Expected Practices

Specialty: Women's Health

Subject: Management of Uncomplicated Sexually Transmitted Infections (STIs) in Women

Date: February 1, 2015

Purpose:
1. Summarize the management of women with uncomplicated gonorrhea (GC), chlamydia (CT), trichomonas (trich), bacterial vaginosis (BV), genital herpes, and syphilis.
2. Directs the use of patient delivered partner therapy (PDPT) for patients diagnosed with CT, GC and trichomonas.

It does not include the management of syndromes that may be caused by STIs (pelvic inflammatory disease, cervicitis, vaginitis and genital ulcer disease, other than herpes), nor the management of HIV and hepatitis.

Target Audience:
Urgent Care, ER, Primary Care and Women's Health Providers

Expected Practice:

Important considerations

- For patients diagnosed with CT, GC and trichomonas:
  - Single dose **directly observed therapy** should be provided.
  - The optimal management of partners is prompt in-clinic evaluation and treatment. If this is not feasible Patient Delivered Partner Therapy (PDPT) must be considered.

- California law[1] requires syphilis to be reported to the local public health department within 1 working day and the other reportable STIs (GC, CT, including lymphogranuloma venerum (LGV), chancroid and PID) to be reported within 7 calendar days.

This *Expected Practice* was developed by a DHS Specialty-Primary Care Work Group to fulfill the DHS mission to ensure access to high-quality, patient-centered, and cost-effective health care. SPC Work Groups, composed of specialist and primary care provider representatives from across LA County DHS, are guided by 1) real-life practice conditions at our facilities, 2) available clinical evidence, and 3) the principle that we must provide equitable care for the entire population that LA County DHS is responsible for, not just those that appear in front of us. It is recognized that in individual situations a provider's clinical judgment may vary from this *Expected Practice*, but in such cases compelling documentation for the exception should be provided in the medical record.

---

[1] California Code of Regulations, Title 17, Section 2500

- Management of an STI includes providing education and risk reduction counseling. Depending on the STI, the following may also be indicated: patient and partner treatment, patient follow-up, rescreening and reporting the case to the local health department.
- For consultation about STI clinical management, call the DPH Division of HIV and STD Programs (DHSP) at 213-744-8030 or the California STD/HIV Prevention Training Center at 510-625-6000
- For more information see the California STD Treatment Guidelines Table for Adults and Adolescents 2012 which is focused primarily on STIs encountered in office practice. For more detail and for inpatient and complex cases see CDC Rx guidelines.

Partner Management

Depending on the STI, partner management may include clinical evaluation, testing, treatment and education (see management table for details). For reportable STIs in California, physicians are required by law[2] to attempt to identify all potentially infected partners and make an effort to bring them in for examination and, if necessary, treatment.

Although prompt clinical evaluation and STI testing is preferred for partners exposed to chlamydia, gonorrhea as well as trichomonas, if this is not feasible, patient delivered partner therapy is a legal and recommended option. Partners of early syphilis cases (i.e. primary, secondary and early latent syphilis) and partners of all pregnant women with newly reactive syphilis tests need a full clinical evaluation.

Below is a summary of different methods of partner notification and treatment ranked in order of effectiveness and feasibility. For women with multiple partners, different strategies may be employed for notifying and treating different partners.

Proven effective, most feasible, and highly recommended:

- **Bring Your Own Partner (BYOP) –** simultaneous in-clinic evaluation and treatment of patient and partner.
- **Patient delivered partner therapy (PDPT) –** patient delivers educational material and treatment to partner(s) when partners are unlikely to seek clinical services in a timely manner. For male partner(s) of patients infected with GC, CT, trich and PID.

Proven effective, but dependent on availability of local resources:

- **Health Department Partner Notification –** provider asks the health department to notify partners of their possible infection and the need for treatment of a reportable STI. Due to limited DPH resources, this option is only available for select high priority cases. Contact DPH's Division of HIV and STD Programs (DHSP) to ascertain their current capacity and criteria for health department partner notification.
- **Provider referral -** provider collects from the patient the name(s) and contact information of their partner(s) and notifies these partners about their possible infection and need for evaluation

[2] California Code of Regulations, Title 17, Section 2636

and/or treatment. To protect the patient's confidentiality, her identity is not shared with the partner(s).

Methods with unknown/unclear effectiveness but feasible:

- **Partner treatment cards** for GC, CT and trich – patient gives the card to their partner advising them of the need for treatment and how to access it. Accessible at : www.publichealth.lacounty.gov/dhsp/InforProviders.htm#Partner_Treatment_Cards

- inSPOT **- electronic postcards** for all STIs – patient sends e-card to partners (can be anonymous) at: www.inSPOTLA.org.

Methods shown to have limited effectiveness

- **Patient Self-Referral of Partner(s)** – patient is counseled to inform her partner(s) that they may be infected and need treatment**.**

Patient Education

- Provide information about the STI (especially for STIs that require more than single dose treatment e.g. herpes, genital warts and syphilis) including how to reduce the risk of transmission to others.
- Explain the importance of treating partners, where appropriate
- Advise abstinence until patient and partner have completed Rx or for 7 days if single dose Rx used. If they do have sex, use a condom.
- How to use the treatment (e.g. for patient applied wart therapy)
- When/how to return for further evaluation, retesting or rescreening, including if condition persists or worsens.
- How to avoid STIs in future e.g. use of condoms, limiting number of partners, HPV and hepatitis B vaccination, regular testing of patient and partners.
- How to use condoms and how to obtain free condoms (www.lasexsymbol.com 213 744 5922). Provide condoms if possible.
- Offer risk reduction counselling if possible.

Follow-up

Follow-up may be indicated for clinical evaluation, counseling, test of cure (to detect treatment failure), and/or re-screening (to detect re-infection). See management of STIs table for recommended follow-up. Free DPH CT/GC home test kits are a convenient option for re-screening females age 12-2 available at: www.dontthinkknow.org.

Resources

California STD Treatment Guidelines Summary Table **California Guidelines for STD Screening and Treatment in**	http://www.cdph.ca.gov/pubsforms/Guidelines/Documents/STD-Treatment-Guidelines-Color.pdf http://www.cdph.ca.gov/pubsforms/Guidelines/Pages/SexuallyTransmittedDiseasesScreeningandTreatmentGuidelines.aspx

Pregnancy, 2012	
CDC STD Treatment Guidelines (summary pocket guide, wall chart, online, iPhone and iPad apps)	www.cdc.gov/std/treatment/2010/default.htm
STD clinical consultations	California STD/HIV Prevention Training Center 510-625-6000 LA County DPH Division of HIV and STD Programs 213 744 8030
Reporting an STD	Information and forms can be downloaded from http://publichealth.lacounty.gov/dhsp/ReportCase.htm#STD_Reporting_Information
Los Angeles County Division of HIV and STD Programs (DHSP) provider webpage (including links to reporting, partner treatment cards and PDPT)	http://www.publichealth.lacounty.gov/dhsp/InfoForProviders.htm
Electronic partner notification inSPOT	www.inSPOTLA.org
Free condoms	Find free condoms or have them mailed to you www.lasexsymbol.com 213 744 5922

Summary of Management of Uncomplicated STIs in Women

	Treatment (DHS Preferred in *italics*)	Follow-up	Partner Management
Chlamydia (CT) *Reportable*	*Azithromycin 1g PO once* **or** Doxycyline 100mg PO bid x 7d In pregnancy: Azithromycin 1g PO once Or Amoxicillin 500mg PO tid x 7d	Rescreen 3 months post Rx, or if not possible, any time they present within 1-12 months post Rx **In pregnancy**: Test of cure with NAAT 3-4 weeks after completing therapy. Rescreen in third trimester.	Treat all partners in last 60 days, or if none, the most recent partner. When feasible, test partners for STIs. Do not wait for test results to provide treatment for CT and/or GC
Gonorrhea (GC) *Reportable*	*Ceftriaxone 250mg IM once* ***PLUS*** *Azithromycin 1g PO once* ***or*** *Doxycycline 100mg PO BID x7 days* If allergic to cephalosporins or severe penicillin allergy: Azithromycin 2g PO once In pregnancy: Ceftriaxone 250mg IM once ***PLUS*** Azithromycin 1g PO once	Rescreen 3 month post Rx, or if not possible, any time they present within 1-12 months post Rx Test of cure recommended if not treated with ceftriaxone (Timing: 7 days if culture; 14 days if NAAT) If persistent or recurrent symptoms suspicious for treatment failure (not reinfection) perform test of cure immediately with culture and antibiotic sensitivity testing. Inform local public health department **In pregnancy:** Test of cure with NAAT 3-4 weeks after therapy. Rescreen in third trimester	
Syphilis *Reportable*	Repeat titer on day of Rx **Primary, Secondary, and Early Latent** Benzathine penicillin G (Bicillin® L-A) 2.4 million units IM once **Late Latent &** **Latent of Unknown Duration** Benzathine penicillin G (Bicillin® L-A) 2.4 million units IM once at weekly intervals x 3 weeks **Neurosyphilis and allergies** see CDC guidelines	Type and timing of follow-up depends on stage of syphilis infection, pregnancy and HIV status. **Primary and secondary syphilis** Clinical follow-up only: 1-2 weeks and 1 month Serological & clinical follow-up: HIV negative - 6 & 12 months HIV infected - 3, 6, 9, 12 & 24 months **Latent syphilis** Clinical follow-up only: At each dose of Rx and 1-2 weeks after Rx Serological & clinical follow-up:	Evaluate and treat partners according to stage of syphilis and timing of sexual exposure – **call DHSP nursing line for advice 213 744 8030** **Partners exposed ≤ 90 days** before the diagnosis of primary, secondary, or early latent syphilis in the index patient may be infected **even if seronegative**; so

		HIV negative – 6, 12 & 24 months HIV infected - 6, 12, 18 & 24 months **Late Latent Syphilis Latent Syphilis of Unknown Duration** and **Neurosyphilis** - see CDC guidelines **In pregnancy**: more intensive follow-up is required - see CDC guidelines	should be **treated presumptively**.
Trichomonas	*Metronidazole 2g PO once* In pregnancy: Metronidazole 2g PO once If HIV co-infected: Metronidazole 500 mg PO bid x 7d	None, unless HIV co-infected: Rescreen 3 months post Rx or, if not possible, any time they present 1-12 months post Rx For suspected drug-resistant trichomoniasis, rule out re-infection; see CDC STD Guidelines. For info on metronidazole-resistant *T. vaginalis,* call CDC 404-718-4141	Treat all partners in last 60 days, or if none, the most recent partner. When feasible, test partners for STIs. Do not wait for test results to provide treatment for trich
Bacterial Vaginosis	*Metronidazole 500mg PO bid x 7d* ***or*** *Metronidazole gel 0.75%, one full applicator (5g) intravaginally qd x 5d* In pregnancy: Metronidazole 500mg PO bid x 7d **or** Metronidazole 250mg PO tid x 7d **or** Clindamycin 300mg PO bid x 7d	None	If partner is female, offer evaluation
Ano-genital Herpes - 1st clinical episode	Acyclovir 400 mg PO tid x 7-10d **or** Acyclovir 200 mg PO 5x/d x 7-10 d **or** Famciclovir 250 mg PO tid x 7-10d **or** Valacyclovir 1 g PO bid x 7-10d In pregnancy: Acyclovir 400 mg PO tid x 7-10d **or** Acyclovir 200 mg PO 5x/d x 7-10 d	5-7 days for further education and counseling about natural history, asymptomatic shedding, and sexual transmission.	Sex partners may benefit from counseling and evaluation

<table>
<tr>
<td>Ano-genital Herpes - Suppressive Therapy for established infection</td>
<td>Acyclovir 400 mg PO bid
or
Valacyclovir 1g PO qd
or
Famciclovir 250mg PO BID

<u>HIV co-infected:</u>
Acyclovir 400-800 mg PO bid or tid
or
Valacyclovir 500 mg PO bid
or
Famciclovir 500mg PO BID

<u>In pregnancy:</u>
Acyclovir 400 mg PO bid</td>
<td>If HSV lesions persist or recur during treatment, suspect drug resistance. Obtain a viral isolate for sensitivity testing and consult with an ID expert.

Otherwise, review before next prescription is due</td>
<td>No</td>
</tr>
<tr>
<td>Ano-genital Herpes

Episodic Therapy for Recurrent Episodes</td>
<td>Acyclovir 400 mg PO tid x 5 d
or
Acyclovir 800 mg PO bid x 5 d
or
Acyclovir 800 mg PO tid x 2 d
or
Famciclovir 125 mg PO bid x 5 d
or
Famciclovir 1000 mg PO bid x 1 d
or
Famciclovir 500 mg PO once, then 250 mg PO bid x 2 d
or
Valacyclovir 500 mg PO bid x 3 d
or
Valacyclovir 1 g PO qd x 5 d

<u>HIV co-infected:</u>
Acyclovir 400mg PO tid 5-10 d
or
Famciclovir 500 mg PO bid 5-10 d
or
Valacyclovir 1g PO bid 5-10 d

<u>In pregnancy:</u>
Acyclovir 400 mg PO tid x 5 d
or
Acyclovir 800 mg PO bid x 5 d
or
Acyclovir 800 mg PO tid x 2 d</td>
<td>As needed</td>
<td>No</td>
</tr>
</table>

For patients with allergies or contraindications, see CA guidelines www.cdph.ca.gov/pubsfo