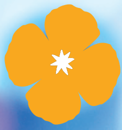

Family PACT

CLINICAL PRACTICE ALERT
CHLAMYDIA AND GONORRHEA
SCREENING, DIAGNOSIS, AND TREATMENT

Introduction

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

In this document, the term "individuals" is used to refer to *individuals with a cervix*. When a guideline is quoted directly, the original term of "woman," "female," or "male" is used.

Key Recommendations

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

Retest CT- and GC-positive individuals three months after treatment to detect reinfection. A test of cure should not be performed unless specifically noted.

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

Provide timely antibiotic therapy to all partners who had contact with the individual during the 60 days prior to the onset of symptoms or diagnosis of CT or GC. While a clinical evaluation of partners is preferred, expedited partner therapy (EPT) is an option shown to improve rates of partner treatment. EPT can be provided as clinic-dispensed medication or by prescription through patient-delivered partner therapy (PDPT).

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 individuals aged 20 to 24 years, followed by 15 to 19 years old. Chlamydial infections are 10 times more prevalent than GC infections in young adult women.[1,2]

When should an individual aged 25 and older be screened for CT and GC?

According to the California Department of Public Health (CDPH) Sexually Transmitted Diseases (STD) Control Branch[2] guidelines, the risk factors for CT and GC infection in individuals over 25 years old 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 3 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 ≥ 3% or gonorrhea ≥ 1%.

Additional risk factors listed by the U.S. Preventive Services Task Force (USPSTF)[1] and Centers for Disease Control and Prevention (CDC)[3] include:

» Inconsistent condom use among individuals who are not in mutually monogamous relationships, having a previous history of a sexually transmitted infection (STI), incarcerated populations, military recruits, and individuals receiving care at public STI clinics.

» Individuals who report contact with a partner known to have an STI including CT, GC, trichomoniasis, non-gonococcal urethritis, epididymitis, syphilis, genital herpes, or HIV.

When should diagnostic testing for CT and GC be performed?

» Clinical findings such as mucopurulent cervicitis, cervical friability (bleeding to touch), dyspareunia, and acute or chronic pelvic pain that could be due to PID.

» Individuals with male genitalia: dysuria, urethral discharge, and epididymal or testicular pain.

» Individuals with other co-existing sexually transmitted infections, including syphilis, HIV, and primary genital herpes.

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

» Individuals who report receptive anal sex should have a rectal sample taken for CT and GC nucleic acid amplification testing (NAAT).

» Individuals who report 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 (i.e., genital, anal, and

oropharyngeal samples) for CT and GC on the same date of service.

- Routine multi-site screening of all individuals is not recommended.

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

- The optimal genital specimens for NAATs are vaginal swabs and for individuals with a penis, a first-catch urine sample. For individuals with a cervix, a cervical or a first-catch urine sample (the first 10 ml) may be used, but vaginal sampling is slightly more accurate.
- Vaginal specimens collected in the office can be obtained by a clinician or self-collected by the individual. If given specific instructions, individuals can perform self-collection at home and return the specimen to the clinic or drop it off at a laboratory.

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

Both chlamydia and gonorrhea are reportable communicable diseases in California. Laboratories routinely notify the CDPH of positive test results.

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

Regimens recommended in the 2021 CDC STI Infection Treatment Guidelines[3] and included in the *Family PACT Pharmacy Formulary* and/or the Clinic Formulary section of the *Family PACT Policies, Procedures and Billing Instructions (PPBI)* manual are:

- CT: doxycycline 100 mg orally twice a day for 7 days.
  - Alternates: azithromycin 1 gm orally in a single dose or levofloxacin 500 mg orally once a day for 7 days.
- GC (genital, rectal): ceftriaxone 500 mg IM in a single dose (ceftriaxone 1 gm IM for those weighing > 150 kg).
  - Alternate, if ceftriaxone is not available: cefixime 800 mg orally in a single dose.
  - If cephalosporin allergy: gentamicin 240 mg IM in a single dose PLUS azithromycin 2 gm orally in a single dose.
- GC (pharyngeal): ceftriaxone 500 mg IM (or ceftriaxone 1 gm IM for those weighing > 150 kg) in a single dose.
  - No alternative regimens are available. Perform a 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 orally twice a day for 7 days. For pregnancy, allergy, or concern for nonadherence, use azithromycin 1 gm orally once.
- Non-gonococcal urethritis (NGU): doxycycline 100 mg orally twice a day for 7 days, or as an alternate, azithromycin 1 gm orally. Consider treating *M. genitalium* if symptoms persist.
- These regimens are inadequate for treatment of PID or epididymitis. Please refer to the 2021 CDC STI Treatment Guidelines[3] and the CDPH STD Control Branch Treatment Guidelines[2] for a full listing of outpatient regimens. Also, refer to the *Family PACT Benefit Update 2023 Training* and the newly updated *Clinical Practice Alert: Urinary Tract Infections in Women* for new program benefits on urethritis and epididymitis.

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

- Test of cure is advised ONLY if: the individual received treatment for pharyngeal gonorrhea, the individual is pregnant, adherence is in question, symptoms persist, or if reinfection or treatment failure is suspected.
  - NAAT testing for chlamydia performed less than 3 weeks after completion of therapy is not recommended because the continued presence of nonviable CT can lead to false-positive results.
  - A NAAT test-of-cure for gonorrhea should be performed 7-14 days after treatment. Testing closer to 14 days may decrease the likelihood of false-positive results.
- If a NAAT test of cure is positive for GC, a 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, the CDPH STD Control Branch can assist in linking providers with laboratory services. Please call (510) 620-3400 for assistance.

How should the individual's sex partners be managed?

To facilitate partner notification and treatment, any individual with laboratory-confirmed or presumptive CT or GC infections should identify all sex partner(s) from 60 days prior to the onset of symptoms or diagnosis. If the individual's last sexual contact was over 60 days prior to diagnosis, the most recent sex partner should be treated. The implementation of expedited partner therapy (EPT) also known as 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 individual (e.g., partner pack) to deliver to their sex partner(s).
- Providing the individual with a prescription (in the *enrolled client's name*) to treat the acute infection in the client and sex partner(s).
  - Family PACT benefits include the client dose and up to 5 partner doses.
- Asking individuals to bring their partner to the clinic so both can be treated at the same time.
- Standard patient referral – asking individuals to tell their partner(s) to seek treatment – is the least effective option.

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

- Individuals diagnosed with CT or GC should be screened for HIV and syphilis, if not recently performed.
- Individuals 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.
- Retesting 3 months (and as early as 1 month) after treatment is recommended. If the individual returns more than 3 months after treatment, retest whenever they next present for clinical services.

- Strategies used by providers to improve retesting rates include:
  - Counseling the individual regarding the reason for, and importance of, retesting, supplemented with written materials.
  - At the time of initial treatment, making an appointment for individual retesting in 3 months.
  - With the individual's approval, contacting the individual via text message, telephone call, letter, or email in advance of the retesting date.
  - Programming a medical record prompt ("flag") with the retest due date for each individual, to alert clinic staff that a retest is needed in case the individual seeks care for another reason.

References

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