Take Home Tips: Sexually Transmitted Infections
Michael F. Rein, MD, MACP (mfr6t@virginia.edu)
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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 po or gemafloxacin 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 until 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.