



Florida/Caribbean AIDS Education and Training Center

HIV CareLink

A Newsletter for HIV/AIDS Primary Care Providers

ABOUT US

The Florida/Caribbean AIDS Education and Training Center provides state-of-the-art HIV education, consultation, and resource materials to health care providers in Florida, Puerto Rico and the US Virgin Islands.

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Sexually Transmitted Diseases Treatment Guidelines – An Update

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In December 2010, the Centers for Disease Control and Prevention (CDC) published an update to the Sexually Transmitted Diseases Treatment Guidelines. These recommendations update the 2006 guidelines, and include new information regarding 1) expanded diagnostic evaluation for cervicitis and trichomoniasis; 2) new treatment recommendations for bacterial vaginosis and genital warts; 3) clinical efficacy of azithromycin for chlamydial infections in pregnancy; 4) the role of *Mycoplasma genitalium* and trichomoniasis in urethritis/cervicitis and treatment-related implications; 5) lymphogranuloma venereum proctocolitis among men who have sex with men (MSM); 6) criteria for spinal fluid examination to evaluate for neurosyphilis; 7) emergence of azithromycin-resistant *Treponema pallidum*; 8) increasing prevalence of antimicrobial-resistant *Neisseria gonorrhoeae*; 9) sexual transmission of hepatitis C; 10) diagnostic evaluation after sexual assault; and 11) sexually transmitted diseases (STD) prevention approaches. This Carelink summarizes these updates, noting when treatment or monitoring recommendations differ for those with HIV infection. Clinicians are encouraged to view the full guidelines at: <http://www.cdc.gov/std/treatment/2010/STD-Treatment-2010-rr5912.pdf>. Go to www.fcaetc.org/treatment to view or order the Treatment of STDs in HIV-infected Patients poster available from the Florida/Caribbean AETC.

CERVICITIS AND TRICHOMONIASIS

In women with persistent symptoms of cervicitis a re-evaluation is needed secondary to a high rate of recurrence after treatment.

Recommended Regimens for Presumptive Treatment of Cervicitis*:

- Azithromycin 1 g po x 1 dose, or
 - Doxycycline 100 mg po bid x 7 days
- *Consider concurrent treatment for gonococcal infection if prevalence of gonorrhea is high.
- HIV-infected patients who have cervicitis should receive the same treatment regimen as those who are HIV negative.

Testing for trichomoniasis is needed in all women seeking care for vaginal discharge and also in high risk population (new/multiple partners, sex workers, IV drug use, hx of STDs). Consider rescreening 3 months after completion of therapy due to high rate of recurrence in HIV-infected women.

Recommended Regimens for Trichomoniasis:

- Metronidazole 2 g po x 1 dose*, or
- Tinidazole 2 g po x 1 dose

Alternative Regimen for Trichomoniasis:

- Metronidazole 500 mg po bid x 7 days*
- *Single dose metronidazole not as effective in HIV-infected, consider use of multi-dose 7 day regimen.

BACTERIAL VAGINOSIS

Diagnosis of bacterial vaginosis (BV) can be made by the use of clinical criteria or Gram stain. Treatment is recommended for patients with symptoms.

Recommended Regimens for BV:

- Metronidazole 500 mg po bid x 7 days, or
- Metronidazole gel 0.75%, one full applicator (5g) intravaginally, once daily x 5 days, or
- Clindamycin cream 2%, one full applicator (5g) intravaginally at bedtime x 7 days

Alternative Regimens for BV:

- Tinidazole 2 g po once daily x 2 days, or
- Tinidazole 1 g po once daily x 5 days, or
- Clindamycin 300 mg po bid x 7 days, or
- Clindamycin ovules 100 mg intravaginally at bedtime x 3 days

For more information,
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www.FCAETC.org

To request clinical consultation, please call the
National Clinicians' Consultation Hotline:

1-800-933-3413

Patients who have BV and also are infected with HIV should receive the same treatment regimen as those who are HIV negative. See guidelines for new discussion of antimicrobial resistance and other treatment options.

HUMAN PAPILLOMA VIRUS (WARTS)

Treatment is directed to the macroscopic (genital warts) or pathologic (precancerous) lesions caused by infection.

Recommended Treatments for External Warts:

Patient-applied:

- Podofilox 0.5% solution or gel, or
 - Imiquimod 5% cream, or
 - Sinecatechins 15% ointment*
- *Not recommended in HIV-infected patients

Provider-administered:

- Cryotherapy with liquid nitrogen or cryoprobe. Repeated every 1-2 weeks, or
- Podophyllin resin 10%-25% in tincture of benzoin, or
- Trichloroacetic acid (TCA) or Bichloroacetic acid (BCA) 80%-90%, or
- Surgical removal

Patients who have warts, and also are infected with HIV, should receive the same treatment regimen as those who are HIV negative; although, HIV-infected persons may have larger and/or more numerous lesions and more frequent recurrences. Because HIV-infected persons are at higher risk for squamous cell carcinoma arising from or resembling warts, any suspicious lesion should be biopsied.

CHLAMYDIAL INFECTIONS IN PREGNANCY

Pregnant women < 25 yo and at high risk for chlamydia (new or multiple sex partners) should be retested in the 3rd trimester. Pregnant women with a chlamydial infection in the 1st trimester should be tested 3 weeks after treatment to document clearance and 3 months after treatment. As compliance with multiday dosing is sometimes difficult, azithromycin should be offered as a treatment option if not contraindicated.

Recommended Regimens for Chlamydia in Pregnancy*:

- Azithromycin 1 g po x 1 dose, or
 - Amoxicillin 500 mg po tid x 7 days
- *See Guidelines for alternative regimens.

Pregnant and non-pregnant patients who have chlamydia and also are infected with HIV should receive the same treatment regimen as those who are HIV negative.

MYCOPLASMA GENITALIUM AND TRICHOMONIASIS IN NONGONOCOCCAL URETHRITIS (NGU)/CERVICITIS

Mycoplasma genitalium, which appears to be transmitted sexually, has been associated with urethritis, urethral inflammation, and cervicitis. Culturing the organism is difficult and can be resistant to recommended NGU treatment. Trichomoniasis also can be associated with NGU and cervicitis.

Recommended Regimens for NGU and Cervicitis (see STD Guidelines for alternatives):

- Azithromycin 1 g po x 1 dose, or
- Doxycycline 100 mg po bid x 7 days

Patients who have NGU or cervicitis and also are infected with HIV should receive the same treatment regimen as those who are HIV negative.

LYMPHOGRANULOMA VENEREUM (LGV)

The most common manifestation is a unilateral inguinal and/or femoral lymphadenopathy. In MSM or women with rectal exposure, it may present as proctocolitis, rectal pain, discharge, or tenesmus. Diagnosis is based on clinical suspicion, epidemiology, and exclusion of other entities. Patients should be treated even in the absence of specific LGV diagnostic testing if the clinical syndrome is consistent with LGV.

Preferred treatment for LGV:

- Doxycycline 100 mg po bid x 21 days

Alternative treatment for LGV:

- Erythromycin base 500 mg po 4x/day x 21 days
- Sexual partners who have had sexual contact with the patient within 60 days before onset of the patient's symptoms, should be examined and treated with a chlamydia regimen.
- Treat HIV-infected patients as above (addition of an aminoglycoside and/or prolonged therapy may be needed).

SYPHILIS

Recommended treatment for syphilis:

Primary, secondary, or early latent syphilis :

- Benzathine penicillin G 2.4 million units IM x 1 dose

Late latent, latent, tertiary syphilis or of unknown duration:

- Benzathine penicillin G 2.4 million units IM once weekly x 3 doses

Emergence of Azithromycin-resistant *T. Pallidum*

While azithromycin 2 g oral dose (option if penicillin allergic) is effective for early syphilis, treatment failures have been documented and it should NOT be used in MSM or pregnant women. See Guidelines for more detailed discussion of management of penicillin-allergic patients.

Neurosyphilis

Cerebrospinal fluid (CSF) laboratory abnormalities are common even in the absence of neurological findings in early syphilis. In HIV-infected patients, CSF abnormalities more common with CD4 \leq 350 cells/mm³ and/or RPR \geq 1:32; however, CSF examination is recommended only if neurologic symptoms present. Pleocytosis and abnormal protein findings should be followed every 6 months until normalization in patients diagnosed with neurosyphilis. If changes persist after two years, retreatment should be considered.

Neurosyphilis Treatment:

- Aqueous crystalline penicillin G 3-4 million units IV q4h or 18-24 million units/day via continuous infusion x 10-14 days.
- See Guidelines for management of penicillin-allergic patients.

HIV Infection and Syphilis

HIV-infected patients may have a different presentation including, higher than expected titers, false-negative serologic tests, or delayed appearance of seroreactivity. Neurosyphilis should be considered in patients with neurologic disease. Recommended regimens for treatment of all stages of syphilis (including neurosyphilis) are the same in HIV-infected vs. HIV-negative. HIV-infected persons should be evaluated for treatment response at 3, 6, 9, 12, and 24 months after therapy. Consider CSF examination and/or retreatment for patients who do not have a 4-fold decrease in nontreponemal titer.

GONOCOCCAL INFECTIONS ANTIMICROBIAL RESISTANCE

Quinolone-resistant strains are prevalent in the US and world and cephalosporins are the recommended antimicrobial treatment class in the US. There have been very few reported cephalosporin-resistance gonococcal infections (~50) in the US. If there is a suspected cephalosporin failure, culture and susceptibility testing should be performed and the case should be reported to the CDC. Patients treated for gonorrheal infection should also be treated for chlamydial infection. The recommended dose of ceftriaxone has been increased from 125 mg IM X 1 dose to 250 mg IM X 1 dose.

Recommended Regimens for Gonorrhea:

- Ceftriaxone 250 mg IM x 1 dose, or

IF NOT AN OPTION:

- Cefixime 400 mg po x 1 dose, or
- Single-dose injectable cephalosporin regimens,

ALL PLUS:

- Azithromycin 1 g po x 1 dose, or
- Doxycycline 100 mg po bid x 7 days

Patients who have gonorrhea and also are HIV-infected should receive the same treatment regimen as those who are HIV negative.

SEXUAL TRANSMISSION OF HEPATITIS C

Recent data indicated sexual transmission of hepatitis C can occur especially in HIV-infected patients. Baseline and periodic hepatitis C screenings are recommended based on risk factors (e.g. substance abuse, multiple sex partners, MSM).

SEXUAL ASSAULT EVALUATION

Initial examination might include:

- Testing for trichomoniasis and gonorrhea, regardless of the sites of penetration or attempted penetration. Nucleic acid amplification tests (NAATs) are now the preferred tests for the diagnostic evaluation.
- Trichomoniasis test should be wet mount and culture or point-of-care testing of a vaginal-swab specimen. The wet mount also should be examined for candidiasis and BV.
- A serum sample for immediate evaluation for HIV infection, hepatitis B, and syphilis. Decisions to perform these tests should be made on an individual basis.

STD/HIV PREVENTION COUNSELING

There are five major strategies utilized for the clinical prevention of STDs:

- Changes in sexual behavior that put persons at risk for STDs
- Identification of asymptomatic infected individuals and infected persons not seeking medical attention
- Effective diagnosis, treatment, and counseling of infected persons with an STD
- Treatment and counseling of sex partners of persons who are infected with an STD
- Persons at risk for STDs should be vaccinated pre-exposure.

High-intensity behavioral counseling is recommended for all sexually active adolescents as well as adults at increased risk for STDs and HIV infection. STDs associated with ulcerative lesions increase the risk of acquiring HIV infection. Counseling is more effective if provided in a nonjudgmental and empathetic manner. In addition, all recommendations should be tailored to the targeted population especially in the communities with a high percentage of minorities or immigrants. These groups may have a different cultural approach or response to the current general guidelines.

References

1. Morbidity and Mortality Weekly Report. Sexually Transmitted Diseases Treatment Guidelines 2010. December 17, 2010/Vol 59/ No. RR-12.
2. Bradshaw CS, Jenson JS, Tabrizi SN, Read TRH, Garland SM, Hopkins CA, et al. Azithromycin failure in Mycoplasma genitalium urethritis. Emerg Infect Dis [serial on the Internet]. 2006 Jul. Available from <http://www.cdc.gov/ncidod/EID/vol12no07/05-1588.htm>.

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