Chlamydia and Gonorrhea Screening and Treatment Guideline

Major Changes as of May 2015 .................................................................................................................... 2
Prevention ..................................................................................................................................................... 2
Screening Recommendations ....................................................................................................................... 3
Treatment
  Goals ...................................................................................................................................................... 4
  Lifestyle/non-pharmacologic options ...................................................................................................... 4
  Pharmacologic options: infected individuals ........................................................................................... 4
  Pharmacologic options: partners of infected individuals (expedited partner therapy) ....................... 5
Follow-up/Monitoring ..................................................................................................................................... 5
  Reporting ................................................................................................................................................ 6
Confidentiality Considerations for Adolescents ............................................................................................ 6
Evidence Summary/References ................................................................................................................... 6
Guideline Team and Development Process ................................................................................................. 7

Last guideline approval: May 2015

Guidelines are systematically developed statements to assist patients and providers in choosing appropriate health care for specific clinical conditions. While guidelines are useful aids to assist providers in determining appropriate practices for many patients with specific clinical problems or prevention issues, guidelines are not meant to replace the clinical judgment of the individual provider or establish a standard of care. The recommendations contained in the guidelines may not be appropriate for use in all circumstances. The inclusion of a recommendation in a guideline does not imply coverage. A decision to adopt any particular recommendation must be made by the provider in light of the circumstances presented by the individual patient.
Major Changes as of May 2015

<table>
<thead>
<tr>
<th>New</th>
<th>Previous</th>
</tr>
</thead>
<tbody>
<tr>
<td>Screening for <strong>both chlamydia and gonorrhea</strong> is recommended. **</td>
<td>Only chlamydia screening was explicitly recommended (although the lab test detects both chlamydia and gonorrhea).</td>
</tr>
<tr>
<td>Screening for HIV and syphilis is also recommended for patients at risk for chlamydia and gonorrhea.</td>
<td>—</td>
</tr>
<tr>
<td>Screening is now recommended for sexually active <strong>men of any age with increased-risk factors.</strong></td>
<td>Screening men at increased risk was not explicitly recommended.</td>
</tr>
<tr>
<td>Sample collection recommendations have been added for men and expanded for women to include use of rectal and/or oral swabs when exposure has occurred at those sites.</td>
<td>Sample collection recommendations included only vaginal self-swab, cervical swab and urine testing.</td>
</tr>
<tr>
<td>Pharmacologic options for the treatment of <strong>gonorrhea</strong> have been added.</td>
<td>Pharmacologic options were for chlamydia treatment only.</td>
</tr>
</tbody>
</table>

Prevention

Risk reduction counseling should be tailored to each patient's individual risk factors, needs, and abilities. Effective measures to reduce risk include:

- Abstaining from sex.
- Maintaining a mutually monogamous relationship with a partner known to have no sexually transmitted infections (STIs).
- Regular and proper use of latex condoms or female condoms.
- Avoiding contact with casual partners and high-risk individuals (e.g., injection drug users, commercial sex workers, and persons with multiple sex partners).
- Avoiding high-risk sexual practices (such as condomless anal intercourse with a person who may have an STI).
Screening Recommendations

Table 1. Recommendations for SCREENING for chlamydia and gonorrhea

<table>
<thead>
<tr>
<th>Eligible population</th>
<th>Test</th>
<th>Frequency</th>
</tr>
</thead>
</table>
| Sexually active women
  - 24 years or younger
  - 25 years or older with increased-risk factors | Nucleic acid amplification test (NAAT) | Annually and when patient reports a new partner. |
| Sexually active men of any age with increased-risk factors | NAAT | Annually and when patient reports a new partner. |
| Pregnant women
  - 24 years or younger
  - 25 years or older with increased-risk factors | NAAT | At the first prenatal visit and during the third trimester if the first test was positive or patient reports a new partner. |

1 The chlamydia screening test used in the Group Health Laboratory tests for both chlamydia and gonorrhea.
2 When testing methods other than NAAT are used, false negatives may occur if sexual contact occurred less than 48 hours prior to testing.

Increased-risk factors for chlamydia and gonorrhea

- History of previous chlamydia or gonorrhea infection or other STI
- New or multiple partners
- A sex partner with concurrent partners or with an STI
- Inconsistent condom use among persons who are not in mutually monogamous relationships
- History of exchanging sex for money or drugs
- Men who have sex with men (MSM)
- History of juvenile detention in jail facilities

Note: Patients with risk factors for chlamydia and gonorrhea are also at risk for HIV and syphilis, and should be screened for these STIs as well, regardless of their test results. See Follow-up/Monitoring, p.5.

Collection methods for nucleic acid amplification testing (NAAT)

For women

Vaginal self-swab is the preferred collection method due to higher sensitivity than cervical swab or urine testing. For women who require a pelvic examination for other reasons, a vaginal swab may be collected by the provider. Collect a rectal and/or oral swab if there has been exposure at those sites.

Urine testing is an acceptable option if the patient prefers this over vaginal self-swab. Cervical swabs are no longer recommended.

For men

First-catch urine is the recommended collection method for men. Urethral swab is also an acceptable option, especially if discharge is visible. Collect a rectal and/or oral swab if there has been exposure at those sites. Testing urine will not detect infection in the rectum or throat. Site-specific testing is needed if there has been an exposure.

Note: For individuals undergoing evaluation following sexual assault, cervical, rectal, or urethral cultures are preferred; special media are required (contact the Lab.) However, NAATs are acceptable in most cases if cultures cannot be obtained.
Treatment

Goals
Eradication of infection in patient and partner(s).

Lifestyle modifications/non-pharmacologic options
Patients who have tested positive should receive counseling to abstain from sex until they and their partner(s) have completed a course of antibiotic treatment.

Pharmacologic options: infected individuals

<table>
<thead>
<tr>
<th>Eligible population</th>
<th>Line</th>
<th>Medication</th>
<th>Regimen</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1&lt;sup&gt;st&lt;/sup&gt;</td>
<td>Azithromycin</td>
<td>1 g PO (single dose)</td>
</tr>
<tr>
<td>Non-pregnant women and men with uncomplicated infections</td>
<td>2&lt;sup&gt;nd&lt;/sup&gt;</td>
<td>Doxycycline</td>
<td>100 mg PO b.i.d. x 7 days</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Erythromycin base</td>
<td>500 mg PO q.i.d. x 7 days</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Levofloxacin</td>
<td>500 mg PO daily x 7 days</td>
</tr>
<tr>
<td>Pregnant women with uncomplicated infections</td>
<td>1&lt;sup&gt;st&lt;/sup&gt;</td>
<td>Azithromycin</td>
<td>1 g PO (single dose)</td>
</tr>
<tr>
<td></td>
<td>2&lt;sup&gt;nd&lt;/sup&gt;</td>
<td>Amoxicillin</td>
<td>500 mg PO t.i.d. x 7 days</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Erythromycin base</td>
<td>500 mg PO q.i.d. x 7 days</td>
</tr>
</tbody>
</table>

Table 3. Recommended pharmacologic options for GONORRHEA treatment ¹

<table>
<thead>
<tr>
<th>Eligible population</th>
<th>Line</th>
<th>Medication</th>
<th>Regimen</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-pregnant women and men with uncomplicated infections</td>
<td>1&lt;sup&gt;st&lt;/sup&gt;</td>
<td>Ceftriaxone plus azithromycin</td>
<td>Give both at the same time: ceftriaxone 250 mg IM plus azithromycin 1 g PO (single dose)</td>
</tr>
<tr>
<td></td>
<td>2&lt;sup&gt;nd&lt;/sup&gt;</td>
<td>Cefixime plus azithromycin ²</td>
<td>Give both at the same time: cefixime 400 mg PO (single dose) plus azithromycin 1 g PO (single dose)</td>
</tr>
<tr>
<td>Pregnant women with uncomplicated infections</td>
<td>1&lt;sup&gt;st&lt;/sup&gt;</td>
<td>Ceftriaxone plus azithromycin</td>
<td>Give both at the same time: ceftriaxone 250 mg IM plus azithromycin 1 g PO (single dose)</td>
</tr>
</tbody>
</table>

¹ Gonorrhea treatment using two antimicrobials with different mechanisms of action is recommended to potentially slow the emergence of resistance to cephalosporins.
² Patients with pharyngeal gonorrhea who are treated with the second-line regimen should return 14 days after treatment for a test of cure, using either culture or NAAT.

1 Gonorrhea treatment using two antimicrobials with different mechanisms of action is recommended to potentially slow the emergence of resistance to cephalosporins.
2 Patients with pharyngeal gonorrhea who are treated with the second-line regimen should return 14 days after treatment for a test of cure, using either culture or NAAT.
Pharmacologic options: partners of infected individuals

Expeditied partner therapy
The Centers for Disease Control and Prevention recommends that all sex partners of infected patients from the preceding 60 days be evaluated, tested, and treated to prevent reinfection and curtail further transmission. With expedited partner therapy (EPT), partners are treated without an intervening clinical assessment; the kit is provided at no charge to the partner.

Note: EPT is not recommended for men who have sex with men (MSM). The public health department should be notified of MSM who test positive for chlamydia and/or gonorrhea, so these patients and their partners can be followed up and treated and tested for HIV.

Table 4. Recommended pharmacologic options for EXPEDITED PARTNER THERAPY

<table>
<thead>
<tr>
<th>Eligible population</th>
<th>Medication</th>
<th>Regimen</th>
</tr>
</thead>
<tbody>
<tr>
<td>Partners of patients with active CHLAMYDIA infections</td>
<td>Azithromycin</td>
<td>1 g PO (single dose)</td>
</tr>
<tr>
<td>Partners of patients with active GONORRHEA infections</td>
<td>Cefixime plus azithromycin</td>
<td>Give both at the same time: cefixime 400 mg PO (single dose) plus azithromycin 1 g PO (single dose)</td>
</tr>
</tbody>
</table>

Additional resources on EPT:
- See the Pharmacy EPT page and clinician information handout on the Group Health staff intranet.
- More information is available through the Washington State Department of Health.
- Use the SmartPhrases RXEPTCHLAMYDIA and RXEPTGONORRHEA for documentation in Epic.

Follow-up/Monitoring

Table 5. Recommended FOLLOW-UP TESTING for patients treated for chlamydia or gonorrhea

<table>
<thead>
<tr>
<th>Eligible population</th>
<th>Test</th>
<th>Timing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sexually active, non-pregnant women and men</td>
<td>NAAT</td>
<td>3 months after initial treatment</td>
</tr>
<tr>
<td>Pregnant women</td>
<td>NAAT</td>
<td>3 weeks after initial treatment and during the third trimester</td>
</tr>
</tbody>
</table>

The majority of post-treatment infections result from reinfection, frequently occurring because the patient’s sex partners were not treated or because the patient resumed sex with a new partner infected with chlamydia or gonorrhea.

Except in pregnant women, test-of-cure (repeat testing 3–4 weeks after completing therapy) is not recommended. Nucleic acid amplification tests conducted less than 3 weeks after completion of therapy in persons who were treated successfully could yield false-positive results because of the continued presence of dead organisms.

The window for detecting syphilis infection is 2–6 weeks, and the window for HIV is 3–4 weeks, so false negatives may occur if testing is done too early. If a patient is screened for and/or diagnosed with gonorrhea or chlamydia less than 4–6 weeks after a sexual encounter, consider repeating the HIV and syphilis tests after this window has passed in order to rule out these infections.
Reporting
For information regarding reporting notifiable conditions such as chlamydia and gonorrhea, see Group Health Infection Control, the Washington State Department of Health, the Washington State Legislature, and the Idaho Department of Health and Welfare.

Confidentiality Considerations for Adolescents
Adolescents at least 14 years of age have a right to confidential STI testing and treatment without parental involvement. For patients younger than 14, community practice based on interpretation of case law supports provision of services related to sexuality and reproductive issues with the patient's consent if the provider determines that the patient is capable of giving informed consent.

For additional information, see “Adolescent Confidentiality and Consent” on the Group Health staff intranet.

Evidence Summary/References
To develop the Chlamydia and Gonorrhea Screening and Treatment Guideline, Group Health has adapted the following externally developed materials:


Guideline Development Process and Team

To develop the Chlamydia and Gonorrhea Screening and Treatment Guideline, Group Health has adapted externally developed evidence-based materials; see Evidence Summary/References, p. 6.

This edition of the guideline was approved for publication by the Guideline Oversight Group in May 2015.

Team

The following specialties were represented on the development and/or update teams: adolescent medicine, anatomic pathology, clinical laboratory, family medicine, residency, and pharmacy.

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Disclosure of conflict of interest

Group Health Cooperative requires that team members participating on a guideline team disclose and resolve all potential conflicts of interest that arise from financial relationships between a guideline team member or guideline team member's spouse or partner and any commercial interests or proprietary entity that provides or produces health care-related products and/or services relevant to the content of the guideline.

Faculty members listed above have disclosed that their participation on a guideline team includes no promotion of any commercial products or services; they have no relationships with commercial entities to report.