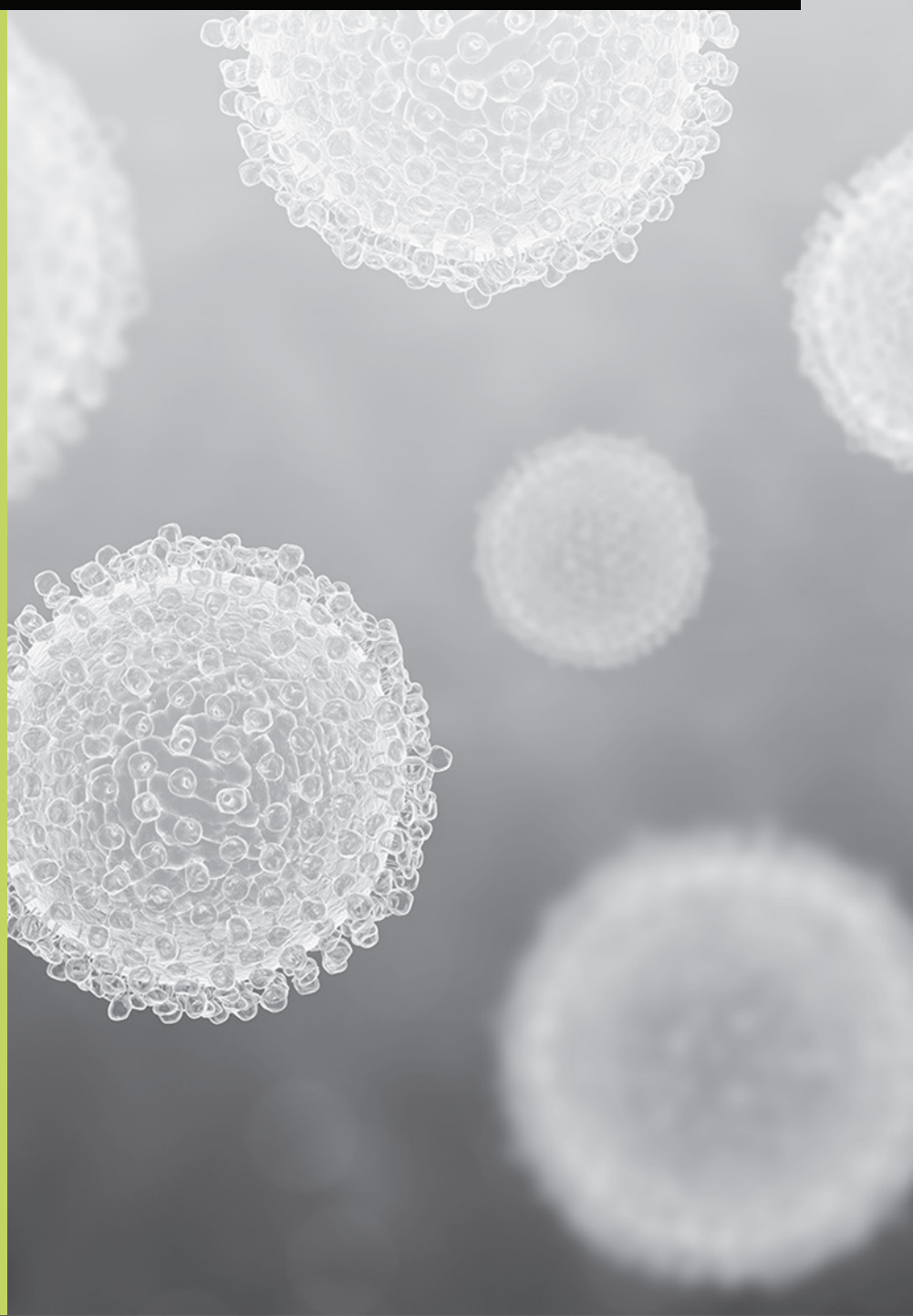
STD PREVENTION PROGRAM

A Provider's Guide to Managing Sexually Transmitted Diseases



2020

State of Indiana
February 2020

Our Mission and Purpose: A Community Effort

Physicians, Practitioners, and Medical Personnel:

Your role in interrupting the chain of transmission for sexually transmitted diseases is vital to the health of Hoosiers. Many communities rely on urgent care or emergency room care for screening and treatment of STDs, and the Indiana State Department of Health (ISDH) STD Prevention Program is providing your agency the tools and materials to provide exceptional sexual health care to Hoosiers in accordance with CDC's recommendations. Your efforts in STD prevention and attention to detail is assisting clients with getting access to critical care in order to lower the disease burden among Indiana communities.

The mission of the STD Prevention Program is to intervene in the spread of sexually transmitted diseases (STDs) and reduce the complications of these diseases. The Program provides technical and financial assistance to local STD programs for surveillance, case detection through screening, ensuring treatment of known cases, case follow-up, and education. Efforts are coordinated among health care providers screening for syphilis, gonorrhea, and chlamydia. Other important aspects of this program include education and prevention counseling for persons impacted by STDs. The Program strongly recommends all providers read the guidance and resources in this document, including information on Expedited Partner Therapy (EPT) and the Indiana State Code that specifies the practice of EPT as legal. Providing STD screening and treatment services, especially for partners, is critical for interrupting the chain of transmission in the community. Current literature provides evidence that EPT reduces reinfection rates in diagnosed patients. This packet includes additional guidance in the Frequently Asked Questions (FAQ) section in regards to EPT. The STD Prevention Program encourages providers to contact the Program to gain additional information or clarifications on EPT.

The STD Program values the hard work that all providers do every day in order to reduce the STD burden in Hoosiers. The Program is looking forward to strengthening relationships between providers and the STD Prevention Program. If you have any questions, concerns, or need additional information, please do not hesitate to reach out to the ISDH STD Prevention Program directly at STD@isdh.in.gov.

Thank you for all you do,

ISDH STD Prevention Program

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Reporting STDs

In this section, the provider will understand confidentiality and HIPPA as it applies to a patient's sexual health information and how that information can be released without authorization. The provider's responsibility of reporting STDs to the Disease Intervention Specialist (DIS) sites in the jurisdiction where the patient resides will also be covered. In case a provider is not familiar with the work of a DIS, this information is available in this section along with contact information for the DIS in your area.

Confidentiality and HIPAA
This document the Indiana code which allows disclosure of protected health information to a public health authority for purposes of preventing or controlling disease

OCR HIPAA Privacy
This document provides details on the HIPAA Privacy Rule, as well as key definitions for terminology used in the rule

Reportable Sexually Transmitted Diseases
This document outlines the sexually transmitted diseases (STDs) that are required, by Indiana law, to be reported to the state or local health department

Patient DIS Brochure
This informational brochure gives providers more information about the role of a disease intervention specialist (DIS) in disease follow-up and lists contact information for the DIS in their area

Positive STD/HIV Result Flow Charts
This document explains the flow of a STD case investigation, including actions to taken by the DIS and the provider

Indiana STD Districts and Fax Numbers
This document is a map of the STD districts in Indiana and the fax numbers associated with them for faxing confidential reporting forms

Indiana Confidential STD Reporting Form
This document provides an example of the online reporting form that providers should use to report new cases of STDs to ISDH

Indiana Legislative Authority and the Federal Health Insurance Portability and Accountability Act (HIPAA)

Access to Confidential Information

Indiana communicable disease legislation and the federal Health Insurance Portability and Accountability Act of 1996, P.L. 104-191 (HIPAA) allows for release of information to Indiana State Department of Health (ISDH) staff during an epidemiological investigation. As part of its mission to protect, promote, and provide for public health in the state, ISDH assists local health departments with disease outbreak investigations, contact tracing, case investigation, and follow up.

This process requires that ISDH staff obtain access to confidential medical or epidemiological information, including, but not limited to, case investigation forms, questionnaires, and reports from hospitals, physicians, and laboratories. The ISDH currently is in the process of such a disease investigation and requests access to and copies of any and all medical and epidemiological records that the ISDH staff deems necessary.

The ISDH, as part of a disease investigation, has the authority to inspect and photocopy medical and epidemiological information wherever found. Authority for this is found at 410 IAC I-2.3-49(g) which reads as follows:

> **Medical or epidemiological information wherever maintained, concerning reportable cases, shall be made available to the commissioner or the commissioner's designee.**

Any information obtained in the course of public health investigations, whether from patient records or other sources, will be maintained by the ISDH as confidential under Indiana Code 16-41-8-1 and 410 IAC 1-2.3-50.

HIPAA does not prevent the disclosure of medical or epidemiological information to public health authorities such as the ISDH. In fact, section 1178(b) of HIP AA reads:

> **Nothing in this part shall be construed to invalidate or limit the authority, power, or procedures established under any law providing for the reporting of disease or injury, child abuse, birth, or death, public health surveillance, or public health investigation or intervention.**

The HIPAA privacy rule at 45 CPR 164.512(b) echoes the statutory language cited above allowing disclosure of protected health information to a public health authority for purposes of preventing or controlling disease, including public health investigations.

OCR HIPAA Privacy
DISCLOSURES FOR PUBLIC HEALTH ACTIVITIES

[45 CFR 164.512(b)]

Background

The HIPAA Privacy Rule recognizes the legitimate need for public health authorities and others responsible for ensuring public health and safety to have access to protected health information to carry out their public health mission. The Rule also recognizes that public health reports made by covered entities are an important means of identifying threats to the health and safety of the public at large, as well as individuals. Accordingly, the Rule permits covered entities to disclose protected health information without authorization for specified public health purposes.

How the Rule Works

General Public Health Activities. The Privacy Rule permits covered entities to disclose protected health information, without authorization, to public health authorities who are legally authorized to receive such reports for the purpose of preventing or controlling disease, injury, or disability. This would include, for example, the reporting of a disease or injury; reporting vital events, such as births or deaths; and conducting public health surveillance, investigations, or interventions. See 45 CFR 164.512(b)(1)(i). Also, covered entities may, at the direction of a public health authority, disclose protected health information to a foreign government agency that is acting in collaboration with a public health authority. See 45 CFR 164.512(b)(l)(i). Covered entities who are also a public health authority may use, as well as disclose, protected health information for these public health purposes. See 45 CPR 164.512(b)(2).

A "public health authority" is an agency or authority of the United States government, a **s**tate, a territory, a political subdivision of a State or territory, or Indian tribe that is responsible for public health matters as part of its official mandate, as well as a person or entity acting under a grant of authority from, or under a contract with, a public health agency. See 45 CPR 164.501. Examples of a public health authority include State and local health departments, the Food and Drug Administration (FDA), the Centers for Disease Control and Prevention, and the Occupational Safety and Health Administration (OSHA).

Generally, covered entities are required reasonably to limit the protected health information disclosed for public health purposes to the minimum amount necessary to accomplish the public health purpose. However, covered entities are not required to make a minimum necessary determination for public health disclosures that are made pursuant to an individual's authorization or for disclosures that are required by other law. See 45 CPR 164.502(b). For disclosures to a public health authority, covered entities may reasonably rely on a minimum necessary determination made by the public health authority in requesting the protected health information. See 45 CFR 164.514(d)(3)(iii)(A). For routine and recurring public health disclosures, covered entities may develop standard protocols as part of their minimum necessary policies and procedures that address the types and amount of protected health information that may be disclosed for such purposes. See 45 CFR 164.514(d)(3)(i).

Other Public Health Activities. The Privacy Rule recognizes the important role that persons or entities other than public health authorities play in certain essential public health activities. Accordingly, the Rule permits covered entities to disclose protected health information, without authorization, to such persons or entities for the public health activities discussed below.

- **Child abuse or neglect.** Covered entities may disclose protected health information to report known or suspected child abuse or neglect, if the report is made to a public health authority or other appropriate government authority that is authorized by law to receive such reports.

- For instance, the social services department of a local government might have legal authority to receive reports of child abuse or neglect, in which case, the Privacy Rule would permit a covered entity to report such cases to that authority without obtaining individual authorization. Likewise, a covered entity could **r**eport such cases to the police department when the police department is authorized by law to receive such reports. See 45 CFR 164.512(b)(l)(ii). See also 45 CFR 512(c) for information regarding disclosures about adult victims of abuse, neglect, or domestic violence.

- **Quality, safety, or effectiveness of a product or activity regulated by the FDA.** Covered entities may disclose protected health information to a person subject to FDA jurisdiction, for public health purposes related to the quality, safety or effectiveness of an FDA-regulated product or activity for which that person has responsibility. Examples of purposes or activities for which such disclosures may be made include, but are not limited to:

  - ☐ Collecting or reporting adverse events (including similar reports regarding food and dietary supplements), product defects or problems (including problems regarding use or labeling), or biological product deviations;
  - ☐ Tracking FDA-regulated products;
  - ☐ Enabling product recalls, repairs, replacement or look back (which includes locating and notifying individuals who received recalled or withdrawn products or products that are the subject of look back); **and**
  - ☐ Conducting post-marketing surveillance.

  See 45 CFR 164.512(b)(l)(iii). The "person" subject to the jurisdiction of the FDA does not have to be a specific individual. Rather, it can be an individual or an entity, such as a partnership, corporation, or association. Covered entities may identify the party or parties responsible for an FDA-regulated product from the product label, from written material that accompanies the product (known as labeling), or from sources of labeling, such as the Physician's Desk Reference.

- **Persons at risk of contracting or spreading a disease.** A covered entity may disclose protected health information to a person who is at risk of contracting or spreading a disease or condition if other law authorizes the covered entity to notify such individuals as necessary to carry out public health interventions or investigations. For example, a covered health care provider may disclose protected health information as needed to notify a person that (s)he has been exposed to a communicable disease if the covered entity is legally authorized to do so to prevent or control the spread of the disease. See 45 CFR 164.512(b)(1)(iv).

- **Workplace medical surveillance.** A covered health care provider who provides a health care service to an individual at the request of the individual's employer, or provides the service in the capacity of a member of the employer's workforce, may disclose the individual's protected health information to the employer for the purposes of workplace medical surveillance or the evaluation of work-related illness and injuries to the extent the employer needs that information to comply with OSHA, the Mine Safety and Health Administration (MSHA), or the requirements of **s**tate laws having a similar purpose. The information disclosed must be limited to the provider's findings regarding such medical surveillance or work-related illness or injury. The covered health care provider must provide the individual with written notice that the information will be disclosed to his or her employer (or the notice may be posted at the worksite if that is where the service is provided). See 45 CFR 164.512(b)(l)(v).

(You can also go to http://answers.hhs.gov/cgi-bin/hhs.cfg/php/enduser/std alp.php. then select "Privacy of Health Information/HIPAA" from the Category drop down list and click the Search button.)

Reportable Sexually Transmitted Diseases

Health care providers are required by law (410 IAC 1-2.5-75&76) to report cases of STDs within 72 hours to their local Disease Intervention Specialists or the State Department of Health. Please refer to the "Indiana STD Districts and Fax Numbers" for where to fax paper reports.

https://www.in.gov/isdh/files/Districts_and_Fax_Numbers_2018_Map.pdf

Reportable STDs in the state of Indiana are:

Chlamydia	**Granuloma Inguinale**
Syphilis	**Chancroid**
Gonorrhea	**Lymphogranuloma Venereum**

Reportable Information

Lab Reports	Person	Submitter
• **Name** • **Date** • **Test Result** • **Specimen source** • **Normal limits for test** • **Test result interpretation**	• **Name** • **Address** • **Phone number** • **Date of birth or approximate age**	• **Name** • **Address** • **Phone number**

The following infections should not be reported:

- Anogenital Herpes
- Trichomoniasis
- Epididymitis
- Urethritis
- Bacterial Vaginosis
- Anogenital Warts

Online Web Communicable disease report link:
https://eportal.isdh.in.gov/SWIMSSWEBCDR/

DISEASE INTERVENTION SPECIALISTS

Disease intervention specialists (DIS) are specially trained workers who focus on improving the overall health of your community through helping those impacted by sexually transmitted diseases (STD) and HIV.

DIS work from local offices in Indiana to stop the spread of STD and HIV by assisting those who have been diagnosed with chlamydia, gonorrhea and syphilis manage their infections. DIS also help people who may have come into contact with STDs/HIV or those who would benefit from testing. Each year in Indiana, with STDs refer about 4,000 people that they have come in contact with for the DIS to contact.

Find Disease Intervention Specialists in your area

DISTRICT 1

Counties: Jasper, Lake, LaPorte, Newton, Porter, Pulaski, Starke

Gary City Health Department
1145 W. Fifth Ave., Gary, IN 46402
Ph: (219) 239-2318
Fax: (219) 881-1396

DISTRICT 2

Counties: Cass, DeKalb, Fulton, Kosciusko, LaGrange, Marshall, Miami, Noble, St. Joseph, Steuben, Whitley

Northern Indiana Maternal Child Health Network - 413 W. McKinley Ave, Ste D, Mishawaka, IN 46545
Ph: (574) 318-4095, Fax: (574) 387-4047

DISTRICT 3

County: Allen

Allen County Health Department
4813 New Haven Ave., Fort Wayne, IN 46803
Ph: (260) 449-3021
Fax: (260) 449-3507

DISTRICT 4

Counties: Benton, Carroll, Clinton, Fountain, Howard, Montgomery, Tippecanoe, Tipton, Warren, White

Tippecanoe County Health Department
629 N. Sixth St., Suite A, Lafayette, IN 47901
Ph: (765) 423-9222, x 2226
Fax: (765) 423-9797

DISTRICT 5

Counties: Boone, Hamilton, Hancock, Hendricks, Johnson, Marion, Morgan, Shelby

Bell Flower Clinic at Eskenazi Health
640 Eskenazi Ave, Indianapolis, IN 46202
Ph: (317) 221-8347
Fax: (317) 221-8301

DISTRICT 6

Counties: Miami, Wabash, Huntington, Wells, Adams, Grant, Blackford, Jay, Madison

Madison County Health Department
206 E. Ninth St., Anderson, IN 46016
Ph: (765) 641-9523
Fax: (765) 646-9208

DISTRICT 7

Counties: Bartholomew, Brown, Clay, Greene, Lawrence, Monroe, Owen, Parke, Putnam, Sullivan, Vermillion, Vigo

Monroe County Health Department
119 W. Seventh St., Bloomington, IN 47404
Ph: (812) 349-2829
Fax: (812) 349-7346

DISTRICT 8

Counties: Daviess, Dubois, Gibson, Knox, Martin, Perry, Pike, Posey, Spencer, Vanderburgh, Warrick

Vanderburgh County Health Department
420 Mulberry St., Evansville, IN 47713
Ph: (812) 435-5683
Fax: (812) 435-5041

DISTRICT 9

Counties: Clark, Crawford, Dearborn, Floyd, Harrison, Jackson, Jefferson, Jennings, Ohio, Orange, Ripley, Scott, Switzerland, Washington

Clark County Health Department
1201 Wall Street, Jeffersonville, IN 47130
Ph: (812) 288-2706.
Fax: (812) 288-1474

DISTRICT 10

County: Elkhart

Elkhart County Health Department
608 Oakland Ave., Elkhart, IN 46516
Ph: (574) 523-2125
Fax: (574) 389-3153

DISTRICT 11

Counties: Delaware, Randolph, Henry, Wayne, Rush, Fayette, Union, Decatur, Franklin

Meridian Health Services
240 N. Tillotson Ave., Muncie, IN 47304
Ph: (765) 288-1928
Fax: (888) 389-9810

HIV/STD/VIRAL HEPATITIS
Indiana State Department of Health

LET'S WORK TOGETHER TO REDUCE SEXUALLY TRANSMITTED DISEASES

HOW CAN PARTNER SERVICES FOR STDS HELP ME?

STD PREVENTION

HIV/STD/VIRAL HEPATITIS
Indiana State Department of Health

COMMON STD RELATED QUESTIONS:

WHAT IS PARTNER SERVICES?

Partner services is the care offered and provided to sex and needle-sharing partners by a disease intervention specialist (DIS). DIS will speak to clients who have been diagnosed with gonorrhea, chlamydia, syphilis, or HIV and give them valuable information regarding the management of their infections. When working with a client, DIS will discuss ways that they can change their behavior to reduce the risk of being infected again. Over the course of the discussion, clients are educated about the infection and how to properly take any medication prescribed to them. Because DIS actively work to stop the spread of STDs in your community, clients will be asked to identify possible contacts they are aware of who may have acquired an STD and would benefit from testing and treatment. DIS are specially trained to work with clients confidentially and their contacts to break the chain of infection.

I'VE HEARD YOU ARE THE "SEX POLICE"!

Participation with partner services is always your choice. DIS should not force you to give information! This is a confidential service available to those diagnosed with infectious syphilis or HIV (and for some who have gonorrhea or chlamydia). Anyone unintentionally exposed to these infections can be informed of their exposure, get tested, and possibly receive treatment if needed without a client's name or involvement ever being mentioned. This is why it is so important for partners to work with a DIS because some agencies have strict medication policies that prohibit the presumptive treatment with antibiotics. DIS work closely with medical providers to give proper treatment to clients exposed as a way to stop any infections that could be growing in their bodies.

WHY SHOULD I CARE IF MY PARTNERS ARE TESTED?

Someone didn't care that they infected me!

STDs and HIV don't have obvious symptoms, and it's possible your sexual partners were unaware they were infected. Most people try not to infect others if they know they themselves are infected.

HERE ARE SOME OTHER REASONS TO USE PARTNER SERVICES:

Most STDs are asymptomatic, so your partner could reinfect you if they aren't treated. All STDs have a period of time where they are without symptoms, so even if your partner doesn't currently have symptoms, he or she may become symptomatic after you have received treatment.

Partner Services is confidential, meaning the DIS legally cannot tell your contacts who referred them to care and services. Protecting your personal information is extremely important to DIS and partner services.

All STDs have been steadily rising in the U.S. for the past few years, causing millions of dollars in health care costs. Those who test positive and their contacts referred to treatment by a DIS can be eligible to receive low-to-no-cost medications for presumptive treatment of an STD.

STDs also cause serious health consequences, such as deformity or death in babies, inability to get pregnant, and serious internal infections of the reproductive system. Syphilis in particular can eventually spread to your heart, lungs, brain and eyes. This can lead to dementia and blindness!

HOW CAN A DIS PROTECT MY PRIVACY WHEN TALKING TO MY PARTNERS?

I'm worried my partner will know I named him or her.

That's understandable. Through special training, DIS learn how to avoid talking about anything that could identify you. This includes your name, sex/age/race, where you live, and timeframes that include when the exposure occurred. DIS simply tell partners they have been exposed to an infection and then provide testing and treatment as needed. Keeping your personal health information is the DIS's top priority.

WHO DO I ASK FOR HELP?

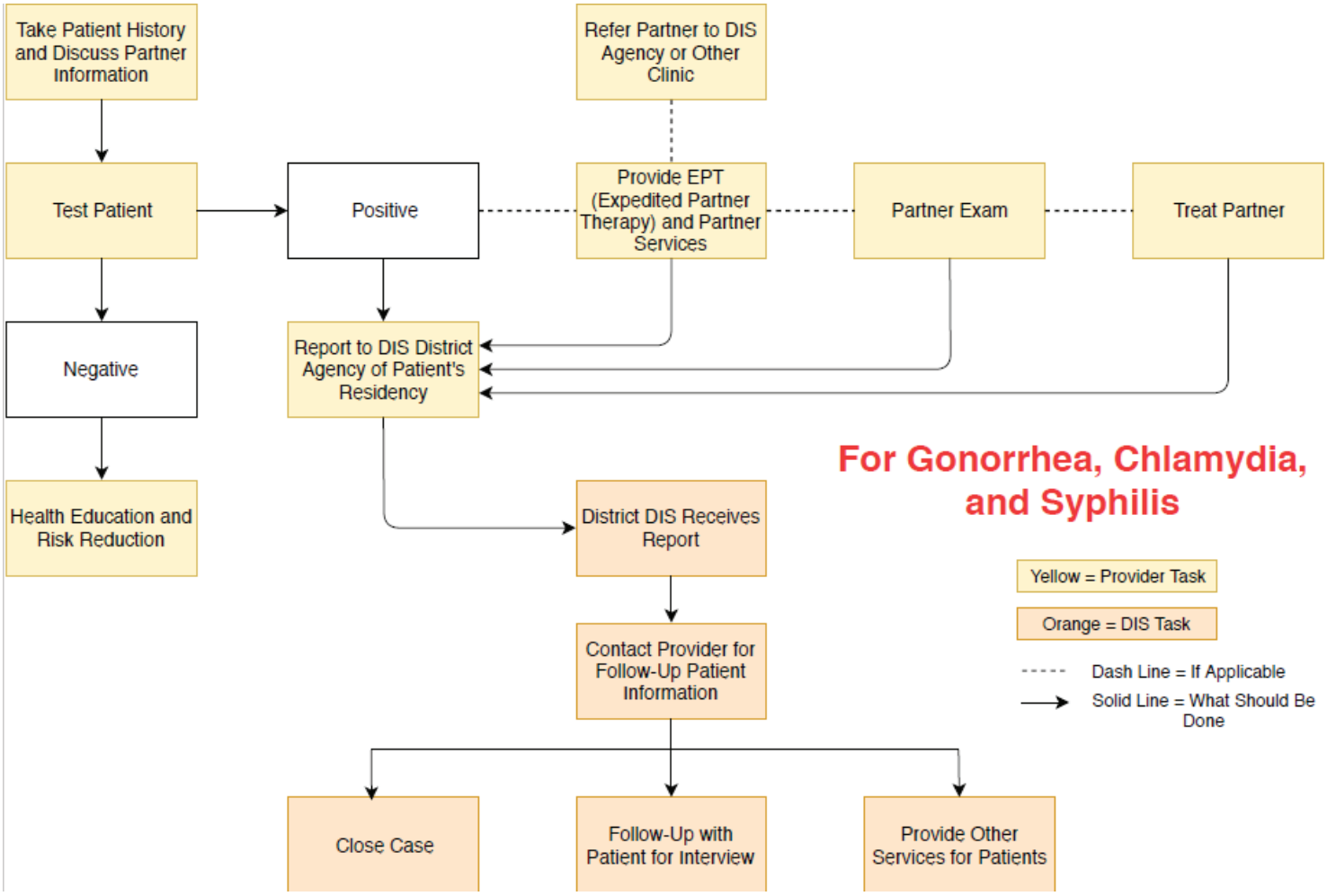
- The doctor who diagnosed you can help you get in touch with us, or sometimes we will reach out to you. Please call us back if we do!
- You can call our district offices in the county where you live and ask to speak with the DIS (see list on back of brochure).
- You will need to give your name, date of birth and be willing to talk honestly with the DIS staff.

WHAT IF I HAVE CHLAMYDIA? AM I ELIGIBLE FOR PARTNER SERVICES?

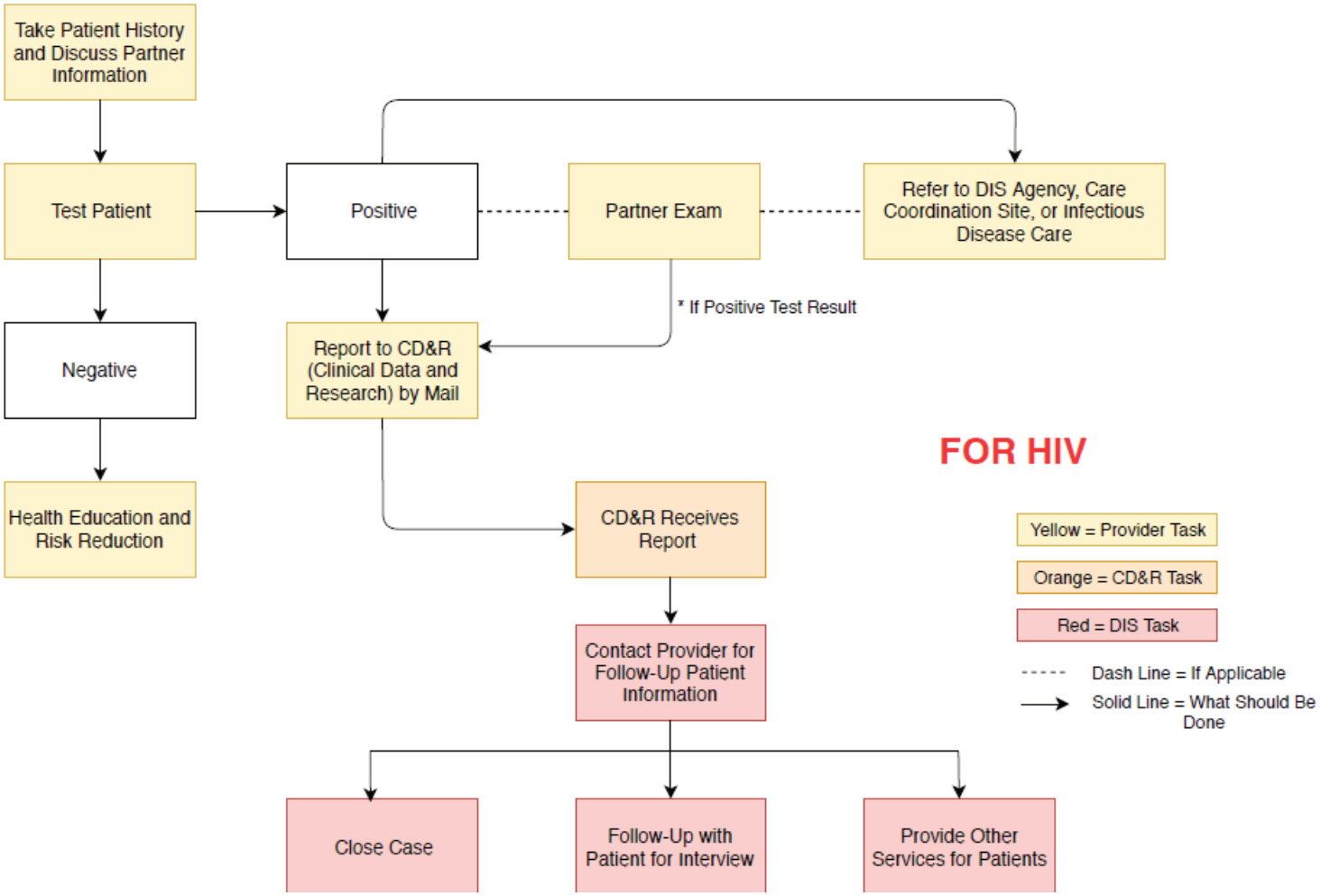
DIS in some areas of the state will be able to assist you if you've been diagnosed with chlamydia. In other instances, DIS do reach out to those with chlamydia if they meet certain risk criteria. The goal of partner services is to ensure that patients who need services the most are able to work with the DIS to prevent future infections. We encourage you to reach out to your local DIS for assistance.

Because there are so many cases of chlamydia reported, DIS in certain areas may not be able to notify all partners exposed to this infection. If the DIS is unable to assist, they can discuss with you how to tell your partners yourself if this is what you'd like to do.

STD Investigation Flow Chart



HIV Investigation Flow Chart



To report STDs,
Fax the completed Indiana Confidential Sexually Transmitted Disease Report form to the appropriate District listed for the county you are reporting from.

Indiana STD Program Districts and Fax Numbers

Jasper, Lake, Newton, Porter, Pulaski, Starke
Gary City Health Dept.
Fax (219) 881-1396

Cass, DeKalb, Fulton, Kosciusko, LaGrange, Marshall, Noble, St. Joseph, Steuben, Whitley
Northern Indiana Maternal Child Health
Fax (574) 387-4047

Elkhart
Elkhart County Health Dept.
Fax (574) 389-3153

Allen
Allen County Health Dept.
Fax (260) 449-3507

Benton, Carroll, Clinton, Fountain, Montgomery, Tippecanoe, Warren, White
Tippecanoe County Health Department
Fax (765) 423-9797

Adams, Blackford, Grant, Huntington, Jay, Madison, Miami, Wabash, Wells
Madison County Health Department
Fax (765) 286-1737

Boone, Hamilton, Hancock, Hendricks, Johnson, Marion, Morgan, Shelby
Marion County Health Dept.
Fax (317) 221-8301

Bartholomew, Brown, Clay, Greene, Lawrence, Monroe, Owen, Parke, Putnam, Sullivan, Vermillion, Vigo
Monroe County Health Dept.
Fax (812) 349-7346

Daviess, Dubois, Gibson, Knox, Martin, Perry, Pike, Posey, Spencer, Vanderburgh, Warrick
Vanderburgh County Health Dept.
Fax (812) 435-5041

Clark, Crawford, Dearborn, Floyd, Harrison, Jackson, Jefferson, Jennings, Ohio, Orange, Ripley, Scott, Switzerland, Washington
Clark County Health Dept.
Fax (812) 288-1474

Decatur, Delaware, Fayette, Franklin, Henry, Randolph, Rush, Union, Wayne
Meridian Health Services
Fax (765) 288-8516

INDIANA CONFIDENTIAL SEXUALLY TRANSMITTED DISEASE (STD) REPORTING

State Form 56459 (1-18)

Indiana State Department of Health

PATIENT INFORMATION

Legal Last Name: _____ **Legal First Name:** _____ **MI:** ____

Preferred Name (*if different than legal name*):_____ **Date of Birth:** ____/_____/_____

Address ***(number and street)***:_____

City/State/ZIP:_____ **County:** _____

Telephone: _____ ☐ Home ☐ Work ☐ Cell

Sex: ☐ Male ☐ Female ☐ Transgender: Male to Female ☐ Transgender: Female to Male ☐ Other **Pregnant**: ☐ Yes ☐ No

Race: ☐ White ☐ Black ☐ Asian ☐ Pacific Islander ☐ American Indian/Alaskan Native ☐ Other ☐ Multiracial ☐ Unknown

Ethnicity: ☐ Hispanic ☐ Non-Hispanic **Health Insurance:** ☐ Yes ☐ No **Marital Status:** ☐ Single ☐ Married

******For reports of positive chlamydia, gonorrhea, and syphilis cases only.******

Check all that apply: ☐ **CHLAMYDIA** ☐ **GONORRHEA:**

☐ Pelvic Inflammatory Disease **Specimen Source:** **Collection Date:** _____/_____/_____

☐ Cervix ☐ Patient-collected vaginal **Test Type:** _____

☐ Urethral ☐ Urine ☐ Rectal ☐ Pharyngeal

Treatment:

☐ Prescribed ☐ Administered ☐ Patient Not Treated ☐ Patient Not Informed of Result **Date:** _____/_____/_____

Treatment Regimen *(including dosage)*:

_____

Does patient have sex with: ☐ Men ☐ Women ☐ Both ☐ Unknown

Were patient's partners notified of exposure? ☐ Yes, by our office. ☐ Yes, patient notified partners. ☐ No ☐ Unknown

Treatment given for patient's partners? ☐ Yes, extra medication given for ___ (#) partners. ☐ Yes, prescription written for ___ (#) partners. ☐ No

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SYPHILIS: ***Please report all positive test results and negative reflex test results.***

☐ Primary ☐ Secondary ☐ Early (less than 12 months duration) ☐ Late (greater than 12 months duration) ☐ Congenital ☐ Unknown

Collection date: _____/_____/_____ **Symptoms:** _____

Onset Date: _____/_____/_____ ☐ Neurologic symptoms? ☐ Ocular symptoms? ☐ Otic symptoms?

Non-Treponemal Tests: **Treponemal Tests:**

☐ RPR ☐ VDRL ☐ CSF-VDRL EIA IgG: ☐ Positive ☐ Negative FTA: ☐ Positive ☐ Negative

☐ Positive ☐ Negative Titer: 1:___ TPPA: ☐ Positive ☐ Negative Other *(specify)*:_____ Result: _____

Treatment:

☐ Prescribed ☐ Administered ☐ Patient Not Treated ☐ Patient Not Informed of Result **Date:** _____/_____/_____

Treatment Regimen *(including dosage)*:

_____

Does patient have sex with: ☐ Men ☐ Women ☐ Both ☐ Unknown

Were patient's partners notified of exposure? ☐ Yes, by our office. ☐ Yes, patient notified partners. ☐ No ☐ Unknown

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Ordering Provider: _____ **Provider Facility:** _____ **Telephone**:_____

Person Completing Form: _____ **Date of Report:** _____/_____/_____

Name: _____

Fax: _____

Contact Telephone: _____

All reports of sexually transmitted disease must be made within seventy-two (72) hours of diagnosis. Please fax form to district STD reporting facility.

For a list of fax numbers by county, please visit http://www.in.gov/isdh/17440.htm. Contains confidential information per 410 IAC 1-2.5-78.

Screening Guidelines and Treatment

This section will cover the screening recommendations and treatment guidelines for adults and adolescents. Additional information on youth sexual health and how to speak to adolescents in the clinic is available.

Screening Guidelines
This document is the 2015 CDC Screening Guidelines for STDs, which provides guidance on who are the appropriate people that should be screened for certain STDs

Essential Health Questions for Adolescents
This document provides focus questions to gather sexual health information on adult and adolescent patients

Treatment Guidelines
This document is the 2015 CDC Treatment Guidelines for STDs, including accepted treatments and alternative treatments

STD Screening Guidelines

STD SCREENING GUIDELINES

The recommendations in this document are based on the 2015 CDC Sexually Transmitted Diseases Treatment Guidelines and **CDC's STD** Screening Recommendations Referenced in Treatment Guidelines and Original Recommendation Sources" **chart referenced here**: http://www.cdc.gov/std/tg2015/screening-recommendations.htm unless otherwise noted. **Please visit the CDC site for full references**. State guidelines and laws may differ; please check with your state for applicable laws and guidelines. Please visit www.nycptc.org for updates and additional STD resources and education. Abbreviations : MSM=men who have sex with men; WSW=women who have sex with women; CT=Chlamydia trachomatis; GC=Neisseria gonorrhea; RAI = Receptive Anal Intercourse; BV=Bacterial Vaginosis; HPV=Human Papillomavirus; HAV=Hepatitis A Virus; HBV=Hepatitis B Virus; HCV = Hepatitis C Virus; TOC = Test of cure; PID=Pelvic Inflammatory Disease.

	CHLAMYDIA[1,2]	GONORRHEA[3,4]	SYPHILIS	HERPES	HIV	TRICHOMONAS & BACTERIAL VAGINOSIS	CERVICAL CANCER	HEPATITIS B	HEPATITIS C
WOMEN	Test at least annually for sexually active women under 25 years of age and sexually active women aged 25 years and older if at increased risk[5] Retest approximately three months after treatment.	Test at least annually for sexually active women under 25 years of age and sexually active women age 25 years and older if at increased risk[6] Retest 3 months after treatment.		Consider type-specific HSV serologic testing for women presenting for an STI evaluation, especially if multiple sex partners	All women aged 13-64 years and all women who seek evaluation and treatment for STIs	**Trichomonas:** consider screening women if at high risk[11] or in high prevalence settings (e.g., STD clinics and correctional facilities) **Bacterial Vaginosis (BV):** no routine screening recommendation	Women 21-29 years of age every 3 years with cytology Women 30-65 years of age every 3 years with cytology or every 5 years with a combination of cytology and HPV testing.	Women at increased risk.	
PREGNANT WOMEN	All pregnant women under 25 years of age Pregnant women, aged 25 years and older if at increased risk[5] Retest during 3rd trimester if under 25 years of age or at risk[5]	All pregnant women under 25 years of age and older women if at increased risk[6] Retest 3 months after treatment	All pregnant women at the first prenatal visit Retest early in 3rd trimester and at delivery if at high risk[10]	Evidence does not support routine HSV-2 serologic screening among asymptomatic pregnant women. However, type-specific serologic tests might be useful for identifying pregnant women at risk for HSV infection and guiding counseling regarding the risk for acquiring genital herpes during pregnancy	All pregnant women at first prenatal visit and at delivery if not previously tested or no prenatal care Retest in 3rd trimester if at high risk[10]	**Trichomonas:** insufficient evidence for screening asymptomatic pregnant women; symptomatic pregnant women should be screened. For pregnant women with HIV infection, screening at first prenatal visit is recommended. **BV:** Insufficient evidence to recommend routine screening in asymptomatic pregnant women at high or low risk for preterm delivery	Screening at same intervals as non-pregnant women	Test for HBsAg at first prenatal visit of each pregnancy regardless of prior testing; retest at delivery if at high risk	Women, men and pregnant women born between 1945-1965 and if other risk factors are present[12]
MEN	Consider screening young men in high prevalence clinical settings (adolescent and STD clinics and correctional facilities) or in populations with high burden of infection (e.g. MSM)			Consider type-specific HSV serologic testing for men presenting for an STI evaluation, especially if multiple sex partners	All men aged 13-64 years and all men who seek evaluation and treatment for STIs			Men at increased risk.	
MSM (HIV negative)	Test at each site of exposure (urethra, rectum) at least annually for sexually active MSM regardless of condom use or every 3-6 months if at increased risk[7]	At least annually for sexually active MSM at each site of exposure (urethra, rectum, pharynx) regardless of condom use and every 3-6 months if at increased risk[7]	At least annually for sexually active MSM and every 3-6 months if at increased risk[7]	Consider type-specific serologic tests for HSV-2 if infection status is unknown in MSM with previously undiagnosed genital tract infection.	At least annually for sexually active MSM if HIV-negative or unknown status and if patient or sex partner has had more than one sex partner since most recent HIV test			All MSM should be tested for HBsAg	MSM born between 1945-1965 and if other risk factors are present[12] Annual HCV testing in MSM with HIV infection.
Persons with HIV	For sexually active individuals, screen at first HIV evaluation and at least annually thereafter. Test at each site of exposure. More frequent screening might be appropriate depending on individual risk behaviors and local epidemiology.	For sexually active individuals, screen at first HIV evaluation, and at least annually thereafter. Test at each site of exposure. More frequent screening might be appropriate depending on individual risk behaviors and local epidemiology.	For sexually active individuals, screen at first HIV evaluation, and at least annually thereafter.	Consider type-specific HSV serologic testing for persons presenting for an STI evaluation, especially if multiple sex partners, persons with HIV infection, and MSM at increased risk for HIV acquisition.		**Trichomonas:** sexually active women at entry to care and at least annually thereafter	Women should be screened within 1 year of sexual activity or initial HIV diagnosis using conventional or liquid-based cytology; testing should be repeated 6 months later.	Test for HBsAg and anti-HBc and/or anti-HBs.	Serologic testing at initial evaluation. Annual testing for HIV+ MSM.

[1] *NAAT testing FDA approved for first catch urine or vaginal swab.*
[2] *Perform local validation study for use of NAAT at anal and pharyngeal sites*
[3] *NAAT testing FDA approved for first catch urine or vaginal swab.*
[4] *Perform local validation study for use of NAAT at anal and pharyngeal sites*
[5] *Those who have a new sex partner, more than one sex partner, a sex partner with concurrent partners, or a sex partner who has a sexually transmitted infection. Screening for Chlamydia and Gonorrhea: U.S. Preventive Services Task Force Recommendation Statement. Annals of internal medicine. Sep 23 2014.*
[6] *Those with a new sex partner, more than one sex partner, a sex partner with concurrent partners, or a sex partner who has a sexually transmitted infection. Centers for Disease Control and Prevention. Sexually Transmitted Diseases Treatment Guidelines, 2015.*
[7] *More frequent STD screening (i.e., for syphilis, gonorrhea, and chlamydia) at 3–6-month intervals is indicated for MSM, including those with HIV infection if risk behaviors persist or if they or their sexual partners have multiple partners. Centers for Disease Control and Prevention. Sexually Transmitted Diseases Treatment Guidelines, 2015*
[8] *Those who have a new sex partner, more than one sex partner, a sex partner with concurrent partners, or a sex partner who has an STI. Additional risk factors for gonorrhea include inconsistent condom use among persons who are not in mutually monogamous relationships; previous or coexisting sexually transmitted infections; and exchanging sex for money or drugs. Clinicians should consider the communities they serve and may opt to consult local public health authorities for guidance on identifying groups that are at increased risk. Screening for Chlamydia and Gonorrhea: U.S. Preventive Services Task Force Recommendation Statement. Annals of internal medicine. Sep 23 2014.*
[9] *US Preventive Services Task Force. Screening for syphilis infection in pregnancy: reaffirmation recommendation statement Annals of internal medicine. 5/19/2009 2009;150(10):705-709.*
[10] *Each state's guidelines and laws may differ; please check with your State DOH for applicable laws and guidelines.*
[11] *Women with multiple sex partners, exchanging sex for payment, illicit drug use, and a history of STDs*
[12] *Past or current injection drug use, receipt of blood transfusion before 1992, long term hemodialysis, born to mother with Hep. C, intranasal drug use, receipt of an unregulated tattoo, and other percutaneous exposures. Moyer VA. Screening for hepatitis C virus infection in adults: US Preventive Services Task Force recommendation statement. Annals of internal medicine. Sep 3 2013;159(5):349-357*

Recommended Laboratory Diagnostics

This diagnostics summary is for educational purposes only. The individual clinician is in the best position to determine which tests are most appropriate. Adapted from the Spokane Washington Regional Health District's STD Toolkit

ETIOLOGIC AGENT	COMMON SYNDROMES	RAPID DIAGNOSTICS	DEFINITIVE DIAGNOSTICS
Chlamydia trachomatis	Non-gonococcal urethritis (NGU), cervicitis, proctitis, PID,	Urine leukocyte esterase can be helpful to look for presence of inflammation	**Nucleic Acid Amplification Tests (NAATs) cervical, urethral or vaginal swabs, or first catch urine.** Local validation studies required for use of rectal or pharyngeal specimen testing.
Neisseria gonorrheae	Urethritis, cervicitis, proctitis, PID,	Gram stain for symptomatic men	**Nucleic Acid Amplification Tests (NAATs) -cervical, urethral or vaginal swabs or first catch urine**). Local validation studies required for use of rectal or pharyngeal specimen testing. Cervical/intraurethral swab for culture if persistent or recurrent infection, or concern for resistance.
Trichomonas vaginalis	Vaginitis, urethritis	Rapid antigen detection test, Saline wet prep	NAAT testing (vaginal, endocervical and urine in women)
Candida albicans, other Candida sp.	Vaginitis, balanitis	10% KOH prep; Gram stain	Culture if wet mount negative and signs or symptoms
Bacterial vaginosis, anaerobic bacteria	Malodorous vaginal discharge with or w/o pruritis	Saline wet prep- clue cells, whiff test (fishy odor with 10% KOH), and vaginal pH >4.5	Rapid tests- e.g., DNA probe and vaginal fluid sialidase activity
Herpes simplex virus (HSV)	Genital ulcer	Point of care HSV2 antibody tests- recent infection may have false negative	Type specific virologic tests: Ulcer- culture or PCR; Type specific serological tests: ELISA and Western blot (glycoprotein gG1/gG2 type-specific antibody test)
***Treponema pallidum* (syphilis)**	Genital ulcer	Ulcer- darkfield microscopy; serological test; RPR, treponemal rapid EIA available reverse algorithm	serological tests: RPR, VDRL, USR, ART, (non-treponemal tests); FTA-ABS, MHA-TP (treponemal tests), TP-PA, darkfield is definitive if positive
***Sarcoptes scabiei*(scabies)**	Dermatitis, ulcers	Mineral oil wet prep	Skin scraping of burrow is definitive
***Phithirus pubis*(pubic lice)**	Dermatitis	Dry mount, observation of nits or lice	Detection of eggs, nits, or louse is definitive
Human Papillomavirus (HPV)	Genital warts (condylomata acuminate)	None; observation of lesions	Pap smear; HPV PCR
Salmonella sp., Shigella sp., Campylobacter sp.	Enteritis, proctocolitis	None	Stool culture; stool PCR
Entamoeba histolytica, Giardia lamblia	Enterocolitis	None	Wet prep or thrichrome stain of fresh or concentrated stool, giardia antigen test. Giardia PCR
Hepatitis virus: (A,B,C)	Hepatitis; elevated liver function enzymes	None; CLIA waived rapid HCV test (OraQuick HCV)	Serological test for specific antibody
HIV	Variable	Rapid HIV-1 Antibody Tests	HIV-1/HIV-2 antigen/antibody immunoassays and HIV differentiation assay (HIV1 vs HIV2 antibodies) and then HIV-1 NAT (for indeterminate or negative differentiation test)

April 2017

Download Link:
https://www1.nyc.gov/assets/doh/downloads/pdf/csi/csi-prep-pep-sti-screening.pdf

Essential Sexual Health Questions to Ask Adults

Ask all of your adult patients the questions on this card to start the conversation and to begin taking a thorough sexual history. For more questions to assess risk, see Table 1 of **"Sexual Health and Your Patients: A Provider's Guide."**

Ask at Least Annually

Have you been sexually active in the last year?

- **YES** → **What types of sex do you have (oral, vaginal, anal)?**
  - **With men, women, or both?**
  - **How many sexual partners have you had?**
- **NO** → **Have you ever been sexually active?**
  - **YES** → same questions as above
  - **NO** → **Continue with medical history.**

Ask Older Adults — Has sex changed for you? If so, how?

Conversational Tips:

- Ensure confidentiality & emphasize this is routine for all patients
- Also, ask open-ended questions, e.g., any sexual concerns or questions you'd like to discuss?
- Be non-judgmental (verbal and non-verbal)

Ask at least once, and update as needed. Gender identity and sexual orientation can be fluid.

1. What do you consider yourself to be?
   - A. Lesbian, gay, or homosexual
   - B. Straight or heterosexual
   - C. Bisexual
   - D. Another (please specify)
   - E. Don't know
2. What is your current gender identity?
   - A. Male
   - B. Female
   - C. Transgender man
   - D. Transgender woman
   - E. Neither exclusively male nor female (e.g. non-binary or nonconforming)
   - F. Another (please specify)
   - G. Decline to answer
3. What sex were you assigned at birth?
   - A. Male
   - B. Female
   - C. Decline to answer

NATIONAL COALITION FOR SEXUAL HEALTH

Recommended Preventive Sexual Health Services for Adults

Service	Females			Males			Transgender Individuals
	18-64	65+	Pregnant	18-64	65+	MSM	
STI Counseling	✓a	✓a	✓a	✓a	✓a	✓a	✓a
Contraceptive Counseling	✓		✓	✓	✓		✓
Cervical Cancer Screening	✓b	✓b	✓b				✓c
Chlamydia Screening	✓d	✓d	✓d	✓e		✓f	✓a
Gonorrhea Screening	✓d	✓d	✓d			✓g	✓a
HIV Testing	✓	✓a	✓	✓	✓a	✓	✓
Syphilis Screening	✓h	✓h	✓	✓h	✓h	✓	✓h
Hepatitis B Screening	✓i	✓i	✓	✓i	✓i	✓	✓i
Hepatitis C Screening	✓jk	✓jk	✓j	✓jk	✓jk	✓jk	✓jk
Hepatitis A Vaccine	✓l	✓l	✓l	✓l	✓l	✓	✓l
Hepatitis B Vaccine	✓m	✓m	✓m	✓m	✓m	✓	✓m
HPV Vaccine	✓n			✓n		✓n	✓n
PrEP	✓*	✓*	✓*	✓*	✓*	✓*	✓*

*= HIV-negative and at substantial risk for HIV infection (sexual partner with HIV, injection drug user, recent bacterial STI, high number of sex partners, commercial sex worker, lives in high-prevalence area or network)

a = At increased risk: inconsistent condom use, multiple partners, partner with concurrent partners, current STI, or history of STI within a year

b = Aged 21 to 65 or when adequate screening history has been established

c = FTM transgender patients who still have a cervix according to guidelines for non-transgender women

d = Sexually-active women aged <25; women aged ≥25 at increased risk

e = Young adult males in high-prevalence communities or settings

f = Screen for urethral infection if insertive anal sex in preceding year; rectal infection if receptive anal sex in preceding year

g= Screen for urethral infection if insertive anal sex in preceding year; rectal infection if receptive anal sex in preceding year; pharyngeal infection if receptive oral sex in preceding year

h = HIV-positive; at increased risk: exchange sex for drugs or money; in high prevalence communities

i = At risk: HIV-positive, unprotected sex, share needles, family member or sexual partner infected with HBV; born in a HBV-endemic country; born to parents from a HBV-endemic country

j = HIV-positive, history of injection or intranasal drug use or incarnation; blood transfusion prior to 1992

k = Born between 1945 and 1965 (at least once)

l = Use illicit drugs; have chronic liver disease; receive clotting factors; travel to HAV-endemic countries; wish to be vaccinated

m = At risk: multiple partners, share needles, family member or sexual partner infected with HBV

n = Women and men aged ≤45

For more information, visit: **nationalcoalitionforsexualhealth.org**

Essential Sexual Health Questions to Ask Adolescents

Ask all your adolescent patients the sexual health questions on this card. This will help you assess your patient's level of sexual risk and determine which additional questions to ask and which preventive services are needed (other side of card).

Ask at Least Annually

1. What questions do you have about your body and/or sex?
2. Your body changes a lot during adolescence, and although this is normal, it can also be confusing. Some of my patients feel as though they're more of a boy or a girl, or even something else, while their body changes in another way. How has this been for you?
3. Some patients your age are exploring new relationships. Who do you find yourself attracted to? (Or, you could ask, "How would you describe your sexual orientation?")
4. Have you ever had sex with someone? By "sex," I mean vaginal, oral, or anal sex. (If sexual activity has already been established, ask about sex in the past year.)

If the Adolescent Has Had Sex, Ask About

- Number of lifetime partners
- Number of partners in the past year
- The gender of those partners
- The types of sex (vaginal, oral, anal)
- Use of protection (condoms and contraception)
- Coercion, rape, statutory rape, and incest

Prepare for the Sexual History Interview

- Explain to a parent or caregiver that you spend a portion of each visit alone with the adolescent.
- Put your patient at ease. Ensure confidentiality except if the adolescent intends to inflict harm or reports being abused. Know your state's laws that affect minor consent and patient confidentiality.
- Incorporate the four essential sexual health questions into a broader psychosocial history.
- Start with less threatening topics, such as school or activities, before progressing to more sensitive topics, such as drugs and sexuality.
- Use open-ended questions, rather than closed-ended, to better facilitate conversation.
- Listen for strengths and positive behaviors and for opportunities to give praise where praise is due.

NATIONAL COALITION FOR SEXUAL HEALTH

Recommended Preventive Sexual Health Services for Adolescents

Service	Females (Aged 13-17)	Males (Aged 13-17)
STI Counseling	✓ a	✓ a
Contraceptive Counseling	✓	✓
Cervical Cancer Screening		
Chlamydia Screening	✓ b	✓ c
Gonorrhea Screening	✓ b	✓ d
HIV Testing	✓	✓
Syphilis Screening	✓ e	✓ e
Hepatitis B Screening	✓ f	✓ f
Hepatitis C Screening	✓ g	✓ g
Hepatitis A Vaccine	✓	✓
Hepatitis B Vaccine	✓	✓
HPV Vaccine	✓	✓
PrEP	✓ *	✓ *

*= HIV-negative and at substantial risk for HIV infection (sexual partner with HIV, injection drug user, recent bacterial STI, high number of sex partners, commercial sex worker, lives in high prevalence area or network) weighing at least 35 kg

If the Adolescent Identifies as Lesbian, Gay, Bisexual, Transgender, Questioning (LGBTQ)

- ✓ Ask whether they have a trusted adult to talk to.
- ✓ Assess safety at home and school and whether they are being bullied or harassed.
- ✓ Link your patient to community or national organizations such as **pflag.org** or **thetrevorproject.org** for education and support.
- ✓ Counsel about using condoms and contraception. Adolescents who identify as lesbian or gay may also have sex with members of the opposite sex, which increases the risk for unintended pregnancy.

a = All sexually-active adolescents

b = Sexually-active women aged ≤24; women aged ≥25 at increased risk

c = Consider screening young adult males in high prevalence communities or settings

d = At least annually for sexually-active MSM at sites of contact

e = HIV-positive; at increased risk: exchange sex for drugs or money; in high-prevalence communities

f = At risk: unprotected sex, had a prior STI, share needles, family member or sexual partner infected with HBV; born in a HBV-endemic country; born to parents from a HBV-endemic country

g = At risk: past/current injection or intranasal drug use, long-term hemodialysis, born to mother with Hepatitis C, unregulated tattoo

For more information, visit: **nationalcoalitionforsexualhealth.org**

SUMMARY OF THE 2015 STD TREATMENT GUIDELINES

These recommendations for the treatment of STDs reflect the **2015 CDC STD Treatment Guidelines**. The focus is primarily on STDs encountered in outpatient practice. This table is intended as a source of clinical guidance and is not a comprehensive list of all effective regimens. For more information, please refer to the complete CDC document at http://www.cdc.gov/std/tg2015 . Clinical and epidemiological services are available through the ISDH's STD Prevention Program. For assistance please call 317-233-7499. For more information about STDs please utilize the state's website http://www.in.gov/isdh/17440.htm

DOSING ABBREVIATIONS: d=day; qd=once each day; bid= twice daily; tid=three times a day; qid=four times a day; po=by mouth; IM=intramuscular injection; IV=intravenous; mg-milligram; g=gram; hs=hour of sleep; prn=as needed.

DISEASE	RECOMMENDED REGIMENS	ALTERNATIVE REGIMENS
CHLAMYDIA		
Uncomplicated Genital/Rectal/Pharyngeal Infections	• Azithromycin 1g po x 1 **or** • Doxycycline 100mg po bid x 7 d	• Erythromycin base 500mg po qid x 7 d **or** • Erythromycin ethylsuccinate 800mg po qid x 7 d **or** • Ofloxacin 300mg po bid x 7 d **or** • Levofloxacin 500mg po qd x 7 d
Pregnant Women	• Azithromycin 1g po x 1	★ Amoxicillin 500mg po tid x 7 d • Erythromycin base 500mg po qid x 7 d **or** • Erythromycin base 250mg po qid x 14 d **or** • Erythromycin ethylsuccinate 800mg po qid x 7 d **or** • Erythromycin ethylsuccinate 400mg po qid x 14 d
GONORRHEA Ceftriaxone 250mg IM PLUS Azithromycin 1g po is the preferred treatment for adults and adolescents with uncomplicated gonorrhea infection and is the only recommended regimen for pharyngeal infections. Dual therapy with a regimen effective against *C. trachomatis* is routinely recommended, regardless of chlamydia test results		
Uncomplicated Genital/Rectal Infections	• Ceftriaxone 250mg IM x 1 **PLUS** • Azithromycin 1g po x 1	★ If ceftriaxone is not available • Cefixime 400mg po x 1 **PLUS** Azithromycin 1g po x 1 ★ If cephalosporin allergy: • Gemifloxacin 320mg po x 1 **PLUS** Azithromycin 2g po x 1 **OR** • Gentamicin 240 mg 1Mx 1 **PLUS** Azithromycin 2g po x 1
Pharyngeal Infections	• Ceftriaxone 250mg IM x 1 **PLUS** • Azithromycin 1g po x 1	
Pregnancy	See completed CDC guidelines	
Adults and adolescents: conjunctivitis	• Ceftriaxone 1g IM x 1 **PLUS** • Azithromycin 1g po x 1	
Children (≤45 kg): urogenital, rectal, pharyngaeal	• Ceftriaxone 25-50 mg/kg IV or IM not to exceed 125 mg IM x1	
PELVIC INFLAMMATORY DISEASE	**Recommended Intramuscular/Oral regimens** • Ceftriaxone 250 mg IM x 1 **or** • Cefoxitin 2g IM x 1 with Probenecid 1g po x 1 **PLUS** • Doxycycline 100mg po BID x 14 d **with or without** • Metronidazole 500mg po bid x 14 d **Parenteral Regimens** • Cefotetan 2g IV every 12 hours **plus** • Doxycycline 100mg po or IV every 12 hours **or** • Cefoxitin 2g IV every 6 hours **plus** • Doxycycline 100mg po or IV every 12 hours	**Parenteral Regimens** • Ampicillin/Sulbactam 3 g IV every 6 hours **plus** • Doxycycline 100 mg orally or IV every 12 hours
CERVICITIS	• Azithromycin 1g po x 1 **or** • Doxycycline 100mg po bid x 7d	
NONGONOCOCCAL URETHRITIS	• Azithromycin 1g po x 1 **or** • Doxycycline 100mg po bid x 7d	• Erythromycin base 500mg po qid x 7 d **or** • Erythromycin ethylsuccinate 800mg po qid x 7 d **or** • Levofloxacin 500mg po qd x 7 d **or** • Ofloxacin 300mg po bid x 7 d
★ **PERSISTENT AND RECURRENT (NGU)**	• Men initially treated with Doxycyline: Azithromycin 1g po x 1 • Men who fail a regimen of Azithromycin: Moxifloxacin 400mg po qd x 7 d • Heterosexual men who live in areas where T. vaginalis is highly prevalent: Metronidazole 2g po x 1 **or** Tinidazole 2g po x 1	
ACUTE EPIDIDYMITIS	Likely due to gonorrhea or chlamydia • Ceftriaxone 250mg IM x 1 **plus** • Doxycycline 100mg po bid x 10 d Likely due to enteric organisms or with a negative GC culture or NAAT • Levofloxacin 500mg po qd x 10 d **or** • Ofloxacin 300mg po bid x 10 ★ For acute epididymitis most likely caused by sexually-transmitted chlamydia and gonorrhea and enteric organisms (men who practice insertive anal sex) • Ceftriaxone 250mg IM x 1 **plus** • Levofloxacin 500mg po qd x 10 d **or** • Ofloxacin 300mg po bid x 10 d	

DISEASE	RECOMMENDED REGIMENS	ALTERNATIVE REGIMENS
TRICHOMONIASIS	• Metronidazole 2g po x 1 **or** • Tinidazole 2g po x 1	• Metronidazole 500mg po bid x 7 d
BACTERIAL VAGINOSIS	• Metronidazole 500mg po bid x 7 d **or** • Metronidazole gel 0.75%, one (5g)applicator intravaginally qd x 5 d **or** • Clindamycin cream 2%, one (5g) applicator intravaginally qhs x 7 d ★ Treatment is recommended for all symptomatic pregnant women	• Tinidazole 2g po qd x 2 d **or** • Tinidazole 1g po qd x 5 d **or** • Clindamycin 300mg po bid x 7 d **or** • Clindamycin ovules 100mg intravaginally qhs x 3d
LYMPHOGRANULOMA VENEREUM	• Doxycycline 100mg po bid x 21 d	• Erythromycin base 500mg po qid x 21 d
CHANCROID	• Azithromycin 1g po x 1 **or** • Ceftriaxone 250mg IM x 1 **or** • Ciprofloxacin 500mg po bid x 3 d **or** • Erythromycin base 500mg po tid x 7 d	
SCABIES	• Permethrin 5% cream (apply to all areas of body from neck down, wash off after 8-14 hours **or** • Ivemectin 200 µg/kg po, repeated in 2 weeks	• Lindane 1% 1 oz.lotion or 30g of cream, applied thinly to all areas of the body from the neck down, wash off after 8 hours
SYPHILIS Benzathine penicillin G, Bicillin® L-A, (trade name), is the preferred drug for treatment of all stages of syphilis and is the only treatment with documented efficacy for syphilis during pregnancy.		
Adults (including HIV-Co-infected)		
Primary, Secondary, and Early Latent <1 year	• Benzathine penicillin G 2.4 million units IM x1	• Doxycycline100mg po bid x 14 d **or** • Tetracycline 500mg po qid x 14 d **or** • Ceftriaxone 1g IM or IV qd x 10-14 d
Latent <1 year, Latent of Unknown duration	• Benzathine penicillin G 7.2 million units, administered as 3 doses of 2.4 million units IM each, at 1-week intervals	• Doxycycline 100mg po bid x 28 d **or** • Tetracycline 500mg po qid x 28 d
Neurosyphilis	• Aqueous crystalline penicillin G 18-24 million units qd, administered as 3-4 million units IV q 4hrs or continuous infusion x 10-14d	• Procaine penicillin G, 2.4 million units IM qd x 10-14 d **PLUS** • Probenecid 500mg po qid x 10-14 d
Pregnant Women		
Primary, Secondary, and Early Latent	• Benzathine penicillin G 2.4 million units IM x1	• None. If PCN allergic, desensitize and treat.
Late Latent and Latent of Unknown duration	• Benzathine penicillin G 7.2 million units, administered as doses of 2.4 million units IM each, at 1-week intervals	• None. If PCN allergic, desensitize and treat.
Neurosyphilis	• Aqueous crystalline penicillin G 18-24 million units qd, administered as 3-4 million units IV Q4hrs or continuous infusion x 10-14d	• Procaine penicillin G, 2.4 million units IM qd x 10-14 d **PLUS** • Probenecid 500mg po qid x 10-14 d
★ Congenital Syphilis	See complete CDC Guidelines	
GENITAL WARTS (Human Papillomavirus)		
External Genital/Perianal	**Patient Applied** ★ Imiquimod 3.75% or 5% cream **or** • Podofilox 0.5% solution/gel **or** • Sinechatechin 15% ointment **Provider Administered** • Cryotherapy: repeat applications q1-2 weeks **or** • Trichloroacetic acid (TCA) 80%- 90% **or** Bichloroacetic acid (BCA) 80%- 90%: apply q week prn • Surgery—electrocautery, excision, laser, curretage	★ Podophyllin resin 10% -25% in compound tincture of benzoin may be considered for provider-administered treatment if strict adherence to the recommendations for application **or** • Intralesional interferon **or** • Photodynamic therapy **or** • Topical cidofovir
GENITAL HERPES (HSV-2 and HSV-1)		
First Clinical Episode	• Acyclovir 400mg po tid x 7-10 d **or** 200mg po 5x/day x 7-10 d **or** • Famciclovir 250mg po tid x 7-10 d **or** • Valacyclovir 1g po bid x 7-10 d	
Recurrent Infections	**Suppressive Therapy** • Acyclovir 400mg po bid **or** • Famciclovir 250mg po bid **or** • Valacyclovir 500mg po bid **or** 1g po qd	**Episodic Therapy for Recurrent Episodes** • Acyclovir 400mg po tid x 5 d **or** 800mg po bid x 5 d **or** 800mg po tid x 2 d **or** • Famciclovir 125mg po bid x 5 d **or** 1g po bid x 1 d **or** 500mg po x1, then 250 mg bid x 2d **or** • Valacyclovir 500mg po bid x 3d **or** 1g po qd x 5 days
HIV Co-Infected	**Suppressive Therapy** • Acyclovir 400-800mg po bid or tid **or** • Famciclovir 500mg po bid **or** • Valacyclovir 500mg po bid	**Episodic Therapy for Recurrent Episodes** • Acyclovir 400mg po tid x 5-10 d **or** • Famciclovir 500mg po bid x 5-10 d **or** • Valacyclovir 1g po bid x 5-10 d

★ Indicates update from the 2010 CDC Guidelines for the Treatment of Sexually Transmitted Disease

ISDH Resources

The STD Prevention Program has provided Fact Sheets that all providers may use and print for educational use. These can be given to patients and their partners for their information regarding their diagnosis. The Program updates these Fact Sheets yearly with new data. The Program also has provided guidance and recommendations on extragenital screening, which the Program strongly recommends all providers participate in— based on the patient's reported sexual activities. In addition, the Program has provided a memo from State Health Commissioner, Dr. Kristina Box.

ISDH Fact Sheets – Updated information on STDs in Indiana

ISDH Chlamydia Fact Sheet
ISDH Gonorrhea Fact Sheet
ISDH Syphilis Fact Sheet
ISDH Congenital Syphilis Fact Sheet

Dr. Box Memo

A description of the most updated testing, symptoms, and reporting of syphilis from the State Health Commissioner

CDC Information for Teens

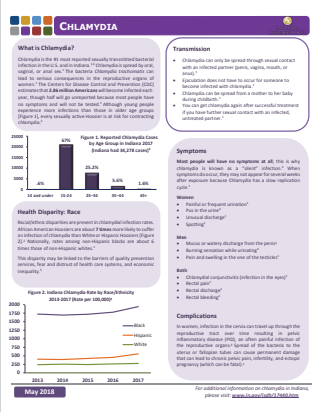
A fact sheet for teens who are sexually active

Extragenital Screening

A note from NCSD (National Coalition of STD Directors) on the importance on extragenital testing

ISDH Fact Sheet Links

Fact sheets are updates yearly, please check back to these links for updated versions yearly.



Chlamydia

https://www.in.gov/isdh/files/Chlamydia%20Fact%20Sheet%202017%20-%20Final.pdf

Gonorrhea

https://www.in.gov/isdh/files/Gonorrhea%20Fact%20Sheet%202017%20-%20Final.pdf

Syphilis

https://www.in.gov/isdh/files/Syphilis%20Fact%20Sheet%202017-Final.pdf

Congenital Syphilis

https://www.in.gov/isdh/files/Congenital%20Syphilis%20Fact%20Sheet%202017-Final.pdf

Indiana State Department of Health
An Equal Opportunity Employer

Eric J. Holcomb
Governor

Kristina Box, MD, FACOG
State Health Commissioner

June 4, 2018

Dear Colleague:

Re: Important Syphilis Testing Reminders for Physicians

As syphilis continues to increase in the U.S. and in Indiana, ISDH needs the help of all health care providers to perform syphilis testing as recommended by the Centers for Disease Control and Prevention in order to guarantee timely identification and treatment of cases.

- Syphilis cannot typically be diagnosed without a screening test (RPR) and a confirmatory test (TPPA, FTA, EIA) when the screening is reactive. Many laboratories require the provider to individually specify which tests be performed rather than allow these to be ordered as a panel or reflex. This results in physicians not receiving syphilis test results that can be used for diagnostic purposes and will add time and expense for additional specimens and testing.
- This may be further complicated if your laboratory uses the "reverse sequence method" of syphilis testing rather than the standard method of RPR first. In reverse sequence testing, labs will run the confirmatory first (EIA or CIA) and will only do the RPR if the first test is reactive. If a discordant result is received during reverse sequence (EIA positive, RPR negative) laboratories are required to perform the TPPA before reporting out the result to the physician.
- An additional problem is that some laboratories will not perform a *quantitative* RPR unless specified by the physician. A quantitative result (titer) is always needed to diagnose syphilis, to assess reinfection, and to assess efficacy of treatment, so please ensure that your laboratory will automatically do a quantitative test on all qualitative reactive RPRs.
- Please remember to test all patients presenting with syphilis symptoms painless ulcer in genital area; generalized body rash or palmar/plantar rash, etc. A list of syphilis symptoms with pictures can be found at: https://www.cdc.gov/std/syphilis/images.htm
- More information may be found here: https://www.cdc.gov/std/syphilis/Syphilis-Pocket-Guide-FINAL-508.pdf and online, free clinical training is available at: https://www.std.uw.edu/
- ISDH has created an easier way for health care providers to report cases of STD via the internet using our **new** electronic communicable disease report form, found on our website: https://www.in.gov/isdh/17440.htm , under the section "Information for Health Care Providers". Or, a fillable PDF can be faxed to your local STD jurisdiction. A list of the fax numbers by county can also be found on the STD website https://www.in.gov/isdh/17440.htm , under "DIS Contact List".

All cases of syphilis, gonorrhea and chlamydia must be reported by health care providers within 72 hours. Many health care providers believe that since the laboratory reports, they do not have to. Unfortunately, this is not true because each entity reports different information for each patient. Only the doctor's office will have critical patient information we need, such as patient race, treatment, pregnancy status, and locating information, while the lab will provide testing information on the lab specimen itself. To truly assess a syphilis diagnosis, we need both laboratories and health care providers to report on each case.

If you have questions or need additional information, please feel free to contact Caitlin Conrad, STD Prevention Program Director at caconrad@isdh.in.gov or 317-234-2871.

Yours in Health,

Kristina M. Box, MD, FACOG
State Health Commissioner