

Infertility Prevention Project (IPP), Region IX
Guidance and Toolkit for the Use of Expedited Partner Therapy and
Retesting at Three Months to Prevent and Detect Chlamydia and Gonorrhea
Reinfections

Summary Recommendations

1. Partner management using Expedited Partner Therapy (EPT)

Where it is a legal to do so, providers in IPP Region IX project areas are strongly encouraged to offer EPT options for partner management to their patients diagnosed with chlamydia or gonorrhea.

While patients should be encouraged to bring their partners in to the clinic for evaluation, testing and treatment whenever possible, it is understood that this strategy for partner management is not always an option or successful. EPT, which allows for empirical partner treatment without provider evaluation, has been shown to be an effective alternative, especially when a partner is unable or unlikely to otherwise receive treatment. Patient-delivered partner therapy (PDPT), a partner management strategy where patients are given medication or a prescription to deliver to their partner(s), is the most widely-used EPT approach; however specific EPT methods and procedures may vary from site to site.

2. Retesting of patients treated for chlamydia or gonorrhea

Retesting patients optimally at 3 months after initial treatment for chlamydia or gonorrhea, or whenever they next seek care within the 3-12 months following treatment, is standard policy for all IPP project areas in Region IX. (Note: For purposes of program evaluation, Region IX IPP analyzes retest estimate data obtained from tests performed 2 through 11 months after the date of the first positive test.) In addition to counseling patients about the importance of retesting, IPP delegate agencies are strongly encouraged to choose and institute an active protocol designed to maximize their retesting rates.

IPP programs operate in a wide variety of clinical settings, and no single approach to increasing retesting rates will likely work for all programs. Choosing and instituting a retesting protocol appropriate and effective for a particular program and patient population is recommended.

Clinics should develop a comprehensive retesting protocol with active strategies that focus on three equally vital objectives:

- 1) To ensure patient's understanding about their high risk for reinfection and related complications, including infertility in women, and the importance of getting retested;
- 2) To assist patients to remember and prioritize their retesting clinic visit approximately 3 months after their initial treatment; and
- 3) To prevent missed opportunities for retesting by developing systems to remind providers to retest if patients return to the clinic for any reason anytime two months or later following the initial treatment.

Introduction

Chlamydia and gonorrhea can result in medical complications in women that lead to infertility, ectopic pregnancy and chronic pelvic pain. Reinfection following an initial chlamydia or gonorrhea infection is common, with reinfection rates often twice as high as the initial prevalence rate in the base population. Repeat infections confer an elevated risk for PID and other complications when compared with the initial infection.

The Infertility Prevention Project (IPP) was established by the Centers for Disease Control and Prevention (CDC) in 1994 with the goal of reducing the incidence of sexually transmitted diseases that can lead to infertility. As stated in the IPP Region IX Chlamydia Clinical Guidelines, interventions to achieve this goal include targeted screening and effective partner treatment. To prevent repeat infection and to reduce further transmission of infection in the community, all sexual partners in the prior 60 days must be provided timely and appropriate antibiotic treatment. In addition, routine retesting of positive patients approximately 3 months after treatment is strongly recommended, regardless of whether the patient believes that his/her sex partners were treated.

This document is intended to provide guidance for implementing policies for both expedited partner therapy (EPT) and retesting at 3 months after initial treatment for chlamydia or gonorrhea in Region IX IPP settings. The guidelines follow the CDC Dear Colleague letter of May 11, 2005¹, the CDC report *Expedited Partner Therapy in the Management of Sexually Transmitted Diseases* 2006², and the CDC 2006 STD Treatment Guidelines³. Please consult these documents for more information.

Background

Persons infected and treated for chlamydia or gonorrhea are known to be at high risk for reinfection. Numerous studies in various clinical settings, including family planning sites, have documented chlamydia reinfection rates that range from 10 to 15% at 3-6 months post-treatment⁴⁻⁶. In Region IX, estimates of reinfection vary by project area and clinic type. Reinfection rates within 1-6 months during 2006 among female patients at family planning sentinel sites ranged from 10-11% in California to 18% in Washoe County NV. In STD clinic sentinel sites, reinfection rates ranged from 16% in Los Angeles, CA for Jan-Jun 2007 to 37% in Washoe County, NV in 2006 (preliminary data, CDPH, unpublished).

Partner Management and EPT

Many reinfections occur because of re-exposure to untreated sex partners⁷. Effective clinical management of persons with laboratory-confirmed or presumptive chlamydia or gonorrhea infections (including urethritis, cervicitis and pelvic inflammatory disease) includes notification and treatment of the patient's current and recent sex partner(s).

Timely and appropriate antibiotic treatment needs to be provided to all partners who had sexual contact with the patient during the 60 days prior to onset of symptoms or diagnosis of chlamydia or gonorrhea. If the last sexual contact was over 60 days prior to the diagnosis, the most recent sexual partner should be treated. Traditionally, partner management has been accomplished by notification and referral of sex partners for medical evaluation. Partner notification and referral

to services can be carried out by the patients themselves, by the provider, or by staff of the local health jurisdiction.

EPT approaches are new options for partner management that facilitate treatment of partners by not requiring an intervening clinical assessment. Research investigating various innovative EPT methods has provided important information about the effectiveness of EPT. One EPT option is patient-delivered partner therapy (PDPT), where patients are given medication or a prescription to deliver to their partner(s) for empirical treatment. In a study of men with urethritis, PDPT reduced reinfection rates by half, from 43% to 23%, compared with patient referral⁸. In women with chlamydia, PDPT reduced reinfection rates from 15% to 12% ($p=.10$)⁷. A recent randomized trial funded by the CDC demonstrated that partner management strategies that included EPT as an option reduced reinfection with gonorrhea among heterosexual men and women by nearly 70% compared with conventional strategies⁹. Repeat gonorrhea infection was 11% in the control group and only 3% in the PDPT group ($p<.05$). Despite potential medical concerns (e.g. STD co-morbidity in partners, antimicrobial resistance, adverse drug effects) and implementation issues (e.g. legal status of EPT¹⁰, funding and privacy concerns, medication packaging), the CDC supports the use of EPT options because of increases in preventing reinfection.

A recent evaluation of family planning clinics in California compared the success of various partner management strategies in their ability to ultimately treat the male partners of chlamydia-positive female patients. Partner treatment was most likely when patients were asked to bring their partners into clinic with them for treatment. Requesting that a patient bring her partner into clinic with her so that both patient and partner could be treated at the same visit was shown to be a highly effective, and was the obvious first choice for providers who offered male services. However, this strategy for partner management was not always an option for patients and was not always successful. PDPT was more likely to result in successful partner management when a patient had a non-steady partner, and this was especially the case when the clinic could directly provide the patient with an extra dose of medication to take back to her partner (as opposed to a prescription that the partner would need to fill). Partner notification and referral, currently the most commonly-used partner management strategy in many family planning sites across the region, was shown to be the least successful in treating partners.

As many local health jurisdictions do not have the resources needed to contact the partners of all persons diagnosed with chlamydia and gonorrhea, partner notification and referral by the health department is often not an option. (CDPH, unpublished)

Retesting after Treatment

The 2006 CDC STD Treatment Guidelines recommend retesting of all women treated for chlamydia or gonorrhea at approximately 3 months following treatment so as to identify reinfections in a timely manner³. However, return rates for retesting continue to be low, despite clinicians' best efforts to educate their patients regarding the importance of getting retested. Estimates of retesting rates in Region IX vary widely by project area and clinic type. Retesting rates within 1-6 months after initial positive test for 2005-2006 in family planning sentinel sites ranged from 6.5% in AZ, 29%-45% in California, Los Angeles, and San Francisco project areas

to 46% in Washoe County, NV. Retesting rates in 2006 for STD clinic sentinel sites ranged from 9% in Washoe County, NV to 37% in San Francisco (preliminary data, CDPH, unpublished).

Certain limitations regarding retesting for chlamydia using highly sensitive tests such as nucleic acid amplification tests (NAATs) should be noted. Because these tests identify nuclear material from chlamydia organisms and not live organisms themselves, positive tests may occur up to 4 weeks following adequate treatment because of residual nuclear material present in host cells still being shed from genital tract tissues. For this reason, retesting should not be performed prior to 4 weeks post-treatment.

Various approaches have been studied or tried to ensure that patients return for retesting. Two studies found that reminder phone calls were effective in increasing clients' retesting rates^{11,12}. Use of mail-in specimens of either urine or self-collected vaginal swabs was also found to be moderately useful¹³.

Guidance for Program Planning, IPP Project Areas, Region IX

Recommendation

Partner management using Expedited Partner Therapy

Where it is a legal to do so, providers in IPP Region IX project areas are strongly encouraged to offer EPT options for partner management to their patients diagnosed with chlamydia or gonorrhea.

Implementation

Infertility prevention programs operate in a wide variety of clinical settings, and no single approach to EPT will likely work for all programs. Instead, choosing and instituting a protocol appropriate and effective for the particular program and patient population is recommended. Specific methods and procedures will vary from site to site because of factors such as differences in program operations and patient populations, the cost of the medication to the program or to the patient, and the number of positive patients the clinical site must manage. EPT procedures should be instituted with written policies and provider training. Procedures should be monitored and evaluated, allowing periodic reassessment and revision as needed.

Providers should use their best judgment when discussing partner treatment with their patients, considering factors such as the patient's report that a partner lacks insurance or a primary care provider, faces significant barriers to accessing care, or will be unwilling to seek care. Whenever feasible, patients should be encouraged to bring partners to the clinic for treatment. EPT has been shown to be particularly successful when used to treat non-steady partners. It is probably most effective to offer several partner management options to each patient, discussing them and individualizing the partner management plan on a case by case basis.

EPT options include

- Patient-delivered partner therapy (PDPT), whereby patients take medication or a prescription to their partner(s). Ideally, medication would be provided by the clinic at no cost.

- Pharmacy access programs, whereby partners can obtain medication at a participating pharmacy.
- Field-delivered therapy, whereby health department personnel deliver medication to partners.

The preferred medication to use would be administered in a single oral dose.

For chlamydia, azithromycin 1 gm is the recommended single-dose oral treatment. There is no alternate single oral dose.

For gonorrhea, cefixime 400mg is the recommended single oral dose in the 2006 CDC STD Treatment Guidelines³. Cefpodoxime 400 mg in a single dose is an alternate treatment that may be less expensive than cefixime. As of April 2007, fluoroquinolones (ciprofloxacin, ofloxacin and levofloxacin) are no longer recommended for treatment of gonococcal infection because of widespread and increasing prevalence of antimicrobial resistance to this class of medications¹⁴.

The following key information and counseling messages must be provided in written format and delivered with the medication or prescription to partner(s):

- Type of medication, contraindications because of allergy, and possible side effects
- Partners who have symptoms should seek care as soon as possible
- Partners should seek a complete STD evaluation in addition to EPT, even without symptoms
- Partners who have allergies to antibiotics or serious health problems should not take EPT, but should see a health care provider as soon as possible
- Partners should abstain from sex for at least 7 days after treatment and until 7 days after all partners have been treated, to decrease the risk of reinfection

Recommendation

Retesting of patients treated for chlamydia or gonorrhea

The retesting of patients optimally at 3 months after initial treatment for chlamydia or gonorrhea, or whenever they next seek care within the 3-12 months following treatment, is standard policy for all IPP project areas in Region IX. (Note: For purposes of program evaluation, Region IX IPP analyzes retest estimate data obtained from tests performed 2 through 11 months after the date of the first positive test.) In addition to counseling patients about the importance of retesting, IPP delegate agencies are strongly encouraged to choose and institute an active protocol designed to maximize their retesting rates.

Implementation

Infertility prevention programs operate in a wide variety of clinical settings, and no single approach to increasing retesting rates will likely work for all programs. Choosing and instituting a retesting protocol appropriate and effective for a particular program and patient population is recommended. Retesting procedures should be instituted with written policies and provider training. Procedures should be monitored and evaluated, allowing periodic reassessment and revision as needed.

Clinics should develop a comprehensive retesting protocol with active strategies that focus on three equally vital objectives:

- 1) To ensure patient’s understanding about their high risk for reinfection and related complications, including infertility in women, and the importance of getting retested;
- 2) To assist patients to remember and prioritize their retesting clinic visit approximately 3 months after their initial treatment; and
- 3) To flag CT- and GC-positive patient charts so that providers do not miss retesting opportunities if patients return to the clinic for any reason anytime two months or later following the initial treatment.

Programs are responsible for counseling any patient with chlamydia or gonorrhea at the time of initial treatment regarding the importance of retesting in 3 months. Clinic staff are also responsible for flagging these patient charts to ensure that opportunities for retesting are not missed if patients return to clinic for any reason anytime two months or later after their initial treatment. In addition, clinics are encouraged to institute a feasible follow-up system in order to assist patients in remembering to get retested at the appropriate time. For this purpose, one or more of the following methods could be employed:

- Advance appointment at the time of initial treatment, and giving patient an appointment card
- Reminder telephone calls
- Reminders by mail (self-addressed letters or postcards)
- Reminder cell-phone text messages
- Reminder e-mail notifications
- Mailed-in specimens
- Field visits for specimen collection
- Internet access to downloadable lab slips for testing at local lab sites
- An internal “tickler system”, with follow-up for patients who do not return

See the Resources Toolkit that accompanies this document for examples of materials to use in implementing a retesting protocol.

References

IPP Guidance, Region IX

Use of Expedited Partner Therapy and Retesting at Three Months to Prevent and Detect Chlamydia and Gonorrhea Reinfections

1. CDC Dear Colleague letter of May 11, 2005 <http://www.cdc.gov/STD/DearColleagueEPT5-10-05.pdf>
2. CDC report *Expedited Partner Therapy in the Management of Sexually Transmitted Diseases* 2006 <http://www.cdc.gov/STD/treatment/EPTFinalReport2006.pdf>
3. CDC 2006 STD Treatment Guidelines <http://www.cdc.gov/std/treatment/2006/rr5511.pdf>
4. Mehta SD, Erbelding EJ, Zenilman JM and Rompalo AM. Gonorrhoea reinfection in heterosexual STD clinic attendees: longitudinal analysis of risks for first reinfection. *Sex Transm Infect* 2003;79:124-8
5. Peterman TA, Tian LH, Metcalf CA, et al. High incidence of new sexually transmitted infections in the year following a sexually transmitted infection: a case for rescreening. *Ann Intern Med* 2006;145:564-72
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12. Gift TL, et al. A cost-effectiveness analysis of interventions to increase repeat testing in patients treated for gonorrhea or chlamydia at public sexually transmitted disease clinics. *Sex Trans Dis* 2004;32:542-549
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14. MMWR April 13, 2007. Update to CDC's *Sexually Transmitted Diseases Treatment Guidelines, 2006*: fluoroquinolones no longer recommended for treatment of gonococcal infections. Vol 56: No.14: 332-336 http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5614a3.htm?s_cid=mm5614a3_e

Resources Toolkit
IPP Guidance, Region IX
Use of Expedited Partner Therapy and Retesting at Three Months to Prevent and Detect Chlamydia and Gonorrhea Reinfections

1. Guidance documents, EPT

Centers for Disease Control

General information re: EPT, website

<http://www.cdc.gov/STD/ept/default.htm>

EPT Review and Guidance

<http://www.cdc.gov/STD/treatment/EPTFinalReport2006.pdf>

CDC 2006 STD Treatment Guidelines

<http://www.cdc.gov/std/treatment/2006/rr5511.pdf>

California STD Control Branch, Department of Public Health

PDPT for Chlamydia and Gonorrhea: Guidance for medical Providers in California, March 2007

<http://www.cdph.ca.gov/pubsforms/Guidelines/Documents/PDPT%20Guidelines%20and%20Ptnr%20Info%20Engl-Span%2008-06-07.pdf>

Guidelines for the Treatment of Chlamydia and Gonorrhea Cases and Exposed Sexual Partners by Health Department Staff in Non-Clinical Settings, March 2007

<http://www.cdph.ca.gov/HealthInfo/discond/Documents/Chlamydia-Gonorrhea-LHD-staff-field-delivered-treatment-Guidelines.pdf>

Region IX IPP Chlamydia Clinical Guidelines, revised October 2008

http://www.centerforhealthtraining.org/projects/pr_ipp_IX.html

2. Dear Colleague letter, Centers for Disease Control, EPT

<http://www.cdc.gov/STD/DearColleagueEPT5-10-05.pdf>

3. Legal issues, EPT

CDC legal resources website, with state-by-state map

<http://www.cdc.gov/std/ept/legal/default.htm>

CDC, Dear Colleague letter, John Douglas

<http://www.cdc.gov/STD/ept/DearColleagueEPTLegal12-19-2006.pdf>

4. Examples of STD information/fact sheets for patients

Centers for Disease Control

CT: <http://www.cdc.gov/std/Chlamydia/chlamydia.pdf>

GC: <http://www.cdc.gov/std/Gonorrhea/gonorrhea.pdf>

California STD/HIV Prevention Training Center

CT: http://www.stdhivtraining.org/resource.php?id=86&ret=clinical_resources

GC: http://www.stdhivtraining.org/resource.php?id=87&ret=clinical_resources

San Francisco Department of Public Health

CT: <http://www.dph.sf.ca.us/sfcityclinic/providers/Chlamydia.pdf>

GC: <http://www.dph.sf.ca.us/sfcityclinic/providers/Gonorrhea.pdf>

5. Examples of instruction sheets, Patient Delivered Partner Therapy

San Francisco Department of Public Health

CT, azithromycin, English:

<http://www.dph.sf.ca.us/sfcityclinic/providers/PDTCTAENG.pdf>

CT, azithromycin, Spanish

<http://www.dph.sf.ca.us/sfcityclinic/providers/PDTCTASPAN.pdf>

6. Example of clinic posters

San Francisco Department of Public Health

http://www.dph.sf.ca.us/sfcityclinic/providers/87_RestestedPoster0606.pdf

7. Training on issues related to EPT and retesting

California STD/HIV Prevention Training Center

<https://www.stdhivtraining.org/>