CDC Screening Guidelines

for Chlamydia, Gonorrhea, Trichomoniasis and *Mycoplasma genitalium*

HOLOGIC®

	Chlamydia (CT)[1]	**Gonorrhea** (NG)[1]	**Trichomoniasis** (TV)[1]	***Mycoplasma genitalium*** (M. gen)[1]
Women	Sexually active women under 25 years of age. Sexually active women aged 25 years and older if at increased risk.[a] Providers might consider opt-out chlamydia and gonorrhea screening (i.e., the patient is notified that testing will be performed unless the patient declines, regardless of reported sexual activity) for adolescent and young adult females during clinical encounters. Rectal chlamydial testing can be considered in females based on reported sexual behaviors and exposure, through shared clinical decision between the patient and the provider.	Sexually active women under 25 years of age. Sexually active women aged 25 years and older if at increased risk.[a] Pharyngeal and rectal gonorrhea screening can be considered in females based on reported sexual behaviors and exposure, through shared clinical decision between the patient and the provider.	Diagnostic testing for *T. vaginalis* should be performed for women seeking care for vaginal discharge. Consider screening for women receiving care in high-prevalence settings[b] and for asymptomatic women at high risk for infection.[a] This screening should be conducted at intake and offered as opt-out screening.	Women with recurrent cervicitis should be tested for M. gen, and testing should be considered among women with PID. Testing should be accompanied with resistance testing, if available. Screening of asymptomatic M. gen infection among women is not recommended. Extragenital testing for M. gen is not recommended.
Women with Bacterial Vaginosis	**Other management considerations:** All women diagnosed with BV should be tested for STIs.[1]			
Pregnant Women	All pregnant women under 25 years of age. Pregnant women, aged 25 and older if at increased risk.[a]	All pregnant women under 25 years of age. Pregnant women, aged 25 and older if at increased risk.[a]	Evidence does not support routine screening for *Trichomonas vaginalis* among asymptomatic pregnant women.	No specific guidelines.
Men	There is insufficient evidence for screening among heterosexual men who are at low risk for infection, however screening young men can be considered in high prevalence clinical settings.[b]	There is insufficient evidence for screening among heterosexual men who are at low risk for infection.	No specific guidelines.	Men with recurrent NGU should be tested for M. gen using an FDA-cleared NAAT. If resistance testing is available, it should be performed, and the results used to guide therapy. Screening of asymptomatic M. gen infection among men is not recommended. Extragenital testing for M. gen is not recommended.
Men Who Have Sex with Men (MSM)	At least annually for sexually active MSM at sites of contact[c] regardless of condom use. Every 3 to 6 months if at increased risk.[d]	At least annually for sexually active MSM at sites of contact[c] regardless of condom use. Every 3 to 6 months if at increased risk.[d]	No specific guidelines.	No specific guidelines. See recommendations above for Men.
HIV-infected Individuals	For sexually active individuals, screen at first HIV evaluation, and at least annually thereafter. More frequent screening might be appropriate depending on individual risk behaviors and the local epidemiology.	For sexually active individuals, screen at first HIV evaluation, and at least annually thereafter. More frequent screening might be appropriate depending on individual risk behaviors and the local epidemiology.	Recommended for sexually active women at entry to care and at least annually thereafter. Routine annual screening for *T. vaginalis* among asymptomatic women with HIV infection is recommended because of the adverse events associated with trichomoniasis and HIV infection.	No specific guidelines. See recommendations above for Men and Women.
Re-testing	All persons who receive a diagnosis of chlamydia should be tested for HIV, gonorrhea and syphilis. **Women:** Retest 3 months after treatment. **Pregnant Women:** Retest during the 3rd trimester for women under 25 years of age or at risk. Pregnant women with chlamydial infection should have a test-of-cure 4 weeks after treatment and be retested within 3 months.	All persons who receive a diagnosis of gonorrhea should be tested for HIV, chlamydia and syphilis. **Women:** Retest 3 months after treatment. **Pregnant Women:** Retest during the 3rd trimester for women under 25 years of age or at risk. Pregnant women with gonorrhea should be retested within 3 months.	All persons who receive a diagnosis of *T. vaginalis* should be tested for HIV, syphilis, gonorrhea and chlamydia **Women:** Retest 3 months after treatment.	No specific guidelines.

a Increased risk includes women who have new or multiple partners, whose partners have concurrent partners or who have sexually transmitted infections, who have a history of STDs themselves, or who exchange sex for payment.[1]
b High prevalence settings include STI/sexual health clinics, adolescent clinics and correctional facilities.
c MSM sites of contact include the urethra, rectum, and pharynx.
d More frequent STI screening (e.g., syphilis, gonorrhea, chlamydia) every 3-6 months is recommended for MSM with ongoing risk behaviors, including those on PrEP or living with HIV.
Note: Gender-based screening recommendations should be adapted based on anatomy for transgender or gender diverse persons.[1]

ACOG Guidelines (CT/NG)	ACOG endorses the CDC guidelines. Refer to the table above.[2]

USPSTF Guidelines (CT/NG)	Recommends screening for chlamydia in sexually active women aged 24 years or younger and in older women who are at increased risk[e] for infection.[3]	Recommends screening for gonorrhea in sexually active women aged 24 years or younger and in older women who are at increased risk[e] for infection.[3]	The current evidence is insufficient to assess the balance of benefits and harms of screening for chlamydia and gonorrhea in men.[3]

e Women 25 years or older are at increased risk if they have a new sex partner, more than 1 sex partner, a sex partner with concurrent partners, or a sex partner who has an STI; practice inconsistent condom use when not in a mutually monogamous relationship; or have a previous or coexisting STI. Exchanging sex for money or drugs and history of incarceration are also associated with increased risk. High community prevalence of chlamydia or gonorrhea may indicate increased risk.[3]

CDC Treatment Guidelines

for Chlamydia, Gonorrhea, Trichomoniasis and *Mycoplasma genitalium*

	Chlamydia[1]	Gonorrhea[1]	Trichomoniasis[1]	*Mycoplasma genitalium*[1]
Recommended Regimens	**Doxycycline** 100 mg orally 2 times/day for 7 days.	**Ceftriaxone** 500 mg* IM in a single dose for persons weighing <150 kg. If chlamydial infection has not been excluded, treat for chlamydia with **Doxycycline** 100 mg orally 2 times/day for 7 days. *For persons weighing ≥150 kg, 1g **Ceftriaxone** should be administered.	**Women:** **Metronidazole** 500 mg orally 2 times/day for 7 days. **Men:** **Metronidazole** 2g orally in a single dose.	Requires a two-stage therapy approach for treating M. gen. Testing should be accompanied with resistance testing, if available. **Stage 1:** Recommended Regimens if M. gen Resistance Testing Is Available: If macrolide sensitive: **Doxycycline** 100 mg orally 2x/day for 7 days, followed by **Azithromycin** 1g orally for initial dose, followed by **Azithromycin** 500 mg orally 1x/day for an additional 3 days (2.5g total). If macrolide resistant: **Doxycycline** 100 mg orally 2x/day for 7 days, followed by **Moxifloxacin** 400 mg orally 1x/daily for 7 days. **Stage 2:** Recommended Regimens if M. gen Resistance Testing Is NOT Available: **Doxycycline** 100 mg orally 2x/day for 7 days, followed by **Moxifloxacin** 400 mg orally 1x/daily for 7 days.
Alternative Regimens	**Azithromycin** 1g orally in a single dose. OR **Levofloxacin** 500 mg orally once daily for 7 days.	**Gentamicin** 240 mg IM in a single dose plus **Azithromycin** 2g orally for a single dose. OR **Cefixime*** 800 mg orally in a single dose. *If chlamydial infection has not been excluded, providers should treat for chlamydia with **Doxycycline** 100 mg orally 2 times/day for 7 days.	**Women and Men:** **Tinidazole** 2g orally in a single dose.	**Doxycycline** 100 mg orally 2 times/day for 7 days, followed by **Azithromycin** (1g orally on day 1 followed by 500 mg once daily for 3 days) and a test of cure 21 days after completion of therapy.* *Because of the high prevalence of macrolide resistance and high likelihood of treatment failure, this regimen should be used only when a test of cure is possible, **and no other alternatives exist**.
Pregnancy	**Azithromycin** 1g orally in a single dose. OR **Amoxicillin** 500 mg orally 3 times/day for 7 days.	**Ceftriaxone** 500 mg in a single IM dose plus treatment for chlamydia if infection has not been excluded.	**Metronidazole** no recommendation available.	No recommendation available.
Partner Treatment	Sex partners should be referred for evaluation, testing, and presumptive treatment if they had sexual contact with the partner during the 60 days preceding the patient's onset of symptoms or chlamydia diagnosis.	Sex partners should be referred for evaluation, testing, and presumptive treatment if they had sexual contact with the partner during the 60 days preceding the patient's onset of symptoms or gonorrhea diagnosis.	Current partners should be referred for presumptive therapy. Partners also should be advised to abstain from intercourse until they and their sex partners have been treated and any symptoms have resolved. EPT might have a role in partner management for trichomoniasis however, no partner management intervention has been demonstrated to be superior in reducing reinfection rates.	Sex partners of patients with symptomatic M. gen infection can be tested, and those with a positive test can be treated to possibly reduce the risk for reinfection. If testing the partner is not possible, the antimicrobial regimen that was provided to the patient can be provided.

References: 1. Workowski KA, Bachmann LH, Chan PA, et al. Sexually Transmitted Infections Treatment Guidelines, 2021. MMWR Recomm Rep 2021;70(No. RR-4):1-187. DOI: http://dx.doi.org/10.15585/mmwr.rr7004a1 **2.** ACOG. ACOG Endorsed Clinical Guidance. Accessed: June 20, 2023. https://www.acog.org/clinical/clinical-guidance/acog-endorsed **3.** Screening for Chlamydia and Gonorrhea: U.S. Preventive Services Task Force Recommendation Statement, Sep. 2021 https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/chlamydia-and-gonorrhea-screening. Accessed April 22, 2025.