Sexual health: did we miss the mark?

Dear Editor.

I am a great fan of your publications. I feel there has been a trend, however, toward publishing articles written by specialists, apparently without going through a filter of assessing their relevance to the daily decision making within a true general practice context. Articles authored by General Practitioners with some advice from specialists are more valuable.

As one example, may I refer to the "How-to guide for a sexual health check up", in BPJ 52 (Apr, 2013). The guidance and recommendations in this article are relevant to practice in a sexual health clinic, where there is a high prevalence of STIs in the patients seen, but this article does not address the issues of pre-test probability and judgement around relevance and appropriateness in ordinary general practice consulting. We see some patients for whom these recommendations are appropriate, but frequently make difficult judgements about how far to take sexual health screening, and it would be very helpful if an article such as this helped us with these decisions.

Working through this article, written by sexual health specialists, one reads that "A sexual health check should generally be undertaken ... for females attending for routine contraceptive or cervical screening visits." Further on in the article one finds, "Routine examination and testing for females should include ...serology for hepatitis B (if not immunised), syphilis and HIV." In mainstream general practice, providing comprehensive care to patients and their families over the years, faced with, for example, a 35 year old woman, well known to us in an apparently stable relationship and with a family, who is seeking a repeat of her contraception, or a 50 year old woman responding to a recall for a now due cervical smear, we need to employ a different set of skills, rather than follow a blanket over inclusive recommendation which has relevance to a sexual health clinic. We know that with such familiar patients, the probability of an STI being present is low, but not altogether negligible. What questions do we ask the patient and what tests do we offer and with what wording in this context? The suggested lead-in statement, "We ask everyone the same questions, they may seem intrusive but I'm just trying to find out risks and what tests you may need," may not seem appropriate.

Furthermore, if we do obtain a positive chlamydia result in an asymptomatic patient, with a personal profile which suggests a very low pre-test probability, how likely is it that this is a true positive result? This article does not address questions like this.

I wonder whether specialists, when invited to contribute, are aware of the nuances that we encounter on a daily basis? In inviting them to contribute, would it be helpful to provide them with a set of vignette scenarios from general practice which would help keep their idealised articles grounded?

Dr Greg Judkins
General Practitioner and Medical Educator
Auckland

All main articles for Best Practice Journal and Best Tests are authored by our in-house writing team, with assistance and guidance from our clinical team, which consists of four General Practitioners and a Pharmacist. Each article is externally reviewed by a relevant subject specialist (or group), who provides expert comment and correction as required. The articles are also reviewed by our Clinical Advisory Group which is made up of primary and secondary care representatives. We then edit the articles for publication, based on the balance of all of these comments.

The article you refer to ("A how-to guide for a sexual health check up") is considered a foundation article, which is intended to give a general overview of all aspects of a particular condition/disease process. Foundation articles are then followed up by more focused articles on specific aspects of managing a condition. Our foundation guidance is intended to cover "what you should do" to manage a condition, in an evidence-based, New Zealand context. However, we intend for clinicians to interpret the information based on the context of their individual practice, i.e. "what you actually do".

We endeavour to keep our information primary-care and practically based, while incorporating latest evidence and commentary from those who specialise in treating the conditions we write about. Your feedback serves as a useful reminder to us of the importance in getting this balance right.

We have asked Dr Jill McIlraith, an experienced General Practitioner from Dunedin, who teaches sexual health to GP registrars, fellow GPs and undergraduates, to comment further on some of the aspects raised in this letter:

"I feel that the article strikes an excellent balance between the detailed knowledge required for a General Practitioner faced with doing a required sexual health checkup, and that of reminding us all of the basics. I think of it as a resource into which we can dip for information rather than a prescriptive guide that we as General Practitioners should use for each and every patient. It was clear, concise and offered good reminders about the essentials of what is often a difficult area for General Practitioners as well as touching on some of the current issues such as antibiotic resistance.

I disagree with the comment that in mainstream general practice, you would not at least discuss the subject of STIs with each patient when doing smears or renewing contraception. I make opportunities to discuss it with my patients, just as I do the same for smoking cessation. My policy has long been to ask all female patients in general terms whether there "is anything else we need to check for while doing the smear". Some patients then ask "what do I mean?" and I reply that people lead complicated lives and it is my policy to ask everyone for whom I do a smear, whether they have any other concerns that I can help with. In other words, I take on the responsibility of broaching the broader aspects of sexual health. In 23 years of general practice, I have never had a patient indicate they are offended by me asking, and most have appreciated my thoroughness and care - particularly those such as in the correspondents example, i.e. a 50-year-old woman who usually find it very difficult to bring up the topic unless the doctor does so first. They are often the ones who most need us to break the mold and be upfront.

It would be naïve of us General Practitioners to think we know all our patients so well that we don't need to broach such sensitive subjects. It is also worth reminding all our colleagues that the fastest rate of increase of STIs in the western world is in those aged over 50 years, and that very little sexual health information is targeted to this age group. They are also the least likely to broach the subject with doctor and nurses, least likely to use condoms and most likely to confuse symptoms of STIs with age-related changes and put off talking to medical staff about it.

Regarding positive chlamydia tests, the NAAT tests used now are very sensitive and very specific and it would be very rare to get a false positive. So a positive result is likely to be just that - positive. Any concerns are more likely to surround the discomfort that the clinician may feel in that they now need to discuss how/when/who gave what to whom. It is a similar comment to what we hear from midwives, i.e. that their "nice" patients wouldn't have an STI so why should they offer testing and if it did come back positive it would create difficulties for them in discussing and stress the relationship.

I would highly recommend the article to my general practice colleagues. Each of them can quite easily filter it through their own knowledge and comfort levels to do the best by their patients in an area that a lot of General Practitioners do poorly in."

Dr Jill McIlraith
General Practitioner, GPEP teacher.

Dr Sunita Azariah, is a Sexual Health Physician from Auckland, who provided expert comment on the sexual health article in Best Practice Journal. Dr Azariah offers some further insight:

"I agree that this article is an example of best practice recommendations in an ideal world. I appreciate that General Practitioners have time constraints, as do all practitioners. Sexual health history and assessment and screening of asymptomatic people fits well within the role of an experienced Practice Nurse. With widespread availability of NAAT testing it doesn't need much time to actually test people as they can do self-collected samples.

Different primary care practices will have different risk profiles for their patients. I think the need to establish an environment where people will feel comfortable to talk about their concerns is what is most important, e.g., the gay man who doesn't know how his General Practitioner will react to disclosure of his sexuality. Many primary care practices market themselves as

"Family medicine" so routinely asking people about their sexual health concerns is a way of breaking the ice and making people feel more comfortable to raise issues if they wish. It will also make them aware that they can bring up concerns if their General Practitioner has signalled they are comfortable discussing these issues with them.

I think too, as with any guidance, one has to use common sense as to what you actually do in clinical practice. The point of the sexual history is to check risk factors as many people will not need to have comprehensive STI screening. However, if you don't ask you won't find out relevant information. One can't assume that the "nice married 30 year-old professional woman" is not having concurrent sexual partners or that her husband is not having an affair. People won't get offended if things are discussed in the right way."

Dr Sunita Azariah
Sexual Health Physician,
Auckland Sexual Health Service

Practice report on dabigatran

We received three similar correspondence items in response to our April 2013 practice report on testing renal function in patients receiving dabigatran. The following is an extract from one of these letters; we have removed practice details for confidentiality.

Dear Editor,
I wonder if other practices were as surprised as us by the latest Practice feedback regarding dabigatran. One of its major features was the percentage of patients that had had renal function measured before starting medication, and the national figure was only 32%. In our practice it was 27%. As we had not taken on the task of change management lightly we were rather surprised, and may I say affronted, by this data. We thought we should investigate so that we could learn from the error and folly of our ways and make the necessary changes to our policies.

The results of our investigations (admittedly our sample size is small at 14) show:

- *Two patients were started on dabigatran in hospital and had renal function measured during the admission before dabigatran was started*
- *Most patients were changed over from warfarin after informed consent and all but two followed the following procedure: discussion, prescription and explanation; renal function and INR within the following few days and then in communication with the practice when the INR was at a suitable level the patient started dabigatran.*
- *Two patients did not have renal function tested within a month of starting dabigatran but had good stable renal function measured within two months*
- *Most of the patients started dabigatran in winter 2011*
- *Our percentage of patients who had had renal function measured within a month before starting dabigatran was therefore actually 86% rather than 27% as appeared on the feedback.*

To us, this raises several questions:

- *What is the relevance of this feedback if the national experience is similar to ours in that most dabigatran was started nearly two years ago*
- *What is the relevance of feedback when the information presented is obviously flawed because of lack of analysis of the raw data*
- *Should we take notice of any feedback that bpac^{nz} presents to us?*

Name withheld

The purpose of the feedback that bpac^{nz} supplies is to facilitate regular audit processes within practices and to stimulate discussion within the primary care team.

Two important factors about practice reports to keep in mind are that:

- Data is presented for all registered patients in a practice, regardless of who prescribed or ordered tests for these patients. In many cases, this includes clinicians outside of the practice and clinicians working outside of primary care.
- Data is extracted from the Ministry of Health Pharmaceutical and Laboratory Claims collections, which encompass prescriptions dispensed from community pharmacies and investigations carried out in community laboratories. This means that medicines given and investigations ordered for patients while in hospital, are not included in the data analysis.

One of the key messages in the dabigatran report was to emphasise the importance of checking renal function prior to starting dabigatran, to ensure that it is prescribed appropriately. In order to investigate this, we identified patients in practices that were prescribed dabigatran, and looked to see if they had a creatinine test within the month prior to their first prescription. In an individual clinical setting, there are many reasons why a test may not fall into this exact time frame, however, for the purposes of putting together a data report, we need to set specific parameters that reflect a "best practice scenario" for all patients.

We reviewed the data from the practice described in the above letter. We found that 15 registered patients had been prescribed dabigatran. Of these patients:

- Four had a creatinine test in the month before their first dabigatran prescription was dispensed (hence the 27% figure reported for this practice)
- Five had a creatinine test one to two days after the prescription was dispensed
- Two had a creatinine test more than one month, but less than three months, before their prescription was dispensed
- Four did not have a creatinine test in the three months before or one month after their prescription was dispensed

In reviewing this practice's data, it is reasonable to say that the patients who had a creatinine test within a day or two of picking up their dabigatran prescription, and the patients who had a creatinine test just over a month prior to starting dabigatran were also managed as recommended. It is possible that some or all of the four patients who did not have a test in a community laboratory, had a test whilst in hospital. Practices could identify this in an audit if they have transcribed this information into the patient record, from the hospital discharge notes.

We acknowledge that our data parameters were strict, and that some leniency on the cut-off dates for testing would have increased the percentages for many practices. However, recommendations are that the results of a creatinine test should be reviewed before prescribing dabigatran, therefore the test needs to take place before the prescription is collected, and a creatinine result should ideally be no more than one month old, as the clinical situation may have changed, given the older age of the patient population who are usually prescribed dabigatran.

In response to the correspondents additional questions;

Although many patients were changed from warfarin to dabigatran two years ago when dabigatran first became available, new patients are regularly being initiated on dabigatran, and the report serves as a reminder to all practices on important points to take into consideration when prescribing dabigatran.

The data analysis is not flawed, it is just subject to limitations such as the criteria we have set for analysis and the fact that the data captures community dispensing and laboratory testing only.

Practice prescribing and/or laboratory testing data reports are created to help reinforce key messages important to primary care, and we strive to make this useful for practices, and to explain the processes and limitations of each report so it can be interpreted meaningfully. We welcome feedback on our reports so we can perfect these processes.

As a footnote, we have recently distributed a practice report on baseline testing prior to prescribing isotretinoin. We have listened to your feedback and defined a baseline test as one that occurred 12 months before or three weeks after a patient received their first prescription for isotretinoin. Baseline tests should ideally occur within one month, but given the younger patient population that is prescribed this medicine, with generally stable health parameters, a longer time period for a baseline test was used for the purposes of the report.

Write to us at: Correspondence, PO Box 6032, Dunedin or email: editor@bpac.org.nz