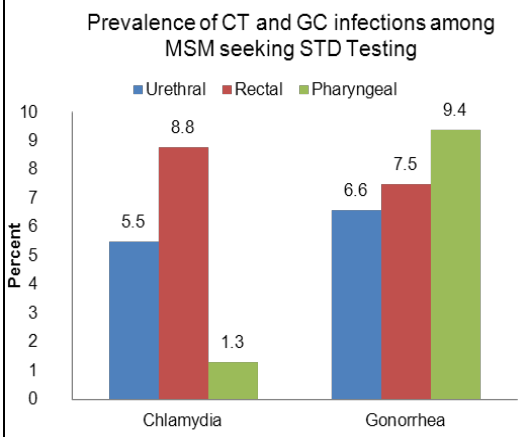
Non-genital Screening for Chlamydia (CT) and Gonorrhea (GC) in Men Who Have Sex With Men (MSM)†

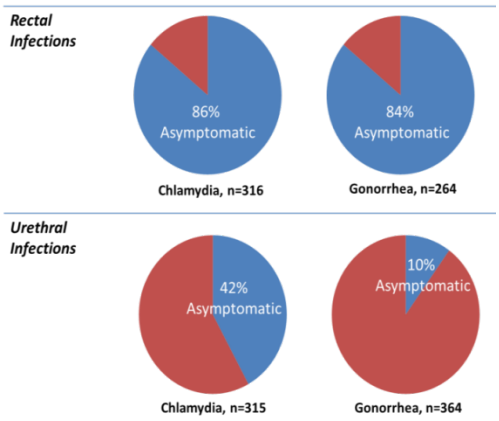
WHY RECTAL AND PHARYNGEAL SCREENING?

Non-genital Infections COMMON



- Pharyngeal and rectal GC prevalence (9.4% and 7.5% respectively) is higher than urethral GC prevalence (6.6%). [1]

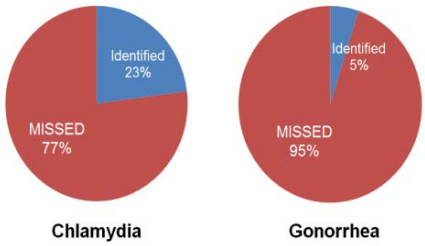
Patients Often ASYMPTOMATIC



- The majority of rectal infections CT & GC infections are asymptomatic, while fewer urethral infections are asymptomatic.[1]

MISSED Infections

Proportion of CT and GC infections MISSED among 3398 ***asymptomatic* MSM** if only urine/urethral sites screened, San Francisco, 2008-2009



- The majority of CT and GC infections would not be identified if only screening urine/urethral sites.[2]

NAATs Preferred Test for GC/CT Detection

- Nucleic acid amplification tests (NAATs) are recommended for screening and diagnosis of CT/GC infections[3]:
  - Urine/Urethral *(first catch urine optimal specimen for men)*
  - Rectal and Pharyngeal
    - Compared to culture, NAATs detected 58% more rectal GC infections, 75% more rectal CT infections, and 61% more pharyngeal GC infections.[4]

NAATs are NOT FDA cleared for rectal/pharyngeal testing → Labs must establish performance specifications CLIA compliance. Many major laboratories have completed this requirement; contact your lab before submitting specimens.

The **Michigan Department of Health and Human Services, Bureau of Laboratories (MDHHS/BOL)** has validated NAATs testing for rectal and pharyngeal samples. Any medical provider can forward specimens to MDHHS/BOL for testing utilizing test requisition DCH-1248.

http://www.michigan.gov/documents/mdch/DCH-1248.12.11_372085_7.pdf

Specimens submitted without sufficient detail to facilitate billing will be charged back to the provider site. Sites with sliding fee scales in place may receive discounted rates.

CT/GC Screening Recommendations for Sexually Active Asymptomatic MSM[5]

	Site	Frequency	Additional Notes
Chlamydia	Urethral/Urine	At least annually*	Retest for repeat infection 3 months after treatment; or anytime 1-12 months after treatment. *Screening every 3-6 months is indicated for MSM, including those with HIV infection, if risk behaviors persist or if they or their sexual partners have multiple partners.
	Rectal	If receptive anal sex, at least annually*	
Gonorrhea	Urethral/Urine	At least annually*	
	Rectal	If receptive anal sex, at least annually*	
	Pharyngeal	If receptive oral sex, at least annually*	

† References from MSM Mini Toolkit developed by California Department of Public Health Sexually Transmitted Diseases Control Branch

1. Data summarized from Kent CK et al. Clin Infect Dis 2005; 41: 67-74

2. Data summarized from Marcus et al. STD 2011; 38: 922-4.

3. American Public Health Laboratories 2009 Expert Report http://www.aphl.org/aphlprograms/infectious/std/Documents/ID_2009Jan_CTGCLab-Guidelines-Meeting-Report.pdf

4. Data summarized from Schachter, et al. STD 2008; 35: 637-642.

5. Centers for Disease Control and Prevention. Sexually Transmitted Diseases Treatment Guidelines. MMWR June 5, 2015; 64 (No. 3). http://www.cdc.gov/std/tg2015/default.htm