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ReachMD
www.reachmd.com
info@reachmd.com
(866) 423-7849

Normalizing STI Screening: The Patient Impact

Dr. Caudle:
Sexually-transmitted infections, such as gonorrhea and chlamydia, can have disastrous health consequences if left untreated. Despite ongoing awareness campaigns towards screening recommendations and current guidelines, STIs have reached a record high in the United States. Young women bear some of the highest burdens from this trend with increased risks of infertility, ectopic pregnancies, stillbirths, and HIV transmission rates, stemming to untreated infections.

This is ReachMD, and I am Dr. Jennifer Caudle, and my guest today is Dr. Tonya Chaffee, Clinical Professor of Pediatrics at UCSF. On today's program, we'll be focusing on STI screening and efforts to prevent the downstream consequences of untreated infections in young women.

Dr. Chaffee, given the updated CDC guidelines, what's the most concerning or surprising information regarding STI screening?

Dr. Chaffee:
Well, as we all know—or some people may not know—nationally, particularly in adolescent women, things like pregnancy rate have gone down significantly, almost half since around the 1990s,but unfortunately, we haven't seen the same trend in sexually-transmitted infection rate, particularly with gonorrhea and chlamydia. They've, over the last 4 years, continued to rise, so a lot of people aretrying to understand what that's about. One of the things that also coincided sort of with the CDC guidelines, for chlamydia screening in particular, was the change in Pap screening guidelines for women. About over 10 years ago it was started screening women shortly after they started having sex. That was a question you asked. That changed to 21. And they noticed then that 2 things started to happen: providers weren't screening women who were sexually active before the age of 21; they were only sort of waiting until they turned 21 to do that test, so a lot of younger women were not being screened. Also, the frequency of Pap testing changed so that the Pap testing wasn't happening as often, and so women were not being seen again to get their sort of co-testing with gonorrhea and chlamydia as they were doing the Pap testing. Another factor that may be more recent is sort of the increasing rise of long-acting reversible contraception in young women. And as we know, those are very, very effective birth control, which probably also contributes to the decreasing pregnancy rates; however, a sort of side result is women are not being seen as frequently now that they're on these methods and not being screened as regularly for gonorrhea and chlamydia.

Dr. Caudle:
Now let's focus on clinicians and their roles here. What challenges do we in the health profession face in light of poor screening rates and our efforts to curb this trend?

Dr. Chaffee:
Well, as I mentioned, sort of what makes a provider do something regularly is those recommendations. And I think with the changing Pap screening, it kind of left people sort of not doing the annual visits. It's sort of like, "Oh, you've got your IUD or your implant. Bye. I'll see you in 4, 5, 6 years." So it hasn't really gotten back that women actually still do need to be seen annually and getting that back into practice. The other thing is the population of young women, of adolescents, often seen by family practitioners and pediatricians who sometimes aren't always trained in taking sort of sexual histories or assuming that their patients aren't sexually active, and then that leads to not getting information that might ding them to know, "I need to screen them today because I've learned that they've become sexually active," and that this is sort of a routine thing that we do with all our young patients that become sexually active is that we need to start annually doing this and letting the patients know that. We're not training a lot of providers in how to take comprehensive sex histories. It's not just, "Are you sexually active?" It's kind of, what kind of sex you're having, who you're having sex with, how often, those things. And sometimes providers aren't comfortable asking those questions, and often patients, particularly younger patients,

aren't comfortable disclosing some of that information, particularly if they don't know a provider very well.

Dr. Caudle:
Now, we talked about some of the downstream effects on patients from poor screening, but let's talk about these consequences in more detail. Which patients are most affected by this issue, and what health impacts do they deal with?

Dr. Chaffee:
Well, one of the things we know, particularly with gonorrhea and chlamydia, is most of the people who are infected don't have any symptoms. So a lot of people only go in when they may have pain with urination, or for women, they may have vaginal discharge, and that's what kind of triggers them to go in. They don't think that they have gonorrhea and chlamydia. So not knowing that then they may have an infection that can lead to consequences like pelvic inflammatory disease, and that's why screening's so important, because if you don't catch it early, it will lead to those downstream complications, which can then lead to infertility later on. And part of the other barrier is that right now the recommendations are you have to determine if a person's sexually active. That's actually the risk factor for determining whether you can do a gonorrhea or chlamydia test, then to get to know more of the details of partners and who you're having sex with and so forth. But if people aren't taking that sexual history in the first place, then they might assume that their patients are not sexually active and not get a screening test.

I think one of the hardest things I have to do sometimes is have to tell a young person that they have chlamydia, and they don't even know what that is. They've never heard of it, and we have to treat them. And that's really unfortunate, because when you do sort of the annual, just making it routine, getting a sexual history and sending that test, it kind of normalizes that this is what you do from now on. You come in and you get the test. Ideally, you want young people going, "It's time for my annual checkup, and I'm probably going to have to get sexually-transmitted infection screened as well," and so that is what I'm hoping more providers will start to do, because it sends a message that this is something we do with all of our patients. We ask them these questions, and we want to make sure that they're getting the testing, that their sexual health is being taken care of.

Dr. Caudle:
So on that last note, Dr. Chaffee, let's talk about solutions that we can bring to the table. What tips and suggestions do you recommend for healthcare providers to better screen patients and help them avoid these downstream consequences?

Dr. Chaffee:
I can actually speak from personal experience but also sort of a public health campaign that's been going on in my own jurisdiction in San Francisco. One of the things is just finding out what are your practice or your individual provider screening rates for gonorrhea and chlamydia. I think sometimes that's the baseline and a lot of people don't even know how to assess that. We did that, and we were quite shocked with how low they were. They were in like the 20% range. And we even looked at like, were they asking about sexual histories and so forth and so on. So that's a starting point, because if you don't know what that is, then you don't know how to improve.

Then it's sort of figuring out your protocol. And I really encourage providers to potentially make this a quality improvement project. There are a lot of examples. One that I was actually involved with is American Academy of Pediatrics Bright Futures. They have it set up to help providers learn how to get confidential information like sexual histories in adolescents. It tells you how to kind of set up your practice. There can be simple things like you want to just do urine-based testing or swabs. However, we found that we had a problem with our bathroom and the line waiting for urine tests. We said, "Well, let's just give women the self-swab so they can do that," and it kind of avoids that line at the bathroom—little things like that, just to think about. But I think if you set up a QA project, that helps your practice kind of figure out and fine tune what works best to get providers to do it.

Dr. Caudle:
On the communication side, we know that many clinicians are hesitant to even bring up sexual health in exam room settings, so how do you advise your colleagues on ways to overcome this reluctance?

Dr. Chaffee:
Well, I think for general reasons, particularly with adolescents, going over what confidentiality means and explaining this, because for a lot of young people, this is the first time they may be seeing a healthcare provider by themselves, without the parent, which I strongly encourage. There should be some time alone. The parent shouldn't always be in the room because the young person may not feel comfortable disclosing their sexual history in front of their parents if their parents aren't aware, so maintaining that, and that can start even before the young person comes in the room or the year visits at the 9-, 10-, 11-year-old visits, talking about, "Well, there's going to be a time when you're going to be seeing the provider by themselves," having signs and information for parents and young people to know what confidentiality mean, what the health information and protection of that means. And then, even more importantly, I think sometimes just to get a sexual history, if it's a time-consuming type of thing, having a questionnaire before the visit or even mailed to the young person to fill out so that they can bring it to the visit and explaining what confidentiality means, that can save time in getting it, and

then you'll know and you can tell them that, "We now learned that you're starting to have sex, and it's important for you to get sexual-transmitted infection screening, and this is what happens." And I think that can take away some of those barriers. Again, these are things that different practices can tweak and work with to figure out what's the most efficient and practical way to kind of move forward with getting more young people screened.

Dr. Caudle:
That's great. Those are excellent, excellent suggestions. Before we wrap up, are there any other thoughts or recommendations you'd like to offer our listening audience to take with them into practice?

Dr. Chaffee:
Yes. One thing that we… Actually, what we found that was really helpful, we just started screening in our urgent care clinics, so these are actually more of our higher-risk young people who don't always come in for their annual checkups. We started universally screening. So we didn't base it on a young person being sexually active. We decided we'd just screen everybody. And we found that actually it decreased a lot of the barriers around finding out if someone's having sex and feeling stigmatized by that or thinking that they may have a sexually-transmitted infection, and it also got around… Parents were sort of like, "Whatever, that's fine, that's great, go ahead." So that's one thing to think about. It's not necessarily recommended by the CDC at this point, but it's a way to kind of work around that. And I think the bottom line is, sexually-transmitted infections are on the rise, and it's really upon providers to start screening more regularly, more frequently. Otherwise, if we don't, we'll just see the rates of gonorrhea and chlamydia increasing and seeing the downstream consequences, as we've talked earlier about, pelvic inflammatory infection and infertility. And I think that's the only way we're really going to reduce sort of the rates that we see that are continuing to rise the last 4 or 5 years.

Dr. Caudle:
Right. Well, that surely makes a lot of sense. And with that, I'd like to thank you, Dr. Tonya Chaffee, for joining me to focus on STI screening recommendations. Thank you so much for being here on our program today.

Dr. Chaffee:
Thank you for having me.