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Guidance for Health Care Providers

Expedited Partner Therapy (EPT)
For Chlamydia, Gonorrhea, and Trichomoniasis

Public Act 525 of 2014 (MCL 333.5110) authorized the use of expedited partner therapy (EPT) for certain sexually transmitted diseases as designated by the state health department. In April 2020, the department designated chlamydia, trichomoniasis and gonorrhea as diseases for which the use of EPT is appropriate. This document provides health care providers with guidance for using EPT.

Expedited Partner Therapy (EPT): An Effective Tool for STI Prevention and Control

Sexually transmitted infections (STIs) are a significant public health problem. In Michigan, reported cases of gonorrhea and chlamydia exceed 55,000 annually, making them the two most reported infections. Although trichomoniasis is not a reportable STI in Michigan, its prevalence is high among sexually active women. These infections are highly transmittable and easy to treat. Rates of chlamydia are highest in men and women under the age of 24, increasing the potential for negative outcomes related to fertility resulting from untreated infection.

To prevent further transmission of these STIs, clinicians can use Expedited Partner Therapy (EPT) to assure that individuals who are at risk due to exposure are provided treatment. Michigan's Public Health Code[1] was amended in 2014, authorizing the use of EPT, which enables clinicians to provide patients with medication or a prescription to deliver to their sex partner(s) without a medical evaluation or clinical assessment of those partners. Furthermore, health professionals who provide EPT in accordance with the law are not subject to liability, except in the case of gross negligence.

EPT is an alternative strategy to assure that sexual partners of patients diagnosed with uncomplicated *Chlamydia trachomatis* (CT), *Neisseria gonorrhoeae* (GC) or *Trichomoniasis vaginalis* (TV) are treated. Due to the high risk of repeat infection from exposure to untreated partners, patients diagnosed with CT, GC or TV cannot be considered adequately treated until all partners have been treated. This is particularly important given the asymptomatic nature of these infections. Traditional methods to notify and treat sex partners (i.e., health department assisted referral and patient referral) are the cornerstone of STI control and should be considered the gold standard; however, it is imperative that partner management options be examined for each patient. EPT is a useful alternative when a partner is unable or unlikely to seek care. It is a proven effective intervention that is highly recommended by the Centers for Disease Control and Prevention (CDC).[2]

Selecting Appropriate Patients for EPT

EPT can be considered for the partners of patients with a clinical or laboratory diagnosis of chlamydia, gonorrhea or trichomoniasis infection. Laboratory confirmation of the diagnosis may be based on the findings of culture, microscopy, or an FDA-approved molecular test. Providing EPT without laboratory confirmation may be considered when the provider has a high clinical suspicion of infection and there is concern the patient will be lost to follow-up.

Clinicians should attempt to refer partners in for comprehensive healthcare including evaluation, testing, and treatment. Clinical services provide the opportunity to confirm the exposure and/or diagnosis, examine the patient, test for other STIs including HIV, ensure treatment, and offer additional services such as family planning, vaccinations, and risk-reduction counseling.

Patients most appropriate for EPT are those with partners who are unable or unlikely to seek prompt clinical service. Factors to consider include whether the partner is uninsured, lacks a primary care provider, faces significant barriers to accessing clinical services, or is unwilling to seek care. The acceptability of EPT to the patient and partners should also be assessed. EPT does not preclude attempts to get partners into care. Even if EPT is provided, the partner should be encouraged to seek follow-up care as soon as possible.

The partners of infected clients within the 60 days prior to treatment are the best candidates for EPT as they are at highest risk for infection. If the last sexual encounter was more than 60 days prior, the most recent sexual partner should be treated. There is no limit on how many partners can be provided treatment via EPT. A combination of partner strategies can also be used. For example, a patient with several partners may refer one or more partners to the clinic and take EPT for other partners. If a partner is pregnant, every effort should be made to contact her for a referral to pregnancy services and/or pre-natal care, and Doxycycline should not be given.

When choosing EPT, providers and patients should work together and utilize shared clinical decision- making when deciding on the best treatment options for partner(s). Currently, the CDC is encouraging STI providers to utilize shared clinical decision-making with patients regarding sexual health and the management of sexual partners.

EPT should **not** be used for the following:

- In cases of suspected child abuse or sexual assault.
- In situations where a patient's safety is in question.
- For partners with known allergies to antibiotics.
- For patients who are co-infected with STIs other than chlamydia, gonorrhea or trichomoniasis.

Recommended Drug Regimens for EPT

The following are the current recommended drug regimens for treatment of chlamydia, trichomoniasis and gonorrhea using EPT:

- For sexual partners of patients with Chlamydia:
  Doxycycline 100 mg orally 2 times/day for 7 days.[5]

- For sexual partners of patients with Gonorrhea only:
  Cefixime (Suprax) 800 mg orally in a single dose.[4]

- For sexual partners of patients with GC who are co- infected with CT, or for whom a CT result is not available:
  Cefixime (Suprax) 800 mg orally in a single dose PLUS Doxycycline(Vibramycin) 100mg orally 2 times/day for 7 days.[4]

- For sexual partners of patients with Trichomoniasis:
  Female Partners: Metronidazole 500 mg orally 2 times/day for 7 days.[5]
  Male Partners: Metronidazole 2 grams orally, as a single dose.[5]

Note: When prescribing or dispensing EPT for Chlamydia and/ or Gonorrhea, Azithromycin 1 gram orally should be substituted for Doxycycline when partner is, or might be, pregnant; or if partner is unlikely to adhere to 7-day regimen.

The medication for EPT may be dispensed or prescribed. Research shows that the method most likely to results in partner treatment is dispensing in a unit-use dose as part of a partner packet that includes medication, informational materials, and a clinic referral for follow up testing and counseling.

If dispensing is not an option, prescriptions can be provided in the partner packet instead of medication. If a prescription is provided:

- Individual prescriptions are given for each partner.
- The prescription should be made out in the partner's name, if possible.
- If the partner's name is unknown, the prescription is made out to "Expedited Partner Therapy."
- When using "Expedited Partner Therapy" as the partner's name, use January 1st of the current year as the date-of-birth.

EPT and Pregnancy

Although EPT is not contraindicated when a patient reports that a female partner might be pregnant, providers should assess whether the pregnant partner is receiving pregnancy services or prenatal care. Every effort should be made to contact the pregnant partner and ensure appropriate care; EPT should be considered as a last resort. The local health department may be of assistance for these special situations. Most of the recommended EPT treatment regimens are considered safe in pregnancy; however, doxycycline should not be used during pregnancy.

Risk of Under-Treating Complicated Infections, Pharyngeal Gonorrhea, and Missing Concurrent STI/HIV Infection

Oral cephalosporins are less effective in eradicating pharyngeal gonorrhea infection making inadequate treatment of partners with pharyngeal infection a potential limitation of EPT. Providers should ascertain the risk by discussing oral sex with their patient and not offer EPT to partners at risk for pharyngeal infection. These partners should seek clinical services where ceftriaxone treatment is available. Another concern when using EPT is missing concurrent STI and HIV infections. This risk can be mitigated through educational materials that clearly instruct EPT recipients to see a health provider for STI and HIV testing.

Patient Counseling Messages for EPT

- Partners should seek a complete STI evaluation as soon as possible, regardless of whether they take the medication.
- Partners should read the informational material very carefully before taking the medication.
- Partners who have allergies to the antibiotics or who have serious health problems should not take the medications and should see a healthcare provider.
- Partners who have symptoms of a more serious infection (e.g., pelvic pain in women, testicular pain in men, and fever in women or men) should not take the EPT medication and should seek care as soon as possible.
- Partners who are or could be pregnant should seek care for their pregnancy as soon as possible.
- Patients and partners should abstain from sex for at least seven days after treatment and until seven days after all partners have been treated, in order to decrease the risk of repeat infection.
- Partners should be advised to seek clinical services for retesting three months after treatment.

Patient Follow-Up and Retesting at Three Months

High prevalence of chlamydia and gonorrhea infection has been observed in women and men after treatment; therefore, the CDC recommends that these patients be retested 3 months after treatment, regardless of whether they believe their sex partners were treated. Partners should also be encouraged to get tested 3 months after treatment.

Frequently Asked Questions

Q1: What if the partner has an adverse reaction to the medication?

EPT has been used across the country since 2005. The medications are highly effective antibiotics. Adverse reactions are rare; the most commonly known reaction is mild gastrointestinal intolerance. California, the first state to use EPT, established a dedicated hotline to monitor adverse reactions. After nearly 10 years with no reports, the hotline was discontinued.

Q2: Won't EPT compromise the quality of care provided to partners?

When used selectively, EPT will benefit partners who would not otherwise receive treatment. Furthermore, these risks can be mitigated through patient education and written materials for partners that provide warnings and encourage them to visit a healthcare provider.

For more information about EPT or other issues pertaining to STI, please contact the Michigan Department of Health and Human Services, Field Services and STI Prevention Program at (517) 241-0870 or visit www.michigan.gov/hivsti.

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