Practice Abstinence

The surest way to avoid STDs is to not have sex.



This means not having vaginal, oral, or anal sex.



<u>The lowdown on</u>

SEXUALLY TRANSM

new STD infections in the United States

Anyone who is sexually active can get an STD.

Some groups are disproportionately affected by STDs



Adolescents and

Young Adults

CDC



Gay, Bisexual, & other Men who have Sex with Men



Some Racial and Ethnic Minorities

DISEASE

The Good News

STDs **ARE** preventable. There are steps you can take to keep yourself and your partner(s) healthy.

Here's How You Can Avoid Giving or Getting an STD:

Use Condoms

Using a condom correctly every time you have sex can help you avoid STDs.

Condoms lessen the risk of infection for all STDs. You still can get certain STDs, like herpes or HPV, from contact with your partner's skin even when using a condom.



Most people claimed they used a condom the first time they ever had sex, but when asked about the last 4 weeks, less than one quarter said they used a condom every time.

View Infographic Online at: www.

Have Fewer Partners

Agree to only have sex with one person who agrees to only have sex with you.



Make sure you both get tested to know for sure that neither of you has an STD. This is one of the most reliable ways to avoid STDs.

Talk With Your Partner

Talk with your sex partner(s) about STDs and staying safe before having sex.

> Why take a chance when we can know for sure?

Let's both get tested together!

It might be uncomfortable to start the conversation, but protecting your health is your responsibility.

Get Vaccinated

The most common STD can be prevented by a vaccine.

The HPV vaccine is safe, effective, and can help you avoid HPVrelated health problems like genital warts and some cancers.

Who should get the HPV vaccine?

Routine vaccination for boys & girls ages 11 to 12

Catch-up vaccination for:







ng women from age 13 to age 26 and young men from age 13 to age 21

Gay, Bisexual, & other Men who have sex with Men up to age 26

Men with compromised immune systems up to age 26

cdc.gov/std/prevention/lowdown/

Get Tested

Many STDs don't have symptoms, but they can still cause health problems.



care provider

recommended tests

tested for STDs

The only way to know for sure if you have an STD is to get tested.

If You Test Positive...

Getting an STD is not the end!

Many STDs are curable and all are treatable.

If either you or your partner is infected with an STD that can be cured, both of you need to start treatment immediately to avoid getting re-infected.

Screening Recommendations and Considerations Referenced in the 2015 STD Treatment Guidelines and Original Sources

	Women	Pregnant Women	Men	Men Who Have Sex With Men (MSM)	Persons with HIV
CHLAMYDIA	Sexually active women under 25 years of age <i>USPSTF</i> ¹ Sexually active women aged25 years and older if at increased risk ² <i>USPSTF</i> ¹ Retest approximately 3 months after treatment <i>CDC</i> ³	All pregnant women under 25 years of age USPSTF ¹ Pregnant women, aged 25 years and older if at increased risk ² USPSTF ¹ Retest during the 3 rd trimester for women under 25 years of age or at risk ⁴ CDC ³ Pregnant women with chlamydial infection should have a test-of-cure 3-4 weeks after treatment and be retested within 3 months	*Consider screening young men in high prevalence clinical settings ⁵ or in populations with high burden of infection (e.g. <i>CDC</i> ⁶	At least annually for sexually active MSM at sites of contact (urethra, rectum) regardless of condom use CDC^6 Every 3 to 6 months if at increased risk ⁷ CDC^7	For sexually active individuals, screen at first HIV evaluation, and at least annually thereafter <i>CDC⁸</i> More frequent screening might be appropriate depending on individual risk behaviors and the local epidemiology <i>CDC⁸</i>
GONORRHEA	Sexually active women under 25 years of age USPSTF ¹ Sexually active women age 25 years and older if at increased risk ⁹ USPSTF ¹ Retest 3 months after treatment CDC ¹⁰	All pregnant women under 25 years of age and older women if at increased risk ¹¹ <i>USPSTF</i> ¹ Retest 3 months after treatment <i>CDC</i> ¹⁰		At least annually for sexually active MSM at sites of contact (urethra, rectum, pharynx) regardless of condom use <i>CDC¹⁰</i> Every 3 to 6 months if at increased risk ⁷ <i>CDC⁷</i>	For sexually active individuals, screen at first HIV evaluation, and at least annually thereafter <i>CDC</i> ¹⁰ More frequent screening might be appropriate depending on individual risk behaviors and the local epidemiology <i>CDC</i> ¹⁰
SYPHILIS		All pregnant women at the first prenatal visit USPSTF ¹¹ Retest early in the third trimester and at delivery if		At least annually for sexually active MSM <i>CDC</i> ¹³ Every 3 to 6 months if at increased risk ⁷	For sexually active individuals, screen at first HIV evaluation, and at least annually thereafter <i>CDC, HRSA, IDSA, NIH</i> ^{14,15,16}

	Women	Pregnant Women	Men	Men Who Have Sex With Men (MSM)	Persons with HIV
		at high risk AAP/ACOG ¹²		CDC ⁷	More frequent screening might be appropriate depending on individual risk behaviors and the local epidemiology <i>CDC</i> ¹³
TRICHOMONAS	*Consider for women receiving care in high- prevalence settings (e.g., STD clinics and correctional facilities) and for women at high risk for infection (e.g., women with multiple sex partners, exchanging sex for payment, illicit drug use, and a history of STD) <i>CDC</i> ¹⁷				Recommended for sexually active women at entry to care and at least annually thereafter <i>CDC</i> ¹⁴
HERPES	*Type-specific HSV serologic testing should be considered for women presenting for an STD evaluation (especially for women with multiple sex partners) CDC ¹⁷	*Evidence does not support routine HSV-2 serologic screening among asymptomatic pregnant women. However, type- specific serologic tests might be useful for identifying pregnant women at risk for HSV infection and guiding counseling regarding the risk for acquiring genital herpes during pregnancy CDC^{17}	*Type-specific HSV serologic testing should be considered for men presenting for an STD evaluation (especially for men with multiple sex partners) <i>CDC</i> ¹⁷	*Type-specific serologic tests can be considered if infection status is unknown in MSM with previously undiagnosed genital tract infection <i>CDC</i> ¹⁷	*Type-specific HSV serologic testing should be considered for persons presenting for an STD evaluation (especially for those persons with multiple sex partners), persons with HIV infection, and MSM at increased risk for HIV acquisition CDC ¹⁷
ΗIV	All women aged 13-64 years (opt-out)** <i>CDC</i> ¹⁸ All women who seek evaluation and treatment for STDs <i>CDC</i> ¹⁹	All pregnant women should be screened at first prenatal visit (opt-out) $USPSTF^{20}$ Retest in the third trimester if at high risk CDC^{21}	All men aged 13-64 years (opt-out)** CDC ¹⁸ All men who seek evaluation and treatment for STDs CDC ¹⁹	At least annually for sexually active MSM if HIV status is unknown or negative and the patient himself or his sex partner(s) have had more than one sex partner since most recent HIV test	

	Women	Pregnant Women	Men	Men Who Have Sex With Men (MSM)	Persons with HIV
CERVICAL CANCER	Women 21-29 years of age every 3 years with cytology Women 30-65 years of age every 3 years with cytology, or every 5 years with a combination of cytology and HPV testing USPSTF ²³ ,ACOG ²⁴ ,ACS ²⁵	Pregnant women should be screened at same intervals as nonpregnant women USPSTF ²³ ,ACOG ²⁴ ,ACS ²⁵			Women should be screened within 1 year of sexual activity or initial HIV diagnosis using conventional or liquid- based cytology; testing should be repeated 6 months later <i>CDC, NIH, IDSA</i> ²⁶
HEPATITIS B SCREENING	Women at increased risk <i>CDC</i> ²⁷	Test for HBsAg at first prenatal visit of each pregnancy regardless of prior testing; retest at delivery if at high risk CDC, ²⁷ USPSTF ²⁸	Men at increased risk CDC ²⁷	All MSM should be tested for HBsAg CDC ²⁷	Test for HBsAg and anti- HBc and/or anti-HBs. <i>CDC</i> ²⁷
HEPATITIS C SCREENING	Women born between 1945-1965 <i>CDC</i> , ²⁹ <i>USPSTF</i> ³⁰ Other women if risk factors are present ³⁰ <i>USPSTF</i> ³⁰	Pregnant women born between 1945-1965 <i>CDC</i> , ²⁹ <i>USPSTF</i> ³⁰ Other pregnant women if risk factors are present ³⁰ <i>USPSTF</i> ³⁰	Men born between 1945- 1965 <i>CDC,²⁹ USPSTF³⁰</i> Other men if risk factors are present ³⁰ <i>USPSTF³⁰</i>	MSM born between 1945- 1965 CDC ²⁹ Other MSM if risk factors are present ³⁰ USPSTF ³⁰ Annual HCV testing in MSM with HIV infection CDC ³¹	Serologic testing at initial evaluation <i>CDC, NIH, IDSA</i> ^{32,33} Annual HCV testing in MSM with HIV infection <i>CDC</i> ³¹

* Please note that portions of this table marked with an asterisk are considerations and should not be interpreted as formal recommendations.

** USPSTF recommends screening in adults and adolescents ages 15-65

- ¹ LeFevre ML. Screening for Chlamydia and Gonorrhea: U.S. Preventive Services Task Force Recommendation Statement. Annals of internal medicine. Sep 23 2014.
- ²Those who have a new sex partner, more than one sex partner, a sex partner with concurrent partners, or a sex partner who has a sexually transmitted infection. Screening for Chlamydia and Gonorrhea: U.S. Preventive Services Task Force Recommendation Statement. Annals of internal medicine. Sep 23 2014.

³ Centers for Disease Control and Prevention. Sexually Transmitted Diseases Treatment Guidelines, 2015.

- ⁴ e.g., those with a new sex partner, more than one sex partner, a sex partner with concurrent partners, or a sex partner who has a sexually transmitted infection. Centers for Disease Control and Prevention. Sexually Transmitted Diseases Treatment Guidelines, 2015.
- ⁵ Adolescent clinics, correctional facilities, and STD clinics. Centers for Disease Control and Prevention. Sexually Transmitted Diseases Treatment Guidelines, 2015.

⁶ Centers for Disease Control and Prevention. Sexually Transmitted Diseases Treatment Guidelines, 2015.

⁷ More frequent STD screening (i.e., for syphilis, gonorrhea, and chlamydia) at 3–6-month intervals is indicated for MSM, including those with HIV infection if risk behaviors persist or if they or their sexual partners have multiple partners. Centers for Disease Control and Prevention. Sexually Transmitted Diseases Treatment Guidelines, 2015.

⁸ Centers for Disease Control and Prevention. Sexually Transmitted Diseases Treatment Guidelines, 2015.

⁹ Those who have a new sex partner, more than one sex partner, a sex partner with concurrent partners, or a sex partner who has an STI. Additional risk factors for gonorrhea include inconsistent condom use among persons who are not in mutually monogamous relationships; previous or coexisting sexually transmitted infections; and exchanging sex for money or drugs. Clinicians should consider the communities they serve and may opt to consult local public health authorities for guidance on identifying groups that are at increased risk. Screening for Chlamydia and Gonorrhea: U.S. Preventive Services Task Force Recommendation Statement. Annals of internal medicine. Sep 23 2014.

¹⁰ Centers for Disease Control and Prevention. Sexually Transmitted Diseases Treatment Guidelines, 2015.

¹¹ US Preventive Services Task Force. Screening for syphilis infection in pregnancy: reaffirmation recommendation statement. Annals of internal medicine. 5/19/2009 2009;150(10):705-709.

¹²American Academy of Pediatrics, American College of Obstetricians and Gynecologists, and March of Dimes Birth Defects Foundation. Guidelines for Perinatal Care. 6th ed. Elk Grove Village, IL: American Academy of Pediatrics; 2007

¹³ Centers for Disease Control and Prevention. Sexually Transmitted Diseases Treatment Guidelines, 2015.

¹⁴ CDC, Health Resources and Services Administration, National Institutes of Health, HIV Medicine Association of the Infectious Diseases Society of America, HIV Prevention in Clincal Care Working Group. Recommendations for incorporating human immunodeficiency virus (HIV) prevention into the medical care of persons living with HIV. Clin Infect Dis. Jan 1 2004;38(1):104-121.

¹⁵ Aberg JA, Gallant JE, Ghanem KG et al. Primary Care Guidelines for the Management of Persons Infected With HIV: 2013 Update by the HIV Medicine Association of the Infectious Diseases Society of America. CID. Jan 1 2014;58: e1-e34.

¹⁶ Centers for Disease Control and Prevention, Health Resources and Services Administration, National Institutes of Health, American Academy of HIV Medicine, Association of Nurses in AIDS Care, International Association of Providers of AIDS Care, the National Minority AIDS Council, and Urban Coalition for HIV/AIDS Prevention Services. *Recommendations for HIV Prevention with Adults and Adolescents with HIV in the United States, 2014.* 2014. <u>http://stacks.cdc.gov/view/cdc/26062</u>. December 11, 2014.

¹⁷Centers for Disease Control and Prevention. Sexually Transmitted Diseases Treatment Guidelines, 2015.

¹⁸ CDC. Revised recommendations for HIV testing of adults, adolescents, and pregnant women in health-care settings. *MMWR*. 9/22/2006 2006;55(No. RR-14):1-17.

¹⁹ Centers for Disease Control and Prevention. Sexually Transmitted Diseases Treatment Guidelines, 2015.

²⁰ Moyer VA, US Preventive Services Task Force. Screening for HIV: US Preventive Services Task Force Recommendation Statement. Annals of internal medicine. 2013;159:51–60.

²¹ Women who use illicit drugs, have STDs during pregnancy, have multiple sex partners during pregnancy, live in areas with high HIV prevalence, or have partners with HIV infection. Centers for Disease Control and Prevention. Sexually Transmitted Diseases Treatment Guidelines, 2015.

²² Centers for Disease Control and Prevention. Sexually Transmitted Diseases Treatment Guidelines, 2015.

²³ Moyer VA. Screening for cervical cancer: US Preventive Services Task Force recommendation statement. *Annals of internal medicine*. Jun 19 2012;156(12):880-891, W312.

²⁴ American College of Obstetricians and Gynecologists (ACOG). Screening for cervical cancer. ACOG Practice Bulletin Number 131. Obstet Gynecol. Nov 2012;120(5):1222-1238.

²⁵ Saslow D, Solomon D, Lawson HW, et al. American Cancer Society, American Society for Colposcopy and Cervical Pathology, and American Society for Clinical Pathology screening guidelines for the prevention and early detection of cervical cancer. CA Cancer J Clin. May-Jun 2012;62(3):147-172.

²⁶ Panel on Opportunistic Infections in HIV-Infected Adults and Adolescents. Guidelines for prevention and treatment of opportunistic infections in HIV-infected adults and adolescents: recommendations from the Centers for Disease Control and Prevention, the National Institutes of Health, and the HIV Medicine Association of the Infectious Diseases Society of America. Available at: http://aidsinfo.nih.gov/contentfiles/lvguidelines/adult_oi.pdf

²⁷ Those at increased risk include persons born in regions of high endemicity (>=2% prevalence), IDU, MSM, persons on Immunosuppresive therapy, Hemodialysis patients, HIV positive individuals, and others. For detailed recommendations refer to: Centers for Disease Control and Prevention. Recommendations for Identification and Public Health Management of Person swith Chronic Hepatitis B Virus Infection, 2008. MMWR September 19th, 2008; 57(RR-8);1-21. Available at: http://www.cdc.gov/mmwr/pdf/rr/rr5708.pdf

²⁸ U.S. Preventive Services Task Force. Screening for Hepatitis B Virus Infection in Pregnancy: U.S. Preventive Services Task Force Reaffirmation Recommendation Statement. Ann Intern Med 2009;150:869-73

²⁹ Smith BD, Morgan RL, Beckett GA, et al. Recommendations for the identification of chronic hepatitis C virus infection among persons born during 1945-1965. MMWR. Aug 17 2012;61(No. RR-4):1-32.

³⁰ Past or current injection drug use, receipt of blood transfusion before 1992, long term hemodialysis, born to mother with Hep. C, intranasal drug use, receipt of an unregulated tattoo, and other percutaneous exposures. Moyer VA. Screening for hepatitis C virus infection in adults: US Preventive Services Task Force recommendation statement. Annals of internal medicine. Sep 3 2013;159(5):349-357.

³¹ Centers for Disease Control and Prevention. Sexually Transmitted Diseases Treatment Guidelines, 2015.

³²Panel on Opportunistic Infections in HIV-Infected Adults and Adolescents. Guidelines for prevention and treatment of opportunistic infections in HIV-infected adults and adolescents: recommendations from the Centers for Disease Control and Prevention, the National Institutes of Health, and the HIV Medicine Association of the Infectious Diseases Society of America. Available at: http://aidsinfo.nih.gov/contentfiles/lvguidelines/adult_oi.pdf

³³ Aberg JA, Gallant JE, Ghanem KG et al. Primary Care Guidelines for the Management of Persons Infected With HIV: 2013 Update by the HIV Medicine Association of the Infectious Diseases Society of America. CID. Jan 1 2014;58: e1-e34.

Planned Parenthood® of Northern New England

STI TESTING AND TREATMENT

Bacterial Infections

Infection	About the Infection	Type of Test	When after exposure to test	Treatment
Chlamydia	 Caused by bacteria Usually no symptoms If symptoms do occur, may include genital discharge pain during urination pelvic or testicular pain 	Urine test or swab of the genital area (from cervix or penis)	2 weeks or more after exposure	Cured with antibiotics
Gonorrhea	 Caused by bacteria Usually no symptoms If symptoms do occur, may include genital discharge pain during urination pelvic or testicular pain 	Urine test or swab of the genital area (from cervix or penis)	2 weeks or more after exposure	Cured with antibiotics
Syphilis	 Caused by bacteria May not have symptoms May have painless sores on genitals or mouth, rash 	Blood test Swab of sore	4-12 weeks after exposure	Cured with antibiotics
Pubic Lice (Crabs)	 Caused by parasite Symptoms include intense itching of genital area Nits (eggs) may be visible on pubic hair 	Visual exam Skin/hair sample viewed under microscope	When symptoms occur	Cured with over the counter medication and thorough cleaning
Scabies	 Caused by parasite Symptoms include intense itching of genital area, mall bumps or rash on genital area, buttocks, breasts, thighs 	Visual exam Skin sample viewed under microscope	When symptoms occur	Cured with over the counter or prescription medication
Trichomonas	 Caused by parasite May not have symptoms May have genital discharge and itching, pain during urination 	Swab of genital area or discharge	2 weeks or more after exposure	Cured with antimicrobials

Viral Infections

Infection	About the Infection	Type of Test	When after exposure to test	Treatment
Hepatitis B and C	 Caused by a virus Symptoms may include tiredness, abdominal pain, yellowing of eyes or skin May not have symptoms Vaccine available for Hepatitis B 	Blood test	3+ months after exposure	There is no cure for Hepatitis B or C; treatment is available to help manage the condition.
Genital Herpes	 Caused by a virus Can cause painful sores on the genitals or other areas of skin May not have symptoms 	Swab of sore during an outbreak	When symptoms occur	There is no cure for Herpes; treatment is available to help manage the condition if needed.
HIV	 Caused by a virus Early infection rarely has symptoms If symptoms do occur, may include flu-like feelings rash joint pain PrEP is a once a day medication that prevents HIV infection 	Blood test or swab from inside of mouth	3+ months after exposure	There is no cure for HIV; treatment is available to help manage the condition.
Human Papilloma Virus (HPV)	 Caused by a virus Usually no symptoms There are many kinds of HPV- some are associated with cancers of the cervix, vagina, vulva, penis, anus, or mouth. Vaccine available 	Pap test (sample from cervix) <i>There is no test available for people who do not have a cervix.</i>	Routine testing is recommended. Infection can take weeks, months, or years to test positive.	There is no cure. Medications can alleviate some symptoms; further treatment may be needed. Immunity develops over time in many individuals.
Genital Warts (HPV)	 Caused by a virus Painless, sometimes itchy genital bumps Vaccine available 	No test for types of HPV that cause warts. Bumps can be checked by a health care provider.	When symptoms occur	There is no cure. Medications can alleviate some symptoms; warts can be surgically removed. Immunity develops over time in many individuals.

STI Screening and Treatment

An Overview

SCREENING

A complete and accurate sexual history is needed to determine sexual risk based on practices and gender of partners. Because STIs and HIV can remain asymptomatic, it is imperative that providers assess all sexually active teens for risky sexual and drug-use behavior at health maintenance visits. For guidance on assessing risk and taking a sexual health history, please refer to pg. 13.

☑ Screening for Chlamydia and Gonorrhea (CT and GC)

- Annual screening for CT in all sexually active females 25 years of age and younger and men who have sex with men is recommended by the Center for Disease Control and Prevention (CDC).
- ➤ Annual screening for GC in all sexually active females 25 years of age and younger is recommended by the U.S. Preventive Services Task Force, and supported by the CDC. Annual screening of men who have sex with men is also recommended by the CDC. Screening in very low prevalence populations (<1%) is generally not indicated.</p>
- More frequent screening based on sexual risk. For adolescents, screening every 6 months in young women and every 3-6 months for men who have sex with men may be indicated. CT and GC screening can be performed at any visit type, regardless of reason for visit.
- If the test is positive for either CT or GC, repeat screening 3-4 months after treatment.

$\ensuremath{\boxtimes}$ Screening for HIV

• The CDC currently recommends an HIV test for all persons aged 13-64 once, and periodic testing for those with on-going behavioral risks. See pg. 18 for more information on HIV testing and counseling recommendation.

☑ Screening for HPV

 See pg. 20 for more information on HPV and HPV-related cancer screening recommendations.

\boxdot Screening for other STIs

- Any positive test for an STI is an indication to screen for all other STIs. For example, if a patient has trichomoniasis, he/she should be screened for CT, GC, syphilis and HIV.
- Men who have sex with men should be screened annually for syphilis.

Screening at the Discretion of the Provider

Currently, there are no screening guidelines for Chlamydia and gonorrhea (CT and GC) for men who only have sex with women (MSW) and women who only have sex with women (WSW).

- Providers may screen MSW selectively for the following high-prevalence settings:
 - \Rightarrow Correctional facilities
 - ⇒ STI clinics
 - ⇒ Adolescent-serving clinics
 - \Rightarrow Individuals with multiple partners
- Young WSW engaging in sexual behaviors involving shared vaginal or anal penetrative items (digital, sex toys, etc.) are at risk of CT/GC and should be screened at the discretion of the provider.
 - ⇒ For more information see the ARHP WSW fact sheet:
 - *www.arhp.org/factsheets*
- Sources:
- STI Epidemiology, Testing and Treatment Strategies. Adolescent Reproductive Health Education Project, PRCH, 2009.
- Center for Disease Control. Sexually Transmitted Diseases Treatment Guidelines 2006. Special Populations. http://www.cdc.gov/STD/treatment/2006/specialpops.htm. Accessed 1/29/10.

TREATMENT



- For the most up-to-date treatment recommendations, refer to the CDC's guidelines: *ttp://www.cdc.gov/STD/treatment/default.htm*
- Chlamydia, gonorrhea, and syphilis are reportable STIs in every state. Other reportable STIs vary by state and sometimes by county. See the CDC's Fastats from A to Z for individual state data:
 - http://www.cdc.gov/nchs/FASTATS/map_page.htm

¹Youth Risk Behavior Survey, National Youth Behavior Survey: 2007. ²Kaiser Family Foundation U.S. Teen Sexual Activity: Source footnote 7.



STI Screening and Treatment cont.

TIPS

- Contact your local health department for prevalence rates and trends to help you tailor STI screening. STI trends can vary significantly by state and county.
- Keep in mind patient consent/confidentiality and let the patient know that you are screening him/her for STIs. This is a great opportunity to educate teens about common STIs and safer sex methods.
- Be aware that patient confidentiality may be compromised by mandated reporting of STIs. Even if the healthcare provider does not file a report, laboratories will report any positive Chlamydia, gonorrhea or syphilis test. Become familiar with local reporting practices around contacting patients and partners and advise patients accordingly.
- Be aware of billing practices. Insurance claims sent home may breech confidentiality especially if tests for STIs are listed.
- Nucleic acid amplification tests (NAATs) are recommended for screening, and can be used on urine and selfcollected vaginal swab specimens, making a pelvic exam unnecessary.
- NAATs can also be used on pharyngeal and rectal specimens.

EXPEDITED PARTNER THERAPY (EPT) AND PARTNER NOTIFICATION

- ⇒ Expedited partner therapy (EPT) is the empirical treatment of sexual partners of an individual who tested positive for a sexually transmitted disease without provider evaluation. Under most circumstances, the patient will deliver the medication to his/her sexual partners.
- ⇒ Partner notification is the act of informing one's sexual partner(s) that he/she has potentially been exposed to an STI. There are three routes of partner notification: provider, patient, or contact referral.
- \Rightarrow EPT has been shown to be more effective than referring sexual partners for treatment of Chlamydia and gonorrhea and has reduced rates of persistent or recurring infections in individuals including adolescents.
- ⇒ EPT for gonorrhea and Chlamydia is safe, effective and should be considered standard medical practice.
- ⇒ Providers need to consider the issues surrounding EPT use and partner notification in adolescents. Dispensing EPT can breech patient confidentiality via insurance billing for medication and both EPT and partner notification can result in mandated reporting if the partner's birth date is required for prescriptions.

Resources:

- **CDC's full review of EPT:** http://www.cdc.gov/std/EPT/. Guidance for use of EPT can be found on page 34.
- **InSpot.org:** This website allows individuals who have tested positive for an STI to anonymously tell their sexual partners through an ecard. The ecard then links the individual to resources for STI testing and treatment in their area. Currently, InSpot is only available in 10 states and 9 metropolitan areas.

Sources:

- Centers for Disease Control and Prevention. Expedited partner therapy in the management of sexually transmitted diseases. Atlanta, GA: US Department of Health and Human Services, 2006.
- Golden MR, Whittington WLH, Handsfield HH, et al. Effect of Expedited Treatment of Sex Partners on Recurrent or Persistent Gonorrhea or Chlamydial Infection. N Engl J Med. 2005; 352(7): 676-685.
- Hogben M, Burstein GR. Expediated Partner Therapy for Adolescents Diagnosed with Gonorrhea or Chlamydia: A Review and Commentary. Adol Med Clinics. 2006; 17: 687-695.
- 4) CDC: Program Operations Guidelines for STD Prevention: Partner Services.

RESOURCES

Centers for Disease Control and Prevention

- Sexually Transmitted Diseases Treatment Guidelines, 2006: http://www.cdc.gov/STD/treatment/2006/toc.htm
- Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Health-Care Settings, 2006: http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5514a1.htm

US Preventive Services Task Force

- Screening for Chlamydia Infection: http://www.ahrq.gov/clinic/uspstf/uspschlm.htm
- Screening for Gonorrhea: http://www.ahrq.gov/clinic/uspstf/uspsgono.htm



HIV Testing and Counseling

Background

BASIS FOR UNIVERSAL HIV TESTING

Up to 30% of all new HIV infections occur in adolescents and young adults 13 to 25 years old.¹ 25% of individuals with HIV are unaware of their HIV diagnosis and account for approximately 54% of new infections.² The Centers for Disease Control and Prevention recommend that all persons \geq 13 years of age be tested for HIV at least once during their lifetime.³ More frequent testing is recommended based on risk for acquiring HIV.

HIV TESTING METHODS

Usually, HIV infection is screened for by an EIA (enzyme immunoassay), from a blood sample, to look for HIV antibodies. A positive or reactive EIA requires a confirmatory test (such as the Western blot) to make the diagnosis of HIV. Depending on the lab, it may take up to 2 weeks to receive results. There are limitations to this option. First, it may limit the ability to counsel patients. Second, because the patient must return in person, it may limit some people in receiving results.

ANONYMOUS TESTING

Anonymous testing is offered in some states at community based organizations or clinics. Clients may feel more at ease with anonymous testing. Refer to your state laws for more information.

RAPID TEST

Rapid Tests are screening tests available at many community or STI clinics and testing centers. Results are generally given within about 20 minutes of processing and clients receive results before they leave, enabling a built-in counseling and referral session. All reactive/positive rapid test results must be confirmed by a blood test which will require a follow-up visit. To find local testing resources go to: www.hivtest.org.

HIV Counseling

The 2006 CDC guidelines recommend that HIV testing should be: 1) opt-out, with the opportunity to ask questions and the option to decline testing; 2) performed without a separate written informed consent for HIV testing; and 3) prevention counseling should not be required with HIV diagnostic testing or part of HIV screening programs in health-care settings. The CDC does recommend counseling in nonclinical settings, such as at community-based organizations. There continues to be controversy around these areas and many state laws are incongruous with the recommended guidelines.

The ACTS⁴ (Advise, Consent, Test, Support) program can be used to prepare an adolescent to have an HIV test, receive results and elicit discussion around ways to prevent HIV quickly and efficiently. For more information about ACTS go to www.adolescentaids.org.

Adolescents may also be referred out to receive pre-test counseling using www.hivtest.org.

TO COUNSEL OR NOT TO COUNSEL?

While the CDC does not recommend counseling in health-care settings, there are times or situations that may warrant counseling.

RE	ASONS FOR COUNSELING	RE	ASONS AGAINST COUNSELING
•	Adolescents prefer to receive STI/HIV information from their provider and studies have demonstrated that provider recommendation remains one of the strongest predictors of testing. ^{5,6} Identifies personal risk of HIV infections.	*	Routine or universal HIV testing (by itself without counseling) was cost-effective even in low prevalent settings (prevalence >0.1%). ^{7,8} Normalizes HIV and makes it a part of regular STI screenings
*	Reduces anxiety by preparing client for a positive diagnosis. Decreases cost of repeat testing and stress for clients with no or low risk for HIV. Opens discussion for additional testing and counseling Assesses social support.	* *	Time constraints for primary care physicians Counseling for HIV can be integrated into risk-reduction counseling for all clients when discussing other STIs and drug use. Client has already been counseled before and does not need more information.

¹Morris M, Handcock MS, Miller WC, et al. Prevalence of HIV infection among young adults in the United States: results from the Add Health study. *Amer J Pub Health*. 2006; 96(6): 1091-1097.





²Marks G, Crepaz N, Janssen RS. Estimating sexual transmission of HIV from persons aware and unaware that they are infected with the virus in the USA. *AIDS*. 2006; 20:1447-50. ³MMWR Morb Mortal Wkly Rep 2006; 55:1-17.

⁴Developed by the Adolescent AIDS Program at Montefiore Medical Center.

⁶Goodman E, Tipton AC, Hecht L, Chesney MA. Perseverance pays off: health care providers' impact on HIV testing decisions by adolescent females. *Pediatrics*. Dec 1994; 94(6 Pt 1):878-82.

⁶Samet JH, Winter MR, Grant L, Hingson R. Factors associated with HIV testing among sexually active adolescents: a Massachusetts survey. *Pediatrics*. Sept 1997;100(3 Pt 1):371-7. ⁷Sanders GD, Bayoumi AM, Sundaram V, et al. Cost-effectiveness of screening for HIV in the era of highly active antiretroviral therapy. *N Engl J Med.* Feb 2005; 352(6):570-85. ⁸Paltiel AD, Weinstein MC, Kimmel AD, et al. Expanded screening for HIV in the United States--an analysis of cost-effectiveness. *N Engl J Med.* Feb 2005; 352(6):586-95.

HIV Testing and Counseling cont.

WHEN A CLIENT DECIDES TO TEST

- > Praise client for considering HIV testing
 - If is great that you are being proactive about your health and taking the initiative to test for HIV today."
- > Remove distractions (cell phones, partners, parents, etc.).
- Discuss confidentiality laws specifically pertaining to testing, results, and parental/partner notification. Check for testing site and state specific protocols and laws.
- Assess risk (intravenous drug users, men who have sex with men, anal sex, inconsistent condom use, sex with a known positive, history of STIs, sex in high prevalence community/network) and ways to reduce risk this can be included in discussing ways to reduce risk for other STIs; Hepatitis and HIV.
 - ☑ "What types of sex are you having? What are some ways that you could have safer sex in your relationships?"
- Discuss the window period. HIV antibodies take anywhere from 2 weeks to 6 months to be detected with the majority being detected at 3 months. Depending on risk level and state of exposure, retesting may be indicated.
- Prepare for a positive or negative diagnosis. Discuss the meaning (from patient's perspective) of a positive or negative test, what their life looks like moving forward, and who they can talk to when the appointment is over.

AFTER TESTING

In some states, giving HIV screening results over the phone is illegal, even in the case of a negative screening. Providers should refer to state laws for more information.

If **NEGATIVE**, review the risk reduction plan, window period, and need to retest. Answer any questions the client may have.

If **POSITIVE**, refer to state-specific laws for follow-up. Many states require additional screening before diagnosis, and reporting laws vary by state. Review the results, allowing additional time if the result is positive. You may want to have a social worker, counselor, or nurse provider available to assess the client and assist with post-test counseling and link to HIV/AIDS services. Discussion of partner notification and a risk reduction plan may need to be performed during a follow up visit. The first visit should be used to repeat HIV testing, and give the client time to receive their result, to process and to assess the client's safety.

Giving HIV results can be stressful. Make sure to take a break to clear your mind and talk with another health care provider about the experience.

Resources



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- *http://www.adolesecentaids.org* HIV educational materials for youth.
- http://www.thebody.com
 Online resource for HIV/AIDS.
- *http://www.hivplus.com*Discusses issues related to HIV/AIDs.
- A http://www.mpowrplus.com
 Popular magazine for HIV positive LGBT community.

^[⊕] *http://www.hivtest.org*

CDC sponsored website that provides information on HIV test centers by going to the website or texting a zip code to KnowIt or 566948.



Human Papillomavirus (HPV) Related Cancers

Screening and Follow-Up

BACKGROUND

The new recommendations for cervical cancer screening are based on a growing understanding about the Human Papillomavirus (HPV) and its causal relationship to 99% of cervical cancer.¹ However, the actual incidence of the virus causing neoplastic cervical lesions, particularly in young, healthy women, is extremely low. While over 80% of sexually active people have the virus, most young women will clear the virus before pre-cancerous cervical lesions occur.² With this understanding the new recommendations are endorsed by the American Society of Colposcopy and Cervical Pathology (ASCCP) and include new management guidelines specific to adolescent women age 20 and younger with abnormal cervical cytology and histology.

¹American College of Obstetrics and Gynecology (ACOG), Committee on Adolescent Health Care. Evaluation and management of abnormal cervical cytology and histology in the adolescent. ACOG. 2006; 107(4): 963-8. ²Ibid

Screening

WHEN TO START SCREENING FOR CERVICAL CANCER^{1,2}:

All women should begin Pap tests at the age of 21. All women, regardless of sexual orientation should undergo pap test screening using current national guidelines.³ The data on cervical cancer incidence and the natural history of HPV infection and of low- and high-grade cervical lesions suggest that a cervical lesion significant for neoplasm would take 5 to 10 years to develop after initial exposure to HPV.

- Victims of sexual abuse: little to no data is available on victims of sexual abuse, however, no evidence suggests that earlier screening would be beneficial, however abuse victims who have had vaginal intercourse, especially post puberty, may be at increased risk of HPV infection and cervical lesions and should be referred for screening once they are psychologically and physically ready (i.e., postpuberty) by a provider who has experience and sensitivity working with abused adolescents.
- *Adolescents engaging in sexual activities excluding vaginal intercourse:* the risk of HPV transmission to the cervix is low for other types of sexual activity.
- Concurrent STIs:
 - ⇒ HIV infection: obtain two Pap tests in the first year after initial diagnosis of HIV infection and if results are normal, annually thereafter.
 - ⇒ All other STIs including genital warts: follow 2002 ACS recommendation
- ➤ Anal HPV infection or anal cancer: precancerous lesions and HPV infection are common in HIV-positive individuals and MSM. Because these populations may be at higher risk of developing anal cancer, some health care providers recommend yearly anal pap tests. Currently, however, the CDC does not recommend anal pap tests due to lack of evidence supporting their use in preventing anal cancer. HPV tests have not been approved for either anal use or use in men and are likely not to be clinically helpful.^{4,5}



¹2002 American Cancer Society Recommendations can be accessed from the CDC's website at http://www.cdc.gov/std/hpv/ScreeningTables.pdf.

²ACOG Practice Bulletin: Clinical Management Guidelines for Obstetrician-Gynecologists. Cervical Cytology Screening. Dec 2009; 109.

³Center for Disease Control. Sexually Transmitted Diseases Treatment Guidelines 2006. Special Populations. http://www.cdc.gov/STD/treatment/2006/special-

pops.htm. Accessed 1/29/10.

⁴http://www.cdc.gov/std/hpv/stdfact-hpv-and-men.htm ⁵Evans, D. Pap Smears for Anal Cancer? Poz Magazine. June 2008.

Human Papillomavirus (HPV) Related Cancers cont.

SCREENING FOR CERVICAL CANCER⁶:

Screening Intervals for normal cervical cytology and histology:

- *Conventional cervical cytology smears*: After the initiation of cervical cancer screening, continue with Pap tests every two years until the age of 30.
- *Liquid-Based Cytology (Thin Prep):* After the initiation of cervical cancer screening, continue with Pap tests every two years until the age of 30.

Intervals for screening women under 30 are more frequent due to the increased likelihood of high-risk HPV acquisition.⁷

In women 20 or younger, HPV testing is not recommended due to the likelihood of this population clearing the virus.



Image taken from "FamilyDoctor.org: Pap Smear": http://familydoctor.org/138.xml

Follow-Up⁸

Recommendation for management of abnormal cervical cytology and histology in the event that the provider decides to screen a young woman under 21

DIAGNOSIS	RECOMMENDATIONS FOR ADOLESCENTS (AGED 20 OR YOUNGER)			
Atypical Squamous Cells of Undetermined Significance (ASC-US) or Low-grade Squamous Intraepithelial Lesion (LSIL)	Repeat Pap test in 12 months for up to two years; then, if remains abnormal or HSIL at any visit refer to colposcopy			
Atypical Squamous Cells, Cannot Exclude High-grade Squamous Intraepithelial Lesion (ASC-H)	Colposcopy			
High-grade Squamous Intraepithelial Lesion (HSIL)	Colposcopy			
Atypical Glandular Cells* (AGC)	Colposcopy, endocervical assessment, possible endometrial evaluation			
Cancer	Colposcopy, endocervical assessment			
Cervical Intraepithelial Lesion - mild cervical dysplasia (CIN I)	Repeat Pap at 12 month intervals, if HSIL or greater, refer back to Colposcopy.			
Cervical Intraepithelial Lesion - moderate cervical dysplasia (CIN II)	Close follow-up at 4-6 month intervals, with cytology and colposcopy; treatment is recommended if CIN II remains at two years			
Cervical Intraepithelial Lesion - severe cervical dysplasia (CIN III)	Ablative or excision therapy			

*Associated with malignant or pre-malignant lesions in up to 40% of women (age over 35 confers greater risk)

For further recommendations regarding management of colposcopy results and/or the management of pregnant adolescents with abnormal cervical cytology and histology refer to CDC website at http://www.cdc.gov/std/hpv/default. htm#resources and refer to the "Clinician's Resources" section.



⁶ACOG Practice Bulletin: Clinical Management Guidelines for Obstetrician-Gynecologists. Cervical Cytology Screening. Dec 2009; 109.

⁷Center for Disease Control and Prevention (CDC) (2007). Human papillomavirus (HPV): Prevalence of high-risk and low-risk types among females 14 to 59

years of age reported from a national survey, 2003–2004. Accessed from http://www.cdc.gov/std/stats07/figures/43.htm on May 12, 2009. ⁸ASCCP Recommendations for the Management of Women with Abnormal Cervical Cancer Screening Tests which can be accessed at http://www.asccp.org/consensus.shtml.

Sexually Transmitted Diseases





National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention

Division of STD Prevention

Sexually Transmitted Diseases: Summary of 2015 CDC Treatment Guidelines These summary guidelines reflect the 2015 CDC Guidelines for the Treatment of Sexually Transmitted Diseases. They are intended as a source of clinical guidance. An important component of STD treatment is partner management. Providers can arrange for the evaluation and treatment of sex partners either directly or with assistance from state and local health departments. Complete guidelines can be ordered online at www.cdc.gov/std/treatment or by calling 1 (800) CDC-INFO (1-800-232-4636).

DISEASE	RECOMMENDED Rx		DOSE/ROUTE	ALTERNATIVES	
Bacterial Vaginosis	metronidazole oral ¹ metronidazole gel 0.75% ¹ clindamycin cream 2% ^{1,2}	OR OR	500 mg orally 2x/day for 7 days One 5 g applicator intravaginally 1x/day for 5 days One 5 g applicator intravaginally at bedtime for 7 days	tinidazole 2 g orally 1x/day for 2 days tinidazole 1 g orally 1x/day for 5 days clindamycin 300 mg orally 2x/day for 7 days clindamycin ovules 100 mg intravaginally at bedtime for 3 days	OR OR OR
Cervicitis	azithromycin doxycycline ³	OR OR	1 g orally in a single dose 100 mg orally 2x/day for 7 days nereased risk (e.g., those aged <25 years has a sexually transmitted infection), esp	occal infection if at risk of gonorrhea or lives in a community where the prevalence of t with antimicrobials for <i>C. trachomatis</i> and <i>N. gonorrhoeae</i> should be provided for women s and those with a new sex partner, a sex partner with concurrent partners, or a sex partner v ecially if follow-up cannot be ensured or if NAAT testing is not possible.	n at who
Chlamydial Infections Adults and adolescents	azithromycin doxycycline ³	OR	1 g orally in a single dose 100 mg orally 2x/day for 7 days	erythromycin base ⁴ 500 mg orally 4x/day for 7 days erythromycin ethylsuccinate ⁵ 800 mg orally 4x/day for 7 days levofloxacin ⁶ 500 mg 1x/day orally for 7 days	OR OR OR
Pregnancy ³	azithromycin ⁷		1 g orally in a single dose	★ amoxicillin 500 mg orally 2x/day for 7 days erythromycin base ^{4,8} 500 mg orally 4x/day for 7 days erythromycin ethylsuccinate 800 mg orally 4x/day for 7 days erythromycin ethylsuccinate 800 mg orally 4x/day for 7 days erythromycin ethylsuccinate 400 mg orally 4x/day for 14 days	OR OR OR OR
Infants and Children (<45 kg): urogenital, rectal	erythromycin base ⁹ ethylsuccinate	OR	50 mg/kg/day orally (4 divided doses) daily for 14 days	★ Data are limited on the effectiveness and optimal dose of azithromycin for chlamydial infection in infants and children ≤ 45 kg	
Neonates: opthalmia neonatorum, pneumonia	erythromycin base ⁹ ethylsuccinate	OR	50 mg/kg/day orally (4 divided doses) daily for 14 days	★ azithromycin 20 mg/kg/day orally, 1 dose daily for 3 days	
Epididymitis ^{10,11}					
For acute epididymitis most likely caused by sexually transmitted CT and GC	ceftriaxone doxycycline	PLUS	250 mg IM in a single dose 100 mg orally 2x/day for 10 days		
★ For acute epididymitis most likely caused by sexually-transmitted chlamydia and gonorrhea	ceftriaxone levofloxacin	PLUS	250 mg IM in a single dose		
and enteric organisms (men who practice insertive anal sex)	ofloxacin	OK	300 mg orally 2x/day for 10 days		
For acute epididymitis most likely caused by enteric organisms	levofloxacin ofloxacin	OR	500 mg orally 1x/day for 10 days 300 mg orally 2x/day for 10 days		
Genital Herpes Simplex	acyclovir	OR	400 mg orally 3x/day for 7-10 days ¹³		
First clinical episode of genital herpes	acyclovir valacyclovir ¹²	OR OR	200 mg orally 5x/day for 7-10 days ¹³ 1 g orally 2x/day for 7-10 days ¹³		
Episodic therapy for recurrent genital herpes	acyclovir	OR	400 mg orally 3x/day for 5 days		
	acyclovir acyclovir valacyclovir ¹²	OR OR OR	800 mg orally 2x/day for 5 days 800 mg orally 3x/day for 2 days 500 mg orally 2x/day for 3 days		
	valacyclovir ¹² famciclovir ¹²	OR OR OR	1 g orally 1x/day for 5 days 125 mg orally 2x/day for 5 days		
	famciclovir ¹² famciclovir ¹²	OR	1000 mg orally 2x/day for 1 day ¹³ 500 mg orally once, followed by 250 mg 2x/day for 2 days		
Suppressive therapy ¹⁴ for recurrent genital herpes	acyclovir valacyclovir ¹²	OR OR	400 mg orally 2x/day 500 mg orally 1x/day		
	valacyclovir ¹² famciclovir ¹²	OR	1 g orally once a day 250 mg orally 2x/day		
Recommended regimens for episodic infection in persons with HIV infection	acyclovir valacyclovir ¹²	OR OR	400 mg orally 3x/day for 5-10 days 1 g orally 2x/day for 5-10 days		
Recommended regimens for daily suppressive	famciclovir ¹² acyclovir	OR	400-800 mg orally 2-3x/day		
therapy in persons with HIV infection	valacyclovir ¹² famciclovir ¹²	OR	500 mg orally 2x/day 500 mg orally 2x/day		
Genital Warts ¹⁵ (Human Papillomavirus)	Patient Applied ★ imiquimod 3.75% or 5% ¹² cream podofilox 0.5% ¹⁵ solution or gel	OR OR	See complete CDC guidelines.		
External genital and perianal warts	sinecatechins 15% ointment ^{2,12}	on	Apply small amount dry apply weekly if necessary	nodenhullin rasin 10% 25% in compound firsture of henzoin may be	
	Cryotherapy trichloroacetic acid or bichloroacetic acid 80%-90%	OR OR	· · · · · · · · · · · · · · · · · · ·	considered for provider-administered treatment if strict adherence to the recommendations for application.	OR
	surgical removal			intralesional interferon photodynamic therapy	OR OR
Gonococcal Infections ¹⁶		DLUG			
Adults, adolescents, and children >45 kg: uncomplicated gonococcal	azithromycin ⁷	PLUS	250 mg IM in a single dose	cefixime ¹⁷ 400 mg orally in a single dose arithromycin ⁷ 1 g orally in a single dose	PLUS
infections of the cervix, urethra, and rectum				 ★ If cephalosporin allergy: 	DLUG
				azithromycin 2 g orally in a single dose	OR
				gentamicin 240 mg IM single dose azithromycin 2 g orally in a single dose	PLUS
Pharyngeal ¹⁸	ceftriaxone azithromycin ⁷	PLUS	250 mg IM in a single dose 1 g orally in a single dose		
Adults and adolescents:	see complete CDC guidelines.	PLUS	1 g IM in a single dose		
Children (≦45 kg): urogenital, rectal, pharyngeal	ceftriaxone ¹⁹		25-50 mg/kg IV or IM, not to exceed 125 mg IM in a single dose		
Lymphogranuloma venereum	doxycycline ³		100 mg orally 2x/day for 21 days	erythromycin base 500 mg orally 4x/day for 21 days	
Nongonococcal Urethritis (NGU)	azithromycin ⁷ doxycycline ³	OR	1 g orally in a single dose 100 mg orally 2x/day for 7 days	erythromycin base ⁴ 500 mg orally 4x/day for 7 days erythromycin ethylsuccinate ⁵ 800 mg orally 4x/day for 7 days	OR OR
.	Man initially tracted with downwaline :			ofloxacin 300 mg 1x/day for 7 days	OK
▼ Persistent and recurrent NGU ^{3,20,21}	azithromycin		1 g orally in a single dose		
	Men who fail a regimen of azithromycin: moxifloxacin		400 mg orally 1x/day for 7 days		
	Heterosexual men who live in areas where <i>T. vaginalis</i> is highly provalent:				
	metronidazole ²² tinidazole	OR	2 g orally in a single dose 2 g orally in a single dose		
Pediculosis Pubis	permethrin 1% cream rinse pyrethrins with piperonyl butoxide	OR	Apply to affected area, wash off after 10 minutes Apply to affected area, wash off after 10 minutes	malathion 0.5% lotion, applied 8-12 hrs then washed off ivermectin 250 µg/kg, orally repeated in 2 weeks	OR
Pelvic Inflammatory	Parenteral Regimens Cefotetan	PLUS	2 g IV every 12 hours	Parenteral Regimen Ampicillin/Sulbactam 3 g IV every 6 hours	PLUS
Diseuse	Doxycycline	OR	2 g IV every 6 hours	Doxycycline 100 mg orally or IV every 12 hours	
	Doxycycline		100 mg orally or IV every 12 hours		
	Recommended Intramuscular/Oral Regimens Ceftriaxone Doxycycline	PLUS WITH or	250 mg IM in a single dose 100 mg orally twice a day for 14 days		
	Metronidazole	WITHOUT OR	500 mg orally twice a day for 14 days		
	Cefoxitin Probenecid, Doxycycline	PLUS PLUS WITH or	2 g IM in a single dose 1 g orally administered concurrently in a single dose 100 mg orally twice a day for 14 days	The complete list of recommended regimens can be found in	
Seabios	Metronidazole permethrin 5% cream	WITHOUT	500 mg orally twice a day for 14 days Apply to all areas of body from neck down wash off after 8-14 bours	lindane $1\%^{23,24}$ 1 oz. of lotion or 30 g of cream annlied thinly to all	
Subles	ivermectin benzathine penicillin G		200 μg/kg orally, repeated in 2 weeks 2.4 million units IM in a single dose	areas of the body from the neck down, wash off after 8 hours doxycycline ^{3,25} 100 mg 2x/day for 14 days	OR
Primary, secondary, or early latent <1 year				tetracycline ^{3,25} 500 mg orally 4x/day for 14 days	
Latent >1 year, latent of unknown duration	benzathine penicillin G		2.4 million units IM in 3 doses each at 1 week intervals (7.2 million units total)	doxycycline ^{3,25} 100 mg 2x/day for 28 days tetracycline ^{3,25} 500 mg orally 4x/day for 28 days	OR
Pregnancy Neurosyphilis	See complete CDC guidelines. aqueous crystalline penicillin G		18–24 million units per day, administered as 3–4 million units IV	procaine penicillin G 2.4 MU IM 1x daily	PLUS
★ Congenital syphilis	See complete CDC guidelines.		every 4 hours or continuous infusion, for 10–14 days	probeneoid 500 mg orally 4x/day, both for 10-14 days. See CDC STD Treatment guidelines for discussion of alternative therapy in	
Children: Primary, secondary, or early latent <1 year Children: Latent >1 year latent of unknown duration	benzathine penicillin G benzathine penicillin G		50,000 units/kg IM in a single dose (maximum 2.4 million units) 50,000 units/kg IM for 3 doses at 1 week intervals	patients with penicillin allergy.	
Trichomoniasis	metronidazole ²²	OR	(maximum total 7.2 million units) 2 g orally in a single dose	metronidazole ²² 500 mg $2x/dav$ for 7 davs	
	tinidazole ²⁶		2 g orally in a single dose	uuju	
Persistent or recurrent trichomoniasis	If this regimen fails:		500mg orally 2x/day for 7 days		
	metronidazole tinidazole	OR	2g orally for 7 days 2g orally for 7 days		
	If this regimen fails, susceptibility testing is recommended				

- The recommended regimens are equally efficacious. 1.
- These creams are oil-based and may weaken latex condoms and diaphragms. Refer to product labeling for 2 further information.
- Should not be administered during pregnancy, lactation, or to children <8 years of age. 3.
- If patient cannot tolerate high-dose erythromycin base schedules, change to 250 mg 4x/day for 14 days. 4. 5. If patient cannot tolerate high-dose erythromycin ethylsuccinate schedules, change to 400 mg orally 4 times a
- day for 14 days.
- Contraindicated for pregnant or lactating women. 6.
- Clinical experience and published studies suggest that azithromycin is safe and effective.
- 8
- Erythromycin estolate is contraindicated during pregnancy. Effectiveness of erythromycin treatment is approximately 80%; a second course of therapy may be 9 required.
- Patients who do not respond to therapy (within 72 hours) should be re-evaluated. 10
- 11. For patients with suspected sexually transmitted epididymitis, close follow-up is essential.
- 12 No definitive information available on prenatal exposure
- Treatment may be extended if healing is incomplete after 10 days of therapy.
 Consider discontinuation of treatment after one year to assess frequency of recurrence.
- 15. Vaginal, cervical, urethral meatal, and anal warts may require referral to an appropriate specialist.

- 16. CDC recommends that treatment for uncomplicated gonococcal infections of the cervix, urethra, and/or rectum should include dual therapy, i.e., both a cephalosporin (e.g., ceftriaxone) plus azithromycin. 17. CDC recommends that cefixime in combination with azithromycin or doxycycline be used as an alternative
- when ceftriaxone is not available.
- Only ceftriaxone is recommended for the treatment of pharyngeal infection. Providers should inquire 18. about oral sexual exposure
- Use with caution in hyperbilirubinemic infants, especially those born prematurely. 19.
- MSM are unlikely to benefit from the addition of nitroimidazoles. 20.
 - 21. Moxifloxacin 400mg orally 1x/day for 7 days is effective against Mycoplasma genitalium.
- 22. Pregnant patients can be treated with 2 g single dose.
- 23
- Contraindicated for pregnant or lactating women, or children <2 years of age. Do not use after a bath; should not be used by persons who have extensive dermatitis. 24.
- Pregnant patients allergic to penicillin should be treated with penicillin after desensitization. 25.
- 26 Randomized controlled trials comparing single 2 g doses of metronidazole and tinidazole suggest that tinidazole is equivalent to, or superior to, metronidazole in achieving parasitologic cure and resolution of symptoms
- ★ Indicates update from the 2010 CDC Guidelines for the Treatment of Sexually Transmitted Diseases.

Reviewed by the CDC 6/2015

Chlamydia Screening

BARRIERS to chlamydia screening for adolescent and young adults (AYA)

Chlamydia screening is not always offered to asymptomatic youth, and may not be offered at all outside of sexual health visits. Additionally, it can be difficult for youth to access sexual health services and STI screening confidentially at a standard primary care clinic due to insurance issues and the Explanation of Benefits (EOB).

STRATEGIES to increase chlamydia screening rates

Instate universal chlamydia screening.

Many settings have instated mass chlamydia screening for all females age 15-24. This may mean some women are over-screened, but it also allows the opportunity to screen those who really need screening but whose visit type did not trigger the provider to consider chlamydia screening. This strategy can catch cases of chlamydia that would otherwise go undetected. And, while some systems start routine screening at age 16, it may be more appropriate to start routine screening at age 15 or even 14 if you're in an area that has high rates of chlamydia or a younger age for sexual debut.

- Create workflows to ensure that any female patient ages 15-24 are screened. Below is a sample workflow:
 - If the patient has not been screened in the past year, she is given a letter at check-in about chlamydia screening, describing that it is a routine part of care recommended for all young women. The patient's parent is given a similar letter if the patient is under 18.
 - As they are called back for their appointment, the Medical Assistant collects a urine sample or has them self-swab, and then pends the order for chlamydia screening. At this time the MA also gets the adolescent's direct contact number.
 - During the visit, the provider will talk to the patient and decide if the screening test should be sent.
 - It is very important to get a direct contact number for the adolescent, because if there is a positive result in someone under 18, you want to contact them directly and treat them without them having to inform their family if they do not want to.
 - By making chlamydia testing routine, families will hopefully not be surprised or concerned if STI screening is sent home in an EOB.

Build-in reminder systems to your EHR.

MICHIGAN MEDICINE

- Many electronic health records have built-in reminder systems for quality measures.
 - For example, EPIC can give you best practice advisories for chlamydia screening, and this can cue the provider to offer screening to patients, and to remind medical assistants to collect a urine sample.
 - You want to use your EHR to its highest capabilities to help you remember when things need to be done.
- Residency sites should consider adding a flag to the EHR to cue preceptors to ensure that residents addressed best practice advisories (BPAs) or quality care reminders. Such a prompt may read, "Were BPAs addressed during this encounter?"

STARTER GUIDE

Chlamydia Screening

Partner with safety net providers, including school-based health centers (SBHCs).

- Safety net providers, including Federally Qualified Health Centers (FQHCs), local health departments, Planned Parenthood clinics, and SBHCs often offer free and confidential STI testing for AYA patients. Connect with your local safety net providers and encourage patients to utilize their services for confidential screening and treatment.
 - <u>Here</u>¹ is a FQHC finder from HRSA. <u>Here</u>² is the health center locator for Planned Parenthood. Find and connect with SBHCs in your area. Maintain a list of local resources that you can give to adolescent patients.
 - If you and the SBHC use a shared EHR, you can pull reports of patients who have been seen at both sites. Care coordinators can help patients coordinate care between PCPs and SBHCs and ensure that care is provided across the continuum.
- PCP payment may hinge on meeting quality measures including chlamydia screening, and it doesn't matter where the patient gets the screening, so creative partnerships may improve your bottom line.
- Read the <u>AAP's Policy Statement</u>³ on SBHC/PCP collaboration.

Should you also screen adolescent males?

The USPSTF recommends that sexually active females under age 25 get screened, and that males should only be screened if they are high risk.

- Every office has to find their own way on how they approach screening young men.
 - Even without automated screening for all males, the familiarity, comfort, and confidence in the benefits
 of chlamydia screening from an automated female screening pathway may lead to screening many
 more males, as well.
- There is a chance you may face barriers with insurance companies paying for universal screening for males.
 - Insurance companies are mandated by the Affordable Care Act to cover all USPSTF Grade A and B evidence screenings without cost sharing on the patient's end. Screening AYA females for gonorrhea and chlamydia gets Grade B evidence, but for males screening gets an "I" grade, for insufficient evidence for or against screening. So, there is no mandate for insurers to cover screening.

ADDITIONAL RECOMMENDATIONS

MICHIGAN MEDICINE

- University of Michigan universal chlamydia screening documents (subsequent pages): 1) Sample workflows;
 2) Script for MAs; 3) Sample parent letter; 4) Sample patient letter; 5) Sample handout for patients
- Asymptomatic sexually active adolescents should be screened for certain STIs. Review <u>USPSTF</u> recommendations⁴ and <u>CDC recommendations⁵</u> on preventive services and STI screening.
- The <u>NAHIC Summary</u>⁶ of Recommended Guidelines for Clinical Preventives Services for Young Adults provides a snapshot of STI recommendations, as well as other preventive recommendations.

STARTER GUIDE

Chlamydia Screening

1) POSSIBLE WORK FLOWS FOR RISK SCREENING AND CHLAMYDIA SCREENING

Confidential risk screening

- 1. Front desk staff gives parent letter about confidential time with adolescent patients.
- 2. MA calls patient, explains to parent "I'll be bringing your child back to get their vital signs and have them complete a brief health survey, and then I'll bring you to the room before the provider comes to see them."
 - a. MA can explain that "We are giving teens a chance to share their views on their health, and that's why we have them complete the health survey on their own." If there is parent push-back, the MA rooms the patient without doing risk screening, and the provider can address the issue.
- 3. The MA rooms the patient, has them complete the risk screening, and brings the results to the provider to review. The MA then gets the parent.
- 4. The provider meets with the parent and patient, and then asks the parent to step out at the end of the visit for confidential time. The provider then reviews the risk screen with the patient.

Workflow for Chlamydia Screening

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- 1. Front desk staff gives patient and parent letters about chlamydia screening.
- 2. MA collects urine sample or has patient self-swab as they room the patient.
- 3. MA collects direct contact information for the patient for results.
- 4. MA "pends" the order for chlamydia screening in the EHR. The provider discusses the test with the patient, signs the order if the test is indicated.

Merged option for chlamydia screening and risk screening

- 1. Front desk staff gives patient and parent letters about chlamydia screening, letter about confidential time with adolescents.
- 2. MA calls patient, explains to parent "I'll be bringing your child back to get their vital signs and have them complete a brief health survey, and then I'll bring you to the room before the provider comes to see them."
- 3. MA collects urine sample or has patient self-swab as they room the patient.
- 4. MA collects direct contact information for the patient for results.
- 5. The MA rooms the patient, has them complete the risk screening, and brings the results to the provider to review. The MA then gets the parent.
- 6. MA "pends" the order for chlamydia screening in the EHR.
- 7. The provider meets with the parent and patient, and then asks the parent to step out at the end of the visit for confidential time. The provider then reviews the risk screen with the patient. The provider discusses chlamydia screening with the patient, signs the order if the test is indicated.

STARTER GUIDE

Chlamydia Screening

ADOLESCENT HEALTH INITIATIVE

2) CHLAMYDIA SCREENING: MA CONVERSATION WITH PATIENT

- We are constantly working to improve the quality of care that we provide to our patients
- One of the measures that we are including is routine Chlamydia screening
- Chlamydia screening is recommended by the United States Preventive Services Task Force for women between the ages of 16 to 24
- The screening is recommended because Chlamydia is the most common sexually transmitted disease and often does not have symptoms, so you may not know you have it
- The problem with Chlamydia is that if it goes untreated it can lead to life-long complications, including infertility.
- It is easily treated with antibiotics
- The test is simple we just need a urine sample

Information for MA

Proper handling of urine sample for Chlamydia and/or urine culture

- Chlamydia screening alone:
 - For best results make sure that last void was more than 2 hours ago
 - (If not, ask if willing to do a vaginal self-swab instead)
 - First catch
 - Refrigerate immediately!
- <u>Chlamydia screening and urine culture:</u>
 - Clean catch

MICHIGAN MEDICINE

Refrigerate immediately



Chlamydia Screening



3) SAMPLE PARENT LETTER

Health Center Contact Information

(Insert your health center's logo, if appropriate)

Dear Parent /Guardian:

Congratulations! Your child has reached the teenage years. Adolescence is a time of transition from childhood to adulthood. We want to help your teen prepare to be an active participant in his/her medical care. We will start talking to your teen independently for part of his/her visit. Since this can be a difficult time of life, we will be taking some time to talk to him/her in private concerning issues that you or he/she may not necessarily be comfortable discussing with each other. Some of the topics that we will be talking about will include:

- healthy eating and sleeping habits
- friends and relationships
- emotions and mood
- sexuality
- drugs and alcohol

MICHIGAN MEDICINE

We will deal with all these subjects in an age and maturity-appropriate manner.

In order for these discussions to be as open and helpful as possible, we will assure your teenager that our discussions will be confidential. If there is a concern about your teen doing harm to him/herself or someone else, we will inform you. On issues of sexually transmitted diseases, birth control, pregnancy, and drug use we will encourage your teen to share this information with you. Also, in order to provide care that aligns with the United States Preventive Service Task Force, we will begin routine screening of all adolescents 16 years and older for an infection called Chlamydia. Chlamydia infections often do not show symptoms and can lead to lifelong complications, including infertility.

If there are any particular issues that you would like to have addressed, please let us know.

Thank you.



Chlamydia Screening



4) SAMPLE PATIENT LETTER

Health Center Contact Information

(Insert your health center's logo, if appropriate)

Dear Patient,

We are writing to inform you of a new process that is taking place in our office. We are constantly working to improve the quality of care that we provide. One of the measures that we are including is routine screening for Chlamydia. Chlamydia screening is recommended by the United States Preventive Services Task Force for any women between the ages of 16 and 24. Chlamydia is the most common sexually transmitted disease and often does not have any symptoms. If it goes untreated it can lead to serious pelvic infections including abscesses and Pelvic Inflammatory Disease. It is one of the leading causes of infertility.

Today in clinic we will ask you to leave a urine sample for Chlamydia testing. If your screen is positive, we will contact you via your cell phone to let you know. We will prescribe an antibiotic for you to take. It is recommended that you notify any sexual partners so that they may also be treated. All positive results will be reported to the Health Department. They will contact you via your cell phone if treatment is not ordered.

Thank you!

RECOMMENDED RESOURCES:

- 1. https://www.cdc.gov/std/chlamydia/stdfact-chlamydia.htm
- 2. <u>https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/chlamydia-and-gonorrhea-screening</u>
- 3. http://www.itsyoursexlife.com/
- 4. Partner notification: http://www.inspot.org/

5) SAMPLE CHLAMYDIA HANDOUT

Chlamydia Screening

WHAT IS CHLAMYDIA?

Chlamydia is a common sexually transmitted disease (STD). It can infect both men and women and can cause serious, permanent damage. Women may even lose the ability to become pregnant and have children. Chlamydia is very common, especially among young people. It is estimated that one in 15 sexually active females aged 14-19 years has chlamydia.

HOW COULD I GET CHLAMYDIA?

You might get chlamydia by having sex with someone who has the infection. You would not know a person has chlamydia, because they might not even know. "Having sex" means anal, vaginal, or oral sex. Chlamydia can be transmitted even if a man does not ejaculate. People who have had chlamydia and been treated for it can be infected again if they have sex with an infected person.

WHAT ARE THE SYMPTOMS OF CHLAMYDIA?

Chlamydia is known as a 'silent' infection because most infected people do not have any signs or symptoms. Even when it causes no symptoms, chlamydia can lead to infertility (not being able to get pregnant). For this reason, it's important for sexually active people to be tested regularly. This is called chlamydia screening. Some women with chlamydia have an abnormal vaginal discharge or a burning sensation when urinating.

WHAT HAPPENS IF CHLAMYDIA IS NOT TREATED?

If not treated early, chlamydia may cause serious health problems, including infertility. If the infection spreads to the uterus and fallopian tubes it can cause pelvic inflammatory disease (PID). PID is a serious disease that may lead to several problems:

- Severe pain that can be long-lasting
- Permanent damage to a woman's reproductive organs that would make impossible for her to have children. This damage may also cause ectopic pregnancy a pregnancy that occurs outside the uterus. This condition can be life threatening.

Untreated chlamydia may also increase a person's chance of getting HIV or infecting others with HIV.

WHO SHOULD BE TESTED FOR CHLAMYDIA?

If you are age 25 or younger and sexually active, we recommend yearly chlamydia testing. Talk to your healthcare provider about your risk factors so they can determine if you need more frequent testing. If you are scheduled for a vaginal exam today, the doctor can take a cotton swab of your vagina to test for chlamydia. Otherwise, you will need to provide a urine sample that will be tested in the lab.

Chlamydia Screening

ADOLESCENT HEALTH INITIATIVE

CAN CHLAMYDIA BE CURED?

Chlamydia can be **easily treated and cured** with antibiotics. If you have chlamydia, do not have sex for seven days after taking single dose antibiotics, or until you complete an entire seven-day course of antibiotics. This will prevent the spread of chlamydia to sexual partners.

Repeat infection with chlamydia is common. Persons whose sex partners have not been treated are at high risk for re-infection. Having chlamydia more than once increases your risk of serious health complications, including pelvic inflammatory disease and ectopic pregnancy. If you have chlamydia, you may need to be re-tested about three months after treatment to be sure the infection has been cured. Please discuss with your provider if you will need to be re-tested.

WHAT ABOUT PARTNERS?

If you are diagnosed with chlamydia, you need to tell all anal, vaginal, or oral sex partners from the past 2 months so that they can see a doctor and be treated. This will reduce the risk that the sex partners will develop serious complications from chlamydia and will also reduce the person's risk of becoming re-infected. A person with chlamydia and all of his or her sex partners must avoid having sex until they have completed their treatment for chlamydia (i.e., seven days after a single dose of antibiotics or until completion of a seven-day course of antibiotics) and until they no longer have symptoms. For tips on talking to partners about sex and STD testing, visit <u>http://www.gytnow.org/talking-to-your-partner/%20</u>

HOW CAN CHLAMYDIA BE PREVENTED?

Using latex male condoms, consistently and correctly, can reduce the risk of getting or giving chlamydia. The surest way to avoid chlamydia is to avoid vaginal, anal, and oral sex or to be in a long-term mutually monogamous relationship with a partner who has been tested and is known to not be infected.

Disclaimer: This document contains information and/or instructional materials developed by the University of Michigan Health System (UMHS) for the typical patient with your condition. It may include links to online content that was not created by UMHS and for which UMHS does not assume responsibility. It does not replace medical advice from your health care provider because your experience may differ from that of the typical patient. Talk to your health care provider if you have any questions about this document, your condition or your treatment plan.

Author: Adapted from the <u>CDC Fact Sheet</u> by Kathy R. Bishop, MHSA Reviewers: Roger Smith, MD; Grant Greenberg, MD;

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¹ <u>http://findahealthcenter.hrsa.gov/</u>

² <u>https://www.plannedparenthood.org/health-center</u>

³ http://pediatrics.aappublications.org/content/129/2/387

⁴ <u>https://www.uspreventiveservicestaskforce.org/BrowseRec/Index#AZ</u>

⁵ https://www.cdc.gov/std/tg2015/screening-recommendations.htm

⁶ <u>http://nahic.ucsf.edu/yaguidelines/s</u>



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An Overview of Minors' Consent Law

Background

The legal ability of minors to consent to a range of sensitive health care services—including sexual and reproductive health care, mental health services and alcohol and drug abuse treatment—has expanded dramatically over the past 30 years. This trend reflects the recognition that, while parental involvement in minors' health care decisions is desirable, many minors will not avail themselves of important services if they are forced to involve their parents. With regard to sexual and reproductive health care, many states explicitly permit all or some minors to obtain contraceptive, prenatal and STI services without parental involvement. Moreover, nearly every state permits minor parents to make important decisions on their own regarding their children. In sharp contrast, the majority of states require parental involvement in a minor's abortion.

In most cases, state consent laws apply to all minors age 12 and older. In some cases, however, states allow only certain groups of minors—such as those who are married, pregnant or already parents—to consent. Several states have no relevant policy or case law; in these states, physicians commonly provide medical care without parental consent to minors they deem mature, particularly if the state allows minors to consent to related services. The following chart contains seven categories of state law that affect a minor's right to consent. Further information on these issues can be obtained by clicking on the column headings.

Highlights

- *Contraceptive Services*: 26 states and the District of Columbia allow all minors (12 and older) to consent to contraceptive services. 20 states allow only certain categories of minors to consent to contraceptive services. 4 states have no relevant policy or case law.
- *STI Services*: All states and the District of Columbia allow all minors to consent to STI services. 18 of these states allow, but do not require, a physician to inform a minor's parents that he or she is seeking or receiving STI services when the doctor deems it in the minor's best interests.
- *Prenatal Care*: 32 states and the District of Columbia explicitly allow all minors to consent to prenatal care. Another state allows a minor to consent to prenatal care during the 1st trimester; requires parental consent for most care during the 2nd and 3rd trimesters. 13 of these states allow, but do not require, a physician to inform parents that their minor daughter is seeking or receiving prenatal care when the doctor deems it in the minor's best interests. 4 additional states allow a minor who can be considered "mature" to consent. 13 states have no relevant policy or case law.
- Adoption: 28 states and the District of Columbia allow all minor parents to choose to place their child for adoption. In addition, 5 states require the involvement of a parent and 5 states require the involvement of legal counsel. The remaining 12 states have no relevant policy or case law.
- *Medical Care for a Child*: 30 states and the District of Columbia allow all minor parents to consent to medical care for their child. The remaining 20 states have no relevant explicit policy or case law.
- Abortion: 2 states and the District of Columbia explicitly allow all minors to consent to abortion services. 21 states require that at least one parent consent to a minor's abortion, while 11 states require prior notification of at least one parent. 5 states require both notification of and consent from a parent prior to a minor's abortion. 6 additional states have parental involvement laws that are temporarily or permanently enjoined. 5 states have no relevant policy or case law.

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Notes: "All" applies to those 17 and younger or to minors of at least a specified age such as 12 or 14. "Some" applies to specified categories of minors (those who have a health issue, or are married, pregnant, mature, etc.) The totals include only those states that allow all minors to consent.

▼ Enforcement permanently or temporarily enjoined by a court order; policy not in effect.

* Physicians may, but are not required to, inform the minor's parents.

† Applies to minors 14 and older.

‡ Delaware's abortion law applies to women younger than 16. Oregon's prenatal care law applies to women at least 15 years old. South Carolina's abortion law applies to those younger than 17.

 Ω A court may require parental consent.

ξ Minor may consent to prenatal care in the 1st trimester and the first visit after the 1st trimester. Parental consent required for all other visits.

• Applies to mature minors 15 and younger and to all minors 16 and older.

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