



Myths and Facts about STIs

| | MYTH | FACT |
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| 1 | Urine tests alone can identify extragenital site gonorrhea and chlamydia infections. | Urine tests alone cannot detect gonorrhea and chlamydia if a client has gonorrhea or chlamydia at an extragenital site. Because chlamydia and gonorrhea infections at extragenital (rectal and pharyngeal) anatomic sites are often asymptomatic, the infection is missed by urogenital-only screening. ¹ |
| 2 | Conducting syphilis and chlamydia/gonorrhea tests annually on clients without symptoms is a best practice. Once-a-year testing is sufficient for all clients. | Those who have two or more partners, anonymous partners, report using alcohol or other drugs with sex, and those who engage in commodity or exchange sex should be screened for STI risk (and tested if risk is still present) every three to six months. ² Likewise, a clinician should not just trust their belief of a longtime client as being not at risk. |
| 3 | Client self-collection of extragenital site chlamydia/gonorrhea nucleic acid amplification test (NAAT) specimens will produce errors and are not reliable. | Client self-collection NAAT specimens has been shown to be equally effective to provider-collection in clinical and non-clinical settings for the following specimens: vaginal, rectal, throat, and urine. ³ |
| 4 | Clinicians know their clients well enough, and if a client has gonorrhea, chlamydia, or syphilis, they will come to the clinic to get tested on their own. | Sexual behavior history can change over time, so doing an interval (since prior clinic visit) sexual history at each clinic visit is useful for identifying who needs STI testing. Also, gonorrhea, chlamydia, or syphilis can be asymptomatic and therefore unknown to the client. ⁴ |
| 5 | People with bacterial STIs are not more vulnerable to HIV acquisition. | People with bacterial STIs including gonorrhea, chlamydia, and syphilis are more vulnerable to HIV acquisition than people who do not have an STI. A sore or inflammation from an STI may facilitate infection with HIV from a person who is not virally suppressed. ⁵ |

Endnotes

¹ Earnest, R., Rönn, M. M., Bellerose, M., Gift, T. L., Berruti, A. A., Hsu, K. K., Testa, C., Zhu, L., Malyuta, Y., Menzies, N. A., & Salomon, J. A. (2020). Population-level Benefits of Extragenital Gonorrhea Screening Among Men Who Have Sex With Men: An Exploratory Modeling Analysis. *Sexually transmitted diseases*, 47(7), 484–490. <https://doi.org/10.1097/OLQ.0000000000001189>

² Centers for Disease Control. (2021). *Sexually Transmitted Infections Treatment Guidelines*. <https://www.cdc.gov/std/treatment-guidelines/default.htm>

³ Kersh EN, Shukla M, Raphael BH, Habel M, Park I. (2021). At-home specimen self-collection and self-testing for sexually transmitted infection screening demand accelerated by the COVID-19 pandemic: a review of laboratory implementation issues. *Journal Clinical Microbiology* 59:e02646-20. <https://doi.org/10.1128/JCM.02646-20>.

⁴ Workowski, K.A., Bachmann, L.H., Chan, P.A., Johnston, C.M., Muzny, C.S., Park, I., ¼ Bolan, G.A., Sexually Transmitted Infections Treatment Guidelines, (2021). *MMWR. Recommendations and Reports*, 70(No. RR-4):1–187. DOI: <http://dx.doi.org/10.15585/mmwr.rr7004a1>

⁵ Centers for Disease Control. (2021). *STDs and HIV—CDC Fact Sheet*. <https://www.cdc.gov/std/hiv/stdfact-std-hiv-detailed.htm>