Expedited Partner Therapy: What Is It, and How Can We Expand Its Use?

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Chlamydia, a sexually transmitted infection (STI), is at epidemic proportions in the United States, with over 1.4 million cases reported annually. In fact, according to the Centers for Disease Control and Prevention (CDC), chlamydia is the most commonly reported STI, and it disproportionately affects adolescents and young adults, particularly young women. Although uncomplicated, chlamydia is easily treated with a single dose of oral medication, but many cases go unrecognized due to a lack of symptoms. Untreated, chlamydia can lead to pelvic inflammatory disease, a significant risk factor for infertility, ectopic pregnancy, and chronic abdominal pain in women.

Given the significant burden of disease, initiatives to improve screening, diagnosis, and treatment are of paramount importance. One crucial component of appropriate treatment is providing medication to the infected person's partner – without treatment of both individuals in an intimate relationship, the infection will continue to be passed back and forth between partners. In fact, up to 20% of women report becoming re-infected within a year. This is a particular issue among adolescents and young adults, who tend to have fewer monogamous relationships than older people, and who may face unique barriers to condom use. Traditionally, partner treatment occurs by encouraging a patient to notify his/her partner(s) to seek treatment, or by the local health department reaching out to partners, if named by the patient. However, these traditional methods tend to be ineffective in reaching the majority of at-risk people.

One important and effective treatment option is expedited partner therapy (EPT), where the clinician provides medication or a prescription of medication to the patient to give to his/her partner. Many research studies have found that EPT is an effective method of chlamydia treatment. The CDC and the American College of Obstetrics and Gynecology support EPT, and several states have enacted laws allowing medical providers to treat patients in this manner. However, in many states, legal, administrative, financial, and personal barriers limit the use of this important treatment option. As a pediatrician specializing in emergency medicine, my colleagues and I are often confronted with adolescents who have multiple episodes of chlamydia because of the difficulty in getting partners treated. For example, we are limited in our options to provide optimal care, given issues around payment for medication and prescription name requirements.

In the September issue of *The Journal of Adolescent Medicine*, my colleagues and I report on our findings of a national survey of providers who treat adolescents for chlamydia, with a focus on potential barriers to EPT in states with varying policy environments. Despite practicing in states that do not explicitly prohibit EPT, only 20% of respondents reported using EPT for adolescents, and the most commonly reported barriers were missed opportunity to counsel partners and ensuring medication delivery. I would argue that these barriers, and others that are similar and stem from providers' personal beliefs, should not limit the use of an effective treatment option. My argument is supported by the fact that our study found that when providers were given a parallel

hypothetical scenario, they were more likely to offer prophylactic antibiotics to a patient's mother for pertussis exposure without a face-to-face visit than to the sexual partner of an adolescent with chlamydia.

The issues surrounding EPT use are complex, and no single policy solution will effectively change provider and patient behaviors. We need to work on the state level to improve the legal status surrounding EPT in order to provide safe practice environments for providers. Equally important, we need to work with providers to address the personal barriers that exist and are limiting the use of EPT.

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