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How to Discuss STI Screening with Your Patients

Announcer Open
Welcome to Women's Health Update on ReachMD, brought to you by Hologic.

Dr. Mackey:
It is estimated that there are 20 million new sexually transmitted infections each year. While universal screening could effectively reduce infection rates in high-risk populations, such as sexually active adolescents and young adults, many clinicians struggle just to bring up the issue of STI risks with their patients. This is ReachMD, and I am Dr. Amy Mackey. My guest is Dr. Kahlil Demonbreun, a women's health nurse practitioner from Orangeburg, South Carolina. Dr. Demonbreun and I will focus on best practices for clinicians to conduct sensitive STI-related conversations with their patients. Dr. Demonbreun, let me begin our interview by level-setting on our audience on what the premise of universal screening is, specifically. Can you give us an overview?

Dr. Demonbreun:
Okay, so when we consider a premise of universal screening, it's basically the position of screen first and screen everyone. So, screen everyone across the board; treat everyone across the board equally. So, when we consider the premise of universal screening, basically what we're saying is to screen everyone and screen consistently across the board, or the cohort, of your patient population.

Dr. Mackey:

So, it's obvious, and maybe a big understatement, to say that you're in support of universal screening, but why should universal screening be adopted by all providers?

Dr. Demonbreun:
So, again, if we're looking at health issues, and in this specific case, sexually transmitted diseases, specifically gonorrhea and chlamydia, and if we consider the 1.6 million cases that were reported to the STD (sic) in the year 2016, and the just under 500,000 cases of gonorrhea that were reported, in addition to the decades of trending or increasing incidence and prevalence of these STIs, universal screening becomes a great tool as we consider the life-long issues that gonorrhea and chlamydia cause. So, we know that there's going to be chronic pelvic disease, or chronic pelvic pain. We know there's going to be PID. We know there can be psychosocial issues related to contracting STI. We know that all these issues will impact not only the individual at younger ages where we have our younger cohort 25 and under who are more, or where we have more data to indicate that they have these STIs, but just consider that these negative outcomes, because of gonorrhea and chlamydia, will impact them across their lifespan. So, we would hopefully want to address these issues early in the life cycle, to make sure that we do have good outcomes later in life.

Dr. Mackey:
So, given all that, what barriers are keeping universal screening from being widely adopted by providers?

Dr. Demonbreun:
I think one of the biggest barriers is personal bias, personal bias associated with maybe lack of education. And what I mean by lack of education, we know we have excellent providers in this country who have attended excellent institutions of higher learning; however, if you don't have the data or you say, for example, the provider didn't read the CDC Surveillance Report every year, or if we don't have excellent commentary articles such as the one we're speaking on, and excellent journals, and they're not readily available for providers to read, then maybe they don't know that STIs are a problem and are becoming of epic proportions as the CDC has just recently let us know last September. So, if we bring that knowledge to providers and we bring the recommendations, so what societies are recommending that we screen and how we screen? Some providers may not have this knowledge, so I think the first step is education to bring providers up to date.

Dr. Mackey:
So, what do you say to the practitioner then who declines to screen universally, but targets that population who they deem have other risk factors for STIs, besides just sexual activity? What do you say to them to help convince them that this is a good plan?

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Dr. Demonbreun:
That's a good question and sometimes that's a particular challenge, because we all bring to our practice our own biases, our own beliefs, our own specifics of why we practice in the first place. So, first of all, I think bringing forth documents or articles, supplementations such as this, bringing the evidence forward, bringing the recommendations forward, allowing them to appreciate and look over what is the evidence, what is the standard of practice, what is the landscape for the goal. We can also demonstrate that chlamydia and gonorrhea rates are increasing and have been increasing since 1994. So, the evidence speaks for itself. I think any prudent clinician, once they're armed with the appropriate knowledge, can make better decisions.

Dr. Mackey:
And I think what you're also saying is that universal screening can help reduce the risks of all of these infections across the board, and without it you're going to miss so many cases that we're not really going to impact on that rising infection rate. Is that correct?

Dr. Demonbreun:
I think, it comes down to, if we miss the opportunity, we have a young person who's in our office, who's receiving healthcare, it's a great time to educate that young person on the risk as they're moving into young adulthood, and the importance of why. Why do we screen for blood pressures? So it's a health phenomenon. It's not a sexual behavior phenomenon. So, I think we have to kind of put it in the context of: These are health issues that impact individuals across their lifespan, not just while they're in their 20s, but they're going to have significant impact when they're 30 or 40, later on in life. And so, I think all of us as healthcare providers, really want to look forward and project out over the individual's lifespan and hopefully increase their positive outcomes in their health status.

Dr. Mackey:
I was impressed with your article on how low the screening rate actually was. But can you share any representative case experiences from your practice that would help illustrate these points for our listeners?

Dr. Demonbreun:
Well, I think you've already hit on a good point. You have many providers who, "Well, my patient population doesn't get that. My patient population doesn't do that. My patient population isn't affected by that, so I don't screen universally." In my practice, I don't look at… I have a saying in my office, "We hunt pathology." So, if you don't go looking for pathology, you won't find pathology. So everyone that comes in your office should be routinely screened for those health phenomena that they are at risk for. The data is very clear. The recommendations are very clear. The guidelines are very clear. So, we

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know that this health phenomenon exists, so as healthcare providers, we should screen for it. So, in my personal practice, I usually have my staff, or the staff that I'm privileged to work with, not really get into the aspects of their sexual behavior during the intake of the patient. I want to know their vitals. I want to know their blood pressure. I want to know their weight. I want to know what their medications are, but I think because of the sensitive nature of sexual questioning and sex health inquisition, you don't want to repeatedly have the patient have to undergo these same questions. I also think that it takes a particular skill set to ask these questions. So, if you have a provider who is not comfortable with asking these questions, or if you have frontline staff who aren't comfortable with asking these sensitive questions, patients are aware of this. So, first of all, they don't want to keep answering the same question over, but they also want to feel like, "Well, if I give an honest answer, I'm not going to be ridiculed. I'm not going to be stigmatized. You're not going to call my mom. This is not going… I am not going to go home and find out that I told something I shouldn't have told." So confidentiality is key. So, I kind of reserve that for when I'm in a history portion of the visit, when I can assess the cues and deliver cues that I can know, can I move forward in this inquisition? Do I need to back off? But the bottom line is I want that individual to know we're partners in this healthcare event. I bring the knowledge. They bring the health. So, we're trying to improve their health status.

Dr. Mackey:
Well, before we wrap up, are there any other thoughts or recommendations you'd like our listening audience to take with them into practice?

Dr. Demonbreun:
The first thing I would really, really encourage every healthcare provider to do is, is definitely stay up-to-date with the state of the science. The CDC provides us with great data every year in their end-of-year Surveillance Report, as well as staying up-to-date with recommendations by the major societies and organizations. Additionally, staying up-to-date with what are the modalities that we use in the clinical realm to assess STIs? And then, sit back and introspectively take a look at how you feel about helping people not have STIs. How can you impact them? Do have an inherent bias? And if you have an inherent bias, why do you have that inherent bias? Once that happens, slowly implement it into your practice. You're not going to come in the next day after you start universal screening and be an expert, but sit down, talk to your staff, at maybe your staff meeting, "Hey, we're going to start doing universal screening across the board for everyone that comes in." So we think of, again, universal screening as opt out. So, opt out is everybody gets it, and whoever doesn't want it, say, we tell every patient, everyone that comes in gets a gonorrhea and chlamydia check. And so, opt out will be, well, give them the opportunity not to have it if they don't want it. Opt in, where we come in and we ask the patient, "How do you feel about us doing STI testing?" Or, "Do you feel comfortable with us doing that?" Well,

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that question in itself kind of, to me, puts an inherent bias in there. It's like, if I'm a patient, I'm going to be, "Well, but, you think I've got an STD?" But, if everyone across the board gets the STD it's common standard practice. Let them know. Let the providers know, as they are also educating and in bringing themselves up-to-date with the information, that confidentially is key in this population. You can let the patient know that you can text back the results. You can also let the patient know when they come in that you don't have to, if your mom brings you in, or if your parent brings you in, none of the information that you and I are going to talk about will be shared with either parent, without your consent, and that is the patient's right. So we have to let them know this is a conversation between the patient and the provider, not the patient and the provider and their parent.

Dr. Mackey:
Dr. Demonbreun, thank you so much for sharing your thoughts and insights today.

Dr. Demonbreun:
Thank you.

Announcer Close
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