A Clinician's Resource for Sexually Transmitted Diseases (STDs) in Gay Men and Other Men Who Have Sex with Men (MSM) –

The MSM Toolkit

Developed by the California Department of Public Health (CDPH) and the California STD/HIV Prevention Training Center

Revised July 2015

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Introduction

Effective communication around STDs is a challenge for many healthcare providers, especially with little time to provide comprehensive health care and social support services for patients.

Why focus on MSM?

- STDs in communities of MSM, particularly among those with HIV infection, are common medical problems with important public health implications.
- In 2014, 85% of all reported male primary and secondary syphilis cases in California with data on sexual orientation were MSM. Of interviewed MSM with known HIV status, 45% were co-infected with HIV.[1]
- Infection with STDs such as syphilis, GC, and CT increase by a factor of 2 to 5 the risk of sexual HIV acquisition and transmission.[2]

A Clinician's Resource for Sexually Transmitted Diseases (STDs) in Gay Men and Other Men Who Have Sex with Men (MSM) – The MSM Toolkit is a resource designed to improve clinicians' knowledge, skills, and comfort in effectively diagnosing and managing STDs in MSM.

Clinical tools are included to support the following:

- Routine and periodic sexual history taking
- Laboratory screening for STDs
- Risk reduction counseling for those at highest risk
- Creating a safe clinical environment for MSM
- Utilizing the health department as a resource for STD and HIV partner management

In addition to these materials for clinicians, we develop educational campaigns to increase MSM awareness of the need for periodic, comprehensive STD screening. This toolkit is designed to work in conjunction with educational campaigns for MSM to improve access to and provision of STD screening among MSM in California.

We appreciate your support of this project. To learn more about this initiative, ask questions or share comments, please visit the CDPH STD Control Branch webpage: www.std.ca.gov/MSMToolkit.

Disclaimer for public health clinical guidelines: These guidelines are intended to be used as an educational aid to help clinicians make informed decisions about patient care. The ultimate judgment regarding clinical management should be made by the healthcare provider in consultation with their patient in light of clinical data presented by the patient and the diagnostic and treatment options available. Further, these guidelines are not intended to be regulatory and not intended to be used as the basis for any disciplinary action against the healthcare provider.

[1] CDPH STD Control Branch, 2013
[2] Wasserheit, et al. 1992. STD 9:61-77.

Acronyms Used In This Document

AFP	Alpha-Fetoprotein	**HBeAg**	Hepatitis B e Antigen
Ag/Ab	Antigen/Antibody	**HBsAg**	Hepatitis B Surface Antigen
AIDS	Acquired Immunodeficiency Syndrome	**HBV**	Hepatitis B
anti-HAV	Hepatitis A Antibody	**HCV**	Hepatitis C
anti-HBc	Antibody to Hepatitis B Core Antigen	**HIV**	Human Immunodeficiency Virus
anti-Hbe	Antibody to HBe Antigen	**HPV**	Human Papillomavirus
anti-HBs	Antibody to Hepatitis B Surface Antibody	**HSV**	Herpes Simplex Virus
anti-HCV	Hepatitis C Antibody	**IM**	Intramuscular
anti-HDV	Hepatitis Delta Antibody	**IV**	Intravenous
ART	Antiretroviral Therapy	**LGBT**	Lesbian, Gay, Bisexual, Transgender
BUN	Blood Urea Nitrogen	**LGV**	Lymphogranuloma Venereum
CalREDIE	California Reportable Disease Information Exchange	**MSM**	Men Who Have Sex with Men
CBC	Complete Blood Count	**NAAT**	Nucleic Acid Amplification Test
CDC	Centers for Disease Control and Prevention	**OA**	Office of AIDS
CDPH	California Department of Public Health	**PAETC**	Pacific AIDS Education and Training Center
CIA	Chemiluminescence Immunoassay	**PCR**	Polymerase Chain Reaction
CMR	Confidential Morbidity Report	**PEP**	Post–Exposure Prophylaxis
CSF	Cerebrospinal Fluid	**PrEP**	Pre-Exposure Prophylaxis
CT	Chlamydia	**PT/INR**	Prothrombin Time/International Normalized Ratio
DNA	Deoxyribonucleic Acid	**RNA**	Ribonucleic Acid
EBV	Epstein-Barr Virus	**RPR**	Rapid Plasma Reagin
EIA	Enzyme Immunoassay	**STD**	Sexually Transmitted Disease
FTA-ABS	Fluorescent Treponemal Antibody Absorption	**TOC**	Test of Cure
GC	Gonorrhea	**TP-PA**	Treponema Pallidum Particle Agglutination Assay
GLMA	Gay and Lesbian Medical Association	**VDRL**	Venereal Disease Research Laboratory
GNID	Gram Negative Intracellular Diplococci	**WBC**	White Blood Cells
HAV	Hepatitis A		

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Things You Can Do to Improve STD Screening

1. Have patients complete a self-administered sexual history questionnaire and risk assessment on a quarterly basis.

2. In each exam room, post a guide for clinicians clarifying what STD tests and specific collection materials are available in your clinic or office.

3. Ensure that lab request forms include HIV, STD, and Hepatitis tests.

4. Make it a point to promote STD screening throughout April, which is National STD Awareness Month.

5. For sexually active HIV+ MSM, order syphilis screening with every CD4 count and viral load, and GC/CT if indicated by risk.

ASYMPTOMATIC SCREENING

CDPH MSM Toolkit

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Sample Sexual Health Screening Protocol for MSM

Three essential components of a sexual health evaluation for MSM are:

- Laboratory-based screening to detect asymptomatic infections,
- Assessment of behavioral risk factors, and
- Assessment of STD-related symptoms

In all MSM, the screening tests listed on the next page should be performed at the **initial medical visit** and repeated at least annually.

STD screening should be repeated **at 3-6 month intervals** for sexually active MSM at highest risk[3], defined as those who

- Have multiple anonymous partners,
- Use illicit drugs, particularly methamphetamine,
- Seek sex partners through the internet, or
- Have sex partners who participate in these activities.

Screening should be performed regardless of reported condom use.

[3] STD Treatment Guidelines, 2015. MMWR. 2015;64(RR3). www.cdc.gov/std/tg2015/specialpops.htm

Sexual Health Screening for MSM: Initial and Annual Visits

1. **Conduct risk assessment**
    a. Ask about the 5 P's (Partners, Practices, Past STDs, Protection, and Pregnancy Prevention[4]) to assess STD risk.
    b. Ask additional questions to further assess HIV and hepatitis risk (e.g., injection drug use).
    c. Assess for recent symptoms associated with STDs.
2. **Conduct physical exam:**
    a. Examine the genitalia and anal area for any of the following: ulcers, papules, lesions, rashes or discharge.
3. **Screen urethral site for GC and CT**
    a. Collect first-catch[5] urine specimen for nucleic acid amplification test (NAAT)[6] to detect GC and CT, according to laboratory directions.
    b. Collect a sample of penile discharge for Gram stain if discharge is present.
4. **Screen pharyngeal site for GC in patients with history of receptive oral sex IN THE LAST 12 MONTHS[7,8]**
5. **Screen rectal site for GC and CT in patients with history of receptive anal sex IN THE LAST 12 MONTHS[5,9]**
6. **Perform blood draw for serologic testing for:**
    a. HIV, unless known positive.
    b. Syphilis: Rapid Plasma Reagin (RPR), Venereal Disease Research Laboratory (VDRL) or other appropriate screening test.[10,11]
    c. Hepatitis C (HCV): enzyme immunoassay (EIA) or chemiluminescence immunoassay (CIA), if HIV-infected or other known risk.[9,12]
    d. Hepatitis B (HBV): Hepatitis B surface antigen (HBsAg) and antibody to HBV core antigen (anti-HBc) unless known positive or vaccinated.[13]
    e. Consider Hepatitis A antibody (anti-HAV), if unvaccinated.[13]
    f. Consider Herpes Simplex Virus Type 2 (HSV-2) type specific serologic test, unless known HSV-2-infected.
7. **Consider anal pap smear screening if HIV-infected[14]**
8. **Vaccinate against:**
    a. Hepatitis A (HAV) unless history of infection or previous vaccination.[12]
    b. HBV unless history of infection or previous vaccination.[12]
    c. Human Papillomavirus (HPV), if 26 years old or younger.

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[4] MSM might also have female sex partners.

[5] Patient should not urinate for approximately 1.5 hours before testing.

[6] NAATs are commercially available for testing urethral or urine specimens to detect GC/CT infections under the names Amplicor (Roche), Aptima (GenProbe) and Probe Tec (BD). If NAAT urine testing unavailable, perform urethral culture for GC and CT.

[7] NAATs for pharyngeal and rectal GC and CT require verification by the lab processing such specimens. See Renault, et al. MLO Med Lab Obs. 11-22. July 2006. A list of national labs that accept NAATs for pharyngeal and rectal GC and CT is available at www.aphl.org/aphlprograms/infectious/Archive/naatestlabs.aspx

[8] For assistance in identifying a laboratory in California that has locally verified NAATs for the detection of GC/CT rectal and GC oropharyngeal infections contact your local STD controller or the CDPH STD Control Branch at 510-620-3400.

[9] The pharynx is not a hospitable environment for CT, and prevalence studies have demonstrated low rates of pharyngeal CT among high risk MSM. As a result, pharyngeal CT screening for MSM is not specifically recommended by the CDC. However, most NAATs combine testing for CT and GC. If a patient tests positive for pharyngeal CT, treat accordingly.

[10] Treponemal screening tests, such as EIA or CIA, are used for screening in some settings.

[11] Some practice settings in high syphilis morbidity areas have added a serologic test for syphilis to their routine panels for HIV-positive patients returning every 3-4 months for HIV laboratory testing.

[12] Patients with past or present drug use, signs or symptoms of liver disease, or other known risk factors, such as blood transfusion or solid organ transplant prior to 1992, receipt of clotting factors prior to 1987, or chronic dialysis, or upon patient request.

[13] All unvaccinated MSM should be vaccinated against Hepatitis A and B if no known prior infection. If pre-vaccination serologic testing is a cost effective approach, the first dose of vaccine should be offered at the time of testing to minimize the number of susceptible patients that are lost to follow up.

[14] Some experts recommend anal Pap screening in HIV infected MSM to screen for anal cancer. Programmatic considerations such as availability of providers to perform diagnostic anoscopy in the case of abnormal results should be considered prior to initiating anal Pap screening.

Higher Risk MSM[15]: Semi-Annual or Quarterly Visits

These tests should be performed in addition to those during the initial and annual visits.[15]

1. **Conduct risk assessment**
    1. Ask about the 5 P's (Partners, Practices, Past STDs, Protection, and Pregnancy Prevention[16]) to assess STD risk.
    2. Ask additional questions to further assess HIV and hepatitis risk (e.g., injection drug use).
    3. Assess for recent symptoms associated with STDs.

2. **Screen urethral site for GC and CT with history of anal or oral insertive sex SINCE LAST VISIT**
    1. Collect first-catch[17] urine specimen for NAAT[18] to detect GC and CT, according to laboratory directions.
    2. Collect a sample of penile discharge for Gram stain if discharge is present.

3. **Screen pharyngeal site for GC in patients with history of receptive oral sex SINCE LAST VISIT[19,20,21]**

4. **Screen rectal site for GC and CT in patients with history of receptive anal sex SINCE LAST VISIT[19,20]**

5. **Perform blood draw for serologic testing for**
    - HIV, unless known positive.
    - Syphilis (RPR/VDRL or other appropriate screening test).[22,23]

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[15] MSM who have multiple or anonymous partners, use illicit drugs (particularly methamphetamine), seek sex partners through the internet, or those who sex partners participate in these activities.

[16] MSM might also have female sex partners.

[17] Patient should not urinate for approximately 1.5 hours before testing.

[18] NAATs are commercially available for testing urethral and urine specimens to detect GC and CT infections under the names Amplicor (Roche), Aptima (GenProbe) and Probe Tec (BD). If NAAT urine testing not available, perform urethral culture for GC and CT.

[19] NAATs for pharyngeal and rectal GC and CT require verification by the lab processing such specimens. See Renault, et al. MLO Med Lab Obs. 11-22. July 2006. A list of national labs that accept NAATs for pharyngeal and rectal GC and CT is available at www.aphl.org/aphlprograms/infectious/Archive/naatestlabs.aspx

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[21] The pharynx is not a hospitable environment for CT, and prevalence studies have demonstrated low rates of pharyngeal CT among high risk MSM. As a result, pharyngeal CT screening for MSM is not specifically recommended by the CDC. However, most NAATs combine testing for CT and GC. If a patient tests positive for pharyngeal CT, treat accordingly.

[22] Treponemal screening tests, such as EIA or CIA are used for screening in some settings.

[23] Some practice settings in high syphilis morbidity areas have added a serologic test for syphilis to their routine panels for HIV-positive patients returning every 3-4 months for HIV laboratory testing.

Rationale for Collecting Rectal and Pharyngeal Specimens for GC/CT

Rectal and pharyngeal infections are common.

- Figure 1 displays prevalence of GC and CT by anatomic site.
- Rectal and pharyngeal GC prevalence (7.5% and 9.4%, respectively) is higher than urethral GC prevalence (6.6%).
- Rectal CT prevalence (8.8%) is greater than urethral CT (5.5%).

Patients are often asymptomatic. [24,25,26]

- Figure 2 illustrates that a majority of rectal CT (86%) and GC (84%) infections in MSM are asymptomatic.
- Fewer urethral CT (42%) and GC (10%) infections in MSM are asymptomatic.

Figure 1. CT and GC infections among MSM seeking STD testing are common.[26]

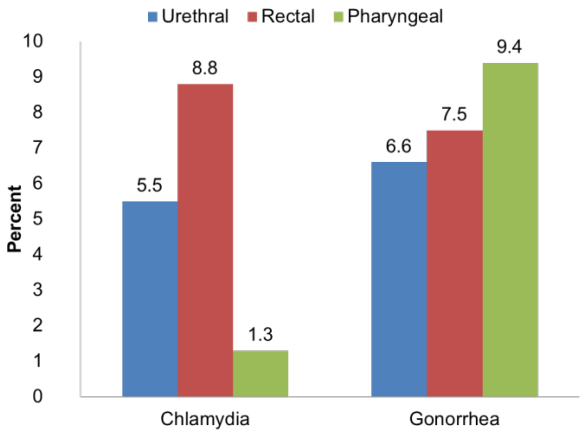
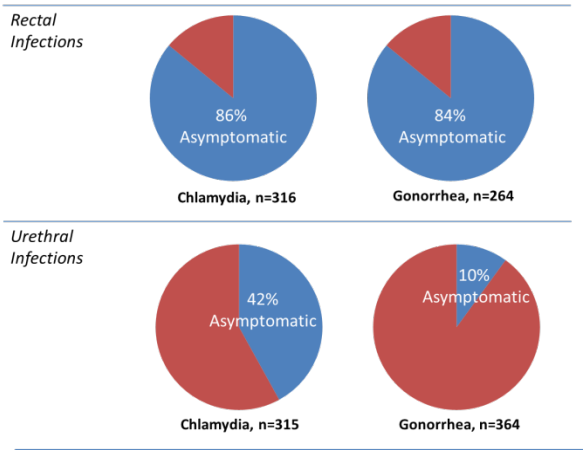


Figure 2. A majority of rectal CT and GC are asymptomatic.[26]

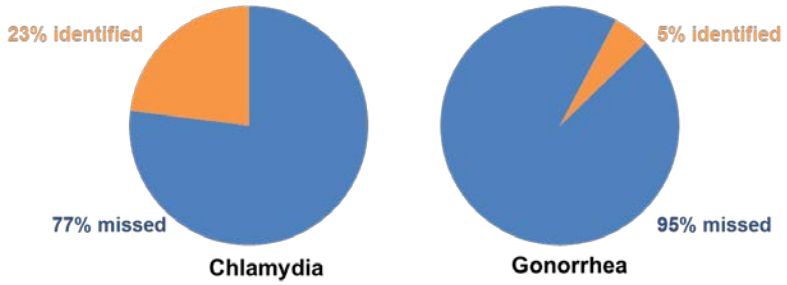


Most infections are missed by urine/urethral screening only.

- Figure 3 shows the majority of CT (77%) and GC (95%) infections among asymptomatic patients would be missed (not identified) by only screening urine/urethral sites.[27]

[24] Peters, et al. BMC Infectious Diseases 2011; 11:203.
[25] Gunn, et al. Sex Transm Dis. 2008 Oct; 35(10):845-8.
[26] Kent, et al. Clin Infect Dis. 2005; 41: 67-74.
[27] Marcus, et al. Sex Transm Dis. 2011; 38: 922-4. Study participants were limited to asymptomatic MSM, with prevalence of urethral, rectal and pharyngeal infections respectively as follows: (CT: 2.3%, 7.8%, 1.9%; GC: 0.4%, 3.4%, 5.0%).

Figure 3. Proportion of CT and GC infections missed among 3398 asymptomatic MSM if screening only urine/urethral sites, San Francisco, 2008-2009[28]



CPT® Codes and Medi-Cal reimbursement for NAAT testing of rectal and pharyngeal specimens are the same for urogenital specimens.

A list of labs that accept rectal and pharyngeal swabs for NAAT testing is available at www.aphl.org/aphlprograms/infectious/Archive/naatestlabs.aspx.

Rectal infections may be associated with HIV acquisition:

- MSM diagnosed with rectal CT or GC who had two additional rectal CT or GC infections in the past two years were over eight times more likely to seroconvert compared with MSM with no prior rectal CT or GC infections.[29]
- Rectal STDs may also cause epithelial erosions that can increase susceptibility to HIV infections. Repeated rectal infections may not only increase the duration of the erosions and the local presence of immune target cells, but may also increase infectivity by altering host immune defenses.[29]

[28] Marcus, et al. Sex Transm Dis. 2011; 38:922-4.
[29] Bernstein, et al. J Acquir Immune Defic Syndr. 2010; 53:537-43.

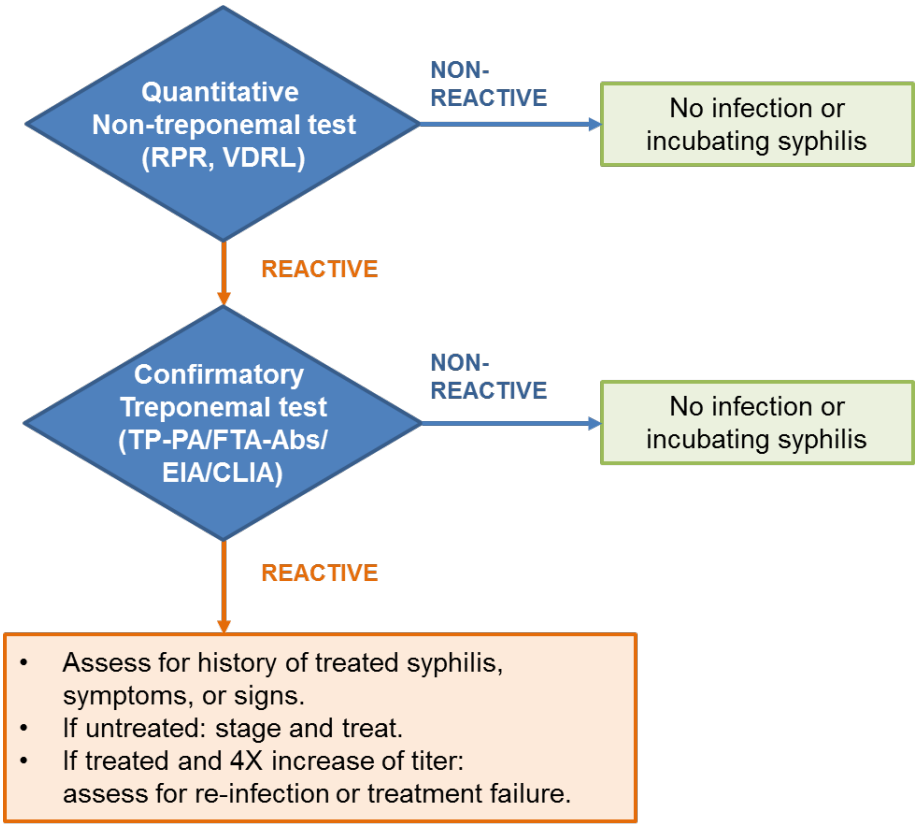
Screening for Syphilis

There are two primary approaches to serologic screening for syphilis. The traditional approach begins with an initial non-treponemal test, either the RPR or VDRL test, followed by a more specific confirmatory treponemal test, commonly either Treponema pallidum particle agglutination assay (TP-PA) or fluorescent treponemal antibody absorption (FTA-ABS) test.

A newer algorithm – 'reverse sequence syphilis screening' – involves initially screening sera with an automated treponemal EIA or CIA, followed by a non-treponemal test (RPR or VDRL) of reactive specimens, after which discordant results are confirmed with TP-PA. Establishing the serologic diagnosis of syphilis requires both non-treponemal and treponemal testing, given limitations in each form of test.[30]

The algorithms below are tools for interpreting test results for screening algorithms that begin with non-treponemal tests (Figure 4) or treponemal tests (Figure 5).

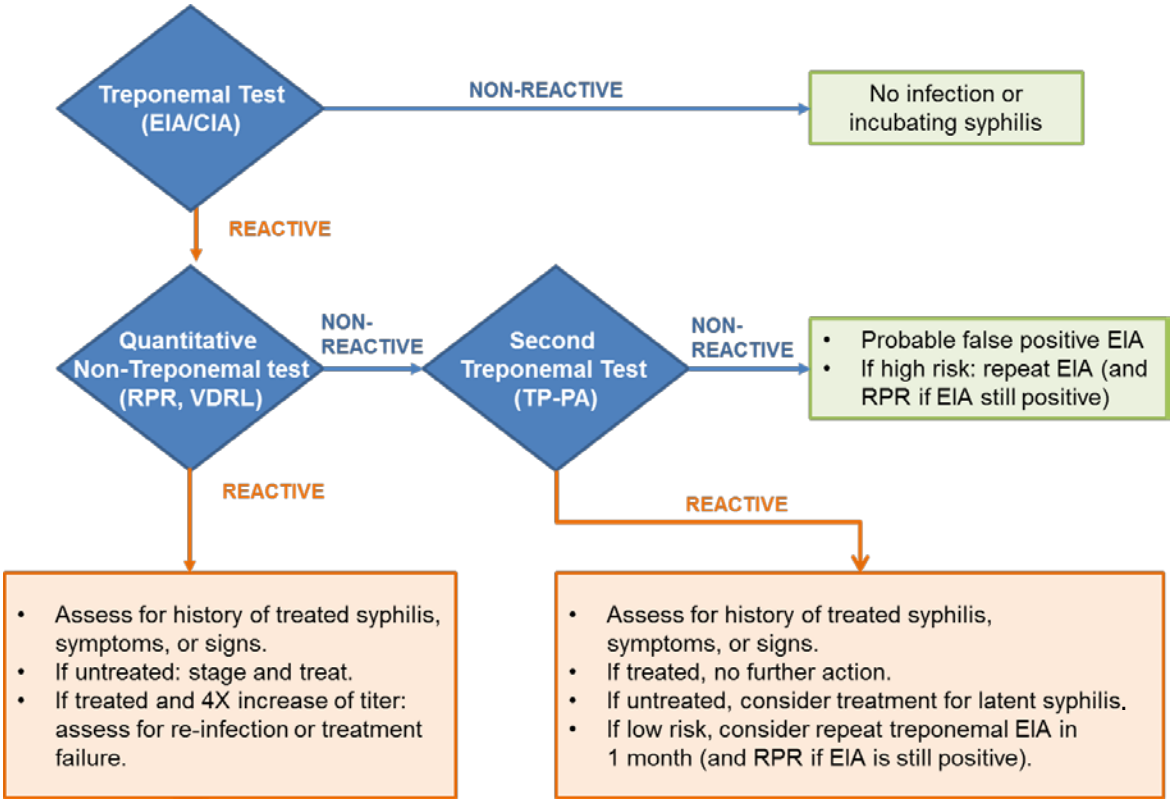
Figure 4: Traditional Non -Treponemal Test (RPR/VDRL) Screening Algorithm



Prepared by the California Department of Public Health

[30] STD Treatment Guidelines, 2015. MMWR. 2015;64(RR3). www.cdc.gov/std/tg2015/syphilis.htm

Figure 5: Treponemal Test (EIA /CIA) Screening Algorithm



Prepared by the California Department of Public Health

For more information, please see the "Use of Treponemal Immunoassays for Screening and Diagnosis of Syphilis" available on the CDPH webpage: www.cdph.ca.gov/pubsforms/Guidelines/Documents/ Treponemal_Immunoassays_for_Syphilis_ Screening_and_Diagnosis.pdf

Screening for HIV

Sexually active gay men and other MSM are at increased risk for acquisition of HIV infection. Screening for HIV infection should occur at least annually among MSM, or more frequently (i.e. at 3-6 month intervals) for MSM at highest risk defined as those who

- Have multiple or anonymous partners,
- Use illicit drugs, particularly methamphetamine,
- Seek sex partners through the internet, or
- Have sex partners who participate in these activities.

Screening should be performed regardless of reported condom use.

Screening for HIV can be conducted with an HIV antibody test or a combined antibody-antigen test (preferred). If acute or recent HIV infection is suspected, then an HIV Ribonucleic Acid (RNA) test should also be performed (see Acute HIV Infection).

HIV Testing in Healthcare Settings

As of January 2008, HIV testing in medical settings is permissible without specific written consent or HIV prevention counseling.[31] General medical consent is considered sufficient to perform the test, as indicated by the *CDC's Revised Recommendations for HIV Testing in Adults, Adolescents and Pregnant Women in Healthcare Settings*[32]. Subsequent California legislation requires that private health insurance providers cover HIV testing, regardless of whether the testing is related to a primary diagnosis.[33]

California law[34] requires that providers, prior to ordering a test, must either orally or in writing:

1. Inform the patient that HIV testing is planned.
2. Provide information about the test.
3. Inform the patient of the many treatment options available to people who test HIV positive.
4. Inform the patient that a person who tests HIV negative should continue to be routinely tested for HIV.
5. Advise the patient that they may decline the test. If a patient declines the test, the medical care provider shall note that fact in the patient's medical file.

Providers should discuss the window period with patients, and advise repeat testing according to risk. The window period is the period after the patient may have been exposed to HIV but before a test can detect it. The length of the window period depends on the kind of test that was used on blood or oral fluid.

Patient Information Sheets that provide this information in many languages can be found at: www.cdph.ca.gov/programs/aids/Pages/OAHIVTestFS.aspx

For more information about HIV testing in healthcare settings visit the CDPH OA webpage: www.cdph.ca.gov/programs/aids/Pages/OAHIVTestHCS.aspx

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[31] Assembly Bill 682, California Health and Safety Code Section 120990.
[32] MMWR Sept 2006;55(RR-14):1-17.
[33] Assembly Bill 1894, California Health & Safety Code 1367.46, California Insurance Code 10123.91.
[34] California Health and Safety Code, Section 120990.

For legal considerations in states other than California, see the *Updated Compendium of State HIV Testing Laws* available through the Consultation Library at the National HIV/AIDS Clinical Consultation Center at www.nccc.ucsf.edu.

Delivering Positive Test Results

Any medical provider can deliver positive HIV test results to a patient. There are a few simple points to help in delivering this information effectively:

1. State the result in a direct, neutral tone, and wait for patient's response.
2. Address individual needs and concerns.
    a. Sources of emotional support
    b. Information about HIV infection and medical care
    c. Information about transmission and partner notification
3. Make a short-term plan.
4. Link to needed services.
    a. Ask what's most important to do first
    b. Link to HIV medical care
    c. Close the session, but not the door

California state law requires that patients who test HIV positive are:

1. Informed that there are numerous treatment options available, and
2. Provided information about follow up testing and care that may be recommended, including contact information for medical and psychological services.

Visit the California STD/HIV Prevention Training Center webpage for resources, including a training video on the delivery of the positive HIV test result: stdhivtraining.org/clinical_videos.html

The Pacific AIDS Education and Training Center (PAETC) also has resources on HIV testing and delivering results: paetc.org/main/?page_id=20

For more information about HIV/AIDS testing, reporting, treatment, and legal responsibilities, visit the CDPH OA webpage: www.cdph.ca.gov/programs/aids/

Reimbursement Rates and Billing Codes

The American Academy of HIV Medicine provides Coding Guide for Routine HIV Testing in Healthcare Settings at its webpage: www.aahivm.org/Upload_Module/upload/Provider%20Resources/AAHIVM%20CPT%20Coding%20Guide.pdf

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SEXUAL HISTORY TAKING AND RISK ASSESSMENT

CDPH MSM Toolkit

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Rationale

Sexual history and risk assessments provide valuable information regarding the health of your patients. A thorough sexual history should be taken with each new patient, and a risk assessment should be conducted at least annually and at every visit for higher risk patients.

Providers who know the sexual orientation of their MSM patients are more likely to recommend HIV testing and HAV or HBV vaccination.[35]

Patients experience less risk assessment than is recommended:

- 38% of MSM do not share their sexual orientation with their medical providers.[35]
- 25% of HIV-infected patients report that they discussed transmission prevention with their providers.[36]
- 6% of HIV-infected patients report discussing sexual practices with their primary care providers.[36]

Assessing specific sexual risk will enable providers to identify:

- Anatomic sites that require testing (oral, pharyngeal, urethral)
- STD, HIV, and hepatitis risks
- Opportunities for counseling and patient education

The Five P's

Figure 6: The Five P's of Risk Assessment

The 5 P's[37]	At First Visit	At Subsequent Visits
Partners	Number and gender of sex partners in the past year	Number and gender of sex partners since last visit
Practices	Types of sex with partners in the past year	Types of sex with partners discussed above
Past history of STDs	Lifetime history of STDs	STD diagnosis since last visit (at current or other clinic)
Protection Pregnancy Prevention	Use of condoms with partners in the past year Method of contraception used with any female partners	Use of condoms with partners since last visit Method of contraception used with any female partners

Remember:

- Make no assumptions.
- Assure confidentiality.
- Ask direct, open-ended questions.
- Ask for explanation of terms you are unfamiliar with.
- Normalizing behavior may result in more honest answers

[35] Petrolli, et al. STD, 2011.(38;1; 63-67).

[36] Among patients receiving care in Ryan White funded clinics. Source: Morin, et al. APHA Annual Meeting, 2003. Abstract #60724.

[37] STD Treatment Guidelines, 2015. MMWR. 2015;64(RR3). www.cdc.gov/std/tg2015/clinical.htm

Sample Questions to Ask During Sexual History and Risk Assessments

Partners

- Do you have sex with men, women, or transgender persons?
- In the past twelve months, how many people have you had sex with?
- Where do you meet your partners (through friends, online, bars, bathhouses)?
- How do you know the HIV status of your partners?
- Do you know if your partners have other partners and what they do with them?
- Have you noticed STD-type symptoms in your partner?
- Do you select partners based on HIV status?

Sexual Practices

- Do you have anal sex, meaning penis in anus sex? If yes, how often do you use condoms for this kind of sex? Are you a top (insertive partner), bottom (receptive partner), or both?
- Do you have oral sex, meaning mouth on penis/anus/vagina? If yes, do you use condoms never, sometimes, most of the time, or always for this kind of sex?
- If sex with women: Do you have vaginal sex, meaning penis in vagina sex? If yes, do you use condoms never, sometimes, most of the time, or always for this kind of sex?
- Compared to other times in your life, are you having more or less sex? Tell me about it.
- Do you do different things sexually depending on the HIV status of your partners?

Past History of STDs

- Have you ever had an STD, such as syphilis, chlamydia, gonorrhea, herpes or warts? If yes, do you know what treatment you received and where you were treated?
- Have any of your partners had an STD? If yes, do you know what the infection was and when it was?

Protection from STDs

- What do you do to protect yourself from sexually transmitted diseases and HIV?
- Do you use condoms when having sex? How often?
- What has been your experience with using condoms?
- What types of situations make you likely to not use condoms?

Injection Drug Related Risks

- Do you share needles or other injection equipment?
- If yes, with how many partners?
- What do you know about the HIV and Hepatitis C status of your needle-sharing partners?
- Do you have sex with your needle-sharing partners?
- Is your equipment clean or sterile? How do you know?
- What drugs do you inject? How often?
- What types of situations or environments make you more likely to use drugs?

HIV and Hepatitis Testing/Vaccination

- Have you ever been vaccinated against hepatitis A/hepatitis B? If yes, how many doses did you receive?
- Have you ever been tested for hepatitis C?
- Have you ever been tested for HIV?

For Men Who Have Sex with Women

- What do you do to prevent any unplanned pregnancies with your female partners?
- Do you use condoms when having sex with women? How often?

PHYSICAL EXAM FINDINGS

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Key Physical Exam Findings and Recommended Testing

Anorectal

Anus and Perianal Area

Assess for ulcerations, condylomata or other lesions.

Recommended Testing

- For all patients: NAAT for GC/CT of rectal swabs. If NAATs are unavailable, culture may be performed.
- For symptomatic patients: anoscopic exam.

Genital

Pubic Hair

Assess for crabs or nits.

Skin of the Penis, Foreskin, Scrotum and Perineum

Assess for the following skin manifestations commonly associated with STDs:

- Lesions, ulcers or rash consistent with primary or secondary syphilis.
- Vesicles, pustules, or papules consistent with HSV infection.
- Papules or verrucous lesions consistent with HPV infection.

Urethral Meatus

Assess for papular lesions consistent with intraurethral warts; vesicles or ulcers consistent with HSV; discharge (following milking/stripping of the penis) consistent with CT or GC.

Testes and Epididymis

Assess for swelling or tenderness consistent with epididymitis.

Recommended Testing

- NAAT for GC and CT of urine specimen.
- Gram stain of urethral specimens, if urethral discharge is present or patient reports discharge or dysuria.
- Consider *Mycoplasma genitalium (M. genitalium)*[38]. Research has shown that the most common cause of persistent or recurrent non-gonococcal urethritis is *M. genitalium*.[39]
- Microscopy of spun first-catch urine for trichomonads or urethral swab for trichomonas culture, if patient has persistent urethritis and has sex with both men and women.[40]
- Special testing of ulcerative, erosive or vesicular lesions, if present, such as darkfield microscopy, HSV culture, or HSV polymerase chain reaction (PCR).

[38] NAAT tests for *M. genitalium* are available in some clinical settings, but there is no diagnostic test for *M. genitalium* that is cleared by the FDA for use in the United States. STD Treatment Guidelines, 2015. MMWR. 2015;64(RR3). www.cdc.gov/std/tg2015/emerging.htm

[39] STD Treatment Guidelines, 2015. MMWR. 2015;64(RR3). www.cdc.gov/std/tg2015/urethritis-and-cervicitis.htm

[40] *T. vaginalis* is known to cause urethritis in men who have sex with women. STD Treatment Guidelines, 2015. MMWR. 2015;64(RR3). www.cdc.gov/std/tg2015/urethritis-and-cervicitis.htm

Extra -Genital

Lymph Nodes
Assess for swollen or tender lymph nodes.

Skin
Assess for any type of new rash, especially macular (flat), papular (raised) or scaly on body, especially trunk, palms and soles, consistent with secondary syphilis.

Recommended Testing
- Punch biopsies of ulcers or lesions in cases where histologic diagnosis is needed.

Hair

Assess for patchy or moth-eaten alopecia, or loss of lateral eyebrows, consistent with secondary syphilis.

Oral Cavity

Tongue, Buccal and Pharyngeal Mucosae
Assess for ulcerative lesions consistent with primary syphilis or HSV infection, white lesions consistent with mucous patches of secondary syphilis, or papules consistent with condyloma lata.

Recommended Testing[41]
- NAAT for GC on pharyngeal swab[42] if patient engages in oral sex. If NAATs are unavailable, culture may be performed.

Neurologic

In patients with suspected or confirmed syphilis, check for cranial nerve abnormalities, changes in vision or hearing, loss of vibratory sense or other sensory or motor loss, and altered mental status. Conduct slit lamp examination if ocular symptoms or signs and otological exam if auditory symptoms or signs.

Recommended Testing
- Cerebrospinal fluid (CSF) examination for VDRL, white blood cell, protein and glucose if symptoms or signs are consistent with neurosyphilis (see Neurosyphilis).

[41] Darkfield examination of oral lesions is not recommended due to presence of non-pathogenic commensal treponemes.
[42] The pharynx is not a hospitable environment for CT, and prevalence studies have demonstrated low rates of pharyngeal CT among high risk MSM. As a result, pharyngeal CT screening for MSM is not specifically recommended by the CDC. However, most NAATs combine testing for CT and GC. If a patient tests positive for pharyngeal CT, treat accordingly.

BACTERIAL STDS

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Chlamydia (CT)

Urethral CT

Symptoms

Urethral CT is often asymptomatic. Symptoms, if present, may be mild and include discharge and/or dysuria. Symptoms typically occur 7-21 days after exposure. Discharge, if present, is typically clear and mucoid.

Diagnostic testing

NAAT on urine specimens is the recommended testing method.

Treatment

Recommended Regimens

- Azithromycin 1 g orally in a single dose, OR
- Doxycycline 100 mg orally twice a day for 7 days

Alternative Regimens

- Erythromycin base 500 mg orally four times a day for 7 days, OR
- Erythromycin ethylsuccinate 800 mg orally four times a day for 7 days, OR
- Levofloxacin 500 mg orally once daily for 7 days, OR
- Ofloxacin 300 mg orally twice a day for 7 days

Follow-Up

CT-infected men should be retested approximately 3 months after treatment to assess for repeat infection. Retesting can be performed opportunistically any time between 1-12 months post-treatment and should be performed regardless of whether the patient believes that their partners were treated.[43] Retesting is different from a test of cure (TOC), which is typically performed to rule out treatment failure. TOC is not routinely recommended for CT.

[43] STD Treatment Guidelines, 2015. MMWR. 2015;64(RR3). www.cdc.gov/std/tg2015/chlamydia.htm

Anorectal CT

Symptoms

Anorectal CT is usually asymptomatic (86%), except for CT strains associated with lymphogranuloma venereum (LGV) [44], which often produce symptomatic proctocolitis. Symptoms may include rectal pain, discharge, bleeding, constipation, tenesmus and fever. Abnormal anoscopic findings include mucopurulent discharge, mucosal erythema, and easily induced mucosal bleeding.

Diagnostic testing

- NAAT performed on rectal swabs is preferred. All commonly available NAATs identify both LGV and non-LGV serovars of CT, but do not differentiate specific serovars. A positive NAAT for CT in a patient with symptoms of proctocolitis supports diagnosis of LGV.
- Culture, if NAAT unavailable. Culture is less sensitive than NAAT.
- Serology is not useful to support a diagnosis of rectal LGV.
- Currently available diagnostics for LGV are limited, therefore healthcare providers must make a clinical decision regarding whether to treat empirically for LGV. Presumptive treatment of LGV is recommended for MSM with proctitis and anorectal CT, particularly if the patient is HIV-infected or if symptoms such as bloody discharge, perianal ulcers, or mucosal ulceration are present.

Treatment

Recommended Regimens (low suspicion for LGV)

- Azithromycin 1 g orally in a single dose, OR
- Doxycycline 100 mg orally twice a day for 7 days

Alternative Regimens (low suspicion for LGV)

- Erythromycin base 500 mg orally four times a day for 7 days, OR
- Erythromycin ethylsuccinate 800 mg orally four times a day for 7 days, OR
- Levofloxacin 500 mg orally once daily for 7 days, OR
- Ofloxacin 300 mg orally twice a day for 7 days

Recommended Regimens (high suspicion for LGV)

- Doxycycline 100 mg orally twice a day for 21 days

Alternative Regimen (high suspicion for LGV)

- Erythromycin base 500 mg orally four times a day for 21 days

Follow-Up

Symptomatic patients should be followed clinically until signs and symptoms have resolved. All CT-infected men should be retested approximately 3 months after treatment to assess for repeat infection. Retesting can be performed opportunistically any time between 1-12 months post-treatment and should be performed regardless of whether the patient believes that their partners were treated.[45] Retesting is different from a TOC, which is typically performed to rule out treatment failure. TOC is not routinely recommended for CT.

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[44] LGV is a systemic STD caused by CT serovars L1, L2 or L3 affecting lymph nodes & rectum. For more information, please refer to the 2015 STD Treatment Guidelines.

[45] STD Treatment Guidelines, 2015. MMWR. 2015;64(RR3). www.cdc.gov/std/tg2015/chlamydia.htm

Pharyngeal CT

Symptoms

Pharyngeal CT is usually asymptomatic and infections are not common among MSM, as the pharynx is not a hospitable environment for CT. As a result, pharyngeal CT screening for MSM is not specifically recommended by the CDC.

Diagnostic laboratory testing

Testing for pharyngeal CT is not recommended. However, most NAATs combine testing for CT and GC. If pharyngeal CT is identified, treat per recommendations.

Treatment

Recommended Regimens

- Azithromycin 1 g orally in a single dose, OR
- Doxycycline 100 mg orally twice a day for 7 days

Alternative Regimens

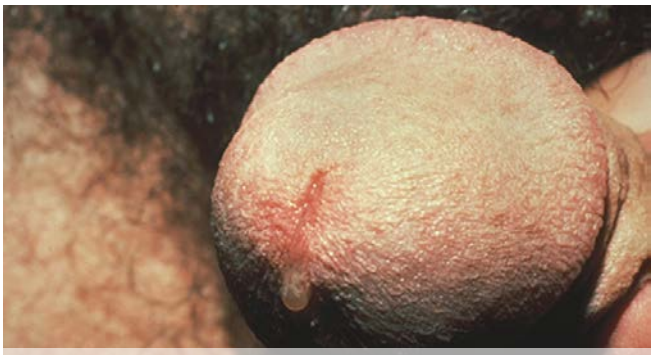
- Erythromycin base 500 mg orally four times a day for 7 days, OR
- Erythromycin ethylsuccinate 800 mg orally four times a day for 7 days, OR
- Levofloxacin 500 mg orally once daily for 7 days, OR
- Ofloxacin 300 mg orally twice a day for 7 days

Follow-Up

CT-infected men should be retested approximately 3 months after treatment to assess for repeat infection. Retesting can be performed opportunistically any time between 1-12 months post-treatment and should be performed regardless of whether the patient believes that their partners were treated.[46] Retesting is different from a TOC, which is typically performed to rule out treatment failure. TOC is not routinely recommended for CT.

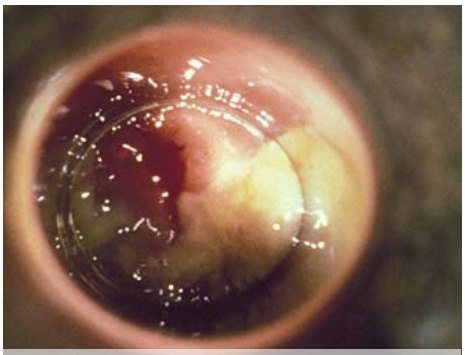
[46] STD Treatment Guidelines, 2015. MMWR. 2015;64(RR3). www.cdc.gov/std/tg2015/chlamydia.htm

Figure 7. Clinical manifestations of CT



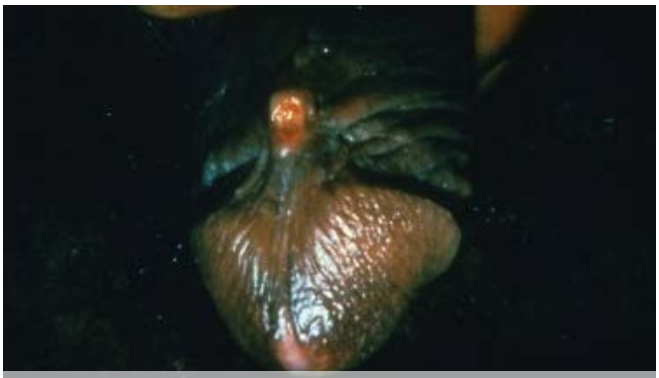
Seattle STD/HIV Prevention Training Center
Source: University of Washington

Nongonococcal urethritis.



Seattle STD/HIV Prevention Training Center
Source: Connie Celum; Walter Stamm

LGV proctitis with mucupurulent discharge.



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LGV primary lesion.

Gonorrhea (GC)

Urethral GC

Symptoms

Urethral GC can be asymptomatic in men (10-20%). Typically onset is abrupt with purulent urethral discharge often accompanied by severe dysuria, but discharge may be clear or cloudy, and mild dysuria can also occur. Onset of symptoms is about 2-10 days after exposure.

Diagnostic laboratory testing

- NAAT performed on urine specimens are the recommended testing method. If NAATs are unavailable, culture may be performed.
- Both culture and NAAT should be performed if there is suspicion for treatment failure due to a resistant strain of *N. gonorrhoeae.* Antimicrobial susceptibility testing should also be requested if culture is performed.
- Gram stain of urethral discharge can be used for symptomatic patients (sensitivity and specificity >95%), but is less sensitive in asymptomatic patients (50%).The presence of Gram negative intracellular diplococci (GNID) is diagnostic of GC.

Treatment

Recommended Regimen

Dual therapy administered concurrently with

- Ceftriaxone 250 mg in a single intramuscular (IM) dose **PLUS** Azithromycin 1 g orally in a single dose (*preferred)*

Alternative Regimens, if ceftriaxone is unavailable

Dual therapy administered concurrently with

- Cefixime 400 mg in a single oral dose **PLUS** Azithromycin 1 g orally in a single dose *(preferred)*

If the patient has cephalosporin allergy or history of severe allergy to penicillin:
Dual therapy administered concurrently with

- Gemifloxacin 320 mg in a single oral dose **PLUS** Azithromycin 2 g orally in a single dose, OR
- Gentamicin 240 mg in a single IM dose **PLUS** Azithromycin 2 g orally in a single dose

Follow-Up

GC-infected men should be retested approximately 3 months after treatment to assess for repeat infection, regardless of whether they believe that their partners were treated.[47] Retesting is different from a TOC, which is typically performed to rule out treatment failure. TOC is not routinely recommended for urethral GC.

[47] STD Treatment Guidelines, 2015. MMWR. 2015;64(RR3). www.cdc.gov/std/tg2015/gonorrhea.htm

Rectal GC

Symptoms

Rectal GC is mostly asymptomatic (more than 90%). When symptoms occur, they may include proctitis, anal irritation, painful defecation, constipation, rectal bleeding and/or discharge, and tenesmus. Anoscopic findings include mucopurulent discharge, mucosal erythema and easily induced mucosal bleeding.

Diagnostic laboratory testing

- NAAT performed on rectal swabs is the preferred testing method. Specimens must be sent to a laboratory that has established performance specifications for performing NAATs on rectal swabs.[48]

Treatment

Recommended Regimen

Dual therapy administered concurrently with

- Ceftriaxone 250 mg in a single intramuscular (IM) dose **PLUS** Azithromycin 1 g orally in a single dose (*preferred)*

Alternative Regimens, if ceftriaxone is unavailable

Dual therapy administered concurrently with

- Cefixime 400 mg in a single oral dose **PLUS** Azithromycin 1 g orally in a single dose *(preferred)*

If the patient has cephalosporin allergy or history of severe allergy to penicillin:
Dual therapy administered concurrently with

- Gemifloxacin 320 mg in a single oral dose **PLUS** Azithromycin 2 g orally in a single dose, OR
- Gentamicin 240 mg in a single IM dose **PLUS** Azithromycin 2 g orally in a single dose

Follow-Up

GC-infected men should be retested approximately 3 months after treatment to assess for repeat infection, regardless of whether they believe that their partners were treated.[49] Retesting is different from a TOC, which is typically performed to rule out treatment failure. TOC is not routinely recommended for rectal GC.

[48] For more information on NAATs in rectal and pharyngeal specimens contact the Health Department or visit the Association of Public Health Laboratories guidance for non-FDA cleared tests at the following links: Rectal swabs: www.cdph.ca.gov/programs/std/Documents/NAATRectalSwabs.pdf Pharyngeal swabs: www.aphl.org/aphlprograms/infectious/std/Documents/NAATThroatSwabs.pdf. A list of national labs that accept NAATs in rectal and pharyngeal specimens is available at www.aphl.org/aphlprograms/infectious/Archive/naatestlabs.aspx

[49] STD Treatment Guidelines, 2015. MMWR. 2015;64(RR3). www.cdc.gov/std/tg2015/gonorrhea.htm

Pharyngeal GC

Symptoms

Pharyngeal GC is mostly asymptomatic (~90%). Signs and symptoms that occur are similar to other causes of pharyngitis.

Diagnostic laboratory testing

- NAAT performed on pharyngeal swab is the preferred testing method. Specimens must be sent to a laboratory that has established performance specifications for performing NAATs on pharyngeal swabs.[48]
- Culture, if NAAT unavailable. Culture is less sensitive and requires use of selective media and environmental conditions that support the growth of *N. gonorrhoeae*.

Treatment

Recommended Regimen

Dual therapy administered concurrently with

- Ceftriaxone 250 mg in a single IM dose **PLUS** Azithromycin 1 g orally in a single dose

Follow-Up

GC-infected men should be retested approximately 3 months after treatment to assess for repeat infection, regardless of whether they believe that their partners were treated.[50]

The CDC also recommends patients treated with an alternative regimen for pharyngeal GC receive a TOC in 14 days using either culture or NAAT. If NAAT is positive, effort should be made to perform a confirmatory culture before retreatment. All positive TOC cultures should undergo antimicrobial susceptibility testing.

Symptoms that persist after treatment should be evaluated by culture for GC and undergo antimicrobial susceptibility testing.

[50] STD Treatment Guidelines, 2015. MMWR. 2015;64(RR3). www.cdc.gov/std/tg2015/gonorrhea.htm

Figure 8. Clinical manifestations of GC

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Urethral GC

Special Considerations for Suspected GC Treatment Failure

Recommendations for management of suspected GC treatment failure may change. Please refer to the California Gonorrhea Treatment Guidelines for Suspected Gonorrhea Treatment Failure[51] for the most updated information.

Treatment failure should be suspected if symptoms persist or recur following initial antibiotic therapy.

Figure 9: Symptoms of potential GC treatment failure by site of infection

Original site of infection	Potential treatment failure symptoms
Urethra	Discharge, dysuria, pyuria (leukocyte esterase on urine dipstick, or ≥ 10 white blood cells (WBC) per high power field on microscopy of urine sediment)
Pharynx	Pharyngitis or odynophagia
Rectum	Discharge, pain, bleeding, pruritis, tenesmus, or painful defecation

Prepared by the California Department of Public Health

For patients with suspected treatment failure, the following steps should be taken to ensure adequate testing, treatment, partner management, and follow up:

- Obtain specimens for NAAT and culture at sites of sexual exposure (i.e., genital, rectal, pharyngeal). If GC culture is not available at your local laboratory, contact the CDPH STD Control Branch clinician warm line at (510) 620-3400, Monday-Friday, 8am-5pm for assistance.
- Treat with either: 1) Gentamicin 240 mg IM **PLUS** Azithromycin 2 g orally, or 2) Gemifloxacin 320 mg orally **PLUS** Azithromycin 2 g orally.
- Report the case to your local health department within 24 hours. Please also call the CDPH STD Control Branch clinician warm line at (510) 620-3400.
- Ensure that all of the patient's partners in the last 60 days are notified and referred for testing and empiric treatment with the same regimen used to treat the index patient. Your local health department should be able to provide assistance with partner notification.
- Instruct the patient to abstain from oral, vaginal, and anal sex until one week after the patient and all of his/her partners are treated and all symptoms have resolved.
- Ensure that the patient returns in 7-14 days for a TOC with culture and NAAT.

[51] www.cdph.ca.gov/pubsforms/Guidelines/Pages/CAGuidelinesGonorrheaTxFailure.aspx

Note: Susceptibility testing should be performed for gonococcal isolates found on a positive TOC culture, including cephalosporin, macrolide, tetracycline, and fluoroquinolone susceptibility. If local susceptibility testing is performed, the specimen (or aliquot of the specimen) should be preserved for future analysis in the event that decreased susceptibility is identified.

The above recommendations are meant for patients with treatment failure after dual therapy with ceftriaxone plus azithromycin. Patients with persistent symptoms or a positive TOC after treatment with a non-recommended regimen (e.g. fluoroquinolones) should be treated with ceftriaxone 250 mg IM plus azithromycin 1g orally. For patients with treatment failure after azithromycin monotherapy, call the CDPH STD Control Branch clinician warm line for consultation.

If patient is allergic to ceftriaxone then additional therapies that can be considered include 1) gentamicin 240 mg IM plus azithromycin 2 g orally in a single dose or 2) gemifloxacin 320 mg orally in a single dose plus azithromycin 2 g orally in a single dose.

Reinfection should be suspected in a patient who reports interim sexual exposure to untreated or new sex partners. Patients with suspected reinfection should be treated with ceftriaxone 250 mg IM plus azithromycin 1 g orally. Providers do not need to inform the local health department for suspected reinfection cases.

For assistance or clinical consultation regarding patients with ongoing treatment failure, patients with severe allergies, or other challenging cases, please call the CDPH STD Control Branch clinician warm line at (510) 620-3400, 8 am – 5 pm, Monday – Friday and ask to speak with the clinician on call. For more information about STDs, please visit the CDPH STD Control Branch webpage: www.std.ca.gov.

Syphilis

Primary Syphilis

Symptoms

Primary syphilis is symptomatic, though ulcers may go unnoticed by patients. Lesions appear 10-90 days (average 3 weeks) after contact at the site of exposure, persist for days to weeks, and resolve without treatment. Typical lesions are single, painless, indurated, clean based ulcers. Atypical lesions can mimic herpes and other genital ulcers.

HIV-infected patients are more likely to have persistent lesions into the secondary stage, and are more likely to present with atypical lesions (40% compared to 25% in HIV-uninfected patients).

Further testing is warranted for persons with clinical signs of neurosyphilis (e.g., cranial nerve dysfunction, auditory or ophthalmic abnormalities, meningitis, stroke, acute or chronic altered mental status, and loss of vibration sense).[52]

Neurosyphilis can occur during any stage of syphilis (see Neurosyphilis).

Diagnostic Laboratory Testing

- Darkfield microscopy on exudate of lesion is the recommended point-of-care test, though it is not widely available. Sensitivity ranges between 80-90% and varies with time of processing, skill of examiner, and age of the lesion.
- STAT RPR can be performed to assist in diagnosis. If not available and high suspicion for syphilis exists, treat presumptively as described below.
- Simultaneous serologic testing for non-treponemal (RPR/VDRL) and treponemal (TP-PA/FTA-ABS/EIA/CIA) tests are recommended, as treponemal tests may become reactive sooner than non-treponemal tests in primary syphilis.[53] A negative RPR/VDRL does not exclude the diagnosis of primary syphilis. Reactive RPR/VDRL tests should be quantified for serologic follow up.

Treatment

Recommended Regimens

- Benzathine penicillin G 2.4 million units IM in a single dose[54]

Alternative Regimens

- Doxycycline 100 mg orally twice daily for 14 days, OR
- Tetracycline 500 mg orally four times daily for 14 days, OR
- Ceftriaxone 1 g IM or intravenous (IV) once daily for 10-14 days

Counsel MSM about the possibility of a Jarisch-Herxheimer reaction, an acute febrile reaction frequently accompanied by headache, myalgias, fever, and other symptoms that usually occurs within the first 24 hours after the initiation of any therapy for syphilis. This reaction does not indicate allergy to antibiotic therapy. Over-the-counter nonsteroidal anti-inflammatory medications may be taken for symptomatic relief.

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[52] STD Treatment Guidelines, 2015. MMWR. 2015;64(RR3). www.cdc.gov/std/tg2015/syphilis.htm

[53] Most patients who have reactive treponemal tests will have reactive tests for the remainder of their lives, regardless of treatment or disease activity.

[54] Available data demonstrate that additional doses do not enhance efficacy when used to treat primary and secondary syphilis, regardless of HIV status.

Follow-Up

MSM should be re-evaluated one to two weeks following treatment for improvement of clinical symptoms and signs. Any symptoms of the Jarisch-Herxheimer reaction can be documented at this time.

Follow-up Titers

HIV-negative patients should receive quantitative RPR/VDRL tests at 6 and 12 months. HIV-infected patients should be evaluated clinically and serologically at 3, 6, 9, 12, and 24 months.

Successful Serologic Response

Serologic response to treatment is defined as a four-fold (or two-dilutional) decrease in the follow-up test titer in comparison to the titer obtained on the day of treatment (e.g., 1:128 to 1:32), over the 6 to 12 month period following treatment.

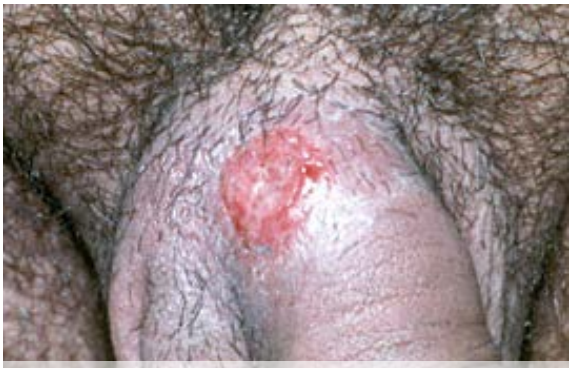
Serofast State

A persistent, low-level positive non-treponemal test titer (typically ≤1:8) is considered 'serofast', and has been found to occur more frequently in HIV-infected patients with syphilis. In the absence of a sustained (greater than 2 weeks) 4-fold rise in titer and/or re-emergence of symptoms and signs following treatment, such persons should be followed at least annually with clinical evaluation, risk assessment, and repeat serology to assess the need for repeat treatment, and lumbar puncture should be performed if neurologic signs or symptoms emerge.

Treatment Failure

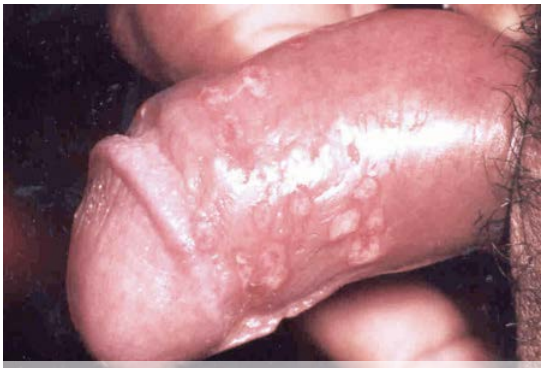
Consider treatment failure in patients with persistent or recurring signs or symptoms, or who have a sustained fourfold increase in RPR/VDRL test titer (i.e., compared with the maximum or baseline titer at the time of treatment). Patients with suspected treatment failure should be retreated and a CSF analysis performed to assess for neurosyphilis. Patients should be treated with weekly injections of benzathine penicillin G 2.4 million units IM for 3 weeks unless CSF examination indicates that neurosyphilis is present, in which case treatment for neurosyphilis should be initiated (see Neurosyphilis).

Figure 10. Clinical manifestations of primary syphilis



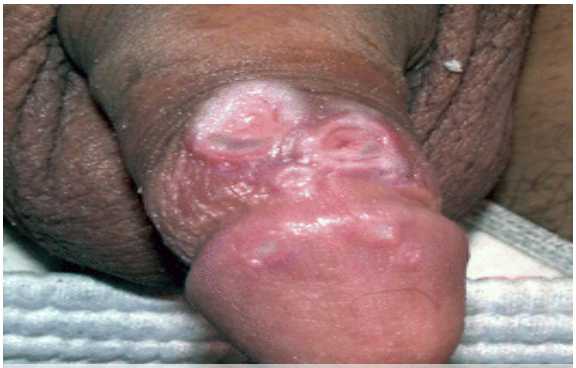
San Francisco City Clinic, Source: Dr. Joseph Engelman

Typical chancre/sore – rubber edges, non-tender.



San Francisco City Clinic, Source: Dr. Joseph Engelman

Unusual shallow, multiple chancres/sores mimicking genital herpes.



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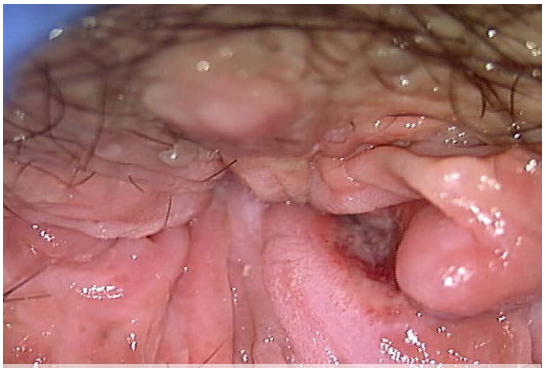
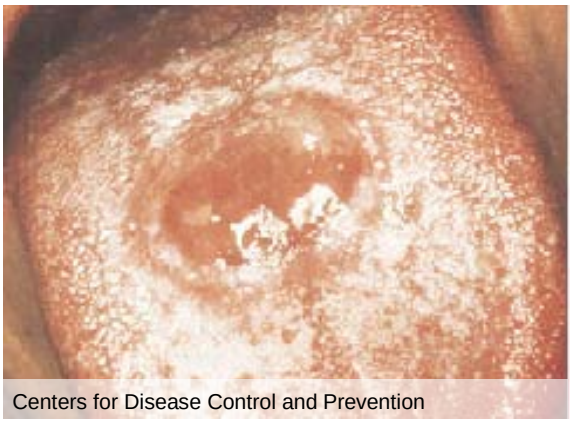
Multiple penile ulcers.



California STD Control Branch

Anal chancre.



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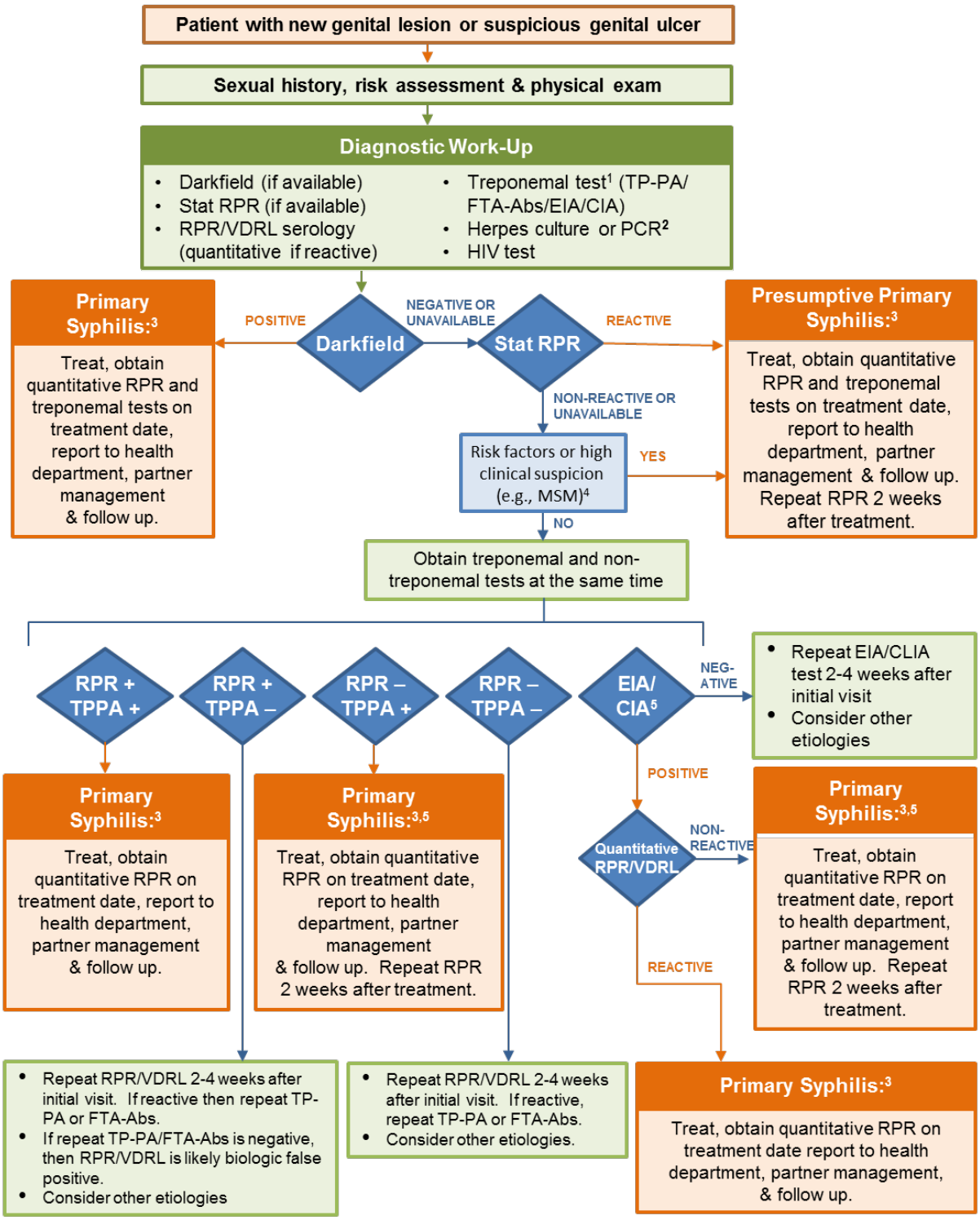
Tongue ulcer.

California STD/HIV Prevention Training Center*

Healing ulcer.

** reprinted from atlas of Sexually Transmitted Disease and AIDS,2nd/ed, Morse, Holmes, Ballard. Copyright 1996, with permission from Elsevier Science.*

Figure 11. Algorithm for evaluating patients for primary syphilis



Prepared by the California Department of Public Health

[1] Treponemal tests may be more sensitive than non-treponemal tests during primary syphilis.
[2] Also consider culture for *Haemophilus ducreyi* (chancroid) if exposure in endemic areas or if lesion does not respond to syphilis treatment.
[3] All patients with suspected syphilis should be tested for HIV infection and screened for other STDs. Repeat HIV testing of patients with primary syphilis 3 months after the first HIV test, if the first test is negative.
[4] If the patient is MSM or has high risk sexual behavior or clinical exam with classic features of a syphilitic ulcer, then standard of care includes presumptive treatment at the time of the initial visit before diagnostic tests are available. Presumptive treatment is also recommended if patient follow-up is a concern.
[5] If the patient does not respond to treatment, repeat RPR/VDRL after treatment and consider other etiologies.

Secondary Syphilis

Symptoms

Signs and symptoms typically occur 3-6 weeks after the primary stage and resolve within 2-10 weeks without treatment, with 15% of patients experiencing relapses of signs and symptoms in the first year.

Signs and symptoms are variable and include:

- Rash (75-90%), which is usually nonpruritic and may involve the palms and soles (60%). A secondary syphilis rash may be widespread or localized, florid or subtle, and can be one or more of the following:
    - Macular (flat)
    - Papular (raised)
    - Squamous (scaly)
    - Pustular (occurs rarely)
    - Annular (occurs rarely)
- Generalized lymphadenopathy (70-90%) most commonly affects the inguinal, axillary and cervical sites.
- Constitutional symptoms (50-80%) include malaise and fever.
- Mucous patches (5-25%) are characterized as flat gray-white patches on the mucous membrane in the oral cavity and genital area.
- Condylomata lata (5-25%) are moist, heaped, wart-like lesions in genital, peri-rectal and rectal areas, and the oral cavity.
- Alopecia (10-15%) is characterized by patchy or moth-eaten hair loss and/or loss of lateral eyebrows.
- Neurosyphilis can occur during any stage of syphilis (see Neurosyphilis).

Diagnostic Laboratory Testing

- STAT RPR can be performed to assist in diagnosis. If not available and high suspicion for syphilis exists, treat presumptively as described below.
- Non-treponemal (RPR/VDRL) serologic testing is recommended, with reflex to treponemal (TP-PA/FTA-ABS/EIA/CIA) testing to confirm syphilis if positive. Non-treponemal tests should be quantified for serologic follow up.[55] If patient has signs or symptoms consistent with secondary syphilis but the RPR/VDRL is negative, request the lab dilute serum to at least 1:16 to rule out a prozone reaction.[56]

Treatment

Recommended Regimens

- Benzathine penicillin G 2.4 million units IM in a single dose

Alternative Regimens

- Doxycycline 100 mg orally twice daily for 14 days, OR
- Tetracycline 500 mg orally four times daily for 14 days, OR
- Ceftriaxone 1 g IM or IV once daily for 10-14 days

[55] Most patients who have reactive treponemal tests will have reactive tests for the remainder of their lives, regardless of treatment or disease activity.

[56] The prozone reaction occurs in 1% of secondary syphilis cases, and is defined as a false negative non-treponemal test due to excess antibody blocking the antigen-antibody reaction.

Counsel patient about the possibility of a Jarisch-Herxheimer reaction, an acute febrile reaction frequently accompanied by headache, myalgias, fever, and other symptoms that usually occurs within the first 24 hours after the initiation of any therapy for syphilis. This reaction does not indicate allergy to antibiotic therapy. Over-the-counter nonsteroidal anti-inflammatory medications may be taken for symptomatic relief.

Follow-Up

MSM should be re-evaluated one to two weeks following treatment for improvement of clinical symptoms and signs. Any symptoms of the Jarisch-Herxheimer reaction can be documented at this time.

Follow-up Titers

HIV-negative patients should receive quantitative RPR/VDRL tests at 6 and 12 months. HIV-infected patients should be evaluated clinically and serologically at 3, 6, 9, 12, and 24 months.

Successful Serologic Response

Serologic response to treatment is defined as a four-fold (or two-dilutional) decrease in the follow-up test titer in comparison to the titer obtained on the day of treatment (e.g., 1:128 to 1:32), over the 6 to 12 month period following treatment.

Serofast State

A persistent, low-level positive non-treponemal test titer (typically ≤1:8) is considered 'serofast', and has been found to occur more frequently in HIV-infected patients with syphilis. In the absence of a sustained (greater than 2 weeks) 4-fold rise in titer and/or re-emergence of symptoms and signs following treatment, such persons should be followed at least annually with clinical evaluation, risk assessment, and repeat serology to assess the need for repeat treatment, and lumbar puncture should be performed if neurologic signs or symptoms emerge.

Treatment Failure

Consider treatment failure in patients with persistent or recurring signs or symptoms, or who have a sustained fourfold increase in RPR/VDRL test titer (i.e., compared with the maximum or baseline titer at the time of treatment). Patients with suspected treatment failure should be retreated and a CSF analysis performed to assess for neurosyphilis. Patients should be treated with weekly injections of benzathine penicillin G 2.4 million units IM for 3 weeks unless CSF examination indicates that neurosyphilis is present, in which case treatment for neurosyphilis should be initiated (see Neurosyphilis).

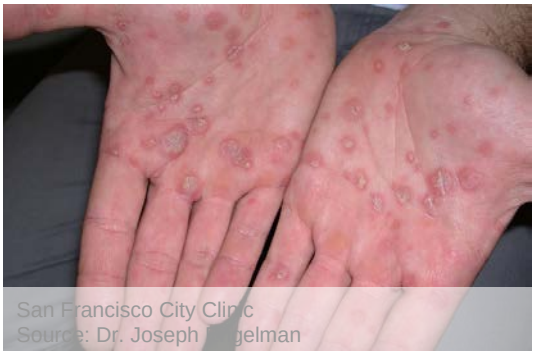
Figure 12. Clinical presentations of secondary syphilis

Centers for Disease Control and Prevention

Macular rash.

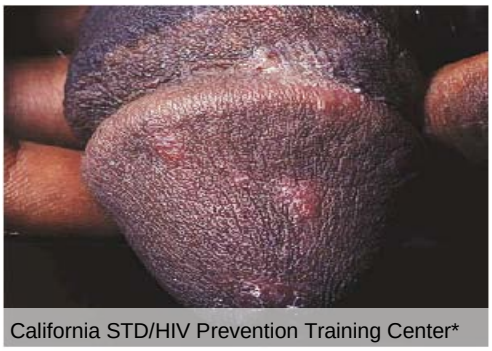
California STD/HIV Prevention Training Center*

Macular and papulosquamous rash.



San Francisco City Clinic
Source: Dr. Joseph Engelman

Palmar rash.

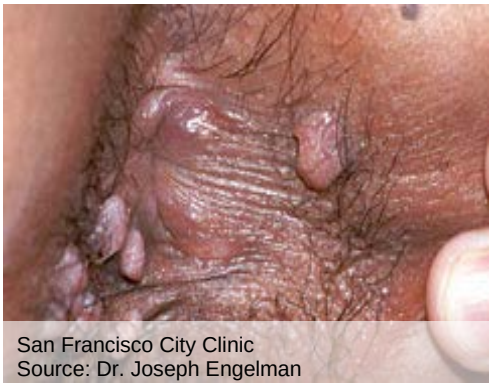


California STD/HIV Prevention Training Center*

Papulosquamous rash (penis).

Centers for Disease Control and Prevention

Papulosquamous rash.



San Francisco City Clinic
Source: Dr. Joseph Engelman

Condyloma lata (anus).

California STD/HIV Prevention Training Center*

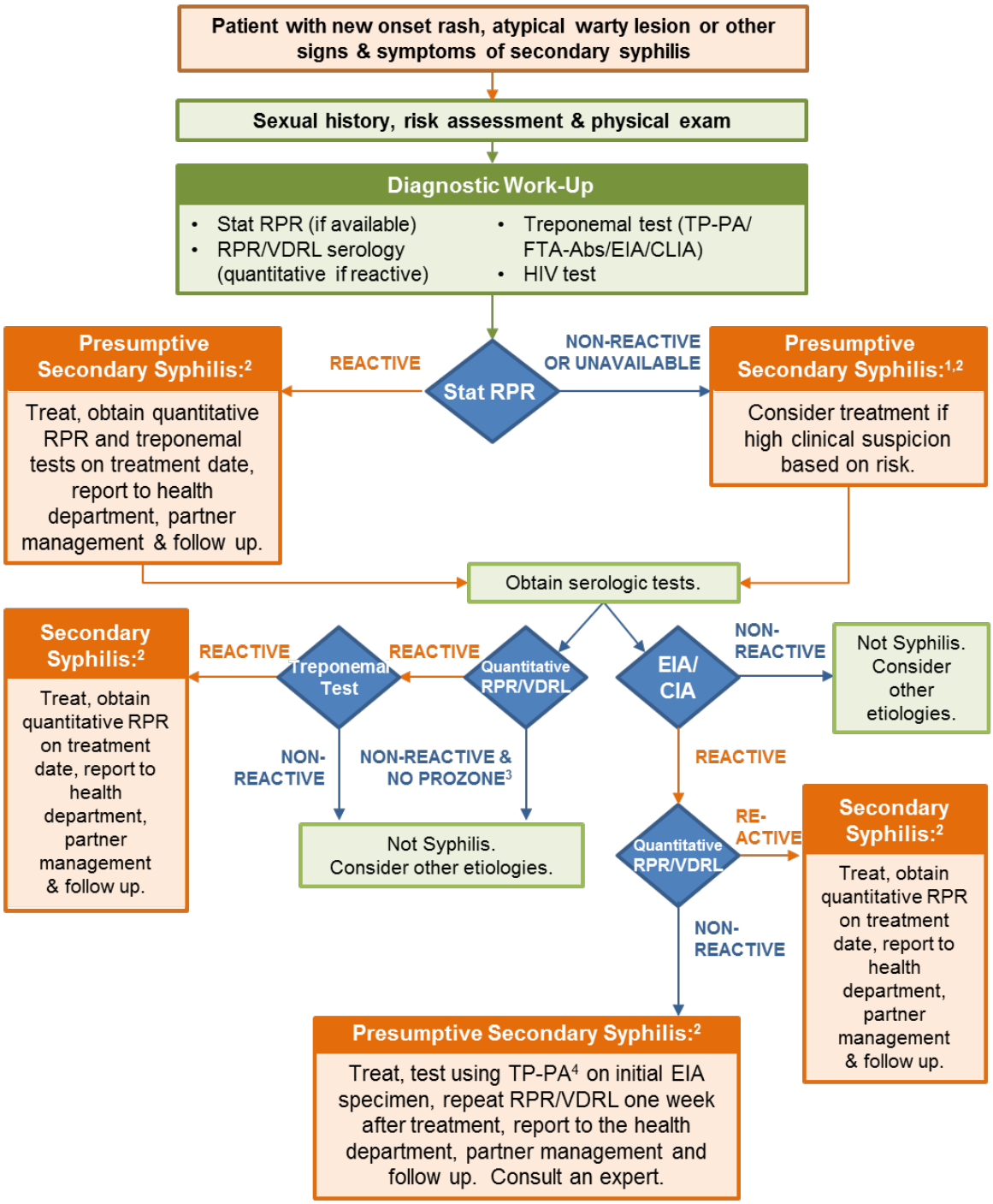
Mucous patches.

Centers for Disease Control and Prevention

Alopecia.

**Reprinted from Atlas of Sexually Transmitted Disease and AIDS,2nd/ed, Morse, Holmes, Ballard. Copyright 1996, with permission from Elsevier Science.*

Figure 13. Algorithm for evaluating patients for secondary syphilis



Prepared by the California Department of Public Health

[1] If the patient is MSM or clinical exam with classic features secondary syphilis, consider presumptive treatment at the time of the initial visit before the diagnostic tests are available. Presumptive treatment is also recommended if patient follow-up is a concern.

[2] All patients with suspected syphilis should be tested for HIV infection and screened for other STDs. Repeat HIV testing of patients with secondary syphilis 3 months after the first HIV test, if the first test is negative.

[3] Prozone reaction is a false negative RPR or VDRL from excess antibody blocking the antigen-antibody reaction.

[4] FTA-Abs is no longer considered the gold standard treponemal test. TP-PA tests for a different antigen than EIA/CIA, and should be used for a second treponemal test when EIS/CIA is positive and RPR is non-reactive.

Latent Syphilis

Latent syphilis is asymptomatic and is identified through routine serologic screening.

Diagnostic Laboratory Testing

- Non-treponemal (RPR/VDRL) serologic testing is recommended, with reflex to treponemal (TP-PA/FTA-ABS/EIA/CIA) testing to confirm syphilis if reactive. Non-treponemal tests should be quantified for serologic follow-up, and to confirm current infection when treponemal tests are used for screening.[57]
- If treponemal immunoassays are used as the initial test (e.g. EIA or CIA), please consult the Treponemal Test (EIA/CIA) Screening Algorithm for recommendations on interpretation of results. For more information regarding the use of treponemal immunoassays for syphilis diagnosis, consult the Reverse Sequence Syphilis Screening: Frequently Asked Questions.[58]

Staging

- Asymptomatic patients who acquired syphilis in the past 12 months are classified as having early latent syphilis. Early latent syphilis diagnosis is given if patient's only possible sexual exposure occurred in the past 12 months, or the patient has any of the following criteria in the past 12 months prior to evaluation:
    - Documented seroconversion of non-treponemal or treponemal tests or four-fold or greater increase in non-treponemal titer
    - Unequivocal symptoms of primary or secondary syphilis
    - Sex partner with documented primary, secondary or early latent syphilis
- Any patient who does not meet the above conditions should be classified as late latent syphilis or syphilis of unknown duration

Treatment

Early Latent (<1 year since last negative serology)

- Recommended Regimen
    - Benzathine penicillin G 2.4 million units IM in a single dose
- Alternative Regimens
    - Doxycycline 100 mg orally twice daily for 14 days, OR
    - Tetracycline 500 mg orally four times daily for 14 days, OR
    - Ceftriaxone 1 g IM or IV once daily for 10-14 days

Counsel patient about the possibility of a Jarisch-Herxheimer reaction, an acute febrile reaction frequently accompanied by headache, myalgias, fever, and other symptoms that usually occurs within the first 24 hours after the initiation of any therapy for syphilis. This reaction does not indicate allergy to antibiotic therapy. Over-the-counter nonsteroidal anti-inflammatory medications may be taken for symptomatic relief.

Late Latent Syphilis or Latent Syphilis of Unknown Duration

- Recommended Regimen
    - Benzathine penicillin G 7.2 million units total, administered as 3 doses of 2.4 million units IM each at 1-week intervals
- Alternative Regimens
    - Doxycycline 100 mg orally twice daily for 28 days, OR
    - Tetracycline 500 mg orally four times daily for 28 days

[57] Most patients who have reactive treponemal tests will have reactive tests for the remainder of their lives, regardless of treatment or disease activity.
[58] www.cdph.ca.gov/programs/std/Documents/STD-301-Reverse-sequence-FAQs.pdf

Follow-Up

Follow-up Titers

HIV-negative patients should receive quantitative non-treponemal serologic tests at 6, 12, and 24 months for latent infection. HIV-infected patients should be evaluated clinically and serologically at 3, 6, 9, 12, and 24 months.

Successful Serologic Response

Serologic response to treatment is defined as a four-fold (or two-dilutional) decrease in the follow-up test titer in comparison to the titer obtained on the day of treatment (e.g., 1:128 to 1:32), over the 12 to 24 month period following treatment.

Serofast State

A persistent, low-level positive non-treponemal test titer (typically ≤1:8), reflecting a 'serofast' state, has been found to occur more frequently in HIV-infected patients with syphilis. In the absence of a sustained (greater than 2 weeks) 4-fold rise in titer and/or re-emergence of symptoms and signs following treatment, such persons should be followed at least annually with clinical evaluation, risk assessment, and repeat serology to assess the need for repeat treatment, and lumbar puncture should be performed if neurologic signs or symptoms emerge.

Treatment Failure

Treatment failure should be considered and a CSF examination should be performed if one of the following criteria is met:

1. Titers increase fourfold,
2. An initially high titer (≥1:32) fails to decline at least fourfold (i.e., two dilutions) within 12–24 months of therapy, OR
3. Signs or symptoms attributable to syphilis develop.

In such circumstances, even if the CSF examination is negative, retreatment for latent syphilis should be initiated.

Tertiary Syphilis

Background

Tertiary syphilis is very rare in the United States. Approximately one-third of people with untreated syphilis will develop late destructive lesions of syphilis many years following infection (3-20 years). These may be benign or may often affect the cardiovascular and/or central nervous system.

Diagnostic Laboratory Testing

- CSF examination for neurosyphilis should be conducted for suspected tertiary syphilis cases.

Treatment

In patients with *no evidence of neurosyphilis*, treatment is the same as late latent syphilis:

Recommended Regimens

- Benzathine penicillin G 7.2 million units total, administered as 3 doses of 2.4 million units IM each at 1-week intervals

Alternative Regimens

- Doxycycline 100 mg orally twice daily for 28 days, OR
- Tetracycline 500 mg orally four times daily for 28 days

Counsel patient about the possibility of a Jarisch-Herxheimer reaction, an acute febrile reaction frequently accompanied by headache, myalgias, fever, and other symptoms that usually occurs within the first 24 hours after the initiation of any therapy for syphilis. This reaction does not indicate allergy to antibiotic therapy. Over-the-counter nonsteroidal anti-inflammatory medications may be taken for symptomatic relief.

In patients with tertiary syphilis and neurosyphilis, treatment should be given for neurosyphilis (see Neurosyphilis).

Follow-Up

Limited information is available concerning clinical response and follow-up of patients who have tertiary syphilis. Consult an infectious disease expert for recommendations.

Neurosyphilis

Neurosyphilis can occur during any stage of syphilis. The CDC recommends a CSF examination only be performed if patients have clinical evidence of neurologic involvement, have suspected treatment failure, or are diagnosed with tertiary syphilis.

Symptoms

Clinical evidence of neurologic involvement can include cognitive dysfunction, motor or sensory deficits, ophthalmic or auditory symptoms, cranial nerve palsies, and signs or symptoms of meningitis.

Diagnostic Laboratory Testing

The laboratory diagnosis of neurosyphilis usually depends on multiple laboratory abnormalities in the CSF. The following abnormalities may be present in an individual with neurosyphilis:

- CSF pleocytosis: >5 WBC/mm^3 in HIV-negative patients, >20 WBC/mm^3 in HIV-positive patients.
- Elevated CSF protein: range depends, consult local laboratory.
- Reactive CSF-VDRL: This is the standard serologic test for neurosyphilis. Unlike the serum VDRL, a reactive CSF-VDRL alone is sufficient to make a diagnosis of neurosyphilis. Sensitivity of the test varies – a patient with a non-reactive CSF-VDRL may still have neurosyphilis. Clinical correlation is recommended.

Non-reactive CSF FTA-ABS: although this test is not FDA approved for diagnostic use in the CSF, it may be used to *rule out* the diagnosis of neurosyphilis. Due to a high rate of false-positive results, it should not be used to make the diagnose neurosyphilis; however if the CSF-FTA-ABS is negative, neurosyphilis is highly unlikely.

Treatment

Recommended Regimens

- 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 Regimens

- Procaine penicillin G, 2.4 million units IM every four hours for 10-14 days, PLUS
- Probenecid 500 mg orally four times per day for 10-14 days

Follow-Up

If CSF pleocytosis was present initially, a CSF examination should be repeated every 6 months until the cell count is normal. Follow-up CSF examinations also can be used to evaluate changes in the CSF-VDRL or CSF protein after therapy; however, changes in these two parameters occur more slowly than cell counts, and persistent abnormalities might be less important. The leukocyte count is a sensitive measure of the effectiveness of therapy.[59]

If the cell count has not decreased after 6 months or if the CSF cell count or protein is not normal after 2 years, retreatment should be considered.

[59] STD Treatment Guidelines, 2015. MMWR. 2015;64(RR3). www.cdc.gov/std/tg2015/syphilis.htm

HIV

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HIV Risk

MSM are profoundly affected by HIV in the United States. In 2010, MSM accounted for 63% of estimated new HIV infections in the United States. Young MSM and MSM of color (particularly black/African-American MSM) bear a disproportionate burden of HIV infection. In 2011, the National HIV Behavioral Surveillance System, a study conducted in 20 cities in the United States, revealed that 18% of MSM tested were HIV-positive. The high prevalence of HIV in MSM places all MSM at increased risk of being exposed.[60]

While the long-term medical management of patients with HIV is outside the scope of this document, all healthcare providers of MSM should be able to:

- Screen and test for HIV infection,
- Identify acute HIV infection,
- Link newly-diagnosed patients to experienced care providers, and
- Counsel patients on HIV prevention methods, including biomedical strategies.

HIV Test Technology

HIV testing technology has improved in the last several years, such that newer tests have shortened the length of the window period substantially. Current HIV tests include:

- **Viral load tests.** These tests can identify HIV RNA in the plasma starting approximately 9-11 days after infection.
- **Fourth-generation combination antigen/antibody (Ag/Ab) immunoassays.** These advanced assays can detect both HIV antibodies and p24 antigen (a major core HIV protein).
    - The p24 antigen can be detected approximately 14 days after infection with HIV and often before HIV antibodies are present.
    - These fourth-generation assays are included in a recently approved laboratory HIV testing algorithm that is designed to identify acute HIV infection and differentiate between HIV-1 and HIV 2. This algorithm is available for use in California laboratories based on a regulation change in June 2013.
- **Third-generation immunoassays.** These assays detect HIV antibodies but not p24 antigen. Most people produce detectable HIV antibodies beginning approximately 3 weeks after infection.
- **HIV-1/HIV-2 antibody differentiation immunoassay.** This serves as the supplemental test in the new diagnostic algorithm.
- **Western blot.** This has been replaced by the HIV-1/HIV-2 antibody differentiation immunoassay in the new algorithm.

See Screening for HIV for information about asymptomatic screening for HIV.

[60] www.cdc.gov/hiv/risk/gender/msm/facts/index.html

Acute HIV Infection[61]

Acute HIV infection occurs immediately after infection; patients exhibit an initial burst of viremia; however anti-HIV antibodies are undetectable at that time. A significant percentage of new HIV infections are thought to be attributable to individuals with early HIV infection that may be unaware of their HIV status.[62]

Suspect acute HIV infection[61]

Signs or symptoms of acute HIV infection (acute antiretroviral syndrome) with a recent (within 2 to 6 weeks) high risk of exposure to HIV may include one or more of the following:

- Fever
- Lymphadenopathy
- Skin rash
- Myalgia/arthralgia
- Headache
- Diarrhea
- Oral ulcers
- Leukopenia
- Thrombocytopenia
- Transaminase elevation

High-risk exposures include:

- Sexual contact with an HIV-infected person or a person at risk of HIV infection
- Sharing injection drug use paraphernalia
- Contact of mucous membranes or breaks in skin with potentially infectious fluids

Presence of these symptoms or signs should motivate consideration of acute HIV infection even in the absence of reported high-risk behaviors.

Differential diagnosis includes, but is not limited to:

- Viral illnesses such as Epstein-Barr virus (EBV)- and non-EBV (e.g., cytomegalovirus) infectious mononucleosis syndromes, influenza, and viral hepatitis
- Streptococcal infection
- Syphilis

[61] National Institutes of Health. aidsinfo.nih.gov/guidelines/html/1/adult-and-adolescent-arv-guidelines/20/acute-and-recent--early---hiv-infection.

[62] Brenner et al. J Infect Dis, 2007; 195:951-9.

Evaluation/diagnosis of acute HIV infection:

For diagnostic purposes, acute infection is defined as detectable HIV RNA or p24 antigen (the antigen used in currently available HIV Ag/Ab combination assays), in serum or plasma in the setting of a negative or indeterminate HIV antibody test result.

- A reactive HIV antibody test or Ag/Ab test must be followed by supplemental confirmatory testing.
- A negative or indeterminate HIV antibody test in a person with a positive Ag/Ab test or in whom acute HIV infection is suspected requires assessment of plasma HIV RNA to assess for acute HIV infection.
- A positive plasma HIV RNA test, typically with a very high viral load, in the setting of a negative or indeterminate antibody result is consistent with acute HIV infection.

Patients presumptively diagnosed with acute HIV infection should have serologic testing repeated over the next 3 to 6 months to document seroconversion.

Antiretroviral therapy (ART) should be offered for early HIV infection.

Patients should be referred promptly to experienced HIV care providers for additional evaluation and treatment.

Initial laboratory evaluation will include

- HIV antibody testing, CD4 T-cell count, and plasma HIV RNA
- Complete blood count (CBC), chemistry profile, transaminases, Blood Urea Nitrogen (BUN), creatinine, and urinalysis
- Serologies for hepatitis A, B, and C
- Fasting blood glucose and serum lipids
- HIV genotypic resistance testing
- Other tests as clinically indicated

Linking to care

Individuals newly diagnosed with HIV should be linked to healthcare providers who are experienced in the treatment of HIV.

Visit California HIV/AIDS Service Referrals at www.cdcnpin.org/ca/ to locate HIV providers near your patient.

HIV Prevention in the Clinical Setting

Asking patients about their sexual history and practices allows providers to understand each patient's individual factors affecting risk and enables providers to tailor their educational and counseling messages to the patient. The type of sex practiced strongly modifies the risk of HIV transmission. Unprotected receptive anal intercourse confers the highest risk of HIV transmission compared to other types of sex acts; however, there are many other factors which affect risk including HIV viral load of the infected partner, presence of co-infections and the integrity of the mucosa exposed, among others.

Many methods exist to reduce the chances of acquiring HIV infection, including counseling patients about consistent and correct condom use, reducing the number of sexual partners, not sharing needles, and others.

The following biomedical strategies are also available for preventing HIV transmission:

- **Pre-Exposure Prophylaxis (PrEP).** This prevention method involves an HIV-negative individual taking antiretroviral medications every day to lower their risk of acquiring HIV. CDC recommends PrEP as one prevention option for sexually-active adult MSM at substantial risk of HIV acquisition. See Figure 14 for guidance on providing PrEP to patients.

- **Post–Exposure Prophylaxis (PEP).** This involves taking antiretroviral medications for 28 days starting as soon as possible (up to 72 hours) after exposure to HIV. PEP is not a long-term daily method of prevention but rather should be considered after a single event in which an individual may have been exposed to HIV (such as after an episode of unprotected sex).

- **Treatment as Prevention.** This concept refers to treating HIV-positive individuals with antiretroviral medications to suppress their viral load, resulting in subsequent improvement in their health and decreased chance of transmitting HIV to sexual partners.

There are now multiple HIV prevention strategies available for MSM. Talking with patients and identifying which strategies they can employ to protect themselves is a key component of reducing new HIV infections in MSM.

Figure 14. CDC Summary Guidance for HIV PrEP Use for MSM

Detecting substantial risk of acquiring HIV infection	• Adult man • Without acute or established HIV infection • Any sex partners in past 6 months • Not in a monogamous partnership with a recently tested, HIV-negative partner AND at least one of the following • Any anal sex without condoms (receptive or insertive) in past 6 months • Any STD diagnosed or reported in past 6 months • Is in an ongoing sexual relationship with an HIV-positive partner • Is a man who has sex with both women and men (behaviorally bisexual)
Clinically Eligible	• Documented negative HIV test result before prescribing PrEP • No signs/symptoms of acute HIV infection • Normal renal function • No contraindicated medications • Documented HBV infection and vaccination status
Prescription	Daily, continuing, oral doses of TDF/FTC[63] (Truvada), ≤90-day supply
Other Services	Follow-up visits at least every 3 months to provide the following: • HIV test • Medication adherence counseling • Behavioral risk reduction support • Side effect assessment • STD symptom assessment At 3 months and every 6 months thereafter, assess renal function Every 6 months, test for bacterial STD's, including oral/rectal STI testing.

Prepared by the California Department of Public Health

The complete PrEP Guidelines are available online: www.cdc.gov/hiv/pdf/PrEPguidelines2014.pdf

Supplementary materials for providers are also available, including checklists, patient information sheets, supplemental counseling information, and PrEP-related diagnosis and billing codes: www.cdc.gov/hiv/pdf/PrEPProviderSupplement2014.pdf

[63] TDF is tenofovir disoproxil fumarate (trade name Viread®), FTC is emtricitabine (trade name Emtriva)

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VIRAL HEPATITIS (A, B, AND C)

CDPH MSM Toolkit

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Hepatitis A, B, and C: Whom to Test and Vaccinate[64]

Most people with viral hepatitis do not know they are infected. Chronic viral infection with hepatitis B virus (HBV) and/or hepatitis C virus (HCV) is associated with cirrhosis, liver cancer, and liver failure. Complications can be prevented or mitigated by early detection, treatment, and lifestyle changes (e.g., reducing alcohol intake). Serologic testing is the primary means for identifying persons with viral hepatitis infection.

1. ***All MSM are recommended for HAV vaccination.***

2. ***All MSM are recommended for HBV testing and vaccination.***

   We recommend that all MSM receive HBV vaccination and testing for hepatitis B surface antigen (HBsAg) and the antibody to hepatitis B surface antigen (anti-HBs) at the same visit. HBsAg testing is not a requirement for vaccination, and lack of testing should not limit vaccination. Following testing, if completed, patients who have negative HBsAg and negative anti-HBs should be given second and third doses per the vaccine schedule at 1 and 6 months post initiation. Patients with anti-HBs are immune and do not need follow-up doses. Patients with positive HBsAg should be evaluated for HBV infection and be linked to care. An alternate dosing schedule of four doses may be used in some populations and risk groups.

3. ***Populations recommended for HCV testing:***

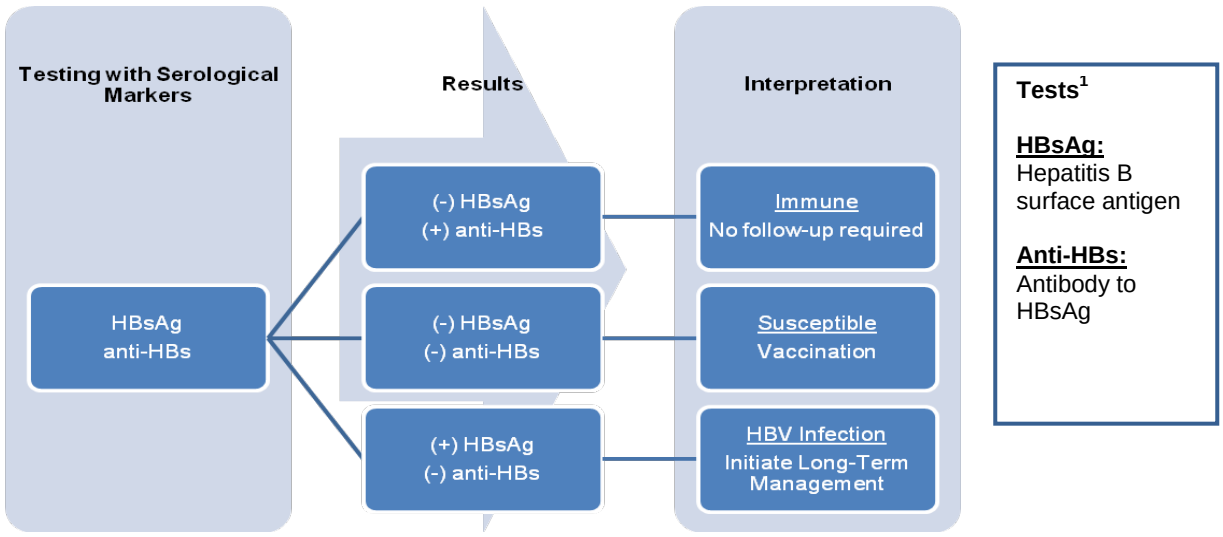
   - Persons who currently or have ever injected illegal drugs, including those who injected only once many years ago
   - Persons with selected medical conditions:
     - All persons with HIV infection, including annual screening for MSM with HIV infection
     - Patients with signs or symptoms of liver disease (e.g., abnormal liver enzyme test results)
     - Recipients of clotting factor concentrates made before 1987
     -
     - Patients who have ever received long-term hemodialysis
   - Persons born during the years 1945-1965
   - Children born to HCV-positive mothers should be tested after 18 months of age to avoid detection of maternal antibodies
   - Persons with known HCV exposures (e.g., healthcare workers after needlesticks involving HCV positive blood)

[64] Access CDC recommendations and other clinical guidelines for viral hepatitis prevention, testing, management, and care as well as patient education materials at www.cdc.gov/hepatitis or www.cdph.ca.gov/programs/Pages/ovhp.aspx.

Hepatitis B Testing and Clinical Management

Hepatitis B is an infection caused by the hepatitis B virus (HBV). Chronic hepatitis B infection is associated with cirrhosis, liver cancer, and liver failure. These complications can be prevented or mitigated by treatment and lifestyle changes (e.g., reducing or eliminating alcohol use and practicing other forms of liver self-care). Serologic testing is the primary means for identifying persons with hepatitis B infection. An effective vaccine is available to prevent HBV transmission.

Figure 15. HBV testing, interpretation, and follow-up



[1]*Another HBV test is total antibody to hepatitis B core antigen (anti-HBc), which can be used to distinguish whether immunity is due to past infection (anti-HBc-positive) or to previous vaccination (anti-HBc-negative). In patients with chronic HBV infection, anti-HBc is present. In the absence of HBsAg or anti-HBs, an anti-HBc-positive test result has one of four interpretations: 1) recovering from acute HBV infection; 2) distantly immune, test not sensitive enough to detect low level of anti-HBs; 3) susceptible with a false positive anti-HBc; or 4) chronically infected with an undetectable level of HBsAg.*

Prepared by the California Department of Public Health

HBV Vaccination for adults

- 3 doses are administered at 0, 1, 6 months; a combination HAV/HBV vaccine is available and follows the same dosing schedule.
- If partially vaccinated, the patient does not need to restart the series.
- Vaccination is safe and recommended for HIV-infected persons.
- Post-vaccine serology testing (anti-HBs) is recommended for household, needle-sharing, and sexual contacts of HBsAg-positive persons, HIV-positive persons, and healthcare workers.
- Booster doses may be indicated for HIV-infected persons, immunocompromised persons, and persons who do not develop effective immune response.
- Patients on hemodialysis and persons with known exposure to HBV may require 4 doses of HBV vaccine following a 0, 1, 2, 12 month schedule.

Principles of Long-Term HBV Management

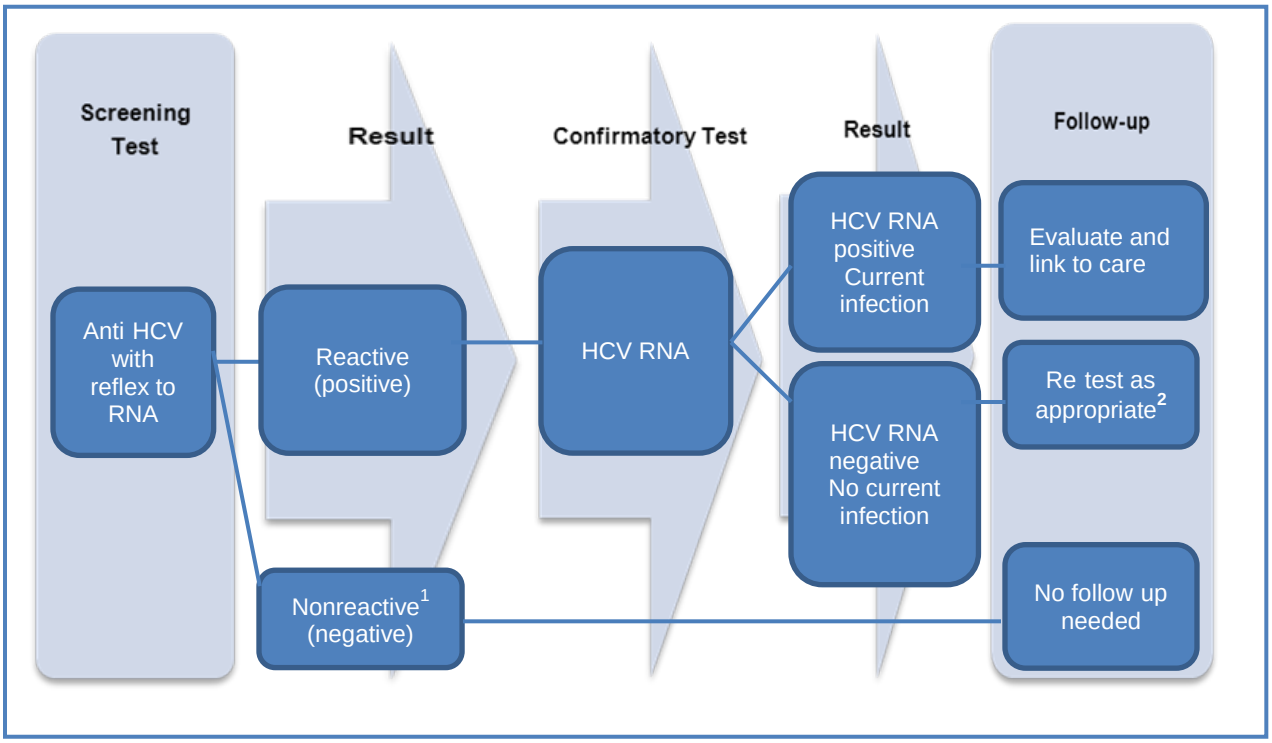
- Provide patient with culturally and linguistically appropriate educational materials (see links below).
- Report case to the local health department or via CalREDIE provider portal within seven days (www.cdph.ca.gov/DATA/INFORMATICS/TECH/Pages/CalREDIEHelp.aspx). Forms and contact information for reporting cases to the local health department can be accessed at: www.cdph.ca.gov/healthinfo/Pages/ReportableDiseases.aspx.
- Vaccinate against HAV (unless immune as indicated by presence of anti-HAV in serum).
- Encourage patient's sex partners, household members, and injection-drug sharing contacts to seek HBV testing, medical evaluation, and vaccination.
- Counsel patient to minimize consumption of alcohol and other liver toxins.
- Counsel patient to avoid sharing razors, toothbrushes, and personal injection equipment.
- Seek a HBV-experienced clinician to evaluate for, manage, and treat HBV infection.
- When referring patients, provide the following test results, if possible:[65]
    - Serologic and virologic tests:
        - anti-HBs
        - HBsAg
        - anti-HBc
        - HBeAg (hepatitis B e antigen)
        - anti-HBe (antibody to HBeAg)
        - HBV DNA
        - anti-HAV (HAV antibody)
        - anti-HCV (HCV antibody)
        - anti-HDV (Hepatitis Delta Virus antibody)
        - HIV
    - Other tests:
        - CBC with platelets
        - hepatic panel
        - PT/INR (prothrombin time/International Normalized Ratio)
        - AFP (alpha-fetoprotein)
        - ultrasound (if high risk per AASLD guidelines)[63]
- Access clinical guidelines for HBV prevention, testing, management, and care as well as HBV patient education materials at www.cdc.gov/hepatitis/ or www.cdph.ca.gov/programs/Pages/ovhp.aspx.

[65]-American Association for the Study of Liver Disease guidelines: www.aasld.org/practiceguidelines/pages/default.aspx

Hepatitis C Testing and Clinical Management

Hepatitis C is an infection caused by the hepatitis C virus (HCV). Chronic infection with HCV is associated with liver failure, cirrhosis, and liver cancer. Significant advances in the development of interferon (IFN) sparing antiviral agents have made current treatment options more effective and easier to tolerate than traditional IFN based regimens. HCV treatment may be managed in primary care settings. Treatment of HCV and lifestyle changes (such as eliminating alcohol use) can prevent or mitigate the complications of chronic hepatitis C infection. Serologic testing is the primary way to identify persons with hepatitis C infection. Currently, no vaccine is available to prevent transmission of HCV.

Figure 16. HCV testing, interpretation, and follow- up[66]



Prepared by the California Department of Public Health

Anti-HCV: Detects the presence of antibodies to the virus, indicating exposure to HCV
HCV RNA: Detects the presence (qualitative) or amount (quantitative) of virus and to diagnose current infection

[1] For persons who might have been exposed to HCV within the past 6 months, qualitative testing for HCV RNA or follow-up testing for HCV antibody is recommended. For persons who are immunocompromised, testing for HCV RNA can be considered.

[2] To differentiate past, resolved HCV infection from biologic false positivity for HCV antibody, testing with another HCV antibody assay can be considered. Repeat HCV RNA testing if the person tested is suspected to have had HCV exposure within the past 6 months or has clinical evidence of HCV disease, or if there is concern regarding the handling or storage of the test specimen.

[66] MMWR 2013, 62 (18):362-365. www.cdc.gov/mmwr/preview/mmwrhtml/mm6218a5.htm

Evaluation and Management

- Report case to local health department or via CalREDIE provider portal within 7 days (www.cdph.ca.gov/DATA/INFORMATICS/TECH/Pages/CalREDIEHelp.aspx). Forms and contact information for reporting cases to the local health department can be accessed at: www.cdph.ca.gov/healthinfo/Pages/ReportableDiseases.aspx.
- Vaccinate patient against HAV and HBV unless immune.
- Seek a HCV experienced clinician to evaluate for, manage, and treat chronic HCV infection, either by referral or through clinical consultation.
- When referring patient, provide the following test results, if possible:[67]
  - Serologic and virologic tests:
    - anti-HBs
    - HBsAg
    - anti-HAV (HAV antibody)
    - anti-HCV (HCV antibody)
    - HCV RNA, quantitative
    - HCV genotype with subtype
    - HIV
  - Other tests:
    - CBC with platelets
    - hepatic panel
    - PT/INR (prothrombin time/International Normalized Ratio)
    - AFP (alpha-fetoprotein)
    - ultrasound (if high risk per AASLD guidelines)[65]
- Access clinical guidelines for HCV prevention, testing, management, and care at www.hcvguidelines.org/ or the CDPH Office of Viral Hepatitis Prevention webpage: www.cdph.ca.gov/programs/Pages/HepatitisCGuidelines.aspx

Patient Counseling

- Counsel patient on the meaning of the test results: a positive HCV antibody test result indicates exposure to HCV (past or present infection); HCV RNA testing is needed to diagnose current HCV infection.
- Advise patient to reduce or eliminate intake of alcohol and other liver toxins
- Counsel patient to practice safer injection, avoid sharing personal items that might have blood on them, such as razors, and follow infection control guidelines in healthcare settings.
- Counsel patient to practice safer sex when engaging with multiple sex partners or persons infected with HIV.
- Provide patient with culturally and linguistically appropriate educational materials.

[67] American Association for the Study of Liver Disease guidelines: aasld.org/practiceguidelines/pages/default.aspx.

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ENHANCING THE CARE SETTING

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Creating a Welcoming Environment for Lesbian, Gay, Bisexual, & Transgender (LGBT) Patients[68]

The Physical Environment

LGBT patients often scan an office to help them determine what information they feel comfortable sharing with their health-care provider. Consider implementing some of the following strategies as appropriate for the type and location of your office:

- Include relevant information for LGBT patients in brochures, educational materials, and trainings.
- Post a rainbow flag, pink triangle, or other LGBT-friendly symbols or stickers.
- Exhibit posters showing diverse same-sex couples or transgender people, or posters from nonprofit LGBT or HIV/AIDS organizations.
- Display brochures (multilingual when possible and appropriate) about LGBT health concerns.
- Disseminate or visibly post a non-discrimination statement that equal care will be provided to all patients, regardless of age, race, ethnicity, physical ability or attributes, religion, sexual orientation, or gender identity/expression.
- Acknowledge relevant days of observance in your practice such as World AIDS Day, LGBT Pride Day, and National Transgender Day of Remembrance.
- Display LGBT-specific media, including local or national magazines or newsletters about and for LGBT and HIV-positive individuals.
- Designate a universal gender-inclusive "Restroom" with unisex signs.
- Display a confidentiality statement prominently and provide it in writing to every patient.

Intake Forms

Filling out the intake forms gives patients one of their first and most important impressions of your office. The experience sets the tone for how comfortable a patient feels being open about their sexual orientation or gender identity/expression.

Suggestions for adapting intake forms include the following:

- Change the term "marital status" to "relationship status" and add "partner" wherever the word "spouse" is used.
- Add "male to female" and "female to male" transgender options to the male/female check boxes on your intake form.

On the following page are a few sample questions to include as part of your intake form or when taking an oral history as part of a comprehensive intake.

[68] Excerpted with permission from "Guidelines for Care of Lesbian, Gay, Bisexual and Transgender Patients," created by the Gay and Lesbian Medical Association (GLMA). May 2005.
www.glma.org/_data/n_0001/resources/live/welcoming%20environment.pdf

Sample Questions for a LGBT-Friendly Intake Form

Legal name:

Name I prefer to be called (if different):

Preferred pronoun?
- She
- He

What is your sex or current gender? (Check all that apply)
- Male
- Female
- TransMale/Transman
- TransFemale/Transwoman
- Genderqueer
- Additional category (Please Specify): _____
- Decline to state

What sex were you assigned at birth?
- Male
- Female
- Decline to state

Are your current partners:
- Men
- Women
- Both

In the past, have your sexual partners been:
- Men
- Women
- Both

Current relationship status: (An alternative is to leave a blank line next to relationship status)
- Single
- Married
- Domestic Partnership/Civil Union
- Partnered
- Involved with multiple partners
- Separated from spouse/partner
- Divorced/permanently separated from spouse/partner
- Other (leave space for patient to fill in)

Living situation:
- Live alone
- Live with spouse or partner
- Live with roommate(s)
- Live with parents or other family members
- Other (leave space for patient to fill in)

Children in home:
- No children in home
- My own children live with me/us
- My spouse or partner's children live with me/us
- Shared custody with ex-spouse or partner

Sexual Orientation Identity:
- Bisexual
- Gay
- Heterosexual/Straight
- Lesbian
- Queer
- Not Sure
- Don't Know
- Other (state "please feel free to explain" and leave a blank space to fill in)

More sample questions available at glma.org/ and the Center of Excellence for Transgender Health at transhealth.ucsf.edu/trans?page=lib-data-collection.

Language

Listen to your patients and how they describe their own sexual orientation, partner(s), and relationship(s), and reflect their choice of language. Be aware that although many LGBT people may use words such as “queer,” “dyke,” and “fag” to describe themselves, these and other words have been derogatory terms used against LGBT individuals and are not appropriate for use by healthcare providers.

Staff Sensitivity and Training

Training for all staff is critical to creating and maintaining a practice environment deemed safe for LGBT patients. Training should be periodic to address staff changes and keep all staff up-to-date.

- Designate an onsite LGBT resource person to answer any staff questions that arise.
- Make sure entire office staff is trained to use transgender patient’s preferred pronoun and name. Clearly indicate this information on their medical record and in a manner that allows you to easily reference it for future visits.
- Have indications and mechanisms for referral to LGBT-identified or LGBT-friendly providers.
- Make it clear to employees that discrimination against LGBT individuals will not be tolerated. Monitor compliance and provide a mechanism for patients to report any disrespectful behavior.

The Gay and Lesbian Medical Association (GLMA) has developed a Cultural Competence Webinar Series[69], which includes additional information about creating welcoming environments for LGBT patients.

[69] www.glma.org/index.cfm?fuseaction=Page.viewPage&pageId=1025&grandparentID=534&parentID=940

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STD/HIV PARTNER SERVICES

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Frequently Asked Questions

What are Partner Services?

Partner Services are safe, evidence-based, effective public health interventions that assist people with HIV infection or an STD in telling their sexual and needle sharing partner(s) about possible disease exposure to facilitate testing and referral to treatment. Partner Services are **voluntary and confidential**. Follow-up with their partners is conducted without disclosing any identifying information about the individual believed to be infected or the physician making the report.

Why is it important?

Studies have shown that **20%** of partners tested through HIV Partner Services programs are identified as **new HIV positive cases**.[70] Informing previous partners of people testing positive for HIV and STD is both a personal responsibility of the patient and a public health responsibility.

How can providers help?

Medical providers and other healthcare professionals have a key role in this process. It is the role of the provider to **motivate their patient** to engage in this valuable public health intervention. The CDC **strongly recommends** that all persons with newly diagnosed or reported HIV infection or early syphilis receive partner services with active health department involvement. In certain instances, some local health jurisdictions are also initiating partner services with high priority GC cases.[71] Trained staff at your local health department are available to assist you and your patients by providing voluntary and confidential partner services to patients infected with HIV or other STDs.

How do providers access partner services?

We recommend contacting your local health department STD and/or HIV program to speak to the partner services specialist staff directly. In some cases, the partner services staff can meet the patient at your clinic when they return for results to provide STD or HIV Partner Services. Communicate with your local health department staff to develop the best strategy for referral of your patients to partner services.

How does it work?

A local health department partner services specialist can assist STD and HIV positive patients with informing their sexual and/or needle sharing partners about possible exposure to STD/HIV.

[70] Hogben, et al. Am J Prev Med. 2007 Aug;33(2 Suppl):S89-100.
[71] MMWR 2008;57(No. RR-9), www.cdc.gov/mmwr/pdf/rr/rr5709.pdf

What happens:

Health department staff engage the original patient in a counseling session in a private and confidential setting.

- Information is provided regarding current infection(s) and other STDs.
- Recent sexual and needle sharing behaviors and places where patients meet partners are discussed. Personal identifying and contact information is elicited for all relevant partners.
- Client-centered counseling is used to develop risk reduction plans to reduce the likelihood of acquiring future STDs.
- Referrals to additional medical or social services are provided.

AND

Health department staff follow-up with the patient's sexual and/or needle sharing partners[72]

- Locatable partners are confidentially contacted by phone, email or in person to inform them that they may have been exposed to HIV and/or an STD.
- No names or identifiers are ever revealed to maintain the anonymity and privacy of the original patient.
- Partners are referred for relevant testing and treatment services. Linkage to HIV care services are provided, as necessary.
- If appropriate, referrals to substance use and mental health programs are offered.

How does Partner Services benefit clinicians and patients?

Benefits to Patients and Partners	Benefits to Clinicians
• Prevents STD or HIV-infected patient from having to reveal presence of STD or HIV status • Fulfills ethical desires for the patient • Provides information about real risk of HIV or STD infection to partners • Provides an opportunity to prevent new infections (e.g., treatment during incubation for STD) • Provides an opportunity to learn status and link to care, for those who may be infected and not know it • Links patients to other services • Intervenes in the spread of STDs or HIV to other partners or unborn children	• Fulfills public health and ethical concerns • Improves patient outcomes, particularly among HIV-infected patients • Provides ongoing health department support to meet legal obligations

[72] California Health and Safety Code 120555, available via www.cdph.ca.gov/programs/std/Documents/CDPH-STD-Regulations-Digest.pdf

PUBLIC HEALTH REPORTING

CDPH MSM Toolkit

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STD/HIV Reporting Requirements in California

The California Health and Safety Code[73] requires healthcare providers and clinical laboratories to report HIV infection by patient name to the local health officer and mandates local health officers to report unduplicated HIV cases by patient name to CDPH.[74]

California law also requires healthcare providers and laboratories to report a case or suspected case of any of the diseases or conditions listed in the table below (Figure 17) to the local health department. [75]

For more information on California law related to reporting, please visit the following CDPH webpages:

HIV/AIDS Surveillance:
cdph.ca.gov/programs/aids/Pages/tOAHIVRptgSP.aspx

HIV/AIDS Legislation and Regulation:
cdph.ca.gov/programs/aids/Pages/OAHIVAIDSLaws.aspx

STD Legislation and Regulation:
cdph.ca.gov/programs/std/Documents/CDPH-STD-Regulations-Digest.pdf

All Reportable Diseases and Conditions:
cdph.ca.gov/healthinfo/Pages/ReportableDiseases.aspx

Figure 17: Reporting requirements by infection or disease

Timing of Report	Infection or Disease	Corresponding Form
Immediately by telephone	Outbreak of any sexually transmitted infection in multiple individuals	CDPH 110a or via the California Reportable Disease Information Exchange (CalREDIE)[76]
Within **one day**	Syphilis (suspect or confirmed) HAV	
Within **7 days**	Chancroid CT infections (including LGV) Gonococcal infections HBV (specify acute case or chronic) HCV (specify acute case or chronic) HDV Hepatitis, other, acute	
	HIV/AIDS	CDPH 8641A

[73] Health and Safety Code, Section 121022(a)
[74] Health and Safety Code, Sections 2641.5-2643.20 provide specificity for reporting cases of HIV.
[75] California Code of Regulations, Title 17, Section 2500(j)
[76] CalREDIE is California's web-based disease surveillance and case management system. It includes a Provider Portal where providers can enter their confidential morbidity reports (CMR) into a secure web browser, with no need for paper reporting.

STD/Hepatitis Reporting

To report STD or hepatitis, complete a Confidential Morbidity Report (CMR) form (CDPH 110a), available at www.cdph.ca.gov/pubsforms/forms/CtrldForms/cdph110a.pdf. CMRs should be submitted to the local health jurisdiction in which the patient resides, as required by law. Blank forms with appropriate health jurisdiction contact information are available from the local health department for reporting.

Instead of reporting by fax or mail, CalREDIE, California's web-based disease surveillance and case management system, has a Provider Portal where providers can enter their CMR reports into a secure web browser, with no need for paper reporting. In addition to reporting new cases, CalREDIE can be used to see which cases you have reported in the past and generate basic reports.

To find out the status of the CalREDIE Provider Portal in your area, contact your local health jurisdiction or email calrediehelp@cdph.ca.gov.

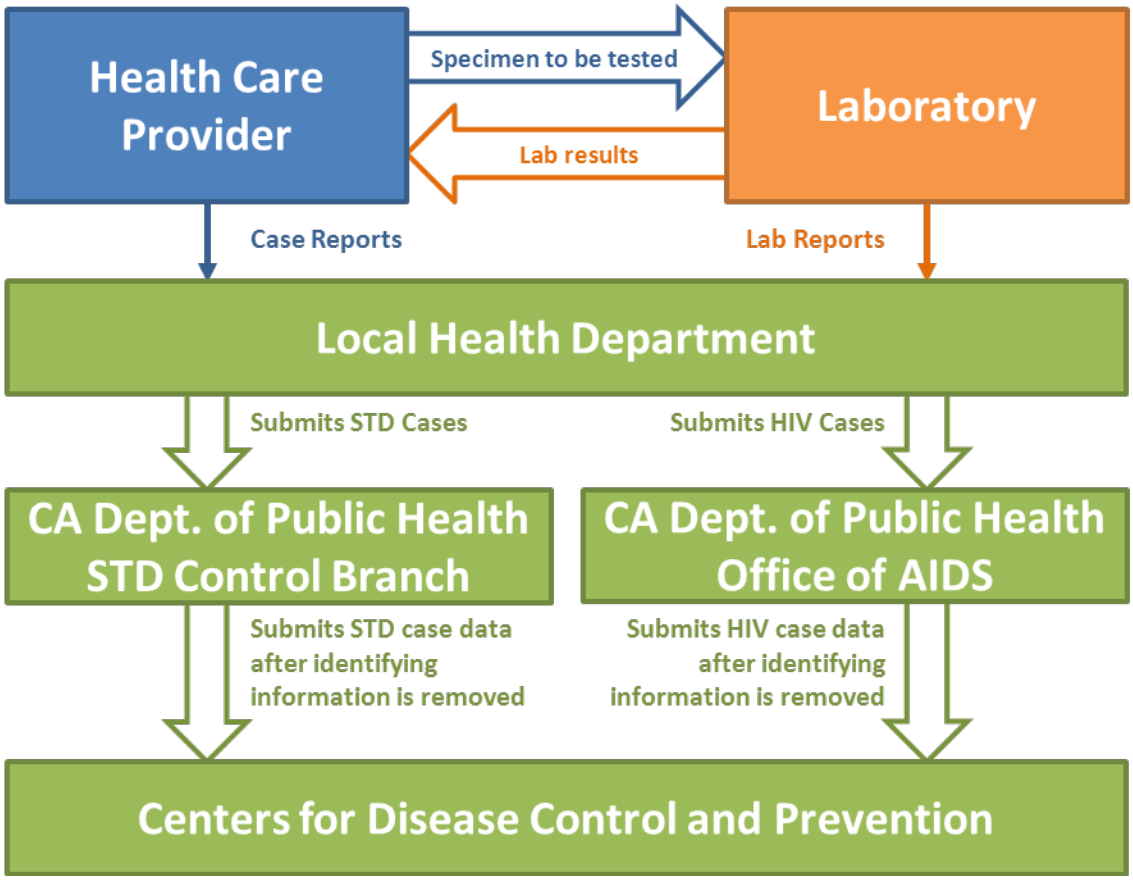
Contact Information for California Local Health Departments is available at www.cdph.ca.gov/HealthInfo/Documents/LHD_CD_Contact_Info.doc

HIV Reporting

To report a case of HIV infection or AIDS, complete the CDPH HIV/AIDS Confidential Case Report Form (CDPH 8641A) available at www.cdph.ca.gov/pubsforms/forms/CtrldForms/cdph8641a.pdf. Contact your local health department's HIV/AIDS surveillance program for information on how to fill out the form and where to send the completed form. The form must be sent to your local health department, not to CDPH. California law requires healthcare providers to submit HIV/AIDS case reports to the local health department within seven calendar days.

For copies of the case report form, information about how to submit case reports in a secure and confidential manner, or for any other inquiries about the reporting process, please contact your local health department's HIV/AIDS surveillance program, or visit the CDPH HIV/AIDS Case Reporting page at www.cdph.ca.gov/programs/aids/Pages/OARptgProviders.aspx.

Figure 18. California name-based disease reporting system



Prepared by the California Department of Public Health

Special Reporting Procedures for Syphilis[77]

All cases of suspected or confirmed syphilis of any stage should be reported within **one day** by phone, fax or electronically to the local health jurisdiction where the patient resides (California Code of Regulations, Title 17, Section 2500(j).) In addition, patients should be informed at the time of syphilis testing that the provider is required by California law to confidentially report new cases of syphilis to the local health department and that the health department may contact the patient to ensure adequate management.

When reporting cases of clinically suspicious syphilis, clinicians should describe the stage of infection using the following classifications:

Primary: Chancre present, with or without laboratory evidence suggestive of syphilis.

Secondary: Localized or diffuse mucocutaneous lesions (e.g., rash, condyloma lata) and laboratory evidence suggestive of syphilis, if available.

Early Latent: Asymptomatic infection, positive serologic test suggestive of syphilis, *and*
1) Documentation of a negative serologic test or a fourfold or greater increase in titer during the prior 12 months, *or*
2) Patient-reported history of symptoms consistent with primary or secondary syphilis within the prior 12 months, *or*
3) Patient-reported history of sexual exposure to a partner who has been diagnosed with primary, secondary, or early latent syphilis in the past 12 months.

Late Latent: Asymptomatic infection, serologically confirmed syphilis, and no evidence that infection was acquired in the past 12 months. Infections that are latent of unknown duration should be classified as late latent.

Late (Tertiary): Serologically confirmed syphilis with clinical or radiographic signs of cardiovascular, bone, or visceral involvement.

Neurosyphilis can occur at any stage of syphilis. Patients diagnosed with neurosyphilis should be staged as above and neurosyphilis signs indicated on the CMR. For criteria on the diagnosis of neurosyphilis, see Bacterial STDs: Neurosyphilis.

Any suspected case of syphilis in which the stage cannot be determined from the above criteria should be reported as “Syphilis - Stage Unknown”.

[77] Adapted with permission from the Medical Board of California’s Guidebook to the Laws Governing the Practice of Medicine by Physicians and Surgeons

RESOURCES AND SELECTED REFERENCES

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Guidelines and Recommendations

California

- California Department of Public Health STD Control Branch: www.std.ca.gov
  - California STD Screening Recommendations
  - California STD Treatment Guidelines for Adults and Adolescents
  - Treatment Guidelines for Suspected Cephalosporin Resistant Gonorrhea
  - Guidelines for the use of HSV Type 2 Serologies

- A Clinician's Resource for Sexually Transmitted Diseases (STDs) in Gay Men and Other Men Who Have Sex with Men (MSM) – The MSM Toolkit: www.std.ca.gov/MSMToolkit

- Understanding Confidentiality and Minor Consent in California: www.teenhealthlaw.org/minorconsent/

National

- STD Treatment Guidelines: www.cdc.gov/std/treatment/

- HIV/AIDS Treatment Guidelines: aidsinfo.nih.gov/guidelines/

- Pre-Exposure Prophylaxis: Guidelines - www.cdc.gov/hiv/pdf/PrEPguidelines2014.pdf; Provider Supplement - www.cdc.gov/hiv/pdf/PrEPProviderSupplement2014.pdf; Clinical Consultation - nccc.ucsf.edu/clinical-resources/pep-resources/prep/

- Recommendations for the Laboratory-Based Detection of *Chlamydia trachomatis* and *Neisseria gonorrhoeae* — 2014. MMWR 2014:63(RR02);1-19. www.cdc.gov/mmwr/preview/mmwrhtml/rr6302a1.htm

- Laboratories Capable of Performing Nucleic Acid Amplification Testing for Chlamydia and Gonorrhea on Rectal and Pharyngeal Specimens: www.aphl.org/aphlprograms/infectious/Archive/naatestlabs.aspx

- Revised Recommendations for HIV Testing in Adults, Adolescents, and Pregnant Women, MMWR 2006:55(RR-14);1-17. www.cdc.gov/mmwr/preview/mmwrhtml/rr5514a1.htm

- Incorporating HIV prevention into the medical care of persons living with HIV, MMWR 2003:52(RR-12);1-24. www.cdc.gov/mmwr/preview/mmwrhtml/rr5212a1.htm

- Recommendations for Partner Services Programs for HIV Infection, Syphilis, Gonorrhea, and Chlamydial Infection, MMWR 2008:57(RR-9);1-83. www.cdc.gov/mmwr/preview/mmwrhtml/rr5709a1.htm

- Recommendations for Identification and Public Health Management of Persons with Chronic Hepatitis B Virus Infection, MMWR 2008:57(RR-8);1-20. www.cdc.gov/mmwr/preview/mmwrhtml/rr5708a1.htm

- Coding Guidelines for Vaccine Preventable Hepatitis www.cdc.gov/hepatitis/Populations/PDFs/04-0103_trifold_sprd1.pdf

- Coding Guidelines for Routine HIV testing in Healthcare Settings
  www.aahivm.org/Upload_Module/upload/Provider%20Resources/AAHIVM%20CPT%20Coding%20Guide.pdf

- Guidelines for Care of Lesbian, Gay, Bisexual and Transgender Patients
  www.glma.org/_data/n_0001/resources/live/GLMA%20guidelines%202006%20FINAL.pdf

Public Health Resources

Disease Reporting

- Reportable diseases and conditions in California
  www.cdph.ca.gov/HealthInfo/Pages/ReportableDiseases.aspx

- Confidential Morbidity Report (for STDs, Hepatitis, and TB)
  www.cdph.ca.gov/pubsforms/forms/CtrldForms/cdph110a.pdf

- Adult HIV/AIDS Confidential Case Report
  www.cdph.ca.gov/pubsforms/forms/CtrldForms/cdph8641a.pdf

- California Local Health Department Contact Information for Disease Reporting
  www.cdph.ca.gov/HealthInfo/Documents/LHD_CD_Contact_Info.doc

California Department of Public Health

- Sexually Transmitted Disease Control Branch: www.std.ca.gov

- Office of AIDS: www.cdph.ca.gov/programs/aids

- Office of Viral Hepatitis Prevention: www.cdph.ca.gov/programs/pages/ovhp.aspx

- California Health and Safety Code, searchable database
  leginfo.legislature.ca.gov/

- California Code of Regulations, searchable database
  ccr.oal.ca.gov/linkedslice/default.asp?SP=CCR-1000&Action=Welcome

Centers for Disease Control and Prevention

- Sexually Transmitted Diseases: www.cdc.gov/std

- HIV/AIDS: www.cdc.gov/hiv

- Viral Hepatitis: www.cdc.gov/hepatitis

Clinical Training/Resources

- California HIV/STD Prevention Training Center
  www.stdhivtraining.org
- AIDS Education Training Centers National Resource Center
  www.aids-ed.org
- Hepatitis Web Study
  www.hepwebstudy.org
- Hepatitis C Online
  www.hepatitisc.uw.edu/index.php
- Gay and Lesbian Medical Association
  www.glma.org
- Center of Excellence for Transgender Health
  www.transhealth.ucsf.edu
- American Academy of HIV Medicine
  www.aahivm.org
- National HIV/AIDS Clinical Consultation Center
  www.nccc.ucsf.edu

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CDPH MSM Toolkit