

	<h2>CLINICAL SERVICES</h2>	Revision: David Lee Ria Fortune Approved by: Ria Fortune Approval: August 2017 Next Review: August 2020
SCREENING OF ASYMPTOMATIC MEN FOR STIs and BBVs BY SEXUAL HEALTH NURSES: PROCEDURE.		

Purpose

This procedure outlines the processes involved for Sexual Health Nurses [SHNs] undertaking screening of Asymptomatic Men for Sexually Transmitted Infection (STIs) and Blood Borne Viruses (BBVs).

Definition of terms

Asymptomatic Men: Men who present to MSHC with no symptoms but with identified risks for STIs and/or BBVs. This may include men with a history of unprotected sexual intercourse, recent or high rate of partner change or contact of confirmed STIs.

Background

Sexual Health Nurses at Melbourne Sexual Health Centre undertake Sexually Transmitted Infection (STI) and Blood Borne Virus (BBV) screening for asymptomatic men. They also initiate and continue genital wart treatments and, in collaboration with the Medical Clinical Coordinator, screen men who are contacts of STIs and initiate pharmacologic treatments

Definition of terms

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Responsibility

- Nursing Services Manager
- Medical Services manager
- Clinical Nursing Coordinator
- Sexual Health Nurses (SHNs) / Nurse Practitioner (NPs)
- Medical Officers (MOs)
- Patient Services Officers (PSOs)

Equipment

- Adjustable light source
- Examination couch/chair
- Disposable gloves
- Urine collection container
- Aptima swab kits and dry cotton swabs
- Normal Saline 10mls plastic vial or Sterile water from MDU
- MG testing tubes
- Viral Transport Medium (VTM)
- Clinical Practice Management System (CPMS)
- CPMS automated microbiology / serology request forms

Process

Prior to testing for STIs and BBVs CASI data [if provided] should be checked for accuracy and a further sexual history and risk assessment performed and documented in the client's electronic medical record (CPMS).

Note for clients under the age of 16 years, or those who may be intellectually impaired, consider triage to MO. This can be helpful if a medical report is required, for example in cases coercion or mistreatment of a minor or impaired vulnerable person

Presenting History

Reason for their visit and reasons why the client requests screening. This may include routine screening or that the client is a contact of a partner with a diagnosed STI

Presence of Symptoms

If it is elicited that the client has symptoms then ascertain the duration and nature of symptoms, including;

- Urethral Discharge and/or dysuria Ano-genital lesions/altered skin integrity such as Lumps (other than warts or Molluscum), Sores/ulcers/blisters/lesions. Rash
- Specifically for Men who have Sex with Men (MSM)
- Anal symptoms (pain, bleeding, discharge etc.)

NB. If the client has uncomplicated symptoms, and the SHN has completed requirements to assess the clients. Please see “Nurse Consult of Uncomplicated symptoms in men” then proceed as per procedure. If on history, the symptoms are more complicated, re-triage the client to see a Medical officer/Nurse Practitioner.

The principles of ISBAR (Identify, Situation, Background, Assessment and Request) are useful for handing over clients to another clinician

Past Medical History

Previous or concurrent medical conditions and treatments undertaken, including mental health issues, chronic medical issues (e.g. diabetes; dermatological problems].

- HEADSS assessment if appropriate
- Known allergies
- Current medications
- Recent antibiotics

Vaccination History

- Hepatitis A (for MSM / PLWHA and men who are hepatitis C positive)
- Hepatitis B
- HPV vaccination

STI and/or BBV History

Previous STI and BBV screening, if not at MSHC, then ascertain and document:

- When and where the tests were performed
- What tests were taken: swab, urine, and/or blood; HIV and/or Hepatitis C
- Previous blood donation (when and where)

Previous STI and BBV Diagnosis

- What infection was diagnosed and when? This is particularly important for infections such as syphilis, hepatitis B and hepatitis C
- Did the client receive treatment (document), follow up and/or referral; and has the condition been followed up by a GP / specialist already.

Sexual Assault History

All clients are to be provided with the opportunity to address any issues relating to their experience of sexual assault in a safe and supportive environment. Assessment relating to sexual assault may include:

- Time of assault: recent/past, in childhood or adulthood
- Has the client received appropriate counselling/support?

The client may be offered referral to MSHC counsellors or another agency such as CASA if he feels he would like support. If the client declines referral document this in the medical record. **If the assault occurred within the past 72 hours, consider referring the client to a Medical Officer, a SHN with experience in Forensic Nursing or an emergency department for forensic testing.**

BBV Risk Assessment

History of Injecting Drug Use (IDU)

- When last injected/used / type of drug(s) including steroids
- History of needle/syringe/equipment sharing

- History of tattoos/body piercing/scarification/acupuncture and the context in which they were undertaken (e.g. professional studio, non professional context, overseas etc.)
- Recipient of blood transfusion/products (Year last transfusion; location – i.e. within Australia or overseas)
- History of surgical or dental procedures in high prevalence countries
- History of sexual practices that involve blood

Sexual History/Risk Assessment

- Time of last sexual contact
- Regular/casual contact; Gender of the contact
- Type of sex (oral, vaginal and/or anal intercourse)
- Condom use; other specific episodes of concern (recreational drug use / alcohol)
- Number of different sexual contacts in the last 3 and 12 months including, gender, type of sex and condom use
- Whether ever any male contact
- Sexual contact overseas or sexual contact with someone from overseas (e.g. a person from a country with high HIV/STI prevalence) in the last 12 months

NB. If it is elicited that the client (e.g. MSM) has had a significant risk exposure to HIV in the preceding 72 hours then the SHN should offer the man a consultation with a MO/NP for the possibility of HIV Non-Occupational Post Exposure Prophylaxis (NPEP). If the client declines this offer then this should be documented in the medical record/consultation notes. (Please see HIV NPEP Policy and Procedure)

Need for Genital Examination

Not all asymptomatic clients require a genital examination. Indication for ano-genital examination should be based on clinical judgement but may include:

- MSM [specifically ano-genitally for any suspicious lesions]
- Contacts of known infection
- If lumps/bumps/warts/molluscum are described
- If a client requests an examination

Genital Examination

Genital examination should be carried out prior to collection of First Pass (Void) Urine (FPU/FVU).

- Ask the client to lie supine on the examination table with lower abdomen and genitals exposed.
- Skin Inspection - Using the examination light, inspect the skin and genitalia: noting general appearance and the presence of any lesions/rash. Also inspect the scrotal skin noting any presence of skin loss, thickened skin; dryness etc.
- Groin: palpate the groin for the presence of enlarged/painful inguinal lymph nodes
- Palpate testes, noting the presence of pain, swelling, lumps and or any hard lumps.
- Locate and palpate the Vas Deferens, noting the presence of pain and/or swelling.
- Inspect the penile shaft, noting the presence of any lesion or alterations in skin integrity.
- If uncircumcised, retract [or ask the client to retract] the foreskin and inspect the skin of the prepuce, glans and frenulum.
- Inspect the urethral meatus, noting the presence of discharge, inflammation or lesions.

Anal Examination (recommended for MSM who indicate any receptive anal/perianal contact)

- Instruct the client to lie on the left lateral side
- Inspect the perianal area noting the presence of erythema, skin intactness, changes in skin colour, warts, skin tags, fissures, haemorrhoids, mass or lesions.

Recommended Screening Tests:

Asymptomatic Heterosexual Men

Most asymptomatic heterosexual men will be eligible for the NETS service, see NETS policy and procedure.

- First Pass Urine (FPU) for gonorrhoea and chlamydia.
- Serological Tests for HIV and Syphilis. Screening for hepatitis B and C should also be offered to heterosexual men if indicated
- [i.e. Hepatitis B if born in HPC; Hep C if BBV risks)

NB. Some clients may choose not to undertake HIV/syphilis screening in the setting of low risk. Clients with identifiable risk factors should be encouraged to undertake this testing. Clients who decline serological testing should have this documented in their consultation notes.

Factors that influence the decision to recommend serological screening include;

- IDU or other blood risks such as non-professional tattoos/body piercing, medical/surgical procedures performed overseas (e.g. blood transfusions).
- Sexual contact or blood contact with HIV positive woman
- Sex in high prevalence HIV/STI countries or with a partner from a HPC
- The client is from a high prevalence HIV country

Asymptomatic MSM

Most asymptomatic MSM who have attended the clinic previously will be eligible for the TAG service, see TAG policy and procedure.

Chlamydia and Gonorrhoea from

The Pharynx

The Rectum

A first Pass Urine sample

The following test should be routinely offered:

- Pharyngeal swab (swipe swab at the posterior oropharynx and tonsillar regions bilaterally) for Gonococcal NAAT, and also chlamydia
- Anal swabs (these may be self-collected if requested by the client)
- Chlamydia and Gonococcal
- FPU for Chlamydia and Gonorrhoea
- Refer to NAAT testing guidelines for instructions



- Serological tests for; HIV, Syphilis and baseline hepatitis A and B at first visit unless proven to have been vaccinated or immune (i.e. check past blood test results). Screening for hepatitis C should also be offered to MSM if indicated.

SHNs should also use the opportunity to

- Recommend STI screening at least once a year and more frequently (every 3 to 6 months) , particularly if they have more than 10 sexual partners per year, attend Sex on Premises Venues, use recreational drugs or seek sex partners via the internet / phone apps. Clients can be offered SMS screening reminders.
- Ensure awareness of access to HIV Non-occupational Post Exposure Prophylaxis (NPEP).
- Discuss PrEP and refer to HIP/PrEPEX clinic if indicated and they have Medicare.

Contacts of Known Infection

Asymptomatic Contacts of Chlamydia

- Asymptomatic clients who present as contacts of chlamydia should be tested for chlamydia by FPU
- Clients who are found to have signs and/or symptoms of urethritis should be examined as per the Policy and Procedure “Nurse Consult of Uncomplicated symptoms in men”
- Encourage MSM who report receptive anal / perianal contact to have anal swabs for chlamydia; if a MSM is found to have symptoms of proctitis then re-triage to be seen by a MO or NP.
- All clients should be offered opportunistic screening for other STI/BBV as appropriate.
- The client should also be encouraged to have presumptive treatment for chlamydia infection in collaboration with the session’s clinical MO. Use the checklist under forms and letters.
- Client will contacted within 7 days any positive/inconclusive results. Negative HIV results will be sent by SMS with their consent within 7 days.
- The clinician is encouraged to offer all client’s who are a contact of chlamydia the form available on the intranet: http://carlton/clinical/patie_infor/review_followup_following_treatment_of_sti.pdf

- Advising them not to have unprotected sex for the next 7 days
- Discuss partner notification [IF +ve for chlamydia], to initiate contact tracing of partner(s) in the preceding 6 months
- [IF +ve for chlamydia], a test-of-reinfection in 3 months

Asymptomatic Contacts of Gonorrhoea

- Asymptomatic clients who present as contacts of gonorrhoea can be offered an examination
- If a client is found to have signs and symptoms of urethritis, proceed if fulfils inclusion criteria for “Nurse Consult of Uncomplicated symptoms in men”. Should the client complain of proctitis then he should be re-triaged to be seen by a MO / NP
- Encourage MSM to have swabs for pharyngeal and anal gonorrhoea as routine
- All clients should also be opportunistically screened for other STIs/BBVs.
- Presumptive treatment option for MSM contact with gonorrhoea at presentation is not recommended routinely, but can be given if the client is very strongly in favour of treatment, or is unlikely to return if positive.
- Culture for gonorrhoea only is performed when the presumptive treatment for gonorrhoea given preferred by client or when client returns for positive gonorrhoea treatment
- The client will be contacted within 7 days with any positive results. Negative HIV results will be sent by SMS with their consent within 7 days. If it is the clients’ preference, they can be offered treatment on the day. http://carlton/clinical/patie_infor/review_followup_following_treatment_of_sti.pdf
- Advising them not to have sex, including oral sex for the next 7 days
- Discuss partner notification [IF +ve for gonococcal], to initiate contact tracing of partner(s) in the preceding 6 months
- [IF +ve for anal or throat GC], Test of cure only dependent on the MIC but not routinely, the FUN will contact them with the appropriate time for a TOC if needed.

Asymptomatic Contacts of MG

- Clients who present as contacts of MG should be tested for MG by FPU (and if MSM, and additional anal swab as well)
- If a client is found to have signs and symptoms of urethritis, proceed if fulfils inclusion criteria for “Nurse Consult of Uncomplicated symptoms in men”. Should the client complain of proctitis then he should be re-triaged to be seen by a MO / NP
- All clients should also be opportunistically screened for other STIs/BBVs as appropriate.
- The man should also receive presumptive treatment for MG infection in consultation with MO.
- The clinician is encouraged to offer all clients who are a contact of MG the form available on the intranet: http://carlton/clinical/patie_infor/review_followup_following_treatment_of_sti.pdf
- Advising them not to have unprotected sex for the next 7 days
- Discuss partner notification [IF +ve for MG], to initiate contact tracing of partner(s) in the preceding 6 months [IF +ve for MG],
- A test-of-cure 3 weeks after the 1st day of 2nd antibiotics Must to be followed

Herpes Simplex Virus (HSV)

Serologic testing for HSV is not recommended in the asymptomatic client, as it is not considered a screening test.

Clients presenting with identifiable symptoms of genital herpes or genital ulceration will normally be triaged to see a doctor, however occasionally clients with unrecognised symptoms may be identified by the SHN through history taking and/or examination. If a man is found to be symptomatic or has signs that are consistent with HSV infection then consult with a MO and swab for HSV (PCR) if advised. The specimen should be collected by;

- Using cotton tipped wooden swab and a Viral Transport Medium VTM.
- If vesicles are present then collect fluid from the vesical, which may require the vesicle to be broken.
- If there are scabs or overlying debris are present then gently debride the lesion and collect any underlying exudate by firmly rubbing the tip of the swab on the lesion.
- Place the swab in the viral transport medium, snap off the end of the swab and seal the vial. Attach a name code sticker the specimen including the site (eg penis, labia etc)
- Complete a VIDRL Pathology Request Form and place together with the specimen in a specimen bag. Place this in the refrigerator in the clean utility room on the M side of the clinic.

Specimen Labelling

- Prior to being collected, all specimens should be labelled with the Client's 2X2 name code sticker with the specimen site clearly documented. Check the labelled collection receptacle (including blood) with the client to confirm that it is the client's specimen. Refer to specimen labelling policy on the intranet.

Specimen collection

FPU for chlamydia /gonorrhoea or MG PCR.

Provide the client with a urine specimen container and instruct him to collect the first part of the urine (when the stream commences), filling the container about ½ full (10-30 mls). Replace the lid securely, place in a plastic bag and return it to the SHN. Ideally, the client should have not passed urine for at least an hour.

Pharyngeal Swab for Gonorrhoea Culture and Sensitivities

- Instruct the client to open his mouth (use a tongue depressor if necessary) and swab the posterior pharynx and the tonsillar crypts.
- Inoculate the swab on to a GC agar plate, on both sides of the plate and label

The preferred method of specimen collection for chlamydia and MG from the urethra is by FPU, if this is not possible (e.g. the client is unable to urinate) then urethral swabs may be used. Using the Aptima swab kit provided soak the swab in Normal Saline, gently inserted into the urethra 2-4 cm and rotating in one direction for ≥ 1 revolution and withdraw and replace swab immediately into the plastic sleeve.

Anal Swabs:



Anal swab for Chlamydia

- Use the Aptima swab kit provided
- Instruct the client to lie in the left lateral position.
- Blind swabbing of the rectum is undertaken by inserting the swab 2-3cm into the anal canal pressing laterally to avoid faecal matter. The swab is then removed and placed back into its transport tube.
- The swab can be lubricated with sterile water or saline
- For anal MG test, a separate FLOQ Swabs is required

Anal Swab for Gonorrhoea

- Use swab provided from the Aptima test kit, place in the media and ensure the sample remains upright until it gets to the lab.
- The swab can be lubricated with sterile water or saline

Requesting Pathology Test for Medical Diagnostics Unit (MDU: on-site lab)

- All requests for pathology tests outlined above should be made and submitted electronically under the MDU tab in CPMS prior to the specimens being transported to the laboratory.
- NB. Specifically requesting tests for MG requires the practitioner to choose the "Test for MG" in the VCS/Mg tab in CPMS. Once complete, print the request form and transport this along with specimen to laboratory for processing.
- When ordering a MG FPU, two MG tubes are required; label the two empty tubes and place together with the FPU and request form.
- When ordering an Anal MG test, a separate swab should be collected.

Serological Tests

- HIV antibody (Ab) (For specific requirements refer to MSHC CS. HIV Antibody Testing Policy and Procedure)
- Hepatitis A Ab

- Ideally should only be requested where the client has a history of MSM, or is known to be hepatitis B, C or HIV positive.
- **Hepatitis B (cab/sab/sag) Testing and Vaccination**
 - ❖ Serological Screening for Hepatitis B should be performed on
 - Clients with family members with hepatitis B
 - Clients from Hepatitis B high prevalence countries
 - Clients with high risk exposure, including IDU and/or MSM
 - Clients with Hepatitis C
 - Clients who are Aboriginal and Torres Strait Islanders
 - ❖ NB. In addition to serologic screening these clients should be offered a course of hepatitis B vaccine at first presentation if no evidence of vaccination (NB. Hepatitis B vaccine produces neither therapeutic effects nor adverse events in hepatitis B Carriers)
 - ❖ For clients who don't fit one of the risk categories listed above then testing for hepatitis B is generally not recommended;
 - ❖ If the client has previous documented immunity (either natural or vaccination immunity) or gives a history of a complete course of vaccination then there is no need to retest for Hepatitis B (NB. Testing for post vaccination immunity is only recommended if the client is at significant occupational risk, is immuno-compromised, or has pre-existing liver disease.) If the client gives a history of partial or incomplete vaccine course then, don't retest and plan a hepatitis B 'catch up' schedule (please refer to CS. Vaccine Provision by Sexual Health Nurses (Hepatitis B): Procedure). If the client has no known history of Hepatitis B infection or vaccination then serology is not indicated and the client should be offered a course hepatitis B vaccination at first presentation.
- **Hepatitis C ab** (For specific requirements see MSHC CS. Hepatitis C Screening and Management Policy and Procedure)
- **Syphilis Screening** is recommended for all MSM.
- **For new clients, particularly GMSM, its very important to document a clear history of syphilis testing and treatment.**

Should there be past evidence of syphilis, please indicate the year of diagnosis, type of treatment provided and where. This should be documented in the past history as well as in the pathology request form. Any client presenting as a contact of confirmed syphilis should be referred to a MO / NP for assessment particularly for any neurological and constitutional signs / symptoms and requirement for presumptive treatment.

Serology Request Forms

- HIV: (see MSHC CS. HIV Antibody Testing Policy and Procedure) and all other serology test should be requested using the VIDRL tab on CPMS, and the serology room nurse will call the client.
- Clinic rooms are also set up for serology testing. The SHN can order and take serology specimens in clinic rooms if appropriate.

Obtaining Results

- All clients should have their contact details checked by the Triage Nurse or admin staff. Ensure that the client has a local Australian mobile number as SMS will not be sent to an international mobile number
- With client permission, we will send their negative HIV result via SMS within seven days.
If their HIV result is either positive or inconclusive, we will call them and ask them to attend the clinic to discuss their result.
If they decide to opt out of this service they may be asked to call to check the status of their HIV test. We will call with other test results only if they need further treatment or follow up.
- If the client indicates that they would not be able to receive a phone call asking them to return to discuss their result and the risk is significant, consider referring to the Counselling Team for a result appointment.
- Any contact of an infection should be asked to phone in seven (7) days to confirm if their results were positive or negative.

NB. If the SHN believes there are circumstances, (e.g. significant risk) which warrant an appointment for results then this should be indicated on the results access slip. The client should then be asked to take this slip (which should have his UR number on it) to reception where an appointment can be booked.

Positive Test Results

The follow up of all positive results falls within the domain of MSHC Follow-Up Nurse (FUN) who ensures all positive results are adequately followed up according to predetermined guidelines.

Referral to MSHC Sexual Health Counsellors

Referral to the counselling unit should be considered (but not limited to) and offered if;

- The client is experiencing excessive anxiety relating to testing that is disproportionate to the actual risk exposure.
- There is concurrent or exacerbated mental health issues particularly if there is a risk of self harm. Please check if the client is already having care provided by an external psychiatrist or counsellor. If so it is probably appropriate to refer them back to this professional rather than engage them with the MSHC counsellors
- There is a likelihood that a positive result may be returned or if further intervention is required to modify risk behaviour
- The client has experienced sexual assault.
- Clients complaining of sexual dysfunction should be referred to their own GP for assessment especially if >40 years old, or to appropriate external clinicians listed on the Referral section of the intranet.
- All offers of referral to counselling should be documented in the electronic medical record. If the client declines the referral then this should be documented.

Reference documents

- CS. HIV Antibody Testing Policy
- CS. HIV Antibody Testing Procedure
- CS. HIV NPEP Policy
- CS. HIV NPEP Procedure
- CS. Hepatitis C Screening and Management Policy and Procedure
- CS. Vaccine Provision By Sexual Health Nurses: Policy
- CS. Vaccine Provision By Sexual Health Nurses (Hepatitis A): Procedure
- CS. Vaccine Provision By Sexual Health Nurses (Hepatitis B): Procedure
- CS. Vaccine Provision By Sexual Health Nurses (Twinrix): Procedure
- CS. Walk-In Triage System Policy
- CS. Walk-In Triage System Procedure
- CS. Results policy and procedure
- “Nurse Consult of Uncomplicated symptoms in men” http://carlton/clinical/treat_guide.html