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INSIDE

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Steep, Sustained Increases in STIs: A Call for Action

2.3 million cases of chlamydia, gonorrhea, and syphilis were reported in 2017

Nearly 2.3 million cases of chlamydia, gonorrhea, and syphilis were diagnosed in the United States in 2017, according to preliminary data released at the recent National STD Prevention Conference in Washington, DC.[1] This number surpasses the previous high level in 2016. This is the fourth year in a row that sexually transmitted infections have increased sharply. (*Inform your practice: Use the Centers for Disease Control and Prevention's fact sheet at https://bit.ly/2dq1S4I.*)

"We are sliding backward," states **Jonathan Mermin**, MD, MPH, director of the Centers for Disease Control and Prevention's (CDC) National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention. "It is evident the systems that identify, treat, and ultimately prevent STDs are strained to near-breaking point."

During a press briefing on the matter, **David Harvey**, MSW, executive director of the National Coalition of STD Directors (NCSD), described the increases as an "absolute STD public health crisis in this country." The STD public health challenge costs the United States more than $16 billion in preventable healthcare costs per year, he noted.[2] Harvey pointed out that the large increase in STD cases comes after years of federal funding reductions.

"Federal STD funding has seen a 40% decrease in purchasing power since 2003," Harvey observed. "That means that state and local health departments, most of which depend primarily on federal funding to support their STD programs, are working with budgets that are effectively half of what they were 15 years ago." (*See the NCSD chart at https://bit.ly/2OGx2ri, which details the decrease in the CDC's spending power from FY2003 to FY2018.*)

The National Coalition of STD Directors estimates that state and local STD programs need an additional $70 million immediately to confront the

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STD crisis sufficiently, said Harvey. This move would translate into Congress' allocation of $227 million in FY19, with additional funding to support STD research activities at the National Institutes of Health, he said.

Gonorrhea Cases Increase

The number of gonorrhea diagnoses was significant, rising 67% overall, an increase from 333,004 cases in 2013 to 555,608 cases in 2017. The number of cases among men nearly doubled, jumping from 169,130 cases to 322,169 cases in the same time period. Among women, diagnoses rose for the third consecutive year, from 197,499 cases in 2013 to 232,587 cases in 2017.[1]

Since 2015, the CDC has recommended that healthcare providers use a two-drug combination, which includes one injection of ceftriaxone and an oral azithromycin dose, to treat patients with gonorrhea, says **Gail Bolan**, MD, director of the CDC's Division of STD Prevention.

"Azithromycin was added to the recommended therapy to shield ceftriaxone from resistance, and that approach seems to be working," said Bolan at the press briefing. "Emerging resistance to ceftriaxone has not been seen since the dual therapy approach was implemented and there has not been a confirmed treatment failure in the United States when using the recommended therapy."

Emerging resistance of azithromycin is increasing in laboratory testing, new CDC findings released at the National STD Prevention Conference suggest. Data indicate that the percentage of samples with emerging azithromycin resistance rose from 1% in 2013 to more than 4% in 2017.

Public health officials are concerned that azithromycin-resistant genes could cross over into gonorrhea strains that are less susceptible to ceftriaxone. If this should occur, someday a gonorrhea strain that is resistant to ceftriaxone could emerge.

"We expect gonorrhea will eventually wear down our last highly effective antibiotic, and additional treatment options are urgently needed," said Bolan at the press conference. "We can't let our defenses down — we must continue reinforcing efforts to rapidly detect and prevent resistance as long as possible."

How About Syphilis and Chlamydia?

Diagnoses of primary and secondary syphilis rose 76%, climbing from 17,375 cases in 2013 to 30,644 cases in 2017, according to preliminary data. In 2017, gay, bisexual, and other men who have sex with men comprised about 70% of the cases of primary and secondary syphilis in which the gender of the sex partner was known.[1] In early stages, syphilis can be cured easily. One 2.4 million unit injection of long-acting Benzathine penicillin G given intramuscularly will cure primary, secondary, or early latent syphilis.

Adolescent reproductive health clinicians should be on the lookout for chlamydia, which remains the most common condition reported to the CDC. In 2017, more than 1.7 million chlamydia cases were diagnosed, with 45% of those identified among young females ages 15 to 24.[1]

The CDC recommends that women younger than 25 years of age who are sexually active receive annual screening for chlamydia and gonorrhea. In addition, older women who have risk factors, such

EXECUTIVE SUMMARY

Nearly 2.3 million cases of chlamydia, gonorrhea, and syphilis were diagnosed in the United States in 2017, preliminary data indicate. This number surpasses the previous high level in 2016 and marks the fourth consecutive year of sharp increases in sexually transmitted infections.

- The growth in gonorrhea diagnoses was significant, up 67% overall, from 333,004 cases in 2013 to 555,608 cases in 2017. The number of cases among men was almost doubled, jumping from 169,130 cases to 322,169 cases in the same time period.
- New findings suggest that azithromycin resistance now is increasing in laboratory testing. If azithromycin-resistant genes cross over into gonorrhea strains that are less susceptible to ceftriaxone, someday a gonorrhea strain that is resistant to ceftriaxone could emerge.

as new or multiple sex partners, or a sex partner with a sexually transmitted infection, should have chlamydia and gonorrhea screening annually, the CDC advises.[3]

To treat chlamydia infection, the CDC recommends either 1 g of azithromycin orally in a single dose or 100 mg of doxycycline twice daily for seven days.[3] To avoid spreading the infection to partners, people with chlamydia should avoid sexual activity for seven days after receiving single-dose antibiotics or until they have completed a seven-day antibiotic course. Providers should counsel patients about the importance of taking the full amount of medication prescribed to cure the infection.

The use of expedited partner therapy (EPT) has been recommended since 2006 by the CDC for treatment of sexually transmitted infections such as gonorrhea and chlamydia. Use of EPT currently is permissible in 42 states and the District of Columbia. (*Check the map maintained by the CDC at http://bit.ly/2sofAfl to see the status of EPT laws in your state.*) In 2017, Georgia became the most recent state to approve EPT use. EPT is "potentially allowable" in six states and Puerto Rico. The practice currently is prohibited in South Carolina and Kentucky.

Check Your Clinical Practice

Although new cases of STDs continue to increase, results from a recent national survey of sexually active young women indicate that many times they do not discuss sex and STD risk with their clinicians. In addition, many women aren't being tested for infection or disease as national guidance recommends.[4]

For the survey, sponsored by Quest Diagnostics in Secaucus, NJ, researchers looked at the perceptions of young women ages 15-24, mothers of young women in this age group, and primary care, obstetrics/gynecology, and other specialty physicians about sexual activity and health, as well as STD knowledge and STD screening. Researchers compared the results to those of 2015 research conducted by the company involving similar populations.

Results indicate that 49% of young women reported that their clinician never asked if they desired testing for STDs. Among sexually active women, less than one in four said she had requested an STD test from her healthcare provider. Fifty-one percent of young women said they did not want to discuss sex or STDs with their healthcare providers.[4]

Among primary care physicians, only 74% indicated they would order chlamydia testing for a sexually active female patient who did not have symptoms. Just 72% said they would order gonorrhea testing for such a patient without symptoms, according to the study. The findings of the study indicate that "key barriers" to STD testing involve patient discomfort with conversations about sexual activity and inaccurate beliefs regarding risk, states **Damian Alagia** III, MD, FACOG, FACS, Quest Diagnostics' medical director of woman's health.

"Half of all new STD cases are acquired by young people between the ages of 15-24, and one in four sexually active adolescents has a sexually transmitted disease," said Alagia in a press statement. "Our hope in sharing this survey's findings with clinicians and the general public is that it prompts open dialogue about reproductive health and STD risk, which is absolutely critical to reversing the trajectory of high STD rates in the United States." ■

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The Well-Woman Visit: Understand New Guidance

In the past decade, clinicians have seen many changes to the recommendations for women's preventive care. A new committee opinion issued by the American College of Obstetricians and Gynecologists (ACOG), in conjunction with the Women's Preventive Services Initiative's rollout of a "Well-Woman Chart," is designed to help clinicians follow the latest updates about preventive care.[1] (*Access the chart in infographic form at https://bit.ly/2F27q3c, and visit the Women's Preventive Services Initiative's web site at www.womenspreventivehealth.org for more details and clinical summaries.*)

The two resources are designed to aid clinicians in addressing the individual needs of each patient more comprehensively, says **Christopher Zahn**, MD, ACOG's vice president of practice activities. By offering a comprehensive source for preventive care recommendations for women, clinicians can ensure a timely, collaborative approach to patient care, he noted in a press statement.

Check the Chart

The Well-Woman Chart is designed as a tool that summarizes the recommendations for preventive services for women's health. It includes guidance from the Women's Preventive Services Initiative, a five-year cooperative agreement with the U.S. Department of Health and Human Services, Health Resources and Services Administration, and spearheaded by national health professional organizations and consumer and patient advocate groups. The chart also covers recommendations from the U.S. Preventive Services Task Force and Bright Futures. The chart is organized according to age groups and categorizes services by general health, infectious diseases, and cancer.

In addition to a comprehensive review of a woman's reproductive health, the well-woman visit is a good time for counseling patients about following a healthy lifestyle and limiting health risks, the committee opinion states.[1] These visits should cover screening, evaluation/counseling, and immunizations according to the patient's age and risk factors.

The timing of certain services may vary according to the needs of individual patients, and the scope of services provided may differ according to the ambulatory care setting. A team-based approach by obstetrician-gynecologists, physician assistants, nurse practitioners, and other related healthcare professionals can address all the aspects of well-woman care.[1]

The new guidance indicates that a comprehensive health history is an essential part of the well-woman visit.[1] Although not all aspects of a physical exam may be necessary at a particular visit, clinicians can use the encounter to engage in shared decision-making with patients, encourage healthy lifestyle behaviors, and counsel patients about effective preventive health practices.

Be sure to cover items such as symptoms, medications, and allergies, as well as medical, surgical, family, social, and gynecologic information when taking a patient history. Include questions on reproductive, sexual, and mental health, and use screening tools as indicated by ACOG and WPSI. By taking a comprehensive history, clinicians are able to determine if certain aspects of the physical examination, such as breast or pelvic examination, are indicated, and will allow shared decision-making for such exams. Also remember to check for items such as bone health, vulvovaginal symptoms, and sexual health at every well-woman exam, as well as screening and counseling for interpersonal and domestic violence.[1]

Because the Patient Protection and Affordable Care Act of 2010 identified preventive health services for women for required coverage without cost-sharing, women's health specialists can assist women with health and well-being at several stages of life through recommended preventive services and counseling.

A women's health professional may provide care for patients through various phases of their lives, from adolescence to reproductive years, through menopause, and beyond, said Zahn. The new resources help women's healthcare providers manage the updates to well-woman care so that they can provide effective and appropriate care for their patients, he stated.

Review the Spectrum of Care

For women of reproductive age, a key part of a well-woman visit involves developing and discussing a reproductive plan to ensure that medical testing and treatments match a woman's current and future plans. Such discussions may include prepregnancy counseling, infertility assessment, or the range of available contraceptive options.[1]

In addition to reviewing birth control options, the well-woman visit can cover cancer screening; vaccinations (including HPV, flu, and more); health screenings for high blood pressure, diabetes, and bone

EXECUTIVE SUMMARY

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- The chart includes guidance from the Women's Preventive Services Initiative, as well as recommendations from the U.S. Preventive Services Task Force and Bright Futures. The chart is organized according to age groups and categorizes services by general health, infectious diseases, and cancer.
- In addition to a comprehensive review of a woman's reproductive health, the well-woman visit is a good time for counseling patients about following a healthy lifestyle and limiting health risks.

density; screening for depression; and screening for sexually transmitted infections.

The visit gives clinicians an opportunity to provide education, screening, and monitoring to help women reduce their risks from cardiovascular disease, such as myocardial infarction and stroke. Clinicians should screen all women for tobacco use and provide counseling regarding smoking cessation options as well as ways to address at-risk drinking and alcohol dependence, the committee opinion states. Be sure to screen women for overweight and obesity, and be prepared to counsel and offer treatment options or referrals, the guidance recommends.

Many women and clinicians focus the well-woman visit only on the woman, but consider that it is a perfect opportunity to talk to women about the health of their children, advises **Susan Wysocki**, WHNP-BC, FAANP, president and chief executive officer of iWomansHealth in Washington, DC, which focuses on information on women's health issues for clinicians and consumers. Specifically, talk to women about the HPV vaccine for their preteen children, both female and male, she says. Also, consider that women who may not have children may have female friends who do; in some cases, an aunt, grandmother, or best friend could be a resource to a mother who has preteen children and may be unaware of the HPV vaccine, says Wysocki.

"Further, women often have questions about issues that affect the people in their care," states Wysocki. "Clinicians can add value and a reason to come back for a well-woman visit if [patients] consider the visit as an opportunity to 'ask an expert.'" ■

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To Reach Goals, About 14 Million More Preteens Will Need HPV Shot

According to a new American Cancer Society report, about 14 million additional children 11-12 years of age will need to be immunized with the human papillomavirus (HPV) vaccine between now and 2026 to reach the 80% vaccination rate goal.[1] This number exceeds the projected total of vaccinations based on current rates.

Researchers led by **Stacey Fedewa**, MPH, PhD, an investigator in the American Cancer Society's surveillance and health services research unit, looked at the number of additional preteens who need to receive the vaccination to reach the 2026 goal, as well as focused on the characteristics of those who have not initiated or completed vaccination, in an effort to increase vaccine uptake.

As of 2016, 35.5% of females and 31.5% of males were up to date with HPV vaccination by age 13, according to national statistics. Researchers estimate that an additional 14.39 million preteens (6.77 million females and 7.62 million males) would need HPV vaccination to reach the 80% compliance goal by 2026. This amounts to 57.62 million total doses to be administered and requires 18.27 million doses above the current level to achieve the goal.[1]

In the analysis, the researchers noted that a disproportionate percentage of males, whites, and privately insured teens are not up to date with HPV immunization. Among these groups, more than 90% had received a wellness checkup between 11-12 years of age, with 80.4% living in households above the poverty level. More than half (56.5%) of teens who had not begun the HPV vaccine were covered by private insurance; less than 5% were uninsured.[1]

EXECUTIVE SUMMARY

About 14 million additional preteens, beyond those who will receive the HPV shot based on current rates, will need to be immunized between now and 2026 to reach the 80% vaccination rate goal, an American Cancer Society report indicates.

- As of 2016, 35.5% of females and 31.5% of males were up to date with HPV vaccination by age 13, according to national statistics.
- A disproportionate percentage of males, whites, and privately insured teens are not up to date with HPV immunization. Among these groups, more than 90% had received a wellness checkup between ages 11 and 12 years, with 80.4% living in households above the poverty level.

On the other hand, public health initiatives, such as Vaccines for Children, that provide free vaccines to low-income children, have led to moderate success in HPV vaccine coverage. The analysis data indicate that vaccination rates were higher in adolescents ensured by Medicaid than among those with private insurance.[1]

Look for Missed Opportunities

Where are providers missing the mark when it comes to HPV vaccination? More than 90% of adolescents who had not begun HPV vaccination by age 13 did have a wellness visit at 11 to 12 years of age, says Fedewa.

"Why it's not happening is a critical question," said Fedewa in a press statement. "While we could not determine whether a provider recommended the vaccine during these visits, previous studies show that only about half of parents reported that they had ever received a recommendation to vaccinate their child against HPV."

Six out of 10 U.S. parents are choosing to get the HPV vaccine for their children, according to a 2017 report from the Centers for Disease Control and Prevention (CDC).[2] Providers may be able to reach more parents with CDC information; visit the resource center at https://bit.ly/2pRvFXQ for fact sheets and answers to questions parents may have regarding vaccination.

Remind parents that HPV vaccination can prevent not only cervical cancer but also uncomfortable testing and treatment, even for cervical precancers. According to the CDC, nearly 300,000 U.S. women each year are diagnosed with high-grade cervical lesions, with testing and treatment for such precancers having lasting effects.

Reaching Teens in Rural Areas

A clinic's location may play an important role. Fewer teens in rural areas are receiving the HPV shot, compared to adolescents in urban areas, results from the 2017 CDC report indicate. Statistics suggest that the rate of rural teens who received an initial dose of the HPV vaccine was 11 percentage points below the rate in urban areas.[2]

"While we understand it can be a challenge for some clinicians in rural areas to stock all recommended vaccines, these clinicians can still play a critical role in their patients' health and protect them from serious diseases by referring them to other vaccine providers," explains **Nancy Messonnier**, MD, director of the CDC's National Center for Immunization and Respiratory Diseases.

How can providers help increase vaccination rates? The CDC notes that receiving a recommendation for vaccination from a provider is the main reason parents choose to vaccinate their children. Clinicians can take advantage of opportunities by recommending the vaccine strongly to parents of children ages 11-12 on the same day and in the same way that they recommend Tdap and meningococcal vaccines.

The low rate of uptake by parents of preteens can motivate those in family planning who care for young men and women to counsel about the importance of the vaccine and to offer it themselves once patients are old enough to make their own health decisions, says **Anita Nelson**, MD, professor and chair of the obstetrics and gynecology department at Western University of Health Sciences in Pomona, CA. This "catch up" vaccination effort is very important because it gives clinicians a second chance to prevent HPV-related malignancies and pre-malignancies, notes Nelson. ■

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Consider Options for Women With Genitourinary Syndrome of Menopause

Sexual function often decreases for women because of the genitourinary syndrome of menopause (GSM). What treatment options are available to help women stay sexually active?

Previously known as vulvovaginal atrophy, this new term expands the areas of concern to include not only the physical changes that occur in the vulva and vagina but also those in the lower urinary tract that result from estrogen deficiency.[1] This deficiency may cause the vagina to shorten and narrow, the introitus to contract, the vaginal epithelium to become thin, and sebaceous gland secretions to diminish. Lubrication from sexual stimulation may be delayed, as well as decreased.[1]

"Fortunately for women who have suffered with GSM, including women who have undergone cancer treatments, there are more options than ever before for maintaining a healthy sex life," says **Jan Shifren**, MD, director of the Midlife Women's Health Center in the Department of Obstetrics & Gynecology at Massachusetts General Hospital in Boston. Shifren presented information on treatment options at the recent North American Menopause Society annual meeting.[2]

Although about one-third of midlife and older women report dryness and pain with intercourse, few seek help for GSM.[1] Women will seek care for vasomotor symptoms associated with menopause, but those with GSM often allow symptoms to progress without treatment.

"It is important for women, as well as their healthcare providers, to understand the information because sex shouldn't hurt at any age," says **JoAnn Pinkerton**, MD, NCMP, North American Menopause Society executive director.

Examine the Choices

For women who wish to use nonhormonal treatment options, using long-acting vaginal moisturizers and lubricants regularly can aid in decreasing friction, notes Shifren. Over-the-counter, water-based or silicone-based vaginal lubricants for sexual activity may be appropriate. Topical lidocaine also can help decrease the pain of penetration, she says.

For some women, introital–vaginal contraction or vaginismus may prevent penetration. By using graduated vaginal dilators facilitated by physical therapists specializing in pelvic floor disorders, women may be able to resume or initiate comfortable sexual activity. Starting low-dose vaginal estrogen therapy may aid progress.[3]

Clinicians also may offer various approved hormone therapies. These include vaginal use of low-dose estrogen therapy, which represents a highly effective treatment for symptomatic GSM.[1] Low-dose tablets, a vaginal ring, and creams have comparable efficacy in treating vulvovaginal symptoms, data indicate.[4] Research suggests that vaginal estradiol may reduce the risk of recurrent urinary tract infections and overactive bladder symptoms in menopausal women.[3] The low-dose vaginal ring is approved to treat urinary urgency and dysuria.[3] Creams may be applied not only intravaginally, but digitally to the vestibular tissues-introitus as well.

Systemic hormone therapy also offers an effective option in treating symptoms of genitourinary atrophy. However, research indicates that 10-15% of women will experience vulvovaginal symptoms during use. These symptoms become more likely

EXECUTIVE SUMMARY

Sexual function often decreases for women because of the genitourinary syndrome of menopause (GSM). This condition includes the physical changes of the vulva, vagina, and lower urinary tract that result from estrogen deficiency.

- Although about one-third of midlife and older women report dryness and pain with intercourse, few consult their clinicians about GSM. Women will seek care for vasomotor symptoms associated with menopause, but those with GSM allow symptoms to progress without treatment.
- For women who wish to use nonhormonal options, regular use of long-acting vaginal moisturizers and lubricants can aid in decreasing friction. Two low-dose estradiol creams, a vaginal ring, and a tablet are available for GSM treatment.

when using doses that are lower than the standard.[3] Low-dose vaginal estrogen can be added in these cases.

Other Treatment Options

Another drug option for treating GSM is ospemifene, a systemic estrogen agonist-antagonist. Research indicates that hot flushes were reported by 7.2% of participants randomized to ospemifene at 60 mg compared with 2.0% of those randomized to placebo.[5] In 2013, the Food and Drug Administration (FDA) approved ospemifene 60-mg oral tablets for treating dyspareunia in postmenopausal women.

Intrarosa is an intravaginal therapy that relies on the vaginal epithelium to locally convert dehydroepiandrosterone (DHEA) into estrogen to treat women experiencing moderate to severe pain during sexual intercourse due to menopause.

Research regarding the use of vaginal testosterone is limited. More robust studies are needed to assess efficacy and safety. ■

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Research Focuses on Untreated Genital Warts and HIV Risk

Of the 630 million new cases of human papillomavirus (HPV) that occur worldwide each year, it is estimated that 30 million develop anogenital warts.[1] New research indicates that genital warts may lead to a higher risk for acquiring HIV from a partner with the infection because anogenital warts may be very susceptible to infection with HIV.[2]

Researchers at Boston University School of Medicine looked at biopsy samples of genital warts, comparing the number of HIV-target cells to that found in normal tissue from the same parts of the body. They also collected genital wart samples from men who were not infected with HIV. The researchers then cultured the samples with HIV to find out if the warts were at high risk for infection with HIV.

The findings suggested that there was an increased density of HIV-target cells in the anogenital warts compared to the normal tissue of the same patient. In about 50% of the anogenital wart samples, the outermost layer of skin demonstrated high concentrations of HIV-target cells. The outer skin layer is most apt to be in contact during sexual intercourse. Of the eight samples that were cultured with HIV, two demonstrated signs of infection with HIV, suggesting that some anogenital warts may be susceptible to infection with HIV.

Such findings signify that clinicians should be more aggressive in treating genital warts, affirms corresponding study author **Deborah Anderson**, PhD, professor of obstetrics and gynecology at Boston University School of Medicine. These findings also have potential implications worldwide, she notes.

"Large scale roll out of HPV vaccines in HIV-endemic areas, such as sub-Saharan Africa, could significantly impact the HIV epidemic in those regions," said Anderson in a press statement.

Ninety percent of genital warts are caused by HPV types 6 and 11. The Gardasil 9 HPV vaccine now available in the United States provides protection against those HPV types.[3]

Understand Treatment Options

Nononcogenic HPV types 6 and 11 cause most cases of anogenital

EXECUTIVE SUMMARY

New research indicates that genital warts may lead to a higher risk of acquiring HIV from a partner who is infected because anogenital warts may be especially susceptible to the infection.

- Most cases of anogenital warts are caused by nononcogenic human papillomavirus (HPV) types 6 and 11. Infection is spread via skin-to-skin contact, usually during sex. Clinicians usually will see flat, papular, or pedunculated growths on the genital mucosa, generally near the vaginal introitus, underneath the foreskin of the uncircumcised penis, and on the shaft of the circumcised penis.
- Although genital warts can be treated, no treatment can cure the HPV virus that causes the lesions. Counsel patients that genital warts can recur after treatment, especially within the first three months.

warts. Infection is spread via skin-to-skin contact, usually during sex. Depending on the wart size and location, some of them can cause pain or itching. Patients typically present with flat, papular, or pedunculated growths on the genital mucosa. In women, this generally occurs around the vaginal introitus; in men, it appears underneath the foreskin of the uncircumcised penis, and on the shaft of the circumcised penis. Appearance of warts also can occur in the anogenital epithelium as well as in the cervix, vagina, urethra, perineum, perianal skin, anus, and scrotum. Although intra-anal warts usually occur in people who have had receptive anal intercourse, they also can occur in people who do not have that history.[4]

The Centers for Disease Control and Prevention 2015 STD Treatment Guidelines recommend using the following factors to guide treatment of anogenital warts: the size, number, and site of the warts; the patient's preference; cost of treatment; convenience; adverse effects; and experience of the provider. There is no definitive evidence indicating the superiority of one treatment to another, and no individual treatment is best for all patients or in all cases, the guidance states.[4]

Recommended patient-applied treatments for external anogenital warts include 3.75% or 5% imiquimod cream; 0.5% podofilox solution or gel; or 15% sinecatechins ointment.[3]

If imiquimod or sinecatchins is prescribed, remind patients that either treatment may weaken condoms or diaphragms.

Clinicians also may use one of the following provider-applied approaches for treatment:

- Cryotherapy using liquid nitrogen or cryoprobe; OR
- Surgical wart removal via tangential scissor excision, tangential shave excision, curettage, laser, or electrosurgery; OR
- Trichloroacetic acid (TCA) or bichloroacetic acid (BCA) 80-90% solution.[4]

Remind patients that although there is treatment for genital warts, there is not a cure for the HPV virus that causes the lesions. Counsel patients that warts can recur after treatment, particularly in the first three months. With correct and consistent use, condoms may reduce the chances that genital warts will be transmitted to a partner. However, HPV can occur in areas that the condom does not cover, so they may not provide full protection against the virus. Although the HPV vaccine can help protect against the virus types that cause anogenital warts, it will not treat HPV infection or genital warts that already exist.[4]

Scientists have been exploring the safety and efficacy of a topical antiviral gel called Teslexivir to treat anogenital warts. In a Phase II, double-blind, randomized, placebo-controlled trial, researchers found complete clearance of warts by week 16 in 30.6% of patients treated with Teslexivir compared to 23.3% of those in the placebo group. However, the researchers noted that the difference was not statistically significant. The company developing the potential drug is analyzing the results further.[5] ■

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TEEN TOPICS

Abortion Access in the United States: Adolescents and Women of Color Face Increased Barriers

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Abortion is a very common, safe medical procedure that nearly one in four women (23.7%) in the United States will experience in their lifetime. Between 2008 and 2014, the national abortion rate declined 25%, with the largest decrease (46%) reported among adolescents ages 15 to 19, in large part because of improvements in contraceptive use.

Although the lifetime incidence of abortion has declined, rates continue to vary widely by race and ethnicity because of structural factors, including racism, discrimination, and lack of access to family planning services. Researchers at the Guttmacher Institute found that black women were overrepresented among abortion patients with the highest abortion rate (27.1 per 1,000). Access to abortion services also varies greatly depending on a woman's health insurance coverage, geographic location, and age.[1]

When accessing reproductive health services, particularly abortion, young people face additional barriers, such as cost, stigma, confidentiality, and privacy concerns. Although research supports adolescents' cognitive ability and autonomy to choose abortion, state-level abortion restrictions present an undue burden for those defined as minors (younger than 18 years of age). Most states require parental notification, parental consent, or both, which has been shown to contribute to adolescents delaying or foregoing healthcare altogether.

Even when a young person has health insurance that includes abortion coverage, billing practices often do not ensure privacy or confidentiality, resulting in sensitive services being revealed to parents or guardians. The Society for Adolescent Health and Medicine and the American Academy of Pediatrics support protections of confidentiality for adolescents and young adults in healthcare billing and insurance claims processes as essential to providing necessary quality healthcare.[2]

Teens Face Barriers in Care

Given these notable barriers, in 2018 researchers assessed differences between adolescents and adults seeking abortion funds. The term abortion fund "refers to a collection of organizations that provide financial assistance and advocacy, with the goal of removing barriers to abortion for those who find it economically inaccessible."[3] Researchers analyzed case data for 3,288 abortion fund recipients from 2010 to 2015. Of the recipients, 481 were adolescents (17 years or younger) and 2,807 were between 18-49 years of age.[2]

Results of this study reiterate that health policy in the United States disproportionately burdens adolescents compared to adults and that young people receiving abortion funds experience greater personal hardships than adult patients. Two additional significant findings showed that adolescents were more likely to seek abortion because of lack of contraception and that a greater proportion of recipients aged 17 years or younger identified as black.[2]

Although overall rates of pregnancy and birth among U.S. adolescents declined between 2007-2014, three in four adolescent pregnancies still are reported as unintended, which suggests a need to explore how providers can support improved contraceptive use. In a recent study, investigators found that increases in using one or more contraceptive methods (78-88%), dual methods (24-33%), long-acting

reversible contraception (LARC; 1-7%), and withdrawal (15-26%) were the primary reasons for the declines. Although these findings are optimistic, we also must examine what access to contraception looks like for adolescents, especially those of color, if we seek to improve them.[4]

Even when financial barriers are removed, numerous other factors affect a young person's ability, motivation, and willingness to use contraception. Economic disadvantage, neighborhood characteristics, and lack of education all are structural barriers that contribute to the disparities in contraceptive use and abortion rates.[5] Equally important, the United States has a troubled history of reproductive abuses against women of color, involving forced sterilization, coercive family planning policies, race-based discrimination, and anti-choice messaging associating abortion with a racist conspiracy.

One national representative survey showed that 42% of blacks and 51% of hispanics believed that the government promotes contraception to limit minorities, compared to only 25% of whites, contributing to skepticism about the motivation of family planning providers.[6] This deep-seated mistrust of the medical system should help inform providers' contraceptive counseling practices, particularly when discussing LARCs with young women of color, to promote reproductive justice for all adolescents. The term reproductive justice, coined by women of color, acknowledges the relation between social justice and reproductive rights and addresses intersecting oppressions regarding access.[7]

Both findings further demonstrate the issue of constrained access to reproductive health services, particularly abortion, in the United States for adolescents and people of color resulting from systemic and structural factors that include racism and discrimination. Health professionals have a responsibility to recognize how these systems affect young people of color and acknowledge how these underlying factors inform provider biases.

The Society for Adolescent Health and Medicine released a position paper in 2018 that addresses the harmful effects of racism on nondominant racial-ethnic youth and youth-serving providers.[8] The paper proposes many recommendations and strategies as a call to action for organizational change, which include:

• Engaging in advocacy efforts that support adolescent patients and reject harmful policies that pose additional barriers for young people and people of color. (*Review the Physicians for Reproductive Health's advocacy training resources at https://bit.ly/2OYvR5z.*)

• Understanding adolescents as autonomous individuals and providing youth-friendly services in your practice that address their specific needs. (*Visit the Physicians for Reproductive Health's Adolescent Reproductive and Sexual Health Education Program module on "Abortion and the Adolescent Patient" at https://bit.ly/2AbkW0a.*)

When we, as front-line staff, counselors, advocates, and providers, educate and inform ourselves about adolescents' specific and local rights and resources to help them navigate the process of accessing an abortion, this speaks volumes to young people and is a distinct form of advocacy. ■

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CME/CE QUESTIONS

1. **Which treatment is recommended by the Centers for Disease Control and Prevention for syphilis?**

   a. Benzathine penicillin G
   b. Doxycycline
   c. Ceftriaxone
   d. Azithromycin

2. **Which of the following is an approved drug option for treating genitourinary syndrome of menopause?**

   a. Paroxetine
   b. Ospemifene
   c. Risedronate
   d. Denosumab

3. **Which of the following is *not* a recommended patient-applied treatment for external anogenital warts?**

   a. Imiquimod 3.75% or 5% cream
   b. Podofilox 0.5% solution or gel
   c. Sinecatechins 15% ointment
   d. Teslexivir 5% antiviral gel

4. **Which drug combination is recommended for treatment of gonorrhea?**

   a. Ceftriaxone and azithromycin
   b. Azithromycin and doxycycline
   c. Cefixime and ceftriaxone
   d. Cefixime and tetracycline

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After reading *Contraceptive Technology Update*, the participant will be able to:

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What Can Clinicians Do to Combat Increase in Congenital Syphilis Rates?

Pregnant women should be tested for infection at first provider visit

The number of cases of congenital syphilis has more than doubled since 2013, according to the Centers for Disease Control and Prevention (CDC). All pregnant women should visit a healthcare provider as soon as possible during each pregnancy to be tested for syphilis, according to recommendations.[1]

The stakes are high. When syphilis infection goes untreated during pregnancy, it directly affects the risk for adverse outcomes in pregnancy. Authors of a 2013 systematic review found that during pregnancy, untreated syphilis infection in mothers was associated with the following absolute differences compared to mothers without the infection: 21% for stillbirth or fetal loss, 9% for neonatal death, and 5% for a premature or low birth weight baby.[2] When infants are born with congenital syphilis, they often don't have symptoms at birth. However, some babies may develop signs of the infection, such as rash, hemorrhagic rhinitis, lymphadenopathy, hepatosplenomegaly, and skeletal abnormalities, within the first several weeks of life.[3] Further symptoms include anemia, meningitis, and neurologic impairment, such as blindness or deafness.

"When passed to a baby, syphilis can result in miscarriage, newborn death, and severe lifelong physical and mental health problems," notes **Jonathan Mermin**, MD, MPH, director of the CDC's National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention. "No parent should have to bear the death of a child when it would have been prevented with a simple test and safe treatment."

The number of reported congenital syphilis cases rose from 362 in 2013 to 918 in 2017, representing the highest number of cases recorded in 20 years, according to the CDC. A total of 37 states reported cases, with most cases concentrated in western and southern states. The increase in congenital syphilis mirrors similar upturns in syphilis among reproductive-age women and is moving ahead of national increases in all sexually transmitted diseases (STDs).[1]

Test All Pregnant Women

The CDC now recommends that all pregnant women undergo syphilis testing the first time they see a healthcare provider about their pregnancy. However, one test may not be enough for many women, the agency advises. Women who are at high risk for the infection or who live in areas of high prevalence of the infection should undergo testing at the first prenatal visit, then again early in the third trimester, and also at delivery. If women are sexually active, they can reduce their risk of acquiring syphilis infection by being in a long-term, mutually monogamous relationship with a partner who has undergone syphilis testing and by using condoms consistently and correctly at every act of intercourse.[4]

Joint guidance from the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists also endorses repeat screening for syphilis. These organizations recommend that women who are at high risk receive repeat screening for the infection early in the third trimester of pregnancy (at about 28 weeks of gestation) and then again at delivery.[5]

To protect every baby, clinicians must start the process by protecting every mother, says **Gail Bolan**, MD, director of the CDC's Division of STD Prevention.

EXECUTIVE SUMMARY

Cases of congenital syphilis have more than doubled since 2013, according to the Centers for Disease Control and Prevention. All pregnant women should visit a healthcare provider as soon as possible to be tested for syphilis, but one test may not be enough to catch all cases.

- The number of reported congenital syphilis cases rose from 362 in 2013 to 918 in 2017, representing the highest number of cases recorded in 20 years. A total of 37 states reported cases, with most cases concentrated in western and southern states.
- Women who have a high risk for syphilis or who live in areas with a high prevalence of the infection should be tested at the first prenatal visit, and again early in the third trimester, and at delivery.

"Early testing and prompt treatment to cure any infections are critical first steps, but too many women are falling through the cracks of the system," said Bolan in a press statement. "If we're going to reverse the resurgence of congenital syphilis, that has to change."

Check your area for syphilis rates, and consider advocating for policy changes to support additional screening beyond the CDC recommendations. Although most states have laws that require syphilis screening during the first trimester of pregnancy, several states also have added third trimester screening. For example, Louisiana, Georgia, and Texas recently added third trimester syphilis screening to state laws.[6]

The CDC is working to support states with a high burden of disease to improve local systems for prevention and enhance identification and treatment of pregnant women with syphilis. It also is examining factors that are contributing to the resurgence of congenital syphilis to improve prevention programs. By partnering with community organizations such as March of Dimes, the agency hopes to increase awareness among pregnant women about the risk factors of congenital syphilis.

The CDC also is funding a pilot project in nine hard-hit areas to address congenital syphilis infection further. These areas include California (excluding Los Angeles and San Francisco), Chicago, Florida, Georgia, Los Angeles, Louisiana, Maryland (including Baltimore), Ohio, and Texas.

Task Force Backs Early Screening

The U.S. Preventive Services Task Force recently published a final recommendation statement on screening for syphilis infection in pregnant women.[7] In its review of available evidence, the task force examined whether screening helps prevent infection in babies.[8] Based on its review, the advisory group now recommends that all pregnant women receive early screening for syphilis infection.

"Screening for and treatment of syphilis in pregnant women is extremely effective in preventing the infection from being passed to the baby," says task force member **Melissa Simon**, MD, MPH, George H. Gardner professor of clinical gynecology, the vice chair of clinical research in the Department of Obstetrics and Gynecology, and professor of preventive medicine and medical social sciences at Northwestern University Feinberg School of Medicine. "Treatment is most effective when it is done early, so we strongly recommend that all women be screened as early in their pregnancy as possible."

Treponema pallidum bacteria cause syphilis infections. The current syphilis screening tests identify the infection by detecting the antibodies to it. Traditional screening for infection has called for an initial "nontreponemal" antibody test, such as a Venereal Disease Research Laboratory test or rapid plasma reagin test, then followed with a confirmatory "treponemal" test to detect antibodies, such as a fluorescent treponemal antibody absorption or *T. pallidum* particle agglutination test. Because of the complexity of nontreponemal tests, a reverse sequence screening algorithm is used. This process involves use of a treponemal test, such as an enzyme-linked, chemiluminescence, or multiplex flow immunoassay, and then a nontreponemal test. A second treponemal test is performed if the reverse sequence algorithm test results are discordant.[7]

Since 2015, the CDC has recommended use of parenteral Benzathine penicillin G to treat pregnant women with syphilis infection.[4] Treatment is most effective when started early in pregnancy.

"An infected mother can pass syphilis to her baby at any time during the pregnancy, causing serious health problems for the baby, including death," says task force member **Chien-Wen Tseng**, MD, MPH, MSEE, Hawaii Medical Service Association endowed chair in health services and quality research, a professor, and the associate director of research in the Department of Family

Medicine and Community Health at the University of Hawaii John A. Burns School of Medicine. "Since the early stages of syphilis may have no symptoms, it is important for all pregnant women to be screened to protect their health and the health of their babies." ■

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Eliminate Barriers to Expedited Partner Therapy

The rate of sexually transmitted infections (STIs) such as gonorrhea and chlamydia continues to climb, despite the Centers for Disease Control and Prevention's (CDC) recommendation of expedited partner therapy (EPT) since 2006. What are the barriers to providing more people with EPT?

Several major medical societies, including the American Academy of Family Physicians, American Academy of Pediatrics, Society for Adolescent Health and Medicine, and American Congress of Obstetricians and Gynecologists, have endorsed the practice, but EPT still is under-used across the country, noted a recent commentary in the *American Journal of Public Health*.[1]

"We need to make sure everyone in the medical and public health community has a basic understanding of what expedited partner therapy is, how it can work, and what it will take for it to reach widespread use," says **Cornelius Jamison**, MD, MSPH, MSc, a family physician and member of the University of Michigan Department of Family Medicine and Institute for Healthcare Policy and Innovation. Jamison served as lead author for the paper, which seeks to offer guidance to overcome barriers to EPT by providing a conceptual framework about the potential barriers that exist.

EXECUTIVE SUMMARY

Since 2006, the Centers of Disease Control and Prevention has recommended the use of expedited partner therapy (EPT) for treatment of sexually transmitted infections such as gonorrhea and chlamydia, but the infection rate continues to climb.

- Although several major medical societies, such as the American Academy of Family Physicians, American Academy of Pediatrics, Society for Adolescent Health and Medicine, and American Congress of Obstetricians and Gynecologists, have endorsed the practice, EPT still is under-used across the country.
- The transmission of undiagnosed sexually transmitted infections can cause serious health complications. If the infections are left untreated, women are at increased risk for pelvic inflammatory disease, chronic pelvic pain, and infertility. Untreated infections also raise the risk of HIV acquisition, research indicates.

Take a Closer Look

The transmission of undiagnosed STIs can cause serious health

complications. If infections are left untreated, women are at increased risk for pelvic inflammatory disease, chronic pelvic pain, and infertility. Untreated infections also raise the risk of HIV acquisition, research indicates.[2]

STIs are on the rise; in 2016, there were more than 1.59 million reported cases of chlamydia, the highest number of annual cases ever reported to the CDC.[3] Young women ages 15-24 accounted for 46% of reported chlamydia cases that year.[3]

Annual chlamydia and gonorrhea screenings are recommended for all sexually active women younger than 25 years of age, according to CDC guidance.[4] Similar screening should be considered for men who report high-risk behaviors and in communities with a high burden of infection.[4]

EPT allows providers to give a prescription or medications to the heterosexual partners of patients diagnosed with chlamydia or gonorrhea without testing or examining the partner. The use of EPT is not recommended for the management of STIs in men who have sex with men because data demonstrating its effectiveness are lacking and there is a concern about missing STI and HIV coinfections among men in this population.[5]

The current CDC-recommended treatment for uncomplicated uro-genital, anorectal, and pharyngeal gonorrhea is combination therapy using one intramuscular dose of ceftriaxone 250 mg plus one 1-g oral dose of azithromycin.[6] However, providers still should consider EPT for heterosexual partners of patients diagnosed with gonorrhea who are unlikely to access timely evaluation and treatment, the CDC advises.

What Is Your State's Stance?

Forty-two states and the District of Columbia currently permit EPT use. (*Check the map maintained by the CDC at http://bit.ly/2sofAfl to see the status of EPT laws in your state.*) In 2017, Georgia became the most recent state to approve EPT use. EPT is "potentially allowable" in six states and Puerto Rico. However, EPT currently is prohibited in South Carolina and Kentucky.[1]

States such as Oklahoma are moving to advance the use of EPT. At the 2018 National STD Prevention Conference, members of the Oklahoma State Department of Health presented results showing that EPT is effective in preventing re-infection.[6]

Oklahoma implemented the EPT program in 78 of the county health department clinics as well as eight clinic sites at the Oklahoma City-County Health Department and the Tulsa Health Department. Researchers found that among 99% of patients who received EPT treatment, there were no reported reinfections within within 30-90 days of that first treatment.[7]

Such results are needed to stem the rising rates of STIs. In 2017, 31,779 cases of chlamydia, gonorrhea, and syphilis were diagnosed in Oklahoma, an increase from the 29,716 cases reported in 2016. Gonorrhea cases increased by nearly 20%, with a total of 21,752 cases of chlamydia reported.[7]

"Implementing EPT in Oklahoma is a huge victory and we are excited about improving treatment outcomes to help reduce rates of re-infection and adverse outcomes," said **Ivonna Mims**, RN, BSN, an STD nurse consultant for HIV and STD Services at Oklahoma City-County Health Department, in a press release. "This scientifically proven method can ensure more Oklahomans have the availability of appropriate treatment for their partners." ■

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