STD TREATMENT GUIDELINES TABLE FOR ADULTS & ADOLESCENTS 2010

These guidelines reflect the recommendations of the 2010 CDC STD Treatment Guidelines and serve as a quick reference for treatment of STIs encountered in an outpatient setting. This is not an exhaustive list of effective treatments, so refer to the complete document from the CDC (www.cdc.gov/std/treatment) for more information or call the STD Program listed below. These guidelines are for clinical care and not to be construed as standards or inflexible rules. Clinical and epidemiological services are available through your STD Program, and staff are available to assist healthcare providers with confidential notification of sexual partners of patients infected with HIV and other STIs. For assistance, please contact:

Center for Sexually Transmitted Infection Prevention, Maryland DHMH/PHPA, 410-767-6690, http://phpha.dhmh.maryland.gov/oipdcs/cstip/

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<th>DISEASE</th>
<th>RECOMMENDED REGIMENS</th>
<th>DOSEROUTE</th>
<th>ALTERNATIVE REGIMENS: To be used if medical contraindication to recommended regimen:</th>
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<tr>
<td>CHLAMYDIA</td>
<td>• Azithromycin or • Doxycline 1</td>
<td>1 g po 100 mg po bid x 7 d</td>
<td>• Erythromycin base 500 mg po qid x 7 d or • Levofloxacin 500 mg po qd x 7 d or • Ofloxacin&lt;sup&gt;10&lt;/sup&gt; 300 mg po bid x 7 d或• Levofloxacin base 500 mg po bid x 7 d or • Erythromycin ethylsuccinate 800 mg po qid x 7 d or • Levofloxacin ethylsuccinate 400 mg po qd x 14 d</td>
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Pregnant Women 1

Dual therapy with • Ceftriaxone or • Doxycycline 2

250 mg IM 400 mg po

1 g po 100 mg po bid x 7 d

• Cefpodoxime 400 mg po or • Cefuroxime axetil 1 g po or • Azithromycin 2 g po in a single dose

Pharyngeal Infections

Dual therapy with • Ceftriaxone or • Doxycycline

250 mg IM

1 g po

100 mg po bid x 7 d

• Azithromycin 2 g po in a single dose

Pregnant Women 1

Dual therapy with • Ceftriaxone or, if not an option • Cefixime 3

250 mg IM 400 mg po

1 g po 100 mg po bid x 7 d

• Cefpodoxime 400 mg po or • Cefuroxime axetil 1 g po or • Azithromycin 2 g po in a single dose

Pelvic Inflammatory Disease <sup>1, 8</sup>

Parenteral 6 • Either Cefotetan or Cefoxitin plus Doxycline 4 or Clindamycin plus Gentamicin

IM/IV

Parenteral 10

Either Cefixime or Cefixime + plus Metronidazole if BV is present or cannot be ruled out

2 g IV q 12 hrs

2 g IV q 6 hrs

100 mg po or IV q 12 hrs

900 mg IV q 8 hrs

2 mg IV q 8 hrs IM followed by 1.5 mg IV or IM q 8 hrs

250 mg IM

2 g IM, 1 g po

150 mg po bid x 14 d

500 mg po bid x 14 d

• Levofloxacin + 500 mg po qd x 14 d or • Ofloxacin + 400 mg po bid x 14 d or • Ceftriaxone 250 mg IM in a single dose and Azithromycin 1 g once a week for 2 weeks or Metronidazole 500 mg po bid x 14 d if IV is present or cannot be ruled out

Cervicitis <sup>4, 7, 11</sup>

• Azithromycin or • Doxycline + plus Metronidazole if BV or trichomoniasis is present

1 g po

100 mg po bid x 7 d

500 mg po bid x 7 d

• Erythromycin base 500 mg po qid x 7 d or • Levofloxacin 500 mg po qd x 7 d or • Ofloxacin 300 mg po bid x 7 d

Nongonococcal Urethritis <sup>1</sup>

• Azithromycin or • Doxycline or Metronidazole if BV or trichomoniasis is present

1 g po

100 mg po bid x 7 d

500 mg po bid x 7 d

• Erythromycin base 500 mg po qid x 7 d or • Levofloxacin 500 mg po qd x 7 d or • Ofloxacin 300 mg po bid x 7 d

Epididymitis <sup>4, 7</sup>

Likely due to Gonorrhea or Chlamydia

• Ceftriaxone plus Doxycline

250 mg IM 100 mg po bid x 10 d

500 mg po qd x 10 d

300 mg po bid x 10 d

• Ceftriaxone or • Ciprofloxacin or • Erythromycin base

1 g po

250 mg IM

500 mg po bid x 3 d

500 mg po bid x 7 d

• Doxycycline 2 2 g po in a single dose

• Azithromycin 1 g po in 3 weeks

Lymphogranuloma Venereum

• Doxycline 2

100 mg po bid x 21 d

• Erythromycin base 500 mg po qid x 21 d or • Azithromycin 1 g po in 3 weeks

Trichomoniasis <sup>13, 14</sup>

Non-pregnant women

• Metronidazole or • Tinidazole 2

2 g po 2 g po

• Metrobid 500 mg po bid x 7 d

Pregnant Women

• Metronidazole

2 g po

• Metrobid 500 mg po bid x 7 d

1. Annual screening for pregnant women aged 25 years or younger. Nucleic acid amplification tests (NAATs) are recommended. All patients should be re-tested 3 months after treatment for chlamydia or gonorrhea.

2. Contraindicated for pregnant and nursing women.

3. Every effort to use a recommended regimen should be made. Test-of-cure follow-up (preferably by NAAT) 3-4 weeks after completion of therapy is recommended in pregnancy.

4. If treatment failure is suspected because GC has been documented, the patient has been treated with a recommended regimen for GC, and symptoms have not resolved, then perform a test-of-cure using culture and antibiotic susceptibility testing and report to the local health department. For clinical consult, call the CA STD Control Branch at 510-620-3400. For further guidance, go to www.std.ca.gov (STD Guidelines).

5. Oral cephalosporins give lower and less-sustained bactericidal activity than cephalosporins + metronidazole. Doxycycline is the preferred treatment for adults and adolescents with uncomplicated gonorrhea. Dual therapy with ceftriaxone 250 mg IM (increased from 125 mg) Plus azithromycin 1 g po or doxycycline 100 mg po bid x 7 d is recommended for all patients with gonorrhea regardless of chlamydia test results. *

6. Treatment failure is more likely if treatment failure is more likely if doxycycline is used alone. Use one of the dual therapy regimens above.

7. Testing for gonorrhea and chlamydia is recommended because a specific diagnosis may improve compliance and partner management, and because these infections are reportable by California law.

8. 100 mg po bid x 14 d

9. If local prevalence of gonorrhea is greater than 5%, treat empirically for gonorrhea infection.

10. If gonorrhea is documented, change to a medication regimen that does not include a fluoroquinolone.

11. For suspected drug-resistant trichomoniases, rule out re-infection; see 2010 CDC Guidelines, Trichomoniases Follow-up, p. 60, for other treatment options, and evaluate for metronidazole-resistant T. vaginalis.

12. For laboratory and clinical consultations, contact CDC at 404-718-4141; http://www.cdc.gov/std.

13. For HIV-positive women with trichomoniases, metronidazole 500 mg po bid x 7 d is more effective than metronidazole 2 g orally.

14. Safety in pregnancy has not been established, pregnancy category C.
22. Persons with HIV infection should be treated according to the same stage-specific recommendations for primary, secondary, and latent syphilis as used for HIV-negative persons. Available data demonstrate that additional... 

24. Some specialists recommend 2.4 million units of benzathine penicillin G q week for up to 3 weeks after completion of neurosyphilis treatment.

21. Benzathine penicillin G (generic name) is the recommended treatment for syphilis not involving the central nervous system and is available in only one long-acting formulation, Bicillin® L-A (the trade name), which contains only benzathine penicillin G. Other combination products, such as Bicillin® C-R, contain both long- and short-acting penicillins and are not effective for treating syphilis.

19. The goal of suppressive therapy is to reduce recurrent symptomatic episodes and/or to reduce sexual transmission. Famciclovir appears somewhat less effective for suppression of viral shedding.

18. Counseling about natural history, asymptomatic shedding, and sexual transmission is an essential component of herpes management.

17. Cervical and intra-anal warts should be managed in consultation with specialists.

16. May weaken latex condoms and contraceptive diaphragms.

15. Safety in pregnancy has not been established, pregnancy category C.

14. Counseling about natural history, asymptomatic shedding, and sexual transmission is an essential component of herpes management.

13. Nevus and intra-anal warts should be managed in consultation with specialist.

12. Counseling about natural history, asymptomatic shedding, and sexual transmission is an essential component of herpes management.

11. Intra-anal and/or perianal lesions should be managed in consultation with specialist.

10. Pregnant women allergic to penicillin should be treated with penicillin after desensitization.