

Sexually transmitted diseases: An update on retesting guidelines and reinfection prevention strategies

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Approximately 20 million new sexually transmitted diseases (STDs) occur in the United States each year.¹ To help healthcare providers (HCPs) treat these infections and prevent new infections, the CDC has issued **Sexually Transmitted Diseases Treatment Guidelines, 2015^A**, an update of its 2010 report.² These updated guidelines include nine new topics, one of which entails retesting to detect repeat infection—the topic of this article.

At least 1 in 10 females becomes reinfected after treatment for chlamydia or gonorrhea and up to 1 in 6 becomes reinfected after treatment for trichomoniasis.^{3,4} Untreated chlamydia or gonorrhea can increase a woman's risk for developing pelvic inflammatory disease (PID), infertility, ectopic pregnancy, and chronic pelvic pain. In fact, women with chlamydia or gonorrhea reinfection may have an even higher risk for PID and ectopic pregnancy than those with a first infection.³ Untreated trichomoniasis can increase the risk for premature delivery.⁵

Retesting several months after diagnosis and treatment of chlamydia, gonorrhea, or trichomoniasis can detect repeat infection early on, and can be used to improve population-based prevention efforts.^{6,7} The CDC recommends that any female or male who tests positive for chlamydia or gonorrhea and any female who tests positive for trichomoniasis be retested 3 months after treatment.

Of note, retesting for reinfection and a test of cure (TOC) are not the same. A TOC is performed 3-4 weeks

after treatment if concern exists regarding persistence of infection despite treatment. A TOC is recommended if symptoms of infection persist or if lack of adherence to the treatment regimen is suspected. TOC is also recommended after treatment of chlamydia during pregnancy.

Retesting for repeat infection may occasionally detect persistent infection. In most cases, however, infections found on retesting are reinfections, transmitted by either an untreated prior partner or an infected new partner.^{4,8,9} Retesting allows for earlier treatment of reinfection, which can prevent complications and further transmission. In addition, retesting, regardless of whether results are positive or negative, provides the opportunity for HCPs to revisit the topic of STD risk reduction with patients.

Is retesting enough? How can HCPs treat their patients, and their patients' partners, to reduce the risk for reinfection?

One of the CDC's major strategies for prevention and control of STDs is to encourage HCPs to conduct an accurate STD risk assessment and counsel patients about ways to avoid these diseases—by changing their sexual behaviors and by using recommended prevention services. HCPs can use the CDC pamphlet, **A Guide to Taking a Sexual History^B**, specifically with respect to the five P's of sexual health—Partners, Practices, Protection from STDs, Past History of STDs, and Prevention of Pregnancy—to assess patients' STD/HIV behavioral risk.¹⁰

A second important strategy is evaluation, treatment, and counseling of sex partners of persons with an STD. Time spent counseling patients on the importance of notifying partners is associated with improved notification outcomes.¹¹ Some evidence suggests that providing patients with written information to share with sex partners can increase rates of partner treatment.¹² When possible, HCPs should ask patients to bring their primary sex partner with them when returning for treatment so that both persons can be treated concurrently. Although this approach can be effective for a main partner,¹³ it may not be feasible for additional sex partners.¹⁴



Expedited partner therapy^C (EPT),¹⁵ also termed patient-delivered partner therapy, is the clinical practice of treating the sex partners of patients diagnosed with chlamydia or gonorrhea. HCPs offer medications or prescriptions to the patients, who then give the medications or prescriptions to their sex partners, thereby obviating the need for the partners to see an HCP. Three U.S. clinical trials of heterosexual men and women with chlamydia or gonorrhea have shown that more partners are treated when EPT is utilized.¹⁶⁻¹⁸ All three trials reported declines in reinfection, with two demonstrating significant declines. Across trials, chlamydia prevalence decreased by about 20% and gonorrhea, by about 50%, at follow-up.

The preferred approach to EPT is to provide patients with appropriately packaged medication. Data on the efficacy of EPT using prescriptions are limited; in fact, many persons do not fill the prescriptions given to them by a sex partner. Medications or prescriptions provided for EPT should be accompanied by treatment instructions, appropriate warnings about taking medications (e.g., if a partner is pregnant or has an allergy to the medication), general health counseling, and a statement advising that partners seek healthcare evaluation for any symptoms of an STD, particularly PID. Please see the patient education page on expedited partner therapy for chlamydia in this issue.

Unless prohibited by law or other regulations, HCPs should routinely offer EPT to heterosexual patients with chlamydia or gonorrhea when HCPs cannot confidently ensure that all of a patient's sex partners will seek treatment on their own. Parameters for treatment include all sex partners from the previous 60 days or the most recent partner if the patient has not had sex in the 60 days prior to diagnosis.

Most states have legalized EPT, but HCPs should obtain the most **up-to-date guidelines for their state^D**, as well as determine whether their state health department has EPT patient handouts available.¹⁹ Also, HCPs should be aware of the clinical limitations of EPT use. Because a person using EPT is not seeing an HCP for this treatment, this person cannot receive the preferred regimen for gonorrhea: single doses of intramuscular ceftriaxone and oral azithromycin.¹⁹ In-

stead, this person will take an oral regimen of cefixime 400 mg and azithromycin 1 g. If at all possible, HCPs should urge patients to request that their sex partners from the preceding 60 days be evaluated by an HCP and treated with the preferred regimen for gonorrhea. If pharyngeal gonorrhea is a possibility, persons treated with the oral antibiotic regimen should be encouraged to return 14 days after treatment for a TOC.

Data on the use of EPT for chlamydia or gonorrhea among men who have sex with men (MSM) are limited. Published studies suggest that more than 5% of MSM without a previous HIV diagnosis have a new diagnosis of HIV infection when evaluated as partners of patients with chlamydia or gonorrhea.^{20,21} EPT should not be used routinely by MSM. HCPs should try to ensure that these sex partners are tested and, if applicable, treated, for HIV infection and other STDs.^{22,23}

Although existing data suggest that EPT may have a role in partner treatment for trichomoniasis, no evidence suggests that it is any more effective at reducing reinfection than treatment onsite or by referral. No data support the use of EPT for syphilis.^{24,25}

Healthcare providers play a critical role in primary prevention of STDs through patient risk assessment and risk reduction counseling. HCPs are also encouraged to implement CDC-recommended strategies for early identification and effective treatment of infected persons, treatment of sex partners, and appropriate follow-up to detect reinfection and provide early treatment. ●

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Visit NPWomensHealthcare.com/?p=4564 for a complete list of references.

Web resources

- A. cdc.gov/std/treatment/SexualHistory.pdf
- B. cdc.gov/std/treatment/SexualHistory.pdf
- C. cdc.gov/std/ept/
- D. cdc.gov/std/ept/legal/default.htm