



The American College of
Obstetricians and Gynecologists
WOMEN'S HEALTH CARE PHYSICIANS

COMMITTEE OPINION

Number 596 • May 2014
(Reaffirmed 2019)

(Replaces Committee Opinion Number 411, August 2008)

Committee on Gynecologic Practice

This Committee Opinion was developed with the assistance of the HIV Expert Work Group. This document reflects emerging clinical and scientific advances as of the date issued and is subject to change. This information should not be construed as dictating an exclusive course of treatment or procedure to be followed.

Routine Human Immunodeficiency Virus Screening

ABSTRACT: Early diagnosis and treatment of human immunodeficiency virus (HIV) can improve survival and reduce morbidity. The Centers for Disease Control and Prevention and the American College of Obstetricians and Gynecologists recommend that females aged 13–64 years be tested at least once in their lifetime and annually thereafter based on factors related to risk. In addition, obstetrician–gynecologists should annually review patients' risk factors for HIV and assess the need for retesting. The opportunity for repeat testing should be made available to all women even in the absence of identified risk factors. Women who are infected with HIV should receive or be referred for appropriate clinical and supportive care. Obstetrician–gynecologists who use rapid tests must be prepared to provide counseling to women who receive positive test results the same day that the specimen is collected. Obstetrician–gynecologists should be aware of and comply with legal requirements regarding HIV testing in their jurisdictions and institutions.

The Centers for Disease Control and Prevention (CDC) estimates that approximately 40,000–50,000 new human immunodeficiency virus (HIV) infections occurred annually in the United States from 2006 to 2009 (1). Almost 1 in 5 (18.1%) of all individuals infected with HIV are unaware of their HIV status (2). In order to identify individuals with undiagnosed HIV infection, the CDC recommends HIV screening for all patients aged 13–64 years in health care settings (3). Because obstetrician–gynecologists provide primary and preventive care for adolescents and women, they are ideally suited to play an important role in promoting HIV screening for their patients. The American College of Obstetricians and Gynecologists (the College) recommends routine HIV screening for females aged 13–64 years and older women with risk factors. Screening after age 64 years is indicated if there is ongoing risk of HIV infection, as indicated by risk assessment (eg, new sexual partners).

Although most obstetrician–gynecologists are familiar with routine HIV testing of their pregnant patients, health care providers should incorporate routine HIV testing into their gynecologic practices as well. There are a number of reasons why it is critical that women, who represent an increasing proportion of overall HIV and acquired immunodeficiency syndrome (AIDS) cases, know their HIV status. Early diagnosis and treatment of

HIV can improve survival and reduce morbidity (4). In addition, women who are infected with HIV can take steps to avoid unintended pregnancy and reduce the likelihood of mother-to-child transmission should pregnancy occur (5). Another emerging benefit to the identification of HIV status is the possibility of initiating pharmacologic interventions, such as combined antiretroviral therapy (6), and behavioral interventions to prevent transmission of HIV to partners (7).

The CDC and the College recommend that females aged 13–64 years be tested at least once in their lifetime and annually thereafter based on factors related to risk. Obstetrician–gynecologists should annually review patients' risk factors for HIV and assess the need for retesting. Repeat HIV testing should be offered at least annually to women who

- are injection drug users
- are sex partners of injection-drug users
- exchange sex for money or drugs
- are sex partners of HIV-infected persons
- have had sex with men who have sex with men since the most recent HIV test
- have had more than one sex partner since their most recent HIV test

The opportunity for repeat testing should be made available to all women even in the absence of identified risk factors. Repeat screening after age 64 years is indicated if there is ongoing risk of HIV infection, as indicated by an individualized risk assessment. Obstetrician–gynecologists also should encourage women and their prospective sex partners to be tested before initiating a new sexual relationship. The benefits of periodic retesting should be discussed with patients and provided if requested, regardless of risk factors. Patients may be concerned about their status and do not know about or want to disclose risk-taking behavior to their health care providers.

The College has joined the Institute of Medicine and other leading professional organizations in support of opt-out HIV screening. Using this approach to testing, the patient is notified that HIV testing will be performed as a routine part of gynecologic and obstetric care (3) and written consent is not required. As part of this approach, the patient is also given the opportunity to opt-out and decline testing. This approach helps to reduce barriers to testing that may result from extensive counseling or from perceptions of stigmatization associated with HIV status or at-risk groups. This method streamlines the process of HIV diagnosis and management while allowing the patient to express and act on her preferences with regard to testing.

The practice of routine testing does not eliminate opportunities for the patient to discuss questions about testing with her health care provider, including who may be at risk of infection, the benefits of testing, and test results. Although HIV-negative test results may be conveyed without direct personal contact, HIV-positive test results should be communicated confidentially and in person by a physician, nurse, or other skilled staff member. Women who are infected with HIV should receive or be referred for appropriate clinical and supportive care. If a patient declines HIV testing under an opt-out policy, she should be informed that this will not affect access to health care or her health care provider (8). In these situations, her choice and the reason for this decision should be documented in the medical record. Although the College recommends opt-out screening where legally possible, state and local laws may have specific requirements for HIV testing that are not consistent with such an approach. Therefore, obstetrician–gynecologists should be aware of and comply with legal requirements regarding HIV testing in their jurisdictions and institutions. Legal requirements for HIV testing may be verified by contacting state or local health departments. The National HIV/AIDS Clinicians' Consultation Center at the University of California San Francisco maintains an online compendium of state HIV testing laws (www.nccc.ucsf.edu).

Because the recommended population for HIV testing includes adolescents, it also is important to have practices in place to assist young patients. This includes a process of discussing safe-sex practices, risk factors, and

behavior that may lead to HIV exposure. Currently, some states allow minors to access HIV testing in a confidential fashion without disclosing testing or results to a parent or guardian (9, 10). However, there are others that require some degree of notification or consent from a parent before testing. It is important for Fellows to be aware of the local policies in place and to fulfill the legal and ethical obligations to their adolescent patients who seek HIV testing as part of their reproductive health care. The Guttmacher Institute maintains an updated list of minors' consent state policies (www.guttmacher.org/statecenter/spibs/spib_OMCL.pdf).

The development of rapid HIV tests is another mechanism to support HIV testing and management. Until recently, HIV testing was performed using the repeatedly reactive enzyme immunoassay followed by confirmatory Western blot or immunofluorescence assay. Although this test is very accurate, the results are not available for 24–48 hours after testing. In contrast, a rapid HIV test is a screening test with results that are available quickly, ideally within an hour. Rapid tests include point-of-care tests performed outside a laboratory (eg, an oral swab testing done in an outpatient setting) as well as testing performed in a laboratory. The tests currently approved by the U.S. Food and Drug Administration range in specificity from 93% to 100% with a sensitivity of 98.6–100% (11). The use of rapid HIV tests may provide test results to patients in a timelier manner and may reduce challenges related to loss to follow-up. Although a positive rapid test result is preliminary and must be confirmed with additional testing, a negative rapid test result does not require any additional testing. Therefore, rapid testing may be a feasible and acceptable approach for an HIV screening program in an obstetric–gynecologic practice (12).

Rapid test results usually will be available during the same clinical visit that the specimen (eg, blood or oral swab sample) is collected. Obstetrician–gynecologists who use these tests must be prepared to provide counseling to women who receive positive test results the same day that the specimen is collected. Women with positive test results should be counseled regarding the meaning of these preliminarily positive test results and the need for confirmatory testing (11). Obstetrician–gynecologists should develop collaborative care plans with health care professionals who can provide these counseling services on an emergent basis or train their own staff to handle the initial encounter and, thereafter, transition infected individuals to professionals who can serve as ongoing resources to them. Women whose confirmatory testing yields positive results and, therefore, are infected with HIV should receive or be referred for appropriate clinical and supportive care.

The College makes the following recommendations for routine HIV screening:

- All females aged 13–64 years should be tested at least once in their lifetime and then annually thereafter based on factors related to risk.

- Obstetrician–gynecologists should annually review patients’ risk factors for HIV and assess the need for retesting.
- Ideally, opt-out HIV screening should be performed.
- Obstetrician–gynecologists who use rapid HIV tests must be prepared to provide counseling to women who receive positive test results the same day that the specimen is collected.
- Women who are infected with HIV should receive or be referred for appropriate clinical and supportive care.

Resources

The American College of Obstetricians and Gynecologists

409 12th Street SW

PO Box 96920

Washington, DC 20024

(800) 673-8444

(202) 638-5577

HIV resources: <http://www.acog.org/goto/HIV>

National HIV/AIDS Clinicians’ Consultation Center
University of California San Francisco Department of
Family and Community Medicine

San Francisco General Hospital

1001 Potrero Avenue, Building 20, Ward 22

San Francisco, CA 94110

National HIV/AIDS Telephone Consultation Service:

(800) 933-3413

(415) 206-8700

<http://www.nccc.ucsf.edu>

American Academy of HIV Medicine, American Medical Association. Coding guide for routine HIV testing in health care settings. Washington, DC:

AAHIVM; Chicago (IL): AMA; 2010. Available at: http://www.aahivm.org/Upload_Module/upload/Provider%20Resources/AAHIVM%20CPT%20Coding%20Guide.pdf. Retrieved December 11, 2013.

Guttmacher Institute. An overview of minors’ consent law. State Policies in Brief. New York (NY): GI; 2013. Available at: http://www.guttmacher.org/statecenter/spibs/spib_OMCL.pdf. Retrieved November 4, 2013.

References

1. Prejean J, Song R, Hernandez A, Ziebell R, Green T, Walker F, et al. Estimated HIV incidence in the United States, 2006–2009. HIV Incidence Surveillance Group. PLoS One 2011;6:e17502. [PubMed] [Full Text] ↵
2. Centers for Disease Control and Prevention. Monitoring selected national HIV prevention and care objectives by using HIV surveillance data—United States and 6 U.S. dependent areas—2010. HIV Surveillance Supplemental Report 2012;17(No. 3, part A). Atlanta (GA): CDC; 2012. Available at: http://www.cdc.gov/hiv/pdf/statistics_2010_HIV_Surveillance_Report_vol_17_no_3.pdf. Retrieved December 11, 2013. ↵

3. Branson BM, Handsfield HH, Lampe MA, Janssen RS, Taylor AW, Lyss SB, et al. Revised recommendations for HIV testing of adults, adolescents, and pregnant women in health-care settings. Centers for Disease Control and Prevention (CDC). MMWR Recomm Rep 2006;55(RR-14):1–17; quiz CE1–4. [PubMed] [Full Text] ↵
4. Palella FJ Jr, Deloria-Knoll M, Chmiel JS, Moorman AC, Wood KC, Greenberg AE, et al. Survival benefit of initiating antiretroviral therapy in HIV-infected persons in different CD4+ cell strata. HIV Outpatient Study Investigators. Ann Intern Med 2003;138:620–6. [PubMed] [Full Text] ↵
5. Panel on Treatment of HIV-Infected Pregnant Women and Prevention of Perinatal Transmission. Recommendations for use of antiretroviral drugs in pregnant HIV-1-infected women for maternal health and interventions to reduce perinatal HIV transmission in the United States. Rockville (MD): Department of Health and Human Services; 2012. Available at: http://aidsinfo.nih.gov/contentfiles/lvguide_lines/PerinatalGL.pdf. Retrieved December 12, 2013. ↵
6. Moyer VA. Screening for HIV: U.S. Preventive Services Task Force recommendation statement. U.S. Preventive Services Task Force. Ann Intern Med 2013;159:51–60. [PubMed] [Full Text] ↵
7. Weinhardt LS, Carey MP, Johnson BT, Bickham NL. Effects of HIV counseling and testing on sexual risk behavior: a meta-analytic review of published research, 1985–1997. Am J Public Health 1999;89:1397–405. [PubMed] [Full Text] ↵
8. Human immunodeficiency virus. ACOG Committee Opinion No. 389. American College of Obstetricians and Gynecologists. Obstet Gynecol 2007;110:1473–8. [PubMed] [Obstetrics & Gynecology] ↵
9. Guttmacher Institute. An overview of minors’ consent law. State Policies in Brief. New York (NY): GI; 2013. Available at: http://www.guttmacher.org/statecenter/spibs/spib_OMCL.pdf. Retrieved November 4, 2013. ↵
10. English A, Ford CA. The HIPAA privacy rule and adolescents: legal questions and clinical challenges. Perspect Sex Reprod Health 2004;36:80–6. [PubMed] [Full Text] ↵
11. Greenwald JL, Burstein GR, Pincus J, Branson B. A rapid review of rapid HIV antibody tests. Curr Infect Dis Rep 2006;8:125–31. [PubMed] ↵
12. Tepper NK, Farr SL, Danner SP, Maupin R, Nesheim SR, Cohen MH, et al. Rapid human immunodeficiency virus testing in obstetric outpatient settings: the MIRIAD study. Am J Obstet Gynecol 2009;201:31.e1,31.e6. [PubMed] [Full Text] ↵

Copyright May 2014 by the American College of Obstetricians and Gynecologists, 409 12th Street, SW, PO Box 96920, Washington, DC 20090-6920. All rights reserved.

ISSN 1074-861X

Routine human immunodeficiency virus screening. Committee Opinion No. 596. American College of Obstetricians and Gynecologists. Obstet Gynecol 2014;123:1137–9.