SEXUAL HEALTH ESSENTIALS FOR GPS

Dr Helen Lawal

GP and Locum Leeds Sexual Health

Challenges of managing sexual health as a GP…

Embarrassment

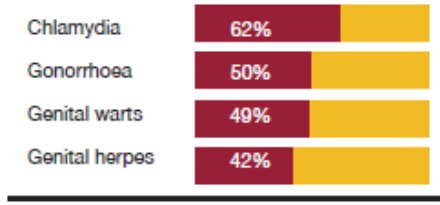
10 minutes

Which swabs do I use in which orifice?

When should I refer?

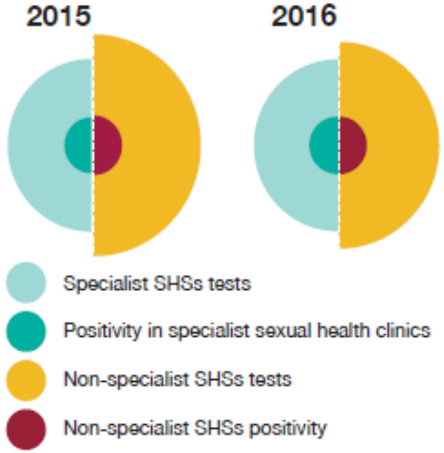
Young people are more likely to be diagnosed with STIs

Compared to those aged 25-59 years, STI diagnosis rates in 15-24 year olds are twice as high in men and seven times as high in women



In 2016, among heterosexuals attending sexual health clinics, most chlamydia diagnoses were in people aged 15 to 24 years

There was a 9% decline in chlamydia tests and a 2% decline in chlamydia diagnoses reported in young people aged 15 to 24 years between 2015 and 2016



There was an 8% decrease in diagnoses of genital warts between 2015 and 2016

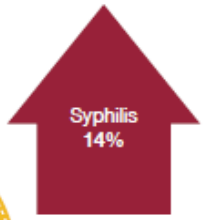
Gay, bisexual and other men who have sex with men (MSM) are more likely to be diagnosed with bacterial STIs

Amongst men diagnosed with STIs in 2016, the following proportions were in MSM

Proportion:

- 86% of syphilis
- 65% of gonorrhoea

Increase from 2015 - 2016:



HIV-positive MSM are up to 4 times more likely to be diagnosed with an acute bacterial STI than those that are HIV-negative or of unknown HIV status

Since July 2016, there has been an ongoing, geographically dispersed outbreak of hepatitis A virus in MSM

Black Minority Ethnic (BME) populations are disproportionately affected by STIs

3x

The rates of gonorrhoea and chlamydia in BME people are 3x that of the general population

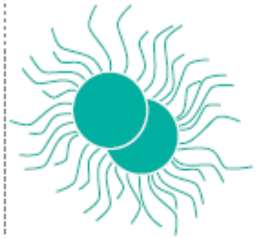
10x

For trichomoniasis, the rate in BME people is 10x that of the general population

Neisseria gonorrhoeae has developed resistance to most antibiotics used for treatment

The first case of treatment failure with dual-therapy (ceftriaxone/azithromycin) in a patient with gonorrhoea was reported in England in 2016

The prevalence of resistance to azithromycin, one of the antibiotics currently used to treat gonorrhoea, was 10% in 2015 and an outbreak of high-level azithromycin-resistant *N. gonorrhoeae*, first identified in Leeds in 2015, spread to other parts of England in 2016



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Terminology

CMP= Casual Male Partner / CFP= Casual Female Partner

RMP= Regular Male Partner/ RFP= Regular Female Partner

UPSI= unprotected sexual intercourse

LSI= Last sexual intercourse

UPVI = Unprotected Vaginal Intercourse

UPOI= Unprotected Oral Intercourse

UPAI= Unprotected Anal Intercourse

RAI= Receptive anal intercourse

IAI= Insertive anal intercourse

PEPSE= Post exposure prophylaxis

PrEP= Pre exposure prophylaxis

SEXUAL HEALTH HISTORY TAKING

In a Nutshell

Dr Helen Lawal

Key Questions

- The symptoms you have described can sometimes be caused by a sexually transmitted infection/ be related to sex- do you mind If I ask you some more questions about this?
- Are you sexually active?
- When was the last time you had sex?
- Have you had sex with anyone new in the past 12 months?
- Do you have sex with men, women or both?
- When was your last STI check up?
- Have you come in contact with someone with an STI?
- Have you ever had an STI?

Discharge

"Have you noticed any change in your usual vaginal discharge? Does it smell? What colour is it? Is it itchy?"

"Have you noticed any discharge from the penis?"

Urinary Symptoms

"Do you have any pain when passing urine? Do you feel you are going more often?"

Bleeding

"Any bleeding after sex or in-between your periods?" or "Any change in your usual periods or pattern of bleeding?"

Genital skin changes

"Have you noticed any blisters, spots or ulcers near the vagina or anus?" " Any itchiness"

Pain

"Have you had any pain when passing urine? Any pain in the testicles, scrotum or groin?", Or

"Any Abdominal pain? Any pain during sex? If so is it in the vagina or deep inside your stomach?"

High Risk Questions

IVDU: *Do you or any of your partners inject drugs?*

CSW: *Have you ever paid for or been paid for sex?*

MSM: *Have you ever has sex with a man? Have you ever had sex with a man who has sex with men?*

Endemic countries: *Where were you born? Have you had sex with anyone that was born abroad?*

HIV: *Have you had sex with anyone who has HIV?*

MSM and Women's Health

Women's Health

- LMP
- Last cervical smear
- Contraception
- Pregnancies

MSM Health

- *Any rimming or fisting?*
- *Have you had group sex or used a sauna or dark room?*
- *Any chemsex?*

SEXUAL HEALTH TESTS & EXAM

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Asymptomatic Screen

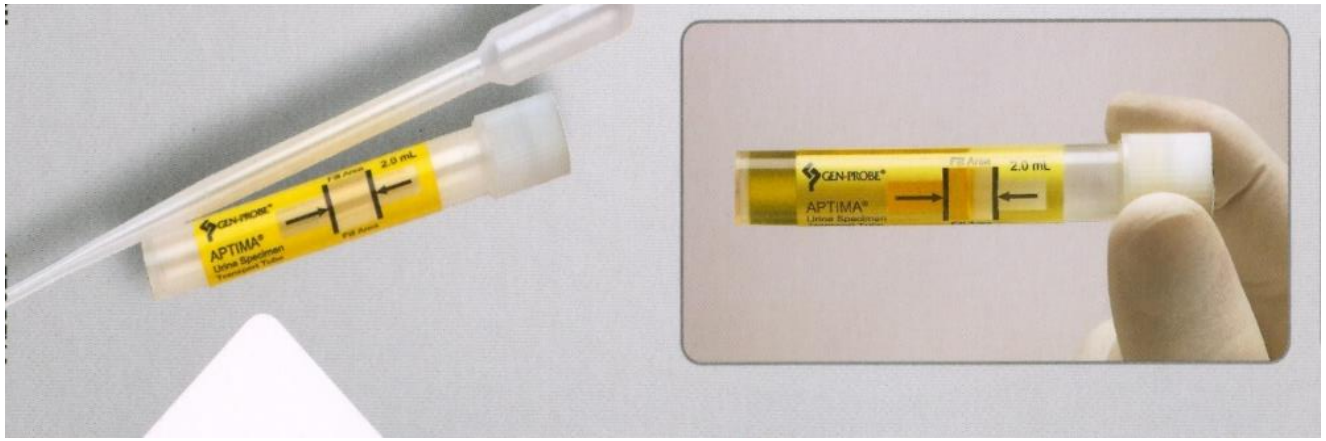
Chlamydia/ Gonorrhoea NAAT test:

- Female- self taken vulvo-vaginal swab (VVS)
- Male- first pass urine (FPU)
- Consider pharyngeal and rectal swabs

Blood tests:

- HIV, Syphilis +/- Hepatitis B
- Window Period


UNIVERSAL CONTAINER
NAME


GEN-PROBE
APTIMA
2.0 mL
GEN-PROBE
APTIMA
2.0 mL

How to take your Vaginal swab

Leeds Centre for Sexual Health

Wash and dry your hands first.

The pack contains a swab stick and a plastic container.

Do not place the swab stick directly on any surface.

Do not touch the cotton wool tip of the swab.

Ask for a new kit if you drop the swab or touch the tip or spill any of the liquid in the container

1. Getting Ready:

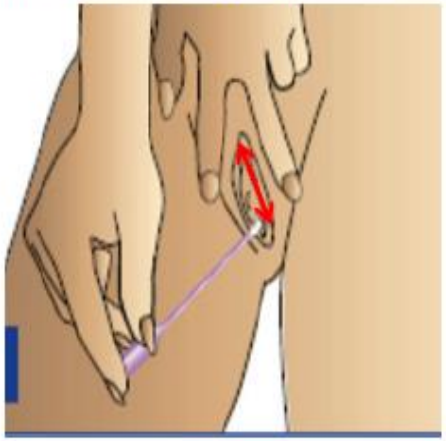
Peel open the pack. Take out the container, carefully unscrew the top and place it on a flat surface .

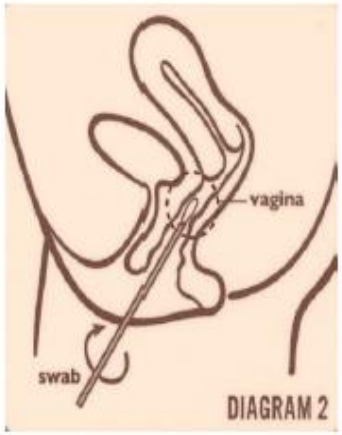
2. How to hold the swab:

Take the swab stick out of its packet and hold the plastic shaft in the middle.

3. Taking the sample

- With your legs apart, spread the opening of your vagina.
- Rub the cotton bud around the upper part of the entrance to the vagina (where the red arrow is) a couple of times.
- Then insert it 1-2 inches into your vagina. Your fingers on the middle of the shaft will stop you going in too far.
- Rotate the swab around your vagina, making sure it touches the inside wall of your vagina for 5 seconds (count to 5 slowly)
- Carefully pull the swab out.





4. To finish off:

Put the swab in the container. Make sure you do not spill any of the liquid.

Snap the stick off at the black line

Screw the lid back on tightly.

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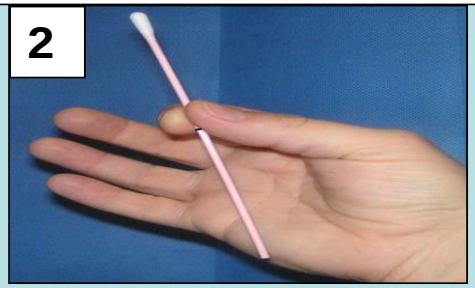
HOW TO TAKE A RECTAL SWAB

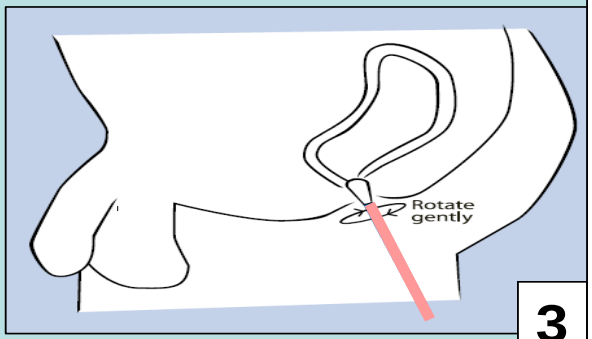
1

Step 1 - Position the patient in the left lateral position. Take the pink or blue swab from the paper sleeve.

Step 2 – Hold the swab stick just in front of the small black line.

2





3

Step 3 – Rectal samples from patients with rectal symptoms should be taken using a proctoscope. Anorectal samples from patients without symptoms may be obtained by 2-4cm blind insertion of the pink or blue swab into the anal canal using lateral pressure to avoid any faecal mass - gently insert the swab into the patient's anus and slide it in a few cm until your fingers are near their anus. Rotate the swab around the rectal walls for 5-10 seconds.

Step 4 – Carefully remove the swab and put the cotton end in the liquid medium. Then snap the stick off at the black line and securely replace the lid. **DO NOT** touch the swab on anything between the paper package and the patient's orifice. **Label tube as 'rectal'.**

4

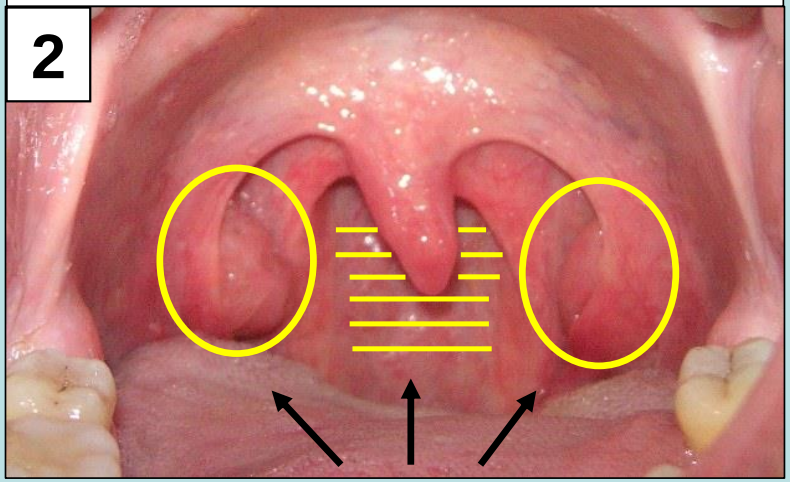
HOW TO TAKE A PHARYNGEAL SWAB

Step 1 - Take the pink swab from the paper sleeve.

1

Step 2 – Ask the patient to open their mouth as wide as possible and say "Ahh". Wipe the cotton tip of the swab around the throat: over the tonsils on both sides and on the very back part of the throat behind the uvula. Try not to touch the teeth, cheeks or tongue with the swab.

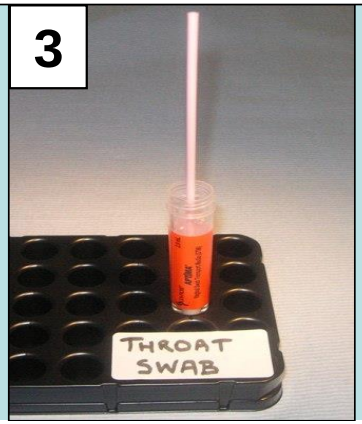
2



Swab from these 3 areas

Step 3 - Carefully remove the swab and put the cotton end in the liquid medium. Then snap the stick off at the black line and securely replace the lid. **DO NOT** touch the swab on anything between the paper package and the patient's orifice. **Label tube as 'pharyngeal'.**

3



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Document Consent and chaperone offered
Patient should undress below waist – cover with bed roll

Female

- **Check groin for lymphadenopathy**
- **Examine vulva for lumps, bumps and ulcers**
- Speculum examination?
- Bimanual ?

Male

- Check groin for lymphadenopathy
- Examine Penis for lumps, bumps and ulcers
- Palpated testicles and epididymis

CASE STUDIES

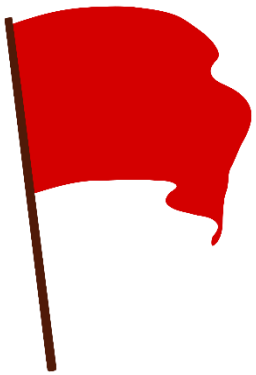
Case: Vaginal discharge

- Kate 24 y/o, 3/52 vaginal discharge
- Implant in situ
- New RMP of 3/12

What would you do next?

White and cottage cheese-like?
Fishy smell?
Any itchiness or irritation?

PID/ Red Flags



- lower abdominal pain
- deep dyspareunia
- abnormal vaginal bleeding, including post coital, inter-menstrual and menorrhagia
- abnormal vaginal or cervical discharge, often purulent

- Recurrent or persistent abnormal discharge
- Recurrent UTIs negative culture
- Superficial dyspareunia

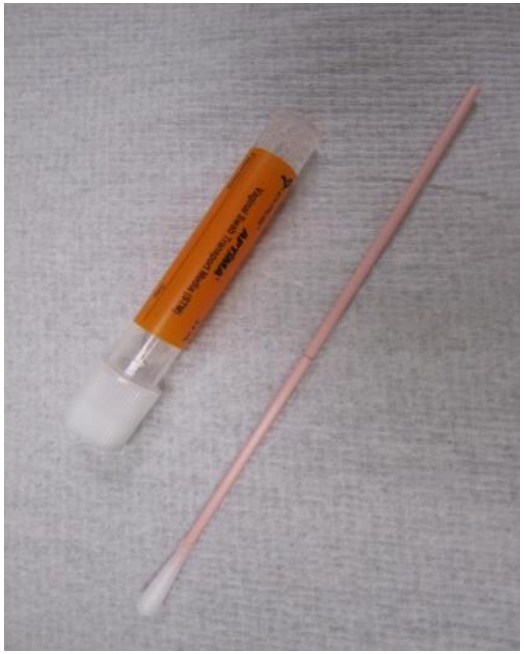
Genital examination

- Offer chaperone
- Patient should undress below waist
- Check groin for lymphadenopathy
- Examine vulva
- Swabs
- Speculum examination?
- Bimanual ?

Swabs

- If under 25 years of age, **ALWAYS offer an annual**

Chlamydia screen (NB LTHT lab will do CT/GC

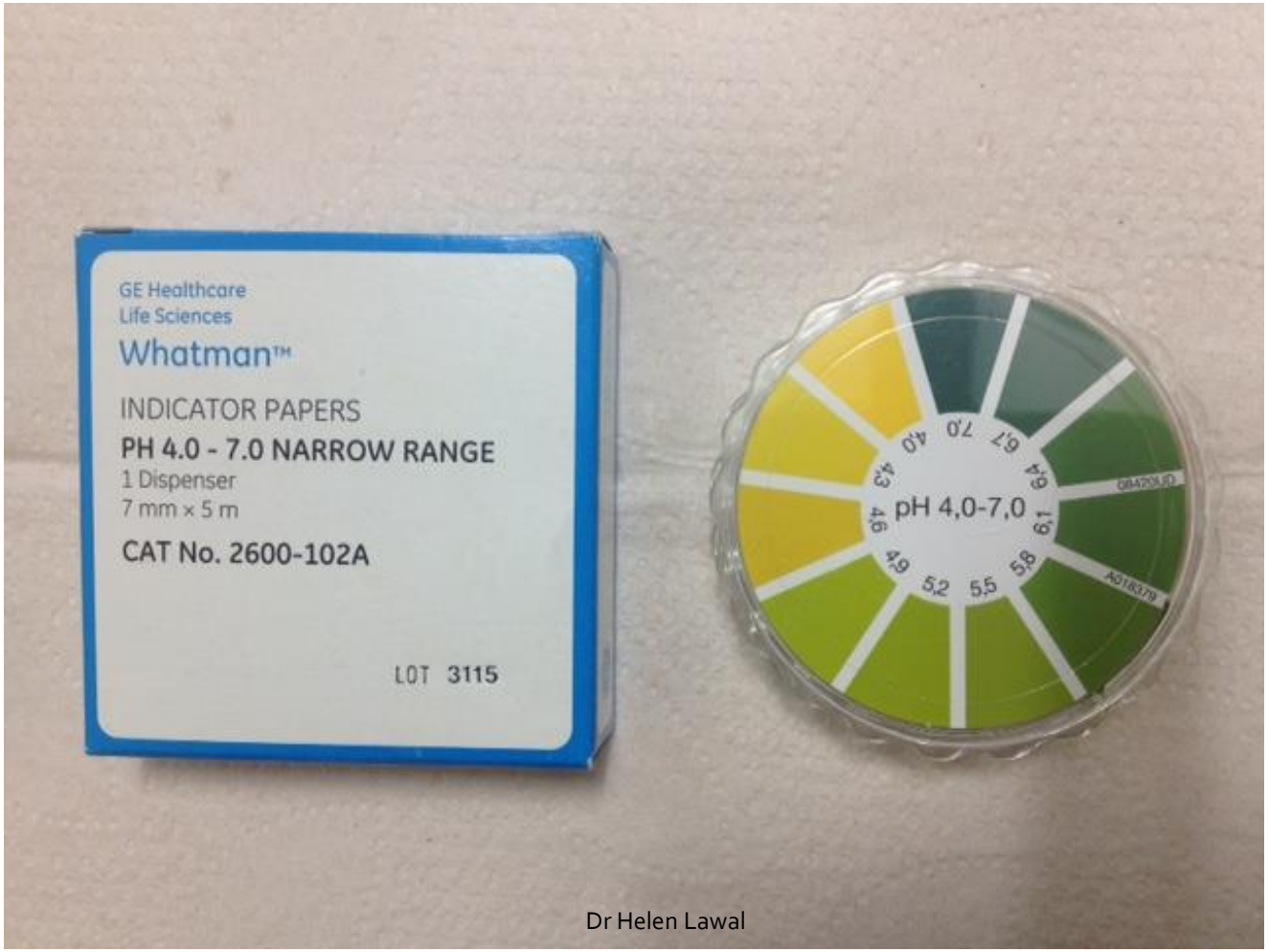


Consider NAATs for women if:

- < 25 years old
- a new sexual partner or more than 1 sexual partner in the last 12 months
- symptoms indicative of upper reproductive tract infection

- The sensitivity of these tests is high (>90%)

What's the PH?


GE Healthcare
Life Sciences
Whatman™
INDICATOR PAPERS
PH 4.0 - 7.0 NARROW RANGE
1 Dispenser
7 mm × 5 m
CAT No. 2600-102A
LOT 3115
pH 4,0-7,0
4,0
4,3
4,6
4,9
5,2
5,5
5,8
6,1
6,4
6,7
7,0

PH Testing

- Leeds lab not testing for BV
- Bedside test – vaginal pH

How to use:

- press strip of paper against mid-vaginal wall with gloved finger or with sponge-holder forceps; or take swab from same & rub on pH paper
- try & avoid touching on cervix as cervical mucus pH higher; blood also higher pH

Suggestion for use

- some are doing vaginal pH routinely at each cervical smear examination so practice nurses gain confidence in using & reading the pH/ recognising normal etc.

Vagi

Thick w
discharge/i

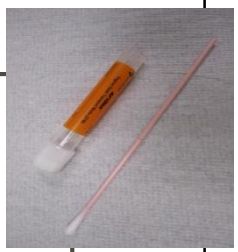
PH 3.5

Cand

hy yellow
scharge,
berry cervix

5 or Green

HINK TV



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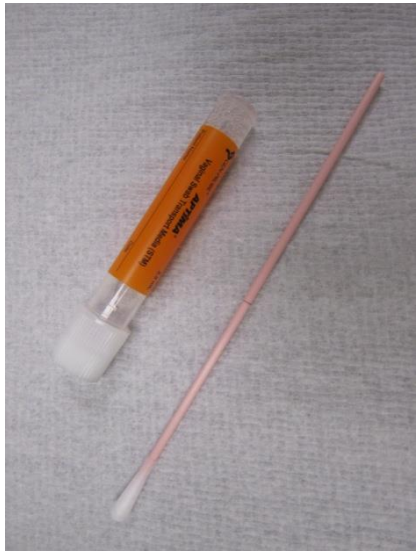
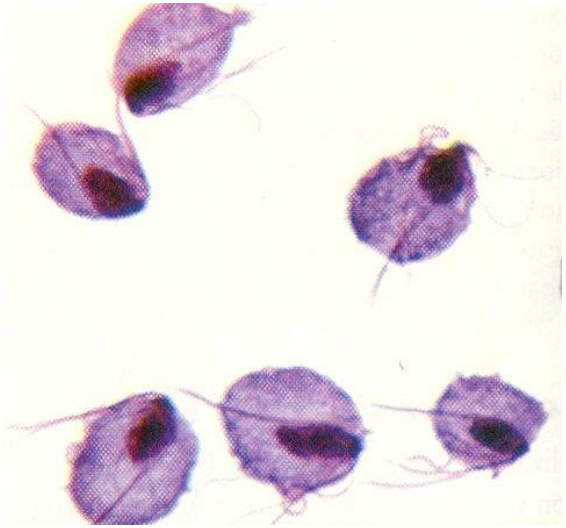
Leeds Lab- TV PCR

- TV PCR in community
- Trichomoniasis (TV)
- consider in BME groups
- overseas contact
- 'recurrent BV' or persistent discharge/dysuria





Management

Trichomonas Vaginalis

- Metronidazole 400mg twice daily for 5-7 days
- Metronidazole 2 g single dose
- TOC if still symptomatic

Case: Genital Lesions

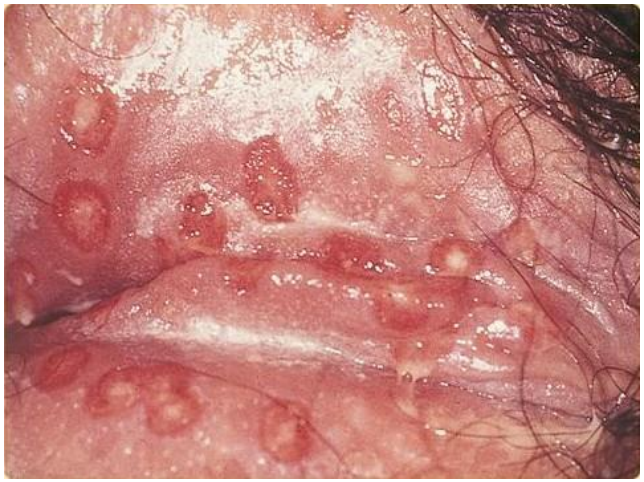
- Ros 28, VI – condom, UPOI with CMP 14/7 ago
- 5/7 painful lesions, stings when PU

What would you do next?

Examination

- Inguinal lymphadenopathy
- Clusters of vesicles/ blisters
- Discharge
- May be assoc. with

mild flu-like symptoms



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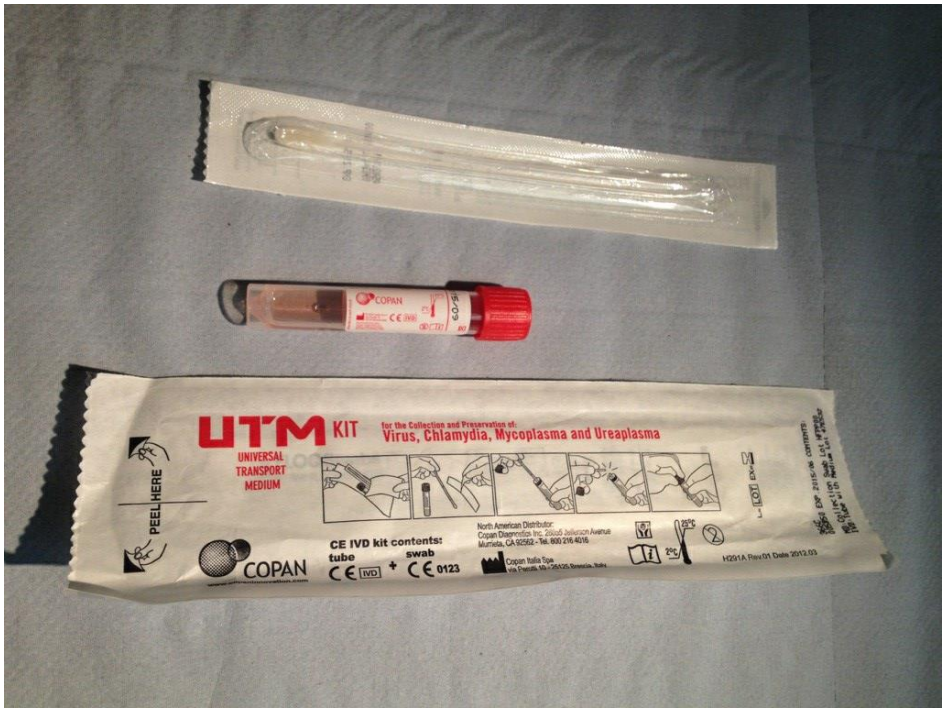
Swabs



“Virus typing to differentiate between HSV-1 and HSV-2 should be obtained in all patients with newly diagnosed genital herpes (III, B). “

HSV

The conviction of David Golding, who pleaded guilty at Northampton crown court to causing grievous bodily harm by passing on genital herpes to his former partner, Cara Lee.

Sentencing Golding to 14 months in jail, the judge said:
"Because it was in a relationship, it was particularly mean and one which amounted to a betrayal – a betrayal in a relationship in which you professed love ***… The injury you caused by this infection is at least or more serious than an injury leaving a scar because it carries continued recurrence, extreme discomfort and consequences for relationships she will have in the future****."*

The Guardian

Genital Herpes Management

- **Aciclovir 400mg TDS start within 5 days**, if new lesions or persistent systemic of symptoms
- Saline bathing
- Analgesia
- Topical anaesthetic agents, e.g. 5% lidocaine ointment or Emla
- If > 6 episodes/ year consider prophylaxis

Case:Urethral Discharge/Discomfort

- Dan 21 3/7 urethral discharge + dysuria
- LSI UPVI + UPOI 5/7 ago with CFP
- 3 CFP in past 3 months

What would you do next?

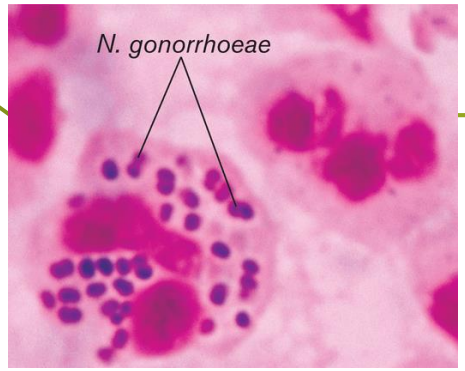
Examination

Inguinal lymphadenopathy
Purulent green/yellow discharge

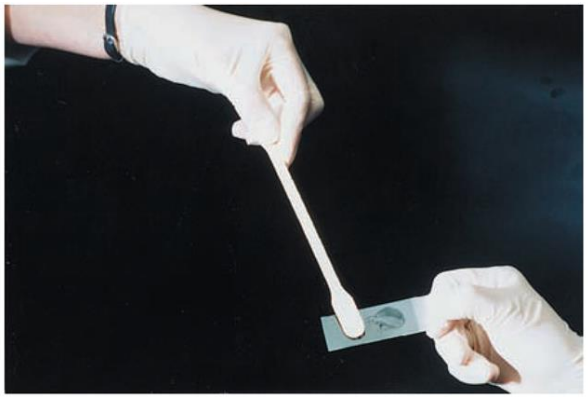
Microscopy of Gram Stained Smears

Urethral Microscopy

Pus cells — NGU



GC



NAAT + Culture Using Ecopan Swabs

Gonorrhoea Culture

- Leeds: Copan Eswabs
- Urethra, endocervix, throat, rectum

Gonorrhoea

Men

- Urethral discharge (80%) and/or dysuria (50%) within 2-5 days
- Anal symptoms in MSM
- Pharyngeal infection is usually asymptomatic (90%)

Women

- Up to 50% have Increased or altered vaginal discharge

- Super gonorrhoea-azithromycin resistant
- Cultures pre-treatment
- **Ceftriaxone 500mg I.M + azithromycin 1g stat PO**

Chlamydia

- **Doxycycline 100mg BD 7d or Azithromycin 1g stat** (95% cure rate)
- Abstain for 1 week post treatment
- Discuss partner notification
- 2/3 of contacts with test positive!
- If re-testing wait 6w after treatment

Non-Gonococcal Urethritis

- Urethral discharge
- Dysuria
- Penile irritation
- Urethral discomfort
- Nil

Micro-organism	Prevalence
C. trachomatis	11%–50%
M. genitalium	6%–50%
Ureaplasmas	11%–26%
T. vaginalis	1%–20%
Adenoviruses	2%–4%
Herpes simplex virus	2%–3%

Recommended

- Doxycycline 100mg twice daily for 7 days

Alternative

- Azithromycin 500mg stat then 250mg once daily for the next four days*

Persistent

- Azithromycin 500 mg stat then 250 mg daily for the next 4 days (To cover M gentialium) plus Metronidazole 400 mg twice daily for 5 days (TV)

Case: Testicular Pain

Mr Rogers, 75 y/o retired gardener presents with a 3 week history of pain in his left groin and testicle…

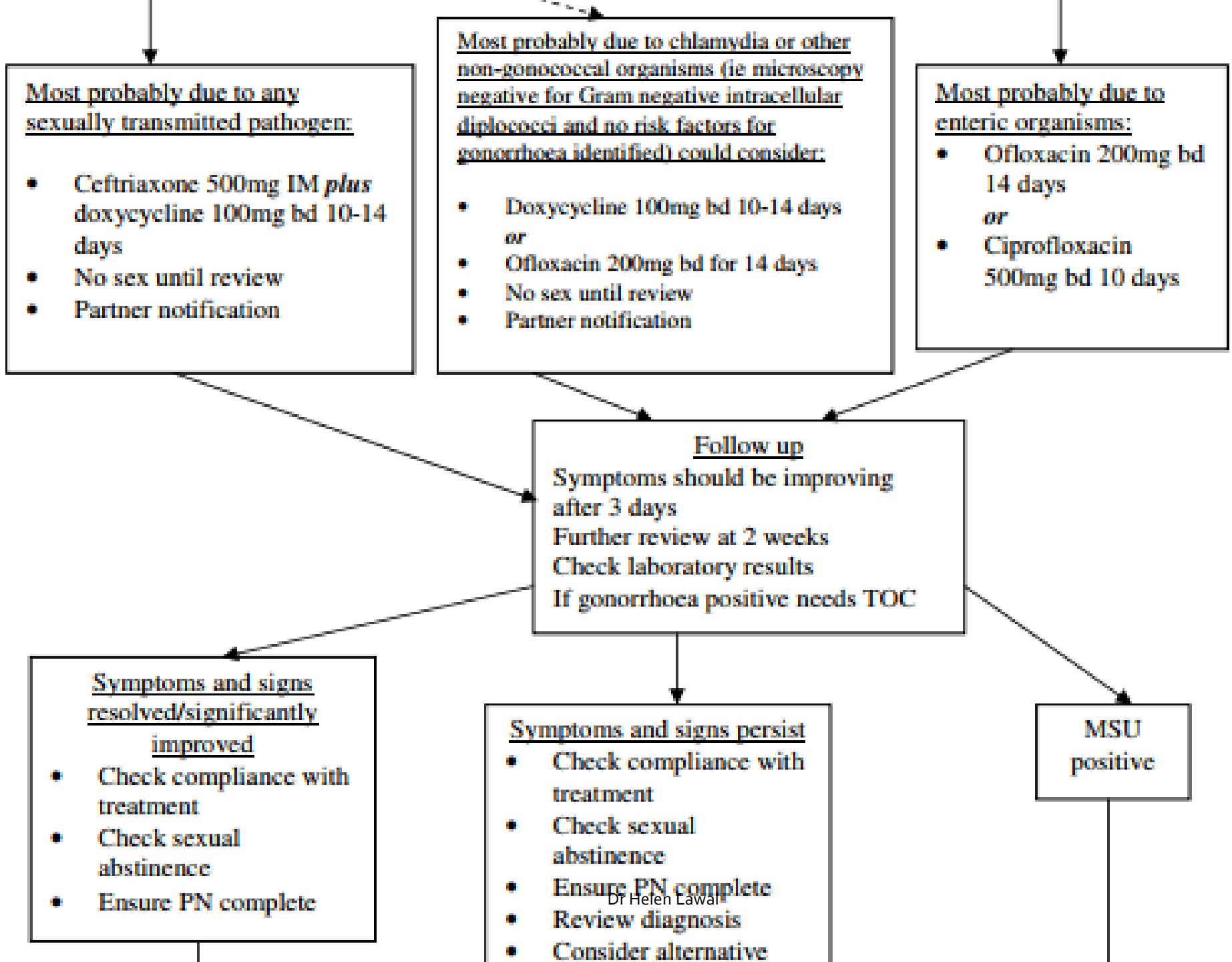
What would you do next?

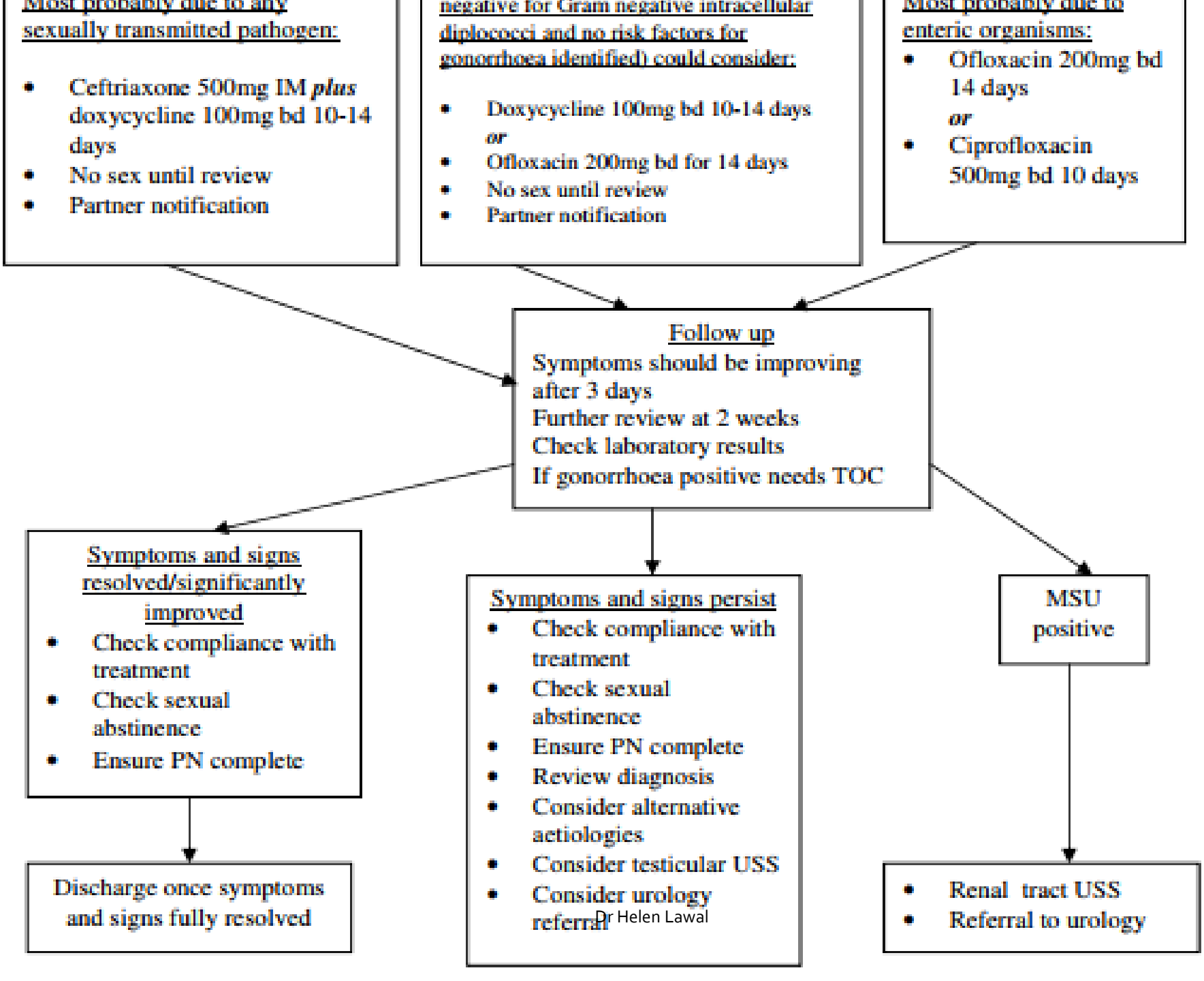
It's important to ask about sexual intercourse in patients of ALL ages!

What examination and tests would you like to do?

- Consent and offer chaperone
- Inguinal lymph nodes
- Scrotal skin inspect
- Palpate tests
- Palpation epididymis

Always send MSU for culture if treating for epididymitis





BASHH Guidelines..

Guidelines | British Assoc

British Association for Sexual Health and HIV (BASHH) [GB] | https://www.bashh.org/guidelines

British Association for Sexual Health and HIV

Search

LOGIN MENU

- All Guidelines
- Urethritis and Cervicitis
- Vaginal discharge
- Genital ulceration
- Systemic presentation and complications
- HIV
- Skin conditions
- Viral hepatitis
- Sexual history taking and STI testing
- Other Clinical Guidance Endorsed by BASHH

BHIVA/BASHH/FSRH guidelines for the sexual and reproductive health of people living with HIV 2017

No-one left behind: A declaration on 'Whole Person Care' in HIV care and support

UPCOMING EVENTS

03 NOVEMBER 2017

Gender and Sexual Minorities (GSM) SIG Biennial Conference Day

The BASHH GSM-SIG Presents: MSM from Seven to Seventy - School, Spirituality and Sex

06 NOVEMBER 2017

BASHH STI / HIV Course 2017

Modules 3 & 4

LATEST JOURNALS

Dr Helen Lawal

2 weeks later Mr Rogers returns..

The pain in his testicle has improved and on examination the epididymis is non-tender but he is still c/o pain in his left groin.

What would you do next?

- PSA?
- Hip/ L spine x-ray ?
- USS testes?

Pelvic Inflammatory Disease

Differential diagnosis of lower abdominal pain in a young woman includes:

- Ectopic pregnancy
- Acute appendicitis
- Endometriosis
- Ovarian cyst torsion or rupture
- Urinary tract infection
- Functional pain

Management of PID

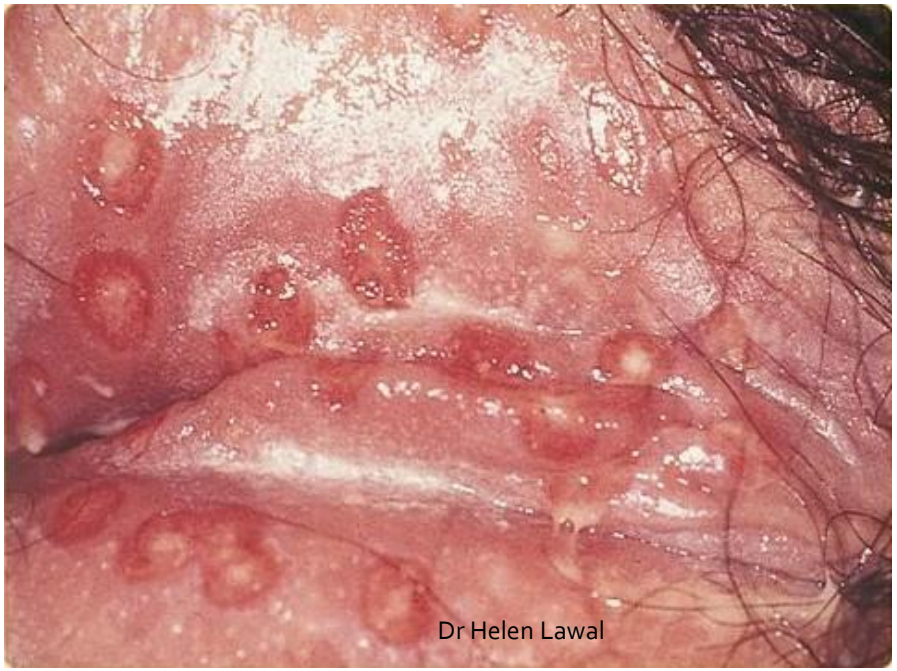
- Pregnancy test negative
- Analgesia
- STI screen

Oral ofloxacin 400 mg twice daily *plus* oral metronidazole 400 mg twice daily, both for 14 days. Levofloxacin may be used as a more convenient alternative to ofloxacin.

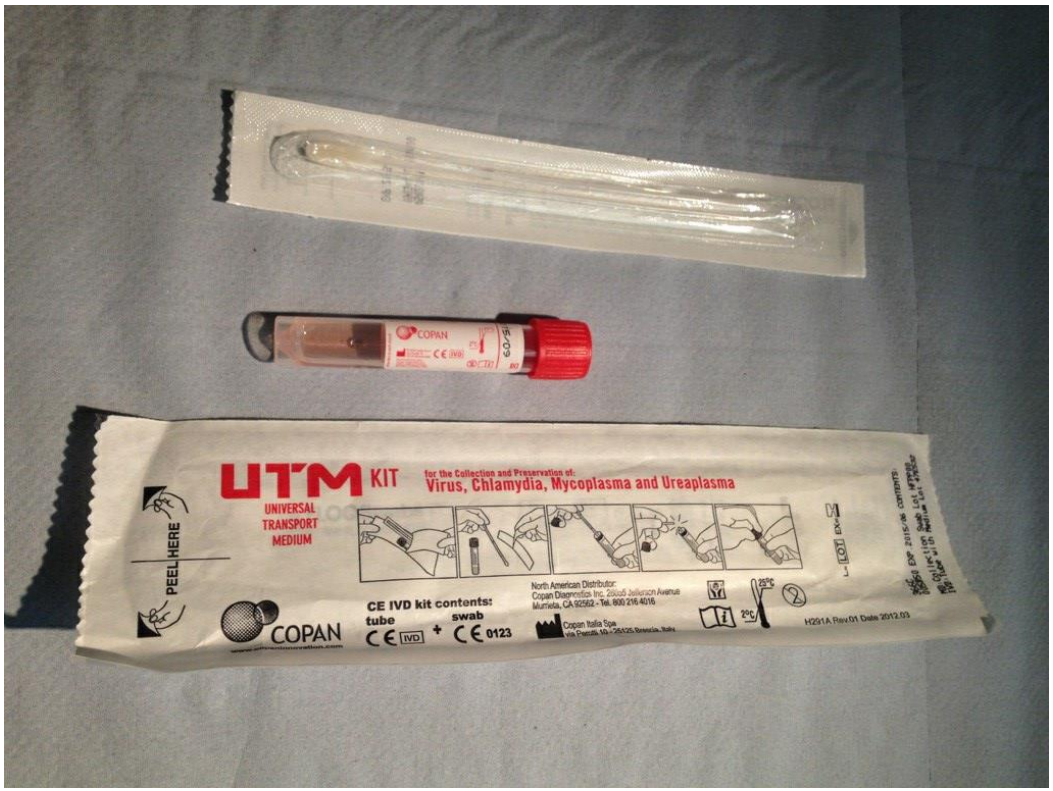
Ceftriaxone 500 mg as a single intramuscular dose, followed by oral doxycycline 100 mg twice daily *plus* oral metronidazole 400 mg twice daily, both for 14 days.

Case 3- Genital Lesions

Sarah is a 35 y/o full-time mum of 2. Presents with a 2 day history of vulval pain (burning), irritation and dysuria. She is tearful.



Viral Swab- use on any genital ulceration or suspicious lesion



Management of Genital Herpes

- Aciclovir 400mg TDS start within 5 days, if new lesions or persistent systemic of symptoms
- Saline bathing. PU in the shower/bath!
- Analgesia
- Topical anaesthetic agents, e.g. 5% lidocaine ointment or Emla
- If > 6 episodes/ year consider prophylaxis
- Must tell partner and all future partners

Must tell partner(s)..

The conviction of David Golding, who pleaded guilty at Northampton crown court to causing grievous bodily harm by passing on genital herpes to his former partner, Cara Lee.

Sentencing Golding to 14 months in jail, the judge said:
"Because it was in a relationship, it was particularly mean and one which amounted to a betrayal – a betrayal in a relationship in which you professed love ***… The injury you caused by this infection is at least or more serious than an injury leaving a scar because it carries continued recurrence, extreme discomfort and consequences for relationships she will have in the future****."*

The Guardian

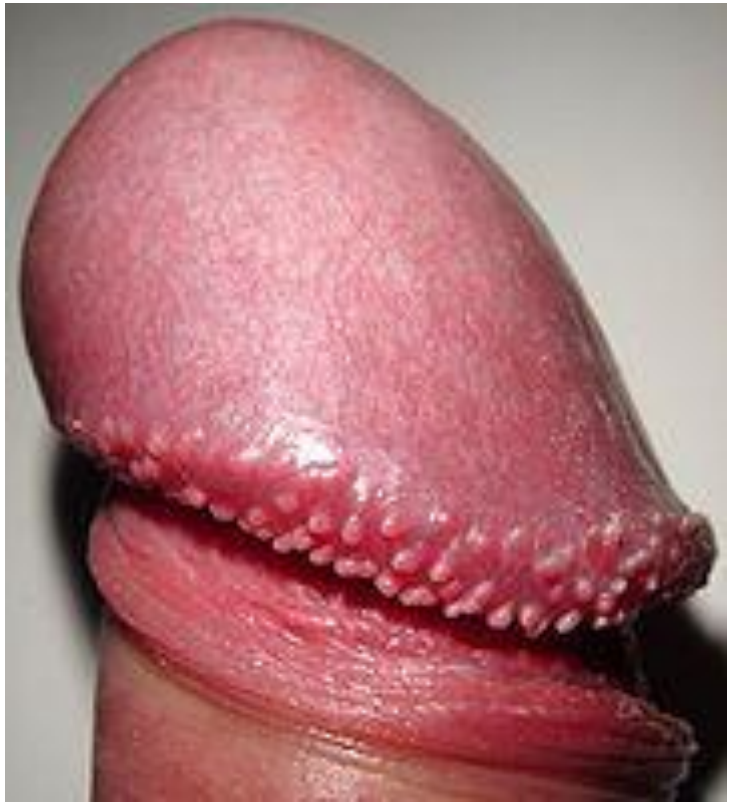
…And you must document that you have told patient!

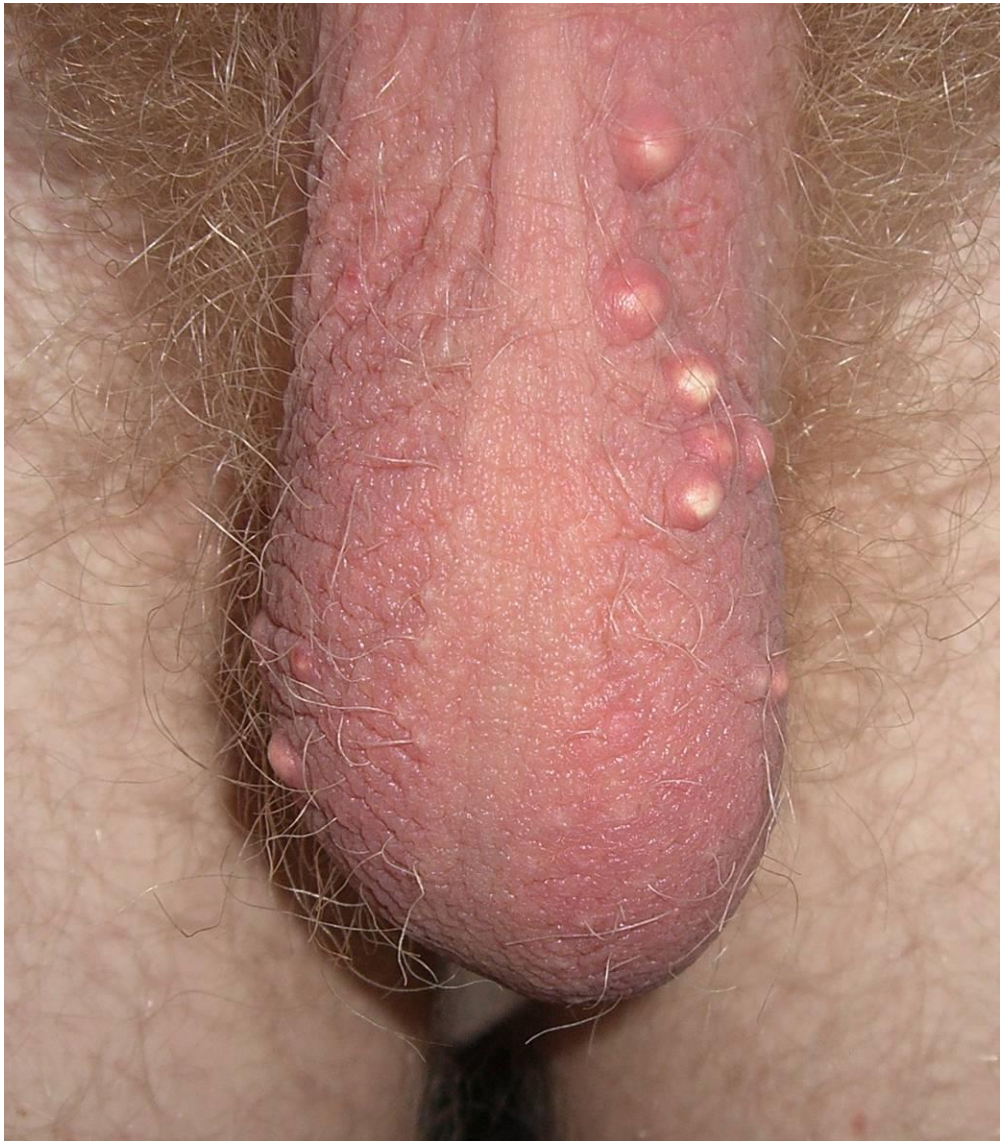
Movement break….

SPOT THE STI

Dr Helen Lawal

“I’ve got these spots on my pecker doctor”





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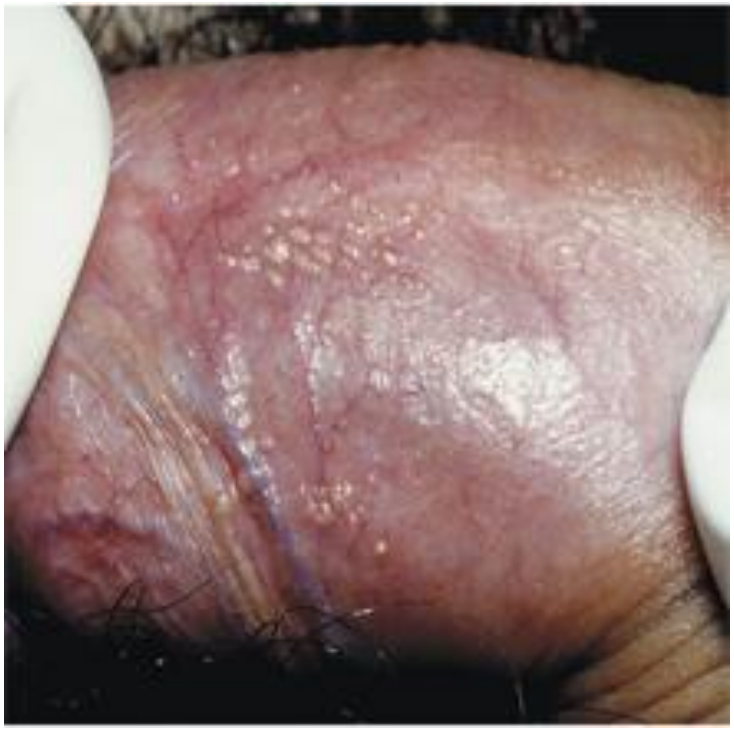

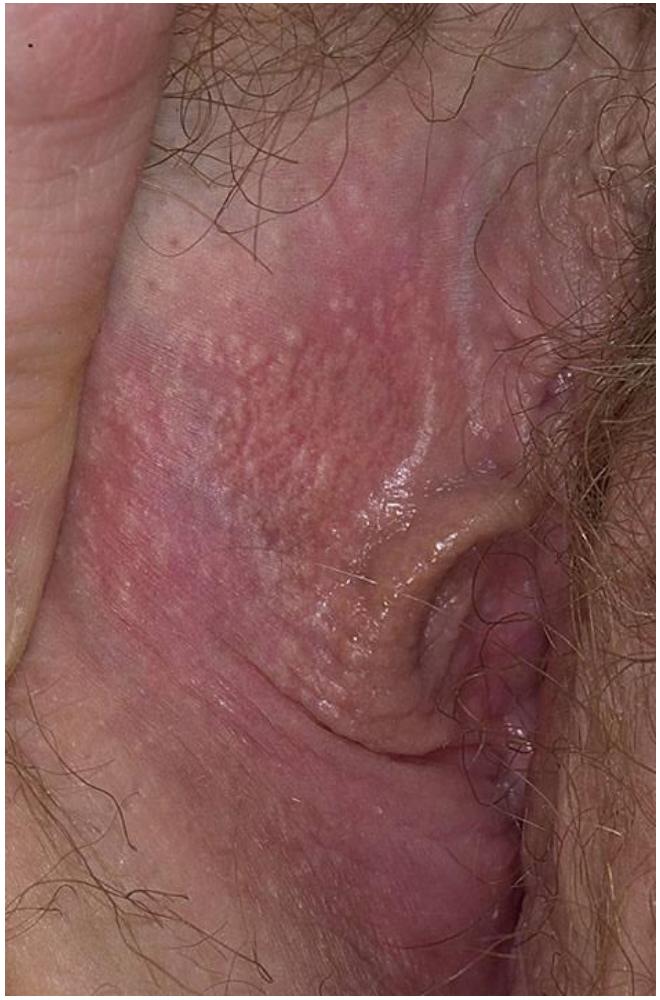

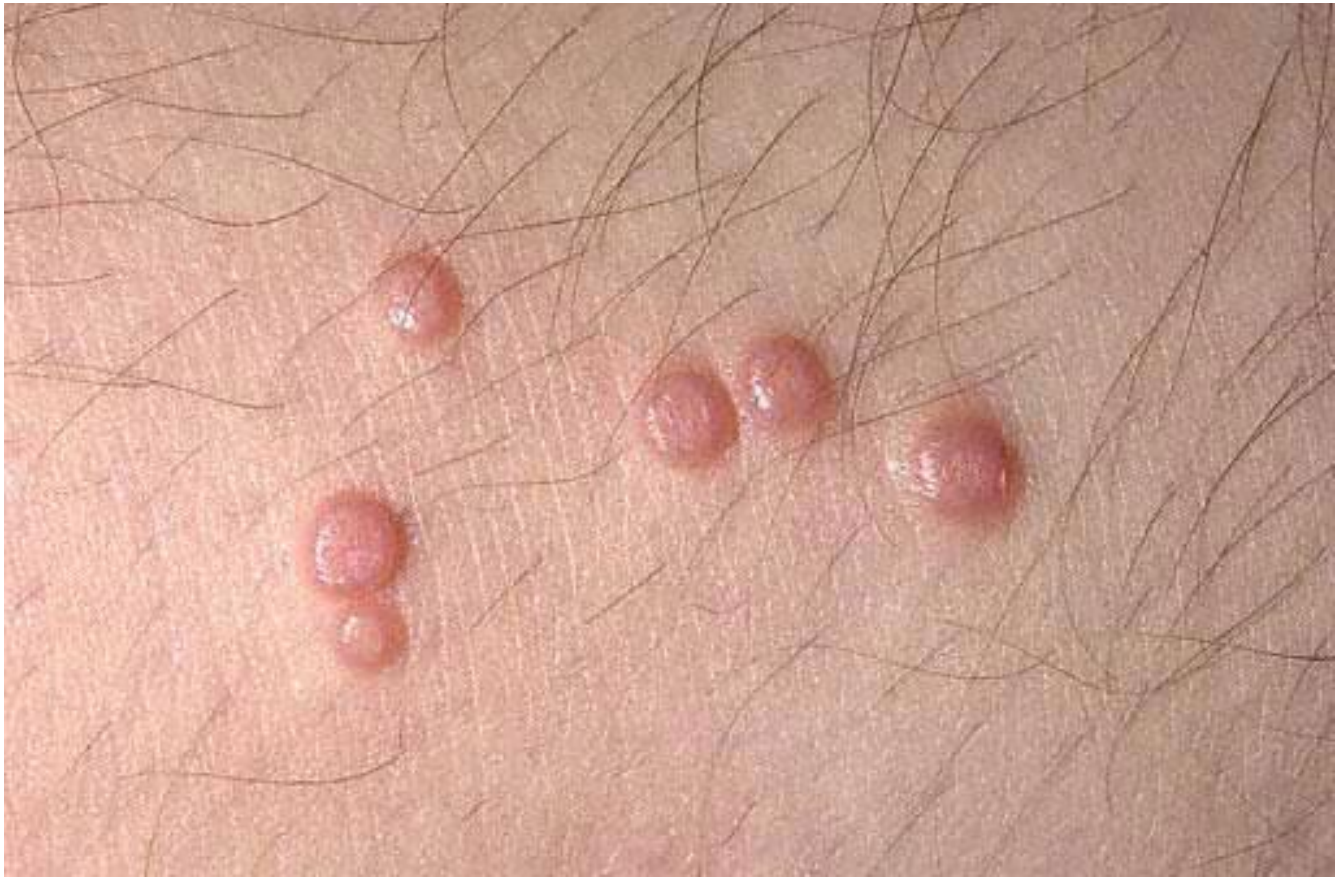

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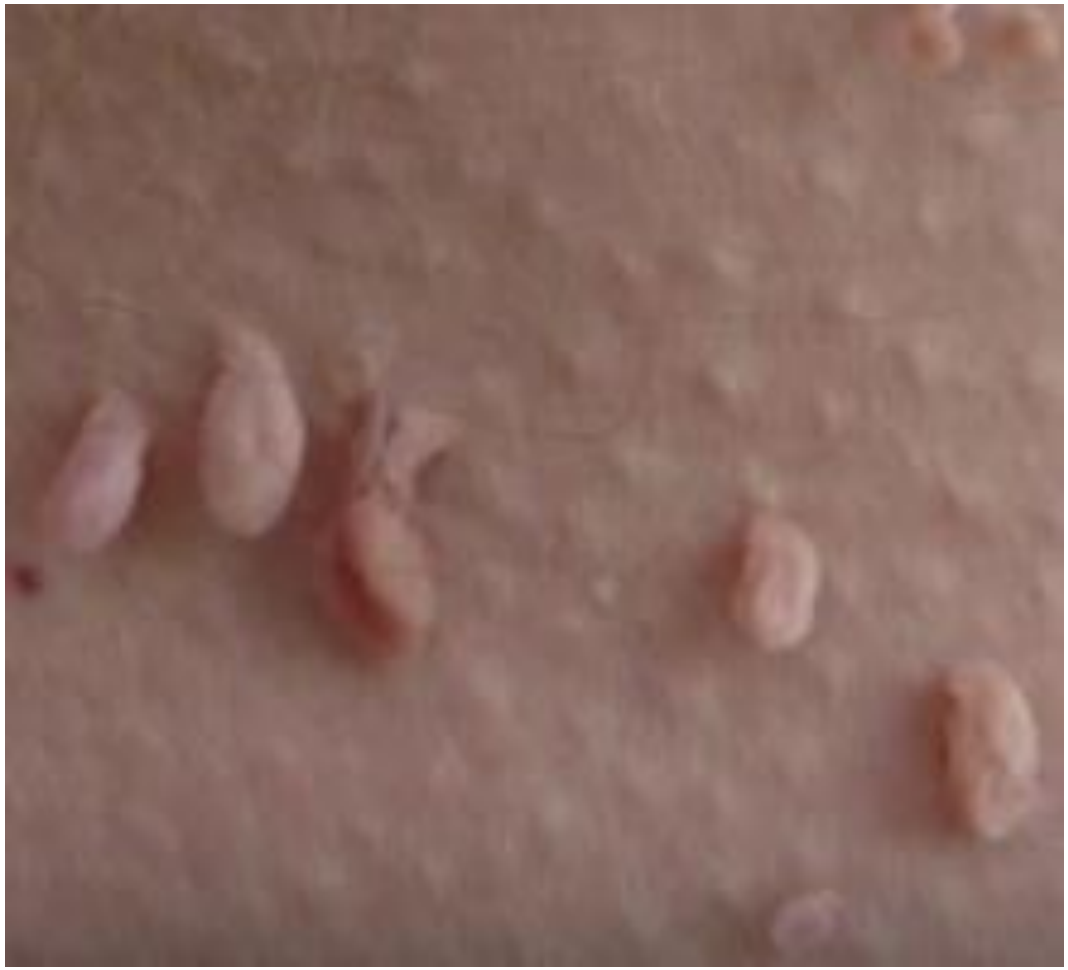

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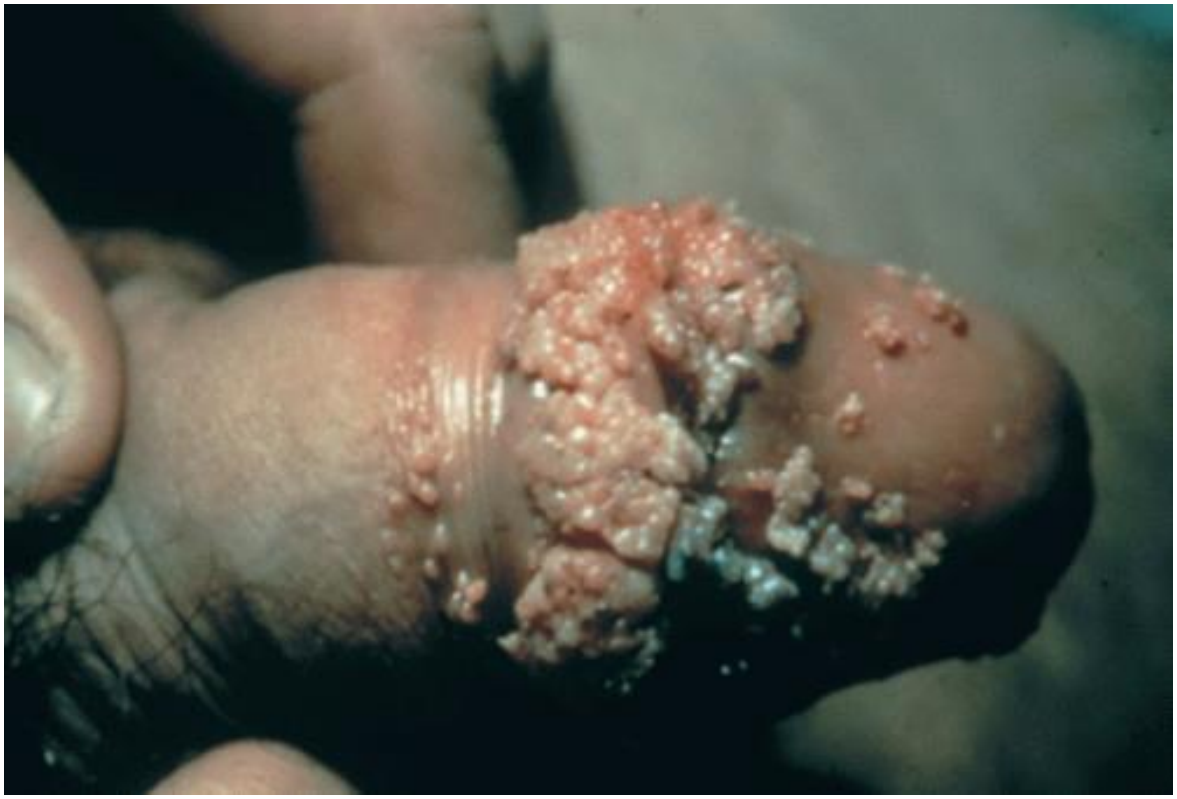

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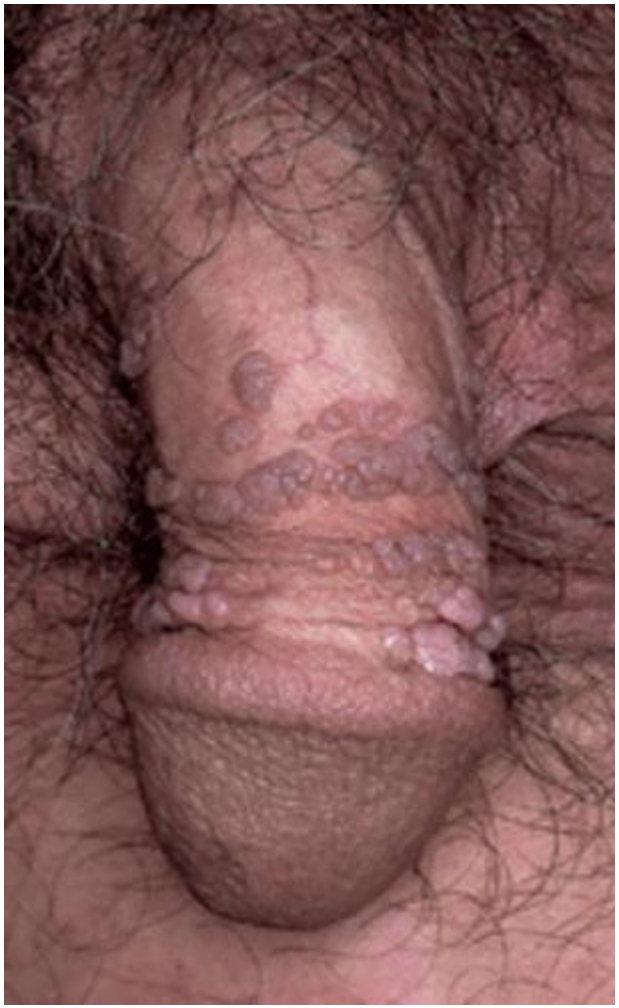

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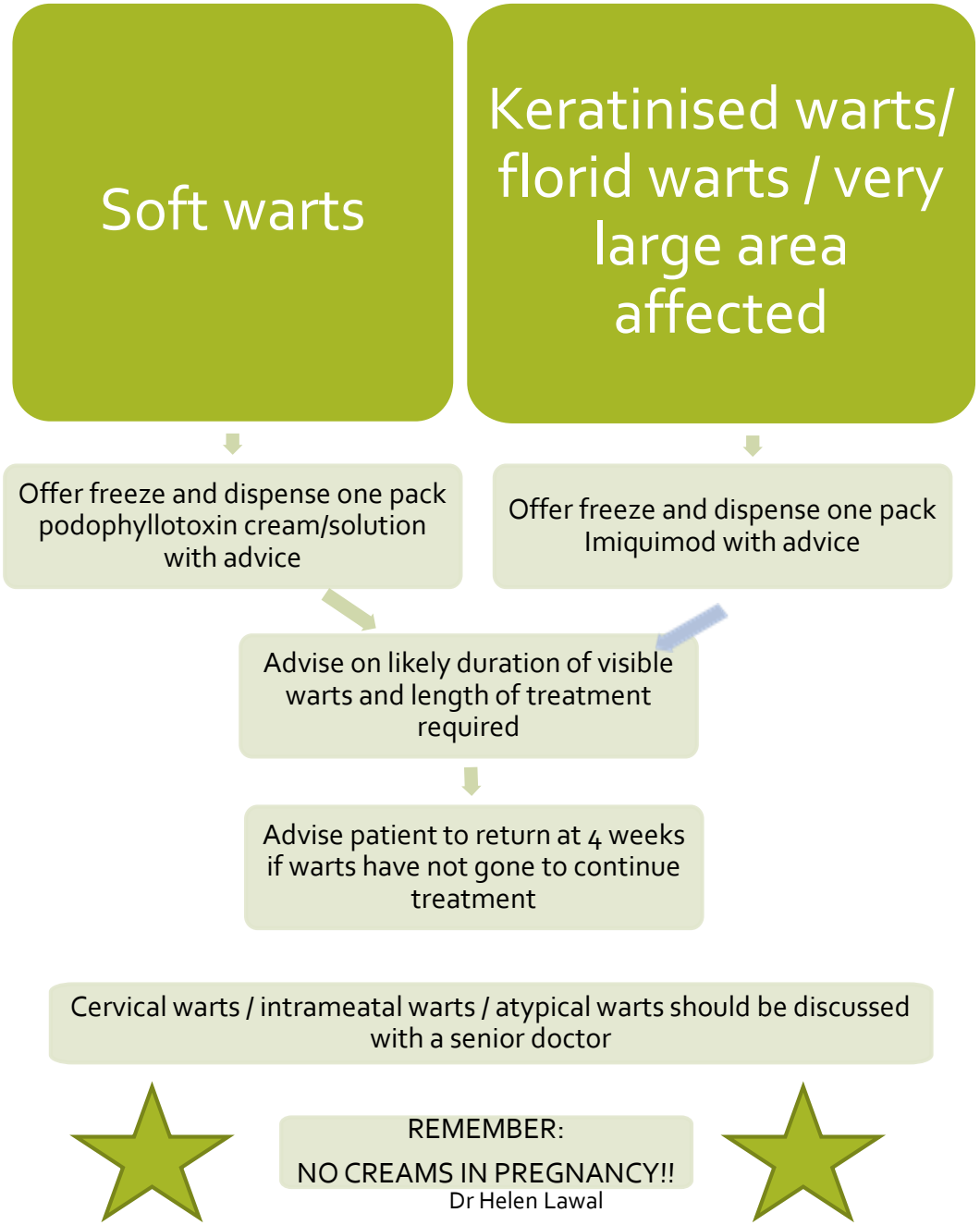
Genital Warts

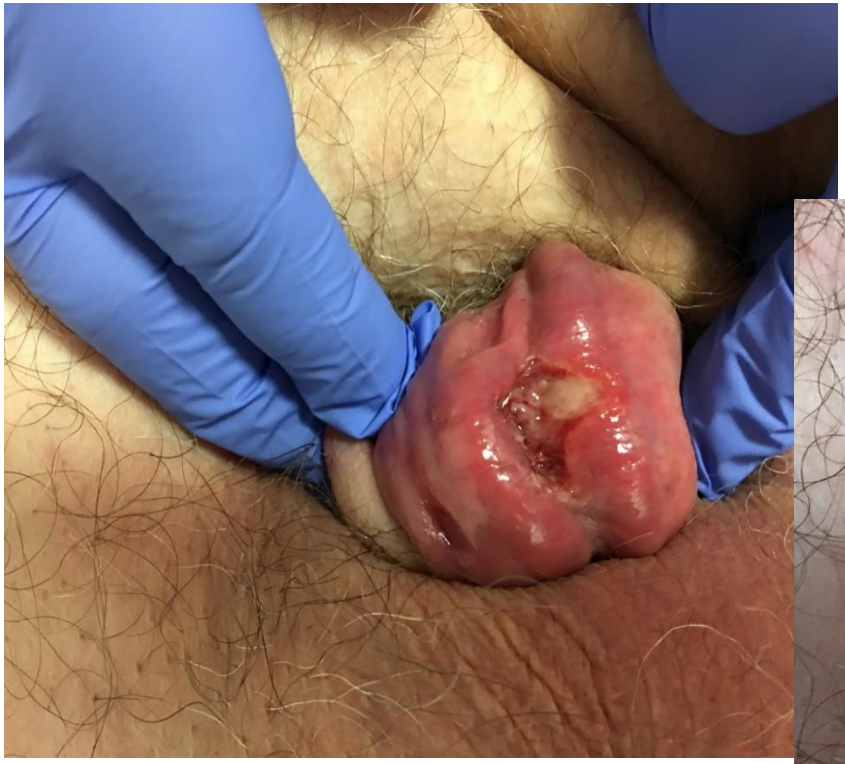
- 90% warts are caused by HPV 6 or 11
- Most resolve spontaneously within 1 to 2 years
- Incubation between 3w to 8m but can be longer
- HPV quadrivalent vaccine (HPV 6/11/16/18) is being used in UK for girls aged 12-13

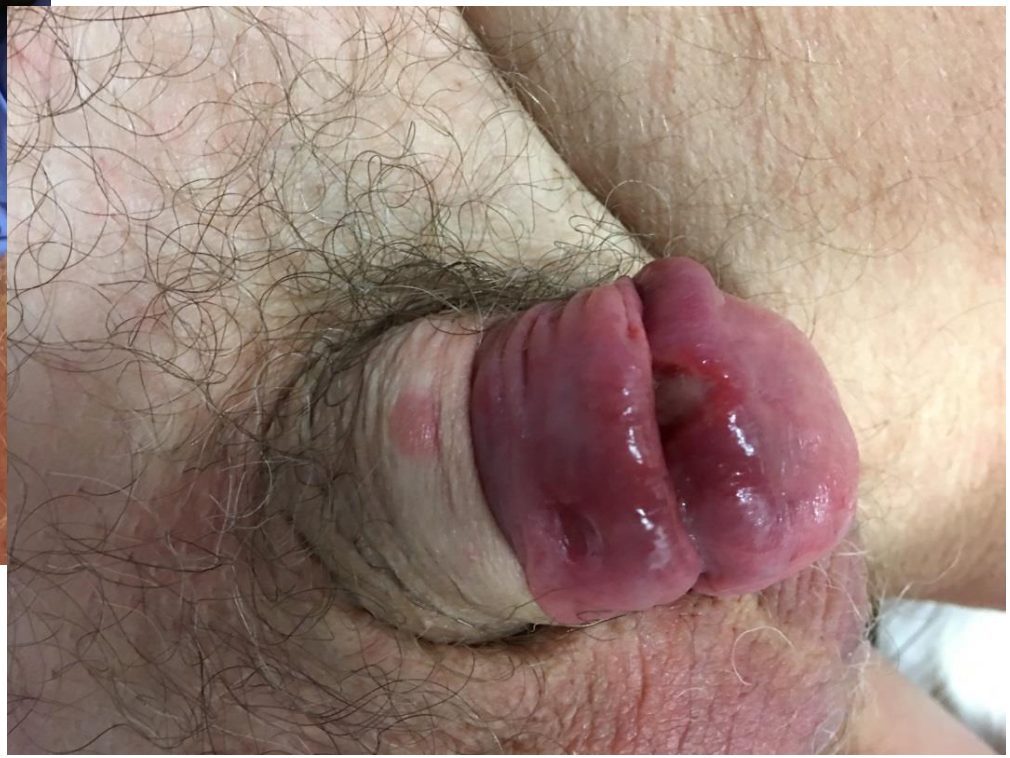

Soft warts
Keratinised warts/ florid warts / very large area affected
Offer freeze and dispense one pack podophyllotoxin cream/solution with advice
Offer freeze and dispense one pack Imiquimod with advice
Advise on likely duration of visible warts and length of treatment required
Advise patient to return at 4 weeks if warts have not gone to continue treatment
Cervical warts / intrameatal warts / atypical warts should be discussed with a senior doctor
REMEMBER:
NO CREAMS IN PREGNANCY!!
Dr Helen Lawal

THINGS YOU WOULDN'T WANT TO MISS…

Credit and thanks to Dr Amy Evans Consultant & Dr Debbie Goode Locum Registrar in GUM and HIV, Leeds

Boris has been on holiday…





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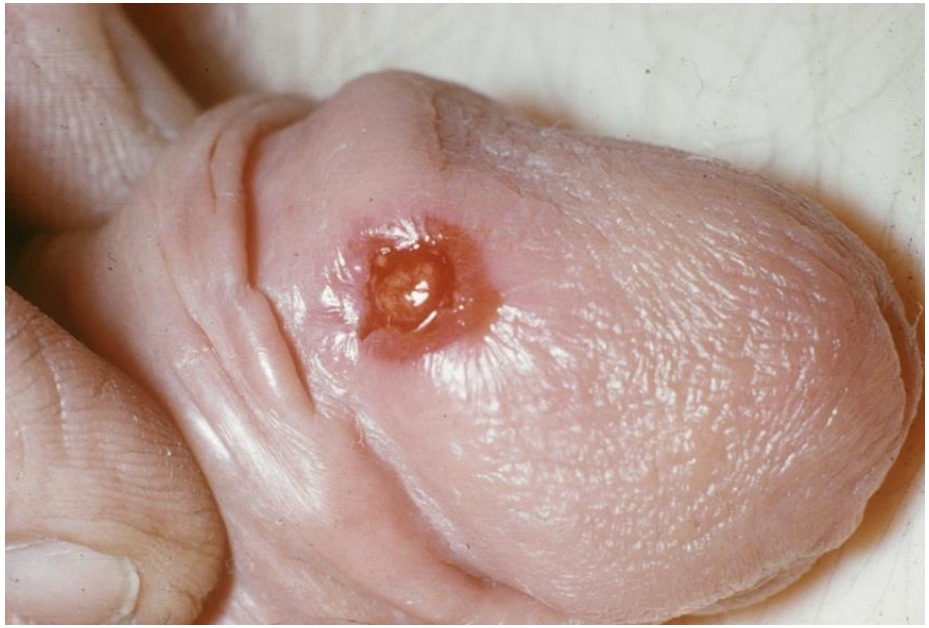
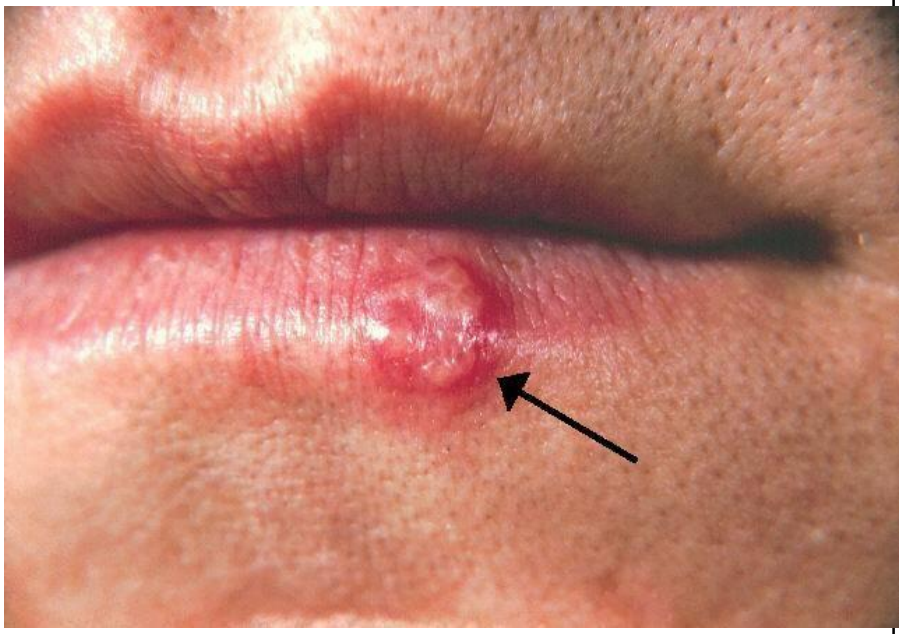
Boris

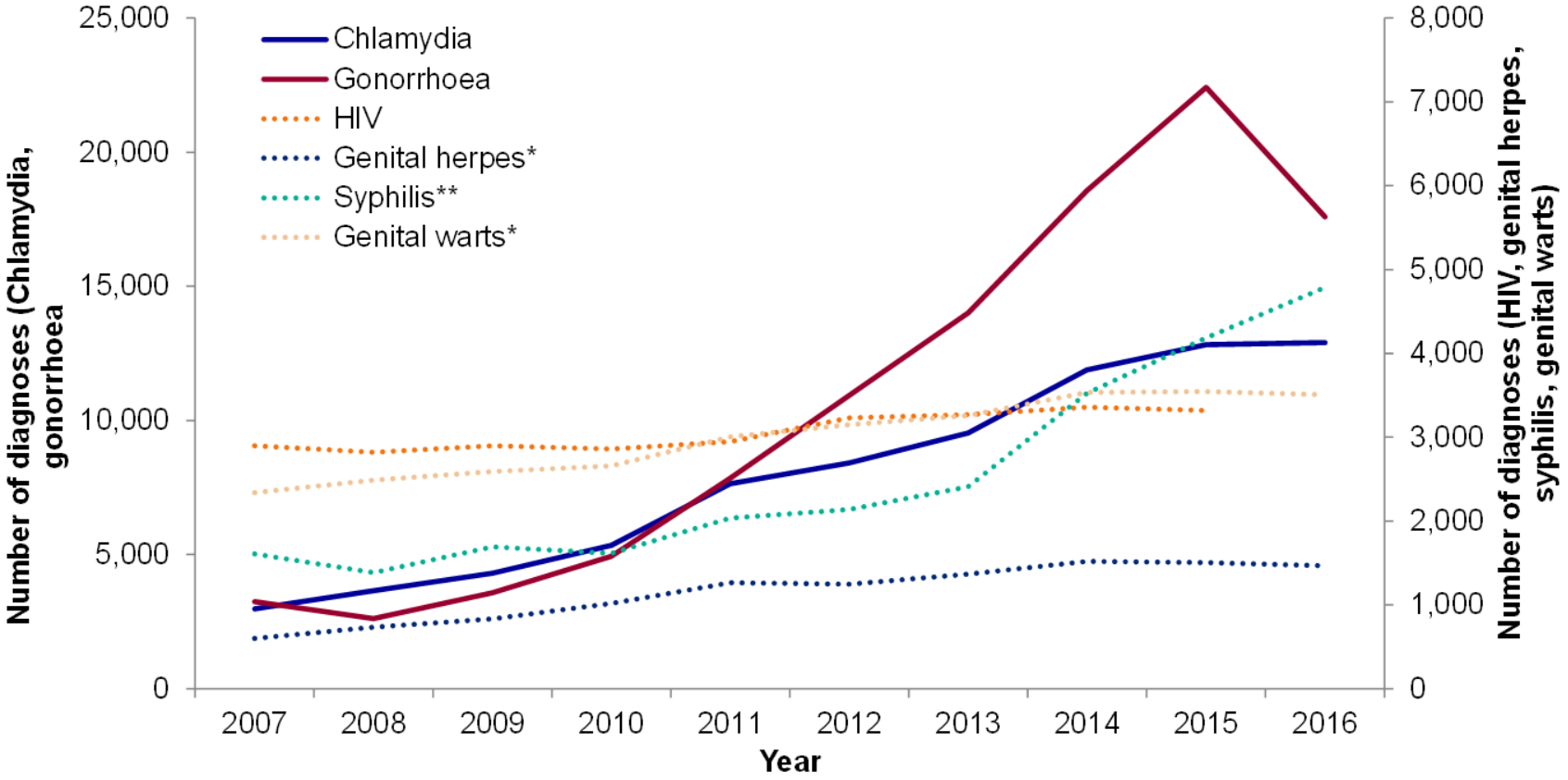
- Age 68, Diabetic
- 6-8wks post Thailand massage
- Comes to the walk-in clinic…
- painless ulcer, rash on chest
- Syphilis positive on microscopy and serology
- HBSAg+ HBeAg+
- HIV-

Primary Syphilitic Chancre





Number of STI diagnoses among MSM: England, 2007-2016

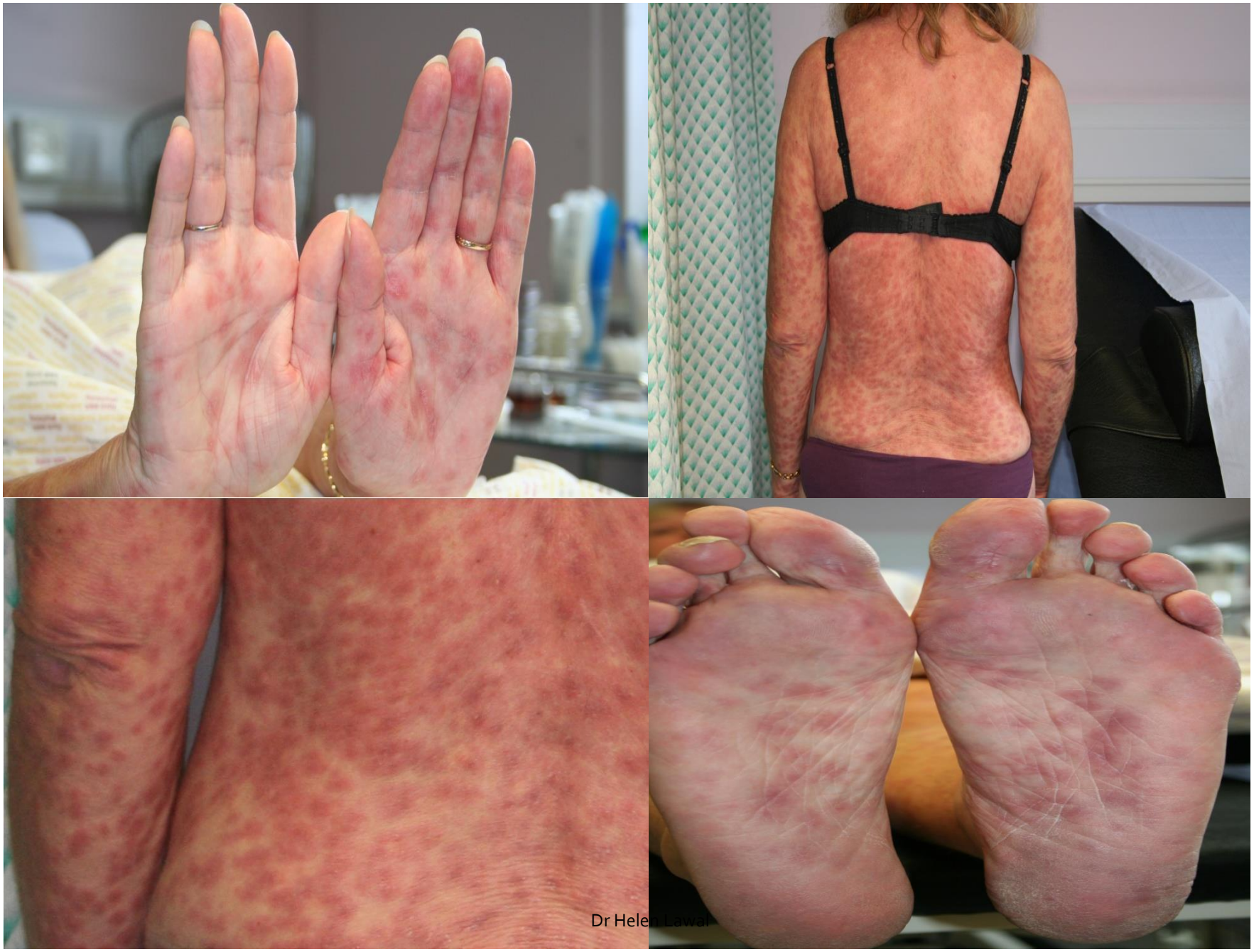


- New HIV diagnoses sourced from the HIV and AIDS Reporting System (HARS) (2016 data unavailable at time of publication). All other data from specialist and non-specialist SHS (GUMCADv2 returns)
- * First episode; **Includes diagnoses of primary, secondary & early latent syphilis
- Chlamydia data from 2012 onwards are not comparable to data from previous years (please see 'Notes' slide for more details)
- Data type: service data

Theresa

- 47 year old heterosexual music teacher
- Recent new partner after marriage break-up
- Worried 'getting old' with hearing & visual problems

- GP referred her to dermatology with a rash…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Secondary Syphilis

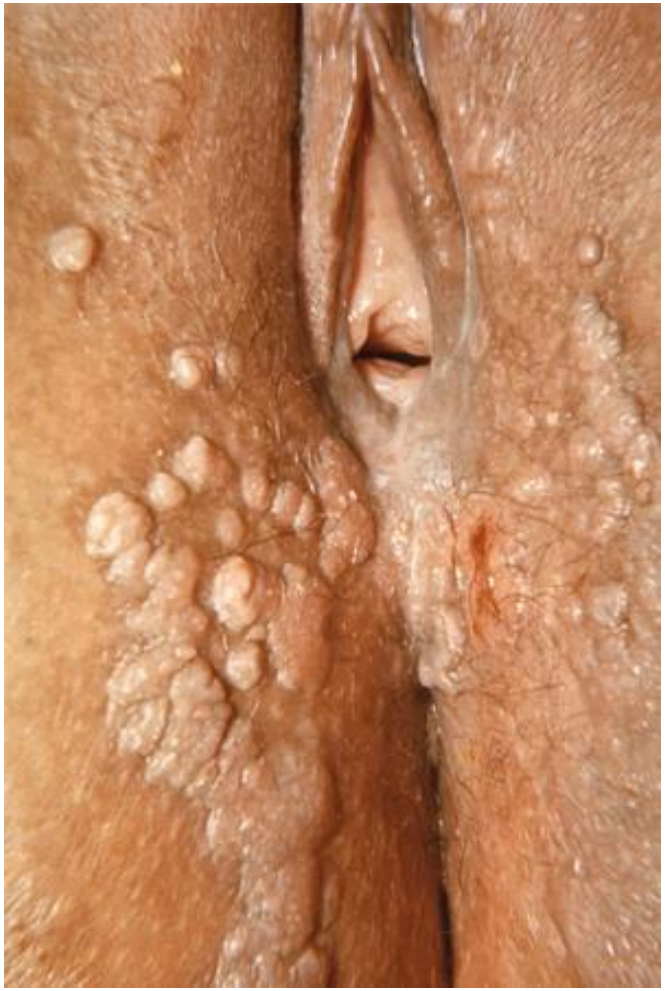
COMMON

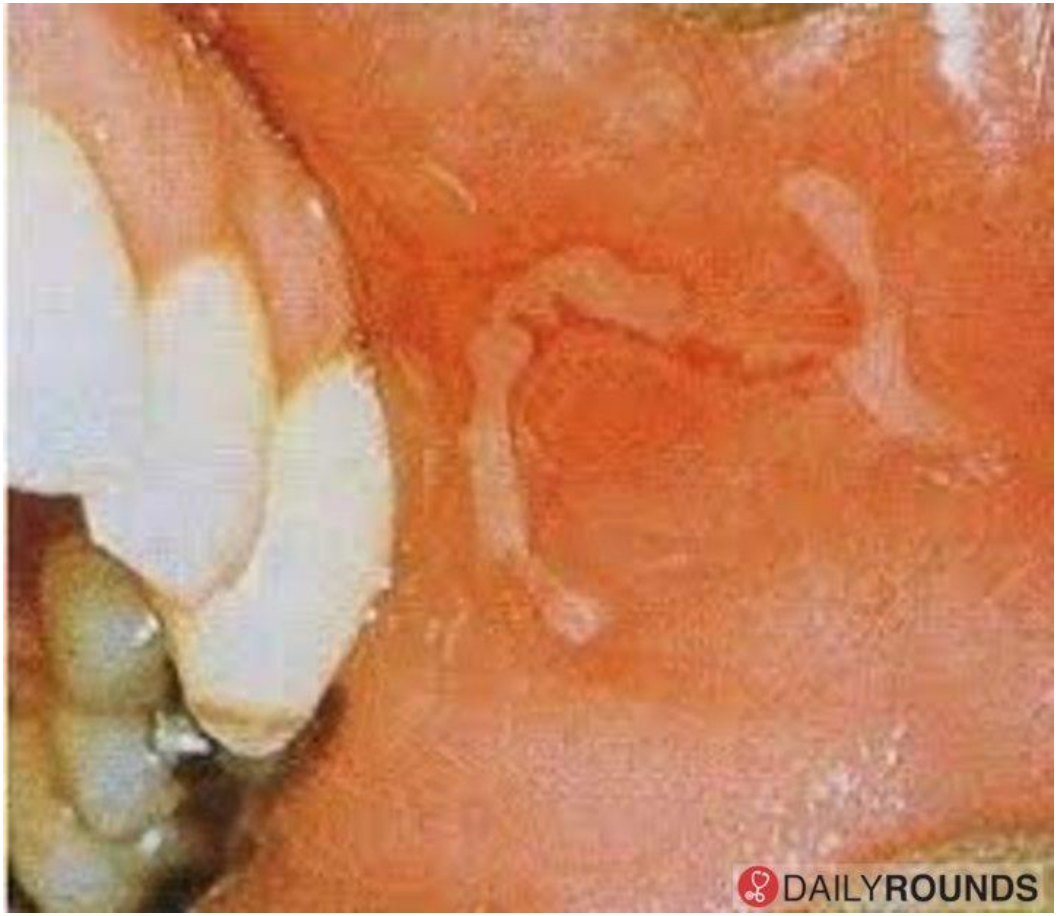
- Fever
- Malaise
- **Rash (incl. palms and soles)**
- **Lymphadenopathy**
- **Mucosal ulcers- snail track**
- Condylomata lata
- **Patchy alopecia**

RARE

- Anterior uveitis/ Retinits
- Optic Neuritis
- Cranial nerve palsies
- Meningitis
- Laryngitis
- Gastritis, proctocolitis
- Hepatitis/ hepatosplenomegaly
- Glomerulonephritis
- Periosteitis/periostitis (bone pain)
- Arthralgia

Secondary Syphilis





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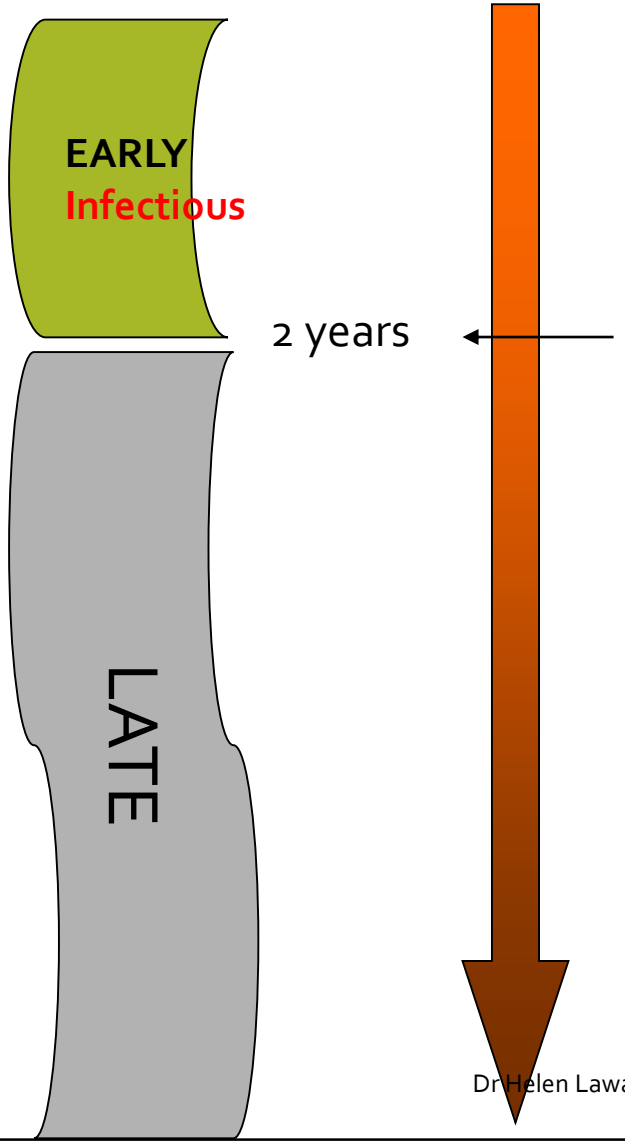
Stages of Syphilis



- Primary Chancre
- Secondary Many signs
- Early Latent No signs
- Late Latent No signs
- Cardiovascular Aortic root
- Gummatous Nodules
- Neurological

Meningovascular, Tabes dorsalis*, General paresis

26 y/o with Lymphadenopathy

- 26 yr old man presented to GP with persistent lymphadenopathy
- Bloods- lymphocytosis otherwise nil of note
- Discussed with haematology; advised cmv/ebv bloods
- All negative, reassured

3 months later…

- Patient returned to GP- ongoing lymphadenopathy, so referred to haematology
- Patient reported a viral illness 3 months ago- around the time he noticed his glands were up
- Currently has a rash all over his body
- Haematology performed routine HIV/hepatitis blood test- HIV positive

Weight Loss and Lethargy

- 56 yr old post menopausal lady presents with lethargy and weight loss
- PMHx: Hypertension, 2 previous episodes of shingles 'the worst the GP had ever seen'.
- Has attended travel clinic for vaccinations and malaria prophylaxis
- Divorced 5 yrs ago

And SOB…

- Started investigations, concerns re underlying malignancy
- Attends GP with progressive shortness of breath, worse on exertion
- Nil on auscultation, no peripheral oedema
- CXR requested- ground glass changes both lungs

HIV positive

- This lady acquired HIV whilst on holiday in South Africa

- She had met a local man in his 30's- having sex every time she went out there

HIV and Syphilis

- **Lymphadenopathy and rashes**
- Ask about travel
- Ask about Sex
- Do the test

- Window periods
- POCT testing

Leeds is now a high prevalence area for HIV (2.48/1000)

- Need to **normalise HIV testing**
- Cannot assume anyone is HIV negative

BHIVA Guidelines

An HIV test should be considered in the following settings where diagnosed HIV prevalence in the local population (PCT/LA) exceeds 2 in 1000 population:

1. all men and women registering in general practice

2. all general medical admissions.

Medical Admissions

- SJUH
- Opt-out HIV testing up to 65 years old
- In 15 months 20 new patients were diagnosed HIV positive
- Several patients lost to follow up were also identified

HIV Care in Primary Care

- www.hiv-druginteractions.org
- Immunisation: hep A, Hep B, annual flu, prevenar PCV13, MMR
- Cervical cytology
- Increased risk of Cancers
- Increased CVD risk
- Abnormal blood results due to ARVs
- Contraception: IUCD and Depo

PEPSE- The Morning After Pill for HIV?

Table 2. Risk of HIV transmission per exposure from a known HIV-positive individual not on ART.

Type of exposure	Estimated risk of HIV transmission per exposure from a known HIV-positive individual not on ART	References
Receptive anal intercourse	1 in 90	10-16
Receptive anal intercourse with ejaculation	1 in 65	10-17
Receptive anal intercourse no ejaculation	1 in 170	17
Insertive anal intercourse	1 in 666	10,12,13,18
Insertive anal intercourse not circumcised	1 in 161	17
Insertive anal intercourse and circumcised	1 in 909	17
Receptive vaginal intercourse	1 in 1000	10,15,19-15
Insertive vaginal intercourse	1 in 1219	14,15,19-25
Semen splash to eye	<1 in 10,000	26
Receptive oral sex (giving fellatio)	<1 in 10,000	13,20,25,27
Insertive oral sex (receiving fellatio)	<1 in 10,000	12,25
Blood transfusion (one unit)	1 in 1	28
Needlestick injury	1 in 333	27,29,30
Sharing injecting equipment (includes chemsex)	1 in 149	26
Human bite	<1 in 10,000	31,32

ART: antiretroviral therapy.

PrEP- HIV Prevention

- Truvada
- Not currently funded by NHS
- Impact Trialstarted
- 3 month check up for urinalysis, STI and HIV bloods

http://prepster.info/
https://www.iwantprepnow.co.uk/

MSM/ Sex Workers

- Triple site testing
- Offer Hep B vax
- PEPSE
- Prep
- Shigella in MSM

Yorkshire MESMAC

BHA

Leeds Skyline

Basis sex work project

Leedssexualhealth.com

What to refer?

- Anything you are unsure of or don't feel confident managing in GP- with letter please!
- Warts
- ? PID
- ? Epididymitis
- Urethral discharge
- Herpes for HSV testing
- PEPSE & PrEP
- MSM for triple site testing
- CSW
- Sexual assault- West Yorkshire SARC Tel 0330 2230099

WY SARC

- Self referral 16+ / via Police
- Children's SARC also
- Tel 0330 2230099 acute number 7 day
- 'You do not have to report to the Police to access this service'

Your local sexual health service provider in Leeds is: **Leeds Sexual Health**

Patient helpline 0113 3920334 / **appointments** 0113 3920333.

Clinical help/referrals

Mon-Fri 9-5pm 0113 3920325 / 20328;

Extended hours M-Th 5-8pm, Sat 11-3pm call 07710027063

email shs.leeds@nhs.net or fax 0113 3920316

For more information about services provided and clinic details, please visit

www.leedssexualhealth.com

Useful Links

www.bashh.org/guidelines

https://www.fpa.org.uk/

https://cks.nice.org.uk

http://spectrumhealth.org.uk/services/sexual-health/find-clinic/wakefield-district-clinics/

http://leedssexualhealth.com/

Further Learning & Training

http://www.stif.org.uk/

https://www.bashh.org/documents/Sexually%20Transmitted%20Infections%20in%20Primary%20Care%202013.pdf

http://www.e-lfh.org.uk/programmes/sexual-health-and-hiv/

http://elearning.rcgp.org.uk/course/info.php?id=179&popup=0

https://www.bashh.org/bashh-groups/sas-group/

Thank you for your time