# Guideline on screening for chlamydia and gonorrhea in primary care for individuals not known to be at high risk – reviewer comments and CTFPHC responses

**Reviewer 01 (Stakeholder):** Dr. Unjali Malhotra, Indigenous Physicians Association of Canada

Disclosure(s): I am PI on cervical screen self swab trial assessing feasibility and accessibility on First Nations communities, partnership with WHRI and BCCDC.

| Question | Reviewer comments | CTFPHC response |
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| 1. Is the objective of the guideline clear? | Yes | Thank you |
| 2. Are the patient groups to whom the guideline is meant to apply clearly described? | No<br>As per my comments in the document "high risk" and " populations" need to be more clear and noted subjectivtity, possible predjudice noted. | We recognize that risk factors will vary regionally across Canada and that clinicians are largely aware of risk factors for their settings. We have provided some examples of high risk groups (in the background) and we have directed readers (in the Scope section) to relevant local, provincial, or national guidance on screening of individuals known to belong to specific high-risk groups, as well as other regionally determined aspects of care (testing of individuals seeking care for symptoms, and for selection of appropriate antibiotic treatment, partner notification, re-testing, and forensic testing strategies). For example, in the background, we state:<br><br>"National guidance from the Public Health Agency of Canada currently recommends chlamydia screening in pregnant women, annual screening for sexually active individuals under the age of 25, and targeted screening of at risk individuals over 25 years old (e.g., those with previous STIs, sex trade workers, among others)."<br><br>Relevant to the comment about subjectivity and prejudgment, clinicians are reminded about psychosocial harms of screening throughout the guideline |

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| | | including barriers to screening (in the equity section) where it is mentioned that "the recommendation would likely improve health equity by normalizing screening as routine for sexually active individuals and thereby reducing important barriers to screening, such as fear of disapproval or discrimination and feelings of stigmatization."<br><br>Additionally, the following sentence has been added to the Implementation section, as a reminder of such sensitive aspects of screening, "Screening for sexually transmitted infection may cause feelings of embarrassment and anxiety for some patients. Offering screening requires sensitivity to stigmatization and fear of social disapproval, especially regarding gender, culture, behaviour and other vulnerabilities." |
| 3. Are the guidelines supported by the evidence? | Yes<br>However clinical commentary of high volume / experienced clinicians should be weighted as well | Thank you for this comment; we recognize that clinical expertise is a pillar of evidence-based medicine. The evidence and recommendation development for this guideline has been interpreted through the practicalities and realities of busy (high volume) family physicians who represent the majority of panel members on the working group for this guideline. |
| 4. Is there any information missing from the guideline that would make it easier to interpret for primary care practitioners? | Yes<br>As above | Thank you |
| 5. Do you have any comments or suggestions to improve the guideline? | There is no discussion of culturally safe and trauma informed care / aware care. This is evident in the lack of clarity as above. It is something that s a potential harm. | Thank you for raising the issue of trauma-informed and culturally safe/competent care. We have added the following to the Implementation section to emphasize this issue, as well as other important considerations, for providers:<br>"Screening for sexually transmitted infection may cause feelings of embarrassment and anxiety for some patients. Offering screening requires |

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| | | sensitivity to stigmatization and fear of social disapproval, especially regarding gender, culture, behaviour and other vulnerabilities." |
| Additional comments in document – Guideline | Line 7-10 (Key Point 1): depression and anxiety | Thank you for this point, we are limited in our word count and have kept this bullet as a non-exhaustive list of potential complications of CT/NG. |
| | Line 13-15 (Key Point 2): in my clinical experience, this is more common than we estimate academically | Please see Appendix 3 for more detail on the task force's judgments related to the extent of harms from screening.<br>We also note that our evidence seemed to indicate these harms may be more likely for those diagnosed with CT/NG, as opposed to undergoing screening. |
| | Line 19-21 (Key Point 5): importance of detailed description of limitations and benefits of said testing must be included in consent | Thank you for this point. We have included in the Implementation section a number of key factors to include when gathering informed consent and will integrate these points into the knowledge translation tool to support implementation of the recommendations. |
| | Line 39 (Introduction): mental health concerns (data exists on MD calling back --> anxiety) | Mental health-related harms such as anxiety were considered in the guideline, and are described in the Methods section of the guideline. |
| | Line 41 (Introduction): most appropriate is to detail the definition of sexually active and all that is included in that definition | While the evidence review underlying this guideline used a broad construct to define sexual activity (including vaginal, anal and oral intercourse), the studies included in the review loosely defined sexual activity in their eligibility criteria. The definition of sexual activity has been added to the Implementation section (first paragraph, last sentence) as follows, "Sexual activity can be generally defined as ever having oral, vaginal or anal intercourse." |
| | Line 164 (Recommendation): as above: please define sexually active | |
| | Line 165 (Introduction): need to define high risk as well | Please see response to Reviewer 1, Question 2 regarding defining high-risk individuals. |
| | Line 184 (Included Studies in systematic review): this is | Thank you, we agree that examining the harms associated with screening interventions is of utmost importance for developing sound recommendations. |

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| | really important for clinicians and warrants attention in all documents related to screening | |
| | Line 227 (Harms of screening): also important to acknowledge the impact on abusive relationships | We agree, and examined this in the systematic review that informed this guideline. Specifically, we examined relationship distress including intimate partner violence as a potential outcome of being screened or testing positive for CT/NG. We have clarified in the methods section the types of psychosocial harms examined. Full details of results for all harms that were examined can be found in the published systematic review. No studies were identified that reported on partner violence from screening for CT. We focused in the guideline manuscript on outcomes for which data was available, but more detail can be found in the published systematic review. |
| | Line 326 (Considerations for implementation): trauma aware care involves offering self screening | Thank you for raising the issue of trauma aware/informed care. We have added a sentence to the Implementation section to highlight this for providers: "Offering screening requires sensitivity to stigmatization and fear of social disapproval, especially regarding gender, culture, behaviour and other vulnerabilities." |
| Additional comments in document – Appendix 1 (Analytical Framework) | *Population Subgroups*<br><br>Specify | This analytical framework is meant to provide a high-level conceptual overview of what we sought to examine in the systematic review that underpins this guideline. For more information on the population subgroups sought, please see the published protocol, Tables 1 and 2. https://systematicreviewsjournal.biomedcentral.com/articles/10.1186/s13643-018-0904-5<br><br>Please also note the subgroups considered in the evidence to decision framework (Appendix 3). |
| | *Harms of screening procedure…* | Harms listed under screening procedure are not included under harms from case management, as the latter refer only to harms that arise directly due to |

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| | this is great, just needs to be throughout<br>*Harms from case management*<br><br>potential mental health harms, abuse impacts (in partnerships) | case management or treatment, such as adverse effects due to antibiotic treatment.<br><br>Harms such as mental health outcomes, or relationship distress that arise as a downstream effect of having been screened or diagnosed in the first place would be captured under harms of screening or diagnosis, despite the fact that they may have occurred during case management. |
| Additional comments in document – Appendix 3 (Evidence to Decision framework) | *Equity*<br><br>there is space here to discussed stigma, perception and subjective nature of risk assessment and discrimination. | We have revised the Equity section accordingly:<br>"In the judgment of the task force, the recommendation would likely improve health equity by normalizing screening as routine for sexually active individuals and thereby reducing important barriers to screening, such as fear of disapproval or discrimination and feelings of stigmatization. Additionally, since females carry most of the burden of the clinical consequences of infection, screening of males (a reservoir of infection for females) may improve health equity for females." |

**Reviewer 02 (Stakeholder):** Jami Neufeld, National Collaborating Center for Infectious Diseases

Disclosure(s): I am also employed as a STBBI testing nurse at Klinic Community Health Centre in Winnipeg, Manitoba.

| Question | Reviewer comments | CTFPHC response |
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| 1. Is the objective of the guideline clear? | No<br>I think it would be useful to have objectives outlined clearly at the beginning of the document. There is a large amount of preamble before the recommendation and it would be useful to have a clear objective stated early in the document. | The objective of the guideline is communicated at various stages with increasing detail. At the beginning, the title indicates the broadest objective, to provide, "Recommendation on screening for chlamydia and gonorrhea in primary care for individuals not known to be at high risk", the Scope section refines the screening objective by population and setting, and the Recommendation and Rationale sections further specify details of the screening objective by population, |

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| | | intervention and expected outcomes. This sequence of information (format) is determined by the journal.<br>In addition, the published guideline will contain a Key Points section at the start of the manuscript, providing a summary of the guideline up front. The published guideline document will also include an easily identifiable box that provides a quick summary of the recommendations for readers. See this recently published guideline for an example (Key Points, and Box 2): https://www.cmaj.ca/content/cmaj/191/46/E1274.full.pdf |
| 2. Are the patient groups to whom the guideline is meant to apply clearly described? | Yes | Thank you |
| 3. Are the guidelines supported by the evidence? | Yes<br>I do want to reiterate my comment from the initial review, "I did have some concerns regarding the methodologies regarding psychological harm (KQ1) and the value of screening (KQ3). NG and CT are infections associated with stigma and healthcare can contribute to this stigma in our management or lack of management of these infections. I think that the paper is unclear in identifying stigma as a harm to access to screening vs. a harm to an individual as a result of screening or infection, or both. I think the exploration of the latter [in the review] is particularly problematic, but | Psychosocial harms as a result screening were identified as important outcomes and are mentioned throughout the guideline. In the summary of findings on harms, 11 studies informed this aspect of screening (see Harms of screening findings). The review on patient values and preferences considered the harm of stigmatization in relation to potential benefit. Clinicians are reminded of stigma, disapproval and discrimination as barriers to accessing screening in the section on equity which states "…the recommendation would likely improve health equity by normalizing screening as routine for sexually active individuals and thereby reducing important barriers to screening, such as fear of disapproval or discrimination and feelings of stigmatization." Additionally, the implementation section now includes this reminder, "Screening for sexually transmitted infection may cause feelings of embarrassment and anxiety for some patients. Offering screening requires sensitivity to stigmatization |

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| | both ideas require more holistic inquiry." | and fear of social disapproval, especially regarding gender, culture, behaviour and other vulnerabilities." |
| 4. Is there any information missing from the guideline that would make it easier to interpret for primary care practitioners? | Yes<br>I think STI risk should be outlined in this document to differentiate and avoid confusion in recommendations. Please see the comments below on page 2. | Please see response to Reviewer 1, Question 2 regarding defining high risk individuals. |
| 5. Do you have any comments or suggestions to improve the guideline? | Line 42, 43 (Intro): The last part of the sentence and statement is confusing since harms have not been discussed to this point of the document. What are criteria for the benefits exceeding the harms? Is this at the judgement of the practitioner? Should the practitioner not ask a person under 30 about screening if they look like they would be embarassed or anxious about testing or being offered testing? What if the lack of addressing or talking about this contributes to stigma, anxiety, or embarrassment? And what if the person is too embarrassed or anxious to ask for testing? Also, what are the criteria for resource use being justifiable or not justifiable? | Thank you for noting the confusion caused by the lack of information on harms in the introduction section.<br><br>The judgment about the balance of consequences of screening (clinical benefits and harms, values and preferences and cost) is weighed in this final recommendation for clinicians. We recognize that not all clinical encounters with individuals under 30 years will be appropriate for offering screening (e.g. grief counselling, among others) and clinicians are best positioned to judge the appropriateness of the timing of the offer to screen. Resource use and cost are considered as domains in the balance of consequences as highlighted in the manuscript.<br><br>To address the remainder of your comment, our recommendation is that those under 30 should be offered screening, because benefits are judged to exceed harms. This recommendation is conditional due to the low quality of evidence, not because it was felt that harms may sometimes outweigh benefits. As noted in the Evidence to Decision framework (Appendix 3), it is the judgment of the task force that the potential benefits of screening outweigh potential harms. |

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| | | The task force uses the GRADE system for developing recommendations, which does not use specific criteria for determining when benefits outweigh harms, or when resource use is justifiable. This requires a judgment on the part of the guideline development panel, using the best available evidence. In this case, the task force has summarized their judgments related to the balance of benefits and harms in a GRADE Evidence to Decision framework (Appendix 3). This stakeholder review process represents one avenue by which the judgments of the task force in weighing the evidence can be scrutinized.<br><br>One goal of an offer of screening approach to all patients under 30 not known to belong to a high risk group is to help prevent potential feelings of embarrassment or stigma that might be felt when someone has to ask for screening, as opposed to having it offered to them by their physician as a matter of routine. |
| | Line 52, 53 (Overview): The portion of the sentence "(e.g., those with previous STIs and 50 vulnerable populations, such as sex trade workers)" is misleading. Also the term vulnerable populations is no longer a politically correct term.<br><br>Referenced: *Section 5-2 of the Canadian Guidelines on Sexually Transmitted Infections – Management* | Thank you for this point. We did not intend for this to be read as an exhaustive list of populations where PHAC recommends screening, and have edited the sentence accordingly. PHAC has also recently edited their web content regarding chlamydia, and we have therefore edited this section to match the new content, and to remove 'vulnerable populations':<br><br>*"*(e.g., those with previous STIs, sex trade workers, among others)" |

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| | *and treatment of specific infections – Chlamydial Infections states* and *Section 2 - Primary Care and Sexually Transmitted Infections states* | |
| | Line 57 (Scope): It might be important to consider identifying national criteria for high-risk groups somewhere in this document because STI risk factors are broad and require at least a routine and brief assessment of STI risk. In my role as a STBBI nurse, I think it would be useful to have a sample population survey of STI risk across the lifespan, because I think many would be surprised at the number of people that would be included in the list below at different times throughout the lifespan.<br><br>Referenced: *Section 2 - Primary Care and Sexually Transmitted Infections* | We recognize that risk factors will vary regionally across Canada and that clinicians are largely aware of risk factors for their settings, we have provided some examples of high risk groups (in the background section) and we have directed readers (in the Scope section) to relevant local, provincial guidance on screening of individuals known to belong to specific high-risk groups, as well as other regionally determined aspects of care (testing of individuals seeking care for symptoms, and for selection of appropriate antibiotic treatment, partner notification, re-testing, and forensic testing strategies). |
| | Line 162-164 (Recommendation): Please consider adding the word "routine" to the recommendation, "We recommend [routine] opportunistic screening of sexually active individuals under 30 years of age who are not known to belong to a high-risk group for chlamydia and gonorrhea at primary care visits, using a self- or clinician-collected sample | We strive for streamlined recommendations without redundancy and believe that routine is captured in the concept of opportunistic screening.<br><br>We have included the word 'routine' in the Equity and Implementation sections. |

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| | (Conditional recommendation; very low-certainty evidence). | |
| | Line 179: Please consider linking or referring to the Considerations for Implementation section (Line 308) at this point in the document because they are relevant to the recommendation. | Thank you for this suggestion. We previously included a sentence under the recommendation leading readers to the implementation section; however, it was ultimately removed based on feedback from CMAJ peer review. |
| | Line 262-264 (Feasibility, acceptability, cost and equity): Public Health programs in most provinces and territories have recommended a Test for One, Test for All approach to STI testing (CT/NG and serology screening) in the context of current STI outbreaks and to avoid missed opportunities for early intervention, harm reduction, and later risk of syphilis, HIV, and other blood borne infections. | Thank you for this additional information. We have indicated in the Rationale section that part of the reason for testing for both CT/NG together is:<br>"The incremental costs of screening for both chlamydia and gonorrhea (versus, for example, chlamydia alone) is uncertain but likely minimal, as many provincial schedules already include NAAT for chlamydia and gonorrhea together under a single price."<br><br>This information seems to support this rationale.<br><br>We did not seek to address the effectiveness of co-testing for other STBBIs with CT/NG, and therefore as unable to make specific recommendations to that regard. |

**Reviewer 03 (Peer reviewer):** Dr. Marc Steben, Université de Montréal

Disclosure(s):

My family and I have mutual funds that may include shares of pharma, vaccines, diagnostic and therapeutic companies.

I have received funds from companies for CME activities = ViiV healthcare, Merck, Bayer, Actavis, Paladin, Valeant.

I am on the advisory boards of Merck, Genocea and Inovio.

I own a Consulting company, Communications Action Santé Inc.

| Question | Reviewer comments | CTFPHC response |
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| 1. Is the objective of the guideline clear? | Yes | Thank you |
| 2. Are the patient groups to whom the guideline is meant to apply clearly described? | No<br>Many of patients considered in the general population are engaging in extra genital sex such as oral and anal sex. It would be good to make a note that we cannot presume people are not engaging in extra genital sex if they are not telling us…<br>Would you put, excluding people who are engaging in oral or anal sex… that would exclude a lot of people. | Thank you for this comment, there are 2 issues for clinicians here; 1) how to identify those that are sexually active and 2) how to screen for those engaging in extra genital intercourse.<br>1) The evidence review used a broad construct to define sexual activity including vaginal, anal and oral intercourse and would have included relevant information if available. The definition of sexual activity has been added to the Implementation section (first paragraph, last sentence) as follows, "Sexual activity can be generally defined as ever having oral, vaginal or anal intercourse."<br>2) With respect to screening extragenital sites, clinicians are reminded to consider pharyngeal and rectal swabs if clinically warranted, although we did not identify any evidence to evaluate screening at these sampling sites (Implementation section, third paragraph). |
| 3. Are the guidelines supported by the evidence? | Yes | Thank you |
| 4. Is there any information missing from the guideline that would make it easier to interpret for primary care practitioners? | Yes<br>See question 2 | Thank you. Please see response to Reviewer 3, Question 2, above. |

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| 5. Do you have any comments or suggestions to improve the guideline? | There would be a need to discuss pooled specimen in patient in oral-anal-genital tests?<br>An Alberta group showed adding anal swab for women increases the wield of screening for CT | Our systematic review used a broad definition for sexual intercourse (anal, oral and vaginal intercourse) and would have included available information on swabbing one way or another (single versus multiple collection sites). However, we unfortunately did not identify any studies that examined extragenital screening. We have therefore been unable to provide recommendations for screening at these sites, beyond indicating that clinicians should consider pharyngeal and rectal swabs if clinically warranted. |

**Reviewer 04 (Stakeholder):** Dr. Paula Schwann, College of Family Physicians of Canada

Disclosure(s): None

| **Question** | **Reviewer comments** | **CTFPHC response** |
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| 1. Is the objective of the guideline clear? | Yes | Thank you |
| 2. Are the patient groups to whom the guideline is meant to apply clearly described? | Yes | Thank you |
| 3. Are the guidelines supported by the evidence? | Yes | Thank you |
| 4. Is there any information missing from the guideline that would make it easier to interpret for primary care practitioners? | No | Thank you |
| 5. Do you have any comments or suggestions to improve the guideline? | I like them. They are simple, easy to remember and inclusive. | Thank you for your feedback. |

**Reviewer 05 (Stakeholder):** Dr. Sharon Vipler, College of Family Physicians of Canada

Disclosure(s): Nil

| Question | Reviewer comments | CTFPHC response |
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| 1. Is the objective of the guideline clear? | Yes | Thank you |
| 2. Are the patient groups to whom the guideline is meant to apply clearly described? | Yes | Thank you |
| 3. Are the guidelines supported by the evidence? | Yes<br>Difficult question to some degree, as there is very little evidence to truly guide approach to screening. The guidelines doesn't *depart* from any of the available evidence at any rate. | Thank you. We agree that the lack of evidence is a challenge in this area. |
| 4. Is there any information missing from the guideline that would make it easier to interpret for primary care practitioners? | Yes<br>I think primary care physicians will have no difficulties with interpreting these guidelines. I think it's important to have a quick summary of how this guideline changes current practice (like providing a "before" and "now" approach to screening recommendations. | Thank you for this suggestion. This feedback is helpful for developing the accompanying knowledge translation tool to support implementation of the recommendation.<br><br>Table 2 includes a summary of this guideline's recommendation and previous/existing Canadian CT/NG screening recommendations (Public Health Agency of Canada (2020), Public Health Ontario (2018) and Ministère de la santé et des services sociaux du Québec (2019)) to help readers distinguish how they may or may not differ.<br><br>The published guideline document will also include an easily identifiable box that provides a quick summary of the recommendations for readers. See this recently published guideline for an example: https://www.cmaj.ca/content/cmaj/191/46/E1274.full.pdf |

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| 5. Do you have any comments or suggestions to improve the guideline? | See above answer to question 4 | Thank you. Please see response to Question 4. |

**Reviewer 06 (Peer reviewer):** Dr. Mark Yudin, University of Toronto

Disclosure(s): None

| Question | Reviewer comments | CTFPHC response |
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| 1. Is the objective of the guideline clear? | Yes | Thank you |
| 2. Are the patient groups to whom the guideline is meant to apply clearly described? | Yes<br>Although it is clear that the guideline recommends screening up to age 30, I'm not sure it has done an adequate job of justifying this. This recommendation is a diversion from other Canadian and international guidelines, almost all of which recommend screening up to age 25. There is only one line, on page 9, explaining the rationale for this. I think it is important to better justify this recommendation, or expand on the rationale/reasons for choosing this new age cutoff | Thank you for this comment.<br><br>Your comment refers to the Other Guidelines section, where we noted:<br>"The present recommendation extends to age 29 years (see recommendation rationale above), whereas other guidelines recommend screening to age 25 years, except for Australia, which recommends screening to age 30 years.."<br>We have moved and expanded the rationale for screening up to age 30 to the Rationale section as follows; "The recommendation to screen individuals younger than 30 years is based on the fact that almost all of the underlying evidence comes from studies of individuals in this age group. Further, the rates of chlamydia and gonorrhea are increasing among those aged 25–29 years in Canada, with rates and total cases similar to those aged 15–19 years. Conversely, rates of chlamydia for those aged 30–39 years are less than 50% of |

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| | | those for individuals 15–19 and 24–29 years, and less than 25% of those for individuals aged 20–24 years. Similarly, rates in those aged 40–59 years are less than 25% of those in individuals aged 30–39 years."<br><br>The section on 'other guidelines' now directs readers to the rationale section, "The present recommendation extends to age 29 (see recommendation rationale above)." |
| 3. Are the guidelines supported by the evidence? | Yes<br>See above- I'm not sure there is really compelling evidence for choosing an age cutoff of 30, rather than 25 | See response above to question 2, reviewer 6. |
| 4. Is there any information missing from the guideline that would make it easier to interpret for primary care practitioners? | No | Thank you |
| 5. Do you have any comments or suggestions to improve the guideline? | See above | Thank you |

**Reviewer 07 (Stakeholder):** Cindy Parrill, Department of Health and Wellness, Charlottetown, P.E.I.

Disclosure(s): I have nothing to disclose.

| **Question** | **Reviewer comments** | **CTFPHC response** |
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| 1. Is the objective of the guideline clear? | Yes | Thank you |

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| 2. Are the patient groups to whom the guideline is meant to apply clearly described? | Yes | Thank you |
| 3. Are the guidelines supported by the evidence? | Yes | Thank you |
| 4. Is there any information missing from the guideline that would make it easier to interpret for primary care practitioners? | No | Thank you |
| 5. Do you have any comments or suggestions to improve the guideline? | No | Thank you for your review. |

**Reviewer 08 (Stakeholder):** Monica Durigon, Community Health Nurses Canada

Disclosure(s): N/A

| **Question** | **Reviewer comments** | **CTFPHC response** |
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| 1. Is the objective of the guideline clear? | Yes and No<br>See below | Thank you |
| 2. Are the patient groups to whom the guideline is meant to apply clearly described? | Yes and No<br>See below | Thank you |
| 3. Are the guidelines supported by the evidence? | Yes<br>Absolutely | Thank you |
| 4. Is there any information missing from the guideline that would make it easier to interpret for primary care practitioners? | Yes<br>See below | Thank you |
| 5. Do you have any comments or suggestions to improve the guideline? | I think the biggest obstacle for me is that this guideline is exceptionally academic and not very clinically oriented. By that I mean, as an academic reading this paper, | This guideline will be disseminated along with knowledge translation tools (e.g., algorithms, harms and benefits posters, or frequently asked question sheets) to help implement this |

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| | it is very thorough and sound methodologically. It reads like a manuscript. As a clinician reading this, it is challenging to follow. It is not (apologies for being frank) "user friendly". I am not sure how this guideline will be disseminated or how it will be presented in it's final format, but I would strongly recommend a synoposis somewhere of all the findings clearly outlining the objective, the patient group, and the recommendation. The key points at the beginning is not clear enough. | recommendation and to guide clinicians in understanding and integrating the recommendation into clinical practice. Knowledge translation tools from previous task force guidelines can be found online: https://canadiantaskforce.ca/tools-resources/<br><br>The published guideline document will also include an easily identifiable box that provides a quick summary of the recommendations, as well as key messages for the public. |
| | In reading these recommendations, I do not fully appreciate how this is different than what one normally (currently) does in any practice when confronted with a sexually active individual at risk for acquiring an STI. If one is sexually active, then one is at risk for STIs, and testing should be offered. | We appreciate this perspective. The goal of this guideline is to fill in gaps with respect to evidence informed recommendations for primary care on both CT and NG screening and specifically to define the population to focus primary care resources on.<br><br>We have noted, as you have, in our Other Guidelines section, that our evidence-based recommendations are similar to those developed by other groups in Canada, aside from the increased age cut-off, and the addition of NG screening. |
| | I am sure this has come up in discussion previously, but I am wondering if there should be consideration or note of gender affirming care. I believe this is | Thank you for this comment. We have added a sentence to the Implementation section to highlight this for providers:<br>"Offering screening requires sensitivity to stigmatization and fear of social disapproval, |

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| | important when outlining any kind of sexual health guidelines. | especially regarding gender, culture, behaviour and other vulnerabilities.” |

**Reviewer 09 (Stakeholder):** Dr. Joan Robinson, Canadian Paediatric Society

Disclosure(s): None

| Question | Reviewer comments | CTFPHC response |
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| 1. Is the objective of the guideline clear? | Yes | Thank you |
| 2. Are the patient groups to whom the guideline is meant to apply clearly described? | Yes | Thank you |
| 3. Are the guidelines supported by the evidence? | No<br>Evidence was of low quality and did not really address the question. I think that the task force recommendations are reasonable but it maybe ought to be clearer that they are primarily based on expert opinion. There should at least be some discussion on how the cut-off age of 30 yrs was selected. | The recommendations in the guideline are based on a systematic review of RCT evidence on benefits of screening, and various study designs to inform harms of screening and patient preferences. This was supplemented with information from patient focus groups, and other sources of data such as our national notifiable disease surveillance data. While the judgment of the task force is involved in determining the balance of benefits and harms of screening, as indicated in the Evidence to Decision framework (Appendix 3) and the Rationale section of the guideline, we feel it would be incorrect to say that they are primarily based on expert input. Based on the empirical evidence on benefits, harms, and patient preferences, we have concluded:<br>“The task force judged that the potential benefits of screening for chlamydia and gonorrhea to |

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| | | reduce pelvic inflammatory disease in females, albeit very uncertain, outweigh possible harms. Evidence suggests that most Canadian patients also prioritize the benefits over the harms of screening for chlamydia and gonorrhea, even when provided with the evidence and its uncertainty. Therefore, considering the balance of benefits and harms as well as evidence uncertainty, the task force provides a conditional recommendation in favour of opportunistic screening for chlamydia and gonorrhea in primary care for individuals younger than 30 years. ”<br><br>Our stakeholder review process represents a method by which the judgment of the task force in weighing the empirical evidence can be scrutinized, so we thank you for your comment.<br><br>As noted above in response to another reviewer (Reviewer 6, Question 2), we have made the rationale for the 30-year age cut-off clearer in our Rationale section. |
| 4. Is there any information missing from the guideline that would make it easier to interpret for primary care practitioners? | No<br>I would make it clearer in the actual recommendations how frequently the task force suggests screening. Buried deep in the guideline is the recommendation for annual screening. I think that the guideline needs to | We had initially not included the screening frequency in the recommendation statement due to the uncertainty regarding the optimal screening interval. However, we agree that clinicians require this critical information to implement the recommendation, we have added this item to key points, “The Canadian Task Force on Preventive |

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| | acknowledge that primary care visits are not common for this age group, especially now that PAP smears start at age 25 yrs and are done every 3 yrs. If screening is only done at primary care visits, it will hardly ever get done. Should screening not be done annually if the patient is seen for any reason, including an ED visit? In most provinces one can quickly sort out when screening was last performed. | Health Care recommends screening of sexually active individuals younger than 30 years for chlamydia and gonorrhea annually at primary care visits, as feasible."<br><br>We have also added this information to the recommendation statement:<br>"We recommend opportunistic screening of sexually active individuals younger than 30 years who are not known to belong to a high-risk group, annually, for chlamydia and gonorrhea at primary care visits, using a self- or clinician-collected sample."<br><br>This is also reported in the implementation section as follows with the following caveat, "While the optimal screening interval is unknown, an annual offer of screening may be appropriate for individuals at general risk, recognizing that encounters with primary care may occur less frequently. Most identified studies used annual screening, and in one study, most pelvic inflammatory disease cases occurring within one year were in individuals who were chlamydia-negative at baseline (general risk)."<br><br>There are a variety of opportunistic screening venues for primary care, examples of which have been identified in the background section. |

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| 5. Do you have any comments or suggestions to improve the guideline? | In the first paragraph, it is not clear whether these are annual rates. | This has been clarified, by adding 'annual' to the sentence for abundant clarity. |

**Reviewer 10 (Stakeholder):** Marilyn Barrett, Department of Health and Wellness, Charlottetown, P.E.I.

Disclosure(s): President of Canadian Nurses Protective Society (CNPS)

| Question | Reviewer comments | CTFPHC response |
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| 1. Is the objective of the guideline clear? | No<br>It sounds like initially the guidelines are to reduce the incidence of PID; then later it looks like the screening could potentially reduce clinical complications and transmission. | We have indicated in the Key Points section that the "Opportunistic offering of screening for chlamydia in primary care may reduce pelvic inflammatory disease in females, although the evidence is uncertain."<br><br>This is because this was the only outcome for which evidence of benefit was identified.<br><br>Potential benefits that were examined in the systematic review included reduced PID, ectopic pregnancies, cervicitis, and chronic pelvic pain in females; and for both females and males, reduced infertility and transmission (prevalence).<br><br>However, we found very uncertain effects on infertility, very low-certainty evidence for little to no difference in ectopic pregnancy rates, and low-certainty evidence for little to no difference in CT transmission. Other outcomes had no available evidence. Therefore, the recommendations were driven by the benefits seen for the PID outcome. |

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| | | We have accordingly noted in the rationale section that “the very uncertain or lack of evidence for some outcomes of interest for chlamydia screening and for all outcomes of interest for gonorrhea screening” was a major source of uncertainty for the recommendation, and that “pelvic inflammatory disease may be reduced for those accepting and undergoing chlamydia screening and for those interested in being screened who are offered it (low certainty).” |
| 2. Are the patient groups to whom the guideline is meant to apply clearly described? | No<br>It is a little confusing around why pregnant females are excluded in the scope, yet a recommendation later on recommends to screen all pregnant women. | Thank you for pointing out this need for clarification. The scope has been re-drafted as follows. “This guideline is intended for clinicians in primary care settings who are positioned to offer opportunistic screening for chlamydia and gonorrhea directly to ~~non-pregnant,~~ sexually active individuals not specifically seeking care for a possible STI and not known to belong to a high-risk group. Readers should refer to relevant national, provincial, or local guidance for the screening of individuals known to have specific high-risk behaviours (e.g., having multiple sexual partners, previous STIs, sex without condoms, although this will vary by jurisdiction), testing of individuals seeking care for symptoms; **pregnant individuals**; and for selection of appropriate antibiotic treatment, partner notification, re-testing, and forensic testing strategies.” |

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| | | We have also removed reference to screening of pregnant women in Table 2, where other guidelines are summarized, to prevent confusion for readers. |
| 3. Are the guidelines supported by the evidence? | Yes<br>There is a good discussion around the quality of the evidence that is helpful. | Thank you |
| 4. Is there any information missing from the guideline that would make it easier to interpret for primary care practitioners? | Yes<br>I am not seeing evidence about how individuals who are positive for CT/NG may be at higher risk of HIV infections. | We appreciate that STBBIs other than chlamydia or gonorrhea may be an important consideration when patients test positive, however this would fall under the umbrella of case management, which is beyond the scope of this screening guideline, as outlined in the Scope section. |
| 5. Do you have any comments or suggestions to improve the guideline? | We launched a self-swab/urine testing in the bathrooms on campus and have seen a significant uptake in testing. The individuals bring the specimen to us to label and send to the lab and they can check back with us for their results (if positive we obviously do not wait for them to contact us.) | This is fascinating, thank you for sharing this as a potential avenue for increasing screening. |

**Reviewer 11 (Stakeholder):** Dennis Williams, Planned Parenthood Toronto

Disclosure(s): None

| **Question** | **Reviewer comments** | **CTFPHC response** |
|---|---|---|
| 1. Is the objective of the guideline clear? | Yes | Thank you |

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| 2. Are the patient groups to whom the guideline is meant to apply clearly described? | Yes | Thank you |
| 3. Are the guidelines supported by the evidence? | Yes | Thank you |
| 4. Is there any information missing from the guideline that would make it easier to interpret for primary care practitioners? | No | Thank you |
| 5. Do you have any comments or suggestions to improve the guideline? | I would encourage the task force to develop policy on addressing trans inclusion (or naming trans exclusion) in research and guidelines. Trans-inclusive language is possible, desirable, and necessary for clinican guidance even when drawing on research that has not focused on trans people or used trans-inclusive language. | Thank you for this point. We will bring this back to the broader task force for consideration.<br><br>This guideline applies to <u>all sexually active individuals</u> under 30 who are not known to belong to a high-risk group, regardless of their gender identity.<br><br>In the Scope, we note "the terms male and female, when used, refer to sex (i.e., biological attributes, particularly the reproductive/sexual anatomy at birth) unless otherwise indicated."<br><br>Potentially of note, we have added a sentence to the Implementation section to emphasize this: "Offering screening requires sensitivity to stigmatization and fear of social disapproval, especially regarding gender, culture, behaviour and other vulnerabilities." |

**Reviewer 12 (Stakeholder):** Dr. Claude Laberge, Ministère de la Santé et des services sociaux

Disclosure(s): None

| Question | Reviewer comments | CTFPHC response |
|---|---|---|
| 1. Is the objective of the guideline clear? | Yes | Thank you |
| 2. Are the patient groups to whom the guideline is meant to apply clearly described? | Yes | Thank you |
| 3. Are the guidelines supported by the evidence? | Yes | Thank you |
| 4. Is there any information missing from the guideline that would make it easier to interpret for primary care practitioners? | No | Thank you |
| 5. Do you have any comments or suggestions to improve the guideline? | Table 2 and lines 51 and 52: I am not sure that your interpretation of screening recommendations for NG in PHAC guidelines is right. The chapters for CT and NG are different. There is no 'screening" section in NG chapter, but there is a 'Individuals at risk" section and "Sexually active youth < 25 years of age" are at increased risk. | In both cases we have specified that PHAC has screening recommendations for CT, but not for NG, as you have indicated. We have also updated the sections on PHAC's CT screening recommendation to match the most recent information online. |

**Reviewer 13 (Peer reviewer):** Dr. Barbara Romanowski, University of Alberta

Disclosure(s): N/A

| Question | Reviewer comments | CTFPHC response |
|---|---|---|
| 1. Is the objective of the guideline clear? | Yes | Thank you |

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| 2. Are the patient groups to whom the guideline is meant to apply clearly described? | Yes | Thank you |
| 3. Are the guidelines supported by the evidence? | Yes | Thank you |
| 4. Is there any information missing from the guideline that would make it easier to interpret for primary care practitioners? | No | Thank you |
| 5. Do you have any comments or suggestions to improve the guideline? | The title of the paper should be amended to "Recommendations on opportunistic screening for …" The report is about opportunistic screening not general screening. | We did not solely seek evidence on opportunistic screening, and as such, we feel that changing the title would be misleading. The recommendation to screen opportunistically is based on the evidence identified when seeking to make recommendations generally about screening. This is also consistent with how other task force guidelines are titled. No change made. |
| | The second sentence of "Overview" (line 26) uses 2017 stats to point out that rates of CT/NG are increasing. I'm aware of the lag in producing national STI stats but it is 2020. You would be better utilize unpublished 2019 figures rather than ones that are 3 years out of date. | We have updated the figures in the guideline with 2018 data, which is currently the most recent publically available data.<br><br>Pointing to unpublished data that is not accessible would put readers to a disadvantage and would limit the transparency of our rationalizations. |
| | Line 85 – please insert date of prepub search. | The date of latest search will be added prior to publication. |
| | Appendix 3, first page, last line in paragraph four. Chlamydia cultures have not been in use for years. | Have updated the wording to 'can be analyzed using…' instead of 'are analysed using' to indicate that this is an option, however unlikely. |

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| | Appendix 3, page 2 “number of people affected”. Again the use of old stats is an issue for me. | See responses above. |
| | Appendix 3, page 4. “ in the judgment of the task force, the benefits… are anticipated to be small but important, although uncertain”. On is left with the impression that you’re really not sure what to recommend. Would suggest you remove “although uncertain” | Good point, however we do feel it is important that we acknowledge the uncertainty directly in our judgment statement. We have revised the sentence as follows:<br><br>“In the judgment of the task force, the benefits of opportunistic screening for CT and NG via clinicians’ offices are anticipated to be small but important, recognizing the very low certainty of the evidence”. |
| | Appendix 3, page 17, implementation considerations. Bullet 5-if NAAT is not available then swabs for CT would not be possible. | We understand that culture and sensitivity swabs for CT or NG are a possibility and may be used in certain situations. However, to avoid confusion we have removed “or where NAAT is not available” from the examples. |
| | Appendix 3, page 17, implementation considerations. Bullet 7 -please expand “clinically warranted” for pharyngeal and rectal swabs as many primary care physicians would never consider taking these samples. | The systematic review used a broad definition for sexual intercourse (anal, oral and vaginal intercourse) and would have included available information on screening extra genital sites. However, we did not identify any such studies to provide this guidance. This text is added to remind clinicians to consider extra genital sampling. We do not have a basis for further direction. |

**Reviewer 14 (Stakeholder):** Dr. Anne Bruneau, Institut national de santé publique du Québec

Disclosure(s): None

| Question | Reviewer comments | CTFPHC response |
|---|---|---|
| 1. Is the objective of the guideline clear? | Yes | Thank you |
| 2. Are the patient groups to whom the guideline is meant to apply clearly described? | Yes | Thank you |
| 3. Are the guidelines supported by the evidence? | Yes | Thank you |
| 4. Is there any information missing from the guideline that would make it easier to interpret for primary care practitioners? | No | Thank you |
| 5. Do you have any comments or suggestions to improve the guideline? | Line 32 consequences: cervicite is a manifestation of Ct /ng infection. (consequences (complications) is mostly PID, infertility, chronic pain, orchitsis fitz-Hugh_Curtis is a rare complication mostly for Ct infection) | Thank you for your comment. The use of the 'consequences' rather than 'complications' here is intentional, to capture both manifestations of primary infection, as well as complications of infection, both of which are a consequence of being infected. No change made. |
| | Line 37 : pharynx infection with Ct is considered as a transitional infection . transmission by oral sex is not clearly supported by literature. | Be that as it may, pharyngitis is still a potential consequence of CT infection. No change made. |
| | Line 48 QC recommendations for screening Ct + Ng all females under 25 and Ct for mens | We have included a summary of guidance from the Ministère de la santé et des services sociaux du Québec in Table 2. |

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| | Line 329: reminded to consider.. (every exposed site should be tested (pharynx, rectum etc..)) | As we did not identify any evidence to evaluate screening at these sampling sites, we have suggested that providers consider when these sites as may be clinically warranted. |
| | Table 2: MSSS recommend annual evaluation for STI risk factors and offer sti tests as need instead opportunistic tests<br>https://www.msss.gouv.qc.ca/aide-decision-app/conclusion.php?situation=pc-adulte#collapse-adultes-Table 2<br>individual from endemic regions : also if they are sexually active or had sexual contact | We recognize that the recommendations from MSSS require an evaluation of risk factors. For the purposes of this table, we have limited to the recommendations related to who and how often to screen.<br><br>The text in Table 2 is translated directly from the 2019 version of the MSSS guideline, Section 8.4.2 (p.52, and Table 3 (p. 56):<br>https://publications.msss.gouv.qc.ca/msss/fichiers/2019/19-308-13W.pdf<br>"Il est recommandé d'offrir un test au moins une fois par année aux personnes pour qui le dépistage est indiqué (voir le tableau 3 – ITSS à rechercher selon les facteurs de risque décelés)" |
| | Table 2: individual from endemic regions : also if they are sexually active or had sexual contact | Yes, that is correct. In such cases the individual may fall under one of the other risk groups listed in Table 2 for the MSSS guideline. No change made. |

**Reviewer 15 (Stakeholder):** Dr. Lana Beth Barkhouse, College of Family Physicians of Canada

Disclosure(s): None

| Question | Reviewer comments | CTFPHC response |
|---|---|---|
| 1. Is the objective of the guideline clear? | Yes | Thank you |
| 2. Are the patient groups to whom the guideline is meant to apply clearly described? | Yes | Thank you |

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| 3. Are the guidelines supported by the evidence? | Yes | Thank you |
| 4. Is there any information missing from the guideline that would make it easier to interpret for primary care practitioners? | No | Thank you |
| 5. Do you have any comments or suggestions to improve the guideline? | [via e-mail]<br>I did not have any comments or suggestions to improve the guidelines, and just wanted to say that the work to build this recommendation is phenomenal, and is an excellent guideline. | Thank you for these kind words. |

**Reviewer 16 (Stakeholder):** Dr. Katherine Bell, College of Family Physicians of Canada

Disclosure(s):

1) I am a Director on the BCCFP Board of Directors (Nov 2019 – present)

2) I represent family doctors from British Columbia on the Family Medicine Forum planning committee (CFPC National)

3) I was a co-investigator of a food security study funded by the Government of Prince Edward Island (Department of Land and Fisheries) ($10 000), in partnership with the PEI CFP, which has finished accruing data and is in the analysis/dissemination stage.

| **Question** | **Reviewer comments** | **CTFPHC response** |
|---|---|---|
| 1. Is the objective of the guideline clear? | YES, recommendations on opportunistic screening for pts >30 yrs of age presenting to primary care for any reason | Thank you |
| 2. Are the patient groups to whom the guideline is meant to apply clearly described? | YES, age <30, M/F, presenting to primary care, not known to be in high risk category for CT/GN | Thank you |

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| 3. Are the guidelines supported by the evidence? | YES, in so much as the limited evidence is clearly outlined and the reasoning behind the recommendation even in the absence of some important evidence is outlined. However, acceptability of psychologic risk is based on a single population (downtown Toronto) and a small # of patients | Thank you for this feedback. This data on acceptability comes from the task force's patient engagement activities. The task force recruits members of the public to provide input during the guideline development processes via surveys, focus groups and interviews at two phases of guideline development (early at the outcome prioritization stage and later after evidence is synthesized). For this guideline, patients were recruited from Ontario, Nova Scotia, Saskatchewan, Quebec, British Columbia, Manitoba, Alberta, Yukon and New Brunswick. Methods for patient engagement processes can be found on the task force website: https://canadiantaskforce.ca/ . Reports from Phase 1 and Phase 2 patient preferences activities for this guideline will also be posted on the task force website.<br><br>The systematic review also included patient values and preferences to inform how patients prioritize benefit relative to harm. |
| 4. Is there any information missing from the guideline that would make it easier to | YES, 1) pt sexual orientation is not addressed – do guidelines apply equally to LBGTQ patients as to heterosexual patients 2) | Thank you for this feedback. Please see responses to these three points below. |

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| interpret for primary care practitioners? | costs/cost analysis data for implementation of guideline<br>3)availability of self-administered vaginal swabs across Canada | 1) This guideline applies to <u>all sexually active individuals</u> under 30 who are not known to belong to a high-risk group, regardless of their sexual orientation.<br>2) We note that while we did not conduct a systematic review on resource use or cost-effectiveness. We identified many cost effective studies (including the Canadian study by Tuite AR et al. referenced in the guideline) and we have summarized the cost-effectiveness data noting that "cost-effectiveness estimates based on opportunistic screening scenarios suggest that high versus low rates of screening may improve cost-effectiveness and that screening may be cost-effective in Canada provided that the probability of chlamydia progressing to PID is at least 10%, although this is of very low certainty."<br><br>Based on factors such as the availability of NAAT to test for both CT and NG under a single price, we judge that this recommendation to screen for CT and NG at *opportunistic visits* would have moderate costs due to clinician time and costs of the screening test.<br><br>3) Thank you for this point. Many Canadian laboratories will process self- |

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| | | collected vaginal swabs, however, their application may be limited to facilities able to support patients by explaining the procedures and precautions (Korownyk et al., 2018; PHO, 2020). We have reported that self collected sampling is most accurate for vaginal swabs for females and urine collected samples for males. |
| 5. Do you have any comments or suggestions to improve the guideline? | MISSING INFORMATION IN GUIDELINE PACKAGE<br>Line 82 – no appendix 2 was included in my package for review | Appendix 2 (Acknowledgements) will be completed following stakeholder and peer review of this guideline. Sorry this was not communicated. |
| | USEFUL FEATURES AS A FAMILY PHYSICIAN/PRIMARY CARE CLINICIAN<br>1) Incidence of negative health outcomes<br>Lines 32-39<br>Useful to lay out the prevalence of complications of CT/GN – practically these are the types of numbers I like to know when explaining to pts why such testing might be useful for them | Thank you for this feedback.<br><br>This is helpful information to highlight in the knowledge translation tools which will accompany the guideline to support clinician and patient discussions around CT/NG screening. |
| | USEFUL FEATURES AS A FAMILY PHYSICIAN/PRIMARY CARE CLINICIAN<br>2) Patient values re negative health outcomes potentially reduced by screening<br><br>Line 243-244 – interesting information, may be useful in targeting our communications with patients when discussing risk/benefit | Thank you for this suggestion. We will certainly be taking into account information on patient values when designing the knowledge translation tools that will accompany this guideline. |

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| | "the avoidance of infertility and chronic pelvic pain may be more important to females than ectopic pregnancy, PID, or cervicitis (low-to-moderate certainty) (24)" | |
| | USEFUL FEATURES AS A FAMILY PHYSICIAN/PRIMARY CARE CLINICIAN<br>2) Summary of relevant guidelines<br>Table 2 – I found the comparison of guidelines (Cdn and international) useful as a clinician | Thank you for this feedback. |
| | SUGGESTIONS TO IMPROVE USEFULNESS TO A FAMILY PHYSICIAN/PRIMARY CARE CLINICIAN<br>1) Explain why GN is being included in this guideline upfront<br><br>Lines 45-52<br>The point is made that the Public Health Agency of Canada has recommendations for CT but not GN. Not sure the overview preceding is clear why this guideline has focused on both.<br>Line 287-294 – does address why GN is included – but this is buried deep in document – why not reference the logic upfront?<br><br><u>Rationale is given in Appendix 3</u><br>(Appendix 3 pg 1 cites CT and GN are common co-infections – but no stats given)<br>(Appendix 3 pg 4 "Benefits of screening this population for NG are unknown due to lack of evidence for critical outcomes. However, current Canadian clinical and laboratory practice is to combine testing for NG with CT using a single sample, and most commercial NAAT assays test for both organisms simultaneously with a single specimen (27). Also, as with CT, many NG cases are asymptomatic (17,28) and identified only | Thank you for this suggestion.<br><br>We have provided potential consequences of NG infection in the background, noting that some may be more severe when occurring as a result of NG infection. Additionally, the Rationale section specifically describes why a recommendation for NG is included (as you have noted) immediately after the recommendation.<br><br>We have a strict limitation on word count and feel this information is in most appropriate location. |

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| | through screening. Additionally, up to 40% of those with NG may have CT (29-31)."<br>(Appendix 3 pg 11 "Despite the lack of available evidence on NG, like CT, many NG cases are asymptomatic and identified only through<br>screening. Additionally, up to 40% of those with NG may have CT (29-31)."<br><br>(Appendix 6 pg 16 "The recommendation to also screen for NG was made (despite the lack of available evidence) given that current Canadian clinical and laboratory practice is to combine testing for NG with CT using a single sample, and most commercial NAAT assays test for both organisms simultaneously with a single specimen (27). Also, as with CT, many NG cases are asymptomatic (17,28) and identified only through screening. Additionally, up to 40% of those with NG may have CT (29-31).") | |
| | SUGGESTIONS TO IMPROVE USEFULNESS TO A FAMILY PHYSICIAN/PRIMARY CARE CLINICIAN<br>2) Screening intervals<br>Line 322/323 – a key piece of info for clinicians should be in summary (upfront, easily located), not just background (screening interval) "While the optimal screening interval is unknown, an annual offer of screening may be appropriate for individuals at general risk." | Thank you. We acknowledge this to be necessary for clinicians to implement the recommendation and consequently the following has been added to the key points at the beginning of the guideline and the recommendation statement:<br><br>"The task force recommends screening of sexually active individuals under 30 years of age for chlamydia and gonorrhea annually at primary care visits, as feasible (Conditional recommendation; very low-certainty evidence)." |

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| | SUGGESTIONS TO IMPROVE USEFULNESS TO A FAMILY PHYSICIAN/PRIMARY CARE CLINICIAN<br>3) Rate of screening offered<br>Line 258-260 – "Notably, one included RCT indicated that patients accepted screening 80% of the time that it was offered (although the overall screening rate in this trial was low due to lack of offer) (68)."<br>- as a clinician, I want to know the rate of offer as well. You cite this several times in the documentation with this caveat but why not just give us the % of visits screening was offered in? | We have revised the acceptability section as follows "Notably, one included RCT indicated that patients accepted screening 80% of the time that it was offered (although the overall screening rate in this trial was low [24%] due to lack of offer)" |
| | SUGGESTIONS TO IMPROVE USEFULNESS TO A FAMILY PHYSICIAN/PRIMARY CARE CLINICIAN<br>4) Child abuse<br>Line 330-333 - Important topic/caveat but why lumped in here? Misplaced in document. ?Address with caveat at beginning where you differentiate high risk populations from target of the guideline (Line 168/169)<br>"In cases of actual or suspected child abuse, clinicians are directed to their local, provincial and territorial authorities (public health offices, child protection services, pediatricians and clinical experts), for STI testing, treatment, reporting and management." | Thank you for this suggestion.<br><br>We believe that this represents an implementation issue for practice rather than a factor defining the target population to be screened (scope of the guideline). |
| | SUGGESTIONS TO IMPROVE USEFULNESS TO A FAMILY PHYSICIAN/PRIMARY CARE CLINICIAN<br>5) Change in age of targeted patients for screening<br>this is a key difference vs other guidelines (<30 yrs of age vs <25 yrs of age) – important in your knowledge translation tools to family physicians/other HCP and should be highlighted in the guideline | Thank you for this suggestion.<br><br>We have expanded the Rationale section to emphasize the reasons for including those aged 25 to 29:<br>"The recommendation to screen individuals younger than 30 years is based on the fact that almost all of the |

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| | | underlying evidence comes from studies of individuals in this age group. Further, the rates of chlamydia and gonorrhea are increasing among those aged 25–29 years in Canada, with rates and total cases similar to those aged 15–19 years.4,60 Conversely, rates of chlamydia for those aged 30–39 years are less than 50% of those for individuals 15–19 and 24–29 years, and less than 25% of those for individuals aged 20–24 years.4 Similarly, rates in those aged 40–59 years are less than 25% of those in individuals aged 30–39 years."<br><br>We will certainly consider this as an important element when developing the knowledge translation tools to accompany this guideline. |
| | INFORMATION NOT ADDRESSED IN GUIDELINE<br>1) How often does population of interest actually seek medical care from family physician/primary care clinician?<br>Appendix 3 pg 2 – Problem<br>no mention of infrequency of the target population seeking care from primary care (we don't often see these patients which limits opportunities for opportunistic care) | In the Implementation section, we have noted:<br>"While the optimal screening interval is unknown, an annual offer of screening may be appropriate for individuals at general risk, recognizing that encounters with primary care may occur less frequently."<br><br>There are a variety of opportunistic screening venues for primary care (beyond |

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| | | family physicians), examples of which have been identified in the background section. |
| | INFORMATION NOT ADDRESSED IN GUIDELINE<br>2) Sexual orientation of individual screened – how does this influence screening?<br>Appendix 3 – Pg 11<br>benefit to males is unknown, but screening recommendations "Uncertain evidence for a small but potentially important benefit to reduce PID in females. Evidence in males is lacking, but they serve as a reservoir for transmission to females."<br><br>Clearly a hetero-normative bias. This may not apply equally to all male patients – benefit for non-heterosexual males may not be equivalent (on individual or on population level)<br><br>Appendix 3 pg 16 Subgroup considerations "A number of subgroups were sought but sufficient evidence was unavailable to develop recommendations on CT / NG screening focused to specific groups who may be at increased risk based on sexual behaviours and/or other factors (e.g., geography, membership in a vulnerable group, high-risk sexual behaviours, and biological and epidemiological factors)." | We disagree that this represents a hetero-normative bias, but reflects the properties of sexual networks. The benefit of also screening males (including men who have sex with men) is intended to reduce consequences in females who carry the burden of consequences. This may improve health equity for females. Wording in the Rationale section has been updated accordingly, for clarity.<br><br>Note that the recommendation to screen all sexually active patients not known to belong to a high-risk group does not require the clinician to ask about a patient's sexual orientation in order to offer screening. |
| | INFORMATION NOT ADDRESSED IN GUIDELINE<br>3) Costing data – would be useful to family physicians<br>Line 258-254 Resource use – a gap in guideline<br><br>Appendix 3<br>Absence of Costing data pg 12 – is a limitation to the applicability of this guideline<br>Cost effectiveness Pg 12 "In the judgment of the task force, cost-effectiveness varies depending on screening rates, and | We note that while we did not conduct a systematic review on resource use or cost-effectiveness analysis, we identified many cost effectiveness studies (including the Canadian study by Tuite AR, 2012). The final recommendation weighs the balance of consequences (clinical benefit, harm, patient values and preferences and cost |

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| | may favour screening for CT and screening rates are higher (50-75%) rather than lower (10-30%)." | considerations) and maintains applicability as a guideline. |
| | INFORMATION NOT ADDRESSED IN GUIDELINE<br>4) When to begin screening?<br><br>Table 2 pg 9 Age limit – no lower limit, just an upper limit given (<30yrs) – the assumption I make is screening recommended as soon as pt sexually active? | This is correct; screening is recommended when patient is sexually active. We have added further clarification in the Implementation section:<br>"To implement this screening recommendation, clinicians in primary care settings are advised to identify individuals who are eligible for screening (sexually active individuals under 30 years of age), not seeking testing for a possible STI, and to offer chlamydia and gonorrhea screening opportunistically (i.e., without requiring a separate screening visit, and not only during sexual health visits)…<br>Sexual activity can be generally defined as ever having oral, vaginal or anal intercourse." |

**Reviewer 17 (Stakeholder):** Natalie Fawcett, Community Health Nurses of Canada and Toronto Public Health

Disclosure(s): None

| **Question** | **Reviewer comments** | **CTFPHC response** |
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| 1. Is the objective of the guideline clear? | Yes | Thank you |
| 2. Are the patient groups to whom the guideline is meant to apply clearly described? | Yes | Thank you |

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| 3. Are the guidelines supported by the evidence? | Yes | Thank you |
| 4. Is there any information missing from the guideline that would make it easier to interpret for primary care practitioners? | No | Thank you |
| 5. Do you have any comments or suggestions to improve the guideline? | I think that this was a very though review. I didn't have any questions and enjoyed the opportunity to see the evidence for screening. Thank you. | Thank you |

**Reviewer 18 (Stakeholder):** Dr. Christelle Kom Mogto, Centre intégré de santé et de services sociaux de l'Outaouais

Disclosure(s): Membre de Comité sur les ITSS du Québec (CITSS)

| **Question** | **Reviewer comments** | **CTFPHC response** |
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| 1. Is the objective of the guideline clear? | Yes | Thank you |
| 2. Are the patient groups to whom the guideline is meant to apply clearly described? | Yes | Thank you |
| 3. Are the guidelines supported by the evidence? | Yes | Thank you |
| 4. Is there any information missing from the guideline that would make it easier to interpret for primary care practitioners? | No | Thank you |
| 5. Do you have any comments or suggestions to improve the guideline? | The guideline precision «at primary care visits» has the potential to create inequalities. For some people there is a need for outreach. | As reported in the findings section on benefits, we included evidence from outreach strategies as available (mailed invitations to screen at home, school based screening) and identified the indirectness of such strategies to the scope of this |

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| | | guideline which is specified in the Scope section as being intended for primary care clinicians. We were unable to comment on the relative effectiveness of outreach screening. |