STBBI: Guides for health professionals: Summary of Recommendations for *Chlamydia trachomatis* (CT), *Neisseria gonorrhoeae* (NG) and Syphilis

TIPS FOR SCREENING, TREATMENT AND FOLLOW-UP OF BACTERIAL STBBI

DO YOU KNOW IF THE PERSON IN FRONT OF YOU HAS EVER BEEN SCREENED FOR SEXUALLY TRANSMITTED AND BLOOD-BORNE INFECTIONS (STBBI)?

IN 2018, 50% OF CANADIANS REPORTED THAT THEY HAD NEVER BEEN SCREENED FOR STBBI

REPORTED CASES OF STBBI IN CANADA ARE INCREASING (2019)

139,386 cases of *Chlamydia trachomatis* (CT)

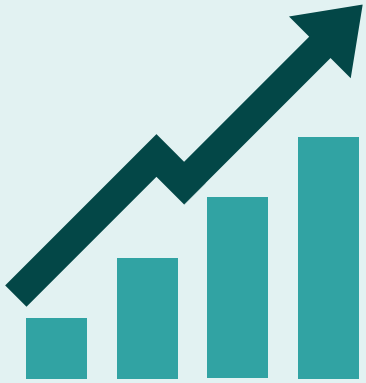
- 74% of cases were aged 15 to 29
- 58% of cases were female

35,443 cases of *Neisseria gonorrhoeae* (NG)

- 51% of cases were aged 15 to 29
- 66% of cases were male

9,245 cases of infectious Syphilis

- 72% of cases were male
- Among females aged 15 to 39 years, rates were 18 times higher than in 2010



NORMALIZE DISCUSSIONS ABOUT SEXUAL HEALTH AND OFFER STBBI SCREENING TO SEXUALLY ACTIVE PEOPLE AS PART OF ROUTINE CARE

- Screening is an opportunity to discuss transmission, signs and symptoms, risk reduction and preventive strategies
- Undiagnosed and untreated STBBI can lead to serious complications, e.g., pelvic inflammatory disease (PID), epididymo-orchitis, adverse pregnancy outcomes

OFFER ANNUAL SCREENING TO:

- Individuals < 25 years old
- Gay, bisexual and other men who have sex with men (gbMSM)
- Transgender persons

OFFER SCREENING TO PEOPLE ≥ 25 YEARS OLD BASED ON RISK FACTORS*

OFFER SCREENING ROUTINELY DURING PREGNANCY

NEW

CT and NG:

- Screen in the 1st trimester or at the 1st prenatal visit AND in the 3rd trimester
- Screen during labour if: no prenatal screening has occurred (no results are available) OR 3rd trimester screening did not occur OR follow-up for a positive result was not completed

Syphilis:

- Screen in the 1st trimester or at the 1st prenatal visit
- Screen between 28 and 32 weeks of pregnancy AND during labour in areas experiencing outbreaks AND for people at ongoing risk for infection*

MORE FREQUENT SCREENING MAY BE APPROPRIATE FOR THOSE WITH ONGOING RISK FACTORS FOR STBBI*

**Risk factors for STBBI acquisition include but are not limited to: previous STBBI diagnosis, new sexual partners, multiple or anonymous sexual partners, sexual partners having a STBBI, condomless sex and sex while under the influence of alcohol or drugs.*

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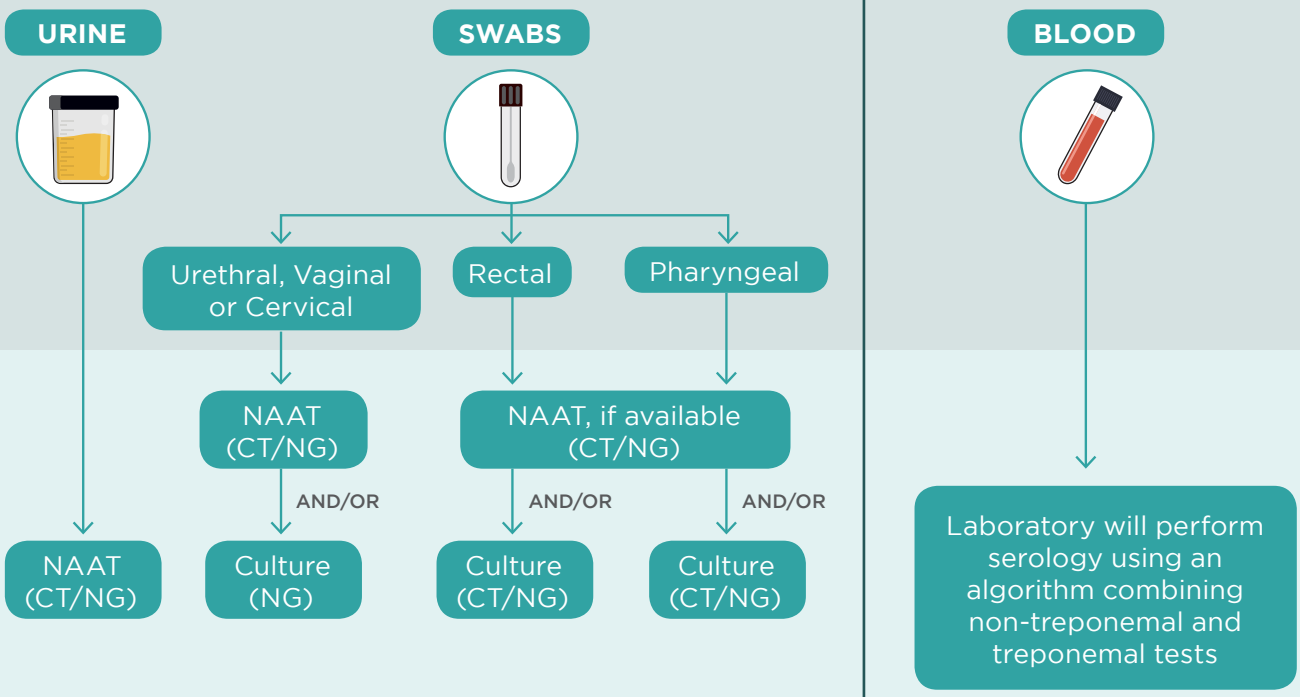
STBBI ARE OFTEN ASYMPTOMATIC. SCREEN FOR ONE STBBI, SCREEN FOR ALL!

SCREENING: Early STBBI detection in asymptomatic individuals†

***Chlamydia trachomatis* (CT) AND *Neisseria gonorrhoeae* (NG)**	**Syphilis**



Offer HIV testing when screening for other STBBI†

TIPS

- **Nucleic Acid Amplification Test (NAAT) is highly sensitive and the test of choice when screening asymptomatic individuals for CT and NG**
  - Preferred specimens for NAAT are first void urine or self-collected vaginal swab
  - Collect pharyngeal and rectal specimens from individuals with a history of performing oral sex or having receptive anal intercourse, respectively
  - Check with your laboratory for the availability of NAAT for rectal and pharyngeal specimens
- **Collect specimens for both CT and NG due to high rates of co-infection**
- **When NG is suspected, collect specimens for NAAT AND culture**
  - Culture permits antimicrobial susceptibility testing to guide treatment
  - Ideally, collect specimens prior to empirical/ epidemiological treatment

TIPS

- **Testing algorithms may vary by province and territory**

† For HIV specific guidance consult the *HIV Factsheet: Screening and Testing* available on *Canada.ca*

EARLY DIAGNOSIS AND TREATMENT LEAD TO BETTER HEALTH OUTCOMES

TREATMENT: Preferred treatment in the absence of contraindications, allergies or pregnancy

Chlamydia trachomatis (CT)

Doxycycline 100 mg PO bid for 7 days

OR

Azithromycin 1 g PO in a single dose

Neisseria gonorrhoeae (NG)

For anogenital and pharyngeal infections

Ceftriaxone 250 mg IM in a single dose PLUS Azithromycin 1 g PO in a single dose

OR

For anogenital infections

Cefixime 800 mg PO in a single dose PLUS Azithromycin 1 g PO in a single dose

Note: Cefixime is not the preferred treatment for gbMSM

Syphilis

For infectious syphilis (primary, secondary and early latent)

Long-acting benzathine penicillin G 2.4 million units IM in a single dose

For late latent syphilis

Long-acting benzathine penicillin G 2.4 million units IM weekly for 3 doses

TIPS

- **For NG infections, always use combination therapy to prevent resistance and treat possible CT co-infection**
  - The use of two antimicrobials with different mechanisms of action may improve treatment efficacy and prevent or delay the emergence and spread of resistant NG
  - Ceftriaxone 250 mg IM in a single dose PLUS Azithromycin 1 g PO in a single dose is the recommended treatment for pharyngeal NG and for gbMSM
- **For CT infections, consider using Azithromycin if poor compliance is expected**
- **Individuals and their partners should abstain from sexual contact until the completion of a multiple-dose treatment or for 7 days after a single-dose treatment**
- **All partners who have had sexual contact with the individual within 60 days prior to specimen collection or onset of symptoms, should be tested and treated**

TIPS

- **Inform individuals of potential Jarisch-Herxheimer reaction to penicillin treatment**
- **Consider penicillin desensitization for individuals with a penicillin allergy, followed by treatment with long-acting benzathine penicillin G**
  - There is no satisfactory alternative treatment to penicillin for the treatment of syphilis in pregnancy
- **Individuals and partners should abstain from sexual contact for 7 days after treatment**
- **All sexual partners or perinatal contacts should be tested and treated according to the individual's stage of infection and date of specimen collection or onset of symptoms:**
  - Primary syphilis: 3 months
  - Secondary syphilis: 6 months
  - Early latent syphilis: 1 year
  - Late latent/tertiary: individual's long-term sexual partner(s) and children as appropriate

FOLLOW-UP: Post STBBI screening and treatment interventions including test of cure (TOC)

Chlamydia trachomatis (CT)	*Neisseria gonorrhoeae* (NG)	Syphilis
TOC using NAAT 3–4 weeks after the completion of treatment is recommended only when: ▸ Compliance to treatment is suboptimal ▸ Unresolved or persistent symptoms are present ▸ Alternate treatment regimen was prescribed ▸ Individual is pregnant or prepubertal	**Routine TOC is recommended:** ▸ Using culture, 3–7 days after completion of treatment; and/or ▸ Using NAAT 2–3 weeks after completion of treatment **TOC is of particular importance when:** ▸ Treatment failure and resistant NG are suspected ▸ Compliance to treatment is suboptimal ▸ Unresolved or persistent symptoms are present ▸ Alternate treatment regimen was prescribed ▸ Individual is pregnant or prepubertal ▸ Pharyngeal infection was detected	**Indications for post-treatment monitoring and follow-up serology:** ▸ Infectious syphilis (primary, secondary and early latent): 3, 6 and 12 months ▸ Late latent and tertiary syphilis: 12 and 24 months ▸ Neurosyphilis: 6, 12 and 24 months ▸ Co-infection with HIV: 3, 6, 12 and 24 months and yearly thereafter ▸ Pregnancy: • Primary, secondary and early latent syphilis: if at risk of re-infection, monthly until delivery; otherwise 1, 3, 6 and 12 months • Late latent syphilis: at time of delivery and 12 and 24 months

TIPS

- **When test of cure (TOC) is indicated, specimens should be collected from all positive sites**
- **TOC using NAAT should be performed at recommended post-treatment interval to avoid detection of residual genetic material**
- **In addition to TOC, repeat screening is recommended 3 to 6 months post-treatment due to risk of reinfection**

TIPS

- **Post-treatment serology is used to assess treatment response**
- **Consult a colleague or specialist experienced in syphilis management if the serologic response to treatment is inadequate**

Consult the **STBBI: Guides for health professionals** for more detailed information

Recommendations do not supersede any provincial/territorial legislative, regulatory, policy and practice requirements or professional guidelines that govern the practice of health professionals in their respective jurisdictions, whose recommendations may differ due to local epidemiology or context.

ADDITIONAL INFO

- STBBI: Guides for health professionals
- HIV Fact Sheet: Screening and Testing (PHAC)
- Discussing sexual health, harm reduction and STBBIs: A guide for service providers (CPHA)
- Reducing stigma and discrimination through the protection of privacy and confidentiality (CPHA)

Learn more: visit **Canada.ca** and search **SEXUAL HEALTH** or download the **STBBI Guides** mobile application