MALTESE ASSOCIATION OF DERMATOLOGY & VENEREOLOGY

# CONFERENCE ON WOMEN'S SEXUAL HEALTH ABSTRACTS

**Saturday 28th April 2018 at Verdala Palace, Rabat, Malta**

***Organised by the Maltese Association of Dermatology and Venereology and the Genitourinary Clinic, Mater Dei Hospital in collaboration with The Malta College of Obstetricians and Gynaecologists and the British Association for Sexual Health and HIV***

## ABSTRACTS

## MORNING SESSION 1

### Sexually transmitted infections in Malta

*Dr Valeska Padovese, Consultant Dermatovenereologist, Head of GU Clinic, (Malta)*

STIs in Malta are on the rise. In the last 2-3 years we have doubled the number of HIV positive cases. The prevalence of syphilis and gonorrhea has also increased among high risk groups. The most affected group in Malta, like in the other European countries, is that of men having sex with men (MSM), especially those who have multiple sexual partners, who do not use condoms and do not get tested routinely. However, there are other groups at high risk of acquiring STIs, particularly vulnerable people like sex workers (male and female prostitutes), inmates and migrants.

The author describes epidemiological trends of STIs diagnosed at the GU clinic in Malta, with particular attention to the demographic characteristics of the population affected and

prevalence in high risk groups. The presentation focuses on complications on reproductive health and the strategies adopted locally to prevent STIs spreading.

**Breast is best ... or is it a viral milkshake ...? - Case Study Presentation 1**

*Dr Donia Gamoudi, Higher Specialist Trainee in GU Medicine (Malta)*

We have come a long way in HIV care. Last year, the hugely important U=U campaign (Undetectable = Untransmittable) changed public perception of HIV transmissibility. Does this also apply to HIV positive undetectable mothers who would like to breastfeed their child? Or will this increase mother to child transmission rates? This case presentation helps to shed light on this highly controversial topic.

**Case Study Presentation 2**

*Dr Marie Claire Vassallo, Higher Specialist Trainee Obs & Gynae (Malta)*

The case of a 23-year-old Maltese lady diagnosed with syphilis during antenatal serology screening at 14 weeks' gestation and who also tested positive for gonorrhoea at 19 weeks' gestation will be presented. The patient's past medical and social history as well as her antenatal progression until delivery will be described. The effects of syphilis and gonorrhoea in pregnancy will be briefly discussed, highlighting the importance of antenatal screening in clinical practice.

**Is it a simple gastroenteritis? - Case Study Presentation 3**

*Dr Anette Portelli, Higher Specialist Trainee Infectious Diseases (Malta)*

The case is a 60-year-old lady, known to suffer from hypothyroidism, who presented to the surgeons with a 3-week history of altered bowel habit and post-prandial vomiting. This was associated with subsequent fever up to 38°C 1 week prior to presentation.

She was hospitalized for rehydration and further investigations including stool and endoscopic studies. Baseline bloods showed lymphopaenia, normocytic anaemia and raised inflammatory markers. She was started empirically on ciprofloxacin and metronidazole for probable infective diarrhoea. Stool studies were positive for *Clostridium difficile* toxin. A CT scan of her abdomen showed recto-sigmoiditis. The patient was consented for an HIV test in view of the prolonged and unresolving diarrhoea and she tested positive with a nadir CD4 count of 137 cells/µl and a baseline HIV viral load of 114,000 copies/ml. She was started on triple anti-retroviral treatment consisting of zidovudine, lamivudine and efavirenz.

Twenty days after started anti-retroviral drugs, the patient developed an extensive rash over lower limbs suggestive of erythema multiforme associated with bilateral lower limb swelling, more marked on the right. This was presumed to be secondary to efavirenz, thus latter was stopped and eventually started on lopinavir/ritonavir. Doppler studies of right lower limb were negative for deep vein thrombosis. However, in view of positive D-dimer, a repeat Doppler was done 1 week after which confirmed right tibial vein thrombosis. She was thus started on warfarin.

This lady gradually started to improve after several weeks and is currently doing very well on anti-retroviral treatment.

Nearly 15 percent of HIV-infected persons remain unaware of their HIV infection, leading to significant morbidity and the risk of further transmission to others. Improved access to HIV testing can decrease the number of individuals who present with advanced immunocompromise, enhance the detection of newly infected individuals, and reduce transmission to others. Chronic diarrhea of unknown cause is one of the documented clinical indicator diseases where HIV testing should be offered.

**Vaginal discharge and diagnostic tests**

*Dr Jackie Sherrard, Consultant in Genitourinary and HIV Medicine, Buckinghamshire (UK)*

This presentation will cover the causes of altered vaginal discharge and then examine the presentation and clinical findings of BV, candida and the STIs which present with increased discharge. The range of diagnostic tests and a diagnostic algorithm will be discussed.

**Out of Africa**

*Prof Joseph Pace, Consultant Dermatologist (Malta)*

In this presentation the author compares two "scourges of mankind" syphilis and HIV AIDS, both of which may well have originated in Africa. The mode of spread within and outside the African continent shows a clear association with mass movements of populations be it for religious reasons, wars, colonialism, slavery, or the more current massive refugee displacements of these troubled times.

The relevance of these infectious diseases to the welfare of both refugees and the inhabitants of the countries they seek refuge in is discussed. Migrants are more susceptible to disease and do not have appropriate access to health care. Although control of these infections is daunting but not impossible, recent history makes us question the real commitment of many countries to effect even simple and appropriate control measures, to diseases which will, slowly but surely, reach the local populations.

Finally, consider the following:
*Should we be concerned?*
*Are we doing anything about it?*
*Is this purely a "national" problem or should the EU be more involved when threats exist to all member countries?*

## MORNING SESSION 2

**What's new in the management of pelvic inflammatory disease?**

*Professor Jonathan Ross, Professor of Sexual Health and HIV Medicine, Birmingham (UK)*

Prof Ross will provide an update on the new European PID treatment guideline highlighting the changes in recommended therapy and their rationale. He will address the management of women with PID presenting with an intrauterine device in situ, and whether metronidazole should be part of the treatment regimen in all women. The increasingly recognised role of Mycoplasma genitalium will be discussed and how this impacts on the investigation and treatment of PID. Finally a revised treatment algorithm will be presented to guide clinical management.

**What’s new in genital herpes infection?**

*Professor Raj Patel, Consultant in Genitourinary and HIV Medicine, Southampton (UK)*

Five of the eight human herpes viruses have been shown to be often present on genital mucosal surfaces or in genital secretions raising the possibility of sexual transmission. However, it is members of the alpha herpes group HSV-1 and HSV-2 that are uniquely adapted to this environment and use sexual behaviour to facilitate their passage.

Genital infections due to HSV-1 or HSV-2 are characterized by initial primary infections of variable severity followed by a period of neuronal latency which is interrupted by reactivation. Data from recent shedding and biopsy studies challenge traditional models of latency and reactivation and suggest that disease at the neuronal level is probably much more recurrent than previously thought and that shedding (both symptomatic and asymptomatic) is frequent. Control of the disease occurs at both the ganglionic (CD8 mediated) and at the neuronal – dermal junction (CD4/8 and antibody dependent). Such a model explains the limits of antiviral therapy for herpes – in particular the lack of success that antiviral suppression for herpes has had on the control of HIV acquisition or transmission. In addition it may also explain the somewhat complex interactions of HSV-1 and HSV-2 when they are acquired in the same or different locations and also the general trends seen in HSV-2 in the recent NHANES studies (declines in HSV-2 infection in white males and females, where HSV-1 as a genital pathogen is gaining increasing significance). Similar patterns are also being seen in Europe.

Both the acquisition illness and the recurrent disease may become complicated. In addition patients will often have complex psychosexual problems and suffer extreme anxiety around transmission to partners.  Rare but devastating complications may occur in pregnancy.

Where necessary and when required interventions that will benefit patients are possible. Assessing clinical effectiveness is complicated by large placebo effects and the relatively short therapeutic window for acute interventions. However, it is only by understanding the scientific basis of therapy that we can use and design interventions that will benefit our patients.

The control of both symptomatic and asymptomatic HSV infection has recently been shown to be possible using therapeutic vaccination.  The effect in well controlled studies appears to last to at least one year and the reduction in asymptomatic shedding is in the order of 50%. This raises the tantalizing prospect of early vaccination as a standard adjunct to conventional management to allow patients and clinicians to be more proactive in disease management.

Sequencing extended section sections of the genome has recently been achieved for many hundreds of HSV isolates across the globe. Valuable insights into the phylogenetics of herpes viruses as well as the limited conservation of many glycoprotein elements has been demonstrated – this explains some of the difficulties we have had with using first world technology in the developing world, as well as raising concerns for vaccine technology whose benefits may be limited geographically.

**Lichen sclerosus vulvae**

*Dr Michael Boffa, Consultant Dermatologist, Sir Paul Boffa Hospital (Malta)*

Lichen sclerosus (LS) is a fairly common inflammatory anogenital dermatosis that may also involve other body sites. It is most frequent in adult women but may also affect men and children of both sexes. LS in females may present to dermatologists, gynaecologists, genito-urinary physicians, general practitioners and paediatricians so it is important that all doctors working in these fields are aware of the condition.

LS often follows a chronic course and can lead to significant physical and psychological scaring. Complications include concern about the genital appearance, loss of self-esteem, sexual and urinary dysfunction, dysaesthesiae and neoplastic change. Correct management can usually provide adequate disease control and improve the quality of life of affected patients, however it is important to diagnose and treat the condition early to reduce complications.

This presentation will cover presentation, diagnosis, investigation and management of LS in female patients, quoting recent guidelines, and emphasising the importance of multidisciplinary management for optimum patient outcome.

**Vulvodynia**

*Dr Philip Carabot, Consultant in Genitourinary Medicine, St James Hospital (Malta)*

Vulvodynia is common, poorly understood, often misdiagnosed, under researched and a source of significant morbidity. A brief review will summarise main clinical aspects hopefully enabling practitioners to be more aware of it and more confident to start treatment.

## AFTERNOON SESSION

**Scaling up HIV treatment**

*Dr Tonio Piscopo, Consultant in Infectious Diseases, Mater Dei Hospital (Malta)*

The presentation will address the process of scaling up of anti-retroviral treatment with a special reference to the Malta HIV cohort. The epidemiology, characteristics of the cohort, and outcomes are discussed, with particular reference to the last few years. The calculated targets for Malta will be compared to the 2020 UNAIDS targets.

**HIV infection in pregnancy; preventing mother-to-child transmission**

*Dr Elizabeth Foley, Consultant in Genitourinary and HIV Medicine, Southampton (UK)*

HIV infection can be transmitted from an HIV-positive woman to her child during pregnancy, childbirth and breastfeeding. Mother-to-child transmission (MTCT), also known as 'vertical transmission', accounts for the majority of new infections in children.

When a mother has HIV infection the risk of MTCT is approximately 25%, but with effective interventions this risk can be reduced to <1% even with vaginal delivery.

Most transmissions to the infant occur at the time of delivery so prevention of MTCT programmes are designed to detect new HIV infections in pregnancy so that antiretroviral therapy (ARTs) can be started to reduce the HIV viral load in the blood to an undetectable level in the third trimester.

As HIV infection is now considered to be a treatable long-term condition many women already known to have HIV infection will choose to have children. This talk will cover the current strategies to achieve pregnancy without infecting sero-discordant sexual partners and the safety of antiretroviral therapy use in pregnancy.

### The impact of infections in pregnancy

*Mr Mark Formosa, Consultant Obstetrician and Gynaecologist, Mater Dei Hospital (Malta)*

The impact of infections on pregnancy is multifactorial. There are both embryotoxic and important maternal effects of infectious agents on pregnant mothers. Preventive strategies and early recognition are key to maintaining the upperhand in this struggle. However the adversary is a potent one and new fronts are established all the time (e.g. zika virus) so vigilance is essential.

### Congenital syphilis in Malta

*Dr David Pace, Consultant Paediatrician (Infectious Diseases), Mater Dei Hospital (Malta)*

Congenital syphilis is a vertically acquired infection that affects multiple organs and results in a plethora of disabilities which manifest during childhood. Proper antenatal care aimed at detecting and treating maternal syphilis, which is often in the asymptomatic latent phase, is crucial in preventing these devastating effects on the child. In Malta all pregnant women are offered screening for syphilis as part of their routine antenatal care and their newborns are screened and managed accordingly. From 2008 to 2017 there were 40 babies born to 36 mothers (mean age of 31.7 years), all of whom had latent syphilis. Syphilis was first diagnosed in pregnancy in 23 mothers, 18 of who were given treatment during the $2^{nd}$ or $3^{rd}$ trimester. Twenty nine babies were born to foreign mothers, 82% of who came from Eastern Europe and sub-Saharan Africa. Two mothers were coinfected with HIV. None of the newborns had clinical manifestations of syphilis but 15 were treated with benzylpenicillin: 7 because their mother was not treated, or was not adequately treated, and 8 because of serological evidence suggesting possible congenital syphilis. Close follow up of all babies showed the disappearance of treponemal antibodies during the first year of life, proving that none of the children had actually acquired congenital syphilis. The most effective way of preventing congenital syphilis in children is through screening and treatment of syphilis (if indicated) during pregnancy.