July 2007

Clinical Letter

Medical Director

I hope you are well and warm. I sit writing this column on the Winter Solstice – it always makes me happy to think that the days get longer from here on in!

The Clinical Newsletter is packed this quarter – it really has a sexually transmissible infection theme. There is a practical and straightforward look at the treatment of genital warts by Damian Conway and Cathy Pell and while on the subject of warts, Judi Cornell has written a patient friendly piece on trying to understand the dilemma that is HPV infection. You might even find it useful to photocopy this piece as a patient handout! Deborah Bateson, meanwhile has been looking at some interesting research into female controlled methods to prevent HIV transmission - did you know that;

'HIV/AIDS is rapidly becoming a women's epidemic with women making up half of the approximately 14,000 people infected with HIV every day'?

Australia truly is the lucky country where HIV/AIDS is concerned, but there is no room for complacency and I recommend you read Deborah's fascinating exploration into the largely unknown (at least to me) world of the role of microbicides in HIV.

I hope you have registered for our Conference and Open Day on the 11th August – if not you can download the program and application form from our website fpahealth.org.au Enclosed with the Newsletter is information about the Australasian Menopause Society Congress in Adelaide 14-16 September 2007. The program for this is brilliant, and looks particularly at the issues of the younger woman going through menopause – I'll be there, hope to meet up with you! Dr Christine Read

The Treatment of Genital Warts

Treatment at home is often preferred by patients who may be inconvenienced by repeated visits to the doctor. Home therapy applied by the patient or their partner saves healthcare resources and gives the patient control over their treatment. Before home therapy is prescribed, however, the patient requires education regarding the recognition of lesions, side-effects and adverse reactions to therapy and teratogenicty of drugs.

Appropriate choices for self treatment:

Wartec paint 0.5% (podophyllotoxin) self-applied bd for 3 consecutive days, then rest for 4 days; repeat cycle weekly until lesions resolve. Wartec paint is best used for lesions that the patient has a clear view of – if the patient has perianal warts on the other hand, Wartec cream 0.15% should be used as the same degree of accuracy with application is not required.

Aldara (imiquimod 5%) cream self-applied 3 times weekly on alternate days nocte and wash off in the morning for 8-12 weeks is highly effective, but expensive.

Other treatments:

Cryotherapy with liquid nitrogen or CO_2 sprays applied by doctor/nurse.

Surgical or gynae referral for **diathermy, laser ablation or surgical excision** for larger or recalcitrant lesions.

Patient information:

Provide written information about warts and transmission of human papilloma virus (HPV) infection.

Stop smoking! Advise on the link between smoking and persistence of HPV in the skin: "Every time you light up a cigarette, think of your genital warts!"

Offer **partner screening** for sexually transmissible infections (STI).

Psychological support and **counselling** around the issues of how it feels to have an STI, risk to partner, likely success of treatments, how to reduce risk of transmission (low efficacy of condoms in case of HPV).

Remember that in **pregnant** women, podophyllotoxin paints cannot be used nor can imiquimod cream due to the risk of teratogenicity, hence cryotherapy would be the treatment of choice in this situation.

Contributed by:

Dr Damian Conway, Education and Training Division Manager at ASHM and CMO in Sexual Health at Royal North Shore Hospital, St Leonards

Dr Cathy Pell, Primary Care Liaison Officer at ASHM and HIV Community Prescriber at Taylor Square Private Clinic, Darlinghurst

Microbicides – what, why and where are we now???

I was was lucky enough to be invited along to the first Australian Microbicide Symposium in May of this year. This was convened by the Australian Reproductive Health Alliance with participants from a wide variety of backgrounds in the world of sexual and reproductive health.

HIV/AIDS is rapidly becoming a women's epidemic with women making up half of the approximately 14,000 people infected with HIV every day. NIH-funded studies have found that marital sex is the greatest HIV risk for women around the world indicating that prevention programs that take a 'just say no' approach and encourage men to be monogamous are unlikely to be effective. Millions of women lack the social and economic power to insist on HIV prevention measures such as condoms, abstinence or mutual monogamy.

What are microbicides?

An alternative female-controlled strategy comes in the form of microbicides – a range of products that share the ability to prevent the sexual transmission of HIV and other STIs when applied topically in the vagina. A microbicide could be delivered as a gel, cream, suppository, film or lubricant or in the form of a sponge or vaginal ring that slowly releases the active ingredient. They could prevent HIV by either killing or immobilizing the virus, by creating a barrier between the virus and the vaginal cells or by preventing the infection from taking hold after it has entered the body.

Many women want to get pregnant - for their own reasons and/or to achieve the status and security that, in many societies, may only be attained through motherhood. It would be important to have both non-contraceptive microbicides as well as "dual-action" products so that women and couples can protect their health and still have children.

Why advocate for microbicides?

When used consistently and correctly, male or female condoms are likely to provide better protection against HIV and STIs than microbicides, so they will still be the preferred option. But for people who cannot or will not use condoms, and particularly for women whose partners refuse condoms, using microbicides can save lives and have a substantial impact on the spread of HIV. A mathematical model has shown that if even a small proportion of women in lower income countries used a 60% efficacious microbicide in half the sexual encounters where condoms are not used, 2.5 million HIV infections could be averted over 3 years.

Where are we now?

Scientists are currently testing many potential substances although there is no safe and effective microbicide currently available to the public. There are more than 30 product leads at the pre-clinical level, including 10 that have proven safe and effective in animals and are now being tested in people. However, vital lessons have been learnt from the early closure of three large scale efficacy trials: 892 women enrolled in a study of Nonoxynol-9 in Africa and Thailand were found to be at increased risk of HIV through its irritant effect on the vaginal mucosa (despite this agent having been used safely as a spermicide for over 30 years); two large phase III trials of an HIV-fusion inhibitor gel called cellulose sulfate were closed in January 2007 due to increased incidence of HIV in the treatment arm. It is therefore essential that early safety indicators are in place to ensure trial participants are not at increased risk of infection.

Despite the potential market size, neither pharmaceutical nor major biotech companies have made significant financial investments in the field because they see it as too much financial risk for too little return. As a result, the task of microbicide development has fallen to scientists at non-profit organizations, universities and small biotech companies, all of which rely on government grants and foundation contributions. The Global Campaign for Microbicides has been set up to ensure that the science in this important area proceeds, that there is accountability in relation to access and use of microbicides and that advocacy for their development and use is sustained. Visit the website at *www.global-campaign.org/download.htm*

Dr Deborah Bateson Medical Coordinator

Congratulations to our
" Quick Combined Hormonal Contraceptives and Migraine quiz" prize winner - Dr Margaret Hamilton of Cremorne:

Just a reminder: combined hormonal contraceptive methods are contraindicated in women who have migraine with aura; an aura may not always be followed by a headache. Among women with migraine, those using COCs have a 2- to 4-fold increased risk of stroke compared with women who do not use COCs; women using sumatriptan for acute migraine where there are no other contraindications fall into the WHO Medical Eligibility Criteria for Contraceptive Use Category 2: i.e. a situation "where the advantages of the method generally outweigh the theoretical or proven risks".

The HPV Dilemma – Frequently Asked Questions.

What is HPV? Human Papilloma Virus. This must be present for the development of cervical cancer.
How do you get it? HPV enters through tiny abrasions in the skin, usually during sexual intercourse. Condoms provide only partial protection.
How do you know you have it? You don't! There are commonly no symptoms, it is usually transient, harmless and 90-97% of women clear HPV naturally.
How common is HPV? Extremely! Consider it the common cold of sex. It is estimated that 80% of sexually active women and men will be exposed to HPV in their lifetime.
How long does it last? It usually takes your immune system 8-14 months to clear.
Why is HPV a problem? A small percentage of women that don't clear the virus may develop cervical cancer.

Pap tests: **why are these so important?** This test looks for cell changes in the cervix. Low grade changes reflect acute infection with HPV. It is estimated that there are 100,000 cases each year in Australia and most of these revert back to normal. High grade changes occur in 15,000 women each year. Without treatment some will become cancer. Cervical cancer normally takes 10 years to develop; 800 new cases are diagnosed each year and 250 Australian women die from cervical cancer each year. Notably 70% of these women have never had a pap smear.

What about the vaccine? Gardasil is an intramuscular synthetic vaccine against HPV 6,11,16 and 18, ideally administered prior to starting sexual activity. It is not designed to treat HPV infection. Gardasil is approved for use in females aged 9 – 26 and males aged 9 – 15. The current government sponsored program is for 12 – 26 year old females. Cervarix is a synthetic vaccine against HPV 16 and 18 and is approved for use in 10 – 45 year old females.
Note that the vaccines do not prevent cancer from other HPV types, so Pap tests are still required.

Already exposed to HPV 16 or 18? Vaccinated women remain at risk of disease from HPV present at the time of vaccination and newly acquired infections with other HPV types so they need ongoing Pap tests. There are no known adverse effects from the vaccine if already exposed to these types.

HPV Tests: what is their role?
HPV DNA test (Digene's Hybrid Capture 2) can detect the presence of 13 high risk HPV types . Medicare funds a "test of cure" following treatment to the cervix of high grade lesions using this test. It is important to note that there is no treatment required for HPV if the Pap test is normal.
Tampap: This is an HPV test for 17 high risk HPV types. It involves self collection of a vaginal sample by inserting a tampon for 10 seconds then posting it to a pathology company. It costs $50 and is marketed through doctors or pharmacists and results must be collected from these health professionals. This test may sound very appealing to a lot of women but it is important to note that Tampap does not replace the pap smear as it does not detect abnormal cells on the cervix, only the presence of HPV.
Shouldn't all women with a positive HPV test be treated? It is important to identify the women at greatest risk of developing cervical cancer - they are not ALL of the women who test positive for HPV infection. Prevalence studies indicate that 23% of Australian women will be positive for high risk HPV and that it is more common in young women. Most of the infections will clear, so there may be a lot of unnecessary worry for these women; they may even think that they have cervical cancer!

So what does a positive HPV test mean?
It may be due to transient HPV infection that is not associated with any cervical abnormality (especially in women younger than 30 years) and requires no treatment. These women are usually asymptomatic and their immune system clears the infection.
A positive result is more relevant in the older woman.
A positive result in a woman older than 30 may reflect a persisting infection which is associated with a higher risk of developing cervical cancer. Conversely, a negative result in an older woman is very reassuring in a woman with an abnormal Pap test result.
In the future HPV testing may be used as a triage tool to guide management of cervical abnormalities including follow up and treatment options.
It is important to be aware that;
HPV testing does not replace the Pap test.
Vaccination does not replace the Pap test.
No screening test is needed prior to vaccination or Pap tests –future recommendations may change our management, but at the moment the Pap test every 2 years is still the best test.

Contributed by Dr Judi Cornell FPNSW

All FPA Health Medical Education courses are exempt from GST

MEDICAL EDUCATION COURSES

SH&FPA Certificate in Sexual and Reproductive Health

This course is recognised by RANZCOG and ACHSHM. It is also recommended by the RACGP for all trainees wishing to increase their knowledge base and clinical skills in sexual and reproductive health. **(RACGP CPD Points - 60 Category 1 - have been allocated for this course. Clinical Training module receives additional 30 Category 1 points).** Financial members of the GP Registrars Association can obtain a discount of $150.00

Dates: 14-19 October 2007
Time 9.00am - 5.00pm
Cost: $1500.00 (all 3 modules)
(includes course materials, lunch and clinical training)

Management of Menopause

This six hour Active Learning Module aims to enhance your practical skills in managing menopause.

RACGP CPD 30 Category 1 Points (Active Learning Module) allocated

- Review current thinking about menopause management
- Case studies with feedback and discussion
- How to prescribe, give relevant patient information and follow up useful resources and websites will be identified to enhance practice

Dates: Saturday 17 November 2007
Time: 9.00am-3.30pm ***Cost:*** $175
Venue: Family Planning Ashfield

Applications can be downloaded from www.fpahealth.org.au or contact Course Coordinator 02 8752 4335

FPNSW CONFERENCE and OPEN DAY 11th August 2007

Plenary Sessions 9.00am—1.30pm

Menopause and More: *Prof Rod Baber Director RNS Menopause Unit*
Sexual Rights and the Law: *David Buchanan SC Barrister*
Big Boofy Blokes and their Health: *Dr Ray Seidler GP*
Pills Rings and Things: *Dr Christine Read Medical DirectorFPNSW*
What's New Under the G String?: *Dr Gayle Fisher Dermatologist RNS*
Leaking Down Under: *Prof Kate Moore & Dr Emmanuel Karantanis Pelvic Foor Unit St George*

Concurrent Sessions 2.15-5pm

Implanon Insertion Training : *Dr Judy Gardiner FPNSW*
Sex Aids: *Loretta Healey, Senior Counsellor Sexual Health Service*
Disability and Sex : *Patrick Duley Senior Health Promotion Officer FPNSW*
Young, Gay and What to Say? *Liz Hammond, Manager Health Promotion FPNSW*
Cervical Screening Upskilling/HPV&NH&MRC Guidelines: *Dr Deborah Bateson Medical Coordinator Ashfield fPNSW*
Sticky Moments: *Dr Tania May Medical Coordinator Fairfield & Penrith FPNSW*
Sexually Transmissible Infections Update: *Dr Lynne Wray Manager Clinical Services Sydney Sexual Health*

Registration Fee $150.00 Application Form can be downloaded from www.fpahealth.org.au for more information contact Iris Lawler 02 8752 4335

FPNSW Steroidal contraception module online (30 Group 1 points) go to: http://www.thinkgp.com.au/education

Whether donating by cheque or credit card, please complete the following and a receipt will be issued to you.

Donations to the Family Planning NSW Foundation are tax deductible.

Name: Address:

State: Postcode: Telephone:

Donation by Cheque: Please make your cheque payable to Family Planning NSW Foundation and send it to Karen Gannon at 328-336 Liverpool Road Ashfield NSW 2131. Please fill in the above details and enclose with your donation.

Donation by Credit Card: Visa ☐ MasterCard ☐

Card no ________/_________/________/_________ Expiry_______/_______

Amount: $50 ☐ $100 ☐ $200☐ Other ________

Quick "HPV" Quiz

1. Low grade changes detected on a Pap test mostly reflect acute HPV infection **T/F**
2. The quadrivalent vaccine Gardasil© is approved for use in females aged 10 to 45 years **T/F**
3. Pap tests are no longer necessary for women immunized with an HPV vaccine **T/F**
4. Women with a positive test result for high risk HPV types who have a negative Pap test result do not require treatment. **T/F**

Name: ....

Address:...

Contact number:..............................Email: ....

Please fax us your answers to 02 9716 5073 (answers will be supplied in the next newsletter). A draw will be made of all correct answers on the 1st October 2007 and the winner will receive a $100 voucher from the FPA Healthrites Bookshop.