LOS ANGELES COUNTY STD SCREENING RECOMMENDATIONS 2022

The following recommendations are based on guidelines for STD screening from the Centers for Disease Control and Prevention, United States Preventive Services Task Force, Infectious Disease Society of America, and the California Department of Public Health-STD Control Branch and Los Angeles County (LAC) Department of Public Health/Division of HIV & STD Programs. In populations for whom no recommendations exist, screening should be based on risk factors, local epidemiology and prevalence of specific STDs in the particular clinical setting. All women diagnosed with chlamydia (CT), gonorrhea (GC), or trichomonas should be retested for repeat infection at 3 months after treatment. Men diagnosed with chlamydia or gonorrhea should also be retested at 3 months. Retesting can also be performed opportunistically anytime the patient returns for care in the 1-12 months after treatment. Other factors to consider prior to screening are summarized in the footnotes below.

	Population	STD Screening Recommendations	Frequency	Comments
Women	**Women < 25 years of age**[1-4]	CT and GC (vaginal, cervical, or urine)	Annually	Consider screening more frequently for those at increased risk.
		Syphilis	All women at least once[9]	
		HIV	All women at least once, repeat according to risk	
	Women 25 years of age and older[1-4]	No routine screening for CT and GC Screen according to risk.		Targeted CT/GC screening recommended for women with risk factors. See footnote 4.
		Syphilis	All women 15-44 years at least once[9]	
		HIV	All women up to age 64 at least once, repeat according to risk	
	Pregnant women[1,3, 5]	CT and GC (vaginal, cervical, or urine)	First trimester	Repeat screening in 3rd trimester if at increased risk.
		HIV		
		Hepatitis B Surface Antigen (HBsAg)		
		Syphilis	First trimester, third trimester (28-32 weeks) & delivery	Repeat screening highly recommended in 3rd trimester (28-32 weeks) & at delivery as LA County is considered a high morbidity area. Emergency Department (ED) providers recommended to screen for syphilis in the ED prior to discharge if documented test results in pregnancy are unavailable. Adult correctional facilities recommended to screen all pregnant women or those who may become pregnant upon intake or as close to intake time as possible.
	HIV-positive women[1,6-8]	CT and GC (vaginal, cervical, or urine) CT and GC (rectal) GC (pharyngeal)	Annually Annually (if exposed) Annually (if exposed)	Repeat screening more frequently for those at increased risk.
		Syphilis	Annually	
		Trichomoniasis	Annually	
		Hepatitis B Surface Antigen (HBsAg) Hepatitis C	First visit	
Men	**Heterosexual men**[3]	No routine screening for STDs. Screen according to risk.		Targeted screening for CT in high-risk settings (e.g. corrections) or if risk factors (e.g. CT in past 24 months).
		HIV	All men 13-64 years of age at least once, then annually if high-risk	
	HIV-positive men[6-8] and/or **Men who have sex with men (MSM)**[1,6]	CT and GC (urine) MSM only: CT and GC (rectal) MSM only: GC (pharyngeal)	At least annually or more frequently if high risk behavior	MSM only: As patients may underreport receptive anal and/or oral sex, consider an opt-out approach to testing e.g., say "for men who have sex with men I routinely collect a mouth, rectal and urine specimen.
		Syphilis	Annually or more frequently if high risk behavior	
		HIV (if uninfected)	Repeat screening every 3-12 months, as indicated by risk.	
		Hepatitis B Surface Antigen (HBsAg)	At least once	
		Hepatitis C	HIV-negative MSM: At least annually if injection drug use. HIV-positive men: Annually	

1. CDC. STD Treatment Guidelines. June 5, 2015 / 64(RR3);1-137.
2. Human papillomavirus (HPV) testing is recommended as part of cervical cancer screening and management of cervical intraepithelial neoplasia. It is not recommended as part of routine STD screening or prior to initiating HPV vaccination. See the American Society for Colposcopy and Cervical Pathology (www.asccp.org) for further guidance.
3. Screening for asymptomatic HSV-2 infection should be offered to select patients including those in partnerships or considering partnerships with HSV-2-infected individuals. Counseling should be provided to patients tested for HSV-2. Guidelines for the Use of Herpes Simplex Virus (HSV) Type 2 Serologies– California Department of Public Health. www.std.ca.gov
4. Risk factors for CT or GC: prior CT or GC infection, particularly in past 24 months; more than one sex partner in the past year; suspicion that a recent partner may have had concurrent partners; new sex partner in past 3 months; exchanging sex for drugs or money in the past year; African American women up to age 30, and local factors such as community prevalence of infection.
5. In pregnant women with a history of injection drug use or a history of blood transfusion or organ transplantation before 1992, screening for hepatitis C should be conducted. California Guidelines for STD Screening and Treatment in Pregnancy. www.std.ca.gov
6. Routine hepatitis B vaccination is recommended for all HIV-infected patients and all MSM. Routine hepatitis A vaccination is recommended for all MSM. Pre-vaccination serologic testing may be considered, however if testing is not feasible in the current setting, routine vaccination should continue.
7. Primary Care Guidelines for the Management of Persons Infected with Human Immunodeficiency Virus: 2013 Update by the HIV Medicine Association of the Infectious Disease Society of America. *Clinical Infectious Diseases* 2013; doi: 10.1093/cid/cit665.
8. Data are insufficient to recommend routine anal cancer screening with anal cytology among HIV-positive men and women. Some clinical centers perform anal cytology screening in populations at high-risk for anal cancer. Programmatic considerations such as availability of providers to perform diagnostic anoscopy in the case of abnormal results should be considered prior to initiating anal cancer screening.
9. Screening for syphilis in women of childbearing age (15-44 years) is recommended at least once, and should be repeated according to individual level of risk.
   Expanded Syphilis Screening Recommendations for the Prevention of Congenital Syphilis Guidelines for California Medical Providers 2020

Adapted for Los Angeles County with permission from the California Prevention Training Center and the California Department of Public Health STD Control Branch

County of Los Angeles Public Health

Los Angeles County Sexual Risk Assessment and Risk Factors for Sexually Transmitted Diseases

Sexually transmitted diseases (STDs) including chlamydia (CT) and gonorrhea (GC) are among the most common reportable infections nationwide. If left untreated, STDs can result in serious health consequences including infertility, ectopic pregnancy, and chronic pelvic pain in women. STDs can also increase risk of HIV transmission and acquisition. Because many STDs do not have symptoms, *screening* for asymptomatic infection is a cornerstone of STD prevention.

Performing a sexual risk assessment

A brief risk assessment can guide decisions about what screening tests for STDs are indicated for particular patients. The content of a brief risk assessment should cover the following areas, summarized as **"The 5 P's":**

Past STDs:	"Have you ever had an STD in the past?"
Partners:	"Have you had sex with men, women, or both?" "In the past six months, how many people have you had sex with?" "Have any of your sex partners in the past 12 months had sex with other partners while they were still in a sexual relationship with you?"
Practices: (sexual/needle sharing)	Do you have… vaginal sex (penis in vagina)?" …anal sex (penis in anus/butt)?" …oral sex (penis in mouth or mouth on vagina/vulva)?" "Have you ever used needles to inject/shoot drugs?"
Prevention:	"What do you do to prevent STDs and HIV?" "Tell me about your use of condoms with your recent partner."
Pregnancy plans and HIV prevention:	"How would it be for you if you were to get pregnant now?" "What are you doing to prevent pregnancy now?" "What are you doing to prevent HIV infection?"

Risk factors by population

Adolescents and young women (age 25 and younger)	Because of high levels of disease in this age group, sexual activity alone represents a significant risk for acquiring CT, GC, and syphilis.
Women over age 25	Risk factors for CT, GC, and syphilis include: o Prior CT or GC infection, particularly in past 24 months o Multiple sex partners within the past year o Suspicion that a recent partner may have had concurrent partners o New sex partner in the past 3 months o Exchanging sex for drugs or money within the past year o African American women up to age 30 may be at increased risk; annual screening should be offered. o Other factors identified locally, including prevalence of infection in the community
Men who have sex with men	Risk factors that indicate need for more frequent screening for STDs (CT, GC, syphilis, HIV) include: o Multiple or anonymous partners o Intravenous drug use o Sex in conjunction with illicit drug use, including methamphetamine o Sex partners who engage in these activities
Men who have sex with women	CT screening targeted to men in high-risk settings including adolescent clinics, correctional facilities and STD clinics as well as CT/GC screening in men with prior infection (in past 24 months).

Adapted for Los Angeles County October 2019 with permission from the California Prevention Training Center and California Department of Public Health STD Control Branch

County of Los Angeles Public Health

County of Los Angeles Sexually Transmitted Infections (STI) Treatment Recommendations in Pregnancy 2022

These treatment regimens reflect recent updates in the CDC 2021 STI Treatment Guidelines and are specific to PREGNANT PERSONS. Non-pregnant persons may have different recommended regimens. See the CDC 2021 STI Treatment Guideline (www.cdc.gov/std/ treatment) for comprehensive recommendations. Please call the Los Angeles County Department of Public Health's Clinical Consultation line at (213) 368-7441 for clinical consultations regarding STDs, assistance with the management of pregnant persons with syphilis and confidential notification of sexual partners of patients with syphilis, gonorrhea, chlamydia, or HIV.

DISEASE	RECOMMENDED REGIMENS	ALTERNATIVE REGIMENS: To be used if medical contraindication to recommended regimen
CHLAMYDIA (CT)[1]	Azithromycin 1 g po once	Amoxicillin 500 mg po three times a day x 7 d
GONORRHEA (GC)[2] **Monotherapy with IM ceftriaxone is recommended for all patients with uncomplicated GC, inclusive of pregnant persons. If co-infection with CT has not been excluded, add azithromycin 1 g po x 1 dose in pregnant persons.**		
Genital/Rectal Infections	Ceftriaxone 500 mg IM once for persons weighing <150kg (330 lb) Ceftriaxone 1g IM once for persons weighing ≥150kg (330 lb)	If ceftriaxone not available or not feasible: • Cefixime 800 mg x 1 dose[3] If cephalosporin allergy: • Azithromycin 2 g po x 1 dose[4]
Pharyngeal Infections[5]	Ceftriaxone 500 mg IM once for persons weighing <150kg (330 lb) Ceftriaxone 1g IM once for persons weighing ≥150kg (330 lb)	No reliable treatment alternatives. Consult an infectious disease specialist or submit a question online at www.stdccn.org
CERVICITIS[6]	Azithromycin 1 g po once	None
PELVIC INFLAMMATORY DISEASE (PID)[6] **Pregnant patients with PID have high risk for maternal morbidity and pre-term delivery. Such patients should be hospitalized and treated with IV antibiotics in consultation with an Infectious Diseases specialist.**		
SYPHILIS[7,8] Primary, Secondary, AND Early Latent	Benzathine penicillin G 2.4 million units (mu) IM once[9]	None
Late Latent and Unknown Duration	Benzathine penicillin G 7.2 mu, as 3 doses of 2.4 mu IM each, in 1-week intervals (not >8 days apart)[8]	None
Neurosyphilis and Ocular Syphilis	Aqueous crystalline penicillin G 18-24 mu daily, administered as 3-4 mu IV q 4 hours x 10-14 d[10]	Procaine penicillin G 2.4 mu IM daily for 10-14 d **PLUS** Probenecid 500 mg po qid for 10-14 d
LYMPHOGRANULOMA VENEREUM (LGV)[11]	Azithromycin 1 g po once weekly x 3 weeks[12] Erythromycin base 500 mg po qid x 21 d	None
TRICHOMONIASIS[13]	Metronidazole[14] 500 mg po bid x 7 d	None
BACTERIAL VAGINOSIS	Metronidazole[14] 500 mg po bid x 7 d **or** Metronidazole 0.75% gel, 5 g intravaginally daily x 5 d **or** Clindamycin 2% cream, 5 g intravaginally qhs x 7 d	Clindamycin 300 mg po bid x 7 d **or** Clindamycin ovules[15] 100 mg intravaginally qhs x 3 d
ANOGENITAL HERPES First Clinical Episode of Herpes[16]	Acyclovir 400 mg po tid x 7-10 d **or** Valacyclovir[17] 1 g po bid x 7-10 d	None
Episodic Therapy for Recurrences	Acyclovir 800 mg po bid x 5 d **or** Acyclovir 800 mg po tid x 2 d **or** Valacyclovir[17] 500 mg po bid x 3 d **or** Valacyclovir[17] 1 g po daily x 5 d	
Daily Suppressive Therapy in Pregnant Patients (start at 36 weeks gestation)[18]	Acyclovir 400 mg po tid **or** Valacyclovir[17] 500 mg po bid	
ANOGENITAL WARTS[19] External Genital/Perianal	Cryotherapy once q 1-2 weeks **or** Trichloroacetic acid (TCA) 80%-90% once q 1-2 weeks **or** Bichloroacetic acid (BCA) 80%-90% once q 1-2 weeks **or** Surgical removal	
Mucosal Genital Warts (Vaginal, Vulvar, Anal)	Cryotherapy[20] **or** Surgical removal **or** TCA or BCA 80%-90%	

1. Test-of-cure follow-up by NAAT 4 weeks after completion of therapy is recommended in pregnancy.
2. See CDPH Gonorrhea Treatment Guidelines and Management of Suspected Treatment Failure. if suspect treatment failure.
3. Oral cephalosporins give lower and less-sustained bactericidal levels than ceftriaxone. Cefixime should only be used when ceftriaxone is not available.
4. Obtain a test of cure in 14 days if using azithromycin monotherapy.
5. Test of cure by culture or NAAT is recommended 14 days after treatment for pharyngeal GC.
6. Test for GC/CT, bacterial vaginosis and trichomoniasis. If patient lives in community with high GC prevalence, or has risk factors (e.g. age <25, new partner, partner with concurrent sex partners, or sex partner with an STI), consider empiric treatment for GC.
7. Benzathine penicillin G is available only in one long-acting formulation, Bicillin® L-A (the trade name). Other combination products, such as Bicillin® C-R should NOT be used; they contain long- and short-acting penicillins and do not effectively treat syphilis.
8. Pregnant patients allergic to penicillin should be desensitized and treated with Benzathine penicillin G. There are NO alternatives during pregnancy. The optimal treatment interval in pregnancy is 7 days. If treating outside of 6-8 day intervals, the full treatment course should be restarted.
9. Some specialists recommend a second dose of benzathine penicillin G 2.4 million units IM administered 1 week after the initial dose in pregnant people with primary, secondary, or early latent syphilis.
10. Some specialists recommend 2.4 million units of benzathine penicillin G once weekly for up to 3 weeks after completion of neurosyphilis treatment.
11. Perform a test of cure 4 weeks after the initial CT-positive NAAT test in all pregnant patients treated for LGV.
12. Because this regimen has not been rigorously studied, perform a test of cure four weeks after treatment.
13. For suspected drug-resistant trichomoniasis consult the 2021 CDC STI treatment guidelines, contact the Los Angeles County Public Health's Clinical Consultation Unit at 213-368-7441 or consult https://www.stdccn.org.
14. Although metronidazole crosses the placenta, there is no evidence of teratogenicity or mutagenic effects. Metronidazole at a dose of 500 mg PO BID for up to a week is considered compatible with breastfeeding. Drug levels peak 2-4 hours after dosing, so breastfeeding times may be shifted to avoid peak drug levels if patient prefers.
15. May weaken latex condoms and contraceptive diaphragms. Use of such products within 72 hours after treatment with clindamycin ovules is not recommended.
16. Treatment may be extended if healing is incomplete after 10 days.
17. Data regarding prenatal exposure to valacyclovir are limited. Animal trials indicate this drug poses a low risk to pregnant people.
18. At the onset of labor, all pregnant people should be questioned thoroughly about symptoms of herpes including prodromal symptoms (e.g., pain or burning at site before a lesion develops) and be examined thoroughly for herpetic lesions. People without signs or symptoms of herpes or its prodrome can deliver vaginally. Although Cesarean section does not eliminate the risk for HSV transmission, people with active genital herpetic lesions at the onset of labor should have cesarean section to reduce the risk for neonatal HSV.
19. Anogenital warts may proliferate and become friable during pregnancy. Although removal of warts during pregnancy can be considered, resolution might be incomplete or poor until pregnancy is complete. Cesarean delivery is ONLY indicated if the warts are large, and the pelvic outlet is obstructed, or vaginal delivery would result in bleeding. Pregnant people should be counseled about the low risk of warts on the larynx of their infants or children.
20. The use of a cryoprobe in the vagina is NOT advised due to risk of vaginal perforation and fistula formation.

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