HIV Infection

Detection, Counseling, and Referral

Infection with HIV causes an acute but brief and nonspecific influenza-like retroviral syndrome that can include fever, malaise, lymphadenopathy, pharyngitis, arthritis, or skin rash. Most persons experience at least one symptom; however, some might be asymptomatic or have no recognition of illness (*406–409*). Acute infection transitions to a multiyear, chronic illness that progressively depletes $CD4^+$ T lymphocytes crucial for maintenance of effective immune function. Ultimately, persons with untreated HIV infection experience symptomatic, life-threatening immunodeficiency (i.e., AIDS).

Effective ART that suppresses HIV replication to undetectable levels reduces morbidity, provides a near-normal lifespan, and prevents sexual transmission of HIV to others (*95–97*,*410–412*). Early diagnosis of HIV and rapid linkage to care are essential for achieving these goals. Guidelines from both the U.S. Department of Health and Human Services and the International AIDS Society–USA Panel recommend that all persons with HIV infection be offered effective ART as soon as possible, both to reduce morbidity and mortality and to prevent HIV transmission (*413*).

STD specialty or sexual health clinics are a vital partner in reducing HIV infections in the United States. These clinics provide safety net services to vulnerable populations in need of HIV prevention services who are not served by the health care system and HIV partner service organizations. Diagnosis of an STI is a biomarker for HIV acquisition, especially among persons with primary or secondary syphilis or, among MSM, rectal gonorrhea or chlamydia (*197*). STD clinics perform only approximately 20% of all federally funded HIV tests nationally but identify approximately 30% of all new infections (*414*). Among testing venues, STD clinics are high performing in terms of linkage to HIV care within 90 days of diagnosis; during 2013–2017, the percentage of persons with a new diagnosis in an STD clinic and linked to care within 90 days increased from 55% to >90% (*415*,*415*).

Screening Recommendations

The following recommendations apply to testing for HIV:

- HIV testing is recommended for all persons seeking STI evaluation who are not already known to have HIV infection. Testing should be routine at the time of the STI evaluation, regardless of whether the patient reports any specific behavioral risks for HIV. Testing for HIV should be performed at the time of STI diagnosis and treatment if not performed at the initial STI evaluation and screening (*82*,*195*,*416*).
- CDC and USPSTF recommend HIV screening at least once for all persons aged 15–65 years (*417*).
- Persons at higher risk for HIV acquisition, including sexually active gay, bisexual, and other MSM, should be screened for HIV at least annually. Providers can consider the benefits of offering more frequent screening (e.g., every 3–6 months) among MSM at increased risk for acquiring HIV (*418*,*419*).
- All pregnant women should be tested for HIV during the first prenatal visit. A second test during the third trimester, preferably at <36 weeks' gestation, should be considered and is recommended for women who are at high risk for acquiring HIV infection, women who receive health care in jurisdictions with high rates of HIV, and women examined in clinical settings in which HIV incidence is ≥1 per 1,000 women screened per year (*138*,*140*).
- HIV screening should be voluntary and free from coercion. Patients should not be tested without their knowledge.
- Opt-out HIV screening (notifying the patient that an HIV test will be performed, unless the patient declines) is recommended in all health care settings. CDC also recommends that consent for HIV screening be incorporated into the general informed consent for medical care in the same manner as other screening or diagnostic tests.
- Requirement of specific signed consent for HIV testing is not recommended. General informed consent for medical care is considered sufficient to encompass informed consent for HIV testing.
- Providers should use a laboratory-based antigen/antibody (Ag/Ab) combination assay as the first test for HIV, unless persons are unlikely to follow up with a provider to receive their HIV test results; in those cases screening with a rapid POC test can be useful.
- Preliminary positive screening tests for HIV should be followed by supplemental testing to establish the diagnosis.
- Providing prevention counseling as part of HIV screening programs or in conjunction with HIV diagnostic testing is not required (*6*). However, persons might be more likely to think about HIV and consider their risk-related behavior when undergoing an HIV test. HIV testing gives providers an opportunity to conduct STI and HIV prevention counseling and communicate risk-reduction messages.
- Acute HIV infection can occur among persons who report recent sexual or needle-sharing behavior or who have had an STI diagnosis.
- Providers should test for HIV RNA if initial testing according to the HIV testing algorithm recommended by CDC is negative or indeterminate when concerned about acute HIV infection (https://stacks.cdc.gov/view/cdc/50872).