JAMES COOK UNIVERSITY AUSTRALIA

Celebrating 50 YEARS 1970 - 2020

General Practice Training Queensland

HEALTH PROFESSIONALS WEBINAR SERIES

Sexual Health

TUESDAY, 16 JUNE 2020

7:00PM QLD/NSW/ACT/VIC, 6:30PM SA/NT, 5:00PM WA

Sexual Health in Primary Care

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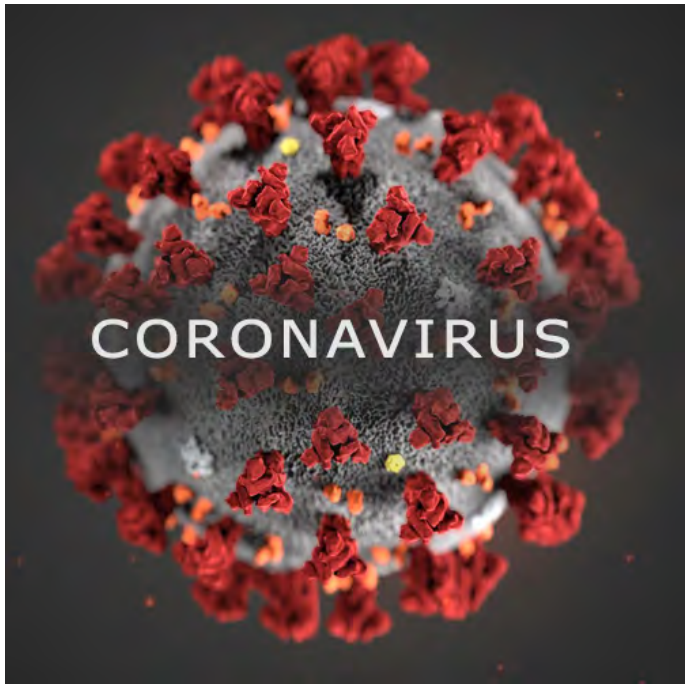
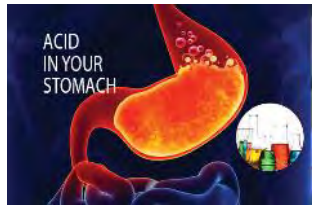
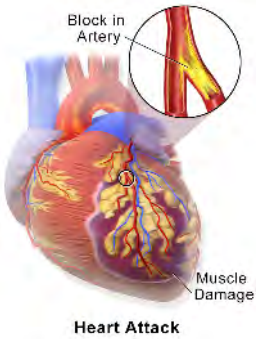
Tutor and Guest Lecturer, University of Queensland

Board Member, HIVe Queensland

Sexual Health







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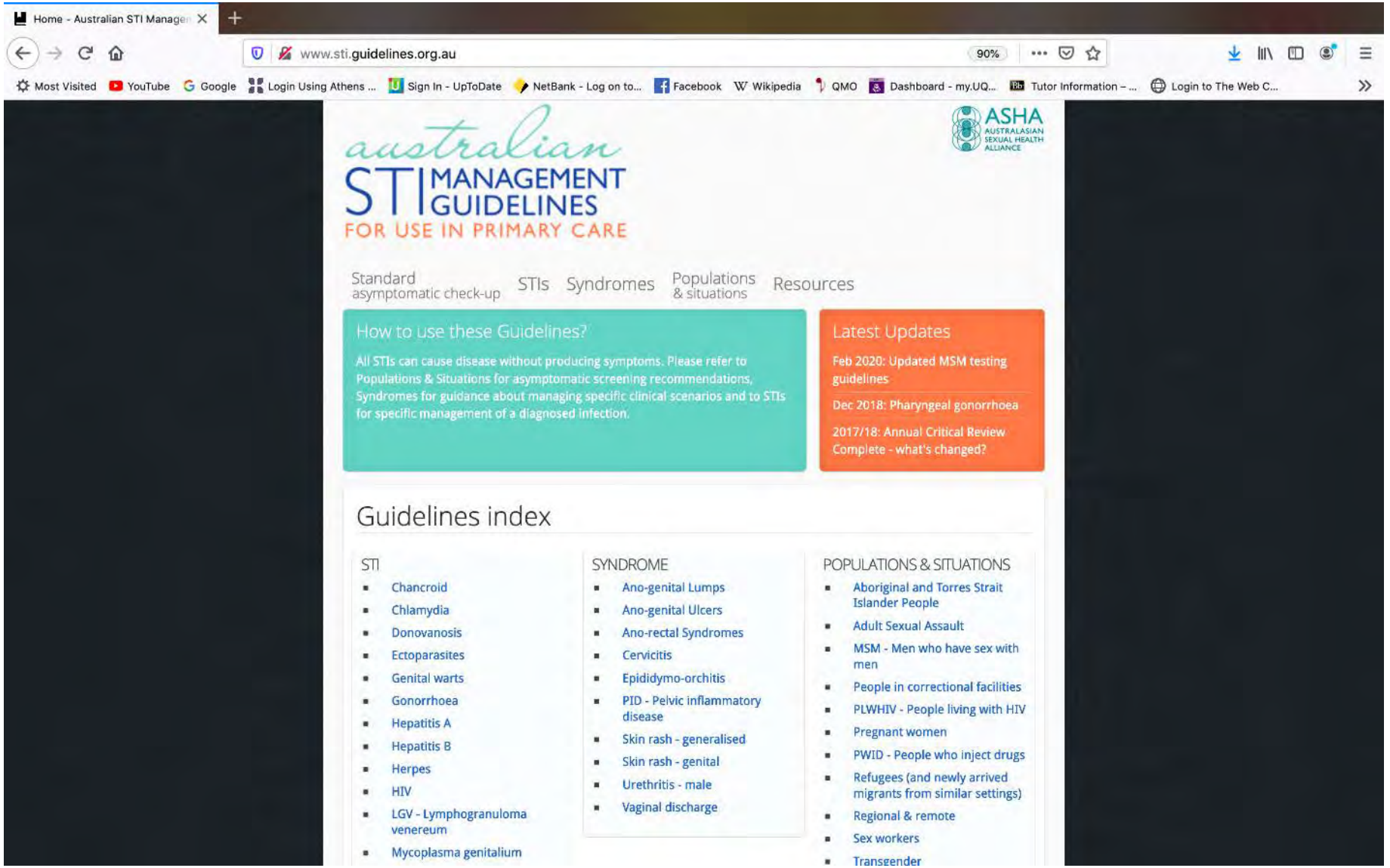
Sex During a Global Pandemic

- People showing more interest in *risk reduction*
- Reviewing their sexual behaviours
- Reviewing their partners & their health status
- Focus on *prevention*
- Pre-Exposure Prophylaxis (**PrEP**) for HIV
  - 2 drug, fixed dose, single table medication
  - PBS Authority streamlined for *individuals at medium to high risk of HIV infection defined by the ASHM guidelines; HIV -ve*
- Condoms

A Quest to Test!

- People want to ‘check that they are healthy’
  - Perfect opportunity for health promotion in GP :)
- As we have seen with COVID-19, testing early and often is how we prevent the spread of infectious pathogens
- With respect to STI testing, perhaps the most important question is *‘do you have any symptoms that are worrying you?’*
- This differentiates asymptomatic screening from symptomatic testing.
- Also useful to ask *‘is there any other reason you are here for an STI test today?’*

Sexual Health



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Asymptomatic Screening - What to Test?

- **Throat** - swab for Chlamydia & Gonorrhoea PCR*
- **Genitals** - urine for Chlamydia & Gonorrhoea PCR
- **Anorectum** - swab for Chlamydia & Gonorrhoea PCR*
- **Blood** - HIV serology, syphilis serology, Hep B serology (if unknown)
  - Consider assessing immunity to Hep A in at risk patients
  - Consider testing Hep C serology once yearly in at risk patients

Symptomatic Testing - How to Investigate?

- SAME TESTS AS ASYMPTOMATIC SCREEN, PLUS:
- For **male urethral discharge** - swab for M/C/S
- For **vaginal discharge** - swab for M/C/S (can be self collected)
  - can also add on PCR for Trichomonas
  - consider red flags such as cervicitis and PID; needs pelvic exam
- For **anogenital ulcers** - swabs for HSV I & II PCR, Syphilis PCR, Chlamydia (LGV) PCR, M/C/S
- For **proctitis** - swabs for HSV I & II PCR, M/C/S. Chase LGV serovars
- For **epididymo-orchitis** - urine PCR is appropriate initially

Treatment - CHLAMYDIA

Management

Principal Treatment Options		
Situation	Recommended	Alternative
Uncomplicated genital or pharyngeal infection	Doxycycline 100mg PO, BD 7 days OR Azithromycin 1g PO, stat	
Ano-rectal infection	Doxycycline 100mg PO, BD 7 days if asymptomatic, but 21 days if symptomatic (see ano-rectal syndromes)	Azithromycin 1g PO, stat, and repeat in 1 week

Test of cure by PCR at least 4/52 after Rx for pregnant women and rectal infections

Treatment - GONORRHOEA

Management

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*	Alternative treatments are not recommended because of high levels of resistance, EXCEPT for some remote Australian locations and severe allergic reactions.

Test of cure by PCR at least 2/52 after Rx for pharyngeal, rectal and cervical infections

Treatment - SYPHILIS

Management

- Early referral or discussion with a sexual health specialist or service is strongly recommended
- Patients being treated for primary and secondary syphilis should have rapid plasma regain (RPR) repeated on the day treatment is commenced to provide an accurate baseline for monitoring treatment.

Principal Treatment Options		
Situation	**Recommended**	**Alternative**
Infectious syphilis (primary, secondary, early latent)	Benzathine penicillin 1.8g IMI, stat	Procaine penicillin 1.5g IMI, for 10 days
Non-infectious syphilis (late latent)	Benzathine penicillin 1.8g IMI, weekly for 3 weeks	Procaine penicillin 1.5g IMI, for 15 days

Treatment advice

Intramuscular penicillin formulation used should be long acting, as short acting formulations (e.g. benzyl penicillin) are ineffective.

Special considerations

- Jarisch-Herxheimer reaction is a common reaction to treatment in patients with primary and secondary syphilis. It occurs 6-12 hours after commencing treatment, and is an unpleasant reaction of varying severity with fever, headache, malaise, rigors and joint pains, and lasts for several hours. Symptoms are controlled with analgesics and rest. Patients should be alerted to the possibility of this reaction and reassured accordingly.
- Procaine reaction is a rare reaction to procaine penicillin. It is characterised by a sensation of impending doom with hallucinations. The reaction is self-limiting and lasts about 30 minutes. The patient needs to be reassured and given general supportive measures.

Treatment - SYPHILIS 2

- Review all patients clinically and with repeat reactive plasma regain (RPR) testing at **3 months**, then at **6 months**
    - Your friendly local Sexual Health Physician is more than happy to assist you in interpreting Syphilis results :)

- Because of the nature of Syphilis serology testing, all new infections and all rises in RPR will trigger Public Health to contact YOU as the GP who requested the test
    - Be ready to go through some contact tracing questions with the patient when they return for treatment!

Treatment - GENITAL HERPES

Management

Principal Treatment Options		
Situation	Recommended	Alternative
Initial episode	Valaciclovir 500mg PO, BD for 5 - 10 days	Aciclovir 400mg PO, TDS for 5 - 10 days
Recurrence: Episodic therapy	Valaciclovir 500mg PO, BD for 3 days	Famciclovir 1g PO, BD for 1 day
Recurrence: Suppressive therapy	Valaciclovir 500mg PO, daily for 6 months	Famciclovir 250mg PO, BD for 6 months

- Treatment should not be delayed, especially initially (i.e. by Ix).
- Suppressive therapy PBS criteria: *recurrent moderate to severe genital herpes*. Review this with patient every 6/12.

Further Reading about PrEP

- **NPS Medicinewise Article**

https://www.nps.org.au/radar/articles/tenofovir-with-emtricitabine-for-hiv-pre-exposure-prophylaxis-pr-ep

- **2-Page 'Decision Making in PrEP' Resource from ASHM**

https://ashm.org.au/resources/hiv-resources-list/decision-making-in-prep/

- **Full ASHM PrEP Guidelines** (updated September 2019)

https://ashm.org.au/resources/hiv-resources-list/prep-guidelines-2019/

Sexual Health Specialist Care

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Sexual Health

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I practice at:

- Stonewall Medical Centre, Windsor
- Our GP Medical Centre, Springhill
- Ochre Health, Sippy Downs
- Lilian Cooper, Springhill

What do I do?

- S100 prescriber: HIV/HCV/HBV, PEP & PrEP
- Sexual health & wellbeing
- Sexual health & aging
- Sexual function & dysfunction
- Contraception & complexities
- Menopause & complexities
- Transgender health
- Youth sexual health
- Sex worker health
- Pregnancy & complexities
- HTLV-1 Medicine

My Clinic on a Thursday in April 2020

1. 18y, Transgender male:

- STI & endocrine results review
- Medroxyprogogesterone acetate i.m to suppress menstruation
- Include psychologist for sexual child abuse

2. 24y, MSM:

- Results review of GC TOC
- Physical: new onset of generalised rash, mostly bothered by genital rash
- Diagnosis: Psoriasis guttata

3. 36y, female, telehealth Hobart:

- HTLV-1 diagnosis and major depression, asymptomatic carrier, assessment, management, contact notification

4. 30y, female and nonbinary:

- sex worker, major depression
- STI screen, CST, sex worker certificate, FSFI assessment
- Diagnosis: DSM-5, situational HSDD (hypoactive sexual desire disorder)
- Inculde: sex therapist

What do you need to know?

- How to ask about sexual wellbeing?
- What to investigate for?
- Which problems to manage yourself and which to refer for?
- Who to refer to?

Break the ice and be non-judgmental

INVITATION:

- ‘I offer all my patients an STI screen every year. Would you be OK if we discussed this a little?’

  - All patients should have had at least once an STI screen during their adult life.
  - We cannot tell if our patients have had condom-less sex.
  - Patients may not tell us, may not know, may have forgotten.
  - When we offer we offer them a choice.

CONSENT:

- ‘I will need to ask some private questions. Would this be OK with you?’

Assessment

- ‘On our files we have recorded you here as a man/woman. Are you happy with this?’
- ‘Which pronouns do you prefer: He/him, She/her, They/Them?’
- ’When it comes to sexual preferences, may I ask how you would describe yourself? Heterosexual, bisexual, lesbian, gay, etc (LBGTIQ+)
- ’Before I ask you any specific questions, may I ask if you have any problems related to your sexual wellbeing you like to share with me? Any pain, lump, rashes, discharges? Or sexual dissatisfaction?.... Thank you …. We will come back to this specific problem/s once I have a better overall picture of your sexual health…

Assessment

- ‘I would like to ask you a little about the type of sex and how many people you have had sex with over the last 3 months. Is this OK with you?
- LSI: ‘When did you have last sex? May I ask ….Reg or casual partner? ….With or without condoms? ….Oral? Vaginal? Anal?
- PSI: ’When did you have sex before the last time’ etc.
- Have you ever had a STI screen before? When? Which?
- Have you ever had a STI before? When? Which?
- Other risks: Injecting drugs, unwanted pregnancies, sex abroad etc

Management

- Offer all tests and let the patient OPT out!
- ‘I offer all these tests to all my patients:
  - Blood tests: HIV/STS/HBsAB and GC+CT NAAT **SELF** swabs/urine (depending on sites: pharyngeal/rectal/anal)
  - Offer HCV and HAV if: If PWID/LBGTIQ/Indigenous
- ‘Is there any test you would like me to leave out?’
- Consider long-term & emergency contraception
- Consider HBV or HAV vaccine if patient reports contact and unsure if immune
- Consider PEP or PrEP

Think: Will the patient benefit from seeing a sexual health specialist?

- Specialists are there to support you and your patient as a member of your team.
- Specialists have longer initial appointments (45-60 min).
- Specialists have longer follow up appointments (30min).
- They have access to allied health who can support you and the patient.

It takes a village to raise the child.

You are not on your own.

You don’t have to know it all.

Examples of when to refer

HIV/HCV/HBV/HTLV/Syphilis/MGEN/GC:

- Complex cases
- Difficult to interpret results
- Reinfections
- Resistance
- Aging & Comorbidities

Sexual Dysfunction (FSD): Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5)

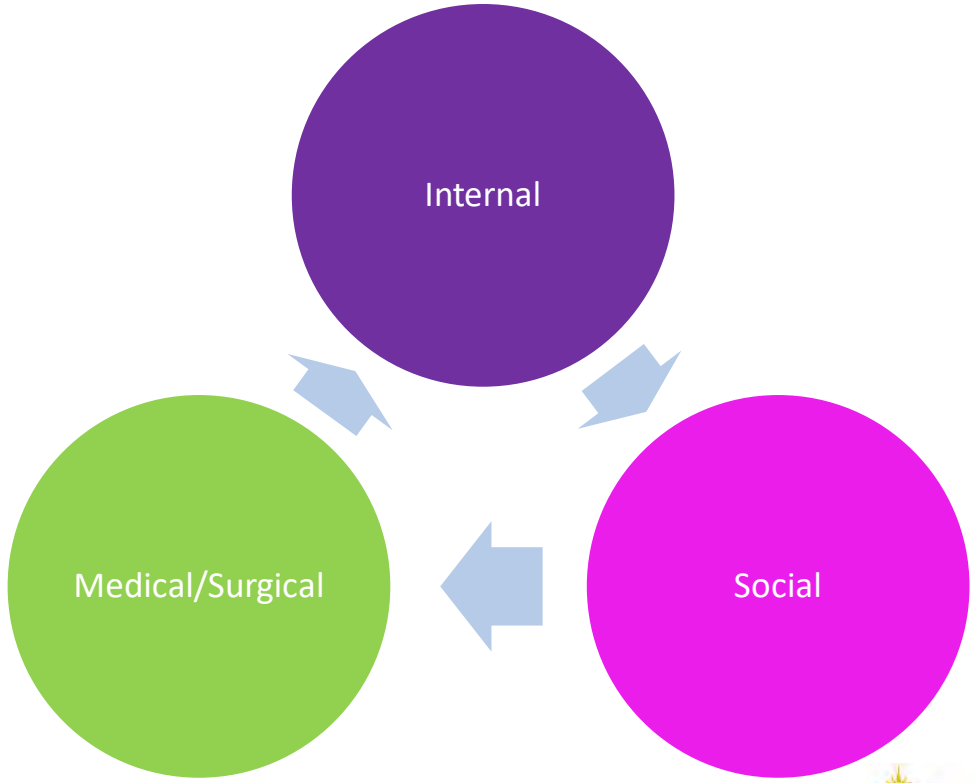
ALL (hetero/LBGTIQ+):

- Sexual interest & arousal disorder
- Sexual orgasmic disorder
- Genito-pelvic pain/penetrative disorder
- Erectile Disorder
- Premature Ejaculation
- Delayed/Inhibited Ejaculation
- Substance/Medication- induced sexual dysfunction

Transgender Health

Transgender female
Transgender male
Non-binary
Parent consultation

Dysphoria
Self-harm/ Suicide
STI
Trauma
Drug/Alcohol



Thank you

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