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Treatment of STDs in HIV-Infected Patients

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This resource is intended to assist clinicians in managing STDs in HIV-infected patients (pts). This resource provides photographs, and recommended and alternative regimens for selected STDs. Please see the STD guidelines for additional information including diagnostic considerations and managing sex partners as well as other STDs.

Information adapted from:

Centers for Disease Control and Prevention. Sexually Transmitted Diseases Treatment Guidelines, 2015. MMWR 2015; 64(No. RR-3):1-140. Available at <http://www.cdc.gov/std/tg2015/default.htm>. Accessed July 13, 2015.

The information contained in this publication is intended for medical professionals, as a quick reference to the national guidelines. This resource does not replace nor represent the comprehensive nature of the published guidelines. Recognizing the rapid changes that occur in this field, clinicians are encouraged to consult with their local experts or research the literature for the most up-to-date information to assist with individual treatment decisions for their patient (pt). If your pt should experience a serious adverse event, please report the event to the FDA (www.fda.gov/Safety/MedWatch/HowToReport/default.htm) to help increase pt safety.

Visit www.FCAETC.org/treatment for the most up-to-date version of this resource.

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HUMAN PAPILLOMAVIRUS - CONDYLOMA ACUMINATUM (EXTERNAL ANOGENITAL WARTS)

Patient-administered Treatment

- Podofilox 0.5% solution or gel applied bid (3 days on 4 days off) for up to 4 cycles **or**
- (Imiquimod 5% cream applied 3 times **or** imiquimod 3.75% cream applied daily) per week at bedtime and washed off after 6-10 hours for up to 16 weeks

Comments

- Podofilox contraindicated in pregnancy
- Imiquimod may weaken condoms and vaginal diaphragms.
- Safety not established in pregnancy

Provider-administered Treatment

- Cryotherapy with liquid nitrogen or cryoprobe once weekly; repeat every 1-2 weeks (repeat every 1-2 weeks for up to 4 weeks) **or**
- Trichloroacetic or Bichloroacetic acid 80-90%, apply small amount to warts and allow to air dry (repeat weekly for up to 6 weeks) **or**
- Surgical removal (as needed)

Comments

- See STD guidelines for management of urethral meatus, vaginal or intra-anal warts

LYMPHOGRANULOMA VENEREUM

Recommended Treatment

Duration of therapy: 21 days

- Doxycycline 100 mg po bid

Alternative Treatment

Duration of therapy: 21 days

- Erythromycin base 500 mg po 4 times per day

Comments (for recommended and alternative)

- Delay in resolution of symptoms may occur and prolonged therapy might be required in HIV-infected

BACTERIAL VAGINOSIS

Recommended Treatment

Duration of therapy: 7 days (5 days for metronidazole gel)

- Metronidazole 500 mg po bid **or**
- Metronidazole 0.75% gel, one applicator full intravaginally once daily **or**
- Clindamycin 2% cream, one applicator full intravaginally once daily at bedtime

Comments

- Avoid consuming alcohol during metronidazole therapy and for 24 hours after complete
- Clindamycin cream may weaken latex condoms for 3 days after use

Alternative Treatment

- Tinidazole 2 g po once daily for 2 days **or**
- Tinidazole 1 g po once daily for 5 days **or**
- Clindamycin 300 mg po twice daily for 7 days **or**
- Clindamycin ovules 100 mg intravaginally once daily at bedtime for 3 days

Comments

- Avoid consuming alcohol during tinidazole therapy and for 72 hours after complete
- Clindamycin ovules may weaken latex condoms for 3 days after use

CHANCROID

Treatment

- Azithromycin 1 g po for 1 dose **or**
- Ceftriaxone 250 mg intramuscularly (IM) for 1 dose **or**
- Ciprofloxacin 500 mg po bid for 3 days **or**
- Erythromycin base 500 mg po tid for 7 days

Comments

- HIV-infected more likely to experience treatment failure and may need longer duration of therapy

CHLAMYDIA

Treatment

- Azithromycin 1 g po for 1 dose **or**
- Doxycycline 100 mg po bid for 7 days

Comments

- See [STD Guidelines](#) for alternative regimens

PELVIC INFLAMMATORY DISEASE (PID)

Inpatient Treatment

Duration of therapy: 14 days

- Cefotetan 2 g IV q12h **or** Cefoxitin 2 g IV every 6 hours **plus**
 - Doxycycline 100 mg IV or po every 12 hours

----- OR -----

- Clindamycin 900 mg IV every 8 hours **plus**
 - Gentamicin 2 mg/kg loading dose IV or IM followed by 1.5 mg/kg IV every 8 hours as maintenance dose (single daily dosing [3-5 mg/kg] may be used)

Comments

- Can switch to oral therapy 24 hours after pt clinically improving: doxycycline 100 mg po bid to complete 14 day course
- See [STD Guidelines](#) for alternative parenteral regimens

Outpatient Treatment

- Ceftriaxone 250 mg IM for 1 dose **plus**
 - Doxycycline 100 mg po bid for 14 days with or without
 - Metronidazole 500 mg po bid for 14 days

Comments

- Addition of metronidazole should be considered since 3rd generation cephalosporins have limited anaerobic coverage
- See [STD Guidelines](#) for other recommended and alternative regimens

EPIDIDYMITIS

Treatment

- Ceftriaxone 250 mg IM for 1 dose **plus**
 - Doxycycline 100 mg po bid for 10 days **or**
 - Levofloxacin 500 mg po once daily for 10 days **or**
 - Ofloxacin 300 mg po bid for 10 days

Comments

- For men at risk for STDs and enteric organisms (MSM insertive anal intercourse) use fluoroquinolone with ceftriaxone

GENITAL HERPES

First Episode

Duration of therapy: 7-10 days

- Acyclovir 400 mg po tid **or**
- Valacyclovir 1 g po bid **or**
- Famciclovir 250 mg po tid

NOTE: extend treatment if incomplete healing at 10 days

Episodic Therapy for Recurrent Episodes

Duration of therapy: 5-10 days

- Acyclovir 400 mg po tid **or**
- Valacyclovir 1 g po bid **or**
- Famciclovir 500 mg po bid

Comments

- For severe disease, treat with acyclovir 5 mg/kg IV every 8 hours initially and then switch to oral therapy (as listed above) when lesions begin to regress
- Perform culture and sensitivity testing if lesions do not begin to resolve within 7-10 days after treatment initiation
- See [STD Guidelines](#) for management of treatment failure or acyclovir-resistant HSV

Suppressive Therapy Treatment

Duration of therapy: Indefinitely

- Acyclovir 400 mg to 800 mg po bid or tid **or**
- Famciclovir 500 mg po bid **or**
- Valacyclovir 500 mg po bid

Suppressive for Pregnant Women

- Acyclovir 400 mg po tid **or**
- Valacyclovir 500 mg po bid

Comments

- Suppressive therapy recommended for severe recurrences or to minimize frequency of recurrences. Suppressive therapy should be continued indefinitely without regards to CD4 improvement.

SYPHILIS

See [STD Guidelines](#) for treatment of penicillin-allergic pts as the efficacy of non-penicillin regimens has not been well evaluated in HIV-infected pts.

Primary, Secondary, Early Latent Infection Treatment

Duration of therapy: 1 dose

- Benzathine penicillin G 2.4 million units IM

Comments

- Rule out neurosyphilis; early latent infection defined as < 1 year

Tertiary, Late Latent Infection Treatment

Duration of therapy: 3 weeks

- Benzathine penicillin G 2.4 million units IM once weekly

Comments

- Rule out neurosyphilis; late latent infection defined as > 1 year or of unknown duration

Neurosyphilis, Otic, or Ocular Disease Treatment

Duration of therapy: 10-14 days

Recommended:

- Aqueous crystalline penicillin G 3-4 million units IV every 4 hrs or 18-24 million units per day given as continuous infusion

Alternative:

- Procaine penicillin 2.4 million units IM once daily plus probenecid 500 mg po 4 times a day

Comments (for recommended and alternative)

- Consider benzathine penicillin G 2.4 million units IM once weekly for 3 weeks after completion of IV therapy (CIII)
- Procaine penicillin regimen is not recommend in sulfa allergic pts since probenecid cannot be used with sulfa allergy

TRICHOMONIASIS

Recommended Treatment

Duration of therapy: 7 days

- Metronidazole 500 mg po bid

Comments

- Avoid consuming alcohol during metronidazole therapy and for 24 hrs after complete
- Single dose metronidazole or tinidazole regimens are no longer recommended in HIV-infected
- Retest HIV-infected women within 3 months of treatment utilizing NAAT

VULVOVAGINAL CANDIDIASIS

Treatment

- Multiple OTC products as directed (see [STD Guidelines](#)) **or**
- Fluconazole 150 mg po for 1 dose

Clinical Consultation

To request clinical consultation, visit:
www.FCAETC.org/consultation

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Clinician Consultation Center HIV/AIDS Management Consultation

800.933.3413

National HIV/AIDS Telephone Consultation Service

Clinician Consultation Center Post Exposure Prophylaxis Consultation (PEPline)

888.HIV.4911 (448.4911)

GONORRHEA

Combination therapy with azithromycin (preferred) or doxycycline is recommended to hinder the development of antimicrobial-resistant *N. gonorrhoeae* and treat for presumed chlamydia coinfection.

Cervix, Urethra, Rectum Treatment

Recommended:

- Ceftriaxone 250 mg IM for 1 dose **plus**
 - Azithromycin 1 g po for 1 dose

Alternative:

- Cefixime 400 mg po for one dose **plus**
 - Azithromycin 1 g po for 1 dose

Comments

- Doxycycline 100 mg po bid for 7 days may replace azithromycin in either regimen above if pt is azithromycin allergic

Pharynx Treatment

Recommended:

- Ceftriaxone 250 mg IM for 1 dose **plus**
 - Azithromycin 1 g po for 1 dose

Comments

- Doxycycline 100 mg po bid for 7 days may replace azithromycin if pt is azithromycin allergic
- If alternative regimen is used (e.g., doxycycline in place of azithromycin), pt should return in 2 weeks for a test of cure using nucleic acid amplification test (NAAT) or culture
- Pts with pharyngeal infections are usually asymptomatic
- Pharyngeal infections are more difficult to eradicate and oral cefixime is not recommended as an alternative treatment option

Disseminated Treatment for Arthritis ± Dermatitis

Syndrome

Duration of therapy (recommended/alternative): ≥ 7 days

Recommended:

- Ceftriaxone 1 g IM or IV every 24 hours **plus**
 - Azithromycin 1 g po for 1 dose

Alternative:

- (Cefotaxime 1 g IV every 8 hrs **or** Ceftizoxime 1 g IV every 8 hrs) **plus**
 - Azithromycin 1 g po for 1 dose

Comments (for recommended and alternative)

- Doxycycline 100 mg po bid may replace azithromycin if the pt is azithromycin allergic
- Can switch to oral therapy guided by antimicrobial susceptibility testing 24-48 hours after clinical improvement seen, for completion of at least 7 days of antimicrobial therapy
- See guidelines for management of other disseminated gonococcal infections (e.g. meningitis and endocarditis)

TREATMENT OF STDs IN HIV-INFECTED PATIENTS

AUGUST 2015



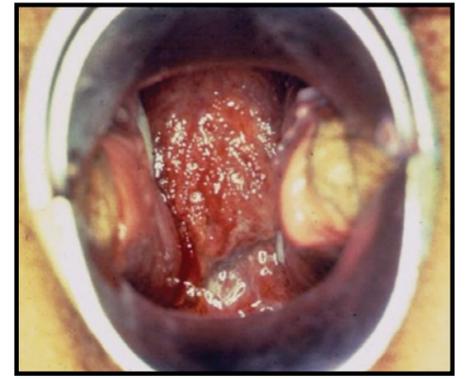
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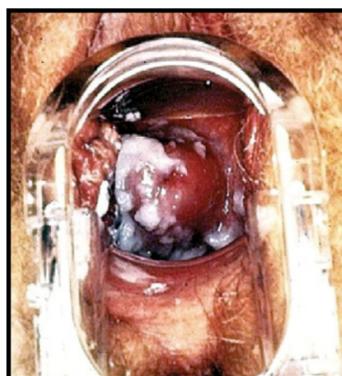
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