Teen Urinary Complaints Must Have STI Follow-Up

BY KATE JOHNSON
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TORONTO — Despite guidelines to the contrary, 55% of adolescents presenting to the emergency department with urinary complaints were not investigated for a sexually transmitted infection in one study, Dr. Najah Musacchio said at the annual meeting of the Pediatric Academic Societies.

"It's not just an issue in our emergency departments [EDs], I think it's an issue in a lot of pediatric private practices as well," Dr. Musacchio said in an interview. "We all need to be more comfortable dealing with issues of sexual health among our adolescent patients."

In a retrospective chart review of 163 adolescents (82% girls, mean age 16 years) presenting to the ED, the patients had the following symptoms:

- Dysuria (87%),
- Urinary frequency (45%),
- Abdominal pain (45%),
- Hematuria (29%),
- Back pain (29%),
- Urgency (27%),
- Genital discharge (17%),
- Fever (17%), and
- Vomiting (10%).

Forty-nine (30%) of the patients were not asked if they were sexually active, reported Dr. Musacchio of Children's Memorial Hospital in Chicago.

"There are several guidelines saying any adolescents who present with urinary complaints should be asked if they're sexually active," she said, adding that urinary tract infections (UTIs) are extremely uncommon in men "so we have to have a really high index of suspicion for an STI in males with those symptoms."

Factors associated with sexual history taking included age more than 19 years (odds ratio 1.4), evening presentation at the ED (OR 2.3), being afebrile (OR 2.7), and having genital discharge (OR 4.6).

Among the 114 (70%) of patients who were asked about sexual history, 84 (74%) confirmed sexual activity. However, only 43 (51%) of those 84 patients were tested for sexually transmitted infection (STI). Among them, 13 had a UTI, and 12 had either gonorrhea or chlamydia. Of the 41 sexually active patients who were not tested for STI, 24 had a UTI.

The 55 % of patients who were not investigated for an STI represent "a missed opportunity for diagnosis and treatment of STI," said Dr. Musacchio.

"First … we're not thinking about it, and then there are also a number of systems issues. In an extremely busy emergency department, spending the time to do a pelvic exam sometimes is really difficult—[as] in a busy pediatric practice. To fit in the time to do a full STI evaluation, there are billing issues and time issues."

The implications of the findings are significant because gonorrhea and chlamydia are epidemic in adolescents—15- to 25-year-olds have the highest rates of these diseases in the United States—and the consequences can be devastating. In addition, adolescents who seek help in the ED may represent an even higher risk group because they are often of lower socioeconomic status and have poor access to primary care.

Dr. Musacchio stressed that one of the underrecognized barriers to STI diagnosis and treatment is the presence of an adolescent's parents during a visit. It's always important when teenagers present with any complaint that you spend some time speaking to them alone, she advised. ■

Not All Pediatric Vaginal Infections Require Treatment

HOUSTON — Although most pediatric vaginal infections require treatment, asymptomatic condyloma acuminatum and molluscum contagiosum are exceptions, according to Dr. Abbey B. Berenson.

"It's counter to our training, but sometimes a little benign neglect is the best option," said Dr. Berenson, a professor of obstetrics and gynecology at the University of Texas at Galveston.

Condyloma acuminatum, caused by the human papillomavirus (usually a low-risk type), is different in children than in adults, "not by presentation but by etiology," she said. In adults, this infection is often sexually transmitted, but children can acquire it at birth; it may first manifest up to 3 years later. They also can autotransmit cutaneous types from their hands to their genitalia, she said at a conference on vulvovaginal diseases jointly sponsored by Baylor College of Medicine and the Methodist Hospital, Houston.

Treatment is warranted if the warts are persistent or symptomatic, but otherwise, observation is recommended, particularly because there is a high rate of recurrence after treatment, she said.

—Kate Johnson

CLINICAL GUIDELINES FOR FAMILY PHYSICIANS

Sexually Transmitted Diseases

BY NEIL SKOLNIK, M.D., AND KATY GOODMAN, M.D.

The Centers for Disease Control and Prevention issued guidelines for the treatment of sexually transmitted diseases in the United States in 2006. This column will cover new and important highlights of the guidelines that are most applicable to primary care physicians.

Guidelines are most useful when they are available at the point of care. A concise yet complete handheld version of this guideline is available for download, compliments of FAMILY PRACTICE NEWS, *at www.redi-reference.com*

Partner Management

When partners of patients who are treated for STDs are also treated, the risk of reinfection is reduced. Providers should encourage patients to notify their partners to seek medical evaluation, counseling, and treatment.

A new option is patient-delivered therapy, or expedited partner therapy (EPT). This involves providing a patient with a prescription to treat the partner without a medical exam or counseling. Three clinical trials showed that patient-delivered therapy can reduce rates of reinfection and result in more partners being notified than would be the case with conventional partner notification. The legal status of EPT varies by state. For more information, visit www.cdc.gov/std/ept/legal/default.htm.

Chlamydial Infections

The prevalence of chlamydia infection is greatest in those aged younger than 25 years. These infections are often asymptomatic, and if untreated can lead to pelvic inflammatory disease, ectopic pregnancy, and infertility. All sexually active women aged 25 years or younger—and older women with risk factors, such as new or multiple sexual partners—should be screened annually. The CDC suggests either of the following regimens for chlamydia cervicitis:

- Azithromycin 1 g orally in a single dose.
- Doxycycline 100 mg orally twice daily for 7 days.

Test-of-cure is generally not necessary (except in pregnancy), but given the prevalence of recurrent chlamydial infections in women who are treated for such infections, providers should consider retesting 3 months after treatment.

Gonococcal Infections

Gonorrhea is the second most commonly reported STD, with an estimated 600,000 new infections each year in the United States.

In men, gonococcal infections are usually symptomatic, but they are often asymptomatic in women until complications occur. Women younger than age 25 are at highest risk for this infection. Other risk factors include history of sexually transmitted infections, variable condom use, commercial sex work, and drug use. Providers should screen all sexually active women, including pregnant women, if they are at increased risk of infection.

Patients with gonorrhea infections are often coinfected with chlamydia, so those treated for gonococcal infection should also be treated with a regimen effective against chlamydia.

The prevalence of quinolone-resistant *Neisseria gonorrhoeae* (QRNG) has increased in the United States. Fluoroquinolones are no longer recommended for the treatment of gonorrhea. As of April 2007, the CDC recommends either of the following updated regimens for gonorrhea cervicitis or urethritis, in addition to the recommended treatment for chlamydia:

- Ceftriaxone 125 mg IM in a single dose.
- Cefixime 400 mg orally in a single dose.

Pelvic Inflammatory Disease

Acute PID can be difficult to diagnose, as symptoms are often mild. Because of the difficulty of diagnosis and possible damage to the reproductive tract if it goes untreated, providers should have a low threshold for diagnosing PID. Therapy should be started in sexually active young women —and older women with STD risk factors—who have pelvic or lower-abdominal pain when no other source can be identified and if the patient has one of the following: cervical motion tenderness, uterine tenderness, or adnexal tenderness.

All treatment regimens should be effective against *N. gonorrhoeae* and *Chlamydia trachomatis*. Treatment should begin immediately after the presumptive diagnosis of PID. In women with PID of mild to moderate severity, outpatient therapy has equivalent outcomes, compared with inpatient therapy. Women who do not respond within 72 hours to oral therapy should be reevaluated to confirm the diagnosis and begin parenteral therapy. The CDC suggests either of the following regimens:

- Ceftriaxone 250 mg IM in a single dose, plus doxycycline 100 mg orally twice a day for 14 days, with or without metronidazole 500 mg orally twice a day for 14 days.
- Cefoxitin 2 g IM in a single dose and probenecid 1 g orally administered concurrently in a single dose, plus doxycycline 100 mg orally twice a day for 14 days, with or without metronidazole 500 mg orally twice a day for 14 days.

The Bottom Line

- Encourage patients infected with STDs to notify their partners and to seek treatment.
- Retest those diagnosed with chlamydial infections 3 months after treatment ends.
- In the United States, fluoroquinolones are no longer an acceptable treatment option for gonorrheal infections.
- Clinicians should have a low threshold for diagnosis and treatment of PID.

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