Take Home Tips: Sexually Transmitted Infections

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Tip 1: Oral and anal sex are common and must be part of the sexual history and the results acted upon: among women endorsing anal sex, GC and chlamydia were found only at the anus in about 20% and only in the pharynx in about 28% Examine involved "extragenital" sites.

Tip 2: Serological tests for *genital* HSV of very little utility. 30% of genital HSV and 70% of newly acquired genital HSV is type 1. Do not use HSV serology for screening.

Tip 3: Suppressive therapy of HSV reduces symptomatic recurrences and reduces but **does not eliminate** transmission of infection to partners. When D/C of suppressive Rx, expect flare of symptoms.

Tip 4: Always treat gonorrhea with 2 drugs. Currently ceftriaxone 250 mg im plus azithromycin 1.0 gm po. Treat all cases of gonorrhea for concurrent NGU: that includes sexual partners. Even if chlamydia negative. Check for postgonococcal urethritis. Azithromycin preferred over doxycycline. Never use single-dose fluoroquinolones.

Tip 5: Followup testing is best done at 3 months, looking for reinfection. NAATs may pick up dead Ct for 3 wks and GC for 3-9 days after treatment. Culture for GC; sensitivity test.

Tip 6: Salvage treatment for GC: gentamicin 240 mg im plus azithromycin 2 mg p or gemafloxacine 320 mg po plus azithromycin 2 gm po. Remember need to treat sexual partners with the same regimen. Consider for severe β-lactam allergy. Not (yet) FDA approved.

Tip 7: You can probably get away with expedited partner therapy. Probably. Recommended regimen: Cefixime 400 mg po and azithromycin 1 gm po. Not the first-line Rx for GC.

Tip 8: Treat contacts to NGU even if chlamydia-negative. *Chlamydia trachomatis* causes only about 25% of cases. *Mycoplasma genitalium* also causes about 25%. Some etiologies are associated with fellatio. For: GC, NGU, Ct, Syphilis, Trich, Chancroid

Tip 9*: Mycoplasma genitalium* (identified in 1981) is a bad actor. Appears to cause as much NGU as does *C. trachomatis*. Common among sexual partners including MSM. Cervicitis, salpingitis, infertility, adverse outcomes in pregnancy. Associated with decreased semen quality (?male-factor infertility)

Tip 10: *M. genitalium* is rapidly becoming resistant to antibiotics. Azithromycin 1 gm po *probably* still initial treatment of choice. Salvage regimen: moxifloxacin 400mg po qd x 10-14 d

Tip 11: Remember trichomoniasis as a cause of treatment-failure NGU: Tetracycline failure: Azithromycin 2 gm + Metronidazole 2 gm (not at the same time) Azithromycin failure: Metronidazole 2 gm + moxifloxacin 400 mg orally for 10 days. Possible new treatment for NGU: Doxycycline 100 mg bid X 7 days, then azithromycin 2 mg followed by 500 mg qd X 3 days

Tip 12: Seriously consider treating trichomoniasis with metronidazole 500 mg bid for 7 days.

Tip 13: Syphilis: Always obtain a nontreponemal test (RPR) for syphilis, even if treponemal test already known to be positive: Test q3mo until 4X drop, test annually untyil seronegative or persistent titer stabilizes. Look for 4X drop in 3 months. 4X rise suggests relapse or reinfection (consider CSF exam)

Tip 14: Screen "seniors" over 60 for STI; at least take a sexual history.

Tip 15: Sexual transmission of Zika is real. **Men** with infection or possible exposure: Planning to conceive: ≥ 6 mo after sex or last possible exposure before unprotected sex; not planning to conceive: abstain or use condoms ≥ 3 mo after sex or last possible exposure before unprotected sex. **Women**: No unprotected sex for ≥ 2 mo after symptoms or exposure.