

Things You Can Do to Improve STD Screening in Your Practice

1. Have patients complete a self-administered sexual history questionnaire and risk assessment on a quarterly basis.
2. In each exam room, post a guide for clinicians clarifying what STD tests and specific collection materials are available in your clinic or office.
3. Ensure that lab request forms include HIV, STD, and Hepatitis tests.
4. Make it a point to promote STD screening throughout April, which is National STD Awareness Month.
5. For sexually active HIV+ MSM, order syphilis screening with every CD4 count and viral load, and GC/CT if indicated by risk.

ASYMPTOMATIC SCREENING

www.std.ca.gov/MSMToolkit

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Sample Sexual Health Screening Protocol for MSM

Three essential components of a sexual health evaluation for MSM are:

- Laboratory-based screening to detect asymptomatic infections,
- Assessment of behavioral risk factors, and
- Assessment of STD-related symptoms

In all MSM, the screening tests listed on the next page should be performed at the **initial medical visit** and repeated at least annually.

STD screening should be repeated **at 3-6 month intervals** for sexually active MSM at highest risk³, defined as those who

- Have multiple anonymous partners,
- Use illicit drugs, particularly methamphetamine,
- Seek sex partners through the internet, or
- Have sex partners who participate in these activities.

Screening should be performed regardless of reported condom use.

³ STD Treatment Guidelines, 2015. MMWR. 2015;64(RR3). www.cdc.gov/std/tg2015/specialpops.htm

Sexual Health Screening for MSM: Initial and Annual Visits

1. Conduct risk assessment

- a. Ask about the 5 P's (Partners, Practices, Past STDs, Protection, and Pregnancy Prevention⁴) to assess STD risk.
- b. Ask additional questions to further assess HIV and hepatitis risk (e.g., injection drug use).
- c. Assess for recent symptoms associated with STDs.

2. Conduct physical exam:

- a. Examine the genitalia and anal area for any of the following: ulcers, papules, lesions, rashes or discharge.

3. Screen urethral site for GC and CT

- a. Collect first-catch⁵ urine specimen for nucleic acid amplification test (NAAT)⁶ to detect GC and CT, according to laboratory directions.
- b. Collect a sample of penile discharge for Gram stain if discharge is present.

4. Screen pharyngeal site for GC in patients with history of receptive oral sex IN THE LAST 12 MONTHS^{7,8}

5. Screen rectal site for GC and CT in patients with history of receptive anal sex IN THE LAST 12 MONTHS^{5,9}

6. Perform blood draw for serologic testing for:

- a. HIV, unless known positive.
- b. Syphilis: Rapid Plasma Reagin (RPR), Venereal Disease Research Laboratory (VDRL) or other appropriate screening test.^{10,11}
- c. Hepatitis C (HCV): enzyme immunoassay (EIA) or chemiluminescence immunoassay (CIA), if HIV-infected or other known risk.^{9,12}
- d. Hepatitis B (HBV): Hepatitis B surface antigen (HBsAg) and antibody to HBV core antigen (anti-HBc) unless known positive or vaccinated.¹³
- e. Consider Hepatitis A antibody (anti-HAV), if unvaccinated.¹³
- f. Consider Herpes Simplex Virus Type 2 (HSV-2) type specific serologic test, unless known HSV-2-infected.

7. Consider anal pap smear screening if HIV-infected¹⁴

8. Vaccinate against:

- a. Hepatitis A (HAV) unless history of infection or previous vaccination.¹²
- b. HBV unless history of infection or previous vaccination.¹²
- c. Human Papillomavirus (HPV), if 26 years old or younger.

⁴ MSM might also have female sex partners.

⁵ Patient should not urinate for approximately 1.5 hours before testing.

⁶ NAATs are commercially available for testing urethral or urine specimens to detect GC/CT infections under the names Amplicor (Roche), Aptima (GenProbe) and Probe Tec (BD). If NAAT urine testing unavailable, perform urethral culture for GC and CT.

⁷ NAATs for pharyngeal and rectal GC and CT require verification by the lab processing such specimens. See Renault, et al. MLO Med Lab Obs. 11-22. July 2006. A list of national labs that accept these specimens is available at www.aphl.org/aphlprograms/infectious/Archive/naatestlabs.aspx

⁸ For assistance in identifying a laboratory in California that has locally verified NAATs for the detection of GC/CT rectal and GC oropharyngeal infections contact your local STD controller or the CDPH STD Control Branch at 510-620-3400.

⁹ The pharynx is not a hospitable environment for CT, and prevalence studies have demonstrated low rates of pharyngeal CT among high risk MSM. As a result, pharyngeal CT screening for MSM is not specifically recommended by the CDC. However, most NAATs combine testing for CT and GC. If a patient tests positive for pharyngeal CT, treat accordingly.

¹⁰ Treponemal screening tests, such as EIA or CIA, are used for screening in some settings.

¹¹ Some practice settings in high syphilis morbidity areas have added a serologic test for syphilis to their routine panels for HIV-positive patients returning every 3-4 months for HIV laboratory testing.

¹² Patients with past or present drug use, signs or symptoms of liver disease, or other known risk factors, such as blood transfusion or solid organ transplant prior to 1992, receipt of clotting factors prior to 1987, or chronic dialysis, or upon patient request.

¹³ All unvaccinated MSM should be vaccinated against Hepatitis A and B if no known prior infection. If pre-vaccination serologic testing is a cost effective approach, the first dose of vaccine should be offered at the time of testing to minimize the number of susceptible patients that are lost to follow up.

¹⁴ Some experts recommend anal Pap screening in HIV infected MSM to screen 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 Pap screening.

Higher Risk MSM¹⁵: Semi-Annual or Quarterly Visits

These tests should be performed in addition to those during the initial and annual visits.¹⁵

1. Conduct risk assessment

1. Ask about the 5 P's (Partners, Practices, Past STDs, Protection, and Pregnancy Prevention¹⁶) to assess STD risk.
2. Ask additional questions to further assess HIV and hepatitis risk (e.g., injection drug use).
3. Assess for recent symptoms associated with STDs.

2. Screen urethral site for GC and CT with history of anal or oral insertive sex SINCE LAST VISIT

1. Collect first-catch¹⁷ urine specimen for NAAT¹⁸ to detect GC and CT, according to laboratory directions.
2. Collect a sample of penile discharge for Gram stain if discharge is present.

3. Screen pharyngeal site for GC in patients with history of receptive oral sex SINCE LAST VISIT^{19,20,21}

4. Screen rectal site for GC and CT in patients with history of receptive anal sex SINCE LAST VISIT^{19,20}

5. Perform blood draw for serologic testing for

- HIV, unless known positive.
- Syphilis (RPR/VDRL or other appropriate screening test).^{22,23}

¹⁵ MSM who have multiple or anonymous partners, use illicit drugs (particularly methamphetamine), seek sex partners through the internet, or those who sex partners participate in these activities.

¹⁶ MSM might also have female sex partners.

¹⁷ Patient should not urinate for approximately 1.5 hours before testing.

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Rationale for Collecting Rectal and Pharyngeal Specimens for GC/CT

Rectal and pharyngeal infections are common.

- Figure 1 displays prevalence of GC and CT by anatomic site.
- Rectal and pharyngeal GC prevalence (7.5% and 9.4%, respectively) is higher than urethral GC prevalence (6.6%).
- Rectal CT prevalence (8.8%) is greater than urethral CT (5.5%).

Patients are often asymptomatic.^{24,25,26}

- Figure 2 illustrates that a majority of rectal CT (86%) and GC (84%) infections in MSM are asymptomatic.
- Fewer urethral CT (42%) and GC (10%) infections in MSM are asymptomatic.

Figure 1. CT and GC infections among MSM seeking STD testing are common.²⁶

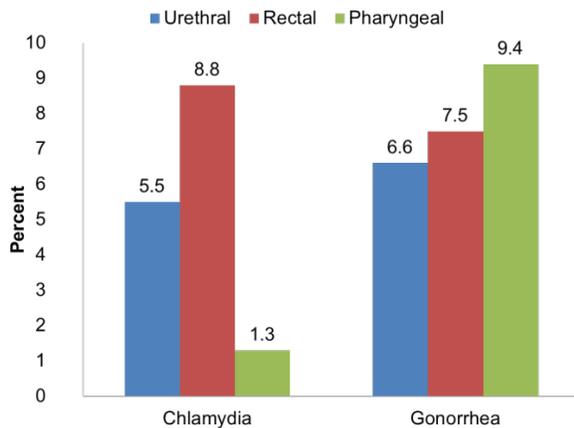
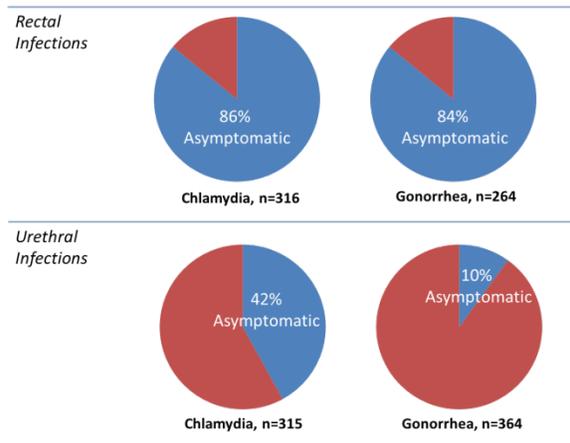


Figure 2. A majority of rectal CT and GC are asymptomatic.²⁶



Most infections are missed by urine/urethral screening only.

- Figure 3 shows the majority of CT (77%) and GC (95%) infections among asymptomatic patients would be missed (not identified) by only screening urine/urethral sites.²⁷

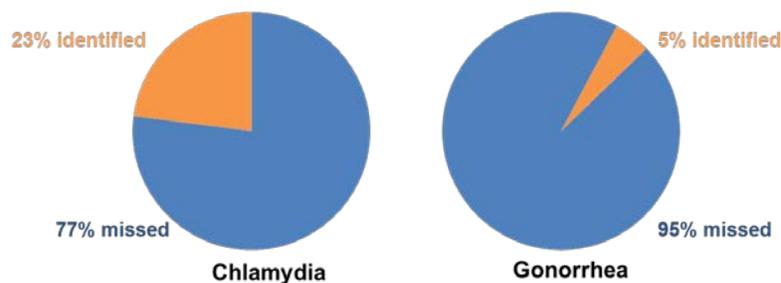
²⁴ Peters, et al. BMC Infectious Diseases 2011; 11:203.

²⁵ Gunn, et al. Sex Transm Dis. 2008 Oct; 35(10):845-8.

²⁶ Kent, et al. Clin Infect Dis. 2005; 41: 67-74.

²⁷ Marcus, et al. Sex Transm Dis. 2011; 38: 922-4. Study participants were limited to asymptomatic MSM, with prevalence of urethral, rectal and pharyngeal infections respectively as follows: (CT: 2.3%, 7.8%, 1.9%; GC: 0.4%, 3.4%, 5.0%).

Figure 3. Proportion of CT and GC infections missed among 3398 asymptomatic MSM if screening only urine/urethral sites, San Francisco, 2008-2009²⁸



CPT® Codes and Medi-Cal reimbursement for NAAT testing of rectal and pharyngeal specimens are the same for urogenital specimens.

A list of labs that accept rectal and pharyngeal swabs for NAAT testing is available at www.aphl.org/aphlprograms/infectious/Archive/naatestlabs.aspx.

Rectal infections may be associated with HIV acquisition:

- MSM diagnosed with rectal CT or GC who had two additional rectal CT or GC infections in the past two years were over eight times more likely to seroconvert compared with MSM with no prior rectal CT or GC infections.²⁹
- Rectal STDs may also cause epithelial erosions that can increase susceptibility to HIV infections. Repeated rectal infections may not only increase the duration of the erosions and the local presence of immune target cells, but may also increase infectivity by altering host immune defenses.²⁹

²⁸ Marcus, et al. Sex Transm Dis. 2011; 38:922-4.

²⁹ Bernstein, et al. J Acquir Immune Defic Syndr. 2010; 53:537-43.

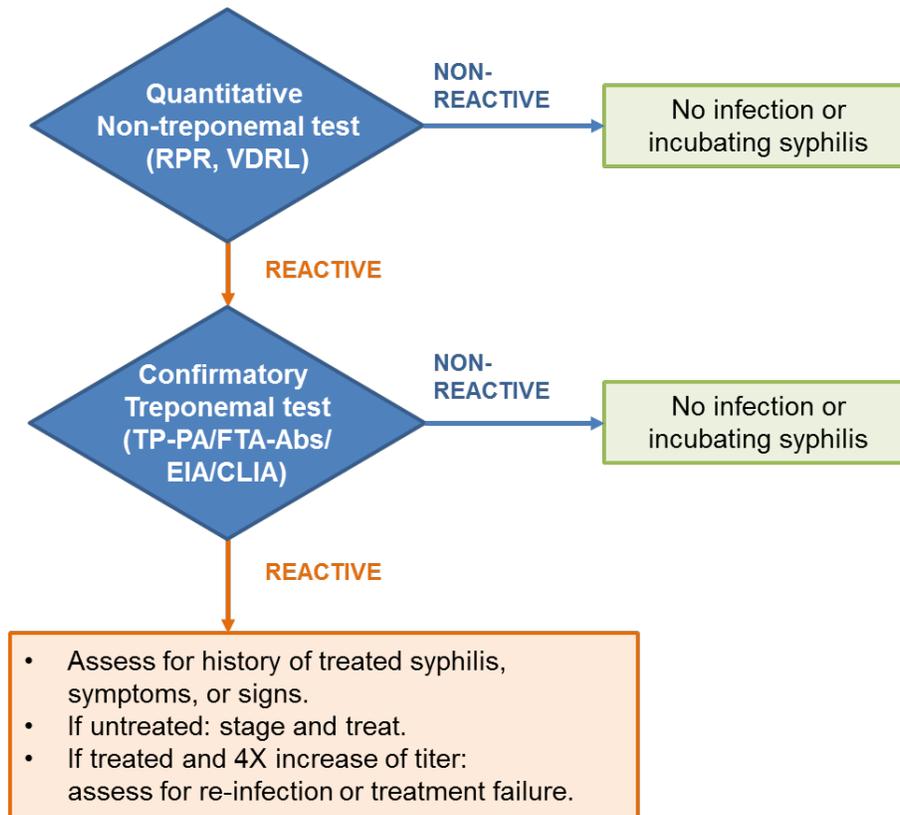
Screening for Syphilis

There are two primary approaches to serologic screening for syphilis. The traditional approach begins with an initial non-treponemal test, either the RPR or VDRL test, followed by a more specific confirmatory treponemal test, commonly either *Treponema pallidum* particle agglutination assay (TP-PA) or fluorescent treponemal antibody absorption (FTA-ABS) test.

A newer algorithm – ‘reverse sequence syphilis screening’ – involves initially screening sera with an automated treponemal EIA or CIA, followed by a non-treponemal test (RPR or VDRL) of reactive specimens, after which discordant results are confirmed with TP-PA. Establishing the serologic diagnosis of syphilis requires both non-treponemal and treponemal testing, given limitations in each form of test.³⁰

The algorithms below are tools for interpreting test results for screening algorithms that begin with non-treponemal tests (Figure 4) or treponemal tests (Figure 5).

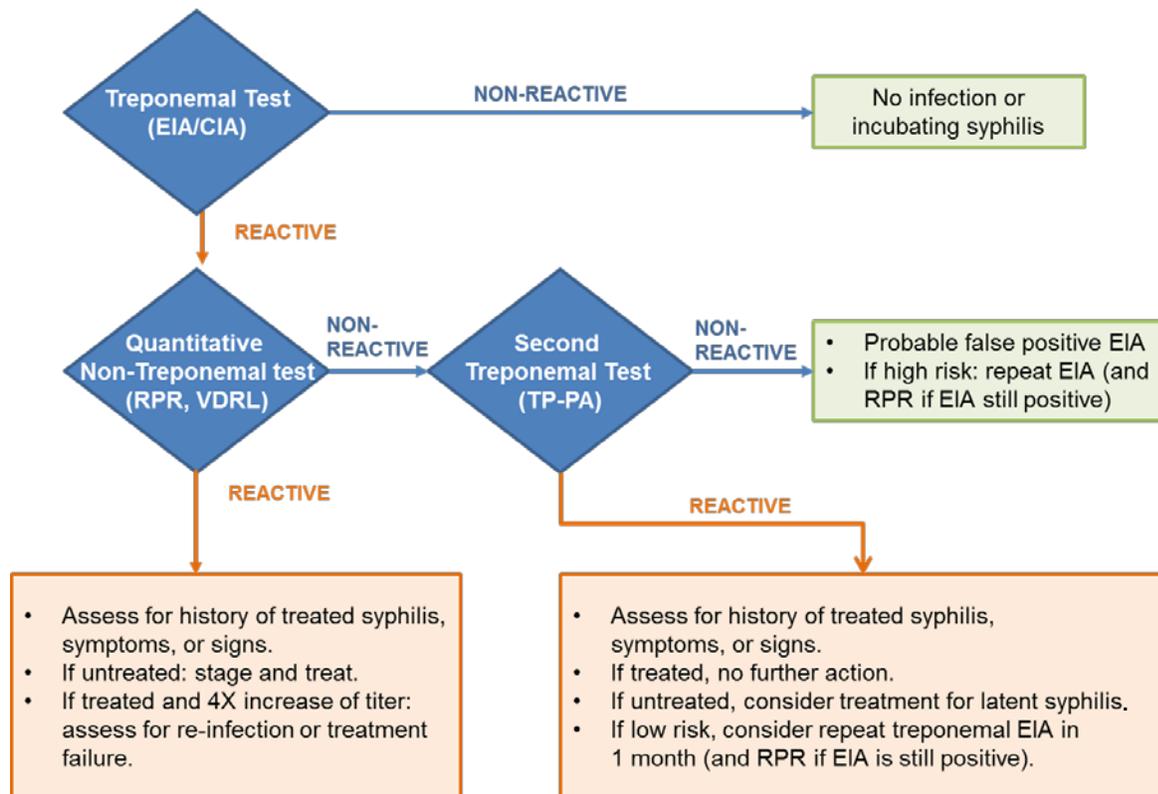
Figure 4: Traditional Non -Treponemal Test (RPR/VDRL) Screening Algorithm



Prepared by the California Department of Public Health

³⁰ STD Treatment Guidelines, 2015. MMWR. 2015;64(RR3). www.cdc.gov/std/tg2015/syphilis.htm

Figure 5: Treponemal Test (EIA /CIA) Screening Algorithm



Prepared by the California Department of Public Health

For more information, please see the “Use of Treponemal Immunoassays for Screening and Diagnosis of Syphilis” available on the CDPH webpage:

www.cdph.ca.gov/pubsforms/Guidelines/Documents/Treponemal_Immunoassays_for_Syphilis_Screening_and_Diagnosis.pdf

Screening for HIV

Sexually active gay men and other MSM are at increased risk for acquisition of HIV infection. Screening for HIV infection should occur at least annually among MSM, or more frequently (i.e. at 3-6 month intervals) for MSM at highest risk defined as those who

- Have multiple or anonymous partners,
- Use illicit drugs, particularly methamphetamine,
- Seek sex partners through the internet, or
- Have sex partners who participate in these activities.

Screening should be performed regardless of reported condom use.

Screening for HIV can be conducted with an HIV antibody test or a combined antibody-antigen test (preferred). If acute or recent HIV infection is suspected, then an HIV Ribonucleic Acid (RNA) test should also be performed (see *Acute HIV Infection* on page 56).

HIV Testing in Healthcare Settings

As of January 2008, HIV testing in medical settings is permissible without specific written consent or HIV prevention counseling.³¹ General medical consent is considered sufficient to perform the test, as indicated by the *CDC's Revised Recommendations for HIV Testing in Adults, Adolescents and Pregnant Women in Healthcare Settings*³². Subsequent California legislation requires that private health insurance providers cover HIV testing, regardless of whether the testing is related to a primary diagnosis.³³

California law³⁴ requires that providers, prior to ordering a test, must either orally or in writing:

1. Inform the patient that HIV testing is planned.
2. Provide information about the test.
3. Inform the patient of the many treatment options available to people who test HIV positive.
4. Inform the patient that a person who tests HIV negative should continue to be routinely tested for HIV.
5. Advise the patient that they may decline the test. If a patient declines the test, the medical care provider shall note that fact in the patient's medical file.

Providers should discuss the window period with patients, and advise repeat testing according to risk. The window period is the period after the patient may have been exposed to HIV but before a test can detect it. The length of the window period depends on the kind of test that was used on blood or oral fluid.

Patient Information Sheets that provide this information in many languages can be found at: www.cdph.ca.gov/programs/aids/Pages/OAHIVTestFS.aspx

For more information about HIV testing in healthcare settings visit the CDPH OA webpage: www.cdph.ca.gov/programs/aids/Pages/OAHIVTestHCS.aspx

³¹ [Assembly Bill 682, California Health and Safety Code Section 120990.](#)

³² MMWR Sept 2006;55(RR-14):1-17.

³³ [Assembly Bill 1894, California Health & Safety Code 1367.46, California Insurance Code 10123.91.](#)

³⁴ [California Health and Safety Code, Section 120990.](#)

For legal considerations in states other than California, see the *Updated Compendium of State HIV Testing Laws* available through the Consultation Library at the National HIV/AIDS Clinical Consultation Center at www.nccc.ucsf.edu.

Delivering Positive Test Results

Any medical provider can deliver positive HIV test results to a patient. There are a few simple points to help in delivering this information effectively:

1. State the result in a direct, neutral tone, and wait for patient's response.
2. Address individual needs and concerns.
 - a. Sources of emotional support
 - b. Information about HIV infection and medical care
 - c. Information about transmission and partner notification
3. Make a short-term plan.
4. Link to needed services.
 - a. Ask what's most important to do first
 - b. Link to HIV medical care
 - c. Close the session, but not the door

California state law requires that patients who test HIV positive are:

1. Informed that there are numerous treatment options available, and
2. Provided information about follow up testing and care that may be recommended, including contact information for medical and psychological services.

Visit the California STD/HIV Prevention Training Center webpage for resources, including a training video on the delivery of the positive HIV test result:
stdhivtraining.org/clinical_videos.html

The Pacific AIDS Education and Training Center (PAETC) also has resources on HIV testing and delivering results: paetc.org/main/?page_id=20

For more information about HIV/AIDS testing, reporting, treatment, and legal responsibilities, visit the CDPH OA webpage: www.cdph.ca.gov/programs/aids/

Reimbursement Rates and Billing Codes

The American Academy of HIV Medicine provides Coding Guide for Routine HIV Testing in Healthcare Settings at its webpage:
www.aahivm.org/Upload_Module/upload/Provider%20Resources/AAHIVM%20CPT%20Coding%20Guide.pdf

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