### RECOMMENDED TREATMENT FOR SEXUALLY TRANSMITTED DISEASES IN HIV-INFECTED ADULTS

This table reflects the Centers for Disease Control and Prevention (CDC) 2010 STD Treatment Guidelines and focuses on STDs encountered among HIV-infected adults in an outpatient setting.

<table>
<thead>
<tr>
<th>DISEASE</th>
<th>RECOMMENDED TREATMENT</th>
<th>ALTERNATIVE TREATMENTS / COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>SYPHILIS</strong> (see CDC guidelines for follow-up recommendations and treatment of syphilis in pregnancy)</td>
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</tbody>
</table>
| PRIMARY, SECONDARY OR EARLY LATENT (< 1 YEAR) | Benzathine penicillin G 2.4 million units IM in a single dose (Bicillin® L-A) | If history of allergy to penicillin:  
- Doxycycline 100 mg orally 2 times a day for 14 days OR  
- Tetracycline 500 mg orally 4 times a day for 14 days OR  
- Ceftriaxone 1g IM or IV once a day for 10-14 days  
Efficacy of non-penicillin regimens in HIV-infected patients is not well studied. If compliance or follow-up cannot be ensured, patients should be desensitized and treated with penicillin. Close serologic and clinical follow-up is recommended. |
| LATE LATENT (> 1 YEAR) OR LATENT OF UNKNOWN DURATION | Benzathine penicillin G 2.4 million units IM for 3 doses, 1 week apart (total 7.2 million units) | Benzathine penicillin G 2.4 million units IM once daily PLUS benzathine penicillin 2.4 million units IM one time per week for up to 3 weeks after completion of treatment for neurosyphilis. |
| **NEUROSYPHILIS** | Aqueous crystalline penicillin G 18-24 million units per day, administered as 3-4 million units IV every 4 hours or continuous infusion, for 10-14 days  
- For late syphilis, consider adding benzathine penicillin 2.4 million units IM one time per week for up to 3 weeks after completion of treatment for neurosyphilis. | Procaine penicillin 2.4 million units IM once daily PLUS probenecid 500 mg orally 4 times a day, both for 10-14 days (use only if compliance with therapy ensured)  
For late syphilis consider adding benzathine penicillin 2.4 million units IM one time per week for up to 3 weeks after completion of treatment for neurosyphilis. |
| **GONOCOCAL INFECTIONS** (see www.cdc.gov for recommendations for suspected treatment failure) | Dual antibiotic therapy is now recommended for all patients with gonorrhea regardless of Chlamydia trachomatis test results.  
**DUAL THERAPY WITH:**  
- Ceftriaxone 250 mg IM single dose (preferred for treatment at all anatomic sites)  
OR, IF NOT AN OPTION:  
- Cefixime 400 mg PO orally single dose (NOT recommended for pharyngeal infection) OR  
- Other single-dose injectable cephalosporin regimens PLUS  
- Azithromycin 1 g orally single dose OR  
- Doxycycline 100 mg orally twice a day for 7 days2 | If allergic to cephalosporins or history of severe allergy to penicillin:  
- Azithromycin 2 g orally single dose1  
As of April 2007, fluoroquinolones are no longer recommended for treatment of gonococcal infection in the United States.  
If treatment failure suspected (patient treated with recommended regimen and symptoms have not resolved), perform a test-of-cure using culture and report to the local health department. For clinical consult, call the CA STD Control Branch at 510-620-3400. |
| **CONJUNCTIVA** | Ceftriaxone 1 g IM once, plus consider lavage of infected eye with saline solution once | | |
| **CHLAMYDIAL INFECTIONS** | Azithromycin 1 g orally single dose OR  
- Doxycycline 100 mg orally 2 times a day for 7 days2 | 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  
Levofloxacin2 500 mg orally once a day for 7 days OR  
Ofloxacin2 300 mg orally 2 times a day for 7 days  
Prolonged therapy may be required.  
Azithromycin 1 g orally once weekly for 3 weeks  
Levofloxacin2 500 mg orally once a day for 7 days OR  
Ofloxacin2 300 mg orally 2 times a day for 7 days  
For acute epididymitis most likely caused by enteric organisms  
Levofloxacin 500 mg orally once a day for 10 days OR  
Ofloxacin 300 mg orally 2 times a day for 10 days  
If parenteral cephalosporin therapy is not feasible and risk of gonorrhea is low:  
Levofloxacin 500 mg orally once a day for 14 days2 OR  
Ofloxacin 400 mg orally 2 times a day for 14 days2  
PLUS  
Metronidazole 500mg orally 2 times a day for 14 days (if BV present or cannot be ruled out) | |

Developed by the California Department of Public Health  
And the California STD/HIV Prevention Training Center  
Updated February 2012
### HERPES SIMPLEX VIRUS (HSV)-non-pregnant adults

(See www.cdc.gov/std for the management of herpes in pregnancy)

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<td>First clinical episode of genital HSV</td>
<td>• Aцикловир 400 mg orally 3 times a day for 7-10 days OR • Ацикловир 200 mg orally 5 times a day for 7-10 days OR • Фамцикловир 250 mg orally 3 times a day for 7-10 days OR • Валацикловир 1 g orally 2 times a day for 7-10 days</td>
<td>No data to differentiate therapeutic response between HIV-infected and uninfected patients</td>
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<tr>
<td>Daily Suppressive Therapy</td>
<td>• Aцикловир 400–800 mg orally 2 to 3 times a day OR • Фамцикловир 500 mg orally 2 times a day OR • Валацикловир 500 mg orally 2 times a day</td>
<td>One study found фамцикловир was less effective in reducing viral shedding compared to валацикловир.</td>
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<tr>
<td>Episodic Recurrent Infection</td>
<td>• Aцикловир 400 mg orally 3 times a day for 5-10 days OR • Фамцикловир 500 mg orally 2 times a day for 5-10 days OR • Валацикловир 1 g orally 2 times a day for 5-10 days</td>
<td>• Малатион 0.5% lotion applied for 8-12 hours and washed off OR • Ивермектин 250 mcg/kg orally, repeated in 2 weeks</td>
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<tr>
<td>PEDICULOSIS PUBIS</td>
<td>• Перметрин 1% cream rinse applied to affected area and washed off after 10 minutes OR • Перметрин с пиперонил бутоксидом applied to affected area and washed off after 10 minutes</td>
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<td>BACTERIAL VAGINOSIS (BV)</td>
<td>• Метронидазол 500 mg orally 2 times a day for 7 days OR • Метритонидазол гель 0.75% интраганально once a day for 5 days OR • Клиндамycin cream 2% интраганально at bedtime for 7 days</td>
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<td>TRICROMONIASIS*</td>
<td>• Метронидазол 2 г orally single dose OR • Тиндазол 2 г orally single dose</td>
<td>• Метронидазол 500 mg orally 2 times a day for 7 days (in one clinical trial in HIV-infected women, 7 day regimen was more effective than a single dose of метронидазол 2 г)</td>
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<td>HUMAN PAPILLOMAVIRUS (HPV)-ANOGENITAL WARTS</td>
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<td>EXTERNAL WARTS PROVIDER-ADMINISTERED THERAPY*</td>
<td>• Криотерапия with liquid nitrogen or cryoprobe OR • Подофиллин 10%-25% in a compound tincture of benzoin. Apply and allow to air dry. Wash off 1-4 hours after application OR • Трихлороуксусная кислота (TCA) or бихлороуксусная кислота (BCA) 80%-90%. Apply small amount to warts. Allow to dry. If excess applied, powder with тальк/baking soda OR • Стержневое удаление</td>
<td>• Криотерапия with liquid nitrogen OR • Подофиллин 10%-25% in a compound tincture of benzoin. OR • Трихлороуксусная кислота (TCA) or бихлороуксусная кислота (BCA) 80%-90%. Apply small amount to warts. Allow to dry. If excess applied, powder with тальк/baking soda OR • Стержневое удаление</td>
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<td>PATIENT-APPLIED THERAPY*</td>
<td>• Подофиллин 0.5% solution or gel*. Apply 2 times a day for 3 days, followed by 4 days off. Repeat cycle as necessary up to 4 times. Total wart area should not exceed 10 cm² and total volume applied daily should not exceed 0.5 ml OR • Имикимод 5% cream*. Apply once daily at bedtime 3 times a week for up to 16 weeks. Wash treatment area with soap and water 6-10 hours after application.</td>
<td>• Криотерапия with liquid nitrogen OR • Подофиллин 10%-25% in a compound tincture of benzoin. OR • Трихлороуксусная кислота (TCA) or бихлороуксусная кислота (BCA) 80%-90%. Apply small amount to warts. Allow to dry. If excess applied, powder with тальк/baking soda OR • Стержневое удаление</td>
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### Footnotes
1. For patients with cephalosporin allergy, or severe penicillin allergy, (e.g., anaphylaxis, Stevens Johnson syndrome, and toxic epidermal necrolysis), азитромицин is an option. However, because of GI intolerance and concerns regarding emerging resistance, it should be used with caution. Test-of-cure is prudent because efficacy data are limited and because of concerns over emerging resistance.
2. Contraindicated in pregnancy.
3. Цефтриаксон and doxycycline are recommended for epididymitis most likely caused by gonococcal or chlamydial infection. Левофлоксацин or офлоксацин is recommended if epididymitis is most likely caused by enteric organisms.
4. Quinolones can be considered for PID if the risk of GC is low, a NAAT test for GC is performed, and follow-up of the patient is assued. If GC is documented, re-treat with recommended цефтриаксон and doxycycline regimen. If cephalosporin therapy is not an option, add азитромицин 2 g orally as a single dose to a quinolone-based PID regimen. It is not known whether HIV-infected women require more intensive treatment for PID.
5. Multiple studies and meta-analysis have not demonstrated a consistent association between metronidazole use during pregnancy and teratogenic or mutagenic effects in newborns.
6. Pregnancy category C. Тиндазол is contraindicated in the first trimester of pregnancy and should only be used in the second/third trimester if no other treatment options exist and benefits of treatment outweigh the risks.
7. May weaken latex condoms and contraceptive diaphragms.
8. For suspected drug-resistant trichomoniasis, see 2010 CDC Guidelines under Trichomoniasis Follow-up, p. 60, or http://www.cdc.gov/std for other treatment options. For laboratory/clinical consultations, contact CDC at 404-718-4141.
9. Safety in pregnancy has not been established. Pregnancy category C.
10. Синекатехин 15% ointment applied topically three times a day for up to 16 weeks has been FDA approved for genital warts but is not currently recommended in HIV-infected populations due to lack of clinical efficacy data.