Obtaining a Sexual History in MSM

Kristin D'Acunto, MPA, PA-C; Brenda Swanson-Biearman, DNP, MPH, RN
September 02, 2015
CLINICAL FEATURE

Clinicians must address the sexual health of their patients. This can be done effectively when the patient's sexual behaviors are discussed openly. We must feel comfortable with talking about sensitive issues, which may include sexual practices, sexual partners, and sexually transmitted infections, including HIV. By familiarizing ourselves with language that we, as health care providers, may not commonly use, we can develop successful patient-provider relationships. Obtaining a sexual history can be uncomfortable for even the most seasoned clinicians. Lack of understanding of gay culture, as well as subcultures, sexual practices, health risks, and terminology, can further hamper communication and promotion of safe sex practices.

Establishing patient trust is critical in evaluating this vulnerable population. Patients may become reticent and unwilling to share sexual practices if they believe that they are being judged or misunderstood. They may feel embarrassed about their sexual concerns and may be ambivalent about broaching the topic. Therefore, we need to choose our words carefully and know the current nomenclature regarding certain practices. Patient education and counseling are some of the cornerstone services that physician assistants (PAs) and nurse practitioners (NPs) can provide to patients. Communication is key in the caregiver-patient dyad.

Men who have sex with men (MSM) represent approximately 4% of the U.S. population. MSM are the most profoundly affected by HIV infection, and among races, African Americans are disproportionately affected. Although MSM represent a minority of the general population, this group accounted for 78% of new HIV infections in 2010. In addition, 52% of all people living with HIV in 2009 were MSM.[1] Sexual health is a priority for these men and needs to be routinely addressed. Therefore, to improve the care of these individuals, we must ensure that efficient communication and understanding of language regarding specific sexual behavior is achieved.

As health care providers, we must provide these individuals with information that is useful to protect them from other sexually transmitted infections (STIs) and to prevent them from transmitting disease. One way this can be accomplished is to obtain an accurate sexual

history from these men. A thorough sexual history is essential in understanding patient behaviors that will provide the framework for delivering care and education that is specific to their needs. Unfortunately, less than 40% of clinicians obtain sexual histories with patients.[2] In addition, a recent study by Barber et al showed that general medicine health care providers do not take a sexual history, and therefore, rarely offer HIV screening.[3]
Homosexual men may have complicated histories that can include substance abuse and depression. Evidence has shown that gay adolescents (ages 18-24 years) have a greater risk for developing mental health problems, including sexual violence, physical abuse, depression, and suicide.[4] This is further affected with the stigma of negative societal views often associated with homosexuality. This stigma may be experienced directly by a patient, or perceived. In other words, the patient may feel that the provider may have preconceived negative ideas or attitudes about homosexuality and/or HIV.[5] This perceived stigma may hinder the willingness of the patient to share intimate details of his sex life for fear of being judged or looked at differently. Therefore, clinicians must interview patients with an open-minded, nonjudgmental approach. While obtaining the sexual history, the clinician must also assure confidentiality and privacy. Adequate time without interruptions must be dedicated to gathering a thorough sexual history.
The provider's office should be a welcoming environment. For instance, the waiting room should include a visible statement expressing that equal care is given to all patients regardless of race, ethnicity, and sexual preference. Brochures addressing concerns of the gay community should be available and accessible. Examination rooms can have posters and/or magazines showing same-sex couples, or material provided by HIV/AIDS organizations.

Furthermore, the incidence of mental health issues, such as anxiety, mood disorders, substance use, and suicidal ideations and plans, is increased in the MSM population. One explanation for these comorbidities is that stresses due to experiences with discrimination and stigmatization are more common in this group than in heterosexuals. This, in turn, can lead to elevated levels of distress. Other factors, such as isolation and victimization, may also contribute to these mental health issues.[6]
The following is an example of a scenario that involves specific terms and sexual practices that clinicians may encounter and during which they should be prepared to counsel and educate patients who may have specific concerns about their sexual behaviors. Would you be comfortable talking about these topics with this patient? Could you properly advise this patient of his risks? How would you counsel your patient?

Patient: I have questions about what is safe and not safe during sex. I am a barebacker and like fisting and watersports. What are the risks for my partners and me when participating in these activities?
The key to communication is understanding the terminology (*Table 1*). The clinician must know what barebacking, fisting, and watersports

involve. What does it mean to "bareback"? What is "fisting" and "watersports"? Is this patient being fisted (the fister) or is he the partner who is doing the fisting (the fistee)? The patient should feel comfortable speaking with the clinician and listening to the medical advice that he or she receives. By knowing these terms, and what they mean, the clinician is beginning to build a relationship with the patient. The information must be conveyed to the patient in a clear and nonjudgmental manner.

Clinician: I am glad you asked me about this. By knowing the risks, you can protect yourself and your partners from sexually transmitted diseases, including HIV. Having sexual intercourse without protection (barebacking) puts you at risk for getting a sexually transmitted infection, such as gonorrhea, chlamydia, herpes, syphilis, hepatitis, or a different strain of HIV than what you have. Also, you will allow your partners to become exposed to HIV. These risks can easily be prevented. If you are the person who is fisting, you must be sure to have clean hands without open sores or cuts and keep your nails clipped short. You can reduce the risks associated with fisting by wearing latex gloves. However, if you are the person being fisted, then you need to know there is a risk of rectal tissue damage. Damaged tissue is more susceptible to infection through sexual activities that may occur after fisting. Using lubricant is very important to minimize tears in your rectum. Next, participating in watersports (sexual activity involving urine), does not carry a risk of HIV transmission. Infectious HIV has never been isolated from urine, and no cases of HIV transmission have been reported through taking urine into the mouth or broken skin.

TABLE 1. Sexual behavior-specific questions to be included in patient histories

QUESTION	RATIONALE
Do you participate in receptive anal intercourse? Do you participate in insertive anal intercourse?	Unprotected receptive anal intercourse carries a higher risk of disease transmission than unprotected insertive anal intercourse.
What type of lubrication do you use during sexual encounters? Oil-based lubricant Water-based lubricant Silicone-based lubricant Saliva	Patient needs to be counseled on the appropriate use of lubricant, including the potential risks associated with oil-based lubricant, condoms, and sex toys, and potential disease transmission associated with saliva.
What anal hygiene method do you use (if any)? Douche Enema Laxative	Patient should be educated on the potential risk of dehydration with laxative use. Patient should be informed not to do this the day before Hemoccult or anal Pap screening.
Do you participate specifically in: Rimming Fisting Watersports Sounding Barebacking Anodigital penetration	Patient needs to be educated on the specific risks of disease transmission and tissue injury associated with the act in which they participate.
Do you/have you ever use(d) alcohol and/or drugs during sexual intercourse?	Patient needs to be informed of the increased risk of disease transmission if drugs and/or alcohol are used during sexual intercourse.

When obtaining a sexual history, it is recommended that the clinician uses terms that the patients are familiar and comfortable with. This is of utmost importance when talking with a homosexual patient. Some sexual practices have some physical risk and must be discussed openly with all participants.

Sounding

Recreational urethral sounding is a sexual practice in which a metal probe (or other object) is inserted into the urethra to provide sexual gratification. Sounding can result in infections, urethral tears, urethral strictures, loss of foreign body, or permanent damage. A recent study by Breyer and Shindel found that men who participate in urethral sounding are more likely to have a high number of lifetime sexual partners.[7] In addition, these men are more likely to have sex with men they do not know well, as well as participate in sadomasochistic activities and anal fisting. Providers must educate these men on risk reduction, including using smooth devices with flared bases to prevent trauma or loss of the object and proper cleaning techniques.

Barebacking

Another term that we may encounter when gathering a history from homosexual men is "barebacking." Research has shown that only a minority of MSM participate in bareback sex, ranging from 10% to 45%.[8] Barebacking is intentional unprotected anal intercourse between men. Although many reasons exist as to why one would participate in barebacking, this behavior is very risky. According to a study by Parsons et al, one reason men participate in unprotected anal intercourse (UAI) is that it is more enjoyable and it is associated with a sense of freedom.

A subculture of men who participate in barebacking may also be termed as "bug chasers" or "gift givers." A "bug chaser" is an HIV-negative individual who intentionally does not use condoms to become HIV positive. A "gift giver" is an HIV-positive man who purposely does not use condoms with the intent to infect someone with HIV. According to Truinfol, "gift-giving" and "bug-chasing" are practices that share a goal in creating a type of brotherhood in which the HIV virus represents life rather than death and unprotected sex is the expression of true love.[9] In addition to feeling like they are part of a "brotherhood," other reasons why one may desire HIV infection have been considered. For instance, some believe that the anxiety of the possibility of becoming infected is relieved with becoming HIV positive. They believe that the "worry" is over.

Some individuals may have the misconception that HIV is a curable illness, and they erroneously think that taking antiretroviral medications can cure this virus. In addition, the fear of becoming HIV positive is diminished or even nonexistent, which may contribute to decreased vigilance about safer sex practices. Although this is a very small subculture of the MSM population, health care providers should be familiar with this term. If health care providers do encounter someone who desires to become HIV positive, they should ask the patient why he wants to become infected and educate the individual, explaining any

misconceptions he may have and refer to appropriate resources and support groups.

A person can transmit an STI, knowingly or unknowingly by barebacking, or an HIV-positive man can be "re-infected" and be given a new, resistant HIV virus for which his current antiretroviral treatment may be ineffective in controlling. Therefore, we must know that this sexual behavior and subcultures within it exist and to screen and test these men for HIV, hepatitis, and other STIs, such as gonorrhea, chlamydia, syphilis, herpes, and human papillomavirus (HPV).

Anilingus

Rimming, or anilingus, is another sexual practice that carries risk. Rimming is the practice of licking or "tonguing" a partner's anus to provide sexual stimulation. The risk of getting HIV by rimming is very low; however, it comes with a high risk of transmitting hepatitis A and B, parasites, and other bacteria to the partner who is doing the rimming. *Giardia lamblia* is one such parasite that has been linked to illness in MSM who participate in anilingus.[10] Individuals who participate in rimming must be counseled to use a barrier method, such as a dental dam or a cut, open unlubricated condom over the anus to help prevent infections. In addition, clinicians need to be more vigilant in vaccinating these patients against hepatitis A and B.

Fisting

Fisting is performed when one inserts most or all of his hand into his partner's rectum. Fisting presents a minimal risk of HIV transmission when specific precautions are followed. However, fisting can cause damage to the rectal tissue, and in rare instances, colorectal perforation. Clinicians must convey to the patient to be sure his hand is free of open sores and abrasions and have nails cut short to minimize tissue damage, anorectal fissures, fistulae, and abscesses, as well as decrease transmission of infections. Studies have shown that fisting has been identified as a risk factor for hepatitis C among HIV-positive gay men. The risk of transmission of hepatitis C was increased fivefold among HIV-positive MSM.[11]

Risk of infection can be reduced by hand washing and wearing latex gloves. If one is allergic to latex, gloves made of vinyl or nitrile may be used. Choice of lubricant must also be discussed when counseling a patient who participates in anal fisting. Several commercial lubricants intended for fisting are available, such as oil-based, water-based, and silicone-based lubricants. Silicone-based lubricants should be avoided with use of silicone gloves and sex toys because silicone can actually break down the integrity of the toy surface. However, vegetable shortening is also used because of the low cost and viscosity. If the "fister" is using latex gloves, he must be aware to not use an oil-based lubricant, as it can degrade latex, thereby increasing the risk of latex failure that could result in disease transmission. An essential point to communicate to these patients is to never share lubricant or to "re-dip" hands in the lubricant container.[12] This will aid in prevention of hepatitis and HIV. Anodigital sex, or digital penetration, also carries a risk of disease transmission and rectal tissue damage if nails are not cut short and kept clean.

Saliva lubrication

Using saliva as a lubricant during anal sexual practices may also be discussed while collecting a sexual history. This practice is done often in the MSM population. Saliva has been used as a lubricant in anal intercourse and fisting. Potentially, pathogens can be exchanged when coming in contact with rectal mucosa, possibly transmitting diseases such as cytomegalovirus (CMV), hepatitis B, and Kaposi sarcoma-associated herpes virus (KSHV). The provider needs to be familiar with potential risks involved. Trauma to the rectal membrane associated with anal intercourse and fisting can facilitate transmission of these pathogens. According to a study by Butler et al, 38% of 809 HIV-negative men have used saliva as a lubricant during anal sex at least once in the prior six months, and HIV-positive men are less concerned about using saliva as lubricant.[13]

Sexual mechanical devices.

The use of sexual mechanical devices, or sex toys, should also be addressed during the sexual history. Sharing sex toys and improperly disinfecting them pose a high transmission risk of HIV, hepatitis, and other STIs. The devices must be inspected regularly, while looking for damaged areas that may harbor bacteria. In addition, the toys must be cleaned between uses on different parts of the body. Cleaning methods vary on the type of material. If sex toys are used with unused condoms and are properly cleaned before use, the risk is very low. Water-based lubricant is recommended instead of oil-based lubricant. Oil or petroleum-based lubricants can damage sex toys made of latex. Additionally, lubricant containing a spermicidal agent, such as nonoxynol-9, is contraindicated as it can be irritating to the rectal mucosa, which can increase risk of disease transmission. Damaged sex toys increase the likelihood of transmission of infections due to trapped bacteria. Similar to fisting, tissue damage or inflammation can result from the use of sex toys, also increasing the risk of infection.

Watersports

Watersports, also known as "urine play" or "golden showers," is another sexual practice that involves sexual pleasure from urinating on a partner's body, genitals, or face. HIV transmission has never been reported involving urine from an HIV-positive person onto broken skin or taken into the mouth. HIV concentrations in urine are too small to pose a risk of transmission. However, CMV is a virus that can be transmitted through urine. CMV can present with symptoms similar to a flu-like illness. Those who are immunocompromised, including HIV-positive individuals, are at increased risk for contracting this virus through watersports if urine is ingested. In addition, chlamydia and gonorrhea, which are present in the urethra of those infected, could also potentially be transmitted through this sexual practice.

Substance use

Besides specific sexual behaviors, clinicians must also be aware that gay and bisexual men are at risk for other sensitive issues. Illicit substance use among gay men occurs at a higher rate than in the general population. These substances are often termed as "club drugs" and include amyl nitrate ("poppers"),

marijuana, 3,4-methylenedioxy-N-methylamphetamine (MDMA/ecstasy), powdered cocaine, ketamine (Special K), gamma hydroxyl butyrate (GHB), and amphetamines.

The reasons why illicit drugs are used vary. For instance, methamphetamine may be used to prolong sexual encounters, which allow men to have sex with numerous partners. "Poppers" are often used to relax the anal sphincter during anal intercourse.[14] In addition, PDE-5 inhibitors, used to treat erectile dysfunction, have also been used in combination with these substances to enhance sexual performance while their inhibitions are lessened. Other reasons for the combined use of PDE-5 inhibitors and club drugs include escaping burdensome life situations (e.g., poor self-image, feelings of victimization for being gay, and HIV-positive status) and disinhibiting from the emotions that may prevent them from meeting sexual partners.[15]Substance use increases the risky sexual behavior, thereby increasing the risk of obtaining an STI.[16] Tobacco and alcohol use are seen at higher rates than in heterosexual men.[17] Human papilloma virus (HPV) infection is also a concern for MSM. HPV infection is a significant cause of anal, oropharyngeal, and penile cancers.

The risk of oropharyngeal cancer in these men is increased especially if they use tobacco. MSM have a higher prevalence of anal HPV when compared with the general population. The incidence of anal cancer is high among MSM (35 cases per 100,000 annually), compared with women (1.8-1.4 per 100,000). MSM who are HIV positive have a higher prevalence than non-HIV-infected MSM.[18,19] HIV-positive MSM are thought to have an even higher incidence of anal cancer (70 to 100 cases per 100,000).[20] A recent study by D'Souza et al showed that sexual behaviors are associated with the risk of developing anal cancer. These behaviors include anal receptive intercourse, number of receptive anal intercourse partners, and a higher number of sexual partners.[21] Anal Papanicolau (Pap) screening has been used in screening for anal cancer. Therefore, providers should be able to perform an anal Pap smear, or refer to a provider who is proficient in performing anal Pap smears and interpreting the results.

Anal hygiene

Another issue to discuss during the sexual history is anal hygiene or anal douching. MSM prefer to have a "clean" rectum if he is the receptive partner, or the "bottom." Therefore, they may use disposable enemas, laxatives, or other methods involving an anal douche bulb or shower douche. Laxatives should not be recommended for this reason because of the potential for dehydration. If anal douching is used, the patient needs to be sure to check the water temperature before using, ensuring the temperature is lukewarm, and use no soaps or perfumes as these may be irritating to the rectal tissue and promote disease transmission. In addition, this practice should not be done before the clinician obtains a fecal Hemoccult screening or anal Pap smear. Having a "clean" rectum interferes with obtaining fecal matter for the Hemoccult screening and may result in an "unsatisfactory for cytologic diagnosis"

reading after an anal Pap screening is obtained.

Summary

Although not all MSM participate in these behaviors, this is a complex subculture. Health care providers need to be informed about sexual practices and the appropriate and current nomenclature to provide optimal care and accurate education and counseling. Clinicians must not be timid or brief when taking a sexual history. Instead, they should take the initiative and openly discuss sexual health with their patients. PAs and NPs encounter gay or bisexual men in all venues in health care; therefore, it is essential that we use correct terminology and understand nontraditional behaviors when discussing sexual practices.

MSM usually have greater anxiety than heterosexuals while they are providing details regarding their sexual histories. These anxieties may be a result of prior clinical experiences in which clinicians were judgmental or the patients perceived they were being criticized. Patients may feel that they will become embarrassed or judged during a clinical interview. Therefore, verbal and nonverbal cues are essential to convey to these patients that they can be comfortable and relaxed, which, in turn, can lead to an honest interaction. Truthful, detailed answers from the patients are critical so providers can educate them about protecting themselves from STIs and trauma, which may result in other types of infections.

Often, when patients are uncomfortable discussing personal issues, they can be vague and unclear. Providers need to be comfortable and clarify the meanings of what their patients tell them. For example, the patient may tell his provider that he is sore "down there." The provider needs to elicit from the patient where exactly the patient does have pain. This can indicate anything from a urinary tract infection to genital herpes. Or, the pain can be a result from sounding or fisting.

Health care providers must tailor the terminology they use with the patient. For instance, the patient may not know what anilingus is, but may be familiar with the term "rimming." Using nonmedical terms will create a comfortable atmosphere, allowing for a more open and informative discussion about the patient's sexual history. Depression, anxiety, and other mental health issues also play an important role in obtaining an accurate sexual history. If a patient has a psychiatric illness, he may be negligent and/or inconsistent with safe sex practices.

Discussing sexual practices such as fetishes, fisting, barebacking, and sex toys may make clinicians uncomfortable. We must be careful to not convey this to our patients. Instead, we must know what they mean and how they are done to ensure the patient's trust. Homosexual patients need clinicians to understand the different sexual practices and other issues they may encounter. This knowledge will lead to collecting a comprehensive sexual history, allowing the patient to develop a trusting relationship with his health care provider.