

July 28, 2011

Dear Indiana Health Care Provider:

I would like to highlight two very important developments that affect your care of patients with sexually transmitted diseases: a change in the CDC treatment recommendation for gonorrhea and clarification of syphilis testing.

CDC treatment recommendation for gonorrhea

Persons with a **positive** gonorrhea test should be co-treated for **both** gonorrhea AND Chlamydia regardless of Chlamydia test results. The new treatment recommendation is to co-treat with *Ceftriaxone 250 mg IM* (considered the first line of treatment for uncomplicated gonorrhea) **and** either *1 g Azithromycin PO* in a single dose, **or** *Doxycycline 100 mg bid X 7 days*. A single dose of *Suprax 400 mg PO* is an acceptable treatment alternative for gonorrhea. For additional information please refer to: <http://www.cdc.gov/std/treatment/2010/>

In addition, because the risk of reinfection is higher for patients previously infected with Chlamydia or gonorrhea, these patients should be re-tested for these infections within three months of treatment. This is not a test of cure, but rather a check for re-infection.

Clarification of syphilis tests

There have been changes in the way some labs are currently testing for syphilis. Many labs have altered their syphilis screening algorithm to increase testing efficiency. These labs are using a *Treponema pallidum* specific Enzyme-linked Immunoassay (EIA) or chemiluminescence immunoassay (CIA) as an initial screening test, and performing a quantitative RPR on every positive result. This is referred to as reverse sequence testing.

While this algorithm has advantages for labs, it is not recommended by the CDC because it presents major challenges for both the ordering physician and for public health partners seeking to conduct disease intervention with patients and sex partners.

The CDC recommendations for syphilis testing have not changed. In summary, the CDC continues to recommend the traditional screening algorithm using a nontreponemal test (e.g., RPR or VDRL), and confirming reactive nontreponemal tests with treponemal testing (e.g., EIA or CIA). The ISDH continues to support CDC's recommendations for syphilis testing which can be viewed in its entirety: <http://www.cdc.gov/std/syphilis/treatment.htm>

However, if reverse sequence screening is used, reactive sera by a treponemal test should be tested reflexively with a *quantitative* nontreponemal test. When test results are discordant (i.e., reactive EIA/CIA and nonreactive RPR), the specimen should be tested reflexively using the Treponema pallidum particle agglutination (TP-PA) test as a confirmatory treponemal test. Results from *all* serologic testing should be reported promptly and concurrently from laboratories to both the clinician and public health department.

A reactive EIA/CIA for T. pallidum may indicate a prior history of exposure, but **does not** reliably diagnose current disease activity. These tests must be followed by quantitative RPR testing. Negative RPR tests after a positive EIA/CIA must be followed by a second confirmatory test (TP-PA is recommended). Some laboratories are reporting results back to health care providers without the full complement of tests having been performed. All positive syphilis tests must be reported to public health authorities. Algorithms for both traditional syphilis testing and reverse sequence testing are included as an attachment to this letter.

Please contact ISDH STD Prevention Program at 317-233-7426 if we may assist you with these changes to STD testing and treatment. Thank you for your continued cooperation with disease reporting requirements and dedication to quality patient care.

Sincerely,

Joan M. Duwve, MD, MPH
Chief Medical Officer
Indiana State Department of Health