## CLAMYDIA (CT)

- **Urethoginal/Recurrent/Pharyngeal infections**
  - *Doxycline* 100 mg po bid x 7 d
  - *Ampicillin* 500 mg po x 1 dose

- **Pharynx infections**
  - *Ampicillin* 1 g po x 1 dose

## GONORRHEA (GC)

- **Urethoginal/Recurrent infections**
  - *Ceftriaxone* 500 mg IM x 1 dose for persons weighing ≤150 kg OR
  - *Cefixime* 1 g IM x 1 dose for persons weighing >150 kg

- If ceftriaxone allergy, dual therapy with:
  - *Gentamicin* 240 mg IM x 1 dose PLUS
  - *Azithromycin* 2 g po x 1 dose

## PHYLIC INFLAMMATORY DISEASE (PID)

- **(Etiologies: CT, GC, anorectos, possibly M. genitalium, others)**
  - **Parenteral**
    - *Ceftriaxone* 1 g IV q 24 hrs PLUS
    - *Doxycline* 100 mg po or pq 12 hrs PLUS
    - *Metronidazole* 500 mg IV q 24 hrs or po 12 hrs OR
    - Either *Cefotaxim* 2 g IV q 12 hrs OR *Cefoxitin* 2 g IV q 6 h PLUS
    - *Doxycline* 100 mg po or IV q 12 hrs
  - **IM/Oral**
    - Either *Ceftraxone* 500 mg IM x 1 dose (or a second 3rd generation cephalosporin) OR
    - *Cefotaxim* 2 g IM x 1 dose administered with Probenecid 1 g po x 1 dose PLUS
    - *Doxycline* 100 mg po bid x 14 d
    - *Metronidazole* 500 mg po bid x 14 d

## CERVICITIS

- **(Etiologies: CT, GC, T. vaginalis, HSV, possibly M. genitalium)**
  - *Doxycline* 100 mg po bid x 7 d
  - *Azithromycin* 1 g po x 1 dose

## NONGONOCOCCAL URETHRITIS (NGU)

- **(Etiologies: M. genitalium, M. hominis, T. vaginalis, other bacteria)**
  - *Doxycline* 100 mg po bid x 7 d
  - *Azithromycin* 1 g po x 1 dose

## RECURRENT/ PERSISTENT NGU

- **(Etiologies: M. genitalium (MG), T. vaginalis, other bacteria)**
  - **1) Test for M. genitalium (MG)**
    - If MG test positive but resistance testing unavailable, use:
      - *Doxycline* 100 mg po bid x 7 d FOLLOWED BY
      - *Moxifloxacin* 400 mg po daily x 7 d
    - If MG test positive and resistance testing is available, use:
      - *Macroide sensitive*
        - *Doxycline* 100 mg po bid x 7 d FOLLOWED BY
        - *Azithromycin* 1 g po once, then 500 mg daily on next 3 d
      - *Macroide resistant*
        - *Doxycline* 100 mg po bid x 7 d FOLLOWED BY
        - *Moxifloxacin* 400 mg po daily x 7 d
  - **2) Test and treat presumptively for T. vaginalis in men who have sex with women (MSW) in areas where infection is prevalent**
    - *Metronidazole* or Tinidazole 2 g po x 1 dose (applies to both medications)

## PROCTITIS

- **(Etiologies: CDC CT including LOV, HSV, T. pallidum, possibly M. genitalium)**
  - *Ceftriaxone* 500 mg IM x 1 dose for persons weighing ≤150 kg OR
  - *Cefixime* 1 g IM x 1 dose for persons weighing >150 kg
  - *Doxycline* 100 mg po bid x 7 d

## LYMPHOGRAVLUMA VENEREUM (LGV)

- **(Etiologies: CDC CT including LOV, HSV, T. pallidum, possibly M. genitalium)**
  - *Doxycline* 100 mg po bid x 21 d
  - *Azithromycin* 1 g po once weekly x 3 weeks OR
  - *Erythromycin base* 500 mg po qid x 21 d

## TRICHMONIASIS

- **Note: Treatment recommendations do not vary by HIV status.**
  - *Cervicovaginal infection*
    - *Metronidazole* 500 mg po bid x 7 d OR
    - *Clindamycin* 900 mg IV q 8 hrs
  - *Penile infection*
    - *Metronidazole* 500 mg po bid x 7 d OR
    - *Clindamycin* 900 mg IV q 8 hrs

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1. Condendicated for pregnant patients.
2. *Every effort should be made to use a recommended regimen. Test-of-cure follow-up with a nucleic acid amplification test (NAT) 4 weeks after completion of therapy is recommended in pregnancy.*
4. *For persons weighing ≤150 kg, use 1 gm IM ceftriaxone x 1 dose instead.*
5. *Oral cephalosporins give lower and less sustained bactericidal levels than ceftriaxone. Ceftriaxone should only be used when ceftriaxone is not available.*
6. *Test of cure by culture or NAT is recommended 14 days after treatment of phyllicoginous GC.*
7. *Parenteral therapy is selected initially, discontinue 24-48 hours after patient improves clinically and continue with either IM or oral therapy for a total of 14 days.*
8. *Other parenteral third-generation cephalosporin (e.g., cefotaxime or ceftraxime) could be substituted for ceftraxime.*
9. *If allergy to cephalosporins, consider fluoroquinolones/azithromycin for PID treatment if community prevalence and individual risk of GC is low, and follow-up is assured. Obtain NAAT testing and GC culture before using fluoroquinolones/azithromycin treatment.*
10. *If patient lives in community with high GC prevalence, or has risk factors (e.g., age <25 years, new partner, partner with concurrent sex partners, sex partner with a STI), consider ampicillin treatment for GC.*
11. *Extend doxycycline course to 21 days to cover LGV if perianal or mucosal ulcers, bloody rectal discharge, or tenesmus and rectal CT positive. If perianal or mucosal ulcers present, consider treating for HSV as well.*
12. *Because this regimen has not been rigorously validated, consider a test of cure with CT NAAT 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 www.stdccn.org.*
14. *Safety in pregnancy has not been established, avoid during pregnancy. When using tinidazole, breastfeeding should be deferred for 72 hours after 2 g dose.*
15. *Sporadic oral granules on applesauce/yogurt/pudding before ingestion. Glass of water after dose can aid in swallowing. FDA- approved for treatment of trichomoniasis after the release of the CDC’s 2021 STI Treatment Guidelines.*
### INFECTION/DISEASE

<table>
<thead>
<tr>
<th>BACTERIAL VAGINOSIS</th>
<th><strong>RECOMMENDED REGIMENS</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Metronidazole 500 mg po bid x 7 d OR</td>
<td><strong>ALTERNATIVE REGIMENS:</strong> To be used if medical contraindication to recommended regimen.</td>
</tr>
<tr>
<td>• Metronidazole gel 0.75% one full applicator (5 g) intravaginally once daily x 5 d OR</td>
<td>• Trimethoprim 2 g po daily x 2 d OR</td>
</tr>
<tr>
<td>• Clindamycin cream 2% one full applicator (5 g) intravaginally qhs x 7 d</td>
<td>• Secnidazole 2 g po x 1 dose OR</td>
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<table>
<thead>
<tr>
<th>EPIDIDYMITIS</th>
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<tbody>
<tr>
<td>If likely due to GC or CT</td>
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<tr>
<td>• Ceftriaxone 500 mg IM x 1 dose PLUS</td>
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<tr>
<td>• Doxycycline 100 mg po bid x 7 d</td>
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<tr>
<th>ANOGENITAL WARTS</th>
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<tbody>
<tr>
<td>If likely due to IG, CT or enteric organisms (history of insertive anal sex)</td>
</tr>
<tr>
<td>• Ceftriaxone 500 mg IM x 1 dose PLUS</td>
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<tr>
<td>• Levofloxacin 500 mg po daily x 10 d</td>
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<tr>
<th>ANOGENITAL HERPES</th>
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<tbody>
<tr>
<td>• Acyclovir 400 mg po tid x 7-10 d OR</td>
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<tr>
<td>• Valacyclovir 1 g po bid x 7-10 d OR</td>
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<tr>
<td>• Famiclovir™ 250 mg po bid</td>
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### SYNHIPS® © NOTE: Treatment recommendations do not vary by HIV status.

<table>
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<tr>
<th>PHASE</th>
<th>SYNHIPS® © COMBINATION</th>
<th>RECOMMENDED DOSAGE</th>
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</thead>
<tbody>
<tr>
<td><strong>Primary, Secondary, and Early Latent</strong></td>
<td>Benzathine penicillin G 2.4 million units IM x 1 dose</td>
<td>Doxycycline® 100 mg po bid x 14 d OR</td>
</tr>
<tr>
<td>Latent Latent or Syphilis of Unknown Duration</td>
<td>Benzathine penicillin G 7.2 million units total, administered as 3 doses of 2.4 million units IM each at 1 week intervals^8</td>
<td>Doxycycline® 100 mg po bid x 28 d OR</td>
</tr>
<tr>
<td>Syphilis with normal CSF</td>
<td></td>
<td>Tetrazycline® 500 mg po qid x 28 d OR</td>
</tr>
<tr>
<td>Syphilis of Ocular Syphilis</td>
<td>Aqueous crystalline penicillin G 18-24 million units daily, administered as 3-4 million units IV q 4 hrs or as continuous infusion x 10-14 d</td>
<td>Procaine penicillin G 2.4 million units IM daily x 10-14 d PLUS</td>
</tr>
<tr>
<td><strong>Pregnant Patients © NOTE: Pregnancy patients who miss any dose of therapy must repeat full course of treatment</strong></td>
<td>Procaine penicillin G 2.4 million units IM x 10-14 d PLUS</td>
<td></td>
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^8 Clindamycin ointments may weaken latex or rubber products (such as condoms and diaphragms). Use of such products within 72 hours following use of clindamycin ointments is not recommended.

© Gonorrhea should be ruled out prior to starting a fluoroquinolone-based regimen.

1 May weaken condoms and diaphragm diaphragms. Advice patients to follow package insert directions carefully. Imiquimod usage is not indicated for area 5 d.

2 The use of a contraceptive in the vagina is not advised due to risk of vaginal perforation and fistula formation.

3 Treatment can be extended if healing is incomplete after 10 days of antiviral therapy.

4 Consider high dose valacyclovir (1 gm daily) or acyclovir in people who have frequent recurrences (i.e., 10 or more episodes annually.)

5 Famiclovir is somewhat less effective for suppression of viral shedding.

6 If concern for resistance based on persistent HSV lesions, obtain a viral isolate for sensitivity testing. Consultation with an infectious disease expert is recommended.

7 Benzathine penicillin G is available in only one long-acting formulation, Bicillin® L-A (the trade name), which contains only benzathine penicillin G. Other combination products, such as Bicillin® C-R, contain both long- and short-acting penicillins and are not effective for treating syphilis.

8 Alternative treatments should be used only for penicillin-allergic patients. If compliance or follow-up cannot be ensured, the patient should be desensitized and treated with benzathine penicillin.

9 In non-pregnant patients, pharmacologic considerations reveal an interval of 7-9 days is ideal.

* Some pregnant women allergic to penicillin should be desensitized and treated with penicillin. There are no alternatives.

* For early syphilis, many experts give a 2nd dose of benzathine penicillin G 2.4 million units IM one week after the initial dose.

* The recommended treatment interval in pregnancy is 7 days. If treatment occurs outside of 6-8-day intervals, the full treatment course should be restarted.

California Department of Public Health STD Control Branch
Phone: 510-620-3400, email stdch@cdph.ca.gov

California Prevention Training Center
Submit a question online at www.cdph.ca.gov
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