregnancy All women should have a syphilis test in the first 12 weeks of pregnancy or at the first antenatal visit. Additional testing is recommended up to five times during pregnancy for certain at-risk populations and in areas affected by a syphilis outbreak. Please refer to the Queensland Syphilis in Pregnancy Guideline[7] and local area guidelines for current recommendations.

Step 2 (A):

"STI/BBV testing – who to test and how often"

STI/BBV Testing Tool for Asymptomatic People: https://stoptherise.initiatives.qld.gov.au/sites/default/files/wysiwyg-files/QH1214_STI-BBV_TestingTool_Screen.pdf

STI/BBV Testing tool for asymptomatic people

STEP 2B How to test[1] – infection, specimen site and test type

INFECTION	SPECIMEN COLLECTION SITE	TEST
♀ FEMALES		
CHLAMYDIA	Vaginal swab* (preferred) OR Endocervical swab** (preferred) First catch urine* (at any time of the day)	Chlamydia NAAT (PCR)
GONORRHOEA	Vaginal swab* (preferred) OR Endocervical swab** (preferred) First catch urine* (at any time of the day) Throat swab* (if patient has oral sex) Rectal swab* (if patient has anal sex)	Gonorrhoea NAAT (PCR) + culture if discharge present
TRICHOMONIASIS	Vaginal swab* OR First catch urine* (at any time of the day)	Trichomoniasis NAAT (PCR)
♂ MALES		
CHLAMYDIA	First catch urine* (at any time of the day) Plus throat swab* (for MSM) Plus rectal swab* (for MSM)	Chlamydia NAAT (PCR)
GONORRHOEA	First catch urine* (at any time of the day) Plus throat swab* (for MSM) Plus rectal swab* (for MSM)	Gonorrhoea NAAT (PCR) + culture if discharge present
TRICHOMONIASIS	First catch urine* (at any time of the day)	Trichomoniasis NAAT (PCR)
	*consider self-collected **health provider-collected	
♀♂ FEMALES AND MALES		
SYPHILIS	Blood	Syphilis serology
HIV	Blood	HIV Ab/Ag
HEPATITIS A	Blood	Total HAV antibodies or anti HAV IgG if indicated[2]
HEPATITIS B	Blood	HBsAg anti-HBc antibody anti-HBs antibody
HEPATITIS C	Blood	HCV Ab

Step 2 (B):

"How to test – infection, specimen site and test type"

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Other tools

AUSTRALIAN SEXUALLY TRANSMITTED INFECTION & HIV TESTING GUIDELINES 2019

For asymptomatic men who have sex with men

After appropriate pre-test discussion, all of the STI tests listed should be offered:

3-monthly testing for sexually transmitted infections in all men who have had any type of sex with another man in the previous 3 months*

Blood tests:

- **Syphilis serology**
- **HIV antibody/antigen screening test:** If not known to be HIV-positive
- **Hepatitis A antibody:** Test if not vaccinated. Vaccinate if antibody negative
- **Hepatitis B core antibody, surface antigen:** Test if not vaccinated. Vaccinate if no history or documentation of full vaccination course
- **Hepatitis C:** Test once a year in people living with HIV, on PrEP or with history of injecting drug use

NAAT/PCR^ tests for gonorrhoea and chlamydia:

- **Oropharyngeal swab**
- **First pass urine** defined as the first part of the urine stream, not the first urine of the day
- **Anorectal swab** (self-collected, see overleaf)

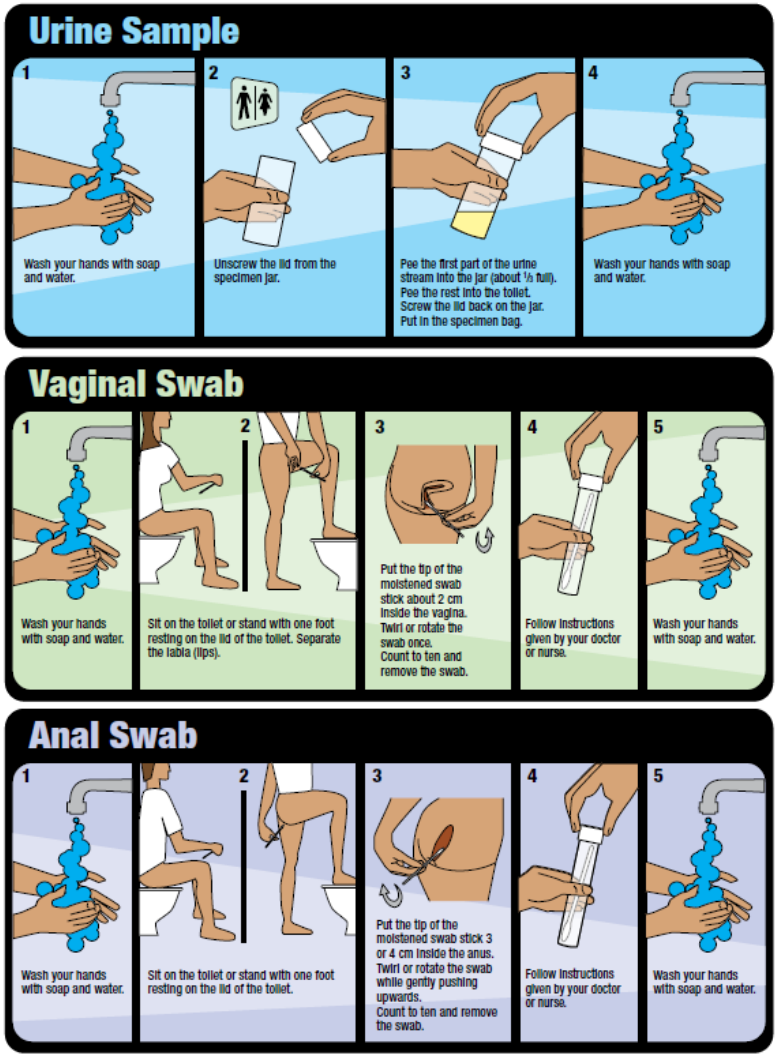
^ NAAT- nucleic acid amplification test e.g. Transcription-Mediated Amplification (TMA), Strand Displacement Amplification (SDA), Polymerase Chain Reaction (PCR)

*** Men who have sex with men (MSM) who are not sexually active or in monogamous relationships may be tested less frequently, but at least annually.**

Screening for *Neisseria gonorrhoeae (NG)* and *Chlamydia trachomatis (CT)* should be by NAAT/PCR. Confirmation of positive NG result by culture is not necessary and should not delay treatment, but to assist surveillance for antimicrobial resistance, gonorrhoea culture should be collected prior to administering antibiotics.

All people living with HIV should be tested for STIs three-monthly, including a blood test for syphilis (even if they are only having six-monthly viral load monitoring) unless they are not sexually active or are at low risk.
All HIV-positive MSM should have at least annual HCV testing.

Specimens for Sexually Transmitted Infections



Asymptomatic screening - what tests?

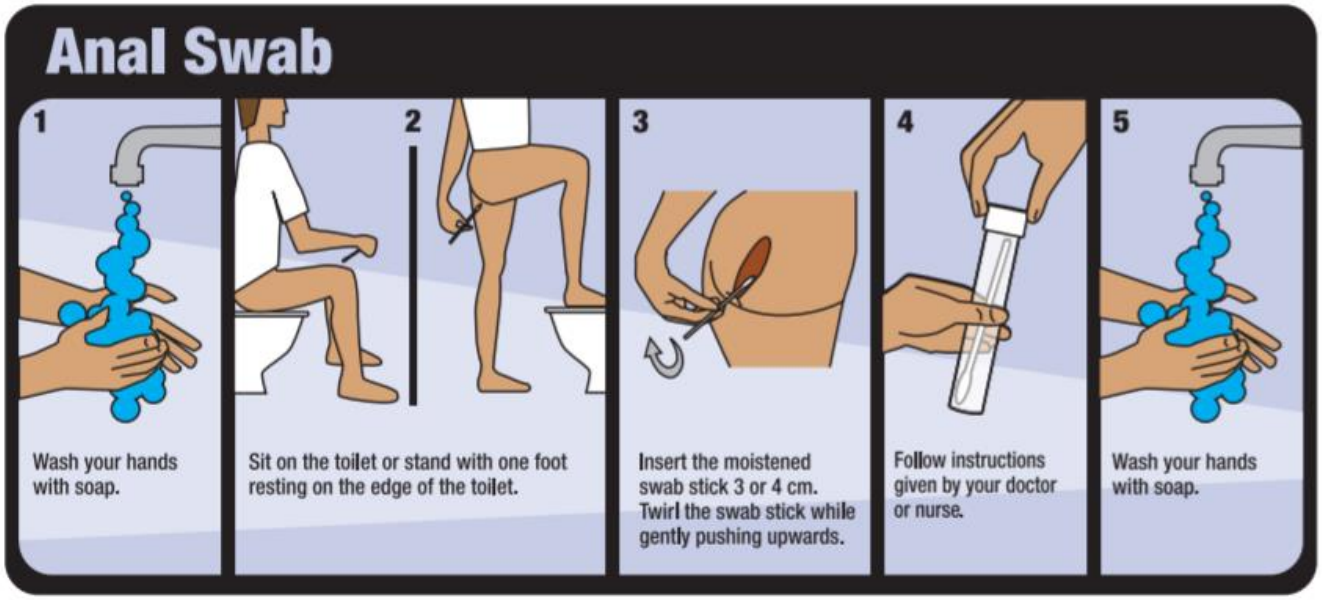
Blood: HIV, Syphilis serology, Hepatitis B serology

Gonorrhoea and chlamydia

- Women: vaginal* or cervical swab, first pass urine*
- Heterosexual men: first pass urine*
- Men who have sex with men (MSM): first pass urine*, anal swab*, throat swab
  - *can be self collected

Self collected swabs

- Pharyngeal swab taken in clinic room
- First pass urine, vaginal and anal swab self collected in bathroom



Developed by the NSW STI Programs Unit – NSW Health and reproduced by the Sunshine Coast Hospital and Health Service, ASHM, and the Communicable Diseases Branch with permission, 2018

https://stoptherise.initiatives.qld.gov.au/sites/default/files/wysiwyg-files/QH1214_ChlamydiaGonoTesting_Screen.pdf

Other tools

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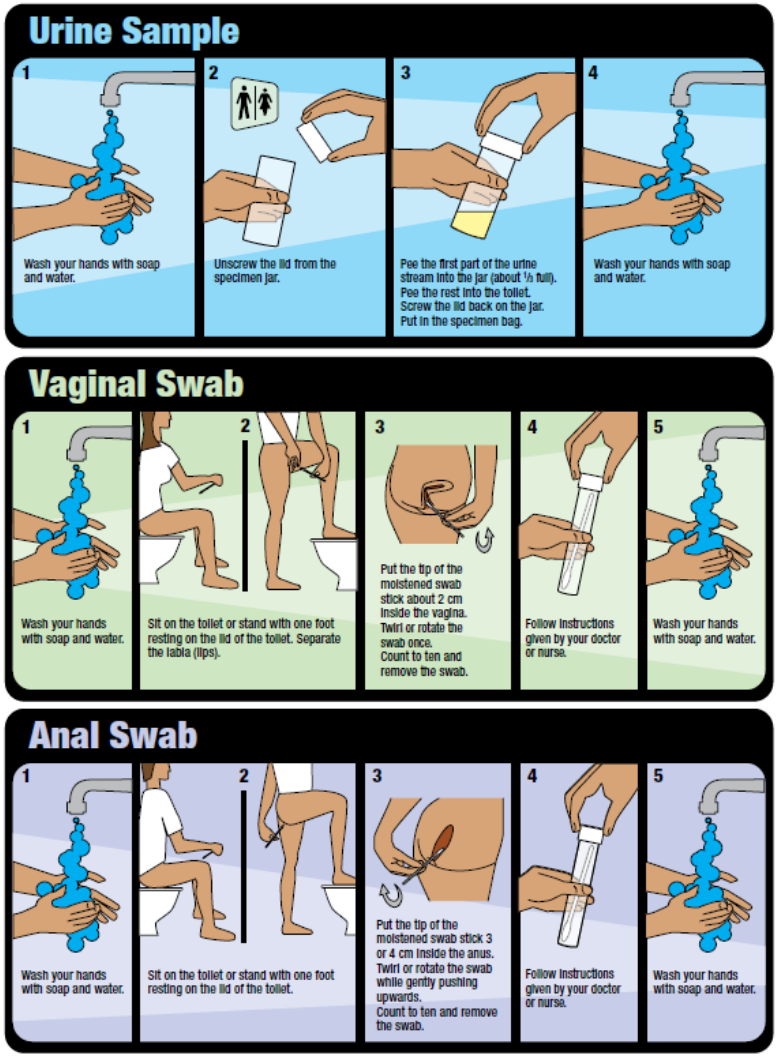


Questions

Clinical presentation

Will a person with an STI most likely have symptoms?

(Yes or No)

Tell us via the chat box

Everything you need to know: http://www.sti.guidelines.org.au/

Gonorrhoea

Gonorrhoea quiz

Gonorrhoea in women is commonly asymptomatic?

A. True
B. False

Urethral gonorrhoea in men is commonly symptomatic?

A. True
B. False

The best way to test for genital gonorrhoea in general practice is?

A. A biopsy of the site
B. Serology for men and NAAT for women
C. Urine NAAT for men and women
D. Urine NAAT for men and a cervical or vaginal NAAT for women

Gonorrhoea: Clinical presentation

Female genitals

- Cervical infection
- Vaginal discharge
- Pelvic pain or abnormal bleeding
- Untreated may lead to PID
- Asymptomatic

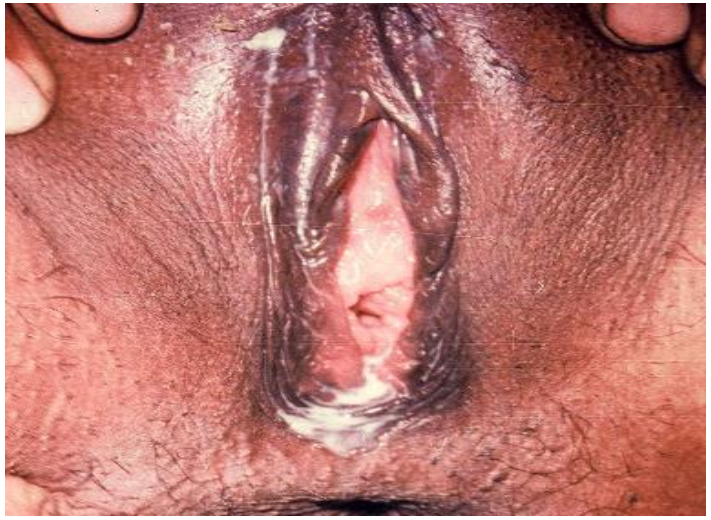
Male genitals

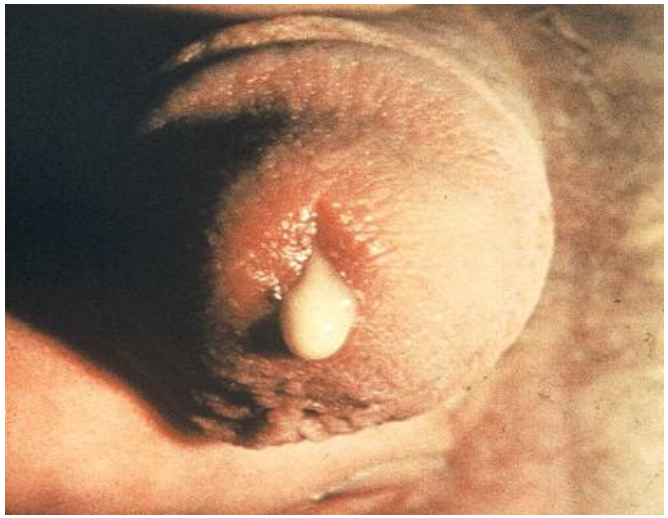
- Urethral discharge
- Urethral irritation
- Dysuria
- Some men asymptomatic
- Untreated may lead to epididymitis and chronic pain

- Throat asymptomatic
- Rectal may be:
  - asymptomatic,
  - discomfort
  - discharge

Content warning
Graphic images about to start!

Gonorrhoea: Clinical presentation





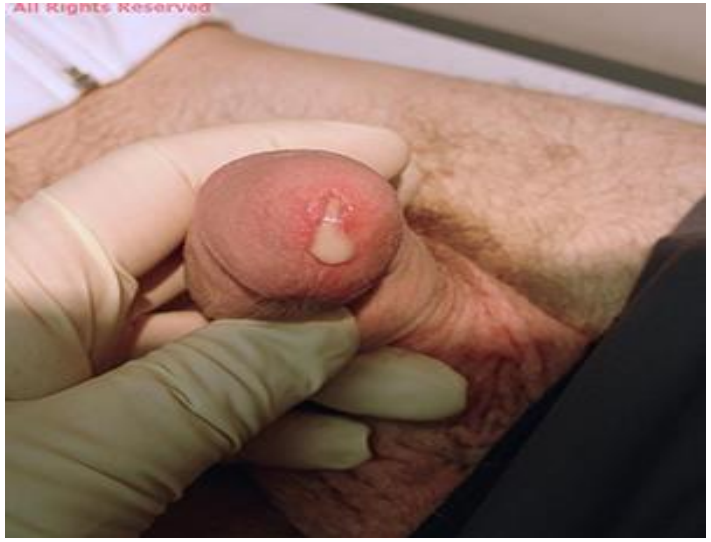


Image source MSHC STI Atlas http://stiatlas.org/

Gonorrhoea: Testing

Screening

NAAT (PCR) sites as per sexual history

swabs clinician or self collected

Which sites?
*Rectum *Urethra
*Cervix *Pharynx
*conjunctiva

Culture sample

Why?

Rising rates of resistance

- Second line treatment
- Remains symptomatic despite treatment

When?

- At time of specimen collection
- prior to treatment

(STI Management Guidelines, 2019)

Gonorrhoea: Treatment

Check and follow guidelines as they can change!

Principal Treatment Options		
Situation	Recommended	Alternative
Uncomplicated genital & ano-rectal infection	Ceftriaxone 500mg IMI, stat in 2mL 1% lignocaine PLUS Azithromycin 1g PO, stat	Alternative treatments are not recommended because of high levels of resistance, EXCEPT for some remote Australian locations and severe allergic reactions. Seek local specialist advice.
Uncomplicated pharyngeal infection	Ceftriaxone 500mg IMI, stat in 2mL 1% lignocaine PLUS Azithromycin 2g PO, stat*	
Adult gonococcal conjunctivitis	Ceftriaxone 500mg IMI, stat in 2mL 1% lignocaine PLUS Azithromycin 1g PO, stat	

(STI Management Guidelines, 2019)

Gonorrhoea: Follow up

- ✓ **No sex for 7 days**
- ✓ **Longer abstinence if drug resistance suspected**
- ✓ **Proof of cure at 2-4 weeks and retest at 3 months (for pharyngeal, rectal or cervical infection)**
- ✓ **Partner notification – 2 months**
- ✓ **Full STI screening – HIV and syphilis**

(STI Management Guidelines, 2019)

Gonorrhoea: take home message

Gonorrhoea as well as chlamydia

Questions?

Syphilis

Syphilis: an introduction

Syphilis:

- **Can be confusing/complicated**
- **Imitates lots of other conditions**
- **Is categorised into stages**
- **The stage dictates what treatment the patient needs**

(STI Management Guidelines, 2019)

Syphilis quiz

Syphilis symptoms include?

A. Rash
B. Swollen lymph nodes
C. Painless sore (chancre)
D. All of the above

How is syphilis transmitted?

A. Crossing the placenta in a pregnant woman to the foetus
B. Skin to skin contact with a syphilis rash
C. Skin to skin contact with a syphilis sore (chancre)
D. All of the above

The screening test for syphilis is?

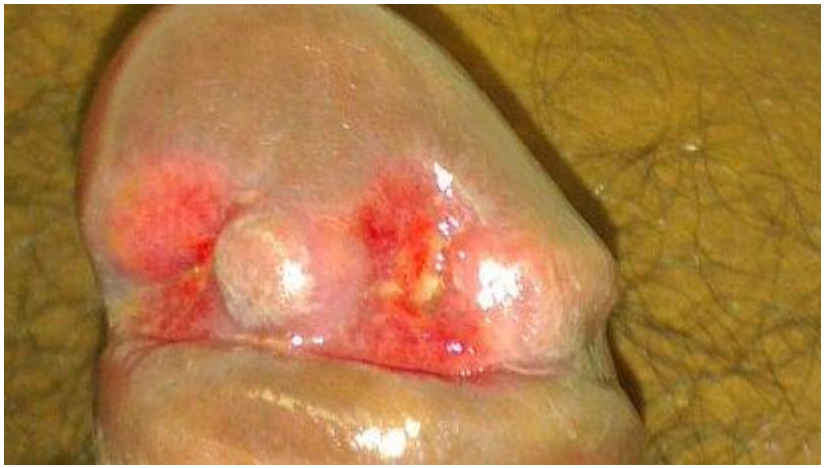
A. Urine
B. Blood
C. Vaginal / Anal / throat swab
D. All of the above

Case 3 Mr SF

17yrs aboriginal youth

Requests ‘check up’

On examination



What investigations would you perform?

What investigations would you perform?

PCR lesion

HIV

HepBsag, hepBsab, hepBcab

TPPA

RPR

FCU chlamydia, gonnorhoea, trichomonas

(Hep C, Hep A)

Results

RPR 1 in 32

TPPA reactive

Gonnorhoea positive

Chlamydia negative

HIV negative

Hep Bsag neg, sab<10

How would you treat this patient?

Syphilis register :
1800 032 238

Benzathine penicillin 0.9g each buttock (doctors bag)

Ceftriaxone im 500mg

Azithromycin 1g stat

Contact tracing

Hep B immunisation

What clinical stage of syphilis are these symptoms? Answer in the chat box

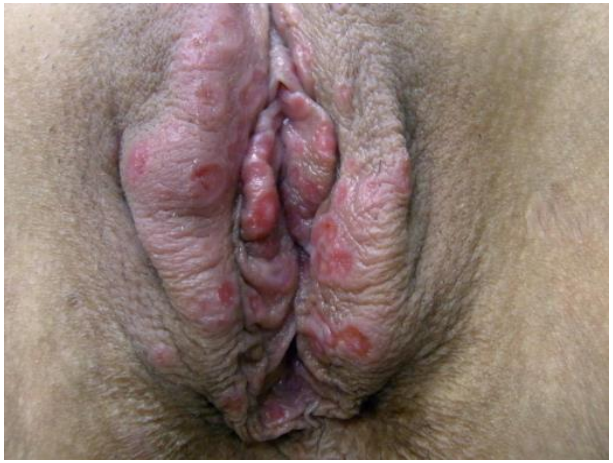
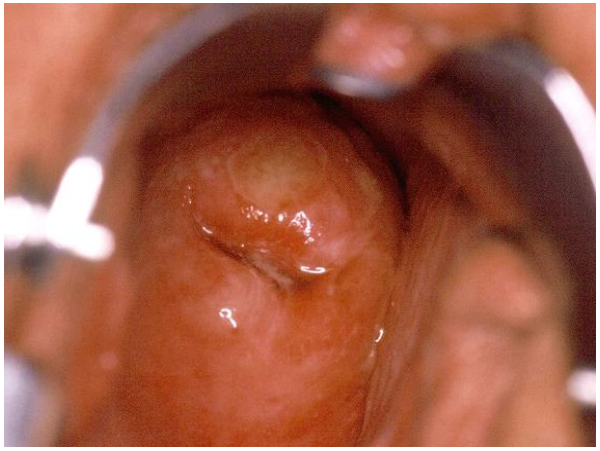
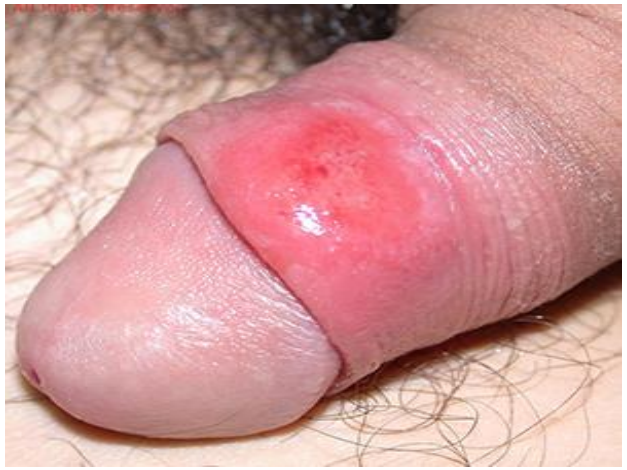
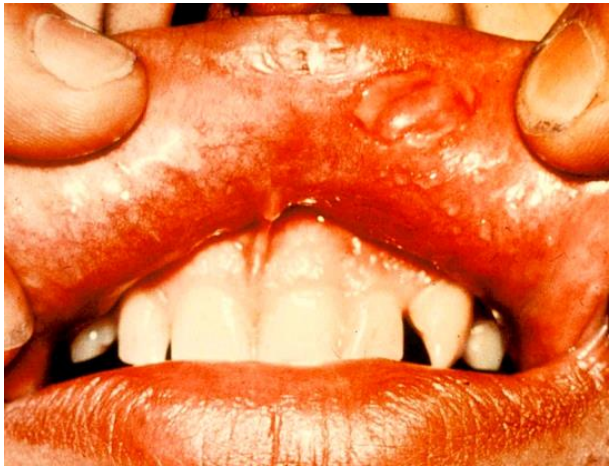
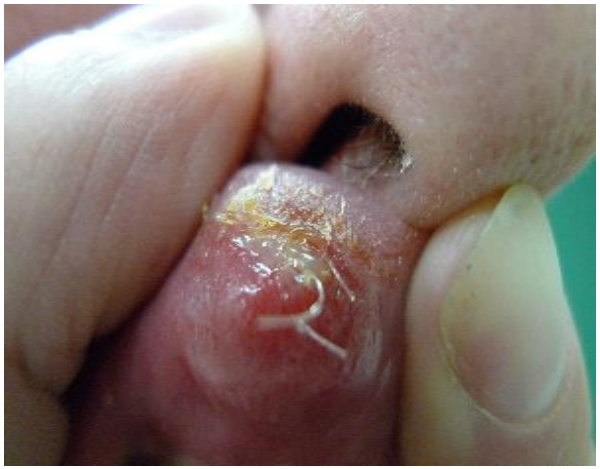
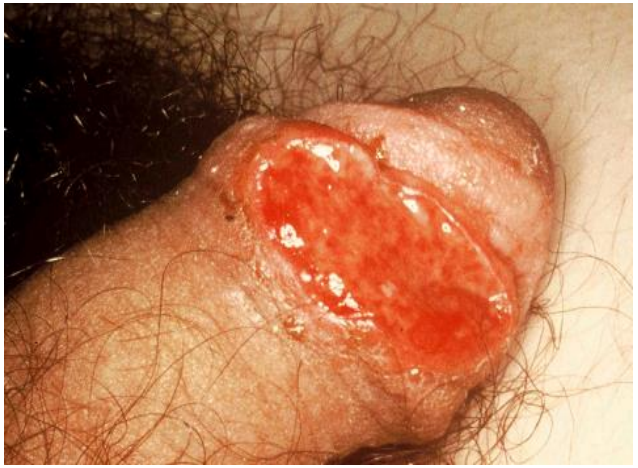
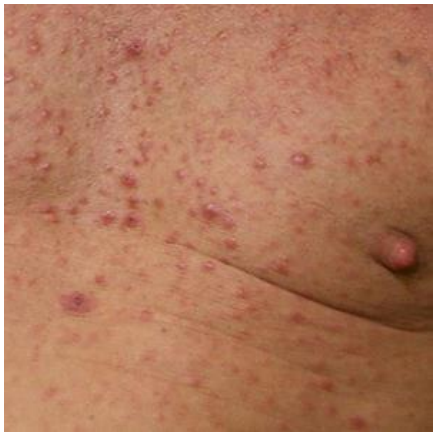
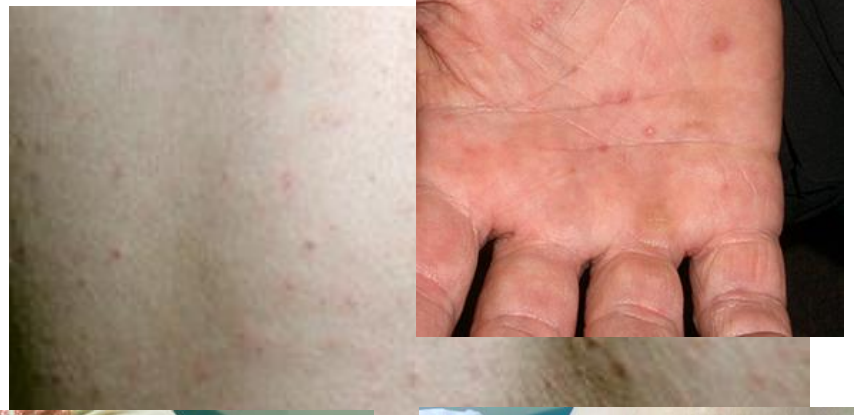
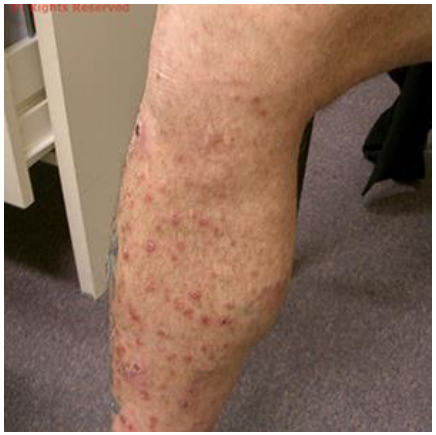







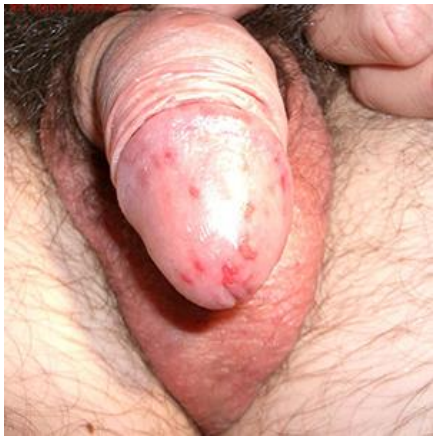
Image source MSHC STI Atlas http://stiatlas.org/

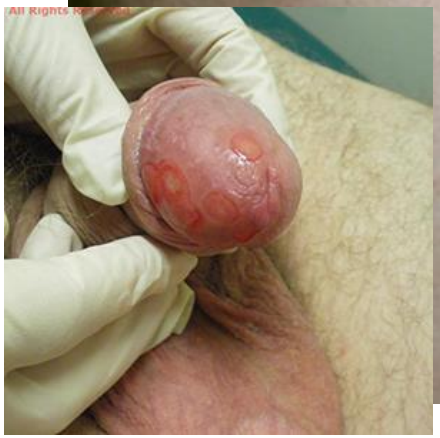
What clinical stage of syphilis are these symptoms? Answer in the chat box

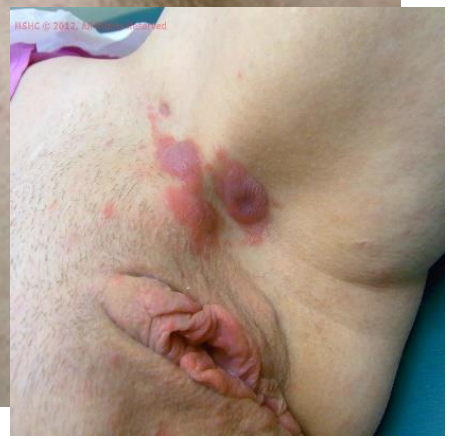












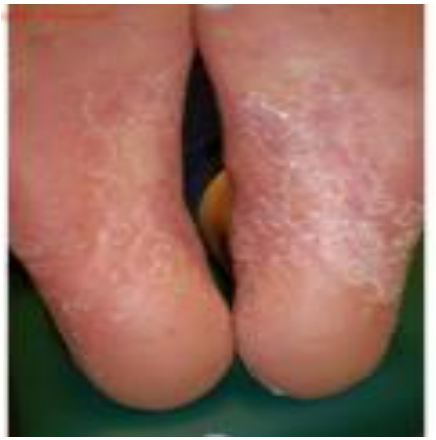
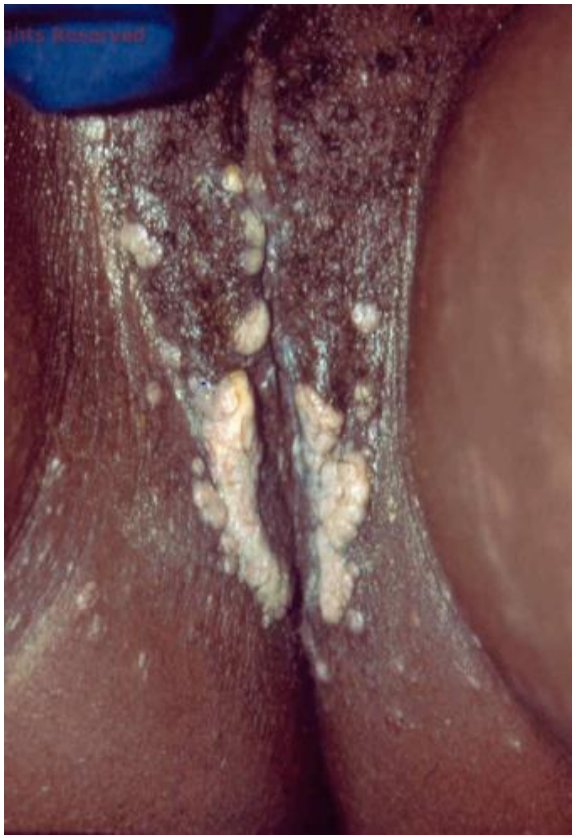
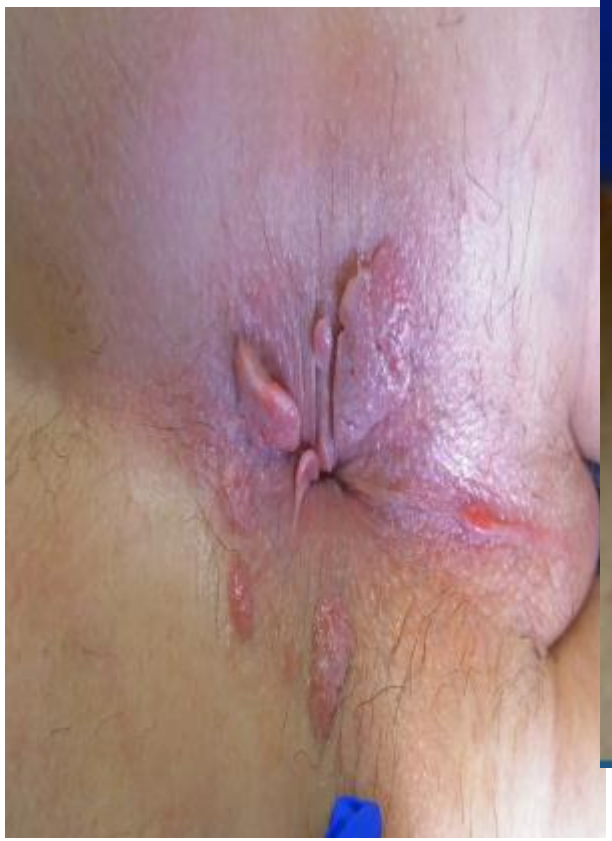


Image source MSHC STI Atlas http://stiatlas.org/

Secondary syphilis





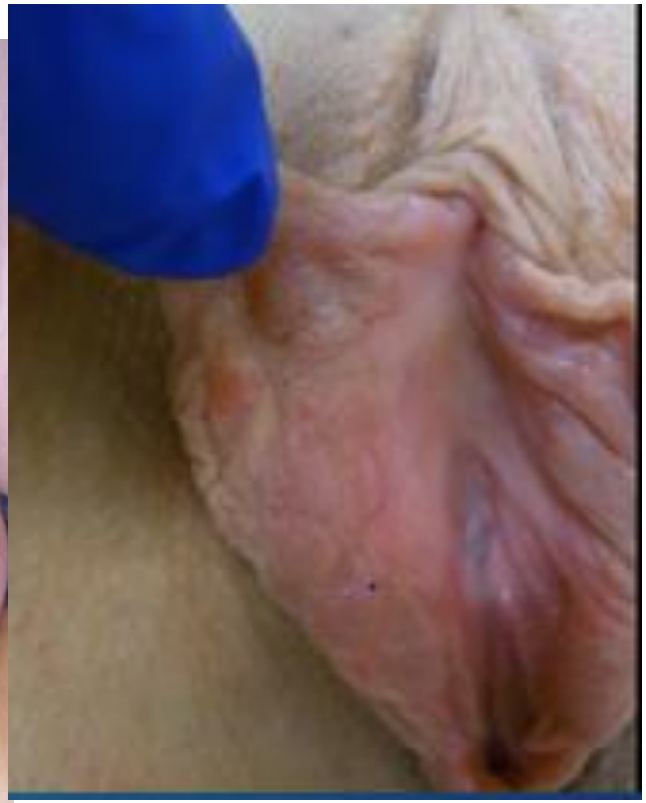


Image source MSHC STI Atlas http://stiatlas.org/

Secondary syphilis

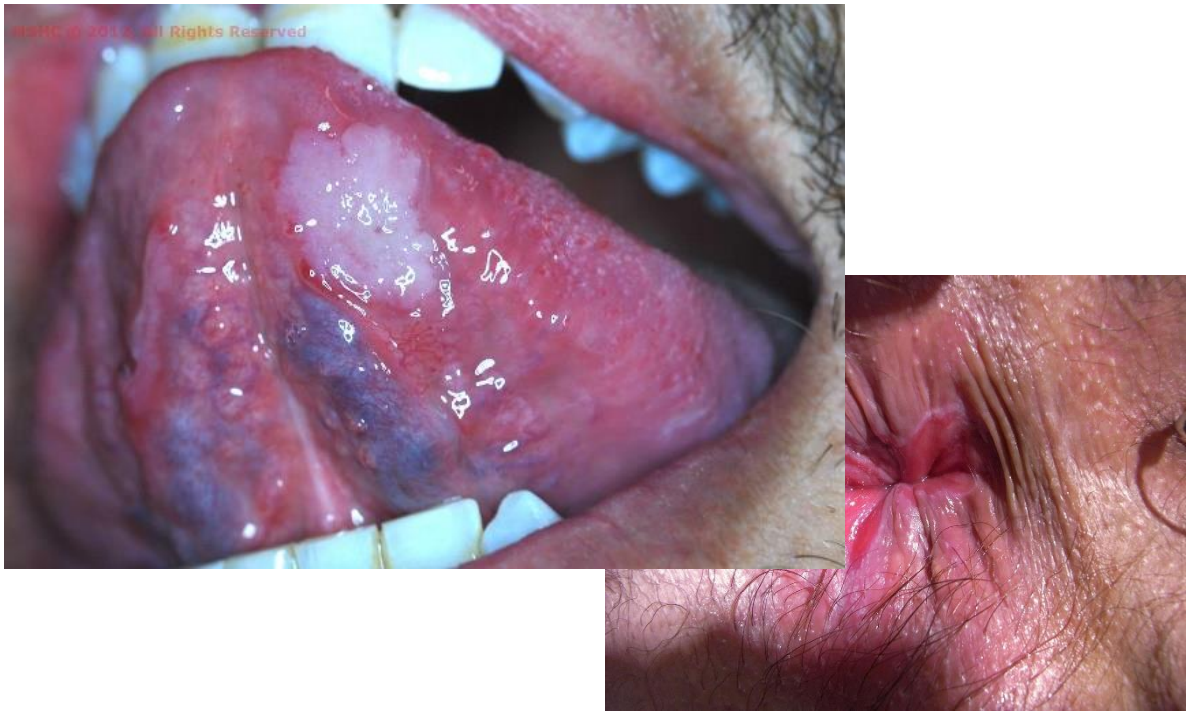
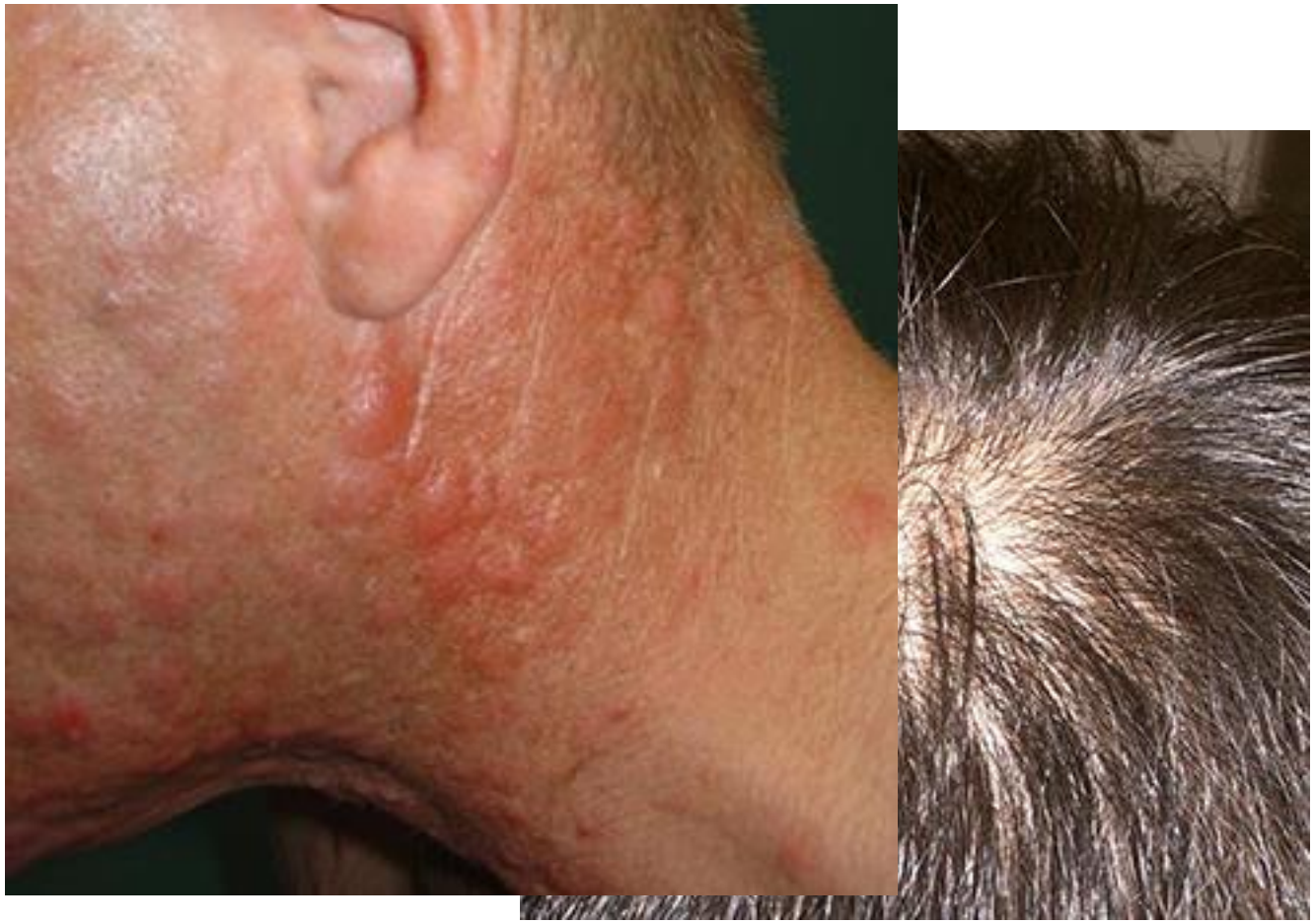


Image source MSHC STI Atlas http://stiatlas.org/

Nodular rash and patchy alopecia



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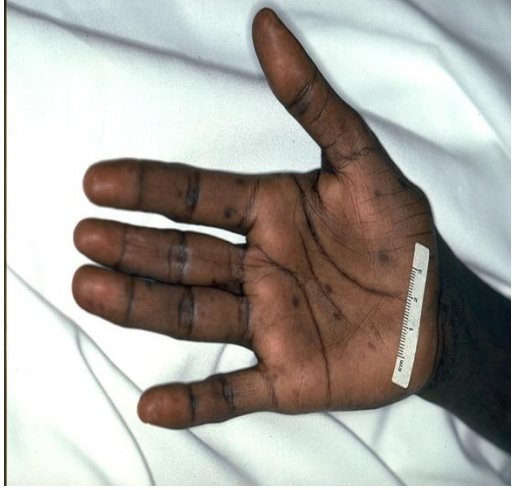
Secondary Syphilis



- Incubation 6/52- 6 months
- Primary and secondary same time
- Non specific symptoms:fever, malaise, headache, sore throat, arthralgia
- Rash 75% patients; extremely variable

Congenital syphilis

IS PREVENTABLE

Syphilis serology is part of antenatal screening

- Repeat in early 3rd trimester if “high risk”
- In outbreak areas: test at first antenatal visit, 28, 36 weeks, at delivery and at 6 weeks

Urgently refer and treat

Otherwise COMPLICATIONS can include stillbirth, foetal loss, preterm birth, neonatal death, low birthweight. neurological and other disabilities.

Slide acknowledgment: Nicholas Medland VHHITAL

Risk assess all women

Universal risk
- All pregnant women

Increased risk
- Woman or her partner identify as Aboriginal and/or Torres Strait Islander
- Adolescent pregnancy
- STI in current pregnancy or last 12 months
- Ongoing sexual links in high prevalence countries (woman or partner)

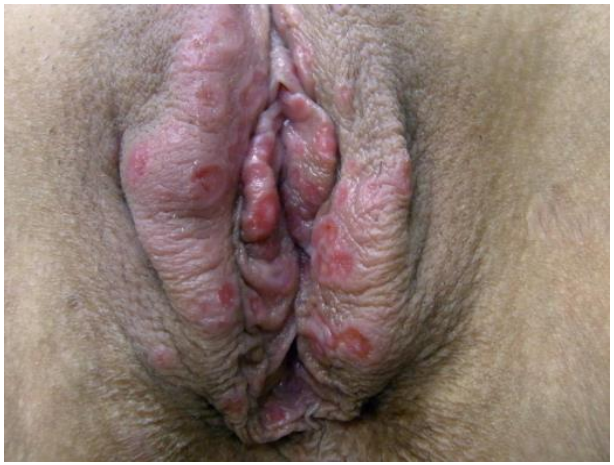
High risk
- Sexual contact with infectious syphilis case
- Woman or partner identify as Aboriginal and/or Torres Strait Islander AND reside in an outbreak declared area
- Substance use – particularly methamphetamine ('ice')
- Woman's partner is MSM
- Late, limited or no antenatal care
- Engages in high risk sexual activity

Antenatal screening

All pregnant women
- Serology at first antenatal visit (preferably < 10 weeks gestation)
- Dry swab (PCR) if lesions/chancre present
- Repeat if change in risk status

If increased risk
- Repeat serology at 26–28 weeks gestation

If high risk
- Repeat serology at:
  - Around 20 weeks gestation (opportunistically between 16–24 weeks)
  - 26–28 weeks gestation
  - 34–36 weeks gestation



Syphilis: Diagnosis

Most commonly used diagnostic tests are as follows:
Syphilis register :
1800 032 238

1. Serological testing – two types

- Treponemal-specific antibody tests (TP EIA; FTA-Abs; TPPA/TPHA)
- Non-treponemal tests (RPR, VDRL)

(If screening with a past Hx of treated syphilis only request a rapid plasma regain (RPR))

2. NAAT

- Detection of T.pallidum by nucleic acid amplification test from clinical specimen e.g. CSF, tissue and chancre

Slide acknowledgment: Nicholas Medland VHHITAL

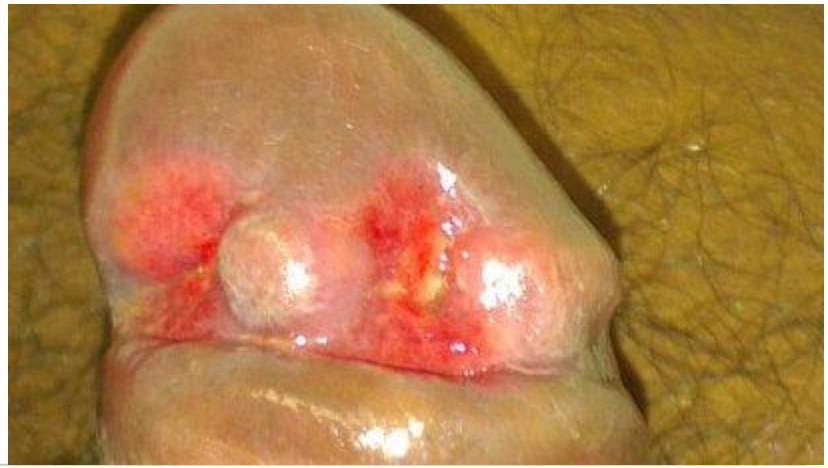
Interpretation of RPR

- A two titre (four fold) rise/fall significant
- 1:1 > 1:4 or 1:8 > 1:32 (indicates infection)
- 1:128 > 1:32 or 1:8 > 1:2 (response to treatment)

Contact tracing

All partners within 90 days

BLA 1.8g im



Before treating syphilis, would you contact your nearest sexual health clinic or specialist?

Tell us via the chat box

Syphilis: Management

Treatment determined by stage of infection:

Infectious syphilis (primary, secondary, early latent)	Non-infectious syphilis (late latent)
Benzathine penicillin 1.8g IMI, stat	Benzathine penicillin 1.8g IMI, weekly for 3 weeks
If allergic to penicillin	
Doxycycline (D) 100 mg/po BD 14 days alternative if penicillin allergy and compliance reliable (do not use in pregnancy)	Doxycycline (D) 100 mg/bd po 28 days

Other useful information:

- Previous test results
- Documented or highly reliable history of treatment

(STI Management Guidelines, 2019)

- Primary syphilis, secondary syphilis, early latent syphilis (less than 2years since diagnosis)
- Benzathine penicillin 1.8g IM weekly x3

- Late latent (greater than 2 years)
- Benzathine penicillin 1.8g IM weekly x3

- Neuro or CVS
- Admit iv penicillin

- Benzathine Penicillin (Bicillin) in doctors bag
- Please be careful of dose

Syphilis: take home messages

Increase syphilis testing in your practices.

Be aware of the rash

Request:

- Syphilis serology (antibody + RPR)
- Use RPR to monitor treatment, detect re-infection
- + PCR if there is anything to swab

If in doubt, treat, don’t wait

Get advice about treatment

Slide acknowledgment: Nicholas Medland VHHITAL

Contact Tracing/Partner Notification

Whose responsibility is it to initiate contact tracing?

A. The diagnosing clinician's (or their delegate)
B. The pathology laboratory
C. The public health unit
D. None of the above

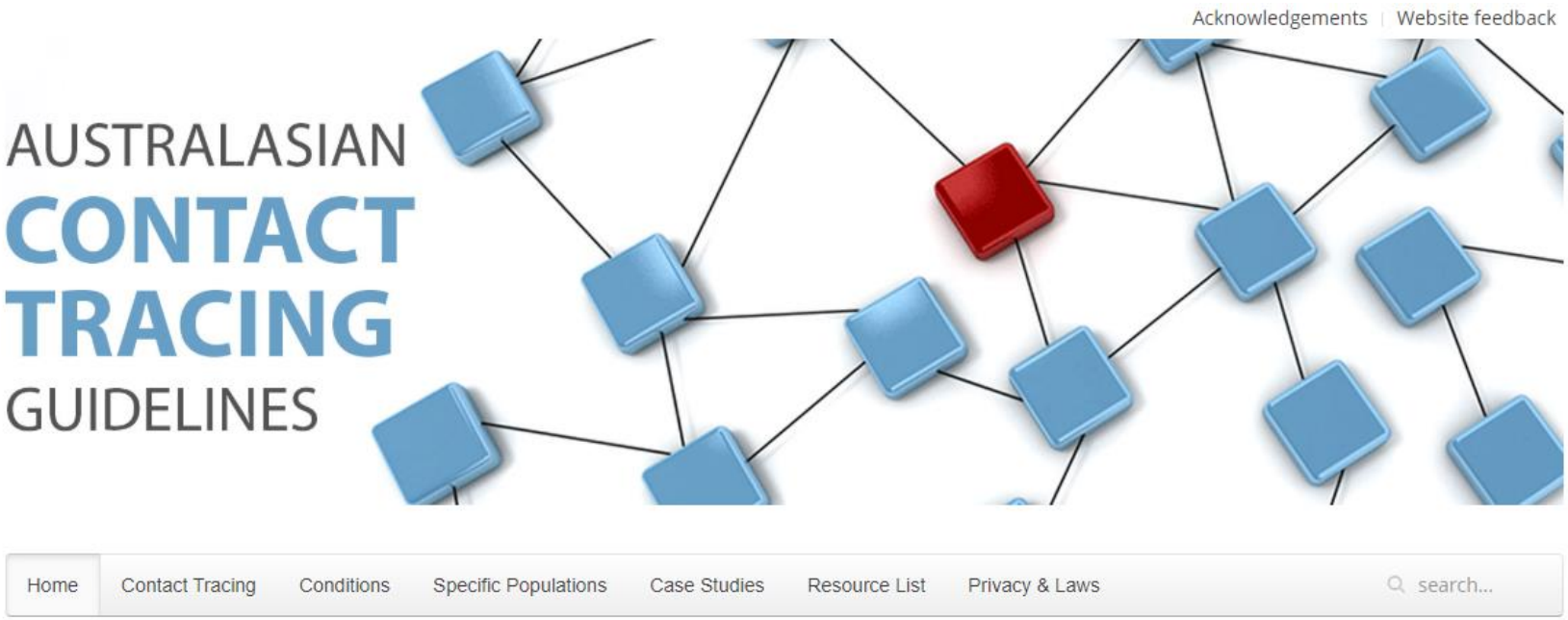
Aims of contact tracing

- ✓ To **interrupt** ongoing transmission and limit prevalence of infection in the population
- ✓ To **minimise** complications in those infected
- ✓ **Prevent** re-infection

Key component of STI control!

Refer to the ASHM Contact Tracing Guidelines: http://contacttracing.ashm.org.au/

Australasian Contact Tracing Guidelines



Australasian Contact Tracing Guidelines
http://contacttracing.ashm.org.au/

STI/BBV Testing tool for asymptomatic people

STEP 3 Contact tracing/partner notification[1,8]

INFECTION	HOW FAR BACK TO TRACE
CHLAMYDIA	6 months
GONORRHOEA	2 months
SYPHILIS	Primary syphilis – 3 months plus duration of symptoms Secondary syphilis – 6 months plus duration of symptoms Early latent syphilis – 12 months
HIV	Start with recent sexual or injecting drug use needle-sharing partners Outer limit is onset of risk behaviour or last known HIV negative test result
HEPATITIS B	6 months prior to onset of acute symptoms. If asymptomatic, according to sexual history For newly acquired cases contact your local Public Health Unit (PHU) and/or specialist
HEPATITIS C	Low risk for sexual exposure (except for HIV positive men) so contact tracing not generally performed for sexual partners. Contacts via parenteral exposure (shared needles, injecting equipment) should be tested if possible. Children of mothers who are hepatitis C positive should be tested. *Note: rarely sexually transmitted except in HIV co-infection*
TRICHOMONIASIS	Unknown; important to treat all sexual partners

Step 3:

"Contacting tracing/partner notifications"

STI/BBV Testing Tool for Asymptomatic People: https://stoptherise.initiatives.qld.gov.au/sites/default/files/wysiwyg-files/QH1214_STI-BBV_TestingTool_Screen.pdf

How far back to contact trace?

Infection	Length
Chlamydia	6 months
Gonorrhoea	2 Months
Syphilis	Primary syphilis – 3 months plus duration of symptoms Secondary syphilis – 6 months plus duration of symptoms Early latent syphilis – 12 months
HIV	Start with recent partners Outer limit is onset of risk behaviour or last known HIV-negative test result
Hepatitis B	6 months prior to onset of acute symptoms. If asymptomatic, according to risk history. For newly acquired cases contact your local Public Health Unit (PHU) and/or specialist.
Hepatitis C	6 months prior to onset of acute symptoms. If asymptomatic, according to risk history. For newly acquired cases contact your local PHU and/or specialist.

Mackay Sexual Health Service
12-14 Nelson Street Mackay

If there are any difficulties with

Contact tracing

Ask for Help

Contact Tracing Support Officer

Katie Edmondson

07 4433 9600

Patient referral contact tracing

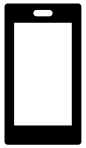
Websites offer anonymous partner notification services

» Let them Know

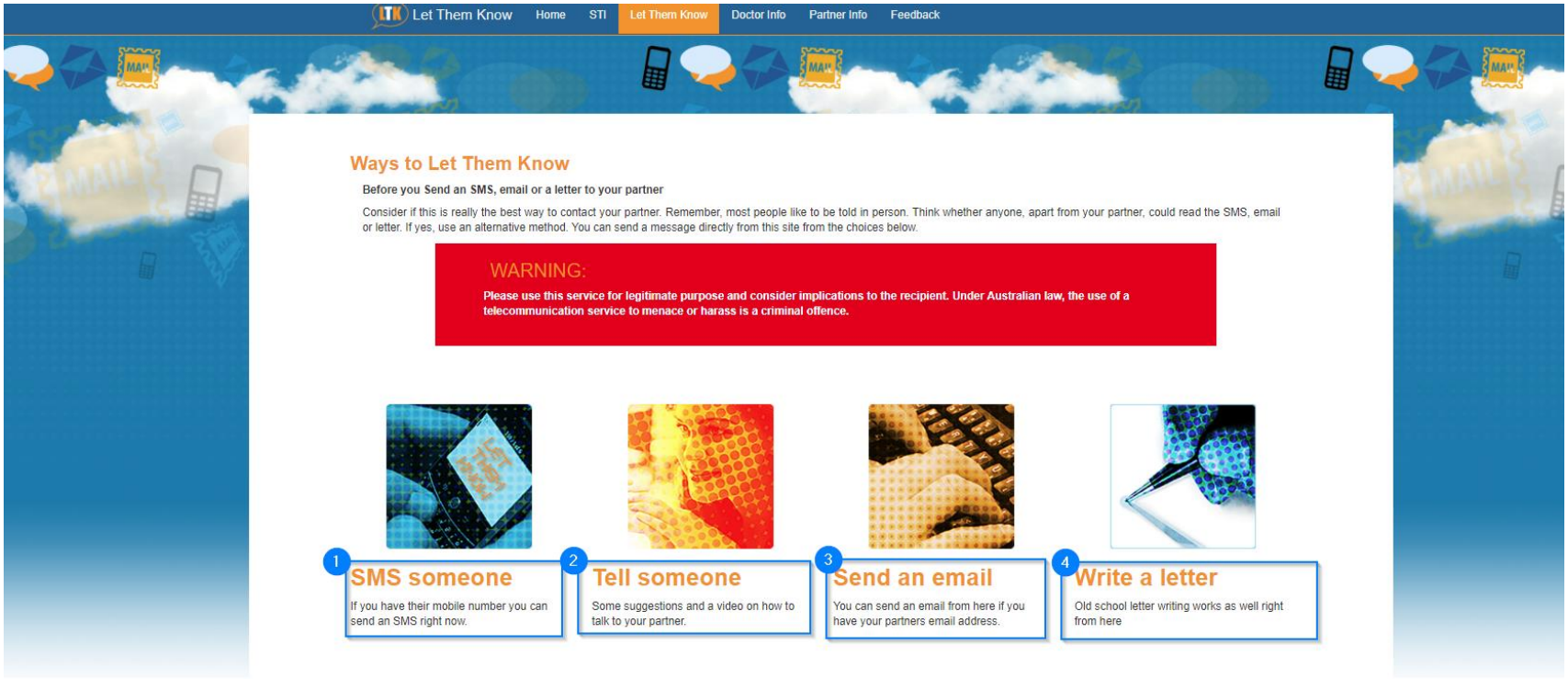
» www.letthemknow.org.au/

» Drama Down Under – Men who have sex with men

» www.thedramadownunder.info/



» Better to Know - Aboriginal people
http://www.bettertoknow.org.au/



Let them Know

www.letthemknow.org.au/

LetThemKnow

Sending an SMS

Send an anonymous SMS

Partner's name

Partner's mobile

Notification

Your IP address is: 210.9.25.178

Next

Information for Partners

Frequently asked questions FAQ

This section is for people who have received a message via the website from a sexual partner. The person who sent the message has been diagnosed with a Sexually Transmitted Infection (STI). They have used the website to advise you that you may be at risk of the infection. It is important to get a test because in most cases STIs are silent infections, meaning there are no signs or symptoms. The STIs listed on this website can be treated with antibiotic medicine. For more information see our **STI Fact Sheets**. Depending on an individual's risk profile it may be important to test for other STIs at the same time. To find out more about these other tests go to **Check Your Risk.**

Any GP (local doctor) can test and treat you for an STI. Just print off the The **letter to your Doctor** relavant to your STI and take this to your appointment.

- If you live in Victoria you can attend Melbourne Sexual Health Centre at 580 Swanston Street Carlton, phone **03 9341 6200**.
- The Melbourne Sexual Health Centre website has a link to **other health services,** form services in your area.
- If you live in NSW you can call the Sexual Health Infoline on **1800 451 624** to speak with a sexual health nurse
- If you live in **QLD visit the website**

Example SMS notifications

"A msg from www.letthemknow.org.au (First Name) you may have been at risk of (insert STI). Pls have a sexual health check. See web 4 more info. PLS DO NOT REPLY"

"A msg from www.dramadownunder.info - (First Name) U may have been exposed to (insert STI). U may need to do a sexual health check-up. See www.thedramadownunder.info/beentold for info. PLS DO NOT REPLY"

Recommendations for Aboriginal

	Suggestions
Confidentiality	Attempt face to face contact
Partnerships	Create and work in partnership with a network of health care workers that are trusted by the community Engage with community on regular basis Involved in other aspects of community- not just sexual health
Contact details	Record nick-names and aliases, record age of partners to be contacts - to reduce risk of talking to wrong family member with similar name
Innovate	See if you can find people at local sporting clubs, parks,taverns. Be aware of maintaining confidentiality
Gender	Where possible offer health care worker of same gender
Patient support	Be mindful of domestic violence issues, separate consultations with person and their sexual partners

Adapted from: Rob Monoghan and Peter Patterson 'Recommendations for Contact Tracing in Aboriginal Communities'. Poster

Provider referral

Recommended in the following circumstances:

- HIV, syphilis and gonorrhoea diagnosis
- Repeat infections
- Aboriginal and Torres Strait Islander communities
- Incarcerated or detained partners
- Casual or ex-partners
- If the patient requests

Provider referral

Do not give feedback to index patient

Ensure there is appropriate documentation of outcomes

- Including note made in index patient file

Contact Management

- Access to prompt testing and treatment for the contact – through your practice or referral to local sexual health clinic
- If contact tests positive, determine if any additional partner(s) need to be notified

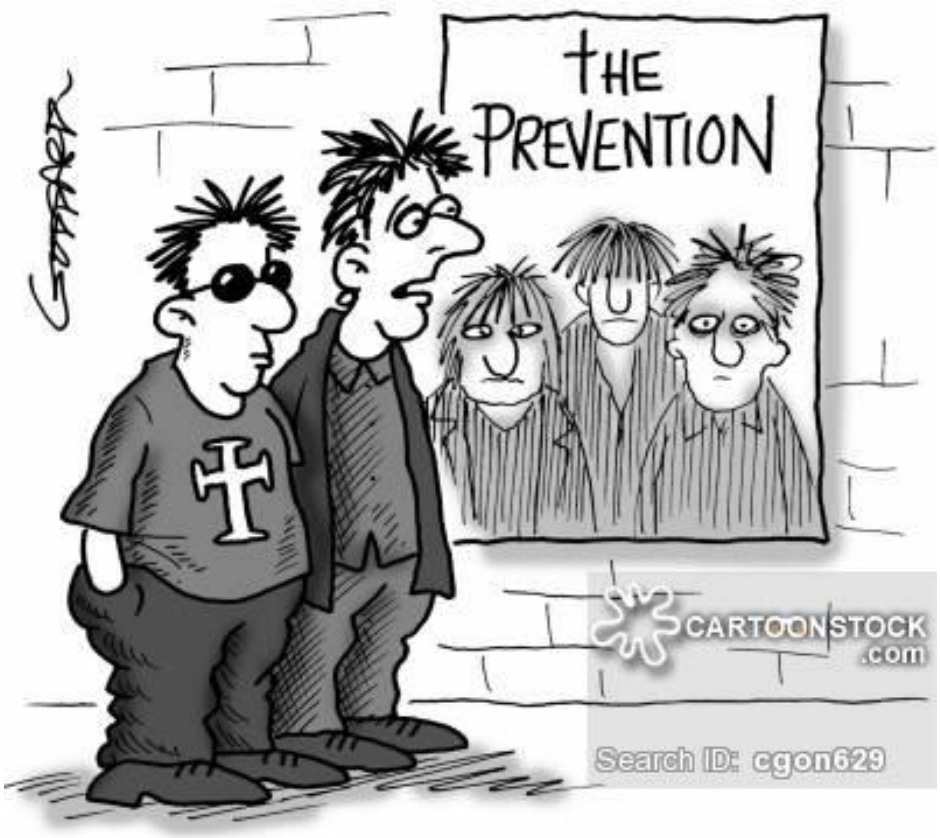
Key Messages

- **Contact Tracing is a component of good clinical management of STIs**

- **GPs and Primary Health Care Nurses (PHCNs) are well placed and skilled to take on the role of contact tracing**

- **Contact tracing relies on the co-operation of the patient**

Pre-exposure prophylaxis (Treatment as prevention)



"Apparently they're better than The Cure."

Pre-exposure prophylaxis

- **Daily Truvada (Tenfovir / Emitricitabine)**
- **To prevent infection in HIV –ve individuals**
- **Very effective – 99% reduction risk infection**
- **PBS approved March 2018**
- **Risk- benefit and cost- benefit ratio**

✓**HIV expensive and serious**

✓**PrEP safe and effective**

1. WHO. Guidance on pre-exposure oral prophylaxis (PrEP) for serodiscordant couples, men and transgender women who have sex with men at high risk of HIV: recommendations for use in the context of demonstration projects
2. CDC 2014, Preexposure prophylaxis for the prevention of HIV infection in the United States – 2014.

How to Start PrEP

Risk assessment (ASHM guidelines)

Mod risk of HIV

HIV test, STI screening, renal function tests

Streamline authority 7580

Continuing PrEP

3 month cycles HIV and STI screening

6 monthly renal function tests

Streamline authority 7580

Decision Making in PrEP

PrEP

ashm

Prescribing Pathway for PrEP in Australia

1 BEHAVIOURAL ELIGIBILITY

Assess HIV risk as per *ASHM PrEP Clinical Guidelines*:
See Table 1 (other side)

- Medium or high risk → **ELIGIBLE** Progress to Step 2
- **Not** medium to high risk → Refer to PrEP Guidelines. Consider PrEP if likely future risk

Discuss alternate methods of HIV risk reduction. Offer or refer to counselling.

Gaining Informed Consent:

- **testingportal.ashm.org.au/hiv**
- Discussion should be appropriate to the person's gender, culture, language, behaviour and risk factors
- **Discuss** the patient's reason for testing, testing procedure, window period, transmission, prevention
- **Talk about** confidentiality and privacy issues around testing, implications of positive and negative test results

2 CLINICAL ELIGIBILITY

Note: Steps 1, 2, & 3 can be completed at the same visit

Confirm HIV status and medical history including renal function

- **HIV Negative** (test result within last 7 days)*
  - Confirm no signs or symptoms of acute HIV infection
    e.g. fever, fatigue, myalgia, rash, headache, pharyngitis, cervical lymphadenopathy, arthralgia, night sweats, diarrhoea
  - Confirm normal renal function*
    eGFR > 60mL/min
  - Confirm patient is not taking any nephrotoxic medication
    e.g. high dose NSAIDs
    www.hiv-druginteractions.org
  - **ELIGIBLE** Progress to Step 3
- HIV negative **BUT** recent exposure within 72 hours
  - **Start NPEP**
    For more information, refer to **getpep.info**
  - Once PEP course completed, assess again for PrEP
  - Repeat Step 1
- **HIV Positive**
  - **NOT ELIGIBLE**
  - Refer to specialist clinic or s100 prescriber www.ashm.org.au/HIV/HIV-prescribers and to the following online resource *Making a new diagnosis* at www.ashm.org.au/HIV/prevention-testing-and-diagnosis/making-new-diagnosis

3 OTHER TESTING

Assess and test for STIs and hepatitis coinfection

- STI testing as per the *Australian STI Management Guidelines*
  www.sti.guidelines.org.au
- Hepatitis B serology (HBsAg, Anti-HBs, Anti-HBc).
  Vaccinate if not immune.
  If HBsAg+ve, refer to HBV specialist.
  www.ashm.org.au/hbv-prescriber-locator
- Hepatitis C serology (anti-HCV; if +ve, HCV RNA).
  If HCV RNA+ve, treat HCV.
  www.ashm.org.au/hcvdecisionmaking
- Progress to Step 4

4 PRESCRIBING PrEP

Daily PrEP:
Daily continuous oral dosing of TDF/FTC (tenofovir/emtricitabine) is the standard recommended regimen.
Daily PrEP is the recommended regimen for PWID and vaginal sex.

OR

On-demand PrEP:
Intermittent dosing of TDF/FTC is an alternative non-standard dosing regimen that should only be used after discussion with an experienced clinician.
On-demand PrEP is only recommended for MSM - see *ASHM PrEP Clinical Guidelines*.

- Progress to Step 5

5 ONGOING MONITORING

Ongoing monitoring:
See Table 2 (other side)

&

Patient Education:
Discuss how PrEP works, frequency, missed dose protocol, continued condom use. See Box 1 for more (other side).

- Repeat both every 3 months

- **PrEP** (Pre-Exposure Prophylaxis)
- **NPEP** (Non-Occupational Post Exposure Prophylaxis)
- **PEP** (Post-Exposure Prophylaxis)

*Can prescribe PrEP on the same day as HIV or renal function tests

For more information about PrEP: www.ashm.org.au/HIV/PrEP

www.ashm.org.au

Decision Making in PrEP

PrEP

Prescribing Pathway for PrEP in Australia

Table 1: Behavioural eligibility criteria for PrEP

RISK CRITERIA FOR MSM

High Risk – Recommend PrEP

Last 3 months	Next 3 months*
• CLAI with a regular HIV+ partner (not on treatment and/or detectable viral load) • Receptive CLAI with any casual HIV+ male partner or a male partner of unknown status • Rectal gonorrhoea, rectal chlamydia or infectious syphilis diagnosis • Methamphetamine use	• Multiple episodes of CLAI with & or without sharing intravenous drug equipment

Medium Risk – Consider PrEP

Last 3 months	Next 3 months*
• Anal intercourse when proper condom use was not achieved (e.g. condom slipped off) where the serostatus of partner was not known, or was HIV+ and not on treatment or with a detectable viral load • *If patient uncircumcised:* more than one episode of insertive CLAI where the serostatus of partner was not known, or was HIV+ and not on treatment or with a detectable viral load	• Multiple episodes of CLAI with & or without sharing intravenous drug equipment

RISK CRITERIA FOR TRANS & GENDER DIVERSE PEOPLE

High Risk – Recommend PrEP

Last 3 months	Next 3 months*
• Regular sexual partner of an HIV+ person (not on treatment and/or detectable viral load) with inconsistent condom use • Receptive CLAI with any casual HIV+ partner or a male partner of unknown status • Rectal or vaginal gonorrhoea, chlamydia or infectious syphilis diagnosis • Methamphetamine use	• Multiple episodes of anal or vaginal CLI with & or without sharing intravenous drug equipment

Medium Risk – Consider PrEP

Last 3 months	Next 3 months*
• 1+ episodes of anal or vaginal intercourse when proper condom use was not achieved (e.g. condom slipped off) and where the serostatus of partner was not known, or was HIV+ and not on treatment or with a detectable viral load • *If patient uncircumcised:* 1+ episodes of insertive CLAI where the serostatus of partner was not known, or was HIV+ and not on treatment or with a detectable viral load	• Multiple episodes of anal or vaginal CLI with & or without sharing intravenous drug equipment

RISK CRITERIA FOR HETEROSEXUAL PEOPLE

High Risk – Recommend PrEP

Last 3 months	Next 3 months*
• A regular sexual partner who is HIV+ (not on treatment and/or with detectable viral load) with inconsistent condom use • Receptive anal or vaginal CLI with any casual HIV+ partner, male homosexual or bisexual partner of unknown status • A female patient in a serodiscordant heterosexual relationship, who is planning natural conception in the next 3 months	• Multiple episodes of CLI with & or without sharing intravenous drug equipment

Medium Risk – Consider PrEP

Last 3 months	Next 3 months*
• CLI with a heterosexual partner, not known to be HIV–, from -a country with high HIV prevalence	• Multiple episodes of CLI with & or without sharing intravenous drug equipment

RISK CRITERIA FOR PWID

High Risk – Recommend PrEP

Last 3 months	Next 3 months*
• Shared injecting equipment with an HIV+ individual & or with a gay or bisexual man of unknown HIV status	• Multiple events of sharing injecting equipment with an HIV+ individual or a gay or bisexual man of unknown HIV status • Inadequate access to safe injecting equipment

- **PWID** (People Who Inject Drugs)
- **CLI** (Condomless Intercourse)
- **CLAI** (Condomless Anal Intercourse)

*Is the patient **likely** to behave like this in the next 3 months (indicates a sustained risk)

Table 2: Laboratory evaluation & clinical follow-up of individuals who are prescribed PrEP

Test	Baseline	±30 days after initiation (optional)	90 days after initiation	Every 90 days on PrEP	Other frequency (minimum)
HIV testing and assessment for signs or symptoms of acute infection	✔	✔	✔	✔	n/a
Assess side effects	n/a	✔	✔	✔	n/a
Hepatitis B serology	✔	n/a	n/a	n/a	n/a
Hepatitis C serology	✔	n/a	n/a	n/a	Every 12 mths
STI (i.e. syphilis, gonorrhea, chlamydia) as per *Australian STI Management Guidelines*	✔	n/a	✔	✔	n/a
eGFR ±urine protein: creatinine ratio (PCR) at 3 mths and then every 6 mths	✔	n/a	✔	n/a	Every 6 mths
Pregnancy test (women of child-bearing potential)	✔	✔	✔	✔	n/a

Box 1: Patient Education

- Discuss HIV-risk behaviours
- Discuss combination HIV/STI prevention, including the central role of condoms
- Discuss safer injecting practices if applicable
- Check mental health and recreational drug use
- Discuss the importance of medication adherence at every visit
- Patients need to take a daily dose of PrEP for 7 days to achieve high levels of protection, 20 days to achieve maximum protection
- If stopping PrEP – patients on daily PrEP should continue PrEP for 28 days following exposure
- Ongoing monitoring every 3 months is required – see Table 2; discuss potential side effects include early e.g. headache, nausea and long term e.g. renal injury, lowered bone density;
- Ask about medications that can affect renal function, eg regular use of NSAIDs

Electronic version downloadable from: www.ashm.org.au/resources

 ISBN: 978-1-920773-77-9

Downside to PrEP

Impaired renal function tests

Use only if GFR > 60

Increased risk of STIs

SECRETARIAT OF STATE

No. 64.781

From the Vatican, 5 June 2015

Dear Dr Montaner,

His Holiness Pope Francis thanks you for informing him of the forthcoming International Conference on HIV/AIDS in Vancouver. He sends prayerful greetings to all taking part, and expresses his esteem for their work and the dedication it requires.

His Holiness is grateful for the many advances made in the prevention and treatment of HIV/AIDS, particularly through Highly Active Antiretroviral Therapy, and the promotion of "Treatment through Prevention". The lives that have been saved, both through the reduction in the number of new infections and the better health and longer lifespan of those already diagnosed, gives witness to the possibilities for beneficial outcomes when all sectors of society unite in common purpose. He hopes that further efforts may be made to make the fruits of research and medicine available to the world's poorest people, especially orphaned children, upon whom this scourge often places the heaviest burden. He likewise prays that all advances in pharmacology, treatment and research will be matched by a firm commitment to promote the integral development of each person as a beloved child of God. Upon all of you, the Holy Father invokes abundant divine blessings of wisdom and peace.

With every good wish, I am

Yours sincerely,

Pietro Card. Parolin

Secretary of State

Medical termination of pregnancy

MS- 2 – step

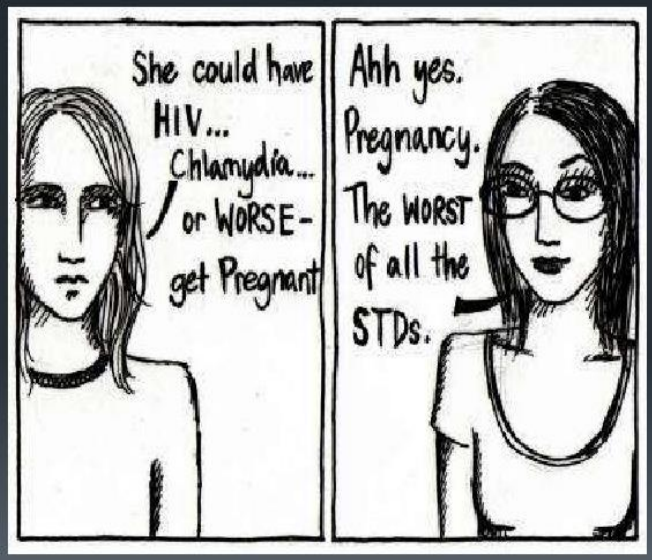
Mifepristone 200mg orally

Misoprostol 200 micrograms x 4 buccal 36 to 48hrs later

Up to 63 days

Heavy bleeding 2-3 days, bleeding continues 10-14 days

2% failure rate ongoing pregnancy



Medical termination management

Confirm pregnancy and gestational age USS[2]

1 hr from medical care for 14 days.

Exclude contraindications to mifepristone/misoprostol[2]

- chronic adrenal failure
- hypocoagulation diseases
- anticoagulation
- allergy to mifepristone, misoprostol or other prostaglandin.

Consider relative contraindications

(eg, anaemia, renal failure, hepatic impairment**).**[2]

Mycoplasma

Discovered 1980

Similar symptoms chlamydia

Asymptomatic, Urethritis, cervicitis, PID

PCR test available 2015

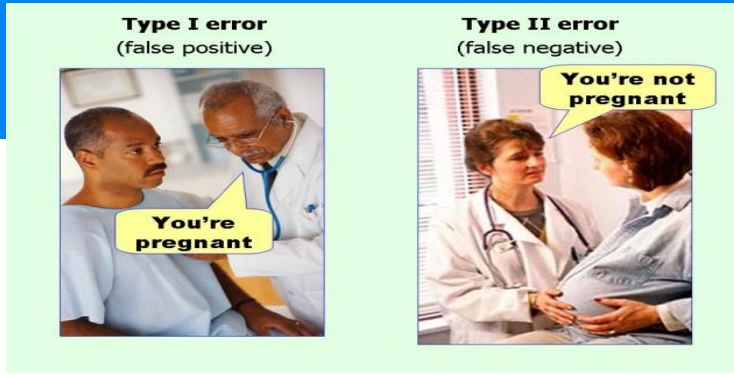
Mycoplasma

Prevalence 2.5%?

Natural history not well known

Macrolide resistance

General Practice



Don't screen population

Test in symptomatic patients

Treat doxycycline 100mg 7 days then azithromycin

Proof of cure 2 weeks

M.Gen: Management

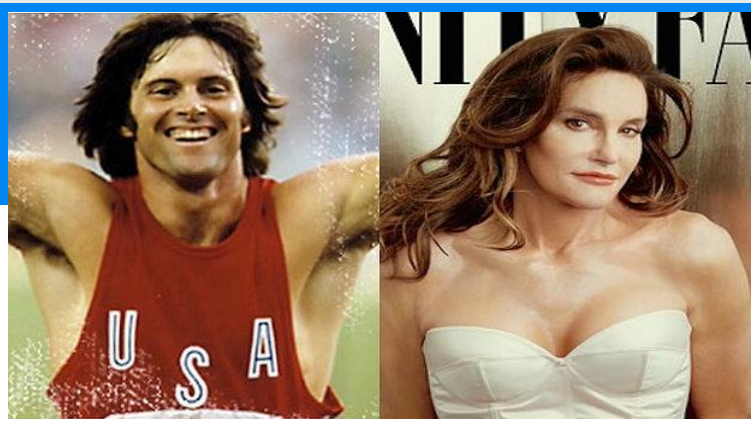
Principal Treatment Options		
Situation	Recommended	Alternative
M. genitalium infection known or suspected to be macrolide-susceptible	Doxycycline 100mg bd for 7 days followed by Azithromycin 1g stat then 500mg daily for three days (total 2.5g)*	Doxycycline 100mg bd for 7 days followed by Azithromycin 1g single dose*
M. genitalium infection known or suspected to be macrolide-resistant	Doxycycline 100mg bd for 7 days followed by Moxifloxacin 400mg daily for 7 days	
Pelvic inflammatory disease due to *M.genitalium*	Moxifloxacin 400mg daily for 14 days**	

Urethritis: Treatment

Principal Treatment Options		
Situation	Recommended	
chlamydia Likely	Doxycycline 100mg PO, BD for 7 days	Azithromycin 1g PO, stat Or symptomatic Rx until result
Gonorrhoea likely	Ceftriaxone 500mg in 2mL of 1% lignocaine IMI, stat PLUS Azithromycin 1g PO, stat	Ceftriaxone 500mg in 2mL of 1% lignocaine IMI, stat PLUS Doxycycline 100mg PO, BD for 7 days
Mycoplasma genitalium	After completing doxycycline, use either azithromycin or moxifloxacin. See Mycoplasma genitalium	Seek specialist advice

(STI Management Guidelines, 2019)

Transgender



43 year old long term married accountant

Says he is gender dysphoric

What do you do?

Adult Transgender

History – psychiatric, sexual abuse

Investigations – fsh,lh oestradiol,testosterone

Psychiatric referral – exclude psychosis

Adult Transgender – medical Mx

MTF - cyproterone, oestradiol (progynova)

FTM – testosterone – reandron 3 monthly

Regular psychologist

Wrap up and key messages

1. Every STI diagnosed reduces the duration of infectivity

2. Contact Tracing is a component of good clinical management of STIs

3. General Practice plays a critical role in addressing the ongoing and increasing burden of STIs and BBVs

Questions

Wrap up and key messages

- **Every STI diagnosed reduces the duration of infectivity**
- **Contact Tracing is a component of good clinical management of STIs**
- **General Practice plays a critical role in addressing the ongoing and increasing burden of STIs and BBVs**

Thanks for attending

There is a wide range of resources, online training module and other trainings available to support health professionals to test, diagnose, manage and treat STIs

Check our resource list

https://ashm.org.au/resources/STI-Resources-List/

Check our Online Training Modules

https://ashm.org.au/sexual-health/training/

Check ASHM Training Calendar

https://ashm.org.au/training/

Queensland sexual health resources

Primary Clinical Care Manual https://www.health.qld.gov.au/rrcsu

Kirby Annual Surveillance Reports https://kirby.unsw.edu.au/report/annual-surveillance-report-hiv-viral-hepatitis-and-stis-australia-2017

Australian STI Management Guidelines for use in primary care http://www.sti.guidelines.org.au

The Aboriginal and Torres Strait Islander Adolescent Sexual Health Guidelines https://www.health.qld.gov.au/__data/assets/pdf_file/0018/161541/adolescent_sexual_health_guideline.pdf

References: Quick hook up

Australian STI Management Guidelines

http://www.sti.guidelines.org.au/

ASHM HIV Management Guidelines

http://hivmanagement.ashm.org.au/

ASHM Guide to Australian laws and policies for health care professionals

http://hivlegal.ashm.org.au

Decision Making in HIV

www.ashm.org.au/resources

Testing portal HIV, HBV & HCV

References: Who to test & who to screen

Health Knowledge - Differences between screening and diagnostic tests and case finding

https://www.healthknowledge.org.uk/public-health-textbook/disease-causation-diagnostic/2c-diagnosis-screening/screening-diagnostic-case-finding

Australian STI & HIV Testing Guidelines 2019 for Asymptomatic MSM

https://stipu.nsw.gov.au/stigma/stihiv-testing-guidelines-for-msm/

HIV, viral hepatitis and sexually transmissible infections in Australia: annual surveillance report 2018

https://kirby.unsw.edu.au/sites/default/files/kirby/report/KI_Annual-Surveillance-Report-2018.pdf

References: Specimen collection

NSW STI Programs Unit – Specimens for Sexually Transmitted Infections card

- https://stipu.nsw.gov.au/wp-content/uploads/DIY-sheet-2020.pdf

Queensland Health Chlamydia and Gonorrhoea Testing card

- https://www.health.qld.gov.au/__data/assets/pdf_file/0024/726522/chlamydia-gono-testing.pdf
-

Resources

Australian STI Management Guidelines

http://www.sti.guidelines.org.au/

ASHM HIV Management Guidelines

http://hivmanagement.ashm.org.au/

ASHM Australasian Contact Tracing Guidelines

http://contacttracing.ashm.org.au/

ASHM Guide to Australian laws and policies for health care professionals http://hivlegal.ashm.org.au

Resources

Decision making in PrEP

http://www.ashm.org.au/resources/HIV-Resources

Decision Making in HIV

www.ashm.org.au/resources

HIV Treatment Guidelines (ARV Guidelines)

http://arv.ashm.org.au/

National NPEP guidelines

http://www.pep.guidelines.org.au/