Gonorrhea (GC)

Disease Plan

Quick Links:

CDC STD Treatment Guidelines, Gonorrhea
CDC Expedited Partner Therapy (EPT)
Utah's EPT law
UDOH GC report form

CONTENTS

DISEASE AND EPIDEMIOLOGY ................................................................. 2
PUBLIC HEALTH CONTROL MEASURES ............................................... 6
CASE INVESTIGATION ........................................................................... 8
REFERENCES .......................................................................................... 11
VERSION CONTROL .............................................................................. 12
UT-NEDSS MINIMUM/REQUIRED FIELDS BY TAB ................................. 13

Last updated: October 20, 2016 by Scott White

Questions about this disease plan?

Contact the Utah Department of Health Bureau of Epidemiology: 801-538-6191.
WHY IS GONORRHEA IMPORTANT TO PUBLIC HEALTH?

Gonorrhea is the second highest reportable sexually transmitted disease (STD) in Utah and the United States. Gonorrhea is easily transmitted through infected fluids, and is one of the leading causes of preventable infertility in women. Pregnant women who have gonorrhea can pass this infection on to the child during vaginal delivery. Pelvic Inflammatory Disease (PID) is a serious complication of gonorrhea in women, and can lead to infertility and chronic pelvic pain. In men, epididymitis, a testicular condition, is a concern for untreated gonorrhea. Gonorrhea is a treatable condition, although there have been reported resistant strains of gonorrhea in other countries. There is only one recommended regimen currently in place as adequate treatment for this infection.

DISEASE AND EPIDEMIOLOGY

Clinical Description
Gonorrhea is a common sexually transmitted disease caused by the bacterium Neisseria gonorrhoeae. Most males with urethral infection have symptoms of purulent or mucopurulent urethral discharge. Men may also have epididymitis (inflammation of the epididymis – swollen/painful testes) due to N. gonorrhoeae. In women, the symptoms of gonorrhea are often mild, or they have no symptoms. If present, symptoms for women can include abdominal pain, and mucopurulent or purulent cervical discharge. Women may also get urethritis (inflammation of the urethra – painful urination). N. gonorrhoeae can cause pelvic inflammatory disease (PID) in women. Disseminated (bloodstream) infection can occur with rash, and joint and tendon inflammation. Infection of the throat and the rectum can also occur and are often asymptomatic. Perinatal infections may result in inclusion conjunctivitis or ophthalmia neonatorum (red, irritable eyes with a sticky discharge) and pneumonia in newborns.

Causative Agent
Gonorrhea is caused by Neisseria gonorrhoeae, a gram-negative oxidase-positive bacterium that appears as a diplococcus.

Differential Diagnosis
The differential diagnosis for gonorrhea depends on the particular clinical syndrome and includes other sexually transmitted pathogens such as Chlamydia trachomatis, Trichomonas vaginalis, and Mycoplasma genitalium. Among men who have sex with men with infectious proctitis, the differential diagnosis includes C. trachomatis, herpes simplex virus, and Treponema pallidum infections.
Laboratory Identification
A person with one or more of the laboratory findings listed below:

- Isolation of *Neisseria gonorrhoeae* by culture of a clinical specimen.
- Microscopic visualization of *N. gonorrhoeae* (gram-negative intracellular diplococci of typical morphology associated with neutrophils) in a urethral specimen from men.
- Detection of *N. gonorrhoeae* by nucleic acid amplification (e.g., PCR) in a clinical specimen.
- Detection of *N. gonorrhoeae* nucleic acid by hybridization with a nucleic acid probe in a clinical specimen.
- Detection of *N. gonorrhoeae* antigens in a clinical specimen.
- Microscopic visualization of *N. gonorrhoeae* (gram-negative intracellular diplococci of typical morphology associated with neutrophils) in an endocervical specimen from a woman.

Gonorrhea is typically identified by testing endocervical, vaginal, male urethra or urine specimens. Culture, nucleic acid hybridization tests, and nucleic acid amplification tests (NAAT) are available for the detection of genitourinary infection with *N. gonorrhoeae*. Culture and nucleic acid hybridization tests require female endocervical or male urethral swab specimens. NAAT offer the widest range of testing specimen types because they are FDA-cleared for use with endocervical swabs, vaginal swabs, male urethra swabs, and female and male urine. In general, culture is the most widely available option for the diagnosis of infection with *N. gonorrhoeae* in nongenital sites (e.g., rectum and pharynx).

While the nucleic acid tests are more sensitive than culture, there are some situations where culture is recommended: rectal and pharyngeal cultures, pediatric patients with suspicion of sexual abuse, and individuals who have failed antibiotic therapy.

Some laboratories have initiated NAAT of rectal and pharyngeal swab specimens after establishing the performance of the test to meet CLIA requirements.

**Utah Public Health Laboratory (UPHL):** The UPHL provides NAAT testing for both gonorrhea and chlamydia. UPHL can facilitate culture and antimicrobial susceptibility testing (AST). In the event a specimen requires AST, contact the UDOH Bureau of Epidemiology 801-538-6191.

**Treatment**
The following treatment is recommended for uncomplicated gonococcal infections of the cervix, urethra, rectum and pharynx:

- Ceftriaxone 250 mg in a single intramuscular (IM) dose
  
  **PLUS**
  
  Azithromycin 1 g orally in a single dose
As dual therapy, ceftriaxone and azithromycin should be administered together on the same day, preferably simultaneously and under direct observation.

**Alternate regimens**

If ceftriaxone not available:

Cefixime 400 mg single oral dose (not recommended for oropharyngeal infections)

**PLUS**

Azithromycin 1 g orally in a single dose

If documented allergy to:

Cephalosporin:

Gemifloxacin 320mg orally in a single dose

**PLUS**

Azithromycin 2 g orally in a single dose

OR

Gentamicin 240mg in a single intramuscular (IM) dose

**PLUS**

Azithromycin 2 g orally in a single dose

Azithromycin/erythromycin:

Ceftriaxone 250 mg in a single intramuscular (IM) dose

**PLUS**

Doxycycline 100 mg orally twice daily for 7 days*

*Contraindicated in pregnant women

For unique circumstances or additional treatment options please go to [http://www.cdc.gov/std/tg2015/gonorrhea.htm](http://www.cdc.gov/std/tg2015/gonorrhea.htm) for CDC’s Sexually Transmitted Disease Treatment Guidelines, 2015 and Updates.

**Expedited Partner Therapy (EPT)** is the clinical practice of treating the sex partners of patients diagnosed with gonorrhea by providing prescriptions or medications to the patient to take to his/her partner without the healthcare provider first examining the partner. EPT is legal in Utah; for details see [Utah’s EPT law](http://www.cdc.gov/std/tg2015/gonorrhea.htm).

**Case Fatality**

Gonorrhea is not fatal.
Reservoir
Humans are the only known natural hosts and reservoirs of infection.

Transmission
Gonorrhea is transmitted by direct sexual contact either through oral, vaginal or rectal sex. Gonorrhea can also be transmitted at birth through contact with an infected birth canal.

Susceptibility
Sexually active individuals are susceptible to infection. People who are infected develop antibodies, but there are many different gonococcal strains so prior infection does not confer immunity to all strains and reinfection is common. Women using an intrauterine contraceptive device have higher risks of gonococcal salpingitis (infection of the fallopian tubes) during the first three months of insertion. Some people have hereditary complement deficiency and may be more susceptible to bacteremia. Younger women are more susceptible to infection than older women due to a change in the vaginal epithelium that occurs during aging.

Incubation Period
The incubation period of gonorrhea is highly variable and poorly defined. For symptomatic patients, an incubation period of 1–14 days or longer is estimated.

Period of Communicability
The period of communicability is unknown, and may be prolonged in untreated individuals. Effective treatment ends communicability within hours.

Epidemiology
Gonorrhea is the second most frequently reported communicable disease in Utah and in the United States. Although Utah rates are much lower than the national rates, from 2011 to 2014 Utah rates have increased 399%.

Gonorrhea rates among males in Utah have consistently been higher than among females over the past 10 years; and from 2008 to 2012, males have had rates at least 2.5 times higher than females. However, from 2011 to 2014 males have had rates 1.5 times higher than females. Two-thirds of male gonorrhea cases in 2009 and 2010 were among men who have sex with men (MSM). This percentage decreased every year, from 62% in 2011 to 42% in 2014. The gonorrhea rate in females increased 714% from 4.7 cases per 100,000 population to 38.3 in 2014.

Drug resistance is an increasingly important concern in the treatment and prevention of gonorrhea. CDC monitors trends in gonorrhea drug resistance through the Gonococcal Isolate Surveillance Project (GISP), which tests gonorrhea samples (“isolates”) from the first 25 men with urethral gonorrhea attending STD clinics each month in sentinel clinics across the United States (27 cities in 2014). Utah does not currently participate in GISP.
PUBLIC HEALTH CONTROL MEASURES

Public Health Responsibility

- Investigate all suspect cases of gonorrhea, complete and submit appropriate disease investigation forms.
- Facilitate early detection and effective treatment of patients and their contacts.
- Provide education to the general public and clinicians regarding disease transmission and prevention.
- Identify clusters or outbreaks of this disease.
- Identify sources of exposure and stop further transmission.

Prevention

- Emphasis should be placed on early detection and effective treatment of patients and their contacts.
- Educate the community in general health promotion measures:
  - Provide health and sex education that teaches the importance of delaying sexual activity until the onset of sexual maturity as well as the importance of establishing mutually monogamous relationships and reducing the numbers of sexual partners;
  - Discourage multiple sexual partners and anonymous or casual sexual activity;
  - Teach methods of personal prophylaxis applicable before, during and after exposure, especially the correct and consistent use of condoms;
  - Protect the community by controlling STDs in sex workers and their clients.
- Ensure the availability of health care facilities for early diagnosis and treatment:
  - Encourage their use through education of the public about symptoms of sexually transmitted infections and modes of transmission;
  - Ensure these services are culturally appropriate and readily accessible and acceptable, regardless of economic status;
  - Provide adequate partner notification;
  - Conduct routine annual screening of sexually active adolescent girls;
  - Provide annual screening to women who are less than 25 years and to women 25 years or older who have sex with more than one partner, have a new partner, and/or use barrier contraceptives inconsistently. Both males and females with other STDs should be screened as well;
  - Screen all pregnant women during their first prenatal visit. Women less than 25 years, at increased risk for gonorrhea (e.g., women who have a new or more than one sex partner), and/or found to have gonorrhea infection during the first trimester should be retested during the third trimester.
  - Subgroups of men who have sex with men (MSM) are at high risk for gonorrhea infection and should be screened at multiple sites of exposure (urethral, pharyngeal, and rectal).
  - Test and adequately treat individuals who engage in commercial sex work and illicit drug use.
Chemoprophylaxis
All sexual partners of infected patients should receive prophylaxis as well as infants born to untreated mothers with gonorrhea. For dosage information, see the treatment section of this document.

Vaccine
None.

Isolation and Quarantine Requirements

Isolation: Avoid sexual contact until 7 days post-treatment.

Hospital: Not applicable.

Quarantine: Not applicable.
CASE INVESTIGATION

Reporting
Gonorrhea is a reportable disease. Providers should report cases meeting the following criteria using the UDOH GC report form.

<table>
<thead>
<tr>
<th>Criterion</th>
<th>Reporting Gonorrhea</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Laboratory Evidence</strong></td>
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Note:
S = This criterion alone is sufficient to report a case

Case Definition (2013)
Epidemiologists classify infections according to the following:

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**Gonorhhea (2013):**

**Clinical Description**
Infection with *N. gonorrhoeae* may result in urethritis, epididymitis, cervicitis, acute salpingitis, or other syndromes when sexually transmitted; however, the infection may be asymptomatic. Perinatal infections may result in inclusion conjunctivitis and pneumonia in newborns.

**Laboratory Criteria**
- Observation of gram-negative intracellular diplococci in a urethral smear obtained from a male or an endocervical smear obtained from a female, or
- Isolation of typical gram-negative, oxidase-positive diplococci by culture (presumptive *N. gonorrhoeae*) from a clinical specimen, or
- Demonstration of *N. gonorrhoeae* in a clinical specimen by detection of antigen or nucleic acid.

**Case Classification**

*Probable:* demonstration of gram-negative intracellular diplococci in a urethral smear obtained from a male or an endocervical smear obtained from a female.

*Confirmed:* a person with laboratory isolation of typical gram-negative, oxidase-positive diplococci by culture (presumptive *N. gonorrhoeae*) from a clinical specimen, or demonstration of *N. gonorrhoeae* in a clinical specimen by detection of antigen or detection of nucleic acid via nucleic acid amplification (e.g., PCR) or hybridization with a nucleic acid probe.
Case Investigation Process
- Contact medical provider to gather patient demographics, clinical, and treatment information, as well as patient notification status.
- Conduct a client interview.
- Complete a Case Morbidity Record (CMR) in UT-NEDSS/TriSano according to the minimum data set on the original patient.
- Conduct investigations on contact event(s) and create UT-NEDSS contact event(s) for contacts identified.
- Provide/facilitate treatment and follow-up for contacts.
- Complete CMR and contact event, if applicable.

Outbreaks
A gonorrhea outbreak occurs when the observed rate of disease in a geographical area exceeds the normal (endemic) rate.

Identify Case Contacts
Patients should be instructed to refer their sex partners for evaluation, testing, and treatment if they had sexual contact with the patient during the 90 days preceding onset of the patient’s symptoms or gonorrhea diagnosis. Although the exposure intervals defined for the identification of at-risk sex partners are based on limited evaluation, the most recent sex partner should be evaluated and treated, even if the time of the last sexual contact was greater than 90 days before symptom onset or diagnosis.

Case Contact Management
Among heterosexual patients, if concerns exist that sex partners who are referred to evaluation and treatment will not seek services (or if other management strategies are impractical or unsuccessful), patient delivery of antibiotic therapy (expedited partner therapy or EPT) to their partners can be considered. Compared with standard partner referral, this approach, which involves delivering a prescription or the medication itself, has been associated with a trend toward a decrease in rates of persistent or recurrent gonorrhea. Patients must also inform their partners of their infection and provide them with written materials about the importance of seeking evaluation for any symptoms suggestive of complications (e.g., testicular pain in men and pelvic or abdominal pain in women). Patient-delivered partner therapy is not routinely recommended for MSM because of a high risk for coexisting infections, especially undiagnosed HIV infection, in their partners.

All contacts should be instructed to abstain from sexual intercourse until seven days after a single-dose regimen or 24 hours after completion of a seven-day regimen. Timely treatment of sex partners is essential for decreasing the risk for re-infecting the index patient.
REFERENCES


ARUP Labs; Physician’s Guide to Laboratory Test Selection and Interpretation.

Centers for Disease Control and Prevention, Case Definitions for Infectious Conditions Under Public Health Surveillance. MMWR 46 (RR-10), 1997.I.

Centers for Disease Control and Prevention, Sexually Transmitted Diseases Treatment Guidelines, 2015.


✓ VERSION CONTROL

V.06.15: Updated Epidemiology information, added Utah specific epidemiology. Updated treatment according to 2010 CDC treatment guidelines and included information regarding Expedited Partner Therapy (EPT). Added Minimum Data Set (MDS), added Table of Contents.

V.08.15: Updated treatment according to 2015 CDC treatment guidelines.

V.10.16: Updated Minimum Data Set (MDS).
**UT-NEDSS MINIMUM/REQUIRED FIELDS BY TAB**

### MORBIDITY EVENT

#### Demographic
- Last Name
- First Name
- Street
- Unit Number
- City
- State
- County
- Zip code
- Date of Birth
- Area Code
- Phone Number
- Birth Gender
- Ethnicity
- Race
- Disposition *(if promoted contact)*
- Disposition Date *(if promoted contact)*
- Contact Type *(if promoted contact)*

#### Clinical
- Disease
- Date Diagnosed
- Pregnant *(if female)*
- Expected Delivery Date *(if pregnant)*
- Treatment Given
- Treatment *(if treated)*
- Date of Treatment *(if treated)*
- Clinician Last Name
- Clinician Area Code
- Clinician Phone
- Diagnostic Facility
- Type of facility
- Method of Case Detection

#### Specimen Source Section
- Specimen Source
- Collection Date

#### Contacts
- How many sex partners has the case had in the past 3 months?

#### Reporting
- Date first reported to public health

#### Investigation
- Was the case interviewed?
  - Interview date *(if yes)*
  - Interview period *(if yes)*
  - Reason not interviewed *(if no)*
- Date closed
- Is the patient MSM? *(if male)*

#### Administrative
- State Case Status *(completed by UDOH)*

### CONTACT EVENT

#### Demographic
- Contact Name
- Contact Address County *(if known)*
- Contact Birth Gender *(if known)*
- Contact Disposition
- Contact Disposition Date
- Contact Type

#### Clinical
- Contact Pregnant *(if known)(if female)*
- Contact Expected Delivery Date *(if pregnant)*
- Contact Treatment Given *(if known)*
- Contact Date of Treatment *(if treated)*