STD/HIV UPDATE
2010 STD Report and Treatment Guidance

DATE: April 11, 2011
TO: Medical Providers
FROM: Wendi J. Dick, MD, MSPH, Assistant Health Officer/STD Controller

STD/HIV Surveillance in San Joaquin County
- Chlamydia & Gonorrhea increased in 2010. Many cases were teens or adults <30.
- The Syphilis outbreak continues§. Recent cases were mainly gay/bisexual men (61%), but 27% were female. Over half were HIV co-infected, and 1/3 reported drug use.
- For HIV, >400 new adult cases were recorded in 2006-2009. Almost 1/4 reported heterosexual contact only. African-Americans are disproportionately affectedΦ.

STD Treatment
- New CDC Treatment Recommendation for Gonorrhea:
  \(250 \text{ mg ceftriaxone/Rcephin}^\circ\) (up from 125 mg)
- plus-
  \(1 \text{ g azithromycin or 100 mg doxycycline BID x7d}\) (Chlamydia regimen)
  Adding an antibiotic against Chlamydia may slow emergence of resistant gonococci.
- Treat partners, too. Under California lawϒ, physicians can legally provide antibiotics for the partners of patients with Chlamydia or Gonorrhea.
- Re-test patients with Chlamydia or Gonorrhea in 3 months to pick up reinfections.
- Doxycycline remains a treatment option for Syphilis (if pregnant, must give Bicillin L-A°).

STD Reporting
California is transitioning to new reporting forms for STDs/Communicable Diseases∂.

Questions on STDs/HIV? Please feel free to contact us at (209) 468-3845.

Would your practice like a Syphilis Refresher?
Call us to schedule a 15 to 60 minute medical presentation for your site.

§ Infectious/Early Stage Syphilis (Primary-chancre/ulcer; Secondary-rash, alopecia, etc; Early Latent-ax can revert to Secondary).
ϒ Partner-Delivered Therapy for Chlamydia & Gonorrhea is Legal in Calif http://www.sjcphs.org/healthcare_providers/providers.htm MD/DO can prescribe and NP/PA/CNMW dispense antibiotics for the partner(s) of a patient with a clinical diagnosis of chlamydia/gonorrhea, even if the provider has been unable to examine the partner(s). First-choice mgt is still to bring in the partner for evaluation. No. of doses is limited to # of partners in past 60 days (or most recent partner). Counsel to abstain from sex until >7 days after patient and partner treated.
∂ See http://www.sjcphs.org/disease/disease_control_reporting.htm

VIEW PHS HEALTH ALERTS, ADVISORIES, & UPDATES ONLINE: see http://www.sjcphs.org under “Health Care Providers”
Table 1: STDs in San Joaquin County, 2009 and 2010

<table>
<thead>
<tr>
<th></th>
<th>2009</th>
<th>2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gonorrhea</td>
<td>8</td>
<td>714</td>
</tr>
<tr>
<td>Syphilis 1 &amp; 2</td>
<td>3719</td>
<td>3719</td>
</tr>
<tr>
<td>Early latent</td>
<td>70</td>
<td>33</td>
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<tr>
<td>Unk. Latent</td>
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<tr>
<td>Late latent</td>
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<td>16</td>
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<tr>
<td>Neuro</td>
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<td>1</td>
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<tr>
<td>Congenital</td>
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Table 2: Gonorrhea cases in SJC by age and gender, January-December 2010

<table>
<thead>
<tr>
<th>Age category</th>
<th>Female</th>
<th>Male</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-4</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>5-9</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>10-14</td>
<td>6</td>
<td>3</td>
<td>9</td>
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<tr>
<td>15-19</td>
<td>135</td>
<td>67</td>
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<tr>
<td>20-24</td>
<td>121</td>
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<td>25-29</td>
<td>55</td>
<td>84</td>
<td>139</td>
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<tr>
<td>30-34</td>
<td>28</td>
<td>32</td>
<td>60</td>
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<tr>
<td>35-39</td>
<td>12</td>
<td>28</td>
<td>40</td>
</tr>
<tr>
<td>40-44</td>
<td>9</td>
<td>15</td>
<td>24</td>
</tr>
<tr>
<td>45-54</td>
<td>6</td>
<td>9</td>
<td>15</td>
</tr>
<tr>
<td>55-64</td>
<td>1</td>
<td>5</td>
<td>6</td>
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<td>65+</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>unknown</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>TOTAL</td>
<td>374</td>
<td>335</td>
<td>709</td>
</tr>
</tbody>
</table>

Note: Morbidity is based on the date of report. Totals may change due to additions and/or deletions from the database.

Table 3: Chlamydia cases in SJC by age and gender, January-December 2010

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<td>0</td>
</tr>
<tr>
<td>10-14</td>
<td>21</td>
<td>10</td>
<td>31</td>
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<tr>
<td>15-19</td>
<td>939</td>
<td>261</td>
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<td>20-24</td>
<td>949</td>
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<td>25-29</td>
<td>342</td>
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<td>620</td>
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<tr>
<td>30-34</td>
<td>131</td>
<td>94</td>
<td>225</td>
</tr>
<tr>
<td>35-39</td>
<td>78</td>
<td>53</td>
<td>131</td>
</tr>
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</tr>
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<td>20</td>
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<td>40</td>
</tr>
<tr>
<td>55-64</td>
<td>5</td>
<td>7</td>
<td>12</td>
</tr>
<tr>
<td>65+</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>unknown</td>
<td>16</td>
<td>12</td>
<td>28</td>
</tr>
<tr>
<td>TOTAL</td>
<td>2526</td>
<td>1167</td>
<td>3693</td>
</tr>
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TABLE FOR ADULTS & ADOLESCENTS 2010

These guidelines reflect the 2010 CDC STD Treatment Guidelines and the Region IX Infertility Clinical Guidelines. The focus is primarily on STDs encountered in office practice. These guidelines are intended as a source of clinical guidance; they are not a comprehensive list of all effective regimens and are not intended to substitute for use of the full 2010 STD treatment guidelines document. Call the local health department to report STD infections; to request assistance with confidential notification of sexual partners of patients with syphilis, gonorrhea, chlamydia or HIV infection; or to obtain additional information on the medical management of STD patients. The California STD/HIV Prevention Training Center is a resource for training and consultation about STD clinical management and prevention (510-625-6000) or www.stdhivtraining.org.

### CHLAMYDIA

<table>
<thead>
<tr>
<th>DISEASE</th>
<th>RECOMMENDED REGIMENS</th>
<th>DOSE/ROUTE</th>
<th>ALTERNATIVE REGIMENS: To be used if medical contraindication to recommended regimen</th>
</tr>
</thead>
<tbody>
<tr>
<td>Uncomplicated Genital/Rectal/Pharyngeal Infections</td>
<td>Ceftriaxone plus Doxycycline</td>
<td>250 mg IM 100 mg po bid x 7 d</td>
<td>Erythromycin base 500 mg po qid x 7 d or Erythromycin ethylsuccinate 800 mg po qid x 7 d or Levofloxacin 1 g pm bid x 7 d or Ofloxacin 300 mg po bid x 7 d</td>
</tr>
<tr>
<td>Pregnant Women</td>
<td>Doxycycline</td>
<td>1 g po in a single dose</td>
<td>Azithromycin 2 g po in a single dose</td>
</tr>
</tbody>
</table>

### GONORRHEA

Ceftriaxone is the preferred treatment for adult and adolescent patients with uncomplicated gonorrhea infections. 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. 4

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</tr>
<tr>
<td>Pregnant Women</td>
<td>Doxycycline</td>
<td>1 g po in a single dose</td>
<td>Azithromycin 2 g po in a single dose</td>
</tr>
</tbody>
</table>

### PELVIC INFLAMMATORY DISEASE (PID) 4, 5, 6

<table>
<thead>
<tr>
<th>DISEASE</th>
<th>RECOMMENDED REGIMENS</th>
<th>DOSE/ROUTE</th>
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<tr>
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</tr>
<tr>
<td>Pregnant Women</td>
<td>Doxycycline</td>
<td>1 g po in a single dose</td>
<td>Azithromycin 2 g po in a single dose</td>
</tr>
</tbody>
</table>

### CERVICITIS 7, 8

<table>
<thead>
<tr>
<th>DISEASE</th>
<th>RECOMMENDED REGIMENS</th>
<th>DOSE/ROUTE</th>
<th>ALTERNATIVE REGIMENS: To be used if medical contraindication to recommended regimen</th>
</tr>
</thead>
<tbody>
<tr>
<td>NONGONOCOCAL URETHRITIS</td>
<td>Azithromycin</td>
<td>1 g po in a single dose</td>
<td>Erythromycin base 500 mg po qid x 7 d or Erythromycin ethylsuccinate 800 mg po qid x 7 d or Levofloxacin 1 g pm bid x 7 d or Ofloxacin 300 mg po bid x 7 d</td>
</tr>
</tbody>
</table>

### EPIDIDYMIDITIS 9, 10

<table>
<thead>
<tr>
<th>DISEASE</th>
<th>RECOMMENDED REGIMENS</th>
<th>DOSE/ROUTE</th>
<th>ALTERNATIVE REGIMENS: To be used if medical contraindication to recommended regimen</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHANECROD</td>
<td>Azithromycin</td>
<td>1 g po in a single dose</td>
<td>Erythromycin base 500 mg po bid x 21 d or Azithromycin 1 g po in 3 weeks</td>
</tr>
</tbody>
</table>

### LYMPOPHRAGNOMA VENEREUM

<table>
<thead>
<tr>
<th>DISEASE</th>
<th>RECOMMENDED REGIMENS</th>
<th>DOSE/ROUTE</th>
<th>ALTERNATIVE REGIMENS: To be used if medical contraindication to recommended regimen</th>
</tr>
</thead>
<tbody>
<tr>
<td>TRICHRONOSIS 11, 12</td>
<td>Metronidazole or Tinidazole</td>
<td>2 g po</td>
<td>Metronidazole 500 mg po bid x 7 d</td>
</tr>
</tbody>
</table>

1. Annual screening for women age 25 years or younger. Nucleic acid amplification tests (NAATs) are recommended. All patients should be retested 3 months after treatment for chlamydia or gonorrhea. 1
2. Contraindicated for pregnant and nursing women. 2
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. 3
4. If treatment failure is suspected because 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 consultation, call the CA STD Control Branch (510-620-3400). For further guidance, go to www.std.ca.gov ("STD Guidelines"). 3
5. Oral cephalosporins give lower and less-sustained bactericidal levels than ceftriaxone 250 mg and have limited efficacy for treating pharyngeal GC. Therefore, ceftriaxone is the preferred medication. 5
6. For patients with cephalosporin allergy, or severe penicillin allergy, (e.g., anaphylaxis, Steven Johnson syndrome, and toxic epidermal necrolysis), azithromycin is an option. However, because of GI intolerance and concerns regarding emerging resistance, it should be used with caution. 6
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 state law. 7
8. Evaluate for bacterial vaginosis. If present or cannot be ruled out, also use metronidazole. 8
9. Discontinue 2 hours after patient improves clinically and continue oral therapy for a total of 14 days. 9
10. Fluoroquinolones can be considered for PID if the risk of GC is low, a NAAT test for GC is performed, and follow-up of the patient can be assured. If GC is documented, the patient should be re-treated with the recommended ceftriaxone and doxycycline regimen. If ceftriaxone therapy is not an option, the addition of azithromycin 2 g orally as a single dose to a quinolone-based PID regimen is recommended. 10
11. If local prevalence of gonorrhoea is greater than 5%, treat empirically for gonorrhoea infection. 11
12. If gonorrhoea is documented, change to a medication regimen that does not include a fluoroquinolone. 12
13. For suspected drug-resistant trichomoniasis, trichomonacidal route is recommended; see 2010 CDC Guidelines, Trichomonas Follow-Up p. 60, for other treatment options, and evaluate for metronidazole-resistant T. vaginalis. 13
14. For HIV-positive women with trichomoniasis, metronidazole 500 mg po bid x 7 d is more effective than metronidazole 2 g orally. 14
15. Safety in pregnancy has not been established; pregnancy category C.
BACTERIAL VAGINOSIS

Adults/Adolescents
- Metronidazole or
- Metronidazole gel or
- Clindamycin cream

Pregnant Women
- Metronidazole or
- Metronidazole gel or
- Clindamycin

500 mg po bid x 7 d
250 mg po tid x 7 d
300 mg po bid x 7 d

0.75%, one full applicator (5g) intravaginally q 5 d
2%, one full applicator (5g) intravaginally q 5 d

ANOGENTAL WARTS

External Genital/Perianal Warts

Patient Applied
- Imiquimod 5% cream or
- Podoflox 1.5% solution or gel or
- Sinacalectines 15% ointment

Provider Administered
- Cryotherapy or
- Podophyllin 10-25% in tincture of benzoin or
- Trichloroacetic acid (TCA) 80-90% or
- Bichloroacetic acid (BCA) 80-90% or
- Surgical removal

Topically qhs 3 x wk up to 16 wks
Topically bid 3 x followed by 4 x no bx
for up to 4 cycles
Topically tid, for up to 16 wks

Apply once q 1-2 wks
Apply once q 2-3 wks
Apply once q 1-2 wks

Mucosal Genital Warts
- Cryotherapy or
- TCA or BCA 80-90% or
- Podophyllin 10-25% in tincture of benzoin or
- Surgical removal

Topically for up to 16 wks

Vaginal, urethral meatus, and anal
Vaginal and anal
Urethral meatus only
Anal warts only

ANOGENTAL HERPES

First Clinical Episode of Anogenital Herpes
- Acyclovir or
- Famciclovir or
- Valacyclovir

Established Infection

Suppressive Therapy
- Acyclovir or
- Famciclovir or
- Valacyclovir or
- Valalclovir

Episodic Therapy for Recurrent Episodes
- Acyclovir or
- Famciclovir or
- Valacyclovir or
- Valalclovir

HSV Co-infected

Suppressive Therapy
- Acyclovir or
- Famciclovir or
- Valacyclovir

Episodic Therapy for Recurrent Episodes
- Acyclovir or
- Famciclovir or
- Valacyclovir or
- Valalclovir

SYphilis

Primary, Secondary, and Early Latent
- Benzathine penicillin G

Late Latent and Latent of Unknown duration
- Benzathine penicillin G

Neurosyphilis

- Aqueous crystalline penicillin G

Pregnant Women
- Benzathine penicillin G

15. Safety in pregnancy has not been established; pregnancy category C.
16. May weaken latex condoms and contraceptive diaphragms.
17. Cervical and intra-anal warts should be managed in consultation with a specialist.
18. Counseling about natural history, asymptomatic shedding, and sexual transmission is an essential component of herpes management.
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.
20. HIV-lesions persist or recur during antiretroviral treatment, drug resistance should be suspected. Obtaining a viral isolate for sensitivity testing, and consulting with an infectious disease expert is recommended.
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.
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 doses of benzathine penicillin G, amoxicillin, or other antibiotics in early syphilis do not result in enhanced efficacy, regardless of HIV status.
23. Alternates should only be used for penicillin-allergic patients because efficacy of these therapies has not been established. Compliance with some of these regimens is difficult, and close follow-up is essential. If compliance or follow-up cannot be ensured the patient should be desensitized and treated with benzathine penicillin.
24. Consider treatment with 2.4 million units of benzathine penicillin G q week for up to 3 weeks after completion of neurosyphilis treatment for patients with late syphilis.
25. Pregnant women allergic to penicillin should be treated with penicillin after desensitization.