2016 Guidelines for the Use of Expedited Partner Therapy in Men who Have Sex with Men 2016

Recommendations:

Public Health – Seattle & King County (Public Health) and the Washington State Department of Health (WADOH) recommend that medical providers do not routinely use expedited partner therapy (EPT) in men who have sex with men (MSM). Instead, providers should seek to assure that the sex partners of MSM diagnosed with gonorrhea or chlamydial infection undergo complete medical evaluation, including testing for HIV, syphilis, gonorrhea and chlamydial infection; evaluation for HIV preexposure prophylaxis; and assessment of engagement in care among persons with HIV-infection. However, both Public Health and WADOH recognize that there are unusual instances in which EPT may be appropriate for individual MSM patients. MSM patients and partners who may be good candidates for EPT include men whose partners cannot be readily treated though a mechanism which involves more comprehensive care, and have the following characteristics:

1) MSM with chlamydial infection only - Unlike gonorrhea, antimicrobial resistance is not currently an identified problem that limits the effectiveness of EPT in persons with chlamydial infection.

2) Partners to be treated with EPT are known to be HIV-infected and well engaged with medical care.

3) Partners to be treated with EPT are known to be HIV-uninfected, but the medical provider has established that they recently tested for HIV.

Medical providers using EPT should seek to speak directly with their patients' partners to discuss the partner's treatment and broader healthcare needs whenever possible. In King County, partners of persons with bacterial STI can be seen at the Public Health clinic at Harborview. The STD clinic sees patients regardless of their ability to pay.

Background and Rationale for Recommendations:

EPT refers to the practice of treating the sex partners of a person with a sexually transmitted infection (STI) without requiring the partner to first undergo a medical evaluation or testing. In most instances, EPT involves giving patients medication to give to their sex partners, or patient delivered partner therapy (PDPT). EPT has been extensively studied in heterosexuals with gonorrhea, chlamydia and trichomonas, with randomized controlled trials demonstrating that the intervention is safe, decreases the rate of reinfection among persons given PDPT to give to their partners, and may diminish STI transmission at the population-level[1-5]. Based on these data, the U.S. Centers for Disease Control and Prevention (CDC) recommends that medical providers "routinely offer EPT to heterosexual patients with chlamydia or gonorrhea infection when the provider cannot confidently ensure that all of a patient's sex partners from the prior 60 days will be treated." Washington State guidelines include an almost identical recommendation[6].

EPT has not been widely studied in MSM, and no large randomized controlled trials have evaluated EPT in MSM. The intervention is acceptable to some MSM and is sometimes used by medical providers[7,8] though national data suggest that only 2.6% of MSM with gonorrhea currently receive PDPT from medical providers (unpublished CDC data. Mark Stenger, Personal Communication). In a randomized trial of 53 MSM in Seattle, PDPT increased partner treatment[9]. An observational study with passive follow-up undertaken in an STD clinic in San Francisco found that EPT did not reduce reinfection in MSM[7]. (This observational study also showed no impact on reinfection in heterosexuals.) MSM interviewed about their interest in using PDPT report that they would be less likely to seek HIV/STI testing if a partner gave them PDPT[10].

Washington State and CDC guidelines recommend against the use of EPT in MSM[6,11]. Beyond the paucity of data on the effectiveness of EPT in MSM, a number of important concerns limit the use of EPT in MSM. These include:

1) Evidence that approximately 5% of MSM without a prior HIV diagnosis who seek medical care because of sexual contact to a man diagnosed with gonorrhea or chlamydia are newly diagnosed with HIV infection[12]. Limited evidence suggests that the partners of MSM who receive PDPT are less likely to seek medical evaluation and testing[10].
2) In the U.S., antimicrobial resistant *Neisseria gonorrhoeae* occurs primarily in MSM. At present, approximately 5% of gonococcal isolates in MSM in Seattle are resistant to azithromycin, one of the two drugs typically used to treat gonorrhea. Approximately 25% of persons with pharyngeal gonorrhea caused b**y** azithromycin-resistant gonorrhea will fail treatment with EPT[13]. Most persons who fail treatment are asymptomatic, and their persistent infections have the potential to foster ongoing transmission of resistant gonorrhea in the community.
3) HIV uninfected MSM with bacterial STIs, particularly men with rectal gonorrhea, are at elevated risk for future HIV acquisition[14]. PHSKC and WADOH recommend that medical providers initiate preexposure prophylaxis (PrEP) for HIV in men with rectal gonorrhea, and discuss PrEP with other MSM treated for bacterial STIs. Insofar as partners with rectal gonorrhea forgo medical evaluation after receiving EPT, EPT results in a missed opportunity to provide PrEP to men at high risk for HIV acquisition.
4) Approximately 10% of HIV-infected MSM with bacterial STIs in Seattle are not on effective antiretroviral therapy, in many instances because they are out of care. Use of EPT bypasses outreach to these men resulting in missed opportunities to reengage them with care.
5) Some evidence suggests that rectal chlamydial infection is better treated with doxycycline than azithromycin[13]. PDPT typically includes azithromycin and consequently may be an inferior treatment for rectal chlamydial infection.

Because of these concerns, Public Health's primary strategy for increasing partner treatment among MSM with gonorrhea and chlamydial infection is to provide active partner services to MSM with these infections. These services include proactive efforts to contact men with bacterial STIs and their sex partners and refer them for comprehensive care. This care involves testing and treatment of gonorrhea and chlamydia, testing for HIV and syphilis, evaluation for possible PrEP and, among persons with HIV infection, assessment of engagement with medical care.

References:

1. Schillinger JA, Kissinger P, Calvet H, et al. Patient-delivered partner treatment with azithromycin to prevent repeated Chlamydia trachomatis infection among women: a randomized, controlled trial. *Sex Transm Dis* 2003; **30**(1): 49-56.
2. Golden MR, Whittington WL, Handsfield HH, et al. Effect of expedited treatment of sex partners on recurrent or persistent gonorrhea or chlamydial infection. *N Engl J Med* 2005; **352**(7): 676-85.
3. Kissinger P, Mohammed H, Richardson-Alston G, et al. Patient-delivered partner treatment for male urethritis: a randomized, controlled trial. *Clin Infect Dis* 2005; **41**(5): 623-9.
4. Kissinger P, Richardson-Alston G, Leichliter J, et al. A comparison of three different strategies to treat partners of men with urethritis. 2004 STD Prevention Conference; 2004; Philadelphia, Pennsylvania; 2004.
5. Golden MR, Kerani RP, Stenger M, et al. Uptake and Population-Level Impact of Expedited Partner Therapy (EPT) on Chlamydia trachomatis and Neisseria gonorrhoeae: The Washington State Community-Level Randomized Trial of EPT. *PLoS Med* 2015; **12**(1): e1001777.
6. Health WSDo. Washington State Provider Guidelines for Patient Delivered Therapy. 2005.
7. Stephens SC, Bernstein KT, Katz MH, Philip SS, Klausner JD. The effectiveness of patient-delivered partner therapy and chlamydial and gonococcal reinfection in San Francisco. *Sex Transm Dis* 2010; **37**(8): 525-9.
8. Introcaso CE, Rogers ME, Abbott SA, Gorwitz RJ, Markowitz LE, Schillinger JA. Expedited partner therapy in federally qualified health centers--New York City, 2012. *Sex Transm Dis* 2013; **40**(11): 881-5.
9. Kerani RP, Fleming M, DeYoung B, Golden MR. A randomized, controlled trial of inSPOT and patient-delivered partner therapy for gonorrhea and chlamydial infection among men who have sex with men. *Sex Transm Dis* 2011; **38**(10): 941-6.
10. Kerani RP, Fleming M, Golden MR. Acceptability and intention to seek medical care after hypothetical receipt of patient-delivered partner therapy or electronic partner notification postcards among men who have sex with men: the partner's perspective. *Sex Transm Dis* 2013; **40**(2): 179-85.
11. CDC. Expedited Partner Therapy. 2011. http://www.cdc.gov/std/ept/default.htm (accessed February 3, 2011).
12. Stekler J, Bachmann L, Brotman RM, et al. Concurrent sexually transmitted infections (STIs) in sex partners of patients with selected STIs: implications for patient-delivered partner therapy. *Clin Infect Dis* 2005; **40**(6): 787-93.
13. Barbee LA, Kerani RP, Dombrowski JC, Soge OO, Golden MR. A retrospective comparative study of 2-drug oral and intramuscular cephalosporin treatment regimens for pharyngeal gonorrhea. *Clin Infect Dis* 2013; **56**(11): 1539-45.
14. Pathela P, Braunstein SL, Blank S, Schillinger JA. HIV incidence among men with and those without sexually transmitted rectal infections: estimates from matching against an HIV case registry. *Clin Infect Dis* 2013; **57**(8): 1203-9.