Aotearoa New Zealand STI Management Guidelines for Use in Primary Care

HIV

Cause

- Human immunodeficiency virus (HIV)

Overview

- Around 3500 people in Aotearoa New Zealand are currently estimated to be living with HIV, with approximately 200 new infections per year
- Transmission is via condomless vaginal and anal sex, sharing needles, from mother to child, and direct blood-to-blood contact with someone living with HIV
- In Aotearoa New Zealand, HIV disproportionately affects gay and bisexual men, however heterosexual transmission also occurs. In Auckland, it is estimated that 1 in 15 gay and bisexual men are living with HIV, with 20% of these unaware of their positive status
- The number of new infections among men who have sex with men (MSM) in Aotearoa New Zealand has been declining since 2016, probably due to a combination of pre-exposure prophylaxis (PrEP) and early treatment of those who are diagnosed positive
- Although the number of heterosexual people diagnosed with HIV In Aotearoa New Zealand each year is low, a significant proportion have a low CD4 count at the time of diagnosis, indicating late-diagnosed infection
- Without treatment, HIV causes chronic and progressive immune deficiency, with AIDS occurring around 8 years after initial infection
- Effective funded antiretroviral therapy (ART) is available for anyone living with HIV in Aotearoa New Zealand, regardless of residency status
- Current treatment options are generally very well tolerated, with minimal

pill burden. It is recommended that all people living with HIV should start ART as soon as possible after diagnosis

- People living with HIV who are on ART and maintain an undetectable viral load for at least 6 months do not sexually transmit HIV. This is known as U=U (undetectable = untransmissible)
- Effective ART also greatly reduces risk of vertical transmission during pregnancy and delivery
- With early and effective treatment, people living with HIV will have a life expectancy similar to those without HIV. However there is an increased incidence of co-morbidities including cardiovascular disease, liver disease and some cancers
- Unfortunately HIV stigma is still prevalent and very harmful, and often causes significant distress to people living with HIV
- All people diagnosed with HIV should be referred to specialist services for management, usually either infectious diseases or sexual health services. In addition, non-governmental organisations (see resources) can provide free counselling and peer support
- People living with HIV who are moving to Aotearoa New Zealand from overseas will need rapid connection to local health care, to avoid interruption in treatment. Note ART may need to change to locally available treatment options
- Primary care has an important role in diagnosis, screening for and managing co-morbidities, ensuring vaccinations are up to date, and psychosocial support

Clinical presentation

- Many people living with undiagnosed HIV appear well for years following infection
- People who are tested regularly, and diagnosed and treated early, are unlikely to develop HIV-related complications or progress to AIDS
- HIV can occur in people who may appear to be low risk, so always consider testing if any person presents with possible signs and symptoms, as well as offering testing as a routine part of sexual health screening or on request

Signs and symptoms
Acute infection: (in 50% of patients) fever, rash, lymphadenopathy, pharyngitis, myalgia, arthralgia, headache about 3-6 weeks after exposure
Asymptomatic infection: for several years following infection
Immune deficiency: multiple symptoms related to declining CD4 T-cell count such as oral thrush, diarrhoea, weight loss, skin infections, herpes zoster
Complications
AIDS: opportunistic infections such as *Pneumocystis jiroveci* pneumonia, oesophageal candidiasis, cerebral toxoplasmosis and cancers such as kaposi sarcoma, death

Diagnosis

Decision-making tool for HIV

Patients must know what they are being tested for, and consent to testing, but extensive pre- and post-test counselling is not required (unless the patient indicates that this is needed, or the result is positive)

Indications for testing:

• Patient with signs or symptoms which could be consistent with HIV, even if the person is considered to be low risk

• As a routine part of a sexual health check

• Patient with possible signs or symptoms of a sexually transmitted infection (STI) as part of a sexual health check

• Sexual contacts of people with STIs as part of a sexual health check

• Pregnancy

• In persons with a recent change in sexual contact, or multiple sexual contacts as part of a sexual health check

• MSM – at least annually as part of a sexual health check; every 3 months if frequent partner change or on PrEP

• After a non-consenting sexual encounter

• Injecting drug users

• At patient's request

Note: If patient is asymptomatic and is concerned about a specific recent sexual event the recommended testing interval is 6 weeks from time of last unprotected sexual intercourse

Test	Consideration
HIV serology	Window period is approximately 6 weeks
HIV point-of-care test (blood/saliva)	Result available within 10-20 minutes, however lacks sensitivity for very early infections Point-of-care testing is only reliable from 3 months following infection

Investigations

• Further investigations will be arranged by the specialist

• These include:

◦ CD4 count: a marker of immune function, normally > 500 cells/μL

◦ HIV viral load: a marker of HIV level in serum. Viral load should become undetectable soon after starting treatment

◦ HIV resistance testing

◦ Other tests: standard biochemistry, glucose, lipids, urinalysis, and hepatitis A, hepatitis B and hepatitis C

◦ The patient may be screened for tuberculosis

Management

- Discuss the positive result:

        - Ideally give the result in person
        - Inform the patient that ART will control the infection, prevent transmission and allow recovery of immune function. With early and effective treatment, people living with HIV will have a life expectancy similar to those without HIV
    - Offer patient information
    - Assess supports and direct to non-governmental organisations (see resources) for free counselling and support
    - Discuss prevention of transmission pending initiation of treatment and advise that contact tracing will be discussed further by secondary care
    - Discuss duty of disclosure (see below)
    - Refer to specialist (infectious diseases or sexual health) for management
    - Offer another appointment while they are waiting for their first specialist assessment
    - HIV is a notifiable infection. Requesting health practitioners will be sent a questionnaire to complete and return

Duty of disclosure

- In Aotearoa New Zealand, there is no legal obligation to disclose HIV status if condoms are used every time the person has vaginal or anal penetrative sex
- Once on ART with an undetectable viral load for more than 6 months, there is no risk of sexual transmission. However, the legal consequences of this have never been tested in Aotearoa New Zealand courts, so it is still recommended to use condoms with partners who are unaware of the person's HIV status
- Legal obligations vary in different countries, and it is important to be aware of this when travelling

Ongoing Care

- Offer peer support, and address mental health needs
- Arrange appropriate screening
    - Annual cardiovascular risk assessment
    - Annual cervical screening for people with a cervix aged 25-69 years. Young people who are sexually active and who have been living with HIV for more than five years should start screening

before 25 years, regardless of HPV vaccination status

- For MSM over 50 years of age, annual digital ano-rectal exam for anal squamous cell carcinoma
- HIV is an independent risk factor for cardiovascular disease, therefore manage cardiovascular risk factors aggressively. Consider starting a statin at a lower threshold
- Ensure vaccinations are up to date. Hepatitis B, influenza, pneumococcal and meningococcal vaccinations are funded for people living with HIV. Human papillomavirus (HPV) vaccination is funded for people aged 9 to 26 years, and is also recommended (but not funded) for older people living with HIV. Be aware that live vaccines are contraindicated if CD4 count is less than 200 cells/µL
- Always review drug interactions with ART before starting any new medications. Consider using the University of Liverpool HIV Drug Interactions tool.
- There is no cure for HIV and life-long adherence to ART is required to keep the virus controlled and maintain good health. Ongoing engagement in care is vital. Peer support can assist with ongoing engagement

Contact tracing

- This will be discussed by secondary care

Follow up

- A follow-up appointment or phone call may be useful while waiting for the first specialist assessment
- A follow-up appointment may be beneficial after first specialist assessment to discuss the plan and arrange ongoing care and recalls

Auditable outcomes

- 100% of patients living with HIV are offered cardiovascular risk assessment annually
- 100% of people with a cervix aged 25-69 years living with HIV are offered cervical screening annually

- 100% of patients diagnosed by primary care are offered referral to specialist services for management

Useful patient resources
New Zealand AIDS Foundation

Body Positive

Positive Women Inc

Endorsement: These guidelines have been endorsed by the Blood Borne Viruses and Sexually Transmitted Infections Standing Committee (BBVSS).

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