**Chlamydia** – *Chlamydia trachomatis*

**Chlamydia tx:**

Azithromycin 1 g po x 1\*Pregnant – Azith only

Doxycycline 100 mg po BID x 7d

Alt:Erythromycin 500 mg po QID x 7d

Levofloxacin 500 mg po daily x 7d

Ofloxacin 300 mg po daily x 7d

* Infects columnar epithelial cells
* Most frequently reported STD in US – 3 million cases per year
* Often asymptomatic
* Annual screening for women recommended
* NAAT is the preferred testing/most sensitive
* abstain for 7 days after tx completion

**Gonorrhea tx: always treat for chlamydia too/always use dual therapy to prevent resistance**

Uncomplicated: Ceftriaxone 250 mg IM x 1

Disseminated: Ceftriaxone 1 g IV q24h until sx improve

then Cefixime 400 mg po BID for total 7d

Meningitis: Ceftriaxone 1-2 g IV q12h x 10-14d

Endocarditis: Ceftriaxone 1-2 g IV q12h x 4 weeks

\*PCN allergy – Azith 2 g po x 1 dose

**Gonorrhea** *– Neisseria gonorrhea*

* Infects mucus-secreting epithelial cells
* Uncomplicated: urogenital, anorectal, pharyngeal
  + Sx: dysuria, purulent discharge
  + sx develop within days, 90% develop sx within 2 weeks
* Disseminated: SKIN LESIONS, septic arthritis, tenosynovitis,

perihepatitis, endocarditis, meningitis

**PID** – usually from gonorrhea/chlamydia

**PID tx: INPATIENT – 14 days**

Cefotetan 2 g IV q12h + doxy 100 mg po BID

Cefoxitin 2 g IV q6h + doxy 100 mg po BID

Clinda 900 mg IV q8h + gent 2 mg/kg IV x 1, then 1.5 mg/kg q8h

Alt: Amp/sulbactam 3 q IV q6h + doxy 100 mg po BID

**PID tx: OUTPATIENT – 14 days**

Ceftriaxone 250 mg IM x 1 + doxy 100 mg po BID

+/- metronidazole 500 mg po BID

Cefoxitin 2 g IM x 1 + probenecid 1 g po x 1 + doxy 100 mg po BID

+/- metronidazole 500 mg po BID

* Need biopsy or ultrasound to detect scarring
* Endometritis, salpingitis, tubo-ovarian abscess, pelvic peritonitis
* 60% asymptomatic
* 25% - infertility, ectopic preg, chronic pelvic pain
* Need abx for gonorrhea, chlamydia, anaerobes, gram(+), gram(-)
* Treat partners of past 60 days for chlamydia/gonorrhea

**Syphilis** *– Treponema pallidum*

**Syphilis tx:**

**Primary, Secondary, Early latent**

Benzathine penicillin G 2.4 million units IM x 1

PCN allergy: doxy 100 mg po BID x 14d

**Tertiary, Late latent**

Benzathine penicillin G 2.4 million units IM x 3

(1 dose weekly x 3 weeks)

PCN allergy: probably doxy but consult specialist

**Neurosyphilis**

Aqueous crystalline penicillin G 3-4 million units IV q4h x 6 doses

or 18-24 million units IV 24hr continuous infusion

Alt: Procaine penicillin 2.4 million units IM daily

+ probenecid 500 mg po QID x 10-14 days

* Mucous membrane -> lymphnode -> blood
* Dx: treponmeal Ab test, RPR (rapid plasma regain)
* **Primary Syph:** ulcer or chancre
* **Secondary Syph:** rash on palms/soles, mucocutaneouus lesions,

lymphadenopathy

* **Tertiary Syph:** cardiac involvement-attacks aorta, gummy lesions
* **Early latent:** + test <1 year after first sx (not contagious)
* **Late latent:** + test >1 year after first sx (not contagious)

**Neurosyphilis:**

* Can travel to CNS at any stage
* Cranial nerve dys, memingitis, stroke, altered mental status,

loss of vibration sense, auditory/ophthalmic abnormalities

\*If patient is pregnant/neurosyphilis, must desensitize PCN allergy

**Trichomoniasis** – *Trichomonas vaginalis* (protozoa)

**Trich tx:** DO NOT USE TOPICAL GEL

Metronidazole 2 g po x 1

Alt: 500 mg po BID x 7d

If that fails: 2 g po daily x 5d

* Damage genital epithelium -> microulcerations
* Women: 50% asymptomatic, green frothy discharge, strawberry cervix
* Men: mostly asymptomatic, may have sml amt discharge
* Patient-delivered partner therapy

**Bacterial Vaginosis (BV)** – not an STD

**BV tx:**

Metronidazole 500 mg po BID x 7d (preg- oral only)

Metrogel 0.75% x 5d

Clinda cream 2% qHS x 7d

Alt: Clinda 300 mg po BID x 7d, Clinda ovules 100 g qHS x 3d

* Normal vag pH = 3.8-4.5
* pH change causes things besides lactobacillus to grow
* thin white discharge, fishy odor, Whiff test
* sequelae: prematureu rupture of membranes, premature

delivery, low birth weight, PID, risk for HIV/STDs

**Herpes 1st Episode –** usually the most severe

Valacyclovir 1 g po BID x 7-10 d

Acyclovir 400 mg po TID x 7-10 d

**Suppression**

Valacyclovir 1 g or 500 mg po daily

**Episodic** – start tx within 1 day of lesion onset or during prodrome

Acyclovir 400 mg po TID x 5d

Valacyclovir 500 mg po BID x 3d

Valacyclovir 1 g po daily x 5d

**Severe/CNS/disseminated**

Acyclovir 5-10 mg/kg IV q8h 2-7d until sx improve (ideal body weight)

then po until 10 total days tx

**Herpes Simplex Virus** – usually HSV-2

* lifelong infection, often asymptomatic
* **prodrome:** tingling/burning sensation, flu-like sx
* papule -> vesicle -> pustule -> ulcer -> crust -> healed
* **lytic phase**: infects epithelial cells, can replicate, get sx
* **latent phase:** stays in sensory ganglia
* must treat preggers bc neonatal infection is almost always fatal
* abstain during lesion or prodrome

**Human Papilloma Virus**

* 16, 18 = cancer 6, 11 = warts
* Warts usually go away on their own
* Treat only to alleviate sx