STI SCREENING GUIDELINES

The recommendations in this document are based on the 2021 CDC Sexually Transmitted Infections Treatment Guidelines and CDC's STI Screening Recommendations Referenced in Treatment Guidelines and Original Recommendation Source chart referenced here: https://www.cdc.gov/std/treatment-guidelines/screening-recommendations.htm unless otherwise noted. Please visit the CDC site for full references. State guidelines and laws may differ; please check with your state for applicable laws and guidelines. **Some patients may fall into more than one of the populations/risk categories listed; in such cases, the more rigorous screening recommendation should be followed**. Please visit www.nycptc.org for updates and additional STI resources and education. Abbreviations: MSM=men who have sex with men; WSW=women who have sex with women; MSW=men who have sex with women; CT=Chlamydia trachomatis; GC=Neisseria gonorrhea; RAI = Receptive Anal Intercourse; BV=Bacterial Vaginosis; HPV=Human Papillomavirus; HAV=Hepatitis A Virus; HBV=Hepatitis B Virus; HCV = Hepatitis C Virus; TOC = Test of cure; PID=Pelvic Inflammatory Disease. Updated January 2026.

	CHLAMYDIA[1,2]	GONORRHEA[3,4]	SYPHILIS	HERPES	HIV	TRICHOMONAS & BACTERIAL VAGINOSIS	HPV, Anal Cancer, Cervical Cancer	HEPATITIS B	HEPATITIS C
WOMEN	Test at least annually for sexually active women under 25 years of age and those aged 25 years and older if at increased risk[5] Rectal chlamydial testing can be considered in females based on sexual behaviors and exposure through shared clinical decision making. Retest approximately three months after treatment	Test at least annually for sexually active women under 25 years of age and those aged 25 years and older if at increased risk[5] Pharyngeal and Rectal chlamydia testing can be considered in females based on sexual behaviors and exposure through shared clinical decision making. Retest approximately three months after treatment	Screen asymptomatic adults at increased risk for syphilis infection***	Type-specific HSV serologic testing can be considered for patients presenting for an STI evaluation (especially if multiple sex partners).	All women aged 13-64 years and all women who seek evaluation and treatment for STIs Opt-out testing preferred.	**Trichomonas:** consider screening women if at high risk[6] or in high prevalence settings (e.g., STD clinics and correctional facilities) **Bacterial Vaginosis (BV):** no routine screening recommendation	Women 21-29 years of age every 3 years with cytology Women 30-65 years of age every 3 years with cytology or every 5 years with a combination of cytology and HPV testing	Women at increased risk	*All adults aged ≥18 years should be screened at least once in a lifetime, and all pregnant women should be screened during each pregnancy, regardless of prevalence*
PREGNANT WOMEN	All pregnant women under 25 years of age and those aged 25 years and older if at increased risk[5] Retest during 3rd trimester if under 25 years of age or at risk[7] Test of cure 4 weeks after treatment and re-test within 3 months	All pregnant women under 25 years of age and older women if at increased risk[8] Retest during 3rd trimester if under 25 years of age or at risk[7] Retest 3 months after treatment	All pregnant women at the first prenatal visit Retest at 28 weeks and at delivery if at high risk or in a community with high syphilis rates[9]	Evidence does not support routine HSV-2 serologic screening among asymptomatic pregnant women. However, type-specific serologic tests might be useful for identifying pregnant women at risk for HSV infection and guiding counseling regarding the risk for acquiring genital herpes during pregnancy	All pregnant women at first prenatal visit and at delivery if not previously tested or no prenatal care Retest in 3rd trimester if at high risk[9]		Screening at same intervals as non-pregnant women	Test for HBsAg at first prenatal visit of each pregnancy regardless of prior testing; retest at delivery if at high risk	
MSW (Men Who Have Sex W Women)	Consider screening young men in high prevalence clinical settings (adolescent and STI clinics and correctional facilities)	There is insufficient evidence for screening among heterosexual men who are at low risk for infection	Screen asymptomatic adults at increased risk# for syphilis infection***	Type-specific HSV serologic testing can be considered for patients presenting for an STI evaluation (especially if multiple sex partners).	All women aged 13-64 years and all women who seek evaluation and treatment for STIs Opt-out testing preferred.			Men at increased risk	
MSM (Men Who Have Sex W Men)	At least annually, test at each site of exposure (urethra, rectum) for sexually active MSM regardless of condom use or every 3-6 months if at increased risk***	At least annually, test at each site of exposure (urethra, rectum, pharynx) for sexually active MSM regardless of condom use or every 3-6 months if at increased risk***	At least annually for sexually active MSM and every 3-6 months if at increased risk***	Type-specific serologic tests can be considered if infection status is unknown in MSM with previously undiagnosed genital tract infection.	At least annually for sexually active MSM if HIV-negative or unknown status and if patient or sex partner has had more than one sex partner since most recent HIV test Consider more frequent HIV screening (e.g., every 3–6 months) to MSM at increased risk for acquiring HIV infection		Digital anorectal rectal exam Anal cytology may be considered for MSM with HIV per NIH and IDSA guidelines.	All MSM should be tested for HBsAg, HBV core antibody, and HBV surface antibody.	*All adults aged ≥18 years should be screened at least once in a lifetime, and all pregnant women should be screened during each pregnancy, regardless of prevalence*

	GONORRHEA[3,4]/ CHLAMYDIA[1,2]	SYPHILIS	HIV	TRICHOMONAS & BACTERIAL VAGINOSIS	HPV, Anal Cancer, Cervical Cancer	HEPATITIS A	HEPATITIS B	HEPATITIS C
ANATOMY-BASED	-Screening should be adapted based on anatomy (e.g., annual screening for chlamydia if age <25 or at increased risk for people with a cervix. -Consider screening at the rectal site based on reported sexual behaviors and exposure	-Screening should be adapted based on anatomy (e.g., annual screening for gonorrhea if age <25 or at increased risk for people with a cervix. -Consider screening at pharyngeal and rectal sites based on reported sexual behaviors and exposure	Consider screening at least annually based on reported sexual behaviors and exposure.		Screening for people with a cervix should follow current screening guidelines for cervical cancer.	Consider type specific HSV serologic testing for individuals presenting for an STI evaluation	-HIV screening should be discussed and offered to all patients and frequency based on risk. -Frequency of repeat screenings should be based on level of risk	*All adults aged ≥18 years should be screened at least once in a lifetime, and all pregnant women should be screened during each pregnancy, regardless of prevalence*
PATIENTS WITH HIV	-For sexually active individuals, screen at first HIV evaluation and at least annually thereafter. -More frequent screening might be appropriate depending on individual risk behaviors and local epidemiology	-For sexually active individuals, screen at first HIV evaluation and at least annually thereafter. -More frequent screening might be appropriate depending on individual risk behaviors and local epidemiology	-For sexually active individuals, screen at first HIV evaluation, and at least annually thereafter -More frequent screening might be appropriate depending on individual risk behaviors and local epidemiology	**Trichomonas:** sexually active women at entry to care and at least annually thereafter	Women should be screened within 1 year of sexual activity or initial HIV diagnosis using conventional or liquid-based cytology; testing should be repeated 6 months later. With 3 normal and consecutive Pap tests, screening should be every 3 years	Type-specific HSV serologic testing can be considered for patients presenting for an STI evaluation (especially if multiple sex partners).	Test for HBsAg and anti-HBc and/or anti-HBs	Serologic testing at initial evaluation. Annual testing for HIV+ MSM
PATIENTS TAKING PrEP[10]	-All patients starting and taking oral PrEP should have genitourinary and extra-genital testing performed at baseline and every 3 months. -For injectable cabotegravir MSM and people with penises who have sex with penises should have GC/CT testing at initiation and every four months and heterosexually active men and women every 6 months unless at increased risk	-All patients starting and taking oral PrEP should have syphilis testing performed at baseline and every 3 months. -For injectable cabotegravir MSM and anatomy-based populations should have syphilis testing at initiation and every four months and heterosexually active men and women every 6 months unless at increased risk.	-All patients taking oral PrEP should have an HIV test done at initiation and every 3 months -For injectable cabotegravir HIV testing should be performed at every visit -For individuals actively taking antiretroviral therapy for PrEP an HIV NAAT and Ab/Ag test should both be used.			At baseline, MSM starting PrEP and other individuals at high risk of HAV infection[17] Rescreening: If a new elevation in serum liver enzymes is present (if not immune or status is unknown)	All patients starting PrEP Rescreening: If a new elevation in serum liver enzymes is present (if not immune or status is unknown)[11]	All patients starting PrEP Rescreening: Annually for MSM, people with penises who have sex with penises, patients using injection drugs and other patients with ongoing risk of HCV exposure as well as for patients with a new elevation in serum liver enzymes (if status is unknown)[11]

*[1]NAAT testing FDA approved for first catch urine or vaginal swab. [2]Perform local validation study for use of NAAT at anal and pharyngeal sites [3]NAAT testing FDA approved for first catch urine or vaginal swab. [4]Perform local validation study for use of NAAT at anal and pharyngeal sites [5]Those who have a new sex partner, more than one sex partner, a sex partner with concurrent partners, or a sex partner who has a sexually transmitted infection. Screening for Chlamydia and Gonorrhea: U.S. Preventive Services Task Force Recommendation Statement. Annals of internal medicine. Sep 23 2014. [6]Women with multiple sex partners, exchanging sex for payment, illicit drug use, and a history of STDs [7]Those with a new sex partner, more than one sex partner, a sex partner with concurrent partners, or a sex partner who has a sexually transmitted infection. Centers for Disease Control and Prevention. Sexually Transmitted Infection Treatment Guidelines, 2021. [8] US Preventive Services Task Force. Screening for syphilis infection in pregnancy: reaffirmation recommendation statement Annals of internal medicine. 5/19/2009 2009;150(10):705-709. [9] Each state's guidelines and laws may differ; please check with your State DOH for applicable laws and guidelines. [10]Preexposure prophylaxis for the prevention of HIV infection in the United States – 2017 Update, CDC ***Increased risk of infection: history of incarceration or transactional sex work, geography, race/ethnicity, and being a male younger than 29 years [11]Individuals at high risk of acquiring STIs include those who self-identify and/or who report any of the following for self or partner: multiple or anonymous sex partners, a bacterial STD diagnosed at a previous visit or since last STD screening, participation in sex parties or sex in other high-risk venues, participation in any type of transactional sex (e.g. commercial sex work), use of recreational substances during sex, PrEP for HIV Prevention, NYS Department of Health, www.hivguidelines.org/prep-for-prevention/*

Recommended Laboratory Diagnostics *This diagnostics summary is for educational purposes only. The individual clinician is in the best position to determine which tests are most appropriate. Adapted from the Spokane Washington Regional Health District's STD Toolkit*

ETIOLOGIC AGENT	COMMON SYNDROMES	RAPID DIAGNOSTICS	DEFINITIVE DIAGNOSTICS
Chlamydia trachomatis	Non-gonococcal urethritis (NGU), cervicitis, proctitis, PID	Urine leukocyte esterase can be helpful to look for presence of inflammation	**Nucleic Acid Amplification Tests (NAATs)** **(Test all sites of exposure)**
Neisseria gonorrheae	Urethritis, cervicitis, proctitis, PID	Gram stain for symptomatic men	**Nucleic Acid Amplification Tests (NAATs)** **(Test all sites of exposure)** Swab for culture and anti-microbial resistance testing if persistent or recurrent infection, or concern for resistance
Trichomonas vaginalis	Vaginitis, urethritis	Rapid antigen detection test, Saline wet prep	NAAT testing (vaginal, endocervical and urine in women)
Candida albicans, other Candida sp.	Vaginitis, balanitis	10% KOH prep; Gram stain	Culture if wet mount (for women) negative and signs or symptoms. NAAT testing in men on urine or urethral samples is FDA cleared only for specific testing kits. Provider should review this before sending.
Bacterial vaginosis, anaerobic bacteria	Malodorous vaginal discharge with or w/o pruritis	Saline wet prep- clue cells, whiff test (fishy odor with 10% KOH), and vaginal pH >4.5	Rapid tests- e.g., DNA probe and vaginal fluid sialidase activity
Herpes simplex virus (HSV)	Genital ulcer	Point of care HSV2 antibody tests- recent infection may have false negative	Type specific virologic tests: PCR Type specific serological tests: ELISA and Western blot (glycoprotein gG1/gG2 type-specific antibody test) (2 stage testing)
***Treponema pallidum* (syphilis)**	Genital ulcer	Ulcer- darkfield microscopy; serological test; RPR, treponemal rapid EIA available reverse algorithm	Serological tests: RPR, VDRL, USR, ART, (non-treponemal tests); FTA-ABS, MHA-TP (treponemal tests); TP-PA, darkfield is definitive if positive
***Sarcoptes scabiei*(scabies)**	Dermatitis, ulcers	Mineral oil wet prep	Skin scraping of burrow is definitive
***Phithirus pubis* (pubic lice)**	Dermatitis	Dry mount, observation of nits or lice	Detection of eggs, nits, or louse is definitive
Human Papillomavirus (HPV)	Genital warts (condylomata acuminate)	None; observation of lesions	Pap smear; HPV PCR
Salmonella sp., Shigella sp., Campylobacter sp.	Enteritis, proctocolitis	None	Stool culture; stool PCR
Entamoeba histolytica, Giardia lamblia	Enterocolitis	None	Wet prep or thrichrome stain of fresh or concentrated stool, giardia antigen test. Giardia PCR
HIV	Variable	Rapid HIV-1 Antibody Tests	HIV-1/HIV-2 antigen/antibody immunoassays and HIV differentiation assay (HIV1 vs HIV2 antibodies) and then HIV-1 NAT (for indeterminate or negative differentiation test). For patients with signs/symptoms of acute HIV, also send HIV RNA VL testing
Hepatitis virus: (A,B,C)	Hepatitis; elevated liver function enzymes	None; CLIA waived rapid HCV test (OraQuick HCV)	Serological test for specific antibodies. For Hepatitis B and C confirmatory testing with quantitative PCR.
Mycoplasma genitalium	Persistent urethritis or cervicitis; consider for women with PID	None	FDA cleared NAAT for urine, urethra, penile meatal, endocervical and vaginal swab. Use of molecular markers for macrolide resistance encouraged.