

STD SCREENING GUIDELINES

The recommendations in this document are based on the 2015 CDC Sexually Transmitted Diseases Treatment Guidelines and CDC's STD Screening Recommendations Referenced in Treatment Guidelines and Original Recommendation Sources" chart referenced here: <http://www.cdc.gov/std/tq2015/screening-recommendations.htm> unless otherwise noted. **Please visit the CDC site for full references.** State guidelines and laws may differ; please check with your state for applicable laws and guidelines. Please visit www.nycptc.org for updates and additional STD resources and education. **Abbreviations :** MSM=men who have sex with men; WSW=women who have sex with women; CT=Chlamydia trachomatis; GC=Neisseria gonorrhoea; RAI = Receptive Anal Intercourse; BV=Bacterial Vaginosis; HPV=Human Papillomavirus; HAV=Hepatitis A Virus; HBV=Hepatitis B Virus; HCV = Hepatitis C Virus; TOC = Test of cure; PID=Pelvic Inflammatory Disease.



	CHLAMYDIA ^{1,2}	GONORRHEA ^{3,4}	SYPHILIS	HERPES	HIV	TRICHOMONAS & BACTERIAL VAGINOSIS	CERVICAL CANCER	HEPATITIS B	HEPATITIS C
WOMEN	Test at least annually for sexually active women under 25 years of age and sexually active women aged 25 years and older if at increased risk ⁵ Retest approximately three months after treatment.	Test at least annually for sexually active women under 25 years of age and sexually active women age 25 years and older if at increased risk ⁸ Retest 3 months after treatment.		Consider type-specific HSV serologic testing for women presenting for an STI evaluation, especially if multiple sex partners	All women aged 13-64 years and all women who seek evaluation and treatment for STIs	Trichomonas: consider screening women if at high risk ¹¹ or in high prevalence settings (e.g., STD clinics and correctional facilities) Bacterial Vaginosis (BV): no routine screening recommendation	Women 21-29 years of age every 3 years with cytology Women 30-65 years of age every 3 years with cytology or every 5 years with a combination of cytology and HPV testing.	Women at increased risk.	
PREGNANT WOMEN	All pregnant women under 25 years of age Pregnant women, aged 25 years and older if at increased risk ⁵ Retest during 3rd trimester if under 25 years of age or at risk ⁶	All pregnant women under 25 years of age and older women if at increased risk ⁹ Retest 3 months after treatment	All pregnant women at the first prenatal visit Retest early in 3rd trimester and at delivery if at high risk ¹⁰	Evidence does not support routine HSV-2 serologic screening among asymptomatic pregnant women. However, type-specific serologic tests might be useful for identifying pregnant women at risk for HSV infection and guiding counseling regarding the risk for acquiring genital herpes during pregnancy	All pregnant women at first prenatal visit and at delivery if not previously tested or no prenatal care Retest in 3rd trimester if at high risk ¹⁰	Trichomonas: insufficient evidence for screening asymptomatic pregnant women; symptomatic pregnant women should be screened. For pregnant women with HIV infection, screening at first prenatal visit is recommended. BV: Insufficient evidence to recommend routine screening in asymptomatic pregnant women at high or low risk for preterm delivery	Screening at same intervals as non-pregnant women	Test for HBsAg at first prenatal visit of each pregnancy regardless of prior testing; retest at delivery if at high risk	Women, men and pregnant women born between 1945-1965 and if other risk factors are present ¹²
MEN	Consider screening young men in high prevalence clinical settings (adolescent and STD clinics and correctional facilities) or in populations with high burden of infection (e.g. MSM)			Consider type-specific HSV serologic testing for men presenting for an STI evaluation, especially if multiple sex partners	All men aged 13-64 years and all men who seek evaluation and treatment for STIs			Men at increased risk.	
MSM (HIV negative)	Test at each site of exposure (urethra, rectum) at least annually for sexually active MSM regardless of condom use or every 3-6 months if at increased risk ⁷	At least annually for sexually active MSM at each site of exposure (urethra, rectum, pharynx) regardless of condom use and every 3-6 months if at increased risk ⁷	At least annually for sexually active MSM and every 3-6 months if at increased risk ⁷	Consider type-specific serologic tests for HSV-2 if infection status is unknown in MSM with previously undiagnosed genital tract infection.	At least annually for sexually active MSM if HIV-negative or unknown status and if patient or sex partner has had more than one sex partner since most recent HIV test			All MSM should be tested for HBsAg	MSM born between 1945-1965 and if other risk factors are present ¹² Annual HCV testing in MSM with HIV infection.
Persons with HIV	For sexually active individuals, screen at first HIV evaluation and at least annually thereafter. Test at each site of exposure. More frequent screening might be appropriate depending on individual risk behaviors and local epidemiology.	For sexually active individuals, screen at first HIV evaluation, and at least annually thereafter. Test at each site of exposure. More frequent screening might be appropriate depending on individual risk behaviors and local epidemiology.	For sexually active individuals, screen at first HIV evaluation, and at least annually thereafter.	Consider type-specific HSV serologic testing for persons presenting for an STI evaluation, especially if multiple sex partners, persons with HIV infection, and MSM at increased risk for HIV acquisition.		Trichomonas: sexually active women at entry to care and at least annually thereafter	Women should be screened within 1 year of sexual activity or initial HIV diagnosis using conventional or liquid-based cytology; testing should be repeated 6 months later.	Test for HBsAg and anti-HBc and/or anti-HBs.	Serologic testing at initial evaluation. Annual testing for HIV+ MSM.

¹NAAT testing FDA approved for first catch urine or vaginal swab.

²Perform local validation study for use of NAAT at anal and pharyngeal sites

³NAAT testing FDA approved for first catch urine or vaginal swab.

⁴Perform local validation study for use of NAAT at anal and pharyngeal sites

⁵Those who have a new sex partner, more than one sex partner, a sex partner with concurrent partners, or a sex partner who has a sexually transmitted infection. Screening for Chlamydia and Gonorrhea: U.S. Preventive Services Task Force Recommendation Statement. *Annals of internal medicine.* Sep 23 2014.

⁶Those with a new sex partner, more than one sex partner, a sex partner with concurrent partners, or a sex partner who has a sexually transmitted infection. Centers for Disease Control and Prevention. *Sexually Transmitted Diseases Treatment Guidelines, 2015.*

⁷More frequent STD screening (i.e., for syphilis, gonorrhea, and chlamydia) at 3–6-month intervals is indicated for MSM, including those with HIV infection if risk behaviors persist or if they or their sexual partners have multiple partners. Centers for Disease Control and Prevention. *Sexually Transmitted Diseases Treatment Guidelines, 2015*

⁸Those who have a new sex partner, more than one sex partner, a sex partner with concurrent partners, or a sex partner who has an STI. Additional risk factors for gonorrhea include inconsistent condom use among persons who are not in mutually monogamous relationships; previous or coexisting sexually transmitted infections; and exchanging sex for money or drugs. Clinicians should consider the communities they serve and may opt to consult local public health authorities for guidance on identifying groups that are at increased risk. Screening for Chlamydia and Gonorrhea: U.S. Preventive Services Task Force Recommendation Statement. *Annals of internal medicine.* Sep 23 2014.

⁹US Preventive Services Task Force. Screening for syphilis infection in pregnancy: reaffirmation recommendation statement *Annals of internal medicine.* 5/19/2009 2009;150(10):705-709.

¹⁰Each state's guidelines and laws may differ; please check with your State DOH for applicable laws and guidelines.

¹¹Women with multiple sex partners, exchanging sex for payment, illicit drug use, and a history of STDs

¹²Past or current injection drug use, receipt of blood transfusion before 1992, long term hemodialysis, born to mother with Hep. C, intranasal drug use, receipt of an unregulated tattoo, and other percutaneous exposures. Moyer VA. Screening for hepatitis C virus infection in adults: US Preventive Services Task Force recommendation statement. *Annals of internal medicine.* Sep 3 2013;159(5):349-357

Recommended Laboratory Diagnostics

This diagnostics summary is for educational purposes only. The individual clinician is in the best position to determine which tests are most appropriate. Adapted from the Spokane Washington Regional Health District's STD Toolkit

ETIOLOGIC AGENT	COMMON SYNDROMES	RAPID DIAGNOSTICS	DEFINITIVE DIAGNOSTICS
<i>Chlamydia trachomatis</i>	Non-gonococcal urethritis (NGU), cervicitis, proctitis, PID,	Urine leukocyte esterase can be helpful to look for presence of inflammation	Nucleic Acid Amplification Tests (NAATs) cervical, urethral or vaginal swabs, or first catch urine. Local validation studies required for use of rectal or pharyngeal specimen testing.
<i>Neisseria gonorrhoeae</i>	Urethritis, cervicitis, proctitis, PID,	Gram stain for symptomatic men	Nucleic Acid Amplification Tests (NAATs) -cervical, urethral or vaginal swabs or first catch urine). Local validation studies required for use of rectal or pharyngeal specimen testing. Cervical/intraurethral swab for culture if persistent or recurrent infection, or concern for resistance.
<i>Trichomonas vaginalis</i>	Vaginitis, urethritis	Rapid antigen detection test, Saline wet prep	NAAT testing (vaginal, endocervical and urine in women)
<i>Candida albicans, other Candida sp.</i>	Vaginitis, balanitis	10% KOH prep; Gram stain	Culture if wet mount negative and signs or symptoms
Bacterial vaginosis, anaerobic bacteria	Malodorous vaginal discharge with or w/o pruritis	Saline wet prep- clue cells, whiff test (fishy odor with 10% KOH), and vaginal pH >4.5	Rapid tests- e.g., DNA probe and vaginal fluid sialidase activity
Herpes simplex virus (HSV)	Genital ulcer	Point of care HSV2 antibody tests- recent infection may have false negative	Type specific virologic tests: Ulcer- culture or PCR; Type specific serological tests: ELISA and Western blot (glycoprotein gG1/gG2 type-specific antibody test)
<i>Treponema pallidum (syphilis)</i>	Genital ulcer	Ulcer- darkfield microscopy; serological test; RPR, treponemal rapid EIA available reverse algorithm	serological tests: RPR, VDRL, USR, ART, (non-treponemal tests); FTA-Abs, MHA-TP (treponemal tests); TP-PA, darkfield is definitive if positive
<i>Sarcoptes scabiei</i>(scabies)	Dermatitis, ulcers	Mineral oil wet prep	Skin scraping of burrow is definitive
<i>Phthirus pubis</i>(pubic lice)	Dermatitis	Dry mount, observation of nits or lice	Detection of eggs, nits, or louse is definitive
Human Papillomavirus (HPV)	Genital warts (condylomata acuminata)	None; observation of lesions	Pap smear; HPV PCR
<i>Salmonella sp., Shigella sp., Campylobacter sp.</i>	Enteritis, proctocolitis	None	Stool culture; stool PCR
<i>Entamoeba histolytica, Giardia lamblia</i>	Enterocolitis	None	Wet prep or trichrome stain of fresh or concentrated stool, giardia antigen test. Giardia PCR
Hepatitis virus: (A,B,C)	Hepatitis; elevated liver function enzymes	None; CLIA waived rapid HCV test (OraQuick HCV)	Serological test for specific antibody
HIV	Variable	Rapid HIV-1 Antibody Tests	HIV-1/HIV-2 antigen/antibody immunoassays and HIV differentiation assay (HIV1 vs HIV2 antibodies) and then HIV-1 NAT (for indeterminate or negative differentiation test)