Audit of STI testing at a standalone HIV unit

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BACKGROUND

HIV positive individuals are at risk of sexually transmitted infections (STIs). Patients with concurrent STIs are more likely to have detectable HIV in their genital secretions[i,ii], and therefore prompt identification and treatment of STIs reduces onward HIV transmission, and should be a routine part of HIV care. BHIVA guidance states that all patients should have STI screening at presentation and at least annually (depending on risk)[iii]. We decided to audit STI screening at a standalone HIV unit without integrated sexual health services.

METHODS

10% of the clinic cohort was included in the audit with a sampling frame including every 9th routine consultant appointment attendance over a 12 month period (1st January 2011 – 31st December 2011). Paper notes and electronic patient records were reviewed. Data collected included demographics and details of STI tests (Chlamydia trachomatis, Neisseria gonorrhoea (CT/GC NAATs), Syphilis) done at baseline (first visit to clinic) and in the preceding 12 months.

RESULTS

92 patients out of a cohort of 926 patients were examined. The demographics are presented in table 1. 88/92 patients had baseline serological tests for syphilis (STS) with 9 positive results (table 2). Of the 11 patients whose first visit was after the launch of BHIVA guidance on STI testing, 10 had CT/GC urine NAATs sent at baseline; all results were negative. In the preceding 12 months, 14/92 patients had STS tests (Fig. 2) and 8 had CT/GC urine testing (Fig. 3). There were no STI screens done on extra-genital sites. All of the 14 STS and 8 STI screens were negative.

Table 1 Demographics of sampled cohort

	Males	Females
Number of patients	46	46
Median age (years)	47	40
Inter-quartile range	9.8	8.9
Range	22-73	26-59
Sexuality		
Heterosexual	15 (33%)	46 (100%)
MSM	31 (67%)	n/a
Ethnicity		
Black African	24	38
Black Caribbean	3	0
White British	11	5
Indian	1	1
White European	4	1
Brazilian	2	0
Philippines	1	0

Table 2 Baseline syphilis serology tests in sampled cohort

Males (total 46)	YES	NO
Baseline Syphilis serology done?	44 (95%)	2 – never done
Baseline Syphilis positive:	7 (15%)	
Baseline Syphilis negative:	37 (85%)	
Females (total 46)	**YES**	**NO**
Baseline Syphilis serology done?	45 (98%)	1 – never done
Baseline Syphilis positive:	2 (4%)	
Baseline Syphilis negative:	44 (96%)	

Fig.2: Syphilis tests (STS)

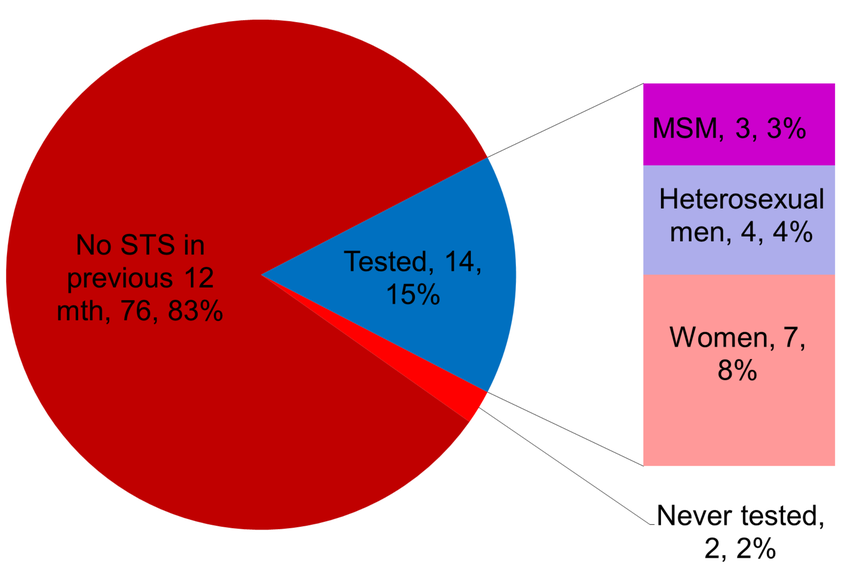
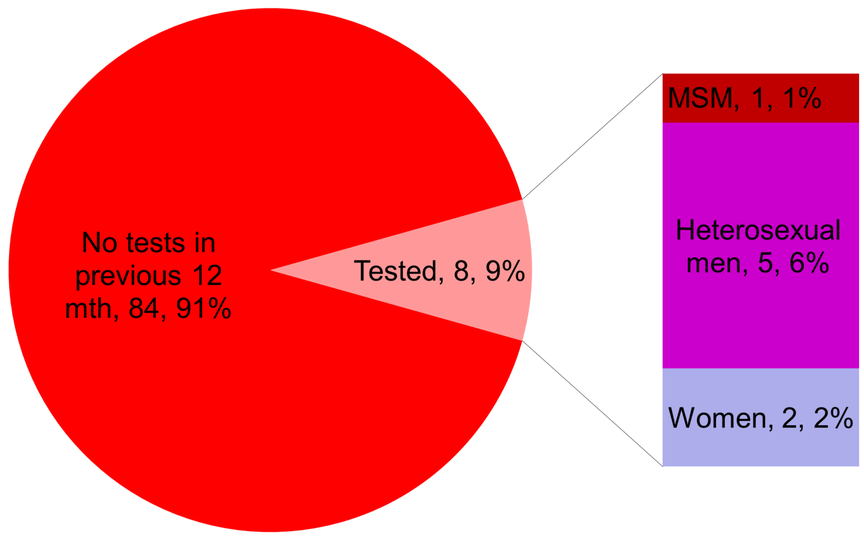


Fig. 3: Chlamydia/Gonorrhoea tests



DISCUSSION

A major limitation of this audit was absence of documentation of the offering of routine STI screening compared to baseline STI screening. These discussions may have taken place and not have been documented, or screens may have been declined. Secondly, the sample of notes reviewed was chosen by a sequential sampling frame and this may not be a truly representative sample of the cohort.

31% of our sample are MSMs (men who have sex with men), some of whom are at higher risk of STIs. All male patients were offered only urine testing for CT/GC and not pharyngeal and rectal testing; this was due to a lack of swabs, which has now been rectified.

Of the cases reviewed, it is not clear what triggered CT/GC testing done in the 8 cases within the last twelve months. For syphilis testing within the last twelve months, 2/14 had symptoms that initiated testing (rash in one patient and joint pains in another).

The lack of an integrated service makes it challenging to adequately manage sexual and reproductive health, but we have fast track access to GUM services when necessary. It may be that there is a low prevalence of STIs in our cohort; all the recent tests in the sample were negative, but the number of tests in this audit were too few to make any meaningful comments on the prevalence of infections in this clinic cohort. The prevalence of STIs and risk factors should be determined for our cohort. It may be more useful to routinely assess risk and to offer targeted STI testing if STI prevalence is low. Given the current financial situation, it may not be economically justifiable to routinely screen all patients for STIs annually.

We have recommended that the new electronic patient record (Climate™) have a reminder for the clinician if sexual history and STI screening has not been documented in the preceding twelve months. There is plan to re-audit after these implementations are in place and see if there is an increased pick up in infections.

REFERENCES

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iii. British HIV Association, BASHH and FSRH guidelines for the management of the sexual and reproductive health of people living with HIV infection 2008.