MEMO FROM THE MEDICAL DIRECTOR

DATE: 10/3/2003

TO: ALL STD/HIV STAFF

CC: FILE

FROM: THAD ZAJDOWICZ, MD, MPH,FACP

RE: CIPROFLOXACIN RESISTANT GONORRHEA

1. To date in 2003, we have found four cases of ciprofloxacin-resistant gonorrhea (QRNG) in Chicago. On review, all 4 of these cases were from the samples submitted for the CDC GISP program though the Lakeview Clinic. All 4 were in MSM patients.

2. Our estimate of the overall prevalence of QRNG at Lakeview is 7.3%, with a 95% confidence interval of 3.86% to 12.5%. If the estimate is confined to the MSM population at Lakeview, the prevalence estimate is 17.9%, with a 95% confidence interval of 10.2% to 28.3%.

3. This clearly exceeds any reasonable limit to continue general use of ciprofloxacin (or other fluoroquinolone antibiotics) to treat gonococcal infections at Lakeview. There may also be implications for MSM clients seen at other clinics.

4. The following should apply immediately in all Chicago STD clinics:

a. **At Lakeview Clinic, ciprofloxacin should no longer be used for the treatment of gonococcal infections**. The preferred therapy is ceftriaxone at either 125 mg or 250 mg IM. Oral cefixime is no longer available.

b. **In all Chicago STD clinics, MSM clients with gonococcal infection should be treated with ceftriaxone at either 125 mg or 250 mg IM**.

c. Contacts of MSM clients with gonococcal infection should not receive ciprofloxacin, but rather should also receive ceftriaxone at either 125 mg or 250 mg IM.

d. It remains very important to ask travel history for a client presenting with possible gonococcal infection. A client with recent (within the past 60 days) travel to the West Coast of the U.S. Hawaii, or the Pacific area should receive ceftriaxone at either 125 mg or 250 mg IM if gonococcal infection is detected. If a client with gonococcal infection has sex partners who have traveled to the areas indicated above, ceftriaxone 125 mg or 250 mg IM should be used.

e. Ciprofloxacin 500 mg PO may continue to be used to treat gonococcal infections where neither travel history nor sexual contact with MSM suggests possible exposure to QRNG. However, clinicians must be aware that failure of such a regimen strongly suggests the presence of QRNG.

f. If a patient returns after treatment for gonococcal infection with possible treatment failure, **especially if the treatment was ciprofloxacin or another fluoroquinolone antibiotic**, the patient should be treated with ceftriaxone at either 125 mg or 250 mg IM and considered a possible case of QRNG. A culture should be obtained and sent to IDPH labs clearly labeled "Possible cipro-resistant gonorrhea - please do susceptibility testing" and both Dr Zajackowski and myself should be notified.

5. The points of contact are Dr Thad Zajdowicz at 312-747-0130 and Dr Mark Zajackowski at 312-747-0126.

TRZ