Clinical Practice Alert: Chlamydia and Gonorrhea Screening and Treatment
June 20, 2019

Dr. Michael Policar:
Have to do with chlamydia and gonorrhea screening and where we are with the state of the art and then, at the end, she will be asking me a few questions that have to do with the Family PACT of benefits that relate to this topic. So, let's go to our first question, and Ina, will you explain the difference between routine gonorrhea and chlamydia screening in comparison to targeted testing? And as it relates to targeted testing, specifically which criteria should clinicians use for women who are 25 and older? Then finally, are those guidelines any different in regard to screening men and are there any males that should be screened routinely or should that all be targeted testing?

Dr. Ina Park:
So, Mike, I'm going to go over this a little bit faster this second go around, but when we talk about routine screening, what we're talking about here is usually for cis-gender women and those are women under the age of 25. We recommend screening, those are national guidelines recommend screening annually if they've ever been sexually active, and then, for targeted screening, when we talk about cis-gender women it's really for women 25 years or older if they're at risk, and I'm going to talk specifically about what at risk means. Then we do recommend routine screening, again, for all pregnant women under the age of 25 and then, again, targeted screening for pregnant women 25 years of age or older if they're at risk. When we get to the topic of men, for men who have sex with women, targeted screening is the only thing that's recommended and here, the CDC really recommended in certain high-prevalent settings, so that would be teen clinics, correctional settings, STD clinics, and many family planning clinics are choosing to screen men who have sex with women. And then we go back to routine screening for men who have sex with men. So that's really regardless of age, any sexually active men who have sex with men is recommended to have gonorrhea and chlamydia screening at least annually at all sites of exposure. So that's genital, rectal, and pharyngeal. And although this isn't specifically in the CDC guidelines, we know that rates of infection are very high for transgender men and women. And so, I think it's a reasonable thing to screen transgender folks who are having sex with men at all exposed sites at least annually, as well. And then we're going back to routine screening, again, after treatment, so anybody who's had gonorrhea or chlamydia should be re-tested at three months after being treated. And you asked me specifically about, well what is at-risk mean, and somebody is asking on the chat box, what does high prevalence mean?

Dr. Ina Park:
We're going to talk about that in a second. So, when we talk about who is at risk for gonorrhea and chlamydia? It's really folks that have had a chlamydia or gonorrhea infection within the past two years, or someone who's had multiple sex partners within the past year. So, the CDC guidelines are a little vague and they might just say multiple partners. But in California, we like to put a little bit of definition

around that. And I think the third goal is actually pretty important, Mike, which is, someone may come to you and say that they only have one partner, but it's good to ask them if their partner might have other partners and if they do think that their partner has other partners, that's a good person to screen. Any kind of exchange sex for money, drugs, etc., or sex in conjunction with drug use would be risk factors.

Dr. Michael Policar:

Right, thanks for reviewing that. I think it really stresses the importance of taking a good sexual history because often times these are things that a patient might not disclose in a family planning visit, and it really is necessary, or family planning clinicians, as well as health educators, counselors, and others, to make sure that these questions are asked as part of the visit.

Dr. Ina Park:

Absolutely.

Dr. Michael Policar:

So, let's go to the next question and that is, some of the older guidelines that came from the California Department of Public Health said that it was not only important to do routine and targeted testing the way that you just described it, but that in certain high-prevalence practice sites, that it would be important to screen routinely for gonorrhea and chlamydia if the prevalence of chlamydia was 3% or more, or gonorrhea was 1% or more. So, the questions are, do those recommendations still apply? And second, how can a clinic or a practice actually determine what prevalence or positivity rates are for gonorrhea and chlamydia for different age groups at their site?

Dr. Ina Park:

Yeah, so Mike, those are older guidelines that we put out and we haven't actually revised those. And so, what we were saying is that, and Anna Hart asked this question on the chat about, what does high prevalence mean? So, we defined it as chlamydia rates over 3% and gonorrhea rates over 1% in women over 25. And so, some practices actually choose to screen all women 25 to 29, for example, and so they screen those folks routinely and don't do targeted screening. There are a couple ways to get this information and I'll say one, and then you can share a different one that I know you've used, which is you can do this in your site, for example, by doing a pilot and saying, for an entire month, we're going to screen all sexually active women between the ages of 25 to 29. If you have someone that can easily pull the information out of your medical record, you can actually pull data for women based on their date of birth during that study period that you're actually piloting screening for older women, and then you can calculate the positivity. So, the number of positive chlamydia test results, for example, over the total number of women screened, and then you can calculate the positivity for 25, 26, 27, each individual age year, year of age. And, Mike, you had a different way that you said that we can do this, which sounds even simpler, actually.

Dr. Michael Policar:

Yeah, and that is to get in touch with the laboratory that you send your chlamydia and gonorrhea nucleic acid application tests to. Of course, they immediately have access to records from your practice

for people with different age groups in regard to the positive test divided by the number of tests that have been done and the denominator for women in respective age groups. So, you can either clump them, like 25 to 29, or ask for individual positivity rates in women of, let's say, 25 years old, 26, and so on. And that can be very helpful and during the years I was working at San Francisco General in Women's Healthcare Environment, we were really curious what our positivity rate was for gonorrhea to see whether we should be screening everyone, and it turns out, it was up to 1%. So, we could do much more targeted screening. So, it is helpful to know that. And those rates can be quite different on different parts of the state and with different types of practices. Let me go on to the next question. And that is, are there any new data that you'd consider to be important regarding gonorrhea or chlamydia transmission? And, in fact, I've heard about a study that said that kissing, alone, might lead to the spread of gonorrhea and chlamydia.

Dr. Ina Park:

Yeah, so there's actually been a couple of studies out by the Australians who are looking at the connection between gonorrhea in the saliva and potential and risk of transmission. And so, when I first saw these data, I said, oh no, are we going to have to tell people that they can't kiss each other without some sort of barrier protection? But just a brief summary because I had specific ask from one of our clinicians on the line to talk about this study. So they looked at men who had sex with men who completed a survey about their sexual behavior and that included deep kissing or French-kissing, oral sex and anal sex, and they did find that men with four or more partners who reported, these are partners that they had for just kissing, alone, that they did have an increased risk for gonorrhea in the throat and that risk was lower than men who actually had multiple partners and reported both kissing and either, oral or anal sex with these partners. They didn't find that some people reported, well we just had sex and there was no kissing, there was no association found there with gonorrhea in the throat. And so, the issue here, Mike, is that these data are cross-sectional. So, they're looking at what is the risk and what is the outcome at the same time. And it's not something that you can do a randomized trial of and you can't say, okay you can only kiss people, you can't kiss people and let's see if you end up transmitting gonorrhea in the throat. So, it's not enough, I would say, to change our California messages around that. I don't think it's a huge independent risk factor for gonorrhea in the throat, but there is, potentially, something there and the Australians are now doing a randomized trial of medicated mouthwash to try to see if they can eradicate or prevent gonorrhea of the throat. And because of killing it in the saliva, and also killing it in the back of the throat.

Dr. Michael Policar:

Do you know if any earlier studies looked at that relationship or is this study one of a kind in looking at this?

Dr. Ina Park:

There was an earlier study, as well, that also looked like there might be some association with kissing, which was just a few months before. This is a newer area of research, I would think.

Dr. Michael Policar:

And both studies only looked MSM or did any of them look at male to female transmission or sources?

Dr. Ina Park:

The two studies I'm aware of only looked at men who have sex with men.

Dr. Michael Policar:

Right, thank you. All right. Next question is, now that we've talked about who to screen, let's talk about how you obtain your samples to send off the nucleic acid application test that you do for gonorrhea and chlamydia virtually all lab have switched to NAA tests. So, what is the best way to obtain genital tract samples for gonorrhea and chlamydia in each of females and males? And more specifically, are there any differences in how we would take that sample in a transgender woman who's had a vaginoplasty? And any specific tips regarding how clinicians should both obtain the samples and then transport them in such a way that we maximize the likelihood that the test results are going to be accurate?

Dr. Ina Park:

So, the nice thing about, I'm going to start with your last question first, which is, the nice thing about these tests is that they are less dependent on how we handle them, in terms of their very stable even with fluctuations in temperature and they're still very highly sensitive and specific and so I am going to talk a little bit about specimen collection, after this. But just to talk about the optimal specimen types. Some of you who are in the webinar, I know will remember the days when we used to put a urethral swab inside the penile urethra. And now we've become less draconian in our specimen collection techniques. So first catch urine, so the first urine that comes out, first part of the stream is recommended for men. There is new data, also, that looks at men actually self-collecting a swab just from the opening of the urethra, the urethral meatus, that also works. But for now, the CDC guidelines recommend just the urine for men, and self-collected vaginal swab for women. Urine is also very good for women, it's just a little bit less sensitive than the vaginal swab. And then, also for rectal and oropharyngeal infections, these tests were not FDA cleared for many, many years, and just, in May, so last month 2019 the FDA finally approved those for two manufacturers, the Hologic and Cepheid platforms. And so, they're certainly preferred over culture for those sites.

Dr. Ina Park:

And to get at your other question about, well what's the best way for us to handle these specimens? So, Mike, you've looked at this before, when you look at the package insert for these nucleic acid tests, a patient really shouldn't urinate for an hour before they provide a specimen. We want to catch any organisms that are actually sitting in the urethra, but sometimes, that's just not the reality. A patient comes in, they've actually urinated less than an hour before, and so I would say not to make them come back, it's okay to use the specimen. But just know that you might not have as good a sensitivity if they'd actually urinated less than an hour before they showed up. I think another situation, which I'm sure you're familiar with working women's health, is that sometimes we're doing diagnostic testing from a clean catch urine because a woman's coming in because she thinks she has a UTI. And so, someone actually looked at this in New Zealand and they took 100 women who actually had chlamydia on a first void urine and then when they came back for their treatment, they actually had them do a clean catch and they compared, before they actually got any antibiotics. And they found that 96 out of 100 actually had a positive clean catch as well as a first void urine. So, it's pretty good. And so, if you only have a clean catch, I will go ahead and send that, as well. Again, sensitivity might be slightly reduced.

Dr. Michael Policar:

Can you say a little bit more about how vaginal swabs in obtaining a sample for gonorrhea and chlamydia, and in particular, this issue of whether the clinician needs to do the collection or whether it can be self-selected, self-collected, excuse me, by the patient? And if so, what kind of advice do you give the patient before she goes into the bathroom, in terms of how to take a self-collected sample?

Dr. Ina Park:

Yeah, patients can absolutely take their own self-collected sample, they do just as good of a job as the clinicians. Patients really like it, it's very acceptable. There's been many studies looking at the acceptability of self-collected swabs. What we ask patients to do is, essentially, go ahead and swab the vaginal opening, so just inserting the swab about three centimeters in and just sort of twirling their wrist around to make sure that they collect the specimen, but they do a fantastic job compared to clinicians. Just as sensitive by having patients collect as clinicians collect.

Dr. Michael Policar:

And you were saying that patients find that quite acceptable

Dr. Ina Park:

They do.

Dr. Michael Policar:

When they're asked to do that?

Dr. Ina Park:

Yeah, and you know, these days, especially when we're, for our teens who are not getting a routine pelvic exam for a pap smear, it's a great thing that they don't need to actually have a full pelvic exam. They can self-collect, it's less invasive and they like it.

Dr. Michael Policar:

I think that's really important. The question comes up, every now and then, about whether or not payers like Medi-Cal or Family PACT will pay for self-collected vaginal swabs, and the answer is that, if it's collected in the clinic, absolutely.

Dr. Ina Park:

Great.

Dr. Michael Policar:

The lab doesn't know the difference where it's collected from and has exactly the same CPT code, so they will be covered. There's also been studies looking at self-collected vaginal swabs at home and then sent to a laboratory. Currently, that's not a Family PACT or Medi-Cal, it has to be collected in the clinic.

Dr. Ina Park:

Yes, and so that's a great point because some laboratories do offer the option of actually having people take a kit home and mailing it back in, but that's something that we need to clarify is not covered under Family PACT.

Dr. Michael Policar:

How about vaginoplasty?

Dr. Ina Park:

Yeah, so vaginoplasty is really challenging in terms of which is the best specimen to use because it depends on what type of surgery the patient had and what epithelium or mucosa was used. So, these days, most people are having a vaginoplasty and they're using penile skin, so squamous epithelium and they're inverting it to create a new, a neovagina. Sometimes the urethra, some of the urethral mucosa might be used, sometimes people are using the lining of the mouth, so the buccal mucosa so that it provides some lubrication, as well, as well as some people are using peritoneal tissue so that there's some lubrication, as well. So, there's a lot of diversity in what tissue is being used. So, if it's just squamous epithelium, then you can't really get a gonorrhea or chlamydia infection of that tissue. So, for those folks, it's reasonable just to screen the urine, but when people have had other types of tissue used for their vaginoplasty, it's really hard to say, right now, what's the best specimen to use. I think it's reasonable to screen the urine if they've used other mucosa types to create the neovagina, you could do a vaginal swab, as well, but there's not guidelines on this. For folks that had their vaginoplasty decades ago, they might have actually used sigmoid colon, in which case, that mucosa could be infected with gonorrhea and chlamydia and it would be a good idea to swab the neovagina.

Dr. Michael Policar:

That's great, that's really helpful, particularly the idea of sort of relying on the urine sample if you're not sure what you're going to graft.

Dr. Ina Park:

Right, yep.

Dr. Michael Policar:

All right, the next question has to do with a topic where there are frequent questions that are submitted to the Office of Family Planning about both recommendations and coverage for sampling multiple sites. So, the question is, when an individual discloses either oral or anal-receptive contact, how should multi-site screening, on the same day the service being performed, it happened very often that a female is gonorrhea or chlamydia negative, let's say, from her cervix or vagina, but positive in her oropharynx or her rectum. What's the best way to obtain the samples from the oropharynx and from the anus? And then lastly, do any national guidelines recommend routinely screening the throat or the anus if a patient doesn't disclose that in their sexual history?

Dr. Ina Park:

So, I'm going to start with your last question first. I'm going to leave the question slide up here. Right now, there aren't guidelines. The guidelines are really saying, screen at the sites that a patient discloses in terms of exposure. That was, we were just screening enough for the treatment guidelines consultation and that was actually discussed. Because some people don't want to disclose all the different sites of exposure. And the question was, should we just actually say, screen everything even if people don't disclose that they've had sex there. And so, right now there aren't any national recommendations around that, I don't think that that's going to change. In certain communities, people actually have stigma around disclosing that they're having sex with men, for example, and so right now, that's not recommended. But I can very much appreciate the feeling and the intention behind that question.

Dr. Ina Park:

And I want to get to your next question, which goes into extra genital, so non-genital infections in women. There are a lot of data around rectal infections in women, not so much around oropharyngeal infections. So, I'm going to talk a little bit about rectal infections. And I'm going to lead off by saying, right now the CDC does not mention it in the treatment guidelines at all. It doesn't talk about situations where it might be warranted or anything like that and I do know that there will be some mention of it in the next iteration. So, I found, these are some of the data that were reviewed for the recent consultation. And so interestingly in various high-prevalence settings that are seeing lots of family planning, this is a group of family planning and STD clinics, etc., they found that rectal chlamydia positivity in women was 6%, so it's pretty high, and certainly over the 3% that we talked about earlier, and if you look at women who actually report anal sex, then it's actually one in four who had a rectal chlamydia infection.

Dr. Michael Policar:

That's remarkable.

Dr. Ina Park:

Which is remarkably high. And the thing that we looked at was, well what if those folks already have an infection in the cervix, then we don't really have to screen the rectum because if we screen the cervix, then we'll catch those infections, and they'll get treated appropriately. And so, there was a review of this to look at, well what percentage of infections in the rectum would be missed if you only screened women with a vaginal swab or urine, and it's about 18 to 23%. So, it's substantial.

Dr. Michael Policar:

Exactly, that can mean really, I think makes the case for doing multi-site screening when a woman discloses that there have been multiple sites of exposure, rather than just saying, well the vagina or the cervix is most likely to be positive, so we only have to check there.

Dr. Ina Park:

Yeah, and when we get to your portion about Family PACT benefits, we can talk a little bit more about what Family PACT would allow for screening of the rectum and oropharynx in women. This point about 18 to 23% of infections would be missed if we don't screen the rectum is really different for women than it is for men that have sex with men.

Dr. Ina Park:

This is from the STD Surveillance Network, which is a network of STD clinics. And if you look, these are positive rectal and pharyngeal tests that were matched to a urine specimen, looking at what proportion of infections would be missed if we only look at the urine and it ranges, you can see, from 70 to 90%. So, for men who have sex with men, it's absolutely necessary to screen the rectal and pharyngeal sites because you'll miss a ton of infections if you only look at the urine.

Dr. Michael Policar:

And that recommendation was made by the CDC at least five or six years, maybe longer.

Dr. Ina Park:

Yeah, I think longer.

Dr. Michael Policar:

For men having sex with men that have a high index of suspicion that non-general sites could be positive or to screen all three.

Dr. Ina Park:

Yep, and so CDC recommends, actually I'm just going to focus on the chlamydia and gonorrhea recommendations here. They recommend screenings for those infections at least once a year and for folks that are on Prep, it's every three months and for folks that are reporting multiple anonymous partners or drug use or partners who are engaged in any of those activities screening people every three to six months. So, I think three months is the maximum frequency that the CDC recommends right now for folks at high risk.

Dr. Michael Policar:

One second, can we say a word about what's in the yellow box in regard to screening for anal cancer in HIV positive men having sex with men because questions come up about whether or not there should be anal cytology done, which could lead to, HRA by the way stands for High Resolution Anoscopy.

Dr. Ina Park:

Yeah, so right now there aren't any national recommendations to do anal pap smears in men who have sex with me, not yet. The NIH actually funded a very large clinical trial, which is going on at UC San Francisco, which will not have results for at least another five to eight years, but it's called the Anchor Study. And so right now, there aren't any national recommendations. What is being recommended is for men who have sex with men who are HIV positive to do an annual rectal exam with the finger, a digital

rectal exam, so that any sort of masses or cancers might be detected early. So, a routine pap program is not recommended for all institutions at this time.

Dr. Ina Park:

Yeah. And so, you asked, specifically, about how techniques should be done and so for the throat, it's very similar to what you might do for a throat culture. So, you want to swab both tonsillar pillars. And I say watch out for gagging, but in fact, actually someone did a study looking at folks, whether you make them gag or don't make them gag. And actually, if you get a gag, it's more likely to result in a positive test than if you don't, so gagging on your end is a good thing. But for the rectal swab, because you're just picking up the remnants of RNA or DNA, you don't have to get to the rectal mucosa, but it is helpful, so you want to insert the swab about three to four centimeters in, past the anal verge and twirl it around so that you're sampling the rectal mucosa. But if there are contaminants in the anal canal, it'll probably catch those, as well.

Dr. Michael Policar:

And any particular position to do that in? For women, in lithotomy position, or for a guy, just bending over?

Dr. Ina Park:

Yeah, so usually guys can stand and just bend over and put their elbows on the table or sometimes, people can stand and just put one leg up, you know what I mean? Up on a chair or something, and you can get it that way. If the woman's already in lithotomy to do a pap, for example, then you can do it at that time.

Dr. Michael Policar:

All right, our next question is, what should providers do when a gonorrhea or chlamydia test result is positive regarding public health surveillance reporting? And of course, we've had those laws on the books for decades and I just included that question because I wanted to make sure that clinicians have a good sense of what the lab is responsible for as opposed to what the practice is responsible for.

Dr. Ina Park:

Yeah, so both gonorrhea and chlamydia, as you know, have been reportable to the Health Department and to the CDC for decades and so those lab reports are automatically reported to the Health Department and the only reason that the Health Department sends you these Confidential Morbidity Reports is that the information that is really important to look at trends in the state, such as race/ethnicity, pregnancy status, and treatment, are missing. So, the lab report gives very little information and so if you want to help the state monitor disparities, racial disparities, for example, in disease incidents, how well providers are treating people, what percentage of folks who are pregnant are getting STIs, the CMR or the Confidential Morbidity Report is absolutely essential for that. And so please complete your CMRs.

Dr. Michael Policar:

And are they still done on paper or can you submit them electronically?

Dr. Ina Park:

You can submit them electronically. I know some folks are all still doing the old-school paper, as well, so I believe both are available right now.

Dr. Michael Policar:

Okay, well let's switch gears and have a talk a little about treatment. So, will you review for us what the current recommended treatments are for gonorrhea and chlamydia? We all know that there's been a problem with gonorrhea being resistant, now, to multiple antibiotics. Is that a problem in California, which is worse than other parts of the country? And are management recommendations more stringent, for example, in any parts of the state where the prevalence of multi-growing resistant gonorrhea might be higher? And then the last part of it is, since we're talking about treatment, how important is it for a clinic that currently does not do IM injections of Ceftriaxone to develop that capability in order to make treatment with Ceftriaxone available?

Dr. Ina Park:

Okay, so I'm going to start with the recommended treatments for gonorrhea and chlamydia. So, they are still the same from the 2015 guidelines. Azithromycin 1 gram in a single dose, which is nice because it can be done as directly observed therapy, or Doxycycline for seven days. And for pregnancy, azithro is the only recommended regimen. And for the alternatives, there's a new extended-release Doxycycline, which is just once a day instead of twice a day. And then for pregnant women, the alternative would be Amoxicillin for seven days. But there is something very nice about being able to do single dose directly observed therapies. So that's where we'd like to go, if possible.

Dr. Ina Park:

And so, this is kind of getting to your third bullet-point on that question slide about Gonorrhea Dual Therapy. So right now, this is the only recommended regimen, which is Ceftriaxone IM 250 milligrams, plus Azithromycin one gram, and so, I do think it's important for clinics to be able to develop this capability, particularly because we're concerned about antibiotic resistant gonorrhea and potentially needing to accelerate or increase the dose of Ceftriaxone, eventually. And if clinics don't have that capability, our ability to use oral cephalosporins is shrinking by the minute here. And so, I do think it's important for people to be able to use IM therapy for gonorrhea and would strongly recommend that you look into getting that capability in your clinic, if it doesn't already exist.

Dr. Ina Park:

So right now, there is an alternative, cephalosporin regimen, which is Cefixime 400 milligrams plus Azithromycin. We don't think it's quite as effective as IM therapy, which is why I think IM therapy is certainly preferred, if possible.

Dr. Michael Policar:

Just a quick question about that. For a while there were reports of difficulty, and even of pain, of Cefixime that the supply was insufficient. Has that been cleared up? Is it easier now for pharmacies and clinics to obtain a supply of Cefixime to be able to dispense?

Dr. Ina Park:

Yes, from my understanding, I think it's different in different parts of the country, but I have not heard that particular issue. But it has been an issue in the past, absolutely. And in fact, for most of these drugs that we use for STI, we get shortages here and there. We just came out of a very long spell of having a penicillin shortage, as well, for syphilis, but for now I think there aren't any major shortage issues. And getting to your point around gonorrhea resistance, so California does not have a particular issue, right now, which is wonderful. But nationally, about half of all gonococcal isolates have resistance to at least one antibiotic and these are the latest data from CDC, which are the 2017 data, the 2018 data are not out yet, but you'll see, here in blue, that half of isolates, you can treat with really anything and they'll respond, and half of isolates have resistance to at least one antibiotic, and you'll see that about 5% have resistance to three or more antibiotics. I know, scary.

Dr. Ina Park:

And maybe, one think you might have heard of in the late press, Mike, is that, so in Hawaii there was a case where there was gonorrhea that was resistant to four antibiotics and I know that we have some folks from Hawaii on the line right now, and it also reduced susceptibility to Ceftriaxone. So that was truly frightening because typically, resistance patterns, the flow resistance patterns are that they often come from Asia to Hawaii and then to California. We did not see the Hawaii strain in California. It sorts of seemed to die out. It did not result in a wide-spread outbreak in Hawaii, either, but you'll see that in Canada, England, Australia, and then again in England, there were cases of multi-drug resistant gonorrhea. The two highlighted in red represent one case in each category in March and January of 2019, who required hospital admission, they had to have three days of IV antibiotics with ertapenem to eradicate their infections. So that is a scary thought. To get admitted to the hospital for gonorrhea.

Dr. Michael Policar:

Indeed, and let's hope those number of case reports stay as low as they are on that slide.

Dr. Ina Park:

Yes, exactly.

Dr. Michael Policar:

All right, let's go to our next question. And that is, how common is it for penicillin or cephalosporin allergies to cause a switch from using the recommended regimens of Ceftriaxone and Azithromycin so that you have to tailor based on a history of that kind of drug allergy? How should a person with gonorrhea be managed if they have that allergy? And one of the older recommendations was that for people who had penicillin or cephalosporin allergies, that they could be treated with two grams of Azithromycin as the full treatment for gonorrhea. Is that one still on the books?

Dr. Ina Park:

Yeah, so to start with your last question first, I really don't think it's a good idea to use Azithromycin monotherapy anymore as an alternative treatment. I'll go over the alternative treatments in a second. So, because there's going to be lots of people in your practice who are going to report penicillin allergies

because 10% of Americans report a penicillin allergy and 90% of these are not true allergies. There have been multiple studies, including a systematic review looking at which proportion of penicillin allergies reported are actually true allergies and analysis of data from Kaiser Southern California where they had over a million patients exposed to cephalosporins and some of those actually happened to be people who had a history of a penicillin allergy. They found the chance of anaphylaxis, they had an estimate and the range around that estimate, the risk is about 100,000 to 1 in 1.5 million. So very rare, but believe it or not, anaphylaxis to cephalosporins did not seem to be related at all to a history of penicillin allergy. So certainly, people will have anaphylaxis to cephalosporins, absolutely, but it didn't actually seem to be related to a penicillin allergy. And so, on the left is just a screen shot. I don't expect you to be able to read it. But CDC has a handout that is a really nice handout going over whether or not, going over a checklist. Is this really a true penicillin allergy? People who said they had a rash as a child to penicillin do not have a penicillin allergy. The people report hives or wheezing, shortness of breath, anything like that, then those people, certainly, should never be given penicillin or a cephalosporin, either, for that matter. There is still a very, very tiny amount of cross-reactivity between third generation cephalosporins and penicillin, but for folks that don't have true anaphylaxis, you can give Ceftriaxone and someone, I saw in the chat box that people are asking about, should you wait after you administer just to make sure the patient doesn't have a reaction. And I think that's very reasonable, and we've done that at our own clinic where we wait for 15 minutes, some people say 30 minutes, and you observe them just to make sure that they're doing okay. But now with penicillin allergy, there's been a movement, now, to actually do a lot more skin testing, not just allergists, but they reported at the CDC Guidelines Meeting that this is being done now, a lot, by hospitalists and being done in an inpatient setting for folks that are hospitalized to be able to use antibiotics that are related to the beta-lactams while people are inpatient. And it helps with antibiotic stewardships, so you don't have to use weird alternative antibiotics.

Dr. Michael Policar:

Exactly.

Dr. Ina Park:

Yeah.

Dr. Michael Policar:

Yeah, that's very helpful just because the false positive rates, so to speak, of the people who think they're allergic is far higher than the people who actually are.

Dr. Ina Park:

Right, exactly. I mean over 90%. One of the studies was actually 95% of people who said they were allergic to penicillin were not allergic to penicillin. So, getting to your, the first thing we talked about which is, well what should I use? The recommendation is to use Gentamicin 240 milligrams plus Azithromycin. And Gemifloxacin is another option, but that has been under a shortage since 2015 or 16. So I don't think you can get it. So, Gentamicin is typically available in inpatient pharmacies. Often outpatient clinics don't stock it. And so, it is tricky. And so, I have asked, providers have come and asked me, well I'm pretty desperate, all I have is Azithromycin, I can't get Gentamicin. And if people are

treated with Azithromycin alone, then it's really, really important to do a test-of-cure to make sure that they are okay. And that would be done at three to four weeks.

Dr. Michael Policar:

And by the way, while those regimens are important as backups, they're at least for now not Family PACT benefits.

Dr. Ina Park:

Okay, that's good to know.

Dr. Michael Policar:

Next slide, number nine. Okay, so when a person is found to have gonorrhea or chlamydia, what's the best way to notify their partner so that they can be treated? Of course, that leads to a question about PDPT, patient-delivered partner therapy. How is that best done? And what is the evidence say about the various alternatives about notifying partners? Is there one approach which is more successful than another?

Dr. Ina Park:

Yeah, I mean I will say, here's some partner management options on this slide. And the ones in the boxes are the ones for whom we have actual research. And so, the most effective of these would be what you described, which is patient-delivered partner therapy and the best way to do that would be to actually, at the time of treatment of the patient, to give them medication to give to a partner. Or you can also give a prescription, but then partners are less likely to fill a prescription than to actually take medication if medication is given. The other thing for which there is research is the top box in purple. Which is, at the time that you notify a patient that they have gonorrhea or chlamydia, you ask them if they have one main partner, to bring their partner in with them for treatment. And if they happen, if the partner happens to be a Family PACT member, then that's really helpful and easy to bring them in. So, you treat the patient and the partner at the same time, if the patient isn't too angry at their partner and isn't speaking to them anymore because that definitely happens and they do not want to bring them in because they say, let that person deal with themselves. I'm angry with them. What doesn't work well, Mike, which probably not going to surprise you, but if I were just to tell you I had chlamydia and I tell you, you're responsible, just go notify everybody. You may or may not do that. That's not a very effective method. And most health departments are not equipped and don't have the bandwidth to go ahead and do that for you.

Dr. Ina Park:

So, if at all possible, giving medication to patients and having them give them to their partners is a great way to go. It's very effective for reducing reinfection with gonorrhea. It reduced it a little bit for chlamydia. It wasn't statistically significant in this particular randomized trial.

Dr. Ina Park:

But I wanted to let folks know that clinics can actually access free medication. It's provided to clinic sites that are seeing folks that are lower income. Many Family PACT providers would be eligible for this and

they dispense this particular group, Essential Access Health, they're the Title Ten grantee for the State of California and so they dispense pre-packaged medication with instructions as well as instructions around allergy and you can get that at essentialaccess.org/pdpt.

Dr. Ina Park:

And so clinical evaluation of a partner is certainly the first-line option. If they have one main partner, you can ask them to bring them with them, but expedited partner therapy is great for patients when a partner doesn't have access to care or they think, I'm really not going to be able to get my partner in for an evaluation and so those are my take-home points for that.

Dr. Michael Policar:

Okay, well that leads us to the next question. And that is that now that our patient found to have gonorrhea or chlamydia has been treated, hopefully their partners have been contacted and treated, as well. What about the follow-up of patients who have been diagnosed and treated for either gonorrhea or chlamydia or both? When should retesting occur? What's the best way of getting advice to have those patients come back in three months? Separate question is, can you remind us of what the specific recommendations are regarding test-of-cure and when that should be done, specifically how many weeks after treatment? And what do we do if the test-of-cure, in that subset of people who need it, turns out to be positive?

Dr. Ina Park:

Sure. Reinfections, once you have chlamydia or gonorrhea are very common, so this is actually Family PACT data. Family PACT and Quest data. And so, if we look at this is the baseline positivity for all-comers for chlamydia in different age ranges. But then for folks who've already had chlamydia, if we look at the proportion of those who are going to get a repeat infection in the next year, it's very high. You see it's much higher than the baseline positivity. And it stays pretty high regardless of age. So, if you've had chlamydia, then the chance of you actually having a repeat infection in the next year is really high.

Dr. Ina Park:

And we know that repeat infections increase the risk of PID, they increase the risk of ectopic pregnancy. By the time you have three or more infections, your risk of pelvic inflammatory disease increases by six-fold and it's increase of risk of ectopic pregnancy is by five-fold. So, we certainly strongly recommend retesting. CDC recommends doing that retesting at three months. It's different than a test-of-cure because with retesting or rescreening, we want to see if somebody's been reinfected. We don't have any doubt that the medication actually worked in that patient. Whereas with a test-of-cure, it's recommended for chlamydia and gonorrhea, excuse me I should have added that on the slide, it's really only recommended for people that are pregnant, three to four weeks after completion of therapy, or in someone who's not pregnant, if you're concerned that they didn't actually take their medication, or if they're not getting better after they've already been treated.

Dr. Ina Park:

And so, the retesting should happen at three months. But really, if the patient comes in any time after three to four weeks because they just happen to be there because now, they have a sore elbow or

something like that. And oh, you know you can go ahead and take that opportunity to do a retest at that time. But you do want to wait at least three weeks because that chlamydia, which is an intracellular organism can actually hang around and there could be dead DNA or RNA there. It doesn't mean they have an infection; it just means that the --

Dr. Michael Policar:

False positive.

Dr. Ina Park:

False positive, exactly.

Dr. Ina Park:

And then in terms of effective, research in terms of effective ways to get patients back in is the counseling messages about, why reinfection is important and that reinfections are common and that they're dangerous, but really giving patients tools about how to remember. Telling them to set a phone reminder. Some clinics actually will send out a little post-card that just have a little, it's just a little cartoon that says, a reminder, it doesn't say what the reminder is for, do you know what I mean?

Dr. Michael Policar:

Makes sense.

Dr. Ina Park:

Yeah, it just says, come on back in. But having a way that a patient can actually remind themselves is really important because if you just tell them, come in in three months, most people will forget. And then if they are, if the test-of-cure, so let's say someone came in and said, you gave me Azithromycin, I threw it up immediately, and I just, I went home, I threw it up, and I never came back, and I'm not feeling any better. Well, for that person, then I would go ahead and go to Doxycycline for seven days if their test-of-cure was positive after they took Azithro.

Dr. Ina Park:

And then for gonorrhea, if you're worried that they have a treatment failure, then I would absolutely, the first box, is get a culture and talk to your health department and then treat them with Gentamicin and two grams of Azithromycin. But you want to bring those people back who you think may have failed treatment to do another test-of-cure in 7 to 14 days with a culture and another nucleic acid test. So, especially because we're concerned about antibiotic resistant gonorrhea, if you really think you're dealing with that, please contact your health department.

Dr. Michael Policar:

All right so a question that came up every now and then during my years at San Francisco General is that if a person who was treated for gonorrhea or chlamydia returns, let's say a week or 10 days later stating that they had sexual contact with an untreated partner, particularly the partner that they may have

shared that infection with in the first place, then should the patient be retested, empirically treated, or both?

Dr. Ina Park:

That's the right question and you're not going to find a guideline for this particular circumstance. But here's some practical things and you can tell me if you agree or not. I was thinking that if a patient has a main partner or primary partner and they're the likely source of the infection, that it's reasonable to treat empirically if they know their partner didn't get treated and we know they were re-exposed. Now if a patient has multiple partners and they don't know if they were possibly re-exposed, I thought it might be reasonable to test. But if this is someone who you don't think you're going to see again or there's multiple issues that make it difficult for them to come into clinic, I also think it's okay to treat them empirically again. But I don't know what you think, Mike.

Dr. Michael Policar:

No, I agree with that. In the best of situations, it would be helpful, I think, to retest. But oftentimes we do have those concerns that patients won't come back for their test results and the treatment has relatively huge side effects and it's important to avoid a second infection.

Dr. Ina Park:

Yep, it's true.

Dr. Michael Policar:

All right. The last question that I have for you is about *Mycoplasma genitalium*. So, starting in the 2015 CDC STD Treatment Guidelines, there was a new section about *Mycoplasma genitalium*, but I got the infection, excuse me, I got the impression --

Dr. Ina Park:

I hope you didn't get the infection.

Dr. Michael Policar:

I got the impression that that was mainly a problem in men. So many clinicians are confused about screening and treatment of *Mycoplasma genitalium* infections in women. Can you summarize what's known about this topic and what the guidelines recommend?

Dr. Ina Park:

Sure. So, *Mycoplasma genitalium*, you'll see, we didn't discover this in the field until the 1980s, so it's a relatively newer STI.

Dr. Ina Park:

But it's more common than you might imagine. It's actually somewhere in between chlamydia and gonorrhea, in terms of its prevalence. So, this is national data from young adults from the Ad Health Study. But if we look at STD clinic or emergency department attendees, and most of those people

coming to an ED, of course, are having symptoms. Many people coming to STD clinics are having symptoms then the positivity is much higher, ranging anywhere from 7 to 20%. So, it's certainly out there.

Dr. Ina Park:

Now what is it actually doing? Well, this is a little bit trickier because we know that it's associated with urethritis in men, there's no doubt about that. Most likely, it's associated with PID in cis-gender women. The strength of the association is not as strong as it is for urethritis in men. And then the cervicitis question is a little bit tricky. The data are not as clear. So there has been a systematic review of this for all of these things listed here, which is cervicitis, PID, and infertility, and preterm delivery, and the increased odds. There were increased odds, about two-fold higher for all the conditions, but it's probably like 5 to 10-fold higher for urethritis in men. And for cervicitis, it's probably under a two-fold risk. So, it's not as strong as the link between HPV and cervical cancer, for example, or gonorrhea and PID. But there are inklings that it's probably not a great thing to have in your reproductive tract and it's certainly caused with certain conditions in men and likely in women, as well.

Dr. Ina Park:

So, because the associations are not so definitive around cervicitis, for example, in women, there isn't a national guideline on screening, currently. Right now, what CDC is recommending, because they didn't have an approved test to use, was they were saying if someone fails treatment for urethritis, then treat them for *Mycoplasma genitalium*. But now, we actually have a test, which I'm going to go into. And what I would say to the audience is that it's reasonable to test for Mycoplasma when you have treatment failure for urethritis in cis-gender men, cervicitis treatment failure or PID treatment failure. Because certainly, we think it can be implicated in these situations.

Dr. Ina Park:

But finally, in January of this year, there was an FDA-approved test for Mycoplasma. It's Hologic's GenProbe test. You can see all the specimen types that it's approved for. Many commercial laboratories actually have developed their own in-house tests, but they don't publish the data on their performance so I can't comment on how good they are. But most reputable labs who are putting out their own tests have done testing on those in-house. But at least now we have an FDA approved test that is available. I just don't know if it's covered with Family PACT, yet.

Dr. Michael Policar:

Does the accuracy of that seem to be quite high?

Dr. Ina Park:

Very good. Yes, it's very good, very sensitive and very specific. And so, the treatment, though, for Mycoplasma is Moxifloxacin, usually seven days is enough. If you need to extend the treatment, you can. It's very effective for treatment failure when you're talking about urethritis and cervicitis with very high cure rates. There is public health pricing available. The usual price for seven days is over $100 out of pocket, but the 340b price is less than $2 a pill, it's much more reasonable. There are Moxifloxacin treatment failures emerging and I just want to point out that if we look at antibiotic resistance data all

over the world for Mycoplasma, you'll see that the purple bars are Azithromycin resistance. The blue bars are Fluroquinolone resistance, that's resistance to Moxifloxacin. And the yellow bars represent both. So, in Japan, for example, 25% of the *Mycoplasma genitalium* is actually resistant to Moxifloxacin or Azithro, so they have to use other antibiotics, such as Pristinamycin, which are not available in the US. So now I get to switch over to you, Mike. This is exciting.

Dr. Michael Policar:

I'm ready.

Dr. Ina Park:

So, if I'm a Family PACT provider and I'm sending a gonorrhea or chlamydia sample to the lab, I need to include an ICD-10 code, right? And so, I want to know what are the codes that are allowable and why do I need to do that?

Dr. Michael Policar:

Well, the reason it's necessary, actually, has an interesting history and that is, going back around 10 years ago, there was a perception looking at Family PACT data, that while most providers were doing a really good job of screening, doing routine screening on women who were 25 and under, that potentially, there was over-screening of older women where the rates of screening were just about as high as they were for younger women. There was a concern that that was just being done as a rogue screening test without evidence to back that up. So, the first thing that was done was to issue clinical practice alerts, to do webinars, and so on, about specifically what the indications were for targeted screening, it didn't make much difference.

Dr. Michael Policar:

The next phase was the Family PACT provider profiles, which were basically report cards that were sent out for years, and two of the indicators were, what's your rate of screening for gonorrhea and chlamydia in women under 25, which was quite high. And then what was the rate of screening women that were 25 and older? And then we would report that back to provider sites so that they could see whether or not there was a differentiation between younger women and older women. That helped a little to bringing that lower screening rates down, but not very much. The end of the story is the fact that a study was actually done by the city clinic in San Francisco that tried this approach of requiring, initially it was ICD9, now ICD10 diagnosis codes, to make sure that clinicians really thought about why they were screening people who were candidates for targeted screening rather than routine screening. So, Family PACT's been doing this for about five years or so. So, here's what the rules are, and this comes directly from the clinical practice board that we'll be seeing in the next month or two. So, for women who are under 25 years of age, who are having routine annual screenings for gonorrhea and chlamydia, you have to put the Z-code for which method of contraception they're using, but you do not need to put any kind of ICD-10 code for STD risk on the lab slip. Next is for women under 25 who are screened more than once a year because of high-risk behaviors or information disclosed in the sexual history, then both the family planning code, as well as the ICD-10 code is required on the lab slip. And then for people who are 25 years and older, then the additional ICD-10 code is required. Now the middle column lists what the acceptable ICD-10 diagnosis codes are that can go on a laboratory slip.

Dr. Ina Park:

That's a lot of them.

Dr. Michael Policar:

There are, and I have to remind providers that this will not affect how you're paid when you see a Family PACT patient. What it affects is the lab and if you don't put down the ICD-10 code on the lab slip, then it could mean that the lab will not be paid. And what you'll see is a differentiation, basically, between what codes can be used for screening tests as opposed for diagnostic tests for gonorrhea and chlamydia. Then the final column is about the codes that are available to men.

Dr. Michael Policar:

Now, just to give you a little bit more detail about the codes, both for men and women that would be used for targeted screening. You can see that there are a variety of Z-codes which are currently accepted to go on the laboratory slips. Those definitions are what are contained in the ICD-10 book, maybe they don't make a lot of sense. So, I made a sort of derivative slide which gives you an idea of the kind of history that would trigger using a specific code. So, for example, for the patient who comes in and says, screen me for everything, or the clinician who recognizes that this is a high chlamydia prevalence location, use Z11.3. If it's a high gonorrhea prevalence location, use Z11.8. If the patient says, I'm here to be screened because my partner screened positive for an STD, you'd use Z20.2. For the patient who already has one STD and therefore you're screening for others, you'd use Z22.4. And so on down the list. And this is very clearly outlined in the PPBI, the Policies, Procedures, and Billing Instructions for Family PACT about which situations in which you would use these specific Z-codes on a lab slip.

Dr. Ina Park:

I like how you decoded it, though, into language that a clinician can understand, like me.

Dr. Michael Policar:

In addition, if a patient has a symptomatic presentation and you're going to do a gonorrhea or chlamydia test, then you have the option of showing that, as well. So, if she has a vaginal discharge, mucus pus coming from her cervix, painful intercourse, dysuria, where you're concerned that this may not be a typical e-coli bladder infection, but could be related to chlamydia, then you would use those diagnosis codes, as well.

Dr. Michael Policar:

Then when you see a patient for retesting, when they come back in three months, the way that Ina just described it, you can either use the A-code for the type of infection that the person had three months earlier, or you can use the Z-code, which is at the very bottom, which is personal history of other infectious or parasitic diseases.

Dr. Ina Park:

So either is perfectly valid is what you're saying?

Dr. Michael Policar:

Yes, either way.

Dr. Ina Park:

Great. So, we have already talked about rectal and pharyngeal infections on women because CDC is really silent on this particular issue, but I'm very curious because, just a little anecdote, we were at a meeting together, Mike, in March and a provider came up to me and said, well Family PACT won't cover three-site screening if somebody is exposed at multiple anatomic sites. And I said, you know what, let's have Mike Policar address this particular issue and how often could we do that if it's indicated?

Dr. Michael Policar:

Okay, so the answer to that is that the Family PACT and Medi-Cal rules have changed about that. So, what the Family PACT PPBI says, currently, is that for patients who have disclosed a history of anal-receptive sex, they should have GC and CT NAAT samples taken at the rectal site. The same is true for the oral pharyngeal site. Men who have sex with men should be screened at least annually, or even more often, based on sites of exposure. And the important piece about billing is that both, Family PACT and Medi-Cal now have frequency limits for gonorrhea and chlamydia tests, up to three tests per patient on the same date of service and that became official in the announcement of September 2018. So that is something that Family PACT will cover, as indicated. Routine multi-site screening, though, is not recommended and not covered. So, in other words, you should only screen multiple sites based on sexual history, based on the recommendations that Ina just shared with you and then it shouldn't be done for every patient who you're seeing who requires STD screening.

Dr. Ina Park:

But I think that's great because this is more specific than the national guidelines, which don't really say anything about what to do about rectal screening in women, for example, Family PACT will allow that and allow samples for both the pharynx, the rectum, and a vaginal swab or a urine to be done on the same day, for example.

Dr. Michael Policar:

Exactly, yes.

Dr. Ina Park:

That's great.

Dr. Michael Policar:

Just don't do it for everybody.

Dr. Ina Park:

Yeah, not for everybody who walks in the door. And so, this is a very common question that has come up for me when I worked at the State was about Family PACT coverage of patient delivered partner therapy. And so obviously the patient's partner has Family PACT eligibility, we would cover treatment

for both the patient and their partner, but right now, is there other ways that partner therapy can be covered by Family PACT?

Dr. Michael Policar:

And the answer is, not at the present time. Under current Family PACT policy, patient delivered partner therapy for either gonorrhea or chlamydia is not a covered benefit, but you do have the option that was mentioned earlier about the program from the Central Access Health. And I will say that both Medi-Cal and Family PACT are reconsidering that policy at the current time and stay tuned.

Dr. Ina Park:

Okay that's great.

Dr. Michael Policar:

You'll probably be hearing more about it.

Dr. Ina Park:

That's very exciting. And that's been a long time coming, I have to say. So, what about covering the consequences of a chlamydia or gonorrhea infection. So, I'm talking about an upper tract infection in men or women, PID or epididymitis?

Dr. Michael Policar:

So, coverage for those conditions have been a part of Family PACT from the very beginning, so if you see a patient who has PID, use the diagnosis code of N70.03 or 93 and for a male who has epididymitis or epididymo-orchitis, you can see the N-code for that. So, for PID, Family PACT covers a number of laboratory tests as well as a large majority of out-patient regimens that are recommended by the CDC and for men who have epididymitis, Family PACT does cover Ceftriaxone and Doxycycline for that purpose. Just be sure to use the right ICD-10 diagnosis codes in order to have the antibiotics covered.

Dr. Ina Park:

And actually, in the chat box, people were asking about *Mycoplasma genitalium*, whether or not testing or treatment was covered. But my specific question was around presumed *Mycoplasma genitalium*, when you have someone who's got a urethritis or cervicitis treatment failure because testing wasn't available until very recently.

Dr. Michael Policar:

Right, and the answer is that while Family PACT does not cover *M. genitalium* testing yet, they have, over at least a year, covered use of Moxifloxacin, so that is part of the benefit grid and basically, Moxifloxacin 400 milligrams daily for a week, specifically for persistent or recurrent cervicitis in females or NGU in males that has not responded to treatment can be covered. Now, it's only covered for pharmacy dispensing, not for clinic dispensing and it does require TAR. But given the fact that this is listed in the Family PACT formulary, Ina, you shouldn't have any problems in having that TAR approved

as long as in the explanation section of it, you say that the patient meets one of these criteria. The reference for that is in the benefit grid, which you can get online on page 22.

Dr. Ina Park:

That's really helpful, Mike, and particularly because this is such an expensive medication out of pocket that the fact that Family PACT covers it is wonderful. And so, we've reached the end of our webinar. We went seven minutes over.

Renyea Colvin:

Good job, thank you guys for getting all that content in. We do have quite a few questions and because we are, because we are over a few minutes, like 9 or 10 minutes, we don't want to answer every single question. So, what I'm going to ask is that you guys prioritize the questions that are specific to Family PACT. There are a few of them. You can start with, let me go to the very last question.

Dr. Ina Park:

Sure, and then we can collect the questions. What we've done for prior webinars is we can collect the questions and I'm happy to answer some in a document that we can post with the slides.

Renyea Colvin:

Thank you.

Dr. Ina Park:

Sure. So, let's see. Okay, oh there it is, this one. This one was already answered about Mycoplasma testing and treatment, so testing not, yet right? But treatment, yes?

Dr. Michael Policar:

Yes.

Dr. Ina Park:

Okay, let's see. Let's see is there anything else that's Family PACT specific? Let's see, let's go backwards. Could we clarify if test-of-cure, if the Azithromycin is vomited up and did it say test-of-cure in seven days, or did I misread? So, test-of-cure for chlamydia has to actually be done in three weeks. Three to four weeks. But for gonorrhea, in the cases of gonorrhea treatment failure, for gonorrhea treatment failure, gonorrhea is cleared much more quickly than chlamydia so 7 to 14 days is probably fine for gonorrhea. For chlamydia you do need to wait for three weeks. In terms of vomiting, if the vomiting occurs more than an hour after the medication has been taken, usually the patient does not need to be retreated.

Dr. Michael Policar:

This one's a good one for you. What's the best practice for EPT prescription documentation? Curious to know what people are doing.

Dr. Ina Park:

So, in terms of how you document it in the chart?

Dr. Michael Policar:

Yes.

Dr. Ina Park:

You know, I think typically in the plan section of your SOP note that you would say the problem list and so the diagnosis would be gonorrhea and then I think you would just document Ceftriaxone 250 IM plus Azithromycin given. And you could say, partner pack of Cefixime plus Azithromycin dispensed to patient with instructions for complications for allergy, etc. So, I think documenting what you dispensed to the partner, as well as documenting the fact that you're giving them information about allergy, for example, and not to take in case of allergy are two important things. But you know, this practice has been legal since 2007 for gonorrhea and 2001 for chlamydia and there have been no legal issues regarding this for providers, so just to reassure providers about that.

Dr. Michael Policar:

Okay, I'm having trouble with not moving up.

Dr. Ina Park:

Oh sure. And so, what's your recommendation for EPT for gonorrhea? Do you recommend, do you send the patient home with oral Cefixime? For right now, for EPT for gonorrhea, we recommend doing two antibiotics. So, we actually recommend if you're going to give pre-packaged medication, that you give both Cefixime 400 and one gram of Azithromycin. This is a question about penicillin allergy, which is, what is the recommendation for folks who think they are penicillin allergic request a test to confirm their allergic status? I think yes, unless the patient says to you, they had a very clear history of hives or wheezing or something that's clearly an anaphylactic type of situation, then I don't recommend skin testing those patients. But if somebody has a vague history. Like if someone says they just had a rash as a child, we actually treat all those patients and we just observe them for a few minutes after treatment. For folks that are in between that are not sure, then we do recommend getting skin testing and that usually can be done as an out-patient. Not as an inpatient.

Dr. Michael Policar:

The next question is similar to the last, it says, our patients wait 30 minutes post-administration. What are other clinics doing?

Dr. Ina Park:

Yeah. I think we do 15, actually. I know that some providers have actually tried this whole waiting period, and nothing happens so now they don't do a waiting period at all. So, it's sort of all over the map. But yes, when people say that they thought they had a penicillin allergy, when we give them Ceftriaxone, we do observe them afterwards.

Dr. Michael Policar:

One of the questions up here is, what about using Ceftriaxone IV?

Dr. Ina Park:

Yeah, so you know what? In Japan, that's exactly how it's done. So, it's actually given IV, one gram IV is what they have to use. And so, you could give it IV. But that's a lot harder to do than giving an IM. So, if someone got an IV, some people go to the ED, for example, and then they've been given their Rocephin IV and you wonder whether or not it's equivalent, it's fine. So, you don't need to retreat them again.

Dr. Michael Policar:

Let me clarify this one. Doxycycline as an option, you put a line through it.

Dr. Ina Park:

Yeah, this was a question for Rebecca Segarri, on one of the slides, Doxycycline was crossed off as the second agent for gonorrhea. And yes, it used to be one of the agents, and I crossed it off because there is so much antibiotic resistance to the Doxycycline in gonorrhea nationally, that it's no longer recommended as a second agent, so Azithromycin is really the only second agent along with Ceftriaxone right now. And the question, does the CMR, does the Confidential Morbidity Report have to have a social security number? And I honestly don't know the answer to that.

Dr. Michael Policar:

I don't think so.

Dr. Ina Park:

I don't think so. I actually looked at the CMR before this talk, but I don't think the social security numbers required. I think that's most of them. But what we didn't get to, we will get to later.

Dr. Ina Park:

Oh, and I'll just answer Roseanne's question really quickly, what's the earliest number of days after a potential gonorrhea and chlamydia that you should screen in order to avoid getting a false negative? So that's a difficult question. When some of these patients come in the day after they've had sex and they want to know. And so, you can screen them. It is possible that they have contaminates from their partner, for example, from semen and they're not actually going to end up with the true infection. But if you get a positive, it means that they were exposed and it's okay to treat them anyways. So, I don't actually set limits in terms of, even if they had sex just the day before, it's okay to go ahead and screen them. But typically, I would tell people, if they say I just had unprotected sex, when would you like me to come in? I tell them to wait a week or two weeks before coming in. But if they happen to show up on your doorstep, it's okay to screen them anyway.

Renyea Colvin:

Do you want to answer another?

Dr. Michael Policar:

Yeah, I'm just seeing. You know, quite honestly, I think that we have, that there are a fair number of repetitious questions.

Dr. Ina Park:

Oh, and then someone wants to discuss LGB, but we're not going to be able to get, I'm sorry. We are not going to be able to get to that.

Dr. Michael Policar:

Thank you for trying.

Dr. Ina Park:

I know. Oh, and someone was asking, they're asking about EPT, how do you document it on the prescription? And actually, so in some states, they actually say that they want you to document that this is for partner therapy. But in the State of California, there are no requirements around that. So, it would, essentially, just be filling out a prescription with the partner's name and you don't have to do any special documentation that this is for partner therapy.

Dr. Michael Policar:

Just one very helpful resource if you need more detail about expedited partner therapy or patient delivered partner therapy. On the CDC website, in the section on sexually transmitted diseases, there's actually a couple of web pages filled with really good advice about how to do expedited partner therapy. And, of course, there's a map which changes every now and then about the laws in states. All you have to do is just click on your state and it will tell you about the laws. Fortunately, it looked like 48 out of 50 states now permit this, only two do not. But there's also lots of helpful information. So just go to, what is it? cdc.gov

Dr. Ina Park:

Yep.

Dr. Michael Policar:

Type in the search box, PDPT and you'll find that section that has some very useful tips for you.

Dr. Ina Park:

Yep. Thank you.

Renyea Colvin:

Okay, thank you two for your awesome presentation, and also, thank you, participants, for hanging in there with us. We really appreciate it. On your screen, right now, you see the link to complete the two-minute evaluation. Your honest feedback is greatly appreciated. And, of course, we will be sure to send the slides and any supplemental materials to you via email using the email address that you used to register for today's webinar. Thank you and we'll also be sure to send you the answers to any lingering

questions that come up. We will hang out for a few more minutes and other than that, you all are free to leave. Thank you for participating.