MAKO MEDICAL

APRIL

STI
Awareness Month

Did you know...

19.7M

NEW STIs DISCOVERED IN THE US IN 2018

44%

OF STIS OCCUR AMONG INDIVIDUALS 15-24 YEARS OLD

1/6

PEOPLE ARE AFFECTED BY GENITAL HERPES

SCREENING INFORMATION & PROCEDURES FOR:

- *Syphilis*
- *Herpes*
- *Trichomonas*
- *HIV*
- *HPV*
- *Cervical Cancer*
- *Chlamydia*
- *Gonorrhea*
- *Hepatitis B/C*
- *And more*

The Five P's

The Five P's approach for health care providers obtaining sexual histories: partners, practices, protection from sexually transmitted infections, past history of sexually transmitted infections, and pregnancy intention

1. Partners

- "Are you currently having sex of any kind?"
- "What is the gender(s) of your partner(s)?"

2. Practices

- "To understand any risks for sexually transmitted infections (STIs), I need to ask more specific questions about the kind of sex you have had recently."
- "What kind of sexual contact do you have or have you had?"
  - "Do you have vaginal sex, meaning 'penis in vagina' sex?"
  - "Do you have anal sex, meaning 'penis in rectum/anus' sex?"
  - "Do you have oral sex, meaning 'mouth on penis/vagina'?"

3. Protection from STIs

- "Do you and your partner(s) discuss prevention of STIs and human immunodeficiency virus (HIV)?"
- "Do you and our partner(s) discuss getting tested?"
- For condoms:
  - "What protection methods do you use? In what situations do you use condoms?"

4. Past history of STIs

- "Have you ever been tested for STIs and HIV?"
- "Have you ever been diagnosed with an STI in the past?"
- "Have any of your partners had an STI?"
- Additional questions for identifying HIV and viral hepatitis risk:
  - "Have you or any of your partner(s) ever injected drugs?"
  - "Is there anything about your sexual health that you have questions about?"

5. Pregnancy Intention

- "Do you think you would like to have (more) children in the future?"
- "How important is it to you to prevent pregnancy (until then)?"
- "Are you or your partner using contraception or practicing any form of birth control?"
- "Would you like to talk about ways to prevent pregnancy?"

Screening Recommendations for Women (CDC)

Chlamydia 424075	• Sexually active women under 25 years of age • Sexually active women 25 years of age and older if at increased risk • Retest approximately 3 months after treatment • Rectal chlamydial testing can be considered in females based on reported sexual behaviors and exposure, through shared clinical decision between the patient and the provider
Gonorrhea 424075	• Sexually active women under 25 years of age • Sexually active women 25 years of age and older if at increased risk • Retest 3 months after treatment • Pharyngeal and rectal gonorrhea screening can be considered in females based on reported sexual behaviors and exposure, through shared clinical decision between the patient and the provider
Syphilis 423041	• Screen asymptomatic adults at increased risk (history of incarceration or transactional sex work, geography, race/ethnicity) for syphilis infection
Herpes 424080	• Type-specific HSV serologic testing can be considered for women presenting for an STI evaluation (especially for women with multiple sex partners)
Trichomonas 424440	• Consider screening for women receiving care in high-prevalence settings (e.g., STI clinics and correctional facilities) and for asymptomatic women at high risk for infection (e.g., women with multiple sex partners, transactional sex, drug misuse, or a history of STI or incarceration)
HIV 423035	• All women aged 13-64 years (opt-out) • All women who seek evaluation and treatment for STIs
HPV, Cervical Cancer 472175	• Women 21-29 years of age every 3 years with cytology • Women 30-65 years of age every 3 years with cytology, or every 5 years with a combination of cytology and HPV testing
Hepatitis B Screening 423030	• Women at increased risk (having had more than one sex partner in the previous 6 months, evaluation or treatment for an STI, past or current injection-drug use, and an HBsAg-positive sex partner)
Hepatitis C Screening 423005	• All adults over age 18 years should be screened for hepatitis C except in settings where the hepatitis C infection (HCV) positivity is < 0.1%

Screening Recommendations for Pregnant Women (CDC)

Chlamydia 424075	• All pregnant women under 25 years of age • Pregnant women 25 years of age and older if at increased risk • Retest during the 3rd trimester for women under 25 years of age or at risk • Pregnant women with chlamydial infection should have a test of cure 4 weeks after treatment and be retested within 3 months
Gonorrhea 424075	• All pregnant women under 25 years of age, and those 25 and older if at increased risk • Retest during the 3rd trimester for women under 25 years of age or at risk • Pregnant women with gonorrhea should be retested within 3 months
Syphilis 423041	• All pregnant women at the first prenatal visit • Retest at 28 weeks gestation and at delivery if at high risk (lives in a community with high syphilis morbidity or is at risk for syphilis acquisition during pregnancy [drug misuse, STIs during pregnancy, multiple partners, a new partner, partner with STIs])
Herpes 424080	• Routine HSV-2 serologic screening among asymptomatic pregnant women is not recommended. 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.
HIV 423035	• Routine HSV-2 serologic screening among asymptomatic pregnant women is not recommended. 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.
HPV, Cervical Cancer 472175	• Pregnant women should be screened at same intervals as nonpregnant women
Hepatitis B Screening 423030	• Test for HBsAg at first prenatal visit of each pregnancy regardless of prior testing; retest at delivery if at high risk
Hepatitis C Screening 423005	• Pregnant women should be screened for hepatitis C except in settings where the hepatitis C infection (HCV) positivity is < 0.1%

Screening Recommendations for Men Who Have Sex with Women (CDC)

Chlamydia 424075	• There is insufficient evidence for screening among heterosexual men who are at low risk for infection, however, screening young men can be considered in high prevalence clinical settings (adolescent clinics, correctional facilities, STI/sexual health clinic)
Gonorrhea 424075	• There is insufficient evidence for screening among heterosexual men who are at low risk for infection
Syphilis 423041	• Screen asymptomatic adults at increased risk (history of incarceration or commercial sex work, geography, race/ethnicity, and being a male younger than 29 years) for syphilis infection
Herpes 424080	• Type-specific HSV serologic testing can be considered for men presenting for an STI evaluation (especially for men with multiple sex partners)
HIV 423035	• All men aged 13-64 years (opt-out) • All men who seek evaluation and treatment for STIs
Hepatitis B Screening 423030	• Men at increased risk (i.e., by sexual or percutaneous exposure)
Hepatitis C Screening 423005	• All adults over age 18 years should be screened for hepatitis C except in settings where the hepatitis C infection (HCV) positivity is < 0.1%12

Screening Recommendations for Men Who Have Sex with Men (CDC)

Chlamydia 424075	• At least annually for sexually active MSM at sites of contact (urethra, rectum) regardless of condom use • Every 3 to 6 months if at increased risk (i.e., MSM on PrEP, with HIV infection, or if they or their sex partners have multiple partners)
Gonorrhea 424075	• At least annually for sexually active MSM at sites of contact (urethra, rectum, pharynx) regardless of condom use • Every 3 to 6 months if at increased risk
Syphilis 423041	• At least annually for sexually active MSM • Every 3 to 6 months if at increased risk
Herpes 424080	• Type-specific serologic tests can be considered if infection status is unknown in MSM with previously undiagnosed genital tract infection
HIV 423035	• At least annually for sexually active MSM if HIV status is unknown or negative and the patient or their sex partner(s) have had more than one sex partner since most recent HIV test • Consider the benefits of offering more frequent HIV screening (e.g., every 3–6 months) to MSM at increased risk for acquiring HIV infection.
HPV, Anal Cancer 472510	• Digital anorectal rectal exam • Data is insufficient to recommend routine anal cancer screening with anal cytology
Hepatitis B Screening 423030	• All MSM should be tested for HBsAg, HBV core antibody, and HBV surface antibody
Hepatitis C Screening 423005	• All adults over age 18 years should be screened for hepatitis C except in settings where the hepatitis C infection (HCV) positivity is < 0.1%

Screening Recommendations for Transgender and Gender Diverse Persons (CDC)

Chlamydia 424075	• Screening recommendations should be adapted based on anatomy (i.e., annual, routine screening in cisgender women < 25 years old should be extended to all transgender men and gender diverse people with a cervix. If over 25 years old, persons with a cervix should be screened if at increased risk). • Consider screening at the rectal site based on reported sexual behaviors and exposure.
Gonorrhea 424075	• Screening recommendations should be adapted based on anatomy (i.e., annual, routine screening for gonorrhea in cisgender women < 25 years old should be extended to all transgender men and gender diverse people with a cervix. If over 25 years old, screen if at increased risk). • Consider screening at the pharyngeal and rectal site based on reported sexual behaviors and exposure.
Syphilis 423041	• Consider screening at least annually based on reported sexual behaviors and exposure
HIV 423035	• HIV screening should be discussed and offered to all transgender persons. Frequency of repeat screenings should be based on level of risk.
HPV, Cervical Cancer 472175	• Screening for people with a cervix should follow current screening guidelines for cervical cancer

Screening Recommendations for Persons with HIV (CDC)

Chlamydia 424075	• For sexually active individuals, screen at first HIV evaluation, and at least annually thereafter • More frequent screening for might be appropriate depending on individual risk behaviors and the local epidemiology
Gonorrhea 424075	• For sexually active individuals, screen at first HIV evaluation, and at least annually thereafter • More frequent screening might be appropriate depending on individual risk behaviors and the local epidemiology
Syphilis 423041	• For sexually active individuals, screen at first HIV evaluation, and at least annually thereafter • More frequent screening might be appropriate depending on individual risk behaviors and the local epidemiology
Herpes 424080	• Type-specific HSV serologic testing should be considered for persons presenting for an STI evaluation (especially for those persons with multiple sex partners)
Trichomonas 424440	• Recommended for sexually active women at entry to care and at least annually thereafter
HPV, Cervical Cancer 472175	• Providers should defer to existing Guidelines for the Prevention and Treatment of Opportunistic Infections in Adults and Adolescents with HIV for guidance on cervical cancer screening and management of results in persons with HIV
Anal Cancer 472510	• Digital anorectal rectal exam • Data is insufficient to recommend routine anal cancer screening with anal cytology
Hepatitis B Screening 423030	• Test for HBsAg and anti-HBc and anti-HBs
Hepatitis C Screening 423005	• Serologic testing at initial evaluation • Annual HCV testing in MSM with HIV infection

Screening Recommendations for HIV (CDC)

Women	• All women aged 13-64 years (opt-out) • All women who seek evaluation and treatment for STIs
Pregnant Women	• All pregnant women should be screened at first prenatal visit (opt-out)9 • Retest in the 3rd trimester if at high risk (people who use drugs, have STIs during pregnancy, have multiple sex partners during pregnancy, have a new sex partner during pregnancy, live in areas with high HIV prevalence, or have partners with HIV) • Rapid testing should be performed at delivery if not previously screened during pregnancy
Men Who Have Sex with Women	• All men aged 13-64 years (opt-out) • All men who seek evaluation and treatment for STIs
Men Who Have Sex With Men	• At least annually for sexually active MSM if HIV status is unknown or negative and the patient or their sex partner(s) have had more than one sex partner since most recent HIV test • Consider the benefits of offering more frequent HIV screening (e.g., every 3–6 months) to MSM at increased risk for acquiring HIV infection.
Transgender and Gender Diverse Persons	• HIV screening should be discussed and offered to all transgender persons. Frequency of repeat screenings should be based on level of risk

Screening Recommendations for Hepatitis C (CDC)

Women	• All adults over age 18 years should be screened for hepatitis C except in settings where the hepatitis C infection (HCV) positivity is < 0.1%
Pregnant Women	• Pregnant women should be screened for hepatitis C except in settings where the hepatitis C infection (HCV) positivity is < 0.1%
Men Who Have Sex with Women	• All adults over age 18 years should be screened for hepatitis C except in settings where the hepatitis C infection (HCV) positivity is < 0.1%
Men Who Have Sex With Men	• All adults over age 18 years should be screened for hepatitis C except in settings where the hepatitis C infection (HCV) positivity is < 0.1%
Persons with HIV	• Serologic testing at initial evaluation • Annual HCV testing in MSM with HIV infection

Screening Recommendations for Hepatitis B (CDC)

Women	• **Women at increased risk (having had more than one sex partner in the previous 6 months, evaluation or treatment for an STI, past or current injection-drug use, and an HBsAg-positive sex partner)**
Pregnant Women	• **Test for HBsAg at first prenatal visit of each pregnancy regardless of prior testing; retest at delivery if at high risk**
Men Who Have Sex with Women	• **Men at increased risk (i.e., by sexual or percutaneous exposure)**
Men Who Have Sex With Men	• **All MSM should be tested for HBsAg, anti-HBc, and anti-HBs**
Persons with HIV	• **Test for HBsAg, anti-HBc, and anti-HBs**

Screening Recommendations for Syphilis (CDC)

Women	• Screen asymptomatic women at increased risk (history of incarceration or transactional sex work, geography, race/ethnicity) for syphilis infection
Pregnant Women	• All pregnant women at the first prenatal visit • Retest at 28 weeks gestation and at delivery if at high risk (lives in a community with high syphilis morbidity or is at risk for syphilis acquisition during pregnancy [drug misuse, STIs during pregnancy, multiple partners, a new partner, partner with STIs])
Men Who Have Sex With Women	• Screen asymptomatic adults at increased risk (history of incarceration or transactional sex work, geography, race/ethnicity, and being a male younger than 29 years) for syphilis infection
Men Who Have Sex With Men	• At least annually for sexually active MSM • Every 3 to 6 months if at increased risk • Screen asymptomatic adults at increased risk (history of incarceration or transactional sex work, geography, race/ethnicity, and being a male younger than 29 years) for syphilis infection
Transgender and Gender Diverse People	• Consider screening at least annually based on reported sexual behaviors and exposure
Persons with HIV	• For sexually active individuals, screen at first HIV evaluation, and at least annually thereafter • More frequent screening might be appropriate depending on individual risk behaviors and the local epidemiology

Screening Recommendations for HPV, Cervical Cancer, Anal Cancer (CDC)

Women	• Women 21-29 years of age every 3 years with cytology • Women 30-65 years of age every 3 years with cytology, or every 5 years with a combination of cytology and HPV testing
Pregnant Women	• Pregnant women should be screened at same intervals as nonpregnant women
Men Who Have Sex With Men	• Digital anorectal rectal exam • Data is insufficient to recommend routine anal cancer screening with anal cytology
Transgender and Gender Diverse People	• Screening for people with a cervix should follow current screening guidelines for cervical cancer
Persons with HIV	• Providers should defer to existing Guidelines for the Prevention and Treatment of Opportunistic Infections in Adults and Adolescents with HIV for guidance on cervical cancer screening and management of results in persons with HIV

Screening Recommendations for Herpes (CDC)

Women	• Type-specific HSV serologic testing can be considered for women presenting for an STI evaluation (especially for women with multiple sex partners)
Pregnant Women	• Routine HSV-2 serologic screening among asymptomatic pregnant women is not recommended. 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
Men Who Have Sex with Women	• Type-specific HSV serologic testing can be considered for men presenting for an STI evaluation (especially for men with multiple sex partners)
Men Who Have Sex With Men	• Type-specific serologic tests can be considered if infection status is unknown in MSM with previously undiagnosed genital tract infection
Persons with HIV	• Type-specific HSV serologic testing should be considered for persons presenting for an STI evaluation (especially for those persons with multiple sex partners)

Screening Recommendations for Chlamydia (CDC)

Women	• Sexually active women under 25 years of age • Sexually active women 25 years of age and older if at increased risk • Retest approximately 3 months after treatment • Rectal chlamydial testing can be considered in females based on reported sexual behaviors and exposure, through shared clinical decision between the patient and the provider
Pregnant Women	• All pregnant women under 25 years of age • Pregnant women 25 years of age and older if at increased risk • Retest during the 3rd trimester for women under 25 years of age or at risk • Pregnant women with chlamydial infection should have a test of cure 4 weeks after treatment and be retested within 3 months
Men Who Have Sex with Women	• There is insufficient evidence for screening among heterosexual men who are at low risk for infection, however, screening young men can be considered in high prevalence clinical settings (adolescent clinics, correctional facilities, STI/sexual health clinic)
Men Who Have Sex With Men	• At least annually for sexually active MSM at sites of contact (urethra, rectum) regardless of condom use • Every 3 to 6 months if at increased risk (i.e., MSM on PrEP, with HIV infection, or if they or their sex partners have multiple partners)
Transgender and Gender Diverse Persons	• Screening recommendations should be adapted based on anatomy, (i.e., annual, routine screening for chlamydia in cisgender women < 25 years old should be extended to all transgender men and gender diverse people with a cervix. If over 25 years old, persons with a cervix should be screened if at increased risk.) • Consider screening at the rectal site based on reported sexual behaviors and exposure
Persons with HIV	• For sexually active individuals, screen at first HIV evaluation, and at least annually thereafter • More frequent screening might be appropriate depending on individual risk behaviors and the local epidemiology

Screening Recommendations for Gonorrhea (CDC)

Women	• Sexually active women under 25 years of age • Sexually active women 25 years of age and older if at increased risk • Retest 3 months after treatment • Pharyngeal and rectal gonorrhea screening can be considered in females based on reported sexual behaviors and exposure, through shared clinical decision between the patient and the provider
Pregnant Women	• All pregnant women under 25 years of age, and those 25 and older if at increased risk • Retest during the 3rd trimester for women under 25 years of age or at risk • Pregnant women with gonorrhea should be retested within 3 months
Men Who Have Sex with Women	• There is insufficient evidence for screening among heterosexual men who are at low risk for infection
Men Who Have Sex With Men	• At least annually for sexually active MSM at sites of contact (urethra, rectum, pharynx) regardless of condom use • Every 3 to 6 months if at increased risk
Transgender and Gender Diverse Persons	• Screening recommendations should be adapted based on anatomy (i.e., annual, routine screening for gonorrhea in cisgender women <25 years old should be extended to all transgender men and gender diverse people with a cervix. If over 25 years old, screen if at increased risk.) • Consider screening at the pharyngeal and rectal site based on reported sexual behaviors and exposure
Persons with HIV	• For sexually active individuals, screen at first HIV evaluation, and at least annually thereafter • More frequent screening might be appropriate depending on individual risk behaviors and the local epidemiology

Screening Recommendations for Mycoplasma genitalium (CDC)

Women	• Women with recurrent cervicitis should be tested for MG, and testing should be considered among women with PID. Testing should be accompanied with resistance testing, if available. • Screening of asymptomatic MG infection among women is not recommended. • Extragenital testing for MG is not recommended.
Men	• Men with recurrent nongonococcal urethritis (NGU) should be tested for MG using an FDA-cleared nucleic acid amplification technologies (NMT). • If resistance testing is available, it should be performed, and the results used to guide therapy. • Screening of asymptomatic MG infection among men is not recommended. • Extragenital testing for MG is not recommended.

Treatment Guidelines for Syphilis (CDC)

Risk Category	Recommended Regimen	Alternatives
Primary, secondary, and early latent adults (including pregnant women and people with HIV infection)	• benzathine penicillin G 2.4 million units IM in a single dose	
Late latent adults (including pregnant women and people with HIV infection)	• benzathine penicillin G 7.2 million units total, administered as 3 doses of 2.4 million units IM each at 1-week intervals	
Neurosyphilis, ocular syphilis, and otosyphilis	• aqueous crystalline penicillin G 18-241 million units per day, administered as 3-4 million units by IV every 4 hours or continuous infusion, for 10-14 days	• procaine penicillin G 2.4 million units IM lx/day PLUS probenecid 500 mg orally 4x/day, both for 10-14 days
For children or congenital syphilis	• See Sexually Transmitted Infections Treatment Guidelines, 2021.	

Treatment Guidelines for Vulvovaginal Candidiasis (CDC)

Indication and/or Condition	Drug Formulation	CDC Recommended Dosage and Duration
Uncomplicated VVC	Over-the-Counter Intravaginal Agents	
	Clotrimazole 1% cream	5 g intravaginally daily for 7-14 day
	Clotrimazole 2% cream	5 g intravaginally daily for 3 days
	Miconazole 2% cream	5 g intravaginally daily for 7 days
	Miconazole 4% cream	5 g intravaginally daily for 3 days one suppository daily for 7 days one suppository daily for 3 days one suppository for 1 day
	Miconazole 100 mg vaginal suppository	5 g intravaginally in a single application
	Miconazole 200 mg vaginal suppository	Miconazole 200 mg vaginal suppository
	Miconazole 1,200 mg vaginal suppository	Miconazole 1,200 mg vaginal suppository
	Tioconazole 6.5% ointment	Tioconazole 6.5% ointment
	Prescription Intravaginal Agents	
	Butoconazole 2% cream	(single-dose bioadhesive product) 5g intravaginally in a single application
	Terconazole 0.4% cream	5 g intravaginally daily for 7 days
	Terconazole 0.8% cream 5 g	5 g intravaginally daily for 3 days
	Terconazole 80 mg vaginal suppository	one suppository daily for 3 days
	Prescription Intravaginal Agents	
	Fluconazole 150 mg	orally in a single dose

Treatment Guidelines for Vulvovaginal Candidiasis (CDC)

Indication and/or Condition	Drug Formulation / CDC Recommended Dosage and Duration
Complicated or Recurrent VVC	• **Recurrent VVC** - Most episodes of recurrent VVC caused by C. albicans respond well to short-duration oral or topical azole therapy. However, to maintain clinical and mycologic control, a longer duration of initial therapy (e.g., 7-14 days of topical therapy or a 100-mg, 150-mg, or 200-mg oral dose of fluconazole every third day for a total of 3 doses [days 1, 4, and 7]) is recommended, to attempt mycologic remission, before initiating a maintenance antifungal regimen. • **For maintenance** - Oral fluconazole (ie, 100 mg, 150 mg, or 200 mg dose) weekly for 6 months is the first line of treatment. If this regimen is not feasible, topical treatments used intermittently as a maintenance regimen can be considered. • **Severe VVC** - Either 7-14 days of topical azole or 150 mg of fluconazole in two sequential oral doses (second dose 72 hours after initial dose) is recommended. • **Nonalbicans VVC** - Longer duration of therapy (7-14 days) with a nonfluconazole azole drug (oral or topical) as first-line therapy. If recurrence occurs, 600 mg of boric acid in a gelatin capsule is recommended, administered vaginally once daily for 3 weeks.

Treatment Guidelines for Bacterial Vaginosis (CDC)

BV is a vaginal dysbiosis resulting from replacement of normal hydrogen peroxide and lactic-acid-producing Lactobacillus species in the vagina with high concentrations of anaerobic bacteria, including G. vaginalis, Prevotella species, Mobiluncus species,A. vaginae and other BV-associated bacteria. A notable feature is the appearance of a polymicrobial biofilm on vaginal epithelial cells.

Women with BV are at increased risk for STI acquisition, such as HIV, N. gonorrhoeae, C. trochomatis, T. vaginalis, M. genitalium, HPVand HSV-2; complications after gynecologic surgery; complications of pregnancy; and recurrence of BV.

Treatment for BV is recommended for women with symptoms. The following is taken from CDC recommendations:

Indication and/or Condition	Drug Formulation	CDC Recommended Dosage and Duration	Alternative Regimens
Adults and/or adolescents	Metronidazole 500 mg or	500 mg po bid for 7 days	Clindamycin 300 mg orally 2 times/day for 7 days Clindamycin ovules 100 mg intravaginally once at bedtime for 3 days Secnidazole 2 g oral granules in a single dose^ Tinidazole 2 g orally once daily for 2 days Tinidazole 1 g orally once daily for 5 days
	Metronidazole 0.75% gel or	one full applicator, 5 g intravaginally qd for 5 days	
	Clindamycin 2% cream *	one full applicator, 5 g intravaginally qhs for 7 days	
All women with BV should be tested for HIV and other STIs. * Clindamycin ovules use an oleaginous base that might weaken latex or rubber products (e.g., condoms and diaphragms). Use of such products within 72 hours after treatment with clindamycin ovules is not recommended. ^ Oral granules should be sprinkled onto unsweetened applesauce, yogurt or pudding before ingestion. A glass of water can be taken after administration to aid in swallowing.			

Oral therapy has not been reported to be superior to topical therapy for treating symptomatic BV in effecting cure or preventing adverse outcomes of pregnancy. Pregnant women can be treated with any of the recommended regimens for nonpregnant women, in addition to the alternative regimens of oral clindamycin and clindamycin ovules.

Women should be advised to refrain from sexual activity or to use condoms consistently and correctly during the BV treatment regimen. Douching might increase the risk for relapse, and no data support use of douching for treatment or symptom relief.

Treatment Guidelines for Trichomoniasis (CDC)

Trichomoniasis (TV) infection is caused by T. vaginalis, which is not considered normal flora. Treatment of sexual partners is recommended. The following is taken from CDC recommendations:

Indication and/or Condition	Drug Formulation	CDC Recommended Dosage and Duration	Alternative Regimens
Women	Metronidazole 500 mg	500 mg orally 2 times/day for 7 days	Tinidazole 2 g orally in a single dose
Men	Metronidazole 2 g	2 g orally in a single dose	Tinidazole 2 g orally in a single dose
	If this treatment regimen fails: Metronidazole 2 g or Tinidazole 2 g If this treatment regimen fails, susceptibility testing is recommended.	2 g po bid for 7 days 2 g po bid for 7 days	
HIV-positive Women	Metronidazole 500 mg or	500 mg orally 2 times/day for 7 days	
Because of the high rate of reinfection among women treated for trichomoniasis, retesting for T. vaginalis is recommended for all sexually active women <3 months after initial treatment regardless of whether they believe their sex partners were treated or 72 hours after completion of tinidazole. Providers should advise persons with T. vaginalis infections to abstain from sex until they and their sex partners are treated (i.e., when therapy has been completed and any symptoms have resolved). Testing for other STIs, including HIV, syphilis, gonorrhea, and chlamydia, should be performed for persons with T. vaginalis.			

Treatment Guidelines for Chlamydia (CDC)

Chlamydia (CT) infection is caused by C. trochomotis, which is not considered normal flora. Evaluation of sexual partners is recommended. The following is taken from CDC recommendations:

Indication and/or Condition	Drug Formulation	CDC Recommended Dosage and Duration	Alternative Regimens
Adults and/or Adolescents	Doxycycline 100 mg	100 mg orally 2 times/day for 7 days	Azithromycin 1 g orally in a single dose
			Levofloxacin 500 mg orally once daily for 7 days
Pregnant Women	Azithromycin 1 g	1 g orally in a single dose	Amoxicillin 500 mg orally 3 times/day for 7 days

Note: Patients who are coinfected with HIV and chlamydia should receive the same treatment regimen as those who are HIV negative.
To minimize disease transmission to sex partners, persons treated for chlamydia should be instructed to abstain from sexual intercourse for 7 days after single-dose therapy or until completion of a 7-day regimen and resolution of symptoms if present.
To minimize risk for reinfection, patients also should be instructed to abstain from sexual intercourse until all of their sex partners have been treated.
Persons who receive a diagnosis of chlamydia should be tested for HIV, gonorrhea and syphilis. MSM who are HIV negative with a rectal chlamydia diagnosis should be offered HIV PrEP.

Treatment Guidelines for Gonorrhea (CDC)

Gonorrhea (NG) infection is caused by N. gonorrhoeoe, which is not considered normal flora. Evaluation of sexual partners is recommended. The following is taken from CDC recommendations:

Indication and/or Condition	Drug Formulation	CDC Recommended Dosage and Duration	Alternative Regimens
Uncomplicated Gonococcal Infections of the Cervix, Urethra, and Rectum in Adults and Adolescents <150 kg	Ceftriaxone 500 mg	500 mg IM in a single dose	Gemtamicin 240 mg IM in a single dose plus Azithromycin 2 g orally in a single dose or Cefixime 800 mg orally in a single dose
Pregnant Women	Ceftriaxone 500 mg	500 mg in a single dose	
If chlamydia! infection has not been excluded, treat for chlamydia with doxycycline 100 mg orally 2 times/day for 7 days. Note: Patients who are coinfected with HIV and gonococcal infection should receive the same treatment regimen as those who are HIV negative. All persons who receive a diagnosis of gonorrhea should be tested for other STIs, including chlamydia, syphilis and HIV. Those persons whose HIV test results are negative should be offered HIV PrEP.			

Treatment Guidelines for Anogenital Herpes (CDC)

Anogenital Herpes (HSV1/HSV2) infection is caused by the herpes simplex virus. Anogenital HSV cannot be cured, but antiviral therapy is recommended for infected individuals, and evaluation recommended for sexual partners. The following is taken from CDC recommendations:

Indication and/or Condition	Drug Formulation	CDC Recommended Dosage and Duration
Primary Infection		
First Clinical Episode of Genital Herpes	Acyclovir 400 mg	400 mg orally 3 times/day for 7-10 days
	Famciclovir 250 mg	250 mg orally 3 times/day for 7-10 days
	Valacyclovir 1 g	1 g orally 2 times/day for 7-10 days
Suppressive Therapy for Recurrent Genital Herpes	Acyclovir 400 mg	400 mg orally 2 times/day
	Famiciclovir 250 mg	250 mg orally 2 times/day
	Valacyclovir 500 mg	500 mg orally once a day
	Valacyclovir 1 g	1 g orally once a day
Pregnant Women		
Pregnant Women with Recurrent Genital Herpes	Acyclovir 400 mg	400 mg orally 3 times/day
	Valacyclovir 500 mg	500 mg orally 2 times/day
Established Infection		
Episodic Therapy for Recurrent Genital Herpes	Acyclovir 800 mg	800 mg orally 2 times/day for 5 days
	Acyclovir 800 mg	800 mg orally 3 times/day for 2 days
	Famciclovir 125 mg	125 mg orally 2 times/day for 5 days
	Famciclovir 1 g	1 g orally 2 times/day for 1 day
	Famciclovir 500 mg	500 mg orally, once followed by 250 mg 2 times/day for 2 days
	Valacyclovir 500 mg	500 mg orally 2 times/day for 3 days
	Valacyclovir 1 g	1 g orally once daily for 5 day
HIV Coinfection		
Suppressive Therapy for Recurrent Genital Herpes	Acyclovir 400-800 mg	400-800 mg orally 2-3 times/day
	Famciclovir 500 mg	500 mg orally 2 times/day
	Valacyclovir 500 mg	500 mg orally 2 times/day
Episodic Therapy for Recurrent Genital Herpes	Acyclovir 400 mg	400 mg orally 3 times/day for 5-10 days
	Famciclovir 500 mg	500 mg orally 2 times/day for 5-10 days
	Valacyclovir 1 g	1 g orally 2 times/day for 5-10 days

Treatment can be extended if healing is incomplete after 10 days of therapy.
Valacyclovir 500 mg once a day might be less effective than other valacyclovir or acyclovir dosing regimens in patients who have very frequent recurrences (i.e., less than 10 episodes per year).
Treatment recommended starting at 36 weeks of gestation.

Treatment Guidelines for Mycoplasma genitalium (CDC)

M. genitalium causes symptomatic and asymptomatic urethritis among men and is the etiology of approximately 15%-20% of NGU, 20%-25% of nonchlamydial NGU, and 40% of persistent or recurrent urethritis. Infection with C. trachomatis is common in selected geographic areas, although M. genitalium is often the sole pathogen.

M. genitalium lacks a cell wall, and thus antibiotics targeting cell-wall biosynthesis (e.g., ß,-lactams including penicillins and cephalosporins) are ineffective against this organism. Because of the high rates of macrolide resistance with treatment failures and efficient selection of additional resistance, a 1-gram dose of azithromycin should not be used. Two-stage therapy approaches, ideally using resistance-guided therapy, are recommended for treatment. Resistance-guided therapy has demonstrated cure rates of more than 90% and should be used whenever possible; however, it requires access to macrolide-resistance testing.

As part of this approach, doxycycline is provided as initial empiric therapy, which reduces the organism load and facilitates organism clearance, followed by macrolide-sensitive M. genitalium infections treated with high-dose azithromycin; macrolide-resistant infections are treated with moxifloxacin.

Indication and/or Condition	Drug Formulation	CDC Recommended Dosage and Duration
Recommended Regimen if M. genitalium Resistance Testing Is Available	If macrolide sensitive: Doxycycline 100 mg	100 mg orally 2 times/day for 7 days, FOLLOWED BY azithromycin 1 gm orally initial dose, FOLLOWED BY azithromycin 500 mg orally once daily for 3 additional days (2.5 gm total)
	If macrolide resistant: Doxycycline 100 mg	100 mg orally 2 times/day for 7 days followed by moxifloxacin 400 mg orally once daily for 7 days
Recommended Regimen if M. genitalium Resistance Testing Is Not Available	Doxycycline 100 mg	100 mg orally 2 times/day for 7 days, followed by moxifloxacin 400 mg orally once daily for 7 days
Persons who have M. genitalium and HIV infection should receive the same treatment regimen as those persons without HIV.		

Our Testing Portfolio

Components	**Bacterial vaginosis** **Atopobium vaginae, BVAB-2, Megosphoero-1** **C. olbicons, C. globroto, Trichomonos**	**Bacterial vaginosis** **Atopobium vaginae, BVAB-2, Megosphoero-1** **C. olbicons, C. globroto, Chlamydia, Gonorrhea, Trichomonos**	**Chlamydia Gonorrhea Trichomonas HSV 1/2**	**Chlamydia Gonorrhea Trichomonas**	**Bacterial vaginosis C. albicans and C. glabrata Candida Six-species Profile C. albicans C. tropicalis C. parapsilosis C. glabrata C. krusei C. lusitaniae Chlamydia/Gonorrhea Genital Mycoplasma Profile M. genitalium, M. hominis, Ureaplasma species HSV 1/2 (188056) Mycoplasma genitalium Trichomonas**
Clinical Use	**Symptoms of vaginitis/ vaginosis, such as discharge.**	**Symptoms of vaginitis/ vaginosis and/or patients at risk for coinfection with Ct/Ng.**	**Screening high-risk patients. Testing patients with symptoms of multiple STIs or coinfections.**		**Flexibility to order any individual component.**
Specimen Type	**APTIMA® vaginal (preferred) or unisex swab. Transported at room temperature.**				

The portfolio combines high-quality testing with the convenience of multiple specimen collection types, providing reliable and actionable information to manage your patients better. The test menu offers a targeted approach for clinically appropriate, cost-effective care with profiles that contain fewer, select individual tests without sacrificing the content needed for comprehensive results. Better information from fewer tests ... smart testing has arrived.