STD PREVENTION
GONORRHEA AND CHLAMYDIA
SCREENING AND TREATMENT
SCHOOL-BASED HEALTH CARE SETTINGS

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DISCLOSURE

The presenter has no financial disclosures.

New CDC STD Treatment Guidelines are due to be released in 2015

www.cdc.gov
March 2015

LEARNING OBJECTIVES

- Describe the rationale for gonorrhea and Chlamydia screening for patients seen in School-based Health Care Settings (SHCS) particularly for those aged 15-19 years.
- List the types of screening tests that are recommended by the Centers for Disease Control and Prevention (CDC) for these infections.
- Identify source for billing information for gonorrhea and Chlamydia screening.
- Identify resources for STD screening and treatment, continuing education opportunities, and consumer educational materials.

CHLAMYDIA TRACHOMATIS – CT – INFECTION

- CT – most commonly reported notifiable infectious disease in the US
  - 1.40 million reported cases in 2013 (last year for which data are available)
  - 68% among persons aged 14-24 years with the female to male ratio 2:1
- Responsible for 25-50% of the 1 million PID cases/year
- Up to 25% of PID result in long-term sequelae
  - 9% with verified PID – experience ectopic pregnancy
  - At least 15% of tubal factor infertility is due to PID
  - Direct cost – $2.5 billion/year
- Like other STDs – CT infection can facilitate the sexual transmission of HIV
### Chlamydia trachomatis Epidemiology and Risk Factors
- Female sex – though tested more routinely than males
- Young age – especially 15-24 year olds
- New or multiple sex partners
- Hx of STD infection or presence of another STD
- Oral contraceptive user (female)
- Lack of barriers (condoms)
- Widely distributed throughout the US – NYS having among the highest rates (589/100,000 population)

### US Chlamydia Rates by State and Territories 2013

In addition to the CDC website, NYS data can also be found – [www.health.ny.gov](http://www.health.ny.gov)

### US Chlamydia Rates by Age and Sex 2013

<table>
<thead>
<tr>
<th>Age</th>
<th>Men Rate (per 100,000 population)</th>
<th>Women Rate (per 100,000 population)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0-14</td>
<td>15-19</td>
</tr>
<tr>
<td></td>
<td>20-24</td>
<td>25-29</td>
</tr>
<tr>
<td></td>
<td>30-34</td>
<td>35-39</td>
</tr>
<tr>
<td></td>
<td>40-44</td>
<td>45-54</td>
</tr>
<tr>
<td></td>
<td>55-64</td>
<td>65+</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>623.1</td>
</tr>
</tbody>
</table>

Note: The rates for ages 5-19 & 20-24...
WHY SCREEN FOR CT?
- High prevalence – particularly among adolescents
  - Screening decreases the prevalence of infection in the population which "reduces the reservoir" volume
  - Screening reduces the transmission of disease by finding & treating cases
- Screening can reduce the incidence of PID by more than 50%
  - Preventing PID will reduce significant long-term sequelae
  ➔ Most infections are asymptomatic with few/no clinical signs

DOES CT SCREENING REDUCE POST-INFECTION PID RATES?
- Scholes et al conducted study at Group Health Cooperative of Puget Sound*
  - Outcome of interest – PID diagnosis within the 12 month follow-up period
- Randomized controlled trial
  - Women randomized to screening arm or to standard care
  - Women in screening arm tested for CT & treated if infected
- PID reduced by ~60% (95% with CI 20-90%) in screening arm
  * Scholes et al. (1996). NEJM, 334(21), p 1362-6

CT TRANSMISSION
- Transmission is sexual or vertical
- Highly transmissible
- Incubation period 7-21 days
- Significant asymptomatic reservoir exists in the population – high background prevalence
  - Re-infection is common
- Most common clinical diseases are male urethritis & cervicitis

Image – www.ashasexualhealth.org
**CT Male Urethritis**

- **Incubation** – 5-10 days in symptomatic
  - However >50% asymptomatic
- **Symptoms** – urethral discharge, dysuria
- **Signs** – clear/mucoid/mucopurulent discharge, urethral erythema
  - Most have no abnormal discharge

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**CT Cervicitis**

- **Incubation** – unsure as > 80% asymptomatic
- **Symptoms** – non-specific, including
  - Vaginal discharge, dyspareunia, vaginal spotting
- **Signs** – 30-50% with signs of mucopurulent cervicitis (MPC), including purulent endocervical discharge, edematous cervical ectopy, cervical friability
  - However, many to most have no clear clinical sign

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**CT Other Manifestations**

- Neonatal diseases
- Conjunctionitis – adults
  - Usually d/t auto-inoculation
- Proctitis/Proctocolitis
  - Mostly occurs in MSM
- Reiter’s syndrome
  - An inflammatory autoimmune disease occurring post-CT infection – associated with HLA-B27 & more common in males
- LGV (Lymphogranuloma Venereum)
  - Caused by serovars L1-L3 & is rare in US
- PID – as noted
- Epididymitis
  - Not nearly as common as PID

*See STD Guidelines for specifics; also NNPTC for clinical training info – www.cdc.gov; http://nnptc.org
THE AFFORDABLE CARE ACT AND STD/HIV SCREENING

- The ACA has provisions for specific health screening to address public health issues
- HIV testing & new codes for STD screening for GC, CT, syphilis, & Hepatitis B
- These changes allow for STD screening that make it easier to conduct
  - See Handout
- There is also reimbursement for HIBC (High Impact Behavioral Counseling)

CT TESTING RECOMMENDATIONS

- CDC has recently updated recommendations for CT (& gonorrhea) testing
  - MMWR released March 2014

  www.cdc.gov/std/laboratory/2014LabRec/default.htm

CT SCREENING RECOMMENDATIONS – FEMALES

- Non-pregnant
  - Sexually active females ≤ 25 years should be screened annually
  - Those >25 years should be screened if have risk fx (e.g., new or multiple partners)
  - Repeat screening of women 3-4 months post-Rx for CT infection – especially adolescents (more to follow)
  - Repeat screening of all females Rx’d for CT when they next present for care
- Pregnant
  - Screen all pregnant females at the 1st prenatal visit
  - Pregnant women aged ≤ 25 years & those at increased risk for CT should be re-screened in the 3rd trimester
CT SCREENING RECOMMENDATIONS – MALES

- Nucleic Acid Amplification Tests (NAATs) are the recommended method
  - Urine is recommended
  - Swab can also be collected
- MSM (men who have sex with men) should also have rectal CT test – culture is recommended
  - NAATs can be used under specific circumstances – more to follow

CHLAMYDIA TESTING – MUCH MORE ACCURATE OPTIONS THAN IN THE PAST

- Culture
- Non-Amplified Assays
  - Direct Fluorescent Antibody (DFA)
  - ELISA/EIA
  - DNA probe – Gen-Probe ™
- Nucleic Acid Amplification Assays (NAATs) – as of May 2013 – these are the current manufacturers
  - Abbott
  - Roche
  - Gen-Probe
  - Becton Dickinson
  - Cepheid
- Serology – used only for LGV diagnosis

NAATS

- Detects nucleic acid & “amplifies” it such that even a low microbe nucleic acid amount can be found
- Sensitivity & specificity are very high
- Uses various technologies – now automated
  - Urethral swabs from men
  - Urine from men/women
  - Cervical & vaginal swabs
  - Some labs have conducted specific testing to use for non-genitourinary site testing – though this requires CLIA or CLEP waiver“
NAATS – ADVANTAGES

• Highly sensitive – 95% urine & 97% swab*
• Convenient for patient & clinical setting – since collection without a clinical exam is possible ~ & ~ can be collected by the patient (increases acceptability)
  – Urine – males & females
  – Vaginal swab (including self-obtained)
• Less likely to be inaccurate due to collection & handling – as can occur with CT culture*
  – Able to detect 20-50% more CT infection as compared to culture & earlier non-culture tests *
* www.cdc.gov/std/laboratory/2014LabRec

NAATS – DISADVANTAGES

• They are not approved for non-genitourinary sites – unless laboratory receives CLIA/CLEP waiver (as noted)
• NAATs are not FDA-approved for test-of-cure (TOC) – Culture is recommended
• Antibiotic susceptibility testing is not possible – as it would be with culture
  ➢ Which is extremely important with regard to gonococcal infections (more to follow)

NAATS – DISADVANTAGES

• Specificity can be less reliable – depending on Hx history of recent infection/Rx
  – If recently treated for CT (or GC) infection – residual organism (its nucleic acid) might be still detected by the NAAT – due to the high sensitivity
  – If recently treated for CT – NAAT collection should be deferred until ≥ 3 weeks post-Rx completion
  – If recently treated for GC – NAAT collection be deferred until ≥ 1-2 weeks post-Rx completion
  ▶ Be sure to check manufacturer’s recommendation regarding post-Rx NAAT collection timeframes
CT – Rx for Uncomplicated* Infection

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dose</th>
<th>Route</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Azithromycin</td>
<td>1000 mg</td>
<td>PO</td>
<td>Single Dose</td>
</tr>
<tr>
<td>~ or ~</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Doxycycline</td>
<td>100 mg</td>
<td>PO</td>
<td>BID x 7 days</td>
</tr>
<tr>
<td>Alternative Agents</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Erythromycin</td>
<td>500 mg</td>
<td>PO</td>
<td>QID x 7 days</td>
</tr>
<tr>
<td>~ or ~</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ofloxacin</td>
<td>300 mg</td>
<td>PO</td>
<td>BID x 7 days</td>
</tr>
<tr>
<td>~ or ~</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Levofloxacin</td>
<td>500 mg</td>
<td>PO</td>
<td>QD x 7 days</td>
</tr>
</tbody>
</table>

* Cervicitis, urethritis, proctitis

CT – Rx During Pregnancy

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dose</th>
<th>Route</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Azithromycin</td>
<td>1000 mg</td>
<td>PO</td>
<td>Single Dose</td>
</tr>
<tr>
<td>~ or ~</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Amoxicillin</td>
<td>500 mg</td>
<td>PO</td>
<td>TID x 7 days</td>
</tr>
<tr>
<td>Alternative Agents</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Erythromycin base</td>
<td>500 mg</td>
<td>PO</td>
<td>QID x 7 days</td>
</tr>
<tr>
<td>If poorly tolerated</td>
<td>change dose/frequency to 250 mg PO QID x 14 days</td>
<td></td>
<td></td>
</tr>
<tr>
<td>~ or ~</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Erythromycin ethylsuccinate</td>
<td>800 mg</td>
<td>PO</td>
<td>QID x 7 days</td>
</tr>
<tr>
<td>If poorly tolerated</td>
<td>change dose/frequency to 400 mg PO QID x 14 days</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

CT – Test of Cure vs Re-Screening

- **Test of Cure** (TOC) – should be done with culture*
  - Pregnancy
  - Therapeutic adherence is in question

- **Re-screening**
  - Population studies show that ~35% of those infected with CT will become re-infected within 3-4 months, associated with same risky behavior & untreated sex partners
  - Re-screening is recommended within 3-4 months
  - Re-screen at next visit if not seen within past 12 months of Rx

* Recall that NAATs are not FDA-approved for TOC
**Neisseria Gonorrhoeae – GC – Infection**

- Important GC Rx Update August 2013

**GC – Risk Factors**

- Multiple/new sex partners
- Lack of barrier precautions
- Young age
- Urban residence
- Exchange of sex for drugs/money/services
- Core population
  - Sharing social & sexual networks (which might include substance use as well)

**GC – Epidemiology**

- It is the 2nd most commonly reported of the notifiable infectious diseases
- US incidence geographically variable
  - Highest in South, Lower in West
  - Increasing rates among MSM
- Peak incidence
  - Males – 20-24 years
  - Females – 15-24 years
- High rates among Black, Latino, & Native populations
- 333,004 cases reported (106.1 cases/100,000 population) in 2013
  - NYS case rate was 101.8/100,000 population – denser in upstate counties

www.cdc.gov
GC – US Rates by State and Territories

Note the rates for ages 5–19 & 20–24

GC – US Rates by Age and Sex

Male Gonococcal Urethritis

- **Incubation** – typically 3–7 days but asymptomatic infection may occur (10%)
- **Symptoms** – dysuria, purulent or mucopurulent discharge
- **Signs** – yellow purulent discharge, however, may be mucoid or mucopurulent
**GONOCOCCAL CERVICITIS**

- **Incubation** – unclear
  - If sx occur – they develop by 10 days
- **Symptoms** – present in only ~ 50% of cases & are non-specific
  - Vaginal discharge &/or bleeding
  - Dysuria
- **Signs** – exam is highly variable
  - Normal to frank mucopurulent discharge

![Mucopurulent discharge vs. Normal appearance]

**GC – OTHER MANIFESTATIONS**

- Neonatal diseases
- Conjunctivitis – adults
  - Usually d/t auto-inoculation
- Pharyngitis
  - Common site of infection among MSM & sex workers
- Proctitis
  - Generally occurs in MSM
- Bartholin’s &/or Skene’s Gland abscesses
- Pelvic Inflammatory Diseases (PID)
  - Complication of cervical infection
- Epididymitis – not nearly as common as PID
  - Complication of urethral infection
- Disseminated Gonococcal Infection (DGI)

* See STD Guidelines for specifics; also NNPTC for clinical training info – www.cdc.gov; http://nnptc.org

**GC TESTING RECOMMENDATIONS**

- CDC has recently updated recommendations for CT (& gonorrhea) testing
  - *MMWR* released March 2014

[MMWR logo]

[Link to CDC guidelines]

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![Image of GC testing recommendations]
GC Screening Recommendations — Males

- Nucleic Acid Amplification Tests (NAATs) are the recommended method
  - Urine is recommended
  - Swab can also be collected
- MSM (men who have sex with men) should also have
  - Pharyngeal GC test – culture is recommended*
  - Rectal GC test – culture is recommended*
  - A urethral culture (swab) should be obtained so that antibx susceptibility can be evaluated in males who have a positive GC NAAT ≥ 7 days post-Rx (if did not engage in post-Rx sexual activity upon F/U)

* NAATs can be used under specific circumstances (more to follow)

GC Screening Recommendations — Females — Pregnant and Non-Pregnant

- Sexually active females who are at increased risk of infection should be screened — including those with risk fx such as
  - Those ≤ 25 years who are in areas of high GC prevalence
  - Those with previous GC infection (be sure to know the epidemiology of your area of practice)
  - New or multiple sex partners
  - Commercial sex trade workers who also use/abuse drugs
- Repeat screening of women 3-4 months post-GC Rx
- Repeat screening of all females Rx’d for GC when they next present for care within the following 12 months of infection

GC Screening Tests — NAATs

- Recall earlier information regarding NAATs
  - Sensitivity is very good though the specificity less so
  - Can be collected without clinical exam
  - Patient acceptance is high – which helps to reduce barriers to STD screening
  - Cost prohibitive for some settings

> Not FDA-approved for TOC
GC Screening Tests – Cultures

- Recall earlier information regarding cultures – for GC – there are several important advantages
  - Low cost (in NYS – GC cultures can be obtained through the state or local health department at reduced cost)
  - Suitable for a variety of specimens – all anatomic exposure sites can be tested which is very important for GC screening & testing, especially for populations with higher prevalence related to sexual practices
    - **Antimicrobial susceptibility can be performed** – currently – this is necessary because of increasing incidence of antibiotic-resistant GC
      - Can & should be used for TOC

CDC Conducts Routine Annual Antimicrobial N gonorrhoeae Susceptibility – GISP*

- Fluoroquinolone resistance (Cipro/Levofloxacin)
  - Widely disseminated throughout the US & worldwide
- Approximately 25% of isolates are also resistant to pcn, tcn, cipro – or some combinations of these
  - From 2009-13, increased azithromycin MICs have ranged from 0.2-0.6% (susceptibility testing began in 1992)
- Sporadic cases of decreased susceptibility to ceftriaxone & cefixime have been reported recently


Summary of GISP Studies – 2012 (Most Recent) Antibiotic Susceptibility of N gonorrhoeae

GISP Antimicrobial Susceptibility Criteria

Antimicrobial susceptibility criteria used in GISP in 2012 are as follows:

- Ceftriaxone, minimum inhibitory concentration (MIC) 20.0 µg/ml (decreased susceptibility)*
- Cefixime, MIC 10.0 µg/ml (decreased susceptibility)*
- Azithromycin, MIC 8.0 µg/ml (decreased susceptibility)*
- Spectinomycin, MIC 0.5 µg/ml (resistance)
- Ciprofloxacin, MIC 1.0 µg/ml (intermediate resistance)
- Ceftriaxone, MIC 0.125-1.0 µg/ml (resistance)
- Penicillin, MIC 0.06-0.125 µg/ml (resistance)
- Tetracycline, MIC 2.0 µg/ml (resistance)

The majority of these criteria are also recommended by the Clinical and Laboratory Standards Institute (CLSI):*

* Resistance to ceftriaxone and cefixime, and resistance and susceptibility to azithromycin are not defined by CLSI

**REMINDER – MINIMUM INHIBITORY CONCENTRATION**

- The minimum inhibitory concentration (MIC)
  - The lowest antimicrobial concentration that inhibits visible bacterial growth in the laboratory & it is used to assess antimicrobial susceptibility
  - It can only be conducted on cultures (not NAATs)

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**N. gonorrhoeae** Isolates with Elevated Ceftriaxone MICs (≥0.125 µg/ml) – GISP, 2006-13

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**N. gonorrhoeae** Isolates with Elevated Cefixime MICs (≥0.25 µg/ml) – GISP, 2006-13

- Cefixime unavailable in 2007-8
**CDC Principles of GC Rx for All Sites**

- Base on GISP data – CDC recommends combination therapy – using 2 antimicrobials with different mechanisms of action
  - To improve treatment efficacy & potentially delay emergence and spread of resistance to cephalosporins
- The following slides will give specific regimen recommendations – but in general – Rx should include Ceftriaxone 250 mg intra-muscular injection & Azithromycin 1000 mg orally
  - Azithromycin is preferred to Doxycycline because of convenience & compliance
  - In addition, there is a higher prevalence of gonococcal resistance to tetracyclines

*“Based on experience with other microbes that have developed antimicrobial resistance rapidly, a theoretical basis exists for using combination therapy...”* [CDC. (2012). MMWR, 61(31), p 592]

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**Recommended First-Line Rx for Uncomplicated GC Infections of Cervix, Urethra, Rectum**

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dose</th>
<th>Route</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ceftriaxone</td>
<td>250 mg</td>
<td>IM</td>
<td>once</td>
</tr>
<tr>
<td>Azithromycin</td>
<td>1000 mg</td>
<td>PO</td>
<td>Once</td>
</tr>
<tr>
<td>Doxycycline</td>
<td>100 mg</td>
<td>PO</td>
<td>BID x 7 days</td>
</tr>
</tbody>
</table>

- Quinolones are no longer recommended in the US for Rx of GC & associated conditions (e.g., PID)

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**First Alternative Rx for Uncomplicated GC Infections of Cervix, Urethra, Rectum**

Alternative #1 – if Ceftriaxone is not available

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dose</th>
<th>Route</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cefixime</td>
<td>400 mg</td>
<td>PO</td>
<td>once</td>
</tr>
<tr>
<td>Azithromycin</td>
<td>1000 mg</td>
<td>PO</td>
<td>Once</td>
</tr>
<tr>
<td>Doxycycline</td>
<td>100 mg</td>
<td>PO</td>
<td>BID x 7 days</td>
</tr>
</tbody>
</table>

- Test of Cure (TOC) in one week
SECOND ALTERNATIVE RX FOR UNCOMPLICATED GC INFECTIONS OF CERVICITIS, URETHRA, RECTUM

**Alternative #1 – if serious allergy to Ceftriaxone**

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dose</th>
<th>Route</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Azithromycin</td>
<td>2000 mg</td>
<td>PO</td>
<td>once</td>
</tr>
</tbody>
</table>

~~ plus ~~

TOC in one week

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RX FOR UNCOMPLICATED GC INFECTIONS OF PHARYNX

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dose</th>
<th>Route</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ceftriaxone</td>
<td>250 mg</td>
<td>IM</td>
<td>Once</td>
</tr>
</tbody>
</table>

~~ plus ~~

Azithromycin 1000 mg PO Once

or

Doxycycline 100 mg PO BID x 7 days

There are no specific recommendations for Rx of pharyngeal GC for those who are seriously allergic to cephalosporins – consult an STD/ID Specialist (check with your local Health Department)

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GC RX FOLLOW-UP

- No TOC if the CDC first-line Rx regimen is administered
- *A TOC is recommended if an alternative regimen is administered – to be done on day 7*
  - Recall the information about best test for TOC
- If symptoms persist, perform culture for *N gonorrhoeae*
  - Any gonococci isolated on TOC should be tested for antimicrobial susceptibility
  - Repeat testing in 3 months
  - Population epi data show that ~ 33% of those infected with GC are re-infected within 3-4 months (as seen with CT)
All GC patients should be treated with regimen effective against *Chlamydia trachomatis*

- Test results for CT only to establish cases for partner Rx & surveillance
- Reasoning – false negative CT tests & high prevalence, possibly different incubations (even with NAATs) – combination therapy hopefully will aid in combating resistance in GC

Partners of last 60 days should be evaluated, tested, & Rx’d with regimens effective for both GC & CT

Sex partners should be evaluated, tested, & Rx’d if had sexual contact with the index case patient within past 60 days preceding the onset of symptoms or diagnosis of GC or CT

If no partners within 60 days – contact most recent sex partner

- Traditionally done through Health Department Field Staff who conduct confidential interviews & find partners to be tested/Rx’d
- Labor intensive, low yield, & cases far exceed HD resources

Primary care (including School-based Health Centers) are in a position to help with some of this by timely notification of cases to STD Surveillance & Control (local/state DoH)

Male partners should inform all female partners about the importance of seeking care for assessment of possible PID

Partners of patients with GC should receive CT co-Rx

Not routinely recommended for MSM due to co-morbidities (other STDs, HIV)

EPT has been recommended by CDC since 2006*

- As of 2010 – it is now legal in NYS – but is only approved for CT in heterosexuals – see next slide

**EXPEDITED PARTNER THERAPY – NYSDOH**

- The use of **EPT is limited to CT infection only**
  - Recommended EPT treatment for CT is 1 gm of Azithromycin in a single oral dose
- **EPT should not be provided to CT patients concurrently infected with GC or syphilis**
- **EPT use is not recommended for treating MSM due to a high risk of HIV/syphilis co-morbidity in partners**
- EPT may be in form of dispensed medication or by prescription
  - Must include the phrase “EPT” in the body of the Rx


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**EXPEDITED PARTNER THERAPY – NYSDOH HEALTH LAW**

- Health care providers or pharmacists who dispense EPT in accordance with this law shall not be subject to liability or be deemed to have engaged in unprofessional conduct
- EPT issued as medication or as a prescription to the original patient must be accompanied by written materials for patients & partners, addressing possible side effects & contraindications to EPT medication
- Wealth of information & materials on NYS or NYC DOH websites

* Summarized from NYSDoH Commissioner’s Dear Colleague Letter (March 2011)

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**EPT – NEW YORK STATE DEPARTMENT OF HEALTH RESOURCES**

- Information for medical providers, pharmacists, & patients (& their partners)

CDC STD TREATMENT GUIDELINES – SMART PHONE/TABLET APPLICATION

- Gives clinicians easy access to CDC’s current STD Treatment Guidelines
- Available for mobile phones & tablets
- Includes STD diagnostic & Rx information & “A Guide to Taking a Sexual History”

For more information or to download the app, visit cdc.gov/std/std-tx-app.htm

RESOURCES

- www.ceitraining.org
- www.hivguidelines.org (CEI links to this site)
- www.cdc.gov
  - www.cdc.gov/std/treatment/SexualHistory.pdf (Pocket Guide)
  - STD Treatment Guidelines & Public Health Program Standards
  - Continuing Educations web-based opportunities
  - Many other patient education/counseling materials
- www.ncsddc.org (National Coalition of STD Directors)
  - Medical & Program Provider information (including CE)
- www.cms.gov
  - Billing information & codes

QUESTIONS?

STD CLINICAL CONSULTATION
WARMLINE
866-637-2342

OR EMAIL QUESTIONS TO
std@ceitraining.org