Expedited Partner Therapy Can Be Useful in Treating Chlamydia

Expedited Partner Therapy is one option doctors are using to treat the partners of patients diagnosed with chlamydia. This innovative treatment has caused debate in some states about its legality, but a new CDC-sponsored legal analysis available on the Web can help policymakers and health professionals begin discussing what regulations or laws might be standing in the way in their state.

By Jennifer Ginn
Chlamydia can be a silent enemy. Since most people who are infected with this sexually transmitted disease (STD) never experience symptoms, it can remain hidden and possibly damage a woman’s fertility.

So how do we protect against this common but silent STD? Through education, screening and an innovative treatment option called expedited partner therapy.

Who’s Infected?

According to the Centers for Disease Control and Prevention (CDC), nearly 1 million cases of chlamydia were reported in 2005, making it the most commonly reported infectious disease in the United States. More than 75 percent of the cases were among women, which suggests that many of the women’s sex partners are not being diagnosed, reported and/or treated.

Among women, the infection rate in African-Americans was more than seven times higher than among whites in 2005. American Indian/Alaskan Native women were almost five times and Hispanic women were three times more likely to be infected than white women. Young women were most at risk, with the vast majority of cases being diagnosed in those aged 15–24.

Why is Screening Important?

Because chlamydia is a silent infection with serious health consequences—yet one that is easily treated and cured with antibiotics—CDC recommends annual screening for all sexually active women 25 years old or younger, as well as older women with risk factors, such as a new sex partner or multiple sex partners.

Chlamydia can cause extensive damage to a woman’s reproductive organs. Untreated, up to 40 percent of women will develop pelvic inflammatory disease and 18 percent will develop chronic pelvic pain and scarring. As many as 20 percent will have fertility problems and if they do become pregnant, one in 10 will have a life-threatening ectopic pregnancy.

According to Partnership for Prevention, chlamydia screening is one of the seven most effective but underused clinical preventive services, with less than 50 percent of people being screened. At its annual meeting in 2006, The Council of State Governments’ Health Policy Task Force adopted a resolution urging states to support use of several preventive services, including chlamydia screening and insurance coverage for those services.

Dr. Bruce Trigg, medical director of the STD Program, Regions 1 and 3, New Mexico Department of Health, said testing...
in public health clinics has been common for many years, but now states are pushing to increase the number of people being screened in private doctor’s offices and even jails and schools.

“It’s relatively recent that screening has become prevalent in the private sector,” Trigg said. “It’s about 50 to 60 percent of women who should be screened are being screened. Compared to Pap smears, there’s a long way to go.”

In New Mexico, a unique collaborative group has helped to increase the number of people being screened for chlamydia each year.

“We have collaboration with the private sector called CPI, Clinical Prevention Initiative,” Trigg said. “It’s a joint effort between the New Mexico Medical Society and the Department of Health. I think it’s a good model; it’s been going on for several years. The focus is on clinical prevention, … getting office-based docs to incorporate into their practice evidence-based clinical prevention services.”

One of the areas CPI took on was increasing routine chlamydia screening for all sexually active women 25 years or younger; men or women with more than one sexual partner or a recently diagnosed STD regardless of age; and all pregnant women. The effort has included an informational handout for patients, and a Dear Colleague letter and training for health care providers.

Trigg said although tracking the number of patients being screened in private care settings is hard to measure, there has been an increase over time. Still, he said, he is frustrated that New Mexico has not started testing youth in juvenile detention facilities.

“… That really has to do with state and local governments being willing to put money into it,” he said.

What is Expedited Partner Therapy (EPT)?

There are several options to inform, evaluate and treat the sexual partners of patients diagnosed with chlamydia. Traditional practices include the doctor directly contacting the partners, patients encouraging their partners to visit a doctor or patients giving the names of their partners to public health officials to contact. But the high number of chlamydia cases, combined with decreased financial and personnel resources in public health programs, caused researchers to investigate other options to assure partners received treatment.

With EPT, diagnosed patients deliver either medications or prescriptions to their partners. This has caused some concern among states and health care providers because the doctor doesn’t actually examine the partner and ask about drug allergies or provide counseling. In some states, doctors could lose their licenses for such action.

Dr. Matthew Hogben, a behavioral scientist at CDC, said the goal with any of these treatment methods is to get the patient’s partners notified of their possible infection and treated so reinfection does not occur. While having a doctor or public health official follow-up is ideal, it is rarely a realistic option, he said.

“Something like expedited partner therapy,” said Hogben, “… what it seems to do by and large is to either increase the (partner) notification rates or leave them the same. You don’t do any worse. … It raises the treatment rates quite a bit. You end up with more treated partners and more notified partners.

“What we’ve measured mostly and what is sort of the gold standard is the reinfection of the index case (the original patient). … If you look across the studies, you will find the rates consistently show about a 20 percent reduction in reinfection. This is not the sole answer, but this is another tool to put in the tool box.”

Hogben stressed that the patients should still be counseled about STDs and how to reduce reinfection, information which should be passed along to the partners. Trigg said counseling is easier for him because most of the patients he sees have cell phones. He has his patients get their partner on the phone and he asks them about drug allergies and gives them instructions.

A New Tool for State Policymakers

Many public health officials and policymakers are uncertain about whether EPT is a legal option in their jurisdictions. In some states, regulations by the medical boards prohibit giving medicine to patients doctors haven’t seen. In others, laws may stand in the way.

A new tool on CDC’s STD Web site, (available at http://www.cdc.gov/std/epst/legal/default.htm), can help policymakers and legislators begin to understand the legal landscape in their state.

The Center for Law and the Public’s Health at Georgetown and Johns Hopkins universities and CDC have conducted a legal analysis of the relevant laws and regulations for all 50 states, the
District of Columbia and Puerto Rico. The Web site provides a brief description of the laws examined, a judgment about whether EPT is allowed in each state and if not clearly permitted, what laws or regulations may stand in its way.

James Hodge, executive director of the Center for Law and the Public’s Health, said the study suggests that EPT is permissible in 11 states, possible in 28 and likely prohibited in 13 states. He cautioned that the Web site is merely a starting point for policymakers and health professionals to begin talking about EPT, not legal advice or definitive legal opinion.

“EPT just seems like it must be wrong to do,” Hodge said. “… We don’t regularly allow people to go home with prescriptions for other people.

“The vast majority of states we studied just simply do not prohibit its practice. I think that’s an important finding that came out of this legal review. That doesn’t mean there’s not a need for legislators to step in and provide strong legal support.”

What are States Doing?
The New Mexico Medical Board recently changed regulations in the Medical Practice Act to specifically allow EPT. Trigg said the idea to make the changes came out of the Chlamydia Task Force of the Clinical Prevention Initiative.

“When we were doing the first packet of materials,” he said, “questions came up about why don’t we just send medicine home? … That’s when we found out the Medical Practice Act specifically banned that. We knew that if we could convince the Board of Medicine, we could possibly change that.

“When we first approached them, they were extremely negative. … They saw this as an erosion of medical control over prescription medications. What worked out nicely is we began this dialogue with them.”

Once again, the collaborative effort paid big dividends.

“The CPI group asked for an endorsement of this change,” Trigg said. “The way CPI works, the two groups that have veto power are the New Mexico Medical Society and the Department of Health. So the public health department supported this effort, but the people representing the medical society were hesitant. … We went to the medical society and they endorsed it unanimously.

“This went to the medical board with the endorsement of the public health department and the medical society. We can say, ‘This is the consensus of the medical and public health community and here’s all the studies and CDC recommendations (in favor of EPT),’ … They were willing to listen.”

The guidelines for how EPT should be implemented were written by the New Mexico Department of Health.

The King County region of Washington state, which encompasses the Seattle area, has been using EPT since the late 1990s when it was part of a randomized controlled trial on the effectiveness of EPT.

Once patients are diagnosed with either chlamydia or gonorrhea, they are given the option of informing their partners themselves or having a public health official do it. Either the doctor or the public health official can call in a prescription for the partner to one of 12 participating pharmacies located throughout the county, which will provide the drugs at no cost. As a reminder for the doctor, they must fill out a form on the index patient that says either the public health department should contact the partners or they already have been treated.

Dr. Matthew Golden, director of the Sexually Transmitted Disease Control Program for Public Health, Seattle/King County, said the state Medical Quality Assurance Commission had to make a regulatory change to allow EPT. The drugs are paid for with state health department funds and the medicine is less expensive because it is provided at public health pricing. The pharmacies are used, he said, because they are open longer hours than clinics or doctors’ offices, which increases the chances that a partner will be treated.

“We have three randomized, controlled trials all demonstrating the benefit of EPT,” Golden said. “We have no evidence this is harmful in heterosexuals. There is no evidence this is wrong. We should start taking down the barriers.”

Golden said during the next two years, EPT will be rolled out across the state. He stressed that doctors using EPT are not telling partners they don’t need to visit a doctor, but this kind of treatment does ensure more people will get treated.

“We just know a lot of people won’t do it (notify their partners), particularly asymptomatic men,” Golden said. “It would be nice if the world wasn’t like that. The most important thing is we get these people treated. … This is just an additional option.”

—Jennifer Ginn is a health policy analyst at The Council of State Governments.

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