

Position Statement on Sexually Transmitted Infection (STI) Testing (Approved by the Board of Directors: 8/15/2020)

The American Academy of Dermatology (AAD) encourages dermatologists to take a sexual history and counsel patients on the prevention of HIV and other sexually transmitted infections. AAD considers testing for sexually transmitted infections a matter between the patient and physician, and the decision to test should be guided by the physician's clinical judgment in discussion with the patient.

HIV Testing

Centers for Disease Control and Prevention (CDC) guidelines recommend "that everyone between the ages of 13 and 64 get tested for HIV at least once as part of routine health care. For those with specific risk factors, CDC recommends getting tested at least once a year."¹ This policy is also endorsed by the American College of Obstetricians and Gynecologists (ACOG).² Repeat/annual testing should be considered in the following groups:

- Persons with sex partners with HIV or whose HIV status is unknown
- Men who have sex with men (MSM)
- Transgender women
- Persons who use injection drugs, opioids, or methamphetamines
- Persons who exchange sex for money
- Pregnant women*
- Persons with dermatologic conditions associated with HIV, including: Kaposi's sarcoma, extensive seborrheic dermatitis, papular pruritic eruption, chronic pruritus, eosinophilic folliculitis, Stevens-Johnson syndrome or toxic epidermal necrolysis of unknown cause, opportunistic infections (such as bacillary angiomatosis, cryptococcosis), extensive or refractory presentations of common cutaneous infections (such as dermatophytosis, molluscum contagiosum, disseminated herpes zoster, chronic herpes simplex, or crusted scabies), chronic oral infections (such as oral hairy leukoplakia, oropharyngeal candidiasis).³

*CDC and ACOG recommend routine confidential HIV testing of all pregnant women as part of their prenatal care. Pregnant women should be re-tested for HIV in the third trimester if at high risk.^{1,4}

The initial screen for HIV should include a laboratory-based antigen/antibody combination HIV-1/2 immunoassay, which, if reactive, should be followed by confirmatory testing (such as an HIV-1/HIV-2 antibody differentiation assay, Western blot, or indirect immunofluorescence assay). If a patient has a

¹ Centers for Disease Control and Prevention. HIV Infection: Detection, Counseling, and Referral. 2015. <https://www.cdc.gov/std/tg2015/hiv.htm> (accessed September 20, 2019).

² Committee on Gynecologic Practice. ACOG Committee Opinion No 596: routine human immunodeficiency virus screening. *Obstet Gynecol.* 2014;123(5):1137-9.

³ World Health Organization. Guidelines on the treatment of skin and oral HIV-associated conditions in children and adults. 2014. https://www.who.int/maternal_child_adolescent/documents/skin-mucosal-and-hiv/en/ (accessed September 20, 2019).

⁴ HIV EW, Committee on Obstetric Practice. ACOG Committee Opinion No. 752: prenatal and perinatal human immunodeficiency virus testing. *Obstet Gynecol.* 2018 Sep;132(3):e138.

reactive immunoassay but negative confirmatory test, plasma HIV RNA testing should be performed to determine if the discordant results represent acute HIV infection.⁵

Syphilis Testing

Syphilis incidence is increasing rapidly in the U.S. Dermatologists should have a high index of suspicion and a low threshold for testing. Following US Preventive Services Task Force (USPSTF) following groups should be considered higher risk:

- MSM*
- People with a history of incarceration or commercial sex work
- HIV-infected persons**
- Pregnant women***
- People with dermatologic conditions associated with syphilis, including: a painless ulcer or ulcers at any site of sexual exposure (chancre), typical symmetric widespread papulosquamous eruption with or without palmoplantar involvement, typical papulosquamous eruptions and papulonecrotic eruptions (lues maligna), moist papulonodules in the genital region (condyloma lata), white or pink patches or erosions in the oropharynx (mucous patches), patchy “moth-eaten” alopecia, ulcerative nodules or tumors (gummata)
- Neonates or infants with unexplained papulosquamous eruptions or blisters (syphilitic pemphigus), condyloma lata, perioral rhagades, snuffles
- Children or adults with ‘stigmata’ of congenital syphilis, including rhagades, characteristic dental and skeletal abnormalities, interstitial keratitis, and deafness

*MSM should be screened at least every six months if sexually active, and at three-month intervals if at increased risk.⁶

**Persons living with HIV should be screened for syphilis at the time of HIV diagnosis, and at least annually afterwards.⁶

***All pregnant women should be screened for syphilis as early as possible and should be re-screened during the third trimester if at high risk.⁷

All patients with suspected or confirmed syphilis at any stage should be screened for signs and symptoms of both ocular and neurosyphilis. Positive symptoms warrant referral to ophthalmology and/or for lumbar puncture.⁸

The traditional screening algorithm for syphilis consists of an initial non-treponemal RPR/VDRL test. False positive nontreponemal tests can occur in a variety of conditions, so any positive nontreponemal test must be followed by a confirmatory treponemal test. False negative nontreponemal tests can also occur both in very early and very late infection. Treponemal tests can also be negative in primary syphilis. Thus, even if treponemal and nontreponemal serologies can be negative during primary syphilis, options for diagnosis include biopsy of chancre with immunohistologic staining or dark field microscopy, or, if suspicion is high enough, empiric treatment. In addition to the traditional screening algorithm, the CDC also endorses the newer reverse sequence screening algorithm, which consists of a high-throughput treponemal assay

⁵ Centers for Disease Control and Prevention. Laboratory testing for the diagnosis of HIV infection: updated recommendations. 2014. <https://stacks.cdc.gov/view/cdc/23447> (accessed September 20, 2019).

⁶ Bibbins-Domingo K, Grossman DC, Curry SJ, et al. U.S. Preventative Services Task Force. Screening for Syphilis Infection in Nonpregnant Adults and Adolescents: US Preventive Services Task Force Recommendation Statement. JAMA. 2016;315(21):2321-7.

⁷ Force USPST, Curry SJ, Krist AH, et al. Screening for Syphilis Infection in Pregnant Women: US Preventive Services Task Force Reaffirmation Recommendation Statement. JAMA. 2018;320(9):911-7.

⁸ Forrestel AK, Kovarik CL, Katz KA, Sexually Acquired Syphilis. Part 1: Historical aspects, microbiology, epidemiology, and clinical manifestations, Journal of the American Academy of Dermatology (2019).

followed by nontreponemal testing.⁹ Clinicians should contact their laboratories to determine which algorithm to follow.

Human Papillomavirus (HPV)

Anogenital Warts

Patients who are immunosuppressed and/or have multiple sexual partners are at higher risk of developing anogenital warts. The diagnosis of anogenital warts can be made clinically, though a biopsy should be performed if the lesions are pigmented, indurated, affixed to underlying tissue, bleeding, or ulcerated.¹⁰ Additionally, biopsy should be considered if the patient is immunosuppressed (including people with HIV), especially if the lesion is atypical or does not respond to standard therapy. Anogenital squamous cell carcinomas (anal, penile, vulvar and vaginal cancers) arise more frequently among people who are immunosuppressed, which is why it is recommended to biopsy any atypical lesion resembling an anogenital wart in immunosuppressed individuals.¹⁰ Additionally, patients with anogenital warts should be tested for other STIs.¹⁰

Anal Cancer Screening

Currently, there is insufficient information to endorse screening for anal cancer due to lack of data on interpretation of screening tests and no approved standard of care if screened positive.¹⁰ However, some societies do promote screening with digital rectal exams (DRE), anal cytology testing (also known as anal pap test), and/or high resolution anoscopy for MSM, women who have had cervical or vulvar cancer, people with anogenital warts, people living with HIV, and organ transplant recipients.^{11,12,13} Anal cytology should not be performed without the availability for follow up high resolution anoscopy.

Other STI Testing

Dermatologists should be aware of CDC guidance regarding routine testing for other STIs based on a patient's symptoms and risk factors as follows. "Sexually active women under 25 years of age" or "sexually active women aged 25 years and older if at increased risk" should be tested for chlamydia and gonorrhea. "Consider screening young men in high prevalence clinical settings or in populations with high burden of infection (e.g. MSM)" for chlamydia. Consider screening for gonorrhea "at least annually for sexually active MSM at sites of contact (urethra, rectum, pharynx)." Persons with HIV should be screened for gonorrhea and chlamydia "at first HIV evaluation, and at least annually afterwards." Trichomonas screening should be considered "for women at high risk for infection" and "sexually active women with HIV at entry to care and at least annually thereafter." Type-specific herpes simplex virus (HSV) serologic testing should be considered for all persons presenting for an STI evaluation, persons with HIV, and MSM at increased risk for HIV acquisition."¹⁴

⁹ Forrestel AK, Kovarik CL, Katz KA, Sexually Acquired Syphilis. Part 2: Laboratory diagnosis, management, and prevention, *Journal of the American Academy of Dermatology* (2019).

¹⁰ Centers for Disease Control and Prevention. 2015 STD Treatment Guidelines. 2015. <https://www.cdc.gov/std/tg2015/qa/screening-qa.htm> (accessed September 20, 2019).

¹¹ American Cancer Society. Anal Cancer. 2017. <https://www.cancer.org/content/dam/cancer-org/cancer-control/en/cancer-types/anal-cancer-complete.pdf> (accessed October 24, 2019).

¹² New York State Department of Health AIDS Institute. HIV Clinical Resource: anal dysplasia and cancer. New York, NY: New York State Department of Health; 2007.

¹³ Aberg JA, Gallant JE, Ghanem KG, Emmanuel P, Zingman BS, Horberg MA. Primary care guidelines for the management of persons infected with HIV: 2013 update by the HIV Medicine Association of the Infectious Diseases Society of America. *Clin Infect Dis*. 2014;58:1–10.

¹⁴ Centers for Disease Control and Prevention. Screening recommendations and considerations referenced in treatment guidelines and original sources. 2016. <https://http://www.cdc.gov/std/tg2015/screening-recommendations.htm> (accessed September 20, 2019).

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This Position Statement is provided for educational and informational purposes only. It is intended to offer physicians guiding principles and policies regarding the practice of dermatology. This Position Statement is not intended to establish a legal or medical standard of care. Physicians should use their personal and professional judgment in interpreting these guidelines and applying them to the particular circumstances of their individual practice arrangements.