CLINICAL PRACTICE

ALERT

November 2009

Update: CHLAMYDIA AND GONORRHEA SCREENING AND TREATMENT

Because a majority of women with *Chlamydia trachomatis* (Ct) and gonorrhea (GC) infections have no symptoms or signs, screening is essential for detecting infection. Early diagnosis and prompt management are intended to prevent reproductive complications including pelvic inflammatory disease (PID), tubal infertility, ectopic pregnancy, and chronic pelvic pain.

KEY POINTS

- **Routinely screen all sexually active females 25 years of age and younger annually for Ct.**
- **Routinely screen all sexually active females 25 years of age and younger annually for GC <u>if the prevalence of GC in your client population is one percent or higher</u>.**
- **Target Ct and GC screening of females over 25 years of age <u>only to those with risk factors</u>.**
- **Retest Ct- and GC-positive clients three months after treatment to detect re-infection. A test of cure should not be performed if recommended antibiotic regimens are used.**
- **Provide timely antibiotic therapy to all partners who had contact with the client during the 60 days prior to onset of symptoms or diagnosis of Ct or GC. While a clinical evaluation of partners is preferred, patient delivered partner therapy and patients bringing in partners at the time of the treatment visit (bring in your own partner [BYOP]) improve partner treatment rates.**

QUESTIONS AND ANSWERS

When should a woman over 25 years of age be screened for Ct?

According to California (CA) Sexually Transmitted Diseases (STD) Control Branch guidelines, the risk factors for Ct in older women are:

- A history of Ct, GC, or PID in the past 12 months
- More than one sex partner in the past 12 months
- A new sex partner in the previous three months
- Belief that a sex partner within the previous 12 months has had other sex partners at the same time
- Surveillance data show that African-American women up to age 30 have higher rates of Ct and GC infections

When should a woman over 25 years of age be screened for GC?

According to CA STD Control Branch guidelines, the risk factors for GC in older women are:

- A history of GC in the past two years
- More than one sex partner in the past 12 months
- Belief that a partner within the previous 12 months has had other sex partners at the same time
- Surveillance data show that African-American women up to age 30 have higher rates of Ct and GC infections

When should diagnostic testing for Ct/GC be performed?

- Women with clinical exam findings such as mucopurulent cervicitis, cervical friability, and acute or chronic pelvic pain that could be due to PID
- Men with clinical findings including dysuria, urethral discharge, or epididymal or testicular pain
- Women and men with a newly diagnosed sexually transmitted infection (STI) or women and men who report contact with partner known to have a STI including Ct, GC, trichomoniasis, non-gonococcal urethritis, epididymitis, syphilis, genital herpes, or human immunodeficiency virus (HIV)

Are oropharyngeal or anorectal tests recommended for persons engaging in oral or anal sex?

CA State and Center for Disease Control and Prevention (CDC) *STD Treatment Guidelines* do not recommend screening of these sites in asymptomatic women who report oral or rectal sex. Men having anal-receptive sex with men may benefit from screening for GC and Ct screening at the rectal site and those having oral sex should be screened for oropharyngeal GC only.

Which laboratory tests are recommended for Ct and GC screening and diagnostic purposes?

<u>N</u>ucleic <u>a</u>cid <u>a</u>mplification <u>t</u>ests (NAATs) can be performed on urine, vaginal, cervical, or urethral specimens with very similar accuracy. Urine specimens and vaginal swab samples eliminate the need for a pelvic examination. Urine specimens should be limited to the first portion of the urine stream.

What treatments are recommended for lower genital tract Ct and GC infections?

Regimens recommended in the 2007 CA *STD Treatment Guidelines* and included in the Family Planning, Access, Care, and Treatment (Family PACT) Formulary are:

- Ct: Azithromycin 1 gram orally in a single dose or doxycycline 100 mg orally twice daily for seven days
- GC: Ceftriaxone 125 mg IM, or cefixime 400 mg, or cefpodoxime 400 mg orally in a single dose
  Ceftriaxone is preferred based on its pharmacokinetics and higher efficacy for pharyngeal sites. Azithromycin 2 grams orally may be used if there is a history of immunoglobulin E-mediated allergy to penicillin (hives, wheezing, anaphylaxis) or an allergy to cephalosporins.
- Clients who have NAATs that are Ct negative and GC positive should be treated only for GC. If a non-NAAT test is Ct negative and GC positive, or a Ct test result is not available, clients should be treated for both Ct and GC.
- These regimens are inadequate for treatment of PID in women or epididymitis in men.

How should the client's sex partners be managed?

An essential component in the clinical management of persons with laboratory-confirmed or presumptive Ct or GC infections includes notification and treatment of all of the client's current and recent sex partner(s), within 60 days prior to the onset of symptoms or diagnosis. If the last sexual contact was over 60 days prior to diagnosis, the most recent sexual partner should be treated.

Recommended partner management options include:

- When notifying the client of positive test result, request that a client "bring your own partner (BYOP)" into clinic so that both can be treated at the same visit. While drugs for partner treatment are not a Family PACT benefit, eligible partners who enroll in Family PACT can receive treatment for Ct and GC at no cost.
- Provide medication or a prescription to clients to deliver to their partner(s) (patient-delivered partner therapy [PDPT]). In CA the use of PDPT for Ct has been legally allowable since 2001 and for GC since 2007.
- Standard patient referral or provider-assisted referral, when available.

What follow-up is recommended for women who test positive for Ct or GC?

Clients treated for Ct and GC are at high risk of repeat infection due to re-exposure to an untreated sex partner or a new partner.

- Re-testing three months after treatment is recommended. If the client fails to return at three months for retest, then test the client when seeking care during the 3-12 months following treatment.
- A test-of-cure is not necessary or recommended because the regimens listed above are highly efficacious. Testing with a NAAT earlier than one month after treatment may cause a false positive result, owing to the detection of dead organisms.
- Strategies used by providers to improve re-testing rates include:
  - Counseling the client regarding the logic and importance of re-testing, supplemented with written materials
  - At the time of initial treatment, making an appointment for client re-testing in three months
  - With the client's prior approval, contact the client via telephone call, letter, or e-mail in advance of the re-testing date
  - Using a medical record prompt ("flag") listing the date of retesting, should the client seek care for another reason

APPLICATION OF FAMILY PACT STANDARDS

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1. **Informed Consent**
   - Clients shall be advised of the availability of STI prevention and management services including education and counseling, testing and treatment.
   - An individual age 12 years and older can consent for STI screening and treatment.
2. **Confidentiality**
   - CA law mandates reporting of Ct and GC to the local health jurisdiction for prevention, control, and contact management. Client information shall be reported on the *Confidential Morbidity Report* within seven days of identification.
3. **Access to Care**
   - Laboratory testing and drugs for STI treatment shall be available at the site of clinical services or by referral to Medi-Cal laboratories and pharmacies.
4. **Availability of Covered Services**
   - Screening, testing, and treatment for STIs as listed in the *Policies, Procedures, and Billing Instructions* (PPBI) manual shall be made available to clients as a condition of delivering services under Family PACT.
5. **Clinical and Preventive Services**
   - STI prevention and management services shall be consistent with current CA STD Control Branch and CDC *STD Treatment Guidelines* and recognized medical practice standards.
   - Physical exam and testing is indicated for symptomatic clients but is not required prior to testing in the absence of symptoms.
   - All sex partners in the last 60 days of Ct-positive or GC-positive clients should be tested and empirically treated at the time of the visit before the test result is available.
   - All women who are diagnosed with acute PID should be tested for Ct and GC and should be screened for human immunodeficiency virus (HIV) infection.
   - CA law requires reporting of Ct and GC to appropriate local public health jurisdictions for contact management, prevention, and control.
6. **Education and Counseling Services**
   - Client-centered prevention and STI and HIV risk-reduction counseling and education shall be provided.

PROGRAM POLICY

This alert provides an interpretation of the Family PACT Standards regarding care of adolescent clients: Providers should refer to the Family PACT PPBI for the complete text of the Family PACT Standards, official administrative practices, and billing information. For the purposes of this and other Family PACT Clinical Practice Alerts, the term "shall" indicates a program requirement; the term "should" is advisory and not required.

RESOURCES FOR INFORMATION ON (SUBJECT)

- **Centers for Disease Control and Prevention (CDC) Web site**: www.cdc.gov/std (CDC 2006 STD Treatment Guidelines)
- **CA STD Treatment Guidelines Web site**: www.cdph.ca.gov/pubsforms/guidelines/pages/sexuallytransmitteddiseasesscreeningandtreatmentguidelines.aspx
- **CA STD/HIV Prevention Training Center Web site**: www.stdhivtraining.org or call (510) 625-6000