

APPENDIX F

Sexually Transmitted Diseases

**SEXUALLY TRANSMITTED DISEASES
TREATMENT GUIDELINES 2002
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PREGNANT WOMEN

Intrauterine or perinatally transmitted STDs can have severely debilitating effects on pregnant women, their partners, and their fetuses. All pregnant women and their sex partners should be asked about STDs, counseled about the possibility of perinatal infections, and ensured access to treatment, if needed.

Recommended Screening Tests

- All pregnant women should be offered voluntary HIV testing at the first prenatal visit. Reasons for refusal of testing should be explored, and testing should be reoffered to pregnant women who initially declined testing. Retesting in the third trimester (preferably before 36 weeks' gestation) is recommended for women at high risk for acquiring HIV infection (i.e., women who use illicit drugs, have STDs during pregnancy, have multiple sex partners during pregnancy, or have HIV-infected partners). In addition, women who have not received prenatal counseling should be encouraged to be tested for HIV infection at delivery.
- A serologic test for syphilis should be performed on all pregnant women at the first prenatal visit. In populations in which use of prenatal care is not optimal, rapid plasma reagin (RPR)-card test screening (and treatment, if that test is reactive) should be performed at the time a pregnancy is confirmed. Patients who are at high risk for syphilis, are living in areas of excess syphilis morbidity, are previously untested, or have positive serology in the first trimester should be screened again early in the third trimester (28 weeks' gestation) and at delivery. Some states require all women to be screened at delivery. Infants should not be discharged from the hospital unless the syphilis serologic status of the mother has been determined at least one time during pregnancy and preferably again at delivery. Any woman who delivers a stillborn infant should be tested for syphilis.
- A serologic test for hepatitis B surface antigen (HBsAg) should be performed on all pregnant women at the first prenatal visit. HBsAg testing should be repeated late in pregnancy for women who are HBsAg negative but who are at high risk for HBV infection (e.g., injection-drug users and women who have concomitant STDs).
- A test for *Chlamydia trachomatis* should be performed at the first prenatal visit. Women aged <25 years and those at increased risk for chlamydia (i.e., women who have a new or more than one sex partner) also should be tested during the third trimester to prevent maternal postnatal complications and chlamydial

- infection in the infant. Screening during the first trimester might enable prevention of adverse effects of chlamydia during pregnancy. However, evidence for preventing adverse effects during pregnancy is lacking. If screening is performed only during the first trimester, a longer period exists for acquiring infection before delivery.
- A test for *Neisseria gonorrhoeae* should be performed at the first prenatal visit for women at risk or for women living in an area in which the prevalence of *N. gonorrhoeae* is high. A repeat test should be performed during the third trimester for those at continued risk.

 - A test for hepatitis C antibodies (anti-HCV) should be performed at the first prenatal visit for pregnant women at high risk for exposure. Women at high risk include those with a history of injection-drug use, repeated exposure to blood products, prior blood transfusion, or organ transplants.
 - Evaluation for bacterial vaginosis (BV) may be conducted at the first prenatal visit for asymptomatic patients who are at high risk for preterm labor (e.g., those who have a history of a previous preterm delivery). Current evidence does not support routine testing for BV.
 - A Papanicolaou (Pap) smear should be obtained at the first prenatal visit if none has been documented during the preceding year.

Other Concerns

Other STD-related concerns are as follows.

- HBsAg-positive women should be reported to the local and/or state health department to ensure that they are entered into a case-management system and that appropriate prophylaxis is provided for their infants. In addition, household and sex contacts of HBsAg-positive women should be vaccinated.
- No treatment is available for anti-HCV-positive pregnant women. However, all women found to be anti-HCV-positive should receive appropriate counseling. No vaccine is available to prevent HCV transmission.
- In the absence of lesions during the third trimester, routine serial cultures for HSV are not indicated for women who have a history of recurrent genital herpes. Prophylactic cesarean section is not indicated for women who do not have active genital lesions at the time of delivery.
- The presence of genital warts is not an indication for cesarean section.
- Not enough evidence exists to recommend routine screening for *Trichomonas vaginalis* in asymptomatic pregnant women.

For a more detailed discussion of these guidelines, as well as infections not transmitted sexually, refer to the following references: *Guide to Clinical Preventive Services*,

Guidelines for Perinatal Care American College of Obstetricians and Gynecologists (ACOG) Educational Bulletin: Antimicrobial Therapy for Obstetric Patients , ACOG Committee Opinion: Primary and Preventive Care: Periodic Assessments, Recommendations for the Prevention and Management of Chlamydia trachomatis Infections, Hepatitis B Virus: A Comprehensive Strategy for Eliminating Transmission in the United States through Universal Childhood Vaccination --- Recommendations of the Immunization Practices Advisory Committee (ACIP), Mother-to-infant transmission of hepatitis C virus, Hepatitis C: Screening in pregnancy, American College of Obstetricians and Gynecologists (ACOG) Educational Bulletin: Viral hepatitis in pregnancy , Human Immunodeficiency Virus Screening: Joint statement of the AAP and ACOG , Preventing Perinatal Transmission of HIV and the Revised Public Health Service Recommendations for HIV Screening of Pregnant Women.

These sources are not entirely consistent in their recommendations. The *Guide to Clinical Preventive Services* recommends screening of patients at high risk for chlamydia, but indicates that the optimal timing for screening is uncertain. The *Guidelines for Perinatal Care* recommend that pregnant women at high risk for chlamydia be screened for infection during the first prenatal-care visit and during the third trimester.

Recommendations to screen pregnant women for STDs are based on disease severity and sequelae, prevalence in the population, costs, medicolegal considerations (e.g., state laws), and other factors. The screening recommendations in this report are more extensive (i.e., if followed, more women will be screened

for more STDs than would be screened by following other recommendations) and are compatible with other CDC guidelines.