# 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. **Some patients may fall into more than one of the populations/risk categories listed; in such cases, the more rigorous screening recommendation should be followed**. 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; MSW=men 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.

NEW YORK CITY STD HIV PREVENTION TRAINING CENTER

| | CHLAMYDIA[1,2] | GONORRHEA[3,4] | SYPHILIS | HERPES | HIV | TRICHOMONAS & BACTERIAL VAGINOSIS | CERVICAL CANCER | HEPATITIS B | HEPATITIS C |
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| **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]<br><br>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[8]<br><br>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)<br><br>**Bacterial Vaginosis (BV):** no routine screening recommendation | Women 21-29 years of age every 3 years with cytology<br><br>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 | Women, men and pregnant women born between 1945-1965 and if other risk factors are present[12] |
| **PREGNANT WOMEN** | All pregnant women under 25 years of age<br><br>Pregnant women, aged 25 years and older if at increased risk[5]<br><br>Retest during 3rd trimester if under 25 years of age or at risk[6] | All pregnant women under 25 years of age and older women if at increased risk[9]<br><br>Retest 3 months after treatment | All pregnant women at the first prenatal visit<br><br>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<br><br>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.<br><br>**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 | |
| **MEN;MSW (Men Who Have Sex With Women)** | 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 | |
| **MEN;MSM (Men Who Have Sex With Men)** | At least annually, test at each site of exposure (urethra, rectum) 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 test 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]<br><br>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.<br><br>Annual testing for HIV+ MSM |

| | GC/CT[13] | SYPHILIS[13] | HIV | HEPATITIS A[14] | HEPATITIS B | HEPATITIS C |
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| **PERSONS TAKING PrEP**[13] | All patients starting PrEP - genital/urine NAAT; extragenital screening should be performed at each site of exposure for at-risk MSM/transgender women (rectal and pharyngeal NAAT) and cisgender women (rectal NAAT).<br>Rescreening: At least every 6 months for all patients on PrEP; At least every 3 months for MSM at high risk[14]; More frequent rescreening could also be considered for other high risk individuals | All patients starting PrEP<br>Rescreening: At least every 6 months for all patients on PrEP; At least every 3 months for MSM at high risk[14]; More frequent rescreening could also be considered for other high risk individuals | All patients starting PrEP- 4th generation antibody/antigen testing (recommended) or 3rd generation antibody-only testing (alternative) at PrEP initiation[15]<br>Rescreening: Every 3 months- repeat 4th generation antibody/antigen testing (recommended) or 3rd generation antibody-only testing (alternative)[15] | At baseline, MSM starting PrEP and other individuals at high risk of HAV infection[17]<br>Rescreening: If a new elevation in serum liver enzymes is present (if not immune or status is unknown) | All patients starting PrEP<br>Rescreening: If a new elevation in serum liver enzymes is present (if not immune or status is unknown)[14] | All patients starting PrEP<br>Rescreening: Annually for persons using injection drugs and other persons with ongoing risk of HCV exposure; rescreening should be performed for patients with a new elevation in serum liver enzymes (if status is unknown)[14] |

*[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 [13]Preexposure prophylaxis for the prevention of HIV infection in the United States– 2017 update, CDC (www.cdc.gov/hiv/pdf/risk/prep/cdc-hiv-prep-guidelines-2017.pdf) [14]Individuals at high risk of acquiring STDs include those who self-identify and/or who report any of the following for self or partner: multiple or anonymous sex partners, a bacterial STD diagnosed at a previous visit or since last STD screening, participation in sex parties or sex in other high-risk venues, participation in any type of transactional sex (e.g. commercial sex work), use of recreational substances during sex, PrEP for HIV Prevention, NYS Department of Health, www.hivguidelines.org/prep-for-prevention/ [15]Rapid testing using oral fluid should not be used because they can be less sensitive than serum testing. Testing should include HIV antibody/antigen testing and HIV RNA (Viral Load) testing if patient reports symptoms of acute HIV infection or possible HIV exposure (e.g. condomless anal/vaginal sex with an HIV-infected partner, injection drug use with shared injection equipment) in the previous 4 weeks or on the day of evaluation. [16]Patients who may benefit from Hepatitis A serology include those: who have chronic liver disease or conditions that can lead to chronic liver disease (e.g., chronic HBV, chronic HCV, alcohol abuse, or genetic liver diseases); are travelers to countries with high or intermediate endemicity of infection; use illicit drugs (particularly injection drugs); live in a community identified by the local health department as experiencing an outbreak of HAV infection; have clotting-factor disorders; want to reduce their risk for HAV infection; are at occupational risk who are not otherwise required to receive HAV vaccination; are at risk of HAV-related morbidity or mortality.*

## 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-gonoccocal 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**<br>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**)<br>Local validation studies required for use of rectal or pharyngeal specimen testing<br>Cervical/intraurethral swab for culture if persistent or recurrent infection, or concern for resistance |
| ***Trichomonas vaginalis*** | Vaginitis, urethritis | Rapid antigen detection test,<br>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;<br>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). For patients with signs/symptoms of acute HIV, also send HIV RNA VL testing |