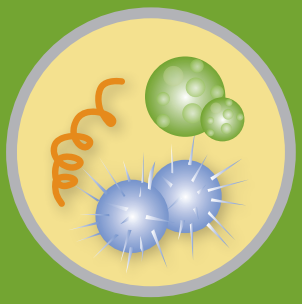
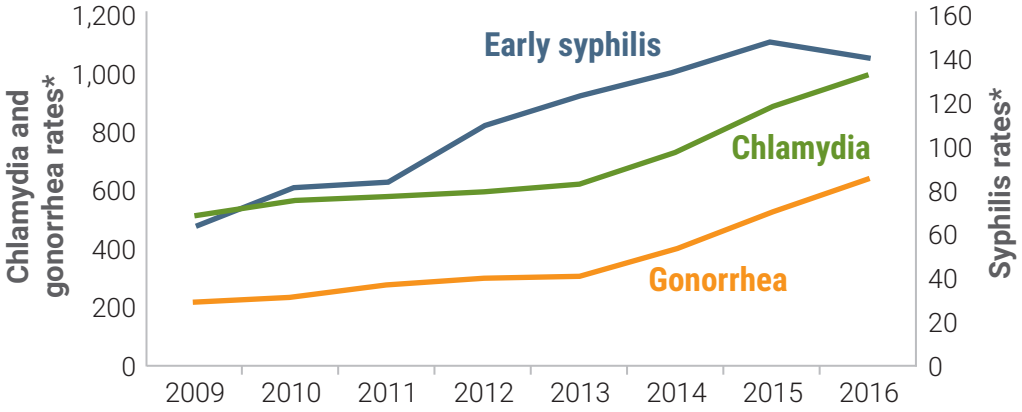


Promoting Sexual Health: A Guide for Clinicians

Healthcare providers can play an important role in reducing syphilis, gonorrhea, and chlamydia, and preventing congenital syphilis

STD rates are increasing in men, women, and some newborns in San Francisco and nationwide.

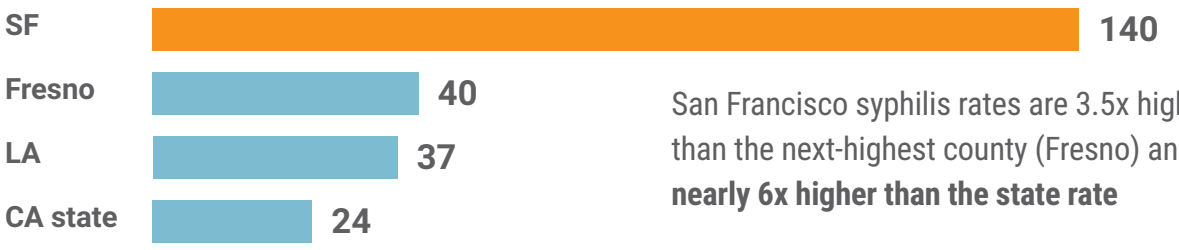
FIGURE 1: STD RATES—SAN FRANCISCO, 2009-2016[1]



*Per 100,000 population

STD cases are increasing even as HIV diagnoses decline.

FIGURE 2: SAN FRANCISCO EARLY SYPHILIS RATES ARE HIGHER THAN ANY OTHER COUNTY IN CALIFORNIA[2]



San Francisco syphilis rates are 3.5x higher than the next-highest county (Fresno) and **nearly 6x higher than the state rate**

2015 county incidence rates, per 100,000 population

STDs can have severe consequences.

- Untreated syphilis is associated with visual impairment, hearing loss, and neurological problems.
- Untreated chlamydia (CT) and gonorrhea (GC) in women can lead to future pelvic inflammatory disease, chronic pelvic pain, ectopic pregnancy, and infertility.
- Pregnant women who are infected with syphilis can pass it to the fetus, causing potential miscarriage, stillbirth, and severe illness in surviving infants.

There are disparities in the burden of STDs, and the highest rates are seen among:

- Gay and bisexual men and other men who have sex with men (MSM)
- Adolescents and young adults (persons 15-25 years old), particularly of color
- Transgender persons

CLINICAL RECOMMENDATIONS

5 steps providers can take to improve sexual healthcare

Take a comprehensive sexual history that includes the gender of sexual partners and anatomic sites of sexual exposure during the past year.

- A thorough sexual history helps identify patients who may need:
  - STD screening
  - Empiric STD treatment
  - Contraceptive counseling
  - HIV pre-exposure prophylaxis (PrEP) or post-exposure prophylaxis (PEP)
- Remind patients that a sexual history is part of routine healthcare and is confidential.
- If limited to one question, ask: "Do you have sex with men, women, or both?" in order to assess potential risk for STDs and determine appropriate screening.

Talk to your patient about sex. The "PREP" mnemonic works well for taking a sexual history, for both PrEP and STD screening.

P artners: What is the gender of your sex partners?
How many sex partners have you had in the last 6 months?

R eceptive or insertive sex: Do you have vaginal sex?
Do you have receptive and/or insertive anal sex?

E ver had STD: Have you ever had an STD?
Have any of your partners told you they have an STD?

P rotection: How often do you use condoms?
Are you planning on getting pregnant in the next year?

2 Perform syphilis and 3-site gonorrhea and chlamydia testing every 3 months for sexually active gay, bisexual, and other MSM.

Over 75% of rectal and pharyngeal STDs are asymptomatic.[3]

FIGURE 3: THE MAJORITY OF CHLAMYDIA AND GONORRHEA INFECTIONS WILL BE MISSED IF ONLY URINE IS SCREENED.[4]

- **Examine sites of sexual exposure**. Inspect skin surfaces including genitals, palms, and soles of feet for rashes suggestive of syphilis.
- **Use nucleic acid amplification tests (NAATs)** for chlamydia and gonorrhea screening at all sites of exposure, which may include pharyngeal, rectal, and urine tests.
- **Perform an HIV test** on all MSM with a suspected STD.
- **Discuss PrEP with HIV negative men** with syphilis or rectal chlamydia or gonorrhea and **offer or refer for initiation**.

PRO-TIP: Implement STD self-collection

- Patient self-collection for STD testing can save time. SFDPH can help your clinic set up a self-collection protocol.

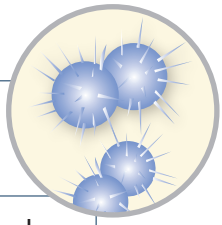
3 Immediately treat and report all syphilis and gonorrhea cases.

- **Empiric treatment** is often indicated based on symptoms. See Table 1 for syndromic management of STDs.
- Patients who report having sex with someone with an STD should be tested and empirically treated.
- Call 415-487-5531 to obtain a patient's syphilis titer and treatment history.

TABLE 1: SYNDROMIC MANAGEMENT OF STDS IN MSM[5]

Syndrome	Sign/Symptom	Immediate next steps
Urethritis	Discharge or dysuria	• Test and empirically treat for GC/CT. • Test for syphilis and HIV. • Consider HSV PCR testing/treatment of suspicious ulcerative lesions. • Consider LGV testing (proctitis).
Proctitis	Ulcer, discharge or pain, bleeding	
Early syphilis dermatologic findings	Possible chancre or rash of secondary syphilis	• Test and empirically treat for syphilis. • Screen for GC/CT and HIV/acute HIV. • Consider HSV PCR testing/treatment of suspicious ulcerative lesions.
Uveitis	Blurry vision, red eye, or eye pain	• Test for syphilis and HIV. • Immediately refer to ophthalmology. • Refer for lumbar puncture if high suspicion for ocular syphilis.

TABLE 2: STD TREATMENT RECOMMENDATIONS[6]



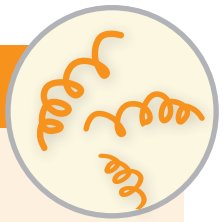
Primary, secondary, and early latent syphilis	Benzathine penicillin G (Bicillin L-A®), 2.4 million units IM* Alternative: Doxycycline 100 mg PO BID x 14 days
Late latent syphilis or syphilis of unknown duration	Benzathine penicillin G (Bicillin L-A®), 7.2 million units, administered as 3 doses of 2.4 million units IM each, at 1-week intervals
Chlamydia (any site)	Azithromycin 1 gram PO **or** Doxycycline 100 mg PO BID x 7 days
Gonorrhea (any site)	**Dual therapy:** Ceftriaxone 250 mg IM + Azithromycin 1 gram PO

**For more information or alternative regimens, see the SF City Clinic protocols or CDC 2015 Treatment Guidelines.*

Report STDs

- SFDPH uses CMRs to track local epidemiological trends and direct services where needed.
- **Use the Confidential Morbidity Report (CMR)** to notify SFDPH of a new HIV or syphilis diagnosis within 24 hours. The form can be found online: **sfcityclinic.org/providers**.
- Document the gender(s) of the patient's sexual partners, staging of syphilis, site of infection for GC/CT, and treatment information.
- **SFDPH can help ensure patients are treated.** If you are having trouble following up with a patient, a field worker can help locate them and deliver medications.
- For questions or help in completing the report, call: 415-431-5530.

PRO-TIP: Look out for syphilis and neurosyphilis



- Think about syphilis whenever you see a bilaterally symmetric rash in a man or a scrotal rash.
- Check a syphilis test when evaluating a genital ulcer and anogenital warts.

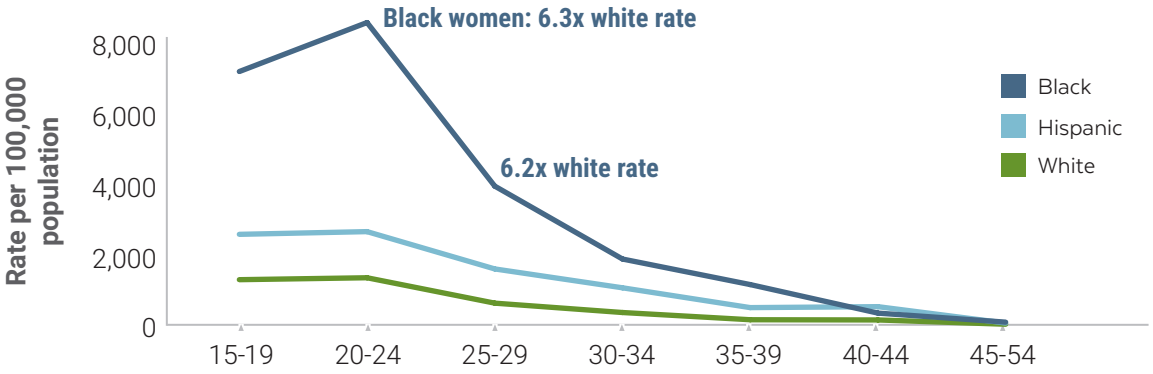
- A patient's past syphilis titer and treatment history is essential for determining appropriate treatment. The health department can help provide this information.
- Check a titer on the day of treatment—this helps monitor the patient's response.
- Patients who have a recent sex partner with syphilis should be presumptively treated for early syphilis with penicillin G or doxycycline even if the syphilis test is negative, as it can take up to 90 days from time of exposure until test results become positive.

- **Neurosyphilis** can occur during any stage of syphilis. All patients with syphilis should be evaluated for neurologic signs and symptoms. Ocular and otologic syphilis are manifestations of neurosyphilis.
- Perform a lumbar puncture for patients when there is concern for neurosyphilis.

4 Screen all women < 26 years old for chlamydia and gonorrhea annually.

Young black women have 5-6x the rate of chlamydia compared to white women.

FIGURE 4: FEMALE INCIDENCE RATES OF CHLAMYDIA, BY RATE/ETHNICITY AND AGE GROUP (YEARS), SAN FRANCISCO, 2016



- Chlamydia is usually asymptomatic in females.
- A vaginal swab can be self-collected in asymptomatic patients.
- **Retest 3 months** after treatment for patients with a positive CT/GC test.
- Perform an HIV test on all women diagnosed with gonorrhea or syphilis.
- California state law allows clinicians to **provide expedited partner therapy (EPT)** to patients who test positive for STDs to deliver to sexual partners in order to prevent reinfection. For more, go to: **cdc.gov/std/ept**.

Go to **sfcitylinic.org** for a patient handout on self-collection.

5 Test and treat ALL pregnant women for syphilis in the first trimester, and retest at the beginning of the third trimester and at delivery if there are ongoing risk factors.

- Increases in congenital syphilis have paralleled the increase in early syphilis.
- **Screening every pregnant woman is essential.** Presenting late to prenatal care, substance use, incarceration, and homelessness place women at greater risk of syphilis.
- Many women do not know the risks of their male sexual partners. Women are at increased risk of syphilis if their male partner(s) have sex with men, have been incarcerated, or have used injection drugs.
- Call SFDPH (415-487-5531) if you diagnose syphilis in a pregnant patient.
- SFDPH can help locate patients and their sex partners to ensure timely treatment and prevent reinfection.
- **Intramuscular or IV penicillin** is the only treatment option for pregnant women with syphilis.
- **Ensure any woman** diagnosed with syphilis has a pregnancy test.

Delivering trans-competent care

- **Ask every patient their gender identity and assigned sex at birth.** This more accurately assesses a patient's sexual health needs (some trans people do not identify as so).
- Screening recommendations will depend on what body parts the patient has and uses for sex. Refer to the SFDPH STD screening recommendations on the back of this brochure.
- Note if your patient or their partners identify as trans on the Confidential Morbidity Report (CMR).
- For more information about transgender health, refer to the UCSF Center of Excellence for Transgender Health: **transhealth.ucsf.edu**.

Ask patients their preferred name, pronouns, and terminology for their body parts.

Gender:

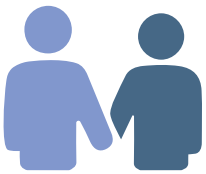
❑ Male ❑ Female

❑ Trans male ❑ Trans female

❑ Gender queer or nonbinary

❑ Other (specify): _____

Partner services



- Partner services is a free program offered by the SFDPH that helps patients determine how to best notify their sex or needle sharing partners. Let patients know that SFDPH staff routinely call patients diagnosed with syphilis and HIV to offer partner services.
- Partner services will also help confidentially contact any partners and ensure they are offered free STD and HIV testing, treatment, and linkage to prevention services, like PEP and PrEP.
- Partner notification is important because treating partners can **prevent reinfection** and **prevent further disease transmission** and complications.

RESOURCES:

- San Francisco City Clinic STD Protocols: sfcityclinic.org/providers
- CDC 2015 STD Treatment Guidelines: cdc.gov/std/treatment
  - CDC Treatment Guidelines App for iOS and Android
- Free online CME, self-study STD modules: std.uw.edu/custom/self-study
- California STD/HIV Prevention Training Center: californiaptc.com
- MSM toolkit: cdph.ca.gov/Programs/CID/DCDC/Pages/STD-MSMToolkit.aspx
- National LGBT Health Education Center: lgbthealtheducation.org

TABLE 3: SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH STD AND HIV SCREENING GUIDELINES

These evidence-based recommendations provide guidance for chlamydia, gonorrhea, syphilis, and HIV screening in persons without symptoms or a need for diagnostic testing.[1]

		Chlamydia and gonorrhea	Syphilis	HIV
Women	25 years and younger	Test every 12 months	Not routinely recommended[2]	At least one lifetime test[2]
	Older than 25 years	Not routinely recommended[2]		
	Pregnant[3]	Test in 1st trimester, repeat in 3rd trimester if at increased risk[2]	Test in 1st trimester, repeat in 3rd trimester if at increased risk[2]	First prenatal visit, repeat in 3rd trimester if at increased risk[2]
Men who have sex with women	Any age, any site	Not routinely recommended[2]		At least one lifetime test[2]
Men who have sex with men (MSM) —OR— Trans women and trans men who have sex with men	Blood	—	Every 3 months	
	Rectal & Pharyngeal[4]	Every 3 months	—	
	Urine[5] / Vaginal Swab	Every 3 months	—	

(1) These are general population recommendations. SFDPH may make separate recommendations for specific groups that correlate with higher risk. **(2)** Consider screening if patient has any of the following risk factors: sex with a man who has sex with men, history of STD in the past year, methamphetamine use, sex work, intimate partner violence, or incarceration. **(3)** Regardless of intentions to carry to term. **(4)** Prioritize these extra-genital sites, as rectal and pharyngeal infections are almost always asymptomatic. **(5)** If cost permits or extra-genital testing not available.

TERMINOLOGY: Transgender (Trans): A person whose gender identity differs from the sex that was assigned at birth. **A trans man** (trans male) is someone with a male gender identity who was assigned female sex at birth; **a trans woman** (trans female) is someone with a female gender identity who was assigned male sex at birth.

IMPORTANT PHONE NUMBERS:

- Syphilis titer and treatment history: 415-487-5513
- San Francisco City Clinic Provider Line: 415-487-5595. For clinical questions, or for help interpreting a syphilis test result or ensuring adequate treatment.
- Confidential Morbidity Report (CMR): 415-431-5530
- Public Health Laboratory: 415-554-2800
- For questions about PrEP or assistance with linking a client to PrEP, call: 415-634-PrEP (7737) or email: PrEP@sfdph.org.

REFERENCES: **1.** San Francisco Department of Public Health. San Francisco Sexually Transmitted Disease Annual Summary, 2015. San Francisco Department of Public Health, San Francisco, California. April 2017. **2.** California Department of Public Health, STD Control Branch. Early Syphilis Ranking of County Incidence Rates, 2015. July 2016. **3.** Kent CK, Chaw JK, Wong W, et al. Prevalence of Rectal, Urethral, and Pharyngeal Chlamydia and Gonorrhea Detected in 2 Clinical Settings among Men Who Have Sex with Men: San Francisco, California, 2003. *Clinical Infectious Diseases*. 2005;41(1):67-74. **4.** Marcus JL, Bernstein KT, Kohn RP, Liska S, Philip SS. Infections Missed by Urethral-Only Screening for Chlamydia or Gonorrhea Detection Among Men Who Have Sex With Men. *Sexually Transmitted Diseases*. 2011;38(10):922-924. **5.** NYC Health. STIs Among MSM Protocol Card. May 2016. **6.** Workowsk KA, Bolan GA, Centers for Disease Control and Prevention. Sexually transmitted diseases treatment guidelines, 2015. *Morbidity and Mortality Weekly Report (MMWR)*. 2015;64(RR-03):1-137.

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