



**SHIP**  
Key Issues in  
Sexual Health for GPs



Resources Support for practices  
Clinical training SHIP Collaboration & liaison  
SEXUAL HEALTH IN PRACTICE  
Commissioned across London and the UK  
Delivers sustained change in clinical practice

### Learning outcomes

By the end of this session you should be able to:

- Explain why diagnosing and treating STIs is important
- Bring up the topic of sexual health when your patient is not expecting it
- Take a partner history from a patient
- Decide which STI tests you should offer to your patients following rapid risk assessment

### What we'll cover today

Clinical significance of STIs in GP

- Diagnosing STIs in GP
- Value of sexual hx & rapid risk assessment in GP
- Doing rapid sexual health risk assessment and formulating clinical management plans

### Lots of evidence that people with high risk use GP

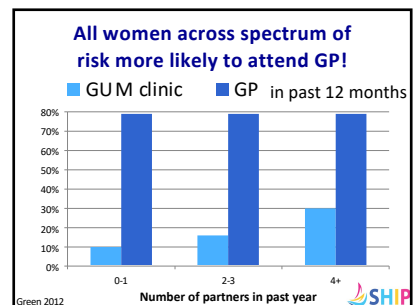
People living with HIV (PLHIV):  
- 95% registered with GP  
- 87% disclosed HIV status  
- 60% prefer GP to HIV clinic

General practice is the preferred health service of street-based sex workers

How visible these attendees are up to us as clinicians

the past year  
60% think staff not aware of sexual orientation

Very likely to attend GP - Very unlikely to attend GUM



### Predominantly sexually transmitted

+ Chlamydia trachomatis	Chlamydia
+ Neisseria gonorrhoea	Gonorrhoea
+ HPV	Genital warts
+ Treponema pallidum	Syphilis
+ HIV	
+ Trichomonas vaginalis	Trichomoniasis
+ Pediculosis pubis	Pubic lice
+ Herpes simplex type II	Genital herpes
+ Mycoplasma Genitalium	
+ Mpox virus	

### Mycoplasma Genitalium

- Men: NG urethritis (discharge & balanitis)
- Women: PID/cervicitis
- Considered harmless in those without symptoms
- Present in 1% population
- Currently no screening
- Often co-exists w Chlamydia and other STIs
- Difficult to diagnose
- Difficult to treat - Macrolide resistance problem

### Mpox epidemic UK 2022

- Usually self-limiting infection, symptoms lasting 2-4 wks
- Occasionally severe
- 99% men who have sex with men; highest risk subgroup
- Usually transmitted by close sexual contact
- Initial presentation may be fever, headache, myalgia, swollen glands, joint pain
- Solitary lesions common

**Sexual transmission well recognised, not predominant route**

- + Hepatitis B
- + Hepatitis A
- + Herpes simplex type 1
- + Sarcoptes scabiei
- + Molluscum contagiosum
- + Shigella flexneri

*Hepatitis C rarely recognised to transmit sexually*

**Genital infections NOT generally sexually transmitted**

- + Candida
- + Bacterial vaginosis
- + Group B Strep

**Vaginal discharge top 3**

1. Physiological pH < 4.5
2. Candida pH < 4.5  
White curdy discharge  
Itch, irritation, soreness, redness
3. BV pH > 4.5  
Thin grey/white discharge  
Generally not sore  
Fisly/offensive odour

**Which of the following symptoms or conditions could be caused by STIs?**

Participant pack

- Seborrheic dermatitis
- IMB
- PCB
- Menorrhagia
- Arthralgia
- Lymphadenopathy
- Flu-like illness
- Epididymitis
- Eye symptoms
- Peri-appendicitis
- Peri-hepatitis

Which of these symptoms/conditions might have a cause **OTHER than an STI?**

→→ There is an issue of **DIFFERENTIAL DIAGNOSIS**

**STIs**

STI	Prevalence
Chlamydia	80-90%
Gonorrhoea	70-80%
TV	70-80%
Herpes	30-60%
HIV	up to 10 years!
Syphilis	20 years +
Hep B & C, HPV	20 years +

**Summary of implications so far...**

- + Left untreated many STIs have serious consequences
- + Often have no symptoms
  - Can still be transmitted
  - People with STIs often unaware
- + Symptoms can be insidious, subtle and not obviously related to the genital area
  - Not recognised as STIs by patients or clinicians

**What we'll cover today**

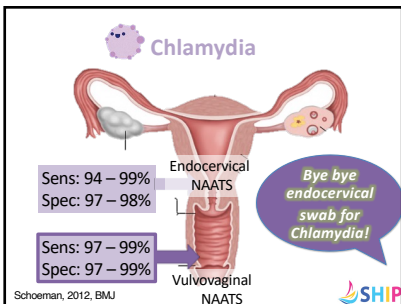
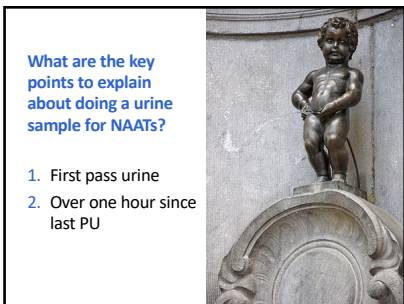
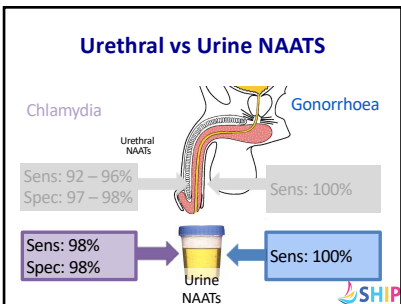
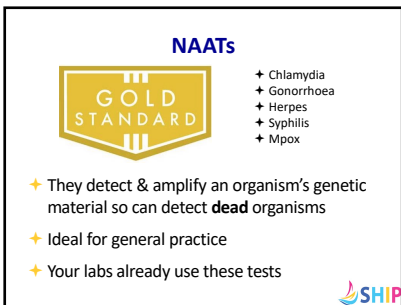
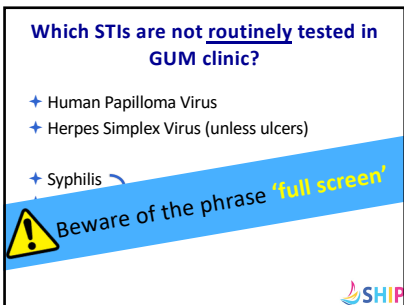
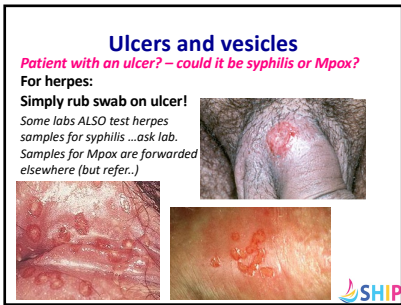
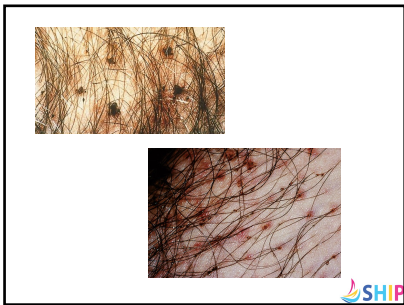
- + Clinical significance of STIs in GP
- + **Diagnosing STIs in GP**
- + Value of sexual hx & rapid risk assessment in GP
- + Doing rapid sexual health risk assessment and formulating clinical management plans

**Diagnosing STIs**

1. Microbiology samples
2. Blood tests
3. Clinical findings

**How are these STIs diagnosed or confirmed?**

STI	Microbiology sample	Blood test	Clinical findings
Chlamydia	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gonorrhoea	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Genital warts	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Herpes simplex virus	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Syphilis	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
HIV	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Hepatitis B	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
TV	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pubic lice	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Mycoplasma genitalium	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mpox	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



### Gonorrhoea

**Endocervical NAATs**  
Sens: 96 – 99%  
Spec: 99 – 100%

**Vulvovaginal NAATs**

Clinician collected	Patient collected
Sens: 95.5%	Sens: 100%
Spec: 99.5%	Spec: 99.3%

**Patient collected vulvovaginal swabs are best!!!**

Stewart, 2012, BMJ

### Gonorrhoea Culture vs NAATs

	Pros	Cons
<b>Culture</b>	<ul style="list-style-type: none"> <li>Gives antibiotic susceptibilities</li> <li>High specificity: positives are true</li> </ul>	<ul style="list-style-type: none"> <li>Low sensitivity: misses cases++</li> <li>Especially poor if transported</li> <li>Invasive</li> </ul>
<b>NAATs</b>	<ul style="list-style-type: none"> <li>Much more sensitive for primary care, unlikely to miss cases</li> <li>Less invasive test</li> </ul>	<ul style="list-style-type: none"> <li>No antibiotic susceptibilities</li> <li>?False positives, risk increases as not-at-risk testing increases</li> </ul>

### Gonorrhoea summary

- Routine testing of those *at risk*
  - Women: vulvovaginal NAATs
  - Men: first pass urine
- High risk patient with relevant symptoms  
Eg Discharge, dysuria, PID  
Consider adding EC or urethral culture too

### Window periods

How long after infection will tests be positive?

**NAATs:** 2 weeks

- Likely sooner if symptomatic
- Take longer to turn negative after infection cleared

**HIV:** 45 days (7 weeks)

- Rapid tests = 90 days

**Viral hepatitis** usually 3 months, occ longer

### High vaginal swabs

For how many STIs is a high vaginal swab in bacterial transport medium the investigation of choice?

- Chlamydia
- Gonorrhoea
- Genital warts
- Syphilis
- HIV
- Trichomonas ?
- Dubious
- Genital herpes
- Mpox

### Permission not to panic about TV

- Natsal study – 4400 tested
- Uncommon in primary care setting – prevalence 0.3%
- TV screening not recommended
- HVS test has low sensitivity (difficult to culture)
- Not a devastating infection to leave undiagnosed...

**Therefore only consider TV culture for women with**

- a sexual health risk
- who have recurrent or persistent vaginal discharge - where commoner causes have been excluded

Field et al. Lancet 2018

### When should we use blue/black culture HVS sample?

- Recurrent or persistent unexplained symptoms
- Post-partum
- Post-instrumentation eg post LLETZ, post-abortion

To exclude TV, staph, wound infections

You see you have written 'For triple swabs' here.....?

I am afraid we no longer use language like that in this practice.



### Online testing - SHL


[www.shl.uk](http://www.shl.uk) SEXUAL HEALTH LONDON

Asymptomatic patients > 16 years  
Sent home sampling STI kit for free

Send the link by Accurus!

### Asymptomatic patients where STI is a possibility

- 
  - Self-taken vulvo-vaginal swab
  - HIV (and syphilis)
  - Hepatitis B & C if risk group
- 
  - First pass urine after no PU for  $\geq 1$  hr
  - HIV (and syphilis)
  - Hepatitis B & C if risk group




### Symptomatic patients where STI is a possibility

Same as for no symptoms but also:

- Examine for warts, vesicles, ulcers, etc

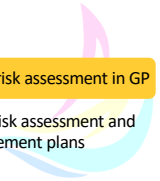
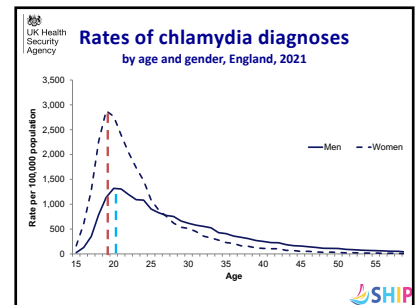
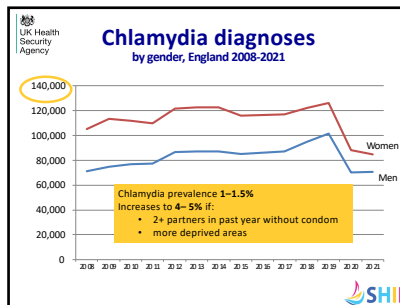
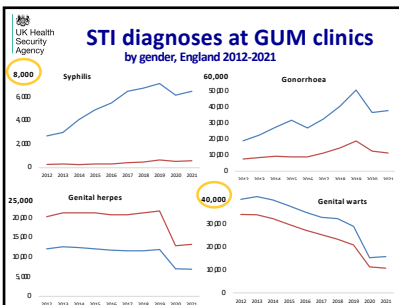
Consider:

- Ulcer swab if possible herpes, syphilis (don't forget Mpox in MSM)
- High vaginal swab if concern about TV
- Gonorrhoea culture if likely gonorrhoea



### What we'll cover today

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### Chlamydia risk factors – risk vs scale

Chlamydia prevalence 1–1.5%  
Increases to 4–5% if:

- 2+ partners in past year without condom
- more deprived areas

However most of those with chlamydia had only had **one partner in the last 12 months** (largest group)

Sonnenberg et al. Lancet 2013



### How many partners have 16-24 year olds had in their lifetime?

10 or more partners  
20% men 16% women

No partners  
20% men 20% women

Of these... only 66% been to GUM/SRY clinic in last FIVE years

GPs see people from across the whole spectrum of risk

Natal 2024

### Why is country of origin and ethnic origin important to clinicians?

Where are you or your family from?

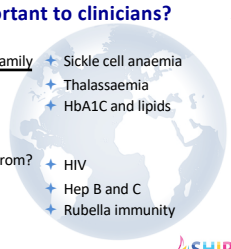

Genetic factors

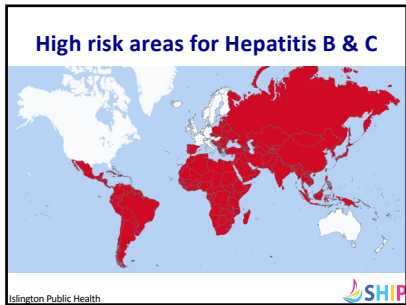
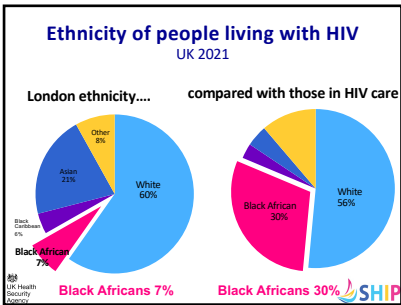
- Sickle cell anaemia
- Thalassaemia
- HbA1C and lipids

Which country are you from?

Infections

- HIV
- Hep B and C
- Rubella immunity



- ### Benefits of rapid SH risk assessment
- ✦ Avoids **misjudgments** and **wrong assumptions**
  - ✦ Raises **patient awareness** and **understanding** of sexual health risks – & supports informed choice
  - ✦ Identifies:
    - who needs **sexual health advice** – & who doesn't!
    - who to **offer tests** (with and without symptoms)
  - ✦ Supports **clinical decisions**
    - eg differential diagnoses, contraceptive choice, tests choice & result interpretation, support partner notification
  - ✦ Clarifies **why offer of tests** has been **declined**
    - Good reasons or poor ones?
- SHIP



### You call Rosa, 19 years old

Participant pack

She has discomfort when she pees. She recently spoke to a colleague and was prescribed Nitrofurantoin. Her MSU specimen showed white cells, but no bacterial growth. You need to check if she is at risk of Chlamydia in order to know whether to offer her a test.

**How are you going to manage the transition from talking about UTIs to talking about an STI?**

Suggest the actual phrases you would use – use quotation marks!

SHIP

### You speak to Ross, 26 years old

Participant pack

You don't know him and there is nothing of note in his records. He has a severe sore throat, fever, tiredness and he aches all over. He has had this for 2 weeks.

**What could this be?**  
Are you even going to think about primary HIV infection (or Mpox?)

**What are the first few things you might do, ask or say?**  
Use quotation marks!

SHIP

- ### Raising the subject 'Out of the blue' with a patient with symptoms
- ✦ Use symptoms to put an STI in context, as only one possible cause amongst others
  - ✦ Make it clear that you do not know if the patient is at risk until you have asked questions to assess **their** risk
  - ✦ Patients can then see that no assumptions have been made about their individual level of risk i.e. they have not been judged by appearance
- SHIP

### Raising the subject 'Out of the blue' with an asymptomatic patient

**Make it ROUTINE:**

As part of this [eg new patient check] we routinely ask everyone questions about their sexual health. Do you mind if I run through these questions with you?

STIs are very common, easily transmitted and often have no symptoms, so we like to discuss risk with all our newly registered patients

SHIP


### Raising the subject 'Out of the blue' with an asymptomatic patient

**SHARE YOUR KNOWLEDGE** of incidence and prevalence

*You're travelling to an area with high levels of STIs. Could I talk with you about whether you are likely to be at risk?*

**Signpost to online services**

*We find a lot of patients like the convenience of sexual health testing online. Could we talk about whether a test is appropriate for you?*




### Partner history

Do you have a partner at present?  
*Is it a sexual relationship?  
 Is your partner male or female?  
 How long have you been together?  
 Have you had any sex with anyone else in that time? Has he/she?*

**Assessing blood borne virus risk:**


Have you ever had sex with someone from another country?  
 Which country?  
 Have you ever had sex with a man? [To men, if not already disclosed]  
 Have you ever injected drugs or shared drug taking equipment?

*Have you ever had sex you didn't want/agree to?  
 Add questions about future risk if relevant*



### Condom questions

- Do you **ever** use condoms?
- Are there times when you **haven't managed** to use condoms?
- Most couples don't manage** to use condoms 100% of the time – **do you?**
- Do you have **any questions** about condom use?
- If you have anal sex don't forget to use lube





**Go back to the most recent risk for the infection you are thinking of**

**It's faster than you think...!**


### Sexual health risk assessment

**Partner history + Condom use**


JOEL BRIAN JOHN JASON TIM  
 PETER MIKE MICHAEL



**+ when last STI tests**



### Rapid SH risk assessment



Do you have a partner at present?  
*Is it a sexual relationship?  
 Is your partner male or female?  
 How long have you been together?  
 Have you had sex with any other people in that time? Has he/she?*


Have you ever had sex with someone from another country?  
 Which country?  
 Have you ever had sex with a man? [To men, if not already disclosed]  
 Have you ever injected drugs or shared drug taking equipment?

Do you use condoms? Are there times you haven't managed to?

When was the last time you had an STI test? Clarify details

Does your method of contraception suit you? Discuss efficacy  
 How would feel about a pregnancy right now?

### Rapid SH risk assessment



Do you have a partner at present?  
*Is it a sexual relationship?  
 Is your partner male or female?  
 How long have you been together?  
 Have you had sex with any other people in that time? Has he/she?*

Have you ever had sex with someone from another country?  
 Which country?  
 Have you ever had sex with a man? [To men, if not already disclosed]  
 Have you ever injected drugs or shared drug taking equipment?

**Phone calls can be perfect for taking a sexual history!**

Do you use condoms? Are there times you haven't managed to?

When was the last time you had an STI test? Clarify details

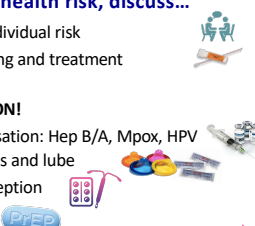

Does your method of contraception suit you? Discuss efficacy  
 How would feel about a pregnancy right now?

### If you identify someone with sexual health risk, discuss...

- Their individual risk
- STI testing and treatment


**PREVENTION!**


- Immunisation: Hep B/A, Mpox, HPV
- Condoms and lube
- Contraception
- PrEP

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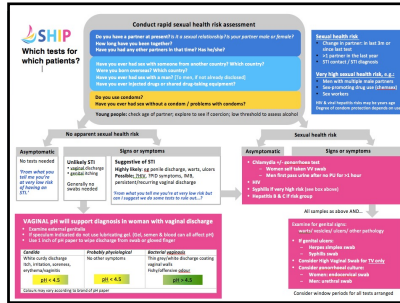




**Shaznia, 19 years old**  
**Abnormal bleeding on COCP**

*Change of partner in last 3m*  
*No condom use*

**Which investigations?**






**Tests if SH risk with symptoms**

- Chlamydia & gonorrhoea test
  - Women self taken VV swab
- HIV
- Hepatitis B & C if risk group

And for those with symptoms... Examine for genital signs: warts/ vesicles/ ulcers/ other pathology


- If genital ulcers:
  - Herpes simplex swab
  - Syphilis swab
- Consider High Vaginal Swab for **TV only**
- Consider gonorrhoeal culture:
  - Women: endocervical swab

**Lee, 26 years old**  
**Dysuria**

*Several sexual partners in the last year*  
*Change of partner in last 3 months*  
*One male partner 6 months ago*  
*Inconsistent condom use*

**Which investigations?**




**Summary of tests for Lee**

- Chlamydia + gonorrhoea test
  - Men first pass urine after no PU for >1 hour
- HIV
- Syphilis if very high risk
- Hepatitis B & C if risk group

And for those with symptoms... Examine for genital signs: warts/ vesicles/ ulcers/ other pathology

- If genital ulcers:
  - Herpes simplex swab
  - Syphilis swab
  - Consider Mpox
- Consider gonorrhoeal culture:
  - Men: urethral swab




**Dawn and Sam (who is the one with symptoms...)**

*Been with baby's father for 3y*  
*Apparent MM, but both had partners prior*  
*Condoms first year only*


**Which investigations?**



**Investigations for baby Sam**



- Chlamydia NAATS swab
- Bacterial swab

**Which investigations is Sam positive for chlamydia?**



**Assuming Dawn is asymptomatic...**


- Chlamydia +/- gonorrhoea test
  - Women self taken VV swab
- HIV
- Syphilis if very high risk
- Hepatitis B & C if risk group

**Taleshia, 15 years old**  
**Requesting EC**

*Mutually first partners*  
*Apparent MM*  
*Condom problem on one occasion*

**Which investigations?**





### The patient at 'no apparent risk'


- Mutually monogamous, mutually first sexual relationship
- No risk since last test
- Never had sex: 10% of 16-44yrs old
- 'Perfect' condom use

Beware risk unwanted pregnancy!

Remember HIV also transmitted by needle sharing

**Remember future risk!**


Natsal 2014



### The patient at 'no apparent risk'

- Try not to disbelieve the history your patient gives!
- Recognition that the patient is at no apparent risk
  - empowers the patient
  - reinforces messages about how to keep safe
- Useful phrase: *From what you tell me.....*

If such a patient has symptoms or signs which strongly suggest an STI (eg PID) then acknowledge they are at low risk, but offer a test anyway so an STI can be 'ruled out'



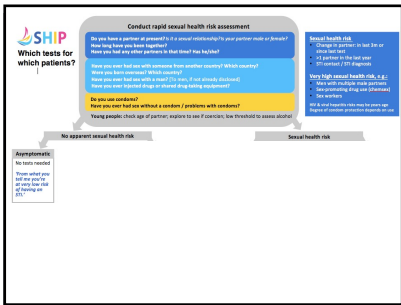
### SHIP Conduct rapid sexual health risk assessment

Which tests for which patients?

**No apparent sexual health risk**



**Sexual health risk**

Appointments: No test needed. Please contact your GP or GUM clinic if you have any symptoms.



### Vaginal discharge


What if Taleshia (no apparent risk of STI) had presented with vaginal discharge?

NOT STI	Might or might not be STI	IS an STI
Eg showing rash	Eg Vaginal discharge Dysuria in a woman	Eg Genital warts Penile discharge Dysuria young man


Rapid risk assessment helps differentiate STI? Or not?

Vaginal discharge is most commonly **NOT** an STI in the general practice context



NOT STI	Might or might not be STI	IS an STI
Vaginal discharge		

Rapid risk assessment finds low / no risk




### VAGINAL pH will support diagnosis in woman with vaginal discharge

- Examine external genitalia
- If speculum indicated do not use lubricating gel. (Gel, semen & blood can all affect pH)
- Use 1 inch of pH paper to wipe discharge from swab or gloved finger

Candida	Probably physiological	Bacterial vaginosis
White curdy discharge Itch, irritation, soreness, erythema/vaginitis	No other symptoms	Thin grey/white discharge coating vaginal walls Fishy/offensive odour
pH < 4.5	pH < 4.5	pH > 4.5

Colours may vary according to brand of pH paper



### NICE National Institute for Health and Care Excellence

Quality Statement 1:

HPs should take a 'brief core sexual history'

If risk identified THEN take a more detailed history, including use of condoms


Key points of contact: FOR EXAMPLE

Newly registered patients, cervical screening

**NICE Quality Standards now support the use of SH rapid risk assessment**

... have a discussion about ...

... responsive to needs of eg MSM]



### STI Management


Treatment

Prevention

Other tests

Partner Notification

Referral



**Treatment**

[www.bashh.org.uk](http://www.bashh.org.uk)

Treatment protocols evolve!  
Always look up!

- Chlamydia
- PID
- Herpes rescue packs

**Prevention**

- Immunisation:
  - Hep B and Hep A
  - Mpox
  - HPV
- Condoms and lube
- Contraception
- PrEP

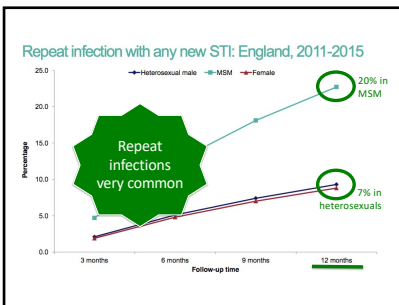
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**Other tests?**

Review tests needed: HIV? Chlamydia?

**Repeat tests?**

- After window period?
- Possible antibiotic failure  
(NB Chlamydia Rx with erythromycin or TV)
- For possible non-compliance / re-infection risk



**Partner notification**

Demystification time!

**Who do patients need to inform?**

For specific infections:

- Current sexual partners/contacts or last sexual partner/contact
- Other recent sexual contacts as per guidance...

HOW MANY PEOPLE DID YOU SAY YOU SLEPT WITH?  
WELL... JUST THE ONE!

SAFER SEX EVERY TIME

**Partner Notification Suggested 'look back' periods**

<b>Gonorrhoea</b>	
• Men with urethral symptoms	• 2 weeks prior to onset Sx
• All others	• 3 months
<b>Chlamydia</b>	
• Men with urethral symptoms	• 4 weeks prior to onset Sx
• All others	• 6 months
<b>PID and epididymo-orchitis</b>	As per infection detected OR 6m
<b>Trichomonas vaginalis</b>	4 weeks prior to Sx onset
<b>Mycoplasma genitalium</b>	Current partner
<b>HIV, Hepatitis B and C, Syphilis</b>	Refer to GUM
<b>Genital warts (HPV), Genital herpes</b>	None!

**Referral**

**Do It well:**  
Give the patient a letter to take

**Check they will go!  
Check they went!**

**Referral**

**Who should we refer?**

- Management of new diagnoses:
  - HIV, HBV, Syphilis, Gonorrhoea
- Severe PID
- Suspect Mpox
- Suspect Mgen:
  - Severe or persistent PID
  - Cervicitis, urethritis, prostatitis, IMB, vaginal discharge
- Diagnostic uncertainty (Does that lump need biopsy? Gynae, derm, GUM?)
- Hard to treat TV or warts
- High sexual health risk esp for PrEP