Public Health

WHAT YOU DON'T KNOW COULD Hurt YOUR PATIENT

Why Taking a Sexual History Matters

BY ELAINE PIERCE, MD, MPH

"One in four adolescent girls in the United States is infected with a sexually transmitted disease (STD)." Perhaps the only thing more startling than this statistic from the recent national population-based study was the fact that 20 percent of teen girls with a single lifetime partner were already infected. The vast majority of persons studied were asymptomatic and unaware of their infections.

STDs take an enormous toll on health here and around the world. Chlamydia and gonorrhea outnumber by far all other reportable diseases. Nationally, there are over one million cases of pelvic inflammatory disease (PID) annually. Twenty percent of these women will become infertile, with the risk of infertility doubling with each subsequent episode of PID. Another 18 percent will develop chronic pelvic pain, and 9 percent will have an ectopic pregnancy. These infections occur mainly in young women who are at the beginning of their reproductive years. Other consequences of these diseases include urethritis, epididymitis, proctitis, adult conjunctivitis, Fitz-Hugh-Curtis syndrome, Reiter's syndrome, neonatal conjunctivitis, and pneumonia. STDs that cause inflammation (e.g., trichomonas and gonorrhea) and those that cause ulceration (e.g., herpes and syphilis) increase risk of both acquisition and transmission of HIV. Congenital syphilis can lead to spontaneous abortion and devastating malformations in newborns.

While any sexually active person may be affected, STDs disproportionately affect persons of color and those with fewer means to seek help. In San Diego County, Latinos and African Americans are more likely to be exposed to chlamydia and gonorrhea, even if they have few sexual partners. Persons of color are more likely than whites to be diagnosed with HIV shortly before developing AIDS.

The county is also experiencing rising rates of syphilis, primarily in gay men and other men who have sex with men (MSM). HIV-positive persons who get infected with syphilis are at risk for early neurosyphilis, which can lead to permanent neurologic deficits, such as blindness or stroke. A report from the New York City Public Health Department showed that while 19 percent of white MSM failed to reveal their status to their medical providers, 60 percent of African American men, 48 percent of Latino men, and 47 percent of Asian men did not disclose their MSM status. This reveals the cultural stigma and discrimination that continue to make some patients reluctant to provide critical information without prompting. Furthermore, despite the 2006 CDC national guidelines, which call for HIV testing for all sexually active persons between 13 and 64, men who did not disclose their risks were only half as likely to be tested for HIV (36 percent vs. 63 percent).

In 2002, only 38 percent of American women seeking emergency contraception after unprotected sex were offered STD/HIV testing. A Canadian study found that primary care physicians and gynecologists discussed condom use with their sexually active patients less than 50 percent of the time and less than 35 percent inquired about specific sexual risks. Male clinicians were significantly less likely to explore these areas than their female counterparts. Examples like these of missed opportunities for detection abound.

Just like the general public, physicians have a wide range of attitudes and beliefs. Many are uncomfortable with discussions about sexual practices and are apprehensive that patients will be upset if conversation about sexual history is initiated; however, studies have found that, far from being offended, patients feel that they receive better care when their sexual health is assessed during medical evaluations. While teenagers rarely bring up sexual matters to their physicians, most are willing to discuss their concerns when asked.

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The take-home message is that clinicians need to do a better job of protecting their patients from diseases that may insidiously do damage to them, or, in the case of women, their unborn children. Providers need to keep any personal opinions to themselves and ask how they can best serve in a compassionate, effective manner those who depend on them.

Wondering how to begin the discussion? Here is a good introduction: "Now I am going to take a few minutes to ask you some direct questions about your sexual

[For the complete version of this article with resources, please go to www.SDCMS.org.]

health. These questions are very personal, but it is important for me to know so I can help you stay healthy. I ask these questions to all of my patients regardless of age, marital status, or sexual preference, and, like the rest of this visit, the information is confidential." Alternatively, the first website listed below provides a patient-administered sexual history questionnaire that can be reviewed during the interview.

The taking of a sexual history matters because it will help you as the provider make three critical decisions:

1. How often to screen the patient.
2. What diseases to screen for.
3. What body sites need to be screened.

The components of a sexual history are "the five Ps":

1. Partners
   a. Number (all sexually active women under 26 should be screened for chlamydia annually; persons with multiple partners or additional risks require more frequent STD screening).
   b. Gender (MSM who are not in a mutually monogamous relationship should be tested for syphilis, chlamydia, and gonorrhea every three to six months).
   c. Risk factors (e.g., sex under the influence of drugs or alcohol; anonymous partners).
2. Pregnancy Prevention
3. Protection From STDs (condom use)
4. Practices (accurate diagnosis of chlamydia or gonorrhea requires specimen collection from each body site exposed; knowledge of sexual practices determines which patients are more likely to have occult primary syphilis ulcers and present with secondary syphilis).
5. Past history of STDs (recent history of chlamydia or gonorrhea increases current risk — rescreening at three months post-diagnosis is recommended; persons with a history of syphilis need follow-up nontreponemal titers to determine whether treatment was successful).

Eliciting a frank sexual history creates an opportunity to discuss risk reduction, especially if a diagnosed STD provides a "teachable moment." These conversations are not a "one size fits all" activity — they should sound very different with a man who has numerous anonymous partners, a middle-aged woman re-entering the dating scene after a divorce, or a teen who has recently become sexually active. Standard didactic messages usually do not modify behavior, but nonjudgmental, individualized risk reduction coaching has been shown to lessen the likelihood of future STDs. The key is to understand the patient's starting point via the sexual history, and to encourage patients who engage in risky behavior to step down one or two levels from the current level of risk.

Despite requiring deeper introspection than most other aspects of one's job, the prevention and treatment of sexually transmitted infections can be a rewarding arena to truly practice the science — and art — of medicine. These resources provide a wealth of information to support your efforts:

- www.stdcheckup.org
- www.cdc.gov/std
- www.sfcityclinic.org/providers
- www.ashastd.org

ABOUT THE AUTHOR: Dr. Pierce is the STD controller for the County of San Diego, Public Health Services.

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