Learning Objectives

• Describe the recent epidemiologic trends for Chlamydia, Gonorrhea, and Syphilis in the United States

• Recognize and describe risk factors, clinical manifestations, screening/diagnosis, and management of Chlamydia, Gonorrhea, and Syphilis
Introduction

- Sexually transmitted infections (STIs) are hidden epidemics of enormous health and economic consequence
  - Estimated annual direct medical cost = $17 billion U.S. dollars, 2010 (range: $14 – 23 billion)
- Disruptive, painful, and associated with long-term negative health consequences
- Increase risk of other reproductive morbidities (e.g. infertility)
- All communities are impacted by STIs – all individuals directly or indirectly pay for the costs of these diseases


Why Focus on Chlamydia, Gonorrhea, and Syphilis?

The New York Times

Reported Cases of Sexually Transmitted Diseases Are on Rise

STD rates reach record high in United States

She may be a bag of trouble.
# Case

- 27 y/o African American male presents with complaints of a clear penile discharge x 3 days (top picture)
- Patient reports having multiple female sex partners and practices unprotected vaginal and anal sex
- Gram stain of urethral discharge is shown (bottom picture).
- Urine nucleic acid amplification test is positive for chlamydia and negative for gonorrhea

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## Chlamydia
1.5 million cases (2015)

Women and Men: 15 – 24 y/o (highest rates)

Rate (per 100,000 population)

Year

NOTE: Data collection for chlamydia began in 1944 and chlamydia was made nationally reportable in 1999; however, chlamydia was not reportable in all 50 states and the District of Columbia until 2000. Refer to the National Notifiable Disease Surveillance System (NNDSS) website for more information: https://www.cdc.gov/ndss/conditions/chlamydia-trachomatis-infection/.

Chlamydia — Rates of Reported Cases by Race/Ethnicity, United States, 2011–2015

Rate (per 100,000 population)

Year

Chlamydia: Risk Factors

- Adolescents and young adults (<25 y/o)
- New sex partner
- Multiple sex partners
- Sex partner with other sex partners
- Previous STI or sex partner with an STI
- Inconsistent condom use (non-monogamous)
- Ethnic minority
- Low or intermediate education


Chlamydia: Manifestations

- Asymptomatic infection (common in men and women)
- Cervicitis
- Pelvic Inflammatory Disease (PID)
  - Infertility
  - Ectopic pregnancy
  - Chronic pelvic pain
- Peri-hepatitis
- Urethritis

- Epididymitis
- Prostatitis
- Proctitis
- Inclusion conjunctivitis (adults and neonates)
- Pneumonia (mainly infants)
- Lymphogranuloma venereum (LGV serovars)
- Reactive arthritis

Mandell, et al. (editors), PPID, 8th Ed. 2015; Workowski KA, et al. MMWR 2015
Chlamydia: Screening Recommendations

- All sexually active women <25 y/o (annually)
- Older sexually active women with risk factors (annually)
- All pregnant women <25 y/o and those older with risk factors
  - 1st prenatal visit
  - 3rd trimester if <25 y/o or if at high-risk for infection
- Incarcerated women ≤35 y/o and men <30 y/o (at intake)
- Sexually active young men (?)
  - Not enough evidence to suggest routine screening, except in high risk settings (e.g. adolescent clinics, prison/jail, STD clinics) or high-burden populations (e.g. men who have sex with men)

Chlamydia screening programs reduce rates of PID in women


Chlamydia: Diagnosis

- Nucleic acid amplification testing (NAAT)
  - High sensitivity ≥90% and specificity ≥99%
- Women
  - Vaginal swabs† ≥ Endocervical swab > First-catch urine‡
  † Self-collected or clinician-collected (equivalent)
  ‡ Can miss up to 10% of infections
- Men
  - First-catch urine§
  § Equivalent/superior to urethral swab

Papp J, et al. MMWR 2014; Workowski KA, et al. MMWR 2015
Chlamydia: Treatment

- 2002 Meta-analysis (n = 12 studies)
  - Equal efficacy: azithromycin (97%) and doxycycline (98%) for urogenital infections
  - Older testing methods, underestimated failure rates, adherence to doxycycline not ensured, repeat exposures (?), single TOC
- 2014 Meta-analysis (n = 23 studies)
  - Marginal superior efficacy (up to 3%) for doxycycline (97.5%) vs. azithromycin (94.4%) for urogenital infections
  - Considerable variability in evidence quality
  - Few double-blind placebo controlled trials
- 2015 Meta-analysis (n = 8)
  - Observational studies; azithromycin was less efficacious than doxycycline for rectal infections (82.9% vs. 99.6%)


- Doxycycline (n = 155) → 100% efficacy
  - No treatment failures
- Azithromycin (n = 155) → 97% efficacy
  - 5 treatment failures
  - Failure rate difference, 3.2% (1-sided 90% CI, 0 – 5.9)
  - Did NOT establish “non-inferiority”

Still very good!
(DOT advantage)
## Chlamydia: Treatment

<table>
<thead>
<tr>
<th>Non-Pregnant Patients</th>
<th>Recommended Regimen</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Azithromycin 1 g PO x 1</td>
</tr>
<tr>
<td></td>
<td>Doxycycline 100 mg PO BID x 7 days</td>
</tr>
<tr>
<td></td>
<td>Alternative Regimen (one example)</td>
</tr>
<tr>
<td></td>
<td>Levofloxacin 500 mg PO QD x 7 days</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Pregnant Patients*</th>
<th>*Test of cure (TOC) in 3 – 4 weeks with NAAT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recommended Regimen</td>
<td>Azithromycin 1 g PO x 1</td>
</tr>
<tr>
<td>Alternative Regimen</td>
<td>Amoxicillin 500 mg PO TID x 7 days</td>
</tr>
</tbody>
</table>

*Workowski KA, et al. MMWR 2015*

## Gonorrhea
Gonorrhea — Rates of Reported Cases by Year, United States, 1941–2015

Rate (per 100,000 population)

Year


395,216 cases (2015)

NOTE: Data collection for gonorrhea began in 1941; however, gonorrhea became nationally notifiable in 1944. Refer to the National Notifiable Disease Surveillance System (NNDSS) website for more information: https://www.cdc.gov/nndss/conditions/gonorrhea/

Gonorrhea — Rates of Reported Cases by Sex, United States, 2006–2015

Rate (per 100,000 population)

Year


Women: 15 – 24 y/o (highest rates)
Men: 20 – 29 y/o (highest rates)
Gonorrhea: Risk Factors

- Adolescents and young adults (<25 y/o)
- New sex partner, multiple sex partners, or sex partner with other sex partners
- Previous/co-existing STI or sex partner with an STI
- Inconsistent condom use (non-monogamous)
- Ethnic minority
- Low or intermediate education
- Commercial sex work (sex for money or drugs)
- High prevalence of gonorrhea at provider’s site

Gonorrhea: Manifestations

- Asymptomatic infection (common in women)
- Cervicitis
- Pelvic Inflammatory Disease (PID)
  - Infertility
  - Ectopic pregnancy
  - Chronic pelvic pain
- Peri-hepatitis
- Urethritis
- Epididymitis
- Proctitis
- Pharyngitis
- Disseminated gonococcal infection (DGI)
- Conjunctivitis (adults and neonates)

Mandell, et al. (editors), PPID, 8th Ed. 2015; Workowski KA, et al. MMWR 2015

Gonorrhea: Screening Recommendations

- All sexually active women <25 y/o (annually)
- Older sexually active women with risk factors (annually)
- All pregnant women <25 y/o and those older with risk factors
  - 1st prenatal visit
  - 3rd trimester if at high-risk for infection
- Incarcerated women ≤35 y/o and men <30 y/o (at intake)
- High-risk men who have sex with men (MSM)
- No screening of older women or men at low risk

Workowski KA, et al. MMWR 2015; LeFevre ML. AIM 2014
Gonorrhea: Diagnosis

- Nucleic acid amplification testing (NAAT)
  - Sensitivity ≥90%, Specificity ≥99%
- Women
  - Vaginal swabs ≥ Endocervical swab > First-catch urine
- Men
  - First-catch urine
  - Urethral Gram stain with GNID in symptomatic men
    - Sensitivity >95%, Specificity >99%
- Culture
  - Antibiotic susceptibility testing

Gram negative intracellular diplococci (GNID)

Papp J, et al. MMWR 2014; Workowski KA, et al. MMWR 2015
Extragenital Chlamydia and Gonorrhea Infections in MSM

- Frequently asymptomatic
- High proportion of MSM with extragenital chlamydia and gonorrhea infections have negative urethral/urine chlamydia and gonorrhea test result (74% pharyngeal GC, 72% rectal GC, 92% pharyngeal CT, 88% rectal CT)
- Rectal chlamydia or gonorrhea infections increase risk of HIV seroconversion in MSM (8-fold if ≥2 episodes of rectal infection in the previous 2 years)

Patton ME, et al. CID 2014; Bernstein KT, et al. JAIDS 2010
Chlamydia and Gonorrhea Screening in MSM

• Reported behaviors in the last 12 months:
  • Insertive intercourse
    • Urethral Chlamydia and Gonorrhea (annually)
  • Receptive anal intercourse
    • Rectal Chlamydia and Gonorrhea (annually)*
  • Receptive oral intercourse
    • Oropharyngeal Gonorrhea only (annually)*
• More frequent testing (every 3 – 6 months) if patient or sex partner has multiple partners or sex while using illicit drugs

*NAAT recommended (Not FDA-cleared)
Gonorrhea: Treatment Failures

Gonococcal Isolate Surveillance Project (GISP)

- Surveillance study sponsored by CDC since 1986
- Tracks gonorrhea antibiotic susceptibility trends in the U.S.
- Informs national treatment recommendations

Gonorrhea: 2014 GISP Results

- 5,093 urethral gonorrhea isolates analyzed
- Tetracycline-R = 25%
- Ciprofloxacin-R = 19%
- Penicillin-R = 16%
- Azithromycin-RS = 2.5% (up from 0.6% in 2013)
  - Greatest increase in Midwestern U.S.
  - MSM > MSMW > MSW
- Cefixime-RS = 0.8% (up from 0.4% in 2013)
- Ceftriaxone-RS = 0.1%

R = Resistance
RS = Reduced Susceptibility

Gonorrhea Treatment

- Uncomplicated urethral, cervical, and rectal infections:
  - Ceftriaxone 250 mg IM + Azithromycin 1g PO x 1 (Recommended)
  - Cefixime 400 mg PO + Azithromycin 1g PO x 1 (Alternative)
  - No test of cure (TOC) necessary
- Uncomplicated oropharyngeal Infections:
  - Ceftriaxone 250 mg IM + Azithromycin 1g PO x 1 (Recommended)
  - Alternative → TOC in 14 days (NAAT or Culture)*

* Perform susceptibility testing if positive

Kirkcaldy RD, et al. MMWR 2016

Workowski KA, et al. MMWR 2015
## Gonorrhea: Treatment

**Dual therapy ALWAYS recommended**
- Treats chlamydia co-infection (20 – 40%) and prevents development of drug-resistant gonorrhea
- Azithromycin preferred over doxycycline* due to high prevalence of tetracycline resistance (25%)
  
  
  *Doxycycline 100 mg PO BID x 7 days (azithro allergy)

**Azithromycin (2 g) monotherapy not recommended**
- Resistance can develop easily (at least in-vitro)
- Multiple documented treatment failures
- Options for patients with “Cephalosporin-allergy”?

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### Gonorrhea: Treatment (New Options)

*National shortage*

- **Gemifloxacin 320 mg* + Azithromycin 2 g PO x 1**
  - 99.5% cure rate for urogenital infections (n = 199)
- **Gentamicin 240 mg IM + Azithromycin 2 g PO x 1**
  - 100% cure rate for urogenital infections (n = 202)
- **Study not powered to detect efficacy for extra-genital infections (rectum or pharynx)**
- **Solithromycin 1 g OR 1.2 g PO x 1 (Phase II Trial)**
  - 100% cure rate among patients (n = 46) with culture positive urogenital, rectal, and pharyngeal infections

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**References**


### Chlamydia and Gonorrhea: Follow-up

- No sex for 7 days after treatment
- Notify, screen, and treat all sex partners in the last 60 days
  - Screen and treat most recent sex partner even if last sexual contact was >60 days
- Re-screen in 3 months after treatment due to high risk of re-infection (if not possible, re-screen whenever medical care is sought within next 12 months)

*Workowski KA, et al. MMWR 2015*
Case

• 28 y/o African American male presents with whole body rash, malaise, and mouth ulcers for the last 4 weeks
• Reports having sex with women and men (~8 sex partners in last 6 months), uses the internet to find sex partners, engages in anonymous sex, uses methamphetamines, and reports unprotected insertive/receptive anal sex and receptive oral sex
• RPR = 1:256
• FTA-ABS = Reactive
• Rapid HIV antibody = Positive (Western Blot +) – Negative 3 months prior

Syphilis — Rates of Reported Cases by Stage of Infection, United States, 1941–2015

Rates (per 100,000 population)

<table>
<thead>
<tr>
<th>Year</th>
<th>Total Syphilis</th>
<th>Early Latent</th>
<th>Primary and Secondary</th>
</tr>
</thead>
<tbody>
<tr>
<td>1941</td>
<td>400</td>
<td>160</td>
<td>0</td>
</tr>
<tr>
<td>1942</td>
<td>320</td>
<td>100</td>
<td>0</td>
</tr>
<tr>
<td>1943</td>
<td>240</td>
<td>50</td>
<td>0</td>
</tr>
<tr>
<td>1944</td>
<td>160</td>
<td>20</td>
<td>0</td>
</tr>
<tr>
<td>1945</td>
<td>80</td>
<td>5</td>
<td>0</td>
</tr>
<tr>
<td>1946</td>
<td>40</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>1947</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>2015</td>
<td>23,872 cases</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

NOTE: Data collection for syphilis began in 1941; however, syphilis became nationally notifiable in 1944. Refer to the National Notifiable Disease Surveillance System (NNDSS) website for more information: https://www.cdc.gov/nndss/conditions/syphilis/

Women and Men
20 – 29 y/o (highest rates)

[Graph showing cases by year and sex]

* 37 states were able to classify ≥70% of reported cases of primary and secondary syphilis as either MSM†, MSW†, or women for each year during 2011–2015.
† MSM = Gay, bisexual, and other men who have sex with men (collectively referred to as MSM). MSW = Men who have sex with women only.

Congenital Syphilis — Reported Cases by Year of Birth and Rates of Primary and Secondary Syphilis Among Women, United States, 2006–2015

CS* Cases

<table>
<thead>
<tr>
<th>Year</th>
<th>CS Cases</th>
<th>P&amp;S Rate (per 100,000 women)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2006</td>
<td>400</td>
<td>2</td>
</tr>
<tr>
<td>2007</td>
<td>450</td>
<td>2</td>
</tr>
<tr>
<td>2008</td>
<td>420</td>
<td>2</td>
</tr>
<tr>
<td>2009</td>
<td>380</td>
<td>2</td>
</tr>
<tr>
<td>2010</td>
<td>350</td>
<td>2</td>
</tr>
<tr>
<td>2011</td>
<td>320</td>
<td>2</td>
</tr>
<tr>
<td>2012</td>
<td>290</td>
<td>2</td>
</tr>
<tr>
<td>2013</td>
<td>260</td>
<td>2</td>
</tr>
<tr>
<td>2014</td>
<td>230</td>
<td>2</td>
</tr>
<tr>
<td>2015</td>
<td>200</td>
<td>2</td>
</tr>
</tbody>
</table>

* CS = Congenital syphilis; P&S = Primary and secondary syphilis.
### Syphilis: Risk Factors in MSM

- Non-white race (OR: 2.1, 95% CI: 1.1–4.4)
- Income >$30,000 per year (OR: 2.7, 95% CI: 1.4–5.2)
- Unprotected anal sex (OR: 2.6, 95% CI: 1.4 – 4.8)
- Stronger gay community affiliation (OR: 2.3, 95% CI: 1.2–4.6)
- Recent internet sex partners (OR: 2.1, 95% CI: 1.0–4.3)
- Methamphetamine use (OR: 3.2, 95% CI: 1.3–7.6)
- Methamphetamine + Sildenafil use (OR: 6.2, 95% CI: 2.6–14.9)
- HIV-positive (OR: 7.3, 95% CI: 3.5–15.4)


### Syphilis and HIV

- Approximately 20 – 60% of MSM with primary and secondary syphilis are HIV infected
- Syphilis can increase risk of HIV transmission and acquisition
  - Incident syphilis strongly associated with HIV acquisition (iPrEx) – HR 2.6 (95% CI: 1.6 – 4.4)
  - Offer HIV pre-exposure prophylaxis (PrEP) to individuals diagnosed with syphilis
- Atypical clinical manifestations and serologic responses; transient increase in HIV viral load and decline in CD4 counts
- Early manifestations of neurosyphilis (median ~9 months)

Syphilis: Screening Recommendations

- Pregnant women (1st trimester, 3rd trimester, and delivery)
  - Women who deliver stillborn infants >20 weeks gestation

- Sexually active MSM and HIV-positive patients
  - Screen at least annually, but every 3 – 6 months if high-risk (e.g. multiple sex partners, anonymous sex partners, sex partner with multiple partners, etc.)

- All at-risk (asymptomatic) non-pregnant adults and adolescents (e.g. history of incarceration, commercial sex work, highly affected races/ethnicities, men <29 y/o, living in areas with increased risk)


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Syphilis: Screening Recommendations

- Other high-risk groups (e.g. sexual contacts of patients diagnosed with early syphilis, patients diagnosed with chlamydia and gonorrhea)

- Inmates at correctional facilities (depending on local prevalence of infectious early syphilis)

# Syphilis: Manifestations

<table>
<thead>
<tr>
<th>Infection</th>
<th>~30% of individuals with Latent Syphilis progress to Tertiary Syphilis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Syphilis (chancre)</td>
<td></td>
</tr>
<tr>
<td>Secondary Syphilis (rash, lymphadenopathy, etc.)</td>
<td></td>
</tr>
<tr>
<td>Latent Syphilis</td>
<td></td>
</tr>
<tr>
<td>Early Latent Syphilis (&lt;1 year duration)</td>
<td></td>
</tr>
<tr>
<td>Late Latent Syphilis (&gt;1 year duration)</td>
<td></td>
</tr>
<tr>
<td>Tertiary Syphilis</td>
<td></td>
</tr>
<tr>
<td>Benign gummatous syphilis</td>
<td></td>
</tr>
<tr>
<td>Cardiovascular syphilis</td>
<td></td>
</tr>
</tbody>
</table>

LaFond RE, Lukehart SA. Clin Micro Rev 2006

# Neurosyphilis

- Can occur at any stage!
- CNS invasion occurs early in the course of infection (30 – 100%; clearance in ~80%)
- Early Neurosyphilis
  - Asymptomatic (14 – 20% within 1\textsuperscript{st} year)
  - Early meningeal syphilis (1 – 6% within 1\textsuperscript{st} year)
  - Meningovascular syphilis (3 – 15% between 5 – 12 years)
- Late Neurosyphilis
  - General Paresis (5% within 15 – 20 years)
  - Tabes Dorsalis (3 – 9% within 20 – 25 years)

Ghanem KG. CNS Neurosci Ther. 2010
Primary Syphilis

Secondary Syphilis

http://phil.cdc.gov/phil/home.asp

Secondary Syphilis with Ocular Manifestations

Tertiary Syphilis

http://phil.cdc.gov/phil/home.asp
**Syphilis: Diagnosis**

- Direct detection from tissue
  - Dark-field microscopy
  - Polymerase chain reaction (PCR)
- Non-treponemal tests*
  - Rapid Plasma Reagin (RPR)
  - Venereal Disease Research Laboratory (VDRL)
- Treponemal tests*
  - *T. pallidum* particle agglutination assay (TPPA)
  - Fluorescent treponemal antibody absorbed test (FTA-ABS)
  - Enzyme immunoassays (EIA), chemiluminescence immunoassays (CIA), and microbead immunoassays (MBIA)

*Traditional and Reverse Sequence screening algorithms

Workowski KA, et al. MMWR 2015; CDC MMWR 2011; https://www.cdc.gov/std/syphilis/syphilis-webinar.htm*

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**Syphilis: Treatment**

- Primary, Secondary, and Early Latent Syphilis
  - Benzathine PCN-G 2.4 MU IM x 1
  - Doxycycline 100 mg PO BID x 14 days (PCN allergy)
- Late Latent Syphilis
  - Benzathine PCN-G 2.4 MU IM Q weekly x 3
  - Doxycycline 100 mg PO BID x 28 days (PCN allergy)
- Tertiary Syphilis (Benign Gummatous and Cardiovascular*)
  - Benzathine PCN-G 2.4 MU IM Q weekly x 3 (if CSF exam is normal)
- Neurosyphilis (All forms)
  - Aqueous Crystalline PCN-G 18–24 MU IV QD x 10–14 days
  - Procaine PCN-G 2.4 MU IM QD + Probenecid 500 mg PO QID x 10–14 days

*Some may treat as neurosyphilis

Workowski KA, et al. MMWR 2015
**Syphilis: Post-Treatment Follow-up**

- **Primary and Secondary Syphilis**
  - HIV negative → RPR at 6 and 12 months
  - HIV positive → RPR at 3, 6, 9, 12, and 24 months
  - ≥4-fold decline in RPR titer by 6 – 12 months
- **Latent Syphilis**
  - HIV negative → RPR at 6, 12, and 24 months
  - HIV positive → RPR at 6, 12, 18, and 24 months
  - ≥4-fold decline in RPR titer by 12 – 24 months
- **Neurosyphilis**
  - If CSF pleocytosis present, repeat CSF every 6 months until normal
  - Decline in CSF WBC by 6 months
  - Normal CSF WBC and protein at 2 years
  - Normalization of CSF protein and VDRL is much slower

*Lack of 4-fold decline in RPR by 12 months (~15 – 20%)


**Syphilis: Need for Lumbar Puncture**

- **Patients with manifestations of TERTIARY SYPHILIS**
- **Patients with NEUROLOGIC SYMPTOMS**
  - Cognitive dysfunction, motor/sensory deficits, ophthalmic/auditory symptoms, cranial nerve palsies, symptoms of meningitis, stroke, etc.
- **Patients with SUSPECTED TREATMENT FAILURE**
  - Recurrence and persistence of signs and symptoms
  - Sustained (>2 weeks) ≥4-fold increase in RPR after treatment
  - *PS and SS → Lack of ≥4-fold decline in RPR (6 – 12 months in HIV negative and 12 – 24 months in HIV positive individuals)*
  - *LS → Lack of ≥4-fold decline in RPR (if ≥1:32) (12 – 24 months in HIV negative and after 24 months in HIV positive individuals)*

*Primary Syphilis (PS), Secondary Syphilis (SS), Latent Syphilis (LS)

## Syphilis: Sex Partner(s) Follow-up

- **Notification and screening**
  - Primary Syphilis → Last 90 days + Symptom duration
  - Secondary Syphilis → Last 6 months + Symptom duration
  - Early Latent Syphilis → Last 12 months

- **Presumptive treatment**
  - All SP exposed <90 days before diagnosis of Early Syphilis
  - All SP exposed >90 days before diagnosis of Early Syphilis if screening results not available or follow-up is questionable
  - SP of patients diagnosed with Late Latent Syphilis with RPR ≥1:32, manage as contact to Early Syphilis

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Workowski KA, et al. MMWR 2015

## Expedited Partner Therapy (EPT)
Expedited Partner Therapy (EPT)

- Also known as Patient Delivered Partner Therapy (PDPT)
- Associated with reduction in both chlamydia (20%) and gonorrhea (50%) prevalence at follow-up
- Potential role in management of trichomoniasis
- No role in management of syphilis
- Most data from heterosexual men and women
  - Limited data among MSM (NOT routinely recommended)
- Legal status of EPT in U.S. → permissible (38 states), potentially allowable (8 states), and prohibited (4 states)


EPT: Ohio Bill Summary

VENEREAL DISEASES PRESCRIPTION AUTHORITY – “Regarding the authority to prescribe without examination a drug for a sexual partner of a patient diagnosed with chlamydia, gonorrhea, or trichomoniasis.”

- Authorizes a physician, APRN, or PA to prescribe or personally furnish a drug for up to two sexual partners of a patient without examining the sexual partner
- Authorizes pharmacist to dispense the prescription
- Grants immunity from civil liability for those acting in good faith

House Bill 124, 131st General Assembly, Ohio
When is EPT appropriate?

- Recipient is a sexual partner of the prescriber's patient
- Patient has been diagnosed with chlamydia and gonorrhea
- Patient reports that the sexual partner(s) is unable or unlikely to be evaluated or treated by a health professional
- Administering appropriately packaged medications is preferred over a written prescription
- Must include treatment instructions, medication warnings (e.g. pregnancy, allergies, etc.), health counseling, and instructions to seek evaluation for STI symptoms (e.g. PID)

Workowski KA, et al. MMWR 2015

Issuing an EPT Prescription in Ohio

- If known, must include the sexual partner's name and address
- If unable to obtain the partner's name and address, then patient's name and address along with the words "expedited partner therapy" or the letters "EPT “
- Includes a written, electronic, or verbal orders

House Bill 124, 131st General Assembly, Ohio
Take Home Points

- Chlamydia, gonorrhea, and syphilis cases are on the rise
  - Adolescents, young adults, MSM, and ethnic minorities
  - Monitor for early neurological complications of syphilis (e.g. ocular involvement)
  - All 3 are associated with incident HIV (must screen for HIV!)
- Important to identify risk factors, screen appropriately, and treat promptly
- Screening and treatment of sex partners is important to prevent re-infection
- EPT is legal in most states, including Ohio
  - Additional tool for management of sex partners of patients diagnosed with chlamydia and gonorrhea