**STANDARD PROTOCOL**

**STI and HIV Screening and Epidemiologic STI Treatment**

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## PURPOSE

* To provide chlamydia, gonorrhea, syphilis, and HIV screening according to national recommendations
* To provide empiric treatment to persons with chlamydia, gonorrhea, or syphilis symptoms prior to the return of confirmatory laboratory results
* To provide expedited treatment to persons and/or partners exposed to chlamydia, gonorrhea, or syphilis prior to the return of confirmatory laboratory results
* To provide expedited partner therapy (EPT) to chlamydia and gonorrhea cases in situations where heterosexual partners are unable or unwilling to present for clinical evaluation and treatment
* To provide referral of high-risk HIV-negative men, transgender women, and others at very high risk for HIV pre-exposure prophylaxis (PrEP)
* To provide diagnosis and treatment of patients with vaginitis or herpes symptoms
* To promote cervical cancer screening and vaccination for human papillomavirus (HPV)
* To promote Hepatitis B vaccination among adults seeking care for possible STI exposure
* To provide treatment for patients diagnosed with STIs, according to CDC Treatment Guidelines, <http://www.cdc.gov/std/treatment/>

## Procedure

### Chlamydia AND GONORRHEA screening for sexually active women under the age of 25 (to be performed annually or more frequently based on sexual risk)

1. Collect urine specimen or vaginal/cervical swab from woman for chlamydia and gonorrhea screening.
2. Place order for chlamydia and gonorrhea screening test called the Nucleic Acid Amplification Test (NAAT).
3. Offer condoms and information on STIs/HIV to the patient.
4. Document testing performed in patient’s medical record.
5. Ensure that correct locating or call-back information is available in the medical record for results reporting.

### STI screening for pregnant women

1. Collect a sexual history. [[1]](#footnote-2)
2. At the time of the first prenatal visit, collect a blood specimen for syphilis, HIV, and Hepatitis B Surface Ag testing.
3. Place order for the syphilis screening test called the “RPR” and the HIV and Hepatitis B Surface Ag tests. Evaluation for syphilis may vary from lab to lab. Newer treponemal tests (EIA or IgG) reflex to RPR or VDRL for quantitative testing.
4. At the time of the first prenatal visit, collect a urine specimen or vaginal swab for chlamydia and gonorrhea testing.
5. Place order for the chlamydia and gonorrhea test called the Nucleic Acid Amplification Test (NAAT)
6. Offer condoms and information on STIs/HIV to the patient.
7. Document testing performed in patient’s medical record.
8. Ensure that correct locating or call-back information is available in the medical record for results reporting.
9. If the pregnant woman is at-risk for STIs, schedule an appointment during the third trimester for repeat syphilis, HIV, chlamydia, and gonorrhea testing.
10. Papanicolaou (Pap) testing at first prenatal visit if indicated by current guidelines. (see p. 13)
11. Evaluation for vaginitis is warranted only in the symptomatic patient. If a patient expresses symptoms (malodorous discharge, itching), perform a clinical exam to diagnose trichomoniasis or bacterial vaginosis (BV) (vaginal pH at a minimum but ideally utilization of Amsel criteria or Nugent scale). Clinical exam and basic diagnostics will also distinguish BV from *Trichomonas vaginalis* infection.

### Chlamydia, gonorrhea, syphilis, HEPATITIS C, and HIV screening for men who have sex with men (MSM) AND TRANSGENDER WOMEN (to be performed annually or more frequently based on sexual risk)

1. Collect a sexual history.†
2. Collect urine, oral (swab), and rectal (swab) specimens for chlamydia and gonorrhea testing depending on sexual history and sexual exposure sites.
3. Place order for chlamydia and gonorrhea screening test called the Nucleic Acid Amplification Test (NAAT). Check with lab to determine the type and availability of oral/rectal chlamydia and gonorrhea tests.
4. Collect a blood specimen for syphilis, HIV, and Hepatitis C testing.
5. Place order for the syphilis screening test called the “RPR” and the HIV test. Evaluation for syphilis may vary from lab to lab. Newer treponemal tests (EIA or IgG) reflex to RPR or VDRL for quantitative testing.
6. Offer condoms and information on STIs/HIV to the patient.
7. High-risk HIV-negative men or men diagnosed with an STI should be referred for HIV pre-exposure prophylaxis (PrEP)
8. Document testing performed in patient’s medical record.
9. Ensure that correct locating or call-back information is available in the medical record for results reporting.

### Screening for chlamydia, gonorrhea, syphilis and HIV among asymptomatic persons at risk for chlamydia, gonorrhea, syphilis, and HIV not described above

1. Collect sexual history to determine if patient is at risk of chlamydia, gonorrhea, syphilis and HIV.[[2]](#footnote-3)
2. Collect urine, oral (swab), cervical/vaginal (swab) and/or rectal (swab) specimens for chlamydia and gonorrhea testing depending on sexual exposure sites.
3. Place order for chlamydia and gonorrhea screening test called the Nucleic Acid Amplification Test (NAAT). Check with lab to determine the type and availability of oral/rectal chlamydia and gonorrhea tests.
4. Collect a blood specimen for syphilis and HIV testing.
5. Place order for the syphilis screening test called the “RPR” and the HIV test. Evaluation for syphilis may vary from lab to lab. Newer treponemal tests (EIA or IgG) reflex to RPR or VDRL for quantitative testing.
6. Offer condoms and information on STIs/HIV to the patient.
7. Document testing performed in patient’s medical record.
8. Ensure that correct locating or call-back information is available in the medical record for results reporting.

### FOLLOW-UP AND TREATMENT OF PATIENTS AND PARTNERS WITH OR EXPOSED TO CHLAMYDIA AND/OR GONORRHEA

#### Follow-up of patients diagnosed with chlamydia

1. For patients diagnosed with chlamydia, schedule an appointment to return in 3 months for repeat testing at the anatomic site of infection to evaluate for re-infection. Pregnant patients diagnosed and treated for chlamydia should return for repeat testing (test of cure) three to four weeks after treatment to ensure chlamydia eradication.
2. Collect a blood specimen for HIV and syphilis testing.
3. Provide treatment with Azithromycin 1 gram to be taken orally in one dose.
4. The patient should be counseled to abstain from sex for 7 days after their partner receives treatment.
5. For heterosexual patients diagnosed with chlamydia whose partners are unlikely to present for testing and treatment, provide treatment to the patient to give to the partner(s) via Patient Delivered Partner Therapy (PDPT) also called Expedited Partner Therapy (EPT).
	* Patient Delivered Partner Therapy (PDPT) ) or Expedited Partner Therapy (EPT) is the clinical practice of treating the sex partners of patients diagnosed with chlamydia or gonorrhea by providing prescriptions or medications to the patient to take to his/her partner without the health care provider first examining the partner.
	* Patients with chlamydia should be provided with the medication or a prescription(s) for azithromycin (1 gram to be taken orally for one dose) to deliver to their partner(s).[[3]](#footnote-4) (Patient-Delivered Partner Therapy or PDPT).
	* Provide information sheets to the patient on PDPT to give to their partner.
	* Document this activity in the medical record.
6. Complete a required infectious disease reporting form and submit to the local health department
7. Notify the patient that they may be contacted by public health nursing and/or health department staff performing case follow up and investigation.
8. Refer to CDC treatment guidelines for additional information, http://www.cdc.gov/std/treatment/

#### Follow-up of patients diagnosed with gonorrhea

1. For patients diagnosed with gonorrhea, schedule an appointment to return in 3 months for repeat testing at the anatomic site of exposure to evaluate for re-infection. Pregnant patients diagnosed and treated for gonorrhea should return for repeat testing (test of cure) three to four weeks after treatment to ensure gonorrhea eradication.
2. If the patient is diagnosed with gonorrhea, collect a blood specimen for HIV and syphilis testing.
3. Provide treatment with Ceftriaxone 250mg IM X 1 dose PLUS Azithromycin 1 gram PO X 1 dose.
4. The patient should be counseled to abstain from sex for 7 days after their partner receives treatment.
5. For heterosexual patients diagnosed with gonorrhea whose partners are unable or unwilling to present for testing and treatment, provide treatment to the patient to give to the partner(s) via Patient Delivered Partner Therapy (PDPT) also called expedited partner therapy (EPT).
6. Patient Delivered Partner Therapy (PDPT) ) or Expedited Partner Therapy (EPT) is the clinical practice of treating the sex partners of patients diagnosed with chlamydia or gonorrhea by providing prescriptions or medications to the patient to take to his/her partner without the health care provider first examining the partner. This practice is also called Patient-Delivered Partner Therapy or PDPT.
	1. Patients with gonorrhea should be provided with the medication or a prescription(s) for cefixime (400mg to be taken orally for one dose) PLUS azithromycin (1 gram to be taken orally for one dose) to deliver to their partner(s).‡
	2. Provide information sheets to the patient on PDPT to give to their partner.
	3. Document this activity in the medical record.
7. Complete a required infectious disease reporting form and submit to the local health department.
8. Notify the patient that they may be contacted by public health nursing and/or health department staff performing case follow up and investigation.
9. Refer to CDC treatment guidelines for additional information, http://www.cdc.gov/std/treatment/

#### Presumptive treatment of patients with symptoms of chlamydia and/or gonorrhea

1. Examine the patient and obtain a sexual history.[[4]](#footnote-5)
2. Patients with symptoms consistent with chlamydia and/or gonorrhea should be questioned about medication allergies. Document allergy history in the medical record.
3. Patients with symptoms consistent with chlamydia and/or gonorrhea such as cervicitis or urethritis should receive treatment with the medications below, even though results are unavailable:
	* Ceftriaxone 250mg IM X 1
	* Azithromycin 1 gm PO x 1 PLUS
4. Collect urine specimen or vaginal/cervical swab and/or rectal swab from the patients for chlamydia/ gonorrhea testing depending on sites of sexual exposure.
5. Collect pharyngeal swab from the patient for gonorrhea testing if oropharyngeal exposure is reported.
6. Place order for chlamydia/gonorrhea screening test called the Nucleic Acid Amplification Test (NAAT).
7. Collect a blood specimen for syphilis and HIV testing.
8. Place order for the syphilis screening test called the “RPR” and the HIV test. Evaluation for syphilis may vary from lab to lab. Newer treponemal tests (EIA or IgG) reflex to RPR or VDRL for quantitative testing.
9. Document testing performed in patient’s medical record.
10. Ensure that correct locating or call-back information is available in the medical record for results reporting.
11. Offer condoms and information on STIs/HIV to the patient.
12. Encourage the patient to provide names of partners or to commit to notifying their partners of their exposure:
	* Patients diagnosed with chlamydia whose partners are unlikely to present for testing and treatment should be provided with the medication or a prescription (s) of azithromycin (1 gram to be taken orally for one dose) to deliver to their partners[[5]](#footnote-6). (Patient-Delivered Partner Therapy or PDPT).
	* Patients diagnosed with gonorrhea whose partners are unlikely to present for testing and treatment should be provided with the medication or a prescription (s) of cefixime (400 mg to be taken orally for one dose) PLUS azithromycin (1 gram to be taken orally for one dose) to deliver to their partners.
	* Provide information sheets to the patient on patient delivered partner therapy (PDPT) to give to their partner.[[6]](#footnote-7)
	* Document this activity in the medical record.
13. Notify the patient that they may be contacted by public health nursing and/or health department staff performing case follow up and investigation.
14. Complete required infectious disease reporting form and submit to the local health department.
15. Refer to CDC treatment guidelines for additional information, http://www.cdc.gov/std/treatment/

#### Partners of cases of chlamydia or gonorrhea

##### Management in the clinical setting

1. Obtain a sexual history.[[7]](#footnote-8)
2. Partners of cases of chlamydia and/or gonorrhea should be questioned about medication allergies. Document allergy history in the medical record.
3. Partners of cases of chlamydia and/or gonorrhea should receive presumptive treatment with the medications below, even though results are unavailable:
	* For partners of chlamydia cases: Azithromycin 1 gram orally for one dose
	* For partners of gonorrhea cases: Ceftriaxone 250mg IM X 1 dose **AND** azithromycin 1 gram orally for one dose
4. Collect urine specimen or vaginal/pharyngeal swab and/or rectal specimen from the partner for chlamydia /gonorrhea testing depending on sites of sexual exposure.
5. Place order for chlamydia/gonorrhea screening test called the Nucleic Acid Amplification Test (NAAT).
6. Collect a blood specimen for syphilis and HIV testing.
7. Place order for the syphilis screening test called the “RPR” and the HIV test. Evaluation for syphilis may vary from lab to lab. Newer treponemal tests (EIA or IgG) reflex to RPR or VDRL for quantitative testing.
8. Document testing performed in partner’s medical record.
9. Ensure that correct locating or call-back information is available in the medical record for results reporting.
10. Offer condoms and information on STIs/HIV to the partner.
11. Notify the partner that they may be contacted by public health nursing and/or health department staff performing case follow up and investigation.

##### Patient delivered partner therapy

1. For Partners of heterosexual chlamydia and gonorrhea cases that are unable or unwilling to present for testing and treatment, provide treatment to the patient to give to the partner(s) via Patient Delivered Partner Therapy (PDPT) also called expedited partner therapy (EPT).
* Patient Delivered Partner Therapy (PDPT) ) or Expedited Partner Therapy (EPT) is the clinical practice of treating the sex partners of patients diagnosed with chlamydia or gonorrhea by providing prescriptions or medications to the patient to take to his/her partner without the health care provider first examining the partner. This practice is also called Patient-Delivered Partner Therapy or PDPT.
* Patients with chlamydia should be provided with the medication or a prescription(s) for azithromycin (1 gram to be taken orally for one dose) to deliver to their partner(s).[[8]](#footnote-9) (Patient-Delivered Partner Therapy or PDPT).
* Patients with gonorrhea should be provided with the medication or a prescription(s) for cefixime (400mg to be taken orally for one dose) PLUS azithromycin (1 gram to be taken orally for one dose) to deliver to their partner(s).[[9]](#footnote-10)
* Provide information sheets to the patient on PDPT to give to their partner.
* Document this activity in the medical record.

### SYPHILIS

#### Presumptive treatment for syphilis

1. Examine and document the location and characteristics of the lesion(s).
2. Collect a sexual history.[[10]](#footnote-11)
3. Patients with genital lesions consistent with syphilis should be questioned about penicillin allergy. Document allergy history in the medical record.
4. Non-penicillin allergic patients with suspected syphilis should receive treatment with: **2.4 MU Benzathine penicillin G (L-A) IM**, even though laboratory results have not been received. Do NOT use other penicillin formulations (e.g. Bicillin C-R). Coordinate care of all pregnant patients with prenatal care provider.
5. For pregnant patients that are allergic to penicillin, consultation with an infectious diseases provider or allergist to document true allergy to penicillin is needed. The penicillin allergic patient will need penicillin desensitization in consultation with a specialist. Coordinate care with prenatal care provider.
6. Alternative (second line) therapy for non-pregnant, penicillin-allergic patients suspected of having early syphilis (primary, secondary, or early latent stage) includes doxycycline (100 mg po BID x 2 weeks), tetracycline (500 mg po QID x 2 weeks), or ceftriaxone (1 g IV or IM daily x 10-14 days).
7. Collect a blood specimen for syphilis and HIV testing.
8. Place order for the syphilis screening test called the “RPR” and the HIV test. Evaluation for syphilis may vary from lab to lab. Newer treponemal tests (EIA or IgG) reflex to RPR or VDRL for quantitative testing.
9. Collect urine specimen or vaginal/penile swab and/or rectal swab from the patient for chlamydia/gonorrhea testing depending on sites of sexual exposure.
10. Place order for chlamydia/gonorrhea screening test called the Nucleic Acid Amplification Test (NAAT).
11. Document testing performed in patient’s medical record.
12. Notify the patient that they will be contacted by public health nursing and/or health department staff performing case follow up and investigation.
13. Offer condoms and information on STIs/HIV to the patient.
14. Complete required infectious disease reporting form and submit to the local health department.
15. Refer to CDC treatment guidelines for additional information, http://www.cdc.gov/std/treatment/

#### Presumptive treatment of partners of early syphilis cases (primary, secondary or early latent stage)

1. Examine the partners for syphilis lesions, collect a sexual history†††.
2. Partners of patients diagnosed with syphilis should be questioned about penicillin allergy. Document allergy history in the medical record.
3. Non-penicillin allergic partners of early syphilis cases should receive treatment with: **2.4 MU Benzathine penicillin G (L-A) IM** prior to receiving laboratory results. Do NOT use other penicillin formulations (e.g. Bicillin C-R). Coordinate care of all pregnant patients with prenatal care provider.
4. Non-pregnant, penicillin allergic, HIV-negative, partners of early syphilis cases should be given a prescription for treatment with doxycycline 100mg BID for 14 days.
5. For pregnant partners to early syphilis cases that are allergic to penicillin, consultation with an infectious diseases provider or allergist to document true allergy to penicillin is needed. The penicillin allergic patient will need penicillin desensitization in consultation with a specialist. Coordinate care with prenatal care provider.
6. Collect a blood specimen for syphilis and HIV testing.
7. Place order for the syphilis screening test called the “RPR” and the HIV test. Evaluation for syphilis may vary from lab to lab. Newer treponemal tests (EIA or IgG) reflex to RPR or VDRL for quantitative testing.
8. Collect urine specimen or vaginal/penile swab and/or pharyngeal and rectal swabs from the partner for chlamydia and gonorrhea testing depending on sexual exposure sites.
9. Place order for chlamydia/gonorrhea screening test called the Nucleic Acid Amplification Test (NAAT).
10. Document testing performed in patient’s medical record.
11. Offer condoms and information on STDs/HIV to the patient.
12. Ensure that correct locating or call-back information is available in the medical record for results reporting.
13. Notify the partner that they will be contacted by public health nursing and/or hea**l**th department staff performing case follow up and investigation.

#### Treatment and Follow-up of Diagnosed Cases of Syphilis by Stage of Disease

1. Syphilis staging is based on symptom presentation or timing of exposure if symptoms are not present.
	1. Primary stage is characterized by a painless chancre at the site of exposure (frequently in the genital region, anal area, or mouth).
	2. Secondary syphilis is characterized by a rash on the palms and soles, trunk, extremities, or face. It can also manifest as mouth lesions (mucous patches), hair loss, or condyloma latum (moist wart-like lesions in genital area).
	3. Early latent syphilis lacks clinical manifestations and was acquired within one year of testing.
	4. Late latent syphilis of unknown duration lacks clinical manifestation and was acquired greater than one year prior to diagnosis.
	5. Syphilis of unknown duration lacks clinical manifestations and timing of infection is unknown.
	6. Tertiary syphilis manifests with neurologic complications of cardiac abnormalities, gummatous lesions, tabes dorsalis, and general paresis and generally occurs 10-30 years after infection.
	7. Neurosyphilis can occur at any stage of syphilis infection. Cranial nerve abnormalities, meningitis, stroke, and mental status changes may occur. Lumbar puncture is required for diagnosis and treatment requires intravenous penicillin.
2. Non-penicillin allergic patients with primary, secondary, or early latent syphilis should receive treatment with: **2.4 MU Benzathine penicillin G (L-A) IM**. Do NOT use other penicillin formulations (e.g. Bicillin C-R). Treatment alternatives are available in the 2015 CDC STD Treatment Guidelines. Coordinate care of all pregnant patients with prenatal care provider.
3. Non-penicillin allergic patients with late latent syphilis or latent syphilis of unknown duration should receive 3 injections of: **2.4 MU Benzathine penicillin G (L-A) IM spaced one week (7 days) apart**. Treatment alternatives are available in the 2015 CDC STD Treatment Guidelines. Coordinate care of all pregnant patients with prenatal care provider.
4. For pregnant patients that are allergic to penicillin, consultation with an infectious diseases provider or allergist to document true allergy to penicillin is needed. The penicillin allergic patient will need penicillin desensitization in consultation with a specialist. Coordinate care with prenatal care provider.
5. Patients with suspected **Neurosyphilis** should be referred to a specialist for diagnosis and treatment.
6. Patients with syphilis should undergo repeat RPR testing at 6 and 12 months after treatment. A fourfold titer decline should been seen among patients treated for primary, secondary, or early latent syphilis. Patients without a fourfold titer decline should be referred to a specialist for consideration of re-treatment.

### VAGINITIS

#### Screening for vaginitis

1. Recommended for women seeking care for vaginal discharge.
2. Should occur as part of overall STI evaluation including for those women who are at increased risk of infection (e.g., new or multiple partners, history of an STI, report inconsistent condom use, exchange sex for payment, injection drug use).
3. Include a clinical examination for BV (vaginal pH at a minimum but ideally use of Nugent score or Amsel criteria).
4. Evaluate for *T. vaginalis* (trichomoniasis) by wet mount microscopy or point of care test and if negative, confirm with culture or nucleic acid amplification testing (NAAT) (if available).

#### Treatment for women with Bacterial Vaginosis

##### Treatment for non-pregnant women with bacterial vaginosis

* Metronidazole 500 mg po BID x 7 days ***or***
* Metronidazole gel 0.75% one full applicator (5g) intravag qHS x 5 d ***or***
* Clindamycin cream 2% one full applicator (5g) intravag qHS x 7 d

Alternatives

* Tinidazole 2 g PO qd x 2 d[[11]](#footnote-12) ***or***
* Tinidazole 1 g PO qd x 5 d‡‡‡ ***or***
* Clindamycin 300 mg PO bid x 7 d ***or***
* Clindamycin ovules 100 g intravag qHS x 3 d

##### Treatment for pregnant women with bacterial vaginosis

* Metronidazole 500 mg PO BID x 7 days ***or***
* Metronidazole 250 mg PO TID x 7 days ***or***
* Clindamycin 300 mg PO BID x 7 days

#### Treatment for patients with Trichomoniasis

Recommended regimen for treatment for women or men with *T. vaginalis (*Trichomoniasis/TV) (*vaginal therapy with a nitroimidazole is ineffective)*. Treat male and female sex partner(s) and consider retesting women for TV in 3 months.

* Metronidazole 2 g PO x 1 ***or***
* Tinidazole 2 g PO x 1‡‡‡

Alternative regimen:

* Metronidazole 500 mg PO BID x 7d

 For HIV-positive women

* Metronidazole 500 mg PO BID x 7 days

### CERVICAL CANCER SCREENING

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1. Women should receive cervical cytology screening (PAP tests) starting at age 21 in accordance with current guidelines. Earlier screening is not recommended regardless of pregnancy status, age of first coitus, or STI history. (American Society for Colposcopy and Cervical Pathology Journal of Lower Genital Tract Disease, Volume 16, Number 3, 2012, <http://www.asccp.org/Guidelines/Screening-Guidelines> )
2. Women from age 21 – 29 should be screened every three years with cervical cytology. Reflex testing for High Risk – Human Papillomavirus (HR-HPV) in the setting of ASCUS may also be ordered. Routine HR-HPV screening is not recommended before age 30.
3. Women age 30 – 64 should be screened every 3 years with cytology alone or every 5 years with cytology and HR-HPV co-testing.
4. Management of abnormal PAP results should be carried out according to the 2012 ASCCP Guidelines, American Society for Colposcopy and Cervical Pathology Journal of Lower Genital Tract Disease, Volume 17, Number 5, 2013, S1YS27 <http://www.asccp.org/Guidelines-2/Management-Guidelines-2>

### Human Papillomavirus (HPV) VACCINATION

1. Identify all females age 11-26 years and males ages 9-21 years who have not completed the HPV vaccination series. For more information about the HPV vaccine and recommendations, visit [www.cdc.gov/std/hpv/default.htm](http://www.cdc.gov/std/hpv/default.htm) . NOTE: the Vaccines for Children program covers costs only through age 18.
2. HPV vaccination is recommended for men who have sex with men and immunocompromised persons (including those with HIV-infection) through age 26 [4].
3. Screen all patients for contraindications and precautions to HPV vaccine:
	* **Contraindication:** a history of a serious reaction after a previous dose of HPV vaccine or to a HPV vaccine compo­nent. For a complete list of vaccine components, go to [www.cdc.gov/vaccines/pubs/pinkbook/down­loads/appendices/B/excipient-table-2.pdf](http://www.cdc.gov/vaccines/pubs/pinkbook/downloads/appendices/B/excipient-table-2.pdf).
	* **Precautions:**
		1. A moderate or severe acute illness with or without fever
		2. Pregnancy; delay vaccination until after completion of the pregnancy
4. Provide all patients (or their parent or legal representative) with a copy of the most current federal Vaccine Information Statement (VIS). You must document, in the patient’s medical record or office log, the publication date of the VIS and the date it was given to the patient (or their parent or legal representative). Provide non-English speaking patients with a copy of the VIS in their native language, if available; these can be found at [www.immunize.org/vis](http://www.immunize.org/vis) .
5. Provide 1) either HPV2 or HPV4 or HPV9 to females or 2) HPV4 or HPV9 to males. Provide either vaccine in a 3-dose schedule at 0, 1–2, and 6 months. Provide vaccine routinely to girls at age 11–12 years; vaccine may be given to girls or boys as young as age 9 years. Administer 0.5 mL HPV vaccine intramuscularly (22–25g, 1–1½" needle) in the deltoid muscle.
6. For children and teens who have not received HPV vaccine at the ages and/or intervals specified in #4, give one dose at the earliest opportunity and then schedule subsequent doses to complete the 3-dose schedule by observing a minimum interval of 4 weeks between the first and second doses, 12 weeks between the second and third doses, and at least 24 weeks between the first and third doses.
7. Document each patient’s vaccine administration information and follow up in the following places:
	* **Medical chart:** Record the date the vaccine was administered, the manufacturer and lot number, the vaccination site and route, and the name and title of the person administering the vaccine. If vaccine was not given, record the reason(s) for non-receipt of the vaccine (e.g., medical contraindication, patient refusal).
	* **Personal immunization record card:** Record the date of vaccination and the name/location of the administering clinic.
8. Be prepared for management of a medical emergency related to the administration of vaccine by having a written emergency medical protocol available, as well as equipment and medications. To prevent syncope, consider observing patients for 15 minutes after they receive HPV vaccine.
9. Report all adverse reactions to the HPV vaccine to the federal Vaccine Adverse Event Reporting System (VAERS) at www.vaers.hhs.gov or by calling (800) 822-7967. VAERS report forms are available at www.vaers.hhs.gov.

### HEPATITIS B VACCINATION

1. The Hepatitis B vaccine should be offered to all persons seeking care for STIs.
2. Screen all patients for contraindications and precautions to hepatitis B vaccine:
	* **Contraindication:** a history of a serious reaction (e.g., anaphylaxis) after a previous dose of hepatitis B vaccine or to a hepatitis B vaccine component. For a list of vaccine components, go to www.cdc.gov/vaccines/pubs/pinkbook/downloads/appendices/B/excipient-table-2.pdf.
	* **Precaution:** moderate or severe acute illness with or without fever
3. Provide all patients with a copy of the most current federal Vaccine Information Statement (VIS). You must document, in the patient’s medical record or office log, the publication date of the VIS and the date it was given to the patient. Provide non-English speakers with the VIS in their native language, if available; these can be found at www.immunize.org/vis.
4. Administer hepatitis B vaccine intramuscularly (22–25g, 1–1½" needle) in the deltoid muscle. For persons age 20 years or older, give 1.0 mL dosage; for persons age 19 years or younger, give 0.5 mL dosage.
5. Provide subsequent doses of hepatitis B vaccine to complete each patient’s 3-dose schedule by observing a minimum interval of 4 weeks between the first and second doses, 8 weeks between the second and third doses, and at least 4 months (16 weeks) between the first and third doses.
6. Document each patient’s vaccine administration information and follow up in the following places:
	* **Medical chart:** Record the date the vaccine was administered, the manufacturer and lot number, the vaccination site and route, and the name and title of the person administering the vaccine. If vaccine was not given, record the reason(s) for non-receipt of the vaccine (e.g., medical contraindication, patient refusal).
	* **Personal immunization record card:** Record the date of vaccination and the name/location of the administering clinic.
7. Be prepared for management of a medical emergency related to the administration of vaccine by having a written emergency medical protocol available, as well as equipment and medications.
8. Report all adverse reactions to hepatitis B vaccine to the federal Vaccine Adverse Event Reporting System (VAERS) at www.vaers.hhs.gov or by calling (800) 822-7967. VAERS report forms are available at www.vaers.hhs.gov.

### GENITAL HERPES

#### Screening

Universal serologic screening is not recommended (not even for pregnant women). Test using isolation of HSV in cell culture in those with genital ulcers or mucocutaneous lesions, or, if available, HSV PCR for more optimal sensitivity.

Type-specific HSV-2 serology tests should be considered for patients presenting for comprehensive STI evaluation and high risk individuals (multiple sex partners, HIV infected, MSM).

Type-specific HSV-2 serology may be useful in:

* Patients with recurrent/atypical symptoms with negative culture,
* Clinical diagnosis without lab confirmation, and
* Patients with a partner with genital HSV

#### Treatment for Genital Herpes

##### Treatment of Genital Herpes (First episode) for both HIV positive/HIV negative

* Acyclovir 400 mg TID x 7-10 d ***or***
* Acyclovir 200 mg 5x/d x 7-10 d ***or***
* Famciclovir 250 mg TID x 7-10 d ***or***
* Valacyclovir 1.0 g BID x 7-10 d

##### Treatment of Genital Herpes (Episodic treatment of recurrences, HIV positive)

* Acyclovir 400 mg TID x 5-10 d ***or***
* Famciclovir 500 mg bid x 5-10 d ***or***
* Valacyclovir 1 gm bid x 5-10 d

##### Treatment of Genital Herpes (Episodic treatment of recurrences, HIV negative)

* Acyclovir 400 mg TID x 5 d ***or***
* Acyclovir 800 mg BID x 5 d ***or***
* Acyclovir 800 mg TID x 2 d ***or***
* Famciclovir 125 mg BID x 5 d ***or***
* Famciclovir 1 g BID x 1 d ***or***
* Valacyclovir 500 mg BID x 3 d ***or***
* Valacyclovir 1 g QD x 5 d

##### Daily Suppressive Treatment of Genital Herpes (For prevention of symptomatic recurrences and reduction in transmission, HIV negative)

* Acyclovir 400 mg BID ***or***
* Famciclovir 250 mg BID ***or***
* Valacyclovir 500 mg QD ***or***
* Valacyclovir 1 g QD

##### Daily Suppressive Treatment of Genital Herpes (For prevention of symptomatic recurrences and reduction in transmission, HIV positive)

* Acyclovir 400-800 mg BID-TID ***or***
* Famciclovir 500 mg BID ***or***
* Valacyclovir 500 mg BID

### PELVIC INFLAMMATORY DISEASE

In patients suspected of pelvic inflammatory disease (PID), one or more of the following criteria may be used to support a diagnosis of PID:

* oral temperature >101°F (>38.3°C),
* abnormal cervical or vaginal mucopurulent discharge,
* presence of abundant numbers of WBC on saline microscopy of vaginal fluid,
* elevated erythrocyte sedimentation rate,
* elevated C-reactive protein, and
* laboratory documentation of cervical infection with *N. gonorrhoeae* or *C. trachomatis.*

The following criteria for hospitalization are suggested:

* surgical emergencies (e.g., appendicitis) cannot be excluded;
* the patient is pregnant;
* the patient does not respond clinically to oral antimicrobial therapy;
* the patient is unable to follow or tolerate an outpatient oral regimen;
* the patient has severe illness, nausea and vomiting, or high fever;
* the patient has a tubo-ovarian abscess.

#### Inpatient Treatment for PID:

Recommended Parenteral Regimens

* 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
* Clindamycin 900 mg IV every 8 hours plus Gentamicin loading dose IV or IM (2 mg/kg of body weight), followed by a maintenance dose (1.5 mg/kg) every 8 hours. Single daily dosing may be substituted (3-5mg/kg)

Alternative Parenteral Regimen

* Ampicillin/Sulbactam 3gm IV q 6 hr PLUS Doxycycline 100 mg PO/IV q 12 hour

#### Outpatient Treatment of PID

Outpatient therapy can be considered for women with mild-to-moderately severe acute PID. The following regimens provide coverage against both the common STI associated with PID and anaerobes as well. Patients who do not respond to oral therapy within 72 hours should be reevaluated to confirm the diagnosis.

Recommended Regimen

* Ceftriaxone 250 mg IM in a single dose ***plus*** Doxycycline 100 mg orally twice a day for 14 days ***with or without*** Metronidazole 500 mg orally twice a day for 14 days ***or***
* Cefoxitin 2 g IM in a single dose and Probenecid, 1 g orally administered concurrently in a single dose ***plus*** Doxycycline 100 mg orally twice a day for 14 days ***with or without*** Metronidazole 500 mg orally twice a day for 14 days ***or***
* Other parenteral third-generation cephalosporin (e.g., ceftizoxime or cefotaxime) ***plus*** Doxycycline 100 mg orally twice a day for 14 days ***with or without*** Metronidazole 500 mg orally twice a day for 14 days

## ONLINE RESOURCES

1. <http://www.cdc.gov/std/treatment/>
2. <http://www.cdc.gov/std/ept>
3. <http://www.cdc.gov/std/hpv/default.htm>
4. <http://www.ihs.gov/epi/index.cfm?module=epi_std_resources>
5. <http://www.cdc.gov/std>
6. <http://www.npaihb.org/epicenter/project/project_red_talon/>
7. <http://www.iknowmine.org>
8. <http://www.ihs.gov/medicalprograms/hivaids/>



1. A sexual history should be based on sexual risk behaviors including, but not limited to, unprotected sex, sex with multiple partners, anonymous sex, male same-sex activity, prior STD history, drug use, and knowledge of partners engaging in high-risk sexual activity. [↑](#footnote-ref-2)
2. A sexual history should be based on sexual risk behaviors including, but not limited to, unprotected sex, sex with multiple partners, anonymous sex, male same-sex activity, prior STD history, drug use, and knowledge of partners engaging in high-risk sexual activity. [↑](#footnote-ref-3)
3. Clinicians should check to ensure that local laws allow for the use of Patient Delivered Partner Therapy also called Expedited Partner Therapy. [↑](#footnote-ref-4)
4. A sexual history should be based on sexual risk behaviors, including but not limited to, unprotected sex, sex with multiple partners, anonymous sex, male same-sex activity, prior STD history, drug use, and knowledge of partners engaging in high-risk sexual activity. [↑](#footnote-ref-5)
5. Clinicians should check to ensure that local laws allow for the use of Patient Delivered Partner Therapy also called Expedited Partner Therapy. The Office of General Counsel (OGC) may also be used as an informational resource. [↑](#footnote-ref-6)
6. Sample literature for informational packets is available within these guidelines documents. [↑](#footnote-ref-7)
7. A sexual history should be based on sexual risk behaviors including but not limited to unprotected sex, sex with multiple partners, anonymous sex, male same sex activity, prior STD history, drug use, and knowledge of partners engaging in high risk sexual activity. [↑](#footnote-ref-8)
8. Clinicians should check to ensure that local laws allow for the use of Patient Delivered Partner Therapy also called Expedited Partner Therapy. [↑](#footnote-ref-9)
9. Clinicians should check to ensure that local laws allow for the use of Patient Delivered Partner Therapy also called Expedited Partner Therapy. [↑](#footnote-ref-10)
10. A sexual history should be based on sexual risk behaviors including, but not limited to, unprotected sex, sex with multiple partners, anonymous sex, male same-sex activity, prior STD history, drug use, and knowledge of partners engaging in high-risk sexual activity. [↑](#footnote-ref-11)
11. Tinidazole (Category C) is contraindicated in pregnancy. [↑](#footnote-ref-12)