State of Alaska Epidemiology **Bulletin** Recommendations and Reports

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Updated National STD Treatment Guidelines Released by CDC in 2002

Introduction

"Sexually Transmitted Diseases Treatment Guidelines 2002" was released by the Centers for Disease Control (CDC) as Morbidity and Mortality Weekly Report (**MMWR**/Vol. 51/No. RR-6) on May 10, 2002. The 84-page document may be downloaded anytime from the CDC website at http://www.cdc.gov/mmwr/PDF/rr/rr5106.pdf. This document is an excellent reference for (1) the treatment of Chlamydia, Gonorrhea, Syphilis, and other common Sexually Transmitted Diseases [STD], (2) managing STDs in special populations, such as pregnant women, children, men who have sex with men, or those infected with HIV, (3) management of exposed sexual partners, and (4) treatment of the complications of STDs such as epididymitis, pelvic inflammatory disease, or perinatal infection of the newborn.

Selected Highlights of the STD Treatment Guidelines 2002

- Each case of STD should be treated according to recommended disease-specific regimens in the guidelines; other antimicrobials are of lesser or unknown efficacy. The guidelines suggest alternative regimens for those who are allergic to the preferred regimens, are pregnant, or have other conditions requiring special consideration.
- Partner notification (PN) is the process of learning from persons with STDs or HIV about their sexual partners and helping to arrange for evaluation and treatment of those partners. This process is critical to interrupting disease transmission.
- Each sexual partner of a case of STD should be tested and treated, on the same visit, for the STD of which he/she is a contact. Do not withhold treatment pending the result of the test. Partners of a gonorrhea case should be treated for gonorrhea and chlamydia ("dual" therapy).
- A patient and his/her sexual partners who are treated for chlamydia and/or gonorrhea should be advised to *abstain* from sexual intercourse until therapy is completed in both the case and the partner(s), i.e., 7 days after a single dose regimen or after completion of a 7-day regimen. Otherwise, the transmission cycle is perpetuated. If abstention is unlikely, using a condom is essential.
- Providers may consider advising a female patient treated for chlamydia to seek rescreening in 3-4 months to assess whether re-infection has occurred.
- HIV counseling and testing should be offered to all persons who seek evaluation and treatment for STDs.
- STD/HIV risk assessment and client-centered prevention counseling should be provided to cases and partners to reduce the likelihood of acquisition or transmission of HIV and other STDs.
- A patient who describes on-going sexual risk behavior, or who has had multiple episodes of STD, demonstrates continuing sexual risk-taking and requires continuing reinforcement of risk-reducing strategies as well as repeat STD screening annually or more frequently. Consult with the HIV/STD Program for guidance and assistance.
- All women should be counseled regarding the use of condoms to reduce the risk for STDs and HIV infection.
- All pregnant women should be tested as follows at the first pre-natal visit: for hepatitis B surface antigen (HbsAg); for chlamydia and gonorrhea infection; and for cervical neoplasia by Papanicolaou smear (if none has been documented during the preceding year). In addition, all pregnant women should be offered voluntary HIV testing at the first pre-natal visit. Consider screening those at risk for Hepatitis C antibodies.

Condensed 2002 STD Treatment Guidelines: Adolescents and Adults

This table of treatment of STDs reflects the 2002 CDC Guidelines for Treatment of Sexually Transmitted Diseases pertaining to STDs commonly encountered in office practice. It is not a comprehensive list of all diseases or recommendations in the Guideline, and does not address infection in children or neonates (see Guidelines). The complete Guidelines are available from the State Section of Epidemiology at (907) 269-8000, or the web site @ http://www.cdc.gov/std/treatment/default.htm.

Providers in Alaska must report to the Section of Epidemiology all diagnosed or suspected cases of Gonorrhea, Chlamydia, Syphilis, HIV and AIDS.

DISEASE	RECOMMENDED TREATMENT	ALTERNATIVE TREATMENT	COMMENTS
BACTERIAL VAGINOSIS (BV)	**Metronidazole** 500 mg orally 2x/day for 7 days, OR **Metronidazole gel** (0.75%) one full applicator (5g) intravaginally daily for 5 days OR **Clindamycin cream** (2%) one 5 g applicator intravaginally at bedtime for 7 days,	**Metronidazole** 2 g orally in a single dose, OR **Clindamycin** 300 mg orally 2x/day for 7 days, OR **Clindamycin** ovules 100 g intravaginally at bedtime for 3 days	Oil-based creams and suppositories may weaken latex condoms and diaphragms. Avoid alcohol for 24 hours following Metronidazole.
Pregnant Women	**Metronidazole** 250 mg orally 3x/day for 7 days, OR **Clindamycin** 300 mg orally 2x/day for 7 days		Existing data do not support the use of topical (intravaginal) preparations during pregnancy.
CHLAMYDIAL INFECTION Adults or Adolescents >45 kg, with uncomplicated infection of the cervix, urethra, or rectum.	**Azithromycin** 1 g orally in a single dose, OR **Doxycycline** 100 mg orally 2x/day for 7 days	**Erythromycin** base 500 mg orally 4x/day for 7 days, OR **Erythromycin ethylsuccinate** 800 mg orally 4x/day for 7 days, OR **Ofloxacin** 300 mg orally 2x/day for 7 days, OR **Levofloxacin** 500 mg orally for 7 days	Providers should consider advising all women with chlamydial infection to be rescreened 3-4 months after treatment, to rule out subsequent re-infection. Providers are also strongly encouraged to rescreen all women treated for chlamydial infection when they next present for care within the following 12 months
Pregnant Women	**Erythromycin base** 250 mg orally 4x/day for 7 days, OR **Amoxicillin** 500 mg orally 3x/day for 7 days	**Erythromycin base** 500 mg orally 4x/day for 14 days, OR **Erythromycin ethylsuccinate** 800 mg orally 4x/day for 7 days, OR **Erythromycin ethylsuccinate** 400 mg orally 4x/day for 14 days, OR **Azithromycin** 1 g orally in a single dose	Erythromycin estolate is contraindicated during pregnancy. Retest pregnant women 3 weeks after completion of medication regimen.
EPIDIDYMITIS	*Epididymitis likely caused by gonococcal or chlamydial infection* **Ceftriaxone** 250 mg IM in a single dose ►►**PLUS**►► **Doxycycline** 100 mg orally 2x/day for 7 days	*Epididymitis likely caused by enteric organisms, for patients allergic to cephalosporins and/or tetracyclines, or in patients > 35 years of age* **Ofloxacin** 300 mg orally 2x/day for 10 days OR **Levofloxacin** 500 mg orally once daily for 10 days	If the diagnosis of epididymitis is questionable, a specialist should be consulted immediately because testicular viability may be compromised. Failure to improve within 3 days of initiation of therapy requires reevaluation of both the diagnosis and the therapy.
GENITAL HERPES SIMPLEX (HSV) First clinical episode of genital herpes	**Acyclovir** 400 mg orally 3x/day for 7-10 days, OR **Acyclovir** 200 mg orally 5x/day for 7-10 days, OR **Famciclovir** 250 mg orally 3x/day for 7-10 days, OR **Valacyclovir** 1 g orally 2x/day for 7-10 days	Treatment may be extended if healing is incomplete after 10 days of therapy. For treatment during pregnancy see the CDC Treatment Guidelines. The safety of Acyclovir sand Valacyclovir during pregnancy is not established.	
Episodes of recurrent infection	**Acyclovir** 400 mg orally 3x/day for 5 days OR **Acyclovir** 200 mg orally 5x/day for 5 days OR **Acyclovir** 800 mg orally 2x/day for 5 days OR **Famciclovir** 125 mg orally 2x/day for 5 days OR **Valacyclovir** 500 mg orally 2x/day for 3-5 days OR **Valacyclovir** 1 g orally once a day for 5 days	Effective episodic treatment of recurrent herpes requires initiation of therapy within 1 day of lesion onset, or during the prodrome that precedes some episodes. The patient should self-initiate treatment when symptoms begin.	
Suppressive therapy	**Acyclovir** 400 mg orally 2x/day OR **Famciclovir** 250 mg orally 2x/day OR **Valacyclovir** 500 mg orally once a day OR **Valacyclovir** 1 g orally once a day	May be considered in reducing the frequency of recurrent episodes for individuals who experience many episodes per year. The extent to which suppressive therapy prevents HSV transmission is unknown.	
GONOCOCCAL INFECTION Adults or Adolescents ≥ 45 kg with uncomplicated infection of the cervix, urethra or rectum: [Drugs with * designation are recommended for treatment of pharyngeal infection with gonorrhea]	**One of:** **Cefixime** 400 mg orally in a single dose, OR ***Ceftriaxone*** 125 mg IM in a single dose, OR ***Ciprofloxacin*** 500 mg orally in a single dose, OR **Ofloxacin** 400 mg orally in a single dose, OR **Levofloxacin** 250 mg orally in a single dose ►►**PLUS one of** ►► **Azithromycin** 1 g orally in a single dose, OR **Doxycycline** 100 mg orally 2x/day for 7 days	**One of:** **Spectinomycin** 2 g IM in a single dose, OR Single-dose **cephalosporin**, OR Single-dose **quinolone**, ►►**PLUS one of:** ►► **Azithromycin** 1 g orally in a single dose, OR **Doxycycline** 100 mg orally 2x/day for 7 days	Quinolones are no longer recommended for gonorrhea infections acquired in Hawaii, California, Asia or the Pacific Islands. Use Spectinomycin for patients who cannot tolerate cephalosporins or quinolones.
Pregnant Women	**See CDC Treatment Guidelines**: Pregnant women should not be treated with quinolones or tetracyclines. Treat gonorrhea with a recommended or alternate cephalosporin. Women who cannot tolerate cephalosporins should be administered a single dose of Spectinomycin IM. For presumptive or diagnosed *C. trachomatis* infection during pregnancy, either erythromycin or amoxicillin is recommended for treatment (see "Chlamydial infection", above).		

HUMAN PAPILLOMAVIRUS (HPV) External genital warts	***Patient applied*** **Podofilox** 0.5% solution or gel. Apply to visible warts 2x/day for 3 days, rest 4 days, may repeat up to 4 cycles maximum OR **Imiquimod** 5% cream. Apply once at bedtime (wash off after 6-10 hours) 3x/week, for a maximum of 16 weeks ***Provider applied*** **Cryotherapy** with liquid nitrogen or cryoprobe. Repeat every 1-2 weeks until resolved, OR **Podophyllin resin** 10%-25%. Apply sparingly to warts only, allow to air dry, May be washed off in 1-4 hours. Repeat weekly. OR **Trichloroacetic Acid** or **Bichloroacetic Acid** 80% - 90% Apply sparingly to warts only, allow to dry. Repeat weekly. OR **Surgical removal** (or rarely, intralesional interferon or laser surgery)		For patient-applied treatments, patients must be able to identify and reach all warts requiring treatment. If possible, the health care provider should demonstrate proper application technique. For pregnant patients and/or those with vaginal, cervical, urethral meatal, oral and anal warts see CDC Treatment Guidelines.
NONGONOCOCCAL URETHRITIS (NGU)	**Azithromycin** 1 g orally in a single dose, OR **Doxycycline** 100 mg orally 2x/day for 7 days	**Erythromycin base** 500 mg orally 4x/day for 7 days OR **Erythromycin ethylsuccinate** 800 mg orally for 7 days OR **Ofloxacin** 300 mg 2x/day for 7 days, OR **Levofloxacin** 500 mg once daily for 7 days	Patients who do not respond following completion of oral therapy should be re-evaluated. See CDC Guidelines for treatment of recurrent or persistent urethritis.
PELVIC INFLAMMATORY DISEASE (PID) The decision whether to hospitalize a woman with PID depends on the clinical severity of symptoms, pregnancy status, and expected non-compliance with oral treatment regimens (see CDC Guidelines).	**Oral regimens** Regimen A: **Ofloxacin** 400 mg orally 2x/day for 14 days, OR **Levofloxacin** 500 mg orally once daily for 14 days Use either one of these Quinolones with or without **Metronidozale** 500 mg orally 2x/day for 14 days Regimen B: **One of:** **Ceftriaxone** 250 mg IM in a single dose, OR **Cefoxitin** 2 g IM in a single dose *and* **Probenecid** 1 g orally concurrently in a single dose, OR A *parenteral* third generation cephalosporin (e.g., **ceftizoxime** or **cefotaxime**) ►►PLUS►► **Doxycycline** 100 mg orally 2X/day for 14 days With or without **Metronidozale** 500 mg orally twice daily for 14 days	**Parenteral regimens** See CDC Guidelines The transition from parenteral to oral therapy can usually be initiated within 24 hours following clinical improvement.	Patients with PID who do not respond to oral therapy within 72 hours should be re-examined and if there is no improvement, should be hospitalized for parenteral therapy and further evaluation. ***For the pregnant patient:*** 1. Because of the high maternal and fetal morbidity pregnant women suspected of PID should be hospitalized. 2. Doxycycline should not be administered during pregnancy, lactation, or to children < 8 years of age. 3. Ofloxacin is contraindicated for pregnant or lactating women, or for children weighing <45 kg. 4. Existing data do not support the use of topical (intravaginal) Metronidazole preparations during pregnancy.
PUBIC LICE (PEDICULOSIS PUBIS)	**Permethrin** (1%) **creme rinse**. Apply to affected area, wash off after 10 minutes OR **Lindane** (1%) shampoo apply to affected area, wash off after 4 minutes OR **Pyrethrins with piperonyl butoxide**. Apply to affected area, wash off after 10 minutes	**Lindane** (1%) Apply thinly 1 oz. of lotion, or 30 g of cream, to all areas of the body from the neck down. Wash off after 8-14 hours. OR **Invermectin** 200ug/kg/ orally, repeated in 2 weeks.	Lindane should not be used immediately after a bath or shower, or by pregnant or lactating women, children < 2 years of age, or people with extensive dermatitis.
SCABIES	**Permethrin cream (5%)** Apply to all areas of body from neck down, wash off after 8-14 hours	**Lindane** (1%) Apply thinly 1 oz. of lotion, or 30 g of cream, to all areas of the body from the neck down. Wash off after 8-14 hours. OR **Invermectin** 200ug/kg/ orally, repeated in 2 weeks.	Lindane should not be used immediately after a bath or shower, or by pregnant or lactating women, children < 2 years of age, or people with extensive dermatitis.
SYPHILIS Due to the complexities of diagnosing, staging, and determining best treatment protocol/s for syphilis infection, providers are urged to review CDC Guidelines and contact the Section of Epidemiology at 269-8000.			
TRICHOMONIASIS	**Metronidazole** 2 g orally in a single dose	**Metronidazole** 500 mg orally 2x /day for 7 days	Pregnant women who are symptomatic with trichomoniasis should be treated to ameliorate symptoms.
VULVOVAGINAL CANDIDIASIS	***Intravaginal Agents**** **Butoconazole** 2% cream, 5 g (sustained released) single intravaginal application, OR **Clotrimazole** 100 mg vaginal tablet for 7 days, OR **Clotrimazole** 100 mg vaginal tablet, 2 tablets for 3 days, OR **Clotrimazole** 500 mg vaginal tablet, 1 tablet in a single application, OR **Nystatin** 100,000-unit vaginal tablet, 1 tablet for 14 days, OR **Terconazole** 0.4% cream 5 g intravaginally for 7 days, OR **Terconazole** 0.8% cream 5 g intravaginally for 3 days, OR **Terconazole** 80 mg vaginal suppository, 1 suppository for 3 days, ***Oral Agents*** **Fluconazole** 150 mg oral tablet, one tablet in a single dose	*These creams and suppositories are oil-based and may weaken latex condoms and diaphragms. Refer to condom product labeling for further information. Preparations for intravaginal administration of butoconazole, miconazole, and tioconazole are available over-the-counter (OTC). Self-medication with OTC preparations should be advised only for women who have been diagnosed previously with VVC and who have a recurrence of the same symptoms. Any woman whose symptoms persist after using an OTC preparation or who has a recurrence of symptoms within 2 months should seek medical care.	

Chlamydia

Treatment for chlamydial infection should be administered as soon as possible to laboratory-confirmed cases of chlamydial infection and to ALL sexual partners with whom they have had sexual activity in the past 60 days. Azithromycin and doxycycline are equally efficacious in eradication of urethral or cervical chlamydial infections; other antimicrobials are less reliable. The specified dose and duration are important to ensure adequate drug concentration to kill the organisms. Azithromycin has the added advantage of single-dose therapy where patient adherence to longer treatment and more frequent dosing is in question. Directly observed, single-dose therapy is the ideal mode of treatment.

Gonorrhea

Treatment for gonorrhea infection should be administered as soon as possible to laboratory-confirmed cases of gonorrhea infection and to ALL sexual partners with whom they have had sexual activity in the past 60 days. Because of the high incidence of co-infection of gonorrhea cases with chlamydia, all gonorrhea cases and their sexual partners should also be treated for chlamydia. Ceftriaxone has a higher cure rate than cefixime, but either of these cephalosporins is recommended over the quinolones (eg. ciprofloxacin, ofloxacin, or levofloxacin) especially when gonorrhea strains are likely to be resistant to quinolone antimicrobials (cases likely acquired in Asia, Hawaii, the Pacific Islands, or California). Directly observed, single-dose therapies for gonorrhea and for chlamydia are the ideal mode of treatment.

Syphilis

Consult with the HIV/STD Program on all cases needing treatment. Penicillin G administered intramuscularly is the treatment of choice for syphilis. The preparation and dosing frequency varies with the stage and clinical manifestations of disease at which the infection is treated. Other antimicrobials should be used with caution since their effectiveness is less well documented. Oral penicillin preparations are *not* considered appropriate for the treatment of syphilis. All sexual partners of a primary, secondary or early latent case should be serologically evaluated and treated accordingly: those whose sexual contact with the case occurred only within the 90 days prior to diagnosis of the case should be treated presumptively, even if they are seronegative. See the 2002 CDC Guidelines for further discussion of syphilis case and partner management, and for special considerations in managing syphilis in children, pregnant women, HIV-infected, or penicillin-allergic persons.

Prevention of STDs

Each case of STD and each of his/her sexual partners should be counseled in how to reduce the risk of transmitting or acquiring STDs. Risk reduction counseling should be tailored to the risks pertinent to each individual. HIV counseling and testing should be offered to all persons who seek evaluation and treatment for STDs. The 2002 Guidelines reinforce the demonstrated benefit of using a new male condom for each act of vaginal, anal or oral sex to reduce exposure to STDs and HIV. Condoms lubricated with Nonoxynol-9 spermicide (N-9) are no more effective against STD or HIV transmission than other lubricated condoms, and the presence of N-9 increases the cost, decreases shelf-life, and is associated with urinary tract infection in women. Providers should consult the Guidelines regarding the lesser effectiveness of other barrier contraceptive methods in preventing STD transmission. Immunization against Hepatitis A and B is recommended for those unvaccinated individuals at increased risk for STD.

Reporting Cases of STD in Alaska

Providers and laboratories in Alaska must report diagnosed or suspected cases of **Gonorrhea, Chlamydia, Syphilis, HIV infection and AIDS** [7AAC 27.00.5]. *A health care provider is not relieved of his obligation to report by virtue of the condition also being reportable by laboratories*. A provider should report a person with HIV infection to the Section of Epidemiology when: (1) HIV infection is diagnosed, *and* (2) when any AIDS-defining condition is diagnosed or T-cell count falls below 200/µl or is <14%, *and* (3) when a provider first undertakes HIV-related medical care of a newly referred patient, *and* (4) when HIV infection or AIDS was diagnosed previously but the person has subsequently moved into Alaska.

Case reports to the State of Alaska Section of Epidemiology should be made by telephoning the Rapid Telephonic Reporting System at 561-4234 (Anchorage) or 1-800-478-1700. Alternatively, the report may be submitted by confidential facsimile to 1-907-561-4239. Please include the name and telephone number of the provider attending to the case. For more information on these and other conditions reportable in Alaska, and on how providers should report, please see the Section of Epidemiology website at http://www.epi.hss.state.ak.us/pubs/conditions/default.stm

For provider assistance with STD diagnosis, test interpretation, treatment recommendations, partner notification services, or any aspect of STD or HIV prevention, please contact the Section of Epidemiology at 269-8000 and ask to speak to a Disease Intervention Specialist or Epidemiologist in the HIV/STD Program.

Additional Information Sources:

Information on other reportable conditions in the State of Alaska may be found at http://www.epi.hss.state.ak.us/pubs/conditions/default.stm .

State of Alaska summary publications of disease surveillance and activities of importance to the health of the public may be found in "Epi Bulletins" at http://www.epi.hss.state.ak.us/bulletins/bullidx.asp

The State of Alaska HIV/STD Program endorses the CDC recommendations in the "Sexually Transmitted Diseases Treatment Guidelines 2002" (Morbidity and Mortality Weekly Report, V. 51, No. RR-6, May 10, 2002). It may be downloaded from http://www.cdc.gov/mmwr/PDF/rr/rr5106.pdf

The "Revised Guidelines for HIV Counseling, Testing and Referral, and Revised Recommendations for HIV Screening of Pregnant Women" (Morbidity and Mortality Weekly Report, V. 50, No. RR-19, November 9, 2001) may be downloaded from http://www.cdc.gov/mmwr/PDF/rr/rr5019.pdf

State of Alaska Epidemiology

Bulletin

Recommendations and Reports

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