SPECIALTY: Sexual Health  
Clinical Problem: HIV testing in all Health care settings

The aim of the guideline is to normalise HIV testing in all settings. Higher testing rates can reduce both the number of undiagnosed HIV infections and those diagnosed late (as demonstrated by universal antenatal testing). This has huge benefits to the individual patient and the wider public health.

The guideline will provide appropriate information about the HIV test, which will enable an individual to be offered an HIV test as a normal screening investigation. It will outline the pathway of care in the event of a positive result and contacts for further testing advice.

The guideline is supported by the BASHH 2008 UK National Guidelines for HIV testing which states that; “it is within the competence of any doctor, midwife, nurse or trained health care professional to obtain consent for and conduct an HIV test” and is consistent with the GMC guidance Consent: patients and doctors making decisions together.

Who to test for HIV (based on 2008 HIV testing guidelines)

A) Universal HIV testing recommended:
   – GUM or sexual health clinic
   – Antenatal service & Termination of pregnancy services
   – Drug dependency programmes
   – Healthcare services for those diagnosed with TB, Hepatitis B/C and lymphoma

B) Routinely offer and recommend HIV test to
   – All patients presenting for healthcare where HIV enters the differential diagnosis, ie particular indicator conditions (see table below)
   – All patients where primary HIV infection enters the differential diagnosis (*see below)

C) Routinely offer and recommend HIV test to all people who belong to a group at higher risk of HIV infection
   – All individuals diagnosed with an STI
   – All individuals with a current or former partner with HIV
   – All men who have sex with men
   – All female sexual contacts of men who have sex with men
   – All patients reporting a history of injecting drug use
   – All individuals (and sexual contacts) from countries of high HIV prevalence >1% (Sub Saharan Africa / SE Asia / Russia)

*Primary HIV Infection

70 - 90% of people experience seroconversion symptoms typically 2-4 weeks after infection. Frequently present to 1/2 care where diagnosis often not considered.

Symptoms: Fever, macular-papular rash, myalgia, pharyngitis, lymphadenopathy, hepatitis, headache / aseptic meningitis, diarrhoea


HIV tests may be negative in early HIV infection. If strong suspicion then refer to GUM / sexual health for follow up testing
<table>
<thead>
<tr>
<th>Clinical indicator diseases for adult HIV infection</th>
<th>AIDS-defining conditions</th>
<th>Other conditions where HIV testing should be offered</th>
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<tbody>
<tr>
<td>Respiratory</td>
<td>Tuberculosis</td>
<td>Bacterial pneumonia</td>
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<td></td>
<td>Pneumocystis</td>
<td>Aspergillosis</td>
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<td>Neurology</td>
<td>Cerebral toxoplasmosis</td>
<td>Aseptic meningitis/encephalitis</td>
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<td>Primary cerebral lymphoma</td>
<td>Cerebral abscess</td>
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<td>Cryptococcal meningitis</td>
<td>Space occupying lesion of unknown cause</td>
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<td>Progressive multifocal leucoencephalopathy</td>
<td>Guillain-Barré Syndrome</td>
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<td>Transverse myelitis</td>
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<td>Dementia</td>
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<td>Leucoencephalopathy</td>
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<td>Dermatology</td>
<td>Kaposi’s sarcoma</td>
<td>Severe or recalcitrant seborrhoeic dermatitis</td>
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<td>Severe or recalcitrant psoriasis</td>
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<td>Multidermatomal or recurrent herpes zoster</td>
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<td>Gastroenterology</td>
<td>Persistent cryptosporidiosis</td>
<td>Oral candidiasis</td>
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<td>Oral hairy leukoplakia</td>
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<td>Chronic diarrhoea of unknown cause</td>
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<td>Weight loss of unknown cause</td>
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<td>Salmonella, shigella or campylobacter</td>
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<td>Hepatitis B infection</td>
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<td>Hepatitis C infection</td>
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<td>Oncology</td>
<td>Non-Hodgkin’s lymphoma</td>
<td>Anal cancer or anal intraepithelial dysplasia</td>
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<td>Lung cancer</td>
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<td>Seminoma</td>
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<td>Head and neck cancer</td>
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<td>Hodgkin’s lymphoma</td>
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<td>Castleman’s disease</td>
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<td>Gynaecology</td>
<td>Cervical cancer</td>
<td>Vaginal intraepithelial neoplasia</td>
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<td>Cervical intraepithelial neoplasia Grade 2 or above</td>
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<td>Haematology</td>
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<td>Any unexplained blood dyscrasia including:</td>
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<td>• thrombocytopenia</td>
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<td>• neutropenia</td>
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<td>• lymphopenia</td>
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<td>Ophthalmology</td>
<td>Cytomegalovirus retinitis</td>
<td>Infective retinal diseases including herpesviruses</td>
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<td>and toxoplasma</td>
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<td>Any unexplained retinopathy</td>
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<td>ENT</td>
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<td>Lymphadenopathy of unknown cause</td>
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<td>Chronic parotitis</td>
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<td>Lymphoepithelial parotid cysts</td>
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<tr>
<td>Other</td>
<td>Mononucleosis-like syndrome (primary HIV infection)</td>
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<td>Pyrexia of unknown origin</td>
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<td></td>
<td>Any lymphadenopathy of unknown cause</td>
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<tr>
<td></td>
<td>Any sexually transmitted infection</td>
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Source: UK National Guidelines for HIV Testing 2008
How to test

Pre-test discussion
- Benefits of testing to the individual (treatable, reduce risk of HIV related disease / AIDS / death, reduce transmission risk)
- Details of how the result will be given
- Some patients may require more explanation as to why test recommended (eg clinical indicator conditions)
- Use appropriate interpreting services for patients where English is not their first language (do not use relatives)
- If patient declines testing explore reasons eg incorrect beliefs about virus or consequence of testing (eg insurance applications)
- Document in the patients notes with any relevant discussion (written consent from patient is unnecessary)
- Testing for other viruses in conjunction with the HIV test may be appropriate
- Refer any high risk patients who decline testing or any complex cases to the Sexual Health team for further discussion (see below for contacts)

Post test discussion
- The result should be given directly by the testing clinician (unless patient agreed to third party involvement eg low risk negative result can be telephoned)

NEGATIVE:
- Discuss need for repeat test if within window period (especially if suspecting primary HIV infection)
  Note: Negative 4th generation HIV Ag/Ab test 4 weeks following exposure is very reassuring. Need test at 3 months to rule out seroconversion.

POSITIVE:
- Ideally contact HIV specialist team / health advisor for advice on giving the result
- Ideally the HCP who performed the test should inform the patient face to face
- Avoid giving results on a Friday unless an in-patient
- Positive patients should be seen by specialist at earliest opportunity, preferably <48 hours, minimum 2 weeks (BASHH guidelines) Refer directly (see contacts below).
- Detailed post test discussion and relevant tests will be undertaken by HIV team
- Partner notification and provider referral will be undertaken by HIV team

Notes:
- Children, individuals with mental health problems, unconscious patients represent special circumstances. Please discuss with HIV specialist.
- Where testing has been undertaken without patient consent in the patient's best interests (for example a child or unconscious patient) the result should not be shared outside of the medical team managing the patient or with those at risk of having acquired HIV from the patient. In these scenarios management of disclosure should be undertaken in conjunction with the HIV team.
- Point Of Care Testing can miss early sero-conversion due to limitations of technology & may have higher rate of false positive results in low prevalence population, therefore importance of referral to local sexual health services for retesting
Request process

- One specimen of clotted blood. Yellow Microbiology form, requesting ‘HIV Ag/Ab test’ (tests for HIV1 & HIV2).
- **Include any relevant clinical details** in request box with **signature**
- Ward patients may be given a choice as to whether they wish a test using their hospital number / name or GUM clinic number
- A “Danger of Infection” label should be placed on the specimen and on the request form if the patient is **positive** for other blood borne viruses.
- Allow up to two weeks for results as per antenatal, positive results in-house are sent to Colindale for confirmatory assay

Referral contact numbers Sexual Health and HIV Services

Chichester (SRH) Sexual Health Unit
Health Adviser: Barbara Hayman 1243 831607, 01243 831605
Consultant: Dr Emma Rutland 01243 831607 or mobile via switch

Worthing Sexual Health, Rowlands Road
Lead Health Adviser/Health Adviser: Richard Williams 01903 285199
HIV/GUM Consultant: Dr Judith Zhou 011903 285199 or mobile via switch

Brighton, Lawson Unit
Health Advisers: 01273 664722
Gary Seaton CNS / HIV 01273 664722, Tracey Buckingham 01273 523085 Lawson Unit or 24 hour SPR cover via switchboard Royal Sussex County Hospital 01273 696955

REFERENCES:
- UK National Guidelines for HIV testing 2008 BASHH
- HIV in Primary Care 2nd edition 2011 Medfash (BMA)
- HIV testing Western Sussex integrated sexual health services leaflet (updated 2010).
  Diagnosing the undiagnosed Medfash 2008
- Pre-test discussion leaflets are also available in other languages
- An alternative leaflet is available for Pregnant women “Why We Recommend Blood Tests in Pregnancy” (2006).

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OTHERS INVOLVED: Susie Jerwood, Consultant microbiologist, St Richards Hospital. The Local Referral and Management Guidelines Committee, St Richard’s Hospital, Western Sussex Hospitals NHS Foundation Trust.

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HIV testing quick reference

Does the patient understand:
- How HIV is transmitted
- The medical advantages of knowing HIV status
- Testing negative has no impact on life insurance / mortgage application
- The significance of the window period and the possible need for a repeat test?

Discussion of risk
- Risk to date
- Future risk / risk reduction

Discussion of implications of positive test

Confidentiality

Coping with the wait
- Who knows you are having the test?
- Who is it safe to tell?

Ask the patient not to drink alcohol or take drugs on the day of the result

Other useful questions
- Is the patient able to consent to testing?
- Is the test best done in primary care?
- Should there be any associated tests eg HepB/C/syphilis?
- Check their contact details
- Have you arranged an appointment for the result to be given to patient?
- Does the patient have a supply of appropriate condoms / lubricant?

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**HIV testing proforma**

<table>
<thead>
<tr>
<th>HIV TEST REQUEST</th>
<th>CONFIDENTIAL</th>
<th>Date</th>
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</thead>
<tbody>
<tr>
<td>Patient: __________________________</td>
<td>DOB: __________</td>
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</tbody>
</table>

**Reason for test**
- [ ] patient request
- [ ] investigation of illness
- [x] needlestick
- [ ] insurance
- [ ] travel
- [ ] antenatal
- [ ] doctor concerned
- [ ] other: __________________________

If patient request, reason for test:

Other issues (e.g., depression, relationship problems, worries about sexual orientation, drug use)

**Assessment of risk**

**Risk behaviours:**

Timing of risk (especially within 3 months):

Patient's understanding of risks:

- [ ] Nature of HIV test
- [ ] 3-month window period
- [ ] Natural history of HIV
- [ ] Monitoring and treatment
- [ ] Confidentiality
- [ ] Life insurance
- [ ] Safer sex
- [ ] Safer injecting
- [ ] Pregnancy

Screen for:

- [ ] HEPATITIS A: [ ] Yes [ ] No
- [ ] HEPATITIS C: [ ] Yes [ ] No
- [ ] CHLAMYDIA: [ ] Yes [ ] No

Coping, help and support

Is this the right time for a test? What would be the worst thing if the result was positive?

Who will you tell? Who do you not have to tell?

**The HIV test**

In window period: [ ] Yes [ ] No

Advice to repeat test: [ ] Yes [ ] No

Appointment for result: __________________________

Will be accompanied: [ ] Yes [ ] No

Support whilst awaiting result (GP, family, friend, telephone helpline):

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