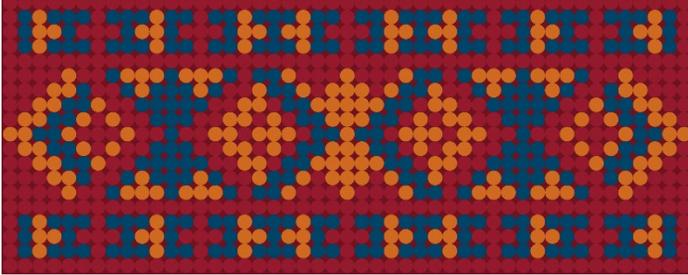


COVID-19 (2019 Novel Coronavirus)

STDs During the COVID-19 Pandemic



In the wake of the arrival of COVID-19 in the United States, health departments, clinics, drug manufacturers, and hospitals around the country have shifted their resources to meet the virus on the frontlines. However, this massive shift in priorities is not without collateral damage in other areas of the healthcare system. There has been a notable decrease in available resources for sexually transmitted disease (STD) testing and treatment.

Within the last five years, rates of syphilis, gonorrhea, and chlamydia have continued to rise, with each year seeing record-breaking numbers.¹ Native communities are disproportionately impacted by the rising rates. In 2018, the reported rate of congenital syphilis among American Indians/Alaska Natives was 5.9 times the rate among Whites, and rates of gonorrhea and chlamydia were 4.6 and 3.7 times the rate among Whites, respectively.² Experts predicted that overall STD rates would only continue to rise. This prediction proved accurate for the first few months of 2020 as cases continued to hit record highs. However, the trend came to a halt in March as the COVID-19 pandemic hit the United States. The Centers for Disease Control and Prevention (CDC) found that cases had decreased by staggering numbers for this period when compared to the prior year. Gonorrhea and syphilis were both down 33%, and chlamydia cases were down 53% compared to their 2019 levels.¹

As opposed to a decrease in cases, there likely is a lag in testing, surveillance, and reporting as healthcare systems and public health departments struggle to keep up. At a time when the COVID-19 crisis has already disproportionately affected Native communities, the effects of an undetected surge of STDs will only compound the inequities facing Native populations.

Factors impacting the rise of STD infections

Testing kit availability has decreased. Manufacturers shifted to COVID-19-related products in March 2020. In states like Michigan, the supply chain of other testing kits took a hit in favor of producing COVID-19 testing kits.³ The CDC sent out a formal letter in September 2020 warning of these shortages, most notably for chlamydia and gonorrhea nucleic acid amplification tests (CT/GC NAAT).

Treatment drugs and therapies are in high demand.

Azithromycin, a popular antibiotic used in the treatment of several STDs, is now experiencing high levels of demand. Azithromycin is one of the many drug therapies used to treat COVID-19 patients.¹ This urgent reallocation of the drug has made it less available for STD patients and their partners.

Testing and prevention sites are fewer and far between. A recent National Coalition of STD Directors survey found that 66% of clinics are reporting a decrease in STD testing.⁵ Several testing sites have modified hours or closed down altogether, with major cities around the nation having their testing locations slashed by over half.^{1,4} The CDC also found that as cities began to re-open and get a handle on COVID-19, their STD case numbers began to increase to the high rates predicted by the previous five-year trends. This data suggests that rather than a decrease in cases, cases are instead going undetected.

Contact tracers are overwhelmed by the demands of COVID-19.

Health experts across the country are rushing to catch up with the demands of COVID-19, and contact tracers are no different. Many disease intervention specialists who normally work to notify others of an STD exposure are now being reassigned to work on COVID-19.⁵ The lack of contact tracers working on STD surveillance leads to fewer people being notified that they have been exposed to an STD.

Recommendations for treating STDs in the COVID-19 era

Presumptive treatment refers to treating a suspected STD based on symptoms rather than test results. Presumptive treatment of suspected STDs allows providers to treat patients when clinic hours or staffing capacity is limited or resources, such as testing kits, are unavailable.

Expedited partner therapy (EPT) allows providers to prescribe treatments for the partners of patients who have a probable or laboratory-confirmed diagnosis of chlamydia, gonorrhea, or trichomonas.⁵ This allows for more patients to be treated without having to schedule telehealth appointments or clinic visits, limiting the risk of re-infection. The status of EPT varies between states. Its legal status can be checked at <https://www.cdc.gov/std/ept/legal/totals.htm>.

April 2020 CDC Guidance Table: Therapeutic options for symptomatic patients and partners when clinical evaluation isn't available¹

Syndrome	Preferred Treatment In clinic, or other location where injections can be given ²	Alternative Treatment When only oral medications are available ³	Follow-Up
Male urethritis syndrome	Ceftriaxone 250mg intramuscular (IM) in a single dose PLUS azithromycin 1g orally in a single dose. ⁴ If cephalosporin allergy is reported, gentamicin 240mg IM in a single dose PLUS azithromycin 2g orally in single dose is recommended.	Cefixime 800mg orally in a single dose PLUS Azithromycin 1g orally in a single dose. ⁵ OR Cefpodoxime 400mg orally q12 hours x 2 doses PLUS Azithromycin 1g orally in a single dose. ⁶ If oral cephalosporin is not available or cephalosporin allergy is reported, azithromycin 2g orally in a single dose.	For alternative oral regimens, patients should be counseled that if their symptoms do not improve or resolve within 5-7 days, they should follow-up with the clinic or a medical provider. Patients should be counseled to be tested for STDs once clinical care is resumed in the jurisdiction. Health departments should make an effort to remind clients who have been referred for oral treatment to return for comprehensive testing and screening and link them to services at that time.
Genital ulcer disease (GUD) Suspected primary or secondary syphilis⁷	Benzathine penicillin G, 2.4 million units IM in a single dose.	Males and non-pregnant females: Doxycycline 100mg orally twice a day for 14 days. Pregnant: Benzathine penicillin G, 2.4 million units IM in a single dose.	Patients should be counseled to be tested for STDs once clinical care is resumed in the jurisdiction. Health departments should make an effort to remind clients who have been referred for oral treatment to return for comprehensive testing and screening and link them to services at that time.
Vaginal discharge syndrome in women without lower abdominal pain, dyspareunia or other signs concerning for pelvic inflammatory disease (PID)	Treatment guided by examination and laboratory results.	Discharge suggestive of bacterial vaginosis or trichomoniasis (frothy, odor): Metronidazole 500 mg orally twice a day for 7 days. Discharge cottage cheese-like with genital itching: Therapy directed at candida.	Patients should be counseled to be tested for STDs once clinical care is resumed in the jurisdiction. Health departments should make an effort to remind clients who have been referred for oral treatment to return for comprehensive testing and screening and link them to services at that time.
Proctitis syndrome⁸	Ceftriaxone 250mg IM in a single dose PLUS doxycycline 100mg orally twice a day for 7 days. ⁹	Cefixime 800mg orally in a single dose PLUS doxycycline 100mg orally bid for 7 days. ¹⁰ OR Cefpodoxime 400mg orally q12 hours x 2 doses PLUS doxycycline 100mg orally bid for 7 days. ¹¹	All patients receiving regimens other than Benzathine penicillin for syphilis treatment should have repeat serologic testing performed 3 months post-treatment.
Expedited Partner Therapy (EPT)¹²	Chlamydia: Azithromycin 1g PO x 1 Trichomoniasis: Metronidazole 2g1	Gonorrhea: Cefixime 800mg PO x 1 PLUS azithromycin 1g PO x 1	

¹ Summarized from: https://www.cdc.gov/nchhstp/dear_colleague/2020/dcl-040620-std-treatment-options.html

² When possible, clinics experiencing closures should make arrangements with local pharmacies or other clinics that remain open and can give injections.

³ Alternative regimens should be considered when recommended treatments from the 2015 CDC STD Treatment Guidelines are not available.

^{4, 5, 6, 9} If azithromycin is not available and the patient is not pregnant, doxycycline 100 mg orally twice a day for 7 days is recommended.

⁷ All pregnant women with syphilis must receive benzathine penicillin G. If clinical signs of neurosyphilis present, further evaluation is warranted.

⁸ Consider adding therapy for herpes simplex virus if pain is present.

^{10, 11} If doxycycline not available or the patient is pregnant, azithromycin 1g orally in single dose recommended.

¹² EPT info retrieved from: <https://www.health.state.mn.us/diseases/stds/hcp/stdtrtopts.pdf>

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