DEPARTMENT OF HEALTH

Sexually transmitted disease (STD) treatment options

PREFERRED & ALTERNATIVE OPTIONS

Many clinical partners are operating in a limited capacity during the COVID-19 pandemic. Below are preferred (in clinic or other location where injections can be given) and alternative (when only oral medicines are available [1]) treatments for STDs.

Syndrome	Preferred Treatments	Alternative Treatments	Follow-up
Male urethritis syndrome *Presumptively treating: gonorrhea*	Ceftriaxone 250mg intramuscular (IM) x 1 **PLUS** azithromycin 1g PO x 1 If azithromycin is not available: doxycycline 100 mg PO BID for 7 days (except in pregnancy[3]) If cephalosporin allergy[5] is reported, gentamicin 240mg IM x 1 **PLUS** azithromycin 2g PO x 1	**Men who have sex with men (MSM) and transgender women[2]:** Cefixime 800 mg PO x 1 **PLUS** doxycycline 100 mg PO BID x 7 days **Men who have sex with women only:** Cefixime 800mg PO x 1 **PLUS** azithromycin 1g PO x 1 If cefixime is unavailable, substitute cefpodoxime 400mg PO q12h x 2 for cefixime in above regimens[4] If oral cephalosporin not available or history of cephalosporin allergy[5]: azithromycin 2g PO x 1 If azithromycin is not available: doxycycline 100 mg PO BID for 7 days (except in pregnancy[3])	Patients should be counseled to be tested for STDs once clinical care is resumed in the local clinics. Clients who have been referred for oral treatment should return for comprehensive testing and screening and linked to services at that time. Patients should be advised to abstain from sex for 7 days following completion of treatment. Patients receiving doxycycline should be advised to avoid direct sunlight during treatment. For alternative oral regimens, patients should be counseled that if their symptoms do not improve or resolve within 5-7 days, they should follow-up with the clinic or a medical provider.
Vaginal discharge syndrome in women without lower abdominal pain, dyspareunia or other signs *Presumptively treating: bacterial vaginosis, trichomoniasis* Additional considerations: -Gonorrhea -Chlamydia (usually asymptomatic) Concerns about dyspareunia, lower abdominal pain or PID – refer to emergency room (call ahead).	**Treatment typically guided by examination and laboratory results:** Bacterial vaginosis: Metronidazole 500mg PO BID x 7 days **OR** Trichomoniasis: Metronidazole 2g PO x 1 **OR** Metronidazole 500mg PO BID x 7 days Gonorrhea: Ceftriaxone 250mg intramuscular (IM) x 1 **PLUS** azithromycin 1g PO x 1 Chlamydia: Azithromycin 1g PO x 1 **OR** doxycycline 100mg PO BID x 7 days	**For presumptive therapy when examination and laboratory results are not available:** **Discharge frothy or malodorous:** Metronidazole 500mg PO BID x 7 days **Discharge mucopurulent:** Cefixime 800mg PO x 1 **PLUS** azithromycin 1g PO x 1 **Discharge cottage-cheese like with genital itching:** Therapy directed at Candida	

Syndrome	Preferred Treatments	Alternative Treatments	Follow-up
Proctitis *Presumptively treating: gonorrhea, chlamydia* If patient is HIV positive: consider adding therapy for herpes simplex virus	Ceftriaxone 250mg IM x 1 **PLUS** doxycycline 100mg PO BID x 7 days. If doxycycline not available or patient is pregnant: azithromycin 1g PO x 1	Cefixime 800 mg PO x 1 **PLUS** doxycycline 100mg PO bid x 7 days **OR** Cefpodoxime 400 mg PO q12h x 2 **PLUS** doxycycline 100 mg PO BID x 7 days If doxycycline not available or patient is pregnant: azithromycin 1g PO x 1	
Expedited Partner Therapy (EPT)[7]: The practice of treating sex partners of people with STDs without a medical evaluation. EPT has been expanded to include partners of MSM and patients diagnosed with trichomoniasis.[6]	**Chlamydia:** Azithromycin 1g PO x 1 **Gonorrhea:** Cefixime 800mg PO x 1 **PLUS** azithromycin 1g PO x 1 **Trichomoniasis:** Metronidazole 2g PO x 1		

1. Alternative regimens should be considered when recommended treatments from the 2015 CDC STD Treatment Guidelines are not available.
2. Alternative oral treatment regimens for suspected and test-positive gonorrhea are of higher dose and longer duration to provide adequate coverage for possible pharyngeal or rectal infection, and to provide adequate coverage for possible resistant strains.
3. Alternatives to doxycycline in pregnancy include amoxicillin or erythromycin (see 2015 Sexually Transmitted Diseases Treatment Guidelines (https://www.cdc.gov/std/tg2015/default.htm).
4. Cefpodoxime has lower efficacy than cefixime in treating gonorrhea, especially oropharyngeal infection, but may be considered if cefixime is unavailable. All patients treated for gonorrhea with oral regimens should have follow-up and undergo test-of-cure when feasible.
5. Closely assess history of penicillin or cephalosporin allergy. Allergic reactions to first-generation cephalosporins occur in <2.5% of persons with a history of penicillin allergy and are uncommon with third-generation cephalosporins (e.g., cefixime or cefpodoxime). Use of cefixime or cefpodoxime is contraindicated in persons with a history of an IgE-mediated penicillin allergy (e.g., anaphylaxis, Stevens Johnsons syndrome, toxic epidermal necrolysis).
6. See recommendations from MDH for EPT: EPT for Chlamydia trachomatis and Neisseria gonorrhoeae (https://www.health.state.mn.us/diseases/stds/hcp/ept/eptguidance.html)
7. Minnesota Department of Health is expanding EPT options to include partner therapy for trichomoniasis and for partners of MSM for all STDs, according to CDC recommendations outlined in a letter dated April 6, 2020: (Department of Health and Human Services: Dear Colleagues Letter (https://www.cdc.gov/std/dstdp/DCL-STDTreatment-COVID19-04062020.pdf).

Minnesota Department of Health
STD/HIV/TB Section
www.health.state.mn.us/std

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