Helping patients to reduce their risk of acquiring sexually transmitted disease

This monthly series was developed from the AOA Task Force on AIDS Writers' Workshop, held August 16 to 18, 1991, in New York. The workshop was sponsored by an education grant from Burroughs Wellcome. It will provide brief clinical updates and perspectives on the human immunodeficiency virus (HIV). Readers may request tear sheets from the AOA editorial offices.

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Question

How can I help my patients to reduce their risk of acquiring a sexually transmitted disease?

Answer

Today, with the inevitable spread of the acquired immunodeficiency syndrome (AIDS) being all too apparent, counseling for the prevention of sexually transmitted disease (STD) is no longer an optional medical service. Rather, it is an essential element of primary care. Recent studies have documented that physicians are much less likely to discuss such matters than other aspects of preventive healthcare.

Globally, human immunodeficiency virus (HIV) disease is a heterosexually transmitted disease. In the United States, the greatest rates of increase of HIV infection are occur-

ring in heterosexual adolescents and heterosexual women. During the first decade of the AIDS epidemic in the United States, the gay community demonstrated that STD prophylaxis and counseling on "safer sex" are effective in reducing the incidence of all STDs, including HIV disease. Therefore, it is vitally important that physicians initiate a dialogue on the prophylaxis of STDs with all sexually active patients.

In addition, it is important that physicians actively encourage patients, community groups, and schools to become involved in discussing STD prophylaxis by making it an integral part of sex education of younger people *before* they become sexually active.

Risk reduction begins with the realization that *abstinence* is the only certain way to avoid STDs, and following this practice, a *monogamous* relationship between uninfected partners is also safe. Unfortunately, if either partner has been previously sexually active, only a thorough screening including serologic testing can ensure that the respective sexual partner is free of STDs, including HIV infection. For all other sexually active individuals who are sexually active outside a stable monogamous relationship with a known uninfected partner, **NOBODY IS SAFE**. For this reason, we must emphasize certain practices of risk reduction that will prevent "silent transmission" from healthy-appearing carriers.

It is necessary to speak in clear, and at times graphic, terms about STD prevention. It is because either the patient or physician are at times embarrassed or uncomfortable with such

matters that important details of condom use or of sexual practice go unspoken or are frequently misunderstood.

Always use a condom, and always use it properly.

Only lubricated latex condoms, preferably with a nipple end and the spermicide nonoxynal-9, should be used. If additional lubrication is necessary, a water-soluble gel is preferable. Condoms are available in various sizes and should fit properly to prevent breakage. Condoms must be applied to the erect penis before any mucosal contact occurs, and withdrawal of the erect penis before detumescence is important. These practices apply to all insertive forms of intercourse—vaginal, oral, or anal. Most often, however, it is the receptive partner who is at greater risk and who must insist without exception that the insertive partner cooperate with proper condom use.

When counseling younger or sexually less-experienced patients, it is important to emphasize the difference between contraception and prophylaxis. Birth control pills, diaphragms, sponges, or foam are not adequate to prevent transmission of viral disease, even though they prevent pregnancy. Anal receptive intercourse is by far the riskiest sexual activity so far as HIV disease is concerned, and should always be performed with a condom and copious water-soluble lubricant. Fellatio with ingestion of semen, preejaculatory fluid, or urethral discharge, as well as cunnilingus during menses or at the time of vaginal discharge all carry a risk of HIV transmission as well as a host

of other STDs. Because condoms were not originally designed for oral or anal insertive intercourse, extra care must be taken that they do not break, or fall off. Even when used properly, condoms may leak, so we can never be 100% sure of their safety.

One thing is certain after you begin diagnosing and treating HIV disease: You must never trivialize or underestimate risk. Anyone who is sexually active is at risk. As the epidemic moves into the second decade, we must all remember that there are no "low-risk groups," only "low-risk behaviors."

Even after patients seroconvert, the opportunity for preventive counseling is not lost, because seropositive patients must understand beyond any doubt just how they can deter further spread. It is also important that seropositive persons not be exposed to any additional—and possibly more virulent—strains of HIV or other STDs that may increase morbidity in the presence of immunodeficiency. Therefore, whether your sexually active patients are HIV-positive or negative, it is imperative that they understand and practice low-risk behaviors.

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