MedicalXpress

With STDs at an all-time high, why aren't more people getting a proven treatment?

September 13 2018

Nearly 2.3 million times last year, Americans learned they had a sexually transmitted disease.

But despite these record-high infection rates for chlamydia and gonorrhea, most patients only receive treatment for their own infection—when they probably could get antibiotics or a prescription for their partner at the same time.

The Centers for Disease Control and Prevention has recommended this approach—called "expedited partner therapy"—since 2006, as a way to slow the growing STD epidemic. Most states have laws allowing doctors who diagnose a patient with an STD to write a prescription or provide medications for their partner, sight unseen. The laws also allow clinics and pharmacies to distribute STD treatment for partners.

In a new paper in the *American Journal of Public Health*, three University of Michigan physicians describe the barriers that stand in the way of getting expedited partner therapy to more people.

Overcoming those barriers, they say, could prevent many STD infections, including reinfections of people who have already gotten tested and treated.

Cornelius Jamison, M.D., M.S.P.H., M.Sc., led the team behind the paper, and also leads current research that is diving deeper into the barriers that may prevent the clinical implementation and use of EPT.

He notes that this is one public health issue where public policy is ahead of clinical practice. Many major medical societies have endorsed EPT based on evidence that it's cost-effective and safe, but it's still under-used across the country.

"We need to make sure everyone in the medical and public health community has a basic understanding of what expedited partner therapy is, how it can work, and what it will take for it to reach widespread use," says Jamison, a family physician and member of the U-M Department of Family Medicine and Institute for Healthcare Policy and Innovation. The new paper includes a conceptual framework that diagrams all the potential barriers to EPT use, to help guide future work to overcome them.

Special considerations for STDs

Some of the barriers to widespread use of EPT relate to the very nature of the diseases it's designed to treat, and the stigma attached to an STD infection. This can drive teens and young adults to avoid seeking STD testing and care in ways that would tip their parents off to their infection status through insurance records, bills or notifications of a positive test result.

Instead, Jamison says, they may seek a diagnosis or treatment at a walk-in clinic, on a free or cash basis. This means that such sites are especially important to increasing the use of EPT.

Similarly, these patients' partners may not have insurance, or may not want to use their insurance to pay for an STD test or treatment even if they do.

A packet of EPT antibiotics given them by a partner who got tested and treated could overcome these barriers, says Jamison. So could a pre-

written prescription.

More about EPT use and barriers

The drugs used to treat chlamydia and gonorrhea are often prescribed together even if the patient only tested positive for one infection. A single 1-gram dose of azithromycin (sold as Zithromax), and a single 400-milligram dose of cefixime (sold as Suprax), taken together can clear both infections. The cost of the EPT medications can vary, but even low costs can be a barrier for low-income people or teens paying out of their own pockets, Jamison notes.

Several guidelines recommend that all sexually active teens and young women be tested for chlamydia and gonorrhea every year. Some recommend testing for all women depending on sexual activity. However, not all providers screen consistently, which means infections can linger. Left untreated, they can lead to pelvic inflammatory disease and infertility and increased risk of HIV in women.

The recent increase in screening, and treatment, means more opportunities for providers to talk with patients who have STDs about the importance of getting antibiotics to their sexual partners, as well as practices such as condom use that can prevent STDs from spreading.

Jamison and his colleagues also say that besides the clinical barriers to EPT, some policy hurdles remain. Seven states and Puerto Rico lack precise laws that give clear legal status to EPT. South Carolina and Kentucky do not allow EPT under current law.

Physician and pharmacist concern about liability if an EPT recipient experiences side effects may drive a lot of the reluctance to provide EPT to their patients, even in states where the law protects them, says Jamison.

Jamison's current research focuses on studying EPT use in federally qualified health clinics, which provide care to any patient at low or no cost, regardless of insurance status. A full list of such clinics nationwide is available at https://findahealthcenter.hrsa.gov/ .

More data is still needed on the actual prescribing and use of EPT in all settings nationwide, and on the specific steps clinics could take to ensure EPT is provided or prescribed to appropriate patients. Protocols in electronic health records, for instance, that automatically suggest EPT to physicians when they tell a patient they have an STD, could assist.

"Our review and conceptual model show the barrier that we as providers, researchers and policy makers face," says Jamison. "But it also shows the importance of coming together to figure out how to do the right thing for patients."

More information: Cornelius D. Jamison et al, Expedited Partner Therapy: Combating Record High Sexually Transmitted Infection Rates, *American Journal of Public Health* (2018). DOI: 10.2105/AJPH.2018.304570

Provided by University of Michigan