CDC Screening Guidelines for Chlamydia, Gonorrhea and Trichomoniasis

	Chlamydia	Gonorrhea	Trichomoniasis
Women	• Annual screening is recommended for all sexually active women aged <25 years. • Screening is recommended for women over age 25 at increased risk factors.[a] • Women with symptoms of cervicitis should be tested for chlamydia.	• Annual screening is recommended for all sexually active women aged <25 years and for older women at increased risk[a] for infection. • Women with symptoms of cervicitis should be tested for gonorrhea.	• Testing for *Trichomonas vaginalis* should be performed on women seeking care for vaginal discharge. • Screening might be considered for women receiving care in high-prevalence settings and for asymptomatic persons at increased risk[a] for infection. • The use of highly sensitive and specific tests, such as NAAT, are recommended over less-sensitive methods including wet-mount microscopy.[b]
Pregnant women	• All pregnant women aged <25 years or older women at increased risk[a] for infection should be screened during their first prenatal visits. • Those aged <25 years and those at increased risk[a] for chlamydia should be retested during their third trimesters. • Those found to have chlamydial infection should have a test-of-cure (preferably by NAAT) 3 to 4 weeks after treatment and retested at 3 months.	• All pregnant women aged <25 years and older women at increased risk[a] for gonorrhea should be screened at their first prenatal visits.[a] • Women found to have gonococcal infection should be treated immediately and retested within 3 months. • Those who remain at high risk[a] for gonococcal infection should be retested during the third trimester.	• Women who report symptoms should be evaluated and treated appropriately. • Evidence does not support routine screening for *Trichomonas vaginalis* in asymptomatic pregnant women.
Men	• Routine screening is not recommended, but testing should be considered for sexually active young men at clinical settings where prevalence is high (i.e., adolescent and STD clinics, correctional facilities).	• Screening is not recommended for men who do not have increased risk of infection.[a]	No specific guidelines.
Men who have sex with men (MSM)	• Annual chlamydia screening is recommended for MSM who have had insertive intercourse[c] or receptive anal intercourse[c] during the preceding year.	• Annual gonorrhea screening is recommended for MSM who have had insertive intercourse,[c] receptive anal intercourse,[c] or receptive oral intercourse during the preceding year.[c]	No specific guidelines.
HIV-infected individuals	• At the initial HIV care visit, providers should test all sexually active persons with HIV infection for chlamydia and perform testing at least annually during the course of HIV care. • Specific testing includes NAAT for *C. trachomatis* at the anatomic site of exposure as the preferred approach.	• At the initial HIV care visit, providers should test all sexually active persons with HIV infection for gonorrhea and perform testing at least annually during the course of HIV care. • Specific testing includes NAAT for *N. gonorrhoeae* at the anatomic site of exposure as the preferred approach.	• Routine screening and prompt treatment are recommended for all women with HIV infection. • Screening should occur at entry to care and then at least annually thereafter.
Re-testing	• Women and men should be retested approximately 3 months after chlamydia treatment.[d] • If retesting at 3 months is not possible, clinicians should retest whenever the individual next receives medical care in the 12 months following initial treatment.	• Patients with symptoms that persist after treatment should be evaluated by culture for gonorrhea and for antimicrobial susceptibility. • Clinicians should advise patients with gonorrhea to be retested 3 months after treatment or when they next seek medical care within the following 12 months.	• Retesting for *T richomonas vaginalis* is recommended for all sexually active women within 3 months following initial treatment regardless of whether they believe their sex partners were treated.

[a] People with increased risk are women who have a history of STDs, exchange sex for payment or use injection drugs; and men and women with new sex partner, more than one sex partner, a sex partner with concurrent partners, or a sex partner who has a sexually transmitted infection.
[b] When highly-sensitive testing (e.g., NAAT) is not feasible, a testing algorithm (e.g., wet mount first, followed by NAAT if negative) can improve diagnostic sensitivity.
[c] Additional risk factors for gonorrhea include inconsistent condom use among persons not in mutually monogamous relationships, previous or coexisting sexually transmitted infection, and exchanging sex for money or drugs.
[d] The use of chlamydial NAATs at <3 weeks after completion of therapy is not recommended because the continued presence of nonviable organisms can lead to false-positive results. *Source: Sexually Transmitted Diseases Treatment Guidelines, 2015 (CDC).*

ACOG Guidelines (CT/NG)	• Routine annual screening for chlamydial infection is recommended for all sexually active women aged 25 years and younger.	• Asymptomatic women aged 26 and older who are at high risk[e] for infection should be routinely screened for chlamydial infection and gonorrhea.	• Women with developmental disabilities should be screened for STDs.

[e] Patients are women with a history of multiple sexual partners or a sexual partner with multiple contacts, sexual contact with individuals with culture-proven STDs, a history of repeated episodes of STDs or attendance at clinics for STDs. *Source: Guidelines for Women's Healthcare, A Resource Manual, Fourth Edition 2014 - ACOG.*

USPSTF Guidelines (CT/NG)	• Recommends screening for chlamydia in sexually active women age 24 years or younger and in older women who are at increased risk[f] for infection.	• Recommends screening for gonorrhea in sexually active women age 24 years or younger and in older women who are at increased risk[f] for infection.	• The current evidence is insufficient to assess the balance of benefits and harms of screening for chlamydia and gonorrhea in men.

[f] Increased risk is defined as high-risk sexual behavior for pregnant and nonpregnant women; as ages younger than 25 years for chlamydia and gonorrhea; and as high community prevalence for chlamydia, gonorrhea. *Source: Screening for Chlamydia and Gonorrhea: U.S. Preventive Services Task Force Recommendation Statement, Dec. 2014.*

Cervical Cancer Screening Guidelines

Population	USPSTF 2012[1]	Consensus Guidelines ACS, ASCCP, ASCP[2]	ACOG 2012[3]
Women Younger than 21	**Do not screen** **Grade: D**	**Do not screen**	**Do not screen**
Women ages 21- 29	• Screen with cytology (pap smear or liquid base) every 3 years Grade: A • Do not screen with HPV testing (alone or in combination with cytology) Grade: D	• Screen with cytology alone every 3 years. HPV testing should not be used for screening in this age group unless it is needed after an abnormal Pap test result.	• Screen with cytology alone every 3 years. Co-testing is not recommended for women younger than 30 years.
Women ages 30-65	• Screen with cytology every 3 years or • co-testing (cytology/HPV testing) every 5 years Grade: A	• Screen with the HPV test and cytology (co-testing) every 5 years (preferred). or • screen with cytology alone every 3 years (acceptable). HPV positive, cytology negative: • 12 month follow-up with co-testing or • Test for HPV 16 or HPV 16/18 genotypes	• Human Papillomavirus and cytology (co-testing) every 5 years (preferred) or Screen with cytology alone every 3 years (acceptable). Negative cytology and positive HPV co-testing result: • Repeat co-testing in 12 months or • Immediate HPV genotype-specific testing for HPV 16 alone, or HPV 16/18 should be performed.
Women older than 65 who have had adequate prior screening and are not at high risk	Do not screen Grade: D	• No screening following adequate negative prior screening. Women with a history of CIN2 or a more severe diagnosis should continue routine screening for at least 20 years.	• No screening is necessary after adequate negative prior screening results. Women with a history of CIN2, CIN3 or adenocarcinoma in situ should continue routine age-based screening for at least 20 years.
Women after hysterectomy with removal of the cervix and with no history of high-grade pre-cancer or cervical cancer	Do not screen Grade: D	• Do not screen. Applies to women without a cervix and without a history of CIN2 or a more severe diagnosis in the past 20 years or cervical cancer ever.	• Do not screen. Applies to women without a cervix and without a history of CIN2, CIN3, adenocarcinoma in situ, or cancer in the past 20 years.
Women who have been vaccinated with the HPV vaccine	• Recommends women who have been vaccinated should continue to be screened.	• Follow age-specific recommendations (same as unvaccinated women).	• Follow age-specific recommendations (same as unvaccinated women).

References:

1) Moyer VA. Screening for Cervical Cancer: U.S. Preventive Services Task Force Recommendation Statement. Ann Intern Med. 2012;156(12):880-91. doi:10.7326/0003-4819-156-12-201206190-00424. **2)** Saslow D, et al. American Cancer Society, American Society for Colposcopy and Cervical Pathology, and American Society for Clinical Pathology screening guidelines for the prevention and early detection of cervical cancer. CA Cancer J Clin. 2012;62(3):147-72. doi:10.3322/caac.21139. **3)** ACOG Practice Bulletin Number 131: Screening for Cervical Cancer. Obstet Gynecol. 2012;120(5):1222-38. doi:10.1097/AOG.0b013e318277c92a.