

Preface

A valuable approach to providing excellent care of patients with sexually transmitted diseases requires that primary care physicians integrate detailed knowledge and clinical wisdom along with empathy to provide care of patients for one of the most emotionally difficult diseases any person encounters during his or her lifetime. STDs are common; they account for 5 % of all outpatient office visits in the United States, and are primarily managed by family doctors, internists, obstetrician-gynecologists, emergency room physicians, primary care nurse practitioners, and physician assistants. Four of the top five reportable infectious diseases in the United States are STDs [1]. In fact, one in ten Americans will have an STD at some time during his or her life [2]. STDs are unique in that they are defined not by their symptoms, or by the body organs that they infect, or by the microorganisms that cause infection, but rather by their mode of transmission—primarily through sexual intercourse. While STDs are related through their mode of transmission, they are heterogeneous and their effects on the body, causing illness that ranges from limited, localized, and asymptomatic disease to serious systemic acute and chronic illness.

STDs reflect the intersection of public health with private decision making and the actions and consequences that ensue from those decisions. Because of their mode of transmission, and the fact that what is inherently a private activity has direct public health consequences, prevention, screening, and treatment of STDs must occur as a part of public discourse as well as private discussions between clinicians and their patients. Unlike most other diseases and infections, the diagnosis of an STD often carries with it a stigma of guilt and embarrassment. This can make the discussion about the mode of acquisition and future prevention difficult for patients and practitioners, resulting in less than optimal communication, misinformation, increased psychosocial burden and the risk of increased disease transmission into the future.

Discussing sexual behavior can be an embarrassing experience that is often avoided by the patient and the practitioner. We as practitioners carry certain biases, recognized or not. These are obvious obstacles to excellent care. The practitioner's approach, however, can change the experience of a patient from embarrassing or even shameful into an opportunity to empower themselves with knowledge and

behavioral change that may save their life. STDs should be handled candidly and honestly, with empathy for the psychosocial ramifications of the illness and an eye toward the possibility of personal growth and modifications of behavior.

The history of STDs is informative. STDs were long ago recognized as being spread by sexual contact, and were therefore referred to as “*venereal diseases*,” named after the Greek goddess of love, Venus. Individuals who had syphilis were shunned. Until the 1960s, syphilis and gonorrhea were the only STDs. During the 1970s *Chlamydia trachomatis* became recognized as causing urethritis, cervicitis, and pelvic inflammatory disease (PID). During the 1980s, HSV-2 appeared to be almost epidemic, and was in fact thought, incorrectly, to be the etiologic agent for cervical cancer. Also during the 1980s the acquired immunodeficiency virus (AIDS) was identified with the human immunodeficiency virus (HIV) being identified as the etiologic agent. During the early part of the AIDS epidemic, paralleling the history of the syphilis epidemic, biases against groups felt to transmit the virus were common [3]. In the latter part of the 1980s and 1990s the role of the sexually transmitted Human Papilloma Virus (HPV) in the development of cervical cancer was recognized, culminating in the development of HPV vaccine, the first vaccine thought to prevent the development of cancer [2].

STDs in the United States continue to be an important public health challenge. There were over 1.3 million cases of chlamydia infections reported in 2010, for a rate of 426.0 per 100,000 population, which represents the highest rate of any infection reportable to the CDC and was a 5.1 % increase compared to the previous year. Chlamydia infections are usually asymptomatic in women but can lead to PID and subsequent infertility, ectopic pregnancy, and chronic pelvic pain. Rates in women were more than twice that of men in 2010, partially due to the increased rates of screening. Racial and ethnic disparities were clear; the chlamydia rate in blacks was 8 times that in whites [1].

In contrast to chlamydia, gonorrhea infection reached its lowest rate ever in 2009. Rates dropped to 98.1 per 100,000 from a high of over 464 per 100,000 population in 1975. 2010 saw a slight increase to 100.8 per 100,000 population. Gonorrhea is a significant cause of PID but, despite the overall decline in infection rates, treatment is becoming more difficult. The *Gonococcal Isolate Surveillance Project* from the CDC in 2012 showed increasing gonococcal resistance to cephalosporins, to the point where oral cephalosporins are no longer recommended as treatment [4].

The rate of reported primary and secondary syphilis in the United States was at an historic low of approximately 11 per 100,000 between 2000 and 2005. A concerning trend, however, has developed recently with the rate climbing by over one-third to 14.9 per 100,000 in 2010, most marked in men who have sex with men.

As mentioned above, new technology is emerging with the most important example being the human papillomavirus vaccine and the probability of decreased development of cervical cancer. The CDC’s Advisory Committee on Immunization Practices (ACIP) in 2006 recommended vaccination of girls starting at age 11–12, and in 2011 recommended routine vaccination of males age 11–12.

Addressing STDs adequately requires individual practitioners with a detailed understanding of STDs to see patients with both knowledge and empathy as a primary directive, as well as a public health approach for disease surveillance, detection, and treatment. Working to eliminate the stigma of STDs by engaging in frank discussions about symptoms and sexual behavior, screening for appropriate STDs in the appropriate setting, and continuing to profess the message of responsible sexual decision making puts primary care physicians in a unique position to carry out prevention, detection, and treatment of sexually transmitted diseases.

Jenkintown, PA, USA
Jenkintown, PA, USA
Abington, PA, USA

Neil S. Skolnik
Amy Lynn Clouse
Curtis Olson

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Sexually Transmitted Diseases

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