

## 2020 STI Guideline update

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### Disclosures

- ▶ None
- ▶ All off-label prescribing or non-FDA testing recommendations will be noted as such

### Objectives

- ▶ Distinguish relevant updates to epidemiology, diagnosis, and treatment for bacterial, viral, and other STDs.
- ▶ Highlight areas where changing STD epidemiology should effect clinical decision making and treatment choices.
- ▶ Discuss how to use the 2020 CDC STI Treatment Guidelines to identify, treat, manage and prevent the most prevalent STIs in the United States.

### CDC 2020 STI Treatment guidelines

Scheduled release Summer 2020

COVID!!

### Disclaimer


This presentation includes a "sneak-peak" into expected changes, but should not be taken as a substitute for the actual guideline release

### No more STD Guidelines

- ▶ Now, "CDC STI Treatment Guidelines"
  - ▶ Solidifies move away from stigmatizing word "disease"

### Adolescents

- ▶ Females:
  - ▶ Screen all females < 25 for gonorrhea and chlamydia
    - ▶ Site specific based on reported activity: urogenital, pharyngeal and rectal
    - ▶ "Opt-out" screening vs "Opt-in"
- ▶ Males:
  - ▶ No screening recommendations save for YMSM (Booooooo!)



### Persons in Correctional Facilities

- ▶ Males:
  - ▶ < 30 years of age screened for gonorrhea/chlamydia
    - ▶ Increase of 5 years from age 25
- ▶ Females:
  - ▶ <35 years of age screened for gonorrhea/chlamydia
    - ▶ Increase of 10 years from age 25
- ▶ Consider "opt-out" language at intake

### Men Who Have Sex with Men (MSM)

- ▶ Screening:
  - ▶ At least annual screening for HIV, syphilis, gonorrhea/chlamydia
    - ▶ Q3months for persons with multiple sexual partners
    - ▶ Q3months for persons on PrEP
    - ▶ All sites, not just urogenital

### MSM Continued

- ▶ Consider adding chlamydia pharyngeal screening
  - ▶ Very low rates: 0.5-2.3%<sup>1</sup>
  - ▶ Will pick up asymptomatic gonorrhea infections
    - ▶ Prevalence 9-15%<sup>2</sup>
    - ▶ More likely to difficult to treat
    - ▶ Rarely causes exudate

1. Park J, Marcus JL, Pandolfi M, Snell A, Philip SS, Bernstein KT. Sentinel surveillance for pharyngeal chlamydia and gonorrhea among men who have sex with men-San Francisco, 2010. Sexually transmitted diseases 2012;89:460-4.

2. Sheldon R, Morris, Jeffrey D, Klausner, Susan P, Buchbinder, Sarah L, Wheeler, Beth, Koblin, Thomas, Coates, Margaret, Chesney, Grant N, Coriak. Prevalence and incidence of Pharyngeal Gonorrhea in a Longitudinal Sample of Men Who Have Sex with Men: The EXPLORE Study. Clinical Infectious Diseases. Volume 43, Issue 10, 15 November 2006, Pages 1284-1289. <https://doi.org/10.1093/cid/cil260>

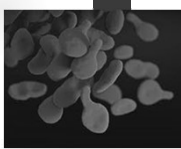
### MSM Continued

- ▶ Possible\*\* addition to PrEP regimen
  - ▶ Doxycycline for prevention of syphilis and chlamydia acquisition
  - ▶ Much more data needed, may not make this round of review

### Transgender Men and Women

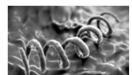
- ▶ Terminology update to include "non-binary" persons
- ▶ Discussion about lack of data on STI risk after transition surgery
  - ▶ Major issue is how to collect the best sample in new anatomy

### Mycoplasma Genitalium




- ▶ Gets its OWN section the round!!
- ▶ New, FDA approved NAAT via Roche and Hologic
  - ▶ Consider with NGU, recurrent vaginitis/cervicitis/PID
  - ▶ No screening yet recommended, diagnostic only
- ▶ Treat like BASHH guidelines:
  - ▶ Doxycycline to reduce bacterial load, then azithromycin\*\* or moxyfloxacin
  - ▶ \*\*Emerging resistance to azithromycin \*British Association for Sexual Health and HIV

### Syphilis



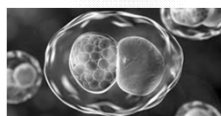
- ▶ New terms: "serofast" vs "serological non-response"
- ▶ Eliminations:
  - ▶ CSF exams in persons with isolated ocular symptoms and confirmed ocular findings on exam
  - ▶ Follow-up CSF exam at 6 months in HIV uninfected OR HIV well controlled persons IF appropriate serological response
  - ▶ CSF exams in persons with isolated otic symptoms

### Syphilis Continued



- ▶ Pregnancy
  - ▶ No ceftriaxone in pregnancy
    - ▶ Attractive because of less frequent dosing, but not as effective.
    - ▶ Penicillin continues to be the best choice
  - ▶ Stronger language re 4-fold decrease by time of delivery
    - ▶ Only 38% of women achieve this without clear increased risk in neonate
  - ▶ Reverse sequence algorithm: +FTA or TPPA, - RPR
  - ▶ Infant get prophylaxis

### Chlamydia

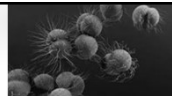


- ▶ Problems with azithromycin
  - ▶ Does not reliably cure rectal chlamydia
    - ▶ Doxycycline better, moved back to "recommended " box
  - ▶ Azithromycin will likely remain for:
    - ▶ Persons with adherence issues
    - ▶ Pregnant women
    - ▶ Short-stay correctional settings

### Chlamydia Continued

- ▶ Point of care testing coming soon!!
  - ▶ GeneXpert, 90 minute turn around
  - ▶ Others in development
- ▶ In children (defined as pre-pubertal) NAAT testing strongly encouraged over culture, even though not FDA approved.
  - ▶ Likely will need a secondary confirmatory test
  - ▶ Azithromycin recommended over erythromycin

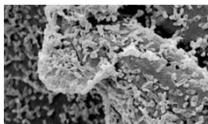
### Gonorrhea



- ▶ Perilously close to losing azithromycin as dual therapy
  - ▶ Increasing MIC, no longer reliable
  - ▶ SINUS INFECTIONS! COVID!
  - ▶ Ceftriaxone only outpatient regimen left ☹
    - ▶ May increase to 500 mg for all infections, all sites
- ▶ Debate about stopping erythromycin ointment for all newborns
  - ▶ Several countries have already stopped (Canada, UK, Australia, others in Europe)

### Bacterial Vaginosis

- ▶ Secnidazole new option
  - ▶ Either 1G or 2G options- 2G option more efficacious
- ▶ Language re alcohol and metronidazole to be changed
  - ▶ Possibly removed



### Trichomoniasis

- ▶ More treatment failures with 2G bolus dose of metronidazole
  - ▶ 500 mg PO BID x 7 days may become preferred regimen



### Vulvovaginal Candidiasis

- ▶ Significant resistance to fluconazole
  - ▶ Topical azoles should be pushed and used first line
  - ▶ Will likely not be a change this round, but consider for 2024-2025

