Face the Facts When Dealing With Genital Herpes

Patient education is critical, especially since many who test positive are asymptomatic.

BY DIANA MAHONEY
New England Bureau

BOSTON — Genital herpes is a recurrent, lifelong viral disease. This is the one thing that patients and providers don't like to say, but there's no way around it, Laura J. Mulcahy said at a conference on contraceptive technology sponsored by Contemporary Forums.

Other difficult truths about infection with herpes simplex virus (HSV) type 2? The overwhelming majority of people infected with the virus don't know that they have it, and people with asymptomatic or unrecognized disease shed the virus intermittently in the genital tract, said Ms. Mulcahy, a certified family nurse practitioner who is assistant medical director of the STD Center for Excellence at Montefiore Medical Center in New York.

"When we ask patients prior to screening for HSV-2 if they have a history of genital herpes … about 90% of those who ultimately test positive for HSV-2 antibodies reported having no history or symptoms of the infection," she said. This underrecognition can be attributed to the fact that the leading cause of HSV-2 infection is asymptomatic shedding of the virus.

"There is a misperception and some clinicians are still telling patients that the infection is spread only through [HSV-2] sores. This is absolutely not true. The virus can shed even when the skin looks normal, and that's when most infections occur," she said.

Patient education about asymptomatic disease is critical to an effective screening protocol. Ms. Mulcahy stressed that patients who come in for STD screening are told that, "from this day forward, the fact that you or your partner have no symptoms means nothing; the fact that you and your partner look fine means nothing; and the fact that you or your partner had a negative screen 6 months ago, if you've had partners in the interim, means nothing."

Another factor contributing to the high rate of unrecognized disease is that many patients who have been screened for STDs believe they have been tested for genital herpes. "A complete STD screen does not include testing for herpes. Many patients believe they are being tested for everything. If their STD screen is negative, they assume that means they don't have herpes," said Ms. Mulcahy.

"Clinicians who don't routinely screen for herpes [as part of an STD screening protocol] must inform patients that they are not being tested and chart that in the patient record so there is no confusion," she said.

If a patient asks to be screened for HSV-2, then several points need to be addressed before testing, Ms. Mulcahy stressed:

▶ The absence of symptoms does not predict a negative screen.

▶ In patients with lesions, a herpes culture has low sensitivity, especially as lesions heal. As such, a negative culture does not rule out HSV-2.

▶ In the event of a positive HSV-2 test in an asymptomatic person, it is not possible to determine how long the virus has been present, when or whether they will have outbreaks, or whether they will ever have a problem with herpes.

▶ In the event of a positive HSV-2 test, patients in some states have a legal obligation to inform current and future sexual partners of their infection status before genital to skin contact.

Counseling patients on these points before testing is imperative. "If you wait until after a positive screen, patients will no longer be listening. They must know what to expect before they hear the word positive," she said.

Among the tools used to screen for HSV-2, clinical examination and history are insensitive and nonspecific. "Symptoms are easily confused with other conditions or may present atypically, for example, as redness rather than sores," Ms. Mulcahy said. Viral culture is the most valid test available, despite the high rate of false negatives.

Polymerase chain reaction assays are another diagnostic option. They have increased sensitivity but are not approved by the Food and Drug Administration, nor are they available in all laboratories. Cellular detection methods, including Tzanck test and Pap smear, are not recommended for HSV detection because of their low sensitivity, she said.

Many type-specific serology tests, such as the older enzyme-lined immunoabsorbent assay tests, can result in false-positive results because of problems with cross reactivity. The newer type-specific HSV glycoprotein G1 (HSV-1) and G2 (HSV-2) tests are more reliable, but their sensitivities vary, she said, noting that a positive test should be confirmed with another test to reduce the risk of false-positive diagnoses. The Western blot is the reference standard serology test, but it is not approved and is only available from one laboratory at the University of Washington, Seattle.

"Do not underestimate the impact of this diagnosis on your patients. They will require extensive, thoughtful counseling [because] the physical impact of genital herpes is nothing compared to the psychological one," Ms. Mulcahy said.

Such counseling should include information about the natural history of disease, the ability to bear children, the transmission risk to sexual partners, and the variations in severity of primary vs. recurrent episodes. It also is important to dispel cancer myths, reiterate the fact that the virus can be transmitted in the absence of symptoms or lesions, remind patients of their obligation to inform current and future partners, and recommend counseling and testing for sexual partners.

Risk-reduction strategies also should be discussed, including avoiding sexual contact when symptoms or lesions are present and using latex barrier protection and suppressive therapy. There are three oral antiviral drugs—acyclovir, valacyclovir, and famciclovir—approved for the treatment of genital herpes. Topical treatments, she stressed, "absolutely do not work and have no role in the treatment of genital herpes." ■

EXPERT OPINION

Universal HIV Screening Renews Disclosure Debate

When a person discloses a positive HIV status to a partner, the disclosure eliminates many of the moral, ethical, and legal considerations inherent in the opposite scenario.

Just what is our responsibility as physicians in this regard? Do we have a duty to protect and warn the known sexual partners of a nondisclosing, HIV-positive person? Such actions can breach the therapeutic alliance between doctor and patient. However, not disclosing has the potential to place a third party at risk.

BY RICHARD BLANKS, M.D., J.D.

I've found that nondisclosure on the part of patients to partners is common. When I was on the hospital ethics committee at the Harvard-affiliated Cambridge Health Alliance, for example, cases arose frequently involving an HIV-positive patient who was not informing her partner.

This leaves us physicians in an awkward position, indeed. Here in Massachusetts, providers must consider two important and conflicting statutes. One law states that HIV information is confidential and test results cannot be disclosed to anyone without the written consent of the patient. Even when a significant other is nearby and asks what is going on, physicians, nurses, and other staff cannot say anything, because to do so would breach the patient's confidentiality.

The other state law outlines the duty that mental health professionals have to disclose information when a patient reveals an intent to inflict serious harm or kill a third party.

This is easier to interpret if, for example, my patient divulges that he has a gun and intends to kill a judge. But what do we do about less acutely lethal forms of harm, including potential HIV infection?

Spurring the controversy are 2006 guidelines from the Centers for Disease Control and Prevention. The CDC proposes that providers screen all adolescents and adults entering the health care system for HIV infection (MMWR 2006;55:1-17). The agency based those recommendations in part on the recognition that about 25% of people who are HIV positive are unaware of their status.

One potential change that would shift the terms of this debate for us is universal screening.

Universal screening would change fundamentally the way in which HIV testing has been done all these years. Most states are working on compliance. For example, some states have dropped pre- and posttest counseling, and about 40 states have eliminated written informed consent requirements.

In Massachusetts, we face a second conflict regarding informed consent. The state's public health commissioner wants to retain the written informed consent rule, while the president of the Massachusetts Medical Society wants to drop the provision and treat HIV like any other communicable disease.

The HIV patient confidentiality laws initially were enacted when there were no effective treatments. As medicines that began to significantly improve patients' health, longevity, and quality of life have reached the market, the original justifications for complete confidentiality may no longer apply.

There appears to be a national policy trend in this particular setting away from favoring individual autonomy to actions that would benefit overall public health.

In 2000, the American Psychiatric Association released practice guidelines for the treatment of patients with HIV/AIDS that stated, in part, that "while it may be ethically permissible to notify [others], it may not be legally permissible."

This position evolved, as reflected in an APA formal position statement 4 years later that states it may be "ethically permissible to notify identifiable persons who the psychiatrist believes to be in danger of contracting the virus, or to arrange for public health authorities to do so."

My associates and I are launching a pilot study aimed at determining what type of stance providers are taking regarding HIV confidentiality in real world settings in 2007.

We plan to survey 2,000 psychiatrists in Massachusetts, and eventually hope to expand this to other clinical specialties and areas of the country. ■

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