TAKING A SEXUAL HISTORY

Your patient's sexual history is an important part of their overall health and wellness. Taking a sexual history at least annually and at every sexually transmitted infection (STI) related visit will help guide the physical exam. Screening all exposed sites for STIs will help you establish your patients' STI and HIV risk.

TAKE A SEXUAL HISTORY FROM ALL PATIENTS.

THE 5 "P"s OF SEXUAL HEALTH

Partners
Number, sex and gender identity of partners

Practices
Types of sex — oral, vaginal, anal and risk behaviors such as injecting drugs, having sex while intoxicated or having anonymous sex partners

Protection from STIs, including HIV
Use of condoms, other barrier methods, HIV PrEP or PEP

Past History of STIs, including HIV
Previous STI diagnoses, history of STI and HIV testing and partners history of STI diagnoses

Pregnancy Intention
Desire for pregnancy and/or use of prevention methods

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"It is important we discuss your sexual practices. I speak with all of my patients about many different aspects of their lives."

Partners

- In the past 12 months, how many sexual partners have you had?
- What is the gender(s) of your partner(s)?
- Do you or your current partner have other partners?

Practices

- In the past 12 months, have you had vaginal sex? Oral sex? Anal sex?
- Have you had receptive anal intercourse?
- Where do you meet your partners? Do you have anonymous partners?

To assess HIV and hepatitis risk, ask:

- Have you or any of your partners ever injected drugs?

Protection from STIs, including HIV

- Do you and your partner(s) discussing getting STI and HIV testing?
- Do you use condoms or other barrier methods consistently? If not, in which situations are you more likely to use a condoms?
- Have you ever used post-exposure prophylaxis (PEP) after a possible exposure to HIV?
- Have you heard of HIV pre-exposure prophylaxis (PrEP)?

Past History of STIs, including HIV

- Have you or your partner ever been diagnosed with an STI, HIV or hepatitis C? When?
- Have you had any recurring symptoms or STI diagnoses?
- When was your last STI or HIV test?

Pregnancy Intention

- Do you think you would like to have (more) children in the future?
- How important is it to you to prevent pregnancy (until then)?
- Are you or your partner using contraception or practicing any form of birth control?
- Do you need any information or referral for birth control or fertility services?

Best Practices for Taking a Sexual Health History

Ensure a safe patient environment • Assure confidentiality
Be nonjudgmental • Be sensitive, and matter-of-fact
Avoid assumptions • Use normalizing language

RECOMMENDATIONS FOR THE TREATMENT OF CHLAMYDIA AND GONORRHEA

Chlamydia

Treating persons with Chlamydia (*C. trachomatis)* prevents adverse reproductive health complications and continued sexual transmission. Furthermore, treating their sex partners can prevent reinfection and infection of other partners.

Treatment Regimens	
Adults and Adolescents	
Recommended Regimen	**Doxycycline** 100 mg orally 2 times/day for 7 days
Alternative Regimens	**Azithromycin** 1 g orally in a single dose **OR** **Levofloxacin** 500 mg orally once daily for 7 days
Pregnant Persons	
Recommended Regimen	**Azithromycin** 1 g orally in a single dose
Alternative Regimen	**Amoxicillin** 500 mg orally 3 times/day for 7 days

- **Test of Cure: Pregnant** persons are recommended for a **test of cure about 4 weeks** after completing treatment. Otherwise, test of cure is only recommended in non pregnant persons if treatment adherence is a concern, symptoms persist or reinfection is suspected.
- **Retesting:** All persons diagnosed with chlamydia should be **retested 3 months** after treatment.
- **Parnter Services: Sex partners** should be evaluated, tested and presumptively treated if they had sexual contact with the partner during the **60 days** preceding the patient's onset of symptoms or chlamydia diagnosis.

For detailed STI treatment guidelines and alternative regimens, see the CDC 2021 ST1 Treatment Guidelines, www.cdc.gov/std/treatment-guidelines

RECOMMENDATIONS FOR THE TREATMENT OF CHLAMYDIA AND GONORRHEA

Gonorrhea

Gonorrhea (GC) can be cured with the right treatment. Antimicrobial resistance in gonorrhea is of increasing concern, and successful treatment of gonorrhea is becoming more difficult. Suspected treatment failures should be reported to NDDoH STI Program.

Treatment Regimens

Adults and Adolescents: Uncomplicated Gonococcal Infection of Cervix, Urethra, Rectum or Pharynx

Recommended Regimen	**Ceftriaxone** 500 mg* IM in a single dose for persons weighing <150kg If chlamydial infection has not been excluded, also treat for CT with doxycycline 100 mg orally 2 times/day for 7 days. *For persons weighing >150kg, 1 g ceftriaxone should be administered.
Alternative Regimen^ ^No reliable alternative regimens are available for pharyngeal GC.	**Gentamicin** 240 mg IM in a single dose **PLUS** **Azithromycin** 2 g orally in a single dose **OR** **Cefixime** 800 mg* orally in single dose *If chlamydial infection has not been excluded, also treat for CT with doxycycline 100 mg PO 2 times/day for 7 days.

- **Test of Cure: Any person with pharyngeal gonorrhea should return 7–14 days after initial treatment for a test of cure by using either culture or NAAT.** A test of cure is unnecessary for persons with uncomplicated urogenital or rectal gonorrhea who are treated with any of the recommended or alternative regimens.
- **Retesting:** All persons diagnosed with gonorrhea should be **retested 3 months** after treatment.
- **Parnter Services: Sex partners** should be evaluated, tested and presumptively treated if they had sexual contact with the partner during the **60 days** preceding the patient's symptom onset or gonorrhea diagnosis.

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www.health.nd.gov/STI

For complete STI treatment guidelines, refer to the CDC 2021 ST1 Treatment Guidelines, www.cdc.gov/std/treatment-guidelines

DIAGNOSING AND TREATING BACTERIAL STIs IN MEN WHO HAVE SEX WITH MEN (MSM)

- STIs are on the rise among MSM. Rectal **gonorrhea** (GC), rectal **chlamydia** (CT) and **syphilis** may facilitate HIV transmission.
- Many anogenital STIs are asymptomatic. Urine/urethral screening alone misses many GC and CT cases in asymptomatic MSM.
- Empiric treatment is often indicated based on symptoms and the most commonly associated pathogens.

Syndrome	Sign/ Symptom	Immediate Next Steps
Urethritis	Discharge or dysuria	• Test and empirically treat for GC/CT. • Test for syphilis and HIV.
Proctitis	Ulcer, discharge or pain	• Consider HSV testing/treatment of suspicious ulcerative lesions.
Early Syphillis 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 testing/treatment of suspicious ulcerative lesions.

Use a 3-Site Screening Strategy

Site	Test for	Type of Sexual Exposure	Notes
Throat	GC only	Perform oral sex	NAAT (Self-collection if patient prefers) NAAT= Nucleic Acid Amplification Test
Anorectal	GC/CT	Anal receptive "bottom"	NAAT (Self-collection if patient prefers; still conduct physical exam)
Urine or urethral	GC/CT	Oral/anal insertive (top)	NAAT (First catch urine preferred)
Serology	Syphillis	Any	Treponemal IgG, RPR, darkfield microscopy of anogential lesions
Serology	HIV	Any	4th generation antibody/antigen test or rapid antibody test

Screening for STIs, including HIV, recommended every 3 to 6 months for MSM with multiple or anonymous sex partners or illicit drug use

EXPEDITED BACTERIAL STI TREATMENT FOR MEN WHO HAVE SEX WITH MEN (MSM)

Treatment Regimens

Syndrome	First-line Empiric Therapy
Urethritis	**Empiric Tx for GC and CT** Ceftriaxone 500 mg* IM in a single dose PLUS Doxycycline 100 mg orally BID for 7 days *For persons weighing ≥ 150 kg, 1 g of ceftriaxone should be administered
Proctitis	**Empiric Tx for GC and CT** Ceftriaxone 500 mg* IM in a single dose PLUS Doxycycline 100 mg orally BID for 7 days *For persons weighing ≥ 150 kg, 1 g of ceftriaxone should be administered ^Extend DOX 100 mg BID to 21 days in the presence of bloody discharge, perianal or mucosal ulcers, or tenesmus and a positive rectal chlamydia test
Chancre or Disseminated Rash	**Empiric Tx for Primary (chancre) or Secondary (rash) Syphilis** Single dose Benzathine penicillin G 2.4 million units IM

For detailed STI treatment guidelines and alternative regimens, see the CDC 2021 STD Treatment Guidelines, www.cdc.gov/std/treatment-guidelines

HIV Pre-exposure Prophylaxis (PrEP) & Post-exposure Prophylaxis (PEP)

- **HIV PrEP** is recommended for MSM who have/had:

HIV positive sexual partner
History of inconsistent or no condom use
***Anonymous sex partners or use apps/internet to meet partners**
**NDDoH Recommendation*

Recent bacterial STI
High number of sex partners
Commercial sex work
Shares drug preparation or injection equipment

- Health care providers should evaluate persons rapidly for **HIV PEP** when care is sought within **72 hours** after a potential exposure.

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www.health.nd.gov/HIV

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EXPEDITED PARTNER THERAPY (EPT)

What is Expedited Partner Therapy?

Expedited Partner Therapy (EPT) is the clinical practice of treating the sex partners of patients diagnosed with chlamydia or gonorrhea by providing prescriptions or medications to the patient to take to their partner without a provider first examining the partner.

EPT may decrease the risk of reinfection among heterosexuals with gonorrhea or chlamydial infection and increases the proportion of partners who receive treatment[1].

Is EPT allowable in North Dakota?

YES! EPT has been an approved method of treating partners since January 2009 according to ND Administrative Code, Chapters 61-04-04-01 Unprofessional Conduct, 54-05-03.1-10 Authority to Prescribe, and 50-05-01 Expedited Partner Therapy.

When should EPT by administered?

The first choice partner management strategy is to bring in sexual partners for a complete clinical evaluation, STI and HIV testing, and counseling and treatment as appropriate. EPT provides an opportunity to ensure sexual partners are treated. Providers should use their best judgment to determine whether their patient's sex partner(s) will or will not seek treatment.

- **EPT is most useful when partners of heterosexual individuals with chlamydia or gonorrhea are deemed unlikely to access health care themselves or when a patient has a re-infection(s).**
- Men who have sex with men (MSM) with gonorrhea have a high risk for coexisting infections among their partners and partners who could benefit from HIV PrEP. **Shared clinical decision-making for EPT with MSM is recommended.**
- **EPT should not be used for patients with syphilis.**

EPT is supported by the American Academy of Family Physicians and American College of Obstretricians and Gynecologists.

EXPEDITED PARTNER THERAPY (EPT)

There are two ways EPT can be delivered.

1. Partner Delivered Partner Therapy (PDPT).

In PDPT, medication is dispensed to the patient for delivery to their partner(s). The patients should be given enough doses to treat each sex partner in the past 60 days whom the patient feels confident contacting.

2. Partner Delivered Prescriptions.

Dispense a prescription to the patient to be delivered to partner(s), who presents the prescription to a pharmacy of their choice to be filled. The patients should be given one prescription for each sex partner in the past 60 days whom the patient feels confident contacting. Prescriptions may not be filled without a name unless prior approval is made with the pharmacy.

Chlamydia and Gonorrhea EPT Regimens

Chlamydia

Doxycycline 100 mg orally BID X 7 days
OR Azithromycin 1 g orally in a single dose*

*Alternative treatment. Limited efficacy in rectal chlamydia infection. Consider if medication adherence if a concern.

Gonorrhea

Cefixime 800 mg

Key Messages for Patients

- When providing medication to partners, include information about possible allergic reactions to antibiotics, possible side effects and drug interactions.
- Patients should abstain from any type of sexual intercourse until at least seven days after treatment and seven days after their partners have been treated.
- Counsel patients to tell their partners to seek follow-up medical care, including testing for STIs and HIV, as soon as possible and three months after treatment.

References: CDC. Expedited Partner Therapy in the Management of Sexually Transmitted Diseases. Atlanta: U.S. Department of Health and Human Services; 2006; 2021 CDC STI Treatment guidelines, www.cdc.gov/std/treatment-guidelines.

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www.health.nd.gov/STI

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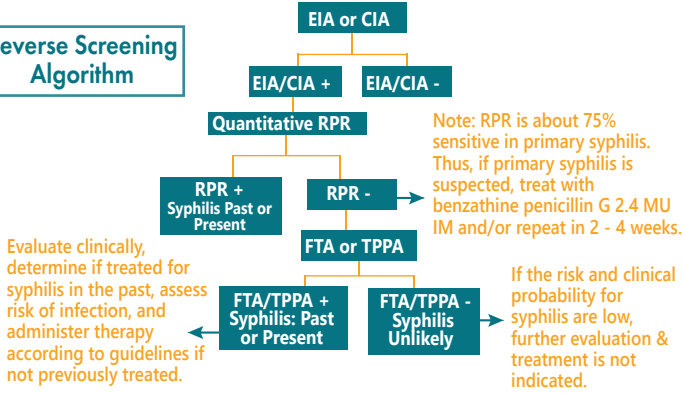
SYPHILIS
SCREENING, DIAGNOSIS, STAGING AND TREATMENT

Syphilis

Syphilis is a systemic disease caused by *T. pallidum*. Syphilis can cause serious health sequelae if not adequately treated.

Syphilis Screening	
Population	**Frequency of Screening**
Pregnant Persons	3x Screening: First Prenatal Visit, 28 Weeks, Delivery
Men Who Sex with Men (MSM)	Annually or Every 3 to 6 Months if at Increased Risk*
Persons with HIV	Annually or Every 3 to 6 Months if at Increased Risk*
At Risk*	Annually or Every 3 to 6 Months *At risk includes those who have multiple sexual partners, a new partner, partner with STIs, anonymous sex partners or who use or have used drugs

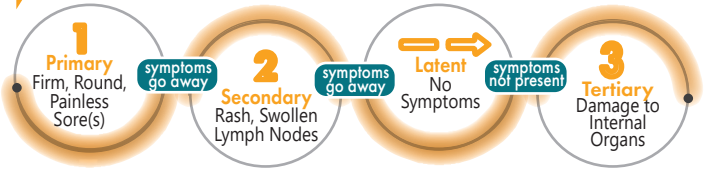
Reverse Screening Algorithm

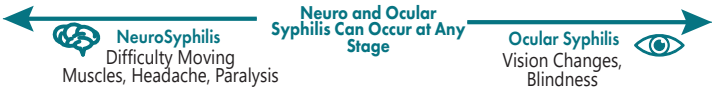


Note: False-positive RPR can be associated with other infections (e.g., HIV), autoimmune conditions, vaccinations, injection drug use, pregnancy, and older age.

SYPHILIS IS DIVIDED INTO STAGES ON THE BASIS OF CLINICAL FINDINGS, WHICH GUIDE TREATMENT AND FOLLOW-UP.

Stages and Types of Syphilis





Additional information used to stage syphilis diagnosis: complete sexual & medical history, history of syphilis testing/treatment, thorough physical exam; risk factors & sexual partner(s) history of syphilis.

Treatment Regimens

Stage of Diagnosis	Syphilis Treatment
Primary & Secondary	Benzathine Pencillin G 2.4 Million Units (MU) IM Single Dose
Early Latent	Benzathine Pencillin G 2.4MU IM Single Dose Confirm early latent diagnosis by one of the following: 1) Documented seroconversion or a sustained (>2 weeks) fourfold or greater increase in nontreponemal titers in a previously treated person; 2) unequivocal symptoms of primary or secondary syphilis; 3) Sex partner documented to have primary, secondary or early latent syphilis.
Late Latent	Benzathine Penicillin G 7.2 MU total, administered as 3 Doses of 2.4 MU IM each at exactly 1 week intervals

- Alternative regimens are available for those with pencillin allergy, but **all pregnant persons must be treated with pencillin regardless of allergy.**
- **Follow-Up:** Serologic response compared with titer at time of treatment. Titers usually decrease after treatment and might become nonreactive over time. Repeat RPR titers at 6 and 12 months after diagnosis for primary and secondary infections and 6, 12, and 24 months for latent infections.

For complete STI treatment guidelines, refer to the CDC 2021 ST1 Treatment Guidelines, www.cdc.gov/std/treatment-guidelines

HIV PRE-EXPOSURE PROPHYLAXIS (HIV PrEP)

PRESCRIBING, BASELINE AND ONGOING ASSESSMENT

ALL SEXUALLY ACTIVE INDIVIDUALS AND PERSONS WHO INJECT DRUGS SHOULD BE ASSESSED FOR HIV PrEP.

PrEP is short for pre-exposure prophylaxis. It is the use of antiretroviral medication to prevent acquisition of HIV infection. PrEP is used by people without HIV who are at risk of being exposed to HIV through sexual contact or injection drug use. Two medications have been approved for use as PrEP by the FDA. Each consists of two drugs combined in a single oral tablet taken daily:

- **Emtricitabine (F) 200 mg in combination with tenofovir disoproxil fumarate (TDF) 300 mg (F/TDF – brand name Truvada®):** Recommended to prevent HIV infection among all persons at risk through sex or injection drug use.
- **Emtricitabine (F) 200 mg in combination with tenofovir alafenamide (TAF) 25 mg (F/TAF – brand name Descovy®):** recommended to prevent HIV infection among persons at risk through sex, excluding people at risk through receptive vaginal sex. F/TAF has not yet been studied for HIV prevention for receptive vaginal sex.

These medications are approved to prevent HIV infection in adults and adolescents weighing at least 35 kg (77 lb).

Who should be offered PrEP?

Sexually-Active Adult and Adolescents	Person Who Inject Drugs (PWID)
Anal or vaginal sex in the past 6 months; and HIV-positive sexual partner (especially if partner has unknown or undetectable viral load); or **Recent bacterial STI;** or History of inconsistent or no condom use with sexual partner(s)	HIV-positive injecting partner; or Shares drug preparation or injection equipment

PrEP should be considered part of a comprehensive prevention plan that includes PrEP adhernece counseling, condom use, other sexually transmitted infections (STIs), and other risk reduction

Baseline Assessment

1. HIV Testing. Draw blood or use rapid, point-of-care fingerstick blood test. Oral rapid tests should not be used. Use combination antibody/antigen assay and viral load test on those with suspected acute HIV.

2. Renal Function. Measure serum creatinine and estimate creatinine clearance. Do not start PrEP if eCrCl <60 mL/min. F/TAF is approved for use in persons with eCrCl ≥30 ml/min.

3. Hepatitis B Serology. Order hepatitis B screening serology (i.e. HBsAg, total anti-HBc and anti-HBs). Hepatitis B infection is not a contraindication to PrEP use. PrEP medications are active against HBV and close monitoring is required for HBV infected individuals. Vaccinate for hepatitis B if not immune.

4. Bacterial STI Screening: Nucleic Acid Amplification Test (NAAT) to screen for gonorrhea and chlamydia based on anatomic site of exposure (genital, rectal, pharyngeal); blood test for syphilis.

5. Hepatitis A and C Testing. Serology for hepatitis A and C. Vaccinate against Hep A if non-immune.

6. Pregnancy Testing. Pregnancy test if applicable. If positive, discuss benefits and risks.

Monitoring on PrEP

Service	Frequency
HIV Testing	3 months after starting PrEP & every 3 months there after
Renal Function	3 months after starting PrEP & every 6 months there after
Bacterial STI Testing	3 months after starting PrEP & every 3 months there after for MSM or 6 months for other sexually active individuals
Pregnancy	3 months after starting PrEP & every 3 months there after
Counseling	Provide medication adherence and behavioral risk reduction suport at every PrEP visit. For PWID, assess access to sterile supplies and substance use disorder treatment services.