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Enhanced risk of HIV sexual transmission during structured treatment interruption

We report a case of HIV transmission through sexual intercourse while the sexual partner underwent antiretroviral structured treatment interruption. We would like to underline that giving proper information about a higher contamination risk during structured treatment interruption is a critical issue. Moreover, we consider that it is the responsibility of a medical investigator and physician to deliver a clear message in order to reinforce prophylaxis indications for sexual intercourse during this period.

A patient was infected with HIV for 9 years when he started HAART. At this time, his CD4 count was 280×10^6/l and plasma viral load was 5.1 $\log_{10}$/ml. A first structured treatment interruption (2 months' duration) was proposed after 2 years, while plasma viral load was undetectable. He was asked to use preservatives strictly at this time. A peak of HIV replication was observed (4.3 $\log_{10}$/ml). Treatment was then reintroduced. One year later, he was still healthy (CD4 count 450×10^6/l and undetectable plasma viral load). He asked for a new structured treatment interruption. Plasma viral load reached 4.6 $\log_{10}$/ml 2 months later.

This homosexual man had a regular HIV negative sexual partner for 2 years. His HIV serology was found to be negative 2 months before the second structured treatment interruption. This sexual partner experienced a short period of unexplained fever 2 months after his boyfriend's treatment was discontinued. He was found to be HIV positive 4 months after structured treatment interruption. He denied having had any sexual relationship with other sexual partners during this period, as well as any other risk factor for HIV transmission. Moreover, genetic sequencing of the viruses, which was performed in both patients at the same date, revealed minor mutations on the protease gene (L63P, A71V, and V77I) in both patients without any mutation on reverse transcriptase, which is another point to suggest the virus transmission by our patient.

Our HIV infected patient told us that he practised safe sex systematically during the first years of HIV infection, but that it was less systematic when viral load became undetectable (around 20% of unprotected sexual intercourse during the past 2 years with this partner). He practised safe sex during the first structured treatment interruption, but not during the second one. Both of them denied any record of sexually transmitted infection except HIV. They were found to be negative for hepatitis B and C and syphilis.

Structured treatment interruption is an attractive strategy currently in evaluation in HIV-1 infected patients after long term viral suppression. As far as we know, antiretroviral interruption does not reduce therapy efficacy once reinitiated, delaying the reduction of viral load.[1] During the phase of drug interruption, plasma HIV RNA rebounds to detectable levels within days of stopping HAART (median increase 0.2 log/day).[2] HAART treatment decreases HIV RNA concentration in blood and is generally associated with a decrease of seminal HIV RNA.[3] Moreover, an increase of HIV RNA in plasma is known to enhance the risk of transmission.[4] Finally, we may assume that a sudden increase in HIV RNA in blood during structured treatment interruption may induce a viral rebound in semen.

Some key messages have to be taken into account. Firstly, the impact of sexual transmission during clinical trials assessing the benefit/risk ratio of structured treatment interruption has to be evaluated prospectively as a side effect of the strategy. Secondly, patients have to be informed that they are particularly at risk of HIV transmission during this period and that sexual relations have to be heavily protected when antiretroviral regimen is stopped. It is the responsibility of investigators involved in such trials to inform patients. Thirdly, in order to avoid complaints against physicians, we believe that patients must be informed of this very high risk period.

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Chaperoning in genitourinary medicine clinics

In 1996 the General Medical Council recommended, where possible, offering chaperones to patients during intimate examinations. This advice was incorporated into a report from a Royal College of Obstetricians and Gynaecologists working party.[1] Subsequently, Torrance *et al* performed a postal survey of practice in 175 genitourinary medicine (GUM) clinics in the United Kingdom.[2] This study also concluded that chaperones should be offered to patients more widely during genital examinations in genitourinary medicine (GUM) clinics.[2] In contrast, other studies have shown that male patients are comfortable with genital examinations being performed by doctors of either sex,[3] and that it is not necessary to provide a chaperone when male patients are examined by a male doctor.[4]

We carried out a postal survey of the use of chaperones in 31 GUM clinics in the North Thames Region in order to assess current practice. Responses were received from 20 centres (64.5%). Only two (10%) clinics had a written clinic policy and only one (5%) had carried out a patient survey on views about the provision of chaperones. None of the clinics had carried out a staff (nurses and doctors) survey of their views about chaperoning.

We identified two interesting observations (table 1). Firstly, there was a significant difference in provision of chaperones for female patients, depending on whether the person carrying out the examination was a female doctor (12/20) or a female nurse (1/20); Yates's corrected χ^2 test = 11.40, 1 df, $p<0.001$. Secondly, there was a difference in provision of chaperones for female patients examined by female doctors (12/20) compared with male patients examined by male doctors (2/20); Yates's corrected χ^2 test = 8.90, 1 df, $p<0.003$ (table 1).

In addition, it was noted that in 18 clinics not offering routine availability of chaperones for male patients being examined by a male

Table 1 Results of a postal survey of practice in 20 GUM clinics in the North Thames Region

	Chaperone offered	
	Yes	No
Female patient:		
Female doctor	12	8
Female nurse	1	19
Male doctor	20	0
Male nurse*†	12	0
Male patient:		
Female doctor‡	4	15
Female nurse§	3	15
Male doctor	2	18
Male nurse†	1	18

*Seven clinics do not allow this interaction; †one clinic does not have male nurses; ‡one clinic does not allow the interaction; §two clinics do not allow this interaction.