ALASKA NATIVE MEDICAL CENTER
SEXUALLY TRANSMITTED DISEASE SCREENING AND TREATMENT GUIDELINES

Current update: 10/8/24 pf/njm

Alaska Native Medical Center
STD Screening and Treatment Guidelines

A. Screening

Recommendations for Chlamydia and Gonorrhea

1. All women less than 25 years old who are sexually active –annually
2. All other sexually active women at increased risk (new or multiple partners, history of sexually transmitted infections, inconsistent condom use, and/or drug use, commercial sex work)—annually
3. Anyone diagnosed with Chlamydia and/or Gonorrhea should be retested 3 months after treatment. If not within 3 months, retest when they present for care within 12 months regardless of partner treatment
4. Consider testing sexually active young men in clinical settings associated with high prevalence of Chlamydia (e.g. Anchorage, AK)
5. Test all sites that a person uses for sex (vagina, pharynx, rectum for women and urethra, pharynx and rectum for men)
6. Persons should abstain from sexual intercourse seven days after treatment and seven days after partners are treated
7. Any person with pharyngeal gonorrhea should return 14 days after initial treatment for a test of cure

Recommendations for HIV

1. Offer screening to all 13-64-year olds regardless of risk. Persons may decline (opt-out testing). For those who decline, providers should address their objections and continue to encourage testing

2. Annually screen those seeking treatment for STDs and/or starting new sexual relationships, men who have sex with men (if HIV status is unknown or negative and the patient himself or his sex partner(s) have had more than one sex partner since most recent HIV test) and/or at high risk persons (i.e. use online dating apps like Grindr, new or multiple partners, history of sexually transmitted infections, inconsistent condom use, and/or drug use, commercial sex work).

3. Consider screening more frequently for persons listed in #2 above, e.g., screen with each new STD infection.

Recommendations for Syphilis

1. Offer to those who have unprotected sex, multiple sex partners, sex partner(s) with syphilis, HIV and high-risk behaviors

2. Consider screening those persons who present with chancre(s) which are firm, round, and painless ulcers or lesions and appear at the location where syphilis entered the body (i.e. mouth, anus, penis, vagina)

Treat all persons immediately if syphilis is suspected (symptoms of primary or secondary syphilis, exposure to early syphilis)
3. Consider testing patients with atypical chancres or lesions of unknown etiology.
4. Diagnosis requires two reactive tests: a treponemal test, **EIA** (syphilis antibody screen) and then a confirmatory nontreponemal test, **RPR with titration**. Contact the SCF STD RN or SCF HIV RN for discordant tests (i.e. a reactive EIA and a non-reactive RPR) for further guidance.

Recommendations for Herpes type 2 (HSV-2)

1. Routine serological screening not recommended in persons with no symptoms suggestive of herpes infection (i.e. the general population)
2. Herpes type 2 blood testing may or may not be included in a full STD evaluation, as STD testing depends on a number of factors, such as behavioral risk factors (e.g. number of partners, consistent condom use, etc.)
3. HIV and syphilis testing should be performed routinely on all persons with HSV-2

Recommendations for Hepatitis A (HAV)

*Transmission of HAV during sexual activity probably results from fecal-oral contact
1. Offer hepatitis A vaccine to the following: men who have sex with men, illegal drug users (of both injection and non-injection drugs) and persons with chronic liver disease, including persons with chronic HBV and HCV infection
2. Vaccination of a person who is already immune is not harmful
3. Vaccination is the most effective means of preventing HAV transmission among persons at risk for infection

Recommendations for Hepatitis B (HBV)

1. Hepatitis B vaccine should be routinely offered to all unvaccinated persons attending STD clinics and to all unvaccinated persons seeking evaluation or treatment for STDs
2. Consider prevaccination serologic testing before initial vaccine dose in adults (Anti -HBc is the test of choice for prevaccination testing). Persons who are anti-HBc–positive should be tested for HBsAg. Persons with HBsAg should be referred to a specialist in the management of hepatitis B infection and receive further serologic evaluation, prevention counseling, and evaluation for antiviral treatment.
3. The first vaccine dose should be administered immediately after collection of the blood sample for serologic testing
4. Postvaccination serologic testing for immunity is not necessary after routine vaccination of adolescents or adults except health-care workers or public safety workers at high risk for exposure to blood or body fluids, persons with HIV and persons who share needles with persons infected with Hepatitis B
5. Vaccination of persons who are immune to HBV infection because of current or previous infection or vaccination is not harmful and does not increase the risk for adverse events

Recommendations for Hepatitis C (HCV)

*Transmission via sexual transmission is rare but can occur especially persons
1. Routine testing recommended for all persons born during 1945–1965
2. In a person newly diagnosed with Hepatitis C, screen for HIV
3. Offer screening to those at high risk (IV drug use, blood transfusion prior to 1992,

long-term hemodialysis, being born to a mother with HCV infection, intranasal drug use, receipt of unregulated tattoos)
4. Screen HIV positive men who have sex with men with HCV antibody assays yearly

Recommendations for Trichomoniasis
1. Consider screening those at high risk for infection (i.e., women who have new or multiple partners, have a history of STDs, exchange sex for payment)
2. Screen women seeking care for vaginal discharge

Recommendations for Pelvic Inflammatory Disease
1. Screening and treating sexually active women for chlamydia and gonorrhea reduces their risk for PID. Although BV is associated with PID, whether PID incidence can be reduced by identifying and treating women with BV is unclear. Whether screening young women for *M. genitalium* is associated with a reduction in PID is unknown.

Recommendations for pregnant people

1. Chlamydia and Gonorrhea:
-All pregnant people at first prenatal visit
-Retest during third trimester, e. g., 36 weeks
-Retest at delivery if high risk / positive STI during prenatal care / or if no prenatal care
-If diagnosed with Chlamydia or Gonorrhea and treated, perform test of cure 4 weeks after treatment
-If diagnosed with Chlamydia or Gonorrhea in first trimester, retest within 3-6 months (preferably third trimester)

2. HIV:
-All pregnant people at first prenatal visit unless they decline testing (opt-out). For pregnant people who decline HIV testing, providers should address their objections, and when appropriate, continue to encourage testing strongly. Pregnant people who decline due to previous negative HIV test should be informed of the importance of retesting during pregnancy.
-Retest in the third trimester (36 weeks gestation)
-Rapid HIV screening should be performed on any woman in labor who has an undocumented HIV status unless she declines
-Please see the separate 'HIV/AIDS in Pregnancy: Screening and Management' guideline document for further details

3. Syphilis:
-All pregnant people at first prenatal visit, 24-28 weeks, 36 wks, and at delivery.

If syphilis is diagnosed and treated at or before 24 weeks' gestation, serologic titers should not be repeated before 8 weeks after treatment (e.g., at 32 weeks' gestation) but should be repeated again at delivery. Titers should be repeated sooner if reinfection or treatment failure is suspected. For syphilis diagnosed and treated after 24 weeks' gestation, serologic titers should be repeated at delivery.

4. Hepatitis B (HBsAb, HBcAb, HBsAg with reflex testing):
- All pregnant people at an early prenatal visit (i.e., a visit during the first trimester), even if they have been previously vaccinated or tested
- Pregnant people who were not screened prenatally, those who engage in behaviors that put them at high risk for infection (e.g., having had more than one sex partner in the previous 6 months, evaluation or treatment for an STD, recent or current injection-drug use, and an HBsAg-positive sex partner) and those with clinical hepatitis should be retested at the time of admission to the hospital for delivery

5. Hepatitis C
-Routine screening recommended
-ACOG recommends that all patients be screened for hepatitis C virus antibodies in each pregnancy.
-ACOG recommends pre-pregnancy screening for hepatitis C virus infection and treatment, when possible, before pregnancy

6. Trichomoniasis
-All symptomatic pregnant people should be treated, regardless of pregnancy trimester.
-Asymptomatic pregnant people with lab evidence of Trich. do not need treatment.

*Pregnant people should undergo a Papanicolaou (Pap) test at the same frequency as nonpregnant people

B. Treatment

Chlamydia

1. Doxycycline 100 mg po bid x 7 days – preferred treatment
2. If pregnant or alternative treatment if compliance with the preferred treatment is a concern.
   - Azithromycin 1 gm po x1
3. Treat all sexual partners

Gonorrhea
1. Ceftriaxone 500mg IM x 1 – preferred treatment
- Doxycycline 100mg PO BID x 7d if co-infection with Chlamydia has not been ruled out
- Ceftriaxone 1g IM x 1 is recommended if patient weighs > 150kg

Alternative regimen (for infection of the cervix, urethra, or rectum)
Gentamicin 240 mg IM in a single dose
plus
Azithromycin 2 g orally in a single dose

No reliable alternative treatments are available for pharyngeal gonorrhea.

2. Treat all sexual partners

Trichomoniasis
1. Men Metronidazole 2g po x1

2. Women Metronidazole 500mg 2x/day for 7 days
but if compliance with the preferred treatment is a concern
-metronidazole 2 gm, Oral, Once

3. Treat all sexual partners

Syphilis

Early Syphilis

1. Benzathine Penicillin G 2.4 million units IM x1 (Primary Syphilis) or Doxycycline 100 mg bid for 14 days
2. During pregnancy a second dose of benzathine penicillin G 2.4 million units IM can be administered 1 week after the initial dose – preferred treatment option at ANMC
3. Treat all sexual partners

Late Latent Syphilis

1. Benzathine Penicillin G 7.2 million units total, administered as 3 doses of 2.4 million units IM at 1-week intervals or Doxycycline 100 mg bid for 28 days.
2. Treat all sexual partners

Pregnancy

Penicillin G is the only known effective antimicrobial for treating fetal infection and preventing congenital syphilis.
Pregnant people treated for syphilis during the second half of pregnancy are at risk for premature labor or fetal distress if the treatment precipitates the Jarisch-Herxheimer reaction.

-If pt < 20 wks, then Tx w 2 hr minimum observation period, will occur in ED
-If pt > 20 wks, then Tx w 2 hr minimum observation period, will occur in OB Triage

Pelvic Inflammatory Disease

Ceftriaxone 1 g IV every 24 hours
PLUS
Doxycycline 100 mg orally or IV every 12 hours
PLUS
Metronidazole 500 mg orally or IV every 12 hours

OR
Cefotetan 2 g IV every 12 hours
PLUS
Doxycycline 100 mg orally or IV every 12 hours

OR
Cefoxitin 2 g IV every 6 hours
PLUS
Doxycycline 100 mg orally or IV every 12 hours

PID Alternative therapies

Ampicillin-sulbactam 3 g IV every 6 hours
PLUS
Doxycycline 100 mg orally or IV every 12 hours

OR
Clindamycin 900 mg IV every 8 hours
PLUS
Gentamicin loading dose IV or IM (2 mg/kg body weight), followed by a maintenance dose (1.5 mg/kg body weight) every 8 hours; single daily dosing (3–5 mg/kg body weight) can be substituted

PID Intramuscular or Oral Treatment

Ceftriaxone 500 mg IM in a single dose*
PLUS
Doxycycline 100 mg orally 2 times/day for 14 days
WITH
Metronidazole 500 mg orally 2 times/day for 14 days
OR

Cefoxitin 2 gm IM in a single dose and Probenecid 1 gm orally administered concurrently in a single dose
PLUS
Doxycycline 100 mg orally 2 times/day for 14 days
WITH
Metronidazole 500 mg orally 2 times/day for 14 days
OR

Other parenteral third-generation **cephalosporin** (e.g., ceftizoxime or cefotaxime)
PLUS
Doxycycline 100 mg orally 2 times/day for 14 days
WITH
Metronidazole 500 mg orally 2 times/day for 14 days
*For persons weighing >150 kg (~300 lbs.) with documented gonococcal infection, 1 gm of ceftriaxone should be administered.

Post exposure prophylaxis (PEP)

Doxy PEP
CDC recommends that men who have sex with men (MSM) and transgender women (TGW) who have had a bacterial STI (specifically syphilis, chlamydia, or gonorrhea) diagnosed in the past 12 months should receive counseling that doxy PEP can be used as postexposure prophylaxis to prevent these infections.

Following shared decision-making with their provider, CDC recommends that providers offer persons in this group a prescription for doxy PEP to be self-administered within 72 hours after having oral, vaginal, or anal sex.

The recommended regimen is a single dose of doxy PEP is 200 mg

A maximum dose of 200 mg every 24 hours should not be exceeded.

C. References

2021 Sexually Transmitted Infection Treatment Guidelines for more information on alternate regimes, pregnant women and patients with allergies
https://www.cdc.gov/std/treatment-guidelines/toc.htm (Accessed 5/18/24)

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https://www.cdc.gov/mmwr/volumes/69/wr/mm6950a6.htm?s_cid=mm6950a6_w (Accessed 5/18/24)

CDC Clinical Guidelines on the Use of Doxycycline Postexposure Prophylaxis for Bacterial Sexually Transmitted Infection Prevention, United States, 2024
Recommendations and Reports / June 6, 2024 / 73(2);1–8.
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