HIV CLINICAL RESOURCE ¼-FOLDED GUIDE

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MANAGEMENT OF GONORRHEA AND CHLAMYDIA IN PATIENTS WITH HIV INFECTION

COMMITTEE FOR THE CARE OF PATIENTS WITH STIs

3/2018

ALL RECOMMENDATIONS P.1

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. (A3)
- When patients with HIV are diagnosed with gonococcal or chlamydial infections, clinicians should educate patients about the following:
  - Risk-reduction strategies, including the value of correct condom use. (A2)
  - The potential for oral transmission of gonorrhea and chlamydia. (A3)
  - The benefits of identifying STIs early. (A3)
  - The need for prompt evaluation and treatment of partners. (A3)

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 annually thereafter if the patient is at low risk of infection. (A2)
    - Low risk: Patient reports no sexual activity or sex only within a mutually monogamous relationship within the year prior.
  - At first visit and every 3 months thereafter if the patient is at high risk of infection. (A2)
    - High risk: Patient self-identifies as being at high risk of STIs 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 type of transactional sex; use of recreational substances during sex.

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(continued from P.1)

ALL RECOMMENDATIONS P.2

SCREENING, cont.

- For all other patients, clinicians should perform genital screening (urine/urethra, vagina/cervix) and extragenital screening (pharyngeal and/or rectal) at sites of contact at the following intervals:
  - At first visit and annually thereafter if the patient is at low risk (see above) of infection. (A2)
  - At first visit and every 3 months thereafter if the patient is at high risk (see above) of infection. (A2)
- Clinicians should screen pregnant patients with HIV infection for gonococcal and chlamydial infections at the first prenatal visit. (AII)
- Clinicians should ask all patients about sexual behaviors and new sex partners at each routine monitoring visit to assess for risk behaviors that indicate the need for repeat or ongoing screening. (A3)

PRESENTATION, DIAGNOSIS, AND REPORTING

- When patients with HIV present with symptoms suggestive of gonococcal or chlamydial infection, clinicians should perform diagnostic testing as follows (AI): [see full guideline for additional details]
  - Urethra: First-catch urine for NAAT
  - Vagina/cervix: Vaginal or cervical swab (recommended) or first-catch urine (alternative) NAAT
  - Rectum: All patients—rectal swab for NAAT
  - Pharynx: All patients—pharyngeal swab for NAAT
- Clinicians should include LGV infection in the differential diagnosis for patients who test positive for rectal chlamydial infection or who present with such symptoms as rectal pain, tenesmus, bloody rectal discharge, or isolated, atypical perianal ulcerative lesions and adenopathy. (A2)

LAB-BASED DIAGNOSIS

- Clinicians should obtain NAAT on samples collected from genital and extragenital sites (A1); if NAAT is not available, clinicians should:
  - Send alternative samples for culture in accordance with the protocols of the lab performing the analysis, with the understanding that culture is significantly less sensitive than NAAT. (A1)
- If a patient has a known exposure to a cephalosporin-resistant strain, clinicians should obtain samples for both culture/susceptibility and NAAT testing from the patient and his/her sex partner(s). (A3)

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ALL RECOMMENDATIONS P.3

- Clinicians should perform syphilis testing for any patient with HIV who is diagnosed with a gonorrheal or chlamydial infection. (A2)

TREATMENT OF UNCOMPLICATED GONOCOCCAL INFECTION

- Clinicians should treat uncomplicated gonococcal infections of the cervix, urethra, rectum, or pharynx as follows:
  - **Preferred:** Ceftriaxone 250 mg intramuscular (IM) injection in a single dose *plus* azithromycin 1 g by mouth in a single dose. (A2)
  - **Alternative, for patients who are allergic to azithromycin:** Ceftriaxone 250 mg IM in a single dose *plus* doxycycline 100 mg by mouth twice daily for 7 days. (A2)
  - **Alternative, if ceftriaxone is not available:** Cefixime 400 mg by mouth in a single dose *plus* azithromycin 1 g by mouth in a single dose. *This regimen is not recommended for treatment of pharyngeal infection.* (A2)
- Clinicians should instruct patients to abstain from sexual activity for at least 7 days after starting treatment, and to continue to abstain until symptoms resolve and all sex partners are treated. (A2)

TREATMENT OF GONOCOCCAL INFECTION IN PATIENTS WITH PENICILLIN ALLERGY

- For patients without prior severe allergic responses to penicillin (e.g., severe IgE-mediated response, such as anaphylaxis or urticaria with pruritic rash; or a severe non-IgE-mediated response, such as Stevens-Johnson syndrome, toxic epidermal necrolysis, or drug-induced hypersensitivity with inflammation of internal organs), clinicians should treat gonococcal infection with a cephalosporin-containing regimen, as recommended above, and monitor carefully for adverse effects. (A2)
- For patients with prior severe allergic responses to penicillin, clinicians should treat gonococcal infection with a single dose of azithromycin 2 g by mouth *plus* a single dose of either gentamicin 240 mg IM or gemifloxacin 320 mg by mouth. (A2)

TREATMENT OF UNCOMPLICATED CHLAMYDIAL AND LGV INFECTIONS

- Clinicians should treat uncomplicated chlamydial infection of the cervix, urethra, rectum, or pharynx as indicated in Table 1, below. (A2)
- Clinicians should treat symptomatic chlamydial proctitis with a medication regimen sufficient to treat LGV. (A3)

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ALL RECOMMENDATIONS *(continued from P.3)* P.4

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. (A3)
- Clinicians should rescreen patients who had confirmed gonococcal or chlamydial infection at 3 months post-treatment for evidence of reinfection. (A2)

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 febrile illness accompanied by rash, lymphadenopathy, myalgias, and/or sore throat. (A3)
- Partners who present within 36 hours of an HIV exposure should be evaluated as soon as possible for initiation of post-exposure prophylaxis therapy. (A3)

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 and HIV testing. (A2)
- 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. (A2)

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 failures.
- 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.

TREATMENT, FOLLOW-UP, AND RE-TREATMENT

TABLE 1: Recommended Treatment for Uncomplicated Chlamydial and LGV Infections [adapted from CDC, 2015]

Infection	Regimen	Comments
Uncomplicated cervical, urethral, rectal, or pharyngeal infection	Recommended: · Azithromycin 1 g by mouth as a single dose OR · Doxycycline 100 mg by mouth twice daily for 7 days. Alternatives: · Erythromycin base 500 mg by mouth four times per day for 7 days OR · 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.	· Treat asymptomatic pharyngeal infection even if it is the only site of infection. · Alternative regimens are NOT recommended for pharyngeal infections.
Symptomatic proctitis	· Doxycycline 100 mg by mouth twice daily for 21 days OR · Azithromycin 1 g by mouth as a single dose once weekly for 3 weeks [Note: Added June 13, 2019].	· Presumptively treat for LGV; if LGV is excluded by testing, then patients should complete the standard seven-day regimen for uncomplicated chlamydial infection.

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

Clinical Circumstance	Recommended Clinician Follow-Up
Asymptomatic after treatment with recommended regimen: · Urogenital or rectal infection treated with preferred or appropriate alternative regimens. · Pharyngeal gonorrhea treated with preferred regimen.	· Retest at 3 months (or as close to 3 months as possible) post-treatment to assess for reinfection. · If the lab test is positive for *N. gonorrhoeae*, assess for re-exposure and partner treatment, and re-treat with recommended regimen.
Asymptomatic after possibly ineffective course of treatment: · Urogenital or rectal infection treated with regimen other than preferred or alternative regimens. · Pharyngeal infection treated with an alternative regimen. · Suspected nonadherence to full course of treatment.	· 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.
Symptomatic post-treatment: Persistent symptoms post-treatment; infection at any site.	· Assess for re-exposure and partner treatment. · Assess patient adherence and use of preferred or appropriate alternative regimen. · Swab symptomatic site(s) for *N. gonorrhoeae* culture and antibiotic susceptibility testing ≥72 hours after treatment. NAAT may be obtained in addition to culture ≥7 days 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.

TABLE 3: Recommended Follow-Up after Completion of Treatment for Uncomplicated Chlamydia Infection [adapted from CDC, 2015]

Clinical Circumstance	Recommended Clinician Follow-Up
Asymptomatic after treatment with preferred or alternative regimen.	· Retest at 3 months (or as close to 3 months a possible) post-treatment to assess for reinfection. · If the lab test is positive for *C. trachomatis*, assess for re-exposure and partner treatment and re-treat with recommended regimen.
Symptomatic post-treatment: Persistent symptoms post-treatment; infection at any site.	· Perform a test of cure at site of infection with *C. trachomatis* NAAT 3 weeks after treatment. · If test of cure is positive, assess for re-exposure and partner treatment, and re-treat with recommended treatment regimen using azithromycin or doxycycline. Azithromycin is preferred to maximize adherence. · If test of cure is negative, consider other STIs* that may cause persistent or recurrent symptoms. · Consider non-STI etiologies as part of the differential diagnosis when the patient is repeatedly symptomatic.

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

TABLE 4: Recommended Retreatment Regimens after Suspected Failure of Treatment for Uncomplicated Gonococcal Infection [adapted from CDC, 2015]

Clinical Circumstance	Recommended Treatment
Possible reinfection (most cases).	Ceftriaxone 250 mg by mouth in a single dose *PLUS* azithromycin 1 g by mouth in a single dose.
Low reinfection risk; initial treatment was incomplete or regimen administered was not preferred or alternative.	Ceftriaxone 250 mg by mouth in a single dose *PLUS* azithromycin 1 g by mouth in a single dose.
Low reinfection risk; initial treatment with cefixime and azithromycin.	Ceftriaxone 250 mg by mouth in a single dose *PLUS* azithromycin **2** g by mouth in a single dose.
Low reinfection risk; initial treatment with ceftriaxone 250 mg IM and azithromycin 1 g by mouth.	Gentamicin 240 mg IM or gemifloxacin 320 mg by mouth *PLUS* azithromycin 2 g by mouth in a single dose.
Reduced susceptibility to relevant antibiotics on antimicrobial susceptibility testing.	Consult local health department.
Patient cannot follow above regimens due to allergies.	Obtain clinical consultation with infectious disease specialist.

→ 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.

← Use this code with your phone's QR code reader to go directly to a mobile-friendly version of this guideline.

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.