HIV/STD PROVIDER PACKET

Updated February 2023

State of Alaska
Department of Health
Division of Public Health
Section of Epidemiology
HIV/STD Program

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THE STATE of ALASKA
GOVERNOR MIKE DUNLEAVY

Department of Health

DIVISION OF PUBLIC HEALTH
Section of Epidemiology

3601 C Street, Suite 540
Anchorage, Alaska 99503
Main: 907.269.8000
Fax: 907.562.7802

Dear Provider,

Enclosed you will find information regarding best practices for HIV/STD screening, testing, treatment, prevention, and reporting. The information in this packet was adapted from various sources including the Center for Disease Control and Prevention and The National Institute of Health. As of February 2023, the information presented in this packet is the most up to date. Due to advances in medical science and changes to the epidemiology of HIV/STDs we advise routinely verifying best practices with CDC guidelines.

Public and private health care systems often intersect to provide optimal care and case management for clients. The Department of Health's HIV/STD Program is available to conduct trainings, facilitate data requests, and provide other types of technical assistance regarding HIV and STDs. If you would like additional technical assistance (presentations, videoconferences, recorded webinars, etc.) on issues related to screening, testing, treatment, prevention, and reporting of HIV/STDs please submit a request to the HIV/STD Program through email at hiv-std@alaska.gov

We appreciate your partnership as we strive to provide quality healthcare to all Alaskans. Please do not hesitate to contact us if you have any questions or concerns.

HIV/STD Program
3601 C St.
Suite 540
Anchorage, AK 99503
(907) 269-8000
HIV-STD@alaksa.gov

HIV/STD Program Contacts

Kamala Stiner
HIV/STD Program Manager
(907)269-8061

For reporting of all persons newly diagnosed with HIV and new-to-state persons living with HIV, and any questions related to HIV (including testing and PrEP/PEP), please contact:

Sarah Brewster
HIV Surveillance Coordinator
(907)269-8057

For coordination of HIV care for persons living with HIV, please contact:

Kayli Helvie
Linkage to Care Coordinator
(907)269-3404

For questions about HIV testing, prevention (including PrEP/PEP), and outreach coordination, please contact:

Taylor Holsinger
HIV Prevention Coordinator
(907)269-5221

For questions about STDs (diagnosis, staging, testing, and treatment), please contact:

Hannah Guzzi
Disease Intervention Specialist 2
(907)717-0127

For case specific questions, or general STD questions, please contact our Disease Intervention Specialists (DIS):

Mahelet Amare
(907)269-8003

Cacelia McBeth
(907)269-8055

TJ Hernandez
(907)269-8081

Sonny Fabiano
(907)269-8065

If you are unable to reach someone, or are unsure who to contact, please call **(907)269-8000** and ask to speak with someone in the HIV/STD Program.

DISEASE REPORTING

Reporting Sexually Transmitted Diseases, HIV and AIDS

Reportable sexually transmitted diseases (STDs) include chlamydia (Chlamydia trachomatis), gonorrhea (Neisseria gonorrhoeae), syphilis (Treponema pallidum), and chancroid (Haemophilus ducreyi). Human immunodeficiency virus (HIV) infection and Acquired Immunodeficiency Virus (AIDS) infection are two distinct reportable conditions (e.g., providers must report a new diagnosis of AIDS in a patient who has already been reported as HIV-positive).

Suspected or confirmed cases should be reported as quickly as possible, but no later than 2 working days after the condition is first diagnosed.

- The preferred method of reporting is through electronical reporting
- If needed, faxing the HIV/STD Report Form to the confidential fax line below and/or reporting via phone is also acceptable.
- HIV/STD Program personnel will follow-up with the reporting health care provider if treatment information is insufficient or inconsistent with current Centers for Disease Control and Prevention (CDC) Sexually Transmitted Disease Treatment Guidelines.
- Providers should report all diagnosed or suspected cases of HIV in patients who are new to their care. This includes reporting positive results from rapid HIV tests.

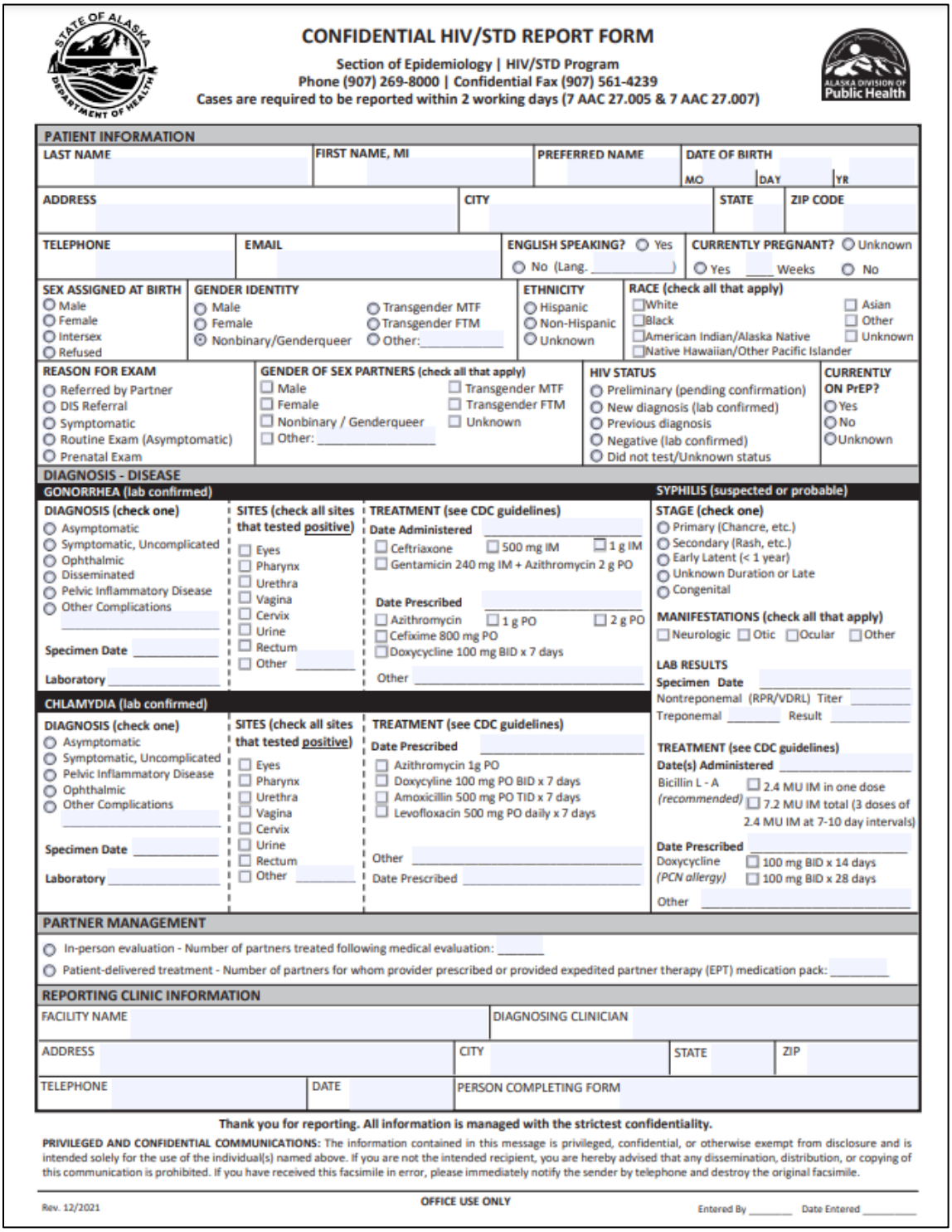
As of December 29, 2013, Health care providers **must also include** in their reports the **pregnancy status of women** who are suspected or confirmed to be infected with HIV or a reportable STD. Any new pregnancy in a woman known to be infected with HIV or syphilis is also reportable.

HIV/STD Report Form:
http://dhss.alaska.gov/dph/Epi/Documents/pubs/conditions/frmSTD.pdf

Contact:	Section of Epidemiology, HIV/STD Program
Telephone:	907-269-8000
Conf. Fax:	907-561-4239
Website:	http://dhss.alaska.gov/dph/Epi/hivstd/Pages/default.aspx
Mail:	3601 C St., Suite 540 Anchorage, AK 99503

Confidential HIV/STD Report Form

Please use the form located on the State of Alaska's HIV/STD Program website.
https://health.alaska.gov/dph/Epi/documents/pubs/conditions/frmSTD.pdf



CONFIDENTIAL HIV/STD REPORT FORM

Section of Epidemiology | HIV/STD Program
Phone (907) 269-8000 | Confidential Fax (907) 561-4239
Cases are required to be reported within 2 working days (7 AAC 27.005 & 7 AAC 27.007)

PATIENT INFORMATION

LAST NAME | FIRST NAME, MI | PREFERRED NAME | DATE OF BIRTH MO DAY YR

ADDRESS | CITY | STATE | ZIP CODE

TELEPHONE | EMAIL | ENGLISH SPEAKING? ○ Yes ○ No (Lang.) | CURRENTLY PREGNANT? ○ Unknown ○ Yes ___ Weeks ○ No

SEX ASSIGNED AT BIRTH
○ Male ○ Female ○ Intersex ○ Refused

GENDER IDENTITY
○ Male ○ Female ◉ Nonbinary/Genderqueer ○ Transgender MTF ○ Transgender FTM ○ Other:

ETHNICITY
○ Hispanic ○ Non-Hispanic ○ Unknown

RACE (check all that apply)
☐ White ☐ Black ☐ American Indian/Alaska Native ☐ Native Hawaiian/Other Pacific Islander ☐ Asian ☐ Other ☐ Unknown

REASON FOR EXAM
○ Referred by Partner ○ DIS Referral ○ Symptomatic ○ Routine Exam (Asymptomatic) ○ Prenatal Exam

GENDER OF SEX PARTNERS (check all that apply)
☐ Male ☐ Female ☐ Nonbinary / Genderqueer ☐ Other: ☐ Transgender MTF ☐ Transgender FTM ☐ Unknown

HIV STATUS
○ Preliminary (pending confirmation) ○ New diagnosis (lab confirmed) ○ Previous diagnosis ○ Negative (lab confirmed) ○ Did not test/Unknown status

CURRENTLY ON PrEP?
○ Yes ○ No ○ Unknown

DIAGNOSIS - DISEASE

GONORRHEA (lab confirmed)

DIAGNOSIS (check one)
○ Asymptomatic ○ Symptomatic, Uncomplicated ○ Ophthalmic ○ Disseminated ○ Pelvic Inflammatory Disease ○ Other Complications
Specimen Date
Laboratory

SITES (check all sites that tested positive)
☐ Eyes ☐ Pharynx ☐ Urethra ☐ Vagina ☐ Cervix ☐ Urine ☐ Rectum ☐ Other

TREATMENT (see CDC guidelines)
Date Administered
☐ Ceftriaxone ☐ 500 mg IM ☐ 1 g IM
☐ Gentamicin 240 mg IM + Azithromycin 2 g PO
Date Prescribed
☐ Azithromycin ☐ 1 g PO ☐ 2 g PO
☐ Cefixime 800 mg PO
☐ Doxycycline 100 mg BID x 7 days
Other

CHLAMYDIA (lab confirmed)

DIAGNOSIS (check one)
○ Asymptomatic ○ Symptomatic, Uncomplicated ○ Pelvic Inflammatory Disease ○ Ophthalmic ○ Other Complications
Specimen Date
Laboratory

SITES (check all sites that tested positive)
☐ Eyes ☐ Pharynx ☐ Urethra ☐ Vagina ☐ Cervix ☐ Urine ☐ Rectum ☐ Other

TREATMENT (see CDC guidelines)
Date Prescribed
☐ Azithromycin 1g PO
☐ Doxycyline 100 mg PO BID x 7 days
☐ Amoxicillin 500 mg PO TID x 7 days
☐ Levofloxacin 500 mg PO daily x 7 days
Other
Date Prescribed

SYPHILIS (suspected or probable)

STAGE (check one)
○ Primary (Chancre, etc.) ○ Secondary (Rash, etc.) ○ Early Latent (< 1 year) ○ Unknown Duration or Late ○ Congenital

MANIFESTATIONS (check all that apply)
☐ Neurologic ☐ Otic ☐ Ocular ☐ Other

LAB RESULTS
Specimen Date
Nontreponemal (RPR/VDRL) Titer
Treponemal Result

TREATMENT (see CDC guidelines)
Date(s) Administered
Bicillin L - A *(recommended)*
☐ 2.4 MU IM in one dose
☐ 7.2 MU IM total (3 doses of 2.4 MU IM at 7-10 day intervals)
Date Prescribed
Doxycycline *(PCN allergy)*
☐ 100 mg BID x 14 days
☐ 100 mg BID x 28 days
Other

PARTNER MANAGEMENT
○ In-person evaluation - Number of partners treated following medical evaluation: ____
○ Patient-delivered treatment - Number of partners for whom provider prescribed or provided expedited partner therapy (EPT) medication pack: ____

REPORTING CLINIC INFORMATION

FACILITY NAME | DIAGNOSING CLINICIAN

ADDRESS | CITY | STATE | ZIP

TELEPHONE | DATE | PERSON COMPLETING FORM

Thank you for reporting. All information is managed with the strictest confidentiality.

PRIVILEGED AND CONFIDENTIAL COMMUNICATIONS: The information contained in this message is privileged, confidential, or otherwise exempt from disclosure and is intended solely for the use of the individual(s) named above. If you are not the intended recipient, you are hereby advised that any dissemination, distribution, or copying of this communication is prohibited. If you have received this facsimile in error, please immediately notify the sender by telephone and destroy the original facsimile.

Rev. 12/2021 **OFFICE USE ONLY** Entered By _____ Date Entered _____

STD RECOMMENDATIONS

Chlamydia and Gonorrhea: Screening and Treatment

Any person who presents at your clinic specifically for STD screening, whether asked or referred, should be tested for all STDs (Chlamydia, Gonorrhea, Syphilis) as well as HIV, regardless of age, sex, or other risk factors.

Key Points:

- When screening for chlamydia and gonorrhea, make sure to swab the throat and rectum in anyone who uses those areas for sex.
- NAATs are the superior and recommended culture for both CT and GC.
- Expedited Partner Therapy (EPT) can be used for all heterosexual individuals with GC/CT, it can be considered in men who have sex with other men (MSM) but strongly encourage MSM partner testing.
- All patients who are seen or referred as a contact to a known exposure need to be screened and tested.

For general patient encounters, the CDC recommends the following screening.

Chlamydia Screening

Women

- Sexually active women under 25 years of age
- Sexually active women aged 25 years and older if at increased risk
- Retest approximately 3 months after treatment

Pregnant Persons

- All pregnant persons under 25 years of age
- Pregnant persons, aged 25 and older if at increased risk
- Retest during the 3rd trimester for persons under 25 years of at or at risk
- Pregnant persons with chlamydial infection should have a test-of-cure 3-4 weeks after treatment and be retested within 3 months

Men

- Consider screening young men in high prevalence clinical settings or in populations with high burden of infection (e.g., MSM)

Men who have sex with men (MSM)

- At least annually for sexually active MSM at sites of contact (urethra, rectum, pharyngeal) regardless of condom usage
- Every 3-6 months if at increased risk

Persons living with HIV

- 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 local epidemiology

Transgender and Gender Diverse Persons

- Consider screening at least annually based on reported sexual behaviors and exposure

Gonorrhea Screening

Women

- Sexually active women under 25 years of age
- Sexually active women aged 25 years and older if at increased risk
- Retest approximately 3 months after treatment

Pregnant Persons

- All pregnant persons under 25 years of age
- Pregnant persons, aged 25 and older if at increased risk

Men

- No screening recommendations

Men who have sex with men (MSM)

- At least annually for sexually active MSM at sites of contact (urethra, rectum, pharyngeal) regardless of condom usage
- Every 3-6 months if at increased risk

Persons living with HIV

- 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 local epidemiology

Transgender and Gender Diverse Persons

- Consider screening at least annually based on reported sexual behaviors and exposure

Expedited Partner Therapy (EPT)

Expedited Partner Therapy is the clinical practice of treating the sex partner[s] of a patient diagnosed with chlamydia or gonorrhea by providing prescriptions or medications to the patient to take to their partner without the health care provider first examining the partner. EPT is permissible under Alaska state law.

The standard approach to partner treatment has included clinical evaluation in a health care setting, with partner notification accomplished by the index patient, by the provider, or by a Disease Intervention Specialist (DIS). Provider-assisted referral is considered the optimal strategy for partner treatment but is not always available to most patients with gonorrhea or chlamydial infection. **The CDC has concluded that EPT is a useful option to facilitate partner management, particularly for treatment of male partners of women with chlamydial infection or gonorrhea.**

When to administer EPT:

- EPT is appropriate for heterosexual patients with GC/CT whose partner[s] treatment cannot be ensured or is unlikely.
- EPT should be prescribed to all partners within the past 60 days of the patient's diagnosis.

    - If no sexual contact within 60 days, attempt to treat the most recent partner
- EPT is not considered ideal for MSM
    - Concern for missing HIV and Syphilis if MSM partners are not individually screened

EPT Treatment Recommendations

Partners should be highly encouraged to present for testing and treatment. However, if partners will not or cannot present, the following should be prescribed.

EPT Treatment Recommendations

Exposure to GC and CT

- Cefixime 800 mg PO x 1 *and* Doxycycline 100 mg PO x 7 days

Exposure to GC Alone

- Cefixime 800 mg PO x 1

Exposure to CT Alone

- Doxycycline 100 mg PO x 7 days

Note

- If any concern about partner's adherence to Doxycycline or possible pregnancy, Azithromycin 1 gm PO is acceptable as an alternative to Doxycycline.

Follow-Up After Chlamydia and/or Gonorrhea Diagnosis

1) Counseling: Advise patient they need to abstain from sex for 7 days after single-dose therapy or until the completion of 7-day treatment course by patient and partners.
2) Treat Partners – if partner exposure was within last 60 days. If last sexual contact was >60 days, most recent partner should be given EPT.
3) Test patient and partners for HIV, and Syphilis
4) Report infection to Public Health
5) Test of Cure is only recommended if adherence is in question, symptoms persist, reinfection is suspended, or patient is pregnant.
    - Test of Cure is recommended for all pharyngeal GC
    - A false positive may occur if repeat NAAT done prior than 3 weeks after completion of therapy

2021 CDC Chlamydia and Gonorrhea Treatment Guidelines

Uncomplicated Chlamydia

Recommended

- Doxycycline 100mg PO BID x 7 days
- Pregnant: Azithromycin 1gm PO, single dose, directly observed

Alternatives

- Azithromycin 1gm PO, single dose, directly observed
- Levofloxacin 500 mg PO Qday x 7 days, *OR*

Note

- Doxycycline is better than Azithromycin for rectal infection
- Oropharyngeal infection treatment is the same as urogenital

Uncomplicated Gonorrhea

Recommended

- Ceftriaxone 500 mg IM as a single dose for persons weight <150 kg
- *For persons weighing ≥150 kg, 1 g of IM ceftriaxone should be administered
- **This is the only regimen recommended for pharyngeal infection

Alternatives

- For cephalosporin allergy: Gentamicin 240 mg IM as a single dose PLUS Azithromycin 2 g orally as a single dose
- OR if ceftriaxone administration is not available or feasible: Cefixime 800 gm orally as a single dose

Note

- Gentamicin and Azithromycin are no longer recommended for pharyngeal GC

Taking Your Patient's Sexual History

Adapted from the CDC's "A Guide to Taking A Sexual History".

For a more complete picture of your patient's health, the following guide put forth by the CDC offers parameters for discussion of sexual health issues. A sexual history needs to be taken during a patient's initial visit, during routine preventive exams, and when you see signs of sexually transmitted diseases (STDs). The dialogue lends itself to the opportunity for risk-reduction counseling and sharing of information about behaviors that may place your patient a risk of contracting STDs. A sexual history allows you to identify those individuals at risk for STDs, including HIV, and to identify appropriate anatomical sites for certain STD tests.

Please Note: This guide is meant to provide you with a sample of the discussion points and questions that may be asked. It is not meant to be a standard for diagnosis or a complete reference for sexual history taking. This guide may need to be modified to be culturally appropriate for some patients based on culture or gender dynamics.

Taking A Sexual History

Some patients may not be comfortable talking about their sexual history, sex partners, or sexual practices. Try to put patients at ease and let them know that taking a sexual history is an important part of a regular medical exam or physical history.

- Dialogue with Patient
    - I am going to ask you a few questions about your sexual health and sexual practices. I understand that these questions are very personal, but they are important for your overall health.

- Just so you know, I ask these questions to all of my adult patients, regardless of age, gender, or marital status. These questions are as important as the questions about other areas of your physical and mental health. Like the rest of our visits, this information is kept is strict confidence. Do you have any questions before we get started?

The 5 "P"s of Sexual Health

These are the areas that you should openly discuss with your patients. You probably will need to ask additional questions that are appropriate to each patient's special situation or circumstances.

The five "P"s stand for:

- **Partners:** To assess the risk of contracting an STD, it is important to determine the number and gender of your patient's sex partners. Remember: never make assumptions about your patient's sexual orientation.
    - If only 1 sex partner is noted over the last 12 months, be certain to inquire about the length of the relationship. Ask about the partner's risk factors, such as current or past sex partners or drug use.
    - If more than one partner is noted in that last 12 months, be certain to explore for more specific risk factors, such as condom use (or non-use) and partner risk factors.
    - Dialogue with Patient
        - Are you currently sexually active? (are you having sex?)
            - If no, have you ever been sexually active?
        - In recent months, how many sex partners have you had?
        - In the past 12 months, how many sex partners have you had?
        - Are you sex partners men, women, or both?
            - If a patient answers "both" repeat first two questions for each specific gender.
    - If a patient has been sexually active in the past, but is not currently active, it is still important to take a sexual history.
- **Practices:** If a patient has had more than one sex partner in the past 12 months or has had sex with a partner who has other sex partners, you may want to explore further his or her sexual practice and condom use.
    - Asking about other sex practices will guide the assessment of patient risk, risk-reduction strategies, the determination of necessary testing, and the identification of anatomical sites from which to collect specimens for STD testing.
    - Dialogue with Patient
        - I am going to be more explicit here about the kind of sex you've had over the last 12 months to better understand if you are at risk for STDs.

        - What kind of sexual contact do you have, or have you had? Genital (penis in the vagina)? Anal (penis in the anus)? Oral (mouth on penis, vagina, or anus)?
- **Protection from STDs:** To learn more about the patient's sexual practices, use open-ended questions. Based on the answer, you may discern which direction to take the dialogue. You will need to determine the appropriate level or risk-reduction counseling for each patient. If a patient is in a monogamous relationship that has lasted for more than 12 months, risk-reduction counseling may not be needed. However, in other situations, you may need to explore the subjects of abstinence, monogamy, condom use, the patient's perception of his or her own risk and his or her partner's risk, and the issues of testing for STDs.
    - Dialogue with Patient
        - Do you and your partner(s) use any protection against STDs?
            - If not, could you tell me the reason?
        - If so, what kind of protection do you use?
        - How often do you use this protection?
            - If "sometimes," in what situations or with whom do you use protection?
            - Do you have any other questions, or are there other forms of protection from STDs that you would like to discuss today?
- **Past History of STDs:** A history of prior STDs may place your patient at greater risk now.
    - Dialogue with Patient
        - Have you ever been diagnosed with an STD? When? How were you treated?
        - Have you had any recurring symptoms or diagnoses?
        - Have you ever been tested for HIV, or other STDs? Would you like to be tested?
        - Has your current partner or any former partners ever been diagnosed or treated for an STD? Were you tested for the same STD(s)?
            - If yes, when were you tested? What was the diagnosis? How was it treated?
- **Prevention of Pregnancy:** Based on partner information from the prior section, you may determine that the patient is at risk of becoming pregnant or of fathering a child. If so, first determine if pregnancy is desired. Questions should be gender appropriate.
    - Dialogue with Patient
        - Are you currently trying to conceive or father a child?
        - Are you concerned about getting pregnant or getting your partner pregnant?
        - Are you using contraception or practicing any form of birth control? Do you need any information on birth control?

SYPHILIS RECOMMENDATIONS

Syphilis: Screening and Testing

Any person who presents at your clinic specifically for STD screening, whether asked or referred, or if you suspect any STD, the patient should be tested for all STDs (Chlamydia, Gonorrhea, Syphilis, and HSV if applicable) as well as HIV, regardless of age, sexual behaviors, or other risk factors.

Key Points:

- All pregnant persons should be screened for syphilis during their first prenatal visit regardless of risk factors and throughout pregnancy if at increased risk.
- Penicillin allergies should be verified if possible, before providing alternative treatment of Doxycycline.
- Providers should document all signs and symptoms they believe to be associated with syphilis—including chancres that may present similarly to HSV.
- Any patient seen for any sexual health concern should be tested for syphilis, even if there are no visible signs or symptoms.
- If you suspect a patient is presenting with HSV, syphilis testing and presumptive treatment should be ordered as a preventative precaution.

For general patient encounters, the CDC recommends the following screening

Syphilis

Pregnant Persons

- All pregnant persons at their first prenatal visit
- Retest early in the third trimester and at delivery if at high risk

Men who have sex with men (MSM)

- At least annually for sexually active MSM
- Every 3-6 months if at increased risk

Persons living with HIV

- 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 local epidemiology

Women

- Screen asymptomatic women at increased risk (history of incarceration or transactional sex work, geography, race/ethnicity) for syphilis infection

Men Who Have Sex with Women

- Screen asymptomatic men at increased risk (history of incarceration or transactional sex work, geography, race/ethnicity) for syphilis infection

Transgender and Gender Diverse People

- Consider screening at least annually based on reported sexual behaviors and exposure

For testing and diagnosis of syphilis, two serological tests are required:

1) A nontreponemal antibody test (RPR)
2) A treponemal antibody tests (TP-PA, FTA-ABS, EIA, etc.)

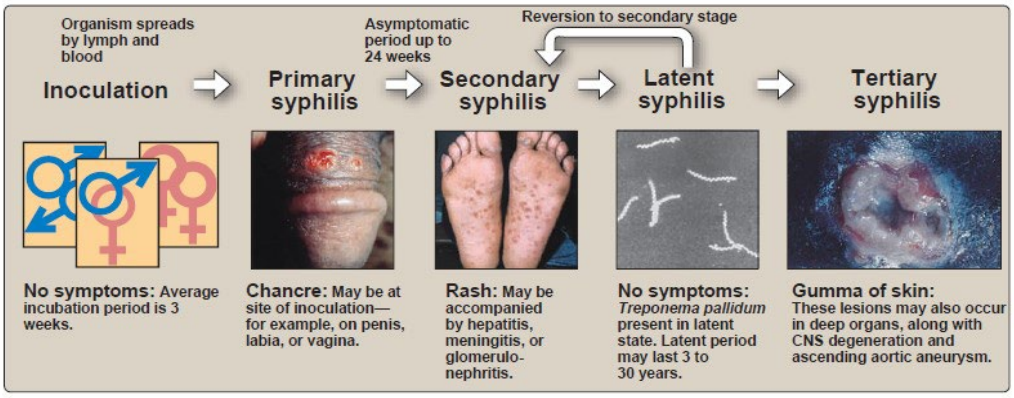
For ease in testing, we recommended ordering the RPR with reflex to titer and confirmatory testing or ordering both tests (RPR and treponemal) simultaneously.

Both tests are required as the RPR detects antibodies that are not specifically directed against the *Treponemal pallidum* bacteria. Reactive RPRs may be a biological false positive and require the treponemal test for confirmation.

If you have any questions regarding syphilis testing or treatment, please contact:
HIV/STD Program (907) 269-8000.

As a reminder, it is your legal responsibility to report within the required timeframe and provide information necessary for public health investigation of communicable disease. Reliance on laboratory reporting is NOT a substitute. Under Alaska State laws, the reporting of communicable diseases to the local public health department is exempt from HIPPA (Section 164.512 (b)). Patient consent is NOT required. Patient information is always treated with strict confidentiality, and information requested is the minimum necessary for public health purposes.

Clinical Symptoms of Syphilis



1. **Primary Syphilis**

   During the primary stage of syphilis, the patient may have single or multiple sores, chancres, or lesions. The sore is the location where syphilis entered the patient's body. Sores are usually (but not always) firm, round, and painless. Because the sore is painless, it can easily go unnoticed. The sore usually lasts 3 to 6 weeks and heals regardless of whether or not the patient received treatment. Even after the sore goes away, you must the patient must receive adequate treatment. This will stop the infection from progressing. The patient is very infectious during this stage.

2. **Secondary Syphilis**

   During the secondary stage, the patient may have skin rashes and/or mucous membrane lesions. Mucous membrane lesions are sores in the mouth, vagina, or anus. This stage usually starts with a rash on one or more areas of the body. The rash can show up when the primary sore is healing or several weeks after the sore has healed. The rash can look like rough, red, or reddish-brown spots on the palms of hands and/or the bottoms of feet. The rash usually does not itch, and it is sometimes so faint that it goes unnoticed. Other symptoms can include fever, swollen lymph glands, sore throat, patchy hair loss, headaches, weight loss, muscle aches, and fatigue. The symptoms from this stage will go away whether or not the patient receives treatment. Without the right treatment, the infection will move to latent stages of syphilis. The patient is very infectious during this stage.

3. **Unknown or Latent Syphilis**

   The latent stage of syphilis is the period of syphilis when there are no visible signs or symptoms of syphilis. If the patient is not tested and therefore does not receive treatment, they will continue to live with the bacteria in their body without any signs or symptoms. Although the patient is not infectious during this stage, it is extremely important adequate treatment is provided to stop the progression of the infection.

4. **Neurosyphilis and Ocular Syphilis**

   Without treatment, syphilis can spread to the brain and nervous system (neurosyphilis) or to the eyes and inner ears (ocular and otic syphilis). This can happen during any stage of syphilis and typically requires a lumbar puncture and VDRL for confirmation. Treatment for neurosyphilis is different than non-neurosyphilis. All patients with reactive syphilis labs should be screened for neurosyphilis and cautiously treated accordingly if ocular or otic symptoms are present. Symptoms of neurosyphilis include:

   - Severe headache—irregular, frequent and/or prolonged
   - Difficulty breathing
   - Paralysis
   - Numbness
   - Dementia
   - Vision changes—blurred and/or loss of vision, eye pain, light sensitivity
   - Hearing changes—loss of or muffled hearing

Syphilis Staging, Symptoms, and Treatment

Signs and symptoms of syphilis can easily be confused with other medical issues. Providers must document all related signs and symptoms to help assist with staging of the patient's infection period.

PRIMARY SYPHILIS

Symptom[s]: Painless lesion in genitalia or other part of body (can be found on hands, feet, tongue – wherever the exposure to the syphilis bacteria occurred). **Treatment:** Benzathine penicillin G—2.4 million units, IM x 1.

SECONDARY SYPHILIS

Symptom[s]: Rash (palmer/planter and/or generalized body rash), condyloma lata, alopecia (patches of hair loss), lymphadenopathy. **Treatment:** Benzathine penicillin G—2.4 million units, IM x 1.

EARLY LATENT SYPHILIS

Symptom[s]: No signs or symptoms and a documented negative lab results or seroconversion or documented 2-fold increase in titer within the last twelve months OR self-reported history of symptoms consistent with primary or secondary syphilis during the previous 12 months. **Treatment:** Benzathine penicillin G—2.4 million units, IM x 1.

LATE LATENT SYPHILIS

Symptom[s]: No symptoms and no documented lab results within a year form when they were tested. **Treatment:** Benzathine penicillin G—2.4 million units, IM x 3, at 1-week intervals (totaling 7.2 million units).

If 2nd or 3rd dose is given more than 10 days after previous dose, the patient must restart series from the beginning. Pregnant persons must get all 3 doses EXACTLY 7 days apart. If an allergy is confirmed in a pregnant patient, the patient MUST be desensitized and treated with Benzathine penicillin G.

NEUROSYPHILIS/OCULAR/OTIC SYPHILIS

Symptom[s]: Occurs when the infection has entered the cerebral spinal fluid and/or brain. This can happen at ANY stage. **Treatment:** Aqueous crystalline penicillin G 18–24 million units per day, administered as 3–4 million units IV every 4 hours or continuous infusion for 10–14 days. **Alternative Regimen:** Procaine penicillin G 2.4 million units IM once daily PLUS Probenecid 50 mg orally 4 times/day, both for 10-14 days

Special Considerations

Penicillin Allergy

Data to support use of alternatives to penicillin in treating primary and secondary syphilis are limited. However, multiple therapies might be effective for nonpregnant persons with penicillin allergy who have primary or secondary syphilis. **Doxycycline (100 mg orally 2 times/day for 14 days) is the preferred alternative**, however, tetracycline (500 mg orally 4 times/day for 14 days) has historically been used. Compliance is likely to be better with doxycycline than tetracycline because tetracycline can cause more gastrointestinal side effects and requires more frequent dosing. Limited clinical studies, along with biologic and pharmacologic evidence, indicate that ceftriaxone (1 g daily either IM or IV for 10 days) is effective for treating primary and secondary syphilis; however, the optimal dose and duration of ceftriaxone therapy have not been defined (*602*,*603*). Azithromycin as a single 2-g oral dose has been effective for treating primary and secondary syphilis among certain populations (*602*,*604*,*605*). However, because of *T. pallidum* chromosomal mutations associated with azithromycin and other macrolide resistance and documented treatment failures in multiple U.S. geographic areas, azithromycin should not be used as treatment for syphilis (*606*–*608*). Thorough clinical and serologic follow-up of persons receiving any alternative therapy is essential.

Persons with a penicillin allergy whose compliance with therapy or follow-up cannot be ensured should be desensitized and treated with benzathine penicillin G. Skin testing for penicillin allergy might be useful in circumstances in which the reagents and expertise are available for performing the test adequately (see Management of Persons Who Have a History of Penicillin Allergy).

Pregnancy

Pregnant persons with primary or secondary syphilis who are allergic to penicillin should be desensitized and treated with penicillin G. Skin testing or oral graded penicillin dose challenge might be helpful in identifying women at risk for acute allergic reactions (see

Management of Persons Who Have a History of Penicillin Allergy; Syphilis During Pregnancy).

HIV Infection

Persons with HIV infection who have primary or secondary syphilis should be treated similarly to those without HIV.

**For more information regarding treatment guidelines, see the CDC's Sexually Transmitted Infections Treatment Guidelines, 2021*

Congenital Syphilis Overview

Per the CDC: https://www.cdc.gov/std/syphilis/stdfact-congenital-syphilis.htm

Congenital Syphilis (CS) is a disease that occurs when a mother who is infected with untreated syphilis passes the infection on to her baby during pregnancy.

CS can have major health impacts on the baby, but how CS affects a baby's health depends on how long the mother had syphilis and if, or when, she received treatment for the infection.

Congenital Syphilis can cause:

- Miscarriage
- Still birth
- Prematurity
- Low birth weight
- Death shortly after birth

Up to 40% of babies born to women with untreated syphilis may be stillborn or die from the infection as a newborn.

For babies born with Congenital Syphilis, CS can cause:

- Deformed bones
- Severe anemia
- Enlarged liver and spleen
- Jaundice
- Brain and nerve problems, like blindness or deafness
- Meningitis
- Skin rashes

All pregnant persons should be tested for syphilis at their first prenatal visit. Some women should be tested more often during their pregnancy depending on their risk factors.

Reminder, there is no alternative treatments for syphilis for pregnant persons. All treatment must be done with Benzathine penicillin G**.**

Congenital Syphilis Evaluation and Treatment for Infants

Per CDC recommendations: https://www.cdc.gov/std/tg2015/congenital.htm

Scenario 1: Proven or Highly Probable Congenital Syphilis

Any neonate with:

1. An abnormal physical examination that is consistent with congenital syphilis.
   OR
2. A serum quantitative nontreponemal serologic titer that is 4-fold higher than the mother's titer.
   OR
3. A positive darkfield test or PCR of lesions of body fluids (these are not typically performed in Alaska)

*The absence of a 4-fold or greater titer for a neonate does not exclude congenital syphilis.

Recommended Evaluation:

- CSF analysis for VDRL, cell count, and protein
- Complete blood count (CBC) and differential and platelet count
- Other tests as clinically indicated (e.g., long-bone radiographs, chest radiograph, liver function tests, neuroimaging, ophthalmologic examination, and auditory brain stem response).

Recommended Treatment

- **Aqueous crystalline penicillin** G 100,000-150,000 units/kg/day, administered as 50,000 units/kg/dose IV every 12 hours during the first 7 days of life and every 8 hours thereafter for a total of 10 days
  OR
- **Procaine penicillin G** 50,000 units/kg/dose IM in a single daily dose for 10 days

Scenario 2: Possible Congenital Syphilis

Any neonate who has a normal physical examination and a serum quantitative nontreponemal serologic titer equal to or less than 4-fold the maternal titer and one of the following:

1) Mother was not treated, inadequately treated, or has no documentation of having received treatment.
   OR
2) Mother was treated with erythromycin or a regiment other than those recommended in by CDC guidelines,
   OR
3) Mother received recommended treatment <4 weeks before delivery

Recommended Evaluation

- CSF analysis for VDRL, cell count, and protein
- CBC, differential, and platelet count
- Long-bone radiographs

A complete evaluation is not necessary if 10 days of parenteral therapy is administered, although such evaluations might be useful. For instance, a lumbar puncture might document CSF abnormalities that would prompt close follow-up. Other tests (e.g., CBC, platelet count, and bone radiographs) can be performed to further support a diagnosis of congenital syphilis.

Recommended Treatment

- **Aqueous crystalline penicillin G** 100,000-150,000 units/kg/day administered as 50,000 units/kg/dose IV every 12 hours during the first 7 days of life and every 8 hours thereafter for a total of 10 days.
  OR
- **Procaine penicillin G** 50,000 units/kg/dose IM in a single daily dose for 10 days
  OR
- **Benzathine penicillin G** 50,000 units/kg/dose IM in a single dose

Scenario 3: Congenital Syphilis Less Likely

Any neonate who has a normal physical examination and a serum quantitative nontreponemal serologic titer equal to or less than fourfold the maternal titer and both of the following are true:

1) Mother was treated during pregnancy, treatment was appropriate for the stage of infection, and treatment was administered >4 weeks before delivery and
2) Mother has not evidence of reinfection or relapse

Recommended Evaluation

No evaluation is recommended.

Recommended Treatment

- **Benzathine penicillin G** 50,000 units/kg/dose IM in a single dose

Scenario 4: Congenital Syphilis Unlikely

Any neonate who has a normal physical examination and a serum quantitative nontreponemal serologic titer equal to or less than fourfold the maternal titer and both of the following are true:

1) Mother's treatment was adequate before pregnancy and
2) Mother's nontreponemal serologic titer remained low and stable before and during pregnancy and at delivery

Recommended Evaluation

No evaluation is recommended.

Recommended Treatment

No treatment is required, but infants with reactive nontreponemal tests should be followed serologically to ensure the nontreponemal test returns negative. Benzathine penicillin G 50,000 units/kg as a single IM injection might be considered, partially if follow-up is uncertain and the neonate has reactive nontreponemal test.

HIV/AIDS

HIV: Screening and Testing

The CDC recommends that everyone between the ages of 13 and 64 get tested for HIV at least once during their lifetime as part of routine health care. For people with certain risk factors, such as gay, bisexual, and other men who have sex with men, transgender persons, and people who inject substances, CDC recommends getting tested at least once a year. Data from the National Institute of Health shows clear benefits to being diagnosed with HIV early and starting treatment right away. This information also highlights the importance of routine HIV testing and its potential impact on better health outcomes.

Key Points

- All patients should be screened at least one time during their lifetime
- Reference the HIV Testing Algorithm for ordering tests and diagnosing HIV
- Viral Suppression is the goal of HIV treatment. An undetectable viral load means a person cannot transmit HIV to their partner.
- STD testing should be performed routinely to reduce the chance of coinfections.
- Guidelines for HIV testing continue to evolve with changes in testing technology and methods to reach persons who can benefit from these services. Visit https://www.cdc.gov/hiv/guidelines/testing.html for a complete list of the most updated CDC guidelines on HIV testing.

Importance of HIV Testing for Prevention of HIV Infection

People with HIV who know their status can get HIV treatment (antiretroviral therapy or ART) and remain healthy for many years. Studies show that the sooner people start HIV treatment after diagnosis, the more they benefit. HIV treatment reduces the amount of HIV in the blood (viral load), reduces HIV-related illness, and prevents transmission to others. People with HIV who take HIV treatment as prescribed and get and keep an undetectable viral load (or stay virally suppressed) will not transmit HIV.

HIV Tests for Screening and Diagnosis

HIV tests are very accurate, but how soon a test can detect HIV depends on the type of test being used. There are three types of HIV tests: antibody tests, antigen/antibody tests, and nucleic acid tests (NAT).

- **Antibody tests** look for antibodies to HIV in the person's blood or oral fluid. Antibody tests can take 23 to 90 days to detect HIV after exposure. Most rapid tests and the only FDA-approved HIV self-test are antibody tests. In general, antibody tests that used blood from a vein can detect HIV sooner after infection than tests done with blood from a finger stick or with oral fluid.
- **Antigen/Antibody** tests look for both HIV antibodies and antigens. Antibodies are produced by a person's immune system when they are exposed to viruses like HIV. Antigens are foreign substances that cause a person's immune system to activate. If a person has HIV, an antigen called p24 is produced before antibodies develop. Antigen/antibody tests are recommended for testing done in labs and are common in the United States. An antigen/antibody test performed by a lab on blood from a vein can usually detect HIV in 18

to 45 days after exposure. There is also a rapid antigen/antibody test, however due to morbidity, this test is not recommended for use in Alaska.

- **NATs** look for the actual HIV virus in the blood. This test should be considered for people who had a recent exposure or a possible exposure with early symptoms of HIV and have tested negative with an antibody or antigen/antibody test. A NAT can usually detect HIV 10 to 33 days after exposure.

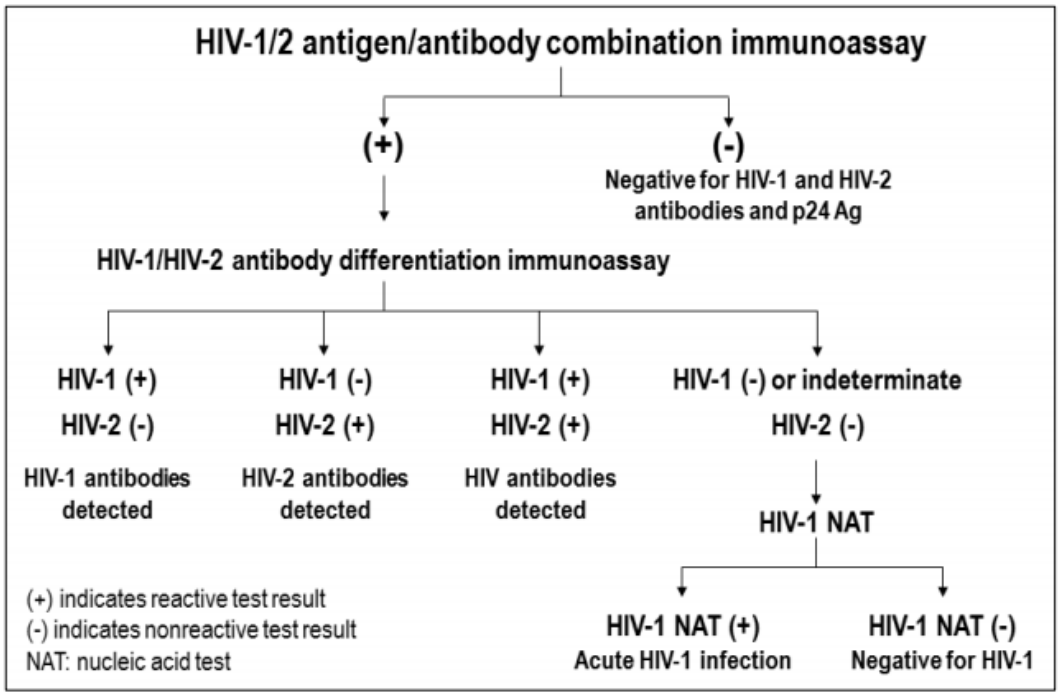
If you have any questions regarding syphilis testing or treatment, please contact:
HIV/STD Program (907) 269-8000.

As a reminder, it is your legal responsibility to report within the required timeframe and provide information necessary for public health investigation of communicable disease. Reliance on laboratory reporting is NOT a substitute. Under Alaska State laws, the reporting of communicable diseases to the local public health department is exempt from HIPPA (Section 164.512 (b)). Patient consent is NOT required. Patient information is always treated with strict confidentiality, and information requested is the minimum necessary for public health purposes.

HIV Testing Algorithm

An initial HIV test will usually be either an antigen/antibody or an antibody test. If the initial HIV test is a rapid or self-test and it is positive, the person should go to a health care provider to get follow-up testing. If the initial HIV test is a lab test and it is positive, the lab will usually conduct follow-up testing on the same blood sample as the initial test. Although HIV tests are generally accurate, follow-up tests allow the health care provider to confirm the results.

Recommended Laboratory HIV Testing Algorithm for Serum or Plasma Specimens (CDC)



1. Laboratories should conduct initial testing for HIV with an FDA-approved antigen/antibody combination immunoassay that detects HIV-1 and HIV-2 antibodies and HIV-1 p24 antigen to test for established HIV-1 or HIV-2 infection and for acute HIV-1 infection. No further testing is required for specimens that are nonreactive on the initial immunoassay.
2. Specimens with a reactive antigen/antibody combination immunoassay result (or repeatedly reactive, if repeat testing is recommended by the manufacturer or required by regulatory authorities) should be tested with an FDA-approved antibody immunoassay that differentiates HIV-1 antibodies from HIV-2 antibodies. Reactive results on the initial antigen/antibody combination immunoassay and the HIV-1/HIV-2 antibody differentiation immunoassay should be interpreted as positive for HIV-1 antibodies, HIV-2 antibodies, or HIV antibodies, undifferentiated.
3. Specimens that are reactive on the initial antigen/antibody combination immunoassay and nonreactive or indeterminate on the HIV-1/HIV-2 antibody differentiation immunoassay should be tested with an FDA-approved HIV-1 nucleic acid test (NAT).
    - A reactive HIV-1 NAT result and a nonreactive HIV-1/HIV-2 antibody differentiation immunoassay result indicates laboratory evidence for acute HIV-1 infection

- A reactive HIV-1 NAT result and indeterminate HIV-1/HIV-2 antibody differentiation immunoassay result indicates the presence of HIV-1 infection confirmed by HIV-1 NAT.
- A negative HIV-1 NAT result and a nonreactive or indeterminate HIV-1/HIV-2 antibody differentiation immunoassay result indicates a false-positive result on the initial immunoassay.

4. Laboratories should use this same testing algorithm, beginning with an antigen/antibody combination immunoassay, with serum or plasma specimens submitted for testing after a reactive (preliminary positive) result from any rapid HIV test.

HIV Staging and Symptoms

When people with HIV do not receive treatment, they typically progress through three stages of the virus. However, HIV treatment can slow or prevent progression of the disease. With advancements in HIV treatment, progression to Stage 3 (AIDS) is less common today than in the early years of HIV.

1. **Stage 1: Acute HIV Infection**
   Acute HIV infection is the earliest stage of HIV infection, generally developing within 2 to 4 weeks after infection. During this time, some people have flu-like symptoms, such as fever, headache, and rash. In the acute stage of infection, HIV multiplies rapidly and spreads throughout the body. The virus attacks and destroys the infection fighting CD4 cells of the immune system. During the acute HIV infection stage, the level of HIV in the blood is very high, which greatly increases the risk of HIV transmission. A person may experience significant health benefits if they start ART during this stage.

2. **Stage 2: Chronic HIV Infection**
   The second stage of HIV infection is chronic HIV infection (also called asymptomatic HIV infection or clinical latency). During this stage, HIV continues to multiply in the body but at very low levels. People with chronic HIV infection may not have any HIV-related symptoms. Without ART, chronic HIV infection usually advances to AIDS in 10 years or longer, though some people it may advance faster. People who are taking ART may be in this stage for several decades. While it is still possible to transmit HIV to others during this stage, people who take ART exactly as prescribed and maintain an undetectable viral load have effectively no risk of transmitting HIV to an HIV-negative partner though sex.

3. **Stage 3: AIDS**
   AIDS is the final, and most severe stage of HIV infection. Because HIV has severely damaged the immune system, the body cannot fight off opportunistic infections. (Opportunistic infections are infections and infection-related cancers that occur more frequently or are more severe in people with weakened immune systems than in people with healthy immune systems.) People with HIV are diagnosed with AIDS if they have a CD4 count of less than 200 cells/mm3 or if they have certain opportunistic infections. Once a person is diagnosed with AIDS, they can have a high viral load and are able to transmit HIV to others very easily. Once a person is diagnosed with AIDS, they're diagnosis will never revert to HIV, even if their viral load decreases, or they become virally suppressed. Without treatment, people with AIDS typically survive about 3 years.

HIV Treatment and Care

Antiretroviral therapy (ART) reduces HIV-related morbidity and mortality at all stages of HIV infection and reduces HIV transmission. When taken consistently as prescribed, ART can suppress viral load, maintain high CD4 cell counts, prevent AIDS, prolong survival, and reduce risk of transmitting HIV to others. Current treatment guidelines recommend ART for all people with HIV, regardless of CD4 cell count. ART should be started as soon as possible after diagnosis and should be accompanied by patient education regarding the benefits and risks of ART and the importance of adherence to ART.

ART Initiation

As health care providers, you play a crucial role in helping patients initiate ART, including describing the benefits of early initiation of ART, offering and prescribing ART, helping to manage long-term ART use, and providing information on other interventions that can reduce HIV transmission risk.

By engaging patients in brief conversations every office visit, providers can emphasize the benefits of consistent, long-term adherence to their prescribed ART regimen and the potential consequence of nonadherence. One way health care providers can enhance communication is to ask their patients open-ended questions during their office visits. Examples of questions to ask about initiating ART include:

- "What have you heard about HIV medicines?"
- "What are the most important results you hope to get form treatment?"
- "What are you concerns about HIV medicines?"

ART Adherence and Viral Suppression

The success of ART is contingent on adherence to achieve and maintain viral suppression. Data show, however, that not all persons living with HIV (PLWH) on ART are virally suppressed, while even fewer maintain viral suppression over time. Health care providers can positively impact ART adherence among PLWH by engaging in regular conversations at every office visit to identify ART adherence barriers, offer adherence support services, and provide information on other interventions that can improved patient adherence and reduce HIV transmission to others.

Viral Load Monitoring

Plasma HIV RNA viral load should be measured regularly to confirm initial and sustained response to ART. Most patients taking ART as prescribed achieve viral suppression within six months. The frequency of viral load testing depends on several factors. Current guidelines recommend viral load monitoring as follows:

- With initiation of ART (before initiation and within 2 to 4 weeks after treatment initiation, followed by 4 to 8-week intervals until the levels become undetectable).
- After ART modification due to suboptimal response (within 2 to 4 weeks after treatment modification, followed by 4 to 8-week intervals until the levels become undetectable).
- After ART modification due to toxicity or need for regiment simplification (within 4 to 8 weeks after changing therapy).

- In patients on a stable, suppressive ART regiment (ever 3 to 4 months, or every 6 months if virally suppressed for more than 2 years, to confirm durable viral suppression).
- In patients with suboptimal response (frequency depends on clinical circumstances).

Patients may experience a temporary increase or "blip" in their viral load, defined as viral loads transiently detectable at low levels. These blips usually go back down by the next viral load test. Patients who are using viral suppression as their primary prevention method and experience a blip may benefit from other prevention strategies until their viral load is undetectable again. These prevention strategies could include condoms and pre-exposure prophylaxis (PrEP) for HIV-negative partners.

FDA-Approved HIV Medicines

A full list of HIV medicines recommended for the treatment of HIV infection in the United States, based on the U.S. Department of Health and Human Services (HHS) HIV/AIDS medical practice guidelines can be found online. Please visit https://hivinfo.nih.gov/understanding-hiv/fact-sheets/fda-approved-hiv-medicines for a list of HIV medicines that are approved by the U.S. Food and Drug Administration (FDA).

HIV/STD Coinfections

STD preventive services are an essential component of HIV prevention and care. Providers should engage patients in regular conversations about STDs, including reviewing sexual history and STD symptoms, at every visit. Patients with HIV should be screened for STDs at least annually, and more frequently if they or their sexual partners have multiple or anonymous sex partners. Certain STDs can increase HIV viral load and genital HIV shedding, which may increase the risk of sexual and perinatal HIV transmission.

People living with HIV are also at risk for a variety of opportunistic infections such as TB and hepatitis virus. These risks can be reduced by viral suppression and a number of other prevention and harm reduction behaviors.

PrEP & PEP FOR HIV PREVENTION

Pre-Exposure Prophylaxis (PrEP)

PrEP is an antiretroviral medication used to prevent HIV infection. PrEP is used by people without HIV who may be exposed to HIV through sex or injection drug use. The FDA has approved three medications for use as PrEP, which are listed below. Two consist of a combination of drugs in a single oral tablet taken daily. The third medication is a medication given by injection every 2 months.

1. Emtricitabine (F) 200 mg in combination with tenofovir disoproxil fumarate (TDF) 300 mg (F/TDF – brand name Truvada® or generic equivalent).
2. Emtricitabine (F) 200 mg in combination with tenofovir alafenamide (TAF) 25 mg (F/TAF – brand name Descovy®).
3. Cabotegravir (CAB) 600 mg injection (brand name Apretude®).

These medications are approved to prevent HIV infection in adults and adolescents weighing at least 35 kg (77lbs) as follows:

- Daily oral PrEP with F/TDF is recommended to prevent HIV infection among all people at risk through sex or injection drug use.
- Daily oral PrEP with F/TAF is recommended to prevent HIV infection among people at risk through sex, excluding people at risk through receptive vaginal sex. F/TAF has not yet been studied for HIV prevention for people assigned female at birth who could get HIV through receptive vaginal sex.
- Injectable PrEP with CAB is recommended to prevent HIV infection among all people at risk through sex. It may be especially useful for people who have problems taking oral PrEP as prescribed, who prefer getting a shot every 2 months instead of taking oral PrEP, or who have serious kidney disease that prevents the use of oral PrEP medications.

PrEP should be considered part of a comprehensive prevention plan that includes a discussion about adherence to PrEP, condom use to prevent other STDs, and other risk-reduction methods.

PrEP Prescribing Guidelines

In December 2021, the CDC published comprehensive guidelines for prescribing PrEP in A Clinical Practice Guideline for PrEP (https://www.cdc.gov/hiv/pdf/risk/prep/cdc-hiv-prep-guidelines-2021.pdf). These guidelines contain additional tools for health care providers prescribing PrEP, such as patient/provider checklists; patient information sheets; provider information sheets; HIV risk screening assessments for gay, bisexual, and other men who have sex with men (collectively referred to as MSM) and people who inject drugs; supplemental counseling information; billing codes; and practice quality measures.

Health care providers who have questions about PrEP or would like advice about prescribing PrEP or HIV testing should consult The National Clinicians Consultation Center PrEP/PEP line at 1-855-448-7737 (5:00 AM – 4:00 PM AKST).

Post-Exposure Prophylaxis (PEP)

PEP is the use of antiretroviral medication to prevent HIV infection in an HIV-negative person who has had a specific high-risk exposure to HIV. Such an exposure typically occurs through sex or sharing syringes (or other injection equipment) with someone who has or might have HIV.

Exposure to HIV is a medical emergency because HIV established infection very quickly, other within 24 to 36 hours after exposure. Health care providers should evaluate persons rapidly for PEP when care is sought within 72 hours after a potential exposure.

HIV Exposures and PEP

PEP initiation should be considered in people whose vagina, rectum, eye, mouth, or other mucous membrane, non-intact skin, or perforated skin (e.g., needle stick) come into contact with potentially contaminated bodily fluids from and HIV-infected sources, as long as the exposure has occurred within a 72-hour window.

PEP Prescribing Guidelines

PEP guidelines (https://www.cdc.gov/hiv/guidelines/preventing.html) published in 2005 were last updated in April 2016. The update incorporates additional evidence about the use of PEP from animal studies and human observation studies, as well as consideration of new antiretroviral agents introduced after.

Any licensed prescriber can prescribe PEP. Emergency medicine physicians are among the most frequent prescribers of PEP, given the need for immediate treatment after exposure. Clinicians working in ambulatory care practices can also ensure that their non-HIV-infected patients who report risk behaviors are aware of PEP and know how to access it.

All persons offered PEP should be prescribed a 28-day course of a 3-drug antiretroviral regimen. Since adherence is critical for PEP efficacy, it is preferable to select regimens that minimize side effects, number of doses per day and the number of pills per dose. **The preferred PEP regimen for otherwise healthy adults and adolescents is tenofovir disoproxil fumarate (TDF) (300 mg) + emtricitabine (FTC) (200 mg) once daily PLUS raltegravir (RAL) (400 mg) twice daily or dolutegravir (DTG) (50 mg) once daily.**

Health care providers who have questions about when to prescribe PEP should consult The National Clinicians Consultation Center PrEP/PEP line at 1-855-448-7737 (5:00 AM – 4:00 PM AKST).

DISEASE INTERVENTION SPECIALISTS

Disease Intervention Specialist (DIS) Referrals

The HIV/STD Program employees several Disease Intervention Specialists (DIS) to assist in limiting the transmission of HIV and STDs by facilitating patient interviews, performing partner services by conducting partner notifications and referrals for testing/treatments.

When working HIV/STD case investigations, DIS frequently refer their patients to the patient's provider of choice for testing and/or treatment. If a DIS refers a patient to your facility they will first initiate a verbal referral and then send a secured HIV/STD Referral Form via fax. Both the verbal and faxed referrals are requests for testing/treatment and are not to be used as testing orders. DIS do not have order privileges, nor will the State of Alaska pay any invoices for referrals made.

DIS will always receive verbal consent from the patient before initiating any referrals [verbal or written]. When your office receives a faxed referral, note which test needs to be completed in the patient's chart. **Reminder, if a patient presents for any STD testing, they should receive testing full HIV/STD testing (all site Chlamydia, all site Gonorrhea, Syphilis, and HI).** Please pay close attention to whether your patient needs preventative treatment during their visit. When testing and/or treatment is completed by a provider, please fill out the provider section of the referral form and fax it to the HIV/STD Program at: 907-561-4239 (f).

A completed sample of the HIV/STD Referral Form for a patient who is a contact to syphilis within the past 90 days and referred for testing and preventative treatment by DIS is shown on the next page.

If you have questions regarding a received HIV/STD Referral From, call the DIS who made the referral—their name and contact number is listed on the referral form.

DIS Referral Form

THE STATE of ALASKA
GOVERNOR MICHAEL J. DUNLEAVY

Department of Health

DIVISION OF PUBLIC HELATH
Section of Epidemiology

3601 C Street, Suite 540
Anchorage, Alaska 99503
Main: 907.269.8000
Fax: 907.561.4239

STD/HIV REFERRAL FORM

The testing and/or treatment below is being requested by the State of Alaska, Division of Public Health, STD/HIV Program as part of a public health investigation. Please call with any questions or concerns regarding this request or if any of the above requests will not be fulfilled. Please notate any items that were not accomplished and the reason.

The State accepts no financial responsibility for services provided to this patient.

Date: XX/XX/2022 **Referred By:** Jane Smith – DIS **Phone:** 907-269-8000
Referred to *(agency/clinic name)*: XXXXXXXXX Health Clinic

PATIENT INFORMATION

Last Name: Doe **First Name:** John
DOB: 01/01/1990 **Address:** 1234 X St.
Phone: 123-456-7890 **Gender Identity:** ☒ Male ☐ Female ☐ Transgender

REFERRAL INFORMATION

Reason for Referral

- ☐ Confirmed positive test, needs treatment (Date of positive test: _____)
- ☒ Disease exposure, needs testing and/or treatment
- ☐ Inconclusive lab result, needs additional testing
- ☐ Other: _____

Diseases *(patient needs testing and/or treatment for the following diseases as indicated)*

☐ Chlamydia ☐ Gonorrhea ☒ Syphilis ☐ HIV

Testing Requested *(please test sites according to risk)*

Chlamydia/Gonorrhea Aptima

☐ Urine ☐ Oral Swab ☐ Rectal Swab

HIV

☐ HIV Screening (i.e. Rapid, HIV 1/2 Ag/Ab combo)

Syphilis

- ☐ Syphilis Screening (e.g. RPR with Reflex to Confirmatory or Syphilis Screening Cascade)
- ☒ Syphilis Suspected or Exposure (RPR **and** FTA through Alaska State Public Health Lab requisition only)
- ☐ TP-PA (Treponema Pallidum Particle Agglutination through Quest or Mayo Laboratories)
- ☐ RPR Quantitative Only (i.e. titer)

Treatment Requested *(testing and treatment, if requested, should be given at the time of initial visit†)*

- ☐ Doxycycline 100mg BID x 7 days ☐ Azithromycin 1g PO
- ☐ Ceftriaxone 500mg IM ☐ Ceftriaxone 500mg IM + Doxycycline 100mg BID x 7 days
- ☒ Benzathine penicillin L.A. 2.4 mu IM (1 dose)
- ☐ Benzathine penicillin L.A. 3 doses of 2.4 mu IM each at 1-week intervals (7.2 mu total)

****Please sign and date when all testing and treatment has been completed and fax back to (907) 561-4239****

Date of Specimen Collection: _____ **Date of Treatment:** _____
Signed: _____ **Date Signed:** _____

†Due to disease incubation, prophylactic treatment is to be given to exposed individuals AT THE TIME OF TESTING per CDC guidelines. This maximizes disease intervention and prevention and promotes improved clinical management with future testing.

BULLETINS AND PUBLICATIONS

State of Alaska: Epi Bulletins and Publications

The following bulletins can be found on the State of Alaska's Department of Health & Social Services Webpage as Epi Bulletins. If viewing electronically, hyperlinks are attached.

- Public Health Advisory: Increase in Newly Diagnosed Cases of HIV in Fairbanks/Interior Region – January, 2023
- Syphilis Update – Alaska, 2021
- Gonorrhea Outbreak Update – Alaska, 2019 and Recommendations for Care
- Chlamydia Infection Update – Alaska, 2019
- Syphilis Outbreak Update – Alaska, 2020
- HIV Update – Alaska, 2019
- Updated Pre-Exposure Prophylaxis [PrEP] Recommendations for the Prevention of HIV Infection

CDC Publication Resources

The following CDC webpages may be useful as additional resources. If viewing electronically, hyperlinks are attached.

- 2015 Sexually Transmitted Diseases Treatment Guidelines
- 2021 Update: Pre-exposure Prophylaxis (PrEP) For the Prevention of HIV Infection in the United States
- Chlamydial Infections
- Gonococcal Infections
- HIV
- HIV Resources for Clinicians
- Ready Set PrEP
- Sexually Transmitted Diseases (STDs)
- STDs During Pregnancy
- Syphilis
- Syphilis Pocket Guide for Providers PDF
- Summary of CDC STI Treatment Guidelines, 2021
- Taking a Sexual History PDF