Commentary

Normalizing HIV testing in primary care

Commentary on: Late HIV diagnoses in Europe: A call for increased testing and awareness among general practitioners

Jan E. A. M. van Bergen

Department of General Practice, Academic Medical Centre-UVA, Amsterdam, Soa Aids Nederland, Amsterdam, and Centre for Infectious Disease Control, National Institute for Public Health and the Environment (RIVM), Bilthoven, the Netherlands

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KEY MESSAGE(S):

- In primary care, an HIV test should be regarded as a routine test procedure, especially in high prevalence areas
- GPs should not be reluctant in initiating HIV testing to patients from high risk groups
- More positive attention for sexual health in general practice is a prerequisite for accelerated HIV testing

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INTRODUCTION

In the past three decades, the perspective of HIV changed dramatically from a deadly disease into a chronic infection with only marginal differences in life expectancy for those infected. Effective antiretroviral therapy contributes greatly toward survival for people with HIV, especially when started timely. Last year the landmark intervention trial of Cohen demonstrated that early treatment of the HIV-positive partner reduced HIV-transmission to the HIV-negative partner in discordant couples by 96% (1). Thus, detection and treatment of HIV infection provides clear benefits, both for the individual and for public health. Yet, many persons with HIV remain undiagnosed, and a considerable proportion enters care (very) late. Late diagnosis is related to a tenfold increase of the risk of dying in the first year after being diagnosed, and an average loss of 10 years of life expectancy (2,3). Of all HIV-infected persons in Europe, the proportion of people not being diagnosed with HIV because they have never been tested is estimated at around 30–40%. Of those newly detected, on average 50% enters too late in care, sometimes already with Aids-defining symptoms (4). Clearly these staggering figures point at the urgent need for more community

and provider-initiated testing practices in Europe for those at risk (5).

In their paper 'Late HIV diagnoses in Europe: a call for increased testing and awareness among general practitioners' (6), Kall et al., make a strong plea to promote HIV testing also in primary care. Many persons visit their primary care physician and indeed many test opportunities are missed in primary care, also in those presenting with symptoms suggestive for HIV infection. However, operationalizing 'routine HIV testing' into feasible, effective and cost-effective testing interventions in primary care that are sustainable and ready for scaling up is not as straightforward as the arguments look. The epidemic is very diverse within and between countries and concentrates mainly among risk groups such as men who have sex with men (MSM), heterosexuals from HIV-endemic countries and intravenous drug users. General practitioners (GPs) serving these populations, like those colleagues practising in highly urbanized, multi-ethnic and deprived areas, will be more exposed, but the average GP in most European countries has limited experience with HIV. The challenge really is how to put the authors' call for accelerated HIV-testing in primary care into action. Which tools do GPs need

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Correspondence: Professor STI in Primary Care, University of Amsterdam-AMC, General Practitioner—Program Manager Soa Aids Nederland, Keizersgracht 390, 1016 GB Amsterdam, the Netherlands. Fax: + 31(0)206275221. E-mail: jvanbergen@soaaids.nl

more to reduce doctors delay in symptomatic patients and how can GPs promote and implement effective testing for their patients at risk?

DIAGNOSTIC TESTING: NORMALIZING THE HIV TEST

The issue of 'missed opportunities' in primary care is not unique for HIV late presenters. Patients ultimately diagnosed with another rare disease or cancer often have visited their GP previously, with symptoms that were in retrospect suggestive for this illness. To prevent under- as well as over-diagnostics, primary care guidelines function as standards for good clinical practice. New guidance on diagnostic HIV testing comes from the European Union Panel on Indicator Diseases, advocating an HIV test in the diagnostic work-up, not only of Aids-defining symptoms, but also for diseases like lymphadenopathy, herpes zoster, unexplained weight loss, tuberculosis, certain skin or blood disorders and other diseases that have an unidentified HIV prevalence of at least 0.1% (7). As an example: a GP considering an EBV test for lymphadenopathy, would discuss with the patient that: '... for this condition we usually perform a diagnostic work-up that includes an HIV test for persons. Would it be OK with you that we perform these tests?' How well these indicator diseases will match prior chances in primary care in different regions in Europe is still an area for further research, but a low threshold on HIV testing in symptomatic patients certainly is recommendable. Normalizing the HIV test, in line with current policies to deliver essential pre-test information without the need to give elaborate pre-test counselling, can remove barriers for HIV testing (5).

TESTING ASYMPTOMATIC PATIENTS: FOCUS AT HIGH RISK AND HIGH PREVALENCE AREAS

Health care seeking behaviour for sexually transmitted infections (STI) differs across Europe, and can change rapidly over time. In the last decade, the number of consultations in general practice for an STI check in the Netherlands doubled (8). Who to screen, and how frequently to test, depends on local characteristics and specific dynamics of the phase of the epidemic. The epidemiological classification in risk groups for HIV in a concentrated epidemic presents pitfalls for misclassification in daily practice, as GPs are not always aware of these risks in current or past behaviour of their patients, let alone in that of their partners. Some evidence suggests that the wrong people are getting tested in general practice. In a publication on HIV testing in general practice in the UK, HIV testing was 10 times lower in a high urban, more deprived and multi-ethnic population in London compared to testing in an urban and rural population in South West England (9). This certainly underscores the argument of Kall et al., to focus on

GPs in high prevalence areas, and implement more routine HIV testing especially in these practices, not only if the reason for encounter is STI related. They describe some pilots in the UK based on the new NICE guideline that advises to test all new registrants entering a general practice in a high prevalence area (defined as HIV prevalence of more than 2/1000 population) (10). However, this strategy is only partial and does not address the question on how to operationalize routine testing in a busy GP practice in a high prevalence area if patients attend for non-STI related reasons like an ankle strain or a common cold. Working myself as a GP in a high prevalence area in Amsterdam South-East (80% of my patients having a Surinamese, Antillean or African background) the last two HIV patients that I diagnosed 'by accident' were a 53-year-old African woman, coming for her annual blood check for her hypertension, and a 56-year-old Surinamese man asking for a cardiovascular health check including diabetes. In both cases, an HIV test was suggested to the patient to be included in the regular blood test mentioning as a reason that 'current advice is to have at least done a HIV test once.'

OPPORTUNITIES AND LIMITS

Limitations to implement accelerated testing in primary care exist at the level of the doctor-patient interaction as well as at more contextual levels. Proper risk assessment by doctors is subject to many barriers, discomfort discussing sexual issues often being mentioned as a reason. None the less, if a patient consults his/her GP for an STI related reason or requests for a test, professional standards of care prescribe a sexual history taking, including sexual orientation and sexual practices, to be able to give a correct test advise. Proper attention for sexual health in (post-graduate) education and training is required. Specialized GP groups focussing on this theme can contribute in agenda setting and facilitate more attention for sexual health in general practice curricula, guidelines and continuous education (11).

A major limitation for more diagnostic testing in general practice is the potential long list of indicator diseases that are given in the guidance, of which some (like recurrent Candida vaginitis) might not have sufficient positive predictive value in general practice. In this area, more (implementation) research is required to fuel practice-based evidence.

Promoting more routine testing and proactive screening in general practice for patients not presenting with STI-related questions or symptoms, presents many challenges. Clearly here is a field for more research, pilots and best practices. Although in pilot settings testing new registrants in high prevalence areas, showed potential feasibility (with re-imbursements), scaling up will present major challenges if these testing

practices are to become part of mainstream family medicine, and not only for 'enthusiasts.' Integrating sexual health issues into a more overall, evidence-based health screen during intake of a (new) patient might give more avenues for the future. HIV is a relatively rare disease for general practice and many other diseases like undiagnosed diabetes, renal insufficiency and undiagnosed hepatitis are being brought forward for early detection and case finding. The future has yet to show if such a new paradigm for proactive personalized risk-stratified 'health care' (rather than 'disease care') is acceptable for doctors and patients, and is not being captured as patronizing, especially if sex is involved.

Last but not least, testing itself will not prevent contracting HIV. A patient-centred dialogue about motivations and barriers in safer sex can be a valuable part of the consultation, certainly if testing is used as a strategy to continue unsafe sex. Current optimism about 'treatment as prevention' is often taken by patients as if HIV hardly is infectious anymore and by doctors that we could treat ourselves out of the HIV epidemic. In reality, in Western Europe a major decline in incidence can not be seen among MSM and in Eastern Europe the epidemic is out of control, increasing rapidly. GPs, and patients, should bear in mind the good news, that indeed a person that is treated and fully suppressed will have a low viral load, a near normal life expectancy and a low transmissibility. However, GPs should also be aware of the many caveats; to name a few: a significant proportion of HIV infected persons are not known to be infected; of those treated, not all are suppressed; resistance might occur and concurrent other STI increase viral shedding in the genital compartment. In addition, most important: a person who tested negative, but who has a new acute HIV infection is highly infectious for his partner(s). In fact, these acute infections with high viraemia are the driving forces in maintaining the epidemic.

Conclusion

More attention for accelerated testing by GPs and normalizing the HIV test in primary care is warranted. Changing paradigms in treatment and prevention for HIV do have to be incorporated in development and implementation of general practice guidelines. The focus should be at-risk groups as well as more routine testing in high prevalence areas. A research agenda, including monitoring and evaluation, is needed to generate more practice based evidence on (cost-) effective strategies in primary care. A prerequisite for accelerated testing is linkage to care, starting from an integrated approach for prevention and treatment and more positive attention for sexual health in general practice. It is indeed a call for action.

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