

2012 European guideline for the organisation of a consultation for sexually transmitted infections.

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Summary: This guideline is intended to serve as a framework for those working in any location where sexually transmitted infections are managed. It offers recommendations which will need to be adapted depending on local facilities and policies, and is not intended to be all encompassing. This guideline should be read in conjunction with other European guidelines on the management of specific infections (see: www.iusti.org/).

Personnel

The following staff are essential to the running of a facility dealing with sexually transmitted infections (STIs):

- Administrative and clerical
- Nursing – qualified and support assistants
- Medical staff – physicians from various disciplines might be involved in such consultations (gynaecology, genitourinary medicine (GUM), dermatology, dermatovenereology, infectious diseases, reproductive and sexual health (RSH), family medicine/general practice, urology, forensic medicine)
- Laboratory staff
- Health care workers who are trained and competent to conduct partner notification (contact tracing).

The following staff can also provide additional services and benefits to such a clinic:

- Research team
- Counsellors and clinical psychologists.

Casenotes and specimens

- All items relating to a specific patient need to be appropriately identifiable throughout their clinical journey – this includes case notes and specimens. Generic guidelines exist for the minimum data set required to identify patient records.¹ The exact details may vary between individual clinics and countries.

Ethics

Many of the topics discussed within a consultation about STIs have the potential to raise ethical issues:

- Confidentiality is pivotal to the doctor-patient relationship within any consultation, but particularly in the setting of sexual health due to the sensitive content. Clinics will need to have clear policies, which should be understood by all staff and which should be made readily available to patients e.g. by displaying posters, providing leaflets or having the policy available on a clinic internet site. This should include clear guidance on the limits of confidentiality, for example when dealing with young or vulnerable persons, and disclosure relating to communicable diseases, including HIV. Specific legal and ethical standards will vary between countries. In the UK, the General Medical Council (GMC) details duties and guidelines which could be adapted to suit local systems.² In addition, many European countries adhere to the Council of Europe's Convention on Human Rights and Biomedicine dealing with consent (Articles 5 and 6), privacy (Article 10) and limitation of these rights in certain circumstances (Article 26).³
- All attempts should be made to maintain patients' dignity, providing privacy to dress and undress, and keeping them covered as much as possible.⁴

Informed consent is a pre-requisite for all examinations, investigations and treatments. Consent is particularly important for intimate examinations of the anogenital area, and a chaperone should be offered in all cases and this offer should be documented clearly in the casenotes.⁴ The presence of a chaperone serves both to reassure the patient and to act as a witness to the consultation. The name of the chaperone should be recorded in the casenotes. Appropriate consideration of best interests must be taken for those who are unable to give valid consent. Staff should seek the express consent of patients for students, or other staff in training, to be present during any part of the consultation, and they must be satisfied that the presence of such an observer will not adversely affect the patient's care.⁵ This is preferably done before the patient enters the consultation room so that they do not feel under any pressure to comply.

History obtained from the patient

This needs to include:

- History of presenting complaint – details of physical symptoms:
 - In females:
 - lower genital tract symptoms:
 - abnormal vaginal discharge
 - vulval symptoms - pruritus, lumps, ulceration, superficial dyspareunia
 - upper genital tract symptoms:
 - pelvic pain
 - abnormal menstruation (inter-menstrual or post-coital bleeding, dysmenorrhoea)
 - deep dyspareunia
 - In males:
 - genital lumps
 - urethral discharge
 - dysuria
 - genital itch, soreness or rash (balanoposthitis, ulceration)
 - testicular pain

- In both:
 - rectal discharge, bleeding or pain
 - anorectal lumps or lesions
 - conjunctivitis
 - mono/pauci-articular arthritis
 - rashes – genital and/or disseminated
 - symptoms suggestive of HIV infection, especially: general malaise; weight loss; night sweats; enlarged lymph glands; skin rashes; oral lesions.

- Past medical history
- Past surgical procedures
- Past history of testing for STIs, including HIV (which may include blood donation or antenatal clinics), and diagnoses of STI
- Drug history, including recent courses of antibiotics
- Drug allergies
- In females – gynaecological, obstetric, menstrual, cervical cytology and contraceptive histories, including the need for emergency contraception. Specific types of contraception should be established, the consistent use of barrier methods for any form of penetrative sex and any condom accidents, will influence the risk of pregnancy and STIs
- Sexual history – details of recent sexual partnerships, specifically enquiring about same sex relationships, and types of sexual contact – vaginal, anal and oral
- Symptoms suggestive of STI (including HIV) in sexual partners
- Characteristics associated with high risk of HIV (and other STIs including the blood borne viruses hepatitis B and C) acquisition:
 - Men who have sex with men (MSM)
 - Commercial sex workers
 - Injection drug users
 - Sexual partners from areas of high HIV prevalence, e.g. Sub-Saharan Africa
 - Recipients of infusions of blood (or blood products), depending upon the date and country of infusion

- Sexual partners of the above

History taking should be done systematically, with more sensitive questions being left until later.

Structured proformas can be used to document key history and examination findings, and subsequent investigations and results. However, it is important not to see the history taking process as a routine, but to remain able to adapt to the patient and clinical situation.

Alternatives to traditional face-to-face history taking include self-completed questionnaires⁶, and computer-assisted structured interviews (CASI). Studies have shown that in many cases reporting by CASI was more reliable, with more patients divulging potentially risky sexual behaviour than when asked via face-to-face interviews. This method may also be more efficient, and has been shown to be acceptable to patients, although language and literacy will need to be taken into consideration.⁷⁻⁹ (Grade B). In both methods, the clinician should confirm the information, and ask further questions as appropriate to clarify and expand.

Physical examination of the patient

Appropriate facilities and equipment for investigations should be available prior to commencing the examination. The room should be well lit, private and soundproofed, with a suitable examination couch of adjustable height. The proposed examination should be adequately explained to the patient before they undress.

It is not necessary to perform a physical examination in all asymptomatic patients. Studies have shown low rates of clinical findings in asymptomatic women attending a consultation for STI screening. Signs are found in less than 4% of cases and many of these are of doubtful clinical significance, such as asymptomatic bacterial vaginosis or candidiasis, genital warts and molluscum contagiosum. In view of this, a genital examination (speculum and bimanual) is not necessary in these cases¹⁰⁻¹⁴. (III, B.)

In asymptomatic men first void urine samples, and in women self-taken vulvo-vaginal swabs, provide sensitive and specific results for *Chlamydia trachomatis* and *Neisseria gonorrhoeae* when nucleic acid amplification tests are utilised, and avoid the need for intimate examinations that may deter some patients from attending.¹⁵⁻¹⁹ In MSM, self-taken oropharyngeal and rectal swabs are a viable and acceptable option.²⁰⁻²¹ (III, B.)

However, patients presenting with symptoms suggestive of a possible STI should have a physical examination (see history section above). Physical examination should include:

- anogenital area
- speculum examination in females
- bimanual pelvic examination in females reporting upper genital tract symptoms
- proctoscopy in males and females complaining of rectal symptoms
- other general (i.e. non-genital) examination as indicated by the history (IV, C.)

Examination of a patient who has been a victim of sexual assault should occur after considering the need for forensic examination within an appropriate time frame for recovery of evidence. Not all clinics will need to provide a forensic service, but a protocol for local referral must be available.

Investigations

- All patients should be offered testing for:
 - *Chlamydia trachomatis*
 - *Neisseria gonorrhoeae*
 - Syphilis
 - HIV
- Other infections should be tested for based on history and examination findings:
 - Vaginal discharge
 - Bacterial vaginosis
 - *Candida albicans*
 - *Trichomonas vaginalis*

- Anogenital ulceration:
 - Herpes simplex virus
 - Chancroid
 - Lymphogranuloma venereum
 - Granuloma inguinale (**Donovanosis**)
- Risk factors for blood borne viruses:
 - Hepatitis B and C viruses
- Urinary symptoms of dysuria and either frequency or haematuria:
 - Urinary tract infections (empiric antibiotic treatment without investigations is an alternative)
 - **Trichomoniasis vaginalis in females.**
- Point-of-care testing (POCT) – consider in symptomatic and high-risk patients, with confirmation by laboratory testing of a venous blood sample:
 - HIV
 - Syphilis

Results and treatment

- Patients should understand how and when they will receive their results prior to testing.
- Diagnoses should be explained, with opportunities for questions, and appropriate patient information leaflets provided where available (leaflets in English and Russian can be found at www.iusti.org).
- In many cases it is possible to give immediate results – e.g. microscopy, POCT.
- Treatment may also be indicated on epidemiological grounds at the initial visit prior to results being available. For example patients who present as the sexual partner of a known STI may be treated at first presentation, in addition to being tested. (Please see guidelines on specific infections for further information). (Grade C.)

- To maximise compliance, and hence successful treatment, single-dose treatments administered in the clinic are preferable. In addition, providing medications without charge is desirable as it removes a barrier to treatment. (Grade C.)
- Appropriate drugs should be prescribed to women who are pregnant or breast-feeding, or in whom pregnancy cannot be excluded.
- Information should be provided about the need to abstain from unprotected sexual intercourse to avoid onward transmission or re-infection.
- If the patient is at high risk of HIV infection then advice should be given on whether to avoid donating blood, either temporarily or in the long-term, depending on blood transfusion policy in the country concerned.
- Attendance at a sexual health clinic offers the opportunity to deliver health promotion advice, regardless of results.
- The reporting of confirmed STI diagnoses should be in line with local policy, and will assist with epidemiological studies and planning of healthcare resources.
- The treatments of specific conditions can be found in other European guidelines, and are not covered here.

Partner notification/contact tracing

- This represents an important opportunity to reduce onward transmission of STI if undertaken well, by detecting and diagnosing cases.
- All patients who have a confirmed STI should be seen by a health professional trained to undertake partner notification. (IV, C.)
- Information gained in the sexual history, and the likely incubation period, will determine which partners require screening and/or treatment.
- Notification of the infection to the sexual partner(s) may be done by the patient or a health professional, and can be done anonymously using links with colleagues in other clinics.
- Legal and ethical frameworks will differ between countries, and must be considered.

Follow-up

- Can be done in various ways, but must always be considered.
- In certain situations a follow-up appointment in clinic should be arranged:
 - If repeat screening is required (e.g. recent antimicrobial use, interval testing to ensure window periods are covered)
 - For tests-of-cure
 - Where repeat treatments are required (e.g. wart treatments, hepatitis vaccinations)
 - To confirm the resolution of symptoms
- In other circumstances, it may be appropriate, and more efficient, to provide a follow up consultation over the telephone:
 - assess adherence to treatment
 - review partner notification/contact tracing
 - assess risk of re-infection and therefore need for further testing or treatment
 - opportunity to reinforce health promotion

Organisations responsible for the production of this guideline

This guideline has been produced on behalf of the following organisations: the European Branch of the International Union against Sexually Transmitted Infections (IUSTI Europe); the European Academy of Dermatology and Venereology (EADV); the European Dermatology Forum (EDF); the Union of European Medical Specialists (UEMS). The European Centre for Disease Prevention and Control (ECDC) and the European Office of the World Health Organisation (WHO-Europe) also contributed to its development.

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Appendix 1.

Declarations of interest:

Neither the authors nor editors had any conflicts of interest for the content of this guideline.

Appendix 2.

Editorial board:

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Appendix 3.

Levels of Evidence.

- Ia Evidence obtained from meta-analysis of randomised controlled trials.
- Ib Evidence obtained from at least one randomised controlled trial.
- IIa Evidence obtained from at least one well designed study without randomisation.
- IIb Evidence obtained from at least one other type of well designed quasi-experimental study.
- III Evidence obtained from well designed non-experimental descriptive studies such as comparative studies, correlation studies, and case control studies.
- IV Evidence obtained from expert committee reports or opinions and /or clinical experience of respected authorities.

Grading of Recommendations.

- A (Evidence levels Ia, Ib) Requires at least one randomised control trial as part of the body of literature of overall good quality and consistently addressing the specific recommendation.
- B (Evidence IIa, IIb, III) Requires availability of well conducted clinical studies but no randomised clinical trials on the topic of recommendation.

C (Evidence IV)

Requires evidence from expert committee reports or opinions and/or clinical experience of respected authorities. Indicates absence of directly applicable studies of good quality.