

It's Time to Expand Chlamydia Treatment for Gay and Bisexual Men

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ABSTRACT

Expedited partner therapy involves prescribing sexually transmitted infection (STI) treatment for a patient's partner(s) without seeing the partner. It is approved for heterosexual partners of patients with chlamydia in most states. However, the Centers for Disease Control and Prevention recommends against expedited partner therapy in men-who-have-sex-with-men (MSM), citing limited data in this population and concerns that expedited partner therapy could discourage comprehensive STI testing, thereby driving increased HIV transmission. In this piece, we describe the case of a 33-year-old gay man on HIV pre-exposure prophylaxis (PrEP) whose cycle of chlamydia reinfection might have been prevented by expedited partner therapy. His case highlights how new HIV prevention strategies—including PrEP and Treatment as Prevention—challenge the assumption that all MSM with chlamydia are at risk for HIV. Until more data on expedited partner therapy in MSM are available, clinicians should incorporate characteristics of patients' sexual networks in weighing the risks and benefits of expedited partner therapy.

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A CASE OF RECURRENT CHLAMYDIA HIGHLIGHTS DISPARITIES IN GUIDELINES

Our patient, a sexually active, 33-year-old gay man, was worried about his HIV risk, so he sought out HIV pre-exposure prophylaxis (PrEP). He never misses a dose and follows up every 3 months for testing and counseling. His primary partner also takes daily PrEP; they use condoms regularly with sexual partners outside the relationship, and they do not use condoms with one another. For 3 consecutive visits, he tested positive for asymptomatic rectal chlamydia and received first-line treatment with azithromycin. During this time, his primary partner was not treated.

His repeated chlamydia infections likely represented reinfection from his primary partner. His cycle of reinfection could potentially have been prevented by prescribing an extra 1g dose of azithromycin that he could offer to his partner(s). This practice, known as expedited partner therapy (EPT), allows a clinician to prescribe sexually transmitted infection (STI) treatment for their patient's partner(s) without examining or testing the partner themselves. In Massachusetts, where we practice, medications may be dispensed at the clinic with an extra dose for the partner(s) or prescribed to non-named partner(s) with "EPT" in the prescription text.¹ Partners' names and dates of birth are not needed.

Expedited partner therapy is highly effective, reducing repeat chlamydia infections by approximately 20%,² and it is widely recommended for heterosexual partners, particularly when partners may be unwilling or unable to seek testing and treatment on their own. EPT focuses health care efforts to specific, high-risk sexual networks at greatest risk of ongoing transmission and community spread.³ In addition to preventing reinfection, EPT

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represents an important strategy to increase partner notification after an STI diagnosis, including among men-who-have-sex-with-men (MSM).⁴

So why wasn't EPT prescribed for our patient? EPT implementation for MSM in Massachusetts and across the country has lagged, due in part to uncertainties in both the Centers for Disease Control and Prevention (CDC) and state guidelines and lingering questions about the downstream consequences of offering EPT to MSM. Anecdotally, our colleagues report varying and conflicting perceptions about the legality of offering expedited partner therapy to MSM, which have influenced their prescribing practices.

THE LEGALITY AND USE OF EPT

The CDC first recommended EPT in limited circumstances for chlamydia and gonorrhea in 2006. At that time, the evidence supporting EPT was based on 3 clinical trials that included mostly heterosexual patients. (The CDC later recommended limiting EPT to chlamydia when increasing gonococcal resistance to cefixime, the oral cephalosporin used in expedited partner therapy, emerged.^{5,6} However, guidelines advise clinicians "should still consider" gonorrhea EPT for heterosexual partners who are unlikely to access treatment). In both the 2006 and updated 2012 recommendations, the CDC recommended against EPT for MSM, citing a lack of high-quality trials in this population and concern for higher rates of coexisting infections, including undiagnosed HIV. If MSM were offered EPT, people worried, it could discourage partners from seeking comprehensive testing and treatment, potentially contributing to the spread of HIV infection. To our knowledge, however, there have been no studies demonstrating that providing EPT reduces partner HIV testing rates.

Expedited partner therapy regulations are governed by states. After the CDC's 2006 guideline release, many states passed legislation supporting EPT, which is now authorized for heterosexual partners in 45 states and the District of Columbia and "potentially allowable" in another 4 states and Puerto Rico.⁷ However, its legality and use in MSM remains widely variable.

Several states, such as California, recommend EPT for MSM.⁸ Other states, such as Arkansas, specifically limit EPT to heterosexual partners. The majority of states defer to the CDC's guidance with policies stating that EPT should not routinely be recommended for MSM, though they do not explicitly ban the practice. The Massachusetts Legislature legalized EPT in 2011 for the general public, though the Massachusetts Public Health Commission later issued guidance recommending that EPT generally be limited to heterosexual partners of infected patients.^{9,10}

A CHANGING HIV PREVENTION LANDSCAPE PROMPTS REEXAMINATION OF GUIDELINES

Is this restriction on EPT still reasonable? It is true that research on EPT in MSM is lacking. Existing data on EPT come from heterosexual populations, and there have been no published studies demonstrating the efficacy of EPT for chlamydia in MSM. A prior clinical trial of EPT in MSM was stopped early due to low enrollment.¹¹ High-quality clinical trial data are urgently needed to guide practice and policy.

However, given new biomedical HIV prevention strategies that became available after the 2011 legalization of EPT in Massachusetts, it may be time to revisit concerns that EPT could contribute to HIV incidence. Specifically, HIV PrEP, which was approved in 2012, offers a 92% to 99% risk reduction in HIV incidence among those with sexual risk.¹² The impact of PrEP on overall STI rates remains under study, and the significant racial and ethnic disparities in PrEP access and uptake must be addressed if PrEP is to fulfill its public health potential.¹³ However, it is clear that PrEP can connect sexually active people—who might otherwise not engage in preventive care—to frequent and comprehensive infection screening services.

Recent studies have also confirmed that people living with HIV who maintain an undetectable viral load on antiretroviral therapy cannot transmit the virus sexually—a paradigm referred to as Treatment as Prevention.¹⁴ The increasing uptake of PrEP in MSM and improved understanding of HIV transmission risk challenge the assumption that MSM with chlamydia are necessarily at risk for HIV. When weighing the risk of HIV transmission in EPT decisions, the use of biomedical prevention strategies by patients and members of their sexual networks must be considered.

Further, the rates of chlamydia-HIV coinfection are low. In 2017, just 2% of patients diagnosed with chlamydia in Massachusetts were co-infected with HIV compared with 7% of patients with gonorrhea and 37% with infectious syphilis.¹⁵ Although past data for chlamydia is not available, the rate of HIV coinfection among Massachusetts patients with gonorrhea—including overall and among MSM—has declined in recent years. This is in the context of rising statewide rates of chlamydia infections since 2010 among men, necessitating new approaches to stem the tide of chlamydia.

WHY CONSIDER PRACTICE CHANGE?

The burden of untreated chlamydia must not be underestimated. Chlamydia increases susceptibility to other

infections, including HIV, and it is a leading cause of urethritis and proctitis in men. In women, chlamydia can lead to pelvic inflammatory disease, chronic pelvic pain, and infertility; women in sexual networks with MSM may be indirectly impacted by our failure to offer EPT to MSM. Limiting EPT to heterosexual people also opposes open and complete patient interviews; had our patient reported a female partner or simply not mentioned the sex of his partner, EPT may have been offered. Differential application of EPT risks undermining the patient-clinician relationship.

Although EPT represents an important potential opportunity to reduce chlamydia infections among MSM, it is not—and will never be—a substitute for a full sexual-health evaluation. However, like in heterosexual patients, EPT could offer a harm reduction option for same-sex male partners who are not able or willing to seek treatment in person.

POLICY CHANGE AND RESEARCH ARE URGENTLY NEEDED

Untreated chlamydia causes individual and public health harms. Expedited partner therapy reduces chlamydia infections in heterosexual populations but is under-studied and infrequently utilized in MSM, potentially contributing to health disparities. Low rates of HIV-chlamydia coinfection in Massachusetts as well as new biomedical HIV prevention strategies have changed the way we think about HIV risk in MSM. We believe clinicians should focus on an individual patient and their sexual network when weighing the risks and benefits of EPT.

In order to definitively guide policy, more data are urgently needed to understand the effectiveness and downstream effects of expedited partner therapy in MSM. Until such data become available, clinicians treating MSM for chlamydia will continue to face a clinical dilemma. Policy makers and public health officials should consider revising guidelines to support shared decision making around expedited partner therapy for MSM while we await the evidence-based recommendations our patients deserve.

To read or post commentaries in response to this article, go to <https://www.AnnFamMed.org/content/19/2/168/tab-e-letters>.

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References

- Massachusetts Department of Public Health, 105 CMR 700.003(J), 2011.
- Workowski KA, Bolan GA; Centers for Disease Control and Prevention. Sexually transmitted diseases treatment guidelines, 2015. *MMWR Recomm Rep*. 2015;64(RR-03):1-137.
- Centers for Disease Control and Prevention. Expedited partner therapy in the management of sexually transmitted diseases: review and guidance. Atlanta, GA: US Department of Health and Human Services; 2006. Accessed Mar 26, 2020. <https://www.cdc.gov/std/treatment/eptfinalreport2006.pdf>
- Clark JL, Segura ER, Oldenburg CE, et al. Expedited Partner Therapy (EPT) increases the frequency of partner notification among MSM in Lima, Peru: a pilot randomized controlled trial. *BMC Med*. 2017; 15(1):94. 10.1186/s12916-017-0858-9.
- Centers for Disease Control and Prevention. Guidance on the use of expedited partner therapy in the treatment of gonorrhea. Updated Aug 20, 2015. Accessed Mar 26, 2020. <https://www.cdc.gov/std/ept/gc-guidance.htm>
- Centers for Disease Control and Prevention (CDC). Update to CDC's sexually transmitted diseases treatment guidelines, 2010: oral cephalosporins no longer a recommended treatment for gonococcal infections. *MMWR Morb Mortal Wkly Rep*. 2012;61(31):590-594.
- Legal Status of Expedited Partner Therapy. Published Jun 26, 2019. Accessed Jan 28, 2021. <https://www.cdc.gov/std/ept/legal/default.htm>
- Bauer HM, Wohlfeiler D, Klausner JD, Guerry S, Gunn RA, Bolan G; California STD Controllers Association. California guidelines for expedited partner therapy for Chlamydia trachomatis and Neisseria gonorrhoeae. *Sex Transm Dis*. 2008;35(3):314-319. 10.1097/OLQ.0b013e31815b0158.
- Boston Public Health Commission. Expedited Partner Therapy. Accessed Apr 22, 2020. <https://www.bphc.org/whatwedo/sexual-health/expedited-partner-therapy/Pages/Expedited-Partner-Therapy.aspx>
- Massachusetts Department of Public Health. Clinical advisory: utilizing expedited partner therapy (EPT) for Chlamydia infection in Massachusetts. Published Aug 2011. Accessed Apr 22, 2020. <https://www.mass.gov/doc/utilizing-expedited-partner-therapy-ept-for-chlamydia-infection-in-massachusetts-2011/download>
- 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):941-946. 10.1097/OLQ.0b013e318223fcbc
- Grant RM, Lama JR, Anderson PL, et al; iPrEx Study Team. Preexposure chemoprophylaxis for HIV prevention in men who have sex with men. *N Engl J Med*. 2010;363(27):2587-2599. 10.1056/NEJMoa1011205
- Huang YA, Zhu W, Smith DK, Harris N, Hoover KW. HIV pre-exposure prophylaxis, by race and ethnicity — United States, 2014–2016. *MMWR Morb Mortal Wkly Rep* 2018;67:1147–1150. DOI: <https://dx.doi.org.ezproxy.bu.edu/10.15585/mmwr.mm6741a3>
- Eisinger RW, Dieffenbach CW, Fauci AS. HIV Viral Load and Transmissibility of HIV Infection: Undetectable Equals Untransmittable. *JAMA*. 2019;321(5):451-452. 10.1001/jama.2018.21167
- Roosevelt K. *STDs and Partner Services in MA*. Massachusetts Department of Public Health, Bureau of Infectious Disease and Laboratory Sciences; 2019.