California STD/HIV Screening Recommendations in Pregnancy 2017

First prenatal visit

- HIV
- Syphilis
- Chlamydia<sup>1</sup>
- Gonorrhea<sup>1</sup>
- Hepatitis B surface antigen (HBsAg)
- Hepatitis C antibody if risk<sup>2</sup>
- Type-specific HSV serology can be considered if high risk<sup>3</sup>
- Pap test if age ≥ 21 years and indicated by national guidelines<sup>4</sup>

Third trimester

- HIV if high risk<sup>5</sup>
- Syphilis if living in an area with high syphilis prevalence or high risk<sup>6</sup> (test in early third trimester at 28-32 weeks)
- Chlamydia if age <25 years, positive test earlier in pregnancy, or high risk<sup>1</sup>
- Gonorrhea if positive test earlier in pregnancy or high risk<sup>1</sup>

During labor & delivery

- HIV rapid testing if HIV status undocumented
- Syphilis (stat RPR) if no prior prenatal care
- Syphilis if living in an area with high syphilis prevalence or high risk<sup>6</sup>
- HBsAg on admission if no prior screening or if high risk<sup>7</sup>

1. CDC recommends screening for chlamydia and gonorrhea if age <25 years or high risk. Risk factors for chlamydia or gonorrhea: prior chlamydia or gonorrhea infection, particularly in past 24 months; new or multiple partners; suspicion that a recent partner may have had concurrent partners; sex partner diagnosed with an STD; commercial sex; drug use; African American women up to age 30; and local factors such as community prevalence of infection.

2. The primary risk factor for Hepatitis C is past or current injection drug use. Additional risk factors include: history of blood transfusion or organ transplantation before July 1992; receipt of an unregulated tattoo; long-term hemodialysis; and intranasal drug use.

3. Risk factors for genital HSV: exposure to partner with genital herpes; recurrent genital symptoms or atypical symptoms with negative HSV cultures; clinical diagnosis of genital herpes without laboratory confirmation; or HIV-infected status.


5. Risk factors for HIV: illicit drug use; new STD diagnosis during pregnancy; new or multiple partners; living in an area with high HIV prevalence; or HIV-infected partner.

6. Risk factors for syphilis among pregnant women: receiving late or limited prenatal care; new or multiple partners; suspicion that a recent partner may have had concurrent partners; partner with male partners; new STD diagnosis in pregnancy; sex partner diagnosed with an STD; commercial sex; drug use; and living in an area with high syphilis prevalence among women.

7. Risk factors for hepatitis B: injection drug use; new STD diagnosis in pregnancy; new or multiple partners; or HBsAg-positive partner.

Recommended vaccinations during pregnancy: Tdap and influenza.
Benzathine penicillin G (generic name) is the recommended treatment for syphilis not involving the central nervous system and is available in only one long-acting preparation.

Anogenital warts may proliferate and become friable during pregnancy. Although removal of warts during pregnancy can be considered, resolution might be incomplete or poor until pregnancy is complete. Pregnant women with anogenital warts should be counseled concerning the low risk for warts on the larynx of their infants or children (recurrent respiratory papillomatosis).

If patient lives in a community with high GC prevalence, or has risk factors (e.g., age <25 years, new partner, partner with concurrent sex partners, or sex partner with a STD), consider empiric treatment for GC.

Assess for bacterial vaginosis and trichomoniasis; if detected, treat per above guidelines.

1. Every effort should be made to use a recommended regimen. Test of cure follow-up [preferably by nucleic acid amplification test (NAAT)] 3–4 weeks after completion of chlamydia treatment is recommended in pregnancy. Retesting 3 months after treatment is recommended for all pregnant women. In case of allergy to both alternative and recommended regimens, consult with the STD Clinical Consultation Network at www.stdccn.org.

2. Dual therapy with ceftriaxone 250 mg IM PLUS azithromycin 1 g po is recommended for all patients with GC regardless of the CT test results. Dual therapy should be simultaneous and by directly observed therapy.

3. If the patient has been treated with a recommended regimen for GC, retesting has been ruled out, and symptoms have not resolved, perform a test of cure using culture, antibiotic susceptibility testing, and NAAT and report to the local health department. For clinical consult and help in obtaining GC culture, call the CA STD Control Branch at 510-620-9400.

4. Oral hydroxychloroquine given lower and less-sustained bactericidal levels than ceftriaxone 250 mg; limited efficacy for treating pharyngeal GC. Cefixime should only be used when ceftriaxone is not available.

5. For consultation, contact the STD Clinical Consultation Network at www.stdccn.org.

6. For STD clinical consultation and help in obtaining GC culture, call the CA STD Control Branch at 510-620-9400.

7. Erythromycin ethylsuccinate 800 mg po qid x 7 d

8. Clindamycin 300 mg po bid x 7 d or Clindamycin ointment 1% 100 mg intravaginally x 3 d

9. Ceftriaxone 1 g orally once

10. Procaine penicillin G 2.4 million units IM qd

11. For 10-14 d PLUS Probenzidine 500 mg po qid for 10-14 d

Cervical and intra-anal warts should be managed in consultation with a specialist.