

Virtual Mentor

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Journal Discussion

It's Getting Better All the Time

by Abraham P. Schwab, PhD

Golden MR, Manhart LE. Innovative approaches to the prevention and control of bacterial sexually transmitted infections. *Infect Dis Clin North Am.* 2005;12:513-540.

Though it would be a stretch to say the silver bullet for bacterial sexually transmitted infections is close at hand, Golden and Manhart show us some encouraging responses produced by recent research.

Changing Behavior

Interventions to change behaviors have provided a number of positive responses. Golden and Manhart note that these "behavioral interventions," whether one-on-one or in groups, induce changes in self-reported risk-taking behavior. They do not rule out that shame (at not changing behavior) could be a factor in the 30 percent decrease in risky behavior self-reported within some groups. Golden and Manhart suggest that inadequate equipment and limited resources play a dominant role in the failure to translate this research into practice. The conclusions of this research lie inert in the pages of journals and data banks. They also suggest that when behavioral interventions are primed for use, they should be used outside of traditional settings such as sexually transmitted disease (STD) clinics.

Non-traditional Testing Sites

Pursuing testing in unusual locations is also recommended by Golden and Manhart. A relatively new test in the diagnosis of infectious disease, the nucleic acid amplification test (NAATs or NAT in acronymic form) allows for much more accurate and less invasive testing. NAATs identify the targeted RNA or DNA and not, as previous assays did, the antibodies caused by the infectious disease. The less invasive means of testing (a urine sample or vaginal swab) allows NAATs to be offered outside of STD clinics. Golden and Manhart list some of these locales but suggest that targeted screening (and not broad population screening) will likely be the most cost-effective. Some groups and subgroups are not as likely to acquire these infectious diseases as others. Here Golden and Manhart leave the reader wanting more. If we are to limit testing, what would be a likely protocol for site selection? If schools and juvenile detention facilities are targets, do we start broader-based testing after a single positive test? A few? A percentage? Moreover, they note that political challenges abound. (You can just hear the parents saying, "Well, my daughter doesn't have sex, so why should she be subject to these tests?") Like the rest of us, they have no solution to this challenge.

Rescreening

Making up for a lack of clarity with succinctness, Golden and Manhart announce, “People who have STIs get STIs” [1]. We are left to presume that they simply forgot the word “had” between “have” and “STIs.” Their point, which they articulate throughout the section, is that rescreening will be a cornerstone public health effort to limit the spread of STIs—sexually transmitted infections. They note with resignation that, although rescreening is merited on the basis of substantial evidence that persons who have STIs are at high risk for infection in the months following their treatment, mechanisms to ensure retesting have not been established. Furthermore, how to promote retesting outside of STD clinics has not been studied [2]. This, of course, may be a problem of access and insurance that Golden and Manhart fail to mention.

Peer Referral and Expedited Partner Therapy

Golden and Manhart identify another area of mixed success. Cluster tracing (or cluster case finding) operates on the assumption that people who have STIs know people who have STIs. It’s a bacterial or viral birds-of-a-feather story. “Suspects” are friends or acquaintances of the positive case, including those with nonsexual contact. Peer referral is an important application of this principle that has included a “carrot” for referrals (though Manhart and Golden do not tell us what these incentives usually are). The new hot topic in STI treatment is expedited partner therapy (EPT). In short, “EPT is a global term for approaches to treating the sex partners of persons with STIs that bypass the traditional requirement that all partners receive a complete medical evaluation before therapy” [3]. According to Golden and Manhart, the less-than-ideal partner treatment rate (50 percent) alongside the existing haphazard partner notification system suggests that public health can be better served by these approaches. The most common example of EPT is patient-delivered partner therapy (PDPT). In most cases this is a low-risk, high-benefit treatment plan (a cited exception is women with trichomonas), but serious medical and nonmedical questions linger. As promising as recent research has been, Golden and Manhart point out that the results are not definitive.

The Centers for Disease Control (with public expressions of support from the AMA) is currently examining the usefulness of PDPT and reviewing evidence regarding EPT efficacy in general, including the practices already in use. One concern, noted by the AMA in Report 9 of the Council on Scientific Affairs, is the legal standing of PDPT [4]. Some states currently do not allow physicians to prescribe or give prescriptions without seeing a patient. Moreover, individuals could game the system in a number of ways, including getting prescriptions at a discount (via insurance) to sell to others at cost. Finally, an important medical question will need to be answered on a therapy-by-therapy basis: what risks are associated with unnecessary treatment (eg, treating the partner who doesn’t have the STI that the patient has). Official sanction of PDPT will likely be withheld until these issues are settled.

Internet Use

Golden and Manhart include a brief analysis of mass treatment and selective mass treatment of STIs. They conclude that only sustained selective mass treatments have any real chance of impact, though the degree of impact is unknown.

There is also encouraging news about the use of the Internet for interventions. Informational links that piggyback on Internet sex sites are accessed often, and chat rooms have been established with some success. There is no research here, but the Internet seems to hold promise for educational material dissemination and partner notification as well as possible counseling.

Next Steps

Golden and Manhart conclude, and it's hard to argue on this point, that future research should focus "more on developing and testing sustainable, cost-effective interventions that focus on those at greatest risk and that can be scaled-up within the existing public health infrastructure" [5]. The need for this focus is indicated, primarily, by the paucity of funding for a more drastic restructuring of the public health infrastructure for screening and treatment of STIs. In terms of medical and administrative factors, I think they're right, but what they don't get at is the critique from proponents of abstinence and monogamy that would suggest we should be telling these people not to have nonmonogamous sex. Indeed, it would have been worthwhile to cite some studies to show that that approach doesn't work.

References

1. Golden MR, Manhart LE. Innovative approaches to the prevention and control of bacterial sexually transmitted infections. *Infect Dis Clin North Am.* 2005;12:523.
2. Golden MR, Manhart LE, 524.
3. Golden MR, Manhart LE, 527.
4. American Medical Association. *Report 9 of the Council on Scientific Affairs (A-05). Expedited Partner Therapy (Patient-delivered Partner Therapy)*. Available at: <http://www.ama-assn.org/ama/pub/category/15334.html>. Accessed September 21, 2005.
5. Golden MR, Manhart LE, 533.

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