

STD Treatment Chart
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| Disease | Treatment | Alternative treatment | Pregnancy | Comments |
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| Chlamydia | Azithromycin 1 gram p.o. single dose Or Doxycycline 100mg BID X 7days | Erythromycin base 500mg QID X 7 days Or Erythromycin ethylsuccinate 800mg QID X 7 days Or Ofloxacin 300mg BID X 7 days Or Levofloxacin 500mg X 7 days | *Doxycycline and Ofloxacin contraindicated in pregnancy *Repeat testing 3 weeks after completion of treatment Erythromycin base 500mg QID X 7days Or Amoxicillin 500mg TID X 7 days Alternative: Erythromycin base 250 mg QID X 14 days Or Erythromycin ethylsuccinate 800mg QID X 7 days or 400mg QID X 14 days Or Azithromycin 1 gram p.o. single dose | *Azithromycin best to use if compliance an issue *Doxycycline is less expensive *Erythromycin tends to have more GI side effects; should do TOC 3 weeks after completion of treatment *Ofloxacin has no advantage over Doxycycline or Azithromycin and is more \$ *Levofloxacin has not been eval for treatment, but pharmacology and vitro microbiology activity similar to Ofloxacin |
| Chancroid | Azithromycin 1 gm p.o. single dose Or Ceftriaxone 250mg IM single dose Or Ciprofloxacin 500mg p.o. BID X 3 days Or Erythromycin base 500mg p.o. TID X 7 days | | Ciprofloxacin is contraindicated in pregnancy and lactating women | |
| Epididymitis | Ceftriaxone 250 mg IM And Doxycycline 100mg BID X 10 days Or Ofloxacin 300 mg p.o. BID X 10 days Or Levofloxacin 500 mg p.o. q day X 10 days | | | Most often caused by Chlamydia or GC *Should see improvement 3 days after treatment initiated *Use Ofloxacin if Levofloxacin is not likely STD related or allergic to cephalosporins or Tetracycline |
| Gonorrhea: Uncomplicated (cx, urethra, and rectum): [Quinolone resistant N. gonorrhoeae (QRNG) seen in Asia, Pacific, Hawaii, and West Coast of US] | Cefixime 400mg p.o. single dose Or Ceftriaxone 125mg IM single dose Or Ciprofloxacin 500 mg p.o. single dose Or Ofloxacin 400mg p.o. single dose Or Levofloxacin 250 mg p.o. single dose Uncomplicated Pharyngeal: Ceftriaxone 125 mg IM single dose Or Ciprofloxacin 500mg p.o. single dose | Spectinomycin 2 gm IM single dose | Quinolones and Tetracycline contraindicated in pregnancy Use cephalosporin or Spectinomycin | Cefixime: 97.4% cure rate Ceftriaxone: 99.1% cure rate at all anatomic sites Ciprofloxacin: 99.8% cure rate caution with QRNG Ofloxacin: 98.6% cure rate Spectinomycin: 98.2% cure rate, but expensive; useful if can not tolerate cephalosporin or quinolone, if suspect pharyngeal need f/u pharyngeal culture 3-5 days after treatment |

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| <p>HPV (Human Papillomavirus Infection)</p> <p>Patient applied:</p> <p>Podofilox 0.5% solution or gel (antimitotic drug that destroys warts) Pt. Applies solution with cotton swab or gel with a finger to the warts BID X 3 days followed by 4 days off. May repeat cycle as necessary up to 4 cycles. Max 0.5 cc/day and area not to exceed 10cm². May experience mild/mod pain or local irritation. Must be able to see and reach warts for self- treatment. Or (Aldara) Imiquimod 5% cream (immune enhancer that stimulates production of interferon and other cytokines) Apply once daily at bedtime 3 X week up to 16 weeks. Must wash off 6-10 hours after application. Local inflammatory reactions are common.</p> <p>Practitioner applied:</p> <p>Cryotherapy (destroys wart by thermal-induced cytolysis) Repeat q 1-2 weeks. May have pain after treatment followed by necrosis and sometimes blistering Or Triachloroacetic acid TCA 80-90% (caustic agent that destroys wart by chemical coagulation of the proteins) Apply small amt to wart only; allow to dry (will see area turn white). May reapply weekly if necessary</p> | | | <p>Do not use in pregnancy; safety has not been established</p> <p>Do not use in pregnancy; safety has not been established</p> | <p>Primary goal of treating visible warts is the removal of symptomatic warts</p> <p>Existing data indicate treating warts may reduce, but probably not eradicate infectivity</p> <p>No evidence suggest one treatment is superior to others</p> <p>Treatment modality should change if no response after 3 provider administered treatments or not cleared after 6</p> <p>The first treatment may be done in the office to demonstrate proper use.</p> <p>F/U may be useful after several weeks to determine response to treatment.</p> <p>Acid can be neutralized with sodium bicarbonate or soap</p> |
| <p>Lymphogranuloma venereum</p> | <p>Doxycycline 100mg p.o. BID X 21 days</p> | <p>Erythromycin base 500mg p.o. QID X 21 days</p> | <p>Doxycycline is contraindicated in pregnancy</p> | |
| <p>Mucopurulent cervicitis</p> | | | | <p>Results of Chlamydia and/or GC should determine need for treatment</p> <p>Pt needs to follow up in 48 hr. (Repeat pelvic examinations to confirm decrease in CMT</p> |

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| Pelvic Inflammatory Disease (PID): Out patient treatment | <p>Regimen A: Ofloxacin 400 mg p.o. BID X 14 days Or Levofloxacin 500mg p.o. q day X 14 days Plus (with both of above) Metronidazole 500mg p.o. BID X 14 days</p> <p>Regimen B: Ceftriaxone 250mg IM single dose Or Cefoxitin 2 gm IM and Probenecid 1 gm p.o. single dose Plus (with both of above) Doxycycline 100mg p.o. BID X 14 days</p> <p>With or without</p> <p>Metronidazole 500 mg p.o. BID X 14 days</p> | | Refer all pregnant patients suspected to have PID | Repeat bimanual exam in 48 hours. If no response in 72 hours need re-evaluation and referral. Ofloxacin effective against both GC and Chlamydia. Levofloxacin as effective and q day dosing, increases compliance |
| <p>Syphilis: Primary and Secondary Syphilis</p> <p>Latent Syphilis-seroreactivity without other evidence of disease Early latent syphilis</p> <p>Late latent syphilis</p> <p>Tertiary and Neurosyphilis</p> | <p>Benzathine penicillin G 2.4 million units IM</p> <p>Benzathine penicillin G 2.4 million units IM</p> <p>Benzathine penicillin G 2.4 million units IM once a week for 3 weeks</p> | <p>Doxycycline 100 mg p.o. BID X 14 days Or Tetracycline 500mg p.o. QID X 14 days</p> <p>Doxycycline 100mg p.o. BID X 28 days Or Tetracycline 500 mg p.o. QID X 28 days</p> | <p>Doxycycline and Tetracycline contraindicated in pregnancy; if allergic to PCN needs referral</p> <p>Late latent refer if pregnant</p> | <p>Serologic f/u 6 months and 12 months after treatment</p> <p>Refer</p> |
| Trichomoniasis | <p>Metronidazole 2 gm p.o. single dose Or Metronidazole 500 mg p.o. BID X 7 days</p> | | | No alcohol 24 hours prior to or after use |

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| <p>Urethritis (nongonococcal)</p> | <p>Azithromycin 1 gm p.o. single dose Or Doxycycline 100 mg p.o. BID X 7 days</p> | <p>Erythromycin base 500 mg p.o. QID X 7days Or Erythromycin ethylsuccinate 800 mg QID X 7 days Or Ofloxacin 300 mg p.o. BID X 7 days Or Levofloxacin 500 mg p.o. q day X 7 days</p> | | |
| <p>Recurrent/Persistent Urethritis (if patient compliant with initial treatment and no re-exposure)</p> | <p>Metronidazole 2 gm p.o. single dose</p> <p>Plus</p> <p>Erythromycin base 500 mg p.o. QID X 7 days Or Erythromycin ethylsuccinate 800 mg p.o. QID X 7 days</p> | | | |