2010 CDC STD Guideline

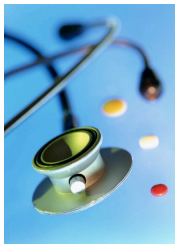
What's new……..

Atlanta : April 18-30th, 2009 Ground Zero ……

- Expanded diagnostic evaluation for cervicitis + trichomoniasis
- New tx rec. for BV and genital warts
- Clinical efficacy of azythromycin for CT in pregnancy
- Role of Mycoplasma genitalium + trich in cervicitis / urethritis and implications of tx
- LGV proctocolitis in MSM
- Increased prevalence of anti-microbial resistance in NG

Atlanta Updates continued….

- Sexual transmission of Hepatitis C
- Diagnostic evaluation after sexual assault
- STD prevention approaches …..lengthy !



Emphasis on Preventive Approaches ….

- Accurate Sexual History : open ended questions, Normalizing language, Understandable language
- Primary Prevention: Reduce behaviors placing pt at risk.
- High-intensity behavioral counseling
- Pre-exposure vaccination (Gardasil,Cervarix,HB)
- Effective diagnosis and treatment

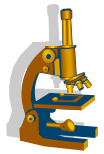
" 5 P's…. "

- Partners
- Preventing unplanned pregnancy
- Protection from STDs
- Past Hx of STDs
- Practices (vaginal VS oral VS anal intercourse)

* If Hep / HIV positive: add questions r/t injectable drugs ,money/drugs for sex, "anything else you'd like to tell me about your sexual practices….."

Fyi…..Lambskin condom pores are 10X diameter of HIV….25X the diameter of HBV !!!

Bacterial Vaginosis



- Dx if > 3 of 4 criteria :

  * homogenous, thin/white D/C smoothly coating the vaginal walls
  * ph of vaginal fluid is > 4.5
  * "fishy" odor after 10% KOH added- "whiff"
  * positive clue cells on microscopic exam

May use Gram Stain – "gold standard"

May use : Affirm III PCR is positive for Gard.

- Cervical pap ---- No diagnostic utility for BV

Bacterial Vaginosis (cont.)

- Remember , it is a polymicrobial clinical syndrome where H2O2 lactobacillus are replaced by anaerobes !
- Treat if symptomatic. Decreasing symtpoms MAY decrease CT, NG, HIV, or other viral STDs.
- Sequelae of not treating include: Increased risk of other STDs, post-op and/or PP complications.

BV……Risk Factors :

- New sexual partner
- Multiple sexual partners
- Douching (may increase relapse rate, no data to support therapeutic value)
- Not using condoms
- Low number of L. bacilli

* May be found in never-sexually active women

BV Treatment Guidelines :

- Metronidazole 500 mg orally BID for 7 days *
  OR
- Metrogel 0.75% intravaginally at HS for 5 d
  OR
- Cleocin 2% Vaginal Gel at HS for 7 days **

* No ETOH for 24 hours after completing therapy with metronidazole.

** Oil based- may weaken latex condoms or diaphragm for 5 days after use.

BV : alternative treatments

- Tinidazole 2 gm orally per day for 2 days *
- Clindamycin 300 mg orally BID for 7 days
- Cleocin Ovules 100 mg ovule vaginally at HS for 3 nights

* No etoh for 3 days after completing therapy.

BV recurrence…..the dilemma

- ? Of using intravaginal L. Bacilli- under research
- Metrogel 2x / week for 4-6 months
- Intravaginal Boric Acid with supportive Metrogel therapy.
- Monthly oral Metronidazole for 7 days with Diflucan
- No follow up needed, only if needed
- ***Treating partners not found to be helpful !

"Chlamydia is not a flower…."

- Most frequently reported STD.
- Recommend annual testing if < 25 yo
- Sequelae include : PID, infertility, ectopic preg
- No routine TOC in 3 wk is needed….HOWEVER :

  Should re-screen in 3 months if compliance problem is suspected

***ALL PREGNANT WOMEN SHOULD HAVE TOC IN 3 weeks. Consider re-test in 3rd trimester.

Chlamydia : Treatment

- Azithromycin 1 gm po X 1 dose (preg)

  OR
- Doxycycline 100 mg po BID X 7 days

  OR
- Amox. 500 mg po TID X 7 days (pregnancy)

- *Abstain from intercourse for 7 days following treatment
- * Doxycycline contraindicated in pregnancy

HSV….anything new ?

- Verbally screen all pregnant women. Perinatal transmission is 30-50% if primary outbreak near delivery. Suppress at 36 weeks.
- Transmission is < 1% for recurrent outbreaks near term or primary outbreaks in 1st trimester.
- Asymptomatic shedding more common in HSV 2, esp in first 12 months after acquisition
- Valacyclovir 500 mg qd may reduce transmission in discordant couples

HSV : Treatment Guidelines

- Acyclovir 400 mg orally TID X 7-10 days (suppression is BID)

  OR
- Acyclovir 200 mg orally 5X per day X 7-10 d (suppression is BID)

  OR
- Famciclovir 250 mg orally TID X 7-10 days* (not effective for suppression) OR
- Valacyclovir 1 gm BID X 7-10 days (suppression is 500 mg -1 gm QD)

Vulvo Vaginal Candidiasis

- 75% of women have 1 lifetime episode, 45% have > 2 episodes.
- Classified by as Complicated or Uncomplicated by 4 criteria :
  - Clinical presentation
  - Microbiology
  - Host Factors
  - Response to therapy

VVC : Uncomplicated

- 80-90% of all VVC is Uncomplicated
- Vaginal ph with VVC is typically < 4.5 (NL), so ph testing is not helpful
- If culture positive, but pt is asymptomatic, no need to treat (10%-20% carrier rate)
- Treatment may be initiated by pt with OTC effectively. If OTC not helpful, or symptoms not improved in 3 days, needs provider eval.

VVC : Complicated

- Recurrent (> 4/yr)
- Severe infection / symptoms
- Non-albicans candidal infection : 20% of RVVC is non-albicans *
- Immunosuppression in Host
- Debilitations in host

* C. Glabrata does NOT form hyphae or pseudo-hyphae. Wet prep not helpful !

Treatment of RVVC

- Oral therapy 1 X / wk for 6 months
- Longer therapy, consider 600 mg Boric Acid in gelatin capsule, vaginally QD X 14 d (70%)
- Consider Terezol vaginal cream; may need PA
- Partner treatment is controversial

*Resistance to azoles is RARE – no need for sensitivity testing

* RVVS occurrence in immunocompetent pt does NOT trigger HIV testing (if prior neg)

VVC in Pregnancy :

- ** Only treat topically **
- Pt is considered immunosuppressed – consider longer course of therapy (7 days)

Trichomoniasis : T. Vaginalis

- Diagnosis : Diffuse, malodorous, yellow-green frothy vaginal discharge with vulvo-vaginal irritation in women.
- Typically asymptomatic or NGU in men
- Microcrospoy is 60-70% sensitive (protozoan)
- AFFIRM III (45 min) + Rapid Test (10 min) are 83% sensitive and >97% specific. Both are POC testing
- PAP SMEARS ARE NOT DIAGNOSTIC

Trichomonas – Treatment

- Recommended is :
  Metronidazole 2 gm po X 1 (cure 90%- 95%)
  OR
  Tinidazole 2 gm X 1 (Cure rate 86-100%)
- Alternate : Flagyl 500 mg po BID X 7d

* NO ETOH Flagyl 1 day, Tindiazole 3 days
* Metrogel is NOT indicated
* If allergic – needs to de-sensitize with specialist.

Trichomoniasis in Pregnancy

- May pre-dispose to PPROM, PTB, LBW
- No routine testing. Can defer tx until 37wk in asymptomatic women (MAY reduce neonatal respiratory and genital infection)
- "Treat ALL symptomatic women, regardless of trimester. Counsel strongly re: condoms, prevention of recurrence."
- Pregnancy/Lactation : Flagyl 2 gm po X 1
- During lactation, pump and discard milk for 24 hours if Flagyl, 72 hours if Tinidazole

*Flagyl has not been shown to decrease perinatal morbidity. Council R/B/alt.

Trichomoniasis (cont.)……

- Nearly 1 in 5 re-infected by 3 months, so a "re-test" @ 3 months is recommd. in females
- Doesn't infect oral sites and rate in MSM is low. No oral or rectal testing is recommended
- HIV – Trichomonal relationship
- Tinidazole not well studied for use in pregnancy

Cervicitis

- Dx with either or both: Purulent or mucopurulent endocervical exudate at cervical canal or sustained endocervical bleeding, even with cotton swab.
- > 10 WBC/hpf or increased PMNs ? diagnostic
- May be asymptomatic, have abnl D/C, or post-coital / intermenstrual bleeding.
- Can be a sign of upper tract infection (endometritis) – consider PID .
- Evaluate for co-morbid GT/ CT/ Trich.

Cervicitis

- Causative agents include :

  Chlamydia Trach.
  Niesseria Gon.
  Abnormal vaginal flora
  Chemical irritants
  Mechanical irritation
  Idiopathic inflammation of ectopy

Cervicitis : Treatment

- Azithromycin 1gm orally for one dose

  OR
- Doxycycline 100 mg orally BID for 10 days

  AND
- Consider tx for NG if high risk population

- Follow up evaluation is recommended

N. Gonorrhea ……runner up

- 700,000 new cases in US annually
- 2nd most reported bacterial STD in U.S.
- Many men are symtpomatic.
- Women typically asymptomatic

NG : Treatment

- Uncomplicated cervical, urethral, rectal:
- Ceftriaxone 250 mg IM X 1 (99.2% cure rate)

OR

- Single dose injectible Cephalosporin

PLUS

- Azythromycin 1 gm po X 1

OR

- Doxycycline 100 mg po BID X 7 days

- Pregnancy: Azythromycin 2 gm po X 1

OR

Amox. 500 mg TID X 7 days

NG : Updates

- Quinolones no longer recommended in US for NG / PID
- Dose is now 250 mg IM X 1 (was 125 mg IM)
- Dual therapy may reduce resistance
- Ceftriaxone 250 mg IM X 1

PLUS

- Azythromycin 1 gm po X 1

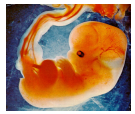
OR

- Doxycycline 100 mg po BID X 7 days

NG : Updates (cont.).....

- Some resistance to cephalosporins in Hawaii and Asian countries – ask about travel!
- Limited data suggests dual therapy with azythro may increase Tx efficiency for pharyngeal infection with NG (98.9)
- Now recommend limiting 2 gm azythromycin due to rapid resistance ID'd in NG
- Screen for co-existing STDs.

Pregnancy Pearls :



- HIV – screen early as possible after notifying pt of routine testing (opt-out only).
- HIV – 3rd trimester repeat if high risk. Test in labor if unknown status(unless refuses) and tx if rapid test is (+) before confirmation done.
- RPR screen early, 3rd trimester(28wks) and @ delivery in high prevalence areas , also for ANY stillbirth.
- HBSag – Screen early and @ admit if high risk. Vaccinate in pregnancy if high risk.

More Pregnancy Pearls :

- HBSaG – If positive, report to HD and vaccinate household contacts and sexual contacts. Notify peds.
- CT – screen early, re-test 3-6 positive. If < 25 yo or high risk, repeat in 3rd trimester!
- HSV / Trich – no routine testing in pregnancy
- HSV – culture near labor ONLY for lesions. If active lesions, do C/S.
- Warts – No indication for C/S (unless vaginal del. Will cause excessive bleeding).

EPT……not a pregnancy test!

- "Clinical practice of treating sexual partners of patients diagnosed with CT or NG by providing medications or a Rx without medical exam of the partner."
- Has some value, though not permissible in all states
- Not allowed in Ohio
- May be patient provided or provider dispensed

STD Reporting …….

- May be provider office-based or lab reporting to Public Health Dept.
- Typical reportables are :

  Syphylis
  NG
  CT
  Chancroid
  HIV / AIDS
  (LGV in some states) – tx Doxy for 21 days

The End……questions ?

CDC- 1-800-CDC-INFO

- http://www.cdc.gov/std