ELECTIVE (SSC5c) REPORT (1200 words)

A report that addresses the above four objectives should be written below. Your Elective supervisor will assess this.

Objective 1: Describe the pattern of disease/illness of interest in the population with which you will be working and discuss this in the context of global health:

To describe the pattern of sexual health provision in the South London population in comparison to global trends & patterns.

According to the Health Protection Report of 2014, 450,000 STI diagnoses were made in England in the preceding year with sexually transmitted HIV included in these diagnoses. As expected chlamydia was the most commonly diagnosed STI with over 208,000 diagnoses made in 2013 alone. Furthermore gonorrhoea diagnoses were also raised by 15% over the 2012-2013 period. The most commonly diagnosed groups & population subsets diagnosed were heterosexuals under the age of 25 & in MSM (men with have sex with men). The reasons for this are two-fold. Firstly there has been much focus on testing in this population subset & furthermore the highest levels of unsafe sexual practice continues to be within this age group (1).

The rates of gonorrhoea in MSM men has increased by 26% nationally and 139,000 chlamydia diagnoses were made in the 15-24 age group which is an increase from previous years. However there is still a lack of comprehensive chlamydia testing coverage nationally in particular in the younger age-group subset. This is reflected in reports from the local authorities nationally which show that unfortunately only 30% of local authorities are meeting the chlamydia diagnosis rate of 2,300/100,000 15-24 year olds which is the rate recommended by PHOF (1).

Figure 1: STI trends across the UK amongst male & females respectively (1).

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As shown by the graphs in figure 1; there is a growing trend in the number of males diagnosed with syphilis & gonorrhoea; which is hitting all-time peaks in the last 2-3 years and is of particular concern. The rates of genital herpes are more of a concern in females; although they are still growing amongst both males & females. Genital warts have shown a decline in growth over the last few years.

From an epidemiological perspective, figure 2 below shows the rates of new STI diagnoses in the London boroughs of Wandsworth, Lewisham, Southwark, Croydon & Lambeth were over twice that of surrounding boroughs e.g. Sutton. This reflects the need for more intervention from sexual health services targeting these areas.

Figure 2: Rates of new STI diagnoses by LA of residence: England 2013

From a global health perspective, the testing services provided to patients in the developed world (UK, US & Australia) is far more comprehensive and extensive than that offered (if offered) to patients in developing countries. This unfortunately delays diagnosis & treatment and results in higher rates of infections e.g. syphilis in developing countries as shown in figure 3.

This is despite the abstinence rate in many countries e.g. Iran, Morocco, India & China being much higher than that of the UK & the number of sexual partners per individual far fewer than that of the UK.

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Figure 3: Percentage of antenatal care attendees positive for syphilis (since 2008) (2)

Objective 2: Describe the pattern of health provision in relation to the country which you will be working and contrast this with other countries, or with the UK:

How is sexual health provision in South London UK different to the rest of the UK?

The demand for sexual health services in London; in particular many of the central London boroughs is extremely high as compared to the rest of the UK as shown by the high prevalence & rates of various STIs diagnosed in these areas.

However given the increasing rates of STIs & funding cuts to PCTs, it is without doubt that service demand is still outstripping supply at every level.

Figure 4: Total rates of chlamydia diagnoses by LA of residence: England 2013 (3)

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Figure 5: Rates of gonorrhoea diagnoses by LA of residence: England 2013 (3)

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Figure 6: Total number of gonorrhoea diagnoses among MSM by LA of residence: England 2013 (3)

Figure 7: Total number of syphilis (primary, secondary & early latent) diagnoses among MSM by LA of residence: England 2013 (3)

As shown in figures 4 & 5, the rates of chlamydia & gonorrhoea in the central South London boroughs under St Georges hospital are very high & significantly higher than other parts of London & the UK; placing a heavy burden on service provision.

Of even more concern are the growing rates of syphilis & gonorrhoea amongst MSM populations in South London; in particular attributable to their high risk activities e.g. Chem-Sex.

MedFASH (Medical Foundation for AIDS & Sexual Health) published a report in Nov 2008 entitled: "London sexual health needs assessment & service mapping". This report sited detailed statistics & information relating to how various PCTs were distributing their resources & how/by who commissioning is undertaken. It is not within the remit of this short report to enter details of the data collected & recommendations made, however it is of particular interest to note the lack of funding & staff levels for the vast majority of PCTs (4).

Objective 3: Health related objective: What is the prevalence of sexual health conditions in South London & how does this impact the general health & quality of life of these patients?

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London has the highest rates of sexual ill health in the UK; up to 3000/100,000 population (figure 2). This disproportionately impacts on public health and finances. The performance of PCTs varies considerably across London and is influenced by myriad factors. Ensuring adequate access to services is the most fundamental aim and priority of all PCTs; however this is again limited by budget cuts.

The report published by MedFash in 2008 highlighted the need for more information across London, on sexual health services currently commissioned and provided. This will identify areas of weakness in the current commissioning of PCTs & enable sexual health services in London to reach world-class levels (4).

Objective 4: Personal/professional development goals:

To excel in communicating difficult concepts to patients with limited sexual health knowledge & education.

To motivate & inspire patients in taking interest in their own health and to promote safe sexual practises.

To improve diagnostic skills & formulate effective management plans.

I was very fortunate to have spent my elective period in the HIV & Sexual Health Department of St Georges hospital (Courtyard Clinic) under the supervision of Dr Aseel Hegazi & her team including Dr Beardall, Dr Lau, Dr Hay, Dr Sadeek, Dr Tout & Dr Malik. I attended several GUM clinics where I was able to practise my consultation & history taking skills in particular taking a sexual health history & how to do a full sexual health screen. I felt my confidence start to grow very quickly & I enjoyed the educational aspect of promoting safe practices to motivate patients & engage them in taking responsibility for their own sexual health.

Dr Beardalls specialist vulvovaginal clinc was an area of medicine I hadn't had the chance to explore before & I found this particularly useful. I witnessed many dermatological diagnoses ranging from lichen sclerosis, herpetic ulcers & vaginitis to more critical cases of VIN (vulval intraepithelial neoplasia) where I was able to take biopsies & view histological changes. I was very inspired by her ability to put highly anxious patients at ease when taking biopsies and swabs & this highlighted the importance of patient communication & creating rapport with patients; especially those with a history of sexual abuse/assault.

The adolescent HIV clinic I attended was emotionally intense but demonstrated the importance of an effective multi-disciplinary team with patients receiving high levels of support from both health advisors & psychologists as well as the Drs. The Courtyard clinic was one of the best examples of this I have witnessed in the NHS as patients were managed holistically with every aspect of their life taken into account when making management decisions to optimise adherence and cooperation. The adult HIV clinic I attended demonstrated to me that it is very rarely that HIV now kills any patient and that the life expectancy of HIV positive patients is actually higher than that of the normal population due to the advances in highly active anti-retroviral therapy (HAART). The importance of adherence in

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preventing patients developing resistance to their medication was highlighted; together with the regular monitoring of CD4 counts and other markers/ratios to optimise treatment.

Finally, my visit to Wandsworth Prison with Dr Lau to see the HIV patients under sentence there was a great experience as it highlighted the importance of ensuring their care is followed up whilst they are there as well as after they have served their sentence & back in the community. Discontinuation of HIV treatment whilst in prison or low adherence due to the poor psychological state of these patients would impact negatively on their response to treatment later on & encourage further resistance development. Thus liasing with the Psychiatrists looking after these patients is of utmost importance.

I would like to extend my thanks to Dr Hegazi & all her team in making this a great learning experience for me & organising the placement at such short notice. Her kind approach towards both patients and staff was a source of inspiration.

References:

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