ALL RECOMMENDATIONS (continued from P.1)

POST-TREATMENT FOLLOW-UP
- Clinicians should follow up with patients who have completed treatment for gonococcal and chlamydial infections as detailed in Tables 2 and 3, below. (All)
- Clinicians should rescreen patients who had confirmed gonococcal or chlamydial infection at 3 months post-treatment for evidence of reinfection. (All)

MANAGEMENT OF HIV EXPOSURE IN SEX PARTNERS
- Clinicians should educate patients with partners who do not have HIV or partners of unknown HIV status to be vigilant for any post-exposure acute HIV symptoms in their partners, such as fever, fatigue, or lymphadenopathy, myalgias, and/or sore throat. (All)
- Partners who present within 36 hours of an HIV exposure should be evaluated as soon as possible for initiation of post-exposure prophylaxis therapy. (All)

MANAGEMENT OF PARTNERS EXPOSED TO N. GONORRHOEAE OR C. TRACHOMATIS
- Clinicians should advise their patients that sex partners who were exposed up to 60 days before the source case’s onset of symptoms or diagnosis of gonococcal or chlamydial infection should seek evaluation and treatment for HIV. (All)
- When a patient with HIV is diagnosed with gonorrhea or chlamydia, clinicians should advise the patient to encourage sex partners to seek medical care for possible exposure to HIV and gonorrhea and chlamydia and should inform the patient that NYSDOH Partner Services offers free, confidential partner notification assistance. (All)

NEW YORK STATE REPORTING REQUIREMENTS:
- NYS Public Health Law mandates that medical providers report all suspected or confirmed HIV, gonorrhea, and chlamydia diagnoses to the local health department in the area where the patient resides.
- Clinicians must report cases of suspected gonorrhea treatment failure that are not due to reinfection:
  - New York State: Report suspected treatment failures to the local health department within 24 hours.
  - New York City: Call 866-692-3641 to notify the health department of suspected treatment failure within 7 days.
- NYS Public Health Law mandates that medical providers talk with individuals with HIV infection about their options for informing their sexual partners that they may have been exposed to HIV.
- NYS Public Health Law mandates that expedited partner therapy not be used for sex partners of patients with gonorrhea, syphilis, and/or HIV.

HIV CLINICAL RESOURCE
VISIT HIVGUIDELINES.ORG TO LEARN MORE OR VIEW COMPLETE GUIDE

MANAGEMENT OF GONORRHEA AND CHLAMYDIA IN PATIENTS WITH HIV INFECTION

COMMITTEE FOR THE CARE OF PATIENTS WITH STIs

ALL RECOMMENDATIONS

TRANSMISSION AND PREVENTION
- Clinicians should inform patients with HIV about the risk of acquiring or transmitting chlamydia, gonorrhea, and other STIs from close physical contact with all sites of possible exposure, including the penis, vagina, mouth, or anus. (All)
- When patients with HIV are diagnosed with early syphilis (primary, secondary, or early latent stage), clinicians should educate patients about risk-reduction strategies, including the value of condom use (All); the potential for oral transmission of syphilis (All), the benefits of identifying infection early (All); and the need for prompt evaluation and therapy for sex partners (All).

SCREENING
- For MSM and transgender women who have sex with men, clinicians should perform three-site screening (genital, pharyngeal, rectal) at the following intervals:
  - At first visit and every 3 months thereafter if the patient is at high risk of infection. (All)
- High risk: Patient self-identifies as being at high risk of HIV infection and/or reports any of the following for self or sex partner(s): Multiple or anonymous sex partners; bacterial STI diagnosed since last STI screening; participation in sex parties or sex in other high-risk venues; participation in any of transactional sex; use of recreational substances during sex
### TABLE 1: Recommended Treatment for Uncomplicated Chlamydial and LGV Infections [adapted from CDC, 2015]

<table>
<thead>
<tr>
<th>Infection</th>
<th>Regimen</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Uncomplicated cervical, urethral, rectal, or pharyngeal infection</td>
<td>Recommended: <em>Azithromycin 1 g by mouth as a single dose OR</em> DFX 100 mg by mouth twice daily for 7 days. Alternatives: <em>Erythromycin base 500 mg by mouth twice daily for 7 days OR</em> Erythromycin ethylsuccinate 800 mg by mouth four times per day for 7 days OR Levofloxacin 500 mg by mouth once daily for 7 days OR Ofloxacin 300 mg by mouth twice per day for 7 days.</td>
<td>• Treat asymptomatic pharyngeal infection even if it is the only site of infection. • Alternative regimens are NOT recommended for pharyngeal infections.</td>
</tr>
<tr>
<td>Symptomatic proctitis</td>
<td>Doxycycline 100 mg by mouth twice daily for 21 days.</td>
<td>• Presumptively treat for LGV; is LGV is excluded by testing, then patients should complete the standard seven-day regimen for uncomplicated chlamydial infection.</td>
</tr>
</tbody>
</table>

### TABLE 2: Recommended Follow-Up after Completion of Treatment for Uncomplicated Gonococcal [adapted from CDC, 2015]

<table>
<thead>
<tr>
<th>Clinical Circumstance</th>
<th>Recommended Clinician Follow-Up</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asymptomatic after treatment with recommended regimen:</td>
<td>• Retest at 3 months (or as close to 3 months as possible) post-treatment to assess for reinfection.</td>
</tr>
<tr>
<td>Urogenital or rectal infection treated with preferred or appropriate alternative regimens.</td>
<td>• If the lab test is positive for N. gonorrhoeae, assess for re-exposure and partner treatment, and re-treat with recommended regimen.</td>
</tr>
<tr>
<td>Pharyngeal gonorrhea treated with preferred regimen.</td>
<td>• Assess for re-exposure and partner treatment. Perform a test of cure at site of infection with N. gonorrhoeae NAAT 14 days after completion of treatment. • If test of cure is positive, perform culture and susceptibility testing before retreatment and re-treat with recommended regimen if possible. • If recommended regimen cannot be used, re-treat with an alternative regimen or according to susceptibility test results.</td>
</tr>
<tr>
<td>Asymptomatic after possibly ineffective course of treatment:</td>
<td>• Assess for re-exposure and partner treatment. Perform a test of cure at site of infection with N. gonorrhoeae NAAT 14 days after completion of treatment. • If test of cure is positive, perform culture and susceptibility testing before retreatment and re-treat with recommended regimen if possible. • If recommended regimen cannot be used, re-treat with an alternative regimen or according to susceptibility test results.</td>
</tr>
<tr>
<td>Urogenital or rectal infection treated with regimen other than preferred or alternative regimens.</td>
<td>• If the lab test is positive for N. gonorrhoeae, assess for re-exposure and partner treatment, and re-treat with recommended regimen.</td>
</tr>
<tr>
<td>Pharyngeal infection treated with an alternative regimen.</td>
<td>• Assess for re-exposure and partner treatment. Perform a test of cure at site of infection with N. gonorrhoeae NAAT 14 days after completion of treatment. • If test of cure is positive, perform culture and susceptibility testing before retreatment and re-treat with recommended regimen if possible. • If recommended regimen cannot be used, re-treat with an alternative regimen or according to susceptibility test results.</td>
</tr>
<tr>
<td>Suspected nonadherence to full course of treatment.</td>
<td>• Assess for re-exposure and partner treatment. Assess patient adherence and use of preferred or appropriate alternative regimens. Swab symptomatic site(s) for N. gonorrhoeae culture and antibiotic susceptibility testing ≥72 hours after treatment. NAAT may be obtained in addition to culture ≥72 hours after treatment. Re-treat for suspected treatment failure. Assess for other STIs that may cause persistent or recurrent symptoms. For persistent or recurrent urethritis negative for N. gonorrhoeae and C. trachomatis, treat empirically for M. genitalium and/or T. vaginalis according to CDC recommendations. Assess for non-STI etiologies as part of the differential diagnosis if a patient is repeatedly symptomatic.</td>
</tr>
<tr>
<td>Symptomatic post-treatment: Persistent symptoms post-treatment; infection at any site.</td>
<td>• Assess for re-exposure and partner treatment. Assess patient adherence and use of preferred or appropriate alternative regimens. Swab symptomatic site(s) for N. gonorrhoeae culture and antibiotic susceptibility testing ≥72 hours after treatment. NAAT may be obtained in addition to culture ≥72 hours after treatment. Re-treat for suspected treatment failure. Assess for other STIs that may cause persistent or recurrent symptoms. For persistent or recurrent urethritis negative for N. gonorrhoeae and C. trachomatis, treat empirically for M. genitalium and/or T. vaginalis according to CDC recommendations. Assess for non-STI etiologies as part of the differential diagnosis if a patient is repeatedly symptomatic.</td>
</tr>
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### KEY POINTS
- Because most gonorrheal and chlamydial infections are asymptomatic, regular screening is essential to protect patients' health and prevent the spread of STIs. This is an essential component of patient education.
- People infected with N. gonorrhoeae are frequently coinfected with C. trachomatis.
- Although LGV occurs only sporadically in the United States, outbreaks of LGV proctocolitis have been reported in NYC and other cities among MSM, and many of these cases occurred in individuals with HIV. Gonococcal and chlamydial reinfection rates are high among people who have been successfully treated.

* Other STIs may include M. genitalium, T. vaginalis, herpes simplex virus, adenovirus, and enteric bacteria.

[QR Code]
This ¼-Folded Guide is a companion to the New York State Department of Health AIDS Institute guideline Management of Gonorrhea and Chlamydia in Patients with HIV. Full guideline is available at hivguidelines.org.