Complete Summary

GUIDELINE TITLE

Special populations. Sexually transmitted diseases treatment guidelines 2006.

BIBLIOGRAPHIC SOURCE(S)

Centers for Disease Control and Prevention, Workowski KA, Berman SM. Special populations. Sexually transmitted diseases treatment guidelines 2006. MMWR Morb Mortal Wkly Rep 2006 Aug 4;55(RR-11):6-10. [222 references]

GUIDELINE STATUS

This is the current release of the guideline.

This guideline updates a previous version: Centers for Disease Control and Prevention. Special populations. Sexually transmitted diseases treatment guidelines. MMWR Recomm Rep 2002 May 10;51(RR-6):5-7.

COMPLETE SUMMARY CONTENT

SCOPE

DISEASE/CONDITION(S)

Sexually transmitted diseases (STDs) including:

- Bacterial vaginosis
- *Chlamydia trachomatis* infection
- Hepatitis B and C virus infection
- Herpes simplex virus infection
- Human immunodeficiency virus (HIV) infection
- Human papillomavirus infection
- *Neisseria gonorrhoeae* infection

- Syphilis

GUIDELINE CATEGORY

Counseling
Prevention
Screening

CLINICAL SPECIALTY

Emergency Medicine
Family Practice
Infectious Diseases
Internal Medicine
Obstetrics and Gynecology
Pediatrics
Preventive Medicine
Psychology

INTENDED USERS

Advanced Practice Nurses
Health Care Providers
Managed Care Organizations
Nurses
Physician Assistants
Physicians
Public Health Departments

GUIDELINE OBJECTIVE(S)

- To update the Sexually Transmitted Diseases Treatment Guidelines 2002 (*MMWR 2002;51[No. RR-6]*)
- To assist physicians and other health-care providers in preventing and treating sexually transmitted diseases (STDs)

TARGET POPULATION

- Pregnant women
- Adolescents
- Children with sexually transmitted diseases (STDs)
- Men who have sex with men (MSM)
- Women who have sex with women (WSW)

INTERVENTIONS AND PRACTICES CONSIDERED

Pregnant Women

1. HIV test, rapid HIV test, serologic test for syphilis (rapid plasma reagin-card test), FDA-approved serologic test for hepatitis B surface antigen (HBsAg),

hepatitis C antibody test, tests for *Neisseria gonorrhoeae* and *Chlamydia trachomatis*, evaluation for bacterial vaginosis, Papanicolaou (Pap) smear
2. Reporting of HBsAg-positive pregnant women to state and/or local health department for appropriate management
3. Vaccination of household and sexual contacts of HBsAg-positive women
4. Appropriate counseling of hepatitis C-positive women and appropriate supportive care
5. Cultures for herpes simplex virus (HSV) and prophylactic cesarean section (not recommended in the absence of active lesions)

Adolescents

1. Provision of education and counseling on the risks and consequences of sexually transmitted diseases
2. Confidential diagnosis and treatment of sexually transmitted diseases
3. Vaccination for hepatitis B

Children

1. Cooperative management involving clinicians, laboratory workers, and child-protection authorities in children with sexually transmitted diseases
2. Official investigation when indicated
3. Vaccination for hepatitis B

Men Who Have Sex with Men (MSM)

1. Assessment of sexual risk for all male patients
2. Prevention counseling
3. HIV testing
4. Syphilis serology
5. Testing for urethral infection with *N. gonorrhoeae* and *C. trachomatis*
6. Testing for rectal infection with *N. gonorrhoeae* and *C. trachomatis*
7. Testing for pharyngeal infection with *N. gonorrhoeae* (Testing for pharyngeal infection with *C. trachomatis* is not recommended)
8. Testing for type-specific HSV
9. Routine testing for anal cytologic abnormalities or anal HPV infection (not recommended)
10. Hepatitis A and B vaccination, with prevaccination serologic testing

Women Who Have Sex with Women

1. Pap test
2. Testing for infection with *C. trachomatis* in bisexual women

MAJOR OUTCOMES CONSIDERED

Prevention of transmission of sexually transmitted diseases (STDs)

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

Not stated

NUMBER OF SOURCE DOCUMENTS

Not stated

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Subjective Review

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Not applicable

METHODS USED TO ANALYZE THE EVIDENCE

Systematic Review with Evidence Tables

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Beginning in 2004, the Centers for Disease Control and Prevention (CDC) personnel and professionals knowledgeable in the field of sexually transmitted diseases (STDs) systematically reviewed evidence (including published abstracts and peer-reviewed journal articles) concerning each of the major STDs, focusing on information that had become available since publication of the *Sexually Transmitted Diseases Treatment Guidelines, 2002*. Background papers were written and tables of evidence constructed summarizing the type of study (e.g., randomized controlled trial or case series), study population and setting, treatments or other interventions, outcome measures assessed, reported findings, and weaknesses and biases in study design and analysis. A draft document was developed on the basis of the reviews.

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus (Consensus Development Conference)

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

In April 2005, the Centers for Disease Control and Prevention (CDC) staff members and invited consultants assembled in Atlanta, Georgia, for a 3-day meeting to present the key questions regarding sexually transmitted disease (STD) treatment that emerged from the evidence-based reviews and the information available to answer those questions. When relevant, the questions focused on four principal outcomes of STD therapy for each individual disease: 1)

microbiologic cure, 2) alleviation of signs and symptoms, 3) prevention of sequelae, and 4) prevention of transmission. Cost-effectiveness and other advantages (e.g., single-dose formulations and directly observed therapy of specific regimens) also were discussed. The consultants then assessed whether the questions identified were relevant, ranked them in order of priority, and attempted to arrive at answers using the available evidence. In addition, the consultants evaluated the quality of evidence supporting the answers on the basis of the number, type, and quality of the studies.

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Not applicable

COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

METHOD OF GUIDELINE VALIDATION

Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

Not stated

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

Note from the Centers for Disease Control and Prevention (CDC) and the National Guideline Clearinghouse (NGC): On September 19, 2008 the CDC released updated guidelines on hepatitis B. For more information see the NGC summary Recommendations for Identification and Public Health Management of Persons with Chronic Hepatitis B Virus Infection.

Pregnant Women

Intrauterine or perinatally transmitted sexually transmitted diseases (STDs) can have severely debilitating effects on pregnant women, their partners, and their fetuses. All pregnant women and their sex partners should be asked about STDs, counseled about the possibility of perinatal infections, and ensured access to treatment, if needed.

Recommended Screening Tests

- All pregnant women in the United States should be tested for HIV infection as early in pregnancy as possible. Testing should be conducted after the woman is notified that she will be tested for HIV as part of the routine panel of prenatal tests, unless she declines the test (i.e., opt-out screening). For

women who decline HIV testing, providers should address their objections, and where appropriate, continue to strongly encourage testing. Women who decline testing because they have had a previous negative HIV test should be informed of the importance of retesting during each pregnancy. Testing pregnant women is vital not only to maintain the health of the patient but also because interventions (i.e., antiretroviral and obstetrical) are available that can reduce perinatal transmission of HIV. Retesting in the third trimester (preferably before 36 weeks' gestation) is recommended for women at high risk for acquiring HIV infection (i.e., women who use illicit drugs, have STDs during pregnancy, have multiple sex partners during pregnancy, or have HIV-infected partners). Rapid HIV testing should be performed on women in labor with undocumented HIV status. If a rapid HIV test result is positive, antiretroviral prophylaxis (with consent) should be administered without waiting for the results of the confirmatory test.

- A serologic test for syphilis should be performed on all pregnant women at the first prenatal visit. In populations in which use of prenatal care is not optimal, rapid plasma reagin (RPR) card test screening (and treatment, if that test is reactive) should be performed at the time a pregnancy is confirmed. Women who are at high risk for syphilis, live in areas of high syphilis morbidity, are previously untested, or have positive serology in the first trimester should be screened again early in the third trimester (28 weeks' gestation) and at delivery. Some states require all women to be screened at delivery. Infants should not be discharged from the hospital unless the syphilis serologic status of the mother has been determined at least one time during pregnancy and preferably again at delivery. Any woman who delivers a stillborn infant should be tested for syphilis.
- All pregnant women should be routinely tested for hepatitis B surface antigen (HBsAg) during an early prenatal visit (e.g., first trimester) in each pregnancy, even if they have been previously vaccinated or tested. Women who were not screened prenatally, those who engage in behaviors that put them at high risk for infection (e.g., more than one sex partner in the previous 6 months, evaluation or treatment for an STD, recent or current injecting-drug use, and HBsAg-positive sex partner), and those with clinical hepatitis should be retested at the time of admission to the hospital for delivery. Women at risk for HBV infection also should be vaccinated. To avoid misinterpreting a transient positive HBsAg result during the 21 days after vaccination, HBsAg testing should be performed before the vaccination.
- All laboratories that conduct HBsAg tests should use an HBsAg test that is FDA-cleared and should perform testing according to the manufacturer's labeling, including testing of initially reactive specimens with a licensed neutralizing confirmatory test. When pregnant women are tested for HBsAg at the time of admission for delivery, shortened testing protocols may be used, and initially reactive results should prompt expedited administration of immunoprophylaxis to infants.
- All pregnant women should be routinely tested for *Chlamydia trachomatis* (see the National Guideline Clearinghouse [NGC] summary of the Centers for Disease Control and Prevention (CDC) guideline Diseases Characterized by Urethritis and Cervicitis the section on Chlamydia Infections, Diagnostic Considerations) at the first prenatal visit. Women aged <25 years and those at increased risk for chlamydia (i.e., women who have a new or more than one sex partner) also should be retested during the third trimester to prevent maternal postnatal complications and chlamydial infection in the infant. Screening during the first trimester might prevent the adverse effects of

chlamydia during pregnancy, but supportive evidence for this is lacking. If screening is performed only during the first trimester, a longer period exists for acquiring infection before delivery.

- All pregnant women at risk for gonorrhea or living in an area in which the prevalence of *Neisseria gonorrhoeae* is high should be tested at the first prenatal visit for *N. gonorrhoeae*. (See the NGC summary of the CDC guideline Diseases Characterized by Urethritis and Cervicitis, the section on Gonococcal Infections, Diagnostic Considerations). A repeat test should be performed during the third trimester for those at continued risk.
- All pregnant women at high risk for hepatitis C infection should be tested for hepatitis C antibodies (see the NGC summary of the CDC guideline Hepatitis C;, the section on Diagnostic Considerations) at the first prenatal visit. Women at high risk include those with a history of injecting-drug use and those with a history of blood transfusion or organ transplantation before 1992.
- Evaluation for bacterial vaginosis (BV) might be conducted during the first prenatal visit for asymptomatic patients who are at high risk for preterm labor (e.g., those who have a history of a previous preterm delivery). Evidence does not support routine testing for BV.
- A Papanicolaou (Pap) smear should be obtained at the first prenatal visit if none has been documented during the preceding year.

Other Concerns

- Women who are HBsAg-positive should be reported to the local and/or state health department to ensure that they are entered into a case-management system and that timely and appropriate prophylaxis is provided for their infants. Information concerning the pregnant woman's HBsAg status should be provided to the hospital in which delivery is planned and to the health-care provider who will care for the newborn. In addition, household and sex contacts of women who are HBsAg-positive should be vaccinated.
- Women who are HBsAg positive should be provided with, or referred for, appropriate counseling and medical management. Pregnant women who are HBsAg positive should receive information regarding hepatitis B that addresses:
  ---modes of transmission
  ---perinatal concerns (e.g., breastfeeding is not contraindicated)
  ---prevention of HBV transmission, including the importance of postexposure prophylaxis for the newborn infant and hepatitis B vaccination for household contacts and sex partners
  ---evaluation for and treatment of chronic HBV infection
- No treatment is available for hepatitis C virus (HCV)-infected pregnant women. However, all women with HCV infection should receive appropriate counseling and supportive care as needed (see the NGC summary of the CDC guideline Hepatitis C, the section on Prevention). No vaccine is available to prevent HCV transmission.
- In the absence of lesions during the third trimester, routine serial cultures for herpes simplex virus (HSV) are not indicated for women who have a history of recurrent genital herpes. Prophylactic cesarean section is not indicated for women who do not have active genital lesions at the time of delivery. In addition, insufficient evidence exists to recommend routine HSV-2 serologic screening among previously undiagnosed women during pregnancy, nor does

sufficient evidence exist to recommend routine antiviral suppressive therapy late in gestation for all HSV-2 positive women.
- The presence of genital warts is not an indication for cesarean section.
- Not enough evidence exists to recommend routine screening for *Trichomonas vaginalis* in asymptomatic pregnant women.

For a more detailed discussion of STD testing and treatment among pregnant women and other infections not transmitted sexually, refer to the references listed in the original guideline document.

Adolescents

The rates of many STDs are highest among adolescents. For example, the reported rates of chlamydia and gonorrhea are highest among females aged 15 to 19 years, and many persons acquire HPV infection during their adolescent years. Among adolescents with acute HBV infection, the most commonly reported risk factors are having sexual contact with a chronically infected person or with multiple sex partners, or reporting their sexual preference as homosexual. As part of a comprehensive strategy to eliminate HBV transmission in the United States, the Advisory Committee on Immunization Practices (ACIP) has recommended that all children and adolescents be administered HBV vaccine.

Younger adolescents (i.e., persons aged <15 years) who are sexually active are at particular risk for STDs, especially youth in detention facilities, STD clinic patients, male homosexuals, and injecting-drug users (IDUs). Adolescents are at higher risk for STDs because they frequently have unprotected intercourse, are biologically more susceptible to infection, are engaged in sexual partnerships frequently of limited duration, and face multiple obstacles to using health care. Several of these issues can be addressed by clinicians who provide services to adolescents. Clinicians can address adolescents' lack of knowledge and awareness regarding the risks and consequences of STDs by offering guidance concerning healthy sexual behavior and, therefore, prevent the establishment of patterns of behavior that can undermine sexual health.

With a few exceptions, all adolescents in the United States can legally consent to the confidential diagnosis and treatment of STDs. In all 50 states and the District of Columbia, medical care for STDs can be provided to adolescents without parental consent or knowledge. In addition, in the majority of states, adolescents can consent to HIV counseling and testing. Consent laws for vaccination of adolescents differ by state. Several states consider provision of vaccine similar to treatment of STDs and provide vaccination services without parental consent. Because of the crucial importance of confidentially, health-care providers should follow policies that provide confidentiality and comply with state laws for STD services.

Despite the prevalence of STDs among adolescents, providers frequently fail to inquire about sexual behavior, assess risk for STDs, provide counseling on risk reduction, and screen for asymptomatic infection during clinical encounters. The style and content of counseling and health education on these sensitive subjects should be adapted for adolescents. Discussions should be appropriate for the patient's developmental level and should be aimed at identifying risky behaviors (e.g., sex and drug-use behaviors). Careful, nonjudgmental, and thorough

counseling are particularly vital for adolescents who might not acknowledge that they engage in high-risk behaviors.

Children

Management of children who have STDs requires close cooperation between clinicians, laboratorians, and child-protection authorities. Official investigations, when indicated, should be initiated promptly. Some diseases (e.g., gonorrhea, syphilis, and chlamydia), if acquired after the neonatal period, are virtually 100% indicative of sexual contact. For other diseases (e.g., HPV infection and vaginitis), the association with sexual contact is not as clear (see the NGC summary of the CDC guideline Sexual Assault and STDs).

Men Who Have Sex with Men (MSM)

Some MSM are at high risk for HIV infection and other viral and bacterial STDs. The frequency of unsafe sexual practices and reported rates of bacterial STDs and incident HIV infection has declined substantially in MSM from the 1980s through the mid-1990s. However, during the previous 10 years, increased rates of infectious syphilis, gonorrhea, and chlamydial infection and of higher rates of unsafe sexual behaviors have been documented among MSM in the United States and virtually all industrialized countries. The effect of these behavioral changes on HIV transmission has not been ascertained, but preliminary data suggest that the incidence of HIV infection might be increasing among some MSM. These adverse trends probably are related to changing attitudes concerning HIV infection because of the effects of improved HIV/AIDS therapy on quality of life and survival, changing patterns of substance abuse, demographic shifts in MSM populations, and changes in sex partner networks resulting from new venues for partner acquisition.

Clinicians should assess the risk of STDs for all male patients, including a routine inquiry about the sex of patients' sex partners. MSM, including those with HIV infection, should routinely undergo nonjudgmental STD/HIV risk assessment and client-centered prevention counseling to reduce the likelihood of acquiring or transmitting HIV and other STDs. Clinicians should be familiar with local community resources available to assist MSM at high risk in facilitating behavioral change. Clinicians also should routinely ask sexually active MSM about symptoms consistent with common STDs, including urethral discharge, dysuria, genital and perianal ulcers, regional lymphadenopathy, skin rash, and anorectal symptoms consistent with proctitis. Clinicians also should maintain a low threshold for diagnostic testing of symptomatic patients.

Routine laboratory screening for common STDs is indicated for all sexually active MSM. The following screening recommendations are based on preliminary data. These tests should be performed at least annually for sexually active MSM, including men with or without established HIV infection:

- HIV serology, if HIV-negative or not tested within the previous year
- syphilis serology
- a test for urethral infection with *N. gonorrhoeae* and *C. trachomatis* in men who have had insertive intercourse (regardless of history of condom use during exposure) during the preceding year

- a test for rectal infection* with *N. gonorrhoeae* and *C. trachomatis* in men who have had receptive anal intercourse (regardless of history of condom use during exposure) during the preceding year
- a test for pharyngeal infection* with *N. gonorrhoeae* in men who have acknowledged participation in receptive oral intercourse (regardless of history of condom use during exposure) during the preceding year; testing for *C. trachomatis* pharyngeal infection is not recommended

*Note: Providers should use a culture or test that has been cleared by the FDA or locally certified in accordance with applicable statutes.

In addition, some specialists would consider type-specific serologic tests for HSV-2, if infection status is unknown. Routine testing for anal cytologic abnormalities or anal HPV infection is not recommended until more data are available on the reliability of screening methods, the safety of and response to treatment, and programmatic considerations.

More frequent STD screening (i.e., at 3-6 month intervals) is indicated for MSM who have multiple or anonymous partners, have sex in conjunction with illicit drug use, use methamphetamine, or whose sex partners participate in these activities.

Vaccination against hepatitis A virus (HAV) and HBV is recommended for all MSM in whom previous infection or immunization cannot be documented. Preimmunization serologic testing might be considered to reduce the cost of vaccinating MSM who are already immune to these infections, but this testing should not delay vaccination. Vaccinating persons who are immune to HAV or HBV infection because of previous infection or vaccination does not increase the risk for vaccine-related adverse events (see Hepatitis B, Prevaccination Antibody Screening).

Women Who Have Sex with Women (WSW)

Few data are available on the risk of STDs conferred by sex between women, but transmission risk probably varies by the specific STD and sexual practice (e.g., oral-genital sex, vaginal or anal sex using hands, fingers, or penetrative sex items, and oral-anal sex). Practices involving digital-vaginal or digital-anal contact, particularly with shared penetrative sex items, present a possible means for transmission of infected cervicovaginal secretions. This possibility is most directly supported by reports of metronidazole-resistant trichomoniasis and genotype-concordant HIV transmitted sexually between women who reported these behaviors and by the high prevalence of BV among monogamous WSW. Transmission of HPV can occur with skin-to-skin or skin-to-mucosa contact, which can occur during sex between women. HPV deoxyribonucleic acid (DNA) has been detected through polymerase chain reaction (PCR)-based methods from the cervix, vagina, and vulva in 13%-30% of WSW, and high- and low-grade squamous intraepithelial lesions (SIL) have been detected on Papanicolaou (Pap) tests in WSW who reported no previous sex with men. However, the majority of self-identified WSW (53%--99%) have had sex with men and might continue this practice. Therefore, all women should undergo Pap test screening using current national guidelines, regardless of sexual preference or sexual practices.

HSV-2 genital transmission between female sex partners is probably inefficient, but the relatively frequent practice of orogenital sex among WSW might place them at higher risk for genital infection with HSV-1. This hypothesis is supported by the recognized association between HSV-1 seropositivity and previous number of female partners among WSW. Transmission of syphilis between female sex partners, probably through oral sex, has been reported. Although the rate of transmission of *C. trachomatis* between women is unknown, WSW who also have sex with men are at risk and should undergo routine screening according to guidelines.

CLINICAL ALGORITHM(S)

None provided

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of supporting evidence is not specifically stated for each recommendation.

Throughout the 2006 guideline document, the evidence used as the basis for specific recommendations is discussed briefly. More comprehensive, annotated discussions of such evidence will appear in background papers that will be published in a supplement issue of the journal *Clinical Infectious Diseases*.

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

- Decreased incidence of intrauterine and perinatally transmitted sexually transmitted diseases (STDs) to the fetuses of pregnant women with STDs
- Decreased incidence of STDs and human immunodeficiency virus (HIV) infection among adolescents, men who have sex with men (MSM), and women who have sex with women (WSW)
- Appropriate management of children with STDs

POTENTIAL HARMS

Not stated

QUALIFYING STATEMENTS

QUALIFYING STATEMENTS

- These recommendations were developed in consultation with public- and private-sector professionals knowledgeable in the treatment of patients with sexually transmitted diseases (STDs). The recommendations are applicable to various patient-care settings, including family planning clinics, private

physicians' offices, managed care organizations, and other primary-care facilities.
- These recommendations are meant to serve as a source of clinical guidance: health-care providers should always consider the individual clinical circumstances of each person in the context of local disease prevalence. These guidelines focus on the treatment and counseling of individual patients and do not address other community services and interventions that are important in STD/human immunodeficiency virus (HIV) prevention.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

An implementation strategy was not provided.

IMPLEMENTATION TOOLS

Personal Digital Assistant (PDA) Downloads

For information about availability, see the "Availability of Companion Documents" and "Patient Resources" fields below.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Staying Healthy

IOM DOMAIN

Effectiveness
Patient-centeredness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

Centers for Disease Control and Prevention, Workowski KA, Berman SM. Special populations. Sexually transmitted diseases treatment guidelines 2006. MMWR Morb Mortal Wkly Rep 2006 Aug 4;55(RR-11):6-10. [222 references]

ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

1993 (revised 2006 Aug 4)

GUIDELINE DEVELOPER(S)

Centers for Disease Control and Prevention - Federal Government Agency [U.S.]

GUIDELINE DEVELOPER COMMENT

These guidelines for the treatment of persons who have sexually transmitted diseases (STDs) were developed by CDC after consultation with a group of professionals knowledgeable in the field of STDs who met in Atlanta, Georgia, during April 19–21, 2005.

SOURCE(S) OF FUNDING

United States Government

GUIDELINE COMMITTEE

Not stated

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

Chairpersons: David Atkins, MD, Agency for Healthcare Research and Quality, Rockville, Maryland; Kimberly A. Workowski, MD, National Center for HIV, STD, and TB Prevention, CDC, and Emory University, Atlanta, GA

Presenters: Heidi Bauer, MD, California Sexually Transmitted Disease Control Branch, Oakland, California; Emily J. Erbelding, MD, Johns Hopkins University School of Medicine, Baltimore, Maryland; William M. Geisler, MD, Department of Medicine, University of Alabama, Birmingham, Alabama; Margaret Hammerschlag, MD, State University of New York, Downstate Medical Center, Brooklyn, New York; Peter Leone, MD, University of North Carolina School of Medicine, Chapel Hill, North Carolina; Jenne Marrazzo, MD, University of Washington, Harborview Medical Center, Seattle, Washington; Kenneth Hugh Mayer, MD, Brown University Medical School, Providence, Rhode Island; Pablo Sanchez, MD, University of Texas Southwestern Medical Center, Dallas, Texas; Bradley Stoner, MD, PhD, Washington University, St. Louis, Missouri; Anna Wald, MD, University of Washington, Harborview Medical Center, Seattle, Washington; George Wendel, MD, University of Texas Southwestern Medical School, Dallas, Texas; Karen Wendel, MD, University of Oklahoma Health Science Center, Oklahoma City, Oklahoma; Harold C. Wiesenfeld, MD, University of Pittsburgh School of Medicine, Pittsburgh, Pennsylvania

Moderators: Willard Cates, Jr., MD, Family Health International, Durham, North Carolina; King K. Holmes, MD, PhD, University of Washington, Harborview Medical Center, Seattle, Washington; David Martin, MD, Louisiana State University Medical Center, New Orleans, Louisiana

Rapporteurs: Hunter Handsfield, MD, National Center for HIV, STD, and TB Prevention, CDC, Atlanta, Georgia, University of Washington, Seattle, Washington; William McCormack, MD, State University of New York Health

Science Center, Brooklyn, New York; Anne Rompalo, MD, Johns Hopkins School of Medicine, Baltimore, Maryland

Consultants: Michael Augenbraun, MD, State University of New York Health Science Center, Brooklyn, New York; Gail Bolan, MD, California Department of Health, Oakland, California; Carolyn Deal, PhD, National Institute of Allergy and Infectious Diseases, National Institutes of Health, Bethesda, Maryland; Kenneth H. Fife, MD, PhD, Indiana University School of Medicine, Indianapolis, Indiana; J. Dennis Fortenberry, MD, Indiana University School of Medicine, Indianapolis, Indiana; Edward Hook, III, MD, Department of Medicine, University of Alabama, Birmingham, Alabama; Franklyn Judson, MD, University of Colorado Department of Medicine and Preventive Medicine, Denver, Colorado; Alice A. Kraman, PharmD; Emory Healthcare, Atlanta, Georgia; Roberta B. Ness, MD, University of Pittsburgh Department of Medicine, Pittsburgh, Pennsylvania; Paul Nyirjesy, MD, Drexel University College of Medicine, Philadelphia, Pennsylvania; Jeffrey Peipert, MD, Women and Infants Hospital, Providence, Rhode Island; Jane R. Schwebke, MD, Department of Medicine, University of Alabama, Birmingham, Alabama; Mary Ann Shafer, MD, University of California, San Francisco Department of Medicine, San Francisco, California; David Soper, MD, Medical University of South Carolina, Charleston, South Carolina; Lawrence Stanberry, MD, PhD, University of Texas Medical Branch, Galveston, Texas; Heather Watts, MD, National Institute of Child Health and Development, National Institutes of Health, Bethesda, Maryland; Jonathan M. Zenilman, MD, Johns Hopkins Bayview Medical Center, Baltimore, Maryland

Liaison Participants: Joanne Armstrong, MD, Women's Health, Aetna, Sugar Land, Texas; James R. Allen, MD, American Social Health Association, Durham, North Carolina; Margaret J. Blythe, MD, American Academy of Pediatrics, Indianapolis, Indiana; Sherry R. Crump, MD, American College of Preventive Medicine, Atlanta, GA; Carolyn D. Deal, PhD, National Institutes of Health, Bethesda, Maryland; Jordon Dimitrakov, MD, PhD, American Urological Association, Boston, Massachusetts; Mark FitzGerald, MD, British Association for Sexual Health and HIV, Southampton, United Kingdom; Edward Harrison, National Commission on Correctional Health Care, Chicago, Illinois; Edward W. Hook, III, MD, Infectious Disease Society of America, Birmingham, Alabama; Michel Janier, MD, PhD, International Union Against Sexually Transmitted Infections Europe, Paris, France; Abe Macher, MD, HIV/AIDS Bureau, Rockville, Maryland; Francis J. Ndowa, MD, World Health Organization, Geneva, Switzerland; Jeffrey F. Peipert, MD, American College of Obstetricians and Gynecologists, Providence, Rhode Island; Kees A. Rietmeijer, MD, PhD, Denver Public Health Department, Denver, Colorado; Richard Rothman, MD, American College of Emergency Physicians, Baltimore, Maryland; David Soper, MD, Infectious Diseases Society for Obstetrics and Gynecology, Charleston, South Carolina; Litjen Tan, PhD, American Medical Association, Chicago, Illinois; Bruce Trigg, MD, National Coalition for Sexually Transmitted Disease Directors, Albuquerque, New Mexico; Julia Valderrama, MD, Pan American Health Organization, Washington, DC; Tom Wong, MD, Public Health Agency of Canada, Ottawa, Ontario, Canada; Miriam Zieman, MD, Association of Reproductive Health Professionals, Atlanta, Georgia

CDC, Division of Sexually Transmitted Disease Prevention Treatment Guidelines 2006 Project. Coordinator: Kimberly A. Workowski, MD, National Center for HIV, STD, and TB Prevention, CDC, and Emory University, Atlanta, GA

Project Manager: Donald F. Dowda, ORISE, Oakridge, Tennessee; Richard Voigt, National Center for HIV, STD, and TB Prevention, CDC, Atlanta, Georgia

Co-Moderators: Lyn Finelli, Ph.D., DSTDP; Robert Johnson, M.D., DSTDP; Lauri Markowitz, M.D., DSTDP

CDC Presenters: Joanna Buffington, MD, National Center for Infectious Diseases; Eileen Dunne, MD, National Center for HIV, STD, and TB Prevention, CDC, Atlanta, Georgia; Matthew Hogben, PhD, National Center for HIV, STD, and TB Prevention, CDC, Atlanta, Georgia; Emily Koumans, MD, National Center for HIV, STD, and TB Prevention, CDC, Atlanta, Georgia; Hershel Lawson, MD, National Center for Chronic Disease Prevention and Health Promotion, Atlanta, Georgia; Catherine McLean, MD, National Center for HIV, STD, and TB Prevention, Atlanta, Georgia; Juliette Morgan, MD, National Center for Infectious Diseases, CDC, Atlanta, Georgia; Lori Newman, MD, National Center for HIV, STD, and TB Prevention, CDC, Atlanta, Georgia; Madeline Sutton, MD, National Center for HIV, STD, and TB Prevention, CDC, Atlanta, Georgia

CDC Consultants: Sevgi O. Aral, PhD, Stuart M. Berman, MD, John Douglas, MD, Susan J. DeLisle, Kathleen Ethier, PhD, National Center for HIV, STD, and TB Prevention, CDC, Atlanta, Georgia; Kevin Fenton, MD, National Center for HIV, Hepatitis, Sexually Transmitted Diseases and Tuberculosis Prevention, CDC, Atlanta, Georgia; John Moran, MD, National Immunization Program, CDC, Atlanta, Georgia; Julia Schillinger, MD, National Center for HIV, STD, and TB Prevention, CDC, Atlanta, Georgia

Support Staff: Valerie Barner, Winda Graves, Garrett Mallory, Deborah McElroy, National Center for HIV, STD, and TB Prevention, CDC, Atlanta, Georgia; Eboney Walker, NAI Personnel, Washington, DC

FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

Not stated

GUIDELINE STATUS

This is the current release of the guideline.

This guideline updates a previous version: Centers for Disease Control and Prevention. Special populations. Sexually transmitted diseases treatment guidelines. MMWR Recomm Rep 2002 May 10;51(RR-6):5-7.

GUIDELINE AVAILABILITY

Electronic copies: Available from the Centers for Disease Control and Prevention (CDC) Web site:

- HTML Format
- Portable Document Format (PDF)

Print copies: Available from the Centers for Disease Control and Prevention, MMWR, Atlanta, GA 30333. Additional copies can be purchased from the Superintendent of Documents, U.S. Government Printing Office, Washington, DC 20402-9325; (202) 783-3238.

AVAILABILITY OF COMPANION DOCUMENTS

The following are available:

- Workowski KA, Levine WC, Wasserheit JN. U.S. Centers for Disease Control and Prevention guidelines for the treatment of sexually transmitted diseases: an opportunity to unify clinical and public health practice. Ann Intern Med. 2002 Aug 20;137(4):255-62. Electronic copies: Available through Annals of Internal Medicine Online.
- The CDC Sexually Transmitted Diseases Treatment Guidelines 2004 for PDA or Palm OS. Available from the CDC National Prevention Information Network (NPIN) Web site.

PATIENT RESOURCES

None available

NGC STATUS

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