Understanding the 2015 Sexually Transmitted Diseases Treatment Guidelines for LGBT People

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Continuing Medical Education Disclosure

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Learning Objectives

By the end of this webinar, participants will be able to

1. Discuss STD prevalence and risk among LGBT people
2. Describe the current recommendations for STD screening, treatment, and follow up for LGBT people
3. Identify opportunities for enhanced STD control among LGBT people
Effective Communication = Effective Care
LGBT People are Diverse

Effective Communication = Effective Care
Do we know our client’s Sex, Gender Identity, Gender Expression, and Sexual Orientation?

**Sex**
- Refers to the presence of specific anatomy. Also may be referred to as ‘Assigned Sex at Birth’

**Gender Identity**
- What your internal sense tells you your gender is

**Sexual Orientation**
- To whom you are physically and emotionally attracted
- With whom you have sex
- How you identify your sexuality

**Gender Expression**
- How you present your gender to society through clothing, mannerisms, etc.

Effective Communication = Effective Care
Sexual Health and Life Stage

Effective Communication = Effective Care
Sexual Behaviors are Diverse

Effective Communication = Effective Care
Beyond the Individual

Individual
- Knowledge
- Experience
- Attitudes
- Physical Health
- Age
- Responsibility

Relationship
- Sexual Partner(s)
- Peers
- Parents
- Family Structure

Community
- Religion
- Social Networks
- Socioeconomics

Society
- Cultural Values
- Gender Norms
- Gender Inequality
- National or State law
Effective Communication = Effective Care
Effective Communication Facilitates Effective STD Control

Accurate Risk Assessment, Education, and Client-centered Counseling

Pre-exposure Vaccination

Screening, diagnosis, and treatment of asymptomatic infection

Diagnosis and treatment of symptomatic infection

Evaluation, treatment, and counseling of sex partners

STD Treatment Guidelines 2015
Resources for taking a history of Sexual Health

http://www.lgbthealtheducation.org/publications/
Resources for taking a history of Sexual Health

The Centers for Disease Control and Prevention (CDC) has developed a simple categorization of sexual history questions to help focus on key issues.


Other resources available for obtaining a sexual history

www.cdc.gov/std/treatment/resources.htm
https://nnptc.org/clinical-ptcs/
STD/HIV Prevention Counseling Guidance

- Client-centered, interactive prevention counseling that involves tailoring a discussion of risk reduction to the individual person
- Brief provider-delivered prevention messages
- Motivational interviewing
Special Populations

- Men who have sex with men
- Transgender People
- Women who have sex with women
MSM and Risk for STIs/HIV
Susceptibility of the Rectum to STIs

Exposure

- 1980s – Mid 1990s
  - Decline in frequency of unsafe sex
  - Decline in rates of bacterial STDs and incident HIV

- Mid 1990s – Present
  - Increase in frequency of unsafe sex
  - Increase in the rates of STIs and steady incident HIV
Primary and Secondary Syphilis in MSM

- 2/3 of cases are diagnosed in MSM
- Increasingly diagnosed in MSM of color
- Increase in screening but...
  - 71% of the syphilis cases still diagnosed when persons sought care for symptoms
- For HIV non-infected MSM, HIV incidence after a new syphilis diagnosis was 10.5%/year

Chesson et al. STI, S3:58-62; 2011
Tarrone et al. JAIDS, 58(3):328-335;2011
Buchacz et al. JAIDS; 47(2);234-240;2008
Syphilis rates are highest in MSM

* Of the reported male cases of primary and secondary syphilis, 16.9% were missing sex of sex partner information.  
† MSW = men who have sex with women only; MSM = men who have sex with men.

High Rates of Syphilis and HIV Co-Infection

Serologic Tests for Syphilis

- Nontreponemal Tests (VDRL, RPR)
  - Antigen - cardiolipin-lecithin-cholesterol
  - Quantitative: might correlate with disease activity

- Treponemal Tests (FTA-ABS, MHA-TP, TPPA, EIAs)
  - Treponemal Antigens
  - Qualitative
Syphilis Treatment

Benzathine Penicillin G
Syphilis: Special Considerations
MSM and in HIV

- Diagnostics and treatment considerations are similar for all people
- Frequency of screening determined by risk
- Persons with HIV infection with primary or secondary syphilis should be treated in the same manner as those without HIV infection
HIV and Syphilis Co-Infection

- Persons with HIV plus early syphilis may be at increased risk for neurologic complications
- May have higher rates of serologic treatment failure with recommended regimens
- Clinical and serologic follow up: 3, 6, 9, 12, and 24 months
- If nontreponemal titer does not decline 4 fold after 24 months, CSF evaluation can be considered
  - CSF findings concerning for neurosyphilis = treat for neurosyphilis
  - CSF findings not concerning for neurosyphilis: Benzathine PCN G 2.4 million units at weekly intervals for 3 weeks
  - If nontreponemal titers do not decline after retreatment, the need for CSF examination or additional therapy is unclear but generally not recommended.
Gonorrhea and Chlamydia in MSM

- Rates of gonorrhea increasing in men
- Genital & extra-genital prevalence is high
  - Pharyngeal Infections
    - Gonorrhea = 7.3%
    - Chlamydia = 2.3%
    - Insertive oral sex is associated with urethral gonorrhea
  - Rectal Infections
    - Gonorrhea in HIV negative MSM = 10.9% (newly diagnosed HIV = 25.9%)
    - Chlamydia in HIV negative MSM = 7.8% (newly diagnosed with HIV = 18.2%)
    - Recurrent rectal gonorrhea and chlamydia infection associate with increased risk for HIV seroconversion

Park et al, STD;39(6):482-484;2012
Lafferty et al.  STD, 24(5):272-278;1997
Kim et al.  STD, 30(11):813-817; 2003
Bernstein et al.  JAIDS, 53(4)L537-543, 2010
Pathela, CID, 57(8):1203-1209;2013
Extragenital Collection

http://emedicine.medscape.com/article/2121004-overview#aw2aab6b4

https://www.scripps.org/articles/907-rectal-culture
Gonorrhea Resistance

Figure 1. History of antibiotic treatment of gonorrhea and evolution of resistance in *N. gonorrhoeae* in the United States that is highly influenced from other geographic regions, especially through the import of resistant strains from Asia. Modified from a figure prepared by Paul Johnson (Emory University School of Medicine).
Emergence of Fluoroquinolone-Resistant N. gonorrhoeae (QRNG) in the US, 1989–2007

*Resistance to ciprofloxacin defined as MIC ≥ 1 µg/ml
Note: MSM = Men who have sex with men; MSW = Men who exclusively have sex with women
Uncomplicated Gonorrhea

Ceftriaxone 125 mg IM
or
Cefixime 400 mg PO
or
Ciprofloxacin 500 mg PO
or
Ofloxacin 400 mg PO
or
Levofloxacin 250 mg PO

Plus, IF CHLAMYDIAL INFECTION IS NOT RULED OUT Azithromycin 1.0 g Single Dose Or Doxycycline 100 BID x 7d
Proportion of Isolates with MICs to Cefixime \(\geq 0.25 \mu g/ml\) by Sex of Sex Partner

- MSM = Men who have sex with men
- MSW = Men who exclusively have sex with women

Note: Preliminary data

Percentage of isolates

Gonococcal Isolate Surveillance Project (GISP)
Treatment of Gonorrhea Uncomplicated Gonococcal Infections of the Cervix, Urethra, and Rectum

- **Recommended**
  - Ceftriaxone 250 mg IM in a single dose
  - Azithromycin 1 gm orally in a single dose

- **Alternative (if ceftriaxone is not available)**
  - Cefixime 400 mg orally in a single dose
  - Azithromycin 1 gm orally in a single dose

- Retest at 3 months

- **Persistence of symptoms:**
  - Cultures and susceptibility testing

Pharyngeal Gonococcal infections
- Typically asymptomatic and relatively common in some populations
- More difficult to eradicate
- Test of cure at 14 days recommended in cases of pharyngeal gonorrhea and treatment of an alternative regimen

Ota, CID;48:1237-43;2009
Treatment of Chlamydia

- Azithromycin 1 mg orally in a single dose
  or
- Doxycycline 100 mg twice a day for 7 days

- Retest at 3 months
# Proctitis, Proctocolitis, and Enteritis

<table>
<thead>
<tr>
<th>Proctitis</th>
<th>Proctocolitis</th>
<th>Enteritis</th>
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</thead>
<tbody>
<tr>
<td><strong>Symptoms</strong></td>
<td><strong>Symptoms of proctitis plus</strong></td>
<td><strong>Symptoms</strong></td>
</tr>
<tr>
<td>- Anorectal pain</td>
<td>- Diarrhea</td>
<td>- Diarrhea</td>
</tr>
<tr>
<td>- Tenesmus</td>
<td>- Abdominal Cramping</td>
<td>- Abdominal cramping</td>
</tr>
<tr>
<td><strong>Pathogens</strong></td>
<td><strong>Pathogens</strong></td>
<td><strong>Pathogens</strong></td>
</tr>
<tr>
<td>- <em>N. gonorrhea</em></td>
<td>- <em>Campylobacter sp</em></td>
<td>- Oral <em>Giardia lamblia</em></td>
</tr>
<tr>
<td>- <em>C. trachomatis</em> (including LGV)</td>
<td>- <em>Shigella sp</em></td>
<td>- Opportunistic</td>
</tr>
<tr>
<td>- <em>T. pallidum</em></td>
<td>- <em>Entamoeba histolytica</em></td>
<td>- <em>Opportunistic</em></td>
</tr>
<tr>
<td>- HSV</td>
<td>- <em>LGV serovars of C. trachomatis</em></td>
<td>- Oral anal contact</td>
</tr>
<tr>
<td><strong>Receptive anal intercourse</strong></td>
<td>** opportunist**</td>
<td><strong>Receptive Anal sex, oral anal contact</strong></td>
</tr>
<tr>
<td><strong>Anoscopy with gram stain and diagnostics for specific organisms</strong></td>
<td><strong>CMV</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Treat based on clinical presentation</strong></td>
<td><strong>Opportunistic</strong></td>
<td></td>
</tr>
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STD Treatment Guidelines 2015

[Logo: National LGBT Health Education Center]
Treatment of Acute Proctitis

- Ceftriaxone 250 mg IM
  Plus
- Doxycycline 100 mg orally twice a day for 7 days

MSM with proctitis and positive rectal Chlamydia NAAT, MSM with HIV and proctitis and MSM with bloody discharge, perianal ulcers or mucosal ulcers should be offered LGV treatment

- Doxycycline 100 mg orally twice a day for 21 days

McLean et al, CID;44(S3):S147-152;2007
Van der Big, CID;42(2):186-194;2006
STD Treatment Guidelines 2015
STDs characterized by genital, anal or peri-anal ulcers

- Genital Herpes
- Syphilis
- Chancroid
- Donovanosis

Increase Susceptibility to HIV

STD Treatment Guidelines 2015
STDs characterized by genital, anal or peri-anal ulcers

- Genital Herpes
- Syphilis
- Chancroid
- Donovanosis

- Chronic lifelong infection
- 50 million infection with HSV-2
- Increasing ano-genital infections caused by HSV-1 in MSM
- Most persons with genital herpes are unaware
- Most transmission occur when symptoms are absent
- Genital herpes is a risk factor for HIV
- Suppressive therapy may reduce genital herpes transmission
- Suppressive therapy does not protect from HIV acquisition
- HSV-2 infection with type-specific serologic tests can be considered

Bradley et al, JID;209(3):325-333;2014
Ryder et al, STI;85(6):416-419;2009
Watson-Jones, NEJM;358(15):1560-1571;2008
Celum et al, Lancet;371:2109-2119;2008
HIV in MSM

HIV Incidence by Transmission Category, U.S., 2013

- Male-to-Male Sexual Contact (MSM): 65%
- Heterosexual Contact: 25%
- MSM/IDU: 3%
- Injection Drug Use (IDU): 7%
- Other: <1%

HIV Incidence by Region of Residence, United States, 2013

- South: 51%
- West: 17%
- Northeast: 19%
- Midwest: 13%

HIV Incidence in the United States, 2008-2013

There are approximately 50,000 new HIV diagnoses each year in the US.

Incidence among MSM and MSM/IDU increased 15% from 2008 to 2011. Young black MSM accounted for more than half of new infections among MSM aged 13-24 over this time.

Acute HIV: detection, counseling, and referral

- Symptoms develop in 50-90% within first few weeks
- Test with antigen antibody immunoassay or HIV RNA in conjunction with the antigen antibody test
  - If Immunoassay is negative or indeterminate then test for HIV RNA
- Antiretroviral therapy during acute infection is recommended
- STD screening is a routine part of HIV care

Main symptoms of Acute HIV infection:
- Systemic: - Fever - Weight loss
- Central: - Malaise - Headache - Neuropathy
- Pharyngitis
  - Mouth: - Sores - Thrush
- Lymph nodes: - Lymphadenopathy
- Skin: - Rash
- Esophagus: - Sores
- Muscles: - Myalgia
- Liver and spleen: - Enlargement
- Gastric: - Nausea - Vomiting

Weintrob et al, Arch of Inten Med;163(17):2097-2100;1996
HIV Screening is recommended for all 13-64

<table>
<thead>
<tr>
<th>Key considerations when establishing an HIV diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>• HIV screening is recommended for all persons who seek evaluation or treatment for STDs.</td>
</tr>
<tr>
<td>• HIV testing must be voluntary and free from coercion. Patients must not be tested without their knowledge.</td>
</tr>
<tr>
<td>• Opt-out HIV screening (notifying the patient that an HIV test will be performed, unless the patient declines) is recommended in all health-care settings.</td>
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<tr>
<td>• Specific signed consent for HIV testing should not be required. General informed consent for medical care is considered sufficient to encompass informed consent for HIV testing.</td>
</tr>
<tr>
<td>• Use of Ag/Ab combination tests is encouraged unless persons are unlikely to receive their HIV test results.</td>
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<tr>
<td>• Preliminary positive screening tests for HIV infection must be followed by additional testing to definitively establish the diagnosis.</td>
</tr>
<tr>
<td>• Providers should be alert to the possibility of acute HIV infection and perform an antigen/antibody immunoassay or HIV RNA in conjunction with an antibody test. Persons suspected of recently acquired HIV infection should be referred immediately to an HIV clinical care provider.</td>
</tr>
</tbody>
</table>
HIV Infected at Baseline?

Universal HIV Screening

HIV Positive
- HIV care / antiretroviral therapy/
  Counseling/Adherence

Reduce HIV Incidence

HIV Negative
- Safer sex
  Address STIs
  PEP or PrEP
  Counseling/Adherence

www.lgbthealtheducation.org
STD Treatment Guidelines 2015
HIV in MSM

- Disproportionate risk
- Unknown sero-status
- Behaviors that increase risk
  - Sex without condoms
  - Substance use
    - Sexual performance enhancing drugs

CDC, MMWR 58(4):77-81;2009
The STI History of Symptoms

- Ask about symptoms
  - Urethral discharge
  - Dysuria
  - Genital and perianal ulcers
  - Regional LAD
  - Skin rash
  - Anorectal symptoms consistent with proctitis discharge and pain on defecation or during anal intercourse
  - Absence of symptoms does not equal absence of infection
Annual Screening Recommendations for MSM

**HIV**
- HIV serology if HIV- and who themselves or whose sex partners have had more than one sex partner since most recent HIV test

**Syphilis**
- Syphilis serology, with a confirmatory test to establish whether persons with reactive serologies have incident untreated syphilis, have partially treated syphilis, or are manifesting slow serologic response to prior therapy

**Gonorrhea**
- Urine NAAT to screen for urethral infection with gonorrhea in men who have had insertive intercourse during the preceding year.
- Culture or NAAT (not FDA approved) from a rectal swab to test for rectal gonorrhea in men who have had receptive anal intercourse during the preceding year
- Culture or NAAT (not FDA approved) from pharyngeal swab for pharyngeal gonorrhea in men who have had receptive oral intercourse during the preceding year
Annual Screening Recommendations for MSM

Chlamydia

- Urine NAAT to screen for urethral infection with chlamydia in men who have had insertive intercourse during the preceding year
- NAAT from a rectal swab to test for rectal chlamydia in men who have had receptive anal intercourse during the preceding year
- Testing is not recommended for pharyngeal chlamydia infection

Frequent screening

- More frequent STD screening (3-6 month intervals) is indicated for MSM who themselves or whose sexual partner have had multiple partners
Human Papilloma Virus and MSM

Vaccinate boys 11-12 year old (may start as early as age 9)

Vaccinate boys and men 13-21 who have not started or completed the vaccine series

Vaccinate immunocompromised males (including those with HIV) through age 26

Vaccinate MSM through age 26
Anal Cancer

- Estimated new cases in 2015: 7,270
- Estimated Deaths in the 2015: 1,010
- 0.4% of all cancers diagnosed in the U.S. in 2015
- Rates have increased steadily since the 1970’s
- In men
  - General Population: 0.8/100,000
  - HIV Infected MSM: 70/100,000

Chiao EY. Clin Infect Dis, 2006, 43:223-33
HPV and Anal Cancer

- Insufficient data to recommend routine anal cancer screening with anal cytology

- Annual digital anorectal exam may detect masses

- Cytology followed by high-resolution anoscopy performed in some centers
Sexual Transmission of Hepatitis A, B, C

**Hepatitis A**
- Transmission Fecal-Oral
- Shed in feces from 2-3 weeks before to 1 week after onset of clinical illness
- MSM at risk
- Vaccine available

**Hepatitis B**
- Transmission by percutaneous or mucous membrane exposure to Hepatitis B-infected blood or body fluids that contain blood
- MSM at risk
- Vaccine available
Sexual Transmission of Hepatitis A, B, C

Hepatitis C

- Evidence for sexual transmission
  - High-risk and traumatic sexual practices
  - Concurrent genital ulcerative disease
  - Among person with HIV
    - Group sex
    - Cocaine and non-intravenous drug use during sex
  - No vaccine

Dionne-Odom et al, Lancet Infect Dis;9(12):775-783;2009
Urbanus et al, Aids;23(12):F1-F7;2009
Tohm et al, Hepatology;52(4):1497-1505;2010
Rauch et al, CID;41(3):395-402;2005
Van d Laar et al, JID;196(2):230-238;2007
Danta et al, Aids;21(8):983-991;2007
Other Recommendations for MSM

**HPV**
- Vaccination is recommended for MSM through age 26
- Data are insufficient to recommend routine anal cancer screening by anal cytology

**Hepatitis A**
- Vaccination against HAV is recommended for all MSM in whom previous infection or vaccination cannot be documented

**Hepatitis B**
- All MSM should be tested for HBsAg to detect HBV infection. Identification of chronic infection is essential to ensure necessary care and services to prevent transmission to others
- Vaccination against HBV is recommended for all MSM in whom previous infection or vaccination cannot be documented

**Hepatitis C**
- Serologic screening for HCV is recommended at initial evaluation of newly diagnosed persons with HIV infection
- Repetitive screening should be performed yearly and more frequently depending on local prevalence, incidence, high risk sexual behavior, presence of concomitant ulcerative disease, or presence of STD-related proctitis
- Screening should be performed using HCV antibody assays followed by HCV RNA testing for those with a positive test
MSM initiating HIV care

- High prevalence of STDs in MSM at initiation of HIV care

- Screen for syphilis, gonorrhea, and chlamydia at appropriate anatomical sites of exposure

- Follow up testing dictated by subsequent behavior but recent studies suggest that every 3-6 months may be beneficial

Aberg et al, CID;58(1):1-10;2014
STD Treatment Guidelines and women who have sex with women (WSW)
WSW are a diverse group with variations in sexual identity, sexual behaviors, sexual practices and risk behaviors.

Currently WSW

WSWM

Exclusively WSW

Few comprehensive and reliable resources of sexual health information for WSWs are available.

STD Treatment Guidelines 2015
WSW and Risk for STDs/HIV

Risk

Specific STD

Sexual Practice
WSW Sexual Practice and STD Risk

**Oral Genital**
- HSV-1

**Vaginal/Anal Penetration**
- Transmission of infected cervicovaginal or anal secretions
- Trichomonas vaginalis
- HIV
- Bacterial vaginosis
- HPV

**Oral Anal**
- Hepatitis A

References:
- Feathers et al, STI;76(5):345-349.
- Marrazzo et al, JID;185(9):1307-1313
- Muzny et al, STD; 39(7):556-558;2012
- Kwaka et al, CID;36(3):e40-41;2003
- Marrazzo et al, STD;30(12):890-895;2003
HPV infections are common among WSW and sexual transmission of HPV likely occurs between women.

HPV DNA has been detected through PCR based methods from the cervix, vagina, and vulva in 13-30% of WSW.

Among WSW who reported never having had a male sex partner, 26% had antibodies to HPV-16 and 42% had antibodies to HPV-6.

HSIL and LSIL have been detected on PAP tests in WSW who reported no previous sex with men.

WSW are at risk for acquiring HPV from their female partners and from current or prior male partners, and are at risk for cervical cancer.

Bailey et al, Brit J of Gen Prac;50(455):481-482;2000
Ferris et al, J Fam Prac;43(6):581-584,1996
**HPV Vaccination and Cervical Cancer Screening**

- Women should be offered HPV vaccine as per current guidelines.

- Routine cervical cancer screening should be offered to all women, regardless of sexual orientation or sexual practices.

**Vaccinate girls 11-12 year old (may start as early as age 9)**

**Vaccinate girls and women 13-26 who have not started or completed the vaccine series**
WSW and Bacterial Vaginosis

- Bacterial Vaginosis
  - Common in WSW
  - Facilitated by transfer of vaginal fluid/bacteria
  - Routine screening for BV is not currently recommended

Evans et al, STI;83(6):470-475;2007
STD Treatment Guidelines 2015
WSW and bacterial pathogens

- Less known about transmission of
  - Syphilis
  - Chlamydia
  - Gonorrhea
WSW and STD Screening

- Report of same sex behavior in women should not deter providers from considering and performing screening for sexually transmitted infections in their clients according to the current guidelines.
Transgender Men and Women and the STD treatment Guidelines
The T in LGBT: Transgender

- Gender identity not congruent with the assigned sex at birth
- Alternate terminology
  - Transgender woman, trans woman, male to female (MTF)
  - Transgender man, trans man, female to male (FTM)
  - Genderqueer—one who rejects the gender binary
- Gender identity is independent from sexual orientation
Transgender Women and STDs

- Estimated HIV prevalence in transgender women
  - 28% in US
  - 56% in African-Americans
  - 18-22% worldwide
- Transgender women are nearly 49 times more likely to have HIV than other adults of reproductive age
- STD prevalence Varies
- Risk factors include
  - Social and economic marginalization
  - High unemployment, engaging in sex work
  - Limited health care access
  - Lack of familial support

Transgender men and STDs

- While transgender men are less likely to have HIV than transgender women, their rates of infection are still higher than that of the general population.
- Evidence also suggests high risk of, and rates of, STD’s.
Screen and counsel trans women & men based on STD Risk

- Current Anatomy
- Sexual Behavior
- Partners
- Substance use
Transgender People: Recommendations

- Given the diversity of transgender individuals, their choices regarding surgical affirming procedures and hormone use, and their patterns of sexual behavior, it will be important to assess for symptoms consistent with common STDs, and to screen for asymptomatic STDs based on their behavioral histories.
Special Populations

- Men who have sex with men
- Women who have sex with women
- Transgender People
Identify opportunities for enhanced STD control among LGBT people

- Research
- Communication
- Interventions
Thank you