NEWSLETTER #6

STIs in Gay Men Action Group March 2010

A National Plan for Tackling Syphilis in Gay Men

The syphilis epidemic is is not news to many readers of STIGMA newsletters but the development of a National Gay Men's Syphilis Action Plan (NGMSAP) which aims is to produce a sustained reduction in infectious syphilis by 2013 probably is. The Plan has been guided by mathematical modelling of the expected impact of some public health interventions, complimentary social research about the acceptability of interventions, a technical workshop and summaries of current Australian and international public health responses to syphilis. (www.stigma.net.au for a copy of the plan)

Increasing the frequency of syphilis testing in highly sexually active gay men and contact tracing actions are expected to have the greatest impact on the syphilis epidemic and were considered acceptable to the community. (see graph)

Priorities For General Practitioners

Priority 1: Syphilis testing

1. Sexually active HIV positive gay men every 3 months with HIV monitoring visits
2. Highly sexually active gay men (>20 partners per 6 months) at least every 6 months
3. All gay men presenting for STI/HIV testing

Social research for the NGMSAP revealed a desire for convenient ways of combining syphilis testing with other activities and also the acceptability of reminders to test. Alternative clinical models including rapid syphilis tests were recently undertaken at the Mardi Gras Fair Day and will be explored further soon.

Priority 2: Contact tracing

1. Make contact tracing a standard part of syphilis management

Gay men want to 'do the right thing' by their sexual partners and there was a 'code of ethics' supporting patient-initiated partner notifications. However, they needed support and suggestions of how to contact partners including referral to online resources eg www.whytest.org and www.thedramadownunder.info and to public sexual health services (see http://www.stipu.nsw.gov.au/)

Figure 1.

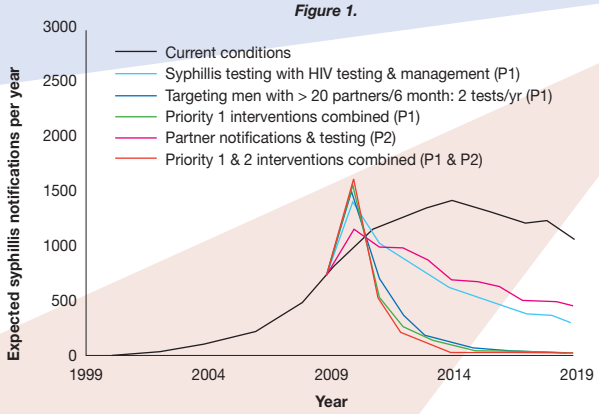


Figure 1. Simulations showing the expected syphilis notifications associated with implementation of interventions listed in Priorities 1 and 2. For each intervention the percentage of men who never get tested is reduced from 15% to 10% (Priority 1) and rates of condom use are maintained (Secondary Priority 1). The light blue curve shows the expected impact of incorporating syphilis testing with HIV testing and management if 90% of diagnosed HIV-infected men are tested 4 times per year and if all HIV tests of men not previously diagnosed with HIV are accompanied with a syphilis test (Priority 1). The dark blue curve shows the expected impact of testing 90% of men who have greater than 20 partners per six months (Priority 1). The expected overall impact of all the interventions in Priority 1 is shown in green. The pink curve shows the expected impact if partner notification (Priority 2, such that 75% of regular partners and 10% of casual partners are notified and receive a syphilis test). The red curve shows the expected impact of effective implementation of both Priorities 1 and 2.

Other Clinical Activities To Come:

- MSM STI testing guidelines are being updated to reflect the NGMSAP
- Public clinics will be reviewing their operations to further increase the ability of gay men to receive accessible and frequent STI testing
- Exploring the use of rapid syphilis testing being integrated into clinical outreach to high risk men and venues.

Supporting Priorities

- A proposed syphilis chemoprophylaxis study was supported
- Gay community health promotion about syphilis, condom use and Syphilis testing

Contribution by Dr Chris Bourne

Syphilis Case

[Interviewer] I understand you had an interesting case of syphilis this week. How did he present?

[Doctor] He went to his GP 6 weeks ago with a penile ulcer, just below the glans. It was indurated and not particularly tender. His GP simply asked him if he has sex with men or women, and the patient said he had a regular male partner. So very quickly his GP thought this was a chancre, the primary lesion of syphilis, and confirmed the man's sexuality which is important as most cases of syphilis in Sydney are in MSM.

What test did he perform?

He took blood for a syphilis screening test, and a swab of the ulcer for herpes and for syphilis by PCR. While he thought it was

This newsletter is produced twice yearly by the STIGMA GP Working Group and is written for general practitioners in metropolitan Sydney.

This working group focuses on informing GPs of issues relating to gay men and STIs and includes sexual health specialists, health promotion and education specialists and GP representatives. Feedback or suggestions to: diana.bernard@sswahs.nsw.gov.au

syphilis, testing for herpes as well is important, because herpes ulcers are very common.

What were the results?

The screening ELISA test for syphilis was positive. The TPPA confirmation test was also positive, and the RPR titre was 1:16. Then the PCR for syphilis was also positive. The herpes test was negative.

Were any other tests performed?

Yes. The GP not only knew that most syphilis is occurring in the gay community, but that HIV infection has been common in these cases. So he ordered serology for HIV too. The man had already been vaccinated for hepatitis A and B, so there was no need to order hepatitis serology as well. The GP also took a throat swab for gonorrhoea by culture, and urine and a rectal swab to be tested by PCR for gonorrhoea and chlamydia.

Pretty straight-forward case so far. What was interesting about it?

Well, his GP wrote the patient a script for benzathine penicillin 1.8gm. This comes in 900mg vials, so two are needed as a stat intramuscular injection. This is the correct treatment for early syphilis. But the patient's partner was a nurse, who obtained some penicillin and then gave him the injection. They made sure the dose was 1.8gm, from two vials of penicillin, but unfortunately, it was only benzyl penicillin, not benzathine. Simple benzyl penicillin is short-acting and not sufficient to adequately treat syphilis.

So what happened?

The patient's chancre healed, so he thought the treatment had been effective. But the chancre of syphilis heals naturally anyway. About a month later, the patient developed a rash over his body, was feeling unwell, and went to see the first GP. They both suspected secondary syphilis. When I saw the patient, he had reddish macules on his trunk and arms, and when the lesions are on the palms of the hands or soles of the feet like it was, you can bet it is syphilis.

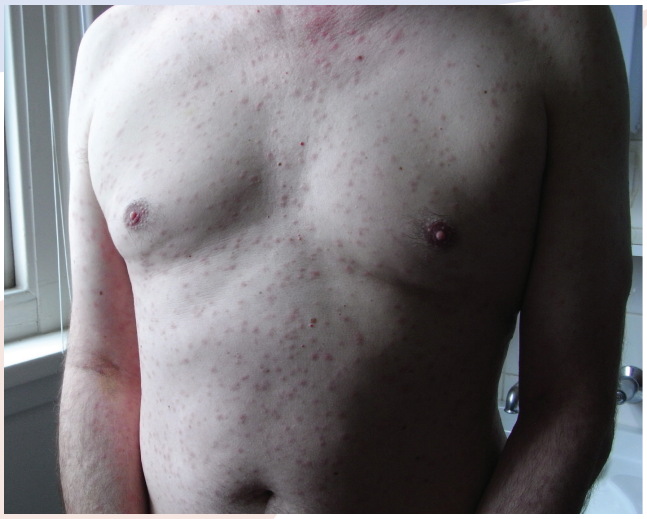
He did not have other clinical features such as lymphadenopathy, patchy hair loss, odd superficial lesions on the mucosa of his mouth. But his RPR had increased to 1:32.

How did you treat it?

With benzathine penicillin as mentioned. I also took another test for HIV because the first one could have been done during the window period for HIV. Fortunately the repeat test was also negative.

So that's it then?

Not quite! If a patient has an important STI to treat, there is at least one partner who also needs treatment. It turns out that the patient's regular partner had treated himself with the same inadequate benzyl penicillin, so he is coming in to get treated too. We will then try to trace back for other sexual contacts who should be treated, or at least tested.



So what do you recommend for the future for your patient?

Well, his screening ELISA test for syphilis will be positive for life - being a marker of both current or past infection whether treated or not, the same as lots of antibody tests. But the RPR (or VDRL) tire should fall dramatically and remain low or revert to negative. He needs a test in 6 months to be sure of this. But all MSM should have regular STI tests. We recommend a minimum of annual blood tests for syphilis and HIV. We recommend that all MSM get tested for hepatitis A and B, and vaccinated if sero-negative. We recommend a throat swab for gonorrhoea by culture, and urine and a rectal swab to be tested by PCR for gonorrhoea and chlamydia. But annual is the minimum - if men are having a lot of partners, then they need more frequent testing. And men who are used to it, or have had instruction, can take their own anal swab. It is very simple to take, and just as accurate as the doctor taking the sample. And remember - you cannot detect rectal gonorrhoea on a sample of urine!

Contribution by Dr Stephen Davies

Other clinical resources:

STI Information for Gay Men:www.whytest.org
AIDS Council of NSW: 9206 2000 or www.acon.org.au
NSW Sexual Health info line: 1800 451 624 or www.health.nsw.gov.au/sexualhealth
Sydney Sexual Health Centre: 9382 7440
Albion St Centre: 9332 9600
Kirketon Rd Centre: 9360 2766
RPA Sexual Health Clinic: 9515 3131
Northern Sydney Sexual Health Service: 9926 7414

Invitation

We would like to invite any interested GPs to be on our Stigma Website Gay friendly list so that we may refer gay men to GPs with particular interest in and knowledge of working with gay men. If you would like to be on our list please go to http://www.stigma.net.au or contact: ddeschamps@csgpn.com.au