### STD TREATMENT GUIDELINES TABLE FOR ADULTS & ADOLESCENTS 2016

These recommendations for the treatment of STDs reflect the 2015 CDC STD Treatment Guidelines; the focus is primarily on STDs encountered in outpatient practice. This table is intended as a source of clinical guidance and is not a comprehensive list of all effective regimens. For more information, please refer to the complete CDC document at [http://www.cdc.gov/std/treatment/2015/default.htm](http://www.cdc.gov/std/treatment/2015/default.htm). Please visit our website at [www.nycptc.org](http://www.nycptc.org) for updates and print versions of this resource, and for additional STD resources and education.

#### DOSING ABBREVIATIONS
- d=day
- qd=once each day
- bid= twice daily
- tid=three times a day
- qid=four times a day
- po=by mouth
- iv=intravenous
- miq=milligram
- g=gram
- hs=home sleep

#### Uncomplicated Genital/Rectal Pharyngeal Infections

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<tr>
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<tr>
<td>C. trachomatis</td>
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#### Pregnancy

- All drug regimens may require reduced dosing due to increased maternal and fetal exposure. For more information, please visit the [CDC Pregnancy and Drug Exposures](http://www.nycptc.org/nycptc_nyc Weinstein/54566.pdf) website.

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<td>N. gonorrhoeae</td>
<td>Metronidazole 2g po x 1</td>
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#### Pelvic Inflammatory Disease

For parenteral regimens, see [www.cdc.gov/std/treatment/2015](http://www.cdc.gov/std/treatment/2015). For an intramuscular injection, consider a single dose of Ceftriaxone 250mg IM plus Azithromycin 1g po as a single dose.

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#### Recurrent and Persistent Urethritis

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#### Acute Epididymitis

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<td>Metronidazole 500mg po bid x 7d</td>
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#### Bacterial Vaginosis

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5. Contraindicated in pregnant and nursing women.
6. For suspected treatment failure: Re-test via NAAT and culture with antibiotic susceptibility testing from affected anatomic sites. If patient was not treated with the recommended regimen, retreat with Ceftriaxone 250 mg IM plus Azithromycin 2 g as a single dose, unless allergies preclude use of that regimen. If patient was previously treated with the recommended regimen without or with sensitivity to the drug, consult with an ID specialist or the NYC PTC [www.nycptc.org](http://www.nycptc.org) website.

2. Oral cephalosporins give lower and less sustained bacteriocidal levels than ceftriaxone 250 mg and have limited efficacy for treating pharyngeal GC. Therefore, ceftaxime plus doxycycline because of the convenience and compliance. Clinicians must make best efforts to ensure patient compliance and adherence to the treatment recommended.

3. Dual therapy with azithromycin plus cefixime 500 mg IM x 1 and doxycycline 100mg po bid x 7d is the preferred treatment for adults and adolescents with uncomplicated gonorrhea. This dual therapy is recommended for all patients with gonorrhea regardless of chlamydia test results to prevent resistance. For ALTERNATIVE REGIMENS: If a patient with oral pharyngeal gonorrhea is treated with an alternative regimen, the patient should return 14 days after treatment for a test-of-cure (NAAT or culture). For all GC infections, if symptoms persist, send culture with susceptibility testing at the infected anatomic site.

4. Due to concerns over emerging antimicrobial resistance, use should be limited to those with severe cephalosporin allergy or history of severe reaction to penicillin. If allergic to cephalosporins or severe penicillin allergy: consult ID specialist.

5. Dual therapy with Azithromycin 1g po and Ceftriaxone 250 mg IM plus doxycycline 100mg po bid x 7d is the preferred treatment for adults and adolescents with uncomplicated gonorrhea. This dual therapy is recommended for all patients with gonorrhea regardless of chlamydia test results to prevent resistance. For ALTERNATIVE REGIMENS: If a patient with oral pharyngeal gonorrhea is treated with an alternative regimen, the patient should return 14 days after treatment for a test-of-cure (NAAT or culture). For all GC infections, if symptoms persist, send culture with susceptibility testing at the infected anatomic site.

6. For more information, please refer to the complete CDC document at [http://www.cdc.gov/std/treatment/2015/default.htm](http://www.cdc.gov/std/treatment/2015/default.htm). Please visit our website at [www.nycptc.org](http://www.nycptc.org) for updates and print versions of this resource, and for additional STD resources and education.

8. Among sexually-active men aged <35 yrs, epididymitis is more likely caused by C. trachomatis or N. gonorrhoeae. For men who practice insertive anal intercourse or men aged >35 yrs, epididymitis may be caused by enteric pathogens.

9. Drug regimens may be more effective in HIV-infected women.

10. Safety during pregnancy has not been established (Pregnancy Category C); interruption of breastfeeding is recommended during treatment and for 3 days after last dose.
DISEASE | RECOMMENDED REGIMENS | ALTERNATIVE REGIMENS
--- | --- | ---
**ACUTE PROCTITIS** | • Ceftriaxone 250mg IM x 1 PLUS | • Erythromycin base 500mg po qid x 21 d or
• Doxycycline 100mg po bid x 7 d | • Azithromycin 1g po qw x 3 weeks

**LYMPHPHAGNOMALVULUM VENEREUM** | • Doxycycline 100mg po bid x 21 d | • Azithromycin 1g po qw x 3 weeks

**CHANCROID** | • Azithromycin 1g po x 1 or | • Ceftriaxone 250mg IM x 1 or
• Ciprofloxacin 500mg po bid x 3 d or | • Erythromycin base 500mg po tid x 7 d

**SYPHILIS** | Benzathine penicillin G, Bicillin-LA, (trade name), is the preferred drug for treatment of all stages of syphilis and is the only treatment with documented efficacy for syphilis during pregnancy. 14

**Adults (including HIV-Co-infected)** | Primary, Secondary, and Early Latent | Benzathine penicillin G 2.4 million units IM x 1
• Doxycycline 100mg po bid x 14 d or | • Tetracycline 100mg po bid x 14 d or
• Erythromycin 500mg po bid x 14 d or

Late Latent and Latent of Unknown Duration 15 | Benzathine penicillin G 7.2 million units, administered as 3 doses of 2.4 million units IM each, at 1-week intervals 16 | Doxycycline 100mg po bid x 28 d or
• Tetracycline 100mg po bid x 28 d or

**Neurosyphilis** | • Aqueous crystalline penicillin G 18-24 million units qd, administered as 3-4 million units IV q 4 hrs or continuous infusion x 10-14 d 19 | • Procaine penicillin G, 2.4 million units IM qd x 10-14 d plus Probeneed 500mg po qid x 10-14 d 19 or

**Pregnant Women** | Primary, Secondary, and Early Latent | Benzathine penicillin G 2.4 million units IM x 1 | • None. If PCN allergic, desensitize and treat.

Late Latent and Latent of Unknown Duration 15 | Benzathine penicillin G 7.2 million units, administered as doses of 2.4 million units IM each, at 1-week intervals 16 | • None. If PCN allergic, desensitize and treat.

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**DISEASE | RECOMMENDED REGIMENS | ALTERNATIVE REGIMENS
--- | --- | ---
**ANOGENTAL WARTS** (Human Papilloma Virus) | **Patient Applied** | **Provider Administered**
• Podofilox 0.5% solution/gel21,22: apply bid x 3 d followed by 4 d treatment; use for up to 4 cycles. Total area treated not to exceed 10cm² and total volume used < 0.5ml per day or | • Cryotherapy: repeat applications q2-1 weeks or
• Imiquimod 5% cream23,24: apply qhs 3x/week for up to 16 weeks; wash off after 6-10 hours or | • Podophyllin resin 10%-25%: apply q2-1 weeks pm; wash off after 1-4 hours. Total area treated not to exceed 10cm² and total volume used < 0.5ml per day or | • Trichloroacetic acid (TCA) 80%-90% or Bichloroacetic acid (BCA) 80%-90%: apply q week pm
• Sinechatechin 15% ointment12,25,26: apply tid (0.5cm strand of ointment per wart) for a maximum of 16 weeks or | • Surgery—electrocautery, excision, laser, curettage

**ANOGENTAL HERPES** (HSV-2 and HSV-1) | **First Clinical Episode** | **Established Infection**
• Acyclovir 400mg po tid x 7-10 d or 200mg po Siday x T-10 d or | • Acyclovir 400mg po bid or
• Famciclovir 250mg po tid x 7-10 d or | • Famciclovir 250mg po bid or
• Valacyclovir 1g po bid x 7-10 d or

**Suppressive Therapy** | • Acyclovir 400mg po bid or | • Acyclovir 400mg po bid x 5 d or
• Famciclovir 250mg po bid or | • Famciclovir 800mg po bid x 5 d or
• Valacyclovir 500mg po qd or 1g po qd | • Famciclovir 800mg po tid x 2 d or

**Episodic Therapy for Recurrent Episodes** | • Acyclovir 4000mg po bid x 5 d or | • Famciclovir 125mg po bid x 5 d or
• Valacyclovir 5000mg po bid or | • Famciclovir 1g po bid x 1 d or
• Acyclovir 800mg po tid x 3d or 500mg po x1, then 250 mg bid x 2d or | • Valacyclovir 500mg po bid x 3d or
• Acyclovir 1g po qd x 5 days or | • Famciclovir 1g po bid x 5-10 d or

**HIV Co-infected** | **Suppressive Therapy** | **Episodic Therapy for Recurrent Episodes**
• Acyclovir 4000-8000mg po bid or tid or | • Acyclovir 4000mg po bid x 5-10 d or
• Famciclovir 500mg po bid or | • Famciclovir 500mg po bid x 5-10 d or
• Valacyclovir 500mg po bid or | • Valacyclovir 1g po bid x 5-10 d

5 Contraindicated in pregnant and nursing women
12 Examining patients by anoscopy and evaluate for infection with HSV, gonorrhoea, chlamydia and syphilis
13 If perianal perianal ulcers are present or mucosal ulcers detected on anoscopy, presumptive therapy should include a regimen for genital herpes and LGV.
14 Benzathine penicillin G is available in one long-acting formulation, Bicillin-LA, which contains only benzathine penicillin G. Combination penicillin drug products, such as Bicillin-CR, contain both long- and short-acting penicillins and should not be used to treat syphilis.
15 Most HIV-infected persons respond appropriately to standard benzathine penicillin regimens. HIV-infected patients with syphilis should be treated according to the stage-specific recommendations for HIV-negative persons.
16 Use alternative regimens for penicillin-allergic, non-pregnant patients only. Data to support the use of alternatives to penicillin are limited. If compliance or follow-up cannot be ensured, the patient should be desensitized and treated with benzathine penicillin.
17 Patients diagnosed with latent syphilis who demonstrate any of the following should have a prompt CSF exam to evaluate for neurosyphilis: 1) neurologic or ophthalmic signs or symptoms; 2) evidence of active tertiary syphilis; or 3) syphilitic or treatment failure.
18 An interval of 10-14 days between doses of benzathine penicillin for late or latent syphilis of unknown duration might be acceptable before restarting the sequence of injections.
19 Some specialists recommend an additional 2.4 million units of benzathine penicillin G IM weekly for up to 3 weeks after completion of neurosyphilis treatment.
20 Mucosal genital warts (vaginal, anorectal, urethral, male urethra) should be managed in consultation with a specialist.
21 Safety profile during pregnancy not established. Pregnancy Category C.
22 Do not wash off after initial application.
23 May weaken condoms and diaphragms.
24 Use is not recommended for HIV-infected or other immunocompromised persons, or those with clinical genital herpes.
25 If HIV-1 lesions persist or recur while receiving antiviral treatment, suspect antiviral resistance. Obtain a viral isolate for sensitivity testing and consult with an HIV specialist.

Download the STD Treatment Guidelines App for both Apple and Android devices.

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