Safer chemsex: consideration of Shigella

We would like to follow up the recent editorial entitled ‘Safer “chemsex”’ by Ma and Perera by including sexually transmissible enteric infections (STEI) among the pathogens whose transmission may be associated with chemsex. Shigella, which causes a range of gastrointestinal symptoms in humans, is the primary example here, although verocytotoxin-producing Escherichia coli has also been described. Until recently, Shigella infections in England were primarily associated with travel to endemic areas. However, in the past decade, a Shigella epidemic has been documented in men who have not travelled, thought due to faecal–oral transmission during sex, in men who have sex with men (MSM). Chemsex may influence willingness to engage in sexual practices that increase the risk of faecal–oral transmission.

Gilbart and colleagues reported an investigation into a Shigella case series in adult males between 2012 and 2013. Of 42 patients interviewed, 34 were MSM, many of whom were HIV positive, and who reported multi-partner condomless sex and chemsex. Importantly, more than half first presented to their GP, emphasising the importance of increasing understanding about this epidemic both within and outside of specialised sexual health clinics.

In the event of a diagnosis of Shigella and no recent travel to an endemic area, we recommend sensitively ascertaining a sexual history from men, particularly in London, Brighton, and Manchester, where we know Shigella transmission is high among MSM.

If a patient with Shigella reports same-sex partners, this should prompt discussion of referral to sexual health services as these patients are likely to be at risk of STIs and HIV co-infection. Providing information on avoidance of sex until a week after symptom cessation, on condom use, and on reducing risk of exposure through oral–anal contact is also important. If the patient presents with infectious bloody diarrhoea there is a duty to notify the health protection team.

REFERENCES

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Rhetoric and reality in person-centred care: introducing the House of Care framework

Many GPs have read NHS England transformation plans and met the ‘primary care home’ model. The recent article on the House of Care promotes the model from a different perspective and suggests benefits from enhancing patient-centred care (PCC), professional exchange, and reducing care inequity. The irony of the imperative to revolutionise and address perceived deficiencies in delivering PCC in the name of patients’ opportunity to take control is however awe-inspiring. By the authors’ admission the PCC construct is immature and it ‘probably leads to only small improvements in some indicators of physical health’. By contrast traditional GP care has high patient satisfaction and given the opportunity patients choose technical quality of care and relationship continuity over PCC.

In an austere environment in which scant primary care resources are dwindling, attracting staff is becoming impossible, the demand for performative (being seen to do rather than really do) escalating, and morale at a nadir, GPs are pragmatism experts. Inevitably, resilience in primary care is essential and at its core lies a moral compass. My compass asserts that, although as a pragmatist I accept healthcare delivery must change, the process by which it is being done is paternalistic, inherently dishonest, and disempowers patients.

This economist-driven enterprise may coincidently improve professional exchange, care coordination, and variability in areas of high population density, but will have a devastating impact on our profession through placing structure and function ahead of people and values. Our local plan fails to define the key attributes of GPs, 50 years to define and 50 months to define. On the ground, the gap between the expressed cooperative ideology and the rapid deconstruction of valued, effective resources is demoralising. All this and little evidence that patients have been consulted, empowered to contribute, or given alternatives to consider.