Increased uptake of HIV screening following introduction of ''opt out'' testing and results by telephone

Rogstad *et al*[1] showed an increase both in the number of patients who were offered the HIV test and those who took the test following the use of a leaflet. We report the increased uptake rate of HIV testing since the introduction of ''opt out'' testing and giving results by phone.

Before January 2002, patients attending our clinic were offered an HIV test if they belonged to high risk groups such as men who have sex with men or injecting drug users. Pretest counselling was done by our health advisers and patients were required to return to the clinic to receive their test results. In 2001, 904 of 2930 new and re-registered patients (31%) underwent HIV testing.

The UK government's national strategy for sexual health and HIV set its target for reducing undiagnosed HIV in genitourinary medicine clinics by increasing the uptake of HIV testing to 40% by the end of 2004 and to 60% by the end of 2007.[2]

From 1 January 2002, we introduced an ''opt out'' system, whereby all patients were offered HIV tests, regardless of risk category. This led to an increase in HIV test uptake in the following 3 months to 37% (272 of 740 new patients).

This caused an increase in the workload of our health advisers, who were spending much time in pretest counselling low risk patients and giving negative HIV results. It became clear that exhaustive, in-depth HIV pretest counselling was impractical and inappropriate when the majority of those tested were ''low risk.'' Accordingly, we decided that only high risk patients should be referred pretest to the health advisers.

It was also observed that some patients who initially agreed to undergo HIV testing changed their minds when they learned that they would be required to return to the clinic to collect their result. We decided to offer HIV results by telephone, in line with our policy for all other screening tests. High risk patients, however, were encouraged to attend in person for their result. In the next 3 months 44% (293 of 663 new patients) took HIV tests. Five patients tested HIV positive, but only one received the result by telephone.

The introduction of a telephone HIV results system enabled us to exceed the Department of Health target for 2004. The new system was adopted after consideration of the pros and cons in a departmental meeting in which the opinions of all staff were canvassed. Some concern was expressed about the potential for self harm by patients given bad news outside the clinical setting. We tried to minimise such outcomes by encouraging patients to telephone in the presence of their partner, a friend, or a relative. Results were only given by telephone when the patient could be seen in clinic on the following day at the latest.

The telephone results system is very popular. One patient said, he would far rather receive bad news in the familiar surroundings of home, with the support of his partner, than in a clinic.

We do not know if it is psychologically harmful (or indeed beneficial) for patients to receive a positive HIV result by telephone; research is needed to answer this question. Given the drive to reduce the number of people with undiagnosed HIV infection and the demands of working life, we believe telephone results are here to stay.

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References

1 **Rogstad KE**, Bramham L, Lowbury R, *et al*. Use of a leaflet to replace verbal pretest discussion for HIV: effects and acceptability. *Sex Transm Infect* 2003;**79**:243–5.
2 **Department of Health**. *The national strategy for sexual health and HIV*. London: DoH, 2001 (www.doh.gov.uk/nshs).

CD-ROM REVIEW

Topics in International Health: Sexually Transmitted Infections, 2nd ed

Institutional licence £120; individual licence £30; developing world licence £20. CD-Roms are not Apple Mac compatible. Disc adviser: Dr J E Richens, Department of Sexually Transmitted Diseases, Royal Free and University College London Medical School, UK. London: The Wellcome Trust, 2003. ISBN 0 85199 631 0.

Having previously resisted the temptation to upgrade from printed text to the 21st century I was suitably impressed by both the technical design and the factual content of this 2nd edition CD-Rom. As a bit of a computer novice I found the software easy to install and navigate with helpful instructions at the touch of a button. The program itself runs on Windows 95, 98, 2000, NT4, or XP and needs 32MB of RAM with at least a 120 MHz Intel Pentium processor (or equivalent).

The CD-Rom provides a vast wealth of information on all aspects of common and tropical STIs that are presented in the form of 18 interactive tutorials, each reviewed by expert authors, and a collection of about 800 images. The material covered ranges from history taking and clinical examination to epidemiology, laboratory diagnosis, and syndromic management of STIs. It includes in-depth tutorials on individual STIs that provide up to date references on management useful both in the developing and developed world. HIV/AIDS is covered in a separate CD-Rom. However, there is detailed mention here of epidemiological synergy with common STIs and trials exploring control of STIs to reduce transmission of HIV.

The 18 tutorials consist of 50–70 slides on each topic. The CD-Rom is therefore topic led with no search facility for those wishing to access a list of differential diagnoses by symptoms and signs. The user's attention span is maximised by a mixture of high quality images interspersed with relevant yet concise text and a useful summary of all sections. Interactive quizzes and diagrams help to reinforce learning and a notepad is strategically placed for users wishing to go back to basics and include their own free text. A glossary is available on each page should any terms need further clarification and all text is fully referenced. The pictures used in all the tutorials appear chronologically in the image collection and can be printed. They can also be sorted and saved in groups of your choice. The only hitch is that they can't be downloaded into presentations, personal slide libraries, or palm pilots—shame!

The detail presented is still not enough to rival textbooks such as King Holmes's *Sexually Transmitted Diseases* but this is not the purpose of the CD-Rom. It is ambitiously designed for use as an educational resource in both developed and developing countries and I think it serves this purpose well. Its appeal spans a broad range: medical students swatting for exams (and SpRs sitting Dip GUM!), academic researchers as a useful point of reference and all healthcare professionals involved in direct clinical care of patients with STIs including nurses and health advisers.

Overall, the CD-Rom provides an interactive way of accessing and assimilating a huge amount of information on all aspects of STIs. It is definitely much more user friendly than lugging a huge textbook around and gets a big thumbs-up from me!

K P Prime

NOTICE

8th European Society of Contraception Congress

The 8th European Society of Contraception Congress will be held from 23–26 June 2004 in Edinburgh, Scotland, UK. For further details please contact ESC Central Office, c/o Orga-Med Congress Office, Essenestraat 77, B-1740 Ternat, Belgium (tel: +32 2 582 08 52; fax: +32 2 582 55 15; email: orgamed.ann@pandora.be; and website: http://www.contraception-esc.com/edinburg.htm).

CORRECTION

There is an error in table 3 of the paper by Pimenta *et al* (J M Pimenta, M Catchpole, P A Rogers, J Hopwood, S Randall, H Mallinson, E Perkins, N Jackson, C Carlisle, G Hewitt, G Underhill, T Gleave, L McLean, A Ghosh, J Tobin, V Harindra. Opportunistic screening for genital chlamydial infection. II: Prevalence among healthcare attenders, outcome, and evaluation of positive cases. *Sex Transm Inf*, 2003;**79**:22–27).

The statistical calculation of this table combined all women, regardless of age. The authors have recalculated this table, and the revised version is available on the website (http://sti.bmjjournals.com/cgi/data/79/1/22/DC1/1 with the correct age restriction — female participants 16 to 24 years only, as originally specified. The majority of these data (general practice, family planning, and youth clinics) have only changed marginally; the main differences lie within the GUM clinics, due to the wider age of women tested at this setting. The conclusions, however, are unaffected by this error. The authors stand by their assertion that prevalence tends to be higher in those reporting and attending with symptoms than those screened opportunistically.