Guidelines for the sexual & reproductive health in PLWH: draft 2016 update

Laura Waters
Consultant GU/HIV Medicine
Mortimer Market Centre, CNWL, London
Content

1. An apology
2. Methods
3. Scope
4. Draft recommendations
Sorry

- I am the chair
- We started the process in 2013
- 2015 Emily Lord, specialty trainee parachuted in
- Draft sections now all submitted

- Sorry
Writing group

- BASHH rep: Laura Waters
- BHIVA rep: Nicky Mackie
- FSRH rep: Louise Melvin
- Trainee rep: Emily Lord
- BASHH CEG rep: Keith Radcliffe
Writing group

- Nominated by self/UK-CAB/HIVPA/other members or invited for specific expertise:

  Jane Ashby  
  Chitra Babu  
  Rageshri Dhairyawan  
  Yvonne Gilleece  
  Sharon Jay  
  Vinod Kumar  
  Chris O’Connor  
  Shema Tariq  
  Shaun Watson  
  Kathy White

  Sexual dysfunction  
  Conception  
  IPV & FGM  
  Conception  
  HIVPA  
  Contraception  
  UK-CAB  
  Menopause  
  NHIVNA  
  Psychology
Methods

- BASHH CEG guidelines for guidelines
- GRADE system, search as outlined in next slide
- Abstract sifting
- Sections allocated to individuals/small teams
- Presented today
- Next steps:
  - Circulated back to writing group
  - BASHH-led consultation (8 weeks)
  - Review of feedback
  - Published with appendix of comments + response
Searching for the Evidence
BASHH reproductive and Sexual Health guideline update 2015
HIV fertility, conception and contraception

• **PICO**
  - **P** = patient population = adults with or at risk of HIV considering reproductive/ contraceptive options
  - **I** = interventions
    - options for conception (UPSI, PrEP, sperm washing etc.
    - other assisted reproduction options including surrogacy and adoption
    - contraceptive options, sexual dysfunction and fertility
  - **C** = no intervention, different interventions
  - **O** = outcomes = good sexual & reproductive health, no onward HIV transmission.....

• Sources searched for published peer-reviewed studies:
  - Medline and Pre-Medline, Embase and the Cochrane Library

• The following conferences were also searched for ‘grey literature’ (oral and poster presentations):
  - IAS HIV Pathogenesis and Treatment, World AIDS, CROI, EACS, BHIVA/BASHH, HIV Drug Congress (Glasgow Meeting), FSRH

• Study types searched for were systematic reviews, clinical trials and observational studies

• Date parameters for the database search were 2004 to the Dec 2015 and the last three years for conference abstracts. Searches were conducted during March & December 2015

• Animal studies, case reports, letters and editorials and comments were excluded

• Results were limited to English language

• This strategy is in line with BASHH Guideline Writing processes

• Keywords were identified by the Writing Committee and the electronic database searches were set up by the information Scientist based on a PI (population, intervention) framework (HIV AND all interventions). A combination of index headings (where available) and text word searching was used and details can be found in the database search protocol in the online appendix to the guideline.

• The following keywords were used for the conference website/ abstract book:
  - conception conceive fertility subfertility infertility sperm washing contraceptive contraception IVF reproduction insemination surrogacy donor egg UPSI.

• The results of the searches were sifted by reading the titles and/or abstracts and potentially relevant papers obtained in full text if available and reviewed. Relevant papers were then appraised
Scope

• **Areas of overlap**
  – Vaccine guidelines
  – PEPSE guidelines
  – PrEP guidelines
  – Monitoring guidelines
  – Hepatitis guidelines
  – Malignancy guidelines
  – Pregnancy guidelines
Scope

• **Main focus:**
  – Contraception
  – Conception
  – Transmission

• **New sections:**
  – Menopause
  – Intimate partner violence
  – Female genital mutilation
4.3.3.7 Sexual health screen

Recommendations

• We recommend a full STI screen at baseline, directed by the sexual history

• The screen should include:
  – Syphilis serology for all
  – Vulvo-vaginal swabs for chlamydia and gonorrhoea NAAT for all women
  – Urine testing for chlamydia and gonorrhoea NAAT for men
  – Pharyngeal and rectal swabs for chlamydia and gonorrhoea NAAT for MSM and heterosexual women with a history of oral or anal sex (1B)
4.4.3 Investigations

Recommendations

• 3 monthly screening for STIs if high risk factors for acquisition e.g. MSM with frequent partner change or chemsex/IVDU with chaotic lifestyle/CSW/patients who frequently use intranasal cocaine/recent tattoo abroad/recent blood transfusion abroad/other risk (1B)

• **We recommend the following (1B):**
  - Screen for GC & CT at all exposed sites
  - Syphilis serology

• **Also consider at least annually in all patients at risk:**
  - HBV sAg or cAb if not known cAb + or vaccinated with sAb >10
  - HCV antibody (antigen or RNA if ALT abnormal)
Draft SRH guidelines: sexual history & STI screening

- We recommend taking a sexual history and offering appropriate STI screening
  - At baseline
  - At every visit thereafter
- We recommend the risks of HIV transmission STI acquisition and hepatitis C acquisition are discussed at baseline and at least annually
- We recommend STI screening as per BHIVA monitoring guidelines
  - May be more frequent than HIV visits
Draft SRH guidelines: HIV transmission

• We recommend all individuals with detectable viraemia are advised and supported to disclose their status to sexual partners

• We suggest that all PLWH are encouraged to disclose their HIV status to sexual partners but this need not be enforced in the context of sustained viral suppression

• Language will be carefully reviewed
The Swiss Statement 2008: revisited

HIV Undetectable Does Equal Uninfectious: The Swiss Statement and the Vindication of Pietro Vernazza

By Heather Boerner
From TheBody.com

October 7, 2016
HIV transmission

• We recommend the findings of HPTN 052 and PARTNER are discussed with all PLWH

• We recommend that heterosexual PLWH with sustained viral suppression (at least 6 months), high adherence to ART & no STI can be advised there is no risk of onward transmission of HIV to others

• We suggest that monogamous MSM meeting ‘Swiss criteria’ are advised the risk of onward HIV transmission is incredibly low and that PEP or PrEP are not indicated
HIV transmission

- We suggest that outside of monogamous relationships MSM are advised that the risk of HIV transmission in the context of sustained viral suppression is very low but caveats are discussed.
- We cannot say zero (yet)
Viral load monitoring: BHIVA monitoring guidelines 2016

3.5 Monitoring of patients established on ART and with the viral load suppressed

**HIV viral load**

- Every 6 months\(^1\) – could be up to 12 months if on a protease inhibitor

\(^1\) If ART is used as a ‘treatment as prevention’ strategy, viral load may need to be measured every 3–4 months
Contraception

• Detailed discussion or pros and cons of different methods
• Efficacy tables, UKMEC criteria and interaction table included

• We recommend all contraceptive options be discussed with WLWH
• We recommend contraceptive history at every visit
• We recommend that where ART is a barrier to the optimal method of contraception, and reasonable alternatives exist, ART be switched
Reproductive planning

- **We recommend documented discussion of reproductive plans in all PLWH with reproductive potential**
  - At baseline assessment & annually
- **We suggest all services/networks have a named health care professional responsible for reproductive advice & signposting**
PrEP for conception (PrEP-C)

• We do not recommend PrEP-C where the positive partner has been undetectable on HIV treatment for >6 months
• We suggest in exceptional situations PrEP-C may be used
Menopause

• **We recommend 3-yearly assessment of fracture risk using the FRAX tool if:**
  – ≥45, menopausal symptoms, postmenopausal

• **We recommend use of HRT as per NICE guidelines**
  – Transdermal first line in NICE (advantages for WLWH)

• **We recommend WLWH in mid-life are provided information on menopause and treatment options**

• **We suggest**
  – Management of menopause in primary care according to NICE guidelines
Intimate partner violence

• We recommend routine enquiry about domestic abuse, including IPV, in sexual health & HIV clinics
  – In accordance with NICE guidelines
• We recommend services develop local guidelines & pathways based on BASHH guidance prior to the introduction of routine questioning
  – Responding to domestic abuse in sexual health settings. BASHH (2016)
Female genital mutilation

• May increase the risk of HIV transmission
  – Trauma of sexual intercourse
  – Increased risk inflammatory GU conditions
  – Increased anal sex if vaginal sex difficult

• In line with the rest of the NHS, it is mandatory for HIV services to report FGM and collect data
Cervical screening: BHIVA monitoring guidelines 2016

5.5.1 Cervical screening

Recommendations

• We recommend that national guidelines for cervical screening in HIV-positive women be followed and cervical screening is not performed under the age of 25 (1A)
Cervical screening

• We recommend annual cervical screening in all WLWH up to the age of 65 as per national guidelines
• We suggest initiating cervical screening 3 years after sexarche in WLWH
BHIVA vaccine guidelines 2015

6. Recommendations for HIV-positive adults

- We recommend previously unvaccinated HIV+ men & women aged up to 26 be offered HPV vax* [1B]
- We recommend previously unvaccinated HIV+ MSM aged up to 40 years be offered HPV vax* [1B]
- We suggest previously unvaccinated HIV-positive women aged up to 40 be offered HPV vax [2D]

*regardless of CD4 count, ART, and viral load
Acknowledgements

• All the writing group
• Yvonne Gilleece
• Annemiek de Ruiter
• Mark Bower
• Nneka Nwokolo
• Emily Lord
Thank you Emily
Thank you!

lwaters@nhs.net
@drlaurajwaters