

Clinical Practice Alert: Chlamydia and Gonorrhea Screening and Treatment Webinar
June 20, 2019
Questions & Answers

1. Do you recommend testing women's throats for GC if they engage in oral sex with men?

The CDC STD Guidelines do not routinely recommend screening women at the throat for GC; however, it is a covered service through Family PACT if the provider deems appropriate. If that is the case, in addition to screening the genital site, a separate oropharyngeal sample for GC and CT should be taken from the woman's throat if the male partner did not wear a condom while she was performing oral sex on him.

2. Do you recommend anal GC and CT screening for heterosexual women?

The CDC STD Guidelines do not routinely recommend screening for rectal GC/CT in heterosexual women; however, it is a covered service through Family PACT if the provider deems appropriate. This would be only be appropriate if woman states in her sexual history that she had anal (receptive) sex with a male partner. There are no guidelines yet that put a timeframe on how recently the anal contact occurred to necessitate screening. If she states in her sexual history that she has not engaged in anal sex, then the anus should not be sampled.

3. What defines "high prevalence" in terms of %?

A high practice-site specific prevalence of gonorrhea is 1% or higher, and for chlamydia it is 3% or higher

4. Shouldn't testing sites just test everyone every way possible, in order to catch every infection?

No. If the pre-test probability of infection is low, based upon the absence of risk factors in women 25 and older, the harms of GC and CT screening are greater than the benefits.

In a low prevalence population, the positive predictive value (of a positive test) is reduced to the point that a false positive result is more likely than a true positive result. False positives lead to unnecessary treatment of patients and partners, as well as potential relationship problems when a partner is told that they may be the source of an infection which is non-existent in the patient.

5. Can men self-collect anal swab? (cytology for anal cancer or for STI screening)

No national guidelines recommend self-collected or clinician-collected anal swabs for anal cytology. However, it can be done for rectal GC and CT, as long as your laboratory accepts self-collected specimens. Stay tuned for the 2020 CDC STD Treatment Guidelines, where there will

hopefully be more discussion of self-collection.

6. If clinics only have oral treatment, would that contribute to eventual resistance of the existing treatment?

Yes. That's why the CDC strongly recommends providing ceftriaxone 250 mg IM (plus azithromycin) for treatment of GC. Oral cefixime is not as effective as ceftriaxone and resistance is a concern. However, since some clinics are simply unable or unwilling to give injectable antibiotics, giving oral cefixime (and azithromycin) is better than the possibility patient not being treated if they do not follow-up on referral to another provider for injection.

7. What is the alternative treatment for Gonorrhea if Azithromycin is contraindicated?

Azithromycin rarely is contraindicated. It may cause several side effects, but true allergy is very uncommon. Since every treatment regimen for gonorrhea includes azithromycin (including the alternative regimens with gentamycin and gemifloxacin), if a patient cannot take azithromycin, there are two potential management strategies: 1) consultation with a STD or infectious disease expert 2) treat with ceftriaxone 250mg IM alone and obtain a test-of-cure in 2 weeks.

8. Are you able to discuss Lymphogranuloma Venereum?

LGV is a serovar (strain) of chlamydia that is relatively is uncommon in California. There have been isolated outbreaks among men who have sex with men in various cities in the United States, but it is not something that is typically part of a standard STI panel of testing. Please consult the 2015 CDC STD Treatment Guidelines at <https://www.cdc.gov/std/tg2015/lgv.htm> for advice on diagnosis and treatment.

9. You mentioned re-testing after patient comes in after re-exposure 7-10 days afterwards, but also mentioned about TOC after 3 weeks; So can you clarify the waiting time prior to re-testing?

Dead gonococcus organisms are cleared within 7 days of treatment, while dead chlamydial organism may take as long as 3 weeks to be cleared. Most patients do NOT need a test of cure after treatment, but if indicated, do not obtain the sample any earlier than 3 weeks from the time of treatment because of the risk of a false positive result.

If a patient is re-exposed shortly after treatment, the recommendation is to empirically re-treat, but not to re-test if the initial treatment was within the past 3 weeks.