The new imperative to test for HIV in pregnancy

EVEN though in the United Kingdom (UK) the current epidemic of HIV has not reached predicted proportions, a significant number of people infected with HIV remain undetected. Anonymous antenatal screening suggests that 87% of women who are HIV positive in London and the South East are unaware of their status.[1] Other studies suggest that often these same patients present to a range of primary and secondary care services before being diagnosed as HIV positive.[2,3] Data from the latest figures show that approximately three hundred babies annually are born with HIV infection in the UK, the majority of whom are diagnosed post-delivery.[4]

There is now good evidence that vertical transmission to the foetus can be substantially reduced by not breastfeeding the newborn baby, by use of zidovudine (AZT), and by elective caesarean section, where possible.[5] Of course, these aspects of care need to be discussed with women in culturally sensitive, patient-friendly ways, and this is often a major challenge to those who work in the larger conurbations, such as London, Birmingham, Manchester, and some Scottish cities. Despite Department of Health guidelines,[6] testing for HIV infection in hospital and community antenatal clinics has been remarkably unsuccessful, even in London where prevalence is highest.[7] Thus the detection rates of women with latent infection remain low even in the areas of highest prevalence in the UK.[4,5] However, any screening programme must be given time before those most 'at-risk' readily accept the test in what is another cogent example of the inverse care law.[8]

Recently, a number of voices have been calling for a wider, more comprehensive attempt to uncover latent HIV infection in those who are pregnant, especially in high-prevalence, inner-city areas.[9,10] The advent of more effective treatments, such as combination antiretroviral therapies, for those infected with HIV is an added incentive to this process. It is important to ascertain the views of general practitioners (GPs) on some of these issues if we are to succeed in identifying a greater proportion of women who are HIV positive and thus reduce levels of morbidity and mortality in both mother and child.

Testing for HIV is undoubtedly one factor. The thinking about HIV testing has changed substantially over the past ten years. Initially, there was an understandable focus on counselling around the test, but short consultation times and the rapid flow of patients in primary care generally precluded full counselling, which could often take up to an hour. Recently, a more pragmatic approach has been advocated, in which a focused testing regime — taking less than a third of the time — is used to encourage normalization of the test. This is especially appropriate where GPs are traditionally very familiar with their practice population. These factors are just as relevant to other members of the primary care team, such as midwives and practice nurses, and to other clinicians who work primarily in community settings, such as family planning doctors. In addition, this strategy is entirely consistent with the current guidance from the Department of Health, which favours a 'discussion' around the test and not 'counselling'.[11,12]

The access of GPs to the population and the scope for HIV prevention within a wider sexual health promotion are rightfully seen to be important. This needs to be emphasized in high-prevalence, urban areas where rates of sexually transmitted diseases and HIV infection are worryingly high and are often associated with poverty, ethnicity, and other socio-economic factors.[13,14] Furthermore, the GP's role in sharing pre-conceptual information lends itself naturally to a more balanced view of how HIV testing can benefit both the woman and the unborn child.

The relaxing of insurer's guidelines with respect to negative HIV tests and heightened awareness of HIV infection may mean that more patients are willing to discuss and request HIV testing in primary care. Thus, a pregnant woman accepting an HIV test in these circumstances will unequivocally not be penalized by insurance companies (or so runs the claim from the British Association of Insurers).[15]

In some areas, communication problems still exist between genitourinary clinics and general practice. The traditional basis for these is diminishing, especially as the recognized morbidity caused by other sexually transmitted diseases, such as chlamydia, is also persistently high.[16,17] The potential for primary care to contribute to a screening programme for chlamydial infection has been found to be successful.[18]

HIV infection is now regarded as a chronic, relapsing condition which is beginning to be more effectively controlled. Great scientific strides have been made over the past few years and it is legitimate to ask questions about the need to identify and treat women with the condition. These questions are going to surface as much in the primary care sector as in any other setting, especially where antenatal care is concerned. Chronic HIV infection and AIDS impacts upon individuals, families, and children, and the general public ought to be able to expect certain standards of care from their GPs and wider primary care teams.

To deny this is to deny the progress made in HIV and AIDS and thus to condemn patients — especially those whose needs are traditionally unmet, such as women — to a preventable form of morbidity and mortality. Moreover, the ethical stance of not identifying women and children at the earliest of stages is dubious in view of the prevailing evidence and the current availability of resources. The education and training necessary for this programme to be carried out will vary. While many GPs and primary care teams will be suitably knowledgeable and aware of some of these issues, others will need targeted training, tailored to and based within particular practices.

One practical way of enhancing uptake of the HIV test is to include it in an antenatal booking schedule (whether computerized or not) as a 'prompt' for either the GP or the booking midwife. In such an example, an audit with feedback to clinicians would be both feasible and educationally sound. Local conditions and the extent of the collaboration between the obstetric team, community midwives, and GPs will ultimately determine whether such audits can be repeated on a regular basis. In this potentially complex process, the voice of the pregnant woman must be vocal, not muted.[19] In an era of evidence-based practice it is time for GPs to come off the 'testing fence' and treat HIV as any other serious, often life-threatening condition, but one that can be modified in the light of current interventions.

SARA MADGE

GP fellow, HIV/AIDS, Royal Free Hospital Trust, London

SURINDER SINGH

Clinical lecturer, Department of Primary Care and Population Sciences, Royal Free Hospital School of Medicine, London

References

1. Unlinked Anonymous Surveys Steering Group. Unlinked anonymous HIV prevalence monitoring programme in England and Wales. London: Department of Health, Public Health Laboratory Services, Institute of Child Health, 1997. pp 35-40.
2. Madge S, Olaitan A, Morcroft A, *et al.* Access to medical care one year prior to diagnosis in one hundred HIV positive women. *Fam Pract* 1997; **14:** 255-257.
3. Olaitan A, Madge S, McCarthy K, *et al.* Unrecognised HIV infection amongst gynaecology patients. *Br J Obstet Gynaecol* 1996; **103:** 470-473.
4. Noone A, Goldberg D. Antenatal testing: what now? *BMJ* 1997; **314:** 1429-1430.
5. Macdonagh SE, Helps BA, Masters JA, *et al.* Antenatal HIV testing in London: policy, uptake and detection. *BMJ* 1996; **313:** 532-533.
6. Department of Health. *Guidelines for offering voluntary named HIV antibody-testing to women receiving ante-natal care.* London: DoH, 1994.
7. Chrystie IL, Wolfe CDA, Kennedy J, *et al.* Voluntary testing for HIV in a community based antenatal clinic: a pilot study. *BMJ* 1995; **311:** 928-931.
8. Tudor-Hart J. The inverse care law. *Lancet* 1971; **1:** 406-412.
9. Essex B. Screening for HIV infection should be part of routine antenatal screening. [Letter.] *BMJ* 1997; **315:** 608.
10. Hudson CN, Sherr L. Consensus document on antenatal HIV testing with special reference to the interests of ethnic minorities. [Letter.] *Lancet* 1997; **350:** 1783.
11. Miller R, Lipman M. HIV pre-test discussion. *BMJ* 1996; **313:** 130.
12. Department of Health. *Guidelines for pre-test discussion on HIV testing.* London: DoH, 1996.
13. Low N, Dakar-White G, Barlow D, Pozniak AL. Gonorrhoea in inner London: results of a cross-sectional study. *BMJ* 1997; **314:** 1719-1723.
14. Lacey CJN, Merrick DW, Bensley D, *et al.* Analysis of the socio-demography of gonorrhoea in Leeds, 1989-93. *BMJ* 1997; **314:** 1715-1718.
15. Byrne L. Insurers relax questions on HIV. *BMJ* 1994; **309:** 360.
16. Taylor-Robinson. Chlamydia trachomatis and sexually transmitted disease. BMJ 1994; **308:** 150-151.
17. Oakshott P, Hay P. General practice update: chlamydia infection in women. *Br J Gen Pract* 1995; **45**: 615-620.
18. Grun L, Tassano-Smith J, Carder C, *et al.* Comparison of two methods of screening for genital chlamydial infection in women attending in general practice: cross sectional survey. *BMJ* 1997; **315:** 226-230.
19. Goldbeck-Wood S. Woman's autonomy in childbirth. *BMJ* 1997; **314:** 1143-1144.

Address for correspondence
Dr S Singh, Department of Primary Care and Population Sciences, Royal Free Hospital School of Medicine, Rowlands Hill Street, London NW3 2PF.

Natural history and management of dizziness: putting evidence into practice

DIZZINESS falls into the category of undifferentiated illness, which forms a substantial part of our work in general practice. I suspect that it may not be one of the more satisfying symptoms to treat, as successful outcomes are often difficult to achieve. Two articles in this month's *BJGP* highlight the importance of this condition. They pose two specific questions: 'how common is the condition?' and 'how can optimum treatment be put into practice?'.

Yardley *et al*[1] surveyed a one-in-three sample of adult patients in four practices who completed a questionnaire exploring the presence of symptoms in the previous month. The results showed that around one in five responders had experienced dizziness during the past month; almost half of these reported some degree of handicap and approximately one-third had symptoms of dizziness over a period of five years. Around half of those with dizziness also reported symptoms of anxiety; multiple physical and psychological symptoms were associated with high levels of handicap. The frequency of dizziness seems high compared with other studies, which have shown levels of 10% for women and 6% for men, with consultation rates of 1.3 per 1000 consultations per year.[2] These differences in findings may relate to the types of questionnaire used, and it is difficult to decide which is the more accurate figure. Suffice it to say that the problem is a common one.

The unanswered question is 'what comes first?': the psychological problem or the dizziness? The extent to which an underlying propensity to anxiety predisposes a patient to dizziness is difficult to tease out, but it may be too easy to label people as 'anxious' if they consult frequently with non-specific problems.

It was somewhat surprising to discover that only one in four of the responders who experienced episodes of dizziness had received any form of treatment. Had they been dismissed as 'worried well', or had their symptoms not been taken seriously? The fact that 40% of those with dizziness and who were working reported occupational difficulties emphasized the disturbance that these patients experienced. Overall, the finding of symptomatic prevalence in the community of more than 20% and recorded annual consultation rates of less than 2% show that there is a significant number of cases where dizziness is a persistent and untreated complaint.

While the causes of dizziness are well described in standard text books, management recommendations tend to concentrate on a range of drug treatments. In practice, the extent to which drug treatments are successful is often unknown and the side-effects of many of the drugs used in caring for patients with dizziness may result in unsatisfactory outcomes.

Yardley *et al*[3] investigated the use of vestibular rehabilitation (VR) in the management of persistent dizziness where no underlying pathology is found. VR takes 30 to 40 minutes and involves eight sets of standard head and body movements performed twice daily, supplemented with training in relaxation and slow breathing. In a randomized controlled trial, the authors demonstrated significant improvements compared with controls in patients receiving VR, in terms of postural control and reports of symptoms and emotional states.

Two important findings emerge from these studies. First, dizziness is a common problem; secondly, vestibular rehabilitation is a successful method of treatment. The second finding raises questions about the application of research results to everyday practice. At a time when 'getting evidence into practice' is being actively promoted, how can the results of these projects be acted upon?

From the results described, for every thousand adult patients aged 18 to 64, there will be around 200 with reported episodes of dizziness, 100 of whom will have some degree of handicap; between 60 and 70 of these will have had a problem for more than five years. In a five-partner practice of 10 000 patients, of whom approximately 7500 will be adults, there may be 750 potential patients who will report some degree of handicap that may benefit from VR.

The next question is who is going to conduct the management programme? It is unlikely that a general practitioner can fit 30- to 40-minute sessions into routine surgeries, and, from all accounts, practice nurses are similarly stretched for time.