



Emerging Issues in Sexually Transmitted Diseases

STD Treatment Guidelines 2010 Webinar



Managing STDs in Correctional Settings: Behind the Walls

Please listen to the webinar on your computer using speakers or a headset.

We will compile and answer salient questions from the webinar and will post them online at www.nnptc.org and www.cdc.gov/std/treatment/2010 as soon as we can.

Disclosures

- CDC, our planners, and our presenters wish to disclose they have no financial interests or other relationships with the manufacturers of commercial products, suppliers of commercial services, or commercial supporters.
- Presentations will not include any discussion of the unlabeled use of a product or a product under investigational use with the exception of Drs. Bolan and Lincoln's discussion on STD screening in correctional facilities. They will be discussing NAA tests from alternate body sites.
- CDC does not accept any commercial support.



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- For WD1956 the UAN is 0387-9999-11-099-H01-P.
- Course Category: This activity has been designated as Knowledge-Based.
- There is no fee for this course.



Instructions on how to receive Continuing Education credits will be available at the end of the webinar and will also be e-mailed to you following the live webinar.

A link to the archived version of the Webinar will be available at www.cdc.gov/std/treatment/2010 within a few days.

If you have questions about screening and treating persons in correctional facilities for STDs following the Webinar you may submit them to stdtraining@cdc.gov.

Emerging Issues in Sexually Transmitted Diseases



Managing STDs in Correctional Settings: Behind the Walls

November 9, 2011



Gail Bolan, MD

Director

Division of STD Prevention

**National Center for HIV/AIDS,
Viral Hepatitis, STD, and TB
Prevention**

**Centers for Disease Control and
Prevention**



Learning Objectives

- Discuss clinical significance of the sexual health/clinical issue.
- Describe epidemiological trends related to the sexual health/clinical issue.
- Identify key screening and treatment recommendations for management of the sexual health/clinical issue, in accordance with CDC 2010 STD Treatment Guidelines.
- Promote health improvement, wellness, and disease prevention in cooperation with patients, communities, at-risk populations, and other members of an interprofessional team of health care providers.

Presenters



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and of Medicine
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Thomas Lincoln, MD

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Correctional Center
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Sharon Adler, MD, MPH

Clinical Faculty
California STD/HIV
Prevention Training Center
Clinical Specialist
California Department of
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Webinar Overview

- Epidemiology of STDs in correctional facilities
- Health consequences of untreated STDs
- STD screening in correctional facilities
- 2010 STD Treatment Guidelines relevant to persons in correctional facilities
- Additional resources
- Question and answer session

How many people are watching the webinar with you?

- Watching solo
- 2 in room
- 3 in room
- 4-10 in room
- >10 in room

What is your primary profession or discipline?

- RN
- APRN (NP, CNM) or PA
- MD/DO
- Public health professional
- Other

What is your area of expertise?

- General Medicine/Family Practice
- Adult Medicine
- Women's Health/Ob-Gyn
- Pediatric/Adolescent Medicine
- Other

What type of correctional facility do you work in most of the time?

- Adult Jail
- Adult Federal or State Prison
- Juvenile Detention Center or other facility primarily serving youth
- Other correctional facility
- Not currently working in a correctional setting

Anne Spaulding, MD, MPH

Assistant Professor of Medicine

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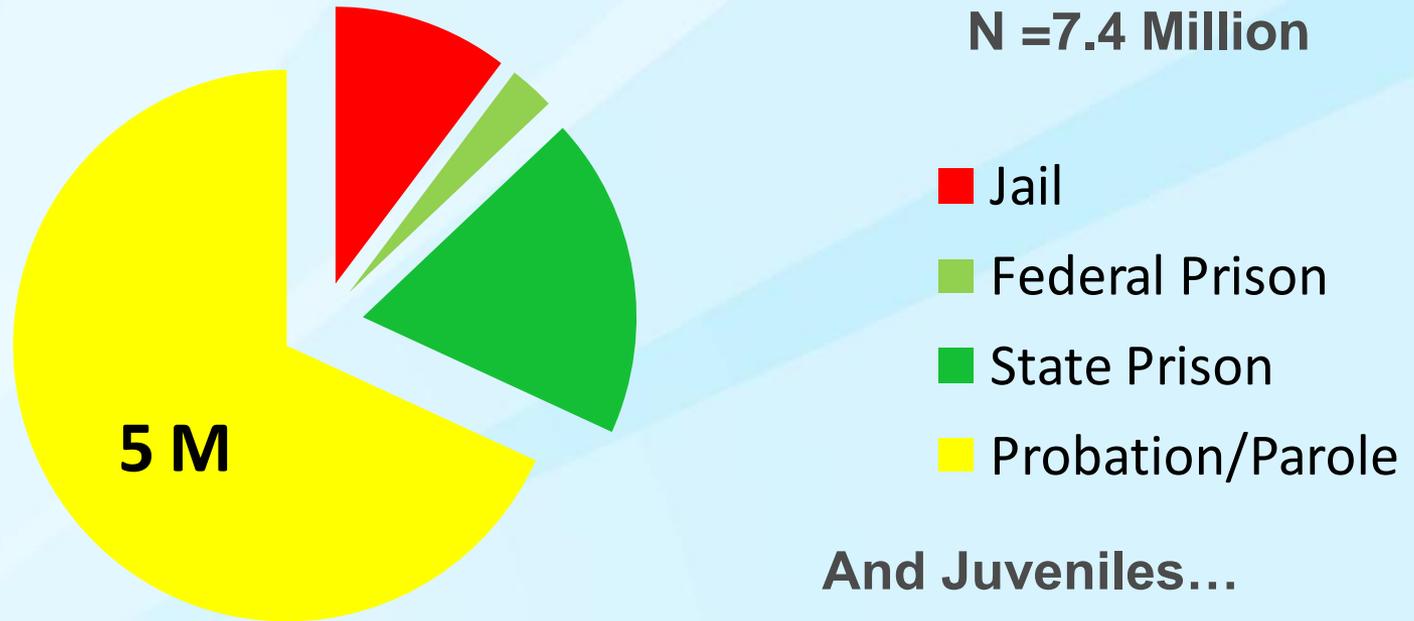


Overview: Epidemiology of STDs in Corrections

- Where inmates are located in the U.S. criminal justice system
- Why jails concentrate STDs particularly well
- The potential impact of jail screening for STDs

Where Are Offenders in the U.S. Criminal Justice System?

June 2008: 2.4 million persons behind walls



Correctional Populations: Jails vs. Prisons

Prison and Jail Populations at a Single Point in Time:
Data from June 2008



Prison
N = 1.6 Million

Approximately twice
as many offenders
are in prison than jail
on any given day



Jail
N = 0.8 Million

Rapid Turnover in Jails

Number of Individuals Discharged from Prisons and Jails across One Year



Approximately 95% of the 10 million offenders discharged from the criminal justice system each year are released from jails*

Jails Concentrate STDs

Chlamydia

- Prevalence among non-institutionalized men and women ~**2%**.¹
- Incarcerated prevalence much higher
 - Highest prevalence in girls in juvenile detention facilities and women up to age 35 in adult facilities.²
 - **16.6% among Females <20 yrs of age**
 - **10.8 % among Men < 20yrs of age**

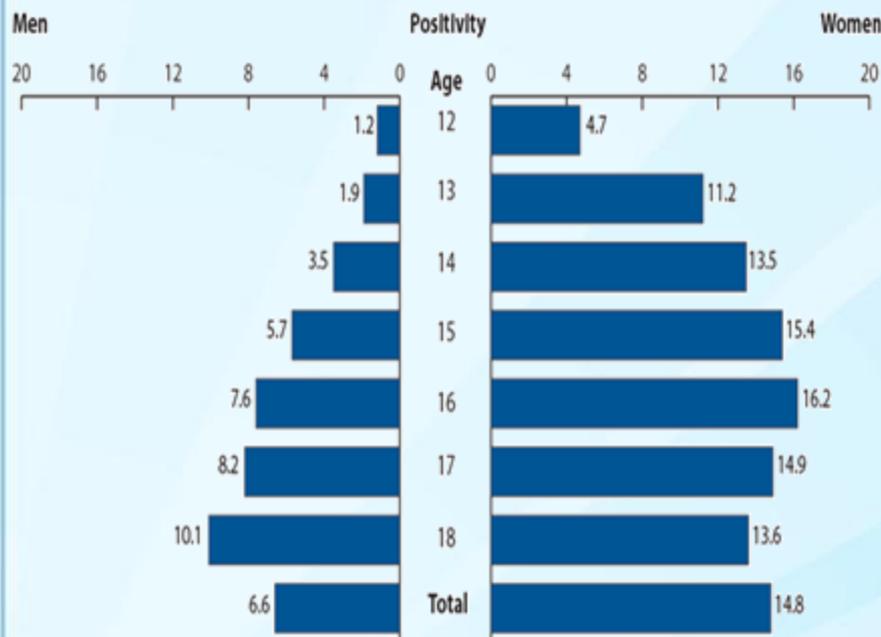
¹National Health and Nutrition Examination Survey (NHANES)

²Centers for Disease Control and Prevention. Sexually Transmitted Disease Surveillance, 2009.

Chlamydia & Gonorrhea—by Age and Sex in Juvenile Corrections Facilities, 2009

Juvenile

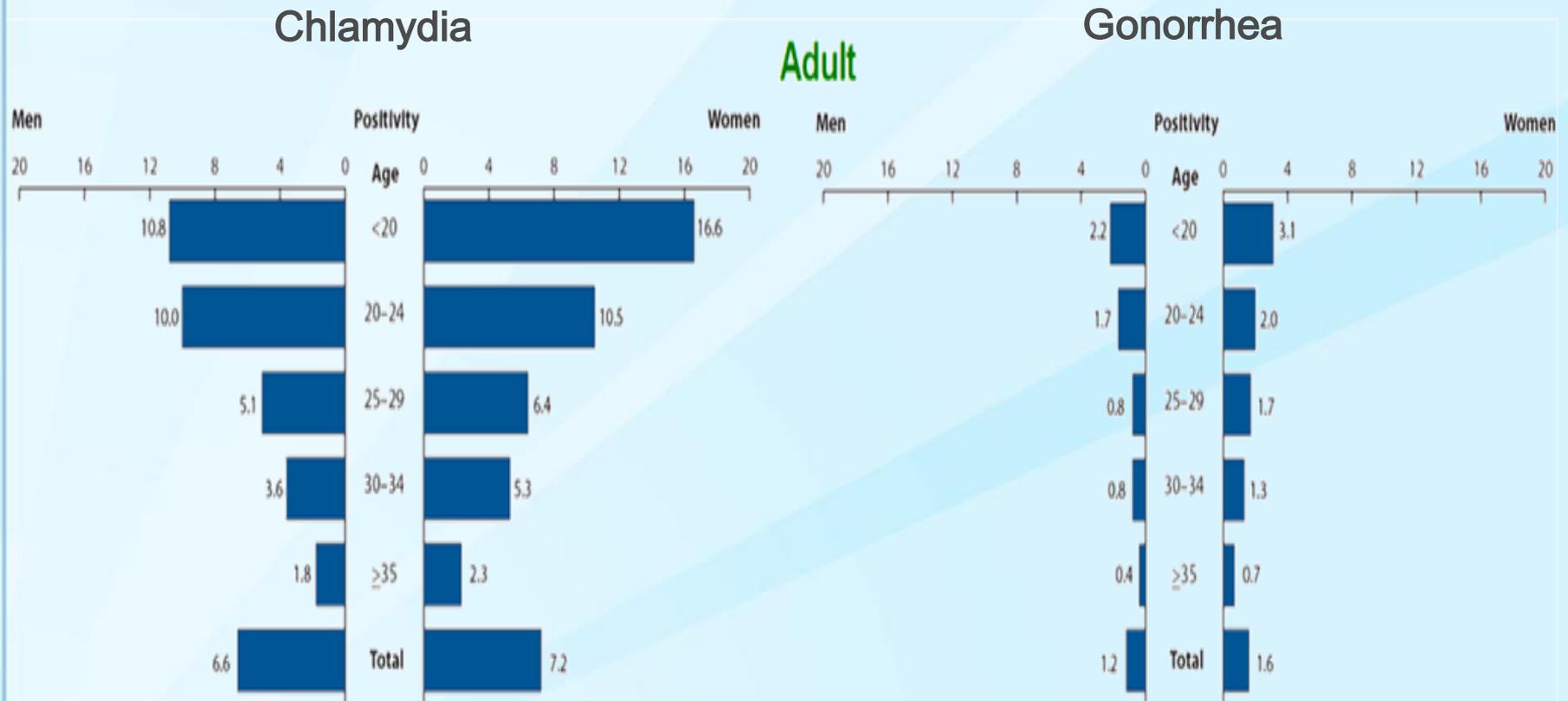
Chlamydia



Gonorrhea



Chlamydia & Gonorrhea—by Age and Sex in Adult Corrections Facilities, 2009



GC and CT in Women:

Testing women ≤ 35 years at Fulton County Jail found most infections

	No. of Tests	GC+ (%)	CT+ (%)
≤ 35 years	890	25 (2.8%)	90 (10.1%)
> 35 years	518	7 (1.4%)	11 (2.1%)
Total	1408	32 (2.3%)	101 (7.2%)

Impact of Jail Screening on Community Chlamydia Rates: San Francisco

Objective and Method

- Determine whether screening adults in jail can impact community CT rates
- Describe CT trends among females aged 15–25 years at 2 neighborhood clinics with different incarceration rates

Jail Screening Evaluation — San Francisco, 1997–2004

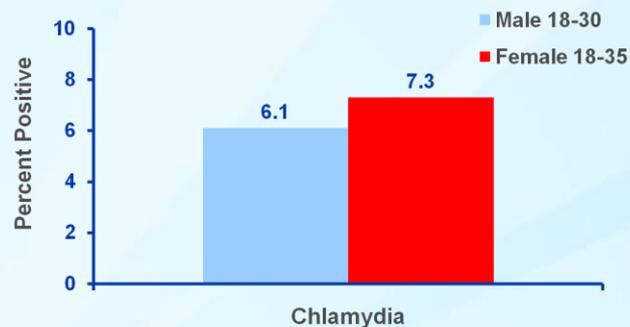
Intervention

Sample Population

Jail Screening
Males 18–30
Females 18–35

Clinic S Positivity
Females 15–25

Clinic O Positivity
Females 15–25

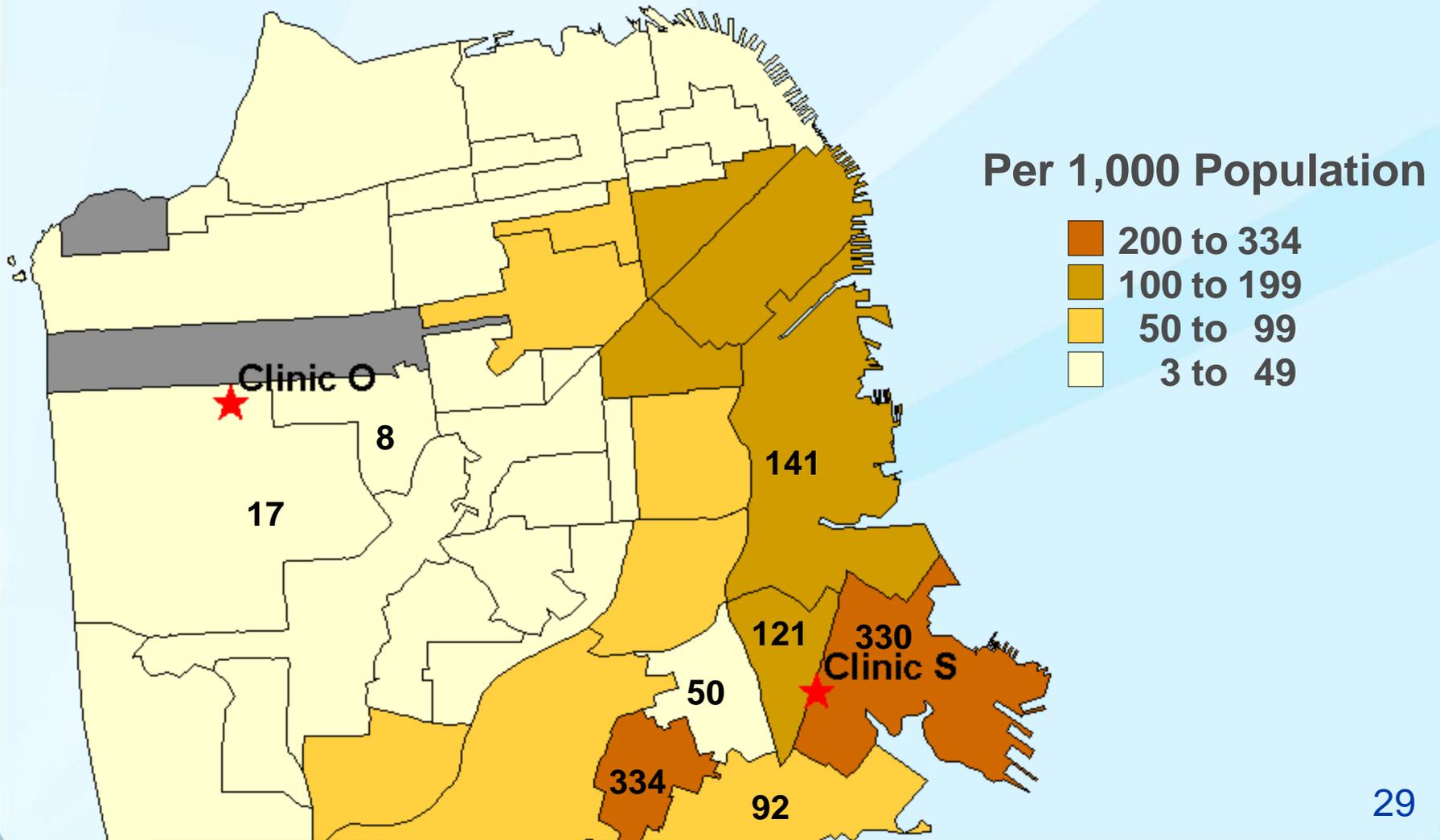


Jail Testing Density

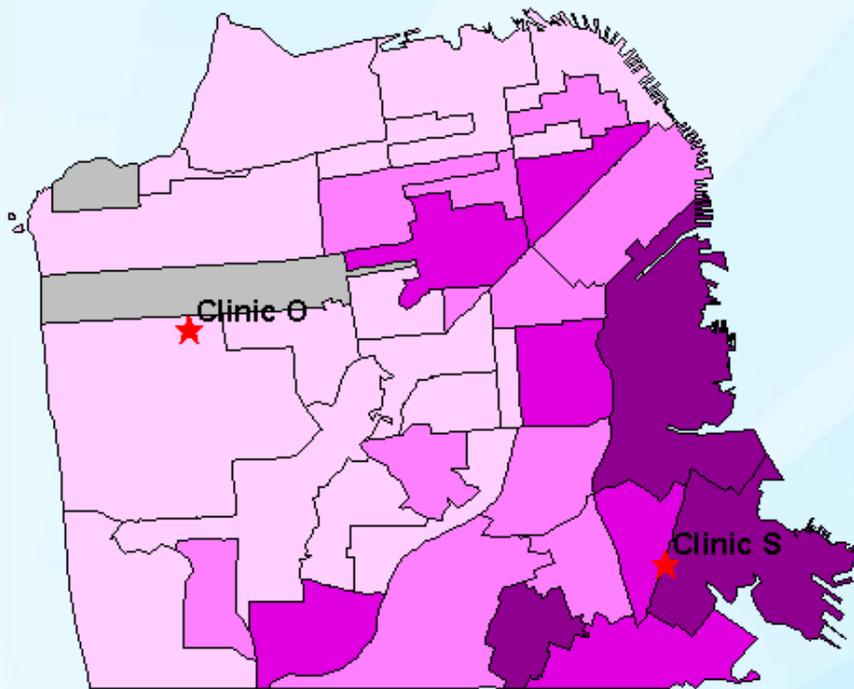
Number of
Males 18–30 and Females 18–35 tested
at least once in jail during 1997–2004

Year 2000 Census population
For Males 18–30 and Females 18–35

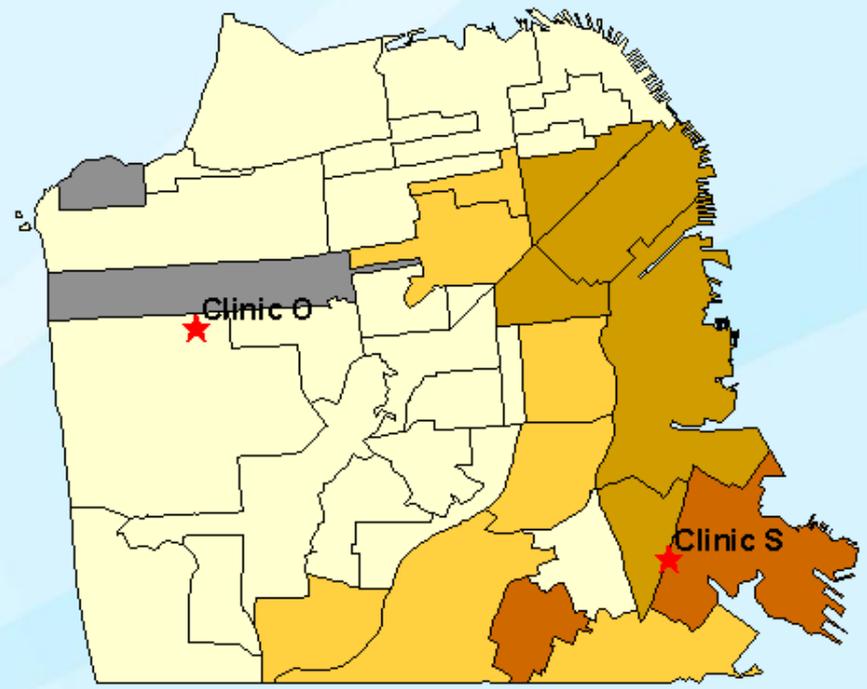
Jail Chlamydia Testing Density by Neighborhood, 1997–2004



Female Chlamydia Rates and Jail Testing Density by Neighborhood, 2004



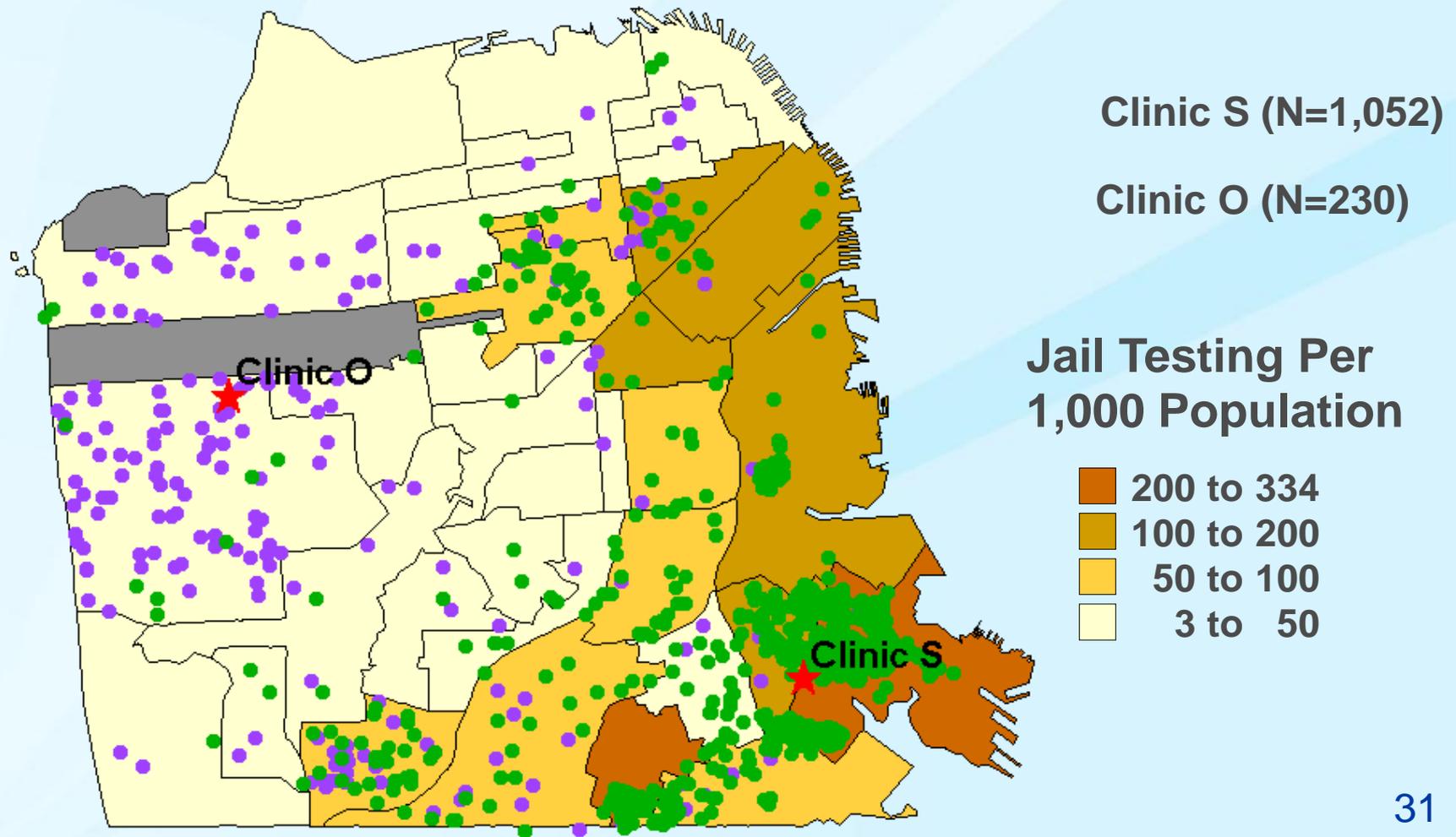
Female Chlamydia Rate
Per 100,000 Population



Jail Chlamydia Testing Density
Per 1,000 Population



Jail Chlamydia Testing Density and Females 15–25 Tested in Clinics by neighborhood and clinic, 1997–2004



Chlamydia Positivity Among Females Aged 15–25 Years by Clinic and Year



Jails Concentrate STDs

Syphilis

- Primary and Secondary (P&S) syphilis case rates are significantly lower than CT and GC.²
- Studies have shown that patients diagnosed with syphilis in the community had a history of incarceration prior to their diagnosis.³
 - Concerns older correctional population
 - Most cases represent old infections
- Still important to screen in high prevalence areas.

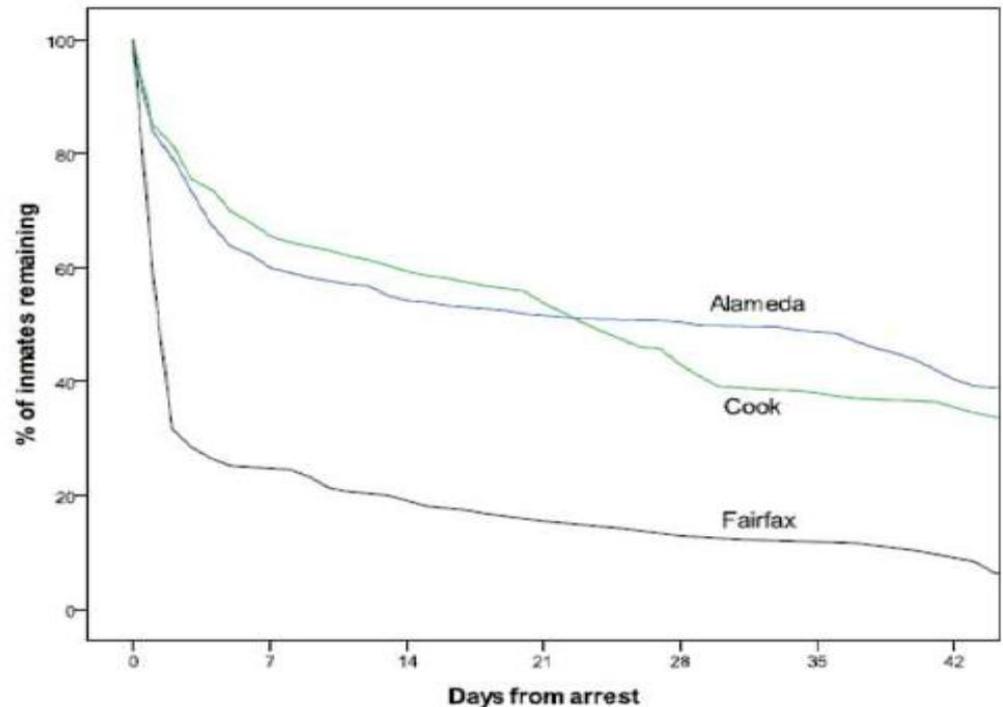
²Centers for Disease Control and Prevention. Sexually Transmitted Disease Surveillance, 2009.

³Burke, R. and J. Rhodes (2009). "Lessons learned on the implementation of jail syphilis screening in Nashville, Davidson County Jail, 1999-2005." Sexually Transmitted Diseases **36**(2 Suppl).

Screening – Time Element

- 10 million persons pass through jails each year
 - Median length of stay is 48 hours
 - Need for quick
 - Testing
 - Return of results

Figure 3. Duration of Jail Stay for Three US Counties, 2004



Implications for Programs & Policy

- Implementation of selective screening & treatment programs for young men and women in jails might reduce community prevalence in females.
- Through targeted screening & innovative treatment strategies, correctional screening programs can use their limited resources more effectively.

Thomas Lincoln, MD

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Baystate  Brightwood Health Center/Centro de Salud
COMPREHENSIVE FAMILY CARE AND COMMUNITY HEALTH

Health Consequences of Untreated STDs

- Women's reproductive health
 - Untreated Chlamydia (CT) or gonorrhea (GC) may lead to pelvic inflammatory disease (PID)
 - Leading infectious cause of infertility in the U.S.
- Infant mortality/morbidity
 - Neonatal HIV, herpes simplex virus (HSV) and congenital syphilis
- Multiple other organ system infections and consequences of infection
- HIV transmission and acquisition

Overview:

STD Screening In Corrections

- Who to screen in correctional facilities
 - Details regarding MSM and HIV-infected
- Which STDs to screen for
- STD re-screening in previously infected individuals
- Newer laboratory assays used to screen for STDs

In your correctional setting, which STDs are routinely screened for during intake?

- Chlamydia
- Gonorrhea
- Syphilis
- HIV
- Trichomonas

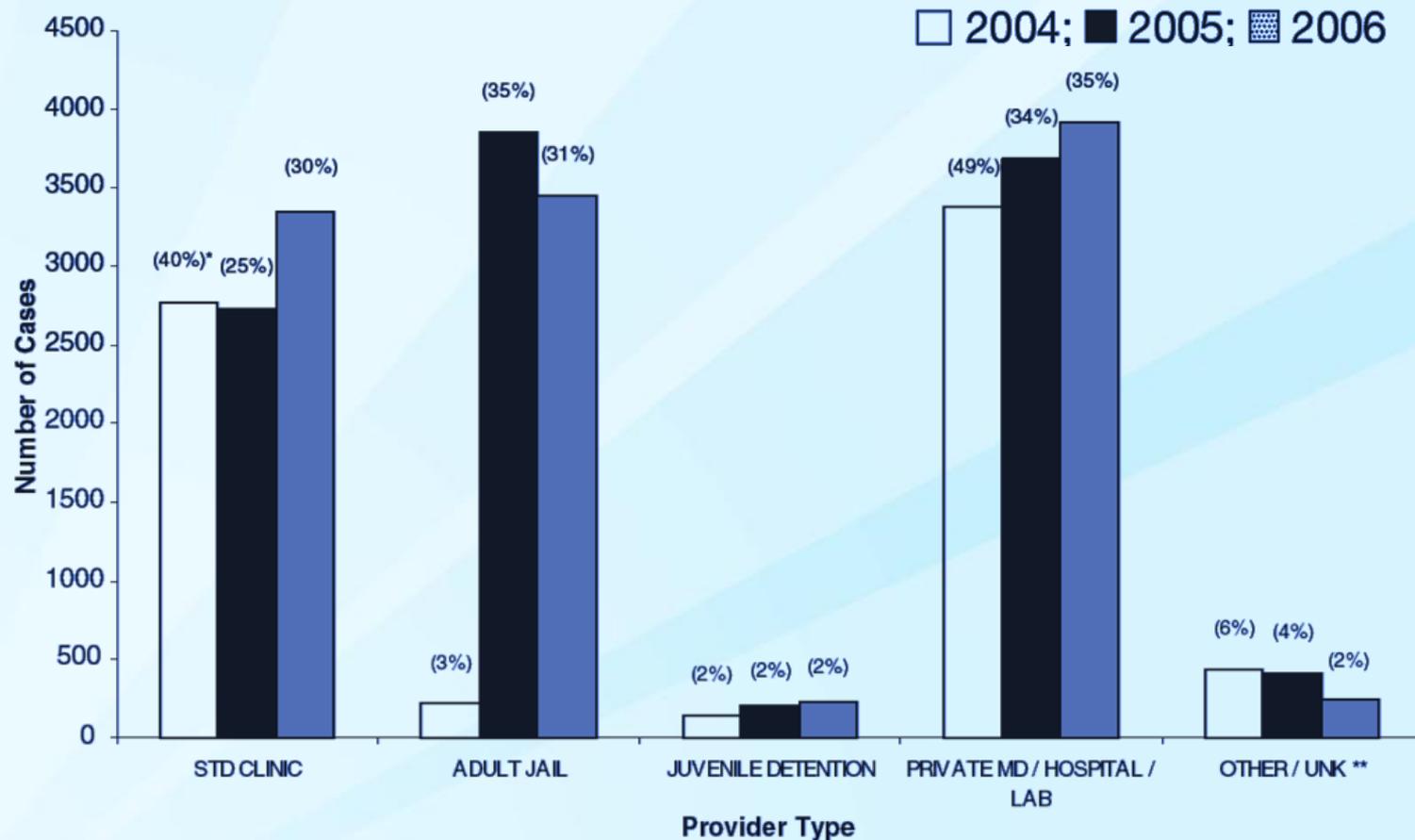
Screening in Corrections: 2010 STD Treatment Guidelines

- Persons in Correctional Facilities added to Special Populations
- Universal screening for chlamydia and gonorrhea
 - Adolescent females at intake in juvenile detention or jail facilities
 - Adult females up to 35 years of age (or based on local institutional prevalence data) at intake
- Universal screening for syphilis
 - Based on local prevalence of infectious syphilis (primary, secondary, and early latent syphilis)
- Consider screening sexually active young men for chlamydia in clinical settings of high prevalence
 - However, women are the priority

Screening in Corrections: Chlamydia Screening

- Cost effectiveness varies with prevalence and gender
 - Cost-effective if prevalence >5% in females
 - Higher prevalence in males required for cost-effectiveness
- Jail screening can be major component of population testing
 - NYC
- Ecological studies:
 - San Francisco - community rates in young women fell in clinic serving neighborhood with high jail testing and treatment and not in clinic in neighborhood with low
 - Philadelphia- in similar study did not find difference in declining rates by neighborhood

Chlamydia Infections By Clinical Setting: NYC males ≤ 35 years old



*numbers in parentheses represent % of citywide cases;

**includes cases reported from non-NYC jails and NYC jails without universal screening programs.

Pathela et al., *Sex Trans Dis* 2009

Screening in Corrections

Gonorrhea screening

- Similar cost-effectiveness analyses to chlamydia, but prevalence is generally below cost-effectiveness threshold

Syphilis screening

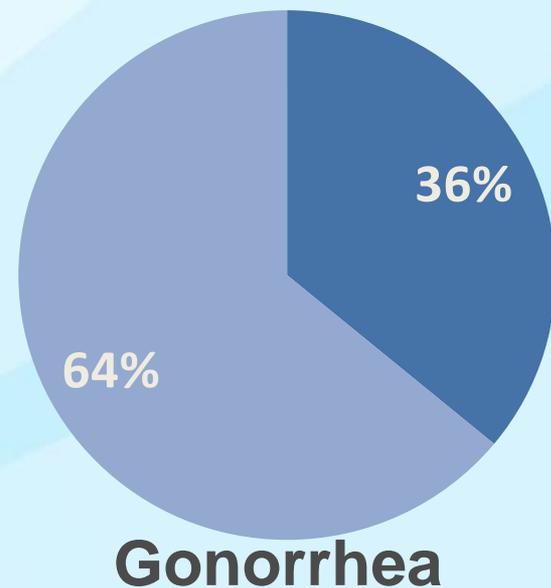
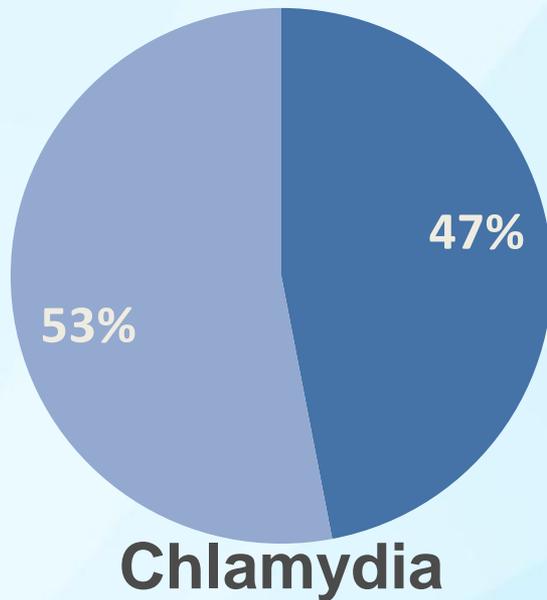
- Had been routine or mandatory in most prison systems and a fraction of jails
- Large variation in impact based on local prevalence
- Computerized registry to interpret positive serology

STD Screening for MSM

- HIV
- Syphilis
- Gonorrhea and chlamydia
 - Urethral
 - Rectal (if receptive anal intercourse)
 - Pharyngeal (if receptive oral intercourse), gonorrhea only
- Hepatitis B (HBsAg)
- Hepatitis C
 - If history of IV drug abuse
 - If HIV+
- HSV-2 serology (consider)
- Anal Pap (consider for HIV+)

- Frequency
 - At least annually, more frequently (every 3-6 months) if at high risk (multiple, anonymous, and/or high risk partners; drug use)

Chlamydia and Gonorrhea Infections: Proportion not identified if screening MSM only at urine/urethral sites



■ Identified
■ Not Identified

GC/CT Screening Tests

Nucleic acid amplification tests

- Urine in men and vaginal swab in women are the best NAAT specimens to collect

NAATs Extragenital Sites

- Not FDA-cleared for rectal or pharyngeal specimens but now the preferred testing method over culture
- Validation procedures can be done by labs to allow use of a non-FDA-cleared test or application
- Multiple commercial labs currently provide gonorrhea/chlamydia NAAT for rectal/pharyngeal specimens www.nnptc.org/PHLabs.htm

Non-culture, non-amplified tests such as EIA and DNA probe are inferior to NAATs and not recommended. Urine leukocytes not sensitive or specific enough for screening algorithm.

STD Screening for HIV+

- Syphilis*
- Gonorrhea*
- Chlamydia*
- HSV-2 serology (consider if status unknown)
- Hepatitis B & Hepatitis A (if cost effective prior to vaccination)
- Hepatitis C

Additional Screening for HIV+ women

- Pap
- Trichomoniasis

Screen on initial evaluation (in non-emergent situations), frequency of screening based on risk.

*At least annually for syphilis, GC, CT.

STD Re-Screening

- Chlamydia and gonorrhea
 - Repeat testing for all infected is recommended at 3 months after treatment – test of re-infection, not test of cure
- Syphilis
 - Follow-up testing to monitor for cure
- Trichomoniasis
 - Consider re-screening women 3 months after treatment (for re-infection and/or treatment failure)
 - No data for men

STD Screening: Obstacles and Opportunity

- Benefit largely to community while cost/effort more immediate
- Competing demands
- Space, time, privacy
- Success from:
 - Building into the intake process
 - Urine-based tests
 - Prompt processing with electronic reporting
 - Nursing treatment protocols
 - Public health department collaborations

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Clinical Faculty

California STD/HIV Prevention Training Center

Clinical Specialist

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Control Branch



2010 STD Treatment Guidelines Relevant To Persons In Correctional Facilities



Overview

- CDC Treatment Guidelines development
- Treatment of STDs detected by intake screening
- Treatment/management of STD syndromes
- Additional resources

CDC STD Treatment Guidelines Development



- Evidence-based on principal outcomes of STD therapy
- Recommended regimens preferred over alternative regimens
- Alphabetized unless there is a priority of choice
- Reviewed April 2009; available December 2010
- www.cdc.gov/std/treatment/2010
 - Pocket guides, teaching slides, wall charts
- www.cdc.gov/std/2010-ebook.htm

Case Scenario



- 22 year old female
- Asymptomatic, no prior STDs
- STD screening done on intake
 - Urine NAAT testing for GC/CT and syphilis serology
- GC **positive**
- CT negative
- RPR non-reactive

What regimen would you use to treat gonorrhea?

1. Ceftriaxone 125 mg IM + azithromycin 1 g PO
2. Ceftriaxone 250 mg IM
3. Ceftriaxone 250 mg IM + azithromycin 1 g PO
4. Ofloxacin 400 mg PO
5. Ceftriaxone 125 mg IM

Antibiotic-Resistant Gonorrhoea



Three Changes to Gonorrhea Treatment in 2010

1. Ceftriaxone IM preferred over oral cephalosporins
2. Ceftriaxone dose increased to 250 mg
3. Dual treatment for gonorrhea *regardless of* chlamydia test result

Gonorrhea Treatment

Uncomplicated Genital/Rectal Infections

Ceftriaxone 250 mg IM
in a single dose

OR, if not an option:

Cefixime 400 mg orally
in a single dose

PLUS*

Azithromycin
1 g orally
or doxycycline
100 mg BID x
7 days

* Regardless of CT test result

Gonorrhea Treatment

Oropharyngeal Infections

Ceftriaxone 250 mg
IM in a single dose

PLUS

Azithromycin
1 g orally
or doxycycline
100 mg BID x
7 days

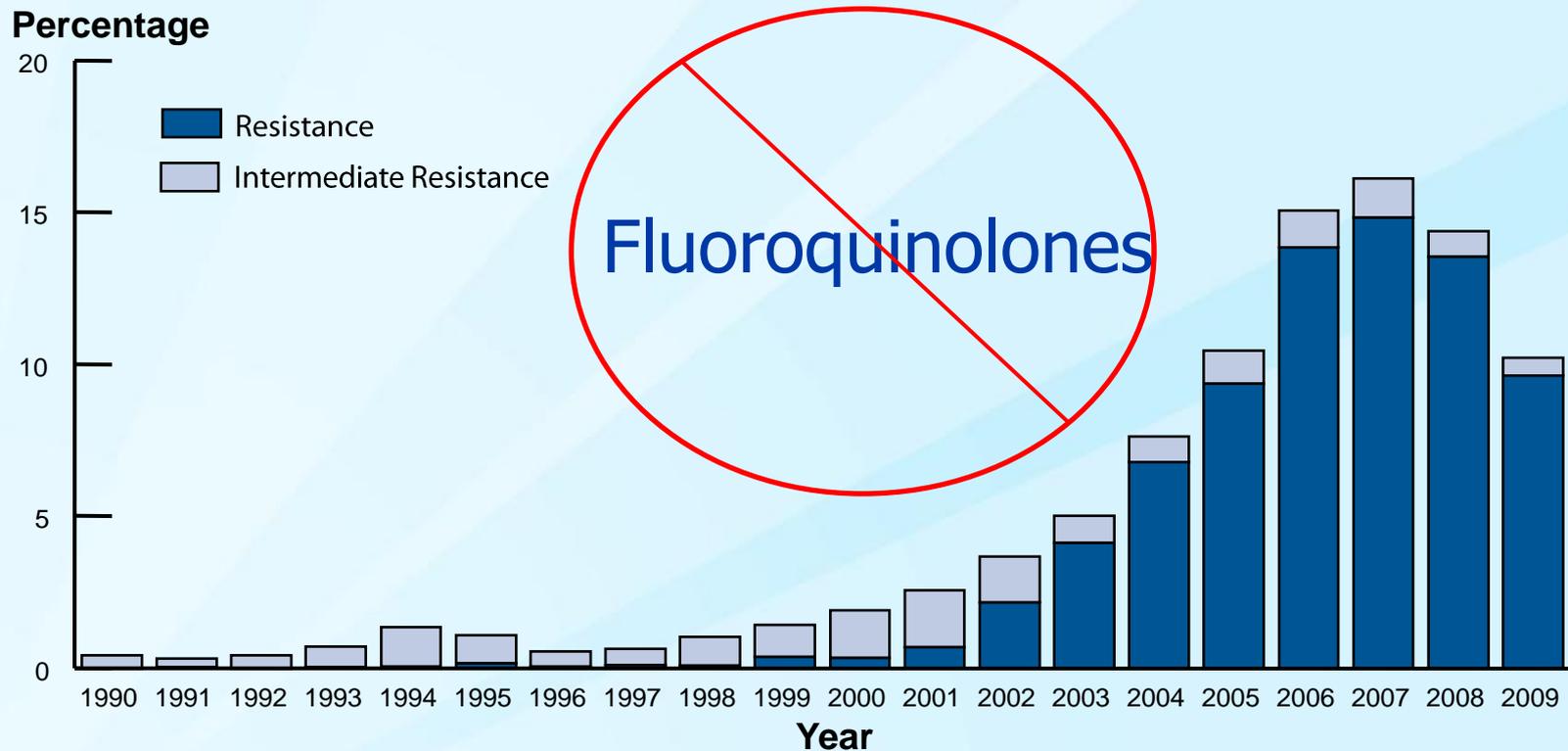
IN CASE OF SEVERE ALLERGY:

❖ Azithromycin 2 g orally once

PCN and Cephalosporin Allergy

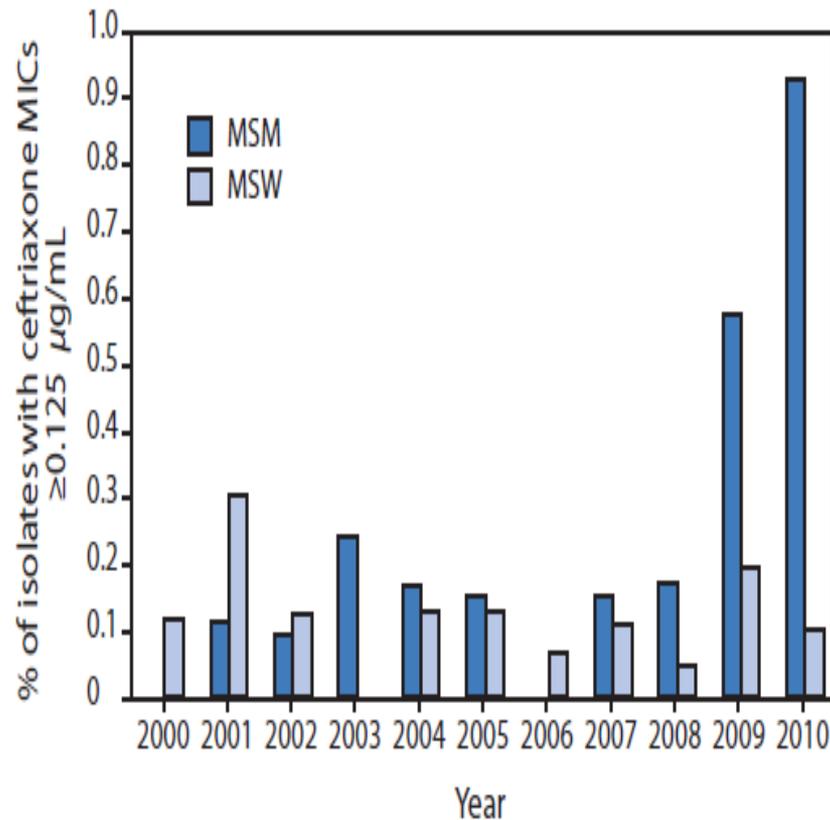
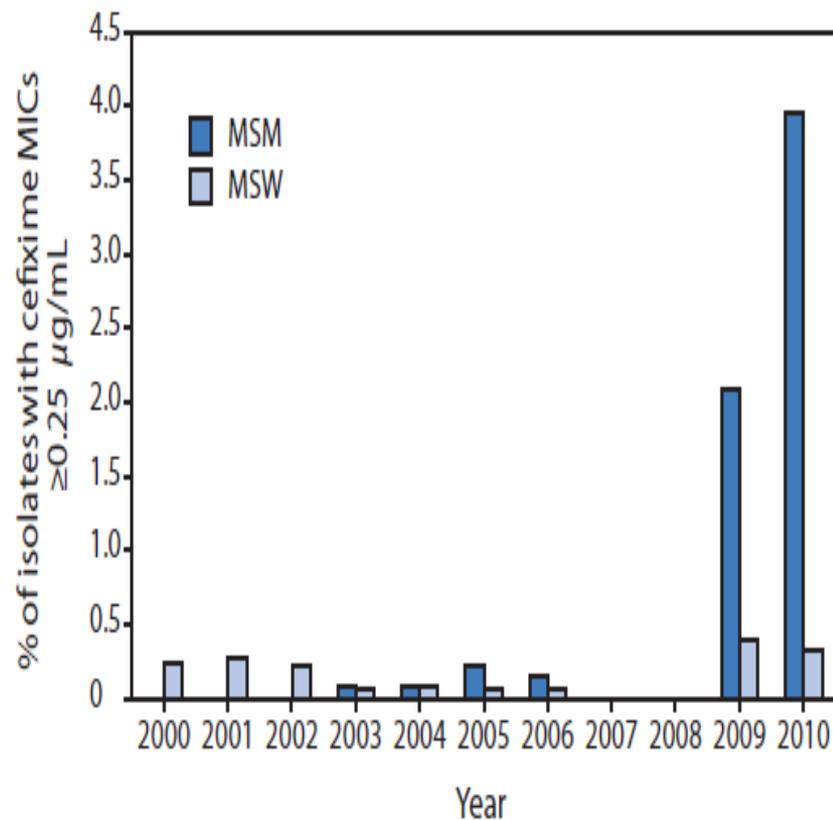
- ~5%-10% cross-reactivity risk with 1st generation cephalosporin in PCN allergic
- Cross reactivity low among 2nd and 3rd generation cephalosporin (used for GC treatment) in PCN allergic
 - No evidence of increased anaphylaxis risk
- Cephalosporin allergy
 - Allergy 1%-3% exposed, usually rashes
 - Anaphylaxis is rare event

Gonococcal Isolate Surveillance Project (GISP)—Percentage of *Neisseria gonorrhoeae* Isolates with Resistance or Intermediate Resistance to Ciprofloxacin, 1990–2009



NOTE: Resistant isolates have ciprofloxacin minimum inhibitory concentrations (MICs) >1 µg/ml. Isolates with intermediate resistance have ciprofloxacin MICs of 0.125–0.5 µg/ml. Susceptibility to ciprofloxacin was first measured in GISP in 1990.

FIGURE 2. Percentage of gonorrhea isolates with cefixime MICs ≥ 0.25 $\mu\text{g/mL}$ and ceftriaxone MICs ≥ 0.125 $\mu\text{g/mL}$, by sex of sex partner — Gonococcal Isolate Surveillance Project, United States, 2000–2010



Suspected GC Treatment Failure

- Retreat with ceftriaxone 250mg IM plus azithromycin 2 gm PO*
 - Consult ID expert/CDC regarding retreatment for ceftriaxone failure**
- Culture TOC within 1 week (NAAT if no culture)
- Partner treatment all within prior 2 months
 - Test for GC
 - Empirically treat dual therapy ceftriaxone/azithromycin
- Report to LHD/State within in 24 hours

*MMWR/ July 8,2011 / Vol 60/No.5 (augments 2010 STD Treatment Guidelines)

**Some states have RX recommendations, consult your state/LHD.

CDC/State HD website to maintain updated content

What if her STD screening detected chlamydia?



- STD screening done on intake
 - Urine NAAT testing for GC/CT and syphilis serology
- GC negative
- CT **positive**
- RPR non-reactive

Chlamydia Treatment

Adolescents and Adults

Recommended regimens (nonpregnant):

- Azithromycin 1 g orally in a single dose
- Doxycycline 100 mg orally twice daily for 7 days

Recommended regimens (pregnant*):

- Azithromycin 1 g orally in a single dose
- Amoxicillin 500 mg orally TID x 7 days

*** Test of cure at 3-4 weeks only in pregnancy**

Case Scenario



- 29 year old male
- Asymptomatic, CT at age 21
- STD screening done on intake
 - Urine NAAT testing for GC/CT and syphilis serology
- GC negative
- CT negative
- Syphilis Treponemal EIA **positive**, RPR negative

What are appropriate next steps?

1. Treat him for Late Latent Syphilis
2. Request TP-PA testing
3. No action necessary, EIA+ is likely false positive
4. Treat him for Early Latent Syphilis

Syphilis Serologic Tests

- Nontreponemal tests

RPR, VDRL & TRUST

- Treponemal tests

FTA-ABS & TP-PA

-Enzyme immunoassays (EIAs)

Trep-Chek & Trep-Sure

-Chemiluminescence immunoassays (CIAs)

LIAISON & Architect

-Microbeadimmunoassays (MBIA)

BioPlex2200 Syphilis IgM & IgG

Reverse Sequence Syphilis Screening

Treponemal tests (i.e., EIA, CIA)

- SPECIFIC TO *TP*
- QUALITATIVE
- REACTIVITY PERSISTS
OVER LIFETIME



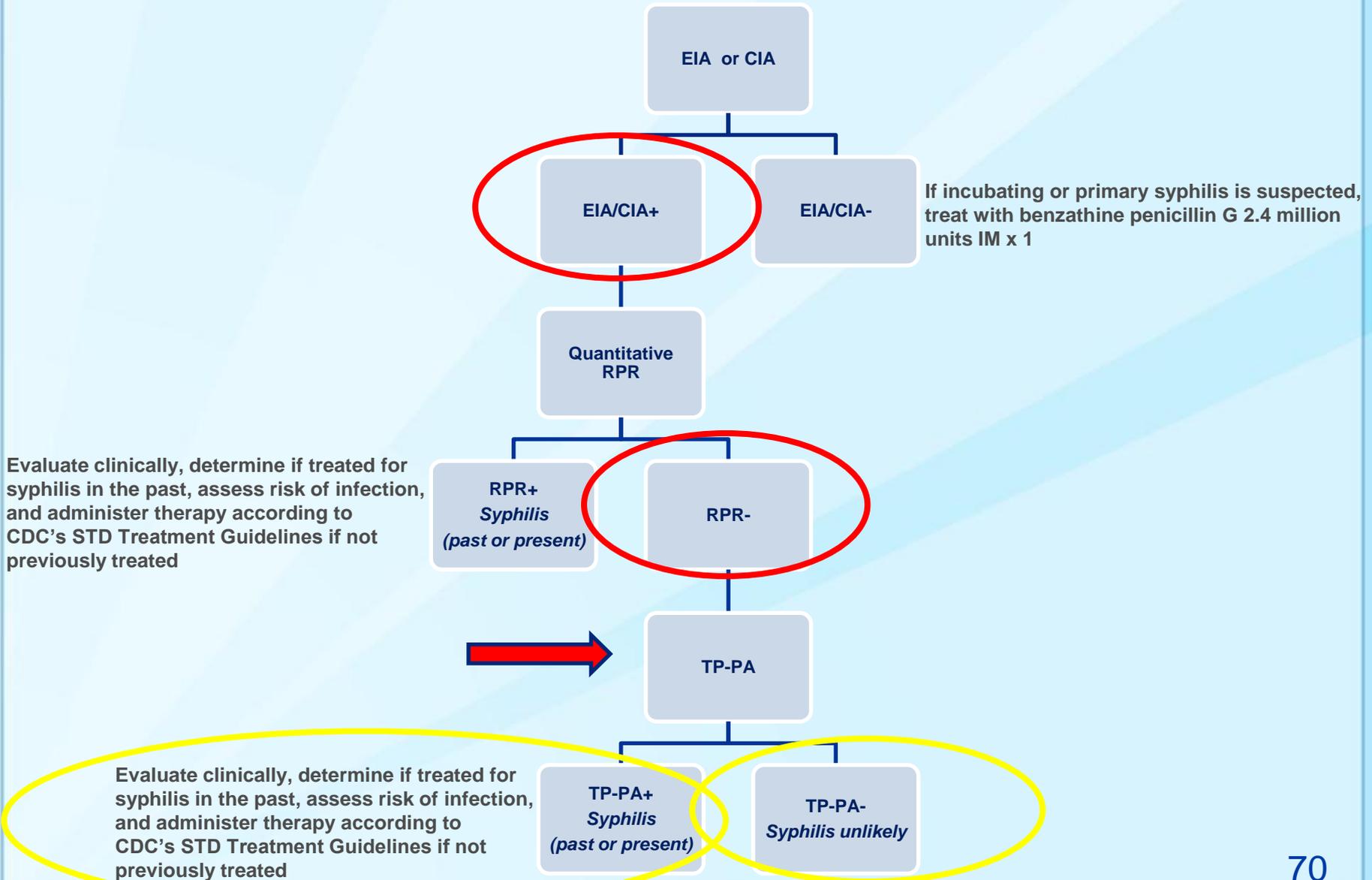
Non-treponemal tests (i.e., RPR, VDRL)

- NOT SPECIFIC TO *TP*
- QUANTITATIVE
- REACTIVITY DECLINES
WITH TIME

CHALLENGES:

- Cannot distinguish between active/old disease (treated/untreated)
- Confusion re: management of patients with discrepant serology

Recommended algorithm for reverse sequence syphilis screening



Syphilis Treatment: Recommended Regimens

Primary, Secondary & Early Latent: *

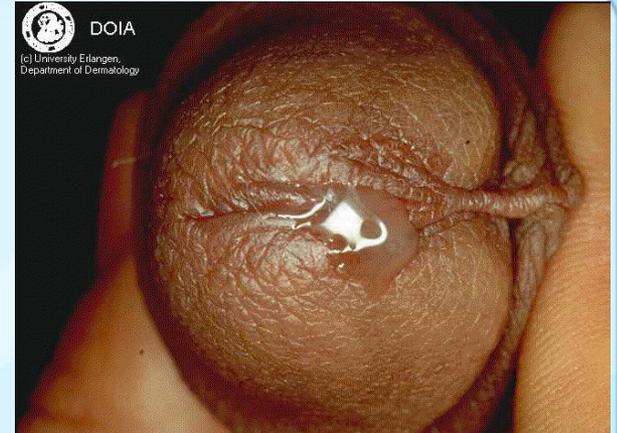
- Benzathine penicillin G 2.4 million units IM in a single dose

Late Latent and Unknown Duration:

- Benzathine penicillin G 7.2 million units total, given as 3 doses of 2.4 million units each at 1 week intervals

**No enhanced efficacy of additional doses of BPG, amoxicillin or other antibiotics even if HIV infected*

Sick Call: Urethral Discharge



- 22 year old male complaint of persistent dysuria & urethral discharge
 - Seen 1 week ago and treated for urethritis (ceftriaxone 250 IM plus azithromycin 1 gm PO)
 - States he initially felt a little better but the discharge never really went away. No sexual exposures in past week
 - **GC/CT NAAT both negative** from prior visit
- Urethral discharge confirmed on exam today

What treatment should he receive?

1. Ceftriaxone 250 mg IM + azithromycin 1 g PO
2. Doxycycline 100 mg PO BID x 7 days
3. Levofloxacin 500 mg PO daily x 7 days
4. Metronidazole 2 gm PO x 1
5. Retest for GC/CT today, no treatment needed

Urethritis: Common Infectious Causes

- Bacterial STDs:
 - GC ~20%
 - CT 15-40%
- Non-gonococcal urethritis (NGU)
 - *Mycoplasma genitalium* 15-25%
 - Ureaplasma <15%?; data inconsistent
 - *Trichomonas vaginalis* ~5-15%
 - HSV 2-3% (in absence of skin lesions)
 - Adenovirus, enterics, Candida, anaerobes

Persistent NGU Treatment

Recommended regimens:

- Metronidazole 2 g orally in a single dose
- OR
- Tinidazole 2 g orally in a single dose
- PLUS**
- Azithromycin 1 g orally in a single dose
(if not used for initial episode)

Moxifloxacin 400 mg PO x 7d effective for NGU treatment failures due to *M. genitalium*

Sick Call: Genital Lesions

- 30 year old female very painful genital “sores” for 2 days
- History of CT and GC in her 20’s
- No known history of syphilis or herpes.



Genital, Perianal, Anal Ulcers

Evaluation and Management

- History and physical examination often inaccurate
- Majority due to HSV or syphilis
 - Chancroid less common
 - Noninfectious causes
- Serologic test for syphilis
- Diagnostic evaluation for HSV
- HIV test
- Presumptive treatment based on clinical and epidemiology
- Biopsy if uncertain

Genital Herpes Treatment

1st Clinical Episode

Acyclovir

- 400 mg TID x 7-10 days
- 200 mg 5x/day x 7-10 days

Valacyclovir

- 1000 mg BID x 7-10 days

Famciclovir

- 250 mg TID x 7-10 days

Higher doses/durations
recommended for HIV (+)

Recurrent Outbreaks (Episodic Rx)

Acyclovir

- 400 mg TID or 800 mg BID x5 days
- 800 mg TID x2 days

Valacyclovir

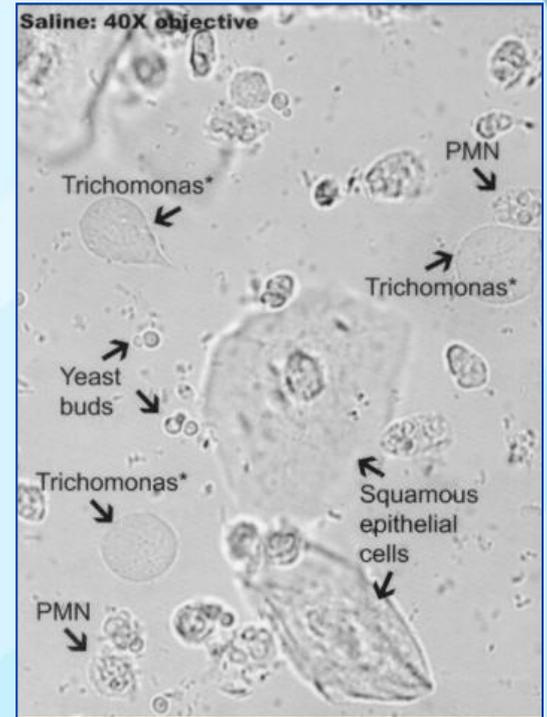
- 500 mg BID x3 days
- 1 gm daily x 5 days

Famciclovir

- 125 mg BID x5 days
- 500 mg x 1, then 250 mg BID x 2days
- 1000 mg BID x1 day

Sick Call: Vaginal Discharge

- 30 yr old HIV positive female treated for trich 4 weeks ago
- Patient states yellow/green discharge is back.
- RX metronidazole 2 gm at her last visit. No sex since RX.
- Trichomonas seen on wet mount today



Seattle STD/HIV PTC

Trichomoniasis Treatment Failure

First treatment failure, re-treat with:

- Metronidazole 500 mg PO BID x 7 days

If repeat failure, treat with:

- Metronidazole 2 g PO x 5 days
- Tinidazole 2 g PO x 5 days

Susceptibility testing: send isolate to CDC

Consultation is available from CDC : 404-718-4141

Trichomoniasis Treatment

Recommended regimen:

- Metronidazole 2 g PO x 1
- Tinidazole 2 g PO x 1

Consider treating HIV-infected women:

- **Metronidazole 500 mg PO BID x 7d**

Alternative regimen:

- Metronidazole 500 mg PO BID x 7d

Recommended regimen in pregnancy:

- Metronidazole 2 g PO x 1

Note: Intravaginal therapy with metronidazole gel is ineffective
Tinidazole is a Category C drug in pregnancy

Trichomoniasis: Diagnosis

- Saline Wet Mount
 - Motile trichomonads
 - pH > 4.5
 - Whiff test may be positive
- Culture (InPouch TV Test, BioMed Diagnostics)
- Point-of-care tests
 - OSOM trichomonas rapid test (Genzyme)
 - Affirm VP III (BD)
- **New:** Modified Nucleic Acid Amplification Tests
 - Roche Amplicor
 - Gen-Probe APTIMA Analyte Specific Reagents



Partner Management Options

- Partner management important for all STDs
- Patient referral
 - Ask patient to notify partner and ensure treatment
 - Internet-based anonymous notification
- Expedited partner treatment (EPT)
 - Legal for GC/CT in ~30 states
- Provider or clinic-based referral
- Health department referral

Additional Resources for Clinicians

- Academy of Correctional Health Professionals
 - www.correctionalhealth.org
- American Correctional Association
 - www.aca.org/hpis
- American Correctional Health Services Association
 - www.achsa.org
- National Commission on Correctional Health Care
 - www.ncchc.org
- Society for Correctional Physicians
 - www.corrdocs.org

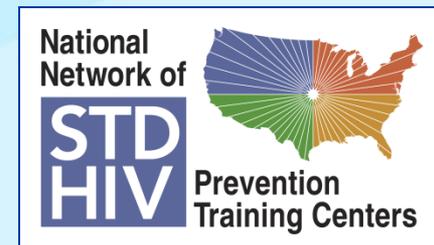


Additional Resources for Clinicians

- CDC 2010 STD Treatment Guidelines
 - www.cdc.gov/std/treatment



- National Network of STD/HIV Prevention Training Centers
 - www.nnptc.org



- CDC Division of STD Prevention
 - www.cdc.gov/std/training



Questions and Answers



Questions can be submitted during the Webinar via the question function.

Due to volume of Webinar participants and time we have allotted, we may not be able to provide live answers to all of the submitted questions.

We will compile and answer salient questions and will post them online at www.nnptc.org and www.cdc.gov/std/treatment/2010 as soon as we can.

Continuing Education Information

- To receive CE credit, an evaluation must be completed at CDC's Training and Continuing Education Online site:
<http://www2a.cdc.gov/TCEOnline/>
- If you have not previously registered as a participant on the CDC Training and Continuing Education Online site, click on *New Participant* to create a user ID and password; otherwise click on *Participant Login*.
- Once logged on to the CDC Training and Continuing Education Online site, you will be on the *Participant Services* page. Click on *Search and Register*.
- For those participating in the program on November 9, 2011 through December 8, 2011, enter **EC1956** into the *Keyword Search* box and then click on view.
- For those participating in the program on or after December 9, 2011, enter **WD1956** into the *Keyword Search* box and then click on view.

Continuing Education Information

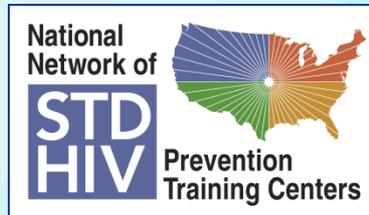
- Select the webinar that you viewed. The course information page will come up. Scroll down to the *Register Here* section of the page. Click on the type of continuing education credit that you would like to receive and then *Submit*. A few demographic questions will come up. Complete the questions and then *Submit*.
- A message will come up thanking you for registering for the course.
- Complete and *Submit* the evaluation and posttest. A record of your course completion and your CE certificate will be located in the *Transcript and Certificate* section of the *Participant Services* page. Print out a copy of your certificate and send it to the appropriate accrediting agency (ACCME, ACPE, ANCC, NCHEC, etc.) so that they will have a record of your certificate.

Emerging Issues in Sexually Transmitted Diseases



Managing STDs in Correctional Settings: Behind the Walls

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The findings and conclusions in this report are those of the authors and do not necessarily represent the official position of the Centers for Disease Control and Prevention.

