Busting The Myth That Condoms Don’t Protect Gay Men Against STIs

In the age of using antiretrovirals to prevent HIV transmission, some gay men have started to believe that condoms don’t matter at all, even for sexually transmitted infections.

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Now that science is showing us that antiretrovirals can prevent the transmission of HIV, a new conversation about the place of condoms in gay men’s sex lives is taking place. This is thanks, for example, to a study published in July that estimates that Truvada (tenofovir/emtricitabine) as pre-exposure prophylaxis (PrEP) lowers the risk of acquiring HIV by 100 percent if gay men take it daily as directed. And other research has suggested that having an undetectable viral load makes HIV-positive guys virtually uninfectious. Hearing all this, some gay guys are questioning whether latex is even needed anymore.

Sure, when it comes to the threat of HIV transmission, condoms might not be required to officially have “safer sex”—so long as you’re an HIV-negative guy on daily PrEP, or you’re a positive guy who has an undetectable viral load or who’s having sex with another positive guy. But then there’s the threat of other sexually transmitted infections (STIs), which neither PrEP nor antiretroviral treatment for HIV protects against. (Although research suggests Truvada apparently does lower the risk of herpes by about a third.)

Such an inconvenient truth seems to have spawned a reactionary philosophy among some gay men, which usually goes something like this: “Well, condoms don’t really make any difference when it comes to STIs, because you can get them from oral sex anyway.” In other words, unless you use condoms during blowjobs, then you’re not at a heightened risk of STIs if you ditch the rubbers for anal sex.

This claim is partly built on fact, but at the end of the day is a myth. Indeed, you can get almost all the major STIs in your throat or around your mouth. (The exceptions are LGV and trichomoniasis.) And those infections can then transmit to another man’s urethra, in the case of bacterial infections, or to his genital area or anus in the case of ulcerative STIs that infect the skin. But the bottom line is this: Using latex for anal intercourse lowers the overall risk of transmitting STIs.

Yes, condoms lower your risk of getting or passing on STIs

Jeffrey Klausner, MD, MPH, a professor of medicine and public health at the University of California, Los Angeles, says that “while people don’t use condoms for oral sex, the idea is harm reduction: We want to meet people where they’re at, and ideally you use condoms where you’re comfortable using condoms.”

Andrew Grulich, PhD, the head of the HIV Epidemiology and Prevention Program at The Kirby Institute in Sydney, who is one of the world’s leading experts on STI transmission among gay men, says, “We do have a clear picture that if you want to reduce your acquisition risk for sexually transmitted infections, you’ll be using condoms when you have new partners. You get very substantial protection by doing so.”

Part of the faulty reasoning that likely goes into the condoms-don’t-make-any-difference argument is an assumption that if someone with an STI has oral sex with his partner, then his partner’s chance of acquiring that STI is as high as it’s going to be. The argument falsely assumes that subsequently adding anal sex to the mix does not then increase the risk of transmission. People’s reasoning on this matter may go askew for a number of reasons. Perhaps they assume that the risk of transmission during oral sex is 100 percent, so therefore it’s not possible to raise the risk any further. But no STI has such a high risk of transmission.

The reality is that the more you expose each of the three major sites of potential infection—the oral region or throat, the genital area or urethra, or the anus or rectum—to an STI, the more you raise your chance of contracting an infection. This is known as cumulative, or overall, risk. Condoms, by creating a barrier between the penis and the rectum and anus, reduce such exposure and in turn reduce overall risk.

Another thing to consider is the fact that STIs generally remain in the area where they were acquired. For ulcerative infections that affect the skin, such as herpes, syphilis or human papillomavirus (HPV, the virus that causes warts and anal cancer), this means that the STI will remain in the genital area, on or around the anus, or around the mouth. (You can also contract syphilis across the buttocks.) For bacterial infections, including gonorrhea or chlamydia, the infection will remain in the urethra, rectum or throat.

If someone contracts an STI in the throat or around the mouth from oral sex, this doesn’t mean he necessarily has it in either or the two other locations. Part of the harm reduction goal is to limit the chance not just of contracting an STI, but of contracting it in multiple sites on or in the body—because infections in multiple sites translates to an increase in the potential consequences to the individual, as well as a raised chance of passing on the STI.

Condoms do less of a stellar job at lowering the risk of infections that affect the skin and which transmit from skin-to-skin contact, because it can be so easy to transmit these STIs from the kind of rubbing that’s common between two guys during foreplay and sex. However, if a guy has a wart on his penis, for example, and he wears a condom for anal sex, this will lower the chance of transmitting the wart to the other guy’s anus. Naturally, you have to consider that he may very well rub his unsheathed penis against the other guy’s anus before putting on the condom. But by

putting on a condom for the actual act of intercourse, he's at the very least cutting down the time spent exposing the wart to his partner's body.

Where condoms really come in handy is in lowering the risk of acquiring gonorrhea and chlamydia in the rectum from someone who has a urethral infection. That's because these two bacterial STIs transmit through bodily secretions. According to Grulich, having the top (insertive partner) use a condom means the bottom (receptive partner) is three to five times less likely to acquire rectal gonorrhea and about three times less likely to get rectal chlamydia.

To give an example that shows the flawed nature of the "condoms don't matter because of the oral transmission factor" line of thought, let's say that a guy named Tony has a bacterial infection in his rectum—gonorrhea in his case. Tony is not going to transmit gonorrhea to Frank if the two of them only exchange blow jobs, because it's hidden away inside his rectum. But if Frank tops Tony, then Frank is at risk of picking up the STI in his urethra. A condom would lower this risk.

Why worry about other STIs—they're either treatable or not so bad, right?

First off, consider that there can be different repercussions for acquiring STIs in different parts of the body.

Some strains of HPV can cause cancer of the throat, penis and anus in a small minority of men. Gay men have a greatly increased risk of anal cancer compared with the general population thanks to higher anal HPV rates, and HIV-positive guys have a 100-fold greater risk of the potentially fatal disease compared with the general population. Again, condoms can't knock out the risk of acquiring anal HPV, but they may lower it. (Fortunately, the Gardasil vaccine protects against four of the most dangerous strains of HPV; gay men may want to ask their health care provider about it. Similarly, they should make sure they've been vaccinated for hepatitis B virus, which transmits readily through anal sex.)

Research suggests that those who have rectal infections of gonorrhea or chlamydia are at increased risk of acquiring HIV as a consequence. The same appears to hold true for anal syphilis, HPV or herpes, although to a lesser extent. Which underlines the notion that catching such an STI in the rectum or on the anus may have more severe consequences down the line than picking up such an infection in the throat.

Also, it's believed that urethral infections of gonorrhea or chlamydia may increase the likelihood that HIV-positive men will pass on the virus, possibly by raising what was otherwise an undetectable viral load to transmissible levels in the semen.

If someone is taking PrEP every day, the chance of acquiring HIV may indeed be off the table. However, evidence suggests that gay men aren't always so good at adhering to PrEP regimens. It's possible that a guy might acquire a rectal STI while also missing significant doses of Truvada and engaging in condomless sex. This opens the door for a greater risk of acquiring HIV.

Looking beyond the “Me! Me! Me!” factor

Something that’s also lost in this whole dialogue about whether gays need to wear condoms to protect themselves against HIV and other STIs is whether men have a responsibility to help protect the larger community.

Let’s say a guy named Bill is on daily PrEP and has condomless sex with Greg, who’s not taking PrEP but who is confident that he’s protected against getting HIV from Bill since Bill’s taking Truvada. The thing is, Bill has a urethral infection of gonorrhea, which he transmits into Greg’s rectum. Greg then dives into a brief relationship with Philip, who contracted HIV shortly before and doesn’t know it yet. Greg and Philip have condomless intercourse a few times without getting tested for HIV first, as often happens between gay men who are entering relationships or who practice “serial monogamy.” Greg’s rectal STI infection raises his risk to the point that he does contract HIV from Philip, whereas if he hadn’t had the STI he would have dodged the bullet.

It’s easy to say that Greg was responsible for his own actions, as we all should be, end of story. But the question remains as to how far Bill’s ethical responsibility extends.

Another way of looking at the larger social implications of transmitting STIs is to acknowledge the danger of gonorrhea that doesn’t respond to antibiotics. During the past few years, a revised protocol for treating gonorrhea has succeeded in fighting back an alarming rise in the rate of drug-resistant gonorrhea that took place between 2006 and 2010.

However, according to Robert Kirkcaldy, MD, a medical epidemiologist in the Centers for Disease Control and Prevention’s Division of STD Prevention, this is no time to rest on our laurels where gonorrhea is concerned.

“CDC estimates that over 800,000 [gonorrhea] infections occur yearly. And the bacteria has acquired resistance to nearly all of the antibiotics that have been used for treatment,” Kirkcaldy says. “There is only one remaining treatment option that is recommended by CDC, and it is only a matter of time before gonorrhea gains resistance to this treatment.

“Some experts have warned of the potential for untreatable gonorrhea,” he continues. “For sexually active people, it is critically important to take steps to protect themselves and their partners from infection, including using condoms, as we continue to address the urgent need to identify more treatment options for gonorrhea.”

The more that gonorrhea is transmitted, and the more we throw antibiotics at it, the more we provide the STI a chance to mutate and develop drug resistance. Yes, regular STI checkups—including looking for infections in the throat, urethra and rectum—and treatment if necessary may lower the population-level risk of treatment-resistant gonorrhea by reducing the chances that someone will transmit gonorrhea to others. But deciding not to use a condom also raises that very risk, which can have serious repercussions not just to the individual, but to the population at large.

There’s also the emerging epidemic of sexually transmitted hepatitis C virus (HCV) among HIV-positive men. (For more information about the hep C issue, check out this past article.) Risk factors include having anal sex without a condom, “aggressive sex,” fisting, group sex, being high on crystal meth, rectal pain and bleeding and the use of nasal drugs. Oral sex is not a recognized risk factor.

Making the final cost-benefit analysis

None of this is to say that gay men should never enjoy condomless sex, that they don’t deserve to have “natural sex” or that doing so is shameful. Ultimately, the choice is up to the individual about whether to use a condom.

As Andrew Grulich reflects, “I think gay men do a bit of a risk-benefit equation between pleasure and risk.” But, in his opinion, “Using condoms with new partners, it’s still not that big an ask. With new partners it makes excellent biological sense that condoms would give you good protection.”

Regardless of your condom habits, you can still mitigate the risks of STI transmission. Jeffrey Klausner recommends what he calls the “three for me”: Every three months, get an STI screening, HIV testing and treatment if necessary.

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