Summary of 2006 United Kingdom National Guideline on the Sexual Health of People with HIV: Sexually Transmitted Infections

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Scope and purpose

• To support people with Human Immunodeficiency Virus (HIV) to enjoy good sexual health for their own personal well-being, as well as to help clinicians to provide treatment and care for people with HIV and to prevent onward transmission of the virus and sexual infections.
• Target population: adults infected with HIV.

The full guideline is available on the BASHH website *(www.bashh.org/guidelines/ceguidelines)*. This summary document lists the key recommendations with relevant page numbers. The full document considers onward HIV transmission and legal & ethical issues. This guideline also updates the previously published 2002 clinical standards for the screening and management of acquired syphilis in HIV-positive adults (US National Guideline Clearinghouse: NGC 2666 (www,guideline.gov). The 3 monthly syphilis serology testing recommendation remains.

Management of Sexually Transmitted Infections in people with HIV

1. Further high quality studies to provide evidence-based approaches to sexual health issues for HIV-positive people in the era of effective antiretroviral therapy are required. *(Page 3)*

2. All HIV service providers should be able to provide ready access to staff trained in taking a sexual history and who can make an appropriate sexual health assessment.
(Evidence level III, B). *(Page 4)*

3. A sexual health assessment including a sexual history should be documented at first presentation and at 6 monthly intervals for all HIV-positive people receiving long-term care. A full sexual health screen (including annual cytology in women) should be offered (regardless of reported history) and the outcome documented in the HIV case notes (Evidence level IIb, B). Syphilis serology should be incorporated into the routine HIV blood set and checked at 3 monthly clinic visits to detect asymptomatic cases (Evidence level IIb, B). *(Page 5)*

4. There should be documented local care pathways for diagnosis, treatment and partner work for sexually transmitted infections in people with HIV which can be actively communicated to all members of clinic staff and to HIV-positive people. (Evidence level IIb, B). *(Page 6)*

5. The majority of sexually transmitted infections in people with HIV including gonorrhoea and Chlamydial infection can be managed the same as in people without HIV (Evidence level IIb, B). STIs should be considered in the differential diagnosis of presentations such as skin rash or proctitis in HIV+ people. *(Page 7)*

Management of syphilis in people with HIV

6. Primary or secondary syphilis can be treated with 2 doses of intramuscular Benzathine Penicillin G one week apart in HIV-positive people who are not profoundly immunosuppressed and in whom adequate follow-up can be maintained to detect relapses. (Evidence level Ib, A). *(Page 8)*

Management of genital herpes in people with HIV

7. First episode genital herpes in HIV-positive people should be treated with aciclovir 400 mg five times daily for 7-10 days. Alternative oral regimens include valaciclovir 1 gram twice daily for 10 days or famciclovir 250-750 mg x3/day for 10 days. (Evidence level IIb, B). In severe cases, initiating therapy with aciclovir 5-10 mg/kg body weight IV every 8 hours may be necessary. (Evidence level IV, C). *(Page 10)*

8. Aciclovir, famciclovir and valaciclovir can all be used as episodic herpes therapy in people with HIV (PWHIV) (Evidence level Ib, A). Famciclovir 500 mg twice daily for 7 days is as effective as aciclovir 400 mg five times daily for 7 days (Evidence level Ib, A). Valaciclovir 1 g twice daily for 5 days is no less effective than aciclovir five times daily for 5 days (Evidence level Ib, A). *(Page 11).* There is no clear evidence of superiority for any of the above regimens.

9. If lesions persist or recur in a PWHIV receiving herpes antiviral therapy, herpes resistance should be suspected and a viral isolate should be obtained for sensitivity testing (Evidence level Ib, A). *(Page 11)*

10. Both topical 1% foscarnet cream and 1% cidofovir gel have been shown to produce significant benefits in lesion healing, pain reduction and virological effect in drug resistant herpes in PWHIV (Evidence level Ib, A). There is limited evidence to support the use of topical trifluorothymidine alone or in combination with interferon-alpha (Evidence level IIb, B). *(Page 12)*

11. Systemic therapy with either foscarnet or cidofovir is preferred to treat drug resistant herpes in those with HIV. There is evidence for foscarnet 40 mg/kg IV daily (Evidence level Ib, A) and cidofovir 5 mg/kg body weight weekly IV infusion for 2 weeks (Evidence level IV). *(Page 12)*

Management of genital human papilloma virus (HPV) infection in people with HIV

12. HIV infected women should undergo annual cervical cytology (Evidence level IV, C). Treatment of low grade CIN should be considered, particularly in women with low CD4 cell counts, in view of the risk of disease progression (Evidence level IV, C). *(Page 13)*

13. After full explanation, proctoscopy should be performed in people with HIV who are found to have ano-genital warts and any atypical lesions should be biopsied and sent for histological examination. The role of anal cytology as a screening method is not yet known. (Evidence level IV, C). *(Page 14)*

14. Imiquimod 5% cream can be used as a topical treatment for genital warts, however comparative studies have not been performed. Surgical methods of wart removal may be used at an earlier stage of disease management compared to immunocompetent patients (Evidence level IV, C). *(Page 14)*

Key auditable outcome measures

A. Local outcome: Percentage of PWHIV with a documented sexual history in the HIV casenotes within 4 weeks of initial HIV diagnosis. This can be in 4 weeks before or after the first HIV-positive test (Audit target = 100%).
B. Local outcome: Percentage of PWHIV with documented offer of sexual health screen in HIV casenotes including syphilis serology within previous 6 months (Audit target = 100%).
C. Local outcome: Percentage of HIV+ women with cytology result in HIV casenotes taken within previous year. Cytology can be performed at settings outside HIV clinic (Audit target = 95%).
D. National or regional outcome: Percentage of service providers who can provide documentation of local care pathways for sexually transmitted infections in PWHIV (Audit target = 100%).