DHCS California Department of HealthCareServices

Family PACT Planning • Access • Care • Treatment

Clinical Practice Alert

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UPDATE: CHLAMYDIA AND GONORRHEA SCREENING AND TREATMENT

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

Routinely screen all sexually active females 24 years of age and younger annually for CT and GC.

Target CT and GC screening of females 25 years of age and older only to those with risk factors.

Retest CT- and GC-positive clients three months after treatment to detect re-infection. A test of cure should not be performed if recommended antibiotic regimens are used.

Provide timely antibiotic therapy to all partners who had contact with the client during the 60 days prior to onset of symptoms or diagnosis of CT or GC. While a clinical evaluation of partners is preferred, patient delivered partner therapy and patients bringing in partners at the time of the treatment visit improves partner treatment rates.

QUESTIONS AND ANSWERS

Why does age influence routine screening compared to targeted screening for CT and GC?

Age is a strong predictor of risk for CT and GC infections, with the highest infection rates occurring in women aged 20 to 24 years, followed by females aged 15 to 19 years. Chlamydial infections are 10 times more prevalent than GC infections in young adult women.[1,2]

When should a woman over 24 years of age be screened for CT and GC?

According to California (CA) Sexually Transmitted Diseases Control Branch[3] (STDCB) guidelines, the risk factors for CT and GC infection in older women are:

- A history of CT, GC, or PID in the past 24 months
- More than one sex partner in the past 12 months
- A new sex partner in the previous three months
- Suspicion that a sex partner within the previous 12 months has had other sex partners at the same time
- A history of exchanging sex for drugs or money in the past 12 months
- Practice-site specific rates of chlamydia of $\geq$ 3% or gonorrhea $\geq$ 1%

Additional risk factors listed by the USPSTF and CDC include:

- Inconsistent condom use among persons who are not in mutually monogamous relationships, having a previous history of a STD, incarcerated populations, military recruits, and patients receiving care at public STI clinics.
- Persons who report contact with partner known to have a STI including CT, GC, trichomoniasis, non-gonococcal urethritis, epididymitis, syphilis, genital herpes, or HIV.

When should diagnostic testing for CT and GC be performed?

- Females with clinical exam findings such as mucopurulent cervicitis, cervical friability (bleeding to touch), dyspareunia, and acute or chronic pelvic pain that could be due to PID.
- Males with clinical findings including dysuria, urethral discharge, or epididymal or testicular pain.
- Females and males with other co-existing sexually transmitted infections, including syphilis and HIV.

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

Persons who disclose a history of having anal-receptive sex should have separate GC and CT NAAT samples taken at the rectal site. Those having oral sex should be screened for oropharyngeal GC. Men who have sex with men (MSM) should be screened for CT and GC at least annually, based on sites of exposure. Family PACT benefits include multi-site screening or testing for GC and CT on the same date of service in these situations. Routine multi-site screening of all patients is not recommended.

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

According to Center for Disease Control (CDC) recommended guidelines:

- The optimal genital specimens for nucleic acid amplification tests (NAATs) are vaginal swabs for women and first-catch urine for men. For females, cervical or a first-catch urine sample (the first 10 ml) also may be tested.
- Vaginal swab specimens obtained in the office can be self-collected by patients or by clinicians, but collection of the sample at home is not a covered Family PACT benefit.

Who reports positive CT or GC results for public health surveillance?

CA law (CCR 2500) mandates that a health care provider confidentially reports positive CT and GC test results to the local health jurisdiction for prevention, control, and contact management. Client information shall be reported on the **Confidential** Morbidity Report within one week of identification. Clients should be informed prior to testing that positive results will be reported.

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

Regimens recommended in the 2015 CDC STD Treatment Guidelines and included in the Family PACT formulary are:

- CT: Azithromycin 1 gram orally in a single dose or doxycycline 100 mg orally twice daily for seven days
- GC infections (genital, rectal, or pharyngeal) require dual therapy: Ceftriaxone 250 mg IM **PLUS** azithromycin 1 gram orally. Dual therapy with oral cefixime 400 mg and azithromycin 1 gram is an alternative if ceftriaxone is not available. Pharyngeal gonorrhea should be treated only with ceftriaxone plus azithromycin.
- Non-gonococcal urethritis (NGU): Azithromycin 1 gram orally OR doxycycline 100 mg orally twice daily for seven days. Consider treating *M. Genitalium and T. vaginalis* if symptoms persist despite treatment with azithromycin.
- These regimens are inadequate for treatment of PID in women or epididymitis in men. Please refer to the 2015 CDC STD Treatment guidelines[4] or the CA STD Treatment Guidelines Website[3] for a full listing of regimens.
- Patients with IgE-mediated allergies to cephalosporins (e.g., anaphylaxis, Stevens-Johnson syndrome) require treatment with antibiotics that are not Family PACT benefits. Azithromycin 2 grams orally is no longer recommended as single drug therapy in cephalosporin allergy.

When should a test-of-cure (i.e., testing 4 weeks after completing therapy to detect therapeutic failure) be performed after treatment of CT or GC?

- Test-of-cure is ONLY advised if: the client is pregnant, the client received an alternative treatment regimen for pharyngeal gonorrhea, therapeutic compliance is in question, symptoms persist, reinfection is suspected, or treatment failure is suspected.
    - Use of chlamydial NAATs less than 3 weeks after completion of therapy is not recommended because the continued presence of nonviable CT can lead to false-positive results.
    - To reduce the risk of false-positive test results, NAAT test-of-cure for gonorrhea should be delayed until at least 14 days after treatment.
- If a NAAT test-of-cure is positive for GC, confirmatory culture is recommended with antimicrobial susceptibility testing. Culture and susceptibility testing are not Family PACT benefits, however if culture and susceptibility testing are indicated, STDCB can assist in linking providers with laboratory services. Please contact (510) 620-3400 for assistance.

How should the client's sex partners be managed?

To facilitate partner notification and treatment, any client with laboratory-confirmed or presumptive CT or GC infections should identify all sex partner(s) from the 60 days prior to the onset of symptoms or diagnosis. If the client's last sexual contact was over 60 days prior to diagnosis, the most recent sexual partner should be treated. Patient-delivered partner therapy (PDPT) has been legal in California since 2001 for CT and since 2007 for GC.
Recommended partner management options include:

- Dispensing medication directly to the client to deliver to his/her partner(s)
- Provide the client with a prescription, written in the name of the client, for the client to deliver to his/her partner(s)
- Asking clients to bring their partner to clinic so both can be treated at the same time
- Provider-assisted referral, when available
- Standard patient referral – asking patients to tell their partner(s) to seek treatment– is the least effective option

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

Persons diagnosed with GC or CT should be screened for HIV and syphilis, if not recently performed.

- Clients treated for CT and GC are at high risk of repeat infection due to re-exposure to an untreated sex partner or a new partner
    - Re-testing three months (and as early as 1 month) after treatment is recommended. If the client returns more than 3 months after treatment, re-test whenever they next present for clinical services
    - Strategies used by providers to improve re-testing rates include:
        - Counseling the client regarding the reason for, and importance of, re-testing, supplemented with written materials
        - At the time of initial treatment, making an appointment for client re-testing in three months
        - With the client's approval, contacting the client via text message, telephone call, letter, or e-mail in advance of the re-testing date
        - Programming a medical record prompt ("flag") with the re-test due date for each client, to alert clinic staff that a re-test is needed in case the client seeks care for another reason

APPLICATION OF FAMILY PACT POLICIES

Beyond the ICD-10 code for the client's contraceptive method, when is it necessary to include an additional ICD-10 code on a lab request for CT and GC NAAT tests?

FEMALES

<25 years: Routine annual screening, any provider. No additional ICD-10-CM code required
<25 years: Screening more than 1x per year, same provider, additional ICD-10-CM code is required
≥25 years: Additional ICD-10-CM code required

ACCEPTAPLE ADDITIONAL ICD-10-CM DIAGNOSIS CODES

Screening: Z11.3, Z11.8, Z20.2, Z22.4, Z72.51 – Z72.53, Z86.19
Diagnostic CT: A56.01, A56.09, A56.3, A56.4, N70.03, N70.93, N72, N89.8, N94.10 – N94.12, N94.19, N94.89, R30.0, R30.9
Diagnostic GC: A54.01, A54.03, A54.5, A54.6, N34.2, N70.03, N70.93, N72, N89.8, N94.10 – N94.12, N94.19, N94.89, R30.0, R30.9

MALES OF ANY AGE (ADDITIONAL ICD-10-CM CODE IS REQUIRED)

Screening: Z11.3, Z11.8, Z20.2, Z22.4, Z72.51 – Z72.53, Z86.19
Diagnostic CT: A56.01, A56.3, A56.4, N34.2, N45.3, R30.0, R30.9
Diagnostic GC: A54.01, A54.22, A54.5, A54.6, N34.2, N45.3, R30.0, R30.9

REFERENCES AND RESOURCES ON CHLAMYDIA AND GONORRHEA SCREENING AND TREATMENT

1. U.S. Preventative Services Task Force Final Recommendation Statement Chlamydia and Gonorrhea: Screening, 2014. Accessed 2.22.19.
2. LeFevre ML. Screening for Chlamydia and Gonorrhea: U.S. Preventive Services Task Force Recommendation Statement. Ann Intern Med. 2014;161:902-910.
3. California Department of Public Health Sexually Transmitted Disease Control Branch Clinical Guidelines
4. Workowski KA, Bolan GA; Centers for Disease Control and Prevention. Sexually transmitted diseases treatment guidelines, 2015. MMWR Recomm Rep. 2015 Jun 5;64(RR-03):1-137
5. CA Prevention Training Center website or call (510) 625-6000
6. California Department of Public Health: Patient-delivered partner therapy (PDPT) for chlamydia, gonorrhea, and trichomoniasis: Guidance for Medical Providers in California