

HAWAII STD TREATMENT GUIDELINES FOR ADULTS AND ADOLESCENTS 2003

These guidelines for the treatment of patients with STD's reflect the 2002 CDC STD Treatment Guidelines and the Region IX Infertility Clinical Guidelines. The focus is primarily on STD's encountered in office practice. These guidelines are intended as a source of clinical guidance and are not a comprehensive list of all effective regimens.

Reportable STDs include chancroid, chlamydia, gonorrhea, PID and syphilis. To report STD infections, 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, call the Hawaii State Health Department at **(808) 733-9281**.

DISEASE	RECOMMENDED REGIMENS	DOSE/ROUTE	ALTERNATIVE REGIMENS
CHANCROID	<ul style="list-style-type: none"> ● Azithromycin or ● Ceftriaxone or ● Ciprofloxacin² or ● Erythromycin base 	1 g po 250 mg IM 500 mg po bid x 3 d 500 mg po tid x 7 d	
CHLAMYDIA			
Uncomplicated Infections Adults/Adolescents ¹	<ul style="list-style-type: none"> ● Azithromycin or ● Doxycycline² 	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
Pregnant Women ³	<ul style="list-style-type: none"> ● Azithromycin or ● Amoxicillin or ● Erythromycin base 	1 g po 500 mg po tid x 7 d 500 mg po qid x 7 d	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			
Co-treatment for chlamydia infection is recommended regardless of Chlamydia laboratory test result. Co-treatment would help control emerging resistant-strain gonorrhea. If gonorrhea is documented and it persists or recurs, test-of-cure culture is recommended to ensure patient does not have an untreated resistant gonorrhea infection.			
Uncomplicated Infections Adults/Adolescents Pregnant Women	Either <ul style="list-style-type: none"> ● Cefixime⁵ or ● Ceftriaxone Plus co-treatment for chlamydia	400 mg po 125 mg IM	Either <ul style="list-style-type: none"> ● Cefpodoxime⁵ 400 mg po or ● Spectinomycin⁵ 2 g IM or ● Ceftizoxime 500 mg IM or ● Cefotaxime 500 mg IM or ● Cefoxitin 2 g IM with Probenecid 1 g po Plus co-treatment for chlamydia
Pharyngeal Infections	<ul style="list-style-type: none"> ● Ceftriaxone 	125 mg IM	
PELVIC INFLAMMATORY DISEASE^{4,6}	Parenteral⁷ Either <ul style="list-style-type: none"> ● Cefotetan or ● Cefoxitin Plus Doxycycline² <ul style="list-style-type: none"> ● Clindamycin plus Gentamicin Oral Treatment/IM Either <ul style="list-style-type: none"> ● Ceftriaxone or ● Cefoxitin with Probenecid Plus Doxycycline With or Without Metronidazole	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	Parenteral⁷ Ampicillin/Sulbactam 3 g IV q 6 hrs plus Doxycycline ² 100 mg po or IV q 12 hrs
SYPHILIS			
Uncomplicated			
Primary, Secondary, and Early Latent	<ul style="list-style-type: none"> ● Benzathine penicillin G 	2.4 million units IM	Doxycycline ^{2,13} 100 mg po bid x 2 weeks, or Tetracycline ^{2,13} 500 mg po qid x 2 weeks or Ceftriaxone ¹³ 1g IM/IV qd x 8-10 d or Azithromycin ¹³ 2 g po
Late Latent and Unknown duration	<ul style="list-style-type: none"> ● Benzathine penicillin G 	7.2 million units, administered as 3 doses of 2.4 million units IM, at 1-week intervals	Doxycycline ^{2,13} 100 mg po bid x 4 weeks, or Tetracycline ^{2,13} 500 mg po qid x 4 weeks
Neurosyphilis ¹⁴	<ul style="list-style-type: none"> ● 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 ¹³ 2 g IM/IV qd x 10-14 d
HIV Infection			
Primary, Secondary, and Early Latent	<ul style="list-style-type: none"> ● Benzathine penicillin G 	2.4 million units IM	Doxycycline ^{2,14} 100 mg po bid x 2 weeks or Tetracycline ^{2,14} 500 mg po qid x 2 weeks
Late Latent, and Unknown duration ¹⁵ with normal CSF Exam	<ul style="list-style-type: none"> ● Benzathine penicillin G 	7.2 million units, administered as 3 doses of 2.4 million units IM, at 1-week intervals	None
Neurosyphilis ^{14,15}	<ul style="list-style-type: none"> ● 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
Pregnant Women¹⁵			
Primary, Secondary, and Early Latent	<ul style="list-style-type: none"> ● Benzathine penicillin G 	2.4 million units IM	None
Late Latent and Unknown duration	<ul style="list-style-type: none"> ● Benzathine penicillin G 	7.2 million units, administered as 3 doses of 2.4 million units IM, at 1-week intervals	None

DISEASE	RECOMMENDED REGIMENS	DOSE/ROUTE	ALTERNATIVE REGIMENS
Neurosyphilis ¹⁴	<ul style="list-style-type: none"> • 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 q d x 10-14 d plus Probenecid 500 mg po qid x 10-14 d
BACTERIAL VAGINOSIS			
Adults/Adolescents	<ul style="list-style-type: none"> • Metronidazole or • Clindamycin cream¹⁰ or • Metronidazole gel 	500 mg po bid x 7 d 2% one full applicator (5g) intravaginally qhs x 7 d 0.75% one full applicator (5g) intravaginally qd x 5 d	Metronidazole 2 g po, or Clindamycin 300 mg po bid x 7 d or Clindamycin ovules 100 g intravaginally qhs x 3 d
Pregnant Women	<ul style="list-style-type: none"> • Metronidazole or • Clindamycin 	250 mg po tid x 7 d 300 mg po bid x 7 d	
EPIDIDYMITIS ^{4,6}	Likely due to gonorrhea or chlamydial infection <ul style="list-style-type: none"> • Ceftriaxone plus Doxycycline Likely due to enteric organisms <ul style="list-style-type: none"> • Ofloxacin or • Levofloxacin 	250 mg IM 100 mg po bid x 10 d 300 mg po bid x 10 d 500 mg po qd x 10 d	
HERPES SIMPLEX VIRUS ¹¹			
First Clinical Episode of Herpes	<ul style="list-style-type: none"> • 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	
Episodic Therapy for Recurrent Episodes	<ul style="list-style-type: none"> • Acyclovir or • Acyclovir or • Acyclovir or • Famciclovir or • Valacyclovir or • Valacyclovir 	400 mg po tid x 5 d 200 mg po 5/day x 5 d 800 mg po bid x 5 d 125 mg po bid x 5 d 500 mg po bid x 3-5 d 1 g po qd x 5 d	
Suppressive Therapy	<ul style="list-style-type: none"> • Acyclovir or • Famciclovir or • Valacyclovir or • Valacyclovir 	400 mg po bid 250 mg po bid 500 mg po qd 1 g po qd	
HIV Infection ¹²			
Episodic Therapy for Recurrent Episodes	<ul style="list-style-type: none"> • Acyclovir or • Acyclovir or • Famciclovir or • Valacyclovir 	400 mg po tid x 5-10 d 200 mg po 5/day x 5-10 d 500 mg po bid x 5-10 d 1 g po bid x 5-10 d	
Suppressive Therapy	<ul style="list-style-type: none"> • Acyclovir or • Famciclovir or • Valacyclovir 	400-800 mg po bid-tid 500 mg po bid 500 mg po bid	
HUMAN PAPILLOMAVIRUS			
External Genital / Perianal Warts	Patient Applied <ul style="list-style-type: none"> • Podofilox¹⁶ 0.5% solution or gel or • Imiquimod¹⁷ 5% cream Provider Administered <ul style="list-style-type: none"> • Cryotherapy or • Podophyllin¹⁶ resin 10%-25% in tincture of benzoin or • Trichloroacetic acid (TCA) or • Bichloroacetic acid (BCA) 80%-90% or • Surgical removal 		Alternative Regimen Intralesional interferon or Laser surgery
Mucosal Genital Warts	<ul style="list-style-type: none"> • Cryotherapy or • TCA or BCA 80%-90% or • Podophyllin¹⁶ resin 10%-25% in tincture of benzoin. or • Surgical removal 	Vaginal, urethral meatus, and anal Vaginal and anal Urethral meatus only Anal warts only	
LYMPHOGRANULOMA VENEREUM	<ul style="list-style-type: none"> • Doxycycline² 	100 mg po bid x 21 d	Erythromycin base 500 mg po qid x 21 d Azithromycin ¹⁸ 1 g po qd x 21 d
MUCOPURULENT CERVICITIS ^{4,6,8}	<ul style="list-style-type: none"> • Azithromycin or • Doxycycline² 	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
NONGONOCOCCAL URETHRITIS ⁶	<ul style="list-style-type: none"> • Azithromycin or • Doxycycline² 	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
TRICHOMONIASIS ⁹	<ul style="list-style-type: none"> • Metronidazole 	2 g po	Metronidazole 500 mg po bid x 7 d

- Annual screening for women age 25 years or younger. Nucleic Acid Amplification Tests (NAATS) are recommended. Women with Chlamydia should be rescreened 3-4 months after treatment.
- Contraindicated for pregnant and nursing women.
- Test-of-cure follow-up is recommended because the regimens are not highly efficacious (Amoxicillin and Erythromycin) or the data on safety and efficacy are limited (Azithromycin).
- If gonorrhea is documented and it persists or recurs, test-of-cure culture is recommended to ensure patient does not have an untreated resistant gonorrhea infection.
- Not recommended for pharyngeal gonococcal infection.
- Testing for gonorrhea and chlamydia is recommended because a specific diagnosis may improve compliance and partner management.
- Discontinue 24 hours after patient improves clinically and continue with oral therapy for a total course of 14 days.
- If gonorrhea is documented, add a gonorrhea treatment regimen.
- Documented infection with treatment failure should be evaluated for metronidazole-resistant *T. vaginalis*. Referral to CDC at (404) 639-8371.
- Might weaken latex condoms and diaphragms because oil-based; not recommended in pregnancy.
- Counseling about natural history, asymptomatic shedding, and sexual transmission is an essential component of herpes management.
- If lesions persist or recur while receiving antiviral therapy, HSV resistance should be suspected and a viral isolate should be obtained for testing.
- Because efficacy of these therapies has not been established and compliance of some of these regimes difficult, close follow-up is essential. If compliance or follow-up cannot be ensured then patient should be desensitized and treated with benzathine penicillin.

- 14 Some specialists recommend 2.4 million units of benzathine penicillin G q week for 1 to 3 weeks after completion of initial treatment.
- 15 Patients allergic to penicillin should be treated with penicillin after desensitization.
- 16 Contraindicated during pregnancy.
- 17 Safety in pregnancy has not been well established.
- 18 Azithromycin may prove useful for treatment in pregnant women but no published data are available regarding its safety and efficacy.