San Bernardino STD/HIV Screening Recommendations in Pregnancy 2019

First prenatal visit

- **HIV**
- **Syphilis**
- **Chlamydia[1]**
- **Gonorrhea[1]**
- **Hepatitis B surface antigen (HBsAg)**
- **Hepatitis C antibody if risk[2]**
- **Type-specific HSV serology can be considered if high risk[3]**
- **Pap test if age ≥ 21 years and indicated by national guidelines[4]**

Third trimester

- **HIV if high risk[5]**
- **Syphilis if living in an area with high syphilis prevalence or high risk[6] (test in early third trimester at 28-32 weeks)**
- **Chlamydia if age <25 years, positive test earlier in pregnancy, or high risk[1]**
- **Gonorrhea if positive test earlier in pregnancy or high risk[1]**

During labor & delivery

- **HIV rapid testing if HIV status undocumented**
- **Syphilis (stat RPR) if no prior prenatal care**
- **Syphilis if living in an area with high syphilis prevalence or high risk[6]**
- **HBsAg on admission if no prior screening or if high risk[7]**

1. CDC recommends screening for chlamydia and gonorrhea if age <25 years or high risk. Risk factors for chlamydia or gonorrhea: prior chlamydia or gonorrhea infection, particularly in past 24 months; new or multiple partners; suspicion that a recent partner may have had concurrent partners; sex partner diagnosed with an STD; commercial sex; drug use; African American women up to age 30; and local factors such as community prevalence of infection.
2. The primary risk factor for Hepatitis C is past or current injection drug use. Additional risk factors include: history of blood transfusion or organ transplantation before July 1992; receipt of an unregulated tattoo; long-term hemodialysis; and intranasal drug use.
3. Risk factors for genital HSV: exposure to partner with genital herpes; recurrent genital symptoms or atypical symptoms with negative HSV cultures; clinical diagnosis of genital herpes without laboratory confirmation; or HIV-infected status.
4. Cervical cancer screening guidelines: http://www.cdc.gov/cancer/cervical/pdf/guidelines.pdf
5. Risk factors for HIV: illicit drug use; new STD diagnosis during pregnancy; new or multiple partners; living in an area with high HIV prevalence; or HIV-infected partner.
6. Risk factors for syphilis among pregnant women: receiving late or limited prenatal care; new or multiple partners; suspicion that a recent partner may have had concurrent partners; partner with male partners; new STD diagnosis in pregnancy; sex partner diagnosed with an STD; commercial sex; drug use; and living in an area with high syphilis prevalence among women.
7. Risk factors for hepatitis B: injection drug use; new STD diagnosis in pregnancy; new or multiple partners; or HBsAg-positive partner.

Recommended vaccinations during pregnancy: Tdap and influenza.

Adapted for the San Bernardino County November 2019 with Permission from the California Prevention Training Center and California Department of Public Health STD Control Branch

SAN BERNARDINO COUNTY
Public Health
Communicable Disease Section

San Bernardino County STD Treatment Recommendations in Pregnancy 2019

These treatment regimens reflect recent updates in the 2015 CDC STD Treatment Guidelines and are specific to PREGNANT WOMEN. Non-pregnant women and men may have different recommended regimens. See CDC 2015 STD Treatment Guidelines (www.cdc.gov/std/treatment) for comprehensive recommendations. Call the local health department for assistance with management of pregnant women with syphilis and confidential notification of sexual partners of patients with syphilis, gonorrhea, chlamydia, or HIV infection. For STD clinical management consultation, submit your question online to the STD Clinical Consultation Network at www.stdccn.org.

DISEASE	RECOMMENDED REGIMENS	DOSE / ROUTE	ALTERNATIVE REGIMENS: To be used if medical contraindication to recommended regimen
CHLAMYDIA (CT) [1]	Azithromycin	1 g po once	Amoxicillin 500 mg po tid x 7 d **or** Erythromycin base 500 mg po qid x 7 d **or** Erythromycin base 250 mg po qid x 14 d **or** Erythromycin ethylsuccinate 800 mg po qid x 7 d **or** Erythromycin ethylsuccinate 400 mg po qid x 14 d
GONORRHEA (GC) [1,2,3]	***Dual therapy with:*** Ceftriaxone **PLUS** Azithromycin	250 mg IM once 1 g po once	Cefixime [4] 400 mg po **PLUS** Azithromycin 1 g po If cephalosporin allergy or IgE mediated penicillin allergy, consult with specialist, see footnotes. [1]
CERVICITIS [5,6,7]	Azithromycin	1 g po once	
PELVIC INFLAMMATORY DISEASE [5,8]	Clindamycin **PLUS** Gentamicin	900 mg IV q 8 hours 2 mg/kg IM or IV loading dose followed by 1.5 mg/kg IM or IV q 8 hours Discontinue parenteral therapy 24 hours after patient improves clinically and continue with oral clindamycin 450 mg po qid for a total of 14 d	
SYPHILIS [9,10]			
Primary, Secondary, Early Latent [11]	Benzathine penicillin G	2.4 million units IM once	NONE
Late Latent and Unknown Duration	Benzathine penicillin G	7.2 million units, administered as 3 doses of 2.4 million units IM each, at 1-week intervals	NONE
Neurosyphilis and Ocular Syphilis [12]	Aqueous crystalline penicillin G	18-24 million units daily, administered as 3-4 million units IV q 4 hours x 10-14 d	Procaine penicillin G 2.4 million units IM qd for 10-14 d **PLUS** Probenecid 500 mg po qid for 10-14 d
CHANCROID	Azithromycin **or** Ceftriaxone **or** Erythromycin	1 g orally once 250 mg IM once 500 mg po tid x 7 d	
LYMPHOGRANULOMA VENEREUM [13]	Erythromycin base	500 mg po qid x 21 d	
TRICHOMONIASIS [14,15]	Metronidazole	2 g po once	
BACTERIAL VAGINOSIS	Metronidazole **or** Metronidazole gel **or** Clindamycin cream [16]	500 mg po bid x 7 d 0.75%, one full applicator (5 g) intravaginally qd x 5 d 2%, one full applicator (5 g) intravaginally qhs x 7 d	Clindamycin 300 mg po bid x 7 d **or** Clindamycin ovules [16] 100 mg intravaginally qhs x 3 d
ANOGENITAL HERPES [17]			
First Clinical Episode	Acyclovir **or** Acyclovir **or**	400 mg po tid x 7-10 d [18] 200 mg po five times daily x 7-10 d	
Episodic Therapy for Recurrent Episode	Acyclovir **or** Acyclovir **or** Acyclovir	400 mg po tid x 5 d 800 mg po bid x 5 d 800 mg po tid x 2 d	
Suppressive Therapy (from 36 weeks gestation until delivery)	Acyclovir **or** Valacyclovir	400 mg po tid 500 mg bid	
ANOGENITAL WARTS [19]			
External Genital/Perianal	Cryotherapy **or** Trichloroacetic acid (TCA) 80%-90% **or** Bichloroacetic acid (BCA) 80%-90% **or** Surgical removal	Apply once q 1-2 weeks Apply once q 1-2 weeks Apply once q 1-2 weeks	
Mucosal Genital Warts [20]	Cryotherapy **or** Surgical removal **or** TCA or BCA 80%-90%	Vaginal, vulvar, anal Vaginal, vulvar, anal Vaginal, vulvar, anal	

1. Every effort should be made to use a recommended regimen. Test of cure follow-up (preferably by nucleic acid amplification test (NAAT)) 3-4 weeks after completion of chlamydia treatment is recommended in pregnancy. Retesting 3 months after treatment is recommended for all pregnant women. In case of allergy to both alternative and recommended regimens, consult with the STD Clinical Consultation Network at www.stdccn.org.
2. Dual therapy with ceftriaxone 250 mg IM PLUS azithromycin 1 g po is recommended for all patients with GC regardless of the CT test results. Dual therapy should be simultaneous and by directly observed therapy.
3. If the patient has been treated with a recommended regimen for GC, reinfection has been ruled out, and symptoms have not resolved, perform a test of cure using culture, antibiotic susceptibility testing, and NAAT and report to the local health department. For clinical consult and help in obtaining GC culture, call the CA STD Control Branch at 510-620-3400.
4. Oral cephalosporins give lower and less-sustained bactericidal levels than ceftriaxone 250 mg; limited efficacy for treating pharyngeal GC. Cefixime should only be used when ceftriaxone is not available.
5. Testing for GC and CT is recommended because a specific diagnosis may improve compliance and partner management and because these infections are reportable by state law.
6. Assess for bacterial vaginosis and trichomoniasis; if detected, treat per above guidelines.
7. If patient lives in community with high GC prevalence, or has risk factors (e.g., age <25 years, new partner, partner with concurrent sex partners, or sex partner with a STD), consider empiric treatment for GC.
8. Hospitalization and treatment with intravenous antibiotics for PID are necessary because of risk for preterm delivery and maternal morbidity. Evaluate for bacterial vaginosis and trichomonas.
9. Benzathine penicillin G (generic name) is the recommended treatment for syphilis not involving the central nervous system and is available in only one long-acting formulation, Bicillin® L-A (the trade name), which contains only benzathine penicillin G. Other combination products, such as Bicillin® C-R, contain both long- and short-acting penicillins and are not effective for treating syphilis.
10. Pregnant women allergic to penicillin should be desensitized and treated with penicillin. There are no alternatives. Pregnant women who miss any dose of therapy (greater than 7 days between doses) must repeat the full course of treatment.
11. Some specialists recommend a second dose of benzathine penicillin G 2.4 million units IM administered 1 week after the initial dose in pregnant women with primary, secondary, or early latent syphilis.
12. Some specialists recommend 2.4 million units of benzathine penicillin G once weekly for up to 3 weeks after completion of neurosyphilis treatment.
13. Azithromycin might prove useful for treatment of lymphogranuloma venereum in pregnancy, but no published data are available regarding an effective dose and duration of treatment.
14. For suspected drug-resistant trichomoniasis, rule out re-infection; see 2015 CDC Guidelines, Persistent or Recurrent Trichomonas section, for other treatment options and evaluate for metronidazole-resistant *T. vaginalis*. For consultation, contact the STD Clinical Consultation Network at www.stdccn.org.
15. All women should be retested for trichomoniasis 3 months after treatment.
16. May weaken latex condoms and contraceptive diaphragms.
17. Herpes simplex virus (HSV) transmission to newborn infants is highest in women who acquire HSV during late pregnancy; these women should be managed in consultation with maternal-fetal medicine and infectious disease specialists.
18. Treatment may be extended if healing is incomplete after 10 days.
19. Anogenital warts may proliferate and become friable during pregnancy. Although removal of warts during pregnancy can be considered, resolution might be incomplete or poor until pregnancy is complete. Pregnant women with anogenital warts should be counseled concerning the low risk for warts on the larynx of their infants or children (recurrent respiratory papillomatosis).
20. Cervical and intra-anal warts should be managed in consultation with a specialist.

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