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HIV screening: better communication instead of searching for a needle in a haystack?

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A serological test for human immunodeficiency virus (HIV) is usually performed to diagnose or rule out the presence of an acute or chronic HIV infection. The request of such a diagnostic test is a mandatory procedure in a patient presenting with signs or symptoms that could be caused directly or indirectly by HIV. A healthcare provider might also propose an HIV test to an asymptomatic person who reports a behaviour that is associated with a higher risk of HIV infection. The situations that should prompt so-called "physician-initiated counselling and testing" (PICT), are well described in a recent recommendation by the Swiss Federal Office of Public Health (SOPH) [1].

Testing asymptomatic individuals at no increased risk for HIV acquisition is a diagnostic procedure with very low chance of success. Based on a recent survey in Switzerland, the number of individuals with an undiagnosed HIV infection is lower than 4 000 individuals (prevalence <50 per 10^5) [2]. As a consequence, HIV testing in the general population is neither recommended nor performed in Switzerland. It is not known whether the prevalence of undiagnosed HIV-infection in the medical setting in Switzerland is discernibly higher than in the general population.

Currently in the *Swiss Medical Weekly*, authors from the University Hospital Lausanne present results of an interesting study performed in the emergency room setting at their institution [3]. The authors did not evaluate the prevalence of HIV in the medical setting. The focus of the study was to understand the beliefs of emergency patients regarding the performance of diagnostic tests on a routine basis. The same group has previously published a similar study performed in patients who underwent an elective surgical procedure [4].

This new analysis in the emergency unit highlights a few important aspects about physician/patient communication. The authors demonstrate that one in four emergency patients just assume that an HIV-test was performed on the blood sample obtained during that visit. This widely held belief of a broad screening procedure in any blood test was even stronger for other tests that were also not performed (cholesterol, glucose). Importantly, patients not only assume an HIV test was performed, but also that the result – no news is good news – was negative. This set of assumptions might in fact pose a risk for patients with an undiagnosed HIV infection and particularly their partners. The study should prompt more general communication about what blood tests are done and, more importantly, what is not done when a blood sample is drawn.

At least as important was the question about the patient's acceptance of a routine HIV test at the emergency visit. However, when asked about their consent to have an HIV-test performed immediately, only one third would have consented to the proposed procedure.

In summary, while one fourth of emergency patients assume that an HIV test will be performed on any blood sample obtained, two third of patients disapprove of the performance of an HIV test when specifically asked to consent. This finding is a call for a broader and more profound communication among caregivers and patients about medical procedures.

In a parallel analysis using the laboratory database the authors suppose that at least one of the 411 patients included in the study was later found to be HIV positive. Of course, the sample size was much too small to define an accurate prevalence rate. It remains to be shown that the prevalence of undiagnosed HIV infection in this setting is substantially higher than the 0.05% in the general population. It would have been interesting to know whether the 34% of patients who would have consented to an HIV test would have done so owing to a higher perceived or real risk of being infected.

The 2015 HIV prevention campaign in Switzerland does focus on the correct diagnosis of primary HIV infection. The lack of communicating sexual risks in the emergency situation of a primary HIV disease results in underdiagnosis of primary HIV infection. The current campaign also tries to inform the public that it is important to talk to the physician about any possible risks for HIV infection because an HIV test is not performed on a routine basis. However, much more needs to be done so physicians and patients understand what is routinely done in an emergency setting and even more importantly, what is not done.

The study by Favre-Bull et al. [3] concludes that more effort should be made in the field of patient communication. One idea would be to hand out information leaflets to the patients in the emergency units informing them about the fact that some blood tests, such as HIV, are NOT done

routinely. The information could also prompt the patients to specifically ask for an HIV test, if they want to have it performed. This might even increase the likelihood that patients with a perceived increased risk that is not recognised by their physicians might indicate the necessity of a blood test.

As noted above, the implementation of an HIV screening programme is likely to be very inefficient. The results of this study also indicate a limited acceptance of such a strategy. It remains to be shown whether a general HIV testing of all emergency patients results in a higher detection rate of undiagnosed HIV infections compared with the 0.25% rate (1/411) found in this preliminary study. An alternative strategy focusing on improved communication of risk behaviour is likely to improve not only testing rates but also the patient-physician relationship.

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