

Section II: Screening, Specimen Collection & Treatment

FEMALE SELECTIVE SCREENING CRITERIA

It is neither economically feasible, nor cost effective, to screen all females. Furthermore, as the prevalence of disease decreases in a population, the likelihood of a false positive result increases. When screening low-risk women in a lower prevalence population, the risk of false positive results may become unacceptably high. "If the prevalence of disease is low, even a highly valid test will yield a low predictive value (of a positive test)." [1] Therefore, selective screening criteria are used to identify the highest risk population in the project's family planning clinics and other (non-STD) clinics. These criteria were developed using published studies, data from clinics in the Region X IPP and from the CDC Screening Criteria published in Treatment of Sexually Transmitted Diseases Treatment Guidelines, Morbidity and Mortality Weekly Report (MMWR), August 2006; and Recommendations for the Prevention and Management of Chlamydia trachomatis Infections, MMWR 1993;42 (No. RR-12).

In January 2002, female selective screening criteria were simplified in all sites except some STD clinics. Because of the presumption of exposure and higher positivity for most clients seen in STD clinics, universal screening of women continues in those settings. Due to restrictions on federal funding, the Region X IPP does not cover widespread screening and treatment services for males unless they are partners of infected women. Some project areas are able to use state or local funds to screen males in STD clinics or other sites. Even when funds other than Region X IPP are used for screening, data collected may be used to enhance the Region X IPP, state and local data sets.

[1] Mausner, JS and Kramer, S, eds. Epidemiology: An introductory text. WB Saunders Co: Philadelphia; 1985,pp.222-3

FEMALE SELECTIVE SCREENING CRITERIA IN FAMILY PLANNING & EXPANSION SITES

1. Women 24 and under should be tested at least annually.*
2. All women 25 and older who meet one of the following criteria should be screened:
 - a) Cervical findings consistent with cervicitis (mucopurulence, friable cervix, or ectopy with inflammation or edema)
 - b) Pelvic inflammatory disease (PID)
 - c) Exposed to *C. trachomatis* (in last 60 days)
 - d) Exposed to *N. gonorrhoeae* (in last 60 days)
 - e) Symptomatic sex partner (in past 60 days)
 - f) Pregnant
 - g) IUD insertion
 - h) Prior chlamydial infection within the past 12 months

**FOR ADDITIONAL SPECIFIC INFORMATION, MMWR AUGUST
2006;55 WWW.CDC.GOV/STD/TREATMENT**

*CDC recommends that all women 25 and younger be screened using the listed criteria. Each state in Region X makes its own decision, depending on local data, resources, etc.

SYMPTOMS DIAGNOSTIC OF CERVICITIS – TESTING REQUIRED

Cervicitis

Cervicitis is a clinical syndrome, not diagnostic of Chlamydia or any other specific infection. Thus, cervicitis is an indication to test for chlamydial infection.

Criteria for diagnosis of cervicitis:

- Mucopurulent secretion from the cervical os (not vagina)—greenish or yellow discharge (positive Q-tip test) from the cervical os in absence of vaginal infection or foreign body such as an IUD.
- Cervical friability—easily induced bleeding on the ectocervix or from the canal characterized by bleeding due to increased vascularity of the area.

With a physical examination consistent with cervicitis, empiric treatment for Chlamydia should generally be given without waiting for Chlamydia test results.

See the most recent of the CDC MMWR STD Treatment Guidelines for treatment recommendations.

SYMPTOMS DIAGNOSTIC OF PID – TREATMENT REQUIRED

Pelvic inflammatory disease (PID)

PID comprises a spectrum of inflammatory disorders of the upper genital tract among women and may include any combination of endometritis, salpingitis, tubo-ovarian abscess, and pelvic peritonitis.

Minimum criteria for initiation of treatment in young, sexually active women include the following:

- Perform pregnancy test to RULE OUT pregnancy.
- RULE OUT other causes e.g., appendicitis.
- Uterine or adnexal or cervical motion tenderness—moderate to severe pain elicited when cervix is manipulated or palpated.

Additional criteria supportive of PID diagnosis:

- Client history of recent onset of pelvic pain or dyspareunia
- Presence of WBCs on wet mount
- Abnormal mucopurulent cervical or vaginal discharge.
- Intermenstrual bleeding or post-coital bleeding.
- Laboratory confirmation of cervical infection with gonorrhea or Chlamydia
- Fever >101°F, tachycardia
- Elevated erythrocyte sedimentation rate
- Elevated C-reactive protein

FOR MORE SPECIFIC CRITERIA, PLEASE REFER TO *MMWR* AUGUST 2006;55, WWW.CDC.GOV/STD/TREATMENT.

SPECIMEN COLLECTION

The sensitivity of all types of *C. trachomatis* tests is dramatically influenced by the quantity of columnar epithelial cells. The greater the number of cells collected, the more likely a chlamydial infection will be detected. Careful and thorough specimen collection will increase the accuracy of patient test results. Additional information on specific laboratory tests is available under the laboratory tab in this manual. A video for clinicians, “Specimen Collection for CT: Cervix and Male Urethra” is available through each state’s IPP Coordinator or Family Planning Nurse Consultant.

Collection of cervical specimen from the female

- Collect other specimens first
- Clean excess discharge from ectocervix
- Always use sterile swab recommended by manufacturer
- Insert appropriate swab into endocervix until most of tip is not visible
- Rotate swab with firm pressure for at least 15 seconds (rotation time varies depending on type of specimen collection or test kit used)
- Carefully remove swab from vagina to avoid contamination
- Place swab in transport tube or bottle provided
- Break off shaft of swab (raise swab well off the bottom of tube or bottle before snapping shaft)
- Cap tube or bottle tightly

NOTE: SPECIFIC INSTRUCTIONS MAY VARY ACCORDING TO TEST MANUFACTURER’S INSTRUCTIONS.

Collection of urethral specimen from the male

- Collect other specimens first
- Insert a sterile swab recommended by manufacturer into the urethra
- Insert the swab a minimum of 2.5 cm or 1 inch
- Rotate at least 2 complete revolutions for 5 seconds

Urine specimen collection (male and female)

- Instructions to client:
 - Do not void for at least one, preferably four hours before giving specimen
 - DO NOT cleanse perineum/urethral meatus as for “clean catch” specimens.
 - Catch urine from beginning of the urine stream, not mid-stream.
 - Collect **only** the first 20-30 ml voided. (Clients will need to be specifically told or shown how full the cup should be when 20-30 ml has been collected)
 - Clinic staff must complete this transfer of urine for transport before using the remainder of urine for any other test.

Remaining urine may then be utilized for other tests not requiring a clean catch specimen e.g. pregnancy test.

Vaginal Specimen Collection (female)

Vaginal specimen testing kits is another testing option available for female clients, which can be used either by the clinician or the client to self collect in the clinic.

Vaginal Specimen Collection kits may not be available in all Region X clinics.

This option can be utilized in several clinical presentations, such as in women:

- without a cervix
- returning to the clinic for follow up testing who are asymptomatic
- not requiring a pelvic exam, but need to be tested

Patient self collections should not be used in clients if:

- a pregnancy is suspected
- a client clinically presents/reports vaginal discharge with or without pelvic pain

NOTE: These instructions are generally useful for either clinician-collected or client-collected specimens. Specific instructions may vary according to test manufacturer's instructions.

- Partially peel open the swab package taking care not to touch the swab tip
- Remove the swab from the package, holding it at about mid-shaft.
- Carefully insert the swab into the vagina about two inches past the introitus and gently rotate the swab for 10-30 seconds. Make sure the swab maintains contact with the vaginal wall.
- Withdraw the swab without touching the skin to avoid contamination.
- Place swab in transport tube or bottle provided.

- Break off shaft of swab (raise swab well off the bottom of tube or bottle before snapping shaft).
- Cap tube or bottle tightly.

(See Appendices section for a sample of client self collection instructions, available in English & Spanish.)

Specimen identification

Each transport tube or bottle label must identify, at a minimum, the client's name and date specimen was collected.

Special circumstances

Women without a cervix

- Use urine sample for amplified test
- Preferred method of examination and specimen collection is use of anoscope to swab for culture.
- DFA is the nonculture test approved for rectal specimens. There is a risk of false positive result due to cross reactivity with fecal flora.

Oral infection – Ordinarily pharyngeal testing is not recommended.

TREATMENT OF UNCOMPLICATED CHLAMYDIAL INFECTION

Treatment for PID is different than for *uncomplicated* chlamydial infection. Refer to the following section on PID treatment.

Definitive diagnosis of chlamydial infection is by a positive test for *C. trachomatis*.

Presumptive diagnosis treatment criteria for females

Clients presumed to have chlamydial infection may be treated prior to receiving test result using the following criteria:

- History of recent sexual partner with confirmed *C. trachomatis* or *N. gonorrhoeae*
- Confirmed gonorrheal infection
- Symptomatic partner
- Physical exam consistent with cervicitis
 - Mucopurulent secretion from the cervical os (not vagina)—greenish or yellow discharge (positive Q-tip test) from the cervical os in absence of vaginal infection or foreign body such as an IUD.
 - Cervical friability—easily induced bleeding on the ectocervix or from the canal, characterized by bleeding due to increased vascularity of the area.

Treatment for presumed or confirmed positive *C. trachomatis* in a non-pregnant female or any male is:

Treatment of choice (**Note:** *both* are equally effective in reasonably compliant clients)

- Doxycycline 100 mg orally 2 times a day for 7 days

–OR–

- **Azithromycin 1 gm orally in a single dose

**** AZITHROMYCIN MAY BE MORE COSTLY THAN DOXYCYCLINE, THUS PROHIBITING ITS USE FOR ALL CLIENTS. PLEASE REVIEW CRITERIA REGARDING USE OF PROJECT-PURCHASED MEDICATION.**

Alternative regimens

- Erythromycin base 500 mg orally 4 times a day for 7 days

–OR–

- Erythromycin ethylsuccinate 800 mg orally 4 times a day for 7 days

–OR–

- Ofloxacin 300 mg orally 2 times a day for 7 days

–OR–

- Levofloxacin 500 mg orally once a day for 7 days

General medication/treatment instructions

- Azithromycin
 - Single dose treatment should be directly observed
 - Tablets and sachet can be taken with food
 - Capsules must be taken on an empty stomach
 - Emphasize sexual abstinence for 7 days after treatment as it takes several days to kill all the organisms.
 - Stress the importance of partner treatment
- Doxycycline
 - Emphasize importance of taking entire supply on twice-daily schedule
 - Take with plenty of water
 - Avoid sunlight during treatment week or use sunscreen of SPF 30 or greater
 - Can be taken with food, avoid antacids
 - Emphasize sexual abstinence during treatment week
 - Stress the importance of partner treatment

Test of cure (TOC)

- Doxycycline or azithromycin-resistant Chlamydia has not yet developed, so clients do not need to be retested after completing treatment with doxycycline or azithromycin.
- Indications for TOC are:
 - Persistent symptoms
 - Client is pregnant
 - Reinfection is suspected
 - Client was noncompliant with doxycycline treatment.
- Post treatment TOCs are not routinely covered through the project. TOCs should not be done in any case less than 4 weeks after initiation of treatment because:
 - Culture may be false negative due to low number of organisms.
 - Amplified DNA tests may be false positive due to continued excretion of dead organisms.

Treatment Options for Pregnant Women

Recommended regimen

- Azithromycin 1 gm orally in a single dose
- OR-
- Amoxicillin 500 mg orally 3 times a day for 7 days.

Alternative regimens

- Erythromycin base 500 mg orally 4 times a day for 7 days
- OR-
- Erythromycin base 250 mg orally 4 times a day for 14 days
- OR-
- Erythromycin ethylsuccinate 800 mg orally 4 times a day for 7 days
- OR-
- Erythromycin ethylsuccinate 400 mg orally 4 times a day for 14 days

Test of cure (TOC) or rescreening pregnant women

The project will cover a test of treatment efficacy for pregnant women. This should be done no sooner than 4 weeks after initiation of treatment. A retest is recommended in the last 6 weeks of pregnancy.

NOTE: AT THIS TIME, AZITHROMYCIN, ERYTHROMYCIN BASE, ERYTHROMYCIN ETHYLSUCCINATE, AND AMOXICILLIN ARE ALL CLASSIFIED AS CATEGORY B DRUGS FOR USE DURING PREGNANCY.

Treatment Options for Women Who are Breastfeeding

Recommended regimen:

- Azithromycin 1 gm orally in a single dose

Alternative regimen:

- Erythromycin base 500 mg orally 4 times a day for 7 days

-OR-

- Erythromycin base 250 mg orally 4 times a day for 14 days

-OR-

- Erythromycin ethylsuccinate 800 mg orally 4 times a day for 7 days

-OR-

- Erythromycin ethylsuccinate 400 mg orally 4 times a day for 14 days

-OR-

- Amoxicillin 500 mg orally 3 times a day for 7 days

**FDA AND AAP (AMERICAN ACADEMY OF PEDIATRICS) ASSIGNED
USE LACTATION RISK CATEGORY**

AZITHROMYCIN: RATED BY FDA AS: L2

**ERYTHROMYCIN AND AMOXICILLIN: RATED BY AAP AS: L1 AND
BY THE FDA AS: CATEGORY B**

DEFINITIONS:

L1 SAFEST: DRUG WHICH HAS BEEN TAKEN BY A LARGE NUMBER OF BREASTFEEDING MOTHERS WITHOUT ANY OBSERVED INCREASE IN ADVERSE EFFECTS IN THE INFANT. CONTROLLED STUDIES IN BREASTFEEDING WOMEN FAIL TO DEMONSTRATE A RISK TO THE INFANT AND THE POSSIBILITY OF HARM TO THE BREASTFEEDING INFANT IS REMOTE; OR THE PRODUCT IS NOT ORALLY BIOAVAILABLE IN AN INFANT.

L2 SAFER: DRUG WHICH HAS BEEN STUDIED IN A LIMITED NUMBER OF BREASTFEEDING WOMEN WITHOUT AN INCREASE IN ADVERSE EFFECTS IN THE INFANT. AND/OR, THE EVIDENCE OF A DEMONSTRATED RISK WHICH IS LIKELY TO FOLLOW USE OF THE MEDICATION IN A BREASTFEEDING WOMAN IS REMOTE.

(TW HALE (2002) *MEDICATIONS AND MOTHER'S MILK*, 10TH ED.. PHARMASOFT MEDICAL PUBLISHING, AMARILLO TX)

DEFINITION CATEGORY B: ANIMAL STUDIES HAVE FAILED TO SHOW A RISK TO THE FETUS, BUT THERE ARE NO ADEQUATE STUDIES IN PREGNANT WOMEN; OR ANIMAL STUDIES HAVE SHOW NO ADVERSE EFFECT BUT HUMAN STUDIES HAVE NOT SHOWN A RISK TO THE FETUS IN THE FIRST TRIMESTER AND THERE IS NO EVIDENCE OF RISK IN LATER TRIMESTERS.

(*NURSE PRACTITIONERS PRESCRIBING REFERENCE*, SPRING 2007. HAYMARKET MEDIA, NYC)

Recommended criteria for selection of azithromycin as treatment medication

- Azithromycin is an effective antibiotic against chlamydial infection. Clinical trials have shown azithromycin and doxycycline to be equally efficacious (about 95%) when properly used by a reasonably compliant client. While azithromycin has the compliance advantage of single dosing, it is more expensive than a comparable treatment regimen of doxycycline. Each state in the Region X Infertility Prevention Project makes its own decision regarding the medications to be provided based on budgetary constraints. It may not be possible to provide azithromycin for general use. Where a shortage exists, priority for treatment with azithromycin should be given to the following clients who have had positive test results:
 - those who probably won't take the meds consistently for seven days
 - pregnant women
 - clients with repeat infections (2 or more in 6 months)
 - clients who are doxycycline intolerant
 - developmentally disabled clients
 - teenagers

PID Treatment options

PID comprises a spectrum of inflammatory disorders of the upper genital tract among women and may include any combination of endometritis, salpingitis, tubo-ovarian abscess, and pelvic peritonitis. No single therapeutic regimen has been established for persons with PID. PID therapy must provide empiric, broad-spectrum coverage of likely pathogens. Antimicrobial coverage should include *N. gonorrhoeae*, *C. trachomatis*, gram-negative facultative bacteria, anaerobes, and streptococci. Treatment options described here are for outpatient treatment only.

Consider physician consultation or referral, hospitalization, or IV antibiotics for patients who:

- are pregnant
- are not responsive to out-patient regimens within 72 hours
- have a pelvic mass on examination
- have high fever (>38°C or 101°F)
- have active nausea and vomiting or otherwise unable to tolerate oral medications
- surgical emergency, e.g., appendicitis, cannot be excluded

Options for outpatient treatment of PID

CAUTION: AZITHROMYCIN IN A SINGLE ORAL DOSE IS NOT INDICATED FOR TREATMENT OF PID.

The following regimen provides coverage against the common etiologic agents of PID. Patients who do not respond to outpatient therapy within 72 hours should have the PID diagnosis confirmed and be considered for parenteral therapy.

- Treatment of choice
 - Ceftriaxone 250 mg IM – *PLUS*
Doxycycline 100 mg orally 2 times a day for 14 days
 - OR –
 - Cefoxitin 2 g IM, concurrently with probenecid 1 g orally in a single dose
 - OR –

Other parenteral third-generation **cephalosporin** e.g., **ceftizoxime** or **cefotaxime**

– PLUS –

Doxycycline 100 mg orally 2 times a day for 14 days

“CDC announced that fluoroquinolones are no longer recommended for the treatment of gonorrhea in the United States. This recommendation was based on analysis of new data from CDC’s Gonococcal Isolate Surveillance Project (GISP), a sentinel surveillance system that monitors trends in antimicrobial susceptibilities of strains of *N. gonorrhoeae* in the U.S. The data on which the recommendation is based were published in this week’s MMWR www.cdc.gov/mmwr/ and show that in the first half of 2006 among heterosexual men, the proportion of gonorrhea cases that were fluoroquinolone-resistant (QRNG) reached 6.7%, an 11-fold increase from 0.6% in 2001. CDC has recommended oral fluoroquinolones (ciprofloxacin, ofloxacin and levofloxacin) as

firstline treatments for gonorrhea since 1993, but over the past several years, as QRNG cases increased steadily, CDC advised that they were not recommended for treating gonorrhea, first in Hawaii (2000), then California (2002), and, most recently, in men who have sex with men nationwide (2004). Recommended options for treating gonorrhea are now limited to a single class of antibiotics, cephalosporins. Within this class, CDC recommends ceftriaxone, available only as an injection, as the preferred treatment for all types of gonorrhea infection (genital, anal and pharyngeal). Recommendations are attached; more details are available at www.cdc.gov/std/treatment/.” *Dear Colleague Letter April 14, 2007* by Dr. John Douglas, MD, Director, Division of STD Prevention

NOTE: MANY EXPERTS RECOMMEND ADDING METRONIDAZOLE 500 MG ORALLY 2 TIMES A DAY FOR 14 DAYS TO EITHER OF THE ABOVE REGIMENS FOR BETTER COVERAGE OF ANAEROBES OR WHEN BACTERIAL VAGINOSIS (BV) IS PRESENT.

Alternative Regimen in extenuating circumstances only:

If parenteral cephalosporin therapy is not feasible, use of fluoroquinolones may be considered if the community prevalence and individual risk of gonorrhea is low.

Testing for gonorrhea must be performed prior to instituting therapy.

Manage the patient as follows:

- If NAAT test is positive, parenteral cephalosporin is recommended.
- If culture for gonorrhea is positive, treatment should be based on results of antimicrobial susceptibility. If isolate is QRNG, or susceptibility can not be assessed, parenteral cephalosporin is recommended.

Alternative Dosing:

- Ofloxacin 400 mg orally 2 times a day for 14 days
- OR –
- Levofloxacin 500 mg orally once a day for 14 days
- PLUS –
- Metronidazole 500 mg orally 2 times a day for 14 days

See “Gonococcal Infections in Adolescents and Adults” in CDC Sexually Transmitted Disease Treatment Guidelines, 2006 for additional detail.

- NSAIDs PRN for pain. Some evidence suggests a reduction in inflammation and scarring with NSAID use.
- No intercourse throughout treatment
- Emergency or urgent care instructions

- Monitor temperature twice a day for two days
- Increased rest
- Push fluids by mouth
- All patients treated for PID must receive re-examination 48-72 hours after treatment is initiated or receive telephone call follow up

Follow up of treated clients

- Clients must receive complete education (see Chlamydia Counseling/Education Protocol).

Contact/partner notification and treatment

- Clients must be educated about the importance of partner notification and treatment (See Chlamydia Counseling/Education Protocol.)
- Sex partners exposed within 60 days of diagnosis for chlamydial infections should be promptly examined for STD, if possible, and treated with one of the regimens described above.

CASE REPORTING OF POSITIVE LABORATORY RESULTS

Clinical providers in each state are required by law to report chlamydia cases to public health authorities. Reporting procedures and case reporting forms are available from the states' STD programs. These procedures vary from state to state. It is important to follow your state's procedures. Report laboratory confirmed cases only, i.e. not presumptively treated cases.

PARTNER NOTIFICATION, EXAMINATION, AND TREATMENT

One of the goals of the Region X IPP is to promote closer working relationships between family planning and STD clinics. Partner notification is an area where collaboration should occur. STD services field staff could assist family planning staff in providing contact tracing for clients with a positive *C. trachomatis* test since most family planning clinics do not have any field staff. While resources may be limited in some areas, there should be an effort to reach high priority patients. Family planning providers are strongly encouraged to seek out assistance as needed.

The purpose of partner notification is to ensure that sexual partners exposed to a client with a diagnosis of chlamydia (by a positive *C. trachomatis* test or a *C. trachomatis*-related syndrome, i.e., MPC, PID, NGU, epididymitis) are examined and tested for *C. trachomatis*. They should also be tested for other STDs and offered HIV counseling and testing services if indicated by risk assessment. In addition, sexual partners should be presumptively treated at the time of their initial visit with one of the regimens for uncomplicated chlamydial infection.

CDC has set standards for the management of sex partners of individuals with diagnosed chlamydia. These are summarized in the 2006 Sexually Transmitted Disease Treatment Guidelines. The standards include:

Refer All Sex Partners Within past 60 Days or Most Recent Sex Partner if Over 60 Days

- Two methods of partner notification are provider referral and patient self-referral. Only where there is staff available for conducting the referral process can provider referral be accomplished. All *C. trachomatis* positive clients should be told to have their partners evaluated and treated. Clinics are strongly encouraged to establish systems whereby follow-up for partner treatment is tracked.
- Not only should sex partners of known *C. trachomatis* positive clients be referred, but any woman diagnosed with PID should be told to refer her partner(s) for evaluation and treatment. A woman, whose sex partner is not treated, is at continued high risk for persistent or recurrent infection.

Evaluate and Treat All Sex Partners

- No person with chlamydia can be considered adequately treated until their sex partner(s) is also treated. Prevention of re-infection is critical to reducing the serious long term consequences of chlamydia, e.g., chronic pelvic pain, PID, infertility and ectopic pregnancy.
- Clinics participating in the Region X IPP must provide for partner evaluation and treatment of *C. trachomatis* positive clients. If such evaluation and treatment is not provided on site, the clinic must provide the client and any partners a referral and information to locations where evaluation and treatment will be provided.
- Examination and testing of a male partner of a *C. trachomatis* positive female is strongly encouraged. Treatment of male partners without examination is preferable to no treatment.
- Client delivered partner treatment is recommended when sex partners will not

seek evaluation and/or treatment. EPT (Expedited Partner Treatment) is allowed in some states. It should not be offered to MSM clients and their partners, and pregnant partners.

Instruct Clients to Abstain from Sex Until They and Their Partners are Cured

- All parties should be instructed to abstain from sex until all concerned have completed the full course of medication and any symptoms have subsided. Patients and their partners should also be counseled to complete the full course of medication, regardless of whether they have symptoms. Inadequate treatment may result in continuation of the infection. When a single dose treatment (azithromycin) is used advise client to abstain for 7 days after both partners have been treated because the medication is actually working to kill bacteria for 5 to 7 days after the single dose. If using a 7 day treatment regimen clients should abstain 7 days after completing treatment.
- If a client cannot negotiate abstinence, explore the problem and help the client consider alternative behaviors with his/her partner:
 - Mutual masturbation
 - Vaginal sex with condom
 - Oral sex with protection

Contact/Partner Notification and Treatment

- Clients must be educated about the importance of partner notification and treatment (See Chlamydia Counseling/Education Protocol.)
- Sex partners exposed within 60 days, or most recent sex partner if greater than 60 days, of diagnosis for chlamydial infections should be promptly examined for STD and treated with one of the regimens described above.
- Expedited Partner Therap: referrals, client delivered partner treatment recommended.

Reporting

- Fill out and submit a Sexually Transmitted Disease Confidential Case Report and other forms as required by your state program.

RESCREENING WOMEN WITH POSITIVE CHLAMYDIA TESTS

NOTE: THE FOLLOWING POLICY AND PROCEDURES ON RESCREENING ARE RELEVANT TO ONLY CERTAIN PROJECT AREAS WITHIN THE REGION X IPP. THE DECISION TO IMPLEMENT A RESCREENING POLICY IS RESOURCE-BASED. CLINICIANS ARE URGED TO ADHERE TO THEIR STATE OR PROJECT AREA POLICY TO CONSERVE PROJECT RESOURCES. A RESCREENING PROGRAM SHOULD NOT DIVERT RESOURCES FROM AN AGGRESSIVE PARTNER MANAGEMENT EFFORT. IF THERE IS ANY QUESTION REGARDING A STAFF POLICY ON RESCREENING, CLINICIANS SHOULD CALL THEIR STATE IPP REPRESENTATIVE OR THE REGIONAL PROJECT COORDINATOR.

Centers for Disease Control and Prevention (CDC) guidelines released August, 2006 discuss rescreening women treated for Chlamydial infection as a means to identify women with recurrent infection, thus preventing further adverse sequelae and interrupting disease transmission. Data show individuals with confirmed infection in the recent past are at especially high risk of reinfection. Region X IPP screening criteria already include screening individuals with infection in the past 12 months.

CDC STATEMENT ON RESCREENING

“A high prevalence of *C. trachomatis* infection is observed in women who are treated for chlamydial infection in the preceding several months. The majority of post-treatment infections result from reinfection, frequently occurring because the patient’s sex partners were not treated or because the patient resumed sex with a new partner infected with *C. trachomatis*. Repeat infections confer an elevated risk for PID and other complications when

compared with the initial infection. Therefore recently infected women are a major priority for repeat testing for *C. trachomatis*. Clinicians and health-care agencies should consider advising all women with chlamydial infection to be retested approximately 3 months after treatment. Providers also are strongly encouraged to retest all women treated for chlamydial infection whenever they next seek medical care within the following 3-12 months, regardless of whether the patient believes that her sex partners were treated. Recognizing that retesting is distinct from a test-of-cure, as discussed in this report, is vital. Limited evidence is available on the benefit of retesting for Chlamydia in men previously infected; however, some specialists suggest retesting men approximately 3 months after treatment.”

The rescreening effort is only directed at females. The effort is not yet shown to be cost-effective for males.

Rescreening women (as opposed to test-of-cure) is recommended at 3-6 months after original treatment of confirmed chlamydial infection, regardless of age, partner Rx, resumption of sex, or other risk factors.

Approaches to recalling patients

- At treatment visit, advise to return 3-6 months later for rescreening.
- Make a specific return appointment if clinic “books” that far ahead.
- Add rescreening message to client education materials and handouts.
- Send reminder letter if client has not returned by end of 4 months (if contact by mail, will not violate client confidentiality).
- Phone call reminder if client has not returned by end of 4 months (if confidentiality is not breached).
- Flag chart and/or problem list and opportunistically test whenever the patient returns to clinic for any reason (refill contraceptive Rx, immunization, etc).