A randomized controlled trial comparing inSPOT and patient-delivered partner therapy to standard partner notification among MSM: The good, the bad, and the ugly

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Background

• Among heterosexuals, patient-delivered partner therapy (PDPT) increases partner treatment and decreases rates of index case reinfection
• No published randomized trials have specifically sought to evaluate different partner notification strategies in MSM
• The effectiveness of PDPT among MSM is unknown
• The effectiveness of inSPOT, a web-based partner notification tool, is also unknown

Research Questions

• Among MSM, do PDPT or inSPOT increase partner notification or treatment, compared to standard partner management?
• Do PDPT or inSPOT result in fewer partners being tested for HIV and/or syphilis, compared to SPM?

Methods

• Study design: randomized, controlled trial
• Study population: MSM reported with gonorrhea or chlamydial infection.
• Participants enrolled at time of contact for partner management services (in STD clinic or by telephone)
• Four arms:
  1. Patient delivered partner therapy (PDPT) - 1 g azithromycin; 400 mg cefixime (if patient had GC), allergy warning, STD information, condoms, invitation to STD Clinic
  2. inSPOT – participants in-clinic offered use of a computer in the clinic and given a card with website URL. Participants enrolled via telephone given web URL.
  3. Combined PDPT/inSPOT
  4. Standard partner management (SPM) – offer of assistance notifying partners
• Outcomes based on participant report at interview 2 weeks following enrollment or based on DIS recorded outcomes for partners contacted directly by DIS

Results

Table 1: Study participants

<table>
<thead>
<tr>
<th>Participant characteristic</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enrollment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>By telephone</td>
<td>2</td>
<td>3.8</td>
</tr>
<tr>
<td>In STD Clinic</td>
<td>51</td>
<td>96.2</td>
</tr>
<tr>
<td>Eligible MSM, N=393 (71%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Declined, (N=318) (81%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Enrolled, N=75 (19%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>[Low enrollment, study halted]</td>
<td></td>
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</tr>
</tbody>
</table>

Table 2: DIS management of partners and use of PDPT and inSPOT

<table>
<thead>
<tr>
<th></th>
<th>Participants</th>
<th>Partners</th>
<th>Partners managed by study staff</th>
<th>Patients who gave PDPT to ≥1 partner</th>
<th>Partners treated via PDPT</th>
<th>Patients who used inSPOT</th>
<th>Partners notified via inSPOT</th>
</tr>
</thead>
<tbody>
<tr>
<td>PDPT</td>
<td>13</td>
<td>44</td>
<td>3 (6.8%)</td>
<td>11 (84.6%)</td>
<td>33 (75%)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>inSPOT</td>
<td>10</td>
<td>30</td>
<td>3 (10.3%)</td>
<td>1 (10%)</td>
<td>3 (10%)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>PDPT/inSPOT</td>
<td>17</td>
<td>70</td>
<td>10 (14.3%)</td>
<td>13 (76.5%)</td>
<td>42 (60%)</td>
<td>1 (5.9%)</td>
<td>1 (1.4%)</td>
</tr>
<tr>
<td>SPM</td>
<td>13</td>
<td>42</td>
<td>14 (33.3%)</td>
<td>7 (17.8%)</td>
<td>2 (4.8%)</td>
<td>1 (7.7%)</td>
<td>2 (4.8%)</td>
</tr>
<tr>
<td>Total</td>
<td>53</td>
<td>186</td>
<td>30 (28%)</td>
<td>26 (78%)</td>
<td>79 (23%)</td>
<td>2 (3%)</td>
<td>3 (4%)</td>
</tr>
</tbody>
</table>

*p<0.05 when compared to standard arm

Figure 1: Study Enrollment

Goal enrollment=420 MSM
MSM with contact attempts, N=548
  Ineligible, N=118 (22%)
  Not contacted, N=37 (7%)
Eligible MSM, N=393 (71%)
Enrolled, N=75 (19%)
[Low enrollment, study halted]
Enrollees with complete data (baseline & follow-up: N=53)

Figure 2: Partners notified, treated and tested for HIV or syphilis per case

Results Summary

• Of eligible patients, 81% declined enrollment
• 80% of MSM in the two PDPT arms gave PDPT to ≥1 partner
• More partners were treated per case in the PDPT arms combined compared to SPM
• inSPOT was used very infrequently
• Highest rates of HIV and syphilis testing occurred in persons receiving standard partner services

Limitations

• We did not reach target enrollment
• Limited power to detect differences
• Limited generalizability

Conclusions

• Population-based randomized trials of different approaches to partner management in MSM may not be feasible using standard, IRB approved protocols
• PDPT is acceptable to MSM, and may increase partner treatment among MSM
• PDPT may decrease HIV and syphilis testing in MSM
• Few MSM appear to be interested is using inSPOT