Philadelphia Department of Public Health
Division of Disease Control

CARMEN I. PARIS, M.P.H.
Interim Health Commissioner

JOSEPH C. CRONAUER
Executive Deputy / Chief of Staff

Caroline C. Johnson, MD
Director, Division of Disease Control

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Health Notification

Updated CDC Treatment Guidelines for Sexually Transmitted Diseases Now Available at *www.cdc.gov/std/treatment*

Since 1982, the Centers for Disease Control and Prevention (CDC) has published Sexually Transmitted Disease (STD) treatment guidelines for practitioners to use in clinical settings. These guidelines are updated periodically. On August 4, 2006 CDC published new guidelines in the MMWR 55 (RR-11):1-100. The guidelines are also available on the internet at www.cdc.gov/std/treatment. The most significant updates included in the 2006 Guidelines include expanded or revised discussions on the following topics: diagnostic evaluation for cervicitis and trichomoniasis; the role of *Mycoplasma genitalium* and trichomoniasis in urethritis/cervicitis; emergence of lymphogranuloma venereum proctocolitis among men who have sex with men (MSM); the criteria for spinal fluid examination to evaluate for neurosyphilis; sexual transmission of hepatitis C; postexposure prophylaxis after sexual assault; and STD prevention approaches. **For more information, the Philadelphia STD Control Program can be reached at 215-685-6737.**

In addition, the following changes have been made in specific treatment recommendations:

Genital Herpes:

Since suppressive therapy has been shown to decrease viral shedding, recommendations for suppressive therapy were placed ahead of recommendations for episodic treatment of recurrent outbreaks. Acyclovir 800 mg orally three times a day for 2 days and famciclovir 1000 mg orally twice daily for 1 day were added to the first line recommendations for episodic therapy for recurrent genital herpes. Dosing of acyclovir 200 mg five times a day for five days was eliminated as a treatment option for recurrent genital herpes in both immunocompetent and in HIV-infected persons.

Chlamydia:

Azithromycin replaces erythromycin as a first line therapy for chlamydia infection in pregnant women. Amoxicillin remains as another first line option for treatment of pregnant women. Repeat testing, 3 weeks after completion of treatment, is recommended for all pregnant women to ensure cure.

Gonorrhea:

While the first-line therapies for uncomplicated infections due to *Neisseria gonorrhoeae* remain unchanged, the most recent guidelines state that "quinolones should not be used for the treatment of gonorrhea among MSM or in areas with increased quinolone resistant *Neisseria gonorrhoeae* (QRNG) prevalence in the United States or for infections acquired while traveling abroad." ***Notably, Philadelphia has a high prevalence of QRNG, therefore quinolones should not be used as empiric therapy.***

Trichomoniasis:

Tinidazole 2 g orally in a single dose was added to the recommended regimens. Pregnant women should be treated with metronidazole.

Pediculosis Pubis and Scabies:

While permethrin 1% cream and pyrethrins remain as recommended therapies for pubic lice, lindane is no longer a recommended regimen because of toxicity. Two alternative regimens have been added: (1) malathion 0.5% lotion applied for 8-12 hours and washed off; and (2) ivermectin 250 ug/kg orally repeated in 2 weeks. Ivermectin was also added to the recommended regimens for the treatment of scabies.

Vulvovaginal Candidiasis:

Miconazole 1,200 mg vaginal suppository as a single dose was added as recommended treatment, and clotrimazole 500 mg vaginally was removed as recommended treatment.