

The Manual for Sexual Health Advisers

Society of Sexual Health Advisers (SSHA)
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Section B

Managing sexual infections

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Patient recall

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Triage

Ethical issues in triage

Sexually transmitted infections

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The sexual health adviser needs to possess an excellent knowledge of the infections dealt with in Genitourinary Medicine (GUM) clinics. With this they help people make informed choices for themselves and their sexual partners.

INTRODUCTION

This chapter is a brief introduction to some of the infections and conditions dealt with in Departments of GUM and Sexual Health. Detailed information can be found in the medical literature and it is vital that health advisers keep up to date with current research findings published in professional journals.

National UK guidelines on the management of sexual infections exist and are important documents that offer a practice framework to assist health advisers in their work.¹

The recommendations for partner notification (*Grade C*) in each condition are outlined and summarised in table 8.6. In general it should be noted that:

- Some conditions merit the offer of a ‘provider referral’ (for definition see Ch.1 Partner notification - introduction). In such circumstances where diagnosis is made in a non-GUM setting, clear and written referral pathways to a community or clinic health adviser are recommended
- Timely treatment of sexual partners is essential for decreasing the risk for re-infecting the index patient
- Patients will require instruction to avoid sexual intercourse until therapy is successfully completed (+/- test of cure) and they and their sexual partners no longer have symptoms. In the case of chronic conditions such as genital warts this may not be desirable or practical

TERMINOLOGY

Some commonly used terms and acronyms need defining:

Sexually transmitted infection (STI) - An unqualified use of the term ‘genital infections’ can be misleading since infection of the rectum, throat, and conjunctiva of the eye are also common, but initial infection of other parts of the body is rare.

Sexually transmitted disease (STD) - The term ‘disease’ is more archaic and holds social connotations that for some can be distressing. As such in the UK the STD acronym has largely fallen out of favour.

Sexually transmissible - Describes infections and conditions that could be passed on through intimate sexual contact but can also be present independent of sexual activity such as candida, scabies, molluscum contagiosum.

Venereal diseases (VD) - A term initially given to syphilis and gonorrhoea, which were once thought to be a single disease. It emphasises the part played by sex in the spread of diseases that would not otherwise be considered as a single group. These two infections along with chancroid constitute the legally defined venereal diseases in British law.²

EPIDEMIOLOGICAL TRENDS

Not only has there been a doubling of attendances at GUM clinics over the 10 year period between 1990 and 2000 but there is an upward trend in reported cases of STIs. Between 1995 and 2000, new episodes seen at GUM clinics in England, Wales & Northern Ireland rose from 887,760 to 1,185,285.³

Table 8.1

<i>Major groups of sexually transmitted and transmissible conditions⁴</i>	
Bacteria	Responsible for gonorrhoea, including gonococcal pelvic inflammatory disease (PID), syphilis.
Mycoplasmas and chlamydiae	These are bacteria but they do not have rigid cell walls - mycoplasmas can be responsible for non-gonococcal urethritis (including chlamydial) and cervicitis. <i>Chlamydia trachomatis</i> is primarily responsible for chlamydial PID.
Viruses	The smallest known disease-causing agents - important viral STIs include hepatitis B, and C, genital herpes, molluscum contagiosum, human papilloma virus (HPV-genital warts), and the human immunodeficiency virus/acquired immune deficiency syndrome (HIV/AIDS).
Fungi	Plant-like organisms - causing candidiasis (thrush).
Protozoa	Single-celled microscopic forms of animal life - responsible for trichomoniasis.
Metazoan	All other parasitic animal life forms - causing scabies and pediculosis pubis (pubic lice or ‘crabs’).

Gonorrhoea⁵

Between 1995 and 2000, uncomplicated gonorrhoea seen at GUM clinics in England, Wales & Northern Ireland increased by 102% (29% since 1999). In women, highest rates of gonorrhoea are in those aged 16 to 19 years and, in 2000, 41% of females with gonorrhoea were aged under 20. In males, highest rates are in 20 to 24 year olds.⁶

The organism *Neisseria gonorrhoeae*. Gram-negative diplococcus

Infection sites Primary- Mucous membranes of the urethra, endocervix, rectum, pharynx. More rarely- blood, skin, joints and conjunctiva

Transmission Direct inoculation of secretions from one mucous membrane to another, therefore very easily passed on through vaginal, anal and oral sex. Sometimes it only takes close physical contact to spread. There is no evidence to show that it can be passed on from toilet seats or sharing towels and cups. An infected mother can pass it on to her baby's eyes at birth. It can be spread to the eyes from the genitals via the fingers

Infection to detection period Symptoms of infection may show up at anytime between 1 and 14 days

Table 8.2

<i>Signs & Symptoms</i>	
<i>Women</i>	<i>Men</i>
Infection is frequently asymptomatic (up to 50%). Increased or altered vaginal discharge is the most common symptom (up to 50%). Lower abdominal pain may be present (up to 25%). Urethral infection may cause dysuria (12%) but not frequency. Gonorrhoea is a rare cause of intermenstrual bleeding or menorrhagia. Pharyngeal infection is usually asymptomatic (>90%).	Urethral infection commonly causes urethral discharge (80%) and/or dysuria (50%). Infection can be asymptomatic (<10%). Rectal infection in homosexual men may cause anal discharge (12%) or perianal/anal pain or discomfort (7%). Pharyngeal infection is usually asymptomatic (>90%).

Complications Spread from the urethra or endocervix to involve the epididymis and prostate in men (1% or less) and the endometrium and pelvic organs in women (probably <10%). Dissemination may also occur from infected mucous membranes, resulting in skin lesions, arthralgia, arthritis and tenosynovitis. Disseminated gonococcal infection is uncommon (<1%)

PARTNER NOTIFICATION RECOMMENDATIONS

- Patients are to be encouraged to refer sexual partners and contacts for evaluation and treatment. Offer provider referral

- Sexual contacts are to be screened and treated for gonorrhoea and chlamydia infections using the following criteria applying to the index case;
 - a. For men with urethral symptoms, two weeks before onset of symptoms
 - b. For men without symptoms and all women, twelve weeks prior to diagnosis at urethra, cervix, rectum, throat
 - c. If a patient's last sexual intercourse was greater than eight weeks before onset of symptoms or diagnosis, the patient's most recent sex partner is to be treated

Chlamydia ⁷

Between 1995 and 2000, Genital chlamydial infection seen at GUM clinics in England, Wales & Northern Ireland increased by 107% (18% since 1999). Highest rates of diagnosis are seen in young people, particularly women in the 16 to 19 and 20 to 24 year age groups.⁸

The organism *Chlamydia trachomatis* is an intracellular pathogen. Types D-K are found in genital infection henceforth referred to as 'chlamydia'

Infection sites Urethra, cervix, rectum, pharynx, conjunctiva

Transmission Principally through vaginal intercourse. Can be through anal and orogenital contact. Vertical transmission to baby during delivery

Infection to detection period 1 to 3 weeks after exposure

Table 8.3

<i>Signs & Symptoms</i>	
<i>Women</i>	<i>Men</i>
Asymptomatic in approximately 80%. Post coital or intermenstrual bleeding. Lower abdominal pain. Purulent vaginal discharge. Mucopurulent cervicitis and/or contact bleeding.	Asymptomatic in up to 50%. Urethral discharge. Dysuria. The severity of these is variable and may be so mild as to be unnoticed by the patient.
RECTAL INFECTIONS Usually asymptomatic, but may cause anal discharge and anorectal discomfort (proctitis).	
PHARYNGEAL INFECTIONS These are usually asymptomatic though a sore throat can be reported.	

Complications

- Pelvic inflammatory disease
- Fitz-Hugh-Curtis syndrome (perihepatitis)
- Tubal damage (infertility, ectopic pregnancy)
- Chronic pelvic pain (adhesions)
- Transmission to neonate (conjunctivitis, pneumonia)
- Epididymo-orchitis

- Adult conjunctivitis
- Sexually acquired reactive arthritis/Reiter's syndrome (commoner in men)
- Facilitates HIV transmission

PARTNER NOTIFICATION RECOMMENDATIONS

- Patients are to be encouraged to refer sexual partners and contacts for evaluation and treatment. Offer provider referral
- Sexual contacts are to be screened and treated for chlamydia infections using the following criteria:
 - 4 weeks prior to the onset of symptoms in men
 - 6 months, or until the last previous sexual partner (whichever is the longer time period) for all women and asymptomatic men
 - A policy of current partner and previous one (1 + 1) can be applied to chlamydia infections

Syphilis^{9 10 11}

Following nearly two decades of consistent decline in England, numbers and rates of infectious syphilis have been steadily increasing since 1997.¹² Between 1995 and 2000, infectious syphilis seen at GUM clinics in England, Wales & Northern Ireland increased by 145% (57% since 1999). Unlike most other STIs, the burden of syphilis does not fall upon young people. Rates have increased sharply in males aged 20 to 44 years old and in females aged 16 to 34 years old.¹³

The organism *Treponema pallidum*. A systemic disease

Classification Syphilis is classified as acquired or congenital

- Acquired syphilis is divided into:
 - Early** (primary, secondary and early latent. Less than 2 years of infection)
 - Late** (late latent. Greater than 2 years)
 - Tertiary** including gummatous, cardiovascular and neurological involvement

The latter two are also sometimes classified as quaternary syphilis

- Congenital syphilis is divided into:
 - Early** (first 2 years)
 - Late** (including stigmata of congenital syphilis)

Transmission Sexual transmission occurs only when mucocutaneous syphilitic lesions are present. However 46-60 % of contactable sexual partners of patients and pregnant women with early syphilis also have the infection

Incubation period Up to 90 days

<i>Signs & Symptoms</i>
Primary syphilis
Ulcer.
Chancres. Classically single, painless and indurated with a clean base discharging clear serum in the anogenital region. However they may be atypical and present as multiple, painful, purulent, destructive and extragenital. It may also result in a syphilitic balanitis.
Regional lymphadenopathy.
Secondary Syphilis
Multisystemic involvement within the first two years of infection. Generalised polymorphic rash often affecting the palms and soles. It is classically non-itchy but may be itchy, particularly in dark-skinned patients. Condylomata lata, mucocutaneous lesions, generalized lymphadenopathy. Less commonly, patchy alopecia, anterior uveitis, meningitis, cranial nerve palsies, hepatitis, splenomegaly, periosteitis and glomerulonephritis.
Tertiary Syphilis
Cardiac, neurologic, ophthalmic, auditory, or gummatous lesions.

PARTNER NOTIFICATION RECOMMENDATIONS

- Patients are to be encouraged to refer sexual partners and contacts for evaluation and treatment. Offer provider referral
- Transmission is uncommon after the first year of infection. However, persons exposed sexually to a patient who has syphilis in any stage needs to be evaluated
- The time periods for identifying at-risk sex partners are:
 - 3 months plus duration of symptoms for primary syphilis
 - 2 years for secondary syphilis and early latent syphilis

Non-specific urethritis (NSU) ¹⁴

Cases of uncomplicated non-specific infection seen at GUM clinics in England, Wales & Northern Ireland from 1990 to 1999 have remained fairly stable. 58,528 in 1999. ¹⁵

The causes

- *Chlamydia* (30-50% of cases)
- *Ureaplasma urealyticum* (ureaplasmas) and *Mycoplasma genitalium* (10-20% of cases respectively)
- *Trichomonas vaginalis* has been reported in 1-17% cases
- *N. meningitidis*, *herpes simplex* virus, *candida albicans*, bacterial urinary tract infection, urethral stricture and foreign bodies probably account for only a small proportion of cases (<10%)
- A possible association with bacterial vaginosis exists
- Between 20-30% of men with NSU have no organism detected. Urethral stricture, mechanical trauma and foreign bodies may play a small part

Signs & symptoms Urethral discharge, dysuria, penile irritation, asymptomatic

Complications Epididymo-orchitis, sexually acquired reactive arthritis / reiter's syndrome. These are infrequent, occurring in fewer than 1% of cases though incomplete forms may be more common

PARTNER NOTIFICATION RECOMMENDATIONS

NSU may play a role in the 40-60% of cases PID where the cause is unknown. Patients are to be encouraged to refer sexual contacts for evaluation and treatment. Provider referral may be offered.

Sexual contacts are to be screened and treated for uncomplicated chlamydia infection using the following criteria:

- 4 weeks prior to the onset of symptoms in men
- 6 months, or until the last previous sexual partner (whichever is the longer time period) for asymptomatic men
- Ideally, contacts details ought to be obtained at the first visit along with consent to contact either the patient or his partners if tests for chlamydia or gonorrhoea are found to be positive. This will greatly facilitate partner notification

Trichomonas ¹⁶

Between 1990 and 1999, trichomoniasis in men seen at GUM clinics in England, Wales & Northern Ireland has doubled but remained fairly static in women.¹⁷

The organism Trichomoniasis is caused by the protozoan *Trichomonas vaginalis*

Infection sites Only isolated in the genital area. Vagina in women and urethra in men (most common)

Transmission Almost exclusively sexually transmitted. Male to female (and vice versa), female to female. Male to male (very rare due to site specificity)

Incubation period 5 to 28 days

Table 8.5

Signs & Symptoms	
<i>Women</i>	<i>Men</i>
10 - 50% are asymptomatic. The commonest symptoms include vaginal discharge (varying thickness, sometimes frothy, often yellow-green), vulval itching, dysuria, or offensive odour. Occasionally the presenting complaint is of low abdominal discomfort. 2% have a strawberry cervix.	15 to 50% do not have symptoms of infection. They often present as sexual partners of infected women. Commonest presentation is with urethral discharge and/or dysuria. Other symptoms include urethral irritation and frequency.

Complications Vaginal trichomoniasis might be associated with adverse pregnancy outcomes, particularly premature rupture of the membranes and preterm delivery. Rarely there may be prostatitis. It may enhance HIV transmission.

PARTNER NOTIFICATION RECOMMENDATIONS

Patients are to be encouraged to refer current sexual contacts for evaluation and treatment.

Chancroid¹⁸

The agent: *Haemophilus ducreyi*. Rarely diagnosed in the UK (less than 100 cases per year) though it is endemic in parts of the developing world, particularly sub-Saharan Africa and Asia

Infection sites Primarily found on prepuce of penis / coronal sulcus and the vaginal introitus

Transmission Skin to skin sexual contact

Incubation period 3 to 10 days

Signs & symptoms

- Painful (more so in men) ulcer (single or multiple) at inoculation site with indistinct borders
- Multiple lesions can merge
- Purulent exudate often observed. Vaginal discharge
- Painful intercourse and defaecation
- Tender inguinal lymph nodes (often unilateral). Can swell, rupture to release purulent material

Complications Tissue loss leading to scarring. Phimosis. Facilitates HIV transmission

PARTNER NOTIFICATION RECOMMENDATIONS

- Both patient and provider referral methods are to be encouraged
- Trace all partners ten days prior to onset of symptoms

Genital Warts¹⁹

Anogenital warts are the commonest STI diagnosed in GUM clinics. 66,044 new diagnoses being made in England, Wales and Northern Ireland in 2000. For males and females, highest rates are found in the 20 to 24 and 16 to 24 year age groups respectively.²⁰

Cause Human papilloma virus. More than 20 have been detected in the genital area. Types 6 & 11 are the most common form of visible genital warts. 99% are sub clinical and therefore go undetected

Infection sites Cervix, vagina, labia, vulva, scrotum, urethral meatus, anus, penile shaft and glans

Transmission Overwhelmingly via sexual contact. Mother to baby during delivery. More rare by fomites and digits

Signs & symptoms

- Single or multiple spots
- Soft or keratinised. Broad based or pimple
- Usually painless but some itching possible

Complications Types 16,18,31,33,& 35 have been associated with cervical dysplasia. Disfiguring. Psychological distress

PARTNER NOTIFICATION RECOMMENDATIONS

- Not routinely offered. No evidence exists that this reduces transmission or prevents re-infection
- Screening current partners for other STIs may however be beneficial

Pubic Lice (Pediculosis pubis)²¹

Between 1993 and 1999, 19% (men) and 13% (women) increases respectively were seen for infestations of scabies and pubic lice at GUM clinics in England, Wales & Northern Ireland.²²

Cause An ectoparasitic infestation with the 'crab' louse, *Phthirus pubis*

Infection sites Course body hair, predominantly pubic, rarely eyebrows and eyelashes

Transmission Close body contact

Signs and symptoms

- Lice and/or eggs (nits) glued to hair
- Pruritis leads to itching as a result of hypersensitivity to feeding lice. This may take several weeks to develop
- Macules (blue) may develop

Complications Nil of note

PARTNER NOTIFICATION RECOMMENDATIONS

Patient referral for partners over the preceding 3 months

Scabies²³

Between 1993 and 1999, 19% (men) and 13% (women) increases respectively were seen for infestations of scabies and pubic lice at GUM clinics in England, Wales & Northern Ireland.²⁴

Cause An ectoparasitic infestation with the *Sarcoptes scabiei* mite. The female burrows into the skin laying 2 to 3 eggs per day which take about 10 days to turn into adult mites

Infection sites Many are found on the hands and wrists but can be found almost anywhere on the body especially in skin creases

Signs & symptoms Itching (especially at night) and raw broken skin (lesions) and lumps (nodules) may occur though this may be weeks after the initial contact. This results from the sensitisation to mite excrement. Silvery lines (burrows) may be observed

Complications Crusted lesions in HIV infection can be observed and contain many mites

PARTNER NOTIFICATION RECOMMENDATIONS

Patient referral for partners over preceding 2 months

Genital Herpes²⁵

From 1990 to 1999 diagnoses of first attack genital herpes simplex virus infection seen at GUM clinics in England, Wales & Northern Ireland increased by 52% in females but remained relatively stable in males.²⁶

Cause *Herpes Simplex virus* type 1 or 2

Infection sites Genital and perianal region (including buttocks and thighs) and mouth. More rarely on nipples and other parts of skin

Transmission Almost exclusively through skin to skin contact. Only scant evidence of spread via fomites

Incubation period Commonly between 2 and 10 days

Signs & symptoms No typical presentation therefore it is often misdiagnosed. Wide-ranging primary occurrence symptoms include:

- Tingling, itching and burning sensations
- Blistering and ulceration of genital and/or perianal region
- Urethral, vaginal discharge and dysuria
- Systemic involvement causing pyrexia, fever and myalgia

Complications Autonomic nervous system involvement leading to urinary retention and meningitis. Neonatal infection rare but carries a high mortality rate and damage to brain, skin and eyes

PARTNER NOTIFICATION RECOMMENDATIONS

- Not routinely offered due to limited therapeutic clinical intervention
- May be beneficial for health education or psychological support

Molluscum Contagiosum²⁷

Between 1995 and 1999 a 66% increase in males and 81% in females with molluscum were seen at GUM clinics in England, Wales & Northern Ireland.²⁸

Cause A species of molluscipoxvirus

Infection sites Skin lesions anywhere on the body. Principally in genital area through sexual contact

Transmission Direct contact or from non-living reservoirs (fomites), such as books or clothing

Incubation period 3 to 12 weeks

Signs & symptoms Distinctive lesions. Can be pearly, popular, smooth, or indurated. Usually less than 5mm in diameter

Complications Can be unsightly and therefore cause psychological distress. Secondary infection can result

PARTNER NOTIFICATION IMPLICATIONS

- None

Viral Hepatitis²⁹ - Type A

The incidence is grossly under estimated. In 1999 notifications of hepatitis A totaled 1676 compared to 1515 in 1998.³⁰

Cause An RNA strand virus

Infection sites Systemic infection initially involving liver

Transmission Most common route of transmission is faecal-oral by contaminated food or water. Sexual transmission is more common in gay men where 'rimming' or 'fisting' is involved. It is also more likely in multiple sexual partners, group sex and 'cottaging'. Outbreaks have been reported in injecting drug users. Viraemia in acute infection is rare but can facilitate bloodborne transmission. No evidence exists that saliva is involved in transmission

Incubation period 15 to 45 days

Signs & symptoms

- Approximately 50% of adults are asymptomatic
- Can begin with malaise, myalgia, fatigue and upper right quadrant abdominal pain in prodromal phase lasting 3 to 10 days

- Jaundice can follow in the later icteric phase with associated anorexia, nausea and fatigue for 1 to 3 weeks though can persist for 3 months

Complications Chronic liver infection is very rare. It carries an overall mortality rate of 0.2%. Miscarriage and premature labour have been reported

PARTNER NOTIFICATION RECOMMENDATIONS

- Patient or provider referral offered to male homosexual contacts (oro/anal, digital/rectal and penetrative anal sex) from 2 weeks before to 1 week after onset of jaundice
- At risk non sexual contacts (household contacts, those at risk from food/water contamination) referred to Public Health Authorities/Health Protection Agency

Viral Hepatitis - Type B

Notifications of hepatitis B infection increased from 886 in 1998 and 864 in 1999 to a total of 1035 cases in 2000. Of the notifications in 2000, 636 (61%) were in males and 393. (38%) were in females.³¹

Cause A DNA strand virus

Infection sites Systemic infection initially involving liver

Transmission

- Sexual transmission responsible for the majority of cases
- More common in unvaccinated gay men and sex workers (see Hep A)
- It can also be spread though parenteral and vertical routes

Incubation period 40-160 days

Signs & symptoms Up to 50% of adults may be asymptomatic in the acute phase. After this the symptoms are very similar to Hep A infection though often last longer and more pronounced

Complications

- Chronic infection may exist in up to 10% of cases and may lead to severe liver disease
- Death can result in 1% of acute presentations often results in the premature death of 50% of chronic carriers
- Miscarriage and premature delivery is more common in infected pregnant mothers

PARTNER NOTIFICATION RECOMMENDATIONS

- Patient and provider referral offered to any sexual contact (penetrative vaginal or anal sex) or needle sharing partners from 2 weeks prior to onset of jaundice until blood tests are surface antigen negative

- Risk assessment informs partner notification for asymptomatic cases
- Arrange screening for hepatitis B of children who have been born to infectious women if the child was not vaccinated at birth
- Other non-sexual contacts thought to be at risk: refer to Public Health Authorities/ Health Protection Agency

Viral Hepatitis - Type C

Laboratory reports of hepatitis C infection have increased each year throughout the 1990s. In 1999 there was a total of 5745 confirmed laboratory reports compared to 4483 in 1998.³²

Cause An RNA virus

Infection sites Systemic infection initially involving the liver.

Transmission

- Unidentified route in many cases
- Parenteral spread through sharing injecting equipment and pre-screening test blood/products transfusions
- Sexual transmission low. Estimated less than 2% per year of year relationship. Up to 11% reported infected in long-term relationships. This increases if HIV co-exists. Seen more in HIV positive gay men and sex workers
- Vertical transmission rarely reported

Incubation period 90% infected are antigen positive after 3 months. Up to 9-month seroconversion period reported

Signs & symptoms Up to 80% asymptomatic. Early stages are similar to Hep A. Chronic cases similar to Hep B

Complications Acute fulminant hepatitis is rare except with Hep A co-infection. 50-85% become chronic carriers. These are usually asymptomatic in the absence of liver disease and high levels of alcohol intake. Pregnancy – as for Hep A

PARTNER NOTIFICATION RECOMMENDATIONS

- Patient and provider referral offered for any sexual contact (penetrative vaginal or anal sex) or needle sharing partners during period of infectivity - 2 weeks prior to onset of jaundice
- Risk assessment informs partner notification for asymptomatic cases
- Consider testing children born to infectious women
- Other non-sexual contacts thought to be at risk: refer to Public Health Authorities/Health Protection Agency

Numbers of heterosexually acquired HIV infections diagnosed in the UK have risen steadily over the last 15 years and since 1999 have been greater than the number acquired through sex between men. However, cumulatively the majority of infections have occurred through sex between men and homosexual men remain the group at greatest risk of acquiring HIV infection within the UK.³⁴

Cause Human Immunodeficiency Virus

Infection sites Multi-system disease due to a depleted immune system eventually causes Acquired Immune Deficiency Syndrome (AIDS)

Transmission Unprotected sex, blood to blood contact and vertical spread

Incubation period Seroconversion to form detectable levels of antibodies usually takes 45 days. Three months is thought adequate in UK testing centres. Extremely unlikely to occur after this

Signs & symptoms Seroconversion can be accompanied by transient sore throat, fever, rash. Rarely meningitis observed. Asymptomatic infection can last for years prior to an AIDS defining diagnosis

Complications Opportunistic infections and tumours with wide ranging symptoms

PARTNER NOTIFICATION RECOMMENDATIONS

- Patient and provider referral offered for partners (sexual and drug equipment sharing)
- Look back period depends on risk assessment and previous testing results

CONCLUSION

It is imperative that the health adviser is fully conversant with the range of conditions that may present at the GUM clinic. Short and long term effects on sexual health will vary considerably across the infections and indeed between patients. A summary of partner notification action per infection is presented in Table 8.6

Table 8.6

<i>Infection</i>	<i>Partner Notification Method</i>		<i>Trace period s = symptomatic as = asymptomatic</i>
	<i>'Patient'</i>	<i>'Provider'</i>	
Syphilis (early)	Yes	Yes	12 weeks (primary). Up to 2 years (secondary, early latent).
Syphilis (late)	Yes	Yes	Vertical transmission possible 10 years post infection. Symptoms of: Gummata – 2 years Cardiovascular – 10 years Neurological – 15 years

Gonorrhoea	Yes	Yes	2 weeks (s) males. 12 weeks (as) males and all females or last partner if longer.
Chlamydia	Yes	Yes	4 weeks (s). 6 months (females and as) or last partner if longer. 1 + 1 partner.
'NSU'	Yes	Possibly	4 weeks (s). 6 months (as) or last partner if longer.
Chancroid	Yes	Yes	10 days prior to onset.
Trichomoniasis	Yes	No	Current partner.
Scabies	Yes	No	8 weeks.
Pubic lice	Yes	No	12 weeks.
Genital Herpes	No	No	No
Genital Warts	Yes	No	Screen current partners.
Molluscum	No	No	No
HIV	Yes	Yes	Risk assessment informs partner notification for asymptomatic cases.
Hepatitis A	Yes	Yes	2 weeks prior and 1 week after onset of jaundice. Risk assess others.
Hepatitis B	Yes	Yes	2 weeks prior to onset of jaundice and until sAg negative. Risk assess others.
Hepatitis C	Yes	Yes	2 weeks prior to onset of jaundice. Risk assessment for asymptomatic cases.
HIV	Yes	Yes	Depends on a thorough risk assessment and previous testing results.

A good knowledge of these infections will assist in the partner notification implications that arise for the vast majority.

FURTHER READING - USEFUL INTERNATIONAL SOURCES

USA Guidelines

Sexually Transmitted Diseases Treatment Guidelines. 2002 Recommendations and Reports May 10, 2002 / Vol. 51 / No. RR-6 Centers for Disease Control and Prevention
<http://www.cdc.gov/std/treatment/rr5106.pdf> (Accessed 10th Nov 2002)

World Health Organisation

Global Prevalence and Incidence of Selected Curable Sexually Transmitted Infections: Overview and Estimates. WHO/CDS/CSR/EDC/2001.10 <http://www.who.int/emc-documents/STIs/docs/whoedcsredc200110.pdf> (Accessed 10th November 2002)

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Patient recall

KATHRYN LEE

Effective management of a recall system for patients with a sexually transmitted infection will ensure that the infection is treated as soon as possible. This will prevent further medical complications and reduce the risks of transmission and re-infection.

INTRODUCTION

The aim of this chapter is to act as guidance in the recall of patients requiring treatment, further screening or medical follow up. These guidelines are not exhaustive but allow the health adviser to work to nationally agreed standards and provide quality patient care. Recall cannot be prescriptive, but requires the health adviser to exercise his/her judgment. It is also important to acknowledge that health advisers may be guided by local protocols, as responsibilities will vary within individual teams. Discuss uncertainties with a consultant, who is ultimately responsible for medico-legal decisions about care.

THE AIMS OF RECALL

Effective recall management plays an important role in streamlining the services provided by a clinic. Responsibility usually lies with the health adviser to recall patients for:

- Antibiotic treatment
- Diagnosis discussion
- Test of cure
- Repeat screen following incubation period
- Hepatitis vaccine and post vaccine serology
- Cytology
- Colposcopy
- Partner notification

RECALL FOR TREATMENT

The aim of the recall of patients with a sexually transmitted infection is to treat the infection as soon as possible in order to:

- Prevent further medical complications
- Reduce the risk of transmission
- Reduce the risk of re-infection to the index patient and partners

Clinics need locally agreed protocols for the management of positive results. These protocols will ensure that the health adviser is made aware of any positive results requiring action as soon as the results are returned to the clinic.

GENERAL INFORMATION ON CONTACTING PATIENTS

The best method of contacting individuals is best established at their first appointment. Patients should be prepared for the possible need for correspondence and asked how they would prefer to be contacted. The agreed address, telephone numbers (both landline and mobile) or e-mail address is to be recorded. Patients wishing to be contacted by telephone are to be asked whether it is also possible to write to them: this is helpful in case a mobile phone becomes unobtainable.

Document if patients less than 16 years of age can be contacted via a social worker, school nurse, youth worker or adult relative. For patients who don't speak English, permission may need to be sought for the interpreter to contact them by telephone, in which case these details ought to be recorded in the case notes. Prior to contacting a patient it is worth checking to see if they have an appointment booked. Unless urgent action is required it may be appropriate to wait until they attend.

No action is to be taken until the notes have been assessed. It is important to take into consideration the patients living arrangements and relationship(s), as the method of recall chosen could potentially breach confidentiality.

MOBILE PHONES

Mobile telephones can be extremely useful and are recommended as the first line approach for recall. This is often the quickest and most effective way of contacting patients (it is essential that these details be obtained when the patient is registered at the clinic). This method of recall often allows a greater degree of independence and privacy and gives the health adviser opportunity to contact a patient during the working day without potentially breaching confidentiality at home. Mobile phones can be especially useful when recalling young people as the autonomy they allow reduces the risk of parental interception.

TELEPHONE CALLS

Management of phone calls

- Telephone numbers that have not been supplied by the patient can often be obtained from:
 - BT directory enquiries

- The hospital Patient Administration System (PAS)
 - Internet services, such as 192.com
 - The general practitioner (GP)
 - The referring agency - for example, the family planning service
- If the patient has not specified which phone number to use, check the occupation and home circumstances to assess whether home or work is more appropriate to call. If it is necessary to leave a message on an answer phone, then be discreet: leave only a first name and a telephone number.
 - Consider the gender and age of the person: ideally the health adviser making the phone call is the team member who is least likely to arouse suspicion if a partner or parent intercepts the message.
 - Think about which telephone number you leave, it may be better not to give the reception number in case someone else rings back and learns of the patient's attendance at the clinic. An ex-directory line in the health adviser's office is an essential resource to protect confidentiality. Staff answering this particular phone ought never disclose its location and answering machine messages on this line are to be discreet.
 - Brief colleagues if you are expecting a patient to call: an alphabetical index file of expected callers, kept by the ex-directory phone, is a useful system for large teams.
 - Always check the persons' date of birth and confirm the date they attended before disclosing any information. If you are unsure that you are talking to the right person, ask for a description of the doctor seen.

When telephone calls fail

If the phone number is unobtainable, or there is no response to an answer phone message after three days, seek an alternative telephone number from one of the sources listed above, or consider a letter.

L E T T E R S

The advantage of sending a letter is that it can give full information in potential privacy. Disadvantages include delay, the risk of the letter not reaching the person, the risk of mail being opened by a third party, or the risk of the person being questioned about the contents of a letter. Again, it is good practice to agree on the best method of contacting the patient during clinic attendance.

Management of letters

When sending letters it is considered good practice to check that the person has agreed to written correspondence and consider the following:

- To protect confidentiality, use the person's full name, not initials
- Use an ordinary stamp rather than a hospital frank

- Consider whether, in the patient's circumstances, an ordinary hand written envelope is more or less likely to arouse third party suspicion than a buff envelope with a typed address
- Consider the benefits and risks of marking the letter "Private and Confidential": for some patients this may be protective; for others it can provoke questioning from a partner or parent
- Send all correspondence on Trust headed paper although the departmental heading may be excluded in circumstances where it would arouse significant suspicion from a third party
- Avoid sending letters on Friday as this may cause unnecessary anxiety
- If a person cannot read English, it is possible to get letters translated. However this can involve considerable delay and is expensive, it may be better to ask an interpreter to ring the patient, preferably by prior arrangement
- Wait one week from sending the letter before taking any further action, if any is required. Before sending a second letter check and confirm the address. If the GP details are available it may be possible to ask the surgery to confirm the address. (see 'When Recall Fails')
- Response to a letter can often be slow, so if a telephone number is available it may be more effective to phone first

When letters fail.

If there has been no response to communications sent by post then consider the following:

- Check that the address exists in the postal address book (supplied free of charge by the Post Office) or A-Z
- Compare details with the GP's surgery. It may be possible that the surgery has a more recent address. It is possible to gain this information without jeopardising the patient's confidentiality for example: "I am a healthcare worker from North Manchester General. We need to recall one of Dr (GP's name) patients. Could we check if they have changed their address?"
- Volunteer full details, including name, known address and date of birth to allay suspicions. If the practice receptionist wishes to ring back, to check that the call is legitimate, give the main hospital switchboard number and your own personal extension. This is better than giving the GUM reception number, where the location would be disclosed
- If the GP details are unavailable contact the local source of patient data
- If the known address is council accommodation, the town hall/neighbourhood offices may confirm whether the person is still resident, or has left a forwarding address
- If the patient is a student, the college office may forward their mail

- If the known address is sheltered accommodation staff may agree to forward their mail
- Negotiate access to a computer database such as hospital PAS, this may give an alternative address
- Consider a registered letter or visit (see below)

E - M A I L

E-mail can be a valuable way of communicating confidentially and efficiently with patients, there needs to be a category for these details on the registration form and permission to use this method should be sought during the patient's first visit. This is also a convenient way of resolving partner notification. It is important to establish whether this is a personal address, as this may influence the content of the correspondence.

R E G I S T E R E D L E T T E R S

Individual Trusts may allow health advisers to use this facility, although obviously it is more expensive than sending standard correspondence. However, sending a registered letter is a more cost-effective alternative to a home visit. This method of contacting patients clarifies whether the letter has reached the intended person or not. Sending correspondence via registered post emphasises to the recipient the seriousness of the matter. If the letter is not returned then one must presume that it has been successfully received. In some circumstances the patient may choose not to collect the letter, if it is returned to the clinic this ought to be documented in the case notes.

V I S I T S

If it has not been possible to establish contact with the patient by letter or telephone, and the risk to health is significant, it may be necessary to consider a home visit. Visits can generally be undertaken as a last resort because they are intrusive, time consuming and a potential risk to staff safety. However, they may be necessary if the patient requires an interpreter or signer, and a telephone translation service cannot be used. Benefits of home visits include the opportunity to discuss, face to face, the importance of re-attendance, and to address any difficulties that are preventing the patient from returning.

The fact that a health worker has taken the trouble to visit may, in itself, persuade the patient that the matter is too important to ignore.¹ It may be possible to ensure attendance by offering to take the patient back to clinic and arrange for them to be seen immediately. If the person is no longer at the address, a current resident may know how they can be contacted. Finding that the premises are empty indicates the need to seek an alternative address (see "When recall fails").

Visits are usually only undertaken within the clinic catchment area. If a patient lives nearer to another clinic, then the local health adviser may be able to do the visit. This will need to be discussed with the neighbouring clinic and may depend on staff resources. Some clinics may prefer to hand deliver a letter from the clinic where the patient was initially seen. If you are asked to do a visit by another clinic, then this may need to be discussed with the consultant. Not all services may be able to justify this use of resources.

Management of home visits

When undertaking a home visit it may be useful to consider the following:

- Check with the GP that the address is the most recent one available
- Consider who is best-placed to do the visit, in view of the patient's age and gender. For example, a female health adviser or a school nurse may be more appropriate for an underage female patient
- Take a prepared letter in a sealed envelope to post through the door or hand to a third party, in case the person is not available
- Take a mobile phone in case difficulties are encountered or appointments need to be booked. This also allows colleagues to make contact to check your safety
- Carry hospital identification to reassure the patient that the visit is legitimate
- Inform office colleagues of the planned visits and route. Reporting back to the office when visits have been completed lets colleagues know you are safe
- For reasons of personal safety two members of staff would ideally undertake visits, although this is often not practical due to poor staff resources. (The second person may not necessarily be a health adviser, although if it is not in the staff member's job description to undertake work away from the hospital site, they may not be covered by the Trust insurance)
- It is recommended that the health adviser remain on the doorstep of the person's home for safety reasons. Sometimes it is difficult to manage confidentiality on the doorstep because neighbours may be within earshot. In these situations it may be appropriate to step inside, providing you are confident that the patient is alone and poses no threat. The person visiting ought to assess the situation and avoid any unnecessary risks. It is essential that the individual's identity is verified; the person is to be asked for by their full name and their date of birth confirmed. A hospital identification card ought to be shown to the patient and an explanation given
- If the patient is alone, explain the reason for the call clearly. If others are within earshot be discreet, or hand the person the prepared letter, asking him or her to phone you. Once the patient realises who the health adviser is, they may wish to discuss their situation in a more confidential environment
- Consider offering the patient a lift to the clinic if compliance with appointments is poor

A health adviser is not obliged to visit any patient, alone or in pairs, if there is a known risk to personal safety. If a patient is known to be violent, or there are other reasons why a visit may be inappropriate, discuss with the consultant physician who carries ultimate medico-legal responsibility for the patient. In difficult cases, advice may be sought from a professional body, such as the Nursing and Midwifery Council, or the Medical Defence Union. Document the reasons for the decision in the case notes.

WHEN RECALL FAILS

If the patient has consented for the department to inform the GP of their attendance, then discuss with the consultant if this is appropriate. A letter can be sent to the GP explaining that the patient has an untreated infection and that you have been unable to inform them. This would need to be written by the consultant. It is considered good practice to inform the patient of this action by letter two weeks prior to the GPs letter being sent. This gives the patient chance to contact the department and protects their confidentiality.

DOCUMENTATION

It is good practice to enter a signed and dated record of the following in the case notes:

- All health adviser actions, including unsuccessful attempts to contact the person by telephone
- The outcome of actions, including whether contact was made, what information was given, and the patient's response
- A second copy of all letters sent
- Discussion involving recall management with any member of the multidisciplinary team

RECORDING FUTURE RECALL

It is the responsibility of the health adviser to ensure that patients are recalled for future follow up and normally that there is a fail-safe system in place. Reminder letters may be sent two weeks before the patient's appointment is due. Letters sent to patients need to clearly outline the importance of attendance explaining what the appointment is for, without being too explicit in case of interception.

CYTOLOGY

Ideally clinics would have a policy whereby patients requesting cytology are asked to sign a disclaimer allowing a copy of their smear results to be sent to their GP. This enables the patient to continue to be part of the National Health Service Cervical Screening Programme (NHSCSP), which will ensure that the health authority will generate future recall. If a copy of the smear result is not sent to the GP then the responsibility for recall rests with the clinic. (See recommended actions).

The NHSCSP recommends all women should receive their cytology result within six weeks from the date the smear was taken. All women ought to receive confirmation of their results in writing. It is the responsibility of the smear taker to insure that any recommended actions as a result of the smear are followed up.²

Current practice is that HIV positive women are recalled for cytology annually although there are no current guidelines for this in the UK. If the clinic manages a caseload of HIV positive patients the health adviser may be required to ensure that all women are sent a reminder letter when their cytology is due and followed up when they next attend.

RECALL OF PATIENTS WITH POSITIVE HIV ANTIBODY RESULTS

The recall of patients who have not returned to collect positive HIVab test results should be managed extremely tentatively. Use the pre-test assessment in the casenotes as guidance as to whether the result was anticipated by the patient. If this was the only investigation performed receipt of a recall letter will almost certainly alert the patient to the results. A balance between allowing the individual the chance to come back and discuss their result and the responsibility of the clinic to inform them must be reached. It should be made clear to the patient during the pre-test discussion that they may need to be contacted regarding this result. If the patient is unsure at this stage about receiving their result then this ought to be explored at the pre-test assessment and perhaps the test postponed. It is important to make clear to the patient that consent to test implies consent to receiving a result.

In this situation letters are often the most appropriate method of contact as telephone calls can be difficult. However, if a prior arrangement has been made with the patient about collecting their HIV result by telephone then this may be the best recall method. If the health adviser is making the telephone call then it is important to remember that the patient has no control over the circumstances in which the result is received and should be given an appointment to discuss the result as soon as possible. Equally, visits can be unpredictable; maintaining confidentiality may prove difficult if the patient is not alone. Visiting a patient at home does not allow them choices about the circumstances in which they receive their result.

It is important that recall letters do not state HIV, as the consequences if intercepted by a third party may be extremely serious. For example the letter may read: "could you please contact the department to make an appointment with the health adviser to discuss the results of your recent test".

Three documented recall attempts ought to have been made and if there is no response then the casenotes should be discussed with the consultant.

RECOMMENDED RECALL ACTIONS

Table 9.1

<i>Purpose</i>	<i>Correspondence: letters/ telephone</i>	<i>Visit / registered letter recommended</i>	<i>Review case notes after action</i>
Needs antibiotic treatment	Minimum 2 Maximum 3, before registered letter or visit	Yes	5 days (3 days if message left on answerphone)
Test of cure/ post treatment review (contact(s) attended)	Maximum 1	No	1 week
Test of cure/ post treatment review (contact(s) not attended)	Minimum 1 Maximum 2	No	1 week
Discuss new diagnosis - herpes	Maximum 1	No	1 week
Discuss new diagnosis (HIV/ infectious hepatitis)	Minimum 2 Maximum 3	Yes	5 days
Hepatitis B vaccine or serology	Maximum 1	No	1 week
Syphilis serology: first post treatment	Minimum 3	No	1 week
Annual syphilis serology, post treatment, if HIV positive, or recommended first line treatment not used ³	Maximum 1	no	1 week

Syphilis serology at 1,2,3,6,12 months ⁴	Maximum 1	no	1 week
Repeat screening serology (STS, HIV, and Hepatitis B. High risk patients only)	Minimum 1 Maximum 2	No	1 week
Colposcopy	Minimum 2 Maximum 3	Yes	1 week
Cytology (abnormal)	Minimum 2 Maximum 3	Yes	1 week
Cytology (routine)	Maximum 1	No	1 week

C O N C L U S I O N

The implications of recall ought not to be underestimated, as there may be the potential for confidentiality to be broken or anxiety caused. Protocols should ideally be in place and foresight used when assessing the need for recall and the most appropriate method chosen. Work may be audited for its effectiveness as successful recall management plays a key role in streamlining patient care.

APPENDIX

EXAMPLES OF SAMPLE LETTERS

"Could you please telephone the department to make an appointment as we need to discuss the results of your recent tests."

"Following your treatment for an infection, I notice that you have not been back to the clinic since. We would like to repeat the test again to ensure the treatment has been effective and the infection has completely gone."

"We now have the results of your tests taken in clinic on 2nd May confirming the infection we treated you for. Please telephone clinic to speak to a health adviser about any follow up that may be necessary."

"We now have the results of your tests taken on 2nd May. One of your tests was positive for an infection. It is important that this infection is treated as it may cause problems if it is not. Your partner will also need to be treated. You can make an appointment to see a health adviser to collect your treatment, and it will only mean a very short visit to clinic."

"I notice you have not been back to clinic since your treatment. I was wondering if you could phone me when you get this letter, as I didn't get the opportunity to see you when you were in clinic."

"We now have the results of the tests taken on 2nd May. One of the tests was unable to be processed. This happens occasionally and does not mean there is a problem, but if you would like it repeated please phone for an appointment with the nurse."

"We now have the results of your smear test taken on 24th May. The result was negative, this means it was normal. You will be recalled by the Cytology Screening Programme when your next one is due."

"We now have the results of your smear test taken on 24th May. The result was inadequate. This means that there was insufficient material in the sample. It is nothing to worry about and you are advised to have it repeated in 3 months. We will write to you when this is due."

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Ethical issues in patient recall

GILL BELL

Recalling patients for essential care may cause harm by jeopardising confidentiality. This section explores some of the ethical issues involved in this conflict of duties.

INTRODUCTION

Patients are recalled for treatment or further investigation in order to bring benefits, or reduce harm. However, situations arise when it is difficult to recall a patient without jeopardizing confidentiality, or contravening his or her stated wishes - thereby violating autonomy. The ethical challenge of recall lies in the need to ensure that the resulting benefits for the patient and/or their sexual contacts outweigh the potential damage done. The following situations explore some of the ethical choices that may need to be made.

Guidelines for the management of an ethical issue can be found in chapter 23, where ethical concepts such as *autonomy*, *beneficence*, *non-maleficence*, *justice* and *confidentiality* are discussed in detail.

THE PATIENT REQUESTED "NO LETTERS"

A patient is unaware she needs an urgent colposcopy as a result of severe dyskariosis on her cytology. She requested "no letters" and is not available by phone. Should the health adviser override her wishes and write to her, or make an even more intrusive home visit, or leave her to suffer the consequences of her decision?

It could be argued that the woman's request for no correspondence does not amount to an autonomous choice because she was not aware of the possibility of a serious risk to her health at the time, and therefore the decision was not fully informed. Even if the patient had been warned of the risk of unfavourable results, failure to inform her might be construed as negligent, in the context of a treatable life-threatening condition.

Consideration would, however, need to be given to the potentially negative consequences of her mail being intercepted by a third party, such as a parent or a partner, who would be made

aware of her attendance at genitourinary medicine (GUM). (This risk could be avoided by using the general hospital stationary, without reference to GUM). Confidence in the confidentiality of GUM services might also be undermined.

REPEAT RECALL

A man fails to present for treatment for gonorrhoea, as promised. Neither his regular partner nor his casual partner has attended for screening. Should the health adviser actively pursue the patient, at the risk of harassing him, or should he be left to assume responsibility for himself and his partners, now that he has been informed?

An argument in favour of taking no further action could be based on the principle that autonomy should not be violated. Another reason might be a concern that the patient's health may suffer more in the long term if he is not encouraged to take responsibility. The risk of alienating the patient in the future by harassing him would also be considered.

A decision to contact him again could be justified as an attempt to communicate the importance of the situation more clearly, thereby facilitating (rather than violating) autonomy. Some may argue that preventing further damage to health is more important than respecting autonomy, in this instance. Consideration may also be given to the rights and welfare of his sexual partners who may be at risk of infection.

INFORMING THE GP

A woman fails to return for chlamydia treatment, and cannot be located. Should the GP be informed? (This action is normally the responsibility of the doctor, but health advisers may be involved in the decision if they bring the case to the doctor's attention, or are involved in discussion).

Reasons for informing the GP include the duty to reduce the health risk to the patient by ensuring that the necessary medical attention can be accessed from elsewhere, at any point in the future. Onward transmission to partners might also be prevented.

Arguments against might point to the importance of safeguarding confidentiality: the patient may regard disclosure to be a breach of trust, or harmful to her relationship with the GP. From a public health perspective, the accessibility of GUM services depends upon public confidence in confidentiality, so consideration ought to be given to the wider consequences of unsanctioned disclosures.

DELIVERING MEDICATION

A female sex worker with a previous history of pelvic inflammatory disease has repeatedly failed to keep appointments for treatment of gonorrhoea. Should medication be delivered to her home?

Arguments in favour would cite an overriding duty to take the necessary steps to protect the woman, her immediate partners and the wider community from harm.

Arguments against would emphasise the importance of encouraging personal responsibility. There is also the danger of creating an expectation among sex workers that treatment will always be delivered. Such an arrangement could be counter-productive if inadequate staffing levels delay home visits: this could lengthen the average gap between diagnosis and treatment

for sex workers, thereby increasing the long-term risk of harm. Patients who did not benefit from this service could feel unfairly treated.

C O N C L U S I O N

There are complex ethical issues that need to be considered during patient recall. It is good practice to discuss difficult choices with colleagues, and document the reasons for the decisions made.

Triage

GILL BELL

Some patients need to be seen before the next available appointment. This chapter explains how a triage system may help to ensure priority access for those in need.

INTRODUCTION

Triage is a system for assessing whether an individual needs to be seen sooner than the next available appointment. The current pressure on genitourinary medicine services has created long waiting lists for many clinics.¹ This delay is unacceptable to many patients and potentially unsafe for those in need of immediate medical attention. Consequently, most clinics that operate an appointment system also have triage arrangements to ensure priority access for those needing to be seen quickly.

PRINCIPLES OF TRIAGE

Entitlement to priority access would be assessed in relation to the person's:

- Risk of developing avoidable complications before the next available appointment
- Level of suffering, related to acute pain, discomfort, anxiety or distress
- Likelihood of having an untreated acute sexually transmitted infection (STI)
- Likelihood of transmitting a potential infection before the next available appointment
- Likelihood of returning to the clinic in future if turned away
- Ability to contribute to STI control, providing good will is maintained

MANAGEMENT OF TRIAGE

Health advisers or nurses may triage by telephone or face to face. Reception staff require guidance on which individuals may be offered triage. The criteria would include those who:

- Are contacts of gonorrhoea, chlamydia, syphilis, HIV or hepatitis

- Complain of pain (abdominal, testicular or genital)
- Are acutely anxious or distressed
- Have been sexually assaulted
- Require emergency contraception or post HIV-exposure prophylaxis
- Are under 16
- Are unwilling to wait until the next appointment
- Have difficulty arranging a suitable appointment because of work or home commitments

THE TRIAGE PROCESS

The use of a proforma may help to ensure a thorough assessment and provide documentation. During triage the nurse or health adviser would:

1. Assess the person's level of **distress or anxiety**.
2. Take a **medical history**, to include the severity and duration of symptoms suggestive of STI, including:
 - Abdominal or testicular pain
 - Penile, rectal or vaginal discharge
 - Fever and/or malaise
 - Dysuria
 - Ano-genital blisters/pain
 - Genital warts or "lumps"
 - Soreness, itching, malodour
 - Take a **sexual history**, to establish the risk of an STI.
3. Enquire about whether any **sexual contacts** are known to have, or are symptomatic of, STI.
4. Consider the **risk of onward transmission** of presumed infection, if medical attention is delayed.
5. Consider the person's **ability to return** to clinic for a future appointment, if not seen. It is important to avoid turning potentially infected people away in case they do not return.
6. Arrange a suitable **appointment** that is compatible with the recommended waiting times (see table below). Liaison with nursing or medical staff may be appropriate if the person is eligible for a same day appointment, or is already in clinic. A senior doctor would be consulted if the person could not be easily accommodated within the recommended time.

7. **Suggest alternatives** if an acceptable/suitable appointment time cannot be offered. For example, a patient needing emergency contraception may be referred to an NHS Walk-in Centre, family planning clinic, GP, accident and emergency department, or a chemist who is able to dispense without prescription.
8. **Document** the patient's name, history, advice given, and appointments offered and made on a triage proforma and/or in the patient's clinic notes. Decisions made by senior staff regarding access would also be recorded. It may be useful to note the circumstances that influenced the decision, such as the waiting time for the next appointment, the patient's level of anxiety, or the workload in the clinic.

Regular evaluation is recommended to ensure the quality of this service.

Table 11.1

<i>Recommended maximum waiting times</i>			
Complains of	Walk-in Maximum wait	Telephone Maximum wait	Suitable alternative service
Abdominal pain	Same session	24 hours Same session if acute	Other GUM, A&E GP if level 2 service *
Testicular pain	Same session	24 hours same session if acute	Other GUM A&E GP if level 2 service
Ano-genital blisters (undiagnosed)	Same session	24 hours	Other GUM GP if level 2 service
Possible chancre	Same session	24 hours	Other GUM
Urinary retention	Same session	Same session	A&E
Discharge or dysuria (males)	Same session	48 hours	Other GUM, GP if level 2 service
Discharge and dysuria (women)	Same day	48 hours	Other GUM, GP if level 2 service
Discharge and vulval itching or soreness	No priority	No priority	Other GUM, GP Anti- fungal, pessary and cream from chemist
Malodorous discharge	No priority	No priority	Other GUM, GP
Genital warts	No priority	No priority	Other GUM GP if level 2 service
Contact of syphilis	Same session	24 hours	Other GUM
Contact of gonorrhoea	Same session	48 hours	Other GUM GP if level 2 service
Contact of chlamydia Female, or symptomatic.	Same session	48 hours	Other GUM GP if level 2 service
Contact of chlamydia Asymptomatic male	Same session	1 week	Other GUM GP if level 2 service
Contact of HIV	Same session	48 hours	Other GUM
Contact of genital warts	No priority	No priority	Other GUM GP if level 2 service
STI/HIV related anxiety (low risk)	1 week	1 week	Other GUM GP
STI/HIV related anxiety (high risk)	Same day	48 hours	Other GUM
Post HIV exposure	Same session	Same session	Other GUM, A&E

* The National strategy for sexual health and HIV suggests that STI screening, treatment and partner notification could be offered within primary care settings that opt to develop expertise in this area. This is described as a "level 2" service.

C O N C L U S I O N

A triage system is necessary to ensure that patients who need to be seen before the next available appointment can be identified and given priority. The use of agreed guidelines is recommended to ensure decisions are fair and appropriate.

R E F E R E N C E S

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- 1 Foley E, Patel R, Green N, Rowen D. Access to genitourinary medicine clinics in the United Kingdom. *Sex Transm Inf* 2001; 77:12-14
 - 2 Department of Health. The national strategy for sexual health and HIV; 2001

Ethical issues in triage

GILL BELL

Giving some patients priority access to services inevitably raises the question of justice. This section considers what might make a triage decision fair.

INTRODUCTION

Guidelines for the management of an ethical issue can be found in chapter 23, where ethical concepts such as *autonomy*, *beneficence*, *non-maleficence*, *justice* and *confidentiality* are discussed in detail.

Whenever a person is added to an already full clinic list, patients with pre-existing appointments may have to wait longer and staff members are subjected to greater pressure. Few would argue that patients in need of urgent medical attention be turned away, but a decision to give priority on social or epidemiological grounds may be more controversial. In such situations ethical consideration would be given to the balance of justice, benefits and harms for the individual, others patients, staff and the wider community. Some examples are considered below:

THE KEY PLAYER

An asymptomatic man calls in without an appointment. He does not have a right or a need to be seen straight away. However, he is well known to the service as a local drug dealer who has a history of repeated STIs, and who has frequent sexual contact with several sex workers.

The argument for seeing the man immediately would be that it is particularly important to build and maintain good will with individuals who play a key role in the social and sexual networks associated with high rates of STI transmission. If he is given preferential treatment he may be more inclined to co-operate with partner notification and encourage associates to use the service. If he is alienated, it may be difficult to secure his attendance in future.

THE GP REFERRAL

A woman attends without an appointment, with a GP letter reporting a vaginal discharge. She has no other symptoms, and is not therefore in need of urgent medical attention. However,

the GP told her she could attend without an appointment. She has travelled across town on two buses with small children.

The argument for asking her to return for the next available appointment might be that she does not have a right or a need to be seen that day, and it would be unfair to others if the triage protocol were not followed for everybody. On the other hand, it may seem unfair to turn her away when she has made an arduous journey in good faith. Her social circumstances may make it difficult for her to return in the near future, and the opportunity to treat a potential infection could be lost, or delayed.

A C H A O T I C L I F E S T Y L E

A young woman has defaulted many appointments and failed to respond to health adviser communications in the past. She has a chaotic lifestyle, and limited ability to protect her sexual health. The woman calls in, expecting her vaginal discharge to be promptly investigated.

She may be turned away because she does not fit the triage criteria that should, in fairness, apply to all. Some may feel that she does not 'deserve' preferential treatment because she has been uncooperative in the past, and should not receive priority over patients who wait for appointments and keep them, without fuss. There could be a concern that, by seeing her on demand, the service is rewarding 'bad behaviour' and discouraging her from developing a more constructive approach to health services.

An alternative view would be that she is disadvantaged by an appointment system because of her poor capacity to organise her life and grasp the rules of service use. If the service is, in effect, less accessible to her than others, there is a sense in which it is fair to make allowances and give her access on the terms she can manage. Furthermore, there is the public health consideration that her chance of having an STI is relatively high and the likelihood of her returning for a future appointment is low. The only sure way of preventing her from developing complications or transmitting infection to others is to see her straight away.

A S E X W O R K E R

A sex worker with self-diagnosed bacterial vaginosis presents at the clinic.

Bacterial vaginosis (BV) is not a medical emergency. It does not cause serious morbidity if left untreated for a short time, and it is not normally sexually transmitted. However, the unpleasant odour associated with the condition can be embarrassing and distressing. This presents an acute problem for sex workers, who may feel unable to work. Effective and ethical health care requires a holistic approach, where due consideration is also given to psychological, social and economic needs. For a sex worker, BV might be a legitimate emergency that needs prompt attention. Consideration would also be given to the possibility of concurrent STI, and the potential for onward transmission.

A S C H O O L G I R L

A 15-year-old girl calls in requesting a check up, having slipped out of school. She does not have any symptoms, but has had unprotected sex with a 25-year old man who has other regular partners.

There is no indication that immediate medical attention is required, but there are several reasons for considering priority access. Firstly, she has been at risk of infection; secondly, she may find it difficult to be absent from home or school without explanation to return at a future time; thirdly, child protection issues need to be explored further.

There is also the importance of first impressions, because attending a clinic for the first time requires courage. The apprehension and embarrassment that many patients feel during a first visit may be more acute for the very young. If the girl is turned away she may find it difficult to come back, and may share her unsatisfactory experience with friends, who may also be discouraged from using the service. The importance of making sexual health services more accessible to young people is emphasised in the national strategy for sexual health and HIV.

C O N C L U S I O N

There are complex ethical issues that need to be considered during triage. It is good practice to discuss difficult choices with colleagues, and document the reasons for the decisions made.

A C K N O W L E D G M E N T S

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