Transcript Details

This is a transcript of a continuing medical education (CME) activity. Additional media formats for the activity and full activity details (including sponsor and supporter, disclosures, and instructions for claiming credit) are available by visiting:
https://reachmd.com/programs/cme/best-practices-for-taking-a-sexual-history-destigmatizing-prep-care/13303/

Released: 04/26/2022
Valid until: 04/04/2025
Time needed to complete: 15 minutes

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

Best Practices for Taking a Sexual History: Destigmatizing PrEP Care

Announcer:
Welcome to CME on ReachMD. This activity, entitled “Best Practices for Taking a Sexual History: Destigmatizing PrEP Care” is provided by Prova Education.

Prior to beginning the activity, please be sure to review the faculty and commercial support disclosure statements as well as the learning objectives.

Dr. Elion:
Hello. This is CME on ReachMD, and I’m Dr. Richard Elion. And I’d like to welcome you to our Patient-Clinician Connection on best practices for taking a sexual history. I am a family medicine specialist and Director of Research at the Washington Health Institute in Washington, D.C.

One’s sexual health can impact overall health and quality of life. A sexual history is an essential part of the assessment of a patient’s overall health and wellness. It helps to guide the physical exam and establishes the patient’s risk and the need for tests to screen for STIs [sexually transmitted infections], including HIV. It also establishes a more personal connection between the physician and the patient.

A sexual history provides a framework for discussing sexual health issues with a patient and providing risk-reduction counseling, as well as identifying potential candidates for antiviral pre-exposure prophylaxis, or PrEP.

I’m going to walk you through taking a sexual history with one of my patients, Larry, who’s a 48-year-old cisgender male who has sex with men [MSM]. I’ll be using the 5 Ps approach, which is one way to help remember the major aspects of a sexual history.

What I’d like to do is I’d like to demonstrate, at this point, the tone by which I’m going to create the sexual history. I want it to be a very relaxed, matter-of-fact conversational tone to help the patient feel comfortable and not to make his sexual history something that is a clinical, but rather a personal, aspect of his life.

Dr. Elion:
Larry, thanks for coming in today. I know we’d been talking about different health exposures you have and your concerns about living healthy. One of the things I’m concerned about is your risk of getting any sexually transmitted diseases, and specifically HIV, as well as other STIs. Are you active sexually now, Larry?

Patient:
I’m active sexually with my partner. We’ve been together for over 25 years. We’re mostly monogamous; we were less monogamous when we were younger. Now we are monogamous to my understanding. He’s HIV positive. He’s been HIV positive for our entire relationship. We practice safe sex, something that we didn’t do when we first got together, but we’ve been using safe sex for many years now.

Dr. Elion:
Well, that’s helpful, but let me ask a few little questions here. The first is when you say you’re just with each other, and do you believe

your partner is monogamous as well? Over the last year, say, are you both monogamous, or are you not sure?

Patient:
We're monogamous.

Dr. Elion:
Okay. And in terms of practices, you said that you practice safe sex. I assume that means if you're talking penetration with a condom. Are you also using a condom for oral sex?

Patient:
We don't use a condom for oral sex. We never have. I don't usually wear a condom, except for penetrative sex.

Dr. Elion:
So, if you're the receptive partner, do you insist that your partner wears a condom?

Patient:
I'm not often the receptive partner, but I would insist that my partner wear a condom, particularly because I know he's HIV positive. Although I do know that his viral load is also undetectable and there's a lower risk when that is the case, I would still insist on his wearing a condom.

Dr. Elion:
And have you or your partner had any STIs in the last year or 2?

Patient:
We haven't had any STIs.

Dr. Elion:
I'd like to make a point now, a teaching point. And the point is, as you'll notice when I talk to Larry, first of all, I'm trying to make this very sensitive to his lifestyle and not have any notion of any stigmatization. I want him to feel respected. I want him to feel a sense of empowerment, that someone's willing to talk to him about his intimate life. All too often, providers can be very leery of talking to patients about intimacy. It's both uncomfortable for them and they fear it's uncomfortable for the patient. And so I think it's critical to foster that kind of intimacy, which hopefully would be the foundation of a provider-patient relationship.

For sexual context, certainly, among all people there's a great stigmatization, and it's even worse for the MSM community. And the specifics of whether he's receptive or insertive during intercourse or the use of a condom during oral sex is something that many providers might not feel comfortable. But in fact, it's very helpful for me to assess the degree of risk, because when a patient says that they're always using safe sex, it's very rare that they're using condoms with oral sex, which would mean not always safe sex. And if oral sex is part of their sexual practices, that's an important way of garnering the necessary clinical information to make a really good recommendation.

Larry had talked about some of the practices he does, but when he talked about it, you'll notice there was a difference in the level of protection for both insertive activities as compared to oral activities. In terms of protection from STIs, the same distinction can be made in that people, a lot of times patients, and Larry in this situation, thought about the protection necessary for insertive but not for oral. And fortunately, in regards to past history, this discrepancy in oral protection versus insertive did not result in any STIs.

One of the issues around PrEP is people will often minimize their exposures and talk about the protections they do but not talk about behaviors that they don't do or practice. The point of this sexual history, besides getting this sort of understanding of the patient's life, is to really ascertain what are their exposures to know if they qualify or are an appropriate candidate for the medication or approaches necessary to prevent HIV acquisition.

Dr. Elion:
Larry, based on your exposures – and one of the CDC guidelines is having a partner who's HIV positive even though that partner is virologically suppressed – I hear your concerns. I do think you'd be a candidate for starting PrEP. And I guess the first thing is are you comfortable taking a medication to prevent HIV acquisition, and if so, do you care if you take something every day? There's also the opportunity to take an injection that you would take every 2 months. How do you feel about those 2 issues?

Patient:
Well, I've thought a good deal about it. Since my partner's viral load is undetectable, I wonder whether or not I need to take PrEP. I take some other pills during the day and adding another one isn't my favorite idea. And my partner and I used to have more sex than we're having now. So, at one point I could see taking daily PrEP, but with our infrequent sexual activity, I am wondering more about another

approach to taking PrEP other than just the daily dose.

Dr. Elion:
Fair enough. Let me lay out for you the choices then, Larry. The 2 most common choices that are currently done is oral PrEP, and oral PrEP would consist of either tenofovir – TDF [tenofovir disoproxil fumarate] and FTC [emtricitabine] – or tenofovir alafenamide and FTC. Both of these medications are agents that are used as part of the cocktail for treating HIV. But when used as just a single tablet, either one of these is very effective prevention against HIV acquisition. The difference between TDF and tenofovir alafenamide has to do that tenofovir alafenamide has a little bit of a lower risk for declines in renal function and declines in bone mineral density. Now, you're 48, and so you're not really obliged to do anything related to protecting your bone mineral density at your age. That wouldn't occur for perhaps another 8 to 10 years. In terms of your renal function, we're going to get a test on you to make sure it's okay, and if it is, either one of these options would be okay. Perhaps as you get older than 55, the use of tenofovir alafenamide, which causes a little bit less decline in renal function than tenofovir, might be appropriate. But for now, I think either option would be okay. In terms of how to take these 2 oral medications, they're both recommended under the way the drugs were approved by the FDA to be taken daily.

Now, in terms of injections, injections would be a whole different approach because 1 injection would last you 2 months. And so, you wouldn't have to think about whether you're having sex frequently or not because those 2-month injections would cover that period. However, at the end of when you decided you didn't wish to continue on the injections, you would have to take oral medications for an extended period of time because the medicine in the injection would wane over time, and there would be a point where that medicine would be low enough to not protect you but high enough that it might develop resistance if you became HIV positive. So, if you choose to do the injection, you wouldn't have to think about all that except for when you stop.

Do you have any questions about those choices I laid out for you?

Patient:
Just a couple. When you mentioned the 2 types of oral medications, you mentioned the difference in the way they can have side effects, but why would you choose one over the other otherwise?

Dr. Elion:
There's no data to suggest that one is more efficacious than the other. I think the benefit of having 2 medications is for adolescence, for folks under 25 where they're still depositing bone, the use of the TAF [tenofovir alafenamide] medication might be beneficial because it doesn't impair that and TDF tenofovir could. And then in folks over 55 where people start to have declines in renal function or there might be changes in their bone density, then that other medication again has benefit. But in the age group you're in, I think these 2 medications are broadly equivalent.

Patient:
Okay. With respect to the injectable PrEP, it feels like a good way to go. The resistance piece is little bit troublesome, however. Given my history, what would you recommend, Dr. Elion?

Dr. Elion:
Well, Larry, I think the issue about what to recommend is so individual, and I think you've always made good choices about your healthcare, and I would really support whatever choice you want to make here. I think all these options are good.

If the issue of resistance after you stop an injectable is still an emerging topic, if that concerns you in having to take the medication, I think you can stop and start easier on the oral. So, if you want to, you could start with oral, see how that goes, see how much sexual contact you're having, and then if you want to switch over to the injectable, easy enough.

Patient:
One question that I just thought of is what if you end up having sex before you took 2 pills of PrEP? What would you do in that situation?

Dr. Elion:
If you have sexual contact before staring PrEP, we wouldn't be able to start you on PrEP if there was a concern that you've been exposed to HIV. There are various things that we can do in that setting ranging from various laboratory analyses we could to do make sure you're HIV negative and determine that and, as well, if we really thought you had an exposure that was concerning, we might want to use post-exposure prophylaxis, which is we use a cocktail of medicines we use to treat HIV for just a month and then start you on PrEP.

Dr. Elion:
I'd like to make a few comments here if I could. If I was talking to a woman instead of a man, it would be identical. The only thing that would be different would be the choice of the regimens. And the one regimen that wouldn't be appropriate for initiating treatment in a

woman would be the tenofovir alafenamide. TDF and FTC and injectables are both FDA-approved for use with women, but tenofovir alafenamide is not unless the woman is a trans woman and, therefore, not having vaginal sex. Otherwise, use of PrEP in females, in cisgender females, tenofovir alafenamide has not been approved for that.

The second piece I'd like to talk about is one of the key issues with using PrEP, I think, is – for many of the patients is the stigma that somehow because they're having sex, they have to use some medication to prevent a sexually transmitted disease. I think in this case, that's not relevant because Larry lives with an HIV-positive person. But for other people, I think it's very important that we get well past any stigma about that and talk about all the things we can do to be proactive and to assert our health. And I think this is really one of the rationales for recommending PrEP. We want a life that's filled with passion, intention, and joy. And sexual life is part of that life, and what we want to be able to make sure that we do is make sure that everybody's sexual life can be safe and that it prevents them from exposure to diseases. And since PrEP is a medication that can prevent HIV acquisition, it's very important to understand the rationale for that when recommending it, this for our patients.

Dr. Elion:
I hope today's conversation has been helpful to you. The key takeaways I'd like to offer you is that first, make sexual histories an integral part of every physical exam and comprehensive history that you have. And also make it part of every visit. Sexual life is a fundamental part of our life and of our health, and for folks under 25, it makes up the majority of the rationale of why people would even come in for visits. At the same time, don't think that someone over 50, over 60, over 80 doesn't have a sexual life. Always inquire about that and make that an issue of curiosity and respect for the patient.

Number two, when talking to the patient, make sure that everything you're doing is helping to instill that sense of respect and concern and compassion and empathy about what are their issues and helping to both express your health desires to keep them safe from disease but also wanting to identify and understand their own health desires. Never, never be judgmental towards patients, questions, or their sexual practices and rather affirm the respect and dignity that they deserve.

And finally, with HIV, I think it's very important to let every sexually active young person know there are now medicines to prevent HIV acquisition. It's an incredibly important therapeutic strategy to keep people being able to protect themselves against HIV without insisting that they change their behaviors. The ability to offer medication to prevent HIV acquisition is a cornerstone of HIV treatment but more importantly is a cornerstone of informed consent for sexual health and should really be part of everybody's conversation with a patient.

I really thank you all for joining us today in our Patient-Clinician Connection on best practices for taking a sexual history.

Announcer:
You have been listening to CME on ReachMD. This activity is provided by Prova Education.

To receive your free CME credit, or to download this activity, go to ReachMD.com/Prova. Thank you for listening.