PHSKC HIV and Sexually Transmitted Infection (STI) Screening* Recommendations for Men who Have Sex with Men (MSM) and Transgender and Non-Binary (TNB) Persons Who Have Sex with Men

January 2026

These guidelines update PHSKC guidance issued in 2018 related to HIV and STI screening in MSM and TNB patients and complement national recommendations in the 2021 Center for Disease Control and Prevention Guidelines. They reflect changes in the public health landscape as well as information that was not available when the prior guidelines were developed. Important changes from the 2018 guidelines are highlighted in the box below.

Interval changes from 2018 guidelines

- The HIV and syphilis screening interval for persons at higher risk for HIV/STI changed to 3-6 months (from every 3 months) for most PrEP users on a stable oral or injectable PrEP regimen for ≥6 months
- Routine screening for asymptomatic gonorrhea and chlamydial infection is no longer recommended in people without a cervix who have sex with men. PHSKC advises medical providers to discuss gonorrhea and chlamydial screening with patients and use shared decision-making to decide whether to screen asymptomatic people without a cervix for these infections. This change is based on:

  1. The absence of known sequelae associated with asymptomatic infections
  2. The fact that these infections are self-limited in the absence of treatment
  3. The uncertain impact of screening on population-level STI incidence
  4. To avoid the unnecessary use of antimicrobials
  5. Gonorrhea and chlamydial screening is costly and is not always covered by insurance

Recommendations:

1. In order to determine the need for and frequency of HIV and STI testing, clinicians should ask every patient about their sexual orientation and gender identity. In addition, clinicians should inquire about which body parts patients use for sex and the gender and sexual anatomy of patients' sex partners. This information will help to most accurately frame shared decision-making discussions around HIV and STI screening.

2. Clinicians should perform at least annual STI and HIV (if not previously diagnosed with HIV) screening* on all sexually active MSM and TNB persons who have sex with men. Sexually active MSM and TNB persons include those engaging in any anal, vaginal/frontal or oral sex. Screening should include the following tests:

- HIV using a 4th generation (antigen/antibody) serological test, if the patient is not previously known to have HIV.
- Serological testing for syphilis (i.e. RPR or other syphilis screening test).
- For TNB people with a cervix who have vaginal/frontal sex, vaginal or cervical swabs for gonorrhea and chlamydia nucleic acid amplification.
- Discussion of screening for rectal, pharyngeal, and urethral gonorrhea and chlamydial infection++ with testing performed based on shared decision-making. Such screening is usually done using a nucleic acid amplification test.

3. Repeat HIV and syphilis testing (as above) should be performed every 3-6 months in MSM and TNB persons who have sex with men with any of the following risks**:

- Diagnosis of a bacterial STI in the prior year (gonorrhea, chlamydial infection or early syphilis)
- Methamphetamine use in the prior year
- ≥10 sex partners (anal or oral) in the prior year
- Condomless anal intercourse with a partner of unknown or discordant HIV status in the prior year
- Persons taking HIV pre-exposure prophylaxis (PrEP)

4. Whether and how often to perform repeat gonorrhea and chlamydial screening among patients without a cervix should be based on shared decision-making.

* Screening refers to testing in the absence of signs, symptoms or a known exposure to STI. Patients in long-term (> 1 year), mutually monogamous, HIV-concordant relationships do not require HIV/STI screening.

++ Asymptomatic urethral gonorrhea is rare, while asymptomatic urethral chlamydial infection is more common.

** Clinicians should offer HIV PrEP to all HIV-negative MSM and TNB persons who have sex with men, and should explicitly recommend PrEP to all MSM and TNB persons who have sex with men with any of the following risks in the prior year: 1) diagnosis of gonorrhea or early syphilis; 2) methamphetamine use; 3) condomless receptive anal sex with someone other than a mutually monogamous partner; 4) history of exchanging sex for money, drugs or other basic needs; or 5) ≥10 sex partners. Clinicians should also recommend that patients initiate PrEP if they have an HIV positive sex partner who is not virally suppressed.

Rationale for discontinuing the recommendation to perform routine screening for asymptomatic rectal and pharyngeal gonorrhea (GC) and chlamydia (CT):

Although PHSKC previously recommended that MSM and TNB persons be screened for rectal and pharyngeal GC and CT every 3-6 months, recent evidence suggests that screening has a very limited impact on the incidence of symptomatic GC and CT infection.[1,2] A 2024 randomized trial comparing quarterly GC/CT screening of the rectum, pharynx and urine to no screening found that not screening was not noninferior to screening, but that 25 people would need to be screened for a year (i.e., 100 testing visits with 300 tests) to prevent one case of symptomatic chlamydial infection;[1] the trial observed no difference in the incidence of symptomatic gonorrhea.

Rectal and pharyngeal GC/CT are usually asymptomatic and self-limited. In a prospective cohort study, the estimated mean duration of pharyngeal gonorrhea, rectal gonorrhea, and rectal chlamydial infection

were 16, 9, and 13 weeks, respectively.[3-5] However, these estimates are likely to include some period of time during which testing detected nucleic acid in the absence of viable bacteria, and screening would not typically identify infections immediately following acquisition. Thus, it seems likely that screening reduces the duration of infection by approximately 4-8 weeks depending on the anatomic site and specific infection. Considering the small clinical benefit associated with screening and its uncertain public health impact, and to limit the unnecessary use of antimicrobials, PHSKC decided to discontinue its recommendation to perform frequent rectal and pharyngeal screening for GC/CT and instead recommend that medical providers engage MSM and TNB patients in shared decision-making regarding whether and how often to screen for asymptomatic GC and CT. This approach is also cost-conscious given that frequent GC/CT screening is not consistently covered by insurance and can yield significant out-of-pocket costs to the patient.

Public Health authorities in the Netherlands and Belgium have also recently ceased to recommend routine GC/CT screening, and the practice is being reconsidered elsewhere in the US and in many other parts of the world. Testing of STI contacts and persons with symptoms has not changed. Patients with symptoms concerning for GC or CT and persons seeking care following contact to a sex partner with diagnosed GC or CT should continue to be tested for those infections. Patients who report contact to a sex partner with GC or CT should be engaged in a shared decision-making discussion on whether to treat them immediately or wait to treat based on test results. Approximately two-thirds of people evaluated as contacts to GC or CT ultimately test negative for both infections; higher levels of infection are observed in contacts who are cisgender women than cisgender men.[6-8] Patients who report contact to a sex partner with syphilis should continue to be treated empirically at time of testing since syphilis serologies can be falsely negative in persons with incubating syphilis.

References

1. Vanbaelen T, Tsoumanis A, Florence E, et al. Effect of screening for Neisseria gonorrhoeae and Chlamydia trachomatis on incidence of these infections in men who have sex with men and transgender women taking HIV pre-exposure prophylaxis (the Gonoscreen study): results from a randomised, multicentre, controlled trial. *Lancet HIV.* 2024;11(4):e233-e244.
2. Bruindernink M, van der Loeff M, FDavicovich U. STI testing rates among PrEP users randomized to 3-monthly (standard of care) or 6-monthly monitoring within the EZI-PrEP trial, the Netherlands: preliminary results - no difference in STIs between 6 vs 3 months visits. Paper presented at: 25th International AIDS Conference2025; Munich, Germany.
3. Barbee LA, Soge OO, Khosropour CM, et al. The Duration of Pharyngeal Gonorrhea: A Natural History Study. *Clin Infect Dis.* 2021;73(4):575-582.
4. Barbee LA, Khosropour CM, Soge OO, et al. The Natural History of Rectal Gonococcal and Chlamydial Infections: The ExGen Study. *Clin Infect Dis.* 2022;74(9):1549-1556.
5. Khosropour CM, Soge OO, Golden MR, Hughes JP, Barbee LA. Incidence and Duration of Pharyngeal Chlamydia Among a Cohort of Men Who Have Sex With Men. *Clin Infect Dis.* 2022;75(5):875-881.
6. Rowlinson E, Golden MR, Berzkalns A, Thibault C, Barbee LA. Epidemiologic Treatment for Contacts to Neisseria gonorrhoeae and Chlamydia trachomatis Infection in Sexually Transmitted Disease Clinic Patients in Seattle, WA; 1994 to 2018. *Sex Transm Dis.* 2020;47(10):665-671.
7. McLaughlin SE, Golden MR, Soge OO, Berzkalns A, Thibault CS, Barbee LA. Pharyngeal Gonorrhea in Heterosexual Male and Female Sex Partners of Persons With Gonorrhea. *Sex Transm Dis.* 2023;50(4):203-208.
8. Rasul R, McIver R, Patel P, Foster R, McNulty A. Non-empirical management of asymptomatic chlamydia and gonorrhoea reduces unnecessary antibiotic use fivefold: a before and after study. *Sex Transm Infect.* 2023;99(1):30-34.