

# Promoting long-acting reversible contraceptives and HIV testing: more work for harassed GPs?

The UK needs to focus on sexual health as 2007 statistics showed another bad year. There were 40 298 conceptions in women aged <18 years (rate 42 per 1000), of which 51% were terminated.<sup>1</sup> Nearly 8000 of these pregnancies were in girls aged <16, a rate that (despite government spin) has changed little since 2001.<sup>1</sup> Of 271 000 chlamydia tests in young people aged <25 years who were screened by the English National Chlamydia Screening Programme, 9.5% of tests in females and 8.4% in males were positive.<sup>2</sup> There were also 702 new diagnoses of HIV in young people aged 16–24 years (incidence 10 per 100 000).<sup>2</sup> Nearly half (48%) of these were in men who have sex with men, most of whom were white and probably infected in the UK. A similar proportion were in heterosexuals, mainly black Africans who were most likely infected abroad.<sup>2</sup>

However, there are some grounds for optimism. Most genitourinary medicine clinics are now achieving the 48-hour access target.<sup>3</sup> The National Chlamydia Screening Programme reported that nearly 25% of under 25s were screened for chlamydia in 2008, although men and ethnic minorities were under-represented.

It is likely that many more chlamydia tests could be done in general practice, particularly in high-risk young people with a recent change of sexual partner or history of chlamydial infection in the past 3 months. (It can take less than 3 minutes of a GP's or practice nurse's time to organise a young person to complete the form and take a self-administered sample.) But the UK still has the highest rate of sexually transmitted infections (STIs) and teenage pregnancies in Europe.

GPs have a responsibility for sexual health as part of holistic care. But as well as screening for STIs, why are we now being asked to promote both long-acting reversible contraceptives (LARC: IUCDs, contraceptive implants, or injections) and HIV testing?

## PROMOTION OF LARC

LARC methods are more cost-effective than the combined oral contraceptive pill because they reduce the likelihood of unplanned pregnancy.<sup>4</sup> Condoms and oral contraceptives need consistent and correct use and have annual failure rates of around 15% and 8% respectively, compared with 0.1% for intrauterine contraceptive devices (IUCDs) and 0.05% for contraceptive implants.<sup>5</sup> IUCDs and implants are also more cost-effective than injectable contraceptives, which depend on women returning for a repeat injection every 3 months.<sup>4</sup> However, in the UK only around 12%<sup>6</sup> of women currently use LARC, and unfounded anxieties about side effects are common.<sup>7</sup>

As LARC are more effective than other methods and actually have relatively few side effects, it seems sensible for GPs and nurses to consider encouraging wider use, particularly in women who have recently had one or more pregnancy terminations. But it is clearly crucial to make it easy for women to access these treatments as soon as possible. Thus, having a doctor in the practice who can fit these devices or close links with the local family planning clinic could be beneficial.

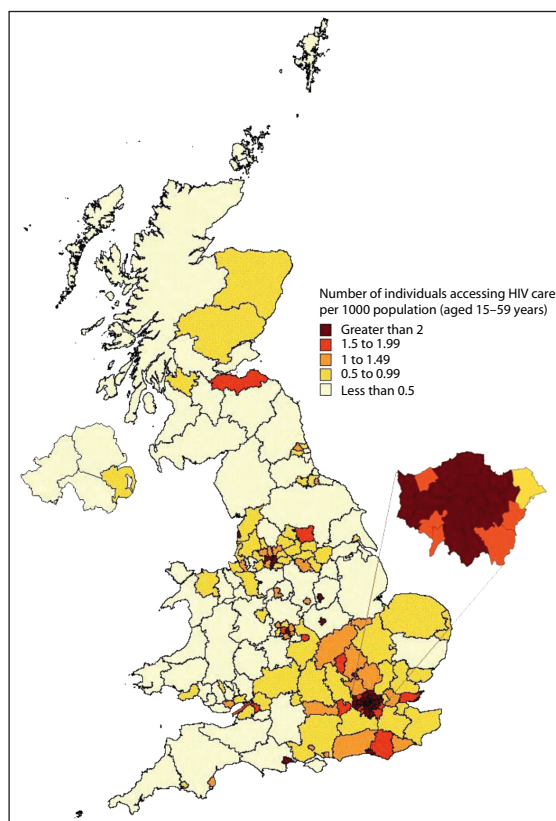
## WHY TEST FOR HIV IN PRIMARY CARE?

There are an estimated 77 000 people with HIV in the UK of whom 21 000 are undiagnosed.<sup>8</sup> Those with undiagnosed HIV are at risk of transmitting it to others and have a worse prognosis if they are missed and present late, which is the case for about a third of new diagnoses in the UK. Effective treatment means that a 20-year-old diagnosed with early

HIV can now expect to live to age 70.<sup>9</sup> However, to date very few primary care trusts (PCTs) seem to have focused on this serious public health challenge.<sup>8</sup> Treating someone with symptomatic HIV costs around £14 000 per annum, and the total cost of HIV to the NHS in 2005 was estimated as £400 million compared with £165 million for all other STIs combined.

In the UK, high-risk areas for HIV are London (rate 4 per 1000 population aged 15–59 years), other major cities, and the south coast of England (Figure 1).<sup>10</sup> GPs working in these areas might consider offering HIV testing more frequently, particularly to men who have sex with men, for whom annual testing is recommended, and those of black African origin in whom HIV prevalence is around 5%.

Figure 1. Rates of diagnosed persons seen for HIV care by residence in 2007.



Source: Health Protection Agency, 2008.<sup>10</sup>

### Box 1. Who should be offered HIV testing?<sup>13</sup>

#### Risk groups

- Men who have sex with men (10% positivity rate in London)
- Individuals from sub-Saharan Africa or the Caribbean
- Injecting drug users
- Sexual partners of the above

#### Indicator conditions, especially if in at-risk group

- Tuberculosis
- Hepatitis B or C
- Oral thrush, chronic diarrhoea, or weight loss
- Severe or recurrent seborrheic dermatitis, psoriasis, or shingles
- Unexplained thrombocytopenia, neutropenia, lymphopenia, lymphadenopathy
- Cervical intraepithelial neoplasia grade 2 or worse, any sexually transmitted infection

HIV testing should enable earlier diagnosis and treatment and reduce transmission; it is estimated to be cost-effective at prevalences of 1 in 1000.<sup>11</sup> Thus routine testing, for example during new patient checks, has been suggested in the 43 PCTs (of the 152 total) where the prevalence of HIV is more than 2 per 1000.<sup>10–12</sup> Box 1 suggests which patients might be offered HIV testing. Although there are a large number of indicator conditions,<sup>13</sup> these are the ones commonly seen in general practice which might prompt an HIV test. Delayed diagnosis often leads to a worse prognosis as illustrated in the scenario in Box 2.

### SEXUAL HISTORY AND DISCUSSION OF HIV TESTS

In high-prevalence areas where routine HIV testing has been suggested, taking a sexual history may be unnecessary and could be a barrier to test uptake. In addition, some GPs have reservations about taking a sexual history, and patients may not disclose risk factors. However when appropriate, possible questions might include:

- When did you last have sex?
- Was it with a man or a woman?
- When did you last have sex with a new partner?
- Have you ever had sex with someone from outside Europe (for example, Africa, the Caribbean, south-east Asia)?
- Have you ever paid or been paid for sex?

Pre-test discussion for HIV testing can be brief and should include details of how the result will be given and the benefits of testing; for example, 'You can live for another 50 years with HIV if it is treated, but if it is not diagnosed you could get ill'.

If there has been a specific exposure within the window period, repeat testing should be advised. Traditionally, a negative test should be repeated after 3 months, but newer assays are usually positive about 4 weeks after exposure, so 6 weeks is now advocated by some services. If the test is positive, telephone a doctor or health adviser in genitourinary medicine before seeing the patient and arrange an urgent appointment within 48 hours. Explain to the patient that a confirmatory test is needed and that you have organised an appointment with a specialist for further management.

### CONCLUSION

Although STI screening in primary care needs to be expanded, many general practices are already screening for chlamydial infection. In line with the recent 'Condom Essential Wear' media campaign, primary care health professionals frequently offer advice on safer sex.

There is good evidence to support promotion of LARC in women at risk of unwanted pregnancy for whom contraceptive methods which depend on patient compliance may be less suitable.

Increased awareness of the burden of undiagnosed HIV in the UK, and simple and accessible HIV tests should now encourage us to offer more HIV testing.

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### Provenance

Commissioned; not peer reviewed.

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### Box 2. Missed opportunity for HIV testing in primary care

A 30-year-old gay man was treated by his GP for shingles. He reported having had a negative HIV test 18 months earlier and was in a long-term stable partnership. A year later he complained of a sore throat and a swab showed oral candida. Two years later he was admitted via A&E with pneumonia. After 3 days of penicillin and erythromycin treatment he was transferred to intensive care where *Pneumocystis carinii* pneumonia was diagnosed. Delayed diagnosis of HIV resulted in a worse prognosis.

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