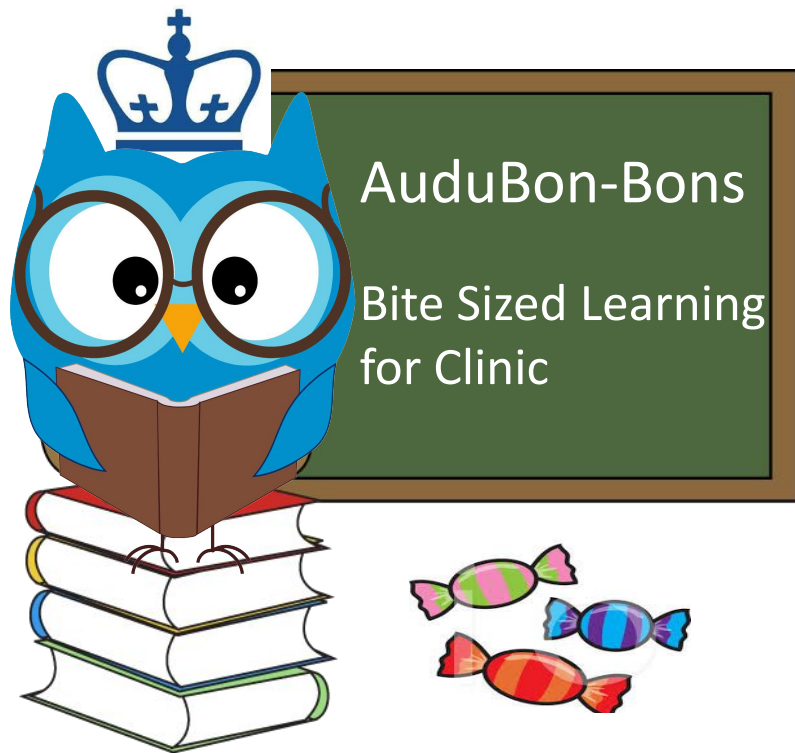


STI SCREENING

Week 19



Prepared by Holli Jakalow, MD

Reading Assignment:

ACOG Guidelines for Women's Healthcare: A Resource Manual, Fourth Edition: Pages 399-420

LEARNING OBJECTIVES



- To understand which patients should be offered STI screening
- To identify common presentations of STIs
- To review appropriate evaluation of patients requesting STI screening
- To identify treatment for patients with an STI
- *NOTE: HPV will not be reviewed in this Audubon-bon as will be covered in different topic*



CASE VIGNETTE

- Ms. Dulce Búho, a 22 yo G1 P0010 woman, presents to clinic requesting STI screening.



FOCUSED HISTORY

- What elements of this patient's history are the most relevant?
 - HPI: No specific concern for STI exposure. Asymptomatic. Feels best with yearly screening.
 - PMH: Denies
 - PSH: Laparoscopic appendectomy
 - POBH: Medical TOP x1
 - PGYNH: Regular menses q28d x 5d
 - LMP 1 week ago
 - Denies history of abnormal pap or STIs
 - Contraception method: Paragard IUD inserted 1 year ago
 - Use of barrier method: No
 - Type of sexual activity: Vaginal intercourse only
 - Number of sexual partners: Currently 2; lifetime 7; men only
 - Meds: Paragard IUD
 - All: NKDA
 - FH: Denies
 - SH: Denies tob, drug use. 3 ETOH per week. Denies IPV.



PERTINENT PHYSICAL EXAM FINDINGS

- What elements of this patient's physical exam are most relevant?
 - Vulva: Normal external female genitalia. No lesions.
 - Vagina: Pink, healthy mucosa. No discharge.
 - Cervix: Nulliparous os. No lesions. No discharge. No CMT.
 - Uterus: NT. Anteverted. Not enlarged.
 - Adnexae: NT. No masses palpable.
 - Groin: No inguinal lymphadenopathy.
 - Skin: No rashes present.



SEXUALLY TRANSMITTED INFECTIONS OVERVIEW

- How can STIs be acquired?
 - Contact during oral, vaginal, or anal intercourse
 - Sharing of insertive sex toys without condoms and cleaning between partners
- What are some of the consequences of STIs?
 - Infertility, chronic pelvic pain, pelvic inflammatory disease, cancer, increased risk of ectopic pregnancy
 - #1 cause of preventable infertility
 - Psychologic distress, strain on personal relationships
- What are the reportable STIs?
 - Gonorrhea, Chlamydia, Syphilis, HIV are reportable in every U.S. state
- How can STIs be prevented?
 - Condom use, limiting number of sexual partners, limiting exposure to high risk partners, limiting risky sexual practices, immunizations
 - Population based:
 - Partner notification and treatment



STI SCREENING RECOMMENDATIONS FOR NON PREGNANT IMMUNOCOMPETENT WOMEN

- **Gonorrhea and Chlamydia**
 - All sexually active women younger than 25yo should be tested every year
 - Women 25 years and older with risk factors such as new or multiple sex partners or a sex partner with an STI should be tested yearly
- **Syphilis**
 - No formal recommendation by CDC
- **Trichomonas**
 - If risk factors are present
- **Herpes**
 - No formal recommendation by CDC
- **HIV**
 - All adults and adolescents from ages 13-64 should be tested at least once for HIV
 - All women who seek evaluation and treatment for STIs
 - Anyone who has unsafe sex or shares injection drug equipment should be tested for HIV at least every year
- **Hepatitis B**
 - If risk factors are present
- **Hepatitis C**
 - One-time HCV screening is recommended if born between 1945-1965
 - Other women should be screened if risk factors are present



COMMON PRESENTATION OF STIS

- **Gonorrhea**
 - Frequently asymptomatic
- **Chlamydia**
 - Asymptomatic, mucopurulent cervicitis, abnormal vaginal discharge, abnormal vaginal bleeding
- **Syphilis**
 - Primary: ulcer or chancre
 - Secondary: skin rash, lymphadenopathy, mucocutaneous lesions
 - Tertiary: Cardiac or ophthalmic manifestations, auditory abnormalities, gummatous lesions
 - Latent: Asymptomatic
- **Trichomonas**
 - Asymptomatic, vaginal discharge that might be diffuse, malodorous, yellow-green, with or without vulvar irritation
- **Herpes**
 - Vesicles/ulcers, asymptomatic
- **HIV**
 - Asymptomatic, acute retroviral syndrome (fever, lymphadenopathy, sore throat, rash, myalgia/arthralgia, diarrhea, weight loss, headache)
- **Hepatitis B**
 - Asymptomatic, acute hepatitis
- **Hepatitis C**
 - Asymptomatic, acute hepatitis



EVALUATION

- **Gonorrhea and Chlamydia**

- Urine or swab specimens from endocervix or vagina
 - Urine testing may miss up to 10% of infections
- For gonorrhea, consider pharyngeal and anorectal swab based on sexual practices
- Nucleic acid amplification tests are most sensitive

- **Syphilis**

- Presumptive diagnosis with nontreponemal tests (VDRL, RPR) and treponemal tests (FTA-ABS and TP-PA) – serum
- Dark-field examinations and direct fluorescent antibody tests of lesions exudate or tissue are definitive

- **Trichomonas**

- Nucleic acid amplification test is most sensitive – urine or swab
- Wet-mount microscopy only 51-65% sensitive – swab

- **Herpes**

- Cell culture or PCR followed by viral culture isolates typing to determine if HSV-1 or HSV-2 is the cause of infection – swab
- Serologic type-specific glycoprotein G-based assays should be requested when serology is performed – serum

- **HIV**

- Combined antigen/antibody immunoassay with confirmatory antibody-only HIV-1/HIV -2 differentiation immunoassay – serum

- **Hepatitis B**

- Hepatitis B surface antigen – serum

- **Hepatitis C**

- Hepatitis C antibody – serum



MANAGEMENT

- **Gonorrhoea**
 - Treat for chlamydial infection as well
 - Ceftriaxone 500mg IM x1 and Azithromycin 1g PO x1
- **Chlamydia**
 - Azithromycin 1g PO x1
 - Abstain from sexual intercourse for 7 days after single-dose treatment and until all of their partners are treated
 - Retest 3 months after treatment
- **Syphilis**
 - Primary: Benzathine Penicillin 2.4 mil u IM x1
 - Unknown (potentially secondary): Benzathine Penicillin 2.4 mil u IM qweekly x 3 weeks if prior negative status not confirmed
 - Treatment goal:
 - 4-fold decline within 3 months; 8-fold decline within 6 months; Non-reactive within 1 year
 - Non-specific tests typically return to negative but may remain weakly positive for life
 - Specific tests typically remain positive for life
- **Trichomonas**
 - Metronidazole 2g orally x1
 - Retest 3 months after treatment
- **Herpes**
 - Valacyclovir 1g PO BID for 7-10 days
- **HIV**
 - Obtain HIV VL
 - Management with HIV clinic
- **Hepatitis B and C**
 - Obtain VL
 - Management with Hepatology



CODING AND BILLING

- Behavioral Counseling to Prevent STIs
 - CPT Codes
 - 99201 – 99205
 - New patient problem visit
 - Document and bill based on counseling time
 - 99211-99215
 - Established patient problem visit
 - Document and bill based on counseling time
 - 99401
 - Preventative medicine counseling and/or risk factor reduction
 - 15 minutes
 - 99402
 - Preventative medicine counseling and/or risk factor reduction
 - 30 minutes
 - 99403
 - Preventative medicine counseling and/or risk factor reduction
 - 45 minutes
 - 99404
 - Preventative medicine counseling and/or risk factor reduction
 - 60 minutes
 - ICD 10 Code
 - Z11.3
 - Encounter for screening for infection with predominantly sexual mode of transmission



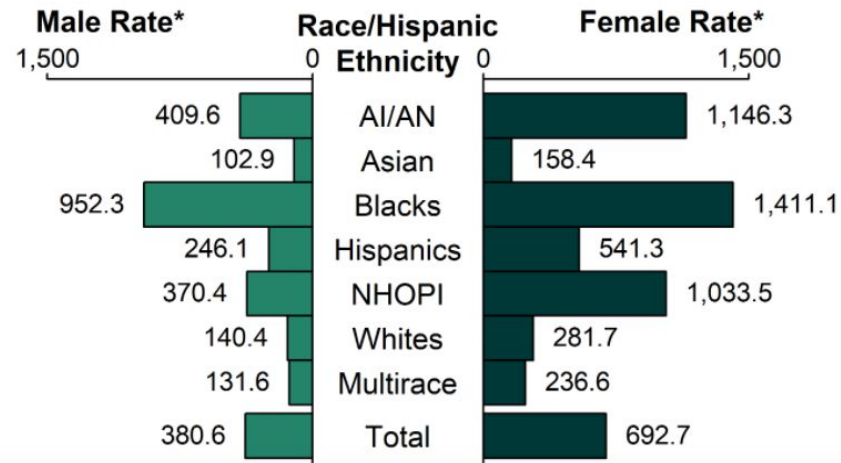
EXPEDITED PARTNER THERAPY

- What is expedited partner therapy?
 - The practice of treating the sexual partners of patients in whom STIs are diagnosed.
 - Expedited partner therapy enables the provider to treat a patient's partners without examining the partners.
- What is ACOG's recommendation on expedited partner therapy?
 - Supports the use of expedited partner therapy as a method of preventing gonorrhea and chlamydial reinfection when a patient's partners are unable or unwilling to seek medical care.
 - Encourages members to advocate for the legalization of expedited partner therapy.
 - Partners receiving expedited partner therapy should be encouraged to see medical evaluation and full STI screening.
 - Always assess risk of IPV associated with partner notification prior to providing expedited partner therapy.
- What is the law in New York State?
 - Expedited partner therapy can be given for the treatment of chlamydia, gonorrhea, and trichomoniasis



SOCIAL DETERMINANTS OF HEALTH

Figure S. Chlamydia — Rates of Reported Cases by Race/Hispanic Ethnicity and Sex, United States, 2018



* Per 100,000.

NOTE: See Section A1.5 in the Appendix for information on race/Hispanic ethnicity in STD case reporting.

ACRONYMS: AI/AN = American Indians/Alaska Natives; NHOPI = Native Hawaiians/Other Pacific Islanders.

The rate of reported chlamydia cases among Black females was five times the rate among White females (1,411.1 and 281.7 cases per 100,000 population, respectively). The rate of reported chlamydia cases among Black males was 6.8 times the rate among White males (952.3 and 140.4 cases per 100,000 population, respectively).

Disparities continue to persist in rates of STIs in different racial groups. As physicians, it is our responsibility to acknowledge the inequality and provide equitable care. Our goal is to provide non-judgmental patient-centered care to help our patients reduce their risks for STIs.



EPIC.PHRASE

.BBSTITREATMENT

Description: STI Treatment Discussion

Patient was diagnosed with *** on ***. Patient was informed on *** and their questions were answered to their satisfaction. Treatment with *** was prescribed to the patient and after they confirmed they were not at risk of intimate partner violence, expedited partner therapy was provided. Education about abstinence during treatment, and prevention of STIs in the future was discussed. Plan for follow up in office on ***.



EVIDENCE

- Addressing Health Risks of Noncoital Sexual Activity. Committee Opinion No. 582. Obstet Gynecol 2013; 122:1378-83.
- CDC. Sexually Transmitted Disease Surveillance 2018.
- Dual Therapy for Gonococcal Infections. ACOG Committee Opinion No. 645. Obstet Gynecol 2015 (reaffirmed 2018); 126:e95-9.
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- “Genital Herpes - STD Information from CDC.” Centers for Disease Control and Prevention, Centers for Disease Control and Prevention, www.cdc.gov/std/herpes/default.htm. (Accessed May 2019)
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- “STD Screening Recommendations - 2015 STD Treatment Guidelines.” Centers for Disease Control and Prevention, Centers for Disease Control and Prevention, www.cdc.gov/std/tg2015/screening-recommendations.htm.(Accessed May 2019)
- “Trichomoniasis - STD Information from CDC.” Centers for Disease Control and Prevention, Centers for Disease Control and Prevention, www.cdc.gov/std/trichomonas/default.htm. (Accessed May 2019)

