Common Challenges in Primary Care – Sexual Health Update

Tuesday 21 February 2023

The Prince Charles Hospital

Dr Srishti Dutta – GPLO, Metro North Health and Brisbane North PHN

phn BRISBANE NORTH
An Australian Government Initiative

Metro North Health | Queensland Government

Acknowledgement

Metro North Hospital and Health Service and Brisbane North PHN respectfully acknowledge the Traditional Owners of the land on which our services and events are located. We pay our respects to all Elders past, present and future and acknowledge Aboriginal and Torres Strait Islander people across the State.

Sexual Health Update

Program

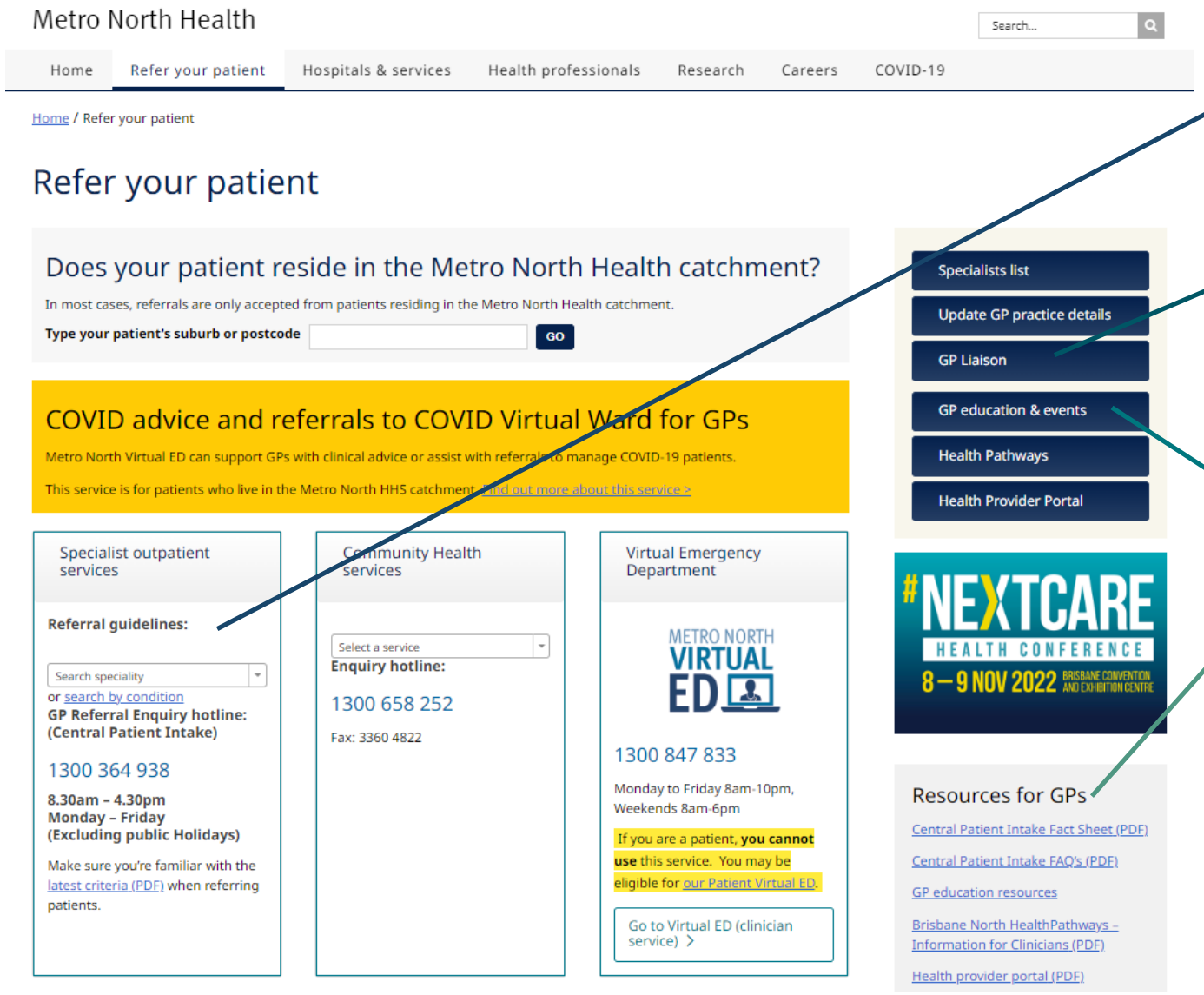
Welcome & GPLO Liaison Update
Including introduction to Brisbane North Sexual Health Service Community and Oral Health

Focus on Syphilis and introduction to contact tracing
Metro North Sexual Health and Public Health Unit teams

Assessment and management of common STIs and managing patients on PrEP
Metro North Sexual Health and Public Health Unit teams

Case based discussion

Metro North – Refer Your Patient



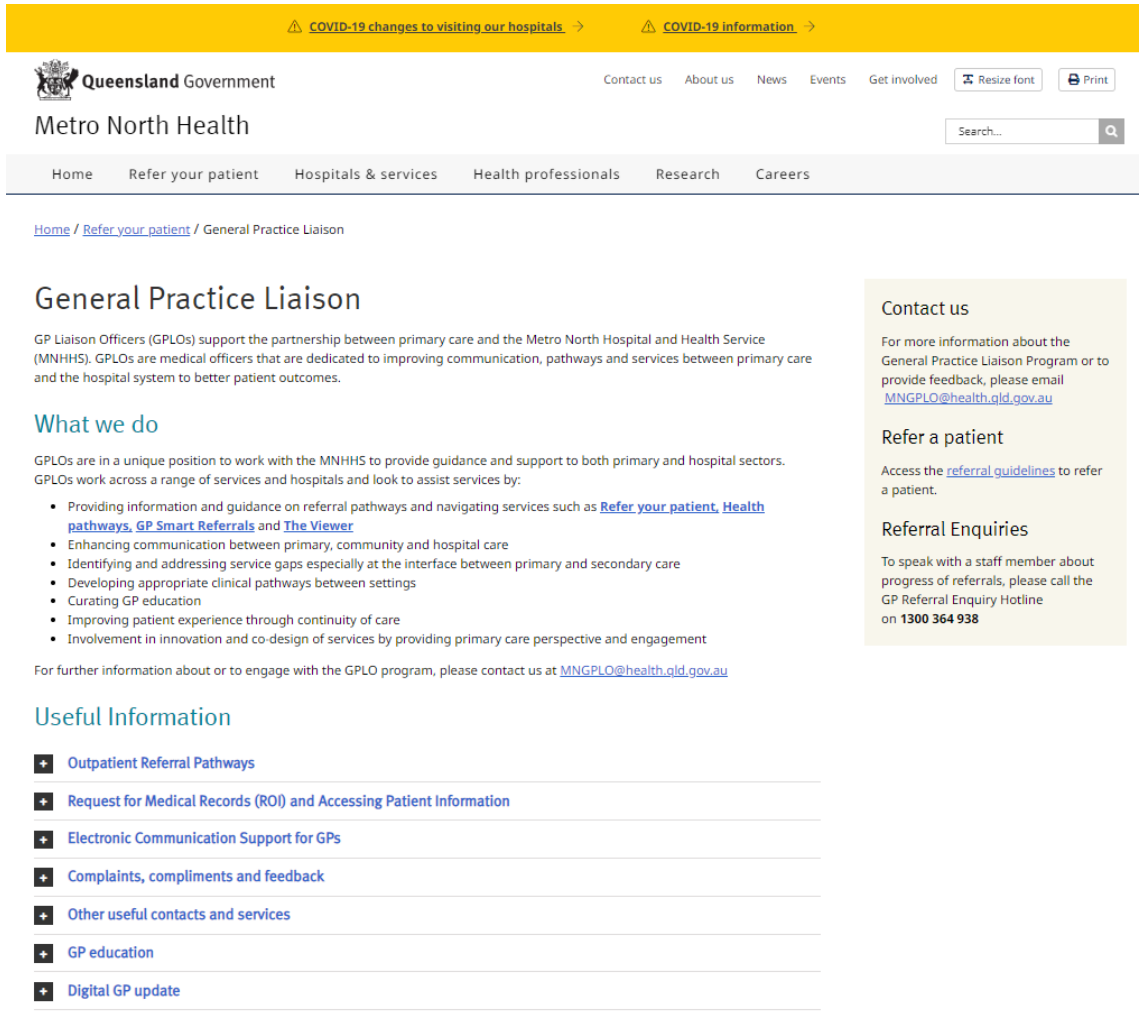
Specialist Referral Guidelines
(condition and specialty based)

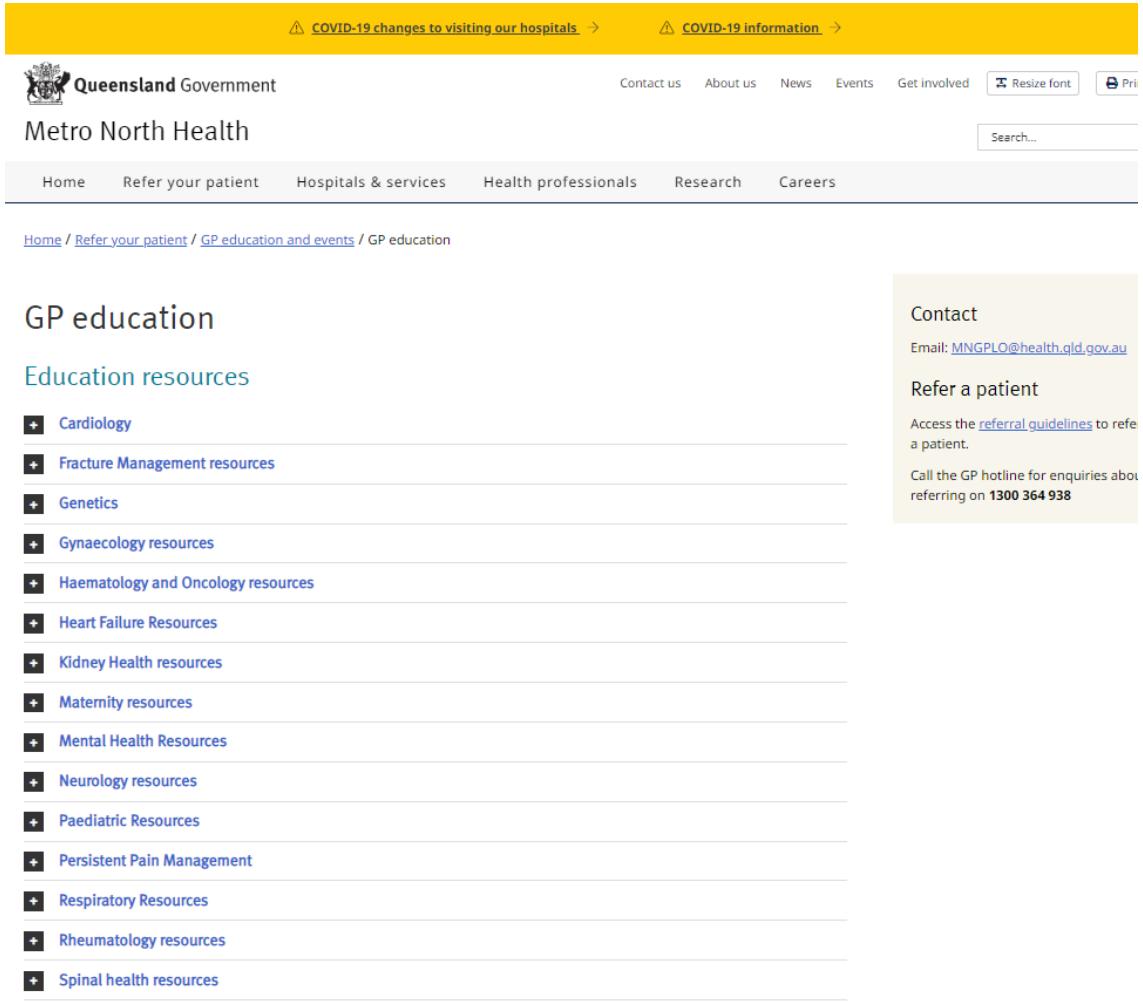
GP Liaison page

GP education and events
(previous events, presentations and resources)

Resources for GPs

Metro North – GP Liaison and GP Education pages





Metro North Virtual ED

Virtual Emergency Department

Open: 7 days
(8am-10pm Monday to Friday | 8am-6pm Saturday and Sunday)

METRO NORTH VIRTUAL ED

Metro North Virtual ED offers alternative pathways that can help avoid waiting in an Emergency Department.

Patients

You can use this service if you:

- Live, are visiting or receive your treatment in the Metro North Health catchment
- Have a device that can enable a telehealth consultation (video, audio, internet)
- Can't make an urgent appointment with a General Practitioner

Virtual ED (patients) >

DO NOT use the Virtual ED for the following medical problems:

- Chest pain
- Breathing problems or turning blue
- Comatose or unconscious
- Sudden inability to move or speak, or sudden facial drooping
- The effects of a severe accident

In an Emergency DIAL 000

GPs

The Virtual ED provides GPs and other primary healthcare clinicians with access to specialist emergency medicine assessment, by telephone or video conferencing.

It is a safe, fast and efficient way for you to consult with an emergency physician and use real-time technology to align treatment and ongoing services for your patient.

Virtual ED (clinicians) >

The Metro North Health Virtual ED Service is for North Brisbane & Moreton Bay Region GPs only.

This is a clinician only service. Patients can contact the Virtual ED direct via the Patient Virtual ED service.

QAS

The Virtual ED provides QAS clinicians with access to specialist emergency medicine assessment, by telephone or video conferencing.

Virtual ED is focussed on working with clinicians to extend the options available to patients who access healthcare through the QAS but may not require assessment or admission at an emergency department.

Virtual ED (clinicians) >

This is a clinician only service. Patients can contact the Virtual ED direct via the Patient Virtual ED service.

How to access Metro North Virtual ED:

Call 1800 847 833 (1300 VIRTED)

Monday to Friday 0800 – 2200

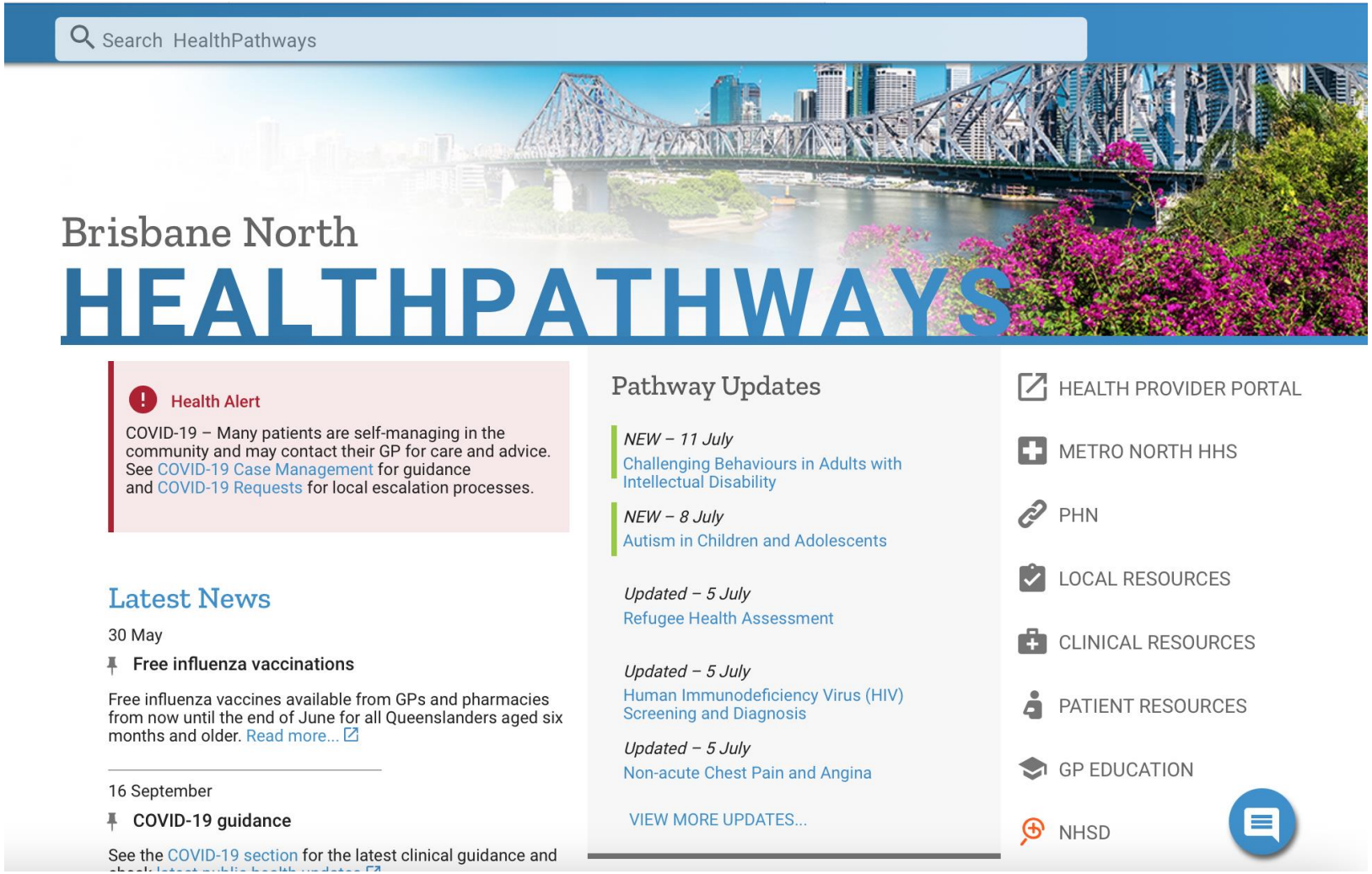
Saturday & Sunday 0800 – 1800

Virtual ED is aware that your time is precious.

You will be connected to an experienced emergency nurse. Please have the following information ready:

- Your name and phone number
- The patient's name, date of birth, hospital number (if available) and brief description of the problem
- The practice phone number

Brisbane North Health Pathways



Brisbane North HealthPathways

Username: Brisbane
Password: North

Statewide Portal

https://qld.healthpathwayscommunity.org

Username: Queensland
Password: Pathways

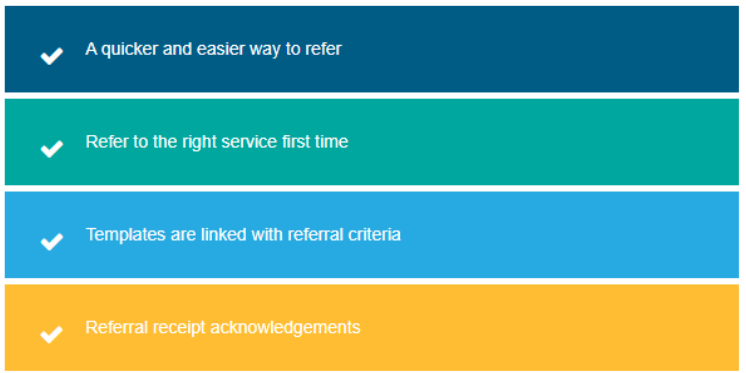
GP Smart Referrals

Why should I use it?

1. Allows you to attach any test results, imaging reports and other clinical documents from the patient's clinical record or your PC to the referral
2. GP Smart Referrals supports you in provision of essential clinical information, reducing the number of referrals being returned to you requesting additional clinical information
3. Integrated with a service directory to ensure the appropriate speciality closest to the patient's address is identified
4. A more automated referral management system, faster to use and process, which contributes to a streamlined patient journey
5. Automated notifications are issued when the referral has been received by Metro North HHS
6. Improved quality of referrals with essential clinical information to assist with more efficient processing and triaging of referrals.

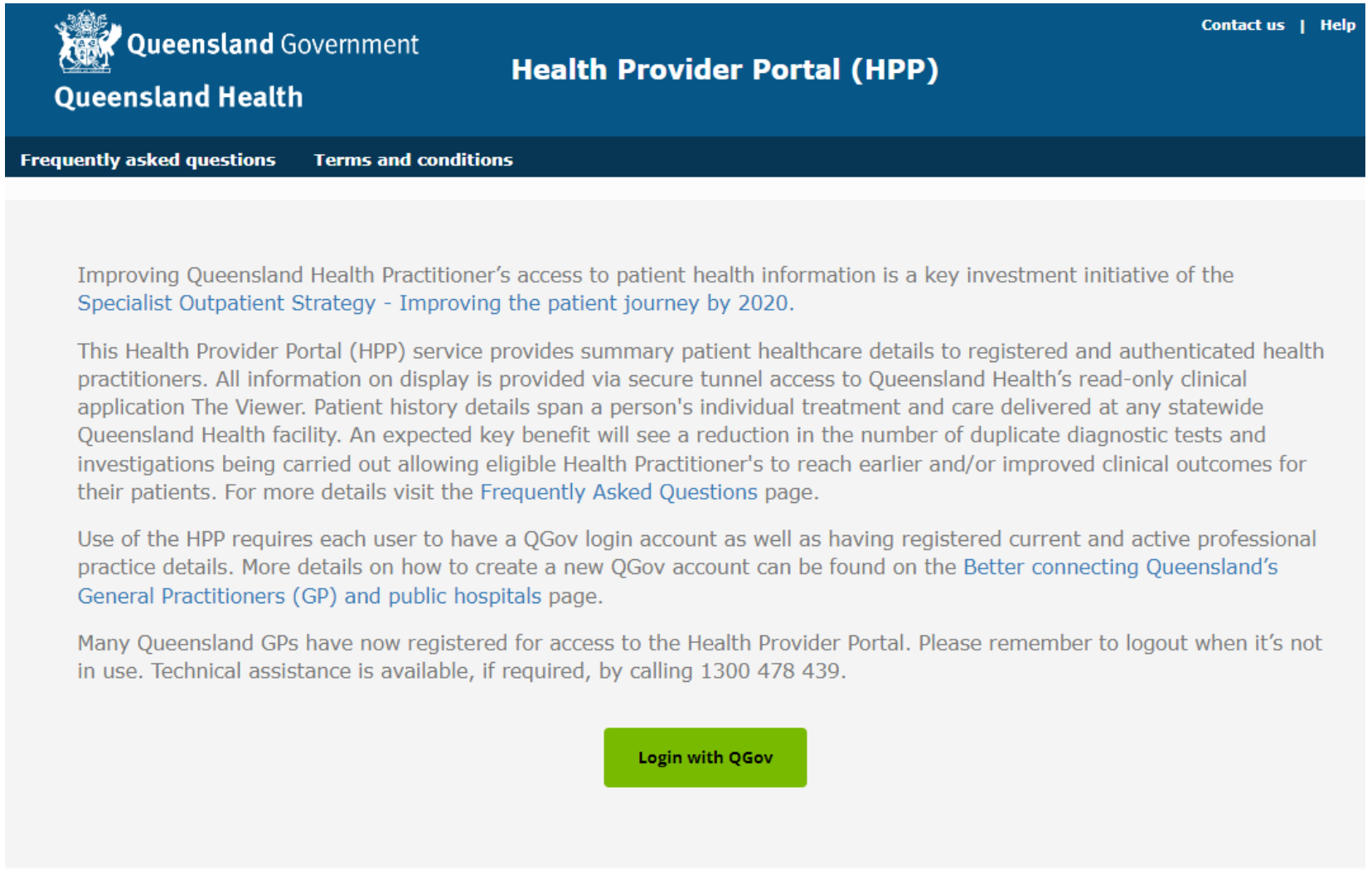
Brisbane North PHN Digital Health Support Officers
GPSR@brisbanenorthphn.org.au

Smart Referrals



- GP Smart Referrals are referral templates that allow for the creation and submission of an electronic referral to a Queensland Health Outpatient Specialty, with the required patient demographics and clinical record auto-populating, reducing time required to submit a referral.
- Integrates with *Best Practice* and *Medical Director* software across Queensland
- Aligned with state-wide referral guidelines to prompt essential referral information required to triage, decreasing the number of referrals returned for additional clinical information.

Health Provider Portal (The Viewer)



Better connecting Queensland's Health Practitioners and public hospitals

- The Health Provider Portal provides Queensland's *eligible health practitioners (HPs) with secure online access to their patient' Queensland Health (QH) records.
- This read-only online access will allow HPs to view public hospital information including appointment records, radiology and pathology reports, treatment and discharge summaries, demographic and medication details.

What's New?

Connecting Your Care – GP Advice Program

Need to connect better with Metro North Specialty Services?

Scoping work undertaken by Metro North and Brisbane North PHN identified that GPs wanted alternative ways to seek specialist advice that would assist them in managing patients confidentially, and prevent them from having to submit avoidable referrals to outpatient services.

From Monday 6 March 2023, Metro North Health will trial two new pathways to support GPs accessing clinical advice for a small number of Metro North specialty services:

- **Pathway 1:** dedicated 1800 telephone number with staff ensuring your call be connected with a specialty in a timely manner
- **Pathway 2:** written electronic request for advice submitted via GP Smart Referrals and response back via same secure system.

These pathways will also support electronic capture of that advice to ensure continuity of care.

If you are not already using the GP Smart Referral platform, you may want to consider doing so.

Read more information about GP Smart Referrals and the pathways, or contact the GP Advice Program via email at cyc_centralarea@health.gov.au.

What's New?

Rapid Access Community Care (RACC)

Rapid Access Community Care (RACC) pathway for timely access to community care for at-risk adult patients

General practitioners and practice nurses can now refer at-risk adult patients who are experiencing an exacerbation of a chronic condition or a new illness or injury that requires rapid community assessment or advice as an alternative to hospital presentation.

Referral to RACC is via phone call to 1300 220 922 between the hours of 9.00 am and 5.00 pm, Monday to Friday. Electronic referrals can be made via GP Smart referrals and e-templates.

The RACC interdisciplinary team will assess the patient in their own home within one business day and refer on to the most appropriate established community support service, which may include:

- Brisbane North PHN's own Team Care Coordination (TCC)
- Metro North Community Health Services
- the My Aged Care program
- Post Acute Care Service (PACS)
- Complex Chronic Disease Team (CCDT)
- non-government organisations (NGOs)
- in home support.

Referring GPs will receive feedback on the patient's assessment and the services that the patient has been referred to.

Please note that GPs can continue to refer directly to Team Care Coordination, and that RACC presents a new rapid access pathway for patients at-risk of avoidable hospital presentation.

GPs are encouraged to continue to refer directly to Team Care Coordination for all other less urgent clients.

Rapid Access Clinics – TPCH General Medicine

Who can be referred to General Medicine RAC?

- The Rapid Access Clinic can see General Medicine Adult Patients (not for surgical patients) within 2-3 days of referral. Patients should be in the Metro North catchment. Telehealth facilities available.
- **Inclusion criteria:** Hemodynamically stable, general medical, adult patients. Referrals may include management for patients with a flare of their chronic disease, wound review, asymptomatic anaemia, low risk TIA review, hypertension, abnormal investigations or pathology that does not require emergency management.
- **Exclusion criteria:** RAC is not suitable for systemically unwell patients. Not suitable for acute chest pain, or those requiring intravenous therapy or emergency care. Known oncology/palliative patients should be referred to existing pathways for those specialties. (see 'Refer your patient' on Metro North website)

How do GPs refer?

- GPs can refer patients by calling The Prince Charles Hospital switchboard on 3139 4000. Request to speak to the General Medicine Consultant On-Call (after 4pm and on weekends ask to speak with the On-Call General Medicine Admitting Registrar).
- If the patient is accepted by the consultant for the RAC clinic, the patient is contacted directly by an admin officer to arrange an appointment time within 2-3 business days after referral. The patient does not need to present to the emergency department

Brisbane North Sexual Health Service

Community and Oral Health
Metro North HHS

Sexual Health Team

Introduction

- Increasing rates of Sexually Transmitted Infections which also include Syphilis in our Priority Populations
- Higher prevalence and impact of STIs on First Australians, Youth 14-25 years and CALD communities.
- Getting a patient centered service “right” when population growth increase in outer city suburbs and demand on services is away from inner city settings.
- In Sexual Health as service must “feel safe”, have cultural and sexual advocacy and be patient centered outcomes through codesign.

The Journey

Timeline	Actions	Outcome
2013-2021	Indigenous Sexual Health Team moved to Community- no clinical governance or delivery	Team seconded and service closed in November 2021
2017-2021	Multiple negotiations/ community consultations and endorsement for Indigenous Team model of care to be integrated into SHHS	Unsuccessful integration or re-establishment 2017,2018,2020,2021
2017 - 2021	Increase in clinics and multi-disciplinary clinical staff and clinical delivery in Caboolture, Redcliffe	Clinics still underutilised by community –Culture? staff skill mix?, services location, access and hours?
2022	Current inner city services at capacity, stakeholders and providers including GPs finding difficulty accessing clinics , outreach underutilised, STIs increasing including Syphilis	Less than >1% of First Australians attending at existing SH clinics If live >10km from city centre less likely to travel If asymptomatic are not going to GPs/Cultural care
2022-23 Strategies	QH/Metro North Health Equity, Queensland Sexual Health Framework, QH 32 Health Reform	

The Journey

Timeline	Actions	Outcome
2022-Current	Identified need for codesign to develop new sexual health service in Brisbane North	Highly experienced staff recruitment – Indigenous Health Worker Nursing CNC/NP Medical SMO/Clinical Director
	Community and stakeholder engagement for codesign	Yarning Circles Community and Stakeholder Consultation Cross Jurisdictional Support
	Model of care	Complete
	Business Case	Complete
	Hub and spoke, outreach	In 2023 Pine Rivers as Hub with rapid expansion to spoke /outreach in 2023-24
	Align with strategies	Aligned
	Operational	Community-stakeholder endorsement Codesign / PREMS /PROMS

Building Capacity in Brisbane North

	Community and stakeholder consultation, codesign and endorsement
	Deliver inhouse cultural and sexual advocacy and safety
	Indigenous Health Workers – Health Equity
	Effective multi-jurisdictional partnerships and collaboration with Primary Care, NGOs, Peer led services , Public Health Units and other QH providers
	Community facing, patient focused
	Enhance local access to best practice sexual health and HIV care
	Sexual Reproductive Health
	GP Advice line
	Compliment existing services and networks in Sexual Health
	Increase capacity in the sector for improved access, timely care, timely referral and improved outcomes
	Hub and spoke model /outreach and integrated Sexual Health, HIV and reproductive health

meet our team > 50 years of Sexual Health Experience

JULIAN LANGTON-LOCKTON

Clinical Director
Specialist Medical Officer

DENE CAMPBELL

Clinical Nurse Specialist
/Nurse Practitioner

MEL KIELLY

Advanced Indigenous
Health Worker

ADMIN OFFICER

Summary –

Brisbane North Sexual Health Service

- Patient centered
- Community facing
- Cultural and Sexual Advocacy
- Codesign for Health Equity
- Best Practice Multidisciplinary Care
- Cohesive and Effective Partnerships
- Compliment Existing Services and Networks
- Enhance access and engagement
- Timely treatment and referral
- Aligns with current strategy

‘Right service for the Right People at Right place and time for the Right outcomes”

thank you

Please meet the Team

Ph 07 3492 1800

Mobiles 0400292876

Common Challenges in Primary Care – Sexual Health Update

Syphilis Update

Elena McLeish

Public Health Nurse

Metro North Public Health Unit

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Content

Notifiable conditions/QSSS

Syphilis statistics for Metro North

Syphilis management updates

Notifiable Conditions Register and QSSS

Some STIs are notifiable under the Public Health Act:

- HIV
- Syphilis
- Chlamydia
- Gonorrhoea
- Lymphogranuloma Venereum (LGV)

Automatically reported to Notifiable Conditions Register by most pathology providers

HIV – HIV PH Team

Chlamydia, Gonorrhoea, LGV

Syphilis:

- Queensland Syphilis Surveillance Service (QSSS)

Queensland Syphilis Surveillance Service

- To improve management of infectious cases – assist in interpretation of results
- A single statewide database which allows for the maintenance of individual syphilis case histories including treatment details
- To improve accuracy of treatment data
- Prevent unnecessary treatment of those adequately treated
- Monitor trends in syphilis epidemiology

- QSSS review all positive syphilis notifications in Queensland
- Identify new notifications/notifications of concern
- Follow up with diagnosing clinicians, providing any relevant information
- Complete NOCs with enhanced surveillance information returned by treating clinician

Syphilis in Queensland *'Notifications of BBVSTIs 1 Jan – 30 Sep 2022'*

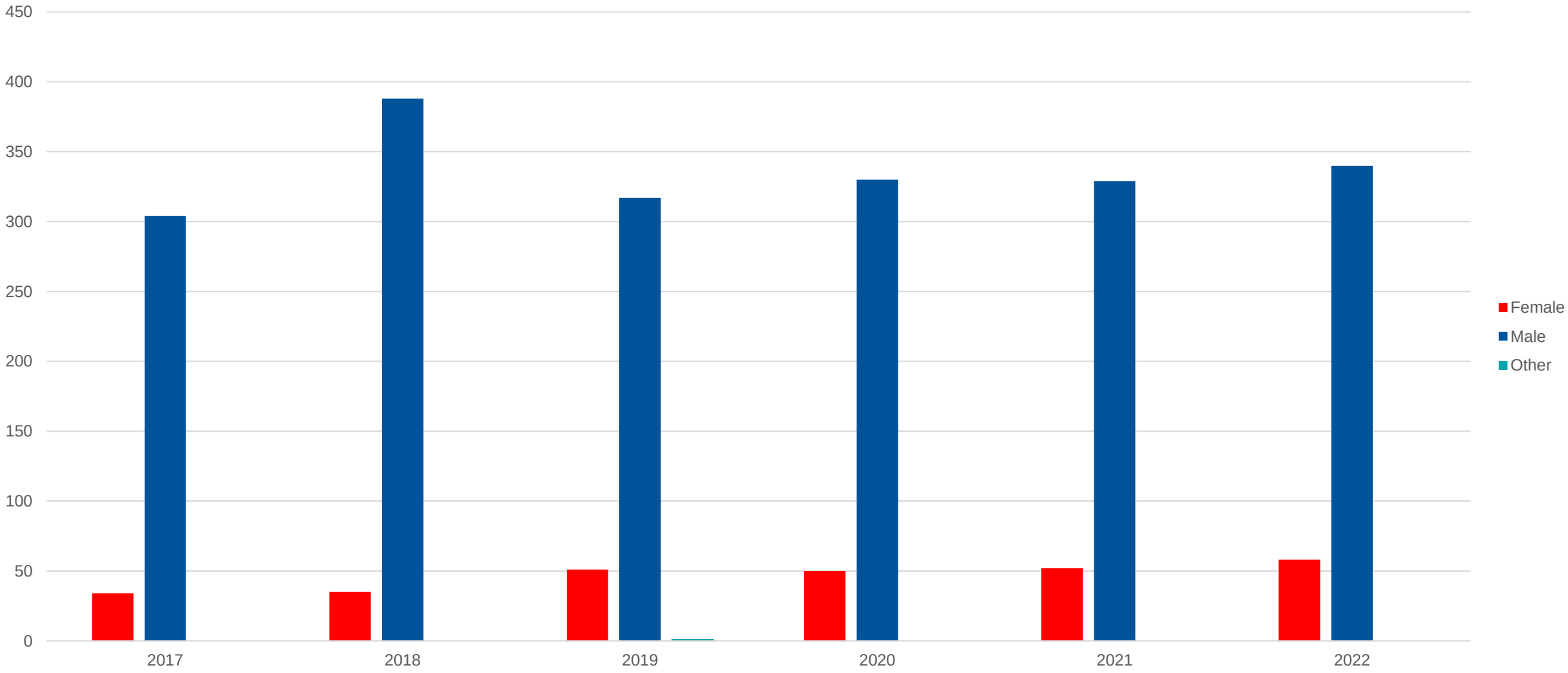
Between 2001 and 2021 annual infectious syphilis notifications have increased from 112 cases to 1049 cases

The highest number of infectious syphilis notifications in 2022 was from Metro North HHS - 290

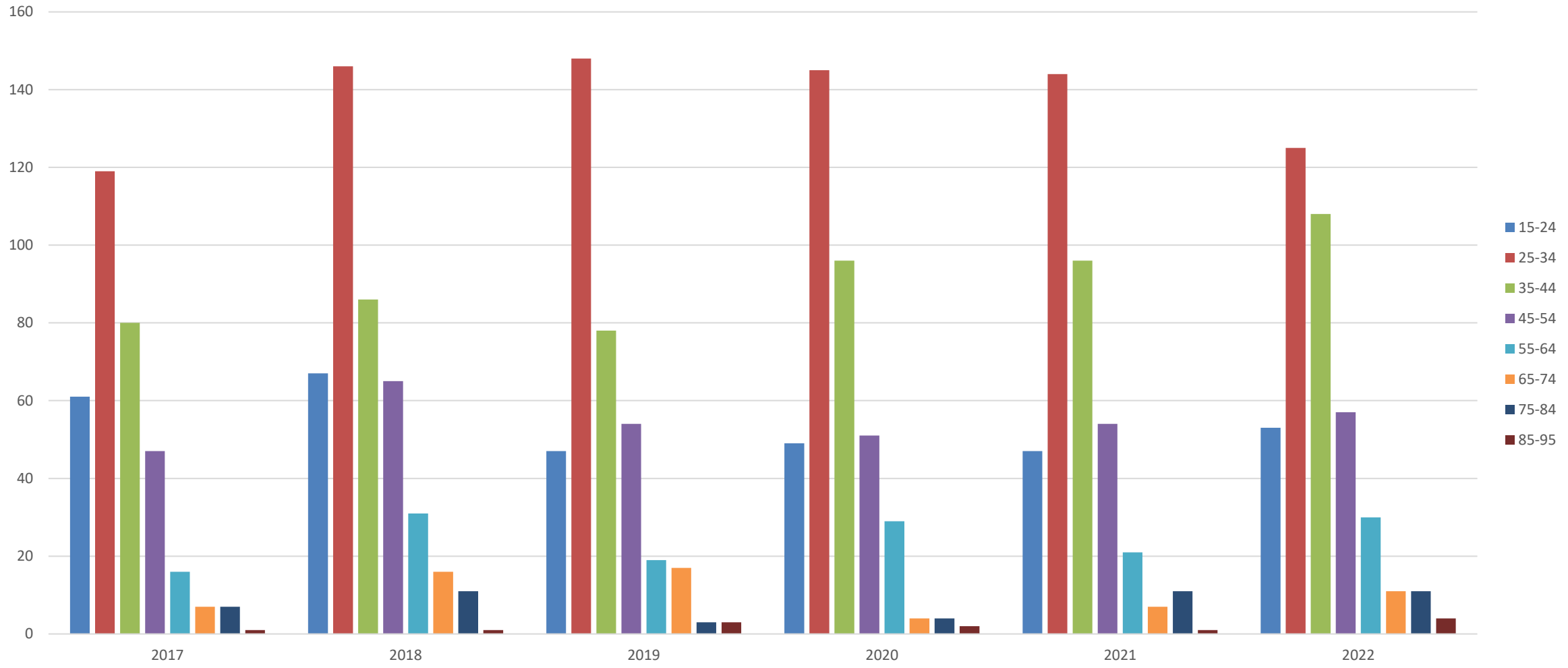
Between 1 January 2011 to 30/09/2022, there were 28 congenital syphilis notifications (18 in Aboriginal and Torres Strait Islander peoples and 10 in the non-Aboriginal and Torres Strait Islander peoples).

Of 181 female cases (up to 30/09/2022), 164 (91%) were in women of reproductive age, 26 of which were in pregnant women.

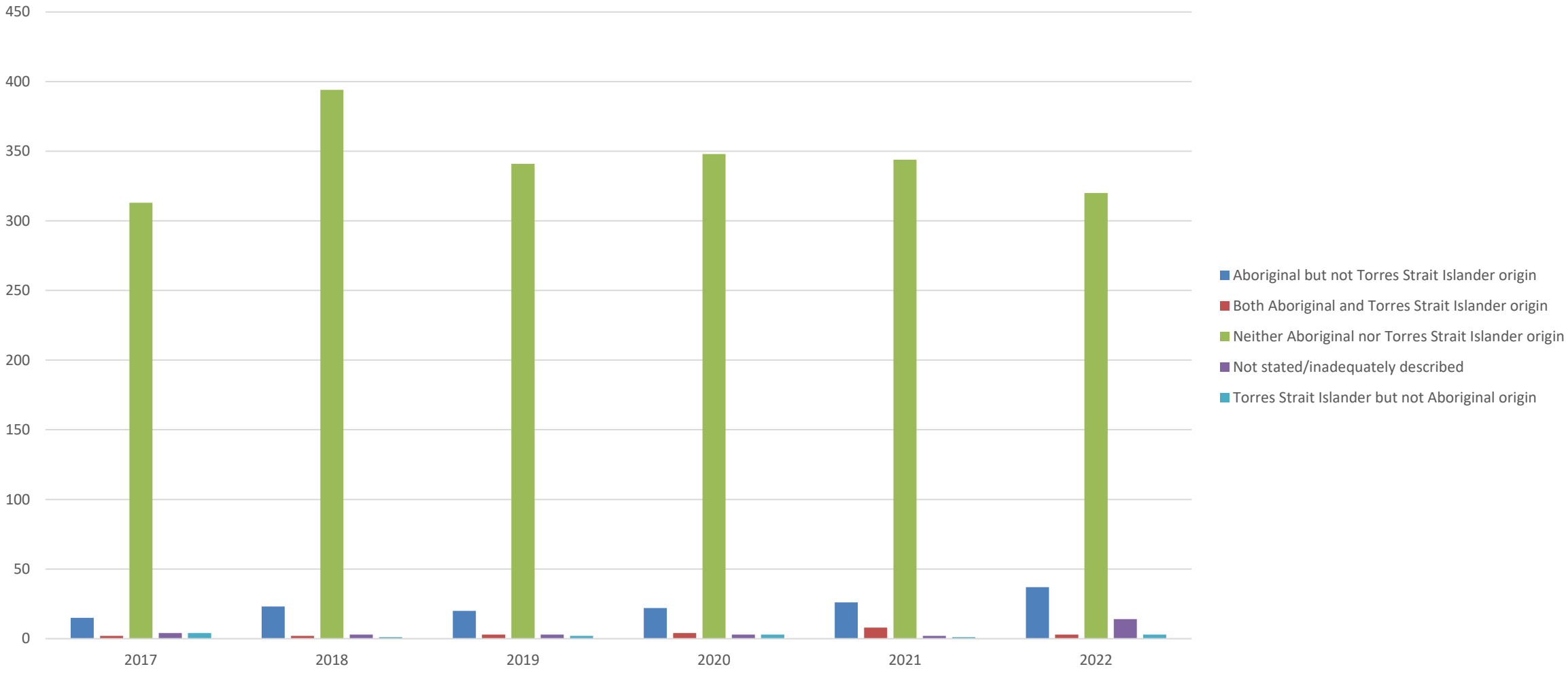
Syphilis notifications Metro North HHS 2017 - 2022



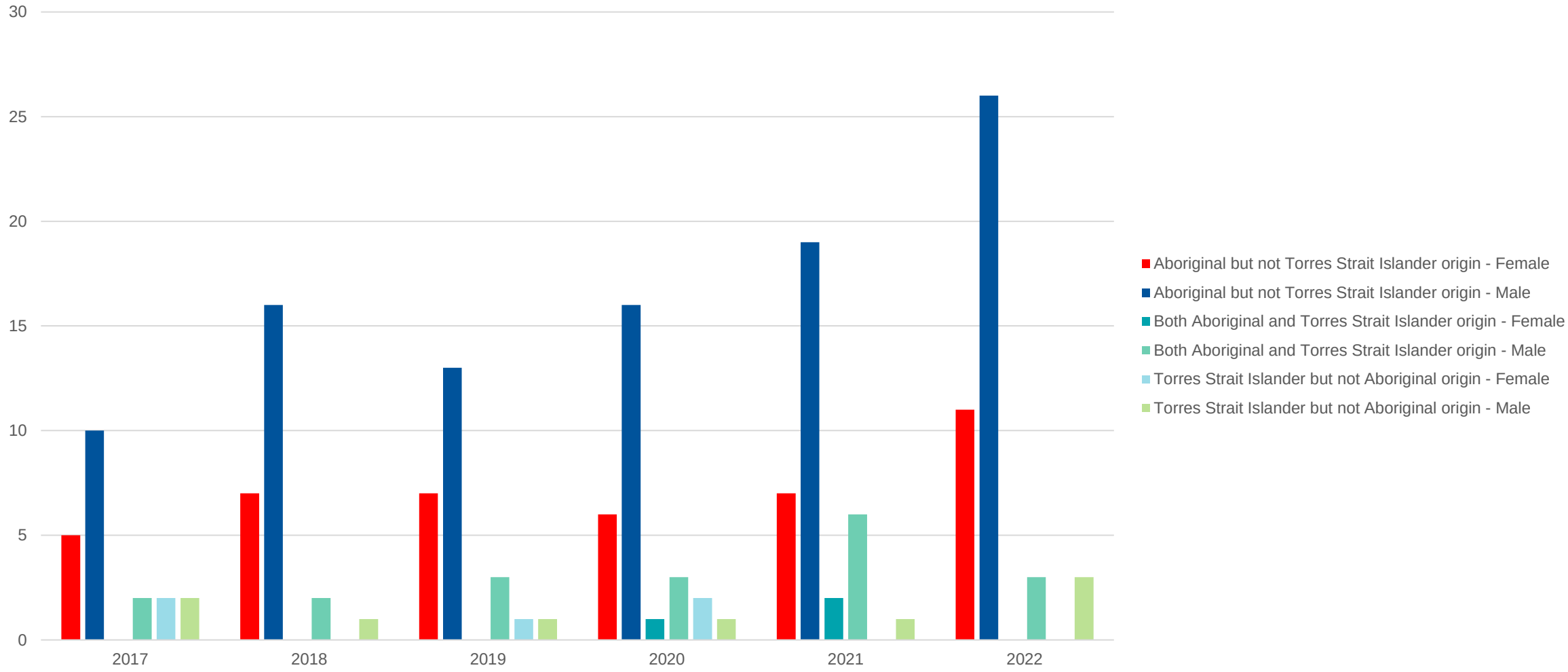
Metro North – Syphilis by Age



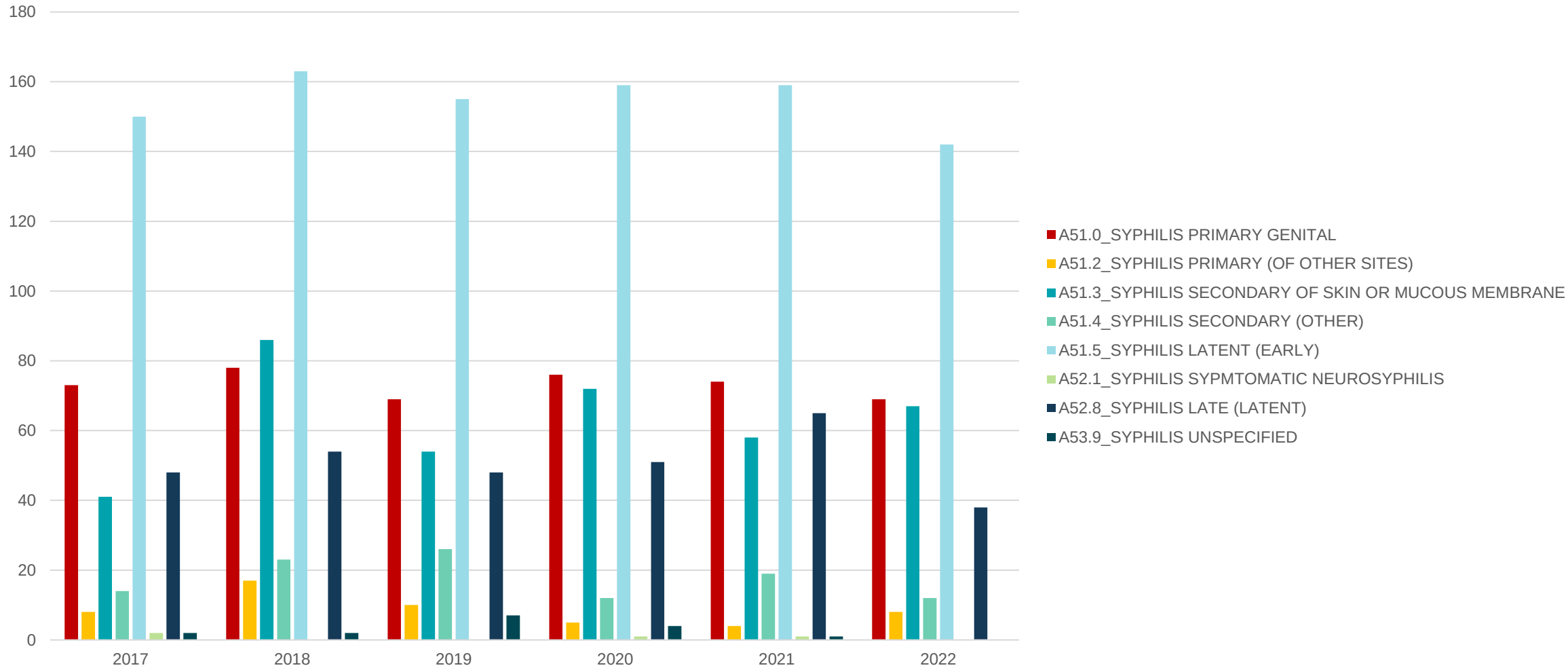
Metro North – Syphilis by Indigenous Status



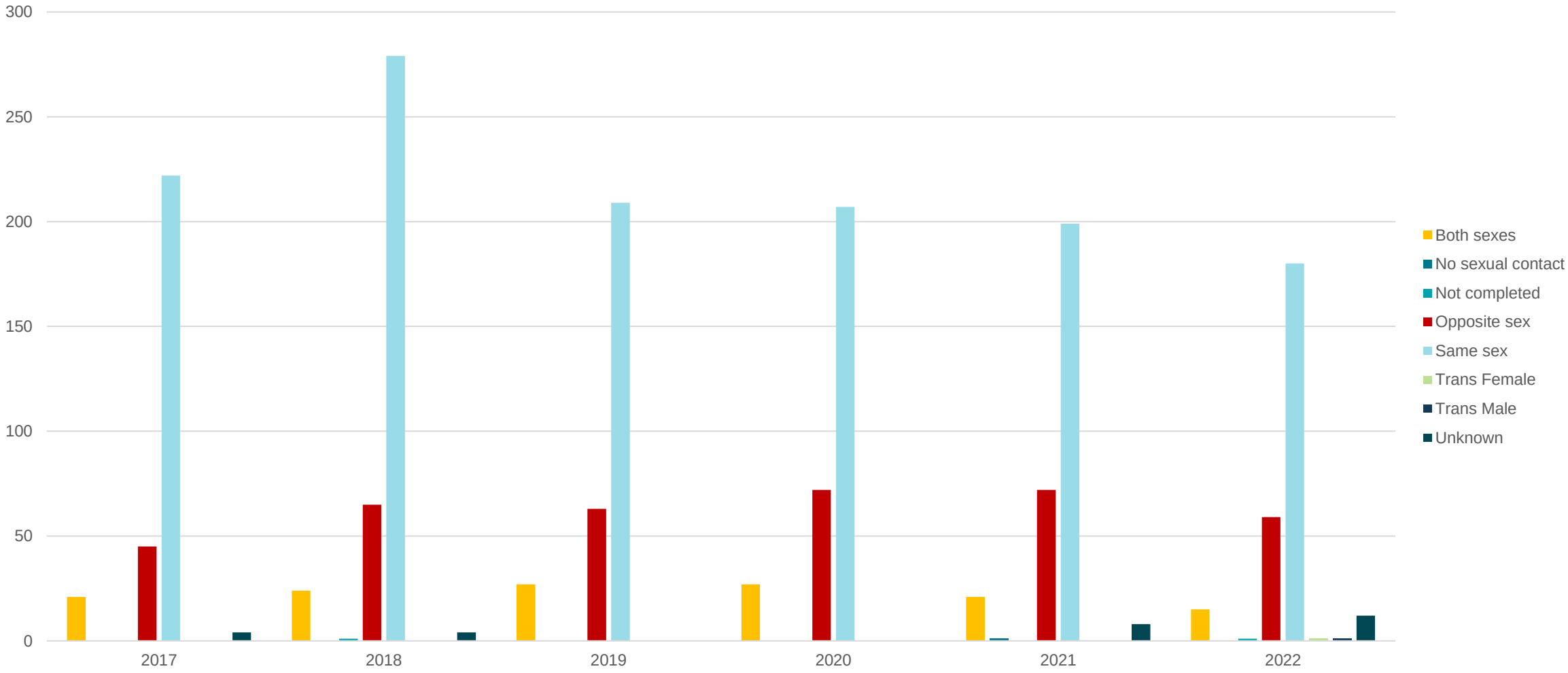
Metro North Syphilis by Indigenous Status and Gender



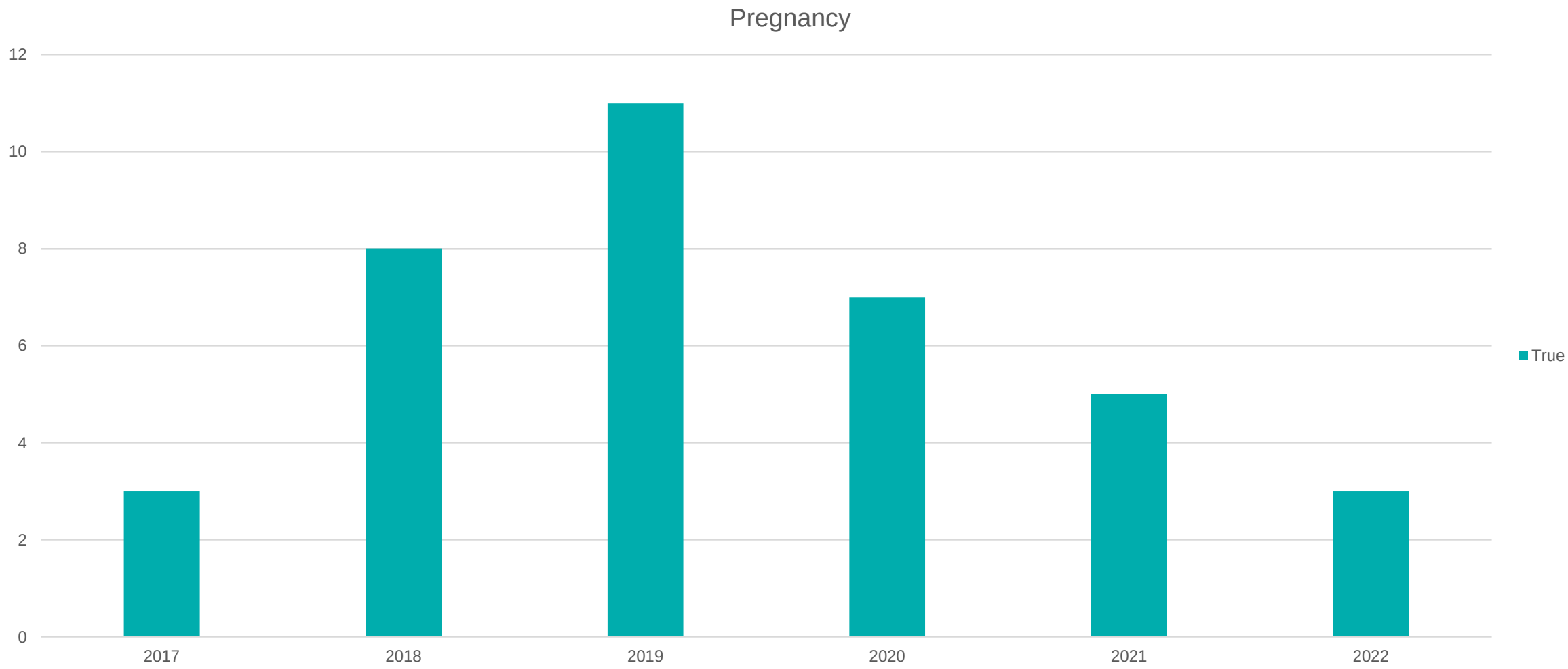
Metro North Syphilis by Clinical classification



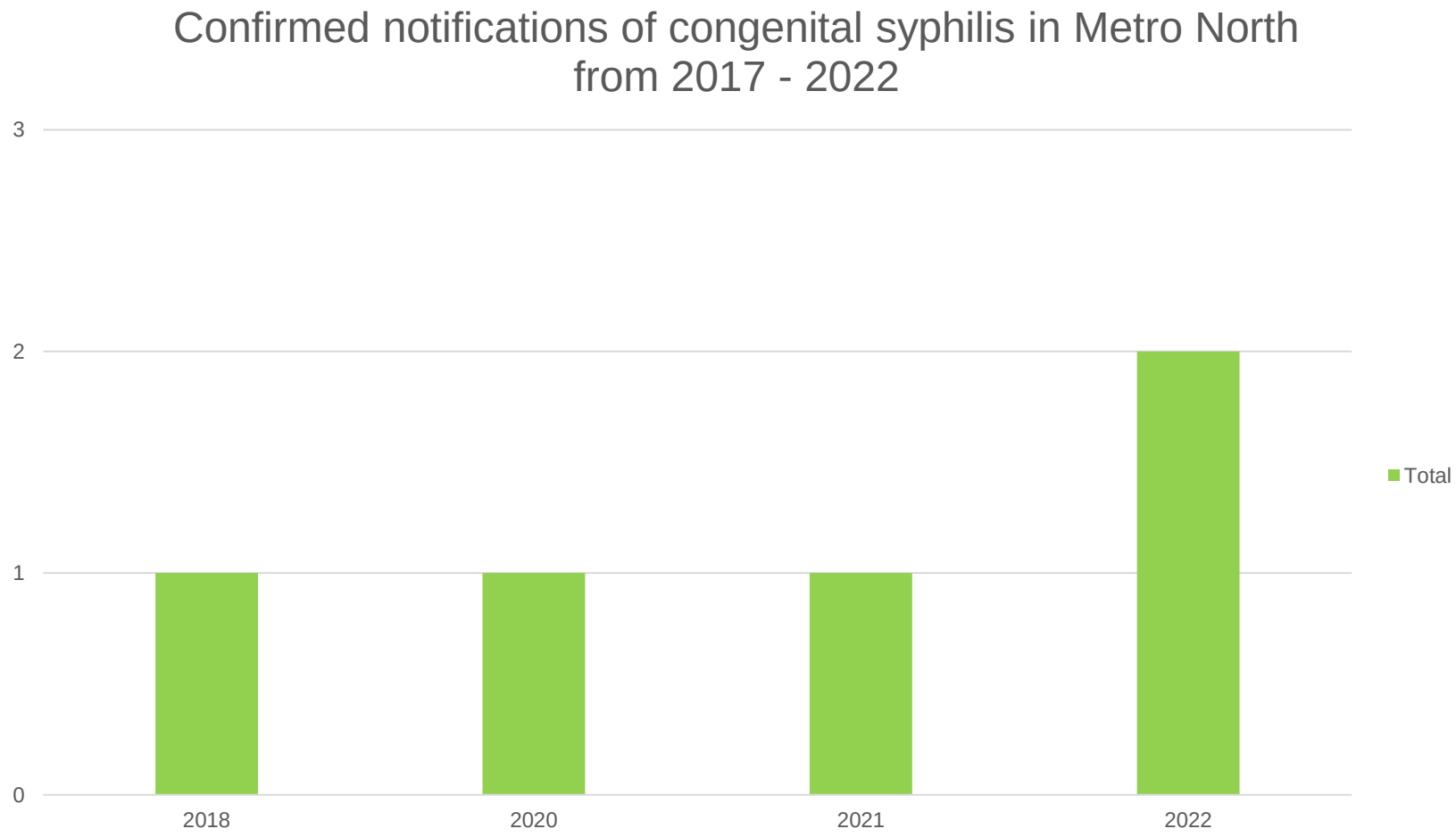
Metro North Syphilis - Gender of contacts



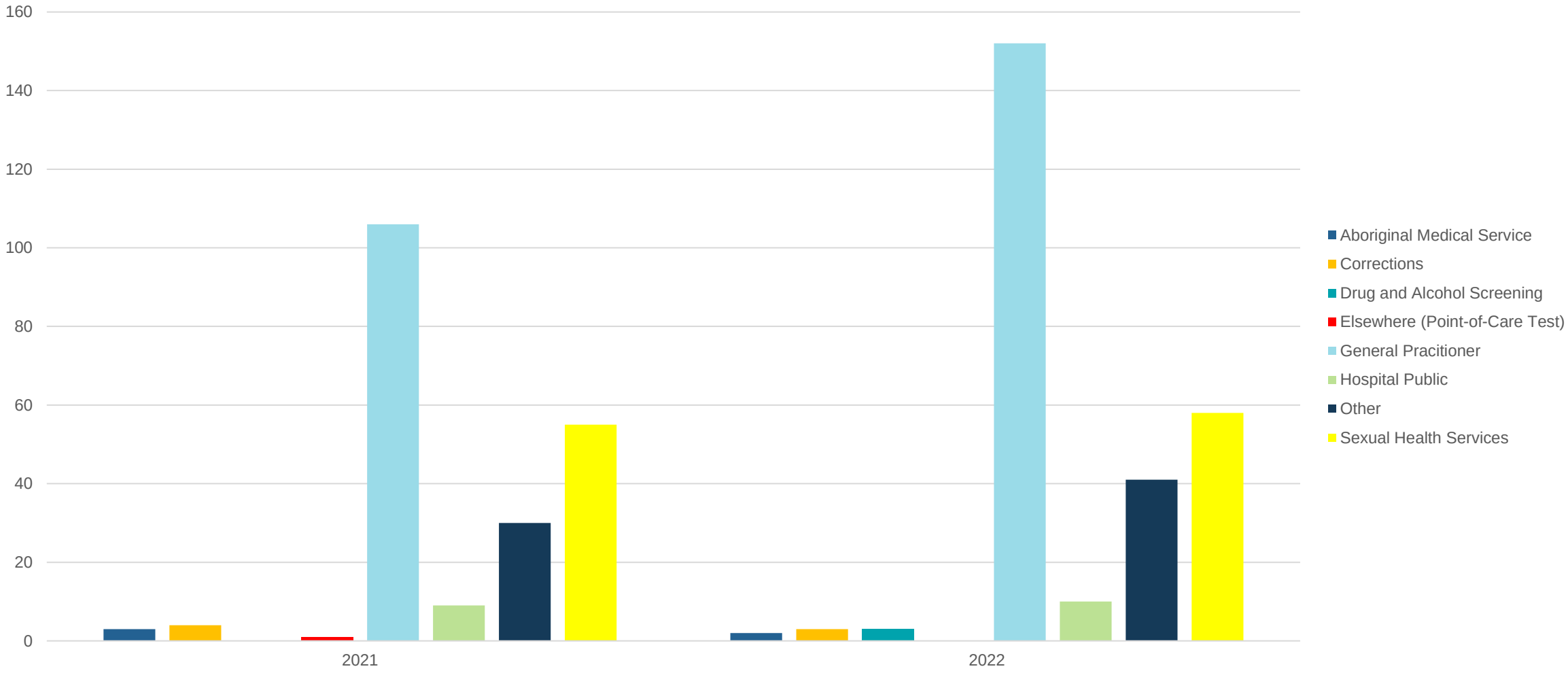
Metro North Syphilis and Pregnancy



Metro North - Congenital syphilis notifications



Metro North Syphilis - Test provider

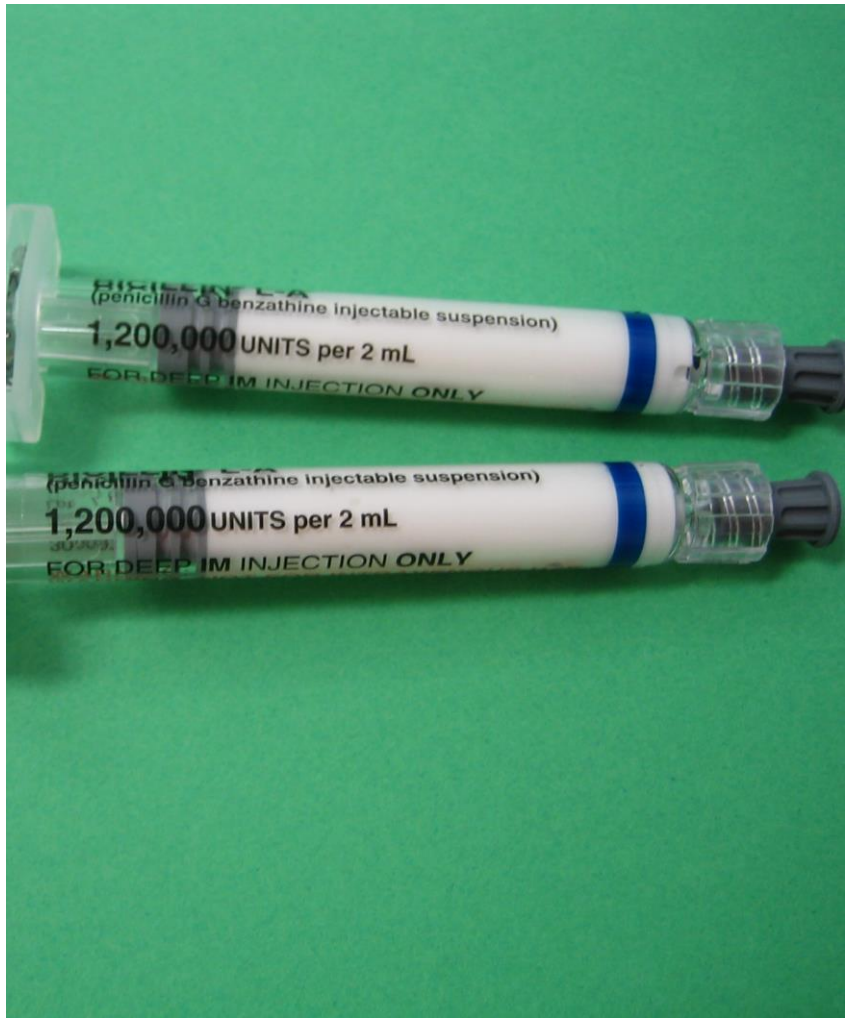


Current Emerging Issues in Syphilis

- AOD
- Homelessness
- Mental health
- Limited or no Ante natal care
- DV situations
- Incarceration
- Multiple partners
- Opportunistic sex work
- Age difference between contacts
- Lost to follow up/longer to access treatment – increased onward transmission risk
- Difficulty with partner notification/Contact Tracing therefore high risk of re-infection

Syphilis Treatment

- Comes in 1.2 mU prefilled syringes
- Each treatment dose is 2.4mU
- (Category A in pregnancy)
- If not in stock pharmacy order may take approx 24 – 48 hrs
- Available via GP Prescriber's bag



Guidelines for syphilis management '*Australasian STI Management Guidelines – for use in primary care*':

- Baseline blood on day of treatment
- No Sexual contact until treatment + 7 days and partner/s treated + 7 days
- Treat contact of infectious syphilis in past 3 months regardless of a negative result
- Follow up bloods -3, 6 and 12 months
  - auditable outcome – '100% of patients with syphilis have had follow-up serology tests by 6 months
- If in any doubt of length of infection treat weekly for 3 weeks

Who/When to test for Syphilis?

- Patients requesting an STI screen
- Patients you would normally opportunistically offer chlamydia testing
- When requesting Hepatitis C testing or any other BBV testing
- Patients with AOD or mental health concerns
- Patients with any unusual rashes or lesions
- Recent release from corrections
- Pregnant women: “*Queensland Clinical Guidelines: Syphilis in pregnancy*’
  - Ante natal bloods
  - 28 weeks
  - ‘High Risk’ – include 20 weeks and 34 – 36 weeks gestation.

Common Challenges in Primary Care – Sexual Health Update

Syphilis (Treponema Pallidum)

Dr Angela Smith

Senior Medical Officer

Brisbane Metro North Sexual Health and HIV Service

Slides with thanks to QLD Syphilis Surveillance Service

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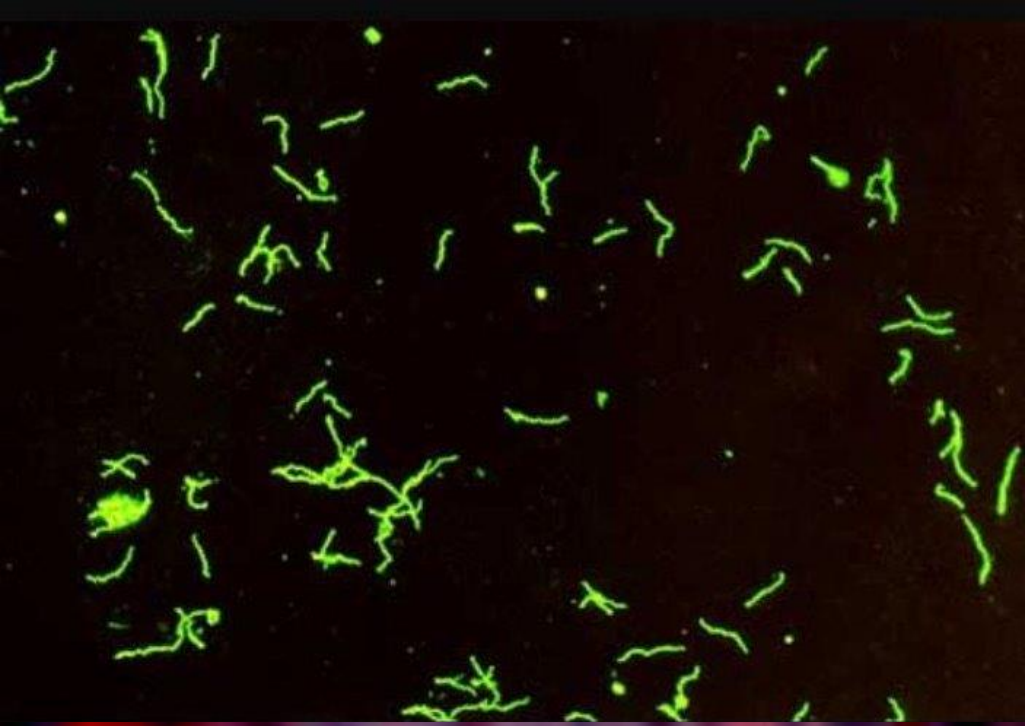
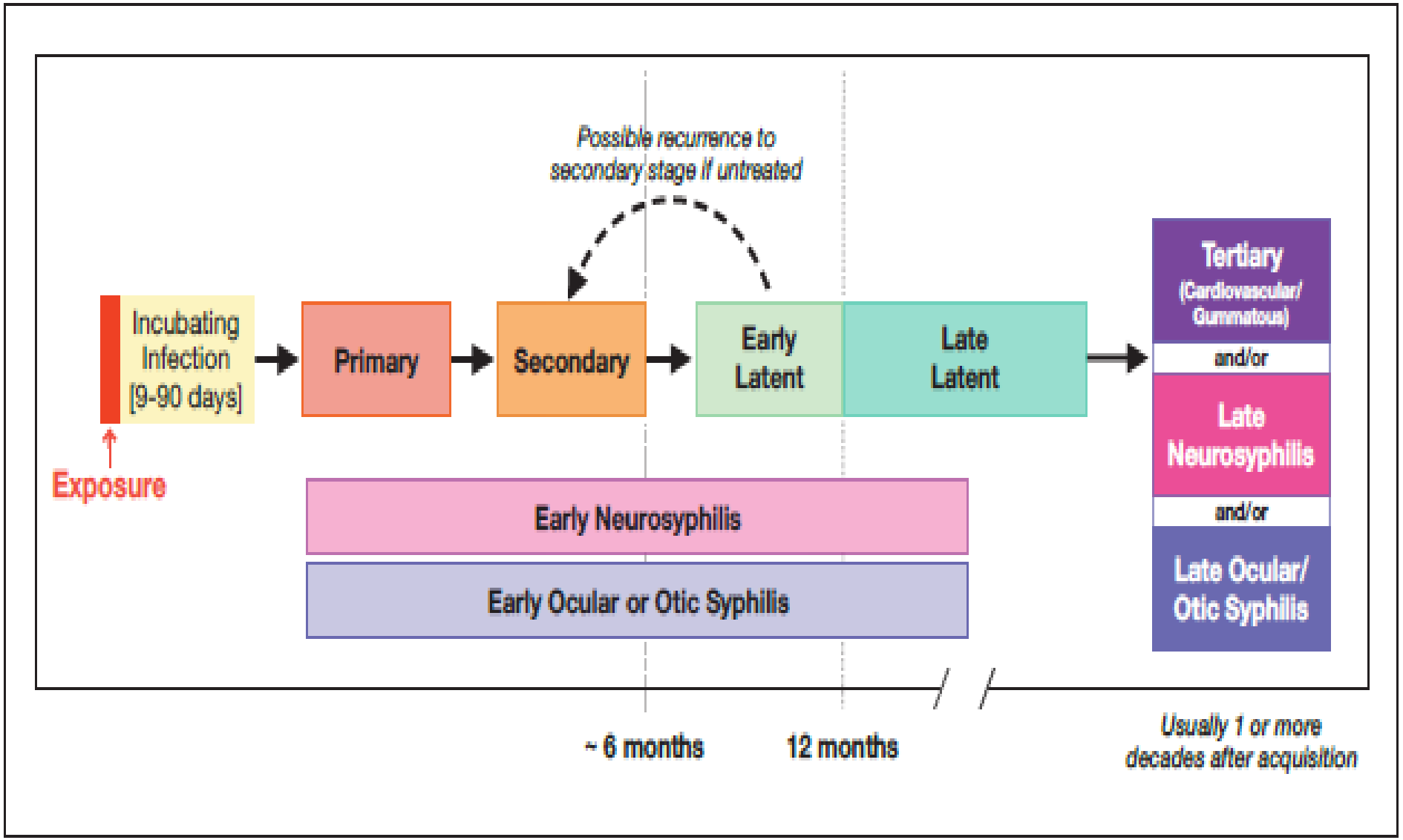


Syphilis Transmission

- Easy sexual transmission
  - Including oral, anal, vaginal
- Congenital transmission
  - Spontaneous abortion
  - Stillbirth
  - Neonatal infection
- Potential serious health sequelae
- Role in HIV transmission

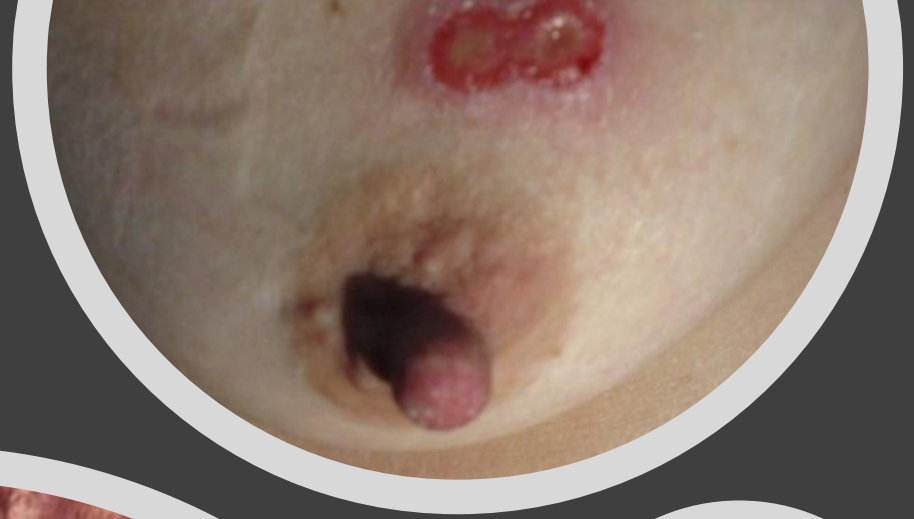
The Natural History of Syphilis

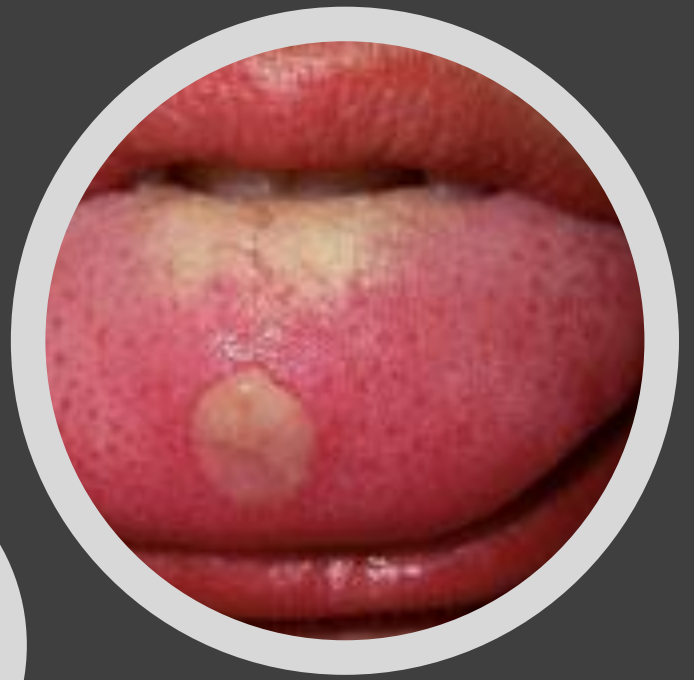


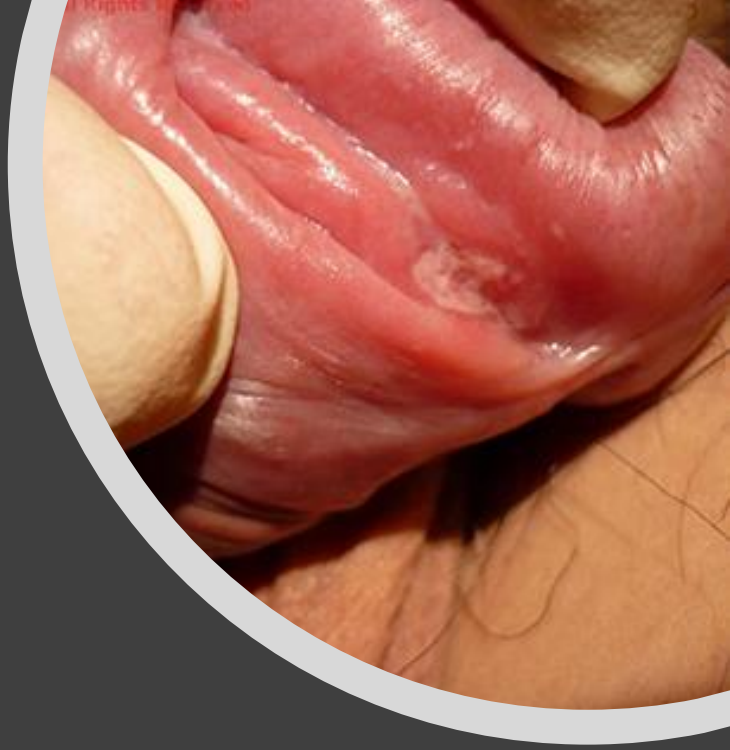
New York City Dept Health and Mental Hygiene; The Diagnosis and Management of Syphilis: An Update and Review March 2019 www.nycptc.org

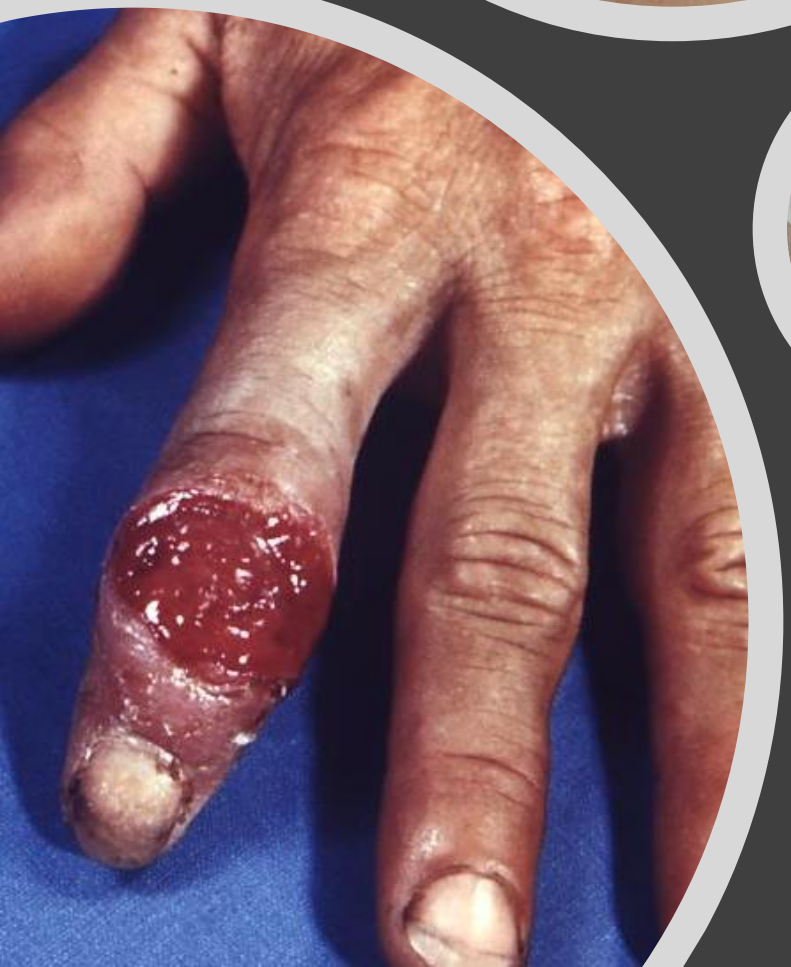
Primary Syphilis

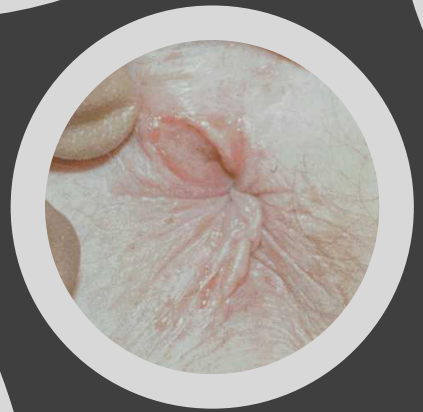
- Incubation 9-90 days (average 3 weeks)
- Primary lesion - chancre
- Early lesion is macule or papule that erodes
- Ulcer – clean base, painless, indurated with smooth firm borders
- Usually single but can have multiple lesions
- Unnoticed in 15-30% of patients
- Resolves in 1-5 weeks
- VERY INFECTIOUS
- Non-tender regional nodes

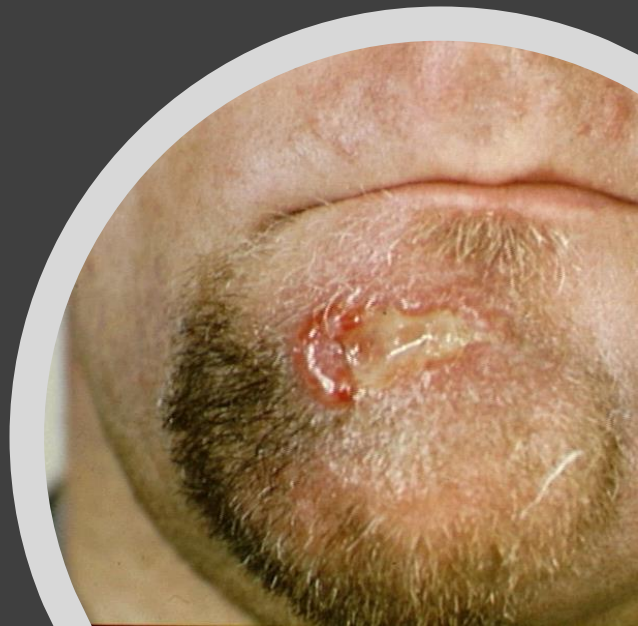








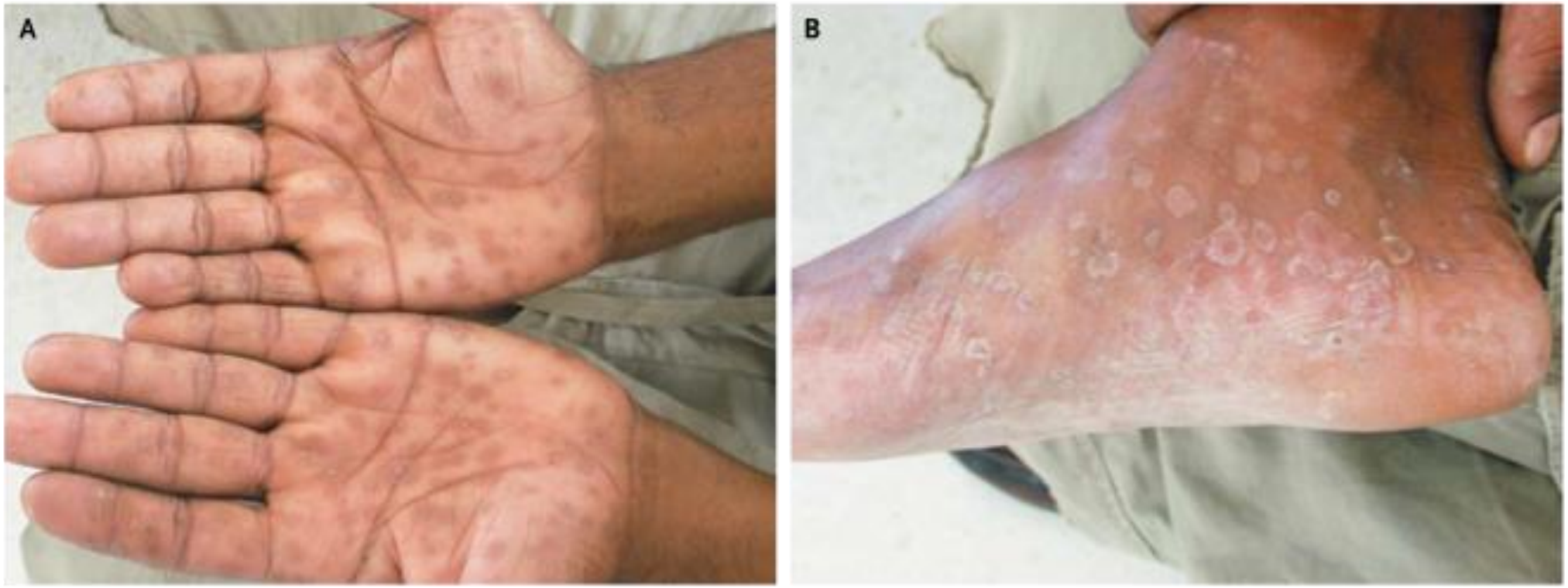




Lesions of Primary Syphilis

Secondary Syphilis

- 4-10 weeks after primary chancre (which may still be present), and may relapse for up to 2 years
- Fever, arthralgia, anorexia, malaise, lymphadenopathy
- Rash – lacy erythematous rash, classically maculopapularover trunk and abdomen. May involve palms & soles
- Condylomata lata (intertriginous areas), mucous patches (mouth)
- Alopecia
- Early neurosyphilis
  - headache, nausea, vomiting, meningism, neck stiffness, photophobia, hearing loss, tinnitus, cranial nerve palsies, uveitis
  - meningovascular – endarteritis causing thrombosis and infarction of cerebral tissue. Spinal cord vessels can also be affected resulting in spastic weakness (particularly lower extremities), sensory loss and muscular atrophy
- **Secondary syphilis mimics**



Secondary Syphilis

- Badri, T. and S. Ben Jennet (2011). "Images in clinical medicine. Rash associated with secondary syphilis." New England Journal of Medicine **364**(1): 71.

Syphilis: who to test

- Anyone seeking a checkup for STIs
  - If a checkup involves an HIV test, then you should include syphilis
  - People you might previously only have offered a chlamydia test
- Women who are pregnant or might become pregnant (new pregnancy guidelines)
- MSM: at least annually, up to 4 times a year.
- Aboriginal and Torres Strait Islander people
- Sex workers
- Anyone with a rash that you can’t immediately explain
- Anyone with any type of genital skin lesion
- Any sexually active person with a skin manifestation

Slides written by Dr Nicholas Medland, Sexual Health Physician Melbourne Sexual Health, 2018

Testing

Direct lesion based testing

- Dark field examination –limited/no availability
- Treponemal PCR

Serology

- RPR, VDRL – nonspecific reagin tests

Specific treponemal tests

- TPHA, TPPA
- Treponemal EIA – (screening assay sensitivity at the expense of specificity)
- FTA-Abs

POCT

- limitations

Syphilis Diagnosis

- Combination of history, clinical assessment and investigation results
- If serology is negative, repeat at 2 weeks if clinical suspicion of syphilis
- Only RPR testing in patient with previous syphilis is necessary due to positive EIA and TPPA for life
- If unsure please seek specialist advise to interpret syphilis results

Test	Site/Specimen	Consideration
Serology	Blood	Blood specimens are usually screened with an EIA, (although some labs still screen with TPPA or TPHA). If reactive, RPR and TPHA (or TPPA) performed as confirmatory testing.
NAAT	Swab of ulcer	Diagnosis may be confirmed by direct identification of *T. pallidum* from an ulcer. NAAT testing may be positive prior to seroconversion in very early cases.

EIA – Enzyme immunoassay

TPPA – Treponema pallidum Particle Agglutination Assay

TPHA – Treponema pallidum Hemaglutination Assay

RPR – Rapid plasma reagin

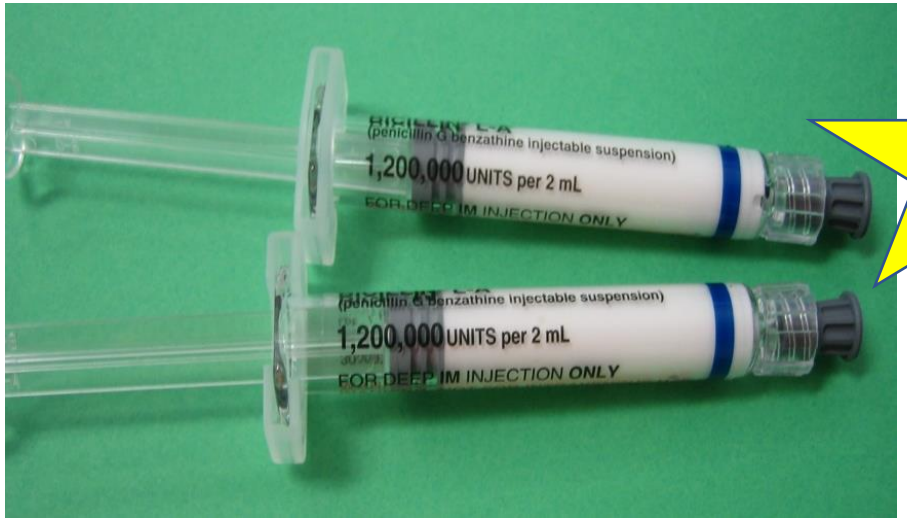
NAAT – Nucleic Acid Amplification Test

Interpreting syphilis serology

- Serology can be difficult to interpret
- Correlation with
  - History and examination
  - Epidemiology
  - Previous treatment and serology history
    - Patient
    - QSSS
  - Repeat serology

Treatment of uncomplicated syphilis

- Benzathine penicillin 2.4MU stat for primary and secondary syphilis (and for early latent syphilis)
- Benzathine penicillin 2.4MU weekly for 3 weeks for late latent syphilis
- Jarisch-Herxheimer reaction – common reaction occurring 6-12 hrs after treatment. Fever, headache, malaise, rigors, joint pains lasting several hours.



Response to treatment

- Fourfold drop in titre within 12 months – considered appropriate treatment response

Patient management & education

- No sexual contact for 7 days after treatment is administered
- No sex with partners from last 3 months (primary syphilis) or 6 months (secondary) until they are tested & treated if required
- Sexual partners are presumptively treated (regardless of serology)
- Patients without HIV need follow up including repeat RPR at 3 months, and then 6 & (if necessary) 12 months to measure response to treatment (?annually thereafter)
- Patients with HIV suggested follow up 3, 6, 9, 12 and 24 months serology
- Consider testing for HIV and other STIs at 3 months (if not performed at first visit or retesting post-window period

(Australian STI Management Guidelines http://www.sti.guidelines.org.au)

Queensland Syphilis Surveillance Service

(QSSS)

ph: 1800 032 238

QLD-Syphilis-Surveillance-Service@health.qld.gov.au

QUESTIONS?!

Common Challenges in Primary Care – Sexual Health Update

Contact Tracing

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An Australian Government Initiative

Metro North Health | Queensland Government

Contact Tracing/Partner Notification

Contact Tracing/Partner Notification is a cornerstone in the control of sexually transmissible infections and an essential part of clinical management for sexually transmissible infections

Public Health Units do not routinely contact trace for STI notifiable conditions

It is the responsibility of the diagnosing clinician or delegate to initiate contact tracing

Partner notification discussions should be done at consultation following initial diagnosis

Contact Tracing/Partner Notification

Process	• of informing someone that they may have been exposed to an STI or BBV, with the aim to:
Interrupt	• transmission of infection
Prevent & minimise	• complications
Identify and reach	• populations more at risk of infection than others
Reduce	• risk of re-infection/Prevent need for re-treatment

Contact Tracing Partner Notification

Set	Check in	Provide	Raise
Set The Scene:	Check in with patient – provide support for diagnosis	Provide health information on infection – • Transmission • Asymptomatic • Possible complications if left untreated or re-infected • Re-infection risk	Raise subject of contact tracing • Person centered approach not public health approach • Use open not closed questions

Contact Tracing/Partner Notification

Sexual history – opportunity to dispel myths

Sexual contacts in look back period	How to tell contacts and what to say	Online contact tracing websites
•Discuss a plan for each sexual partner individually	•Not a blame game	•Can be done by HCP/Individual

↓

Document contact tracing discussion and plan in patient's notes

Review at patient's follow up

↓

Follow up: review contact tracing, asses the risk of re-infection. Offer contact tracing assistance if deemed necessary/high-risk infections

Syphilis in pregnancy	Male with pregnant partner	Repeated infections

↓

Is there someone else in practice who can assist with contact tracing, discussion and follow up discussions?

Practice Nurse?	Indigenous Health Worker?

Contact Tracing Look back periods *'Australian STI Management Guidelines'*

Syphilis	• Primary Syphilis – 3 months plus onset of symptoms, TEST and TREAT • Secondary Syphilis – 6 months plus onset of symptoms,TEST and TREAT • Early Latent - 12 months TEST and TREAT • Late Latent – Regular partner only
Chlamydia	• 6 months, consider presumptive treatment if the sexual contact has been in the past 2 weeks or risk contact may not re-attend for treatment
Gonorrhoea	• 2 months, consider presumptive treatment if the sexual contact has been in the past 2 weeks or risk contact may not re-attend for treatment

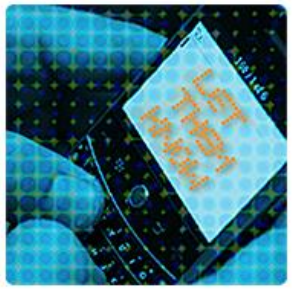
Ways to Let Them Know

Before you Send an SMS, email or a letter to your partner

Consider if this is really the best way to contact your partner. Remember, most people like to be told in person. Think whether anyone, apart from your partner, could read the SMS, email or letter. If yes, use an alternative method. You can send a message directly from this site from the choices below.

WARNING:

Please use this service for legitimate purpose and consider implications to the recipient. Under Australian law, the use of a telecommunication service to menace or harass is a criminal offence.



SMS someone

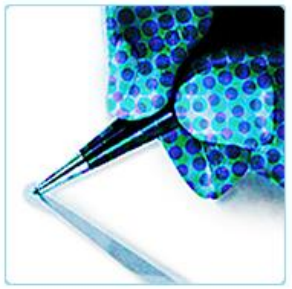
If you have their mobile number you can send an SMS right now.

Tell someone

Some suggestions and a video on how to talk to your partner.

Send an email

You can send an email from here if you have your partners email address.



Write a letter

Old school letter writing works as well right from here

LET THEM KNOW

Been diagnosed with an STI? We can send an email or SMS text message to let your sexual partner(s) know they may have been exposed and how to get tested.

You don't need to provide your name or contact details to use this free and confidential service.

WARNING

Use this service for legitimate purposes only and consider the implications to the recipient. Under Australian law, the use of a telecommunication service to menace or harass is a criminal offence.

Common Challenges in Primary Care – Sexual Health Update

Assessment and management of common STIs

Dr Eugene Priscott

Clinical Director

Sexual Health and HIV Service

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An Australian Government Initiative

Metro North Health | Queensland Government

Australian Sexually Transmitted Infection (STI) Management Guidelines For Use In Primary Care

- Evidence-based, up-to-date guidance targeted at use in primary care settings in Australia
- Major review of the guidelines was undertaken in 2020–22
- Main sections
  1. Standard asymptomatic check-up
  2. Sexual history
  3. Contact tracing
  4. STIs and infections associated with sex
  5. STI syndromes
  6. Populations and situations

australian STI MANAGEMENT GUIDELINES FOR USE IN PRIMARY CARE

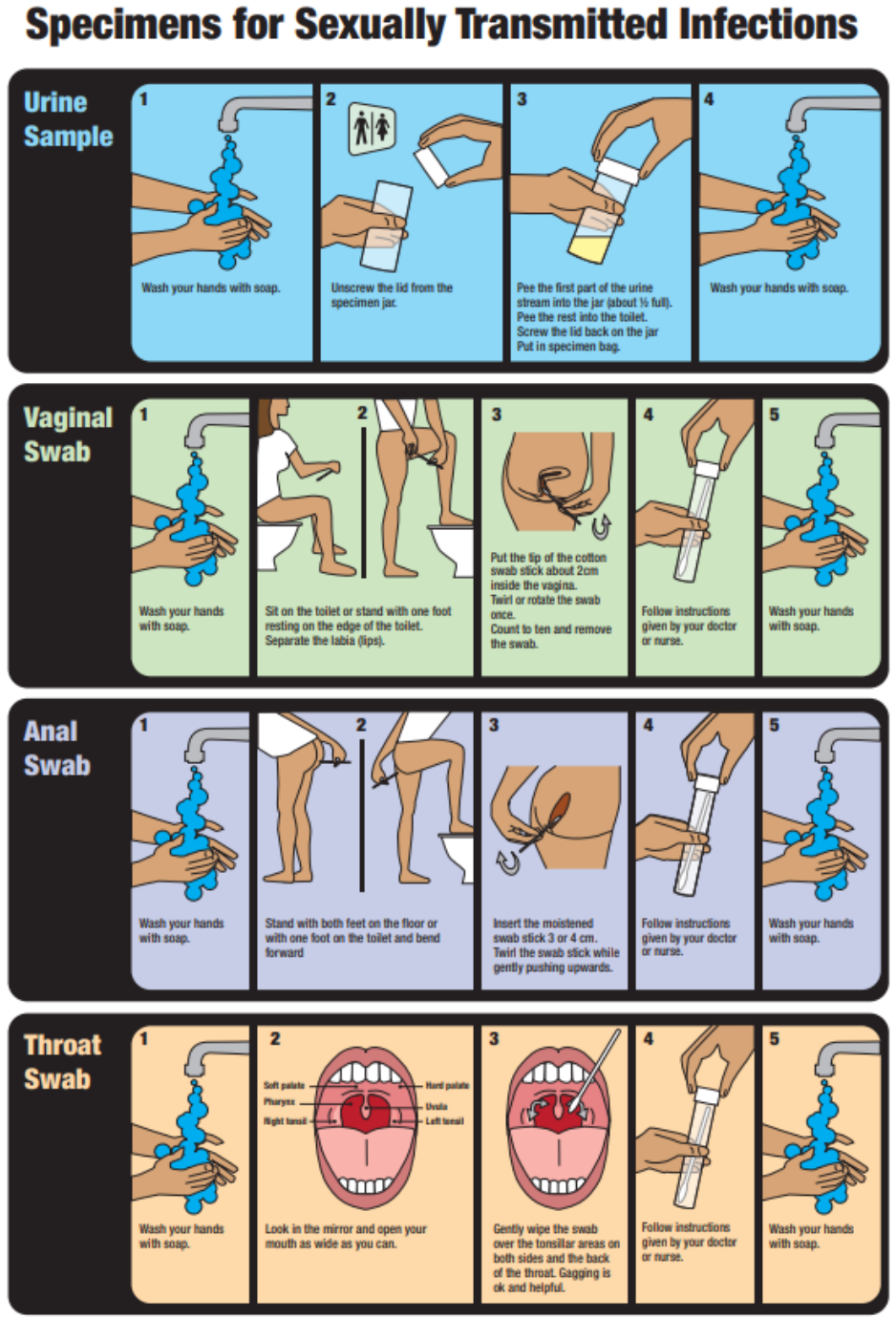
Standard asymptomatic check-up

Recommend STI screening for asymptomatic people who

- request STI testing
- are at increased risk of STIs
  - new sexual partner(s)
  - living in or travelling to areas of higher prevalence in Australia or internationally
- have a known exposure to any STI or history of an STI within the past 12 months
- are a member of, or have partner/s from priority sub-populations
  - Men who have sex with men (MSM)
  - sex workers
  - pregnant people
  - Aboriginal and Torres Strait Islander people
  - trans and gender diverse people

Significant changes

- Recommendation to test for HIV and syphilis whenever STI testing is indicated.



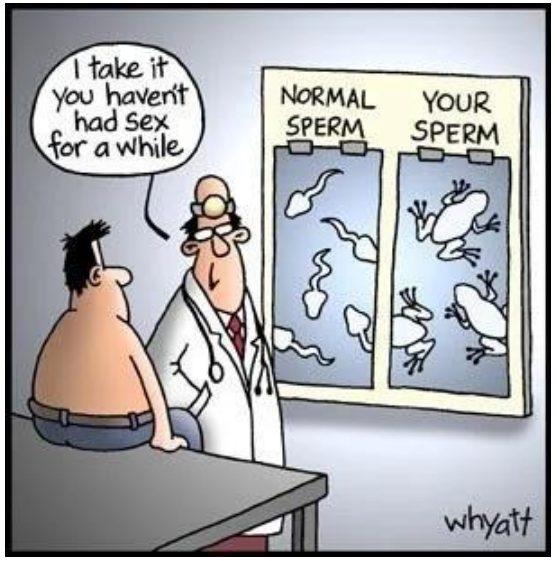
Sexual history

Starting the conversation about sexual health can involve using questions that

- Normalise
  - ‘We are offering STI testing to all sexually active people under the age of 30 as STIs are common and it’s important to treat early. Would you like a test while you’re here today?’

- Using a hook
  - ‘We are seeing a lot more syphilis and gonorrhoea in recent months. These STIs can be serious but they are easy to test for and treat Would you like a test today?

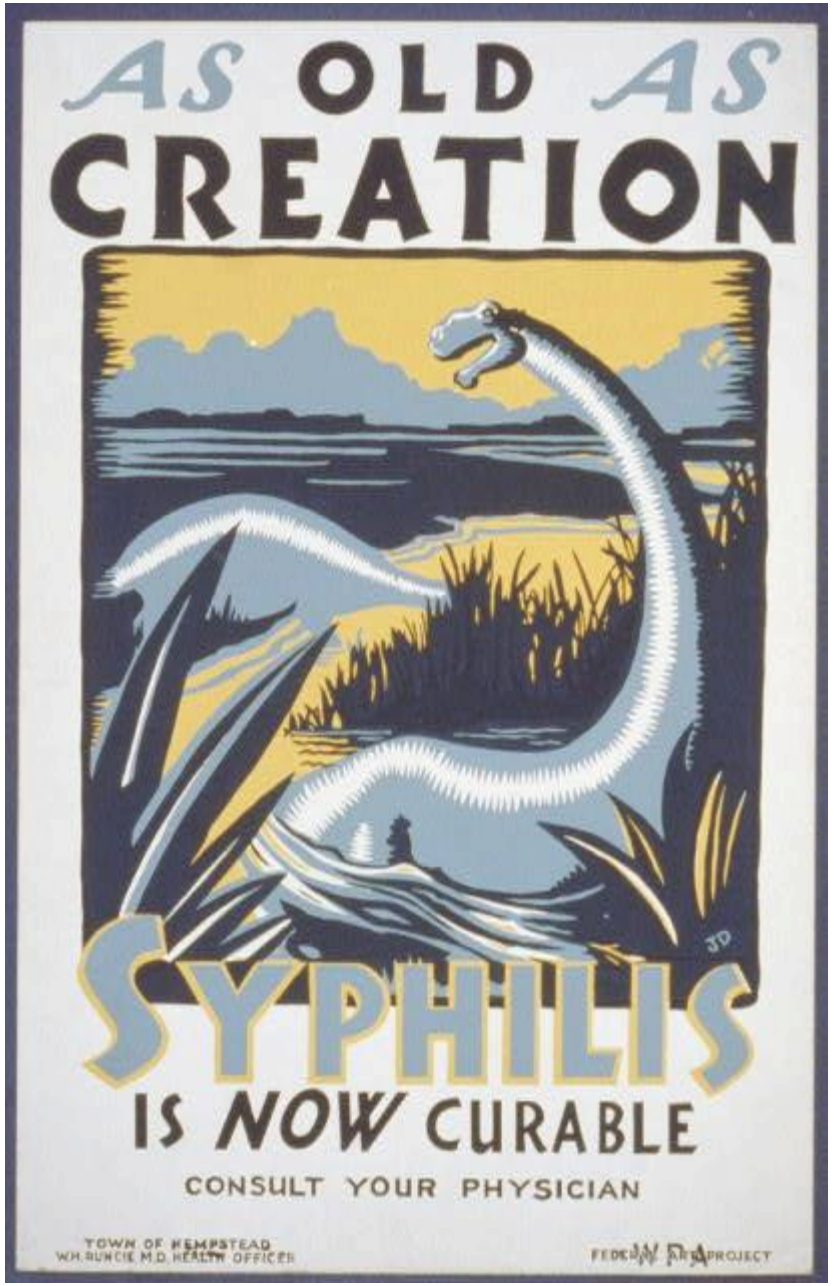
- Incorporating into existing discussions
  - ‘Since you’re here for a cervical screening test (or contraception), could we also talk about other aspects of sexual health?’



STIs and other infections associated with sex

Syphilis

- Ongoing syphilis epidemic throughout Australia
- Increasing infection rates in heterosexuals and during pregnancy
- Outbreaks in many remote areas
- Recommend testing for syphilis whenever STI testing is offered in all populations, with particular attention to
  - antenatal women and other pregnant people
  - test multiple times during pregnancy

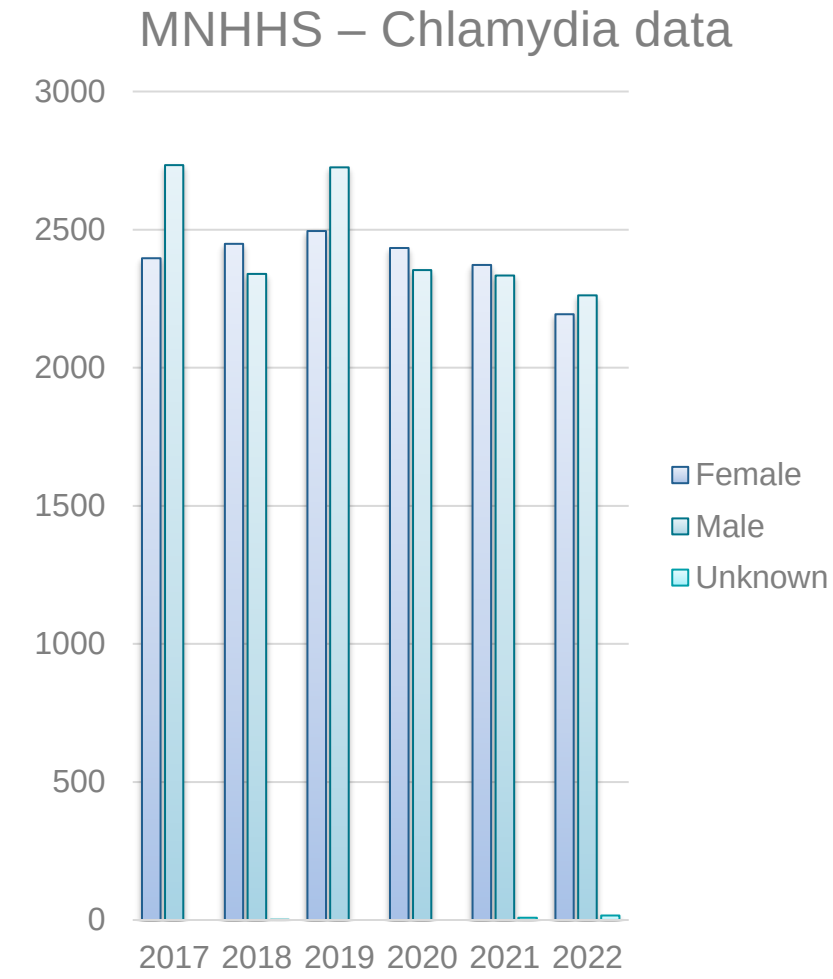


Chlamydia

- Doxycycline
  - Recommended treatment in all anatomical sites
  - Superior over azithromycin for treating anorectal chlamydia
  - Covers non-genital or untested sites
  - May be pre-treatment for concurrent M. genitalium

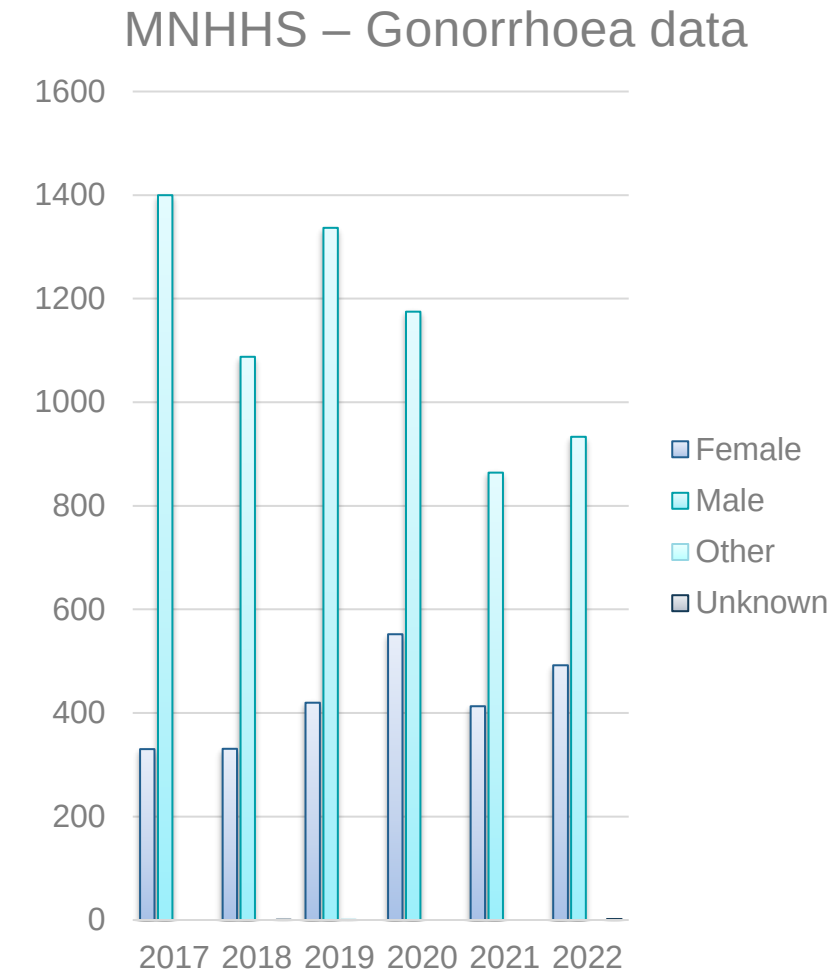
- Azithromycin
  - Alternative treatment
  - Effective when treating isolated genital chlamydia
  - Useful option in cases of suspected poor adherence
  - In anorectal infections
    - Azithromycin 1 g oral stat and repeat in 12–24 h
    - Test of cure after using azithromycin for anorectal infection

- Antibiotic stewardship
  - Immediate treatment not recommended for all sexual contacts
  - Offer testing of exposed anatomical sites instead and await results



Gonorrhoea

- Pharyngeal swabs (for NAAT/polymerase chain reaction)
  - All people with multiple sexual partners, including MSM and sex workers
- Anorectal swabs
  - For anyone who has had anal sex, and all MSM
- Gonococcal culture before antibiotics are administered
  - But treat without waiting for culture results
- Uncomplicated anogenital gonorrhoea
  - ceftriaxone 500 mg intramuscular stat plus
  - azithromycin 1 g oral stat
- Uncomplicated pharyngeal gonorrhoea,
  - ceftriaxone 500 mg intramuscular stat plus
  - azithromycin 2 g oral stat
  - Potential for increased gastrointestinal side effects with a 2 g dose
    - May be better tolerated if the dose is split: 1 g followed by 1 g 6–12 h later
- Ciprofloxacin 500 mg orally immediately can be used to treat gonorrhoea
  - Only if susceptibility has been confirmed on NAAT or culture, and this should not delay treatment



M. genitalium

- Test only symptomatic patients and asymptomatic ongoing sexual partners of index patients
- Avoids potential harms associated with screening asymptomatic populations by exacerbating antimicrobial resistance

- Principal treatment options

Situation	Recommended
M. genitalium infection known or suspected to be macrolide susceptible	Doxycycline 100mg twice a day for 7 days followed by Azithromycin 1g immediately, then 500mg daily for 3 days (total 2.5g)
M. genitalium infection known or suspected to be macrolide susceptible	Doxycycline 100mg twice a day for 7 days followed by Moxifloxacin 400mg daily for 7 days
Pelvic inflammatory disease due to M. genitalium	Moxifloxacin 400 mg daily for 14 days

In cases where moxifloxacin fails or cannot be used

- **Pristinamycin**
  - pristinamycin 1 g 3 times daily combined with doxycycline 100 mg twice daily for 10 days
  - cures 75% of macrolide-resistant infections
  - available through hospital pharmacies, using the Special Access Scheme of the Therapeutic Goods Administration (TGA)

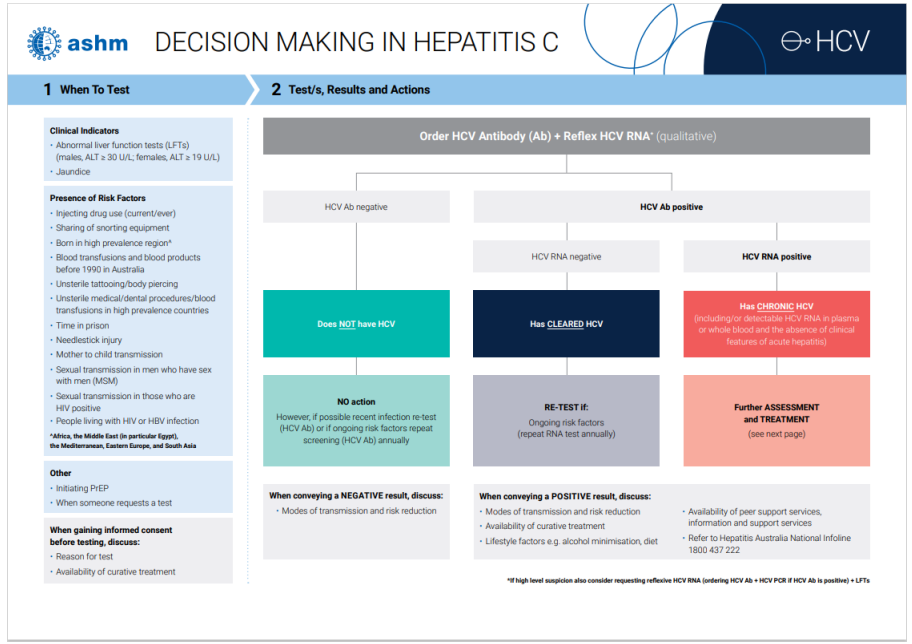
- **Minocycline**
  - minocycline 100 mg twice daily for 14 days
  - cures 70% of macrolide-resistant infections
  - available on private script

In cases who have failed all other available therapies

- **Sitafloxacin**
  - sitafloxacin 100 mg twice daily combined with doxycycline 100 mg twice daily for 7 days
  - > 90% efficacy
  - available through hospital pharmacies, using the Special Access Scheme of the TGA

Hepatitis C

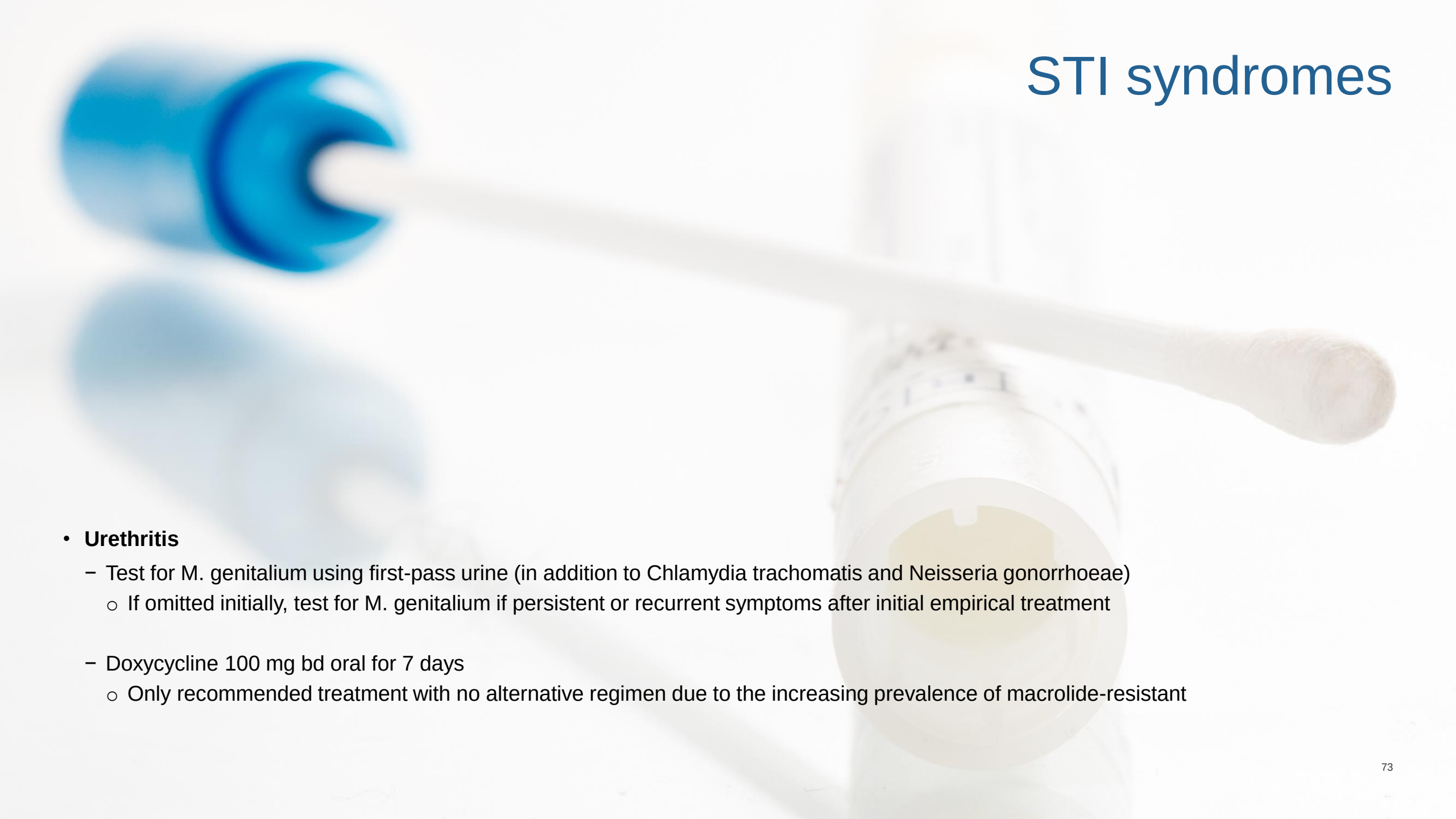
- Use pan-genotypic medicines
- HCV genotype no longer required for treatment
- Current injecting drug use must not be a barrier to starting treatment
- Easy to use clinical assessment tool
- Populations at risk include:
  - people with current or history of injecting drug use
  - people with a prison history
  - people born in HCV endemic countries and regions
  - people who received blood products before 1990 or in developing countries
  - people who engage in condomless anal sex with a partner with HCV infection
  - people who participate in group sex
  - and current HIV PrEP users



https://www.hepcguidelines.org.au/

Hepatitis C Virus Infection Consensus Statement Working Group. Australian recommendations for the management of hepatitis C virus infection: a consensus statement (2022). Melbourne: Gastroenterological Society of Australia, 2022.

STI syndromes



- **Urethritis**
  - Test for M. genitalium using first-pass urine (in addition to Chlamydia trachomatis and Neisseria gonorrhoeae)
    - If omitted initially, test for M. genitalium if persistent or recurrent symptoms after initial empirical treatment
  - Doxycycline 100 mg bd oral for 7 days
    - Only recommended treatment with no alternative regimen due to the increasing prevalence of macrolide-resistant

Population and situations

- **Aboriginal and Torres Strait Islander peoples**
  - The importance of culturally safe care is emphasised.
  - Practice tips are added to encourage greater uptake of relevant Medicare Benefits Schedule item numbers and the involvement of Aboriginal health workers where possible

- **Adult sexual assault**
  - Guidelines based on ‘time from assault’ framework as the assessment, management, and ongoing support will differ depending on how recently the assault occurred
    - The timeframes for when to conduct particular tests are outlined in ‘testing advice’
  - Routine post-exposure prophylaxis (PEP) for STIs no longer advised
  - PEP (after risk assessment) recommended for HIV, HBV and pregnancy
  - Ensure post-assault follow-up for testing rather than considering potential infection from the outset
  - Facilitate psychological support where necessary
  - Encourage patients to involve the police and/or sexual assault support services when appropriate

- **People in custodial settings**
  - May engage in sexual practices different from usual practices
  - May share drug injecting equipment due to lack of needle and syringe programs in prisons
  - All people in custodial settings should be offered screening for STIs and blood-borne viruses regularly throughout their incarceration period and after their release

Population and situations

- **People who use drugs**
  - Need for additional services and support
    - Prescribe naloxone for people who use opioids
    - Refer to harm reduction services such as needle-and-syringe programs (NSP)
    - Peer-based services
    - Drug and alcohol services
    - Offer HIV PrEP

- **Sex workers**
  - Recent changes in laws regarding sex work in some Australian jurisdictions. This section has also been updated to align with the information regarding laws and sexual health support available on the national peak Australian Sex Worker Association website.

Population and situations

- **Trans and gender diverse people**
  - Attention to anatomy and sexual practices, rather than gender, with respect to acquisition and sites of STIs
  - Guidelines removed references to gender diverse people using gender-affirming hormone therapy and/or undertaking gender-affirming surgery
    - Not all people who identify as trans and gender diverse are either ready, able to access, or want hormone therapy or surgery for their gender affirmation
    - it is also irrelevant to their STI testing and treatment
  - Take a careful and sensitive history regarding preferred anatomical terms and sexual practices/partners
  - Avoid assumptions
  - Discuss sexual practices and anatomy using words patients are comfortable with
  - Offer HIV PrEP to those who request or need it
  - Consider effective contraception that does not interfere with hormone treatment

References

1. Ong JJ et al. (2023) Sexual Health, 20(1), 1–8. Australian sexually transmitted infection (STI) management guidelines for use in primary care 2022 update. doi:10.1071/SH22134

2. The Australian Sexually Transmitted Infection (STI) Management Guidelines For Use In Primary Care. www.sti.guidelines.org.au

3. Hepatitis C Virus Infection Consensus Statement Working Group. Australian recommendations for the management of hepatitis C virus infection: a consensus statement (2022). Melbourne: Gastroenterological Society of Australia, 2022.

LET'S TREAT SYPHILIS

SYPHILIS

MAY HAVE NO SYMPTOMS

SYPHILIS IS CURABLE.

TEST EVERY 3 MONTHS.

Common Challenges in Primary Care – Sexual Health Update

HIV Prevention

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phn BRISBANE NORTH
An Australian Government Initiative

Metro North Health | Queensland Government

Learning Outcomes

- Understand HIV transmission
- HIV Prevention strategies
- Role of PrEP in reducing HIV transmission
- Initiating and monitoring a patient on PrEP
- Dosing of PrEP

HIV statistics

- 2021, estimated 27,390 living with HIV in Australia
- 2021 Australia HIV prevalence 0.14%
- 552 new cases HIV in 2021 (48 percent decline)
  - 378 (68% MSM), 148 (27%) heterosexual sex, 9 (2%) IVDU
- 2017 – 2021 vertical transmission rate 1.9%
  - 3 reported cases of vertical transmission (2 x 2018 and 1 x 2019)

HIV/ AIDS

HIV IS TRANSMITTED

Use of non-sterile syringes and tools

Pregnancy Breastfeeding

Blood Transfusion

Organ Transplant

Unprotected Sex

HIV IS NOT TRANSMITTED

Food, Drink, Utensils

Insect Bites

Kiss, Touch

Clothes, Towels

Toilet, Shower

UNAIDS targets - 2025

95% Of people within the sub-population who are living with **HIV know their HIV status.**

95% Of people within the sub-population who are living with HIV who know their HIV status are ***on antiretroviral therapy.***

95% Of people within the sub-population who are on antiretroviral therapy have **suppressed viral loads.**

- Children (aged 0-14 years)
- Adolescent girls and young women (aged 15-24 years)
- Adolescent boys and young men (aged 15-24 years)
- Adult women (aged 25 years and older)
- Adult men (aged 25 years and older)
- Gay men and other men who have sex with men
- Transgender people
- Sex workers
- People who inject drugs
- People in prisons and other closed settings
- People on the move (migrants, refugees, IDPs, etc)

2030 | Ending the AIDS epidemic

UNAIDS

HIV prevention

- Pre Exposure Prophylaxis (PrEP)
- Post Exposure Prophylaxis (PEP)
- Treatment AS Prevention (TASP)
- Undetectable = untransmittable (U=U)

What is undetectable?

- Globally <50 copies/mL
- U=U <200 copies/mL

Pre Exposure Prophylaxis (PrEP)

- Tenofovir and emtricitabine co-formulated
- Standard care in clinical guidelines
- Highly effective with high adherence (daily or on-demand)
  - On demand now recommended for MSM by WHO

Patient access to PrEP

- PBS
- Online
  - $42.50 for 90 tablets + $10 postage
  - $6.80 for 90 tablets with free shipping – concession card
- Private script (non-Medicare)
- Therapeutic Goods Administration's Personal Importation Scheme
  - Green cross pharmacy
  - PrEP access now (www.pan.org.au)

ASHM PrEP Decision Making Tool

PRESCRIBING HIV PRE-EXPOSURE PROPHYLAXIS (PrEP) IN AUSTRALIA

ashm

1 BEHAVIOURAL SUITABILITY

Patient requests PrEP

Proceed to Step 2

OR

Patient unsure whether to start PrEP
or
HIV risk identified during consultation

Refer to HIV risks listed overleaf (Table 1)

- HIV risk → **Proceed to Step 2**
- Low or no HIV risk → **Consider PrEP** (e.g. if likely future risk)

Discuss alternative HIV risk reduction methods.

2 CLINICAL SUITABILITY

Note: Steps 1, 2, 3 & 4 are usually completed at the same visit

Confirm HIV status and review medical history including renal function

HIV Negative
(ideally within the last 7 days but for people who cannot easily access HIV testing, within the past 4 weeks)

Assess clinically for acute HIV infection (e.g. fever, night sweats, fatigue, myalgia, arthralgia, rash, headache, pharyngitis, generalised lymphadenopathy, diarrhoea)

Confirm renal function shows that eGFR is >60 mls/min

Exclude use of nephrotoxic medication (e.g. high-dose NSAIDS) or medications that interact with PrEP
www.hiv-druginteractions.org

Proceed to Step 3

HIV Negative
But recent HIV exposure (within 72 hours)

Immediately seek advice on the need for 3-drug nPEP from nPEP hotline on 1800 737 669. If 2-drug nPEP is recommended, prescribe PrEP **with advice for immediate start.**

Plan to commence PrEP upon completion of nPEP course.

Repeat Step 2

HIV Positive

Not for PrEP

Refer to an HIV prescriber (see below)

Clinician resources when making a new HIV diagnosis
www.ashm.org.au/HIV/prevention-testing-and-diagnosis/making-new-diagnosis
List of HIV prescribers: www.ashm.org.au/HIV/HIV-prescribers

3 OTHER TESTING

Assess for STIs and viral hepatitis

STI testing as per the Australian STI Management Guidelines
www.sti.guidelines.org.au

Hepatitis B serology (HBsAg, Anti-HBs,Anti-HBc)
Vaccinate if not immune
If HBsAg+ve, refer to HBV specialist
www.ashm.org.au/hbv-prescriber-locator

Hepatitis C serology (anti-HCV; followed by HCV RNA if anti-HCV +ve)
If HCV RNA+ve, then treat.
www.ashm.org.au/hcvdecisionmaking

Proceed to Step 4

4 PRESCRIBING PrEP

Daily continuous PrEP

Suitable for anyone with an ongoing risk of HIV.

1 pill daily of Tenofovir Disoproxil + Emtricitabine 300/200. Start 7 days before HIV risk exposure.

Proceed to Step 5

OR

On-demand PrEP† (2-1-1 method)

Suitable only for cis-gender men who have sex with men who do not have hepatitis B and whose HIV risk is from anal sex rather than injecting drug use. For info on effectiveness, see full ASHM guidelines.

tenofovir/emtricitabine:
- 2 pills at least 2h before sex (up to 24h before sex)
- 1 pill 24h later
- 1 pill 48h after first dose

If repeated sexual activity, then continue with 1 pill daily until 48h after last sexual contact.

Proceed to Step 5

5 ONGOING MONITORING

Ongoing monitoring
See Table 2 (overleaf)

&

Patient education
Discuss how PrEP works, frequency, missed dose protocol, continued condom use.
See Box 1 (overleaf)

Notes on prescribing PrEP:
- Prescribe: Tenofovir Disoproxil 300mg + Emtricitabine 200mg (coformulated); 1 tablet daily, Qty 30, Rpt 2.
- PrEP can be initially prescribed on the same day as a HIV test. Patient to be advised to commence PrEP within 7 days of their HIV test.
- PrEP is PBS-listed for patients who have either (i) a negative HIV test result no older than 4 weeks, (ii) evidence that an HIV test has been conducted, but the result is still forthcoming
- PBS Restricted Benefit
- Patients not eligible for PBS subsidised PrEP can be assisted to import PrEP under the TGA's self importation scheme, on a private prescription – www.pan.org.au

† *The Therapeutic Goods Administration (TGA) has not approved this regimen in Australia.*

For more information about PrEP: www.ashm.org.au/HIV/PrEP

TABLE 1: HIV RISK

Men who have sex with men (MSM)	Trans & gender diverse people	Heterosexual people	People who inject drugs
• Receptive CLI with any casual male partner. • Rectal gonorrhoea, rectal chlamydia or infectious syphilis. • Methamphetamine use. • CLI with a regular HIV+ partner who is not on treatment and/or has a detectable viral load.	• Receptive CLI with any casual male partner. • Rectal or vaginal gonorrhoea, chlamydia or infectious syphilis. • Methamphetamine use. • CLI with a regular HIV+ partner who is not on treatment and/or has a detectable viral load.	• Receptive CLI with any casual MSM partner. • A woman in a serodiscordant heterosexual relationship, who is planning natural conception in the next 3 months. • CLI with a regular HIV+ partner who is not on treatment and/or has a detectable viral load.	Shared injecting equipment with an HIV+ individual or with MSM of unknown HIV status.

- If a partner is known to be living with HIV, on antiretroviral treatment and has an undetectable viral load, then there is no risk of HIV transmission from this partner.
- The risks listed above confer a **risk of HIV**, and hence should prompt a clinician to recommend that a patient start PrEP. However, this list is not exhaustive, and patients who do not report these circumstances may still benefit from PrEP.
- A person is considered to be at risk if they had these risks in the previous 3 months, or if they foresee these risks in the upcoming 3 months.

CLI: Condomless intercourse; **MSM:** Men who have sex with men.

BOX 1: PATIENT EDUCATION

- Discuss the role of condoms to prevent STIs, and emphasize role of regular STI testing.
- Discuss safer injecting practices, if applicable.
- Discuss PrEP adherence at every visit.
- Ongoing monitoring every 3 months is required.
- Discuss potential side effects, early (e.g. headache, nausea) and longer term (e.g. renal toxicity, lowered bone density).
- Ask about nephrotoxic medications, eg NSAIDs.

STOPPING PrEP:

- Only cis-gender men who have sex with men (MSM) taking daily or on-demand PrEP† can stop 48 hours after last exposure.
- Non-MSM patients on daily PrEP should continue PrEP for 28 days after last exposure.
- Patients who stop PrEP need a plan to re-start PrEP if their HIV risk increases again.

TABLE 2: LABORATORY EVALUATION AND CLINICAL FOLLOW-UP OF INDIVIDUALS WHO ARE PRESCRIBED PrEP

Test	Baseline (Week 0)	About day 30 after initiating PrEP (optional but recommended in some jurisdictions)	90 days after initiating PrEP	Every subsequent 90 days on PrEP	Other frequency
HIV testing and assessment for signs or symptoms of acute infection	✓	✓	✓	✓	✗
Assess side effects	✗	✓	✓	✓	✗
Hepatitis A serology Vaccinate if non-immune	✓	✗	✗	✗	✗
Hepatitis B serology Vaccinate if non-immune	✓	✗	✗	✗	✓ If patient required hepatitis B vaccine at baseline, confirm immune response to vaccination 1 month after last vaccine dose
Hepatitis C serology	✓	✗	✗	✗	✓ 12 monthly but, more frequently if ongoing risk e.g. non-sterile injection drug use and MSM with sexual practices that pre-dispose to anal trauma
STI (i.e. syphilis, gonorrhoea, chlamydia) as per Australian STI Management Guidelines *	✓	✗	✓	✓	✗
eGFR at 3 months and then every 6 months	✓	✗	✓	✗	✓ At least every 6 months or according to risk of CKD
Urine protein creatinine ratio (PCR) baseline	✓	✗	✓	✗	✓ Every 6 months
Pregnancy test (for women of child-bearing age)	✓	✗	✓	✓	✗

CKD: chronic kidney disease; **eGFR:** estimated glomerular filtration rate; **PrEP:** pre-exposure prophylaxis; **PWID:** people who inject drugs; **STI:** sexually transmissible infection

* http://www.sti.guidelines.org.au/

† *The Therapeutic Goods Administration (TGA) has not approved this regimen in Australia.*

Electronic version downloadable from: www.ashm.org.au/resources

 ISBN: 978-1-920773-77-9

Initiation of PrEP

- As per decision making tool
- Rule out chronic hepatitis B
  - Offer vaccination if not immune
- BBV screening – HIV, syphilis, hepatitis A and hepatitis C
- STI screening
- Baseline kidney function
  - eGFR, Cr, urine protein creatinine ratio
- Able to conceive – urine pregnancy test

Monitoring of PrEP

- 3 monthly STI and BBV screening
- 6 monthly kidney function - eGFR, urine protein creatinine ratio

- Hepatitis C – 12 monthly or more frequent if ongoing risk
- If non immune Hepatitis B at baseline to confirm immunity 1 month post last dose according to Australian Immunisation Handbook vaccination schedule

How to take PrEP

- Daily (women, MSM, transmen, transwomen)
  - Taken daily effective after 7 days
  - Can do ‘quick start’ as per on-demand (MSM only)

- On-demand (MSM only)
  - 2-1-1
  - 2 tablets minimum 2 hours prior to unprotected sexual intercourse (2-24hrs prior) then
  - Daily until 48 hours after last unprotected sexual intercourse

Stopping PrEP

- MSM – cis-gender men
  - PrEP can be ceased as early as 48 hours (2 doses) post last unprotected sexual intercourse)
- Non-cis men are required to continue to take PrEP for 28 days post last exposure

- All patients who stop PrEP require a plan to restart if HIV risk increases again

Clinical points

- Kidney function decline
  - Rule out other causes
  - Could consider on-demand depending on how sexually active the patient is and ability to adhere
  - Tenofovir alafenamide and emtricitabine
  - Cease PrEP and use barrier methods for HIV prevention
- Creatine use in patients
- Telehealth Medicare item numbers

Resources

- ASHM-National-PrEP-Guidelines.pdf (prepguidelines.com.au)
- PrEP – ASHM
- ASHM_National_PrEP_Tool.pdf (prepguidelines.com.au)

This communique is for clinicians involved in HIV, who may be consulted about HIV Pre-Exposure Prophylaxis (PrEP). It assumes an understanding of HIV prophylaxis.

Australian PrEP Clinical Guidelines	New Zealand PrEP Clinical Guidelines	HIV Resources	HIV PrEP Training	PrEP Provider Locator

PBS Changes to PrEP Prescribing

ASHM's submission to the Pharmaceutical Benefits Advisory Committee to change the PBS criteria for prescribing PrEP has been successful.