



Clinical Practice Alert

March 2022

Chlamydia and Gonorrhea Screening and Treatment Update

Introduction

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

Key Recommendations



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 unless specifically noted.



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 Sexually Transmitted Diseases Control Branch (STDCB)² 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 STI, 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, HIV, and primary genital herpes



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 CT and GC NAAT samples taken at the rectal site. Those having receptive oral sex should be screened for oropharyngeal CT and 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 CT and GC on the same date of service in these situations. Routine multisite screening of all patients is not recommended.



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

- 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 obtained by a clinician or self-collected by the client. If given specific instructions, self-collection of the sample at home and returning it to the clinic or a lab drop-off station is acceptable.



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 2021 CDC STI Treatment Guidelines³ and included in the Family PACT formulary are:

- CT: doxycycline 100 mg orally twice daily for 7 days
 - Alternates: azithromycin 1 gram orally in a single dose or levofloxacin 500 mg PO QD for 7 days
- GC (genital, rectal): ceftriaxone 500 mg IM (ceftriaxone 1 gm IM for those weighing > 150 kg)
 - Alternate, if ceftriaxone is not available: Cefixime 800 mg orally once
 - If cephalosporin allergy: gentamicin 240 mg IM in a single dose PLUS azithromycin 2 gm PO once
- GC (pharyngeal): ceftriaxone 500 mg IM (or ceftriaxone 1 gm IM for those weighing > 150 kg)
 - No alternative regimens are available. Perform test of cure 2-3 weeks after treatment.
- When treating GC, if chlamydia has not been excluded with a negative test result, co-treat with doxycycline 100 mg PO BID for 7 days. For pregnancy, allergy, or concern for nonadherence, use azithromycin 1g orally once.
- Non-gonococcal urethritis (NGU): doxycycline 100 mg orally twice daily for 7 days, or as an alternate, azithromycin 1 gram orally. Consider treating *M. genitalium* if symptoms persist.
- These regimens are inadequate for treatment of PID in females or epididymitis in males. Please refer to the 2021 CDC STI Treatment Guidelines³ or the CA STD Treatment Guidelines Website² for a full listing of outpatient regimens.



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 advised ONLY if: the client received treatment for pharyngeal gonorrhea, is pregnant, adherence is in question, symptoms persist, or if reinfection is 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 7 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, STD/CB 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 (e.g., partner pack) to deliver to his/her partner(s)
- Providing the client with a prescription (in the *enrolled client's name*) to treat the acute infection in the client and partner(s)
 - Family PACT benefits include the client dose and up to 5 partner doses
- Asking clients to bring their partner to clinic so both can be treated at the same time
- 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 CT or GC 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
 - Screening more than 1x per year, same provider, additional ICD-10-CM code is required
- **≥25 years:**
 - Additional ICD-10-CM code required



Acceptable 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

1. [U.S. Preventative Services Task Force Final Recommendation Statement Chlamydia and Gonorrhea: Screening, 2021](#). Accessed 10.29.2021.
2. [California Department of Public Health Sexually Transmitted Disease Control Branch Clinical Guidelines](#)
 - a. [Chlamydia](#)
 - b. [Gonorrhea](#)
3. [Workowski KA, Bachmann LH, et al. CDC Sexually Transmitted Infections Treatment Guidelines, 2021. MMWR Recomm Rep 2021;70\(No. RR-4\): 1-187](#). Access at CDC STI Treatment Guidelines, 2021.