Risks of Oral Sex

Oral sex is the contact between one person's mouth and another person's genitals. Oral sex performed on men is referred to as fellatio, and oral sex performed on women is called cunnilingus. Insertive oral sex refers to placing genitals in or on another person's mouth, and receptive oral sex refers to receiving another person's genitals in the mouth. Oral sex may involve the passing of semen, pre-ejaculate or vaginal secretion between partners.

Research Update

Various levels of risk have been associated with oral sex from the time sexual behaviors were first evaluated for their risk of HIV infection. While early reports were inconclusive, in 1990 three cases of infection were reported — two cases were published and one was anecdotally reported — in which oral sex was the only reported risk behavior. The subjects, men in the San Francisco City Clinic Cohort Study, tested HIV antibody positive to ELISA and Western Blot tests.1,2

In the published cases, each subject tested positive after reporting that receptive oral sex with ejaculation was his only high-risk activity. The two subjects indicated they had not engaged in anal sex during the previous two years. They had participated in episodes of receptive oral sex with ejaculation with many partners.

The subject whose case was reported anecdotally told researchers that in the year since his last negative test result he had engaged in receptive oral sex, and he engaged in a single episode of receptive anal sex in which a condom was used.

Blood samples taken at the time of all three subjects' most recent negative test result showed the men also had negative results to polymerase chain reaction (PCR) assays. PCR is an advanced laboratory test that can detect HIV when antibodies are absent, such as during the infection "window period," which is the time after an individual is infected, but in which antibodies to the virus have not yet developed.

The cases are the first in the cohort study in which oral sex alone has been identified as the probable route of transmission. The study includes about 600 gay and bisexual men in San Francisco who are regularly tested for HIV antibody. Most of the men who have tested positive have done so after engaging in anal sex without a condom.

In a separate study initially presented in 1990, researchers reported that 13 of 82 men who tested antibody positive for HIV reported that they engaged in receptive and insertive oral sex since previous negative tests, but no other risk factors, such as anal sex. The individuals in this study were chosen from participants in three San Francisco studies, and included the cases reported by the San Francisco Clinic Cohort Study. The 13 HIV-infected subjects tested antibody positive about one year after their last negative test.

Researchers stated that condom use was not consistent in the group, and it was not known whether subjects had halted their oral sex practices before ejaculation. Researchers have released only preliminary information from their study, and seek to have their findings duplicated elsewhere before they publish their results.3

In another study, published in 1988, researchers in a European cohort of gay men reported five cases in which oral sex was the probable route of infection.4 While subjects from the European study seroconverted in tests performed a mean of 5.4 months after a previous negative test, researchers stated that subjects may have been in the infection
window period. PCR analysis, which is not subject to such a window period, was not performed for these cases.

Many antibody test counselors report seeing clients who have described oral sex as their only risk behavior. The anonymous testing program in San Francisco provides antibody test results to about 200 clients per week. About 8.5 percent of all clients seen in the program in the first half of 1990 tested antibody positive. A test site supervisor anecdotally reported that of subjects testing antibody positive during 1990, about one male client every other week stated that oral sex was his only risk behavior. Women testing positive have not reported oral sex as an exclusive risk behavior. Clients who have named oral sex as their only risk behavior have stated that for prolonged periods they have not engaged in other risk activities.

Counselors in other parts of the state report seeing a significantly smaller percentage of individuals who state that oral sex has been their only "high-risk" activity.

While most reported cases of HIV infection by oral sex appear to be from the insertive partner to the receptive partner during fellatio, transmission of HIV from receptive partner to insertive partner is also considered a potential risk. A 1988 study reported a case of transmission from a female prostitute to a 60-year-old male client. The man, who had been married for more than 30 years but had not had sex with his wife for several years, reported his only risk activity as insertive fellatio with the prostitute.

Because vaginal secretion, as well as menstrual blood, can contain HIV, researchers also consider oral sex with women, cunnilingus, to be a risk behavior. Some researchers have disputed the numerous reports of infection from oral sex. They suggest that infected individuals may want to attribute infection to oral sex because they are unwilling to acknowledge that they have participated in unprotected anal intercourse, a behavior that carries a stigma for some people.

It has also been suggested that individuals may have been infected earlier after engaging in unprotected anal or vaginal intercourse, but were in the infection window period at the time previous tests were conducted.

Assessing the Risk of Oral Sex

Most researchers agree that HIV can be transmitted during oral sex. However, researchers are hampered in their efforts to determine the level of risk from oral sex for several reasons, including the inability to document cases of transmission beyond a doubt.

It appears that the risk of infection from oral sex with an HIV-infected person varies depending on an individual's oral
health and on the type of oral sex practiced. An individual with gum disease, someone susceptible to ulceration or bruising in the mouth or gums or someone who vigorously brushes or flosses his or her teeth immediately prior to or after receptive oral sex is believed to be at increased risk of infection from oral sex.

The American Association of Physicians for Human Rights (AAPHR) issued "refined" guidelines in 1990 on the risk of transmission from sexual activities, including oral sex. All types of oral sex were rated as having "some risk," compared to various forms of anal and vaginal intercourse, which were all ranked as "high-risk" behaviors.

The following are AAPHR's rankings of various oral sex practices, in descending order of risk:

- oral sex with men with ejaculation and without a condom
- oral sex with men with pre-ejaculate and without a condom
- oral sex with men with a condom

Because oral sex with women can put partners in contact with vaginal secretions and blood, AAPHR states this behavior may present a greater risk than oral sex with men who do not ejaculate or secrete pre-ejaculate. In addition, AAPHR's guidelines include concerns that are considered "unresolved." These include the role of pre-ejaculate in transmission and the effectiveness of latex dams or other barriers preventing transmission during oral sex with women.

Researchers attempt to dismiss as incorrect the beliefs that transmission of HIV during oral sex can only occur after ejaculation, or only when an individual swallows another person's semen. In fact, researchers generally believe that the virus can be present before ejaculation, in the form of "pre-ejaculate," or "pre-cum," and that an individual can be infected by pre-ejaculate.

In addition, some epidemiologists state that an insertive partner may have cuts on his penis, or the receptive partner may have cuts in the mouth, and so either partner could be infected from cuts. Also, some men do not always know beforehand when their ejaculate is going to be released and are therefore unable to tell their partners.

Gum disease, which makes an individual susceptible to bruising easily or to developing ulcerations, is a common chronic ailment. Some individuals who have experienced signs of gum disease in the past may incorrectly believe that the absence of symptoms means they have recovered and they are free of disease. Dentists report that the absence of symptoms does not mean an individual is free of gum disease, and that most individuals who have a history of gum disease continue to be susceptible to bleeding and open sores. Men who are insertive partners during oral sex may be susceptible to ulcerations and sores on the penis.

A Related Issue: Condoms For Oral Sex

While many people have been willing to use condoms for anal sex, fewer have been willing to use them during oral sex for many of the same, as well as different, reasons.

Individuals state that condoms inhibit the spontaneity of sex and reduce the sensitivity of the penis. These are common complaints for not using condoms during anal sex. In addition, many people say that condoms taste and feel unpleasant, and that spermicides on condoms leave the mouth feeling "numb" and they taste and feel unpleasant. Also, some clients consider condoms to have odors that make them offensive to use during oral sex.

One manufacturer has developed a "mint-flavored" condom, which is designed to make the taste and odor of the condom more pleasant. However, this condom is not widely available. Gold Circle brand condoms, which have no scent or lubrication, are often mentioned as a preferred choice for oral sex.

Condom use during oral sex may lack general acceptance because health messages have not emphasized condom use for oral sex. Partners may be hesitant to raise the issue of condom use during oral sex because there has been little discussion of this topic in the community or among their peers.

In addition, while condoms were used as a method of contraception for many years before individuals became aware of HIV, they were not used during oral sex, and so there is a lower level of awareness that they should be used for oral sex.
Why Reports of Transmission Have Increased

Researchers have suggested several possible reasons for increased reports of transmission attributed to oral sex. Among them are the following:

- **Oral sex has become much easier to isolate as a risk factor.** As individuals have reduced the frequency of other risk behaviors, such as unprotected anal sex, oral sex has become easier to identify as a cause of transmission. The actual risk of infection from oral sex has not necessarily increased, but only recently has the practice of oral sex been considered a possible cause of infection.

- **Frequency of oral sex.** Surveys and reports from health educators across the state indicate that gay men are having oral sex with greater frequency now than during the mid-1980s or before. In a 1989 survey in San Francisco, 70% of respondents reported having oral sex without the exchange of semen in the previous 30 days, and 22% reported having oral sex with semen. The telephone survey, conducted primarily of gay men, showed an increase in the frequency of oral sex and a decrease in anal sex compared to a similar survey conducted in 1987.6

- **Failure to detect throat-based gonorrhea, herpes, syphilis or other sexually transmitted diseases (STD).** Researchers believe that transmission of HIV may be linked to inflammation in the throat, which is frequently caused by syphilis or herpes. The incidence of several types of STDs has increased in the past three years among gay men in several regions of the country. The prevalence of throat-based gonorrhea, for which tests are not routinely performed, has also increased.

- **Intensity of various forms of oral sex.** As individuals have reduced or eliminated other forms of sexual behaviors that can be considered highly physical and penetrative, individuals' oral sex practices may now be more physical and involve more abrasive contact with the mouth.

References


A Related Issue: Risks of Other Sexual Behaviors

Unprotected receptive anal sex with ejaculation continues to be the sexual behavior most often responsible for HIV infection. Risk of infection from anal sex is greatly reduced by the use of a latex condom and water-based lubricant. While use of a condom during anal sex is generally considered to reduce risk of infection, refined guidelines issued in 1990 by the American Association of Physicians for Human Rights (AAPHR) ranked insertive or receptive anal or vaginal intercourse with a condom as a "high-risk" activity.

In descending order of risk, the behaviors considered by AAPHR to be at "high-risk" are:

- receptive anal intercourse with ejaculation without a condom
- receptive vaginal intercourse with ejaculation without a condom
- insertive anal intercourse without a condom
- insertive vaginal intercourse without a condom
- receptive anal or vaginal intercourse with a condom
- insertive anal or vaginal intercourse with a condom

Other activities considered to put individuals at risk for infection include rimming, which is oral-to-anal contact, and fisting, or handballing, which involves inserting a hand or arm into a person's anus or vagina.

Some health professionals continue to believe that because of the severity of HIV disease, any sexual activity poses an infection risk. While "wet," or "French," kissing is generally believed to present little risk for HIV infection, some researchers state that the practice has not proven to be completely "risk-free," and AAPHR considers the risk from French kissing to be an "unresolved" issue.

APPLICATIONS FOR COUNSELING

For clients, learning about the risk of infection from oral sex may challenge long-held beliefs that the practice is relatively safe. Some clients may choose to forgo oral sex or make the practice safer, while others may continue current practices, either because they do not understand the risks or they are unwilling to change.

Clients may hesitate to give up or alter oral sex practices because they consider oral sex to be the only sexual behavior they have not needed to change since they first adopted safer-sex practices in the mid-1980s. In addition, they may have practiced oral sex for years and continually tested antibody negative.

In discussing the risk of infection from oral sex, antibody test counselors are faced with a subject about which there is limited scientific documentation. Because of this, many clients may be unwilling to accept warnings about the risk of the activity based on what they view as "scattered" reports, or "ever-changing" safer-sex guidelines.

Counselors need to make clients aware that a significant and increasing number of cases of oral sex transmission are being reported and that having oral sex can put clients at risk for infection. Oral sex may be dangerous regardless of whether individuals are insertive or receptive, or whether they stop the activity before ejaculation.

Clients are likely to have various ideas about the risks of specific oral sex practices, such as highly physical forms of oral sex or swallowing semen. Increased conversation about oral sex may allow clients to feel comfortable discussing specific behaviors and the levels of risk associated with various behaviors. For instance, among individuals who have oral sex with men, some believe it is safe to engage in oral sex to the point when pre-ejaculate is released, while others incorrectly consider it safe to continue oral sex beyond ejaculation as long as they do not swallow semen.

Counselors can offer specific guidance based on clients' knowledge, attitudes and practices. For all clients who practice oral sex, counselors can stress the importance of not taking semen into the mouth, regardless of whether it is swallowed. In addition, counselors can discuss the possibility of infection from pre-ejaculate. Some clients may be aware of when they are going to release pre-ejaculate, but others may not know when this occurs,
and still others may not be aware of the existence of pre-ejaculate.

Counselors can strongly suggest that clients use condoms during oral sex. While many clients may resist using condoms, counselors may be able to lessen this hesitation by determining the reasons for resistance. The client may simply have never considered using a condom during oral sex. While condom use during oral sex is not yet widely popular and it still meets with resistance, counselors can suggest that many people have accepted condoms during oral sex after using them regularly.

Counselors can help to make condoms more popular by encouraging their use in "foreplay," and by encouraging the use of flavored condoms. Counselors should caution clients that "outside agents," such as oil-based lubricants, whipped cream or peanut butter, can cause a condom to break or leak, and therefore must be avoided.

Counselors can also discuss the risk of ulcerations in the throat or gums from oral sex, and clients should be aware that blood from the mouth can enter a man's urethra, or ulcerated sites of the penis. In oral sex performed on women, blood from the mouth can enter the vagina.

Discussion should also include an explanation of the danger of gum disease, which is an important concern that a client may have previously dismissed or not seriously considered. A counselor can stress the importance of regular examinations by a dentist to maintain and improve oral health.

Increasingly, counselors are discussing with their clients the importance of good oral hygiene. Good oral hygiene generally includes daily brushing and flossing along with regular monitoring by a dentist to check for signs of disease.

Clients must be aware that good oral hygiene does not mean that they should brush or floss their teeth before or after receptive oral sex. This behavior actually may put individuals at increased risk of infection by opening sores, or irritating areas that may have become inflamed or irritated during oral sex.

Oral hygiene, and the maintenance of overall health related to oral sex, also should involve being tested for STDs, particularly of the mouth, gums and throat, in addition to genital STDs. Tests should be conducted every six months for individuals who are sexually active, and clients should specifically request a throat-based gonorrhea test, which may not be routinely offered. Counselors should be able to offer referrals where clients can receive free or inexpensive tests.

For counselors to be most effective, referrals of dentists and STD clinics should be kept up-to-date. It is important for clients to see dentists who are sensitive to HIV-related issues, and who are willing and able to answer patients' questions about oral sex practices.

Unresponsive Clients

Some clients may not respond to a counselor's suggestions and may be unwilling to eliminate oral sex practices, even when they are aware of the risks. And some clients likely will continue to deny that oral sex is a risk activity, regardless of research reports. Without oral sex, they may view their sexual choices as limited to masturbation and not view this as a satisfactory choice.

The counselor may be unable to overcome the resistance of some clients. For these clients, the counselor may need to re-emphasize the risk in a different way, perhaps by expressing it in a more personal and direct style that relates to the client or by emphasizing that the client's behavior is especially dangerous. In addition, the counselor may want to remind a client that by seeking an antibody test, the client appears to have some doubt about the safety of past practices, and is showing interest and concern in his or her health.

The counselor may not be successful at reaching agreement
A Case Study

Julio, a gay, 25-year-old man who engages in oral sex frequently, is frustrated at what he has been told by his antibody test counselor. The counselor has suggested that to reduce his risk of infection, Julio and his partner should use condoms during oral sex.

Julio replies that he tried wearing a condom on one occasion but found it unnatural. He said he has eliminated unprotected anal intercourse, rimming and other behaviors in recent years, but he is unwilling to eliminate oral sex because he sees little evidence of infection from oral sex. Julio also said that because he has not been infected up to this point from oral sex, he believes he is not at risk.

Counseling Intervention

The counselor should begin by empathizing with Julio about not wanting to change a behavior that gives him a great deal of pleasure. It is understandable that Julio, who has already changed many of his sexual behaviors to make them safer, would believe he has made sufficient changes and resist making further change.

The counselor should then express concern that Julio may be putting himself and others at risk by engaging in unprotected oral sex. To counter Julio's resistance that there is little evidence of HIV transmission by oral sex, the counselor can review recent reports of seroconversion through unprotected oral contact and state that these reports present credible and growing evidence that oral sex is a risk to be considered seriously.

Julio says that he does not believe he is at risk for infection because he has not become infected so far. The counselor must state clearly that Julio is at risk and that he may have not been infected earlier for a variety of reasons. Julio may have avoided infection simply because of luck, which may leave him at any time. The counselor can state that in the 1980s, many men who escaped infection for several years without changing their unsafe sexual practices later became infected from these same behaviors.

The counselor should also attempt to work with Julio in discussing ways to make safer sexual practices more enjoyable. The counselor can develop strategies with Julio about making oral sex with a condom more erotic, and can reduce barriers to condom use during oral sex.

If Julio objects to these attempts, the counselor must state that at the very least, Julio and his partners must be conscious of oral hygiene, and the possibility of cuts or abrasions in the mouth or on the penis that may be present even if Julio doesn't detect them. Julio should see a dentist regularly to have his gums and mouth examined, and he should be tested every six months for sexually transmitted diseases (STD).

Joining a support group may be one of the most helpful actions for Julio. The counselor should emphasize the value of a support group to Julio, and state that in such a group he can be with others who have shared some of his concerns and beliefs. The counselor should provide Julio with support group referrals.

Some clients may not acknowledge the need to practice safer oral sex with women because they do not believe reports that women can transmit HIV through sex, or they believe incorrectly that only gay men are infected. In addition, some clients may believe their partners are unwilling to use latex barriers or change practices. These clients may need to be told in a basic, but direct, manner that some women are infected with HIV, they can infect their partners, and the percentage of infected women is increasing.
TEST YOURSELF

1. True or False: Researchers generally believe that HIV can be transmitted during oral sex, but the risk of infection from oral sex is believed to be lower than from unprotected anal sex.

2. In 1990, the anonymous testing program in San Francisco, seeing about 200 clients weekly, reported how many cases of HIV infection in which clients stated oral sex as their only risk activity? a) none, b) 10 a week, c) two in the past year, d) about one every other week.

3. True or False: Reports in 1990 of HIV infection from oral sex are disputed because the reports are all from individuals who also engaged in anal sex shortly before learning they were infected.

4. True or False: Highly physical forms of oral sex, such as when a man thrusts his penis deep into his partner's mouth, may increase the risk of infection.

5. True or False: Individuals who brush or floss their teeth immediately before or after receptive oral sex may increase their risk of being infected.

6. An increasing number of cases of infection from oral sex have been reported because a) oral sex has become easier to isolate as a risk factor, b) HIV in semen has become more concentrated, c) laboratories can pinpoint oral sex transmission, d) all of the above.

7. In a study of 82 men who tested antibody positive for HIV, how many reported recently engaging in oral sex but no other risk behavior? a) 45, b) 1, c) 13, d) 0.

8. True or False: Surveys find that oral sex has become less popular as the HIV epidemic continues.

DISCUSSION QUESTIONS

- Oral sex is a significant risk, but some people feel its risk is overstated. Consider ways in which it may be overstated, and why this is so.
- Much is still unknown about infection during oral sex. Discuss how you can tell clients what is known and not known.
- What level of risk do your clients attach to oral sex? Why do you think they have these beliefs?
- Some people believe that placing restrictions on oral sex will lead individuals to believe that practicing safer sex is impossible. Do you agree? How would you deal with clients who say they are unable to modify their oral sex?
- Counselors who have discussed oral sex as a risk have been accused by some of being "sex negative," or not supportive of positive feelings about sexuality. Is there a "sex positive" way to talk about the risks of oral sex?

Answers to "Test Yourself"

1. True. Oral sex has been found to carry a risk for infection, but not as much risk as unprotected anal sex.

2. D. About one every other week.

3. False. Two subjects reported they had not performed anal sex in the previous two years, and a third reported performing protected anal sex once in the past year.

4. True. Highly physical forms of oral sex are believed to increase the risk of infection because they may damage throat tissue and increase susceptibility for throat-based gonorrhea, herpes and abrasions.

5. True. Brushing teeth immediately before or after oral sex may irritate or inflame oral ulcerations.

6. A. Oral sex has become much easier to isolate as a risk factor.

7. C. Thirteen men tested antibody positive after reporting oral sex as their only recent risk activity.


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The Research Update reports and analyzes recent research related to the main topic. In Implications for Counseling, the research is applied to the counseling session, and a case study is offered. PERSPECTIVES also includes two sets of questions, one to test yourself on the material presented, and another to discuss with others or consider alone. Each issue can be filed and referred to as an instant resource in the future.