The Disconnect between HIV and STDs: Why Screening for STDs Should Take on a Renewed Focus

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Many of us are missing the simple but critical opportunities to improve the health of our HIV patients that routine screening for STDs provides. Before I routinely began screening my patients for STDs, I discovered that many of them were seeking care for their STD signs and symptoms at public or free clinics. Why this disconnect between their HIV and STD care? Were they embarrassed to discuss with me the possibility of having an STD? Not necessarily, I found. For whatever reasons, many of my patients simply did not think of asking me, their HIV care provider, for STD screening and treatment. Was this because of their misconceptions of my medical expertise or was it because I never brought it up?

Since that time, I've learned that most of my patients want, and often need, to have frank, honest discussions about their HIV and STD risks but often will not initiate these conversations. By not raising the issue ourselves, we are missing an important opportunity to help our patients uncover, discover, and discard their risky behaviors.

To our already time-pressed schedule of reviewing results of laboratory tests and addressing issues of adverse effects, adherence, and comorbid medical conditions, why add STD screening? One of the most obvious benefits is preventing the deleterious effects of the STDs themselves. The presence of an STD can jeopardize the health of our patients. Certain STDs such as syphilis increase HIV viral load and decrease CD4 cell counts [1]. Untreated STDs also increase the risk of transmission of the infection to uninfected partners.

Similarly, our patients are missing the benefits of better health care, not to mention the convenience being able to integrate their medical care instead of addressing their STD and HIV health needs separately. By openly and honestly discussing and understanding our patients' behaviors, we gain a more comprehensive view of their health care needs. Consequently, we are better equipped to take advantage of opportunities when presented and intervene with a variety of strategies for improving our patients' overall health.

STD INFECTION RATES ARE RISING

Of course, another important point is that many HIV-infected patients have asymptomatic STDs. A study of HIV-infected patients at an HIV primary care clinic in San Francisco found that, during routine screening for STDs, 1.8% of HIV-infected patients had new syphilis infections and 10.2% had new cases of chlamydia or gonorrhea [2]. Couple that with recent data indicating that incidence of various STDs, particularly syphilis, is increasing in certain populations, particularly among men who have sex with men (MSM) [3] as well as women and African Americans [4], and we are reminded how important it is to screen HIV-infected patients for STDs and integrate brief discussions on reducing risky transmission behaviors.

In addition to monitoring CD4 cell counts, HIV viral load, and other indications of successful antiretroviral therapy, screening for and identifying STDs must rank high among our priorities in order to:

- Treat infections that otherwise may go unnoticed.
- Maintain and enhance the health of our patients.
- Prevent further transmission of an STD to uninfected partners.
- Decrease the likelihood of HIV transmission to HIV-uninfected partners.
- Identify risky transmission behaviors, and incorporate brief discussions to reduce such behaviors.

In short, screening for and identifying STDs is both medical treatment and *prevention.*

MANY PATIENTS UNCLEAR ABOUT STD RISK FACTORS

The new diagnosis of an STD merits a careful assessment of the patient's sexual and drug-using risk factors, as well as that patient's knowledge of how HIV and STDs

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are transmitted. Many of my patients have a troubling disconnect between their knowledge of transmission risk factors for STDs and those for HIV; many patients are primarily focused on preventing HIV transmission and do not think about (or forget) that there are also behavioral factors that put themselves and others at risk of becoming infected with other STDs. For example, whereas oral sex is considered to be low-risk for HIV transmission, it can easily transmit other STDs such as chlamydia, gonorrhea, and syphilis. The increased annual incidence of syphilis among MSM, MSW and WSM reflects this disconnect.

Sometimes two HIV-infected persons who make a conscious, mutual decision not to use condoms based on their common serostatus do not realize that they remain at risk of transmitting or acquiring other STDs. Some may feel that they have already acquired the "biggest STD," so the others are insignificant. Most STDs are curable with appropriate treatment if detected early, but some, such as syphilis, continue to cause insidious, multiple-organ, and severe neurological damage if not diagnosed and treated promptly. Many STDs can cause varying degrees of physical discomfort, as well as interruptions to sexual activity. Incorporating education about STDs into the routine care of our HIV-infected patients gives them information they need to make well-informed decisions about sexual behavior.

STDs FACILITATE HIV TRANSMISSION

Routine screening for STDs is an important means of preventing HIV transmission to HIV-uninfected partners. Untreated STDs, particularly those possibly asymptomatic infections that cause genital ulcers, such as syphilis, herpes simplex, and lymphogranuloma venereum (LGV), significantly enhance the likelihood of HIV transmission [5].

For example, chlamydial urethritis in men is often asymptomatic or only mildly symptomatic. HIV-infected men with this STD have higher concentrations of HIV in their semen than HIV-infected men without chlamydia, and thus are at increased risk of transmitting HIV to others [6]. Chlamydial cervicitis is frequently entirely asymptomatic and places not only a woman's partners at risk for acquiring this STD, but also places the woman at risk for possible infertility. By identifying and treating STDs, we have opportunities to help our patients decrease the likelihood of transmitting HIV and to address the high-risk behaviors that led to acquisition of the STD: a win-win-win outcome for our patients, their partners, and community health standards.

HOW TO ASSESS RECENT RISKY BEHAVIOR

The first step in STD screening is to conduct a risk assessment. By asking patients about use or nonuse of condoms, number of sexual partners and their serostatus, and sharing of drug paraphernalia (not only needles and syringes but also instruments for snorting drugs), we frequently uncover fruitful areas for discussion and education.

What types of behavior can lead to the acquisition of an STD? A number of screening tools are available to help us ask both open- and closed-ended questions to assess our patients' behavioral risk factors. These tools include electronic- and paper-based questionnaires that are completed by patients and discussed during their office or clinic visits. There are also several suggested scripts that can facilitate the discussion of high-risk behavior with our patients in an open and nonjudgmental fashion. The resource section at the end of this article contains information about how to obtain these tools and other in-depth educational materials.

Based on information obtained from a behavioral risk assessment, we can identify a patient's risk factors for both HIV and STD transmission, which can be addressed over time during routine office or clinic visits. Appropriate management of some of these risks may require the use of specialized interventions such as those offered by the U.S. Centers for Disease Control and Prevention (CDC) under the Comprehensive Risk Counseling and Services. Of paramount importance is determining whether a patient is willing and able to change his or her behavior. Common issues involving risky behaviors that we can address during an office or clinic visit include workable strategies for disclosing HIV serostatus to sex partners, creative ideas for keeping condoms accessible (well-worn wallets or purses are *not* ideal), successful negotiation of routine condom use, and ways to reduce the number of sex or drug-sharing partners (e.g., by avoiding public venues such as bath houses or sex clubs at which a patient is likely to engage in high-risk behavior). Similarly, HIV-positive women can ensure successful negotiation of condom use with their partners by taking the initiative to always have condoms available prior to a sexual encounter and not assuming that their partners will do so.

As clinicians, we are well equipped to educate our patients about HIV transmission risk factors, with emphasis on particular high-risk behaviors such as multiple sex partners, "barebacking," anal sex with either male or female partners, "fisting" and sharing drug paraphernalia. We can develop a realistic plan with individualized and measurable goals for each patient. At each visit, for example, we can discuss a patient's number of sex partners, frequency of condom use, and incidents of shared drug paraphernalia in the interval since the previous visit.

SIMULATING SEXUAL DISCUSSIONS WITH PATIENTS

In my practice, I have found that leading patients through simulated pre-sex discussions between the patients and their prospective sex partners can be very helpful. I incorporate the negotiation of routine condom use prior to sexual activity as a key component of these simulations. I offer as a ground rule for sex between partners (known or anonymous) the condition that condom negotiation must be clearly spoken *before* the initiation of sexual activity. Given that the standard for "safe sex" today is often "have sex, ask

questions later," engaging in pre-sex condom negotiation can minimize assumptions that often lead to unsafe vaginal or anal insertive sex. Mutual agreement for the use of condoms minimizes the need for disclosure of serostatus prior to sexual activity. Furthermore, up-front agreement for condom use reduces the possibility that condoms will not be used in the heat of the moment as well as awkward "mood-killing" discussions about serostatus during sex. In addition, a potential sex partner's assessment of his or her HIV serostatus can be untrustworthy, unreliable, or subject to manipulation. It also can be based on an outdated HIV test.

Rehearsing brief sexual encounter scenarios with patients can be very effective in helping them realize that safe practices can be incorporated into satisfying sexual activity without compromising the experience. Don't underestimate the power and influence of the "caring white coat." HIV clinicians frequently are the only avenue of exposure to the concept of safe sex for our patients. The opportunity to "advocate" the continued good health of our patients and the community we serve is one we cannot afford to miss!

It is also important to realize that referring our patients to other resources may be appropriate in certain cases. Factors such as mental illness, substance abuse and addiction, sexual compulsivity, homelessness, and precarious home or living arrangements can affect transmission risk behavior. We can begin to address these issues in an office or clinic visit and then refer a patient to specialized services.

HOW TO INCORPORATE STD SCREENING

Quite simply, STD screening should be conducted as a component of a broader HIV transmission risk assessment during every patient visit, as discussed above.

One technique that I find helpful is to begin this process with a gently probing question about STD and HIV transmission. With new patients and patients whose STD screening histories are unknown to me, I start with a question as simple as, "When was the last time you were tested or treated for an STD?" With patients whose STD history is familiar to me, I routinely ask about any new signs or symptoms that could indicate the presence of an STD.

Another way to initiate discussion on STD screening is to ask a general, open-ended question such as "How do you practice safe sex?" That approach allows patients to describe their concept of safe sex. Clinicians need to be able to discuss with our patients their sex lives, openly and honestly without embarrassment or judgment. It is important to remember that patients with HIV infection are as sexually active as HIV-uninfected patients. Opening the dialogue with a simple question such as "Tell me about your sex life" is a good way to start and to build trust with our patients. I make sure to tell my patients that these questions are universal (e.g., "I ask all my patients these questions") so that they won't think I am singling them out.

STD screening should include a comprehensive assessment of commonly occurring signs and symptoms associated with STDs. From responses to our questions, we will be able to identify the presence of common STDs, direct the appropriate laboratory workup, and prescribe treatment as needed. According to recommendations of the CDC for incorporating HIV prevention into clinical care, routine laboratory screening for STDs should be undertaken *at least annually* for sexually active patients. Patients at increased risk of STDs include those who have multiple or anonymous sex partners, those who report vaginal or anal intercourse without condom use, those who have a partner of positive or unknown HIV serostatus, and those who have a sex or needle-sharing partner with increased risk factors. These patients should be tested more frequently (every 3–6 months) [7]. Detailed laboratory screening instructions are included in the CDC recommendations.

Improved attention to routine STD screening as part of our overall HIV and STD transmission prevention messages helps our patients protect themselves from the adverse effects of STDs and prevent the further transmission of STDs and HIV to their sex and drug-sharing partners.

ABOUT THE AUTHOR

David Hardy, M.D., is the Consultant Working Group member for the Centers for Disease Control and Prevention's Prevention IS Care campaign, which is designed to support health care providers who treat HIV positive patients to integrate brief conversations about reducing risky transmission behaviors during every patient visit. He is Associate Professor of Medicine at the David Geffen School of Medicine at UCLA and the Director of the Division of Infectious Diseases at Cedars-Sinai Medical Center. A diplomat of the American Board of Internal Medicine, Dr. Hardy is also a member of numerous professional societies including the HIV Medicine Association, the American Academy of HIV Medicine, for whom he serves as a member of the National Board of Directors and Chairman of the California/Hawaii Chapter as well as the International AIDS Society.

RESOURCES

The following resources contain helpful HIV transmission risk screening tools, trainings, and other useful material.

- CDC *Prevention IS Care* Provider Resource Kit. The Resource Kit Includes provider intervention tools, patient education materials (in English and Spanish), HIV risk screening tool, CME, and more. To order free copies, call 1-800-CDC-INFO, e-mail info@cdcnpin.org or visit the Web address listed below.

  http://www.cdc.gov/PreventionISCare

- Incorporating HIV Prevention into the Medical Care of Persons Living with HIV. Recommendations of the CDC, the Health Resources and Services Administration, the National Institutes of Health, and the HIV Medicine Association of the Infectious Diseases Society of America.

http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5212a1.htm

- Prevention in the Care Setting: Online CME Course. From the HIV Medicine Association, this CME course helps clinicians gain perspective on issues of HIV prevention and STD management.

http://www.hivmacme.org/

- Integrating HIV Prevention into the Medical Care of Persons Living with HIV. Slides, handouts, and other training material from the HIV/STD Prevention Training Centers and the AIDS Education and Training Centers.

http://aidsetc.org/aidsetc?page=et-pwp

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