

STI Testing: Which Tests May Be Needed?

A Complete Guide to HIV, Syphilis, Gonorrhoea, Chlamydia, Herpes, Trichomoniasis, Mycoplasma genitalium, Hepatitis B, Hepatitis C and HPV Testing

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A Message From Dr. Nizamuddin Qasmi

One of the most common questions patients ask me after a sexual exposure is:

“Doctor, which STI tests should I get?”

Some patients ask for:

“a complete STD profile.”

Others tell me:

“I had a urine STI test and everything was negative, so I am completely safe.”

Another patient may have had only blood tests and believe this rules out every sexually transmitted infection.

This is where considerable confusion occurs.

My first message is:

There is no single test that rules out every sexually transmitted infection.

And there is no universally standardized medical test called:

“the complete STI panel.”

Different infections require different tests.

Some are detected mainly through:

- blood.



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Some are best detected through:

- urine,
- vaginal swab,
- cervical swab,
- urethral specimen.

Others require:

- throat swabs,
- rectal swabs,
- swabs directly from genital ulcers or blisters.

Timing also matters.

A test performed too early after an exposure may be negative even though infection has occurred.

The exact tests a person needs therefore depend on:

what happened, when it happened, which body sites were exposed, whether symptoms are present, pregnancy status, previous vaccination, partner diagnosis and individual risk.

CDC's updated STI testing information published in **March 2026** similarly emphasizes that the appropriate tests and testing frequency depend on age, sexual history, current sexual practices, symptoms and other risk factors.

At Saira Health Care, I therefore prefer:

risk-based and exposure-based STI testing

rather than simply ordering every commercially advertised laboratory test.

The objective is not:

“How many tests can we order?”

The objective is:

“Which tests can actually answer this patient's clinical question?”

What Does STI Mean?

STI means:



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Sexually Transmitted Infection.

The older term:

STD — Sexually Transmitted Disease

is also commonly used.

The term STI is often preferred because an individual can carry an infection without having:

- symptoms,
- visible disease.

For example, a person may have:

- chlamydia,
- gonorrhoea,
- HIV,
- hepatitis B,
- syphilis

without feeling ill.

This is why testing is important.

CDC emphasizes that many STIs cause no symptoms and can still produce health complications or be transmitted to sexual partners.

Why STI Testing Matters Even When You Feel Completely Normal

Many patients tell me:

“Doctor, I don't have discharge or burning, so why should I test?”

Because several important sexually transmitted infections can remain:

asymptomatic.

Chlamydia is a classic example.

Many women and men infected with chlamydia have no obvious symptoms.

Gonorrhoea at the:

- throat,
- rectum



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is also frequently asymptomatic.

Syphilis may move from an early lesion into a latent stage where the person feels completely healthy.

HIV can remain clinically silent for years.

Hepatitis B and hepatitis C may also cause no early symptoms.

Therefore:

feeling healthy is not an STI test.

STI Testing Is Not the Same for Every Sexual Exposure

I always ask patients about:

- vaginal sex,
- anal sex,
- oral sex,
- condom use,
- genital ulcers,
- blood exposure,
- partner diagnosis.

Why?

Because the body site that was exposed determines:

where we may need to test.

If a person had only a urine test after receptive anal intercourse, a rectal gonorrhoea or chlamydia infection could potentially be missed.

Similarly, after oral sexual exposure:

- throat gonorrhoea

may require a pharyngeal swab.

CDC specifically advises people who have had oral or anal sex to discuss:

- throat testing,
- rectal testing

with their healthcare professional.



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The Most Important Principle: Test the Site That Was Exposed

For gonorrhoea and chlamydia especially:

anatomical-site testing matters.

Possible testing sites include:

- genital tract,
- throat,
- rectum.

CDC notes that a large proportion of extragenital infections can be missed when only genital testing is performed in populations with oral or anal exposure. Among men who have sex with men, CDC reports that approximately 70% of gonorrhoeal and chlamydial infections may be missed if only urogenital testing is performed.

The broader lesson applies to everyone:

your sexual history determines which anatomical sites deserve testing.

Which Sample Is Used for Which STI?

A useful general guide is:

Infection or condition	Commonly useful test/sample
HIV	Blood; antigen/antibody test, antibody test or NAT depending on timing
Syphilis	Blood serology; usually treponemal + nontreponemal tests
Gonorrhoea	NAAT from urine, vaginal/cervical, rectal or throat specimen according to exposure
Chlamydia	NAAT from urine, vaginal/cervical or rectal specimen according to exposure
Trichomoniasis	Vaginal swab or urine NAAT, especially in women; validated testing may also be used in men



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Mycoplasma genitalium	NAAT from appropriate genital/urinary specimen when clinically indicated
Genital herpes	PCR/NAAT from a fresh blister or ulcer when lesions are present; selected blood serology otherwise
Hepatitis B	Blood—HBsAg, anti-HBs and total anti-HBc triple panel
Hepatitis C	Blood—anti-HCV followed by HCV RNA if reactive
HPV	Cervical high-risk HPV testing in appropriate cervical-cancer screening; not a general STI panel test

This table is a guide—not a substitute for individualized evaluation.

A “Full STI Panel” Can Still Miss Important Infections

Commercial laboratory packages vary enormously.

One laboratory's “complete STI panel” may include:

- HIV,
- syphilis,
- hepatitis B,
- hepatitis C.

Another may add:

- gonorrhoea,
- chlamydia.

Some may include:

- herpes antibodies.

Others may not.

M. genitalium may require a completely separate molecular test.

Trichomoniasis may not be included.

HPV generally should not be used as a general STI blood or urine test.

This is why CDC advises clinicians to explain which infections are and are not included in the testing being performed.

I strongly encourage patients to ask:

“Exactly which infections are included in my panel?”

Do not rely only on the word:

“complete.”

Blood Testing Cannot Diagnose Every STI

Blood testing is particularly useful for infections such as:

- HIV,
- syphilis,
- hepatitis B,
- hepatitis C.

But a routine blood sample does not replace:

- gonorrhoea NAAT,
- chlamydia NAAT,
- lesion PCR for herpes,
- vaginal trichomonas testing,
- Mgen NAAT.

Therefore:

normal STI blood tests do not automatically mean that every sexually transmitted infection has been excluded.

Urine Testing Cannot Diagnose Every STI Either

Urine NAAT is excellent for several genital bacterial infections.

In men, first-void urine is especially useful for:

- chlamydia,
- gonorrhoea.

But urine testing cannot by itself reliably exclude:

- HIV,
- syphilis,



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- hepatitis B,
- hepatitis C.

Nor will genital urine testing necessarily identify infection limited to:

- throat,
- rectum.

The correct sample depends upon the infection and exposure.

First-Voided Urine Versus Midstream Urine

Patients are often confused because there are two completely different urine-collection methods.

For ordinary urinary-tract infection testing, we often want:

midstream urine.

But for gonorrhoea/chlamydia STI NAAT in men, we generally want:

first-catch or first-void urine.

Why?

Because the earliest part of urination contains urethral cells and secretions where organisms such as:

- chlamydia,
- gonorrhoea

are most likely to be detected.

CDC identifies first-void urine as an optimal urogenital NAAT specimen for men.

Vaginal Swabs Can Be Better Than Urine in Women

For women, vaginal swabs are excellent specimens for:

- chlamydia,
- gonorrhoea

using NAAT.

CDC identifies:

vaginal swab



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as the optimal urogenital specimen for women using modern NAAT testing.

Importantly, many approved molecular platforms allow:

self-collected vaginal swabs.

When instructions are followed correctly, CDC reports that patient-collected vaginal swabs perform similarly to clinician-collected samples for chlamydia testing.

This can improve:

- privacy,
- comfort,
- testing access.

STI Testing After Oral Sex

If oral sex occurred, the relevant question is:

which person's mouth and which person's genitals were exposed?

Gonorrhoea can infect the:

- throat.

A person with pharyngeal gonorrhoea may have:

no sore throat.

Therefore, after relevant oral exposure:

a throat swab NAAT may be needed.

Urine testing alone can miss it.

Chlamydia can also occur in the oropharynx, although it is substantially less common and its clinical significance is less clear.

CDC recommends exposure-site testing for extragenital chlamydial and gonorrhoeal infections when clinically indicated.

STI Testing After Anal Sex

After receptive anal intercourse, infection can occur in the:

rectum.

Possible organisms include:



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- gonorrhoea,
- chlamydia.

Rectal infection may cause:

- pain,
- discharge,
- bleeding,
- tenesmus,

but many infections are completely asymptomatic.

A rectal swab NAAT may therefore be appropriate based on exposure.

A normal urine test does not exclude:

isolated rectal infection.

HIV Testing

HIV testing deserves special attention because:

different tests have different window periods.

No HIV test can reliably detect infection immediately after exposure.

CDC's current 2026 information gives the approximate detection windows below.

HIV NAT

A nucleic-acid test may detect infection approximately:

10–33 days after exposure.

Laboratory fourth-generation antigen/antibody test

Using blood from a vein:

approximately 18–45 days.

Rapid antigen/antibody test

Using finger-stick blood:

approximately 18–90 days.

Antibody-only test

Many rapid and self-tests fall into this category:



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approximately 23–90 days.

This explains why:

an HIV test performed too early can be negative despite infection.

What Is a Fourth-Generation HIV Test?

A fourth-generation test detects:

- HIV antibodies,
- p24 antigen.

P24 appears earlier than antibodies alone.

Therefore, laboratory fourth-generation testing detects infection earlier than many older antibody-only tests.

It has become one of the most useful standard tests after a recent sexual exposure.

But even a fourth-generation test:

is not immediately positive the day after exposure.

Timing still matters.

What Is an HIV NAT?

NAT means:

Nucleic Acid Test.

It detects viral genetic material directly.

Because it can detect HIV earlier than standard antibody tests, it may be useful when:

- exposure was recent,
- symptoms suggest acute HIV,
- screening results are negative or indeterminate despite significant concern.

NAT is not necessarily needed for every routine HIV-screening visit.

Is a Negative HIV Test After One Week Final?

Usually:



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no.

A one-week test is often too early to definitively exclude infection.

The correct follow-up depends on:

- which test was performed,
- when the exposure occurred,
- whether PEP or PrEP has been used.

CDC specifically advises repeating testing after the relevant test's window period when an early post-exposure test is negative.

Do Not Wait for HIV Testing If PEP May Be Needed

This point can be life-changing.

If a potentially significant HIV exposure occurred within:

72 hours,

the patient should seek urgent assessment for:

HIV post-exposure prophylaxis — PEP.

CDC's updated 2025 PEP recommendations state that PEP should begin as soon as possible, ideally within 24 hours and no later than 72 hours after qualifying exposure. Laboratory testing should not unnecessarily delay the first dose when PEP is indicated.

Therefore:

testing and prevention may need to happen at the same time.

Do not wait for symptoms.

Syphilis Testing

Syphilis is caused by:

*****Treponema pallidum*.**

Diagnosis usually requires:

blood testing using two different types of serological test.

One is a:

nontreponemal test



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such as:

- RPR,
- VDRL.

The other is a:

treponemal test

such as:

- TP-PA,
- treponemal EIA or another validated specific assay.

CDC states that using only one type of serologic test is insufficient for reliable diagnosis because it can produce both false-positive and false-negative interpretations.

Why Do We Need Two Syphilis Tests?

RPR or VDRL measures an antibody response that correlates approximately with disease activity.

Treponemal testing detects antibodies more specifically directed against:

***Treponema pallidum*.**

Used together, these tests help distinguish:

- active infection,
- previous treated infection,
- false-positive results,
- possible early infection.

This interpretation should ideally be made by a clinician rather than by reading one laboratory value in isolation.

Can Syphilis Testing Be Negative Early?

Yes.

During very early primary syphilis, antibodies may not yet have become detectable.

Therefore, when exposure is recent and clinical suspicion remains high, repeating serology may be required.



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CDC specifically recommends repeat nontreponemal testing in approximately:

2–4 weeks

in selected situations where recent infection is suspected despite discordant initial serology.

This should not be interpreted as a single universal “syphilis window period” for every exposure.

The timing depends upon:

- symptoms,
- exposure,
- initial tests.

What If There Is a Genital Ulcer?

A genital ulcer should not be evaluated with only one blood test.

Important causes include:

- syphilis,
- genital herpes.

CDC recommends that patients with genital, anal or perianal ulcers receive specific evaluation that can include:

- syphilis serology,
- direct testing for *T. pallidum* from the lesion where available,
- HSV-1/HSV-2 NAAT or culture from the lesion.

A sore should ideally be assessed:

while the lesion is still present.

Chlamydia Testing

Chlamydia is caused by:

*****Chlamydia trachomatis*.**

The preferred modern diagnostic method is:

NAAT.



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For men, useful specimens include:

- first-void urine,
- urethral swab in selected circumstances.

For women:

- vaginal swab,
- cervical swab,
- first-void urine.

CDC identifies NAAT as the most sensitive recommended test and considers vaginal swabs optimal for women and first-catch urine optimal for men.

Rectal Chlamydia Testing

If receptive anal exposure occurred, a:

rectal NAAT

may be appropriate.

A genital urine test cannot reliably exclude infection confined to the rectum.

This is especially important because rectal chlamydia can be:

asymptomatic.

Throat Chlamydia Testing

Oropharyngeal chlamydia occurs less frequently than pharyngeal gonorrhoea.

Routine throat chlamydia screening is therefore not universally recommended for every person.

However, some combined molecular platforms report:

- gonorrhoea,
- chlamydia

from the same pharyngeal specimen.

Exposure and individual risk should guide testing.

When Should Chlamydia Be Routinely Screened?



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CDC's current screening recommendations include annual chlamydia screening for sexually active women:

younger than 25 years,

and women aged 25 or older when increased risk is present.

For sexually active men who have sex with men, screening is recommended at least annually at anatomical exposure sites, with more frequent testing in those at increased risk.

These are US population recommendations; local Indian public-health guidance and individual clinical risk should also be considered.

Gonorrhoea Testing

Gonorrhoea is caused by:

***Neisseria gonorrhoeae.*

Modern testing commonly uses:

NAAT.

Samples can include:

- first-void urine,
- vaginal swab,
- cervical swab,
- urethral specimen,
- rectal swab,
- throat swab.

CDC states that NAAT generally provides greater sensitivity than culture for detecting gonorrhoea at genital and extragenital sites.

Why Gonorrhoea Culture Is Still Important

If NAAT is so sensitive, why do we still need culture?

Because NAAT tells us:

whether gonorrhoea genetic material is present.



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But it usually cannot tell us:

which antibiotic the organism is resistant to.

Gonorrhoea has become a major antimicrobial-resistance concern.

Therefore, CDC recommends:

culture plus antimicrobial susceptibility testing

when treatment failure is suspected.

This distinction is very important.

Throat Gonorrhoea

Pharyngeal gonorrhoea is particularly easy to miss.

A patient may have:

- no sore throat,
- no fever.

A urine test can be completely negative while a:

throat infection

is still present.

Therefore, oral sexual exposure should be discussed openly with the clinician.

Rectal Gonorrhoea

Rectal gonorrhoea may be:

- asymptomatic,
- painful,
- associated with discharge or bleeding.

A rectal swab may be needed after relevant exposure.

Again:

testing the wrong body site can create a false sense of security.

Trichomoniasis Testing



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Trichomoniasis is caused by:

*****Trichomonas vaginalis*.**

Women may experience:

- vaginal discharge,
- itching,
- dysuria,
- painful intercourse.

Men frequently have:

- no symptoms.

Modern NAAT testing is much more sensitive than traditional wet-mount microscopy.

CDC reports wet-mount microscopy sensitivity of only approximately:

44–68%

and notes that sensitivity can fall to around:

20%

within one hour if the specimen is not examined promptly.

NAATs are therefore particularly valuable.

Is Trichomoniasis Testing Recommended for Everyone?

No.

Testing depends upon:

- symptoms,
- prevalence,
- individual risk.

It is particularly relevant in women with:

- vaginal discharge,
- persistent genital symptoms,

and in selected men with:

- recurrent urethritis,



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- infected female partner.

Mycoplasma genitalium Testing

M. genitalium is increasingly important because it is associated with:

- persistent urethritis,
- recurrent cervicitis,
- PID.

The correct diagnostic method is:

NAAT.

Culture is impractical because the organism can take:

months

to grow in specialized laboratory conditions.

CDC recommends Mgen testing particularly for:

- men with recurrent NGU,
- women with recurrent cervicitis,

and consideration in:

- PID.

Routine screening of asymptomatic men and women is **not recommended**.

This is an important example of why:

a bigger STI panel is not always better.

Why Testing Everyone for Mycoplasma genitalium May Cause Harm

Mgen antibiotic resistance is common.

If completely asymptomatic low-risk people are screened indiscriminately, positive results may lead to:

- repeated antibiotic courses,
- adverse effects,
- further antimicrobial resistance



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without established evidence that universal screening improves health outcomes.

Therefore:

targeted testing is more medically responsible.

Genital Herpes Testing

Genital herpes is caused by:

- HSV-1,
- HSV-2.

The most useful test depends dramatically on whether:

an active lesion is present.

If there is a fresh blister, ulcer or sore:

PCR/NAAT from the lesion

is the preferred diagnostic approach.

CDC describes HSV NAAT as the most sensitive method for testing genital lesions, with reported assay sensitivity generally above 90%.

Therefore:

if you develop a new genital blister, seek medical assessment before it heals.

That is often the best time to test.

Why a Herpes Blood Test Is Different

Herpes blood tests detect:

antibodies.

They do not tell us:

- exactly where infection is located,
- when infection occurred.

They can also produce:

false-positive results,

especially in lower-risk people.



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For this reason, CDC does not recommend routine herpes blood screening in most asymptomatic people.

Type-specific blood testing can be useful in selected situations, for example when:

- a partner has genital herpes,
- symptoms are suggestive but lesion testing was unavailable,
- previous clinical diagnosis was never confirmed.

How Soon Can Herpes Blood Testing Become Positive?

Antibody formation takes time.

CDC notes that after exposure it can take:

up to 16 weeks or more

for current herpes tests to detect infection.

Therefore, very early HSV antibody testing can be falsely reassuring.

If a lesion appears before that time:

swab the lesion rather than waiting for antibody testing.

A Negative Herpes Swab Does Not Always Rule Out Herpes

PCR is very sensitive when obtained from:

- a fresh lesion.

But viral shedding is intermittent.

A specimen taken from an old healing lesion may be negative.

CDC specifically states that failure to detect HSV from an older lesion does not completely exclude infection.

Clinical context still matters.

Hepatitis B Testing

Hepatitis B is particularly important in sexual medicine because:

- it can be sexually transmitted,
- a highly effective vaccine exists.



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The most informative initial screening approach is often the:

hepatitis B triple panel.

This includes:

HBsAg — hepatitis B surface antigen;

anti-HBs — antibody to hepatitis B surface antigen;

total anti-HBc — antibody to hepatitis B core antigen.

CDC currently recommends this triple panel for initial adult screening.

What Does the Hepatitis B Triple Panel Tell Us?

Together these markers can help determine whether someone is:

- currently infected,
- immune after vaccination,
- immune after previous natural infection,
- susceptible.

This is much more informative than ordering:

HBsAg alone

when the objective is to understand a person's overall HBV status.

Hepatitis B Testing After Sexual Exposure

If a person has had sexual exposure to someone known to be:

HBsAg positive,

the first question is not only:

“When should I test?”

It is also:

“Am I vaccinated and immune?”

If an unvaccinated susceptible person has a significant recent sexual exposure to an HBsAg-positive partner, hepatitis B:

- vaccination,



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- HBIG

may be indicated.

CDC recommends hepatitis B vaccine plus HBIG for unvaccinated people after appropriate sexual exposure to a confirmed HBsAg-positive source.

This is another example where:

prevention should not be delayed while waiting for symptoms.

Hepatitis C Testing

Hepatitis C is transmitted mainly through:

blood.

Sexual transmission occurs but is substantially less efficient than with hepatitis B or HIV in most heterosexual exposures.

Testing usually begins with:

HCV antibody — anti-HCV.

If that test is reactive:

HCV RNA

is used to determine whether current infection is actually present.

CDC recommends an HCV antibody test with automatic or reflex HCV RNA testing after a reactive antibody result.

Why a Positive Hepatitis C Antibody Does Not Always Mean Current Infection

HCV antibody can remain positive after:

- spontaneous clearance,
- successful antiviral treatment.

Therefore:

HCV RNA

determines whether active virus remains.

A person can be:

- antibody positive,



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- RNA negative

and have:

no current hepatitis C infection.

Recent Hepatitis C Exposure

Antibodies may not yet be present early after infection.

CDC therefore recommends HCV RNA testing when significant exposure is suspected within the preceding:

six months,

even if antibody testing is negative.

HPV Testing Is Not a General STI Test

This is one of the most commonly misunderstood areas.

HPV tests are primarily designed to detect:

high-risk cervical HPV

for:

- cervical-cancer screening,
- follow-up of abnormal cervical findings.

CDC specifically states that HPV tests should not be used:

- as a general STI test,
- to diagnose genital warts,
- to test male partners,
- as a routine HPV-status test for men.

Therefore:

an “HPV test for everything” does not exist.

Can Men Be Routinely Tested for HPV?

There is no approved routine clinical HPV-status screening test for men comparable with cervical high-risk HPV testing.



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A man with genital warts is generally diagnosed through:

- clinical examination,
- biopsy when atypical.

HPV testing is not routinely used to decide whether a genital wart is present.

Does a Pap Smear Test for All STIs?

No.

A Pap smear is primarily:

cervical cytology.

Its purpose is to detect abnormal cervical cells.

It should not be described as a complete STI test.

CDC explicitly notes that:

Pap tests and HPV tests should not be considered general STI-screening tests.

Chlamydia and gonorrhoea require their own molecular tests.

Does a Semen Analysis Test for STIs?

No.

A routine semen analysis measures parameters such as:

- semen volume,
- sperm concentration,
- motility,
- morphology.

It does not reliably exclude:

- chlamydia,
- gonorrhoea,
- HIV,
- syphilis,
- hepatitis,



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- herpes.

Specific infection tests are required.

This is particularly important in infertility clinics.

STI Testing and Infertility

STI testing can be important in infertility because some untreated reproductive infections can affect:

- fallopian tubes,
- epididymis,
- reproductive tract inflammation.

Chlamydia and gonorrhoea are particularly important because upper reproductive-tract infection in women can cause:

pelvic inflammatory disease

and subsequent:

tubal infertility.

But a previous STI does not automatically explain infertility.

At Saira Health Care, infertility is evaluated as a:

couple-based condition.

A female patient may need assessment of:

- ovulation,
- fallopian tubes,
- uterus,
- ovarian reserve when clinically appropriate.

A male partner may require:

- semen analysis,
- reproductive examination,
- hormonal or genetic testing when appropriate.

STI testing addresses one part of reproductive medicine—not the whole infertility evaluation.



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Can STI Testing Tell Whether Fallopian Tubes Are Damaged?

No.

An STI blood or swab test tells us whether an infection is:

- currently present,
- or whether previous exposure occurred in certain infections.

It does not tell us whether the fallopian tubes are:

- open,
- scarred,
- hydrosalpinx.

If tubal infertility is suspected, tests such as:

- HSG,
- HyCoSy

may be required.

Therefore:

infection testing and fertility testing are different investigations.

STI Testing Before Pregnancy

Preconception sexual-health evaluation can be extremely valuable.

Testing may be appropriate according to:

- age,
- risk,
- previous infection,
- partner history.

Pregnant women deserve particular attention because untreated infections can affect:

- mother,
- fetus,
- newborn.



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CDC's current STI screening recommendations advise early pregnancy testing for:

- HIV,
- syphilis,
- hepatitis B,
- hepatitis C,

with chlamydia and gonorrhoea testing according to age and risk.

India's NACO programme similarly prioritizes universal:

HIV and syphilis testing during pregnancy

as part of its effort to eliminate vertical transmission.

STI Testing in India — Current NACO Approach

India's **National Technical Guidelines on STI and RTI were updated in 2024.**

A 2026 published summary of those national recommendations emphasizes:

- detailed sexual and behavioural assessment,
- laboratory-based etiological diagnosis wherever available,
- enhanced syndromic management where laboratory infrastructure is limited,
- antimicrobial-resistance awareness,
- partner management.

Importantly, India's updated national STI algorithms recommend that:

all clients attending STI clinics be screened for HIV and syphilis.

This is an important public-health principle because STI services provide an opportunity to diagnose infections that may otherwise remain silent.

India's Suraksha Clinics

Under NACO, designated STI/RTI clinics—commonly branded as:

Suraksha Clinics

provide STI and reproductive-tract-infection services through:

- district hospitals,



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- medical colleges,
- other public-health facilities.

India has also strengthened laboratory support through regional and state reference laboratories for:

- etiological diagnosis,
- gonorrhoea antimicrobial-susceptibility testing,
- syphilis quality assurance.

HIV Testing Services in India

NACO's Integrated Counselling and Testing Centres—ICTCs—provide:

- HIV counselling,
- HIV diagnostic testing,
- linkage to treatment and prevention services.

India's national HIV/AIDS helpline is:

1097

which NACO lists as a toll-free 24×7 service.

Who Should Have Routine STI Screening?

There is no single schedule for every adult.

Screening depends upon:

- anatomy,
- age,
- sexual practices,
- partner pattern,
- pregnancy,
- HIV status,
- previous STI,
- local epidemiology.



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CDC's current recommendations include annual chlamydia and gonorrhoea screening for sexually active women under 25 and older women with increased risk; at least annual chlamydia, gonorrhoea and syphilis screening for sexually active MSM, with more frequent testing—often every three to six months—when ongoing risk is higher.

The key principle is:

screening frequency should match continuing exposure risk.

Someone With One Long-Term Mutually Monogamous Partner Does Not Automatically Need Every STI Test Every Three Months

Testing should be proportional to risk.

Repeated expensive panels without:

- new exposure,
- symptoms,
- pregnancy indication,
- medical reason

may generate:

- unnecessary anxiety,
- incidental findings,
- false-positive results.

Medicine is not improved simply by maximizing the number of laboratory tests.

Symptoms That Should Prompt STI Evaluation

Symptoms deserving assessment can include genital discharge, urethral burning, abnormal vaginal discharge, genital ulcers or blisters, pelvic pain, painful intercourse, bleeding after intercourse, testicular or epididymal pain, anal pain or discharge and unexplained rash.

But remember:

absence of symptoms does not rule out STI.

Testing may still be appropriate after significant exposure or because of screening recommendations.



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Genital Ulcer Testing

If a genital ulcer is present, evaluation should be performed while it is:

still visible.

The primary infectious considerations are often:

- herpes,
- syphilis.

CDC recommends lesion-specific testing in addition to syphilis serology.

Do not apply strong acids or herbal preparations to the lesion before examination because this can:

- alter its appearance,
 - interfere with testing,
 - injure the skin.
-

Testing After Sexual Assault

Sexual assault requires urgent, trauma-informed clinical care.

The patient may need assessment for:

- HIV,
- hepatitis B,
- syphilis,
- gonorrhoea,
- chlamydia,
- pregnancy.

But equally important:

do not wait for every test result before discussing preventive treatment.

If HIV exposure may have occurred within 72 hours:

PEP may be indicated.

If hepatitis B exposure occurred in a susceptible person:



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vaccination or vaccine plus HBIG may be indicated.

The patient may also require:

- emergency contraception,
- psychological support,
- forensic care.

What About STI Testing Immediately After Exposure?

This is one of the most important practical questions.

There is no universal “day 7 STI panel” that is perfect for every infection.

Testing immediately after exposure can still be useful for:

baseline status.

For example, a baseline HIV or syphilis test may show that infection existed before the recent exposure.

But an early negative result may require:

repeat testing.

The correct timing depends on the infection and test method.

HIV has well-defined test-dependent window periods.

Herpes serology can take many weeks.

Syphilis serology can be negative during early disease.

For gonorrhoea and chlamydia, molecular testing becomes positive earlier than antibody-based tests, but extremely early testing can still miss newly established infection.

Therefore:

test timing should be individualized rather than using one universal number for all STIs.

A Practical Post-Exposure Testing Approach

When a patient tells me:

“I had an exposure yesterday. Give me every test.”



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I first assess:

urgent prevention.

Was HIV PEP indicated?

Was hepatitis B post-exposure prophylaxis indicated?

Was emergency contraception required?

Only after that do we design:

baseline + follow-up testing.

This prevents the serious mistake of focusing on tests while missing a treatment window.

What Does a Negative STI Test Mean?

A negative result can mean:

no infection was detected by that particular test from that particular specimen at that particular time.

It does **not** necessarily mean:

every STI is impossible.

Interpretation depends upon:

- window period,
- sample quality,
- body site,
- antimicrobial use,
- exposure timing,
- test sensitivity.

The question should therefore be:

“Was the right test performed at the right time from the right site?”

What Does a Positive Test Mean?

A positive result also requires interpretation.

For infections such as:



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- gonorrhoea,
- chlamydia,
- trichomoniasis,
- Mgen,

a positive validated NAAT generally indicates infection requiring appropriate management.

But antibody tests can behave differently.

For example:

herpes antibody

does not reveal exactly when the infection occurred.

HCV antibody

does not prove current active infection.

Treponemal syphilis antibody

may remain positive after successful treatment.

Therefore:

not every positive antibody test means active untreated disease.

When Should Tests Be Repeated After Treatment?

This depends upon the infection.

For chlamydia and gonorrhoea, reinfection is common, and CDC generally recommends:

retesting about three months after treatment.

Pregnant women with chlamydia require a:

test of cure approximately four weeks after treatment

plus later retesting.

Trichomoniasis also has substantial reinfection risk, particularly in women.

Mgen follow-up depends upon:

- treatment regimen,
- symptoms,



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- resistance.

HIV and syphilis follow-up use their own disease-specific protocols.

Therefore:

“test of cure” and “retesting for reinfection” are not the same thing.

A Test of Cure Is Different From Retesting

A:

test of cure

asks:

“Did treatment eradicate the original infection?”

Retesting several months later may instead ask:

“Has the patient become reinfected?”

For some STIs, routine test of cure is unnecessary after standard treatment in nonpregnant patients.

For others, it is important.

This distinction prevents unnecessary repeated laboratory testing.

Antibiotics Before Testing Can Complicate Diagnosis

Patients sometimes take:

- azithromycin,
- doxycycline,
- cefixime

before providing samples.

This can sometimes:

- reduce organism load,
- partially suppress infection,
- complicate interpretation.

Whenever safe and clinically appropriate, specimens should ideally be obtained:



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before empirical antibiotics.

But treatment should not be dangerously delayed in serious syndromes such as:

- PID,
- epididymitis,
- suspected gonorrhoea with complications.

Clinical judgment matters.

The Danger of Testing Without Clinical Context

Modern laboratories can test for dozens of organisms.

But a positive molecular result is not always synonymous with:

disease requiring treatment.

Some genital organisms can be carried harmlessly.

Examples include certain:

- ureaplasmas,
- other components of the genital microbiome.

Indiscriminate multiplex testing can therefore lead to:

- unnecessary antibiotics,
- anxiety,
- relationship conflict.

Testing should answer:

a meaningful medical question.

Do Not Use STI Tests as “Proof of Fidelity”

A positive STI test cannot always establish:

- exactly when infection occurred,
- exactly who transmitted it.

Herpes and HPV can remain unrecognized for long periods.

Syphilis can enter latent stages.



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Hepatitis B may have been acquired many years earlier or even during childhood.

Therefore:

STI testing should be used for healthcare, not as a forensic relationship test.

STI Testing Before Marriage

Some couples choose sexual-health testing before marriage.

This can be reasonable when done with:

- informed consent,
- confidentiality,
- proper counselling.

A basic pre-marital sexual-health evaluation may include discussion of:

- HIV,
- syphilis,
- hepatitis B status and vaccination,
- hepatitis C where appropriate.

Chlamydia or gonorrhoea testing may be relevant according to:

- previous exposures,
- symptoms,
- individual history.

Testing should not become:

- coercive,
 - humiliating.
-

STI Testing Before Fertility Treatment

Fertility centres often screen for selected transmissible infections before:

- IUI,
- IVF,
- ICSI.



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This helps protect:

- partners,
- laboratory personnel,
- pregnancy,
- future child.

But STI screening is only one component of fertility care.

A couple may still require:

- semen analysis,
- ovarian reserve assessment,
- tubal evaluation,
- ovulation assessment,
- uterine evaluation.

The Unani Perspective on STI Testing

As a physician trained in **Unani medicine**, I value the traditional emphasis on:

- detailed history,
- examination,
- Mizaj or constitutional assessment,
- diet,
- urinary symptoms,
- genital discharge,
- sexual health,
- reproductive wellbeing.

Classical Unani literature contains descriptions of conditions corresponding to:

- abnormal genital discharge,
- burning urination,
- genital ulcerative disease,
- syphilis-like conditions,



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- warts.

CCRUM's standardized Unani medical terminology includes historical descriptions corresponding to conditions such as:

- congenital syphilis,
- chancroid,
- warts.

This demonstrates that sexually transmitted and genital disorders have long been recognized in traditional medicine.

However, one major advantage of modern medicine is that today we can identify the actual organism.

Modern Laboratory Testing Strengthens Unani Clinical Practice

In earlier medical eras, the physician had to infer disease mainly from:

- symptoms,
- examination.

Today, NAAT, PCR and modern serology can tell us whether the patient actually has:

- chlamydia,
- gonorrhoea,
- HIV,
- syphilis,
- hepatitis B,
- hepatitis C,
- Mgen.

For an integrative Unani physician, this should be seen as:

an advantage—not a conflict.

A more precise diagnosis allows more rational and safer treatment.

Can Unani Methods Replace STI Laboratory Tests?

No.



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There is no scientifically validated:

- pulse examination,
- urine colour assessment,
- temperament assessment,
- herbal response

that can reliably replace modern laboratory diagnosis of:

- HIV,
- syphilis,
- chlamydia,
- gonorrhoea,
- hepatitis B,
- hepatitis C.

If we want to know whether:

a specific transmissible microorganism is present,

we should use the test validated for that organism.

That is responsible integrative medicine.

How Unani Medicine May Be Useful

After proper diagnosis, individualized Unani care can be useful in selected patients as:

supportive treatment.

Depending upon the person, this may include support for:

- nutrition,
- digestion,
- sleep,
- general health,
- urinary comfort,
- sexual wellbeing,
- reproductive wellbeing,



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- recovery after appropriate infection treatment.

This is particularly useful when patients remain troubled by:

- weakness,
- anxiety,
- sexual avoidance,
- nonspecific genital symptoms

after the serious infection has been appropriately treated or excluded.

Unani Research and Genital Symptoms

CCRUM researchers have clinically studied Unani formulations for conditions such as:

Sayalān al-Raḥīm — leucorrhoea.

One clinical validation study involving more than 100 completed cases reported improvement of leucorrhoea symptoms with a Unani pharmacopoeial formulation.

This is useful evidence for traditional management of:

- vaginal-discharge symptoms.

But it is extremely important not to misinterpret such research.

Leucorrhoea is a symptom—not one single STI.

Improvement in discharge does not prove eradication of:

- chlamydia,
- gonorrhoea,
- trichomoniasis,
- Mgen.

If an STI is suspected:

laboratory diagnosis remains important.

Why This Distinction Protects Unani Medicine

If we treat every vaginal discharge or urethral burning only according to symptoms, we risk missing:



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- chlamydia,
- gonorrhoea,
- trichomoniasis,
- HIV-associated infection,
- cervical disease.

But if traditional supportive therapy is used after accurate diagnosis:

Unani medicine becomes safer, more precise and scientifically responsible.

This is the model I prefer at Saira Health Care.

Special STI Assessment by Dr. Nizamuddin Qasmi

When a patient asks me:

“Which STI test should I take?”

I do not start with a printed laboratory package.

I begin with:

the exposure.

I ask:

When did it happen?

Was it vaginal, oral or anal contact?

Was a condom used?

Did the condom break?

Was blood involved?

Is the partner known to have an STI?

Are there genital ulcers?

Is there discharge?

Is there pelvic pain?

Is there testicular pain?

Is pregnancy possible?

Has the patient already taken antibiotics?



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Is HIV PEP still possible?

Is hepatitis B vaccination complete?

Only then can we decide what the patient actually needs.

What “Special Treatment” Means at Saira Health Care

At Saira Health Care, specialized sexual-health care means:

testing the right infection, at the right anatomical site, at the right time.

It also means:

not ordering unnecessary tests.

And:

not treating laboratory numbers without understanding the patient.

This approach is particularly important in my focused clinical work in:

Sexual Disorders & Infertility.

A patient may come because of an infection concern, but the wider issue may include:

- erectile anxiety,
- painful intercourse,
- fear of infertility,
- marital conflict,
- pregnancy planning.

The patient deserves complete sexual and reproductive counselling.

Patient Example — Unprotected Vaginal Sex Yesterday

The patient asks for:

“every STI test.”

My first concern is:

Is HIV PEP indicated?

If the exposure is potentially significant and within 72 hours, preventive treatment may need to start urgently.



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I also ask whether:

hepatitis B protection exists.

Baseline testing may be performed, but negative results tomorrow will not necessarily exclude infections acquired yesterday.

A follow-up testing plan is therefore required.

Patient Example — Oral Sex Only

A patient has:

- no genital symptoms,
- negative urine gonorrhoea/chlamydia tests.

But there was significant oral exposure.

If the throat was exposed:

pharyngeal gonorrhoea testing

may be relevant.

The urine test alone does not answer the throat question.

Patient Example — Receptive Anal Exposure

A urine test is negative.

That does not automatically rule out:

- rectal gonorrhoea,
- rectal chlamydia.

A:

rectal swab

may be needed depending upon the exposure.

Patient Example — New Genital Blister

Do not wait several weeks for a herpes blood test.

If the blister or ulcer is still present:

HSV PCR/NAAT from the lesion

is generally the most informative diagnostic test.

Syphilis assessment may also be necessary because genital ulcers have overlapping appearances.

Patient Example — Partner Has Syphilis

A negative test performed very early after exposure may not be sufficient.

The patient may need:

- examination,
- appropriate syphilis serology,
- repeat testing,
- sometimes presumptive treatment depending upon exposure and partner stage.

This requires clinician-guided management.

Patient Example — Partner Is HBsAg Positive

The key questions are:

Have you been vaccinated?

What does the triple panel show?

Was the recent sexual exposure significant?

An unvaccinated susceptible partner may need:

- hepatitis B vaccine,
- HBIG

after an appropriate recent exposure.

Patient Example — Persistent Urethral Burning

The patient has already received several antibiotics.

Now we should not simply order another “STD package.”

I want to know whether there is:



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- objective urethritis,
- chlamydia,
- gonorrhoea,
- Mgen,
- trichomoniasis.

If infection tests are negative and inflammation has resolved, the problem may instead be:

- chronic pelvic pain,
- pelvic-floor dysfunction,
- urinary disease.

Patient Example — Recurrent Cervicitis

In a woman with:

- repeated cervical discharge,
- post-coital bleeding,

testing may include:

- chlamydia,
- gonorrhoea.

If cervicitis persists or recurs:

Mgen testing

may become relevant.

Persistent bleeding should also prompt appropriate cervical evaluation rather than endless STI medication.

Patient Example — Couple With Infertility

The couple asks for:

“all infection tests.”

I explain that infection testing may be useful, particularly where there is:

- previous PID,



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- urethritis,
- STI history.

But infertility requires a much broader assessment.

The man may need:

- semen analysis.

The woman may need:

- ovulation assessment,
- tubal evaluation,
- uterine assessment,
- ovarian reserve testing when appropriate.

A negative STI panel does not prove fertility is normal.

STI Testing Should Be Confidential and Nonjudgmental

Patients often delay testing because they fear:

- embarrassment,
- stigma,
- relationship consequences.

India's current NACO approach emphasizes:

- informed consent,
- individualized communication,
- stigma-free services,
- trauma-informed care.

Good sexual medicine requires the patient to feel safe enough to answer honestly.

If someone is afraid to tell the clinician:

“I had anal sex,”

the clinician may order only urine testing and miss the infection.

Confidentiality therefore improves:

diagnostic accuracy.



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Questions Patients Should Answer Honestly

When discussing STI testing, information about the following is medically useful:

Question	Why it matters
When did the exposure occur?	Determines test timing and whether PEP may still help
Vaginal, anal or oral sex?	Determines which anatomical sites may require swabbing
Condom used correctly throughout?	Helps assess risk
Any genital ulcers or blisters?	May require herpes/syphilis lesion evaluation
Any penile or vaginal discharge?	Helps target gonorrhoea, chlamydia, trichomoniasis or Mgen testing
Pelvic pain?	Raises concern for PID
Testicular pain?	Raises concern for epididymitis/torsion
Partner known STI?	Changes testing and sometimes preventive treatment
Hepatitis B vaccination status?	Determines HBV susceptibility and post-exposure strategy
Antibiotics already taken?	Can affect interpretation and treatment planning
Pregnancy possible?	Changes urgency and management of several infections

This is why a good sexual history is itself:

a diagnostic tool.

Common Testing Mistakes

A patient should not assume that one negative urine test rules out every STI, that a negative HIV test immediately after exposure is final, that Pap smear equals STI screening, that herpes blood testing should automatically be included for everybody, that every positive Ureaplasma requires antibiotics, or that repeatedly performing broad PCR panels is always safer.



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The more useful question is:

“Was my testing selected according to my exposure and symptoms?”

When to Seek Urgent Medical Care Rather Than Simply Ordering Tests

Testing alone is not enough when a patient develops:

- severe pelvic pain,
- high fever,
- severe testicular pain,
- rapidly increasing scrotal swelling,
- pregnancy with pain or bleeding,
- neurological symptoms with possible syphilis,
- severe systemic illness,
- sexual exposure potentially requiring HIV PEP within 72 hours.

These conditions need:

clinical assessment.

A laboratory report should never delay treatment of a genuine emergency.

Frequently Asked Questions

Is there one test for all STIs?

No.

Different STIs require different samples and laboratory methods.

What is usually included in an STI panel?

There is no standardized universal panel.

Always ask the laboratory or clinician exactly which infections are being tested.

Can a blood test check everything?

No.



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Blood is useful for HIV, syphilis, hepatitis B and hepatitis C, but gonorrhoea and chlamydia usually require NAAT from urine or swabs.

Can a urine test check everything?

No.

Urine does not replace HIV, syphilis or viral-hepatitis blood testing and can miss throat or rectal gonorrhoea/chlamydia.

Which urine sample is used for chlamydia and gonorrhoea in men?

First-catch or first-void urine is generally preferred.

What is the best chlamydia test?

NAAT is the preferred modern test.

What is the best gonorrhoea test?

NAAT is highly sensitive.

Culture becomes particularly important when antimicrobial treatment failure is suspected.

Can oral sex give gonorrhoea in the throat?

Yes.

A throat swab may be necessary.

Can a negative urine test rule out throat gonorrhoea?

No.

Can anal sex cause rectal chlamydia or gonorrhoea?

Yes.

A rectal NAAT may be required according to exposure.



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What HIV test detects infection earliest?

NAT generally has the earliest detection window, approximately 10–33 days.

What is the window period for a laboratory fourth-generation HIV test?

CDC gives an approximate range of:

18–45 days.

Is an HIV test at seven days final?

Usually no.

Should I wait for an HIV test before taking PEP?

No, not if a significant qualifying exposure occurred within 72 hours.

PEP assessment is urgent and treatment should not be unnecessarily delayed while waiting for laboratory results.

Which tests diagnose syphilis?

Usually a combination of:

- RPR or VDRL,
- treponemal testing.

One type alone is insufficient for full diagnosis.

Can syphilis blood testing be negative early?

Yes.

Repeat testing may be needed when very recent infection is suspected.

What test is best for a fresh herpes blister?

HSV PCR/NAAT from the lesion is the preferred test where available.

Should everybody have a herpes blood test?

No.

CDC does not recommend routine HSV blood screening for most asymptomatic people because false-positive results can occur.

How long can herpes antibodies take to appear?

CDC notes that current tests may require:

up to 16 weeks or more

after exposure.

What test is used for trichomoniasis?

NAAT is highly sensitive, particularly using vaginal or appropriate urine specimens.

Is wet-mount microscopy reliable for trichomonas?

It can diagnose infection when positive, but sensitivity is substantially lower than NAAT and decreases quickly if examination is delayed.

Should I be routinely tested for Mycoplasma genitalium?

Not if you are asymptomatic without a clinical indication.

CDC recommends targeted testing, especially in recurrent urethritis or recurrent cervicitis.

How is Mgen tested?

By specific NAAT.

Can a normal urine culture rule out Mgen?

No.

Ordinary bacterial culture is not the appropriate test.



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What is the hepatitis B triple panel?

It consists of:

- HBsAg,
- anti-HBs,
- total anti-HBc.

Why is anti-HBs important?

It can demonstrate immunity, including immunity after successful hepatitis B vaccination.

My partner has hepatitis B. Should I only get HBsAg?

A complete triple-panel assessment may give more useful information because it can distinguish:

- infection,
- immunity,
- susceptibility.

What test diagnoses active hepatitis C?

A reactive HCV antibody test should be followed by:

HCV RNA.

RNA positivity establishes current infection.

Can hepatitis C antibody stay positive after cure?

Yes.

That is why HCV RNA is used to assess current infection.

Is HPV testing part of a full STI panel?

It should not be treated as a general STI test.



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HPV testing is primarily used in cervical cancer screening and abnormal-cervical-result management.

Can men have routine HPV testing?

There is no standard approved HPV-status screening test for men comparable with cervical HPV testing.

Can HPV testing diagnose genital warts?

Routine HPV testing is not recommended for diagnosing genital warts.

Does a Pap smear check for chlamydia and gonorrhoea?

No.

Specific NAAT testing is required.

Does a semen analysis detect STIs?

No.

Does a negative STI panel mean I am definitely free of every infection?

Only if the correct infections were tested:

- at appropriate anatomical sites,
 - at appropriate times,
 - with suitable tests.
-

Should I repeat chlamydia or gonorrhoea testing after treatment?

CDC generally recommends retesting around:

three months

because reinfection is common.

Should pregnant women be tested for STIs?

Yes.

Important antenatal screening includes:

- HIV,
- syphilis,
- hepatitis B,
- hepatitis C,

and chlamydia/gonorrhoea according to age and risk.

Does India recommend HIV and syphilis testing in STI clinics?

Yes.

India's updated NACO 2024 STI/RTI guidance recommends screening all STI-clinic clients for HIV and syphilis.

Where can STI testing be obtained in India's government system?

NACO-linked Designated STI/RTI Clinics—Suraksha Clinics—and HIV ICTCs provide sexual-health and testing services within the public-health system.

What is India's national HIV helpline?

1097

NACO lists this as a toll-free 24×7 HIV/AIDS helpline.

Can STI testing tell me who gave me the infection?

Usually no.

It can identify infection.

It generally cannot reliably determine which partner transmitted it or exactly when it was acquired.

Can Unani medicine diagnose HIV from symptoms?

No.



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HIV requires validated laboratory testing.

Can Unani examination replace syphilis blood tests?

No.

Modern serological testing is required.

Can Unani medicine replace NAAT testing for chlamydia or gonorrhoea?

No.

A specific laboratory diagnosis requires a validated microbiological test.

Does Unani medicine have a role in sexual-health care?

Yes.

Its responsible integrative role may include support for:

- general wellbeing,
- nutrition,
- digestion,
- urinary comfort,
- sexual wellbeing,
- reproductive wellbeing.

But the laboratory diagnosis of a specific STI should be based on modern validated testing.

A Message From Dr. Nizamuddin Qasmi After a Recent Sexual Exposure

If you have recently had an exposure that worries you, do not begin by searching the internet for the largest laboratory package.

First ask:

Is there anything I need to do urgently?

If HIV PEP may be indicated:

seek care within 72 hours.



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If your partner has hepatitis B and you are not protected:

urgent vaccination/HBIG assessment may be needed.

If there is:

- severe pelvic pain,
- testicular pain,
- genital ulceration,

clinical examination may be more important than ordering random tests online.

Then create a:

sensible testing timeline.

What I Tell Patients With a Negative Early Test

I explain:

“A negative result can only be interpreted according to the test and the timing.”

For example, an HIV antibody test several days after exposure cannot provide the same reassurance as appropriately timed fourth-generation testing.

Likewise, herpes serology immediately after exposure may be negative because antibodies have not yet developed.

The right response is not:

panic.

It is:

follow the correct testing schedule.

What I Tell Patients Who Keep Testing Repeatedly

Some patients repeat:

- HIV,
- syphilis,
- hepatitis

every few days because anxiety remains high.

Once appropriate tests have been performed at appropriate times:



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repeated testing without new exposure may stop being medically useful.

At that stage, counselling and management of health anxiety can become more useful than another laboratory report.

Sexual-health care includes:

psychological reassurance based on evidence.

What I Tell Couples Planning Pregnancy

If there is a history of STI or meaningful exposure:

test appropriately and treat active infection before conception.

But do not assume that STI testing replaces fertility assessment.

If pregnancy is not occurring, both partners need appropriate reproductive evaluation.

At Saira Health Care, this is particularly important because of our focused clinical work in:

Sexual Disorders & Infertility.

What I Tell Patients About Unani Medicine

As a Unani physician, I believe traditional medicine has an important place in comprehensive sexual and reproductive healthcare.

But I also believe that good Unani practice must use the best diagnostic information available.

If modern laboratory science can tell me:

exactly which infection is present,

I should use that information.

Unani principles can then contribute to:

- general health,
- nutrition,
- digestion,
- sexual wellbeing,
- recovery,



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- individualized constitutional care.

This is much more responsible than attempting to diagnose a modern STI from symptoms alone.

Saira Health Care's Approach to STI Testing

At **Saira Health Care**, my approach can be summarized as:

understand the exposure → identify which anatomical sites were involved → determine which infections are realistically possible → recognize urgent PEP or prophylaxis opportunities → choose the correct laboratory tests → interpret window periods carefully → treat confirmed infection → manage partners → assess reproductive consequences where relevant.

The aim is:

not maximum testing.

The aim is:

accurate testing.

That distinction can reduce:

- missed infection,
 - unnecessary medication,
 - repeated antibiotic use,
 - anxiety,
 - unnecessary expense.
-

Latest Medical Understanding — 2026 Update

Modern STI testing is increasingly moving away from a simple idea of:

“blood test versus urine test.”

The current approach is:

infection-specific + anatomical-site-specific + exposure-specific testing.

CDC's updated **March 2026** testing information emphasizes that STI tests may require:

- blood,



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- urine,
- vaginal swabs,
- throat swabs,
- rectal swabs

depending upon the infection and sexual exposure.

Modern NAAT technology is central to diagnosis of:

- gonorrhoea,
- chlamydia,
- trichomoniasis,
- Mgen.

NAATs also permit high-quality testing from self-collected specimens in selected settings.

HIV testing has become increasingly precise, but test interpretation still depends upon window periods. CDC's current ranges remain approximately 10–33 days for NAT and 18–45 days for laboratory antigen/antibody testing.

HIV prevention after exposure has also become more time-sensitive: the CDC's **2025 updated nonoccupational PEP guidance** recommends starting PEP as soon as possible, ideally within 24 hours and no later than 72 hours after qualifying exposure.

Syphilis testing continues to require both treponemal and nontreponemal serology for proper diagnosis and interpretation.

Herpes testing remains an area where indiscriminate screening is discouraged. Lesion NAAT/PCR is preferred when a genital lesion is present, while routine asymptomatic serological screening is generally not recommended because of test limitations and false-positive results.

Hepatitis B evaluation has improved through use of the:

HBsAg + anti-HBs + total anti-HBc triple panel,

allowing simultaneous assessment of infection, previous exposure, vaccine immunity and susceptibility.

Hepatitis C testing increasingly uses:

antibody with automatic reflex RNA testing,



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reducing the chance that a person with a reactive antibody result is lost before active infection is confirmed.

India's **2024 NACO National Technical Guidelines on STI and RTI** place greater emphasis on laboratory diagnosis wherever feasible, while retaining enhanced syndromic management in settings where laboratory access remains limited. The updated programme specifically recommends HIV and syphilis screening for all clients attending STI clinics and emphasizes antimicrobial-resistance-aware testing in persistent and treatment-failure cases.

This is exactly the direction modern sexual medicine should take:

fewer assumptions, better targeted testing and more precise treatment.

Conclusion

STI testing is not one blood test, one urine test or one universal “STD panel.”

Different sexually transmitted infections require different diagnostic methods.

For:

HIV

testing is usually performed with blood using antigen/antibody, antibody or NAT methods depending upon timing.

For:

syphilis

diagnosis generally requires both:

- treponemal,
- nontreponemal serology.

For:

chlamydia and gonorrhoea

NAAT is the principal modern test, using:

- first-void urine in men,
- vaginal swabs in women

for common genital screening, with:

- rectal,



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- throat testing

when exposure occurred at those sites.

For:

trichomoniasis

NAAT is much more sensitive than traditional wet microscopy.

For:

Mycoplasma genitalium

NAAT is used selectively, especially in recurrent urethritis, recurrent cervicitis and selected PID cases; routine asymptomatic screening is not recommended.

For:

genital herpes

a fresh blister or ulcer should ideally be tested directly by PCR/NAAT, while indiscriminate herpes blood testing in asymptomatic low-risk people can produce confusing false-positive results.

For:

hepatitis B

the triple panel:

HBsAg + anti-HBs + total anti-HBc

provides the clearest initial picture of:

- infection,
- previous exposure,
- vaccine immunity,
- susceptibility.

For:

hepatitis C

a reactive antibody result should be followed by:

HCV RNA

to determine whether current infection is present.

And:



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HPV testing should not be used as a general STI test.

It is primarily part of:

- cervical-cancer screening,
- management of abnormal cervical findings.

Timing matters equally.

An early negative HIV test is not automatically final.

Early syphilis serology may not yet be positive.

Herpes antibody testing may require many weeks.

And if a potentially significant HIV exposure occurred within:

72 hours,

testing should not delay urgent consideration of:

PEP.

Similarly, after significant exposure to a confirmed hepatitis B-positive partner, a susceptible person may need:

- vaccination,
- hepatitis B immune globulin

rather than simply waiting for future blood tests.

From the **Unani perspective**, traditional sexual and reproductive medicine can contribute meaningfully to:

- constitutional health,
- nutrition,
- digestion,
- urinary wellbeing,
- sexual wellbeing,
- recovery.

CCRUM has also conducted clinical research on traditional management of symptoms such as pathological vaginal discharge.

But:



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symptom-based Unani assessment cannot replace laboratory diagnosis of a specific transmissible STI.

At **Saira Health Care**, my approach is therefore:

use modern laboratory tests to identify the infection accurately, use evidence-based treatment when infection is present and incorporate individualized Unani care responsibly to support the patient's wider sexual and reproductive health.

The most important message I want patients to remember is:

Do not ask only, “Did I have an STI test?”

Ask:

“Which STI was tested, from which body site, with which test and how long after the exposure?”

That question turns random testing into:

intelligent sexual healthcare.

About the Author

Dr. Nizamuddin Qasmi

**Founder & Chief Physician, Saira Health Care
Focused Practice in Sexual Disorders & Infertility**

Qualifications & Professional Training

BUMS — Hamdard University, Delhi

MD

CGO

Certificate in Infertility — MGBIMS, Delhi

Certificate in Urology — London, UK

Masters in Male Infertility — MasterHealthPro (HealthPro)

Integrated Sexual and Reproductive Health — ISRH, UNFPA

Dr. Nizamuddin Qasmi is a well-qualified physician with a **specialized clinical focus on Sexual Disorders & Infertility** at Saira Health Care.

His clinical work includes assessment of sexual-health concerns, male and female infertility, reproductive-tract infections and the sexual or psychological consequences that can follow an STI diagnosis.

In patients seeking STI assessment, his approach emphasizes:



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choosing tests according to the actual sexual exposure rather than automatically ordering one fixed package.

Depending upon the patient, assessment may include interpretation of HIV window periods, chlamydia and gonorrhoea NAAT, site-specific throat or rectal testing, syphilis serology, hepatitis B immunity and infection status, hepatitis C testing, herpes lesion testing, Mgen testing in persistent genital symptoms and fertility evaluation where reproductive concerns are present.

Where clinically appropriate, individualized Unani principles may be incorporated to support:

- nutritional health,
- digestive wellbeing,
- urinary and genital comfort,
- sexual wellbeing,
- reproductive wellbeing,
- recovery after appropriate infection treatment.

The goal at Saira Health Care is not merely to provide a long list of laboratory investigations.

The goal is to determine:

which tests the patient genuinely needs, when they should be performed, how the results should be interpreted and what the next step should be.

Medical Disclaimer

This article is intended for professional education and general public awareness. It is not an individualized STI-testing prescription and does not replace consultation with an appropriately qualified physician, sexual-health specialist, dermatologist/venereologist, gynecologist, urologist, infectious-disease clinician or other appropriate healthcare professional.

STI-testing requirements depend upon the exact exposure, symptoms, anatomical site, timing and individual risk.

A negative result obtained during an infection's diagnostic window period may need to be repeated.

Anyone with a potentially significant HIV exposure within the previous **72 hours** should seek urgent clinical assessment for HIV PEP rather than waiting for symptoms or a later HIV test.

Anyone who is unvaccinated or not known to be immune to hepatitis B and has had significant recent exposure to a confirmed hepatitis B-positive person should seek prompt medical assessment for vaccination and hepatitis B immune globulin where indicated.

A genital ulcer or blister should be examined promptly because direct lesion testing may be more informative while the lesion is fresh.

Severe pelvic pain, pregnancy-associated abdominal pain or bleeding, severe testicular pain, fever or systemic illness requires medical evaluation rather than online laboratory testing alone.

Routine asymptomatic herpes or *Mycoplasma genitalium* screening is not appropriate for every patient.

Unani medicine may be used as supportive integrative care where clinically appropriate, but it should not replace validated diagnostic testing for specific sexually transmitted infections.

Patients experiencing infertility should undergo complete couple-based fertility evaluation rather than assuming either a positive or negative STI panel explains their reproductive status.

