SAN JOAQUIN COUNTY
Public Health Services
Healthy Future
STD Program: (209) 468-3845 | STD Fax (209) 948-7473 | PHS Website: http://www.sjcphs.org

STD/HIV UPDATE

2010 STD Report and Treatment Guidance

Please share with relevant staff at your facility.

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 affected[Φ].

STD Treatment

- New CDC Treatment Recommendation for Gonorrhea:
  250 mg ceftriaxone/Rocephin® (up from 125 mg)
  -plus-
  1 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 law[ϒ], 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-asx but can revert to Secondary).
Φ 2011 San Joaquin County Community Health Status Report, pages 49-53 http://www.sjcphs.org/Disease/Epidemiology.htm
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

San Joaquin County Annual STD Report

Data for 2010

Table 1: STDs in San Joaquin County, 2009 and 2010

	2009	2010
Gonorrhea	561	714
Chlamydia	3481	3719
Syphilis	65	70
1 & 2	25	33
Early latent	8	10
Unk. Latent	8	9
Late latent	24	16
Neuro	0	1
Congenital	0	1

Figure 1. STD cases in SJC by city of residence, January-December 2010

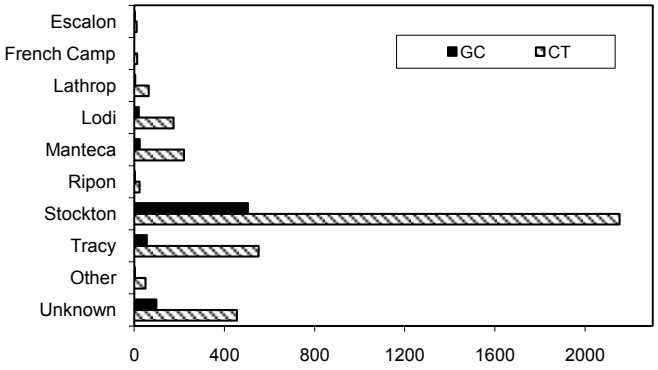

Figure 2. Monthly GC trends for SJC

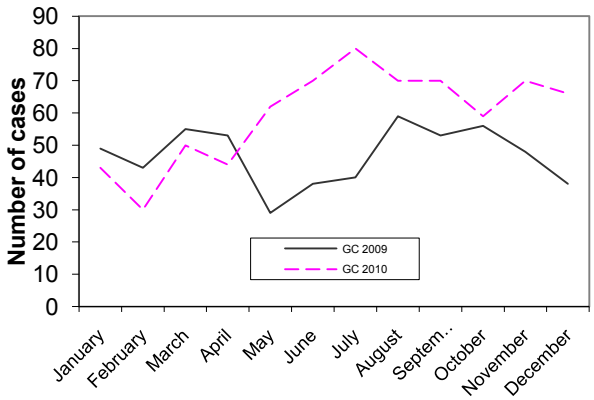

Figure 3. Monthly CT trends for SJC

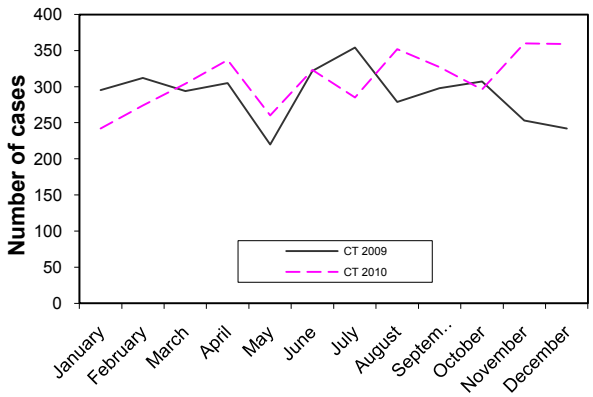

Table 2: Gonorrhea cases in SJC by age and gender, January-December 2010

	Gonorrhea		
Age category	Female	Male	Total
0-4	0	0	0
5-9	0	0	0
10-14	6	3	9
15-19	135	67	202
20-24	121	90	211
25-29	55	84	139
30-34	28	32	60
35-39	12	28	40
40-44	9	15	24
45-54	6	9	15
55-64	1	5	6
65+	0	0	0
unknown	1	2	3
TOTAL	374	335	709

*5 cases were of unknown gender

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

	Chlamydia		
Age category	Female	Male	Total
0-4	0	0	0
5-9	0	0	0
10-14	21	10	31
15-19	939	261	1200
20-24	949	412	1361
25-29	342	278	620
30-34	131	94	225
35-39	78	53	131
40-44	25	20	45
45-54	20	20	40
55-64	5	7	12
65+	0	0	0
unknown	16	12	28
TOTAL	2526	1167	3693

*26 cases were of unknown gender

CALIFORNIA STD TREATMENT GUIDELINES 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**.

DISEASE	RECOMMENDED REGIMENS	DOSE/ROUTE	ALTERNATIVE REGIMENS: To be used if medical contraindication to recommended regimen
CHLAMYDIA			
Uncomplicated Genital/Rectal/Pharyngeal Infections [1]	• Azithromycin **or** • Doxycycline [2]	1 g po 100 mg po bid x 7 d	• Erythromycin base 500 mg po qid x 7 d **or** • Erythromycin ethylsuccinate 800 mg po qid x 7 d **or** • Levofloxacin [2] 500 mg po qd x 7 d **or** • Ofloxacin [2] 300 mg po bid x 7 d
Pregnant Women [3]	• Azithromycin **or** • Amoxicillin	1 g po 500 mg po tid x 7 d	• Erythromycin base 500 mg po qid x 7 d **or** • Erythromycin base 250 mg po qid x 14 d **or** • Erythromycin ethylsuccinate 800 mg po qid x 7 d **or** • Erythromycin ethylsuccinate 400 mg po qid x 14 d
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 days is recommended for all patients with gonorrhea regardless of chlamydia test results. [4]			
Uncomplicated Genital/Rectal Infections [1]	**Dual therapy with** • Ceftriaxone **or, if not an option** • Cefixime [5] **PLUS** • Azithromycin **or** • Doxycycline	 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 [6] 2 g po in a single dose
Pharyngeal Infections	**Dual therapy with** • Ceftriaxone **PLUS** • Azithromycin **or** • Doxycycline	 250 mg IM 1 g po 100 mg po bid x 7 d	• Azithromycin [6] 2 g po in a single dose
Pregnant Women [3]	**Dual therapy with** • Ceftriaxone **or, if not an option** • Cefixime [5] **PLUS** • Azithromycin	 250 mg IM 400 mg po 1 g po	• Cefpodoxime 400 mg po **or** • Cefuroxime axetil 1 g po **or** • Azithromycin [6] 2 g po in a single dose
PELVIC INFLAMMATORY DISEASE [4, 7, 8]	**Parenteral** [9] • **Either** Cefotetan **or** Cefoxitin **plus** Doxycycline [2] **or** • Clindamycin **plus** Gentamicin **IM/Oral** • **Either** Ceftriaxone **or** Cefoxitin with Probenecid **plus** Doxycycline [2] **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/kg IV or IM followed by 1.5 mg/kg IV or IM q 8 hrs 250 mg IM 2 g IM, 1 g po 100 mg po bid x 14 d 500 mg po bid x 14 d	**Parenteral** [9] • Ampicillin/Sulbactam 3 g IV q 6 hrs **plus** Doxycycline [2] 100 mg po or IV q 12 hrs **Oral** [10] • Levofloxacin [2] 500 mg po qd x 14 d **or** • Ofloxacin [2] 400 mg po bid x 14 d **or** • Ceftriaxone 250 mg IM single dose and Azithromycin 1 g po once a week for 2 weeks **plus** • Metronidazole 500 mg po bid x 14 d if BV is present or cannot be ruled out
CERVICITIS [4, 7, 11]	• Azithromycin **or** • Doxycycline [2] **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	
NONGONOCOCCAL URETHRITIS [7]	• Azithromycin **or** • Doxycycline	1 g po 100 mg po bid x 7 d	• Erythromycin base 500 mg po qid x 7 d **or** • Erythromycin ethylsuccinate 800 mg po qid x 7 d **or** • Levofloxacin 500 mg po qd x 7 days **or** • Ofloxacin 300 mg po bid x 7 d
EPIDIDYMITIS [4, 7]	Likely due to Gonorrhea or Chlamydia • Ceftriaxone **plus** Doxycycline Likely due to enteric organisms • Levofloxacin [12] **or** • Ofloxacin [12]	 250 mg IM 100 mg po bid x 10 d 500 mg po qd x 10 d 300 mg po bid x 10 d	
CHANCROID	• Azithromycin **or** • Ceftriaxone **or** • Ciprofloxacin [2] **or** • Erythromycin base	1 g po 250 mg IM 500 mg po bid x 3 d 500 mg po tid x 7 d	
LYMPHOGRANULOMA VENEREUM	• Doxycycline [2]	100 mg po bid x 21 d	• Erythromycin base 500 mg po qid x 21 d **or** • Azithromycin 1 g po q week x 3 weeks
TRICHOMONIASIS [13,14]			
Non-pregnant women	• Metronidazole **or** • Tinidazole [15]	2 g po 2 g po	• Metronidazole 500 mg po bid x 7 d
Pregnant Women	• Metronidazole	2 g po	• Metronidazole 500 mg po bid x 7 d

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.
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 @ 510-620-3400. For further guidance, go to www.std.ca.gov ("STD Guidelines").
5. Oral cephalosporins give lower and less-sustained bacteriocidal levels than ceftriaxone 250-mg and have limited efficacy for treating pharyngeal GC. Therefore, ceftriaxone is the preferred medication.
6. For patients with cephalosporin allergy, or severe penicillin allergy, (e.g., anaphylaxis, Stevens 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.
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.
8. Evaluate for bacterial vaginosis. If present or cannot be ruled out, also use metronidazole.
9. Discontinue 24 hours after patient improves clinically and continue with oral therapy for a total of 14 days.
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 cephalosporin therapy is not an option, the addition of azithromycin 2 g orally as a single dose to a quinolone-based PID regimen is recommended.
11. If local prevalence of gonorrhea is greater than 5%, treat empirically for gonorrhea infection.
12. If gonorrhea is documented, change to a medication regimen that does not include a fluoroquinolone.
13. For suspected drug-resistant trichomoniasis, rule out reinfection; see 2010 CDC Guidelines, Trichomonas Follow-up p. 60, for other treatment options, and evaluate for metronidazole-resistant *T. vaginalis*. For laboratory and clinical consultations, contact CDC at 404-718-4141, http://www.cdc.gov/std.
14. For HIV-positive women with trichomoniasis, metronidazole 500 mg po bid x 7 d is more effective than metronidazole 2 g orally.
15. Safety in pregnancy has not been established; pregnancy category C.

Developed by the California STD/HIV Prevention Training Center
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CALIFORNIA STD/HIV PREVENTION TRAINING CENTER

DISEASE	RECOMMENDED REGIMENS	DOSE/ROUTE	ALTERNATIVE REGIMENS: To be used if medical contraindication to recommended regimen
BACTERIAL VAGINOSIS			
Adults/Adolescents	• Metronidazole **or** • Metronidazole gel **or** • Clindamycin cream [16]	500 mg po bid x 7 d 0.75%, one full applicator (5g) intravaginally qd x 5 d 2%, one full applicator (5g) intravaginally qhs x 7 d	• Tinidazole [15] 2 g po qd x 2 d **or** • Tinidazole [15] 1 g po qd x 5 d **or** • Clindamycin 300 mg po bid x 7 d **or** • Clindamycin ovules 100 mg intravaginally qhs x 3 d
Pregnant Women	• Metronidazole **or** • Metronidazole **or** • Clindamycin	500 mg po bid x 7 d 250 mg po tid x 7 d 300 mg po bid x 7 d	
ANOGENITAL WARTS			
External Genital/Perianal Warts	**Patient Applied** • Imiquimod [15,16] 5% cream **or** • Podofilox [15] 0.5% solution or gel **or** • Sinecatechins [15] 15% ointment **Provider Administered** • Cryotherapy **or** • Podophyllin [15] resin 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 x 3 d followed by 4 d no tx for up to 4 cycles Topically tid, for up to 16 wks Apply once q 1-2 wks Apply once q 1-2 wks Apply once q 1-2 wks Apply once q 1-2 wks	**Alternative Regimen** • Intralesional interferon **or** • Laser surgery or • Photodynamic therapy or • Topical cidofovir
Mucosal Genital Warts [17]	• Cryotherapy **or** • TCA or BCA 80%-90% **or** • Podophyllin [15] resin 10%-25% in tincture of benzoin **or** • Surgical removal	Vaginal, urethral meatus, and anal Vaginal and anal Urethral meatus only Anal warts only	
ANOGENITAL HERPES [18]			
First Clinical Episode of Anogenital Herpes	• Acyclovir **or** • Acyclovir **or** • Famciclovir **or** • Valacyclovir	400 mg po tid x 7-10 d 200 mg po 5/day x 7-10 d 250 mg po tid x 7-10 d 1 g po bid x 7-10 d	
Established Infection Suppressive Therapy [19, 20]	• Acyclovir **or** • Famciclovir [19] **or** • Valacyclovir **or** • Valacyclovir	400 mg po bid 250 mg po bid 500 mg po qd 1 g po qd	
Episodic Therapy for Recurrent Episodes	• Acyclovir **or** • Acyclovir **or** • Acyclovir **or** • Famciclovir **or** • Famciclovir **or** • Famciclovir **or** • Valacyclovir **or** • Valacyclovir	400 mg po tid x 5 d 800 mg po bid x 5 d 800 mg po tid x 2 d 125 mg po bid x 5 d 1000 mg po bid x 1 d 500 mg once, then 250 mg bid x 2 d 500 mg po bid x 3 d 1 g po qd x 5 d	
HIV Co-Infected [20]			
Suppressive Therapy [19]	• Acyclovir **or** • Famciclovir [19] **or** • Valacyclovir	400-800 mg po bid or tid 500 mg po bid 500 mg po bid	
Episodic Therapy for Recurrent Episodes	• Acyclovir **or** • Famciclovir **or** • Valacyclovir	400 mg po tid x 5-10 d 500 mg po bid x 5-10 d 1 g po bid x 5-10 d	
SYPHILIS [21, 22]			
Primary, Secondary, and Early Latent	• Benzathine penicillin G	2.4 million units IM	• Doxycycline [23] 100 mg po bid x 14 d **or** • Tetracycline [23] 500 mg po qid x 14 d **or** • Ceftriaxone [23] 1 g IM or IV qd x 10-14 d
Late Latent and Latent of Unknown duration	• Benzathine penicillin G	7.2 million units, administered as 3 doses of 2.4 million units IM each, at 1-week intervals	• Doxycycline [23] 100 mg po bid x 28 d **or** • Tetracycline [23] 500 mg po qid x 28 d
Neurosyphilis [24]	• Aqueous crystalline penicillin G	18-24 million units daily, administered as 3-4 million units IV q 4 hrs x 10-14 d	• Procaine penicillin G, 2.4 million units IM qd x 10-14 d **plus** Probenecid 500 mg po qid x 10-14 d **or** • Ceftriaxone [23] 2 g IM or IV qd x 10-14 d
Pregnant Women [25]			
Primary, Secondary, and Early Latent	• Benzathine penicillin G	2.4 million units IM	• None
Late Latent and Latent of Unknown duration	• Benzathine penicillin G	7.2 million units, administered as 3 doses of 2.4 million units IM each, at 1-week intervals	• None
Neurosyphilis [24]	• Aqueous crystalline penicillin G	18-24 million units daily, administered as 3-4 million units IV q 4 hrs x 10-14 d	• Procaine penicillin G, 2.4 million units IM qd x 10-14 d **plus** Probenecid 500 mg po qid x 10-14 d

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 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. If HSV lesions persist or recur during antiviral treatment, drug resistence 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.

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