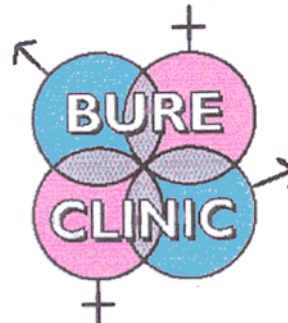
# ANNUAL REPORT 2002




Department of
Genito-Urinary Medicine

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6th Edition

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# Foreword

This sixth annual report is written at a time of anticipated changes in the way sexual health services will be delivered. Consultation document on the National Sexual Health Strategy has now been completed. Increased funding has been received from the Department of Health directly to the GUM Clinics with proper audit trails.

The Bure Clinic website sponsored and commissioned on the 3rd July 1998 by the Great Yarmouth Haven Rotary Club now subscribes to the HONcode principles. The focus this year is on modernisation of our services within our limited stretched resources.

The Bure Clinic will continue to work within Regional and National guidelines, adopt strategies that are in line with good practice and be sensitive and responsive to locally defined needs.

## RESOURCES

**Staffing:**

1 Full time Consultant
1 Full time Locum Consultant (ad-hoc)
2 Hospital Practitioners
1 Full time Sister – G grade
1 Full time Health Advisor – G grade
1 Part time Health Advisor - F grade
3.35 W.T.E Nurses – E grade
2.07 W.T.E Secretarial and Reception staff – Grade 4
Sessional Social Worker, Dietician and Clinical Psychologist
Bank nurses for holiday and sickness cover.

**Department profile:**

The siting of the clinic and the standard of accommodation confirms to the Monks Report recommendations. There are dedicated facilities for counselling and treatment. The department is clearly signposted from all patients' entrances to the hospital.

**Categories of referral**

1. Self referral
2. Referred by contact
3. Health advisor initiated referrals
4. Referrals from GP's
5. Referrals from other Consultants/Department
6. Transferred from other GUM departments

**Clinic Access Times**

| | AM | PM |
|---|---|---|
| Monday | 9.30 – 12.30 | 14.00 – 1700 |
| Tuesday | 9.30 – 12.30 | |
| Wednesday | 9.30 – 12.30 | 14.00 – 1700 |
| Thursday | 9.30 – 12.30 | 14.00 – 1700 |
| Friday | 9.30 – 12.30 | |

## APPOINTMENT SYSTEM

## 1.GENERAL CLINICS

| | |
|---|---|
| Monday (AM session) | Mixed male & female clinic |
| Monday (PM session) | Mixed male & female clinic |
| Tuesday (AM session) | Mixed male & female clinic |
| Wednesday (AM session) | Mixed male & female clinic |
| Wednesday (PM session) | Mixed male & female clinic |
| Thursday (AM session) | Mixed male & female clinic |
| Thursday (PM session | Mixed male & female clinic |
| Friday (AM session) | Mixed male & female clinic |

## 2.SPECIALIST CLINICS

| | |
|---|---|
| Monday (AM session)(males &females) | HIV/AIDS follow up |
| Thursday (PM session) males & females | Genital-Dermatosis Clinic |

## SERVICES PROVIDED BY THE BURE CLINIC

1. Comprehensive screening and treatment for sexually transmissible infections.
2. Partner notification and provider referral
3. HIV antibody tests with pre and post test counselling
4. Clinical, virological and immunological monitoring of HIV antibody positive/AIDS patients.
5. Support for HIV positive patients, family and friends
6. Sexual Health Education for patients schools medical and paramedical staff and other agencies.
7. Genital Dermatosis Clinic run jointly with Consultant Dermatologist Dr I Salvary, FRCP
8. Hepatitis B immunisation programme for “at risk patients”
9. Provision of inpatient care to HIV/AIDS patients
10. Provision of care to patients admitted with sexually transmitted infections in other wards in the hospital
11. Collaborative research with other agencies involved in the enhancement of sexual health

## THE BURE CLINIC PHILOSOPHY STATEMENT

- The department believes that the patients' confidentiality is of the utmost importance and is assured by the Venereal Disease Act.
- Morality of the patient will never be questioned and to achieve this a holistic approach is adopted in treatment with full patient participation.
- The department is run on democratic principles.
- Opinions and suggestions are welcomed and encouraged from both service providers and patients in adopting best practice.
- All staff knows they have an important role to play and they are aware of their responsibilities.
- We assure patients of their rights and encourage a civic discharge of their responsibilities.

## TRENDS IN ATTENDANCE & SUMMARY

In this annual report we have sort to breakdown risk categorisation of attendees. Of the total 2408 new and rebooked patients seen 11(0.45%) were aged under 15 years, 22 (0.9%) were aged 15, 369 (15.3%) were aged 16 -19, 679 (28.1%) were aged 20 -25, 648 (26.9%) were aged 26 – 35 years, 381 (15.8%) were aged 36 -45 years and 298 (12.4%) were aged over 45 years.

From the 2001 census our catchment population is drawn from Waveney (112,342) made up of 48% males and 52% females and Great Yarmouth (90,810) also made up of 48% males and 52% females. This is reflected in our having more female attendants than males. The sex ratios continue to be skewed towards more female attendance. This is reassuring as women more acutely feel most of the morbidity associated with STD's.

In Great Yarmouth & Waveney 14.5% of the population are aged between 16 – 29 years. And this age group represent 70.4% of the total attendees to the clinic and the bear the greatest burden of the acute STI's but not HIV.
HIV is commoner amongst men aged 40 – 64 who make up 32.3% of the total population served.
About 25 % of the catchment population aged 16 and above are single, and 98.7% of the population are white and 0.3% of the population are black.
Unemployment amongst those aged 16 and above is 5.3% and those retired represent 17.2 % of the population. About 37% of those aged 16 – 74 have no formal educational qualification.

These sociological factors contribute to the significant burden of infections in our local population.

For instance 70% of all cases of *Chlamydia trachomatis* were detected in those aged 16 – 24 who make up 43.5% of the total attendees. We have also seen significant increase in the incidence of chlamydial infection to 270 cases. The highest ever recorded in the district.
The increases seen are of concern, as both infections contribute to significant morbidity and are surrogate markers of unsafe sexual practices.

The Vulval clinic run jointly with a Consultant Dermatologist has now been re-established and continues to be over subscribed.

The Colposcopy Service in the Bure Clinic has now been decommissioned.

The acceptability of HIV antibody testing within the department continues to increase in momentum, especially for heterosexual males and females. Greater collaboration continues with the Women and Child directorate in seeking to minimise fetomaternal transmission by offering opportunistic HIV antibody testing and providing antiretroviral treatment to those infected. Post exposure prophylasis to healthcare workers exposed to HIV infection is led from the department in collaboration with the Occupational Health department, Accident & Emergency and Ward 17. The Department of Health guideline for routine screening for HIV and Hepatitis B in pregnancy has now been implemented in the Trust from April 2000. We have so far from April 2000 - March 2001 screened 1754 pregnant mothers with 1 positive case representing a prevalence rate of 57 per 100,000. An uptake rate of 87% was achieved during this period, well within the expected Department of Health targets.

**We need to ensure continuity in providing a fully responsive service for all aspects of Genito-urinary Medicine in the District by assuring adequate staffing level, a mandate for the Organisation.**

## Research & Audit publications 1996 - 2002

Participation in the *Roche* International phase 111b open label safety study of Saquinavir (Ro 31-8959; HIV – proteinase inhibitor) in-patients with proven HIV infection

Harry TC. Are the *Health of the Nation's* targets attainable.
*Int J STD AIDS* 1998; **9**: 185 – 6

Audit of the outcome of inflammatory smears managed in the Bure Clinic. Oral presentation at the British Colposcopy and Cervical Pathology Meeting, Cheltenham, UK 23rd - 26th April 1998. Published as: Harry TC, Cozens C. Outcome of inflammatory smears in women seen in the Bure Clinic. *Int J STD AIDS* 1998; **9**: 299-300.

Partner notification and provider referral differences across the Atlantic. Presented at the MSSVD Spring meeting in Athens. May 1998

Participation in Dupont open label safety study of Efavirenz (DMP 89421 Sustiva) non-nucleoside analogue in patients failing on therapy.

Patient-led survey evaluating responsiveness of the service. Harry TC. Quality and resource management in GUM service delivery. *Int J STD AIDS* 2000; **11**: 751-4.

Audit on the impact of pre-test HIV counselling upon knowledge about HIV and the motivation to change behaviour. Presented as a poster at the 4th International Conference on the Biopsychosocial Aspects of HIV Infection, Ottawa, Canada 15th -18th July 1999.

Evaluation of sexual health knowledge of adolescents in a Great Yarmouth High School. Presented as a poster at the 6th World Congress, Sun City, South Africa 21st - 24th November 1999.

13th International AIDS Conference Durban, **South Africa**, 9th - 14th July 2000. *Ophthalmic manifestations in HIV/AIDS patients on highly active antiretroviral therapy*. (Abstract No. **ThPeB5257**: Poster).

Harry TC. Management of Genital *Chlamydia trachomatis* infection.
*CME BULLETIN STI & HIV* 1998; **2**: 4-5

Harry TC, Clark SL. Are race and ethnicity in STD analysis still of relevance? *Sex Transm Infect.* 1998; **74**: 231.

Harry TC. Sexual ill-health among blacks in the UK. *Lancet* 1998; **351**:1363-4

Harry TC. Sexually transmitted diseases. *Lancet* 1998; **352**:650

Harry TC, Snobl H. Website as a tool for patient education in sexually transmitted diseases. *Int J STD AIDS* 1998; **9**: 779-8

Harry TC HIV/AIDS in Zambia. *eBMJ* 9th August 1999.

Harry TC. Information Technology for postgraduate education.
*Br J Obstet Gynaecol* 2000; **107**: 144

Harry TC. Sexual health knowledge of adolescents in a Great Yarmouth High School. *Int J STD AIDS* 2000; **11**: 129-31

Harry TC, Matthews M, Salvary I. Indinavir use: Associated reversible hair loss and mood disturbance. *Int J STD AIDS* 2000; **11**: 474-6

Harry TC Induced Abortion. *The Obstetrician & Gynaecologist* 2000; **2**:52-3

Harry TC Impact of adequate medical manpower in genitourinary medicine service delivery. *Int J STD AIDS* 2001; **12**: 131-2

Harry TC Infectious syphilis and importance of travel history. *Lancet* 2002; 359: 447 - 8.

8th European Conference on Clinical Aspects & Treatment of HIV-Infection. Athens, **Greece** 28th - 31st October 2001. *To test or not to test: Implications for late diagnosis of HIV/AIDS.* (Poster). Abstract No: **P382**

14th International AIDS Conference Barcelona, Spain, 7th - 12th July 2002. "*Outcome of baseline viral resistance testing in newly diagnosed HIV patients*" (Abstract No **B10406)**

## Total clinic workload

In 1998 we had a growth of 5.5% increase in attendance compared to 1997 and 1996. In 1996 and 1997 there was only an increase of 2.8 and 2.5% respectively. There was an increase of 3.4% attendance of new/re-registered patients in 1999 from 2215 to 2290 cases in 2000. In 2001 we saw 2529 and in 2002 we saw 2408 patients, of whom 52% were female and 48 % males – reflecting our catchment population's sex ratio.

What has significantly varied over the last three years has been the increase in the number of KC60 returns, reportable diagnoses which, which have increased from 2535 in 1995 to 2941 in 1997, 3103 in 1998, 3107 in 1999, 3339 in 2000, 4156 in 2001 and 3993 in 2002. The relevant aspects are that with increase in the numbers of patients attending so also, the complexity, diversity and the STD related problems. These have led to significant increase in the workload of the medical staff. This in turn has increased the resource and manpower demands on supporting diagnostic services. The year 2002 was particularly marred by clinic closures.

## Syphilis

In 2002 there were 4 cases of syphilis all in men. So far from 1997 to 2002 we have seen 6 cases of infectious syphilis. The median age of the men was 36.5 years range (28 -55) years. The declared sexuality of the men: bisexual 4 (66.7%) and homosexuals 2 (33.3%). Only 3 of the 6 men - 50% contact tracing rate- brought in their contacts. Of the 3 contacts seen 2 were concordant[1] and the other not infected. Three partners were casual contacts not seen. This trend has been also noted nationally.

## Gonorrhoea

The incidences of gonorrhoea remain sustained in 1998/99 respectively. There was a four-fold increase from 1995 to 1996 in the Bure Clinic (see annexe). The national goal was to reduce the incidence of gonorrhoea among men and women aged 15 - 64 by at least 20% in 1995 (from 61 new cases per 100,000 population in 1990 to no more than 49 new cases per 100,000 in 1995). There were 31 cases of gonorrhoea seen in Great Yarmouth & Waveney in 1990. Against a total local population of men and women aged 15- 64 of 122,007, this translates into 25 per 100,000. This level of prevalence is still maintained in Great Yarmouth & Waveney. In 1999 there were 51 cases of gonorrhoea including epidemiological treatment, the greatest rise seen in the district. There were 44 cases of gonorrhoea confirmed by culture. Great Yarmouth has the highest incidence of

[1] **Harry TC**: Infectious syphilis and importance of travel history. *Lancet* 2002; 359: 447 - 8

teenage pregnancy in the region, a surrogate marker for unsafe sex. In 2000 there were 44 cases confirmed by culture. In 2001 there were 44 cases and in 2002 we saw a slight decline to 36 cases. Interestingly 33% of the cases of gonorrhoea were seen in those aged 16 – 19 who made up 15.3% of attendees.

In east Norfolk, Great Yarmouth has the highest unemployment rate and deprivation index which is manifested in the sexual ill health markers of high teenage pregnancy and gonorrheal infections.

**Chlamydia trachomatis**

The outcome targets of the Association of Genitourinary Medicine Physicians goals and indicators for the management of sexually transmitted diseases guidelines for purchasers of services is to reduce uncomplicated chlamydial infection from GUM Clinics to 100 cases per 100,000 of the population aged 15 - 64 years in 3 years. We have seen a changing paradigm in the incidence of chlamydia over the last 3 years. The prevalence has increased from 3.6% in 1995, 6.8% in 1996 to 8.4% in 1997. In 1995 there were 75 cases per 100,000. This increased to 149 per 100,000 in 1997. In 1998 a slight decrease was seen which is not of any statistical significance. In 1999 this has increased to 160 cases. This is of concern as during the same period we have seen an increase in the incidence of gonorrhoea. In 2000, we had 199 cases, the highest in the district since we started keeping records. This has now been surpassed respectively in 2001 & 2002 with levels of 232 and 290 respectively.
This is one of the reasons we have launched our website, to supplement sexual health education among adolescents in our catchment population, as 70% of all cases of chlamydia in our district is amongst those aged 16 – 29.

**Herpes simplex infection**

The apparent fall in incidence of first attack herpes simplex has been due to a revised method of recording this data after 1995. Only culture positive cases were required to be recorded. Genuine interpretation of this data indicates a 14.2% increase between 1996 and 1997. Viral typing was introduced in April 1997. In 1998, we had 53 cases. In 1999, an increase of 19% in culture positive cases was noted (63 cases). In 2000 we had 61 cases. In 2001 and 2002 respectively we had 49 cases respectively.

**Genital warts**

Between 1995 and 1996 an in increase of 18.8% of first attack genital warts was noted. The subsequent fall of 8.8% noted between 1996 and 1997 has been due

to implementation of a waiting list scenario and reduced clinical prioritisation of this patient group due to shortage of medical manpower. In 1999 there was a 4% rise noted in new diagnosed cases. There were 205 cases in 1998, 209 cases in 1999, 211 cases in 2000, 220 cases in 2001 and presently 209 cases attended in 2002.

**Candidiasis**

The attendance has remained stable over the last 7 years. Most women with vaginal discharge and vulval pruritus see their primary care physician or Practice nurse either of who initiate referral. Most magazines read by women similarly provide advice to patients to attend the clinic, if symptoms of intractable vulval pruritus are discerned. This would also account for the skewed sex ratio in favour of female noted amongst attendants. In 1999 there were 266 cases. In 2000 & 2001 there were 290 cases each. The clinic closures seen in 2002 diminished the total cases to 218.

**Trichomoniasis**

The prevalence has remained low with an initial fall and slight rise as shown in the graph in the annex. We have now discontinued routine culture in women.
In 1998 there were 3 cases and 5 cases in 1999. In 2000 we had only 6 cases. In 2001 and 2002 respectively there were 10 and 12 cases respectively. The routine cervical cytology screen in women three yearly in the district and the increased use of Metronidazole in treating bacterial vaginosis has all contributed to a steady decline.

**Cervical cytology & Colposcopy**

We have now decommissioned the Colposcopy service and we only perform the occasional cervical cytology in the unit. In 2002 there were only 2 cases of minor cervical dyskariosis seen.

**HIV antibody test**
Between 15 - 35% of attendees to the Bure Clinic in 2000 to 2002 had HIV test at their consultation for sexual health care (see chart).

| Year | Total HIV Tests (%) | Total Attendees | Heterosexuals Tested (%) | Homosexuals Tested (%) | New HIV Positives |
|---|---|---|---|---|---|
| 2000 | 367 (15.3%) | 2393 | 14.1% | 35.9% | 2 (Hetero) |
| 2001 | 551 (21.1%) | 2488 | 21.5% | 28.6% | 3 (Hetero) |
| 2002 | 808 (34.3%) | 2323 | 34.3% | 40.5% | 3 (Hetero) |

During this period only 8 cases were identified from a total of 7204 patients. All cases acquired their infection heterosexually.
We have a did-not-attend (DNA) rate of over 35% and most include patients who had attended for HIV test.
Our current policy is to ask all patients to re-attend for their results a week later.

These negative results are giving largely by medical and health adviser staff members.

The Clinical Effectiveness Group (Medical Society for the Society of Venereal Diseases and Association of Genitourinary Medicine) in their specialty specific standards (copy enclosed) recommend that by the end of 2002, physicians should offer an HIV antibody test to 80% or more of persons attending on the occasion of their first screening for sexually transmitted infections unless the person is already known to be antibody positive. The test shall be offered in accordance with current national guidelines viz-National Sexual Health Strategy. The National Sexual Health Strategy, amongst its aims include:

- *"Setting a national standard that all GUM services should offer an HIV test to clinic attendees on their first screening for STIs".*
- *"Reduce the transmission of HIV & STIs with a national goal of achieving a 25% reduction in the number of newly acquired HIV infections and gonorrhoea infections by 2007.*

This target is to rise to 90% or more by the end of 2003 and 100% by the end of 2004.

**Opportunities:**
We now have in-house testing for HIV antibody by ELISA for antibody and p24 antigen, with a turn around time of about 3.5 hours. Samples submitted by 12.00 noon should have results available by 4.30 pm same day.

Reactive results will need confirmatory test by *Western Blot*, as is the standard of care.

**Results:**
Most of patients without any detectable infection at initial microbiological screen by Gram-stain of genital materials are encouraged to telephone for there

results one to two weeks later. However patients electing to have HIV antibody test are brought back to be given a negative results by either the Attending Physician or Health Advisors in 10 to 14 days. This was due to:
1. Test were batched and tested in Norwich
2. Variable return dates of results

Patients therefore spent a considerable period of time anxious for their results. Most default without attending.
We now hope to redress this by offering choice to our patients.

**Plan:**
1. Patient questionnaire about opinion for telephoning for their results same day
2. Pilot in-house on Thursdays same day test with a patient survey of need to provide service
3. Evaluate impact of failure to attend or phone for results
4. Evaluate difficulties and training needs to improve service delivery
5. Evaluate overall uptake of HIV antibody test.
6. Evaluate seroprevalence of district HIV/AIDS.

**Bibliography:**


1. *KC60* returns from Bure Clinic
2. Speciality Specific Standards for Physicians in Genitourinary Medicine (GUM). www.mssvd.org.uk Accessed 12th March 2003
3. The National Strategy for sexual health & HIV. Department of Health 2001.


## Quality Standard Indicators

1. Any persons presenting with a new clinical problem suggestive of a sexually transmissible disease or who considers him/her self to have been in contact with such a disease should be seen on the day of presentation or failing that

on the next occasion the clinic is open (This was recommended by the CMO in his letter of 30th July 1986 to Regional General Managers)

2. In accordance with the recommendation of the Monks report, arrangements should be made for some evening clinic sessions to be held after 5pm
3. Twenty minutes consultation for new patients recommended by the Royal College of Physicians.
4. Ensure adequate staffing level of Health Advisors to provide their traditional role of contact tracing, partner notification, provider referral, pre and post test counselling for HIV antibody test and opportunistic sexual health education to all attendee and the community from sexual health promotion activities with voluntary and statutory bodies.
5. Regions should be required to review the distribution of their main GUM services and make improvements where necessary

## Recommendations for improvement of Bure Clinic Service delivery in 2002/2003

1. **Full-time 2nd Consultant post.**
2. **Increase additional nursing support.**
3. **Increase additional secretarial support.**