Expanding provider-initiated HIV testing

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The case for expanding provider-initiated HIV testing is widely supported and has been shown to be cost-effective where prevalence of undiagnosed HIV infection is above 0.1%.[1] Motivations include providing timely antiretroviral therapy for improved patient outcome and the opportunity for those who are unaware of their positive HIV status (thought to be approximately 26% of all infected persons in Canada[2]) to enhance their strategies to prevent transmission. Continued advancements in testing technologies that have led to reduced window periods[3] and the availability of point-of-care testing[4] also support expanded HIV testing. In recognition of these developments, providers in the Vancouver Coastal Health (VCH) region are being encouraged to expand their testing practices as part of the STOP HIV/AIDS Pilot Project in BC (STOP AIDS).[5] This article provides considerations for clinicians throughout BC looking to expand their HIV testing practices.

Evidence continues to support HIV testing approaches based on clinical assessment. Examples include symptoms of seroconversion illness, opportunistic infections characteristic of AIDS, and risk of exposure to HIV infection. VCH has suggested routinely extending HIV testing to anyone who is being tested for or diagnosed with a sexually transmitted infection, hepatitis C, or tuberculosis, as well as individuals with a past history of a sexually transmitted infection. Other individuals with a greater likelihood of HIV infection who should be routinely offered HIV testing include gay, bisexual, and other men who have sex with men; people with a current or lifetime history of use of injection or non-injection drugs, and their sex partners; individuals who trade sex for money or drugs; sex workers and their clients; Aboriginal people; people with mental health disorders; people from HIV-endemic countries and their sex partners; and sexually active adolescents seeking care.

Efforts to expand provider-initiated testing should go hand-in-hand with increased efforts to promote HIV testing to encourage client-initiated requests for testing. Additionally, individuals with ongoing risk need to be encouraged to adopt risk event-based testing and to test more frequently. These strategies are also designed to identify HIV infection as soon after infection is contracted at a time when high viral loads, found in acute infection, render individuals far more infectious than during later stages of infection.[6]

Risk-based approaches to HIV testing remain limited and are unlikely to increase HIV case finding without expanding testing into routine clinical practice. This inability to decrease the proportion of those unaware of their HIV infection supports a pilot phase of routine testing and may lead to recommendations for future screening strategies. Equally important, a pilot phase of routine testing affords opportunities for providers to learn directly from their efforts to expand HIV testing within the contexts of their own practice. One approach to a pilot phase of routine testing, suggested by VCH as part of STOP AIDS, asks providers to offer testing to anyone who presents to acute or community care who has ever been sexually active and has not had an HIV test in the past year.

Expanded HIV testing will likely require more streamlined approaches to pretest counseling. Notwithstanding, patients being offered HIV testing should be made aware through adequate pretest counseling that, as with any other medical intervention, they have the opportunity to refuse testing. Patients should also be informed of the nominal or non-nominal option and that HIV is a reportable condition. These are two of the key elements recommended for inclusion by clinicians in BC during their pre- and posttest counseling interactions.[7]

Expanding provider-initiated HIV testing is a critical component of an HIV/AIDS prevention and control strategy. Clinicians should increase their offerings of HIV testing to those at risk of infection and explore how to integrate HIV testing into routine clinical practice.

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The new bcmj.org officially launched on 25 November, and on 1 December we selected the winner of our iPad draw. Dr Barry Turchen, BCMA Board member, officiated the draw and selected our winner: Michael Yang, UBC Medicine Class of 2014, Year 1 President, BSc(Hons), master's of biotechnology.

Thanks to all who entered the contest! We hope you'll continue to share the *BCMJ* articles you enjoy on our social media channels with your friends and followers.

Call for nominations

Coady Medal of Excellence

The Dr Cam Coady Medal of Excellence is awarded annually to recognize physicians whose careers have provided outstanding contributions to the communities they serve. The medal will be presented at the BCMA's Annual General Meeting in June 2011. A letter of nomination including a current curriculum vitae of the candidate should be sent to Dr James Darbyshire, Chair, Dr Cam Coady Foundation, P.O. Box 90, New Westminster, BC V3L 4X9 by **4 March 2011.**

Bachop Gold Medal for Distinguished Medical Service

This award may be made annually to a British Columbia doctor who is judged by the selection committee to have made an extraordinary contribution in the field of organized medicine, community service, or both. Achievement should be so outstanding as to serve as an inspiration and a challenge to the medical profession in BC. Only one award will be made in any year and there shall be no obligation on the fund to make the award annually. A letter of nomination including a current curriculum vitae of the candidate should be sent to Ms Lorie Janzen, BCMA, 115–1665 West Broadway, Vancouver, BC V6J 5A4 by **5 April 2011.**

Cell phone legislation communications plan wins acclaim

A recent BCMA communications plan, Time to Hang Up, has won national acclaim from the International Association of Business Communicators and the Canadian Public Relations Society. The communications strategy promoted the lobbying efforts of BC physicians toward prohibiting the operation of handheld devices while driving.

The concerns voiced by BC physicians were heard, and in 2010 the provincial government introduced legislation making it illegal to operate a cell phone or other handheld device while behind the wheel—violators are subject to a $167 fine and three demerit points on their driver's licence.

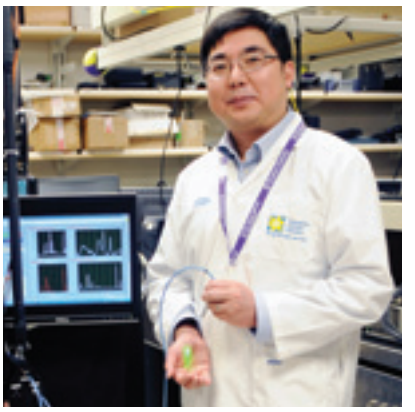
Time to Hang Up won an IABC Silver Leaf Award of Excellence and a CPRS Bronze Award of Excellence.

Non-invasive cancer detection

A new non-invasive cancer detection technology has been developed by cancer researchers and dermatologists at the BC Cancer Agency and the University of British Columbia. The technology is designed to assist in early detection of skin cancer and can be used by any health care professional —dermatologist, family doctor, nurse, or technician.

The device, called the Verisante Aura series, has been in development at the BC Cancer Agency for more than 6 years and has been tested on about 1000 lesions at the Skin Care Centre at VGH. Preliminary clinical results have so far demonstrated 100% efficacy in detecting malignant melanoma.

Using a light ray, the device measures 21 biomarkers to scan a mole or lesion to determine skin cancer in less than 2 seconds. It will help avoid unnecessary biopsies and detect more early-stage cancers that would otherwise go unnoticed. This platform technology is adaptable to other types of cancers such as lung, colon, cervical, and gastrointestinal cancers.



Dr Haishan Zeng, senior scientist at BCCA and one of the co-inventors of a device for early cancer detection.

Vancouver's Verisante Technology, Inc., a medical device company, has obtained the rights to the device.

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