Sexually Transmitted Diseases

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KEYWORDS

• Gonorrhea • Syphilis • *Chlamydia* • Chancroid • Herpes
• Lymphogranuloma venereum • Lice • Genital warts

KEY POINTS

- Many patients with sexually transmitted disease are asymptomatic. Targeted screening of at-risk populations is the most cost-effective measure to reduce the burden of disease.
- The most sensitive tests for gonorrhea and *Chlamydia* are the nucleic acid amplification tests.
- In the United States, most cases of syphilis are found in men who have sex with men (MSM). The incidence peaked around 1990 but is again on the increase.
- Genital herpes can be caused by *Herpes simplex* virus type 1 and type 2 and is a chronic, lifelong disease.
- Proctitis in the MSM population should raise the suspicion of lymphogranuloma venereum.
- Human papilloma virus is the most common sexually transmitted disease, with a worldwide point prevalence of around 10%.
- Prevention measures include education, rapid diagnosis and treatment, partner notification and treatment, condoms, and vaccinations.

INTRODUCTION

Sexually transmitted diseases (STDs) or sexually transmitted infections (STIs) remain a growing worldwide problem and public health issue. In 2002, it was estimated there were 15 million cases of STDs in the United States.[1] By 2010, there were 19 million cases and growing.[2] Half of these cases are among young people aged 15 to 24 yrs. STDs add 17 billion dollars to the health care costs of the country. The family physician is frequently confronted by patients with symptoms of a possible STD, at-risk behavior, or worry about STD exposure. It is important for them to be

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knowledgeable about the signs and symptoms of these diseases and the diagnosis, treatment, and prevention.

There is often a large population of people at risk for STDs in a practice, and this is not always appreciated. One study, conducted among women aged 16 to 29 years presenting to a family planning clinic, found that 8.1% or 1 in 12 of the women had a lifetime history of trading sex for money or other resources.[3] Several studies have shown a need for better provider understanding of STD risk assessment, recognition, legal knowledge of reporting requirements, and counseling.[4–6]

There are differences in STD rates among ethnic and racial groups that are important to consider. High rates of poverty, income inequality, unemployment, and low educational attainment make it more difficult for individuals to protect their sexual health.[7] In 2009, poverty rates, unemployment rates, and high school drop-out rates for blacks, American Indians/Alaska natives, and Hispanics were higher than for whites and these differences were commensurate with observed disparities in STD burden.[8] Even when health care is available, fear and distrust of institutions negatively affect the health care–seeking experience for many minorities.[9] Acknowledging the inequity in STD rates by race or ethnicity is one of the first steps in empowering affected communities to organize and focus on this problem. Detailed data can be found on the Centers for Disease Control and Prevention (CDC) STD Surveillance Report.[10]

Adolescents, in particular, are at high risk of contracting STDs. In the United States and United Kingdom, the average age of first coitus is about 16 years.[11,12] About half of all new STDs in the United States are acquired by those in the 15-year to 24-year age group.[13] Adolescent females have a higher incidence of cervical ectopy, which makes them more susceptible to some STDs such as *Chlamydia*. In 2003, 24% of female adolescents aged 14 to 19 years had laboratory evidence of an STD, specifically, human papilloma virus (HPV), *Chlamydia, Trichomonas*, *Herpes simplex,* or gonorrhea. Of those who reported ever having sex, 40% had laboratory evidence of a STD.[11]

There are barriers for adolescents, such as lack of health insurance, lack of transportation, discomfort of facilities and services, and concerns about confidentiality. Behavioral factors have also been shown to be important for adolescents acquiring an STD:

- Sexual activity in early and middle adolescence, especially for *Chlamydia*
- Multiple partners
- New partners
- Partners with multiple other partners
- Inconsistent use of condoms
- Alcohol and other drug consumption[14–17]

Although the diagnosis and treatment of adolescents is the same as adults, there are special counseling issues that affect adolescents. Privacy and confidentiality are important. Although state laws vary as to notification, all 50 states have self-consent laws for diagnosis and treatment of STDs.[18]

Another group that should be screened includes men requesting prescriptions for erectile dysfunction (ED) drugs. A study looking at insurance claims data of 1,410,806 men older than 40 years found 33,968 men who had filled a prescription for an ED drug. These men had higher rates of STDs, especially human immunodeficiency virus (HIV), both in the year before and after use of these drugs. Counseling about safe sexual practices and screening for STDs should accompany the prescription of ED drugs.[19] A higher prevalence of sexually risky behaviors and STDs has been found in patients with borderline personality disorder (BPD), especially those who

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