GUIDELINES

2018 European guideline on the organization of a consultation for sexually transmitted infections

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New in the 2018 guidelines

This is an update of the 2012 IUSTI guideline. In this new version, we have expanded the sections on sexual history taking to include PEP and PrEP use, intimate partner and gender-based violence, chemsex, swinging and psychosexual problems. We highlight the potential for the use of technology in the context of sexual health to facilitate sexual history taking and partner notification. We have explained the principle of safeguarding young and other vulnerable people who may present to services.

This guideline is primarily aimed at services provided in mainstream clinic/office environments, but increasingly many countries are seeing an era of rapid transition of sexual health services in which satellite clinics and online service provision are centre stage. Services are moving away from the main hospitals/clinics into smaller peripheral sites and various non-traditional or outreach type settings such as saunas, brothels, bars, clubs, educational facilities, prisons and gay pride events. The advantage of such services is that it might allow hard-to-reach groups to be engaged with clinical services.[1] We need a cohesive, multiagency approach to addressing the challenges associated with this style of service provision, if we are to harness the potential for decentralization of sexual health services while safeguarding the most vulnerable and remaining true to the founding principles of sexual health care.

Personnel

The following staff groups are essential in the smooth running of a facility managing patients presenting with sexually transmitted infections (STIs).

- Administrative
- Nursing – qualified and support assistants
- Medical staff – physicians from various medical disciplines might be involved in such consultations (gynaecology, genito-urinary medicine (GUM), dermatology, dermatovenereology, reproductive and sexual health (RSH), infectious diseases, family medicine/general practice, urology, forensic medicine)
- Laboratory staff to process relevant investigations

The following staff can provide additional services and benefits to such a clinic

- Research team
- Health advisors/contact tracers – or other appropriately trained personnel to assist in the process of partner notification, health promotion and risk reduction
- Counsellors
- Psychologists

Pathways for referrals to involve other specialists may be required depending on local service arrangements – for example paediatricians for concerns over paediatric and congenital STIs.

Safety of staff should be considered in all settings. Consideration should be given to use of panic and personal alarms, minimizing lone working, and use of accompanying colleagues for patients who are known to display aggressive behaviour. Local reporting practices for incidents or near misses should be followed.

Confidentiality and other ethical considerations

The particular vulnerability of patients attending a clinic that tests for and/or treats STIs demands strict confidentiality. Services should explain how patient information will be managed and shared, and on what grounds confidentiality might be breached.

When taking a sexual history in a non-confidential environment, encrypted devices should be considered for recording sensitive patient information.

The writing group recommends that healthcare professionals delivering a sexual health service should be familiar with the ethical and legal frameworks on safeguarding adults and children, consent and confidentiality. Safeguarding involves protecting people's health and human rights to enable them to live free from harm or abuse. It involves making an assessment of factors which could make someone vulnerable to such harms, and instigating measures to reduce these. Pathways to support these assessments and procedures will vary according to local practices and legislation.

It is good practice to obtain consent to share information with general practitioners (GPs) or family doctors, where the diagnosis or procedure may have longer term health implications.[2]

All attempts should be made to maintain patients' dignity, allowing them to dress and undress in privacy, and only exposing areas as necessary to examine them.

A chaperone should be offered for all intimate examinations, to reassure the patient, act as a witness and assist in the examination and performing of any investigation. This offer should be documented, along with the name of the chaperone, in the medical record.[3] Consent for any other staff in training to be present in the consultation should be ideally sought before the patient enters the room, to ensure they do not feel under pressure to comply. The staff member should be certain that the presence of such a trainee/observer will not affect the patient's care.[3]

The patient's sociocultural and religious values also need to be taken into consideration when delivering a sexual health service. Social, cultural and economic factors can all affect sexual desire, attitude, behaviour and practices. Therefore, addressing these factors in a globalized society is extremely important. Minority groups need to feel comfortable with, and have trust in, healthcare services and the professionals they encounter. Cultural sensitivity in the patient–provider relationship should enable culturally diverse patients to experience patient-centred health care, which is relevant to their needs and expectations.[4]

History

History taking should be done systemically with more sensitive questions being left until later. Structured proformas can be used to document key history and examination findings, and subsequent investigations and results. However, it is important not to see the history taking process as a routine, but to remain able to adapt to the patient and clinical situation.

When taking a sexual history, the healthcare provider should modify their language to ensure it is comprehensible to the patient. This will often mean avoiding medical jargon and instead utilizing sexually explicit language with which both the patient and the clinician are comfortable.

People presenting to sexual health clinics vary in the complexity of their presentation. Some present asymptomatically for routine STI testing and might be considered 'low risk' attendees. In such circumstances, traditional face-to-face consultations and the taking of an extensive medical history by a healthcare professional might not be necessary. However, if during the consultation process (face-to-face or electronic) the patient is deemed to be at high risk of STIs, is symptomatic or requires assessment for emergency contraception, postexposure prophylaxis or may have safeguarding needs, then the patient should be referred to a suitable healthcare worker for a more detailed assessment and management.

There are many sexual health services which now offer an online consultation/'no-talk' service by self-completed questionnaires and computer-assisted structured interviews (CASI).[5] Studies have shown that in many cases, reporting by CASI was more reliable, with more patients divulging potentially risky sexual behaviour than when asked via face-to-face interviews.[6] This method may also be more efficient, and has been shown to be acceptable to patients, although language and literacy will need to be taken into consideration. Evidence shows a CASI approach to be acceptable in a sexual health setting with similar consultation times and few patients declining to answer risk questions.[7] Although CASI may yield additional disclosures in sensitive question areas, some evidence shows staff may not act on this information and that overall STI or HIV detection rates may not improve.[8]

Some areas have also seen the introduction of the 'eSexual health clinic', which is an online clinical and public health intervention. Patients with chlamydia are diagnosed and managed via an automated online clinical consultation, leading to antibiotic collection from a pharmacy. This could be an innovative model to address growing population sexual health needs. Although it has its merits, particularly for people who may find it uncomfortable to discuss personal issues in a face-to-face environment, it is not a suitable method for vulnerable groups or those where there may be communication difficulties. (2D)[9, 10]

To target the youth population which is at highest risk of STIs and HIV, public health interventions have increasingly turned towards the use of social media and Internet technology. Online resources which are available include online STI/HIV testing, online counselling, partner notification and education services. (2D)[10]

Where a face-to-face consultation is conducted, consideration should be given to the clinical setting. Ideally, this would be a suitable sound-proof room which provides an environment to discuss sensitive issues and develop a clinician–patient rapport to facilitate information exchange.

During history taking, it is important to ask the following in female patients:

- Lower genital tract symptoms:[11]
  - Vaginal discharge that has changed in quantity, texture, colour or smell
  - Vulval symptoms such as pruritus, lumps, ulceration and superficial dyspareunia.

- Upper genital tract symptoms:
  - Pelvic pain
  - Deep dyspareunia
  - Menstrual cycle abnormalities:
    - Intermenstrual bleeding
    - Postcoital bleeding
    - Menorrhagia
    - Dysmenorrhoea.

For male patients, the following symptoms should be enquired about:

- Genital lumps
- Genital Ulceration
- Urethral discharge
- Testicular symptoms:
  - Pain
  - Swelling/lumps.
- Lower urinary tract symptoms:
  - Dysuria
  - Frequency
  - Haematuria
- Genital itching, soreness or rashes.

In both male and female patients, ask about:

- Rectal symptoms (when relevant to the sexual history):
  - Rectal discharge
  - Rectal bleeding
  - Rectal pain
  - Anorectal skin changes
  - Tenesmus.
- Oral lesions
- Conjunctivitis
- Rashes – genital and/or disseminated
- Mono/pauciarticular arthritis
- Systemic symptoms of weight loss, malaise, night sweats, skin lesions, lymphadenopathy.
- Sexual difficulties or dissatisfaction with sexual life should be specifically asked as these may not be volunteered. Where these are identified, appropriate referral pathways should be followed.

Following on from the symptoms, it is important to ask about the patient's general health, sexual history and social history.

- Past medical history
- Past surgical history
- Past history of STI testing, including HIV (which may include blood donation or antenatal screening) and any positive results
- A thorough medication history (including over the counter and herbal remedies)
- Drug allergies
- In females, a gynaecological and obstetric history, to include cervical cytology, including abnormal results requiring treatment, and contraceptive history which may identify women who require emergency contraception
- History of vaccinations relevant to sexual health
  - Hepatitis A
  - Hepatitis B
  - Human papillomavirus (HPV)
- A family history may be relevant for consultations involving contraception choices or in cases where congenital infection may be suspected
- Sexual history
  - Date of last sexual contact
  - Gender of sexual partner
  - Anatomical sites of exposure
  - Condom use including any condom accidents
  - Any suspected infection or symptoms in partner
  - Previous sexual contacts in the last 3 months, or if the patient is known or suspected having a particular STI, the look back period for that particular infection should be used (refer to specific guidelines for more details)
  - Practice of 'Swinging' – heterosexual men and women who as a couple have sex with others. This group represents a high-risk population as they commonly report bisexual behaviour with multiple concurrent partners. Unless questions are specifically asked, they are likely to be an under recognized group. Such questions may include 'are you a swinger', 'do you practice partner-swapping', 'do you have sex with other couples together with your partner' and 'do you visit sex clubs for couples.[12]
- Enquiring about alcohol and recreational drug use may be relevant in terms of risk-taking behaviour.[13, 14] More recently, the phenomenon of 'Chemsex' (use of recreational drugs to facilitate and heighten sexual experiences) has been identified as a public and sexual health problem. The most commonly used drugs are crystal methamphetamine, gamma-hydroxybutyrate (GHB), gamma-butyrolactone (GBL) and mephedrone. Chemsex is associated with risky sexual behaviour and increased risk of STIs including HIV, hence the importance within a sexual health consultation.[15,16]

Onward referral to appropriate services that can support chemsex users towards abstinence or risk reduction strategies should be considered. (2D)

- Previous and current HIV PEP (postexposure prophylaxis) and PrEP (preexposure prophylaxis) use if these are available in your practising country. The provision of PEPSE

should be fully integrated into a course of advice and counselling around safer sex strategies. (2D)

- Gender-based violence (GBV)/intimate partner violence (IPV)/domestic violence should be enquired about as they can be associated with sexual assault, STIs and unintended pregnancy.[17,18]

An assessment of blood-borne virus (BBV) risk will identify characteristics associated with high risk of HIV, hepatitis B and hepatitis C acquisition

- Men who have sex with men (MSM) and other bisexual men and transwomen
- Commercial sex workers
- Intravenous drug user
- People who have sexual partners from areas of high HIV prevalence rates, e.g. sub-Saharan Africa
- History of blood transfusions, non-professional tattoos or piercings
- Sexual partners of the above

Increasingly sexual health clinics are providing an integrated STI and contraception service. The contraceptive and reproductive health history may therefore vary according to whether the service primarily has an STI testing and treatment focus or is providing an integrated service.

A group which often faces healthcare disparities and barriers to care are the transgender and gender diverse populations. Healthcare providers need to be trained to use the appropriate terminology and pronouns. They also need to be mindful of heteronormative assumptions and take steps to ensure they are knowledgeable about transgender health to create a welcoming, inclusive and affirming clinical environment. Many providers assume that transgender patients do not need services such as pelvic examinations or contraception, or that treating transgender patients is too complex for their practice.[19] These dynamics contribute to significant disparities in sexual and reproductive health for transgender people. Clinics should train providers and staff on transgender appropriate care, non-discrimination and inclusivity.[20]

Specific factors to consider in the trans-population

- Transgender people may have any combination of sexual partners who are cis- or transmen or women.
- Transmen, who have not undergone gender reassignment surgery (GRS) and who have sex with cis-men, may be at risk of unintended pregnancy.
- Transpeople need preventive health screenings as recommended for the body parts the patient has, regardless of that patient's gender identity. This will include breast, cervical and prostate cancer screening.
- Transpeople face high rates of social and economic marginalization as well as high rates of physical and sexual abuse.[21]

Physical examination of the patient

It is rarely necessary to examine the patient if there are no symptoms.

Studies have shown low rates of clinical findings in asymptomatic women attending a consultation for STI. Signs are found in less than 4% of cases, and many of these are of doubtful clinical significance such as asymptomatic bacterial vaginosis or candidiasis, genital warts and molluscum contagiosum. In view of this, a genital examination is not necessary in these cases. (2C)[22–26]

In asymptomatic men, first void urine samples and asymptomatic women self-taken vulvovaginal swabs for nucleic acid amplification testing (NAAT), provide sensitive and specific results for *Chlamydia trachomatis* and *Neisseria gonorrhoeae*, and avoid the need for intimate examination which may deter some patients from attending.[27–29] In MSM, oropharyngeal and self-taken rectal swabs are a viable and acceptable option. (1B)[30–33]

However, patients presenting with symptoms suggestive of a possible STI should have a physical examination. Suitable facilities for examination should be available, with examination couches, appropriate lighting and equipment to take necessary samples.

Examination should include the following:

- Anogenital area
- Speculum examination in females
- Bimanual pelvic examination in females reporting upper genital tract symptoms
- Proctoscopy in males and females complaining of rectal symptoms
- Digital rectal examination where prostatic or rectal pathology is suspected
- Other general (i.e. non-genital) examination as indicated by the history (2D)

Examination of a patient who has been victim of sexual assault should occur after considering the need for forensic examination with an appropriate time frame for recovery of evidence. Not all clinics will need, or be able, to provide a forensic service, but a protocol for local referral must be available.

Investigations

Staff should follow local processes for the taking, storage and transportation of microbiological samples.

When ordering investigations for STIs, the window periods need to be taken into consideration. Knowledge of local laboratory assays is required to determine window periods for infections and therefore guide advice about the need for repeat testing.

All patients should be offered testing for

- *Chlamydia trachomatis* (NAAT)

- *Neisseria gonorrhoeae* (NAAT)
- Syphilis
- HIV

Other infections should be tested for based on history, examination findings and the local availability of tests. Please refer to the IUSTI European guidelines available via this link https://iusti.org/regions/Europe/euroguidelines.htm.[34]

  - *Candida albicans*
  - *Bacterial vaginosis*
  - *Trichomonas vaginalis*
  - *Mycoplasma genitalium*
  - Herpes simplex virus (HSV)
  - Lymphogranuloma venereum (LGV)
  - Chancroid
  - Granuloma inguinale

- Hepatitis B and hepatitis C
  - Please refer to the 2017 IUSTI guidelines on hepatitis for more information https://iusti.org/regions/Europe/pdf/2017/IUSTIEuropeHepatitis2017.pdf
- Urinary symptoms
  - Urinalysis and midstream urine for culture and sensitivity
- Pregnancy test
  - Required when there is a risk of pregnancy, particularly when ectopic pregnancy falls within the differential diagnosis
- Point of care testing (POCT)
  - These exist for various infections (including HIV, syphilis and TV) and are useful in certain settings, particularly community or outreach environments.
  - Light-field microscopy of genital smears, or dark-field microscopy of genital ulceration, can provide an immediate result to facilitate appropriate treatment at the time of consultation. The sensitivity of microscopy will vary according to sampling technique and user experience.
  - The sensitivity and specificity of all POCTs can vary, and they must be approved, so liaison with local laboratory services is advised.
- Additional tests in MSM
  - Rectal and pharyngeal NAAT tests (according to sexual history)
  - Proctoscopy if symptomatic
  - LGV testing if rectal chlamydia positive

The need for testing extra-genital sites in women should be considered according to the sexual history. Services may need to decide a local policy on screening asymptomatic women at pharyngeal and rectal sites pending further studies and data on cost-effectiveness. (2C) Clinics should be familiar with the assays used locally and sensitivities may vary for extra-genital sites, and not all are approved for extra-genital testing.

Results and treatment

- At the end of the consultation, it is important to communicate with patients how and when they will receive their results.
- Diagnoses should be explained, with opportunities for questions, and appropriate patient information leaflets provided where available in several other European languages. These can be accessed via https://www.iusti.org/regions/europe/PatientInformation.htm
- In many cases, it is possible to give immediate results – microscopy, POCTs.
- Services need to ensure prompt availability of relevant treatments.
- Treatment may also be indicated on epidemiological grounds at the initial visit prior to results being available. For example, patients who present as the partner of a known STI may be treated at first presentation, in addition to being tested (please see guidelines on specific infections for further information).
- To maximize compliance, and hence successful treatment, single-dose treatments administered in the clinic are preferred where possible. In addition, providing medications without charge is desirable as it removes barrier to treatment. (1C)
- Appropriate treatment should be prescribed to women or who are pregnant, breastfeeding or in whom pregnancy cannot be excluded.
- Information should be provided about the need to abstain from unprotected sexual intercourse to avoid onward transmission or re-infection.
- Attendance at a sexual health clinic offers the opportunity to deliver health promotion advice, regardless of results.
- A brief behaviour change such as motivational interviewing is no more time consuming and is more effective than simply giving advice.[35] Motivational interviewing is a collaborative, person-centred form of guidance aimed at eliciting and strengthening an individual's motivation for change. This strategy seeks to help clients think differently about their behaviour and ultimately to consider what might be gained through change.[35]
- The reporting of confirmed STI diagnoses should be in line with local policy and will assist with epidemiological studies and planning of healthcare resources.
- The treatments of specific conditions can be found in other European guidelines and are not covered here.

Partner notification/contact tracing

- This represents an important opportunity to reduce onward transmission of STIs if undertaken well, by detecting and diagnosing cases.
- Partner notification (PN) should be performed by an appropriately trained healthcare professional according to relevant guidelines for specific infections which will detail necessary look back periods .[34] (1D)
- Notification of the infection to the sexual partner(s) can be done either by the patient themselves, or via a provider referral from the local or another sexual health clinic. These options should be discussed with the patient, to help them choose the appropriate method for them.
- Communication technologies such as text messaging and web-based systems are increasingly used. Internet partner notification provides a means of notifying the increased number of individuals exposed to an STI through Internet dating sites, who may not be traceable by other means. Internet PN facilities allow patients to send electronic postcards to partners without disclosing their own identity.[36–38]

Follow-up

- The need for follow-up should always be considered
- Alternative methods to face-to-face follow-up, such as telephone, text or email, may be suitable options
- Follow-up, by whatever method, gives an opportunity to:
  - assess adherence to treatment
  - review partner notification/contact tracing
  - assess risk of re-infection and hence the need for further testing or treatment
  - reinforce health promotion
- Follow-up in person should be arranged for certain infections where a test of cure is recommended (specific guidelines should be referred for further details)
  - Gonorrhoea
  - Various STIs in pregnancy
  - Some STIs where first-line antibiotics were not used
- Follow-up for repeat screening may be required to ensure that appropriate window periods are covered
- Further review will be required where repeat treatments are necessary (e.g. wart treatments, hepatitis vaccination and follow-up after PEPSE initiation)

Proposed review date

This guideline will be kept under regular review by the editorial board of the European STI guidelines project, and an update initiated when the board feels that there is a need for it. At the latest, a new version will be produced five years after the publication of this one.

Composition of Editorial Board

See: https://www.iusti.org/regions/europe/pdf/2017/EditorialBoardSept2017.pdf

List of contributing organizations

Please refer to the link below for the list of the contributing organizations.

https://www.iusti.org/regions/europe/pdf/2017/EditorialBoardSept2017.pdf

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References

1 Challenor R, Pinsent S, Baker D *et al.* Improving access to Genitourinary Medicine by satellite clinics: an evaluation of the use of pump- priming funding. *Int J STI AIDS* 2005; **16**: 49–51.
2 Gary B, Lesley B, Ceri E *et al.* 2013 UK national guideline for consultations requiring sexual history taking. *Int J STI AIDS* 2013; **25**: 391–404.
3 General Medical Council. Guidance on good practice: Maintaining boundaries. http://www.gmc-uk.org/guidance/ethical. _guidance.asp. Accessed 11/10/2017
4 Tucker C, Marsiske M, Rice K *et al.* Patient centred culturally sensitive healthcare: model testing and refinement. *Health Psychol* 2011; **30**: 342–350.
5 Koch O, De Silva S, Edwards S *et al.* Does using self-completed sexual history questionnaires in HIV positive men who have sex with men affect clinical outcomes? *Int J STI AIDS* 2008; **19**: 203–205.
6 Vodstrcil LA, Hocking JS, Cummings R *et al.* Computer assisted self interviewing in a sexual health clinic as part of routine clinical care; Impact on service and patient and clinician views. *PLoS ONE* 2011; **6**: e18456.
7 Richens J, Copas A, Sadiq S *et al.* A randomised controlled trial of computer-assisted interviewing in sexual health clinics. *Sex Transm Infect* 2010; **86**: 310–314.
8 Ralph L, Berglas N, Schwartz S, Brindis C. Finding teens in their Space: Using social networking sites to connect youth to sexual health services. *Sexuality Res Soc Policy* 2011; **8**: 1–12.
9 Estcourt C, Gibbs J, Sutcliffe L *et al.* The eSexual Health Clinic system for management, prevention, and control of sexually transmitted infections: exploratory studies in people testing for *Chlamydia trachomatis*. *Lancet Public Health* 2017; **2**: e182–e190.
10 Jancin B. Web-based tool makes patient STD screening accessible. *Ob Gyn News* 2009; **44**: 26.
11 Van Der Meijden WI, Boffa M, Harmsel WA *et al.* 2016 European guideline for the management of vulval conditions. *J Eur Acad Dermatol Venereol* 2017; **31**: 925–941.
12 Dukers-Muijrers NHTM, Van Rooljen S, Hogewoning A *et al.* Incidence of repeat testing and diagnoses of *Chlamydia trachomatis* and *Neisseria gonorrhoea* in swingers, homosexual and heterosexual men and women at two large Dutch STI clinics, 2006–2013. *Sex Transm Infect* 2017; **93**: 383–389.
13 Rosario M, Schrimshaw EW, Hunter J. A Model of sexual risk behaviours among young gay and bisexual men: longitudinal associations of mental health, substance abuse, sexual abuse, and the coming out process. *AIDS Educ Prev* 2006; **18**: 444–460.
14 Cook RL, Clark DB. Is there an association between alcohol consumption and sexually transmitted diseases? A systematic review *Sex Trans Dis* 2005; **32**: 156–164.

15 Bourne A. Drug use among men who have sex with men: Implications for harm reduction. In: Stoicescu C, ed. Global State of Harm Reduction 2012. Harm Reduction International, London, 2012: 147–155.
16 Bourne A, Reid D, Hickson F *et al.* Illicit drug use in sexual settings ('chemsex') and HIV/STI transmission risk behaviour among gay men in South London: findings from a qualitative study. *Sex Transm Infect* 2015; **91**: 564–568.
17 Perry G, Hutchinson J. Violence as a cause or consequence of HIV for women in England. http://www.sophiaforum.net/resources/Finalweb_SophiaForum_HIV-GBVreport2013.pdf Accessed 01/09/2017
18 National Institute of Clinical Excellence. Preventing and reducing domestic violence between intimate partners. http://guidance.nice.org/PHG/Wave20/60 Accessed 11/10/2018
19 Herbst JH, Jacobs ED, Finlayson TJ *et al.* Estimating HIV prevalence and risk behaviors of transgender persons in the United States: a systematic review. *AIDS Behav* 2008; **12**: 1–17.
20 Winter S, Diamond M, Green J *et al.* Transgender people: health at the margins of society. *The Lancet* 2016; **388**: 390–400.
21 Rachlin K, Green J, Lombardi E. Utilisation of healthcare among female-to- male transgender individuals in the United States. *J Homosex* 2008; **54**: 243–258.
22 Singh RH, Erbelding EJ, Zenilman JM *et al.* The role of speculum and bimanual examinations when evaluating attendees at a sexually transmitted diseases clinic. *Sex Trans Infect* 2007; **83**: 206–210.
23 Geisler WM, Chow JM, Schachter J *et al.* Pelvic examination findings and Chlamydia trachomatis infection in symptomatic young women screened with a nucleic acid amplification test. *Sex Trans Dis* 2007; **34**: 335–338.
24 Schachter J, Shafer MA, Young M *et al.* Routine pelvic examinations in asymptomatic young women. *N Engl J Med* 1996; **335**: 1847–1848.
25 Green P, Lacey H, Kasperowicz R. Genital examination, microscopy and high vaginal swabs: are these valuable components of a sexually transmitted infection screen in asymptomatic women? *Int J STD AIDS* 2007; **18**: 85–88.
26 Lee DM, Chen MY, Bradshaw CS *et al.* Is routine vaginal examination necessary for asymptomatic women attending sexual health services? *Int J STD AIDS* 2006; **17**: 631–632.
27 Hook EW, Ching SF, Stephens J *et al.* Diagnosis of *Neisseria gonorrhoeae* Infections in women by using the ligase chain reaction on patient obtained vaginal swabs. *J Clin Microbiol* 1997; **35**: 2129–2132.
28 Schachter J, Mc Cormack WM, Chemesky MA *et al.* Vaginal swabs are appropriate specimens for diagnosis of genital tract infection with *Chlamydia trachomatis*. *J Clin Microbiol* 2003; **41**: 3784–3789.
29 Schachter J, Chernesky MA, Willis DE *et al.* Vaginal swabs are the specimens of choice when screening for Chlamydia trachomatis and Neisseria gonorrhoeae: Results from a multicenter evaluation of the APTIMA assays for both infections. *Sex Transm Dis* 2005; **32**: 725–728.
30 Alexander S, Ison C, Parry J *et al.* Self-taken pharyngeal and rectal swabs are appropriate for the detection of *Chlamydia trachomatis* and *Neisseria gonorrhoeae* in asymptomatic men who have sex with men. *Sex Transm Infect* 2008; **84**: 488–492.
31 Wayal S, Llewellyn C, Smith H *et al.* Self- sampling for oropharyngeal and rectal specimens to screen for sexually transmitted infections: acceptability among men who have sex with men. *Sex Transm Infect* 2009; **85**: 60–64.
32 Pittaras TE, Papapareskevas J, Houhoula DP *et al.* Comparison of penile skin swab with intra-urethral swab and first void urine for polymerase chain reaction- based diagnosis of Chlamydia trachomatis urethritis in male patients. *Sex Transm Dis* 2008; **35**: 999–1001.
33 Moncada J, Schachter J, Liska S *et al.* Evaluation of self-collected glans and rectal swabs from men who have sex with men for detection of *Chlamydia trachomatis* and *Neisseria Gonorrhoeae* by use of nucleic acid amplification tests. *J Clin Microbiol* 2009; **47**: 1657–1662.
34 International Union against Sexually transmitted infection guidelines. https://iusti.org/regions/Europe/euroguidelines.htm. Accessed 11/10/2018
35 Miller WR, Yahne CE, Moyers TB *et al.* A randomised trial of methods to help clinicians learn motivational interviewing. *J Consult Clin Psychol* 2004; **72**: 1050–1062.
36 Van Rooijen MS, Gotz H, Vriens P *et al.* Sender and receiver acceptability and usability of an online partner notification tool for STI in the Netherlands. *Sex Transm Dis* 2018; **45**: 354–357.
37 Gill B, John P. Partner notification for sexually transmitted infections in the modern world: a practitioner perspective on challenges and opportunities. *Sex Transm Infect* 2011; **87**: ii34eii36.
38 Rietmeijer CA, Westergaard B, Mickiewicz TA *et al.* Evaluation of an online partner notification program. *Sex Transm Dis* 2011; **38**: 359–364.

Appendix 1 Search strategy

A literature search was performed using EMBASE, CINAHL, MEDLINE and PubMed from 2004 to 2017 for publications in English using the following terms/Medical Subject headings – "sexual history consultation", "sexual history taking", "medical history taking", "medical history taking and sexually transmitted infections", "sexually transmitted infections" OR "STI's", "sexually transmitted infections AND" "sexual history taking", "safeguarding", "vulnerable patients", "safeguarding" and "safeguarding AND vulnerable patients", "chemsex". The results of the searches were sifted by reading the titles and/or abstracts and potentially relevant papers obtained in full text. Relevant papers were then appraised.

The search was limited to humans and the English language.

The following guidelines were reviewed in detail – BASHH guidelines on sexual history taking and STI testing and the previous version of the European guideline for the organization of a consultation for sexually transmitted infections (2012).

Priority was given to randomized controlled trial and systematic review evidence and, where possible, recommendations were made and graded on the basis of the best available evidence (see Appendix 2 for grading of evidence). In areas where evidence is lacking, conclusions were reached by informal consensus within the writing group.

Appendix 2 Grading of evidence

For details of the tables of evidence and grading of recommendations, please see https://www.iusti.org/regions/europe/pdf/2017/ProtocolForProduction2017.pdf

Appendix 3 Declarations of interest

Neither the authors or editors had any conflicts of interest for the content of this guideline, please see https://www.iusti.org/regions/europe/pdf/2017/ProtocolForProduction2017.pdf