2014 Planned Updates/New Content

October 2014

Canadian Guidelines on Sexually Transmitted Infections

This document outlines key content changes to the Canadian Guidelines on Sexually Transmitted Infections.

The Expert Working Group and the Public Health Agency of Canada are revising several chapters and developing new chapters to respond to changing epidemiologic trends, evolving scientific evidence, and advances in laboratory diagnostics and research. Release of the revised chapters is anticipated in 2014; interim guidance statements will be issued in advance, as appropriate.

We are also developing 2-page summary documents containing the most up-to-date management information for many of the existing specific infections and syndromes chapters.

1. Changing Epidemiological Trends

1.1 Issue: Antimicrobial resistance in N. gonorrhoeae

Minimal inhibitory concentrations (MICs) for third-generation oral and injectable cephalosporins have been increasing in Canada and globally, particularly among men who have sex with men (MSM). The number of cases of multi-drug resistant gonorrhea (MDR-GC) reported globally and nationally has increased, and there is the potential for gonorrhea to become untreatable.

1.1.1 Expert Working Group: Summary of key changes to the content of the Gonococcal Infections chapter

The revised 2013 *Gonococcal Infections* chapter is now available on the Agency website.

Key changes include: strengthened recommendations concerning use of culture for diagnosis and for test of cure; the doubling of the dosage of cephalosporin; and its use in combination with azithromycin. This combination therapy is thought to improve treatment effectiveness as well as potentially delay the emergence of resistance.

Ceftriaxone is the treatment of choice for MSM and for pharyngeal infection, due to the increased risk of treatment failure. The chapter provides recommendations for the management of treatment failure.

Clinicians should consult the 2013 *Gonococcal Infections* chapter for recommendations on screening/testing, management, treatment and follow-up of suspected or confirmed gonococcal infection.

1.1.2 Affected chapters of the 2010 version of the Guidelines to be updated:

- Laboratory Diagnosis of Sexually Transmitted Infections
- Chlamydial Infections
- Epididymitis
- Pelvic Inflammatory Disease (PID)
- Pregnancy
- Sexual Abuse in Peripubertal and Prepubertal Children
- Sexual Assault in Postpubertal Adolescents and Adults
- Sexually Transmitted Intestinal and Enteric Infections
- Urethritis
- Vaginal Discharge

2. General treatment considerations and contraindications

2.1 Issue: Identified need to address the risk of cross-sensitivity reactions with the use of second- and third-generation cephalosporins in patients with allergies to penicillin.

2.1.1 Expert Working Group: New guidance on the use of second- and third-generation cephalosporins in patients with a history of allergic reactions to penicillin.

Although cross-sensitivity between penicillin and second- or third-generation cephalosporins is low, patients with a history of immediate hypersensitivity reaction to penicillin may be at increased risk of similar reactions with all cephalosporins. A protocol (e.g., epinephrine, airway management, etc.) to respond to serious reactions should be in place if cephalosporins are administered to patients hypersensitive to penicillin.

Clinicians are advised that this recommendation applies to all chapters of the Guidelines where a second- or third-generation cephalosporin is listed as a recommended treatment option.

3. Disease specific management and follow-up issues

3.1 Issue: Release of 2009 publication related to testing intervals for neonates born to HIV-infected mothers.

3.1.1 Expert Working Group: Resource for information on testing intervals for neonates born to HIV-infected mothers.

For guidance on post-natal testing intervals for neonates born to HIV-infected mothers, please follow the recommendations provided in the 2009 *Canada Communicable Disease Report (CCDR) Volume 35 Supplement 2*.

Clinicians are advised that the recommendations in the above referenced document apply to the HIV and Pregnancy chapters of the Guidelines: these chapters will be updated.

3.2 Issue: Indications for repeating HIV testing using a second specimen.

3.2.1 Expert Working Group: New guidance on repeat testing when interpretation of results is questionable.

HIV serologic testing should be repeated using a second blood specimen if original sample volumes were inadequate; to confirm results where the interpretation is uncertain; or if the test results are incongruous with the patient history.

Clinicians should provide appropriate counselling regarding the meaning of test results and the need for further testing, as well as information on risk behaviours, risk reduction and HIV transmission.

This guidance applies to all situations where HIV testing is provided to a patient and where interpretation of results is questionable.

3.3 Issue: HIV repeat testing for individuals diagnosed with infectious syphilis and or genital ulcer disease of other etiologies.

The Expert Working Group is currently developing recommendations on intervals for repeat HIV testing for individuals diagnosed with infectious syphilis and other genital ulcer diseases.

3.3.1 Expert Working Group: New statement on HIV testing intervals for individuals with genital ulcer disease at risk of being in the window period for HIV infection.

All patients with a genital ulcer disease should be tested for HIV infection at presentation; if test results are negative, and it is suspected that the patient may be in the window period, repeat testing in 3 weeks. If these results are negative and it is suspected that the patient may still be in the window period, repeat testing is recommended at 3 months from baseline.

Clinicians are advised that this statement applies to all chapters of the Guidelines where HIV testing is recommended and where the patient is at risk of being infected with HIV and in the window period at the time of baseline testing.

3.3.2 Affected chapters of the 2010 version of the Guidelines to be updated:

- Chancroid
- Genital Ulcer Disease
- HIV
- HSV
- Lymphogranuloma venereum
- Syphilis

3.4 Issue: Identified need to specify the duration of infectivity of syphilis post-treatment

3.4.1 Expert Working Group: New statement on the duration of infectivity of syphilis post-treatment

The causative organism is highly sensitive to penicillin and is rendered non-infectious on average within 24 hours of treatment with a dose of benzathine penicillin G-LA. To provide a margin of safety, some experts recommend that patients who are treated with single dose benzathine penicillin G-LA be advised to abstain from any sexual contact for 7 days post-treatment. Patients who are treated with doxycycline or ceftriaxone may take longer to be rendered non-infectious, and should be advised to abstain from sexual contact until treatment has been completed. In addition, all patients with potentially infectious lesions such as chancres, condylomata lata, and secondary rash, should be advised to abstain from sexual contact until symptoms have resolved.

Clinicians should be aware that this advice applies to all situations where presumptive treatment is provided for infectious syphilis.

3.4.2 Affected chapters of the 2010 version of the Guidelines to be updated:

- Genital Ulcer Disease
- Pregnancy
- Syphilis

3.5 Issue: Identified need to clarify the indications for treatment of infants born to mothers who were treated for syphilis during pregnancy.

3.5.1 Expert Working Group: Clarification statement for page 23 of the 2010 *Syphilis* chapter.

Infants should be treated at birth:

- If symptomatic.
- If the infant's non-treponemal titre is at least four-fold (2 tubes) higher than the mother's.
- If the mother was treated for infectious syphilis during pregnancy AND the treatment was inadequate; did not contain penicillin; is unknown or occurred in the last month of pregnancy; OR maternal serologic response is inadequate.

- If adequate follow-up of the infant cannot be ensured and born to mother with infectious syphilis during that pregnancy.

Infants born to women treated for late latent syphilis prior to or during pregnancy do not require treatment but require follow-up until they sero-revert

Current Expert Working Group Activities

2010 Guideline chapter revisions

- Laboratory Diagnosis of Sexually Transmitted Infections
- Genital Human Papillomavirus (HPV) chapter

We anticipate releasing these chapters by mid-2014.

New chapters under development

Content development work is currently underway with lead authors and the expert working group for the following chapters:

- Cervicitis
- Genital Mycoplasmas

New 2013/2014 LGV sub-working group

The expert working group has identified the need to address new developments in the laboratory diagnosis of LGV as well as to address the issue of asymptomatic infections. This sub-group includes laboratory specialists, front line clinicians, epidemiologists and topic area specialists.

- A link to a Supplementary Statement for the *Lymphogranuloma Venereum* chapter is now available.

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