California Sexually Transmitted Infections (STI) Treatment Recommendations in Pregnancy

These treatment regimens reflect updates in the U.S. Centers for Disease Control and Prevention (CDC) STI Treatment Guidelines and are specific to PREGNANT PATIENTS. Non-pregnant patients may have different recommended regimens (see California STI Treatment Guidelines). For more comprehensive recommendations, see CDC STI Treatment Guidelines. Call the local health department for assistance with management of pregnant patients with syphilis and confidential notification of sexual partners of patients with STIs or HIV. For STI clinical management consultation, submit your question online to the STD Clinical Consultation Network at www.stdccn.org or consult the California Department of Public Health (CDPH) STD Control Branch via email (stdcb@cdph.ca.gov) or phone (510-620-3400). An ADA-compliant version of this table is available online at https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/California-STI-Treatment-Recommendations-in-Pregnancy.aspx.

DISEASE	RECOMMENDED REGIMENS	ALTERNATIVE REGIMENS: To be used if medical contraindication to recommended regimen
CHLAMYDIA (CT)[1]	Azithromycin 1 g po once	Amoxicillin 500 mg po three times a day x 7 d
GONORRHEA (GC)[2] **Monotherapy with IM ceftriaxone is recommended for all patients with uncomplicated GC, inclusive of pregnant persons. If co-infection with CT has not been excluded, add azithromycin 1 g po x 1 dose in pregnant persons.**		
Genital/Rectal Infections	Ceftriaxone 500 mg IM once for persons weighing <150kg (330 lb) Ceftriaxone 1g IM once for persons weighing ≥150kg (330 lb)	If ceftriaxone not available or not feasible: • Cefixime 800 mg x 1 dose[3] If cephalosporin allergy: • Azithromycin 2 g po x 1 dose[4]
Pharyngeal Infections[5]	Ceftriaxone 500 mg IM once for persons weighing <150kg (330 lb) Ceftriaxone 1g IM once for persons weighing ≥150kg (330 lb)	No reliable treatment alternatives. Consult an infectious disease specialist or submit a question online at www.stdccn.org
CERVICITIS[6]	Azithromycin 1 g po once	None
PELVIC INFLAMMATORY DISEASE (PID)[6] **Pregnant patients with PID have high risk for maternal morbidity and pre-term delivery. Such patients should be hospitalized and treated with IV antibiotics in consultation with an Infectious Diseases specialist.**		
SYPHILIS[7,8] Primary, Secondary, AND Early Latent	Benzathine penicillin G 2.4 million units (mu) IM once[9]	None
Late Latent and Unknown Duration	Benzathine penicillin G 7.2 mu, as 3 doses of 2.4 mu IM each, in 1-week intervals (not >8 days apart)[8]	None
Neurosyphilis and Ocular Syphilis	Aqueous crystalline penicillin G 18-24 mu daily, administered as 3-4 mu IV q 4 hours x 10-14 d[10]	Procaine penicillin G 2.4 mu IM daily for 10-14 d **PLUS** Probenecid 500 mg po qid for 10-14 d
LYMPHOGRANULOMA VENEREUM (LGV)[11]	Azithromycin 1 g po once weekly x 3 weeks[12] Erythromycin base 500 mg po qid x 21 d	None
TRICHOMONIASIS[13]	Metronidazole[14] 500 mg po bid x 7 d	None
BACTERIAL VAGINOSIS	Metronidazole[14] 500 mg po bid x 7 d **or** Metronidazole 0.75% gel, 5 g intravaginally daily x 5 d **or** Clindamycin 2% cream, 5 g intravaginally qhs x 7 d	Clindamycin 300 mg po bid x 7 d **or** Clindamycin ovules[15] 100 mg intravaginally qhs x 3 d
ANOGENITAL HERPES First Clinical Episode of Herpes[16]	Acyclovir 400 mg po tid x 7-10 d **or** Valacyclovir[17] 1 g po bid x 7-10 d	None
Episodic Therapy for Recurrences	Acyclovir 800 mg po bid x 5 d **or** Acyclovir 800 mg po tid x 2 d **or** Valacyclovir[17] 500 mg po bid x 3 d **or** Valacyclovir[17] 1 g po daily x 5 d	
Daily Suppressive Therapy in Pregnant Patients (start at 36 weeks gestation)[18]	Acyclovir 400 mg po tid **or** Valacyclovir[17] 500 mg po bid	
ANOGENITAL WARTS[19] External Genital/Perianal	Cryotherapy once q 1-2 weeks **or** Trichloroacetic acid (TCA) 80%-90% once q 1-2 weeks **or** Bichloroacetic acid (BCA) 80%-90% once q 1-2 weeks **or** Surgical removal	
Mucosal Genital Warts (Vaginal, Vulvar, Anal)	Cryotherapy[20] **or** Surgical removal **or** TCA or BCA 80%-90%	

1. Test-of-cure follow-up by NAAT 4 weeks after completion of therapy is recommended in pregnancy.
2. See CDPH Gonorrhea Treatment Guidelines and Management of Suspected Treatment Failure. (https://www.cdph.ca.gov/Programs/CID/DCDC/CDPH%20Document%20Library/CAGCTreatmentFailureProtocol_Providers.pdf) if suspect treatment failure.
3. Oral cephalosporins give lower and less-sustained bactericidal levels than ceftriaxone. Cefixime should only be used when ceftriaxone is not available.
4. Obtain a test of cure in 14 days if using azithromycin monotherapy.
5. Test of cure by culture or NAAT is recommended 14 days after treatment for pharyngeal GC.
6. Test for GC/CT, bacterial vaginosis and trichomoniasis. If patient lives in community with high GC prevalence, or has risk factors (e.g. age <25, new partner, partner with concurrent sex partners, or sex partner with an STI), consider empiric treatment for GC.
7. Benzathine penicillin G is available only in one long-acting formulation, Bicillin® L-A (the trade name). Other combination products, such as Bicillin® C-R should NOT be used; they contain long- and short-acting penicillins and do not effectively treat syphilis.
8. Pregnant patients allergic to penicillin should be desensitized and treated with Benzathine penicillin G. There are NO alternatives during pregnancy. The optimal treatment interval in pregnancy is 7 days. If treating outside of 6-8 day intervals, the full treatment course should be restarted.
9. Some specialists recommend a second dose of benzathine penicillin G 2.4 million units IM administered 1 week after the initial dose in pregnant people with primary, secondary, or early latent syphilis.
10. Some specialists recommend 2.4 million units of benzathine penicillin G once weekly for up to 3 weeks after completion of neurosyphilis treatment.
11. Perform a test of cure 4 weeks after the initial CT-positive NAAT test in all pregnant patients treated for LGV.
12. Because this regimen has not been rigorously studied, perform a test of cure four weeks after treatment.
13. For suspected drug-resistant trichomoniasis consult the 2021 CDC STI treatment guidelines, contact the CA STD Control Branch, or consult https://www.stdccn.org.
14. Although metronidazole crosses the placenta, there is no evidence of teratogenicity or mutagenic effects. Metronidazole at a dose of 500 mg PO BID for up to a week is considered compatible with breastfeeding. Drug levels peak 2-4 hours after dosing, so breastfeeding times may be shifted to avoid peak drug levels if patient prefers.
15. May weaken latex condoms and contraceptive diaphragms. Use of such products within 72 hours after treatment with clindamycin ovules is not recommended.
16. Treatment may be extended if healing is incomplete after 10 days.
17. Data regarding prenatal exposure to valacyclovir are limited. Animal trials indicate this drug poses a low risk to pregnant people.
18. At the onset of labor, all pregnant people should be questioned thoroughly about symptoms of herpes including prodromal symptoms (e.g., pain or burning at site before a lesion develops) and be examined thoroughly for herpetic lesions. People without signs or symptoms of herpes or its prodrome can deliver vaginally. Although Cesarean section does not eliminate the risk for HSV transmission, people with active genital herpetic lesions at the onset of labor should have cesarean section to reduce the risk for neonatal HSV.
19. Anogenital warts may proliferate and become friable during pregnancy. Although removal of warts during pregnancy can be considered, resolution might be incomplete or poor until pregnancy is complete. Cesarean delivery is ONLY indicated if the warts are large, and the pelvic outlet is obstructed or vaginal delivery would result in bleeding. Pregnant people should be counseled about the low risk of warts on the larynx of their infants or children.
20. The use of a cryoprobe in the vagina is NOT advised due to risk of vaginal perforation and fistula formation.

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