

Sexual and Reproductive Health at a Glance

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Preface



exual and Reproductive Health (SRH) is a specialty which continues to evolve not only in the UK but globally. Community SRH (CSRH) was approved as a new speciality in the UK by the General Medical Council in 2010. In many countries, management of sexually transmitted infections (STIs) and provision of contraceptives and reproductive healthcare are delivered in distinct services. Patients' requirements however do not fit into these artificial categories and this is where SRH as a holistic specialty comes into its own. Providing SRH as integrated care is both practical and entirely rational.

Unlike textbooks which focus solely on either contraception or STIs, this first edition has been planned to encompass all core clinical topics required for integrated SRH provision. The contents are organized broadly into the main elements of the specialty, namely contraception, sexual health (including STIs and blood-borne viruses) and reproductive health. The textbook has been mapped to encompass the clinical topics of the CSRH curriculum.

The information is presented in a highly visual and easy to access format with the needs of the busy clinician or student in mind. The many illustrations and photographs in this book will provide easy to remember prompts.

I have approached the topics from a patient-centred perspective therefore information is not only provided on individual conditions,

but also supplied in the form of syndromic presentations e.g. the management of vaginal discharge. This should make the book appropriate for real clinical practice. Subjects such as general obstetrics (apart from for example STIs relevant to pregnancy) have deliberately been excluded from this text in order to focus on the core SRH information required by the busy clinician.

Although planned with the SRH trainee in mind, this book will be an invaluable source of information to the specialist and generalist alike. SRH is frequently delivered by General Practitioners, Practice Nurses and Nurse Specialists and I am certain this text book will appeal to these groups of readers. Dedicated time for the undergraduate study of SRH is often limited and medical students will find not only the book itself, but also the supporting website with interactive cases helpful for revision.

Our speciality is fortunate to have an abundance of high quality evidence based clinical guidelines available for reference and I would like to draw your attention to those from the Faculty of Sexual and Reproductive Healthcare (FSRH), Clinical Effectiveness Unit (CEU), British Association for Sexual Health and HIV (BASHH) and British HIV Association (BHIVA) which are frequently referred to in this book.

I hope that the reader will find this book a useful tool both for studying and for everyday clinical practice.

Catriona Melville



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Catriona Melville

Abbreviations



AEDs	antiepileptic drugs	EC	emergency contraception
AIDs	acquired immunodeficiency syndrome	ECG	electrocardiogram
AIN	anal intraepithelial neoplasia	ED	erectile dysfunction
ALF	acute liver failure	EE	ethinylestradiol
ART	antiretroviral therapy	Els	entry inhibitors
ALO	actinomyces-like organisms	ENG	etonogestrel
AUB	abnormal uterine bleeding	EP	ectopic pregnancy
BASHH	British Association for Sexual Health	EPR	electronic patient record
DAOIIII	and HIV	ESR	erythrocyte sedimentation rate
BBT	basal body temperature	EVA	electric vacuum aspiration
BBV	blood-borne viruses	FAM	fertility awareness method
BFPR	biological false positive reaction	FBC	full blood count
BHIVA	British HIV Association	FIGO	
		FIGO	International Federation of Gynecology and
BMD	bone mineral density	EME	Obstetrics
BMI	body mass index	FME	forensic medical examination
BNF	British National Formulary	FPU	Family Protection Unit
BPAS	British Pregnancy Advisory Service	FSH	follicular stimulating hormone
ВТВ	breakthrough bleeding	FSRH	Faculty of Sexual and Productive Healthcare
BV	bacterial vaginosis	FVU	first void urine
CBT	cognitive behavioural therapy	GnRH	gonadotrophin-releasing hormone
CD	Crohn's disease	GMC	General Medical Council
CEU	Clinical Effectiveness Unit	GUD	genital ulcer disease
CHCs	combined hormonal contraceptives	GUM	Genitourinary Medicine
CIN	cervical intra-epithelial neoplasia	GBV	gender based violence
СМО	Chief Medical Officer	HAART	highly active antiretroviral therapy
COC	combined oral contraceptive	HAV	hepatitis A virus
CPP	chronic pelvic pain	HBV	hepatitis B virus
CRP	C-reactive protein	HCP	healthcare professional
CSF	cerebrospinal fluid	HCV	hepatitis C virus
CSRH	Community Sexual and Reproductive Health	HERS	Heart and Estrogen/Progestin Replacement
CT	computerized tomography		Study
CTP	combined transdermal patch	HCG	human chorionic gonadotrophin
Cu-IUD	copper intrauterine device	HIV	human immunodeficiency virus
CVD	cardiovascular disease	HIV PEPSE	HIV post-exposure prophylaxis after sexual
CVR	combined vaginal ring		exposure
CXR	chest X-ray	HMB	heavy menstrual bleeding
D&E	dilatation and evacuation	HPS	Health Protection Scotland
DH	Department of Health	HPV	human papilloma virus
DGI	disseminated gonococcal infection	HRT	hormone replacement therapy
DMPA	depot medroxyprogesterone acetate	HSV	herpes simplex virus
DNG	dienogest	HVS	high vaginal swab
DRSP	Daily Record of Severity of Problems	IBD	inflammatory bowel disease
DUB	dysfunctional uterine bleeding	lls	integrase inhibitors
E2V	estradiol valerate	IM	intramuscular
EAGA	Expert Advisory Group on AIDS	IMB	intermenstrual bleeding
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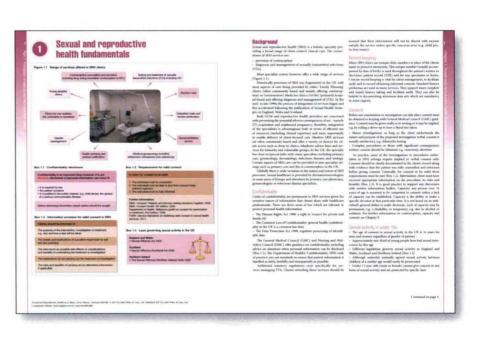
ISPMD	International Society for Premenstrual	PMD	premenstrual disorders
	Disorders	PMNLs	polymorphonuclear leukocytes
ISSVD	International Society for the Study of	PMS	premenstrual syndrome
	Vulvovaginal Disease	PN	partner notification
IUD	intrauterine device	PO	progestogen-only
LAAC	Looked After and Accommodated Children	POC	products of conception
LAM	lactation amenorrhoea method	POCTS	point-of-care tests
LARC	long-acting reversible contraception	POEC	progestogen only emergency
LFT	liver function tests		contraception
LGV	lymphogranuloma venereum	POF	premature ovarian failure
LH	luteinizing hormone	POP	progestogen-only pill
LMP	last menstrual period	PrEP	pre-exposure prophylaxis
LNG	levonorgestrel	PROM	preterm rupture of the membranes
LNG-IUS		PSA	prostate specific antigen
LNG-103	levonorgestrel-releasing intrauterine	PT	
LD	system		prothrombin time
LP	lichen planus	PTSD	post-traumatic stress disorder
LS	lichen sclerosus	PVB	(per) vaginal bleeding
MCV	molluscum contagiosum virus	PVSA	post-vasectomy semen analysis
MI	myocardial infarction	PWIDs	people who inject drugs
MIV	minimally invasive vasectomy	ReA	reactive arthritis
MSI	Marie Stopes International	RCGP	Royal College of General Practitioners
MSM	men who have sex with men	RCOG	Royal College of Obstetricians and
MSSU	midstream sample of urine		Gynaecologists
MTCT	mother to child transmission	RPR	rapid plasma reagin
MVA	manual vacuum aspiration	SARA	sexually acquired reactive arthritis
NAAT	nucleic acid amplification test	SARC	Sexual Assault Referral Centre
NATSAL	National Survey of Sexual Attitudes and	SC	subcutaneous
10/11/07/12	Lifestyles	SI	sexual intercourse
NCSP	National Chlamydia Screening	SIGN	Scottish Intercollegiate Guidelines
14001	Programme	Oldit	Network
NET EN		SLE	
NET-EN	norethisterone enantate		systemic lupus erythematosus
NFP	natural family planning	SPC	summary of product characteristics
NGU	non-gonococcal urethritis	SPRM	selective progesterone receptor modulator
NICE	National Institute for Health and Care	SRH	sexual and reproductive health
- Contract	Excellence	STI	sexually transmitted infection
NMC	Nursing and Midwifery Council	TASP	treatment as prevention
NNRTIS	non-nucleoside reverse transcriptase	TCA	trichloracetic acid
	inhibitors	TENS	transcutaneous electrical nerve stimulation
NOMAC	nomegestrol acetate	TOC	test of cure
NRTIs/NtRTIs	nucleoside/nucleotide reverse	TOP	termination of pregnancy
	transcriptase inhibitors	TSS	toxic shock syndrome
NSAIDs	non-steroidal anti-inflammatory drugs	TSH	thyroid-stimulating hormone
NSV	no-scalpel vasectomy	TV	trichomonas vaginalis
nvCT	new variant chlamydia trachomatis	UC	ulcerative colitis
Ols	opportunistic infections	UKMEC	UK Medical Eligibility Criteria
PCOS	polycystic ovarian syndrome	UPA	ulipristal acetate
PCB	post-coital bleeding	UPSI	unprotected sexual intercourse
PCR	polymerase chain reaction	USMEC	US medical eligibility criteria
PDE5	phosphodiesterase-5	VIN	vulval intraepithelial neoplasia
PDPT	patient-delivered partner therapy	VDRL	venereal disease research laboratory
		VLARC	
PDT	pregnancy detection test	VLARC	very long-acting reversible contraception
PE	premature ejaculation		viral load
PEP	post-exposure prophylaxis	VTE	venous thromboembolism
PHI	primary HIV infection	VVC	vulvovaginal candidiasis
PIs	protease inhibitors	WHI	Women's Health Initiative
PID	pelvic inflammatory disease	WHO	World Health Organization
PIN	penile intraepithelial neoplasia	WHOMEC	World Health Organization Medical Eligibility
PLCS	pre-labour caesarean section		Criteria
PMB	post-menopausal bleeding		

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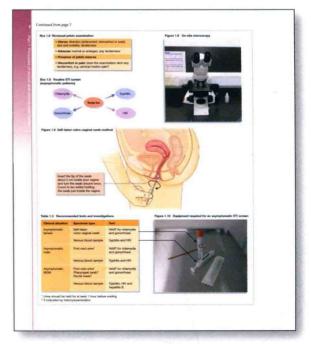


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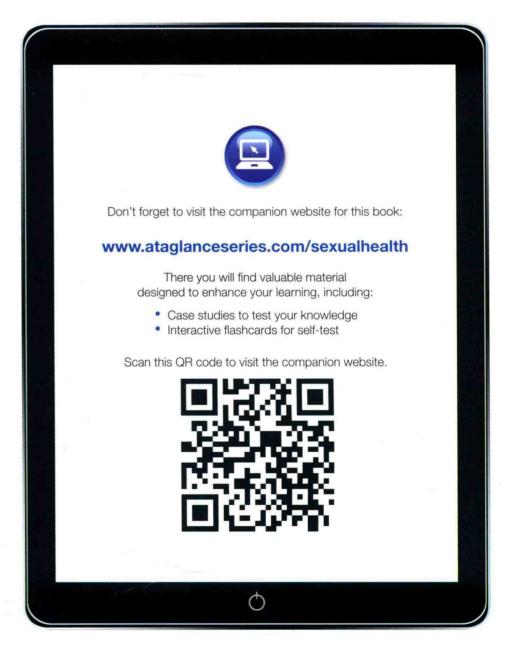


The website icon indicates that you can find accompanying resources on the book's companion website.





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Principles of sexual and reproductive health



Chapter

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Don't forget to visit the companion website at www.ataglanceseries.com/sexualhealth where you can test yourself on these topics.



Sexual and reproductive health fundamentals

Figure 1.1 Range of services offered in SRH clinics Contraceptive counselling and provision Testing and treatment of sexually including long acting reversible contraception (LARC) transmitted infections (STIs) including HIV Young peoples' Abortion care clinics Clinics for sex workers. Outpatient male and the vulnerable or homeless female sterilization Sexual problems Gender reassignment service

Box 1.1 Confidentiality: disclosure

Confidentiality is an important duty; however, it is not absolute. Disclosure of personal information can occur if:

Health advising and

partner notification

- it is required by law
- · the patient consents
- it is justified in the public interest, e.g. child abuse, the spread of a serious communicable disease

Before disclosing information expert advice should be sought

Box 1.3 Information provision for valid consent in SRH

Clients should be informed of:

The purpose of the intervention, investigation or treatment, e.g. why and how a test will be taken

The details and implications of a positive result (both to self and any partners)

The risks (such as possible side effects or complications) and benefits of undertaking the treatment or investigation

The implications of not carrying out the treatment or investigation

The risks and benefits of carrying out an alternative intervention if applicable

Box 1.2 Requirements for valid consent

Medical gynaecology including

ultrasound, menopause and colposcopy

In order for consent to be valid:

- 1. The individual must be competent
- The individual must be able to give their consent freely (without coercion)
- 3. The individual must be fully informed

Further information:

GMC. Consent: Patients and doctors making decisions together. 2008 BMA. Consent toolkit, 5th edition. 2009

Department of Health. Reference guide on consent for examination or treatment. 2nd edition. 2009

FSRH. Service Standards on obtaining valid consent in sexual health services. 2011

Box 1.4 Laws governing sexual activity in the UK

England and Wales

Sexual Offences Act 2003

Scotland

Sexual Offences (Scotland) Act 2009

Northern Ireland

The Sexual Offences (Northern Ireland) Order 2008



Background

Sexual and reproductive health (SRH) is a holistic specialty providing a broad range of client-centred clinical care. The cornerstones of SRH services are:

- · provision of contraception
- diagnosis and management of sexually transmitted infections (STIs)

Most specialist centres however offer a wide range of services (Figure 1.1).

Historically provision of SRH was fragmented in the UK with most aspects of care being provided by either 'Family Planning' clinics (often community based and mainly offering contraception) or Genitourinary Medicine clinics (GUM; primarily hospital based and offering diagnosis and management of STIs). In the mid-to late 1990s the process of integration of services began and this accelerated following the publication of Sexual Health Strategies in England, Wales and Scotland.

Both GUM and reproductive health providers are concerned with preventing the potential adverse consequences of sex – namely STI acquisition and unplanned pregnancy; therefore, integration of the specialities is advantageous both in terms of efficient use of resources (including clinical expertise) and more importantly to enable delivery of client-focused care. Modern SRH services are often community based and offer a variety of choices for client access such as drop-in clinics, telephone advice lines and services for minority and vulnerable groups. In the UK, the specialty has close reciprocal links with many specialties including primary care, gynaecology, dermatology, infectious diseases and urology. Certain aspects of SRH care can be provided in non-specialist settings such as primary care and this is commonplace in the UK.

Globally there is wide variation in the nature and extent of SRH provision. Sexual healthcare is provided by dermatovenereologists in some areas of Europe and elsewhere by primary care physicians, gynaecologists or infectious disease specialists.

Confidentiality

Codes of confidentiality are paramount to SRH services given the sensitive nature of information that clients share with healthcare professionals. There are three areas of law which are relevant to protect personal health information:

- The Human Rights Act 1998: a right to 'respect for private and family life'
- The Common Law of Confidentiality: general health confidentiality in the UK is a common law duty
- The Data Protection Act 1998: regulates processing of identifiable data

The General Medical Council (GMC) and Nursing and Midwifery Council (NMC) offer guidance on confidentiality including advice on situations when personal information can be disclosed (Box 1.1). The Department of Health's 'Confidentiality: NHS code of practice', sets out standards to ensure that patient information is handled as fairly, lawfully and transparently as possible.

Additional statutory regulations exist specifically for services managing STIs. Clients attending these services should be

assured that their information will not be shared with anyone outside the service unless specific concerns arise (e.g. child protection issues).

Record keeping

Many SRH clinics use unique clinic numbers in place of the clients name to preserve anonymity. This unique number (usually accompanied by date of birth) is used throughout the patient's written or electronic patient record (EPR) and for any specimens or forms. Concise record keeping is vital for client management, to facilitate audit and to record obtaining informed consent. Standard history proformas are used in many services. They support more complete and timely history taking and facilitate audit. They can also be helpful in documenting minimum data sets which are mandatory in some regions.

Consent

Before any examination or investigation can take place consent must be obtained in keeping with General Medical Council (GMC) guidance. Consent may be given orally or in writing or it may be implied, e.g. by rolling a sleeve up to have a blood test taken.

- Minor investigations: as long as the client understands the nature and purpose of the proposed investigation verbal consent is usually satisfactory, e.g. chlamydia testing
- Complex procedures or those with significant consequences: written consent should be obtained, e.g. vasectomy, abortion

In practice, most of the investigations or procedures undertaken in SRH settings require implied or verbal consent only. Consent should be clearly documented in the client's record along with evidence that the patient was fully counselled and informed before giving consent. Generally, for consent to be valid three requirements must be met (Box 1.2). Information: client must have received appropriate information on the procedure, its risks and benefits (Box 1.3). It is good practice to support any discussion with written information leaflets. Capacity: any person over 16 years of age is assumed to be competent to consent unless a lack of capacity can be established. Capacity is the ability to make a specific decision at that particular time. It is not based on an individual's general ability to make decisions. Lack of capacity may be permanent, e.g. a disability, or temporary, e.g. due to alcohol or sedation. For further information on contraception, capacity and consent see Chapter 9.

Sexual activity in under 16s

- The age of consent to sexual activity in the UK is 16 years for men and women regardless of gender of partner
- Approximately one-third of young people have had sexual intercourse by this age
- Different legislation governs sexual activity in England and Wales, Scotland and Northern Ireland (Box 1.4)
- Although unlawful, mutually agreed sexual activity between children of a similar age would rarely be prosecuted
- Under 13 year olds (male or female) cannot give consent to any form of sexual activity and are protected by specific laws

Table 1.1 UKMEC categories

UKMEC 1	A condition for which there is no restriction for the use of the method
UKMEC 2	A condition where the advantages of using the method generally outweigh the risks
UKMEC 3	A condition where the risks of using the method usually outweigh the advantages (see text for further explanation)
UKMEC 4	A condition which represents an unacceptable health risk if the method is used

Figure 1.2 Hypothalamic-pituitary-ovarian axis

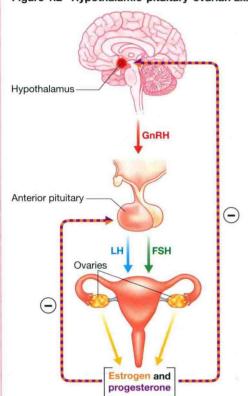


Table 1.2 LARC methods

Contraceptive method	Duration of action for contraception	Pregnancy rate
Cu-IUD	5 – 10 years	< 20 in 1000 over 5 years*
LNG-IUS	5 years	< 10 in 1000 over 5 years
Progestogen-only implant e.g. Nexplanon	3 years	< 4 in 1000 over 2 years
Progestogen-only injection e.g. DMPA	12 weeks for IM-DMPA, 13 weeks for SC-DMPA (8 weeks for NET-EN)	< 1 in 1000 over 3 years

^{*} for devices containing 380 mm² copper

Figure 1.3 Female reproductive cycle

