ADOLESCENT HEALTH SERIES

Female adolescents and sexual health:

"I think I'm okay, but am I?"

By Elizabeth Heavey, PhD, RN, CNM

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CARING FOR a female adolescent seeking healthcare related to her sexuality requires up-to-date knowledge about contraception and guidelines relating to screening, treatment, and prevention of sexually transmitted infections (STIs). Communicating with her effectively requires a sensitive and nonjudgmental approach to obtaining a sexual health history, dealing with issues of confidentiality, anticipating what's involved if she has to share her STI status with her partner, and the implications of all of these issues within the social media–rich environment that most teens live in today. This article addresses these issues with a case study approach.

One patient's story

"Alexandra," 19, presents to her college health center and meets with the nurse. She requests a change in her oral contraceptive because it sometimes makes her nauseated. The nurse completes a sexual health history and behavioral risk assessment with Alexandra, who reports taking her oral contraceptive since age 17 for menstrual cycle regulation. She became sexually active 1 year ago and reports a history of three sexual partners, most recently her current boyfriend of 4 months.

She reports occasional condom use and consistently taking her oral contraceptive when she brushes her teeth in the morning. Her last menstrual period was 10 days ago. She denies any history of STIs but has never been tested for any. She has no complaints of pain, lesions, or vaginal discharge.

When completing a sexual health history, nurses should do so in a way that establishes open communication and facilitates the gathering of accurate information. The CDC recommends asking open-ended questions, using nonjudgmental and normalizing language, and asking about the 5 Ps (partners, practices, prevention of pregnancy, protection from STIs, and past history of STIs).[1] (See *What are the five Ps?*)

When obtaining a sexual health history, nurses should encourage risk reduction interventions and provide prevention counseling appropriate to identified risks. Nurses should also reinforce

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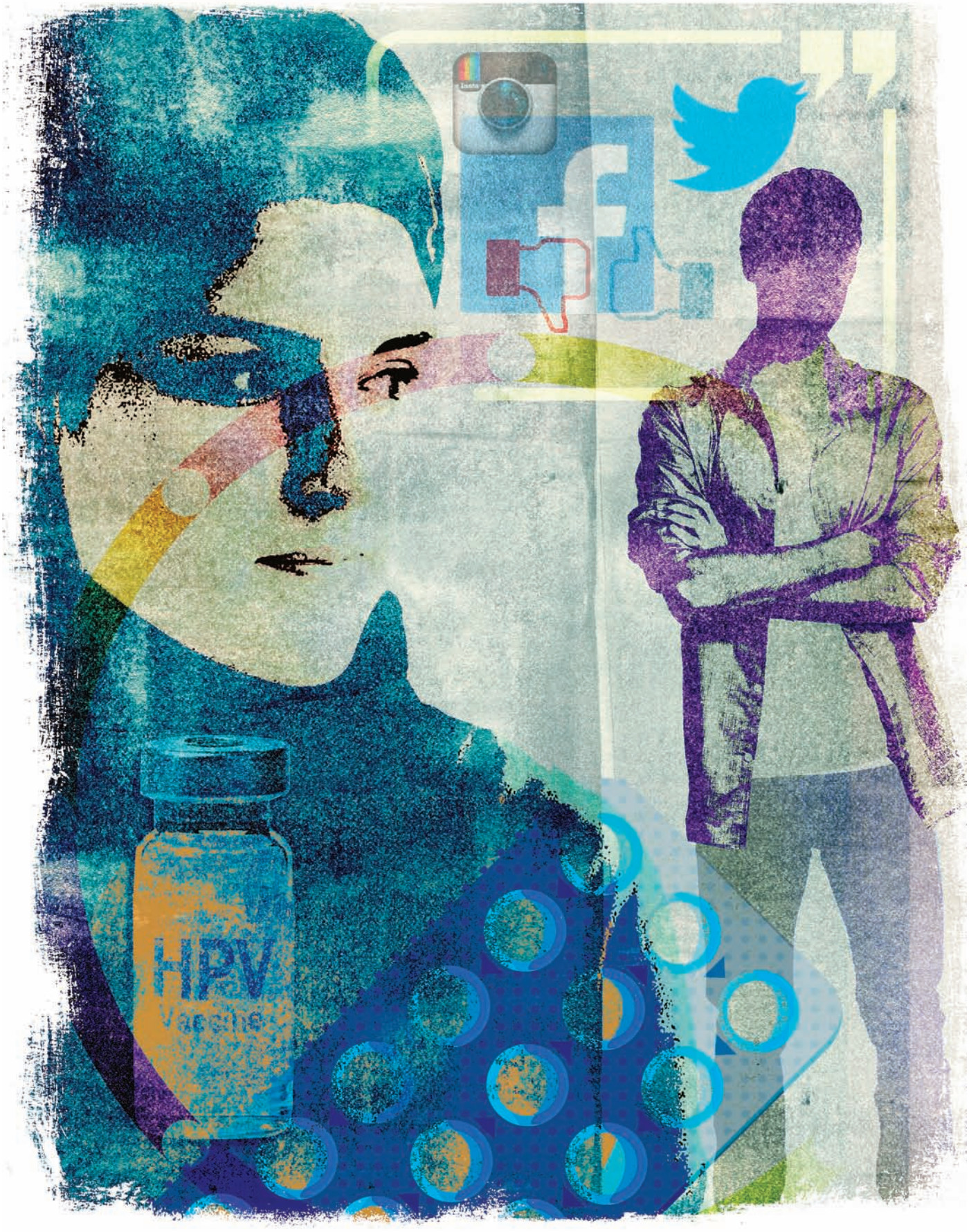


positive behaviors, including consistent use of oral contraceptives and health-seeking behaviors, such as making and keeping appointments for healthcare. Educational material and counseling should be appropriate for the patient's culture, language, gender, sexual orientation, age, health literacy level, and developmental level.[1]

To promote healthy behaviors, adolescents should be involved in all conversations and decisions about their own care. Nurses should focus on the current circumstances as well as future goals. It's important to exhibit belief in adolescents' ability to make well thought-out decisions and promote positive change.[2]

STI screening

Alexandra tells the nurse that she hasn't had STI screening because she doesn't want to have a pelvic exam and is afraid of having her blood drawn with a needle. The nurse explains to Alexandra that these are fairly common concerns because of how samples used to be collected but that other options can be used now for the most commonly required screens.

Alexandra doesn't need a pelvic exam for STI screening. She can perform vaginal swab self-collection in the privacy of the exam room or a bathroom. The nurse explains that HIV screening can be performed using an oral swab collected in the office and results will be available within half an hour.[1] *Alexandra is relieved and when the NP meets with her, she consents to testing for chlamydia, gonorrhea, trichomoniasis, and HIV infection.*

Chlamydia and gonorrhea are the two most common reportable diseases in the United States.[1] Both infections affect adolescents disproportionately. People ages 15 to 24 account for 65% of chlamydia infections and 53% of gonorrhea infections.[3] Further, approximately 1 in every 15 sexually active females ages 14 to 19 is infected with chlamydia.[4] Untreated infections in female adolescents can lead to long-term complications including infertility, ectopic pregnancy, pelvic inflammatory disease, and chronic pelvic pain.[4]

The CDC, the U.S. Preventive Services Task Force, and the American College of Obstetricians and Gynecologists (ACOG) currently recommend annual screening for gonorrhea and chlamydia in sexually active female adolescents.[5]

Pelvic exams are invasive and create barriers to patient participation in screening. Though still widely used for cervical cancer screening and symptomatic women, pelvic exams aren't necessary or recommended for chlamydia or gonorrhea screening in asymptomatic women.[6]

Nucleic acid amplification testing (NAAT) for bacterial DNA is now available for both chlamydia and gonorrhea screening. Patient-collected vaginal swabs sent for NAAT have the same sensitivity and specificity as endocervical samples collected by a provider during a pelvic exam and are frequently preferred by patients. NAAT can also be used on first-void urine samples. NAAT isn't FDA approved for use with rectal and oropharyngeal swabs; in these cases, traditional cultures are still used.[1]

Pap testing is one cervical screening option used to detect cellular changes associated with human papillomavirus (HPV) infection,

What are the five Ps?

Remember the five Ps when obtaining a sexual health history.

1. Partners

- "Do you have sex with men, women, or both?"
- "In the past 2 months, how many partners have you had sex with?"
- "In the past 12 months, how many partners have you had sex with?"
- "Is it possible that any of your sex partners in the past 12 months had sex with someone else while still in a sexual relationship with you?"

2. Practices

- "To understand your risks for sexually transmitted infections, I need to understand the kind of sex you've had recently."
- "Have you had vaginal sex, meaning 'penis in vagina sex'?" If *yes*, 'Do you use condoms never, sometimes, or always?'"
- "Have you had anal sex, meaning 'penis in rectum or anus sex'?" If *yes*, "Do you use condoms never, sometimes, or always?"
- "Have you had oral sex, meaning 'mouth on penis or vagina'?"

Follow up for condom answers:

- If *never*: "Why don't you use condoms?"
- If *sometimes*: "In what situations (or with whom) do you use condoms?"

3. Prevention of pregnancy

- "What are you doing to prevent pregnancy?"

4. Protection from sexually transmitted infections

- "What do you do to protect yourself from sexually transmitted infections, including HIV?"

5. Past history of sexually transmitted infections

- "Have you ever had a sexually transmitted infection?"
- "Have any of your partners had a sexually transmitted infection?"

Additional questions to identify HIV and viral hepatitis risk include:

- "Have you or any of your partners ever injected drugs?"
- "Have you or any of your partners exchanged money or drugs for sex?"
- "Is there anything else about your sexual practices that I need to know about?"

Source: Centers for Disease Control and Prevention. Sexually transmitted diseases treatment guidelines, 2015. *MMWR Recomm Rep.* 2015;64(RR-03):1-137.

which is associated with cervical, vulvar, vaginal, anal, and oropharyngeal cancers in women.[7] Guidelines for appropriate use of Pap testing began to change in 2009 and currently recommend Pap testing and cervical cancer screening beginning at age 21 for women regardless of their HPV vaccine status.[7] (See *More information about HPV vaccination.)* Starting Pap testing at age 21 instead of earlier resulted in a decrease in routine pelvic exams and decreased chlamydia screening rates for women ages 15 to 21 years.[6] Despite the drop in screening rates, diagnosed cases of chlamydia still increased by 5.9% overall from 2014 to 2015 and by 1.5% in women ages 15 to 19.[8] Appropriate screening guidelines for chlamydia and gonorrhea must be followed for sexually active adolescents even though routine Pap tests are no longer recommended before age 21.

HIV screening should also be discussed and offered to all sexually active adolescents as indicated. Other STI tests are available, but they're not recommended for routine screening in asymptomatic adolescents without specific identified risk factors.[1]

More information about HPV vaccination

Multiple versions of the HPV vaccine include coverage for the high-risk (oncogenic) HPV strains 16 and 18. High-risk strains of HPV are responsible for 70% of squamous cell carcinoma and adenocarcinomas of the cervix, 65% of vaginal carcinomas, 50% of vulvar carcinomas, 95% of anal carcinomas, and 60% of oropharyngeal carcinomas.[11] HPV 9-valent vaccine (Gardasil 9) includes coverage of HPV 16 and 18 as well as for HPV 6, 11, 31, 33, 45, 52, and 58, protecting recipients from additional cancers and the two strains of HPV that cause anogenital warts.[7]

In 2016, the recommended HPV vaccination schedule was adjusted from a three-dose to a two-dose series if initiated in patients before age 15.[17] The second injection should occur 6 to 12 months after the first (0,6). The three-dose regimen is still recommended for those who initiate the series at ages 15 to 26. For the three-dose series, the second dose should be 1 to 2 months after the first, and the third should be 6 months after the first (0,2,6).[17]

The recommendation to routinely administer the HPV vaccine at age 11 or 12 has remained consistent. Administration early in adolescence is associated with a stronger immune response to the vaccine, which is why patients require only two injections to achieve the same antibody titer levels.[17] The vaccine may be administered in patients as young as age 9 in appropriate circumstances.[11] Follow-up studies report no waning immunity for a full 10 years after completing the appropriate HPV vaccine series.[17]

Contraception

The NP talks with Alexandra about the change she's requesting in her oral contraceptive while they're waiting for the HIV results. The NP discusses long-term contraceptive options as well as the risk of STIs when condoms aren't used consistently. Alexandra decides to remain on an oral contraceptive but switches to a lower-dose option that's associated with fewer gastrointestinal adverse reactions, which was her main complaint.

Adolescents commonly select short-term contraception options such as condoms and oral contraceptives, which are associated with high rates of unintended pregnancy.[2] Unintended pregnancy rates associated with short-term contraceptive use are 22 times higher than rates associated with the use of long-acting reversible contraception (LARC) such as contraceptive implants and intrauterine devices.[9] Unintended pregnancy rates with short-term contraceptive options are twice as high for women under age 21 as they are for women over age 21.[9] (See *Advantages and disadvantages of LARC.*)

Contraceptive counseling for adolescents should include the full range of options with clear statements about the risks and benefits of LARC.[9] Despite the advantages associated with LARC, oral contraceptives remain the most frequently selected method of hormonal contraception for adolescents.[2] Adolescents taking oral contraception should be given a prescription for a full year and encouraged to return in 1 to 3 months for a follow-up visit to discuss any adverse reactions or challenges with adherence.[2] Patients should be encouraged to "link" taking the pill with another regular daily activity such as tooth brushing, or to use alarms, apps, or reminders in their cell phones to help prevent missed doses.

Even adolescents who are consistently using contraception sometimes change this decision, particularly when a relationship ends. For example, they may decide to stop taking an oral contraceptive because it's "no longer needed." They don't anticipate a potential future need. For this reason, all sexually active adolescents should receive information about the availability of emergency contraception, also called the "morning after pill." Adolescents should be given a prescription in advance that includes directions for use. Adolescents should also be advised how to obtain over-the-counter emergency contraception and use it appropriately.

Various emergency contraception products are available, including a single dose of ulipristal acetate, a single dose of levonorgestrel, or two doses of levonorgestrel taken 12 hours apart. Ethinyl estradiol plus levonorgestrel can also be combined in what is called a Yuzpe regimen.[1] Nurses should advise adolescents that emergency contraception can be effective for up to 5 days after unprotected intercourse but is most

effective when taken as soon as possible.[1]

Emergency contraception is effective only in preventing pregnancy. If the patient is already pregnant, emergency contraception won't disrupt the pregnancy or harm the fetus.[1]

Immunization

Upon reviewing Alexandra's immunization history, the NP also notes that Alexandra is current with all of her immunizations with the exception of HPV vaccination.

The HPV vaccination has been included in the recommended vaccine schedule for female adolescents for more than 10 years. Although improving, HPV vaccination rates remain below those of other adolescent vaccines and below national public health goals.[10]

HPV vaccinations should be administered before the onset of sexual activity to ensure full coverage. Patients with yeast allergies shouldn't be given two versions of the vaccine, quadrivalent HPV vaccine (Gardasil) or 9-valent HPV vaccine (Gardasil 9), and those with latex sensitivities shouldn't receive bivalent HPV vaccine (Cervarix) because these each contain substances that may produce an allergic reaction in sensitive patients.[11] Only Gardasil 9 is currently available in the United States.

HPV vaccines are associated with minimal adverse reactions, the most common being pain, edema, and erythema at the injection site, which tends to get progressively greater with each dose.[7] The series is expensive (over $130 per dose), but as an Advisory Committee on Immunization Practices (ACIP)-recommended vaccine, it's covered by the Patient Protection and Affordable Care Act for private health insurance plans.

To promote healthy behaviors, involve adolescents in all decisions about their own care.

The Vaccines for Children Program covers immunizations for children age 18 or younger who are Medicaid-eligible or underinsured, and Medicaid covers ACIP-recommended vaccines for Medicaid-eligible patients through age 20 and in some states after age 21 as well.[11]

Some primary care providers may be uncomfortable addressing adolescent sexual health issues, may miss a patient's first sexual intercourse or sexual debut, or lack awareness of sexual behaviors and risks.[12] Continued efforts to make this a routine part of practice are encouraged. Nurses and providers should initiate discussions with all adolescents, and parents when appropriate, about the importance of the HPV vaccine and safer sexual health practices. Appropriate patient counseling emphasizes that the HPV vaccine helps prevent cancer, that immune response to the vaccine is best when the vaccine is administered early in adolescence, and that the vaccine is strongly recommended by pediatric and adolescent professional organizations, including the American Academy of Pediatrics, the American Academy of Family Physicians, ACOG, and the CDC.[11] Within primary care settings, providers and nurses should recommend and administer the HPV vaccine at healthcare visits in the same way and at the same visit as other age-appropriate vaccines.[11]

Missed clinical opportunities can be avoided by approaching parents with a statement such as, "Today your daughter is due to receive her Tdap, influenza, and HPV vaccine." Avoid statements that diminish your endorsement and the importance of the vaccine. For example, avoid saying, "Today your daughter is due to receive her Tdap and influenza vaccines. If you'd like, we could also give her the HPV vaccine."

If the vaccine series isn't completed in primary care sites, adolescent care

Advantages and disadvantages of LARC[18,19]

Advantages
- reversible
- highly effective for at least 3 years, decreasing unintended pregnancy rates
- high continuation rates
- cost effective over the life of the contraceptive
- doesn't require situational decision making for use once placed
- high patient satisfaction

Disadvantages
- requires an office visit for placement and removal
- may lead to irregular bleeding patterns, especially after initial placement
- complications from insertion include infection and bleeding, though these are rare.

providers should discuss the vaccine during appropriate care visits, including routine sexual health exams. Multiple studies have found that appropriate presentation of HPV vaccine and provider endorsement is associated with significantly higher vaccination rates in adolescent females.[13]

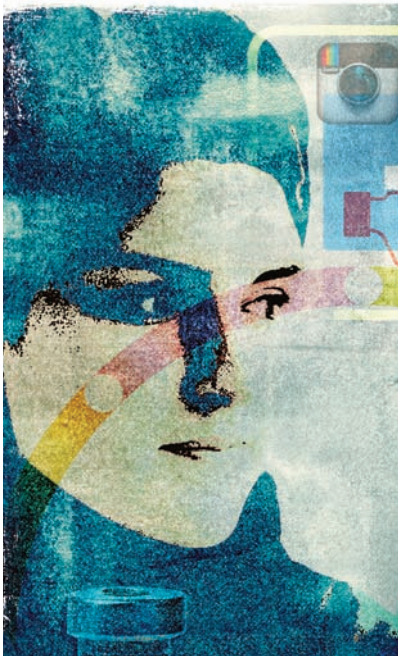
Treatment of STIs

Alexandra agrees to receive her first HPV vaccine and is relieved to learn that her rapid HIV results are negative. The NP counsels Alexandra, emphasizing the need for regular condom usage and minimizing the number of partners. She also discusses the option of returning to abstinence should Alexandra's decision or relationship change in the future. Alexandra expresses understanding and accepts a sample package of condoms.

The following week, Alexandra receives a call from the health center. She's tested negative for gonorrhea and positive for chlamydia. She's upset and wants to know if her current boyfriend gave it to her and if this means he's cheating on her. She expresses disbelief and doesn't understand how she can have chlamydia when she's been monogamous with her partner and neither of them has symptoms.

Many female patients infected with chlamydia are asymptomatic. During a pelvic exam, cervical inflammation, friability, and endocervical mucopurulent discharge may be noted, but patients aren't likely to perceive these signs. Although chlamydia infection can cause vaginal discharge, bleeding after intercourse, or mild dysuria, these may be minimal or even nonexistent in many patients.[14]

Similarly, almost all men infected with chlamydia are asymptomatic. Only 2% to 4% will report even mild symptoms.[14] Most men who report symptoms note a mild dysuria or penile discharge. Depending on sexual practices, rectal and pharyngeal infections are also possible.[14] Because many patients don't have symptoms, they may unknowingly infect others and infections may remain undiagnosed



HPV infection is associated with cervical, vulvar, vaginal, anal, and oropharyngeal cancers in women.

for an extended period. For these reasons, it's important for the patient or the health department to share that a possible exposure may have occurred with all sexual partners she had in the 2 months before she was diagnosed with the infection.[15]

Notification of sexual partners

The nurse explains to Alexandra that it isn't possible to determine the source of the chlamydia infection without notifying her previous partners and having them tested. She also explains that the test result won't tell her if her current boyfriend is monogamous. He may not be the source of the infection. Or he may have been infected in a previous relationship and isn't aware that he has chlamydia. The nurse also takes this opportunity to conduct a safety assessment and provide anticipatory guidance about implications of disclosure of STI status in social media sites.

Sexual partners of patients who test positive for chlamydia should be tested and treated. In some states, providers can offer expedited partner therapy (EPT), which involves providing prescriptions to treat sexual partners of infected people without requiring additional office visits.[15] The infected patient is treated and also given a prescription for his or her partner who's not seen by the provider. EPT helps to promote treatment and decrease reinfection rates by over 29% compared with just telling exposed partners that testing and/or treatment should be obtained.[16] Some health departments have had a great deal of success by proactively promoting EPT and supplying kits that contain condoms, written information, and the actual medication (rather than a prescription) that can be given to partners of infected patients.[16]

Nurses should advise patients that an STI diagnosis needs to be disclosed carefully and cautiously. As healthcare professionals, our instincts may be associated with the need to treat and then stop the spread of the disease. However, our first priority when STI disclosure is considered is to ensure that it's safe for our patients to share this information with their intimate partners. Twenty percent of sexually active female adolescents have experienced dating violence.[9] Disclosure of STI status is a high-risk time that could potentially incite further violence and must be screened for appropriately.

Counseling patients about additional disclosure considerations is also important before the decision is made about whether and how to disclose STI exposure risk or status. Many adolescents turn to friends and intimate partners when they're upset about an STI diagnosis, but sharing a diagnosis with someone who's a friend at one point but later becomes an enemy can have significant ramifications.

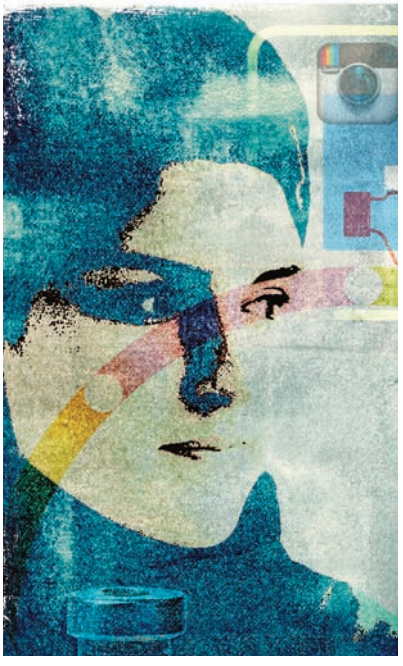
Nurses should discuss the impact of social media in the lives of adolescents. Digital abuse, including posting revealing pictures, disclosing the patient's STI status, and social network humiliation, can all be used by previously trusted confidants with knowledge of sensitive information to establish power and control in relationships.[9] Although health departments may help to anonymously notify partners, adolescents may have a very limited number of sexual partners. In this case, anonymous notification may still inadvertently reveal a patient's STI status. These are all important issues for nurses to discuss with adolescents. Be prepared to refer patients to local domestic violence resources or the National Domestic Violence Hotline at 800-799-7233 or TTY 800-787-3224.

Confidentiality issues

After an extensive dialog, Alexandra states that she's currently on her parents' private insurance plan and doesn't want them to know she's being treated. She doesn't have the money to fill a prescription right now and opts to return to the health center the next day. There, visits and treatment aren't billed to her parents' insurance and are available on a sliding fee scale for students.

Being able to provide confidential testing and treatment for adolescents is a real concern for many. Adolescents who are covered by their parents' private insurance may find their sexual activity or STI status inadvertently revealed on an "Explanation of Benefit" notice that includes the charges made to the insurance company.[2,4]

Adolescents may seek sexual healthcare from offices not affiliated with their regular primary care providers so they can pay in cash and be assured of anonymity. Planned Parenthood and county health department clinics are sometimes sought out for this very reason.



Advise patients that an STI diagnosis needs to be disclosed carefully and cautiously.

In addition, some states allow healthcare providers to notify parents when an adolescent seeks care for sexuality-related issues. Others allow adolescents of only a particular age to consent for screening and treatment. State laws can vary significantly and nurses should be aware of the laws where they practice (www.guttmacher.org/state-policy/explore/minors-access-sti-services). Care providers need to consider the implications of inadvertently revealing an adolescent's confidential healthcare and discuss this reality with their patients before ordering testing or treatment.

Treatment of STIs

The NP orders a single dose of azithromycin to be given orally to Alexandra when she comes to the health center.[1] *The nurse gives Alexandra the medication at her appointment and advises Alexandra not to have any sexual activity for a full week after she and her boyfriend receive treatment.*[1] *Alexandra reports that she's going home for winter break and won't be around her boyfriend for close to a month.*

She spoke to him the night before and he was reluctant to be tested because he didn't have any symptoms that were bothering him and didn't want to spend the money. She ended the conversation unsure of how she feels about continuing the relationship. The nurse discusses the possibility of Alexandra becoming reinfected if her partner is infected and untreated.

She also explains to Alexandra that although the office visit and treatment won't be billed to her parents' insurance, the positive results have to be reported to the county health department and the health department may contact her for follow-up. Alexandra continues to report no safety concerns and declines help telling her previous sexual contacts at this time. She leaves the office with a follow-up visit scheduled in 3 months to discuss how she's tolerating her new oral contraceptives and screen again for chlamydia.

Repeat infections with chlamydia are common, particularly if partners aren't treated at the same time.[15] Patients who have chlamydia should be tested again 3 months after completing treatment to detect reinfection from untreated or new partners.[15]

Building trust

As illustrated by Alexandra's case study, nurses must allow sufficient time to address the sexual and reproductive healthcare needs of adolescents. Developing long-term relationships with adolescent patients helps promote continuity of care and comfort discussing issues related to sexual health.[2] As trusted healthcare professionals, nurses can facilitate open communication and provide accurate sexual health information that female adolescents seek. Staying current on best practices and

professional guidelines for care helps ensure that nurses can provide the best information possible for all adolescent patients. ■

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