Johns Hopkins All Children’s Hospital

Sexually Transmitted Infections (STI) Clinical Pathway

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Sexually Transmitted Infections (STI) Screening and Treatment Clinical Pathway

Rationale
This clinical pathway was developed by a consensus group of JHACH physicians, advanced practice providers, infectious disease physicians, and pharmacists to standardize the management of screening and treating adolescents with chlamydia and gonorrhea, and other sexually transmitted infections (STI). It addresses the following clinical questions or problems:

- When to screen and evaluate for chlamydia and gonorrhea in sexually active adolescents, 14 years and older
- When to consider admission for complications from PID
- When to order additional STI testing or gynecological infection testing and treat
- When to consider treatment after labs hours when testing is not performed
- How to properly treat for gonorrhea and/or chlamydia, yeast infection, trichomonas, bacterial vaginosis, HSV
- How to properly treat PID as an outpatient and inpatient
- Who to contact when a patient is HIV positive

Background

**Chlamydia** - *Chlamydia trachomatis* is a sexually transmitted gram-negative organism. It is the **most common bacterial STI** and is the leading cause of cervicitis in women and urethritis in men in the US. Many times infections are asymptomatic leading to an ongoing reservoir for infection. Chlamydia is transmitted by having unprotected vaginal, anal, or oral sex with someone who is infected with chlamydia. Patients can get re-infected even if they have been previously treated.

Symptoms in women with vaginal infections include burning with urination, and abnormal vaginal discharge. Symptoms in men with penile or testicular infections include burning with urination, penile discharge, unilateral or bilateral testicular pain and swelling. Anal infections include rectal pain, bleeding, and/or discharge.

**Gonorrhea** - *Neisseria gonorrhoeae* is a sexually transmitted gram-negative cocci bacteria. It is the **second most communicable disease in the US**. It can lead to cervicitis in women and urethritis in men. Gonorrhea is transmitted by having unprotected vaginal, anal, or oral sex with someone who is infected with gonorrhea. Patients may also have extra-genital
infections of the pharynx and rectum, or invasive infections including disseminated gonococcal infection, endocarditis, and meningitis. Although these are uncommon they can result in serious morbidity. There is a growing threat of antimicrobial resistance in N. gonorrhoea making it important to ensure the availability of appropriate diagnostic modalities for surveillance.

Most women are asymptomatic. Symptoms in women are usually mild that present with painful or burning sensation for urination, increased vaginal discharge, and vaginal bleeding between periods. (Some do not have symptoms, but when they do symptoms in men include burning sensation with urination, white, green, yellow penile discharge, painful or swollen testicles (less common)). Rectal infections can present without symptoms, or symptoms can occur in both men and women, including discharge, anal itching, soreness, bleeding, and painful bowel movements. If Gonorrhea if left untreated can lead to pelvic inflammatory disease, perihepatitis (Fitz-Hugh Curtis), Bartholinitis, and pregnancy complications including transmission to infant.

Oropharyngeal Gonorrhea infections can occur. The majority of these infections are asymptomatic, but may present with sore throat, tonsillar exudates, and/or cervical lymphadenopathy. In one study of 192 patients presenting for sore throat, less one percent were positive for gonorrhea pharyngitis. Oropharyngeal infections are acquired more efficiently by fellatio than by cunnilingus.

Gonorrhea conjunctivitis mainly affects infants that are infected by untreated mothers. In adults and adolescents there are some cases that can occur from autoinoculation from anogenital infections. Symptoms may range from conjunctival injection, purulent discharge, and periorbital edema, and if left untreated, can progress to corneal ulceration, perforation, or blindness.

Pelvic inflammatory disease- Pelvic inflammatory disease (PID) comprises a spectrum of inflammatory disorders of the upper female genital tract, including any combination of endometritis, salpingitis, tubo-ovarian abscess, and pelvic peritonitis. The majority of PID cases (85 percent) are caused by sexually transmitted pathogens or bacterial vaginosis-associated pathogens. Fewer than 15 percent of acute PID cases are not sexually transmitted and instead are associated with enteric (eg, Escherichia coli, Bacteroides fragilis, Group B streptococci, and Campyllobacter spp) or respiratory pathogens (eg, Haemophilus influenzae, Streptococcus pneumoniae, Group A streptococci, and Staphylococcus aureus) that have colonized the lower genital tract.

PID occurs in highest frequency among those 15 to 25 years of age. Major risk factors include younger age, past infection with chlamydia, a partner with a STI, and previous PID. Acute symptomatic PID is characterized by the acute onset of lower abdominal or pelvic pain for
less than 2 weeks, pelvic organ tenderness, and evidence of inflammation of the genital tract. Pain will be worse with jarring or intercourse. Up to 1/3 of women will have abnormal uterine bleeding. On physical examination patients will have lower abdominal tenderness with palpation, positive chandelier sign, and pain with bimanual examination of the adnexa. There may also be visible vaginal or endocervical discharge.\textsuperscript{7}

\textit{Positive chandelier sign}- cervical motion tenderness on pelvic exam

**Herpes Simplex Virus (HSV)**- Herpes simplex virus (HSV) type 1 and type 2 are common in genital herpes infections. HSV type 2 is the more common cause for recurrent cases. There are 3 types of infections including primary, non-primary, and recurrent. Symptoms include multiple, clustered, bilateral vesicles or pustules to the genitals with associated local pain and itching, dysuria, tender lymphadenopathy, fever, headache, malaise, and/or myalgias. Nonprimary and recurrent episodes usually have less severe symptoms. Diagnosis is made by HSV PCR\textsuperscript{8} and clinical examination. Treatment duration and course are based on type of infection.

**Trichomonas**- Protozoan parasite infection called Trichomonas vaginalis. This the most common curable STI. It occurs in females more than males. Males may experience penile itching, or irritation, burning after ejaculation or urination, and/or discharge from penis. Females may experience itching, redness, burning, or sores to vagina, discomfort with urination, change in vaginal discharge- thin, white, yellow, or green with unusual fishy smell. KOH swab testing is performed. Demonstrates parasites under microscopic exam.\textsuperscript{10}

**Candidal Yeast Infection**- one of the most common causes of vaginal itching and discharge. It can be related to antibiotic use, diabetes, immunosuppression and increased sexual activity. Diagnosis is made clinically or by microscopic evaluation for yeast.

**Bacterial Vaginosis (BV)**- most common vaginal infection in women ages 15-44. Occurs when bacteria accumulates in the vagina and unbalances the pH. Researchers do not know what causes BV, or how sex contributes to getting the infection. It is characterized by vaginal discharge, pain, itching, or burning of vaginal, foul odor after sex, dysuria. Diagnosis is made by preparing microscopic slide and evaluating for clue cells.\textsuperscript{11}

**Human Immunodeficiency Virus (HIV)**- Sexually transmitted disease caused by cytopathic retrovirus. This was initially discovered in the early 1980’s with increase rise of neumocystis carinii pneumonia and Kaposi sarcoma in previously health men. Many patients are asymptomatic or vague flu-like symptoms characterized by fever, lymphadenopathy, sore throat, rash, myalgia/arthritis, diarrhea, and headache. Up to 15% of the population may have HIV who are unaware that they have a HIV infection. Routine screening is recommended for patients from age 13-75 years old. Routine screening is important in identifying patients with
HIV infections, this can lead to earlier intervention with anti-retrovirals, decreasing high risk sexual behaviors, and appropriate preventative care (immunizations and prophylactic antibiotics).

**Syphilis**—sexually transmitted disease caused by the spirochete *Treponema pallidum*. Patients may present during primary, secondary, and tertiary phase of infection. Nontreponemal testing is used to screen from syphilis, at Johns Hopkins All Children's Hospital we use rapid plasma regain (RPR). Treponemal tests are used for confirmatory test, at Johns Hopkins All Childrens we use Fluorescent treponemal antibody absorption test (FTA-ABS). Primary syphilis presents as a painless chancre, which is described as a painless raised 1-2cm ulcer with indurated margin. These lesions usually occur on genitalia but can also appear on posterior oropharynx, anus, or vagina. Secondary syphilis may progress weeks to months after chancre untreated. Symptoms include fever, headache, malaise, anorexia, sore throat, myalgias, and weight loss. They will also present with enlarge lymphadenopathy of cervical, axillary, inguinal, femoral regions, with epitrochlear nodes being more suggestive of diagnosis. Patients may present with rash, classically is a diffuse macular popular rash involving trunk, extremities, palms and soles, but may take on many different forms. Patients may also have hepatitis, GI symptoms including ulcerations, renal abnormalities including nephrotic syndrome, acute nephritis with hypertension and acute renal failure, and/or neurological findings including headaches or meningitis. Tertiary syphilis may appear 1-30 years after primary infections. Cardiovascular involvement includes dilated aorta, and aortic valve regurgitation. Gummatous syphilis mainly occurs in HIV infected patients and can occur anywhere including skin, bones, and internal organs. Gummas may present as ulcers or granulomatous lesions. Neurological involvement can be seen 25 years after infection including general paresis and tabes dorsalis.

**Hepatitis**—viral infection that can be sexually transmitted. Usually affects the liver and can lead to acute and/chronic liver disease. Hepatitis B has a high rate of transmission through sexual intercourse, although rates have improved with vaccination. Hepatitis C can be transmitted sexually, but is low risk. Hepatitis A is usually self-limited, and rarely leads to fulminant liver failure, less than 1%.

**Diagnosis**
Diagnosis is made by collecting thorough and honest sexual history, history of present illness and clinical examination. Laboratory findings can confirm diagnosis, including positive STI testing, pregnancy, or urinalysis.
Sexually Transmitted Infection (STI) Screening Algorithm for Females

**Chief Complaint**
- Lower abdominal pain
- Vomiting
- Abnormal Uterine bleeding
- Vaginal Discharge
- Dysuria

**Exclusion Criteria**
- Less than 14 years old
- Concern/Outcry for Sexual Abuse
- Developmentally delayed or physically disabled

**Yes to any one of the above?**

Order, collect, and send N.Gonorrhea and Chlamydia Urine PCR
Pregnancy POC (Point of Care)

Positive (+) Pregnancy Test
Transfer to Bayfront or appropriate adult facility

**History of present illness and Physical exam**

**Sexual History Questions**
1. Are you sexually active?
2. Would you like to be screened for gonorrhea/chlamydia today?
   *if not already sent based on chief complaint*
3. Do you use condoms?
4. Have you previously been diagnosed with a sexually transmitted infection?
5. Do you currently have a sexually transmitted infection?
6. Have you had multiple partners?

**Orders and Exam**
- N.Gonorrhea and Chlamydia Urine PCR (if YES to any of above questions, or NO to condoms)
- Pelvic Exam with Bimanual Exam
- KOH/Wet prep- tests for yeast for candida infections, clue cells for bacterial vaginosis, and parasites for trichomonas
  Although yeast and bacterial vaginosis are not sexually transmitted infections, they can present with similar symptoms
  If patient cannot tolerate speculum exam, Bimanual should be performed and patient may self-swab for KOH/Wet prep

**Offer additional testing for STIs including**
- **Human Immunodeficiency Virus (HIV)**
  - HIV 1 & 2 Antigen/Antibody Screen, HIV-1, DNA/PCR, Qlt Quest
- **Syphilis**
  - RPR
- **Hepatitis**
  - Acute Hepatitis Panel (A, B,C which includes Hepatitis-A Ab, IgM, Hepatitis B Surface Ag, Hepatitis B Core Ab, IgM, Hepatitis C Ab)
- **Herpes Simplex Virus (HSV)**
  - HSV PCR- any concerning vesicles or lesions

Concern for Pelvic Inflammatory Disease please refer to page 9

Refer to treatment pathways below based on positive results

**Additional Work-Up to Consider**
- Consider Urine Analysis and Urine Culture if having dysuria, flank pain, hematuria, fever, and/or vomiting for Acute Cystitis or Pyelonephritis
- Renal ultrasound for Nephrolithiasis
- Pelvic ultrasound with flow if concern for Ovarian torsion, mass, cyst
- Radiograph of the abdomen to evaluate for constipation
- Appendix ultrasound for acute appendicitis
Gonorrhea and Chlamydia Test Results and Treatment

**Gonorrhea PCR Positive**

First line therapy
- Ceftriaxone 500 mg IM single dose <150kg
  - OR
  - Ceftriaxone 1000 mg IM single dose >150kg

Alternative therapy
- Cefixime 800 mg PO single dose

Cephalosporin Allergic?
- Gentamicin 240 mg IM single dose
  - PLUS
  - Azithromycin 2 gram PO as single dose

**Chlamydia PCR Positive**

First line therapy
- Azithromycin 1 gram PO as a single dose
  - OR
  - Doxycycline 100mg PO BID x 7 days

Alternatives if Doxycycline or Azithromycin allergy
- Levofloxacin 500 mg PO QD x 7 days

**Empiric Treatment for Chlamydia and Gonorrhea or PCR Positive for both**

IF BOTH POSITIVE
- ADD-ON
  - HIV
  - SYPHILIS
  - HEPATITIS

First Line Therapy
- Ceftriaxone 500 mg IM single dose <150kg
  - OR
  - Ceftriaxone 1000 mg IM single dose >150kg
  - PLUS
  - Doxycycline 100 mg PO BID X 7 days

If Cephalosporin Allergic
- Gentamicin 240mg IM single dose
  - PLUS
  - Azithromycin 2 gram PO as single dose

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**JHACH Test Result Times:**

If **before 19:00 (7pm)** wait for results and treat accordingly, patient may be moved to waiting room awaiting results if rest of evaluation has been completed.

If **after 19:00 (7pm)**, discuss treatment options with patient. May treat empirically for Gonorrhea and Chlamydia or call back. Chart patient’s personal phone number for results. Ask and chart if may disclose results to guardian or family members. Make sure patient has transportation and is able to follow up, if positive results, and elects not to treat.

*JHACH lab will run N.Gonorrhea and Chlamydia Urine PCR if they receive the sample by 19:20*
**KOH/Wet Prep, Herpes Simplex Virus (HSV), Syphilis, HIV and Hepatitis Test Results and Treatment**

**Candidal Infection**
*Yeast positive*

- Fluconazole 150mg PO single dose

**Trichomonas**
*Protozoans positive*

- Metronidazole 500mg PO BID for 7 days
- **OR**
  - Metronidazole 2 grams PO single dose
- **OR**
  - Tinidazole 2 grams PO single dose

**Clue Cell Positive**
*Bacterial Vaginosis*

- Metronidazole 500 mg PO BID for 7 days
- **OR**
  - Metronidazole gel 0.75% 5g (one full applicator) intravaginally once a day for 5 days
- **OR**
  - Clindamycin 2% cream 5g (one full applicator) intravaginally at bedtime for 7 days

**Concerning history and physical exam findings consistent with Herpes Simplex Virus (HSV) or HSV PCR positive**

- Acyclovir 400mg PO TID for 7-10 days

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**Additional Testing Information**

**Syphilis**

- RPR positive (will not result same day), contact to return for treatment and send FTA ABS Quest lab for confirmation

**Human Immunodeficiency Virus (HIV)**

- HIV antibody positive (results in about an hour)
  - **MUST wait in Emergency Dept FOR RESULT**
  - **Consult USF Infectious Disease**
  - Dr. Carina Rodriguez 813-259-8800

**Hepatitis**

- Will not result same day.
Pelvic Inflammatory Disease (PID)

- Diagnosis is in women who have pelvic or lower abdominal pain with one or more of the following:
  - cervical motion tenderness or uterine tenderness or adnexal tenderness on pelvic examination

Consider Admission if…
- Ill-appearing patient, febrile (>39.5°C), intractable vomiting, severe abdominal pain
- Pelvic or tubo-ovarian abscess
- Inability to tolerate PO antibiotic therapy
- Failed outpatient management

### Inpatient Therapy
- Cetriaxone IV (1g Q24H)
- **PLUS**
  - Doxycycline 100 mg PO/IV BID
  - **PLUS**
  - Metronidazole 500 mg PO/IV BID
  - **OR**
  - Cefotetan IV (2g Q12H)
  - **PLUS**
  - Doxycycline 100 mg PO/IV BID
  - **OR**
  - Cefoxitin IV (2g Q6H)
  - **PLUS**
  - Doxycycline 100 mg PO/IV BID
  - **OR**
  - Clindamycin IV (900mg Q8H)
  - **PLUS**
  - Gentamicin (2mg/kg once) Followed by 5mg/kg IV q24 hr

Patient Status- Observation
Inpatient Status if continued…
- Fever >39.5 OR
- Protracted vomiting OR
- Tubo-ovarian abscess

### Positive (+) Trichomonas
- **Yes**
- **No**

### Positive (+) Bacterial
- **Yes**
- **No**

### Outpatient Therapy
- Positive (+) Trichomonas
- **Positive (+) Bacterial Vaginosis**

Outpatient therapy
- Ceftriaxone 500mg IM single dose*
- **PLUS**
  - 100mg Doxycycline BID for 14 days
- **PLUS**
  - 500mg BID Metronidazole for 14 days

*For persons weighing >150 kg (~300 lbs.) with documented gonococcal infection, 1 g of ceftriaxone should be administered.

Ceftriaxone 500mg IM single dose*
- **PLUS**
  - 100mg Doxycycline BID for 14 days

Ceftriaxone 500mg IM single dose*
- **PLUS**
  - 100mg Doxycycline BID for 14 days

### Transition to Outpatient Therapy when able to tolerate PO, able to tolerate PO antibiotics and clinically improved

- 100mg Doxycycline BID PO to complete a 14 day course
- **PLUS**
  - 500mg BID Metronidazole for 14 days

- 100mg Doxycycline BID PO to complete 14 day course
Sexually Transmitted Infection Screening Algorithm for Males

Chief Complaint
- Penile discharge
- Testicle pain and/or swelling
- Dysuria

Exclusion Criteria
- Less than 14 years old
- Concern/Outcry for Sexual Abuse
- Developmentally delayed or physically disabled

Yes to any one of the above in triage?

Order, collect and send N.Gonorrhea and Chlamydia Urine PCR

History of present illness and physical exam order work up accordingly

Sexual History Questions
1. Are you sexually active?
2. Would you like to be screened for gonorrhea/chlamydia today?
   *if not already sent based on chief complaint*
3. Do you use condoms?
4. Have you previous been diagnosed with a sexually transmitted disease?
5. Do you currently have a sexually transmitted disease?
6. Have you had multiple partners?

Orders and Exam
- N.Gonorrhea and Chlamydia Urine PCR (if YES to any of above questions, or NO to condoms)
- Genitalia examination

Offer additional testing for STIs including
- Human Immunodeficiency Virus (HIV)
  - HIV 1 & 2 Antigen/Antibody Screen, HIV-1, DNA/PCR, Qlt Quest
- Syphilis
  - RPR
- Hepatitis
  - Acute Hepatitis Panel (A, B, C which includes Hepatitis-A Ab, IgM, Hepatitis B Surface Ag, Hepatitis B Core Ab, IgM, Hepatitis C Ab)
- Herpes Simplex Virus (HSV)
  - HSV PCR- any concerning vesicles or lesions

Additional Work-up to consider
- Consider balanitis if uncircumcised
- Testicular Ultrasound for testicular pain, swelling, erythema to evaluated for possible testicular torsion
- Paraphimosis/Phimosis
- Urine Analysis/Urine Culture- to evaluated for Orchitis, Epididymitis, Nephrotic Syndrome, or Acute cystitis

Refer to treatment pathways below based on positive results
Gonorrhea and Chlamydia Test Results and Treatment

Gonorrhea PCR Positive

First line therapy
Ceftriaxone 500 mg IM single dose <150kg
OR
Ceftriaxone 1000 mg IM single dose >150kg

Alternative therapy
Cefixime 800 mg PO single dose

Cephalosporin Allergic?
Gentamicin 240 mg IM single dose
PLUS
Azithromycin 2 gram PO as single dose

Chlamydia PCR Positive

First line therapy
Azithromycin 1 gram PO as a single dose
OR
Doxycycline 100 mg PO BID x 7 days

Alternatives if Doxycycline or Azithromycin allergy
Levofoxacin 500 mg PO QD x 7 days

Empiric Treatment for Chlamydia and Gonorrhea or PCR Positive for both

First Line Therapy
Ceftriaxone 500 mg IM single dose <150kg
OR
Ceftriaxone 1000 mg IM single dose >150kg
PLUS
Doxycycline 100 mg PO BID X 7days

If Cephalosporin Allergic
Gentamicin 240mg IM single dose
PLUS
Azithromycin 2 gram PO as single dose

JHACH Test Result Times:
If before 7pm wait for results and treat accordingly, patient may be moved to waiting room awaiting results if rest of evaluation has been completed.
If after 7pm, discuss treatment options with patient. May treat empirically for Gonorrhea and Chlamydia or call back. Chart patient’s personal phone number for results. Ask and chart if may disclose results to guardian or family members. Make sure patient has transportation and is able to follow up, if positive results, and elects not to treat.

*lab will run N.Gonorrhea and Chlamydia Urine PCR if they receive the sample by 19:20
Concerning history and physical exam findings consistent with Herpes Simplex Virus (HSV) or HSV PCR positive

Acyclovir 400mg PO TID for 7-10 days

**Additional Testing Information**

**Syphilis**

Concerning history and physical exam, or positive testing treat with Penicillin G benzathine IM (2.4 million units)

RPR positive (will not result same day), contact to return for treatment and send FTA ABS Quest lab for confirmation

**Human Immunodeficiency Virus (HIV)**

HIV antibody positive (results in about an hour)

**MUST wait in Emergency Dept FOR RESULT**

Consult USF Infectious Disease

Dr. Carina Rodriguez 813-259-8800

**Hepatitis**

Will not result same day.
Florida Law about Confidentiality and Notification

384.30 Minors’ consent to treatment.

(1) The department and its authorized representatives, each physician licensed to practice medicine under the provisions of chapter 458 or chapter 459, each health care professional licensed under the provisions of part I of chapter 464 who is acting pursuant to the scope of his or her license, and each public or private hospital, clinic, or other health facility may examine and provide treatment for sexually transmissible diseases to any minor, if the physician, health care professional, or facility is qualified to provide such treatment. The consent of the parents or guardians of a minor is not a prerequisite for an examination or treatment.

(2) The fact of consultation, examination, and treatment of a minor for a sexually transmissible disease is confidential and exempt from the provisions of s. 119.07(1) and shall not be divulged in any direct or indirect manner, such as sending a bill for services rendered to a parent or guardian, except as provided in s. 384.29.

History.—s. 90, ch. 86-220; s. 8, ch. 90-344; s. 12, ch. 93-227; s. 682, ch. 95-148; s. 200, ch. 96-406; s. 90, ch. 2000-318.

Partner Notification Resources

- STDcheck
  - https://www.stdcheck.com/anonymous-notification.php
  - Able to text or email partners
- Inspot
  - https://www.inspot.org/
  - Only able to email partners
- Expedited Partner Therapy (EPT) is legal in Florida, guidelines for prescriptions and treatment
Discharge Instructions and Safe Sex Practices

Patients should be instructed to abstain from sex for at least 7 days following treatment, after symptoms resolved, and when sexual partners are adequately treated. Test for cure is not recommended for Gonorrhea. Test for a cure is recommend in 3 months for Chlamydia and Trichomonas, testing should not be performed within 3 weeks of treatment, may be false positive. You may prescribe expedited partner therapy (EPT), but must know the partners legal name, and patient must have laboratory confirmed STI. Please see links above about EPT and partner notification resources.

Patients should also be educated about safe sex practices including partner testing and treatment, condom use, testing prior to entering sexual relationship.

Admission

Admission criteria for pelvic inflammatory disease: severe abdominal pain, intractable vomiting, sepsis, unclear diagnosis of PID, fever >39.5C, failed outpatient antibiotic management

Additional Considerations

The following diagnostic codes should be considered

Patient meets inpatient status if the following criteria are met- poorly controlled abdominal pain, intractable vomiting, need to surgical intervention, IV antibiotics, sepsis, tubo-ovarian abscess
References


OUTCOME MEASURES:

- Detected and appropriately treated STIs
- Total length of stay of patients being assessed for STI
- G/C urine orders sent from triage.
- The goal is expedite screening and testing process in the ED.
- To properly screen and treat teenagers for STIs to help decrease incidents infection.

Sexually Transmitted Infection (STI) Clinical Pathway
Johns Hopkins All Children’s Hospital

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Disclaimer

Clinical Pathways are intended to assist physicians, physician assistants, nurse practitioners and other health care providers in clinical decision-making by describing a
range of generally acceptable approaches for the diagnosis, management, or prevention of specific diseases or conditions. The ultimate judgment regarding care of a particular patient must be made by the physician in light of the individual circumstances presented by the patient.

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