

Talking about testing: pre-test and post-test discussion

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Introduction

Pre- and post-test discussions are an integral part of testing for human immunodeficiency virus (HIV), hepatitis B virus (HBV), hepatitis C virus (HCV) and sexually transmitted infections (STIs). The aims of pre-test and post-test discussions are to provide information and support around the testing procedure, to minimise the personal impact of diagnosis, to change health-related behaviour and to reduce anxiety of the person being tested. Discussion thus requires the clinician to assess risk, to educate the patient regarding risk of transmission, to obtain informed consent, and to follow up and arrange referrals as indicated.

Changes to terminology

The 2006 National HIV Testing Policy¹ recommends that the term 'pre- and post-test discussion' replace 'HIV test discussion and post-test counselling'. This change recognises that the complexity of the discussion may differ significantly depending on testing context, patient experience of testing and assessment of risk factors.

Formal counselling is frequently required in the management of a person who has tested positive, or in the situation where a person who tested negative is continuing to participate in high-risk behaviours for HIV. This counselling is usually specialised and requires referral to an appropriate service or practitioner.

National Testing Policy

National HIV Testing Policy 2006

http://www.health.gov.au/internet/wcms/publishing.nsf/Content/health-pubhlth-strateg-hiv_hepc-hiv-index.htm#testing

National Hepatitis C Testing Policy 2007

<http://www.health.gov.au/internet/wcms/publishing.nsf/content/phd-hepc-testing-policy-may07>

Key points

- Pre-test discussion is essential for the patient to make an informed decision regarding HIV, HBV and HCV testing.
- Pre-test discussion provides the person with information about HIV, HBV and/or HCV, including modes of transmission and how to prevent infection. It helps the person to consider the implications of a positive result.
- Pre-test discussion should be adapted to a person's knowledge and cultural understandings as appropriate. Testing should not be avoided because pre-test discussion is 'too hard'.
- In positive people, post-test discussion explores support and resources available to the patient and provides education regarding the infection and how to minimise the risk of transmission.
- In negative people, post-test discussion provides information on safe sex and safe injecting and addresses risk behaviours that led to the possible exposure.
- Pre- and post-test discussion is no less important when testing or screening for other STIs, even though most of these are managed relatively easily.

The context of testing

Testing for HIV antibody has been available in Australia since October 1984. At that time, acquired immune deficiency syndrome (AIDS) was associated with high morbidity and mortality and an HIV diagnosis was highly stigmatised due to its association with marginalised social groups. HIV antibody testing was promoted primarily as a tool to enhance education and prevention initiatives. Since the mid-1990s, HIV treatment advances have reduced the number of AIDS-related diseases, AIDS notifications and AIDS-related deaths in Australia.²

The availability of antiretroviral therapy in the contemporary Australian setting has dramatically changed the medical context of HIV antibody testing; an HIV diagnosis now opens up the possibility of appropriate treatment and improved prognosis. However, despite treatment advances and changes in social perceptions, HIV infection remains a

stigmatised condition, and all people who are tested should be engaged in detailed and sensitive pre-test and post-test discussions.

Testing for HCV antibody has been available since 1990. As with HIV, HCV infection is stigmatised due to the association with injecting drug use. During pre-test discussion, questions may be asked about a history of injecting drug use that may be an unwanted reminder of a past phase of a person's life and may be resisted. However, a discussion of previous or present drug use provides an opportunity to educate the person about HCV transmission and the natural history of the disease. As with HIV, the benefits of testing include interventions and treatments to improve clinical outcomes and the facilitation of measures to prevent transmission.

Long-term management of HBV infection has changed due to the introduction of effective antiviral treatment and immunisation. The availability of HBV vaccination enables clinicians to take an active role in case-finding, leading to lower rates of transmission and identification of people with chronic HBV infection who may be suitable for treatment. Widespread community ignorance about the long-term complications of chronic HBV infection (Chapters 5, 7 and 11) still exists, and patients need to be appropriately educated.

Testing for other STIs is generally easily done and opportunistic screening in at-risk but asymptomatic people is a valuable part of best practice in primary care medicine. However, STIs too remain stigmatised conditions and clinicians should always provide information about STIs and discuss the issues with patients before arranging appropriate screening tests (see Chapter 8 on testing for STIs).

The discussion process

During the discussion process, information is exchanged and concerns explored. Coping strategies are developed that may be utilised in the event of a positive result. While discussion does not need to proceed according to any formula, key information areas need to be covered during the consultation with a person about testing (Table 9.1). Referring to a framework of key points ensures that the necessary information regarding blood-borne viruses is conveyed.

Both pre- and post-test discussion should be performed in a way that is relevant and appropriate to the person's gender, culture, behaviour and language¹. That is, discussion involved and information emphasised for a high-risk man who has sex with men (MSM) in a major city will differ from a pregnant, remote Indigenous woman undergoing testing in a remote area of Australia.

TABLE 9.1 Summary of pre-test discussion

• Reason for testing and risk assessment
• Timing of risk and option of post-exposure prophylaxis (PEP)
• Need for other STI and blood-borne virus testing
• History of testing
• Confidentiality and privacy issues around testing
• Ensuring there is informed consent for the test
• Natural history and transmission information (if appropriate)
• Prevention of transmission and risk reduction through behaviour change
• Implication of a positive or indeterminate test result, including availability of treatment
• Implications of a negative test result
• Explanation of the window period
• General psychological assessment and assessment of social supports in the event of a positive result
• Logistics of the test: time taken for results to become available and the need to return for results

Reasons for testing

HIV, HBV and HCV antibody testing is indicated in the following circumstances:

- Patient request
- Identification of clinical symptoms or signs (Chapters 4, 5, 6, and 7)
- Identification of risk factors in the patient history (Chapters 2 and 3)
- Part of a screening process, e.g. pregnancy
- Presentation for post-exposure prophylaxis (PEP) after occupational or non-occupational exposure to HIV
- Diagnosis of another STI. People infected with an STI, especially an ulcerative STI, are at increased risk of acquiring HIV and should be offered testing

Risk factors from the patient history which would indicate HIV testing include:¹

- MSM sexual contact. This is the most common mode of HIV transmission in Australia² and unprotected anal male-male sex is a clear indication for HIV testing, as well as testing for other blood-borne viruses
- Sharing of injecting equipment. This is also a strong reason for offering testing for blood-borne viruses
- Being the sexual partner of a person with HIV infection

- Being from a country or region with a high HIV prevalence, e.g. the Caribbean, Sub-Saharan Africa, South East Asia and Papua New Guinea
- Having recently travelled overseas; travellers may be at risk of HIV through unprotected sex, injecting drugs and medical procedures

Testing may relate to antenatal testing, pre-surgical testing (this is not routinely recommended), military requirements, correctional services, blood donation, and immigration or insurance requirements. Regardless of the reason for testing, pre-test discussion between the clinician and the patient and informed decision-making by the patient are important.

Patients who request testing may not reveal their full level of risk. In some situations, the clinician may assess the risk of infection as low but the patient's actual risk of infection may be high. For this reason, all patients requesting testing should be tested. Some patients, for example young people, may attend hoping to arrange an HIV, HBV or HCV test but are unable to state this request directly. In such cases, a request for a 'check-up' or 'blood tests' may prompt questioning by the clinician to elicit specific concerns (Case study 1).

Legal requirements

The Medicare Benefits Schedule (MBS) stipulates that a practitioner requesting an HIV test has ensured that a patient undergoing an HIV test has given informed consent, received adequate pre-test discussion and understands that further discussion may be necessary once the test result is available. Some States and Territories have specific legal regulations relating to pre-test and post-test discussion for HIV and viral hepatitis, which may be used as a guide for minimum standards of care. Clinicians should contact relevant State or Territory health departments for details.

Chapter 14 contains further discussion of legal responsibilities and highlights the need for full documentation of recommendations, counselling and follow-up undertaken by the clinician.

Pre-test discussion

Pre-test discussion has several objectives:

- To provide information about the implications of a positive or negative result
- To enable informed decision-making about testing
- To communicate the health benefits of testing
- To educate patients about modes of transmission, safe sex and risk reduction measures
- To prepare for a possible positive result.

History-taking and risk assessment

A non-judgemental approach is essential to facilitate honest answers to highly personal questions. Consideration of actual risk practices, rather

CASE STUDY 1

An adolescent may request testing indirectly

Indirect requests for testing

Mary is a 16-year-old girl who presents for a check-up and reports feeling sick. Upon history and examination she is well but the clinician decides to perform a full blood count and iron studies. While the blood is being taken, Mary asks, 'By the way, doctor, does this test for AIDS?' Subsequent assessment indicates that Mary has had unprotected vaginal sex and is concerned about STIs. The clinician performs HIV pre-test discussion and conducts a full STI screen including an HIV test. A follow-up appointment is arranged and information provided about the local youth service which provides targeted health information.

than making assumptions based on the patient's perceived membership of a particular risk group, is the accurate way to perform a risk assessment. Chapter 3 addresses sexual and drug-use history-taking in detail, and Chapters 2 and 3 discuss risk assessment.

Issues to cover during pre-test discussion

Table 9.1 lists topics to be addressed during pre-test discussion. In particular, the key points to be discussed regarding an HIV, HCV, HBV test include:

- **Confidentiality**

Advise the person of the measures the service or practice takes to protect personal information, including results, as well as public health notification requirements (Chapter 14). Patients who do not wish to disclose their name or Medicare number should have access to coded testing (e.g. using the first two letters of surname and first two letters of given name plus date of birth).

- **Medical consequences of infection**

Provide information about the natural history and modes of transmission for HIV, HBV or HCV (Chapters 1 and 2 and Appendix 1–3).

- **Information about prevention**

Discuss the relative risks of transmission of HIV, HBV and HCV associated with various practices. Explore the person's ability to practise safe sex or safe injecting (Chapter 3).

- **The implications of a positive result**

Inform the patient that the presence of antibodies means viral infection has occurred. Discuss implications of chronic infection for sexual relationships, the existence of treatments and the emotional and social supports that people with an infection can access. The benefits of HBV immunisation for household members and sexual partners may be relevant. Some people may be reluctant to test even when the availability of

treatments has been explained to them. They may believe that it will be impossible to keep results private and they may hold well-founded fears of discrimination, social exclusion or personal violence that may follow disclosure of HIV or viral hepatitis infection.

- **Implications of an indeterminate result**

Prepare the patient for the possibility of an indeterminate result and the need to re-test.

- **The window period**

Explain this concept and its possible implications. The window period is usually defined as the period after which it is certain that the person being tested will not seroconvert following a given exposure. The true window periods of HIV and HCV antibody tests have improved greatly over the years. In Australia, the currently used HIV antibody tests (highly sensitive in themselves) are combined with an HIV antigen test and so can demonstrate reactivity as early as two to three weeks³ after the infecting event. With older HIV antibody tests, a window period of three months since the time of exposure was standard. Three months is still usually quoted as the window period, although in practice in Australia, this is rarely the case. It is important to explain that someone who has recently acquired HIV is highly infectious during the window period.

For HCV and HBV, a longer time period post-infection (approximately 70 days)³ is required before serology tests are able to reveal infection, due to a different time course of infection.

- **The implications of a negative result**

Explain that the absence of antibodies (the negative result) means either the person does not have the infection or that he or she is in the so-called 'window period' of infection, prior to the development of antibodies (see above section on the window period).

- **Coping with a positive result**

Previous ways of coping with crises may indicate how the person will cope with a positive test result. People with a history of depression or other psychiatric issues and those without self-perceived social supports are especially vulnerable following a positive diagnosis.

Assess the patient's psychiatric history and risk of suicide or self harm, and identify appropriate interventions in the event of a positive diagnosis. In cases where high-risk practices or clinical features are suggestive of infection, in-depth discussion of these issues may form the basis of a future management plan.

- **Referral**

The need for assistance from other agencies may arise during the pre-test discussion and clinicians need to have a low threshold for referral to specialist

agencies. For example, when assessing patients with a history of injecting drug use, issues related to homelessness, poverty or drug and alcohol dependence may become apparent and referral may be indicated (Chapter 15).

- **Supporting the person while waiting for the result**

Ensure that follow-up appointments are booked at the pre-test assessment. Suggest that a trusted person be told about the test if the patient requires support while waiting for test results. In addition, the patient may be invited to bring a support person when returning for his or her result.

Summary

While pre-test discussion may seem time consuming, practice ensures that time is used efficiently within the primary care context. Clinicians will often develop their own style for discussing HIV and viral hepatitis, tailoring information and language to the needs of individual patients. Not all of the issues listed above may be relevant to every patient each time he or she presents for testing, but assumptions regarding the patient's level of knowledge should be avoided. While the process may seem unnecessary in low-risk patients, thorough pre-test discussion ensures that prevention measures are in place, the patient is prepared for his or her test results, and the clinician's ethical and legal obligations are met.

Post-test discussion

All HIV, HBV and HCV test results must be given in person. Ensure privacy and undertake the consultation in an area where you will not be interrupted. Further testing for other STIs and blood-borne viruses should be recommended as appropriate.

Giving a positive result

Key points to be discussed in relation to a positive HIV, HCV, HBV test include: (see Table 9.2):

- **Assess patient readiness to receive the result**

The person may be asked whether he or she has thought about the likely test result and its implications.

- **State the result clearly**

Some people confuse a 'positive result' with a good result. Ensure that the actual result is understood.

- **Seek consent to repeat the test for confirmation**

Mistakes in labelling at the surgery or in the laboratory are rare but they still do occur. It is important not to raise the patient's hopes too much over this issue, however.

- **Avoid information overload**

Give the patient time to process and react to the information. Listen and respond to the person's needs.

• **Reinforce commitment to health care**

The primary care clinician may reassure the patient that he or she will continue to be a partner in the patient's health care without discrimination.

• **Enlist available supports**

Help plan the person's next 24–48 hours. Arrange a follow-up appointment during the next two days and offer an after-hours phone contact number.

• **Discuss disclosure**

After a positive result, the patient may experience an urge to tell many people. The balance between disclosure and privacy can be difficult, and the clinician may caution the patient about widely disclosing his or her positive status during the first few days after diagnosis, due to the possibility of negative responses from some people.

• **Supply written material**

Supplying written material gives the person something to read outside of the consultation, reinforcing key messages that may not have been heard in the context of the shock of receiving a positive result. Information may address the medical and social consequences of HIV, HBV or HCV infection and provide details about local support services, including telephone information and support lines, AIDS Councils or Hepatitis C Councils (Chapter 15). The ASHM website (www.ashm.org.au) provides patient fact sheets including support services.

• **Reinforce prevention message including information about modes of transmission.**

This may form the basis of starting the contact tracing process.

• **Managing a positive result**

Much of the initial management of a new blood-borne virus diagnosis is psychosocial. Offering the patient the opportunity to return at any time to discuss concerns may help him/her to adjust to the diagnosis.

Chapters 10, 11 and 12 discuss the initial and ongoing assessment, monitoring and management of patients with HIV, viral hepatitis, and STIs.

Clinicians inexperienced in managing patients with BBV infections should collaborate with more experienced general practitioners and/or relevant specialists and specialist centres (Chapter 15 and the *ASHM Directory*).

Giving a negative result

Key points to be discussed in relation to a negative HIV, HCV, HBV test (Table 9.3)

• **Inform the patient of the result**

Tell the patient that he or she does not have the infection. If appropriate, discuss the window period and make an appointment for re-testing.

TABLE 9.2 Summary of post-test discussion: giving a positive result	
First post-test consultation	
•	Establish rapport and assess readiness for the result
•	Give positive test result
•	Avoid information overload
•	Listen and respond to needs (the patient may be overwhelmed and hear little after being told the positive result)
•	Discuss immediate implications
•	Review immediate plans and support
•	Reassess support requirements and available services
•	Arrange other tests and the next appointment
•	Begin contact tracing process and discuss options available to facilitate this
Subsequent consultations	
•	Treatment options, diet and exercise
•	Effect of diagnosis on relationships and prevention information
•	Issues of disclosure
•	Assessment of contact tracing process and difficulties encountered
•	Access to life insurance may be affected
•	Workplace implications
•	Impact of other issues (eg. drug use, poverty, homelessness) on ability to access health care and treatments
•	Referral for on-going counselling, social worker, medical specialist as appropriate

TABLE 9.3 Summary of post-test discussion: giving a negative result	
•	Explain the negative test result and the window period (if relevant)
•	Reinforce education regarding safe behaviours
•	Consider vaccination – for hepatitis B, hepatitis A (if indicated), and, for women aged between 9 and 26, human papillomavirus (HPV)
•	Further discuss anxiety or risk behaviours
•	Discuss testing for other STIs

- **Educate the patient about ongoing risk-taking**

Review safe sex and safe injecting practices. Discuss the role of drugs and alcohol in risk-taking, as well as how and where to access condoms and clean injecting equipment. Offer referral to local services as appropriate (Chapter 15).

- **Offer vaccination**

Hepatitis A and hepatitis B vaccination may be offered, plus one of the HPV vaccines in young women.

- **Address attitudinal barriers**

A negative result leaves time to explore important issues that may impact on infection risk. For example, a negative result after a high-risk encounter may reinforce a sense of invincibility among young people, especially young men. Such responses need to be addressed.

Indeterminate results

Occasionally, an equivocal or indeterminate result from HIV, HBV or HCV testing may occur. This can be a source of great uncertainty and anxiety for the patient. Clinicians may need to consult pathology laboratory staff or the National Serology Reference Laboratory for specialist advice in interpreting indeterminate results. Specific tests for each blood-borne virus have different types of equivocal results and differing rates of false positivity. In the case of HIV antibody testing, a positive ELISA and a single band on Western blot constitutes an indeterminate result.

A patient with an indeterminate result who has reported a recent high-risk exposure is regarded as being in the window period of infection and may require considerable support during this time to deal with the uncertainty. Further tests for viral antigens may be indicated to test for the presence of infection and should be performed in consultation with a specialist clinician. If reactivity in HIV or HCV antibody tests does not progress over approximately two weeks it is unlikely that a person is seroconverting.

The result is likely to remain 'indeterminate' due to the presence of non-specific reactivity in the test. Thus a clinician can draw a second sample soon after the first to determine the progression. However, to be sure and to address absolutely the fears of the person being tested or the healthcare worker's doubts, test results at approximately 12 weeks for HIV and six months for HCV should be obtained.

In populations of low seroprevalence of blood-borne viral infections, indeterminate results may be 'false positives'. Factors such as pregnancy, past blood transfusions, intercurrent viral infections, autoimmune diseases and malignancies may play a role in equivocal results. Upon re-testing at approximately two weeks, a second indeterminate result is regarded as confirmation of negative status.

Special considerations

Aboriginal and Torres Strait Islander People

The rates of HIV diagnosis per capita in the Indigenous and non-Indigenous populations are similar but there is evidence that Indigenous people are more likely to be diagnosed later in the course of the infection, and therefore have a higher AIDS disease diagnosis rate.² Higher prevalence of ulcerative and non-ulcerative STIs in this population may contribute to HIV transmission and STI testing should be offered. The primary objective of the *National Aboriginal and Torres Strait Islander Sexual Health and Blood-Borne Virus Strategy 2005–2008*⁴ is to improve access to testing and medical care for HIV, blood-borne viruses and STIs among Aboriginal and Torres Strait Islander people. Facilitating this goal may involve:

- Understanding differing epidemiology of HIV in different local settings. For instance, higher rates of infection through heterosexual contact and intravenous drug use.²
- Addressing local and cultural issues, such as stigma and shame, associated with HIV and STI testing and diagnosis. Routine screening through antenatal clinics, adult health checks and community STI screening interventions may help reduce the stigma around testing.
- Local systems and policy to ensure confidentiality around STI and HIV testing.
- Specific programs to facilitate testing through collaboration and partnerships between Indigenous organisations and groups and specialist Sexual Health and HIV services. Local input to ensure the relevance and appropriateness of programs aimed at different subgroups, e.g. youth, MSM, sex workers.
- Pre- and post-test discussion may need to incorporate local patterns of transmission and modes of disease prevention. Education around the potential for blood-to-blood transmission in traditional ceremonial practices may be particularly relevant in some Indigenous settings and discussion should incorporate this information in an appropriate manner.
- Pre- and post-test educational resources such as videos or cassettes in Indigenous languages or plain English may assist to ensure informed consent and aid HIV and STI prevention education.
- Antenatal testing. As heterosexual transmission of HIV is more common in many Indigenous settings, antenatal testing may provide an important opportunity to inform, educate and test Aboriginal and Torres Strait Islander women for HIV.
- Consideration of the need for an interpreter. However, an interpreter may be closely connected with the patient's family and may create a fear regarding a possible breach of confidentiality.
- Testing for other STIs and blood-borne viruses. If HIV is detected, Aboriginal and Torres Strait Islanders should also be tested for HTLV-1 as this is more common in this population and may alter disease progression and management.^{1,5}

Other cross cultural issues

Culture, language, literacy level, gender and age will affect how a person accepts and understands HIV, HBV and HCV testing, but this should not interfere with provision of pre-test and post-test discussion. Language barriers may be overcome by the use of an interpreter and language education resources such as leaflets, videos and multimedia.

HIV, HBV or HCV phobia

Occasionally the clinician will encounter a person whose fear of infection with HIV or viral hepatitis is out of proportion with the actual risk of infection. Such people, sometimes referred to as the 'worried well', may repeatedly request HIV or HCV tests after encounters that carry very low or no risk of transmission. Often these people are helped by emotional support or a discussion of the encounter and the provision of factual information about the risk of transmission. This may not be adequate for some people who may have co-existing psychiatric morbidity, such as undiagnosed obsessive compulsive disorder, and may need referral for specialist counselling or psychiatric assessment.

Testing and pregnant women

Why test pregnant women?

The risk of perinatal transmission of HIV and HBV can be significantly reduced with appropriate clinical care and interventions.

The basis for offering pregnant women HIV testing is the ability to prevent mother-to-child transmission. Several studies published in the mid-1990s demonstrated that zidovudine (zidovudine) monotherapy reduced mother-to-child transmission from 25% to 8%.⁶⁻⁸ The use of combination therapy plus planned caesarean delivery and bottle-feeding has reduced HIV transmission to less than 2%.⁹⁻¹² Mother-to-child transmission of HIV has fallen dramatically in countries where antiretroviral therapy is available to pregnant women.¹³

Interventions to prevent HBV infection are well established and reference to the National Health and Medical Research Council's Immunisation Handbook is advised.¹⁴

HIV testing during pregnancy

The 2006 National HIV Testing Policy recommends all pregnant women should be routinely offered HIV testing. Pregnancy is a time when women are in contact with clinicians, and it provides an opportunity for detection of previously undiagnosed infections. Previous policy suggested HIV testing in pregnancy if a risk assessment suggested possible HIV risk. However, many women diagnosed with HIV do not self-acknowledge risk factors, and therefore standard risk assessment may be inadequate to test and detect women with HIV infection.¹⁵⁻¹⁷ Because

prevention of mother-to-child transmission of HIV is highly effective if HIV is diagnosed antenatally, routine testing with informed consent is now the standard of care.

HIV discussion during pregnancy

The issues to be discussed during pre-test discussion listed in Table 9.1 remain relevant for pregnant women.

It is recommended that pre-test discussion in pregnancy should include a standard HIV risk assessment and discussion including informed consent. Pregnant women undergoing testing should be educated as to the benefits of HIV diagnosis and the management and prevention strategies in the case of a positive result.

Educational resources such as leaflets, videos and multimedia may be required in contexts where literacy or English understanding is poor. Interpreters and language resources may assist in these scenarios to ensure an understanding of the testing process and informed consent.

Discussion of an indeterminate result may also be considered, given that pregnancy may slightly increase the likelihood of an indeterminate result.

Post-test discussion of positive tests results should involve all of the points listed in Table 9.2. Antenatal women diagnosed with HIV should have the chance to consider all options regarding their current and future pregnancies with the correct information regarding transmission risk. If known teratogenic antiretroviral treatment is avoided, combination antiretroviral therapy is considered safe for the woman and foetus. Referral information to appropriate specialist HIV services should be facilitated.

Considerable anxiety and guilt may be associated with diagnosis during pregnancy. Special attention should be paid to the psychosocial aspects of receiving a positive test result during pregnancy.

CASE STUDY 2

A request for HIV testing may indicate anxiety not risk

HIV anxiety and sexual identity

Michael is a 39-year-old married man who presents for an HIV antibody test. During discussion, he reports mutual masturbation with a male acquaintance. Although sexual transmission of HIV is highly unlikely from this safe sexual encounter, Michael is convinced that he has HIV infection. On examination he is well and the antibody test comes back negative. In the meantime, Michael now thinks that he may be gay and needs to talk to someone about it. The clinician refers him to a counsellor but continues to offer psychosocial support, as well as HAV and HBV vaccination.

Discussion should include an assessment of the negative effects of diagnosis (e.g. discrimination, domestic violence, psychological difficulties) and should provide information on how to minimise these.

The clinician should evaluate an HIV-infected pregnant woman to determine her need for psychological and social services. Specialist counsellors or midwives with training in this area may be engaged during this process. The implications of the test result for both mother and child should be reiterated, as should treatment options and measures for preventing perinatal transmission so the woman can make informed decisions regarding her options.

- US guidelines can be found at <http://www.aidsinfo.nih.gov>
- The National HIV Testing Policy (2007) is available on the Commonwealth Department of Health and Ageing website at http://www.health.gov.au/internet/wcms/publishing.nsf/content/health-pubhlth-strateg-hiv_hepc-hiv-index.htm#testing (see Reference 1)
- Australian guidelines can be accessed through the ASHM HIV Models of Care database at <http://www.ashm.org.au/moc/>

HCV testing in pregnancy

At present no drug therapies are recommended to reduce the risk of mother-to-child HCV transmission which, providing the patient is not HIV co-infected, is low, at approximately 5%. No specific intervention at the time of delivery has been shown to reduce the risk of transmission and breastfeeding has not been shown to increase the risk of HCV transmission to the baby.

Routine screening of pregnant women is not recommended. Any woman identified as being at risk of, or personally concerned about, HCV infection should be offered testing.

Transmission from mother-to-child will not occur if the mother has spontaneously cleared the HCV infection, so all pregnant women who test positive for anti-HCV antibodies should be offered qualitative HCV RNA testing to determine if they are still viremic. Infants born to anti-HCV positive mothers will have passively acquired antibodies. In uninfected infants, seroreversion or loss of maternal antibodies will be seen within 18 months. Antibody testing should therefore only be carried out after the child reaches 18 months of age.¹⁷

Summary

Pre-test and post-test discussion for HIV and viral hepatitis (as well as for other STIs) provides the clinician with the opportunity to review and reinforce prevention and risk reduction messages. It also protects patient autonomy by ensuring informed consent regarding testing and helps prepare patients for positive test results. The benefits of early diagnosis, in terms of access to treatments and improved disease outcomes, should be highlighted when recommending testing. In the context of a positive result, post-test discussion and referral for counselling deals primarily with psychosocial issues, prevention of further transmission, contact tracing and information about on going monitoring and treatment.

ASHM can provide information and education resources on pre- and post-test discussion.

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