disease prevention news

DPN

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STD Treatment Guidelines

The most current guidelines for the prevention and control of sexually transmitted diseases (STDs) are those published September 24, 1993, by the Centers for Disease Control and Prevention (MMWR, Vol. 42, No. RR-14). This 102-page report includes information on prevention methods, reporting and confidentiality, patient education and counseling, and medical treatment. The following quick reference guide, prepared by the STD/HIV Prevention Training Center of the Dallas County Health Department, excerpts the medical treatment guidelines for the STDs clinicians encounter most frequently.

Bacterial Vaginosis

Recommended Regimen

Metronidazole 500 mg orally 2 times a day for 7 days

NOTE: Patients should be advised to avoid using alcohol during treatment with metronidazole and for 24 hours thereafter.

Alternative Regimens

Metronidazole 2 g orally in a single dose

The following alternative regimens have been effective in clinical trials, although experience with these regimens is limited.

Clindamycin cream 2% one full applicator (5 g) intravaginally at bedtime for 7 days

or

Metronidazole gel 0.75% one full applicator (5 g) intravaginally 2 times a day for 5 days

or

Clindamycin 300 mg orally 2 times a day for 7 days

Chlamydial Infections Among Adolescents and Adults

Recommended Regimens

Doxycycline 100 mg orally 2 times a day for 7 days

or

Azithromycin 1 g orally in a single dose

Alternative Regimens

Ofloxacin 300 mg orally 2 times a day for 7 days

or

Erythromycin base 500 mg orally 4 times a day for 7 days

or

Erythromycin ethylsuccinate 800 mg orally 4 times a day for 7 days

or

Sulfisoxazole 500 mg orally 4 times a day for 10 days (inferior efficacy)

***Recommended Regimen* for Pregnant Women**

Erythromycin base 500 mg orally 4 times a day for 7 days

***Alternative Regimens* for Pregnant Women**

Erythromycin base 250 mg orally 4 times a day for 14 days

or

Erythromycin ethylsuccinate 800 mg orally 4 times a day for 7 days

or

Continued ☞

Also in this issue:

Erythromycin ethylsuccinate 400 mg orally 4 times a day for 14 days

or

Amoxicillin 500 mg orally 3 times a day for 7-10 days (if erythromycin cannot be tolerated)

NOTE: Erythromycin estolate is contraindicated during pregnancy because of drug-related hepatotoxicity. Few data exist concerning the efficacy of amoxicillin.

Pelvic Inflammatory Disease

***Recommended Regimens* for Inpatient Treatment**

Clinical experience and randomized trials have demonstrated the efficacy of each of the following inpatient regimens.

Regimen A

Cefoxitin 2 g IV every 6 hours

or

Cefotetan 2 g IV every 12 hours

PLUS

Doxycycline 100 mg IV or orally every 12 hours

Regimen B

Clindamycin 900 mg IV every 8 hours

PLUS

Gentamicin loading dose IV or IM (2 mg/kg of body weight) followed by a maintenance dose (1.5 mg/kg) every 8 hours

***Recommended Regimens* for Outpatient Treatment**

Either of the following outpatient regimens provide coverage against the common etiologic agents of PID. Regimen B provides broader coverage against anaerobic organisms but at a much higher cost than that of Regimen A.

Regimen A

Cefoxitin 2 g IM concurrently with **probenecid** 1 g orally in a single dose

or

Ceftriaxone 250 mg IM or other parenteral third-generation **cephalosporin** (eg, **ceftizoxime** or **cefotaxime**)

PLUS

Doxycycline 100 mg orally 2 times a day for 14 days

Regimen B

Ofloxacin 400 mg orally 2 times a day for 14 days

PLUS

Clindamycin 450 mg orally 4 times a day

or

Metronidazole 500 mg orally 2 times a day for 14 days

Genital Herpes Simplex Virus Infections

***Recommended Regimen* for First Clinical Episode of Genital Herpes**

Acyclovir 200 mg orally 5 times a day for 7-10 days or until clinical resolution is attained

***Recommended Regimen* for Recurrent Episodes**

Acyclovir 200 mg orally 5 times a day for 5 days

or

Acyclovir 400 mg orally 3 times a day for 5 days

or

Acyclovir 800 mg orally 2 times a day for 5 days

Continued ☞

Vulvovaginal Candidiasis

Recommended Regimen

Butoconazole 2% cream 5 g intravaginally for 3 days*

or

Clotrimazole 1% cream 5 g intravaginally for 7-14 days†

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

Miconazole 2% cream 5 g intravaginally for 7 days*†

or

Miconazole 200 mg vaginal suppository, 1 suppository for 3 days*

or

Miconazole 100 mg vaginal suppository, 1 suppository for 7 days*†

or

Tioconazole 6.5% ointment 5 g intravaginally in a single application*

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 suppository, 1 suppository for 3 days*

* Oil-based preparations (may weaken latex condoms and diaphragms)
† Over-the-counter preparations

***Recommended Regimen* for Recurrent Episodes**

Ketoconazole 100 mg orally, once daily for up to 6 months. Optimal treatment for RVVC has not been established; this regimen reduces frequency of episodes. For women with 3 or more episodes of VC per year, evaluate cases for predisposing conditions.

Human Papilloma Virus Infection

***Regimens* for External Genital/Perianal Warts**

Cryotherapy with liquid nitrogen or cryoprobe

or

Podofilox 0.5% solution for self-treatment (genital warts only). Patients may apply podofilox with a cotton swab to warts twice daily for 3 days, followed by 4 days of no therapy. This cycle may be repeated as necessary for a total of 4 cycles. Total wart area treated should not exceed 10 cm^2, and total volume of podofilox should not exceed 0.5 mL per day. If possible, the healthcare provider should apply the initial treatment to demonstrate the proper application technique and identify which warts should be treated. **NOTE:** The use of podofilox is contraindicated during pregnancy.

or

Podophyllin 10%-25%, in compound tincture of benzoin. To avoid the possibility of problems with systemic absorption and toxicity, some experts recommend that application be limited to $\leq$0.5 mL or $\leq$10 cm^2 per session. Thoroughly wash off in 1-4 hours. Repeat weekly if necessary. If warts persist after 6 applications, other therapeutic methods should be considered. **NOTE:** The use of podophyllin is contraindicated during pregnancy.

or

Trichloroacetic acid (TCA) 80%-90%. Apply only to warts; powder with talc or sodium bicarbonate (baking soda) to remove unreacted acid. Repeat weekly if necessary. If warts persist after 6 applications, other therapies should be considered.

or

Electrodesiccation or **electrocautery**. Electrodesiccation and electrocautery are contraindicated for patients with cardiac pacemakers or for lesions proximal to the anal verge.

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***Regimens* for Vaginal Warts**

Cryotherapy with liquid nitrogen. The use of a cryoprobe in the vagina is not recommended because of the risk for vaginal perforation and fistula formation.

or

TCA 80%-90%. Apply only to warts; powder with talc or sodium bicarbonate (baking soda) to remove unreacted acid. Repeat weekly if necessary. If warts persist after 6 applications, other therapies should be considered.

or

Podophyllin 10%-25% in compound tincture of benzoin. Apply to the treatment area, which must be dry before removing the speculum. Treat ≤2 cm^2 per session. Repeat application at weekly intervals. Because of concern about potential systemic absorption, some experts caution against vaginal application of podophyllin. **NOTE:** The use of podophyllin is contraindicated during pregnancy.

Sexual Assault and STDs in Adults

***Recommended Regimen* for Prophylaxis**

Ceftriaxone 125 mg IM in a single dose

PLUS

Metronidazole 2 g orally in a single dose

PLUS

Doxycycline 100 mg orally 2 times a day for 7 days

Syphilis

***Recommended Regimen* for Adults with Primary and Secondary Syphilis**

Nonallergic, non-HIV-infected, nonpregnant patients with primary or secondary syphilis should be treated with the following regimen.

Benzathine penicillin G, 2.4 million units IM in a single dose

***Recommended Regimen* for Persons with Penicillin Allergy**

Nonpregnant penicillin-allergic patients who have primary or secondary syphilis should be treated with the following regimen:

Doxycycline 100 mg orally 2 times a day for 2 weeks

or

Tetracycline 500 mg orally 4 times a day for 2 weeks

There is less clinical experience with doxycycline than with tetracycline, but compliance is likely to be better with doxycycline. Therapy for a patient who cannot tolerate either doxycycline or tetracycline should be based on whether the patient's compliance with the therapy regimen and with follow-up examinations can be assured.

***Recommended Regimens* for Adults with Latent Syphilis**

These regimens are for nonallergic patients with normal CSF examination (if performed).

Early Latent Syphilis

Benzathine penicillin G, 2.4 million units IM in a single dose

Late Latent Syphilis or Latent Syphilis of Unknown Duration

Benzathine penicillin G, 7.2 million units total, administered as 3 doses of 2.4 million units IM each, at 1-week intervals.

Treatment of Primary and Secondary Syphilis Among HIV-Infected Patients

Treatment with benzathine penicillin G, 2.4 million units IM (eg, patients without HIV infection) is recommended. Some experts recommend additional treatments, such as multiple doses of

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benzathine penicillin G as suggested for late syphilis or other supplemental antibiotics in addition to benzathine penicillin G, 2.4 million units IM. Patient follow-up must continue for at least a year to watch for evidence of relapse (especially CNS relapse).

Gonococcal Infections Among Adolescents and Adults (uncomplicated)

Recommended Regimens

Ceftriaxone 125 mg IM in a single dose

or

Cefixime 400 mg orally in a single dose

or

Ciprofloxacin 500 mg orally in a single dose

or

Ofloxacin 400 mg orally in a single dose

PLUS

A regimen effective against possible coinfection with C trachomatis, such as **doxycycline** 100 mg orally 2 times a day for 7 days.

For further information on STD treatment contact Charles Bell, MD, Chief, or Linda Moore, MS, RN, Bureau of HIV and STD, (512) 490-2505.

For comprehensive screening information regarding childhood sexual abuse and STDs, see DPN Vol. 55, No. 16 (August 7, 1995).

HIV-Infection in Pregnancy: Clinical Practice Guidelines Availability

The Texas Department of Health Bureau of HIV and STD Prevention, in consultation with the Division of Women's Health, has published *Clinical Practice Guidelines: HIV-Infected Pregnant Adult.* The prevalence rate of human immunodeficiency virus (HIV) among Texas women of childbearing age is among the highest in the nation. Since many of the cases of HIV-infection in women are transmitted by sexual contact with HIV-infected males, the number of HIV-infected pregnant women can be expected to rise in the future.

These guidelines, which are based upon current scientific research as well as the clinical experience of recognized experts, incorporate components of prenatal and postpartum care with those required to manage HIV-infection. Minimum experience in serving HIV-infected pregnant women who are in relatively stable physical condition will be required to provide care in a safe and effective manner when using this material. The information is presented in an easy-to-use format.

Copies of these guidelines are available by contacting Cora Flores or Debbie Shepard-White, Bureau of HIV and STD Prevention at (512) 490-2505, or by addressing correspondence to:

Cora Flores, Bureau of HIV and STD Prevention, Texas Department of Health, 1100 West 49th Street, Austin, Texas 78756

To obtain a copy on diskette, please include a 3.5 inch diskette formatted for IBM-compatible systems (1.44 MB) with your written request.

Cholera Morbidity Continues Throughout Western Hemisphere

Cholera remains a serious public health concern in the Western Hemisphere, with over a million cases confirmed since 1991. Thousands of cases continue to occur each year in Central and South America, and in the past 4 years over 40,000 cholera cases have occurred in Mexico. Two Texas cholera cases were confirmed in 1995; both individuals had traveled to Mexico. (A more comprehensive description of these cases will appear in a later issue of DPN.) Physicians should consider the diagnosis of cholera in all patients with severe diarrhea and a recent travel history to countries where cholera is occurring. Cholera cases must be reported immediately by phone to (800) 705-8868.

All *Vibrio cholerae* isolates should be submitted to the Texas Department of Health (TDH) Laboratory for serotyping. Stool specimens should be collected before the patient has received any antimicrobial agent. Fecal material or rectal swabs should be placed in Cary-Blair semisolid transport medium and shipped at ambient temperature in a triple container. If Cary-Blair transport medium is not available, a raw specimen of about 2 tablespoons may be shipped on wet ice or cold packs in a sterile, leak-proof container. A Specimen Submission Form (G-1) must be completed for each isolate or stool specimen; indicate the name of the submitting agency or physician and the address to which the report should be sent. Specimens should be shipped to: Texas Department of Health Laboratory 1100 West 49th Street, Austin, TX 78756-3194.

For further information about cholera or other infectious diseases, call the Infectious Disease Epidemiology and Surveillance (IDEAS) Division, Texas Department of Health, at (512) 458-7676.

Snake Bites

From 1980 and 1994, 12 deaths due to venomous snake bites occurred in residents of Brazoria, Cameron, Dallas, DeWitt, Floyd, Hamilton, Medina, Newton, Scurry, Travis, and Van Zandt counties. The following table shows deaths by age and gender:

Snake Bite Fatalities

Age	Male Deaths	Female Deaths
0-9	1	2
10-19	0	0
20-29	2	0
30-39	1	0
40-49	1	0
50-59	1	1
60 +	0	3

Endemic Arboviral Activity, January-June 1995: none

May/Jun 1996

Bimonthly Statistical Summary of Selected Reportable Diseases

	HHSC Region											Selected Texas Counties								This Period		Cumulative[1]	
Selected Diseases/Conditions	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**Bexar**	**Dallas**	**El Paso**	**Harris**	**Hidalgo**	**Nueces**	**Tarrant**	**Travis**	**1995**	**1996**	**1995**	**1996**
Sexually Transmitted Diseases[2]																							
Syphilis, primary and secondary	17	3	50	3	25	65	12	^6	1	0	4	^2	31	0	55	1	4	14	8	245	186	716	466
Congenital Syphilis	0	0	4	0	0	25	0	^1	0	0	1	^1	3	0	24	1	0	0	0	16	31	73	83
Resistant Neisseria gonorrhoeae	4	0	2	0	0	1	1	^2	0	0	2	^2	2	0	1	0	2	0	0	26	12	100	37
Enteric Diseases																							
Salmonellosis	23	7	28	7	6	14	38	44	10	16	15	32	15	16	2	1	6	1	13	417	208	767	684
Shigellosis	1	1	22	8	2	9	70	87	1	1	39	56	10	1	0	0	29	1	50	360	241	933	719
Hepatitis A	17	6	43	15	4	19	14	44	5	24	94	19	25	22	13	44	13	12	10	523	285	1480	1344
Campylobacteriosis	22	1	8	2	6	8	25	18	0	9	3	13	6	9	5	0	1	0	11	242	102	499	329
Bacterial Infections																							
H. influenzae, invasive	0	0	1	0	0	0	1	0	0	0	0	0	1	0	0	0	0	0	0	0	2	6	3
Meningococcal, invasive	0	0	9	5	2	1	5	2	1	0	0	2	4	0	1	0	0	1	1	44	25	165	142
Lyme disease	1	0	1	0	0	0	0	1	0	0	0	0	0	0	0	0	0	1	0	25	3	49	11
Vibrio species	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	8	0	10	0
Other Conditions																							
AIDS[4]	13	7	255	6	27	381	64	77	9	20	48	63	190	20	346	14	17	33	53	898	982	2604	2453
Hepatitis B	6	5	21	4	10	7	11	21	7	4	9	18	9	4	4	0	8	3	8	227	105	649	494
Adult elevated blood lead levels	0	2	18	0	1	1	3	38	0	3	0	38	13	3	1	0	0	0	0	85	66	286	179
Animal rabies - total	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	93	*	816	*
Animal rabies - dogs and cats	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	9	*	62	*
Tuberculosis Disease[2]																							
Children (0-14 years)	1	1	4	2	1	11	1	1	0	0	1	1	3	0	9	1	0	1	0	42	23	84	76
Adults (>14 years)	3	6	87	9	5	165	27	28	4	21	62	14	62	21	126	22	8	13	15	418	417	973	940
Injuries[2]																							
Spinal Cord Injuries	0	2	14	0	0	2	1	0	0	0	0	0	1	0	2	0	0	10	0	23	19	147	130

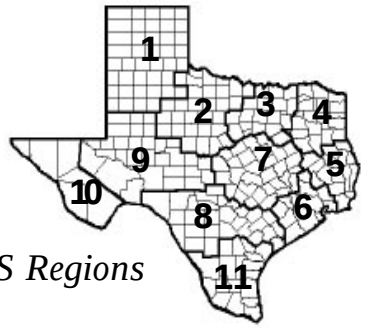
1. Cumulative to this month. 2. Data for the STD's, Tuberculosis, and spinal cord injuries are provided by date of report, rather than date of onset. 3. Voluntary reporting. 4. AIDS totals include reported cases from Texas Department of Corrections, which are not included in the regional and county totals. * Data unavailable. ^ Partial data from Bexar county.

Call 1-800-705-8868 to report

1994 POPULATION ESTIMATES

HHSC REGIONS							
1	751,822	4	931,379	7	1,844,240	10	684,580
2	530,445	5	680,001	8	1,919,939	11	1,499,969
3	4,724,463	6	4,184,163	9	537,820		
STATEWIDE TOTAL	18,286,827						

SELECTED TEXAS COUNTIES			
Bexar	1,268,744	Hidalgo	442,346
Dallas	1,987,680	Nueces	306,499
El Paso	658,498	Tarrant	1,314,613
Harris	3,004,010	Travis	605,804



DHHS Regions

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Vaccine Preventable Disease Update
Confirmed cases with onset from 5/1/96-6/30/96

Condition	County	Number of	Date	Condition	County	Number of	Date
Measles	Harris	1	5/9	**Pertussis**	Nueces	1	5/8
		1	5/29		Midland	1	5/9
		1	6/9			1	5/10
	Dallas	1	6/18		Denton	1	5/13
	Harris	1	6/20		Nueces	1	5/15
		1	6/23		Howard	1	5/20
					Nueces	2	5/20
Mumps	Glasscock	1	5/3		Harris	1	5/30
	Travis	1	5/5		Nueces	1	6/5
	Galveston	1	5/8		Travis	1	6/10
	Travis	1	6/25		Nueces	1	6/13
					Smith	1	6/14
Pertussis	Nueces	1	5/3		Bexar	1	6/18
	Karnes	1	5/5		Panola	1	6/23

YTD	Measles	Mumps	Pertussis	Rubella
	10	**18**	**59**	**1**