

AAP Releases Policy Statement on Screening for Nonviral Sexually Transmitted Infections in Adolescents and Young Adults

Key Points for Practice

- Women 25 years and younger should be screened every year for *C. trachomatis* infection, with repeat testing three months after treatment if the screening test is positive.
- Women younger than 25 years should be screened every year for *N. gonorrhoeae* infection, with repeat testing three months after treatment if the screening test is positive.
- Sex partners of a person diagnosed with *C. trachomatis* infection or gonorrhea within the past 60 days should be screened for infection.
- Sexually active adolescent and young adult males who have sex with males should be screened every year for chlamydia and gonorrhea with testing based on the type of intercourse.

From the AFP Editors

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Many sexually transmitted infections (STIs) have a higher prevalence in the adolescent population. The objectives of screening for STIs include identifying persons with infection or possible infection, providing treatment, reducing transmission, avoiding or lessening consequences of the infection, and decreasing the prevalence of STIs. This policy statement from the American Academy of Pediatrics (AAP) provides recommendations on routine screening for nonviral STIs in adolescents and young adults (25 years and younger).

Recommendations

Physicians should develop clinical processes to include STI risk assessment, screening, treatment, and prevention counseling when providing routine health care for sexually active adolescents. This should include providing

staff with education and training related to procedures and other issues such as consent, confidentiality, and billing. Additionally, physicians should become proficient in screening for STIs with nucleic acid amplification testing. They should strive to reduce barriers to STI screening, including access to and stigma of screening, while being careful to avoid breaching confidentiality. Recommendations about specific STIs are outlined below.

CHLAMYDIA

Chlamydia trachomatis infection, which is the most common reportable communicable disease in the United States, has the highest rates in women 20 to 24 years of age and the second highest rates in female adolescents 15 to 19 years of age. Typically, chlamydia does not cause symptoms; however, if not treated, the infection can persist.

Chlamydia can cause cervicitis, urethritis, proctitis, and rarely, pharyngitis. Complications and sequelae of infection include adverse outcomes in pregnancy and for the infant, including neonatal infections, chronic pelvic pain, ectopic pregnancy, epididymitis, increased transmission of human immunodeficiency virus (HIV), pelvic inflammatory disease (PID), reactive arthritis, and tubal-factor infertility. Additionally, recurrent chlamydia is associated with increased reproductive sequelae.

All sexually active female adolescents and adults 25 years and younger should be screened every year for *C. trachomatis* infection. Sexually active adolescent males and young adult males who have sex with males should be screened every year for rectal chlamydia if having receptive anal intercourse and urethral chlamydia if having insertive intercourse. Males who have sex with males who are high risk (e.g., multiple sex partners, sex combined with illicit drug use) should be screened every three to six months. Annual screening should be considered in sexually active males in settings with a high prevalence of chlamydia (e.g., jail, high school clinics, national job training programs).

Additionally, because of their increased risk of infection, sex partners of persons with chlamydia (in ►

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the 60 days before diagnosis) should also be screened. All adolescents found to have the infection should be screened again three months after treatment; this should be done whether or not the patient thinks his or her sex partner was treated. If it is not possible to perform screening again at three months, repeat screening should be performed when the patient next presents, in the year after treatment of the initial infection.

GONORRHEA

Gonorrhea, the second most common reportable communicable disease in the United States, has the highest rates in women 20 to 24 years of age and the second highest rates in female adolescents 15 to 19 years of age. Many times, the infection does not cause symptoms. *Neisseria gonorrhoeae* infection can manifest as cervicitis, urethritis, proctitis, and pharyngitis, and rarely can lead to conjunctivitis. The upper genital tract can be affected by gonorrhea, causing PID and other problems (e.g., ectopic pregnancy, infertility, and chronic pelvic pain in females; epididymitis in males). Additionally, gonorrhea infection is linked to increased transmission of HIV. In pregnant women, gonorrhea can cause chorioamnionitis, premature rupture of membranes, and preterm labor, and transmission perinatally can lead to ophthalmia neonatorum.

All sexually active female adolescents and adults younger than 25 years should be screened every year for *N. gonorrhoeae* infection. Sexually active adolescent and young adult males who have sex with males should be screened every year for pharyngeal gonorrhea if having receptive oral intercourse, rectal gonorrhea if having receptive anal intercourse, and urethral gonorrhea if having insertive intercourse. Males who have sex with males who are high risk (e.g., multiple sex partners, sex combined with illicit drug use) should be screened every three to six months. Annual screening should be considered in other sexually active young adult males based on individual and population-based risk factors; local epidemiology should be used to decide if gonorrhea screening is appropriate in a particular patient population.

Because reinfection is common, sex partners of persons with gonorrhea (in the 60 days before diagnosis) should also be screened. All adolescents found to have gonorrhea should be screened again three months after treatment; this should be done whether or not the patient thinks his or her sex partner was treated. If it is not possible to perform screening again at three months, repeat screening should be performed when the patient next presents, in the year after treatment of the initial infection.

TRICHOMONIASIS

Based on population studies, *Trichomonas vaginalis* genital tract infection is thought to be the most common nonviral STI. Rates of *T. vaginalis* infection in adolescent females are 2.1% to 14.4%. *T. vaginalis* infection is also common in older women. It usually does not have symptoms; however, it can cause vaginitis, PID, and preterm labor in females, and urethritis, epididymitis, and prostatitis in males. Additionally, it may increase transmission of HIV.

In asymptomatic adolescents, routine screening is not recommended. However, female adolescents and young women may be at higher risk of infection because of individual or population-based factors (e.g., new or multiple partners, a history of STIs, exchanging sex for money, injecting drugs); these patients may need more extensive evaluation, including screening for *T. vaginalis* infection. Rescreening females previously diagnosed with trichomoniasis should be considered three months after treatment; rescreening in males has not been discussed in the literature. If it is not possible to perform screening again at three months, repeat screening should be performed when the patient next presents, in the year after treatment of the initial infection.

SYPHILIS

In recent years, rates of syphilis have significantly increased, particularly among males who have sex with males. If the infection is left untreated, serious complications can occur, including neurosyphilis and, in infants of pregnant women with syphilis, congenital syphilis, which causes a variety of multisystem problems, including intrauterine death.

Routine screening in nonpregnant, heterosexual adolescents is not recommended. However, sexually active adolescent and young adult males who have sex with males should be screened every year; those who are high risk should be screened every three to six months. Additionally, screening can be considered in adolescents and young adults with higher risk behaviors. Local health departments can provide local prevalence rates and risks, which may affect screening decisions.

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