These guidelines for the treatment of patients with STDs reflect the 2006 CDC STD Treatment Guidelines and the Region IX Infertility Clinical Guidelines. The focus is primarily on STDs encountered in office practice. These guidelines are intended as a source of clinical guidance; they are not a comprehensive list of all effective regimens and are not intended to substitute for use of the full 2006 STD treatment guidelines document. Call the local health department to report STD infections; to request assistance with confidential notification of sexual partners of patients with syphilis, gonorrhea, chlamydia or HIV infection; or to obtain additional information on the medical management of STD patients. The California STD/HIV Prevention Training Center is an additional resource for training and consultation in the area of STD clinical management and prevention (510-625-6600) or www.stdhivtraining.org

Table: California STD Treatment Guidelines for Adults & Adolescents 2007

<table>
<thead>
<tr>
<th>DISEASE</th>
<th>RECOMMENDED REGIMENS</th>
<th>DOSE/ROUTE</th>
<th>ALTERNATIVE REGIMENS: To be used if medical contraindication to recommended regimen</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHLAMYDIA</td>
<td>Uncomplicated Genital/Urethral Infections 1</td>
<td>Azithromycin or Doxycycline 2</td>
<td>1 g po 100 mg po bid x 7 d</td>
</tr>
<tr>
<td></td>
<td>Pregnant Women</td>
<td>Azithromycin or Amoxicillin</td>
<td>1 g po 500 mg po tid x 7 d</td>
</tr>
<tr>
<td></td>
<td>Cefixime tablets</td>
<td></td>
<td>An oral suspension formulation is available.</td>
</tr>
<tr>
<td>Pharyngeal Infections</td>
<td>Cefixime 2 or Cefixime 2 plus A chlamydia recommended regimen listed above if not ruled out by NAAT</td>
<td>125 mg IM 400 mg po</td>
<td>Azithromycin 2 g po in a single dose</td>
</tr>
<tr>
<td>Pregnant Women</td>
<td>Cefixime 2 or Cefixime 2 plus A chlamydia recommended regimen listed above if not ruled out by NAAT</td>
<td>125 mg IM 400 mg po</td>
<td></td>
</tr>
<tr>
<td>PELVIC INFLAMMATORY DISEASE 8,9</td>
<td>Cervicitis 10,11</td>
<td>Azithromycin or Doxycycline plus Metronidazole if BV is present</td>
<td>1 g po 100 mg po bid x 7 d 500 mg po bid x 7 d</td>
</tr>
<tr>
<td>NONGONOCOCCAL URETHRITIS 3</td>
<td>Doxycycline</td>
<td>100 mg po bid x 7 d</td>
<td></td>
</tr>
<tr>
<td>EPIDIDYMYSIS 1</td>
<td>Likely due to Gonorrhea or Chlamydia</td>
<td>Ceftriaxone plus Doxycycline</td>
<td>250 mg IM 100 mg po bid x 10 d</td>
</tr>
<tr>
<td>TRICHOMONIASIS 11</td>
<td>Non-pregnant women</td>
<td>Metronidazole or Tinidazole 13</td>
<td>2 g po 500 mg po bid x 7 d</td>
</tr>
<tr>
<td></td>
<td>Pregnant Women</td>
<td>Metronidazole</td>
<td>2 g po 500 mg po bid x 7 d</td>
</tr>
<tr>
<td>BACTERIAL VAGINOSIS</td>
<td>Adults/Adolescents</td>
<td>Metronidazole or Metronidazole gel or Clindamycin cream 16</td>
<td>500 mg po bid x 7 d 0.75%, one full applicator (5g) intravaginally q 5 d or 2%, one full applicator (5g) intravaginally qhs x 7 d</td>
</tr>
<tr>
<td></td>
<td>Pregnant Women</td>
<td>Metronidazole or Clindamycin</td>
<td>500 mg po bid x 7 d 250 mg po tid x 7 d 300 mg po bid x 7 d</td>
</tr>
</tbody>
</table>

1. Annual screening for women age 25 years or younger. Nucleic acid amplification tests (NAATS) are recommended. All patients should be tested 3 months after treatment for chlamydia or gonorrhea infections.
2. Contraindicated for pregnant and nursing women.
3. Test-of-cure follow-up (preferably by NAATS) 3-4 weeks after completion of therapy is recommended in pregnancy.
4. For patients with cephalosporin allergy, another beta-lactam antibiotic should be used for gonorrhea infection. Testing for gonorrhea is recommended because of mounting concern about emerging resistance. Complete guidelines for the treatment of gonorrhea in California are available at www.std.ca.gov.
5. Might weaken latex condoms and diaphragms because oil-based.
6. Safety in pregnancy has not been established; pregnancy category C.
7. Testing for gonorrhea and chlamydia is recommended because a specific diagnosis may improve compliance and partner management, and because these infections are reportable by California state law.
8. Evaluate for bacterial vaginosis. If present or cannot be ruled out, also use metronidazole.
9. Discontinue 24 hours after patient improves clinically and continue with oral therapy for a total of 14 days.
10. Fluoroquinolones may be used for PID in California if the risk of gonorrhea is low, a NAAT test for gonorrhea is performed, and follow-up of the patient is considered likely. If gonorrhea is documented, change to a medication regimen that does not include a fluoroquinolone, or obtain test-of-cure to ensure patient does not have resistant gonorrhea infection.
11. If local prevalence of gonorrhea is greater than 5%, consider adding spectinomycin or cefixime to the initial regimen. If gonorrhea is documented, change to a medication regimen that does not include a fluoroquinolone, or obtain test-of-cure to ensure patient does not have resistant gonorrhea infection.
12. For suspected drug-resistant trichomoniasis, rule out reinfection; see 2006 CDC Guidelines, Trichomonas Follow-up p. 53, for other treatment options, and evaluate for metronidazole-resistant T. vaginalis. For laboratory and clinical consultations, contact CDC at 770-488-4115; http://www.cdc.gov/std.
13. Safety in pregnancy has not been established; pregnancy category C. I.B.3.a. California STD Treatment Guidelines for Adults & Adolescents 2007

Developed by the California STD/HIV Prevention Training Center
Revised March 2007
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</thead>
<tbody>
<tr>
<td>CHANCROID</td>
<td>• Azithromycin or Ceftriaxone or Ciprofloxacin or Erythromycin base</td>
<td>1 g po 250 mg IM 500 mg po bid x 3 d 500 mg po tid x 7 d</td>
<td>• Erythromycin base 500 mg po qid x 21 d or Azithromycin 1 g po q week x 3 weeks</td>
</tr>
<tr>
<td>LYMBOHANGLARULUM VENEREUM</td>
<td>• Doxycycline</td>
<td>100 mg po bid x 21 d</td>
<td></td>
</tr>
</tbody>
</table>

| ANODYNAL WARTS | | | |
| External genital Perianal Warts | | | |
| Patient Applied | | | |
| • Imiquimod 5% cream or Podofilox 0.5% solution or gel | | | |
| Provider Administered | | | |
| • Cryotherapy or Podophyllin resin 10%-25% in tincture of benzoin or Trichloroacetic acid (TCA) 90%-90% or Dichloroacetic acid (BDA) 90%-90% or | | | |
| • Surgical removal | | | |
| | | | |
| Mucosal Genital Warts | | | |
| | | | |
| • Cryotherapy or TCA or BCA 90%-90% or Podophyllin resin 10%-25% in tincture of benzoin or | | | |
| • Surgical removal | | | |

| HIV Co-Infected | | | |
|Suppressive Therapy | • Ayclovir or Famiclovir or Valacyclovir | 400-800 mg po bid or tid 500 mg po bid 500 mg po bid | |
| Recurrent Episodes | • Ayclovir or Famiclovir or Valacyclovir | 400 mg po bid 250 mg po bid 500 mg po qd 1 g po qd | |

<table>
<thead>
<tr>
<th>SYPHILIS</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary, Secondary, and Early Latent</td>
<td>• Benzathine penicillin G</td>
<td>2.4 million units IM</td>
<td>• Doxycycline 100 mg po bid x 14 d or Tetracycline 500 mg po qid x 14 d or Ceftriaxone 1 g IM or IV qd x 8-10 d</td>
</tr>
<tr>
<td>Late Latent and Latent of Unknown duration</td>
<td>• Benzathine penicillin G</td>
<td>7.2 million units, administered as 3 doses of 2.4 million units IM each, at 1-week intervals</td>
<td>• Doxycycline 100 mg po bid x 28 d or Tetracycline 500 mg po qd x 28 d</td>
</tr>
<tr>
<td>Neurosyphilis</td>
<td>• Aqueous crystalline penicillin G</td>
<td>18-24 million units daily, administered as 3-4 million units IV q 4 hrs x 10-14 d</td>
<td>• Procaine penicillin G, 2.4 million units IM qd x 10-14 d plus Probencid 500 mg po qid x 10-14 d or Ceftriaxone 2 g IM or IV qd x 10-14 d</td>
</tr>
</tbody>
</table>

| Pregnant Women | | | |
| Primary, Secondary, and Early Latent | • Benzathine penicillin G | 2.4 million units IM | • None |
| Late Latent and Latent of Unknown duration | • Benzathine penicillin G | 7.2 million units, administered as 3 doses of 2.4 million units IM each, at 1-week intervals | • None |
| Neurosyphilis | • Aqueous crystalline penicillin G | 18-24 million units daily, administered as 3-4 million units IV q 4 hrs x 10-14 d | • Procaine penicillin G, 2.4 million units IM qd x 10-14 d plus Probencid 500 mg po qid x 10-14 d or Ceftriaxone 2 g IM or IV qd x 10-14 d |

| HIV Co-Infected | | | |
| Primary, Secondary and Early Latent | • Benzathine penicillin G | 2.4 million units IM | • Doxycycline 100 mg po bid x 14 d or Tetracycline 500 mg po qid x 14 d or Ceftriaxone 1 g IM or IV qd x 8-10 d |
| Late Latent and Latent of Unknown duration with normal CSF Exam | • Benzathine penicillin G | 7.2 million units, administered as 3 doses of 2.4 million units IM each, at 1-week intervals | • Doxycycline 180 mg po bid x 28 d |
| Neurosyphilis | • Aqueous crystalline penicillin G | 18-24 million units daily, administered as 3-4 million units IV q 4 hrs x 10-14 d | • Procaine penicillin G, 2.4 million units IM qd x 10-14 d plus Probencid 500 mg po qid x 10-14 d or Ceftriaxone 2 g IM or IV qd x 10-14 d |

17. Contraindicated in pregnancy.
18. Cervical warts should be managed by a specialist.
19. Counseling about natural history, asymptomatic shedding, and sexual transmission is an essential component of herpes management.
20. The goal of suppressive therapy is to reduce recurrent symptomatic episodes and/or to reduce sexual transmission.
21. If HSV lesions persist or recur while receiving antiviral treatment, antiviral resistance should be suspected. A viral isolate should be obtained for sensitivity testing, and consultation with an infectious disease expert is recommended.
22. Benzathine penicillin G (generic name) is the recommended treatment for syphilis not involving the central nervous system and 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.
23. Alternates should only be used for penicillin-allergic patients because efficacy of these therapies has not been established. Compliance with some of these regimens is difficult, and close follow-up is essential. If compliance or follow-up cannot be ensured, the patient should be desensitized and treated with benzathine penicillin.
24. Some specialists recommend 2.4 million units of benzathine penicillin G weekly for up to 3 weeks after completion of neurosyphilis treatment.
25. Patients allergic to penicillin should be treated with penicillin after desensitization.