Q&A:

What are the current considerations for asymptomatic infections, since they are a large reservoir of unrecognized, infected individuals who are capable of transmitting the infection to their sexual partners?

- These guidelines that were presented are people with symptoms of STIs. WHO is currently gathering evidence through systematic reviews and will be modelling screening strategies for different populations and different settings (e.g. low and high prevalence settings; availability of laboratory tests.)
- Already available is the dual HIV /syphilis testing that are being recommended for screening of pregnant women and key population and those with other STIs.
- WHO has screening recommendation to screen key population for gonorrhoea an chlamydial infection using NAAT test.
- Screening strategies need to be developed for targeted screening of certain population (key population), risk factors and opportunistic screening for certain individuals seeking care (family planning and adolescent)
- Consideration for screening STIs:
    - Priority STIs – syphilis, gonorrhoea, chlamydial infection
    - High prevalence of STIs in certain populations that has greater potential for transmitting and acquiring STIs
    - Risk factor
    - Population that would likely have greater consequences if not treated: adolescent, pregnant women
    - Partner of people with STIs

Certain genital infections such as Chlamydial infections cannot be easily distinguished from other urethral infections clinically, is there a gold standard that can help differentiate chlamydial infections from other lower genital tract infections with high specificity?

The gold standard to diagnose chlamydial infection is molecular assays /Nucleic Acid Amplification test, which has high sensitivity and specificity.

What are the potentials of targeted interventions for populations at high risk such as sex workers and periodic mass treatment in reducing the prevalence of STIs in the community?

Targeted interventions, which consist of several interventions such as increasing condom use, peer-outreach education, community -led STI services consisting of regular check-ups, increased community engagement and addressing structural barriers have proven to decrease prevalence of STIs. Periodic mass treatment has shown to decrease the rates of STIs dramatically, and has been recommended to reduce STIs but needs to be coupled with more regular and quality STI services, promotion of condom use and other prevention strategies to sustain the reduced STI rates.

With the increase in pathogens developing resistance to antimicrobials and the rapid emergence of some pathogens as significant causes of morbidity and co-factors of HIV transmission, are there standard regimens tailored to the prevalence of AMR especially in resource limited settings?

In resource poor setting, where there is limited laboratory tests to guide appropriate treatment, we strongly recommend countries to conduct regular monitoring of patterns of resistance for gonococcal infection and to ensure that national treatment guidelines are based on patterns of susceptibility/ resistance to certain antibiotics. In addition, efforts should ensure the overall appropriate use of antibiotics and discouraging self-medication.

In syndromic diagnosis, what are the considerations of genital microbiota and biofilm in the diagnosis and treatment of bacterial vaginosis?

Since this is still under development, this has not been considered in the current guidelines. As soon as there are substantial evidences, this can be considered in updating of guidelines.

At what stage of infection would the sexual partner be notified or require prophylactic treatment?
As soon as the sexual partner of the index case (diagnosed for an STIs) has notified the most recent sexual partners, the partners should be provided expedited partner treatment. In practice, we usually ask for the most recent partners with the week up to a month, again based on the incubation period of the STIs.

Vaginal discharge can be caused by non-sexually and sexually transmitted infections, are there differences in the treatment strategy for each cause?
Yes. An appropriate history and physical exam and laboratory diagnosis can provide appropriate treatment regimens. The most common cause of non-STI vaginal discharge such as BV is treated with metronidazole, candidiasis (in the presence of vaginal itchiness and curd-like discharge) is treated with miconazole or fluconazole. STI aetiologies of vaginal discharge include gonorrhoea and chlamydial infections. This is appropriately treated with ceftriaxone for GC and doxycycline or chlamydial infection. However, in resource constrained setting, syndromic approach is being used and treatment strategies include treatment of the most common pathogens causing the specific syndrome.

Any comments on rectal/proctitis management and LGV? Is LGV becoming more prevalent such that a positive rectal CT could be Rxd as LGV?
There has been a steady increase in the confirmed Lymphogranuloma cases in countries (UK, France, Spain and the Netherlands.) It was also noted that there is consistently increasing LGV cases among HIV negative MSM. (It has been suggested that the increased availability of HIV PrEP may lead to changes in sexual behaviour.)

The number of cases is likely under-estimated because many countries do not have national surveillance system for LGV. In addition, the diagnosis of LGV requires confirmation through genotyping that is not available in certain countries.

In sites with high prevalent LGV in MSM for example, it might be prudent to provide an extended treatment of doxycline (21 days recommended for LGV)

Can you thank Dr Teodora for an excellent talk on behalf of British Association of Sexual Health & HIV?
THANKS A LOT.

What is your view about POCs for BV, TV and CA for vaginal discharge in women with low prevalence of CT/NG?
It will be excellent to have affordable POCT for BV, TV and CA, as to ensure appropriate treatment and reduce overtreatment. But in this scenario of low CT/NG prevalence, a low POCT for CT/NG is needed to reduce overtreatment of CT/NG

Are you still recommending low dose ceftriaxone 250mg for GC?
WHO is in the process of revising guidelines. Given the emerging resistance in NG to ceftriaxone, we are in the processing of recommending an increased dose of ceftriaxone 500 mg. (revisions of guidelines take time due to the developmental and approval requirements)

Do you think the cost you assign to AMR is enough? As long as the cost assigned is low the guidelines will always favour over treatment

Yes. AMR tax were based on indirect evidence. AMR tax is also greater than the cost of current cost of NG/CT treatment. Please note that we strongly recommend molecular assays (which reduces overtreatment), and conditionally recommend syndromic approach. A major constrain is the cost of molecular assays. We strongly urge, you the researcher to speed up the development of low cost, high performing, POCTs.