

CONCISE GUIDANCE TO GOOD PRACTICE

A series of evidence-based guidelines for clinical management

NUMBER 3

HIV testing for patients attending general medical services

NATIONAL GUIDELINES

Series Editor: Lynne Turner-Stokes FRCP

The series covers issues that are not covered by the major guideline producers but which are likely to be encountered across several medical specialties and primary care. The guidelines are designed to allow clinicians to make rapid, informed decisions based on up-to-date, systematically reviewed and accessible evidence. Where such evidence does not exist, consensus will be used to complete the clinical pathway.

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Acknowledgements

The HIV Testing Guidelines Group wishes to thank the following for their valuable contributions to and/or comments on this guideline:

The UK Chief Medical Officer's Expert Advisory Group on AIDS (EAGA), particularly Margaret Johnson, Ray Brettle, Andrew Freedman and Mohsen Shahmanesh.

Also: Keith Perry, Mark FitzGerald, Brian Gazzard, George Kinghorn and Richard Walsh.

The Clinical Effectiveness and Evaluation Unit

The Clinical Effectiveness and Evaluation Unit (CEEU) of the Royal College of Physicians has expertise in the development of evidence-based guidelines and the organising and reporting of multicentre comparative performance data. The work programme is collaborative and multiprofessional, involving the relevant specialist societies and patient groups, the National Institute for Clinical Excellence (NICE) and the Healthcare Commission. The CEEU is self-financing with funding from national health service bodies, the Royal College of Physicians, charities and other organisations.

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11 St Andrews Place, London NW1 4LE
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Registered Charity No 210508

ISBN 1 86016 205 3

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Royal College of Physicians of London

Designed and typeset by the Publications Unit
of the Royal College of Physicians

Printed in Great Britain by Sarum ColourView Group,
Salisbury, Wiltshire

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This guideline is a summary of a full guideline which will shortly be available from the website of the British Association for Sexual Health and HIV (BASHH),¹ and aims to encourage HIV testing in clinical situations where this could contribute to the patient's welfare. This is a fuller and revised version of the guideline first published in *Clinical Medicine* in 2004.² It is intended primarily for people aged 16 or over (there are separate guidelines for those under 16³). This guideline is not meant to be a review of all the differential diagnoses in medical practice where HIV could play a part.

Introduction

Increasing the uptake of HIV testing will have both individual and public health benefits. The National Strategy for Sexual Health and HIV⁴ aims to decrease the number of those who are unaware that they are carriers of HIV through increased testing of at-risk individuals. The recommended standards for the NHS HIV services state:

the NHS should develop, implement and monitor strategies to encourage the uptake of testing and reduce the number of people who are unaware of their infection.⁵

Whilst there is limited evidence in this field, it is clear that routine HIV testing in general medical settings has a part to play in increasing the uptake of testing and thus in preventing deaths. These guidelines have, therefore, been designed primarily for clinicians in the medical specialties, and secondarily for use in primary care⁶ and surgical and other specialties.

Until recently, departments of genitourinary medicine (GUM) have carried out the majority of diagnostic HIV tests. However, routine referral to GUM services before testing may increase the stigma associated with testing, lead to delay and result in fewer people being tested. Blood donations, and more recently women attending for antenatal care,

are routinely tested for HIV and, as more testing is undertaken in non-GUM settings, there is a need to ensure standardisation of practice irrespective of context. These guidelines are therefore timely. They offer guidance on when and how to test and on issues of consent and feedback. The appendices include the text for a leaflet, which may be offered to patients before their test, and a summary of the insurance issues that are likely to affect patients following their HIV diagnosis.

As HIV has become a treatable condition there has been a major change in attitudes towards testing. When discussing with patients whether to test for HIV, healthcare providers can now be increasingly confident that treatment can prolong life expectancy in infected individuals. Since 1995, the uptake of highly active antiretroviral therapy (HAART) in the UK has resulted in a two-thirds reduction in deaths from AIDS.^{7,8} However, in order to benefit from such treatment, it is necessary to be tested for HIV. Late presentation and late diagnosis both contribute to unnecessary early deaths. HIV testing can also reduce the risk of the virus being transmitted by infected individuals who were not aware with certainty of their HIV status. By offering HIV tests where clinically indicated, general physicians can therefore ensure that their patients are able to take advantage of appropriate life-prolonging treatment and will help to minimise the risk of onward transmission.

Clinicians must ensure that patient information leaflets on HIV are updated regularly and that clear pathways to specialist HIV services are in place.

Within the UK, men who have sex with men (MSM) remain the group at highest risk of acquiring HIV infection and there is evidence that transmission via this route is continuing at an appreciable rate. Many, however, remain unaware of their HIV status. In recent years, more than half of newly-diagnosed HIV infections in the UK have been in heterosexuals. Of heterosexually-acquired infections diagnosed in the UK in 2003, 75% were in people from, or those exposed in, Africa. Uptake of HIV testing in African migrants is lower than ideal given the relatively high prevalence of HIV in this group; a recent

community-based study noted that only 34% of men and 30% of women in the group reported having had an HIV test,⁹ probably because of stigma and the challenging social circumstances facing many black African people in the UK. As the worldwide epidemic unfolds, people acquiring their infection from other high prevalence areas outside the UK are likely to be seen. It is important not to stereotype heterosexual HIV infection as an African disease.⁷⁻¹⁴

Even if they are known to be at high risk, some individuals may not disclose their risk activities and others may not be in a recognised risk group. At the end of 2003, an estimated 53,000 adults were living with HIV in the UK, of whom 27% were unaware of their infection.⁷

Guideline development process

The protocol used to develop these guidelines is explained in Appendix A. The grades of recommendation and levels of evidence are explained in the table opposite.

Applicability and utility

A potential barrier to the successful implementation of these guidelines may be healthcare providers' attitudes to HIV testing. There is a need to move from targeting high-risk patients in a GUM clinic with intensive pre- and post-test discussion and counselling by a specialist worker, to more widely available testing for a wider range of people, offered by general healthcare providers. The majority of healthcare providers will welcome the opportunity but some will feel reluctant to take on an additional workload or to acquire the skills needed, and others may feel threatened by the perceived loss of their role in this area.

More widespread testing will initially increase costs but this can be offset by informing asymptomatic people of their status and thus reducing onward transmission and providing more timely effective treatment to those who are ill. In addition, savings

will ensue in GUM health adviser time which may more profitably be used in other areas.

The greatest benefit of implementation of this guidance will be the reduction of undiagnosed HIV in the community and in hospitals, thus benefiting the health of both the individual and the public.

Auditable outcome measures

- All patients identified as high risk for HIV to be offered testing.
- All patients with indicator diseases/symptoms to be offered HIV testing.
- All women attending for antenatal care to be offered and recommended HIV testing.
- Informed consent to be obtained on all conscious patients prior to testing.
- Inform 100% of patients found to be HIV positive of their test result.
- Compliance with guidelines.
- All acute trusts to have guidelines on testing available in non-GUM settings.

Editorial independence

One member of the group received small unrestricted grants from a number of pharmaceutical companies in 2003. Another had a small number of personal shares in a pharmaceutical company. However, since the guidelines do not cover prescribing, these were not seen to be material conflicts of interest in the process of guideline development.

Levels of evidence and grades of recommendation

Level of evidence	Type of evidence	Grade of recommendation
Ia	Meta-analysis of randomised controlled trials.	A
Ib	At least one randomised controlled trial.	
IIa	At least one well-designed controlled study, but without randomisation.	B
IIb	At least one well-designed quasi-experimental design.	
III	At least one non-experimental descriptive study.	
IV	Expert committee reports, opinions and/or experience of respected authorities.	C

Guidelines on HIV testing

Recommendation

Grade of recommendation

1 WHEN TO TEST FOR HIV

- HIV testing should be offered wherever knowledge of the individual's HIV status could improve or affect clinical outcome. **C**
- Doctors should strongly recommend HIV testing whenever this enters the differential diagnosis. **C**

This would include:

- any unusual manifestation of bacterial, fungal or viral disease, ie:
 - infection with tuberculosis
 - suspected *Pneumocystis carinii* pneumonia
 - suspected cerebral toxoplasmosis
 - oral/oesophageal candidiasis
 - hairy leucoplakia
 - persistent genital ulceration
 - presence of another blood-borne or sexually transmitted infection, eg syphilis, hepatitis B
 - suspected primary infection with a seroconversion illness (eg flu-like illness, suspected glandular fever with negative EBV serology)
 - unusual tumours, ie cerebral lymphoma, non-Hodgkin's lymphoma or Kaposi's sarcoma
 - unexplained thrombocytopenia or lymphopenia
 - unusual skin problems such as severe seborrhoeic dermatitis, atypical psoriasis or extensive molluscum; and, re-occurring herpes zoster or herpes zoster in a young person
 - persistent generalised lymphadenopathy or unexplained lymphoedema
 - neurological problems including peripheral neuropathy or focal signs due to a space-occupying intra-cerebral lesion
 - unexplained weight loss or diarrhoea, night sweats, or pyrexia of unknown origin
 - any other unexplained ill health or diagnostic problem.
- In addition**, for problems which require immunosuppression, the exclusion of HIV should be considered prior to treatment. This list is not intended to be exhaustive and physicians are encouraged to use their clinical judgement. **C**

2 HOW TO TEST FOR HIV

- If established infection is suspected, an HIV antibody test should be performed on venous blood.(11b)¹⁵⁻²¹ **B**
Patients should be tested on presentation, but as HIV antibodies do not appear in the blood until some weeks after infection this test should be repeated 12 weeks after any suspected contact with the virus. Patients, however, may be infectious to others during the period prior to seroconversion (the 'window period') and should be advised of this. **Detection of the virus using polymerase chain reaction (PCR) during the window period is possible but false positive tests occur and the test is not licensed for this indication.**
- When primary infection is suspected (including needle stick injury) expert advice should be sought from an HIV specialist together with advice from the local laboratory on which tests should be performed **C**

from those locally available and, in the case of needlestick injury, the guidance on post-exposure prophylaxis from the Expert Advisory Group on AIDS should be consulted.²²

- A confirmatory test should be used by the laboratory. **C**
- All HIV positive patients should have a repeat test performed on a different blood sample. **C**
- All equivocal test results should be repeated and the patient referred to a GU medicine or HIV specialist. **C**

3 OBTAINING CONSENT FOR HIV TESTING

- Testing should be undertaken only with the individual's specific informed verbal consent which should be documented. **C**
- A leaflet may be used to provide information to the patient and thus increase uptake of HIV testing (see below and Appendix B). (IIb)²³ **B**
In addition, it is necessary to talk with the patient to explain the reasons for testing, assess risk behaviour and determine most recent risk behaviour and 'window period'. **C**
- Pre-test discussion should include the following: **C**
 - the benefits of testing to the individual (and significant others)
 - a risk assessment, including date of last risk activity to determine window period (see above)
 - how confidentiality will be preserved
 - information on insurance issues where relevant
 - details of how the result will be given
 - information about HIV transmission and risk reduction as necessary.
- Further discussion should take place with those with occupational issues, eg who currently or in the future may perform exposure-prone procedures. These should be referred for expert advice to an HIV specialist. Further discussion may also be necessary for other individuals, eg those with a psychiatric history/high level of anxiety/sexual or relationship issues, and rape/sexual assault victims. **C**
- Testing should be considered for all patients if the outcome could affect their treatment. For patients who are unconscious or unable to understand what is being said to them, testing should be considered on a case-by-case basis according to their healthcare needs and in discussion with an HIV specialist.²⁴ Care should be taken with the results of tests on unconscious patients, for example on ITU where patients' relatives may wish to know information about the status of a patient who is not able to consent to its disclosure. **C**
- If a healthcare worker has occupational exposure, and testing of the source patient is considered necessary, the patient's consent should be obtained. The obtaining of consent and the testing should not be undertaken by the injured health care worker but by another responsible doctor. Each hospital should have a policy for dealing with such events. The guidance from the Expert Advisory Group on AIDS should be consulted.²² **C**
- A written protocol should be available to ensure consistent standards, which can be audited. **C**

Guidelines continued overleaf

4 FEEDBACK OF RESULTS

- Arrangements for communicating the results should be discussed with the patient at the time of testing. Ideally this should be face to face where a positive result is likely or for certain patients with particular issues. (In the future, use of near patient tests may be appropriate in certain circumstances to enable results to be given on the same day.)

C
- All HIV positive patients should be referred to a GUM or HIV specialist for further advice and management.

C
- Post-test discussion in a GUM clinic should be offered if required.

C

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Appendix A. Guideline development process

The guidelines have been developed in accordance with the principles laid down by the Appraisal of Guidelines Research and Evaluation (AGREE) Collaboration (www.agreecollaboration.org), and have been appraised by the Department of Health's Expert Advisory Group on AIDS.

Scope and purpose

Overall objectives of the guidelines	<ol style="list-style-type: none">1. To enable physicians who are considering offering HIV testing to their patients to obtain informed consent after providing appropriate information.2. To improve patient care by enabling general physicians to identify those patients with undiagnosed HIV infection, in order that appropriate treatment can be instituted.
The patient group covered	Individuals at risk of HIV or in whom the diagnosis needs to be considered.
Target audience	All clinicians, including general physicians, GPs and other health professionals who are involved in the decision to test for HIV.
Clinical questions covered	When and how to test for HIV; obtaining consent for testing and feedback of results.

Stakeholder involvement

The Guideline Development Group (GDG)	<p>A multidisciplinary group comprising:</p> <p>Professionals – Consultants in GUM/HIV, health adviser, nurse, a virologist from the Health Protection Agency (HPA, formerly the PHLS), a general practitioner, a public health scientist from the Medical Research Council and a sexual health policy adviser.</p> <p>User representation – The Terrence Higgins Trust was the main facilitator of community and patient input.</p>
Funding	This guideline was commissioned and edited by the Clinical Effectiveness Group (CEG) of BASHH (the British Association for Sexual Health and HIV), and the Clinical Effectiveness and Evaluation Unit of the Royal College of Physicians.
Conflicts of interest	No external funding has been sought or obtained. All authors and group members have declared, and provided details of, any actual or potential conflicts of interest.

Rigour of development

Evidence gathering	Evidence for these guidelines was provided by review of the Cochrane Library, Medline, Embase, conference proceedings and other guidelines up to October 2003. Articles not published in English were excluded. Much of the advice is based on expert opinion and practice because of a lack of other evidence.
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Review process

Links between evidence and recommendations	The system used to grade the evidence and guidance recommendations is that published by the Royal College of Physicians. The gradings are indicated in bold type throughout the text.
Piloting and peer review	The guidelines were reviewed by EAGA and substantially amended.

Implementation

Tools for application	Version including information sheet, screening assays and insurance issues is published separately in the printed version and on the BASHH website (www.bashh.org).
Plans for update	Review is planned in three years, and forms part of the work undertaken by the CEG for BASHH.

Appendix B. Text for leaflet to use in pre-test discussion

The use of a leaflet has been shown to increase uptake of the test and the following text may be useful in forming the basis of the pre-test discussion. Additional discussions will be required for some patients (see main text).²³ A laminate version of this leaflet, designed to be photocopied and distributed amongst patients, is included with this guideline.

The HIV test

Please read the following details to ensure that you understand the facts about the test.

Q. Why have an HIV test?

- A. Treatment is available for people with HIV infection; it is better to have treatment before serious symptoms develop. Only by knowing that you are infected do you have a choice of using these treatments before you get ill. These treatments have been shown to reduce dramatically the risk of serious illness and early death from AIDS. If you know that you have HIV you can also take steps to reduce the risk of passing it on to others, including unborn children.

TESTING IS CONFIDENTIAL

Q. What if I am found to have HIV infection?

- A. If a test shows you have HIV infection you will be offered care and support. Whether or not you should start treatment will be discussed and treatment given if you need it.

Q. How long does it take before the infection will show up in my blood sample?

- A. The HIV test measures antibodies to HIV, which may take three months to show up in your blood after you have been exposed.

Q. Have I been at risk – how is HIV transmitted?

- A. HIV can be passed on in a number of ways:
- Through contact with infected body fluids such as blood, semen and vaginal secretions. This may occur during sex.
 - Using inadequately sterilised needles or equipment for injecting drugs, tattooing and piercing.

- Through a blood transfusion with unscreened blood abroad.

- From an infected woman to her baby before or during birth, or through breastfeeding.

Q. What are the drawbacks of having this test?

- A. If your results do show that you have HIV the benefits of knowing this result usually outweigh any drawbacks. These drawbacks may include worries about relationships with family and friends. Travel to some countries is currently restricted for people who know they have HIV. In a few cases, being HIV positive may affect your employment.

Q. Is the result confidential?

- A. Yes, your confidentiality will be protected according to General Medical Council guidance.²⁴

Q. Will it affect my chance of getting life insurance?

- A. Doctors do not need to report negative HIV tests when writing insurance reports. Insurance companies should no longer ask whether you have had an HIV test, but only enquire whether or not you are HIV positive. People who know they are infected with HIV can have difficulty obtaining new life insurance; this can also affect their ability to obtain certain types of mortgages. This is the same for many other long-term illnesses.

Q. When will I get the results?

- A. Results are normally available after a week. We are able to have HIV test results earlier where necessary.

**PLEASE TALK TO A DOCTOR OR NURSE
IF YOU WOULD LIKE MORE INFORMATION**

Appendix C. Insurance issues

Implications of a negative HIV test

A negative HIV test result, or the fact of having had an HIV test, should not affect an individual's future applications for insurance.¹

Until the mid-1990s insurance companies frequently asked applicants for insurance if they had ever had an HIV test (even if negative), as this was seen as an indicator of higher risk for HIV and therefore relevant for actuarial decision-making. At that time, insurance implications were a significant reason for individuals to choose not to test.

In 1994, the Association of British Insurers (ABI) issued a statement of practice for its member companies, recommending that no questions should be asked of applicants for life insurance about negative HIV tests or previous HIV test counselling. This was re-enforced by guidance issued in November 2004,¹ and has led to a change in practice as ABI members are bound by the statement. (A small percentage of insurers do not have ABI membership and the statement has no legal status, so variations in practice are still theoretically possible.) It is likely that the ABI statement, plus the increasing incentive to test presented by highly active antiretroviral treatment (HAART), has made insurance implications a less important consideration for individuals thinking about taking a test.

Implications of a positive HIV test

Cover under existing insurance policies

A person with existing life insurance who is later diagnosed with HIV will usually be covered for an HIV-related claim (exclusions are relatively rare in life insurance policies). HIV related claims will often be excluded from some other types of insurance, such as critical illness and income protection – details of each policy need to be checked. The ABI advises that excluding claims which are for reasons other than HIV (eg unrelated heart attack in a critical illness policy) purely because someone has HIV would be unlawful.²

Ability to get insurance

Having HIV affects an individual's ability to get insurance related in any way to their health. Insurance companies have the following options when responding to applications from people with HIV, and the option chosen will largely depend on the type of insurance policy applied for:

- to refuse cover entirely
- to offer cover but exclude HIV-related claims
- to offer cover, inclusive of HIV-related claims, but apply restrictions (such as higher premiums, limited length of cover, and specified criteria for acceptance, eg CD4 count and viral load currently available from one company).

Life insurance and endowment policies will be refused. (This approach is currently under discussion in the light of better health outcomes from HAART and should be kept under review for these guidelines.) A person with HIV wishing to apply for a mortgage should consider applying for a repayment mortgage.

Travel insurance

Most off-the-peg travel insurance policies exclude cover for pre-existing medical conditions, including HIV.

A small number of travel insurance policies offer cover for such conditions. Details of these are available from the Terrence Higgins Trust Helpline or the National AIDS Manual. One travel insurance policy has been developed by the National AIDS Trust in partnership with two members of the insurance industry, specifically to meet the needs of people with HIV. Acceptance for cover, and cost of premium, depend on medical assessment.

Disclosing HIV status when applying

A person who knows they have HIV but does not disclose this when applying for life or health-related insurance is failing to disclose a material fact. Such a failure could render the entire policy invalid.

GP reports

Insurance companies may ask the GP of an individual applying for life or permanent health insurance (income

protection) for a medical report, with their patient's consent, particularly if they have declared a medical condition on their application form. Refusal to consent to the GP giving a report will normally result in cover being refused. The GP will be required to state if their patient has had a positive HIV test or is awaiting an HIV test result. GPs are not asked to speculate about the patient's lifestyle on the new version of the general practitioner's report; and the ABI is consulting on making this mandatory.³ The BMA advises GPs not to answer such lifestyle questions.⁴ GPs should not be asked if a patient has had a negative HIV test or counselling for an HIV test.

GMC guidance (2000) on confidentiality emphasises the need to obtain fully informed patient consent for medical reports for a third party.⁵ The consent wording agreed with the BMA has now been amended and expanded to ensure that all patients are aware of the information that GPs are asked to disclose to insurers.⁶ The GMC guidance suggests that GPs show the form to patients before completion, to ensure their understanding of its scope. Life insurance application forms must still offer applicants the option of seeing their GP's completed report before it is returned to the insurance company.

More detailed information about medical reports for insurance can be found in the joint ABI/BMA guidelines.⁷ A standard GP report form, patient consent form and covering letter to GPs have been jointly produced by the BMA and ABI.⁶

HIV testing for insurance applications

In some cases, insurers may require an HIV test as part of medical assessment for individuals applying for insurance. This usually occurs if the policy is of a high value or if the individual has been identified, through details in their application or their GP's report, as being at higher risk of HIV infection. The applicant may be offered the option of arranging the test through their own doctor or through one nominated by the insurance company, but GPs are not obliged to perform HIV tests for insurance purposes for their registered patients. If they do so they should, as with all tests, make sure the patient has sufficient information and has given informed consent.

Public and professional awareness and attitudes to testing

Those accessing testing may prefer to choose GUM as the location for requesting an HIV test because they do not wish to consult their GP because of concerns about confidentiality, including life insurance implications.^{8–10} GPs may choose not to record referrals to GUM for HIV testing because of life insurance considerations, and many GPs still believe that a negative HIV test can adversely affect life insurance applications.¹¹

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