CCHCS Care Guide: Sexually Transmitted Infections

### GOALS
- Prevent sexually transmitted infections (STIs) through counseling patients on safer sexual practices and offering prophylaxis (condoms) to patients as well as other interventions
- Assess all patients for STIs by obtaining a thorough sexual history and appropriate lab testing based on the patient’s risk
- Treat patients with identified STIs and contacts, if known
- Ensure appropriate reporting of STIs to health departments

### ALERTS
- Syphilis can cause irreversible neurologic damage, which can include blindness and deafness
- Pregnant patients are of special concern as STIs can lead to complications including fetal morbidity or mortality
- In the community, patients aged 15 to 24 years are at highest risk for STIs; however, in correctional settings, the age range is older

### DIAGNOSTIC CRITERIA/EVALUATION

**The terms STI and sexually transmitted disease (STD) are frequently used interchangeably. While all patients are “infected,” not every patient is symptomatic, or demonstrates “disease,” so some sources use the term STI. These guidelines are based on the Centers for Disease Control and Prevention (CDC) Sexually Transmitted Infections Treatment Guidelines, 2021. Recently, the CDC has shifted to the preferred usage of STI, since it is considered more inclusive and less stigmatizing. STI will be utilized in this care guide.**

**Risk factors for STIs:** Condom-less sex, sexual contact with multiple partners, history of STI, forced sex, and commercial sex.

**Diagnosis:** Typically by targeted lab testing based on symptoms/history or screening in high risk patients.

**Screening:** In the absence of symptoms, screening should be done on the following patients:
- Adults with risk factors: In CDCR screen all ≤ 44 yrs for gonorrhea/chlamydia; and ♀ ≤ 44 yrs for trichomonas vaginalis
- Men who have sex with men (MSM) and transgender women
- Persons living with Human Immunodeficiency Virus (HIV) (PLWH)
- Current or past history of STIs
- Individuals with a new partner
- All pregnant people

### ASSESSMENT
- **Thorough sexual history:** The CDC recommends the “Five Ps”: Partners, Practices, Protection, Past History, and Pregnancy Intention. (Page 3)
- **Physical examination:** Components based on the patient’s complaints and risks based on sexual history – see individual STI. Referral to Dental for oral examination.
- **Lab/Diagnostic:** Specific tests are indicated and may vary by the patient’s complaints and risks based on the “Five Ps.”
  - CDCR Reception Center Opt-Out Testing includes: gonorrhea/chlamydia/trichomonas vaginalis via urine; serology for rapid plasma reagin (RPR) test for syphilis, HIV, Hepatitis B (HBV), Hepatitis C (HCV), and serum pregnancy for women < 60 years old.
  - Three-site testing refers to collecting three separate specimens at three sites for gonorrhea/chlamydia testing if clinically indicated, based on specific sexual practices: pharynx (swab), anus (swab), and urethra (urine or swab: for females).
  - Biopsy and microscopic examination of oral lesions.

### TREATMENT

**Treatment of STIs** is specific to the infection identified and the extent of disease, if any. (Pages 8-17) Typically, health care staff observe STI treatment administration; prolonged treatment may be Keep-On-Person (KOP). This Care Guide will cover the following most common STIs found in our patients:
- **Syphilis:** Intramuscular benzathine penicillin G or aqueous crystalline penicillin G - dosing/duration based on stage (Pages 8-10)
- **Chlamydia:** Oral doxycycline or azithromycin (Page 11)
- **Gonorrhea:** Intramuscular ceftriaxone (Pages 12-13)
- **Epididymitis and Non-Gonococcal Urethritis** (Page 13)
- **Genital Lesions (Herpes):** Acyclovir, valacyclovir, famciclovir (Pages 14-15)
- **Human Papillomavirus Virus (HPV):** Topical imiquimod or podofilox (Pages 16-17)
- **Trichomonas vaginalis:** Metronidazole (Page 17)

For information regarding HIV, HCV and Hepatitis B virus (HBV) treatments, please see their respective CCHCS Care Guides.
For additional details on these STIs and others covered in the CDC STI Guidelines visit: [https://www.cdc.gov/std/treatment-guidelines/STI-Guidelines-2021.pdf](https://www.cdc.gov/std/treatment-guidelines/STI-Guidelines-2021.pdf)

### MONITORING POST TREATMENT
- After treatment, repeat testing is recommended for chlamydia and gonorrhea at three months to screen for infection.
- Syphilis titers should be followed at an interval based on stage of disease.
  - For all STIs, sex partners need to be informed so they can get tested and treated based on their exposure.
  - Provide ongoing prevention counseling and education.

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Information contained in the Care Guide is not a substitute for a health care professional’s clinical judgment. Evaluation and treatment should be tailored to the individual patient and the clinical circumstances. Furthermore, using this information will not guarantee a specific outcome for each patient. Refer to “Disclaimer Regarding Care Guides” for further clarification. [https://cchcs.ca.gov/clinical/resources/](https://cchcs.ca.gov/clinical/resources/)
The terms STDs and STIs refer to a variety of clinical syndromes and infections caused by pathogens acquired and transmitted through sexual activity. STDs are typically transmitted via contact with mucous membranes, secretions, and blood.

What is the difference in the terms Sexually Transmitted Disease vs Sexually Transmitted Infection?
Some professionals and organizations have recently suggested replacing the term “disease” with “infection.” The concept of “disease,” as in STD, suggests a clear medical problem, usually with some obvious signs or symptoms. However, some of the most common STDs have no signs or symptoms in the majority of persons infected. The sexually transmitted pathogen can be described as causing “infection,” which may or may not result in “disease.” The term “infection” is more inclusive and less stigmatizing. The CDC is currently defining these new recommendations as the “Sexually Transmitted Infections (STI) Treatment Guidelines, 2021.”

Prevention and Control of STIs
The prevention and control of STIs is based on the following five major strategies:

- Accurate risk assessment, education and counseling of persons at risk on ways to avoid STIs through changes in sexual behaviors and use of recommended prevention services
- Pre-exposure vaccination of persons at risk for vaccine-preventable STIs
- Identification of asymptomatic infected persons and persons with symptoms associated with STIs
- Effective diagnosis, treatment, counseling, and follow up of infected persons
- Evaluation, treatment, and counseling of sex partners of persons who are infected with an STI

Primary prevention and control of STIs includes performing a behavioral risk assessment (i.e., assessing the sexual behaviors that may place persons at risk for infection) as well as biologic risk (i.e., testing for risk markers for HIV acquisition or transmission). As part of the clinical encounter, health care providers should routinely obtain sexual histories from their patients and address risk reduction.

Effective techniques for facilitating rapport with patients
Effective interviewing and counseling skills characterized by respect, compassion, and a nonjudgmental attitude toward all patients are essential to obtaining a thorough sexual history and delivering effective prevention messages. Some patients may not be comfortable talking about their sexual history, sex partners, or sexual practices. Try to put patients at ease and let them know obtaining a sexual history is an important part of a complete medical exam or physical history. Techniques include:

- Protecting confidentiality—assure patients that their information regarding sexual behaviors or STIs will not be shared with others. (Notable exceptions are when Prison Rape Elimination Act (PREA) information must be reported; see PREA Page 4.)
- Being sensitive, nonjudgmental and direct.
- Using simple, age- and culturally-appropriate language.
- Avoiding assumptions and generalizations regarding sexual practices.
- Encouraging questions.
- Revisiting the patient’s sexual history at least annually.

Behavioral Risk Assessment (Sexual History)
A sexual history assists in the identification of those individuals at risk for STIs, including HIV, and to identify appropriate anatomical sites of certain STIs. A complete sexual history should be obtained at a patient’s initial visit, during routine health prevention exams, when any sign of STIs are present, or a patient complains of symptoms that are suggestive of an STI.

The “Five Ps” approach to obtaining a sexual history is one strategy for eliciting information concerning the following five key areas of interest. (Page 3).

- Partners
- Practices
- Protection from STIs
- Past history of STIs
- Pregnancy Intention

Providers should also try to gain cultural competency when working with certain populations (e.g., gay, bisexual, MSM, women who have sex with women [WSW], or transgender men and women). (Page 5)
### The Five Ps of Sexual Health

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<th>CDC Language</th>
<th>Suggested CDCR Language for Incarcerated Patients</th>
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<tr>
<td>Partners</td>
<td>Are you currently sexually active (or are you having sex)? If the patient answers no, have you ever been sexually active?</td>
<td>Without making assumptions about the patient’s sexual orientation determine the number of your patient’s different sexual encounter contacts.</td>
</tr>
<tr>
<td></td>
<td>In recent months, how many sex partners have you had?</td>
<td>In the past 12 months, how many different people have you had sexual encounters with?</td>
</tr>
<tr>
<td></td>
<td>In the past 12 months, how many sex partners have you had?</td>
<td>Tell me about your sex partners.</td>
</tr>
<tr>
<td></td>
<td>What is the gender of your partner? Tell me about your sex partner.</td>
<td></td>
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<tr>
<td></td>
<td>Is it possible that any of your sex partners in the past 12 months had sex with someone else while they were still in a sexual relationship with you?</td>
<td></td>
</tr>
<tr>
<td>Practices</td>
<td>In order to better understand your risk for STIs and to facilitate appropriate testing, please tell me about the kind of sex you had these past 12 months.</td>
<td>Different sex practices require specific STI testing/guidance.</td>
</tr>
<tr>
<td>Practices</td>
<td>Have you had vaginal sex, meaning ‘penis in vagina sex’? If yes, do you use condoms: never, sometimes, or always?</td>
<td>In the past 12 months, what kind of sexual contact have you had?</td>
</tr>
<tr>
<td>Practices</td>
<td>Have you had anal sex, meaning ‘penis in rectum/anus sex’? If yes, do you use condoms: never, sometimes, or always?</td>
<td>- Vaginal Sex (penis in the vagina)</td>
</tr>
<tr>
<td>Practices</td>
<td>Have you had oral sex, meaning ‘mouth on penis/vagina’?</td>
<td>- Anal Sex (penis in the anus)</td>
</tr>
<tr>
<td>Practices</td>
<td>For condom answers:</td>
<td>- Oral Sex (mouth on penis, vagina, or anus)</td>
</tr>
<tr>
<td>Protection from STIs</td>
<td>Determine the appropriate level of risk-reduction counseling for each patient.</td>
<td>See Prevention of Pregnancy below</td>
</tr>
<tr>
<td>Protection from STIs</td>
<td>What do you do to protect yourself from STIs and HIV?</td>
<td>- Are you aware of the CCHCS condom program?</td>
</tr>
<tr>
<td>Protection from STIs</td>
<td>Do you and your partner(s) use any protection against STIs? If not, could you tell me the reason?</td>
<td></td>
</tr>
<tr>
<td>Protection from STIs</td>
<td>If so, what kind of protection do you use?</td>
<td></td>
</tr>
<tr>
<td>Protection from STIs</td>
<td>How often do you use this protection? If sometimes, in what situations or with whom do you use protection?</td>
<td></td>
</tr>
<tr>
<td>Past history of STIs</td>
<td>A history of prior STIs may place your patient at greater risk now and require more frequent testing.</td>
<td>Have you ever been diagnosed with an STI?</td>
</tr>
<tr>
<td>Past history of STIs</td>
<td>Have you ever had an STI?</td>
<td>If so, which STI?</td>
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<tr>
<td>Past history of STIs</td>
<td>Have any of your partners had an STI?</td>
<td>Approximate date?</td>
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<tr>
<td>Past history of STIs</td>
<td>Have you ever been diagnosed with an STI? When? How were you treated? Pre-exposure prophylaxis (PrEP), Post-exposure prophylaxis (PEP)?</td>
<td>Was it treated? PrEP, PEP?</td>
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<td>Pregnancy Intention</td>
<td>Based on partner information from the prior section, you may determine that the patient is at risk of becoming pregnant or of fathering a child. If so, first determine if a pregnancy is desired. Questions should be appropriate based on the patient’s history.</td>
<td></td>
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<tr>
<td>Pregnancy Intention</td>
<td>Are you currently trying to conceive or father a child?</td>
<td></td>
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<td>Pregnancy Intention</td>
<td>Are you concerned about getting pregnant or getting your partner pregnant?</td>
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<td>Pregnancy Intention</td>
<td>What are you doing to prevent pregnancy?</td>
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<tr>
<td>Pregnancy Intention</td>
<td>Are you using contraception or practicing any form of birth control? Do you need any information on birth control?</td>
<td>Based on partner information from the prior section, determine if the patient is at risk of becoming pregnant or of fathering a child if having conjugal visits (questions should be gender appropriate). This assists in determining appropriate level of risk-reduction counseling for each patient.</td>
</tr>
<tr>
<td>Pregnancy Intention</td>
<td></td>
<td>- Do you and your partner(s) use any protection against STIs such as condoms? If so, how often?</td>
</tr>
<tr>
<td>Pregnancy Intention</td>
<td></td>
<td>- All of the time</td>
</tr>
<tr>
<td>Pregnancy Intention</td>
<td></td>
<td>- Some of the time</td>
</tr>
<tr>
<td>Pregnancy Intention</td>
<td></td>
<td>- Rarely</td>
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### Biologic Risk Assessment (STI Screening Tests)

STI screening tests can be ordered based on the specific risks identified in the sexual history. Multiple studies have demonstrated that persons entering correctional facilities, especially those aged ≤ 35 years, have high rates of STIs including HIV and viral hepatitis. Risk behaviors for contracting STIs (e.g., having unprotected sex; having multiple sexual partners; using drugs and alcohol; and engaging in commercial, survival, or coerced sex) are common among incarcerated populations. In addition, before incarceration, many patients have had limited access to medical care.

### Population-based Reception Center Opt-out testing:

Upon entering CDCR, patients are given the following diagnostic screening tests and assessments at the Reception Centers based on the Opt-Out screening method:

- Serum pregnancy test (females less than 60 years old)
- HCV ab w/reflex to HCV viral load w/reflex to HCV Genotype
- HIV antibody screening
- RPR
- Gonorrhea/chlamydia urine (all males and females ≤ 44 years old)
- Trichomonas vaginalis (all females ≤ 44 years old)

### Additional Individual Testing

Three-site STI testing, also known as extragenital testing, entails appropriate screening of the throat, urethra, and rectum for gonorrhea and chlamydia. Additional testing should be ordered as clinically indicated based on individual sexual history. For example, if the patient identifies receptive anal/rectal or oral intercourse/contact, then swabs of the anus and mouth should be obtained for gonorrhea and chlamydia in addition to the urine screen. Referral should be made to Dental Services for an oral examination and possible biopsy if lesions are noted in the mouth.

Illicit drug use is also a behavioral risk for STIs and individuals may require the National Institute on Drug Abuse (NIDA) Quick Screen tool to evaluate their risk of substance use disorder.

### Other Testing to Consider

Tests for common STIs (e.g., genital herpes, *Mycoplasma genitalium*, and HPV) that are available but not being performed and reasons why they are not always indicated.

### Public Health Reporting and Response

Diagnosis of HIV, HCV, HBV, syphilis, chlamydia, or gonorrhea should trigger a report to the public health nurse who shall coordinate with the local health department. Should newly identified cases take place outside of the Reception Center, it is to be reported to CCHCS headquarters via the Public Health Outbreak Response System (PORS) in addition to the mandated reporting to local public health described on the California Department of Public Health (CDPH) website. Additional information regarding public health reporting and response can be found in HCDOM Section 3.8.1, Public Health Disease Reporting at: [http://lifeline/PolicyandRiskManagement/IMSPP/HCDOM/HCDOM-Ch03-art8.1.pdf](http://lifeline/PolicyandRiskManagement/IMSPP/HCDOM/HCDOM-Ch03-art8.1.pdf).

### Prison Rape Elimination Act (PREA)

Under the PREA, CCHCS provides medically necessary emergency and follow-up treatment, follow-up care plans, and necessary referrals (including testing for pregnancy and any STIs) for CDCR patients who are identified as possible victims or suspects of sexual violence, staff sexual misconduct, and/or sexual harassment. Additional information regarding PREA and reporting and testing requirements can be found in the HCDOM Section 4.1.6, Prison Rape Elimination Act at: [http://lifeline/PolicyandAdministration/PolicyandRiskManagement/IMSPP/HCDOM/HCDOM-Ch04-art1.6.pdf](http://lifeline/PolicyandAdministration/PolicyandRiskManagement/IMSPP/HCDOM/HCDOM-Ch04-art1.6.pdf).

### 340B Program

CCHCS has partnered with the CDPH Sexually Transmitted Diseases Control Branch to implement control interventions for STIs to improve patient outcomes through the 340B Program. This initiative sets up a program to manage STIs among our patient population and provides an opportunity to enhance a key California public health initiative.

In order to participate in this program, a patient must be “enrolled” for care by a “covered entity.” Each of our institutions will be a separate “covered entity.” Enrollment requires assessment and documentation of the patient’s STI risk/sexual history, along with appropriate treatment and prevention counseling. Enrollment is completed by provider staff (typically for HIV patients and newly diagnosed patients with any STI) and others (screening and education at Reception Center and with Medication Assisted Treatment (MAT) or HCV treatment) using the STI Screening/Education PowerForm.
**EDUCATION**

**Prevention Counseling**
After obtaining a sexual history from their patient, providers should encourage risk reduction by providing prevention counseling. Prevention counseling is most effective if provided in a nonjudgmental and empathetic manner appropriate to the patient's culture, language, gender, sexual orientation, age, and developmental level.

U.S. Preventive Task Force recommends high-intensity behavioral counseling for adults at increased risk for STIs and HIV. Tailoring a discussion of risk reduction to the individual situation is important.

Brief, provider-delivered prevention messages have been shown to decrease subsequent STIs in HIV primary-care settings. Use of motivational interviewing can help move patients toward achievable risk-reduction goals.

In addition to one-on-one STI/HIV prevention counseling, videos and large-group presentations can provide explicit information concerning STIs and reducing disease transmission (e.g., how to use condoms correctly and the importance of routine screening). Nurse Led Therapeutic Groups are being rolled out to all institutions and the following are a sample of the classes available:

- Sexually Transmitted Infections & Diseases Series 2 - Chlamydia
- Sexually Transmitted Infections & Diseases Series 4 - HSV1 & HSV2
- Sexually Transmitted Infections & Diseases Series 5 - Syphilis

The CDCR Condom Program: California state law requires CDCR to make condoms available in all state prisons. Condoms are made available free of charge to inmates. Inmates are allowed to possess up to 3 condoms at any given time. **This law does not change the fact that sexual activity between inmates is illegal and will be addressed according to California Code of Regulations, Title 15, and California Penal Code.**

**Men Who Have Sex with Men**
The term MSM describes a heterogeneous group of men who have varied behaviors, identities, and health-care needs.

Some MSM are at high risk for HIV infection and other viral and bacterial STIs because MSM may practice receptive anal sex, and the rectal mucosa is uniquely susceptible to certain STI pathogens.

In addition, multiple sex partners, substance use, and sexual network dynamics of MSM increase risk for HIV and STIs in this population.

Several studies have demonstrated that early syphilis is associated with HIV infection among MSM.

Consider the following recommendations: PrEP as needed for STI prevention, rectal/pharyngeal testing, digital anorectal exam, enteric pathogens, counseling and education. HIV screening should be completed at least annually. Consider more frequent screening based on risk behavior.

**Women Who Have Sex with Women**
WSW are a diverse group with variations in sexual identity, sexual behaviors, sexual practices, and risk behaviors. Studies show some WSW, particularly those who are young and who have both male and female partners, might be at increased risk for STIs and HIV based on reported risk behaviors.

There is a wide diversity of sexual practices and use of protective/risk reduction strategies among populations of WSW. Few data are available on the risk for STIs from sex between cis-women.

Practices involving digital-vaginal or digital-anal contact, particularly with shared penetrative sex items, present a possible means for transmission of infected cervicovaginal or anal secretions. This possibility is most directly supported by reports of shared trichomonas vaginalis infections and by concordant drug resistance genotype testing and phylogenetic linkage analysis identifying HIV transmitted sexually between cis-women.

HPV, which can be transmitted through skin-to-skin contact, is common among WSW, and while genital transmission of herpes simplex virus type 2 between female sex partners is inefficient, it can occur.

**Transgender Men and Transgender Women**
Persons who are transgender might have sex with men, women, or both. Clinicians should assess STI and HIV-related risks for their transgender patients based on current anatomy and sexual behaviors. Providers must remain aware of symptoms consistent with common STIs and screen for asymptomatic STIs on the basis of behavioral history, sexual practices, and post gender affirming surgery.

**Transgender Women:** A systematic review of studies of HIV among transgender women suggests that the prevalence of HIV in the United States is 27.7% among all transgender women and 56.3% among black transgender women.

Providers caring for transgender women should have knowledge of their patient's current anatomy and patterns of sexual behavior before counseling them about STI and HIV prevention. Most transgender women have not undergone gender affirmation surgery and may retain a functional penis; and might engage in insertive oral, vaginal, or anal sex with men and women.

**Transgender Men:** HIV prevalence and incidence in transgender men suggest that although some transgender men engage in risky behaviors, they have a lower prevalence of HIV than transgender women. Providers should consider the anatomic diversity among transgender men because many still have a vagina and cervix and are at risk for bacterial STIs, cervical HPV, and cervical cancer. *See the CCHCS/DHCS Care Guide: Transgender*

**Cis Men or Women:** Cis is used to describe any person whose gender identity matches the sex they were assigned at birth.

*SSee the CCHCS/DHCS Care Guide: Transgender*
The table below lists the most frequent STIs found in CDCR patients. Patients are offered screening for syphilis, chlamydia, trichomonas vaginalis, gonorrhea, HIV, HCV and HBV on an "opt-out" basis upon arrival at the Reception Center. (Page 1)

- When syphilis, chlamydia or gonorrhea are identified, the patient is offered treatment immediately. Patients identified with HIV are referred to a CCHCS HIV provider, and patients with HCV or HBV are typically managed by their primary care provider once the patients are endorsed to an institution.
- Patients may present at any time with sign/symptoms/complaints related to STIs and should be referred to their primary care provider for a clinically indicated examination, testing, treatment and counseling.


<table>
<thead>
<tr>
<th>STI</th>
<th>Description</th>
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</table>
| Syphilis *(T. pallidum)*                 | Syphilis is a systemic disease caused by the bacterium *Treponema pallidum* *(T. pallidum)*.  
|                                          | The disease is divided into four stages based on clinical findings, to help guide treatment and follow-up.  
|                                          | Primary syphilis infection (i.e., ulcers or chancre at the infection site), secondary syphilis (i.e., manifestations that include, but are not limited to, skin rash, mucocutaneous (including oral) lesions, and lymphadenopathy), or tertiary syphilis (i.e., cardiac, gummatous lesions, tabes dorsalis, and general paresis).  
|                                          | Latent infections are those lacking clinical manifestations, but detected by serologic testing. Latent syphilis acquired within the preceding year is referred to as early latent syphilis; all other cases of latent syphilis are late latent syphilis or syphilis of unknown duration.  
|                                          | *T. pallidum* can infect the central nervous system and result in neurosyphilis, which can occur at any stage of syphilis. Early neurologic clinical manifestations (i.e., cranial nerve dysfunction, meningitis, stroke, acute altered mental status, and auditory or ophthalmic abnormalities) are usually present within the first few months or years of infection. Late neurologic manifestations (i.e., tabes dorsalis and general paresis) occur 10–30 years after infection.  
|                                          | RPR screening (Opt-Out) is offered to all CDCR patients upon arrival at the Reception Center.  |
| Chlamydia *(C. Trachomatis)*             | Chlamydia is a STI caused by the bacterium *Chlamydia trachomatis* *(C. trachomatis)*.  
|                                         | Chlamydial infection is the most frequently reported infectious disease (ID) in the United States, and prevalence is highest (50%) in persons aged 15-24 years.  
|                                         | Asymptomatic infection is common across all genders,  
|                                         | Screening is offered to all CDCR patients upon arrival at the Reception Center.  
|                                         | For men: *Chlamydia/N. Gonorrhea* urine test.  
|                                         | For women: SureSwab *Chlamydia/N. Gonorrheae/T. Vaginalis* urine test.  |
| Gonorrhea *(N. gonorrhoeae)*             | Gonorrhea is a STI caused by the bacterium *Neisseria gonorrhoeae* *(N. gonorrhoeae)*.  
|                                         | Gonorrhea is the second most commonly reported communicable disease.  
|                                         | Men are more commonly symptomatic with urogenital infections.  
|                                         | Women infected with N. gonorrhoea can be asymptotic until complications (e.g., PID) occur. PID can result in tubal scarring that can lead to infertility and ectopic pregnancy.  
|                                         | Rectal infection can cause itching and burning, but pharyngeal infection is often asymptomatic.  
|                                         | Screening is offered to all CDCR patients upon arrival at the Reception Center.  
|                                         | For men: *Chlamydia/N. Gonorrhea* urine test.  
|                                         | For women: SureSwab *Chlamydia/N. Gonorrheae/T. Vaginalis* urine test.  |
| Epididymitis and Non-Gonococcal Urethritis (NGU) | Acute epididymitis is the most common cause of scrotal pain in adults, advanced cases may present with testicular pain.  
|                                         | *N. gonorrhoeae* and *C. trachomatis* are the most common organisms in men under the age of 35.  
|                                         | *Escherichia coli*, other coliforms, and *Pseudomonas* species are more frequent in older men.  
|                                         | *Nongonococcal urethritis* - *C. trachomatis* is the most commonly identified cause. *M. genitalium* is the second most common. There seems to be association between NGU in men who have sex with women (MSW). Sexual practices may contribute to differences in causative agents of NGU in MSM compared with MSW.  |

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### Diagnosis and Treatment of Selected STIs

The table below lists the most frequent STIs found in CDCR patients. Patients are offered screening for syphilis, chlamydia, trichomonas vaginalis, gonorrhea, HIV, HCV and HBV on an "opt-out" basis upon arrival at the Reception Center. (Page 1)
## Diagnosis and Treatment of Selected STIs (con’t)


<table>
<thead>
<tr>
<th>STI Description</th>
<th>Details</th>
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| **Genital Lesions**<br>(Herpes, genital warts)<br>(See pages 14-17) | - In the United States, most young, sexually active patients who have genital, anal, or perianal ulcers have either genital herpes or syphilis.  
- The frequency of each condition differs by geographic area and population; however, genital herpes is the most prevalent of these diseases.  
- More than one etiologic agent (e.g., herpes and syphilis) can be present in a genital, anal, or perianal ulcer. Less common infectious causes of genital, anal, or perianal ulcers include chancroid and donovanosis.  
- Genital herpes, syphilis, and chancroid have been associated with an increased risk for HIV acquisition and transmission. Genital, anal, or perianal lesions can be associated with infectious and noninfectious conditions that are not sexually transmitted (e.g., yeast, trauma, carcinoma, aphthae, fixed drug eruption, and psoriasis). |
| **Trichomonas vaginalis**<br>(T. Vaginalis)<br>(See page 17) | - Trichomonas vaginalis is a STI caused by infection with the protozoan parasite *Trichomonas vaginalis* (*T. vaginalis*).  
- Trichomonas vaginalis is the most prevalent nonviral STI in the United States, affecting an estimated 3.7 million persons.  
- Particularly high prevalence has been detected among incarcerated persons (9%–32% of incarcerated women and 3.2%–8% of incarcerated men).  
- Some infected men have symptoms of urethritis, epididymitis, or prostatitis, and some infected women have vaginal discharge that might be diffuse, malodorous, or yellow-green with or without vulvar irritation.  
- The majority of persons infected (70%–85%) either have minimal or no genital symptoms, and untreated infections might last from months to years.  
- Although partners might be unaware of their infection, it is readily passed between sex partners during penile-vaginal sex or through transmission of infected vaginal fluids or fomites among WSW.  
- Screening with SureSwab *Chlamydia/N. Gonorrhoeae/T. Vaginalis* urine test is offered to CDCR female patients upon arrival at the Reception Center. |
| **HIV** | - See the CCHCS HIV Care Guide. |
| **Hepatitis B and C** | - See the CCHCS HCV Care Guide and CCHCS HBV Care Guide. |
Syphilis is a STI caused by *Treponema pallidum*. Untreated syphilis in pregnant women can cause miscarriage, stillbirth, and preterm birth. Screening all pregnant women for syphilis and providing early treatment for women with syphilis and their sexual partner(s) during prenatal care could completely prevent congenital syphilis.

Syphilis is divided into stages (primary, secondary, tertiary, and latent). There are different signs and symptoms associated with each stage.

- **Primary syphilis** infection (i.e., ulcers or chancres at the infection site including the lips, tongue, and other oral structures)
- **Secondary syphilis** (i.e., manifestations include skin rash, mucocutaneous (including oral) lesions, and lymphadenopathy)
- **Tertiary syphilis** (i.e., cardial, gummatous lesions, tabes dorsalis, and general paresis)
- **Latent infections** (i.e., those lacking clinical manifestations) are detected by serologic testing.
  - Early latent syphilis is acquired within the preceding year.
  - Late latent syphilis or syphils of unknown duration include all those acquired at least 12 months prior to diagnosis.
- **Neurosyphilis**: can occur at any stage of syphilis when *T. pallidum* infects the nervous system.
  - Early neurologic clinical manifestations (i.e., cranial nerve dysfunction, meningitis, stroke, acute altered mental status, and auditory or ophthalmic abnormalities) are usually present within the first few months or years of infection.
  - Late neurologic manifestations (i.e., tabes dorsalis and general paresis) occur 10–30 years after infection.

**Assessment**

There are two types of blood tests available for syphilis: nontreponemal tests and treponemal tests. Both types of tests are needed to confirm a diagnosis of syphilis.

**Nontreponemal tests** (e.g., venereal disease research laboratory [VDRL]) and RPR are simple, inexpensive, and often used for screening, but they are not specific for syphilis and, by themselves, are insufficient for diagnosis.

- A test should be obtained just before initiating therapy (ideally, on the first day of treatment) to establish the pre-treatment titer.
- VDRL and RPR should each have their antibody titer results reported quantitatively.
- Titers usually decline after treatment and might become nonreactive with time.
- False-positive nontreponemal test results can be associated with various medical conditions and factors unrelated to syphilis including other infections (e.g., HIV), autoimmune conditions, immunizations, pregnancy, injection-drug use, and older age.
- Individuals with a reactive nontreponemal test should always receive a treponemal test to confirm a syphilis diagnosis.
- Since nontreponemal titers can increase significantly between the date of diagnosis and the date of treatment, this test is critical to establishing the adequacy of the post-treatment serologic response.

**Treponemal tests** (e.g., fluorescent treponemal antibody absorption (FTA-ABS), treponema pallidum particle agglutination (TPPA), and others) detect antibodies that are specific for syphilis.

- These antibodies appear earlier than nontreponemal antibodies and usually remain detectable for life, even after successful treatment. They do not predict treatment response or reinfection and therefore should not be used for these purposes.
- If a treponemal test is used for screening and the results are positive, a nontreponemal test with titer should be performed to confirm diagnosis and guide patient management decisions.

**All patients with syphilis should be tested for HIV and other STIs.**

**Pregnancy**: All pregnant individuals should be tested for syphilis at their first prenatal visit. Syphilis in pregnancy can have devastating consequences and requires timely treatment with penicillin.

**HIV**: For most persons with HIV infection, serologic tests are accurate and reliable for diagnosing syphilis and following a patient’s response to treatment. However, atypical nontreponemal serologic test results (i.e., unusually high, unusually low, or fluctuating titers) might occur regardless of HIV-infection status. When serologic tests do not correspond with clinical findings suggestive of early syphilis, presumptive treatment is recommended for individuals with risk factors for syphilis and use of other tests (e.g., biopsy and polymerase chain reaction [PCR]) should be considered.

**Neurosyphilis**: All patients diagnosed with syphilis should receive a neurological examination inclusive of hearing and vision to screen for signs of neurosyphilis and the patient should be assessed for new neurological symptoms (i.e., blurry vision, new onset headaches). If signs or symptoms for neurosyphilis or ocular syphilis are present, a cerebrospinal fluid (CSF) evaluation is indicated. Laboratory testing is helpful in supporting the diagnosis of neurosyphilis; however, no single test can be used to diagnose neurosyphilis in all instances. The diagnosis of neurosyphilis depends on a combination of CSF tests (CSF cell count or protein and a reactive CSF-VDRL) in the presence of reactive serologic test results and neurologic signs and symptoms.

CSF-VDRL is highly specific but insensitive. In a person with neurologic signs or symptoms, a reactive CSF-VDRL (in the absence of blood contamination) is considered diagnostic of neurosyphilis.

When CSF-VDRL is negative despite the presence of clinical signs of neurosyphilis, reactive serologic test results, and abnormal CSF cell count and/or protein, neurosyphilis should be considered and testing using FTA-ABS on CSF may be warranted.
SYMPHILIS (CONT’)

Treatment

Penicillin G, administered parenterally, is the preferred drug for treating persons in all stages of syphilis.

- The preparation used (i.e., benzathine or aqueous crystalline), dosage, and length of treatment depend on the stage and clinical manifestations of the disease. If > 7 days have passed after titer was drawn, repeat on the day of treatment for accurate baseline.
- Selection of the appropriate penicillin preparations is important, because T. pallidum can reside in sequestered sites (e.g., the Central Nervous System (CNS) and aqueous humor) that are poorly accessed by some forms of penicillin.
- Combinations of benzathine penicillin, procaine penicillin, and oral penicillin preparations are not considered appropriate for the treatment of syphilis. Reports have indicated that practitioners have inadvertently prescribed combination benzathine-procaine penicillin (Bicillin C-R) instead of the standard benzathine penicillin G product (Bicillin L-A) widely used in the United States. Practitioners, pharmacists, and purchasing agents should be aware of the similar names of these two products to avoid using the inappropriate combination therapy agent for treating syphilis.
- Jarisch-Herxheimer reaction is an acute febrile reaction frequently accompanied by headache, myalgia, fever, and other symptoms that can occur within the first 24 hours after the initiation of any therapy for syphilis. Patients should be informed about this possible adverse reaction and how to manage it if it occurs.
  - This occurs mostly in persons who have early syphilis and/or high titer levels, presumably because bacterial burdens are higher in these stages. Antipyretics can be used to manage symptoms, but they have not been proven to prevent this reaction.
  - This reaction may cause early labor or fetal distress in pregnant patients; this should not prevent or delay therapy.
- Pregnancy: Syphilis screening for pregnant women is important. There has been a dramatic rise in congenital syphilis. In addition to screening all pregnant women at the first prenatal visit, the CDC recommends retesting for syphilis at 28 weeks gestation and at delivery. An expectant mother is at higher risk if she has multiple sex partners, has an STI during pregnancy, or has a partner with an STI. Presumptively treat any patient with a suspected case of infectious syphilis at the initial visit. Parenteral penicillin G is the only treatment with documented efficacy for syphilis during pregnancy. (Per the CDC, pregnant people with syphilis in any stage who report penicillin allergy should be desensitized and treated with penicillin.)
- Late latent syphilis: Is treated with weekly intramuscular (IM) injections of penicillin G. Intervals of 7-9 days between doses is optimal. Intervals greater than 14 days should always be restarted (pregnant people should repeat the full course if an interval exceeds eight days.)
- Penicillin-allergic patients: For non-pregnant patients the alternatives are either doxycycline (100 mg orally twice daily) or tetracycline (500 mg orally four times daily). Primary, secondary or definitively early-latent syphilis receive the selected regimen for 14 days; late-latent or unknown duration syphilis for 28 days.
- HIV: Recommended regimens in patients with HIV infection are the same as for those without HIV infection.
- Treatment Response: A fourfold change in titer, equivalent to a change of two dilutions (e.g., from 1:16 to 1:4 or from 1:32 to 1:8) is considered necessary to demonstrate a clinically significant difference. Certain individuals are considered to have a serofast titer with a low baseline generally ranging from 1 to 128. Patients who have a very low titer at baseline may not decline and may be serofast. If the patient is treated and titer does not improve, contact a specialist.
  - In some patients, nontreponemal antibodies can persist at a low titer (less than 1:8) for a long period of time.
  - Treponemal tests most often remain reactive for life and should not be used to determine treatment response.

<table>
<thead>
<tr>
<th>Stage of Syphilis</th>
<th>Drug</th>
<th>Dose</th>
<th>Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary, secondary, and early latent: Adults (including pregnant women and people with HIV)</td>
<td>Benzathine penicillin G</td>
<td>2.4 million units IM</td>
<td>Single dose</td>
</tr>
<tr>
<td>Late Latent adults (including pregnant women and people with HIV infection)</td>
<td>Benzathine penicillin G</td>
<td>7.2 million units total, administered as 3 doses of 2.4 million units IM each at 1-week intervals</td>
<td>3 weeks</td>
</tr>
<tr>
<td>Neurosyphilis, Ocular Syphilis, and Otosyphilis</td>
<td>Aqueous crystalline penicillin G</td>
<td>18–24 million units per day, administered as 3–4 million units IV every 4 hours or continuous infusion.</td>
<td>10–14 days¹</td>
</tr>
<tr>
<td>Tertiary</td>
<td>Benzathine penicillin G</td>
<td>7.2 million units total, administered as 3 doses of 2.4 million units IM each at 1-week intervals</td>
<td>3 weeks</td>
</tr>
</tbody>
</table>

¹Alternative Regimen: Procaine PCN G 2.4 million units IM once daily plus Probenecid 500 mg orally 4 times/day, both for 10-14 days CNS involvement can occur during any stage of syphilis, and CSF laboratory abnormalities are common among persons with early syphilis, even in the absence of clinical neurologic findings. No evidence exists to support variation from recommended diagnosis and treatment for syphilis at any stage for persons without clinical neurologic findings, except tertiary syphilis. If clinical evidence of neurologic involvement is observed (e.g., cognitive dysfunction, motor or sensory deficits, cranial nerve palsies, or symptoms or signs of meningitis or stroke), a CSF examination should be performed before treatment.
### SYPHILIS (CON’T)

#### Monitoring Post-Treatment

The follow-up of patients with syphilis is extremely important to document response to therapy and to evaluate for reinfection. Observation of the fourfold decline in titer is an indication that treatment was effective. The following are general recommendations for follow-up after treatment.

- **Primary or secondary syphilis:** Patients should be reexamined clinically in 1-2 weeks and again at 4 weeks for resolution of signs.
  - **Repeat serology** should be performed **6 months and 12 months** following treatment.
  - Serologic response (i.e., titer) should be compared with the titer at the time of treatment. However, assessing serologic response to treatment can be difficult, and definitive criteria for cure or failure have not been well established.
  - Persons who have signs or symptoms that persist or recur and those with at least a fourfold increase in nontreponemal test titer persisting for > 2 weeks likely experienced treatment failure or were re-infected.
  - All persons who have primary and secondary syphilis should be tested for HIV infection.

- **Latent syphilis:** Patients should be followed up clinically and **serologically at 6, 12, and 24 mos.** (Quant nontreponemal test)
  - All persons who have latent syphilis should be tested for HIV infection.
  - CSF examination should be performed if 1) a sustained (> 2 weeks) fourfold increase or greater in titer is observed, 2) an initially high titer (≥1:32) fails to decline at least fourfold within 12–24 months of therapy, or 3) signs or symptoms attributable to syphilis develop.

- **Neurosyphilis including ocular syphilis:**
  - All persons who have neurosyphilis should be tested for HIV.
  - If CSF pleocytosis was present initially, a CSF examination should be repeated every 6 months until the CSF cellcount is normal.
  - Follow-up titers should be compared to the maximum or baseline nontreponemal titer obtained prior to treatment.

- **Persons with HIV infection:** Need additional monitoring.
  - **Primary or secondary syphilis** every 3 months for the first year, then again at 24 months.
  - **Latent syphilis** every 6 months for 24 months.

#### Signs of treatment failure:
(Consultation with a subject matter expert is recommended.)

- A patient has persistent or recurring signs or symptoms.
- Patient testing shows sustained fourfold increase in nontreponemal titer. These patients should be retreated and reevaluated for HIV infection. Because treatment failure may be a result of unrecognized CNS infection, CSF examination should be considered.
- Failure of nontreponemal titers to decline fourfold within 12 months after therapy for primary or secondary syphilis may be indicative of treatment failure. Additional clinical and serological follow-up is necessary since the optimal management is unclear. Examination of CSF can be considered in these instances. Certain individuals are considered to have a serofast titer with a low baseline generally ranging from 1 to 128. Patients who have a very low titer at baseline may not decline and may be serofast. If the patient is treated and titer does not improve, contact a specialist. For additional questions, contact Public Health.
## CHLAMYDIA

### Overview

Chlamydia (*Chlamydia trachomatis* or *C. trachomatis*) is the most frequently reported bacterial STI in the United States. Chlamydia is known as a ‘silent’ infection because most infected people are asymptomatic and lack abnormal physical examination findings.

- Chlamydia can cause cervicitis in cis-women/trans-men and urethritis and proctitis in all genders.
- Chlamydial infections of the gynecological tract or reproductive tract can lead to serious consequences including pelvic inflammatory disease, tubal factor infertility, ectopic pregnancy, and chronic pelvic pain.
- In pregnant patients, untreated chlamydia has been associated with pre-term delivery, as well as ophthalmia neonatorum (conjunctivitis) and pneumonia in the newborn.

### Assessment

**Screening:** In the community it is cis-women under the age of 25 years who have the highest burden of chlamydia. All people in the correctional setting have increased risk factors for acquiring STIs, therefore, in CDCR everyone ≤ 44 years is screened.

**Type of tests:** There are a number of diagnostic tests for chlamydia, including NAATs, cell culture, and others. NAATs are the most sensitive tests and can be performed on easily obtainable specimens such as vaginal swabs or urine.

- **Cis-women/transgender men:** Vaginal swabs are the optimal specimen to screen for genital chlamydia using NAATs; urine is an effective alternative specimen type for women.
- **Cis-men/transgender women:** Urine is the specimen of choice.

Chlamydial culture can be used for rectal or pharyngeal specimens but is not widely available. NAATs are preferred because they have demonstrated improved sensitivity and specificity compared with culture for the detection of *C. trachomatis* at non-genital sites.

**Chlamydia:** Infection sites, complications, testing, treatment, follow-up. See table below.

### Infection sites, Complications, Testing, Treatment, and Follow-up

<table>
<thead>
<tr>
<th></th>
<th>MALES</th>
<th>FEMALES</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Genital infections, uncomplicated</strong></td>
<td>Urethritis</td>
<td>Cervicitis, Urethritis</td>
</tr>
<tr>
<td><strong>Reproductive tract complications</strong></td>
<td>Epididymitis, accessory gland infection/abscess, inguinal lymphadenitis, penile edema, balanitis, prostatitis</td>
<td>Pelvic inflammatory disease, endometritis, salpingitis, perihepatitis, infertility, accessory gland infection/abscess, chronic pelvic pain</td>
</tr>
<tr>
<td><strong>Other sites of infection</strong></td>
<td>Conjunctivitis, Pharyngitis, Proctitis, Proctocolitis</td>
<td></td>
</tr>
<tr>
<td><strong>Test specimens, genital</strong></td>
<td>Urine (alternative urethral)</td>
<td>Urine (alternatives vaginal, cervical-swab can be self-collected by patient)</td>
</tr>
<tr>
<td><strong>Test specimens, extragenital</strong></td>
<td>Rectal swab, throat swab (both can be self-collected by patient)</td>
<td></td>
</tr>
<tr>
<td><strong>Diagnostic tests</strong></td>
<td>NAAT combo test 11363 for <em>Chlamydia trachomatis</em>/<em>Neisseria gonorrhoeae</em></td>
<td>SureSwab test 16492 for <em>Chlamydia trachomatis</em>/ <em>Neisseria gonorrhoeae</em>/ <em>T. Vaginalis</em></td>
</tr>
<tr>
<td><strong>Treatment, chlamydia</strong></td>
<td>Doxycycline* 100 mg orally twice a day for 7 days</td>
<td></td>
</tr>
<tr>
<td>Adults and adolescents</td>
<td>Alternatives: Azithromycin 1 g orally in a single dose OR levofloxacin* 500 mg orally 1x/day for 7 days</td>
<td></td>
</tr>
<tr>
<td>(HIV + patients same treatment)</td>
<td>(*Cannot use in pregnancy)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>[To minimize transmission, individuals treated for Chlamydia should be instructed to abstain from sexual intercourse for 7 days after single-dose therapy or until completion of a 7-day regimen and resolution of symptoms if present.]</td>
<td></td>
</tr>
<tr>
<td>Pregnancy</td>
<td>Azithromycin 1 g orally in a single dose OR amoxicillin 500 mg orally 3x/day for 7 days</td>
<td></td>
</tr>
<tr>
<td><strong>Partner treatment</strong></td>
<td>Refer all sex partners in preceding 60 days for evaluation and presumptive treatment</td>
<td></td>
</tr>
<tr>
<td><strong>Follow-up</strong></td>
<td>Test of cure not needed for non-pregnant patients who have uncomplicated infections and are treated with a recommended regimen. Test of cure in 3 to 4 weeks is recommended if an alternative regimen is used or if a patient is pregnant. Test for reinfection in 3 months (ideal), or at next encounter within 12 months.</td>
<td></td>
</tr>
</tbody>
</table>
GONORRHEA

Overview
Gonorrhea is an STI caused by infection with the bacteria *Neisseria gonorrhoeae* or *N. gonorrhoeae*. Gonorrhea is most commonly spread during vaginal, oral, or anal sex. Untreated gonorrhea can increase a person’s risk of acquiring or transmitting HIV.

- **Cis-Men and Transgender Women**: Gonococcal (GC) urethral infections often produce symptoms, such as dysuria or a white, yellow, or green urethral discharge that usually appears 1 to 14 days after infection. As a result, patients more commonly seek curative treatment.
- **Cis-Women and Transgender Men**: GC infections are commonly asymptomatic or might not produce recognizable symptoms until complications (e.g., PID) have occurred. Symptoms, when present, can include: dysuria, increased vaginal discharge, or vaginal bleeding between periods. PID can result in tubal scarring that can lead to infertility and ectopic pregnancy.
- Babies of infected mothers can be infected during childbirth. In babies, gonorrhea most commonly affects the eyes.
- Signs and symptoms of gonorrhea outside the genitourinary system include:
  - Rectal: May be asymptomatic, but may include discharge, anal itching, soreness, bleeding, or painful bowel movements.
  - Pharyngeal: Usually asymptomatic but may cause a sore throat or a burning sensation.
  - Oral: Sometimes painful ulcers or burning of the tongue and other mucous membranes, swollen tonsils and lymph glands of the head and neck.
  - Disseminated (rare): pustular acral skin lesions, asymmetric polyarthritis, tenosynovitis, or oligoarticular septic arthritis.

Assessment

**Screening** in the community is recommended annually for sexually active cis-women/transgender men aged < 25 years and those 25 years or older with increased risk of infection (e.g., more than one partner or a partner with an STI). Everyone in the correctional setting, regardless of gender, has increased risk factors for acquiring STIs, therefore, in CDCR everyone ≤ 44 years is screened.

**Type of Tests**: Culture and NAAT are available for the detection of genitourinary infection with *N. gonorrhoeae*.
- Culture requires endocervical (female) or urethral (male) swab specimens.
- Culture is also available for detection of rectal, oropharyngeal, and conjunctival gonococcal infection. NAAT can be done on endocervical swabs, vaginal swabs, urethral swabs (male), and urine (any gender).
- The sensitivity of NAAT for the detection of *N. gonorrhoeae* in urogenital sites is superior to culture.

All patients who receive a diagnosis of gonorrhea should be tested for other STDs, including chlamydia, syphilis, and HIV.

<table>
<thead>
<tr>
<th>MALES</th>
<th>FEMALES</th>
</tr>
</thead>
<tbody>
<tr>
<td>NAAT combo test 11363 for Chlamydia trachomatis/Neisseria gonorrhoeae</td>
<td>SureSwab test 16492 for Chlamydia trachomatis/Neisseria gonorrhoeae/T. Vaginalis</td>
</tr>
</tbody>
</table>

**Treatment**

Effectively treating gonorrhea remains a public health priority. Gonorrhea can rapidly develop antibiotic resistance and is the second most commonly reported bacterial STI in the US, increasing 56% from 2015 to 2019.

Gonorrhea treatment is complicated by the ability of *N. gonorrhoeae* to develop resistance to antimicrobials. There is a national surveillance system to monitor trends in antimicrobial susceptibilities. Antimicrobial resistance guides decisions about gonococcal treatment recommendations which change based on surveillance antimicrobial sensitivity results. Dual therapy is recommended.

- To ensure adherence to therapy, administration of medication for gonococcal infection should be directly observed.
- Instruct the patient to abstain from sexual activity for 7 days after treatment and until all sex partners are adequately treated.

**Infection Type - Gonococcal Infections**

<table>
<thead>
<tr>
<th>Infection Type</th>
<th>Medications</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Uncomplicated Gonococcal Infections of the Cervix, Urethra, Rectum, and Pharynx: Adults &lt;150 Kg</td>
<td>Ceftriaxone 500 mg IM in a single dose*</td>
<td>If cephalosporin allergy: gentamicin 240 mg IM in a single dose PLUS azithromycin 2 g orally in a single dose</td>
</tr>
<tr>
<td>Adults weighing ≥150 Kg, 1 g ceftriaxone should be administered.</td>
<td>Ceftriaxone 1 g IM in a single dose</td>
<td>If ceftriaxone administration is not available or not feasible: cefixime 800 mg orally in a single dose</td>
</tr>
<tr>
<td>Disseminated Gonococcal Infection</td>
<td>Ceftriaxone 1 g IM or IV every 24 hours</td>
<td>Cefotaxime 1 g by IV every 8 hours OR ceftizoxime 1 g every 8 hours</td>
</tr>
<tr>
<td>Conjunctivitis</td>
<td>Ceftriaxone 1 g IM in a single dose</td>
<td></td>
</tr>
<tr>
<td>Pregnancy</td>
<td>Ceftriaxone 500 mg IM in a single dose</td>
<td></td>
</tr>
</tbody>
</table>

*If chlamydial infection is not ruled out, treat with a regimen of 100 mg of oral doxycycline taken twice daily for 7 days (if pregnant, treat with azithromycin 1 g orally in a single dose).
**GONORRHEA (CON’T)**

**Post Treatment Monitoring**

**Test-of-cure (TOC):** Recommended for patients with pharyngeal gonorrhea 7 to 14 days after treatment, using either culture or nucleic acid amplification tests.

**Repeat testing:** Retest patients 3 months after gonorrhea treatment, regardless of whether they have symptoms.

**Management of suspected gonococcal treatment failure:** Perform culture and susceptibility testing of all relevant clinical specimens. Notify Public Health.

**Management of Sex Partners:** Refer sex partners in the preceding 60 days for evaluation, testing, and presumptive treatment.

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**EPIDIDYMIS**

**Overview**

Acute epididymitis is a clinical syndrome causing pain, swelling, and inflammation of the epididymis and lasting < 6 weeks. Sometimes a testicle is also involved, a condition referred to as epididymo-orchitis. A high index of suspicion for spermatocord (testicular) torsion should be maintained among men who have a sudden onset of symptoms associated with epididymitis because this condition is a surgical emergency.

Acute epididymitis can be caused by STIs (e.g., *C. trachomatis*, *N. gonorrhoeae*, or *M. genitalium*) or enteric organisms (i.e., *Escherichia coli*). Acute epididymitis caused by an STI is usually accompanied by urethritis, which is frequently asymptomatic. Acute epididymitis caused by sexually transmitted enteric organisms might also occur among men who are the insertive partner during anal sex.

**Assessment**

Men who have acute epididymitis typically have unilateral testicular pain and tenderness, hydrocele, and palpable swelling of the epididymis. All suspected cases of acute epididymitis should be tested for *C. trachomatis* and *N. gonorrhoeae* by NAAT. Urine is the preferred specimen for NAAT for men.

**Treatment**

To prevent complications and transmission of STIs, presumptive therapy for all sexually active men is indicated at the time of the visit before all laboratory test results are available.

<table>
<thead>
<tr>
<th>Epididymitis</th>
<th>Medications</th>
</tr>
</thead>
<tbody>
<tr>
<td>For acute epididymitis most likely caused by sexually transmitted chlamydia and gonorrhea</td>
<td>ceftriaxone 500 mg IM in a single dose PLUS doxycycline 100 mg orally 2x/day for 10 days</td>
</tr>
<tr>
<td>For acute epididymitis most likely caused by chlamydia, gonorrhea, or enteric organisms (men who practice insertive anal sex)</td>
<td>ceftriaxone 500 mg IM in a single dose PLUS levofloxacin 500 mg orally 1x/day for 10 days</td>
</tr>
<tr>
<td>For acute epididymitis likely caused by enteric organisms only</td>
<td>levofloxacin 500 mg orally 1x/day for 10 days</td>
</tr>
</tbody>
</table>

---

**NON-GONOCOCCAL URETHRITIS**

**Overview**

NGU is a nonspecific diagnosis that can have various infectious etiologies. *C. trachomatis* is well established as an NGU etiology.

**Assessment**

Clinical presentations include urethral discharge, irritation, dysuria, or meatal pruritus. NGU is confirmed for symptomatic men when diagnostic evaluation of urethral secretions indicates inflammation, without evidence of diplococci by Gram stain, Methylene Blue (MB) or Gentian violet (GV) smear on microscopy. If microscopy is unavailable, urine testing for leukocyte esterase can be performed on first-void urine and microscopic examination of sediment from a spun first-void urine demonstrating ≥ 10 WBCs/HPF has a high negative predictive value.

**Treatment**

<table>
<thead>
<tr>
<th>Medications</th>
<th>Alternative Regimens</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doxycycline 100 mg orally 2x/day for 7 days</td>
<td>Azithromycin 1 g orally in a single dose OR azithromycin 500 mg orally in a single dose, THEN 250 mg 1x/day for 4 days</td>
</tr>
</tbody>
</table>
### Genital Lesions

#### Genital Herpes: Overview

Genital herpes is a chronic, life-long viral infection. Two types of herpes simplex virus (HSV) can cause genital herpes: HSV-1 and HSV-2.

- Most cases of recurrent genital herpes are caused by HSV-2. Less common, HSV-1 can be spread from the mouth to the genitals through oral sex; and can be the cause of genital infection.
- Herpes Simplex infection is characterized by periods of latency punctuated by periods of viral shedding with or without painful genital and oral lesions.
  - Asymptomatic shedding of HSV accounts for the majority of transmitted genital HSV infections.
  - Primary genital infections are characterized by severe multiple bilateral genital ulcers, pain, itching, dysuria, discharge, and tender inguinal adenopathy. They are frequently associated with systemic symptoms (e.g., fever, myalgia, headache, aseptic meningitis or symptoms of autonomic nervous system dysfunction such as urinary retention).
  - Average incubation period for an initial herpes infection is 4 days (range, 2 to 12) after exposure. The vesicles break and leave painful ulcers that may take 2 to 4 weeks to heal after the initial herpes infection. Experiencing these symptoms is referred to as having a first herpes “outbreak” or episode.
  - Recurrent outbreaks are typically shorter in duration and less severe than the first outbreak of genital herpes. The number of symptomatic recurrent outbreaks may decrease over time. Recurrences and subclinical shedding are much less frequent for genital HSV-1 infection than for genital HSV-2 infection.
  - Complications of genital herpes infections include aseptic meningitis, encephalitis, pneumonitis, hepatitis, transverse myelitis, and autonomic dysfunction. Genital herpes increases both acquisition and transmission of HIV infection.
  - HSV infection in pregnant women can be passed to unborn child before birth or at delivery and can be deadly to the baby.

#### Genital Herpes: Assessment

**Screening** for HSV-1 and HSV-2 in the general population is not indicated.

The clinical diagnosis of genital herpes can be difficult, because the painful multiple vesicular or ulcerative lesions typically associated with HSV are absent in many infected persons. Recurrences and subclinical shedding are much more frequent for genital HSV-2 infection than for genital HSV-1 infection.

- A patient’s prognosis and the type of counseling needed depend on the type of genital herpes (HSV-1 or HSV-2) causing the infection; therefore, the clinical diagnosis of genital herpes should be confirmed by type-specific laboratory testing.
- Individuals with genital herpes should be tested for HIV infection.

**Testing options** include:

- **Viral culture** (low sensitivity) - best with younger lesions, ideally un-roof vesicles swab base of the ulcer.
- **Nucleic acid amplification** methods, including PCR assays for HSV DNA (more sensitive) - test of choice for diagnosing HSV infections affecting the central nervous system and systemic infections.
- Failure to detect HSV by culture or PCR, especially in the absence of active lesions, does not indicate an absence of HSV infection because viral shedding is intermittent.

**Serologic Typing HSV**: Viral culture isolates and PCR amplicons should be typed to see which type of HSV is causing the infection.

- Accurate type-specific HSV serologic assays are based on the HSV-specific glycoprotein G2 (HSV-2) and glycoprotein G1 (HSV-1).
- As nearly all HSV-2 infections are sexually acquired, the presence of type-specific HSV-2 antibody implies anogenital infection.
- Since many persons with HSV-1 antibody have oral HSV infection acquired during childhood, it is harder to interpret a positive HSV-1 serology and distinguish anogenital from orolabial or cutaneous infection.

Type-specific serologic tests are useful in the following scenarios:

- Recurrent or atypical genital symptoms with negative HSV cultures;
- Clinical diagnosis of genital herpes without laboratory confirmation;
- Asymptomatic contact to genital herpes (e.g., a sex partner);
- As part of a comprehensive evaluation for STIs in at-risk individuals.
There is no cure for genital herpes. Oral antiviral medications can prevent or shorten outbreaks while the patient takes the medication.

- **First Episode**: Newly acquired genital herpes can cause a prolonged clinical illness with severe genital and/or oral ulcerations and neurologic involvement. Even if symptoms are initially mild the patient can develop severe or prolonged symptoms. Therefore, all patients with first episodes of genital herpes should receive antiviral therapy.

- **Recurrent Episodes**: Most patients with genital HSV-2 infection subsequently experience recurrent episodes of genital and/or oral lesions; recurrences are less frequent after initial genital HSV-1 infection.
  - Antiviral therapy for recurrent genital herpes can be administered either as suppressive therapy to reduce the frequency of recurrences or episodically to ameliorate or shorten the duration of lesions.
  - Effective episodic treatment of recurrent herpes requires initiation of therapy within 1 day of lesion onset or during the prodrome that precedes some outbreaks.

- **Suppression**:Suppressive therapy reduces the frequency of genital herpes recurrences by 70%-80% in patients who have frequent recurrences. Daily suppressive therapy reduces the risk of transmission.
  - Safety and efficacy have been documented among patients receiving daily therapy with acyclovir for as long as six years.

- **Topical therapy** with antiviral drugs offers minimal clinical benefit and is discouraged.

- **Counseling** regarding the natural history of genital herpes, sexual and perinatal transmission, and methods to reduce transmission is integral to clinical management.

- **Sex partners** should be evaluated. If symptomatic should be treated, if asymptomatic counsel and can offer type-specific serologic testing for HSV infection.

### Genital Herpes: Treatment

<table>
<thead>
<tr>
<th>Genital Herpes Simplex</th>
<th>Medication*</th>
<th>Dosage</th>
<th>Frequency</th>
<th>Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>First episode of genital herpes</td>
<td>acyclovir OR famciclovir OR valacyclovir</td>
<td>400 mg orally 250 mg orally 1g orally</td>
<td>3 times per day 3 times per day 2 times per day</td>
<td>7-10** days 7-10** days 7-10** days</td>
</tr>
<tr>
<td>Suppressive therapy for recurrent genital herpes (HSV-2)</td>
<td>acyclovir OR valacyclovir OR famciclovir</td>
<td>400 mg orally 500 mg orally 1 g orally 250 mg orally</td>
<td>2 times per day 1 time per day 1 time per day 2 times per day</td>
<td></td>
</tr>
<tr>
<td>Episodic therapy for recurrent genital herpes (HSV-2)</td>
<td>acyclovir OR acyclovir OR famciclovir OR famciclovir</td>
<td>800 mg orally 800 mg orally 1 g orally 500 mg orally 250 mg orally 125 mg orally 500 mg orally 1 g orally</td>
<td>2 times per day 3 times per day 2 times per day Once, FOLLOWED BY 2 times per day 2 times per day 2 times per day 1 time per day</td>
<td>5 days 2 days 1 day 2 days 3 days 3 days 2 days</td>
</tr>
<tr>
<td>Recurrent Episode (HIV+) (Episodic therapy for persons with HIV infection)</td>
<td>acyclovir OR famciclovir OR valacyclovir</td>
<td>400 mg orally 500 mg orally 1 g orally</td>
<td>2-3 times per day 2 times per day 2 times per day</td>
<td>5-10 days 5-10 days 5-10 days</td>
</tr>
<tr>
<td>Suppression</td>
<td>acyclovir</td>
<td>400 mg orally</td>
<td>2 times per day</td>
<td>Variable - can be years</td>
</tr>
<tr>
<td>Suppression (HIV+) (Daily suppressive therapy for persons with HIV infection)</td>
<td>acyclovir OR famciclovir OR valacyclovir</td>
<td>400-800 mg orally 500 mg orally 500 mg orally</td>
<td>2-3 times per day 2 times per day 2 times per day</td>
<td>Variable - can be years</td>
</tr>
<tr>
<td>Suppression (pregnancy)</td>
<td>acyclovir</td>
<td>400 mg orally</td>
<td>3 times per day</td>
<td>36 weeks gestation through delivery</td>
</tr>
</tbody>
</table>

*Non-formulary options include Valacyclovir and Famciclovir.

**Treatment can be extended if healing is incomplete after 10 days of therapy.
Human Papillomavirus: Overview

Over 100 types of HPV infections have been identified, of which most are self-limited and are asymptomatic or unrecognized. HPV is highly transmissible. Most sexually active individuals become infected with HPV at least once in their lifetime. In most cases, HPV goes away on its own and does not cause any health problems. Treatment of warts or cervical abnormalities will reduce but may not eliminate the risk of transmission.

- **Oncogenic**, high-risk HPV infection (e.g., types 16 and 18) cause most cervical, penile, vulvar, vaginal, anal, and oropharyngeal cancers.
- **Non-oncogenic**, low-risk HPV infection (e.g., types 6 and 11) cause genital and oral warts and recurrent respiratory papillomatosis.
- **Pregnancy**: Although rare, genital HPV infection can be transmitted from mother to newborn during delivery.
- **Vaccine**: Three-dose vaccines for HPV target the more pathogenic strains in addition to five other cancer causing types (e.g., HPV types 16 and 18) and some formulations also protect against additional types (e.g., 6 and 11) for a total of 9 HPV types. The vaccine is recommended starting at age 12-13 and may be provided up to age 26 for males and females.

Human Papillomavirus: Assessment

Genital warts usually appear as a small bump or group of bumps in the anogenital area and warts can also appear in the oral cavity or pharynx. They can be small or large, raised or flat, or shaped like a cauliflower. Most often, genital warts cause minimal symptoms; however, they may cause pain or itching.

Urethral meatal warts may cause hematuria or impairment of the urinary stream. Perianal and intra-anal warts may cause bleeding on defecation.

- Most cases of HPV warts are diagnosed clinically. However, biopsy may be helpful if the diagnosis is uncertain, the patient is immunocompromised, warts are pigmented firm or fixed, the lesions do not respond to or worsen with standard treatment, or there is persistent ulceration or bleeding.
- Persons with newly diagnosed anogenital warts should be tested for other STIs, including chlamydia, gonorrhea, HIV, and syphilis.
- Secondary syphilis condylomata lata lesions can be easily mistaken for anogenital warts.

**Lab Testing**: There are HPV tests to detect oncogenic types of HPV infection that can be used to screen for cervical cancer; these tests are only recommended for use in the context of cervical cancer screening and management or follow-up of abnormal cervical cytology or histology.

- HPV tests are not recommended to screen men, adolescents, or women under the age of 30 years.

Human Papillomavirus: Treatment

- There is no test to find out a person’s HPV status and there is no approved HPV test to find HPV in the mouth or throat.
- **HPV Warts**: The aim of treatment is removal of the wart and amelioration of symptoms, if present. If left untreated, HPV warts can resolve spontaneously, remain unchanged, or increase in size or number.
- Because warts might spontaneously resolve within 1 year, an acceptable alternative for some individuals is to forego treatment and wait for spontaneous resolution. Whether the reduction in HPV viral DNA resulting from treatment reduces future transmission remains unknown.
- Individuals living with HIV infection may have larger and more numerous warts that do not respond as well to therapy and recurrences occur more frequently after treatment.

See next page for treatment medications.
**SUMMARY**

**DECISION SUPPORT**

**PATIENT EDUCATION/SELF MANAGEMENT**

## GENITAL LESIONS (con’t)

<table>
<thead>
<tr>
<th>Infection Type</th>
<th>Medications</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>External Anogenital Warts</strong></td>
<td>Patient-applied: imiquimod 3.75% or 5% cream OR podofilox 0.5% solution or gel OR sinecatechins 15% ointment Provider-administered: cryotherapy with liquid nitrogen or cryoprobe OR surgical removal either by tangential scissor excision, tangential shave excision, curettage, laser, or electrosurgery OR trichloroacetic acid (TCA) or bichloroacetic acid (BCA) 80%–90% solution</td>
</tr>
<tr>
<td><strong>Urethral Meatus Warts</strong></td>
<td>cryotherapy with liquid nitrogen OR surgical removal</td>
</tr>
<tr>
<td><strong>Vaginal Warts, Cervical Warts, Intra-Anal Warts</strong></td>
<td>cryotherapy with liquid nitrogen OR surgical removal OR TCA or BCA 80%–90% solution</td>
</tr>
</tbody>
</table>

### Human Papillomavirus: Post Treatment Monitoring

Most anogenital warts respond within 3 months of therapy. Factors that might affect response to therapy include immunosuppression and treatment compliance. In general, warts located on moist surfaces or in intertriginous areas respond best to topical treatment. A new treatment modality should be selected when no substantial improvement is observed after a complete course of treatment or in the event of severe side effects. Recurrence is common and patients may require multiple treatments.

### TRICHOMONAS VAGINALIS

#### Overview

Trichomoniasis vaginalis is the most common nonviral STI worldwide. Women are affected more often than men. Trichomoniasis vaginalis is one of the three common infectious causes of vaginal complaints among reproductive-aged women, along with bacterial vaginosis and candida vulvovaginitis, and a cause of urethritis in men; however, the infection is often asymptomatic. Trichomonas vaginalis is a relatively common infection among WSW and women who have sex with women and men (WSWM), with prevalence rates higher than for chlamydia or gonorrhea, and direct transmission of trichomonas vaginalis between female partners has been demonstrated. Females ≤ 44 years housed in correctional facilities should be screened for trichomonas vaginalis. This screening should be conducted at intake and offered as opt-out screening.

#### Assessment

Women who report symptoms – purulent, malodorous, thin discharge associated with burning, pruritus, dysuria, lower abdominal pain, or dyspareunia - should be evaluated and treated. Any person who has a positive test for trichomonas vaginalis, should be rescreened 3 months after treatment. Screening is reasonable for women at increased risk of infection, including those with new or multiple partners or a history of STIs. The CDC recommends screening for *T. vaginalis* in all HIV-infected women, annually and at their initial prenatal visits. Evidence does not support routine screening for *T. vaginalis* among asymptomatic pregnant women.

Screen all females ≤ 44 years old using SureSwab test 16492 for *Chlamydia trachomatis/Neisseria gonorrhoeae/T. Vaginalis* urine test. In men, *T. vaginalis* infection is asymptomatic in over three-quarters of cases and often transient (spontaneous resolution within 10 days). Screening for men is not recommended.

#### Treatment

The nitroimidazoles are the only class of medications with clinically demonstrated efficacy against *T. vaginalis* infections. Patients diagnosed with *T. vaginalis* infection should abstain from sex until they and their sex partners are treated (i.e., when therapy has been completed and any symptoms have resolved). Testing for other STIs, including HIV, syphilis, gonorrhea, and chlamydia, should be...
## CCHCS Care Guide: Sexually Transmitted Infections

### Decision Support

**Table: Antibiotics**

<table>
<thead>
<tr>
<th>DRUG CLASS / MEDICATION</th>
<th>DOSING*</th>
<th>ADVERSE EFFECTS / INTERACTIONS*</th>
<th>COMMENTS*</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Amoxicillin</strong></td>
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<tr>
<td>Capsule: 250 mg</td>
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<td>250 mg</td>
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<tr>
<td>Tablet: 500 mg</td>
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<td></td>
<td></td>
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<tr>
<td>Powder for Suspension: 125 mg/5 mL</td>
<td>200 mg/5 mL</td>
<td>250 mg/5 mL</td>
<td>400 mg/5 mL</td>
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<tr>
<td><strong>Azithromycin</strong> (Zithromax&lt;sup&gt;®&lt;/sup&gt;)</td>
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<tr>
<td>Tablets: 250 mg</td>
<td>500 mg</td>
<td>600 mg</td>
<td>$</td>
</tr>
</tbody>
</table>

### Summary

**Chlamydia (Alternative Treatment in Pregnancy):** 500 mg orally 3 times a day for 7 days.

**Hepatic Impairment:** No dosage adjustment needed.

**Renal Impairment:**
- **CrCl < 30 mL/min:** No dosage adjustment needed.
- **CrCl 10 - 30 mL/min:** 250—500 mg orally every 12 hours, depending on the severity of the infection. Do not use the 875 mg-tablet strength or the extended-release tablet for dosing.
- **CrCl < 10 mL/min:** 250—500 mg orally every 24 hours, depending on the severity of the infection. Do not use the 875 mg-tablet strength or the extended-release tablet for dosing.

**Adverse Reactions:** Candidiasis (vaginal, oral-rare), contact dermatitis, diarrhea, dysgeusia, headache, nausea, rash, abdominal pain, vomiting, hypersensitivity reactions, erythema multiforme, Stevens-Johnson syndrome, toxic epidermal necrolysis, *C. diff* diarrhea

**Drug Interactions:** Amiloride, methotrexate, tetracyclines, thyold vaccine, warfarin, aminoglycosides, mycophenolate, probenecid, sulfonamides, oral contraceptives, salicylates, furosemide, indomethacin, ethacrynic acid, digoxin

**Contraindications:** Hypersensitivity to amoxicillin, any other penicillin antibiotics or any component of the product

**Caution in the following:** Cephalosporin or carbapenem hypersensitivity, renal impairment, phenylketonuria (chewable tablets), pregnancy, breastfeeding, the elderly

**Note:** While amoxicillin may be used to treat certain STDs, the drug may mask or delay the symptoms of incubating syphilis when given as part of an STD treatment regimen. All patients with a diagnosed or suspected STD should be tested for other STDs, which may include HIV, syphilis, and gonorrhea, at the time of diagnosis. Initiate appropriate therapy and perform follow-up testing as recommended based upon sexually transmitted disease diagnosis

**Adverse Reactions:** Abdominal pain, diarrhea, nausea, vomiting, flatulence, increased liver enzymes, headache, abnormal vision

**Drug Interactions:** Dronedarone, pimozone, and thioridazine are contraindicated, warfarin, digoxin, donepezil, hydroxychloroquine, sodium phosphate, simvastatin, lovastatin, atorvastatin, class III antiarrhythmic agents and other QT-interval prolonging drugs, lopinavir, phenytoin, fosphenytoin, albuterol, levamlbuterol, aluminum or magnesium containing products, carbamazepine

**Contraindications:** Hypersensitivity to azithromycin or any component of the product, erythromycin, any macrolide or ketoide antibiotic, cholestatic jaundice or hepatic dysfunction with prior azithromycin therapy

**Caution in the following:** Patients with known or congenital QT prolongation, history of torsade de pointes, bradyarrhythmias, uncompensated heart failure, proarrhythmic conditions, concomitant use of medications known to cause QT interval prolongation or electrolyte imbalances, hepatic impairment, renal impairment, pregnancy, breastfeeding, the elderly

**Bold = Formulary**

*See prescribing information for complete description of dosing, adverse effects, drug interactions, precautions and contraindications

The cost scale $-$ represents the relative cost of acquisition of medication only. Frequency and complexity of medication administration (institution workload, effect on adherence) should be considered when determining overall cost-effectiveness of treatment.
### CCHCS Care Guide: Sexually Transmitted Infections

**Medication Tables**

<table>
<thead>
<tr>
<th>Antibiotics</th>
<th><strong>DOSING</strong>*</th>
<th><strong>ADVERSE EFFECTS / INTERACTIONS</strong>*</th>
<th><strong>COMMENTS</strong>*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ceftriaxone  (Rocephin®)</td>
<td><strong>Injectable:</strong> 250 mg vial 1 g vial</td>
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<td></td>
</tr>
<tr>
<td></td>
<td><strong>$</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| **Gonorrhea:** Guideline Dosage | • Uncomplicated infection of cervix, urethra, pharynx, oral cavity, or rectum:  
- < 150 kg: 500 mg IM as a single dose.  
- ≥ 150 kg: 1 g IM as a single dose.  
• Gonococcal Conjunctivitis: 1 g IM as a single dose.  
• Disseminated Gonococcal Infection:  
  - Arthritis-Dermatitis Syndrome: 1 g IM or IV every 24 hours.  
  May switch to an oral agent guided by antimicrobial susceptibility testing 24 – 48 hours after substantial clinical improvement, for a total treatment course of > 7 days.  
  • Meningitis and Endocarditis: 1-2 g IM every 24 hours  
    Meningitis: for 10-14 days.  
    Endocarditis: for at least 4 weeks.  
• Neurosyphilis (penicillin allergic patients):  
  • Limited data suggest that 1-2 g IM or IV once daily for 10 to 14 days can be used as an alternative in non-pregnant patients.  
  For pregnant patients with penicillin allergy, CDC recommends penicillin desensitization.  
**Acute Epididymitis**  
• Most likely caused by sexually transmitted chlamydia and gonorrhea:  
  - < 150 kg: 100 mg orally twice daily for 10 days  
  PLUS ceftriaxone 500 mg IM as a single dose.  
  - ≥ 150 kg: 100 mg orally twice daily for 10 days  
  PLUS ceftriaxone 1 g IM as a single dose.  
• Most likely caused by chlamydia, gonorrhea, or enteric organisms (men who practice insertive anal sex):  
  - < 150 kg: 500 mg IM once as a single dose PLUS levofloxacin 500 mg orally once daily for 10 days.  
  - ≥ 150 kg: 1 g IM once as a single dose PLUS levofloxacin 500 mg orally once daily for 10 days.  
**Mild to Moderate Pelvic Inflammatory Disease**  
• < 150 kg: 500 mg IM as a single dose PLUS doxycycline 100 mg orally twice daily for 14 days.  
• ≥ 150 kg: 1 g IM as a single dose PLUS doxycycline 100 mg orally twice daily for 14 days.  
**NOTE:** Women who do not respond to IM/oral therapy within 72 hours should be reevaluated to confirm the diagnosis and be administered therapy IV.  
**Acute Proctitis**  
• < 150 kg: 500 mg IM as a single dose PLUS doxycycline 100 mg orally twice daily for 7 days.  
• ≥ 150 kg: 1 g IM as a single dose PLUS doxycycline 100 mg orally twice daily for 7 days.  
**Hepatic/Renal Impairment:** Dose adjustments are not necessary for adult patients with hepatic or renal dysfunction alone. In patients with both hepatic dysfunction and significant renal impairment, the dose should not exceed 2 g/day. Close clinical monitoring for safety and efficacy is advised in these patients. | Adverse Reactions: Injection site reaction, eosinophilia, diarrhea, thrombocytosis, rash, leukopenia, elevated hepatic enzymes, pain/tenderness at injection site, increased blood urea nitrogen  
**Drug Interactions:** Warfarin, cyclosporine, live vaccines  
**Contraindications:** Hypersensitivity to ceftriaxone, any component of the product, or other cephalosporins  
Caution in the following: Gastrointestinal (GI) disease or history of GI disease, hypersensitivity to penicillins, malnutrition, hepatic disease, vitamin K deficiency, renal disease, concurrent hepatic/renal impairment, pregnancy, breastfeeding, the elderly |

**SUMMARY**

**DECISION SUPPORT**

**PATIENT EDUCATION / SELF-MANAGEMENT**

*Bold = Formulary*  
*See prescribing information for complete description of dosing, adverse effects, drug interactions, precautions and contraindications*  

The cost scale $-$$$$$ represents the relative cost of acquisition of medication only. Frequency and complexity of medication administration (institution workload, effect on adherence) should be considered when determining overall cost-effectiveness of treatment.
### Antibiotics

<table>
<thead>
<tr>
<th>DRUG CLASS / MEDICATION</th>
<th>DOSING*</th>
<th>ADVERSE EFFECTS / INTERACTIONS*</th>
<th>COMMENTS*</th>
</tr>
</thead>
</table>
| **Doxycycline Hyclate** (Vibramycin® Vibra-Tabs®) | Chlamydia: 100 mg orally twice daily for 7 days. Syphilis (Alternative Treatment)  
- Primary, secondary, or early latent < 1 year: 100 mg orally twice daily for 14 days.  
- Latent > 1 year, or of unknown duration: 100 mg orally twice daily for 28 days. Acute Epididymitis  
- Most likely caused by sexually transmitted chlamydia and gonorrhea:  
  - < 150 kg: 100 mg orally twice daily for 10 days PLUS ceftriaxone 500 mg IM as a single dose.  
  - ≥ 150 kg: 100 mg orally twice daily for 10 days PLUS ceftriaxone 1 g IM as a single dose.  
Nongonococcal Urethritis: 100 mg orally twice daily for 7 days  
  - M. genitalium:  
    - Resistance testing is available:  
      - Macrolide sensitive: 100 mg orally twice daily for 7 days, followed by azithromycin 1 g orally initial dose, followed by 500 mg orally daily for 3 additional days (2.5 g total).  
      - Macrolide resistant: 100 mg orally twice daily for 7 days followed by moxifloxacin 400 mg orally once daily for 7 days.  
    - If *M. genitalium* is detected by an FDA-cleared NAAT and resistance testing is NOT available: 100 mg orally twice daily for 7 days followed by moxifloxacin 400 mg orally once daily for 7 days.  
Mild to Moderate Pelvic Inflammatory Disease  
- < 150 kg: 100 mg orally twice daily for 14 days PLUS ceftriaxone 500 mg IM as a single dose.  
- ≥ 150 kg: 100 mg orally twice daily for 14 days PLUS ceftriaxone 1 g IM as a single dose.  
  NOTE: Women who do not respond to IM/oral therapy within 72 hours should be reevaluated to confirm the diagnosis and be administered therapy IV.  
Acute Proctitis  
- < 150 kg: 100 mg orally twice daily for 7 days PLUS ceftriaxone 500 mg IM as a single dose.  
- ≥ 150 kg: 100 mg orally twice daily for 7 days PLUS ceftriaxone 1 g IM as a single dose.  
Hepatic Impairment: No dose adjustments provided in the manufacturer’s labeling, however, dose adjustments may be needed in severe hepatic disease since hepatic excretion into bile may be delayed and elimination half-life extended.  
Renal Impairment: No dose adjustment needed. | Adverse Reactions: Rash, loss of appetite, diarrhea, nausea, sore gums, abdominal pain, vomiting, myalgia, bacterial vaginosis, back pain, cough, dyspepsia, elevated hepatic enzymes, hypertension, pharyngitis, esophagitis  
Drug Interactions: Acitretin is contraindicated, penicillins, methotrexate, ascorbic acid, live vaccines, retinoids, rifampin, rifapentine, aluminum, calcium or magnesium containing products, iron, warfarin, phenytoin, lithium  
Contraindications: hypersensitivity to doxycycline, any component of the product, or other tetracyclines, pregnancy, breastfeeding (during treatment and for 5 days after last dose)  
Caution in the following: Concomitant use with isotretinoin or penicillins, history of or predisposition to oral candidiasis, history of intracranial hypertension, the elderly | |

**Bold = Formulary**  
*See prescribing information for complete description of dosing, adverse effects, drug interactions, precautions and contraindications*  
The cost scale $-$$$$$$ represents the relative cost of acquisition of medication only. Frequency and complexity of medication administration (institution workload, effect on adherence) should be considered when determining overall cost-effectiveness of treatment.
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<th>ADVERSE EFFECTS / INTERACTIONS*</th>
<th>COMMENTS*</th>
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<tbody>
<tr>
<td><strong>Levofloxacin</strong></td>
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<tr>
<td></td>
<td>Acute Epididymitis</td>
<td>Adverse Reactions: Abdominal pain, constipation, cough, diarrhea, dysgeusia, dizziness, fever, headache, infection, insomnias, nausea, pharyngitis, rash, rhinitis, vomiting, agitation, anemia, angina, anorexia, edema, QT prolongation, torsade de points, photosensitivity, tendinitis, tendon rupture, peripheral neuropathy, and CNS effects. Discontinue levofloxacin and avoid use of fluoroquinolones in patients with these serious adverse reactions. Reserve use of levofloxacin for patients with no alternative treatment options for an uncomplicated UTI, acute bacterial exacerbation of chronic bronchitis, or acute bacterial sinusitis. Fluoroquinolones, including levofloxacin, may exacerbate muscle weakness in persons with myasthenia gravis. Avoid in patients with known history of myasthenia gravis. <strong>Black Box Warning: Fluoroquinolones, including levofloxacin, are associated with disabling and potentially irreversible serious adverse reactions that have occurred together, including tendinitis and tendon rupture, peripheral neuropathy, and CNS effects. Discontinue levofloxacin and avoid use of fluoroquinolones in patients with these serious adverse reactions.</strong> Reserve use of levofloxacin for patients with no alternative treatment options for an uncomplicated UTI, acute bacterial exacerbation of chronic bronchitis, or acute bacterial sinusitis. Fluoroquinolones, including levofloxacin, may exacerbate muscle weakness in persons with myasthenia gravis. Avoid in patients with known history of myasthenia gravis. <strong>Black Box Warning: Fluoroquinolones, including levofloxacin, are associated with disabling and potentially irreversible serious adverse reactions that have occurred together, including tendinitis and tendon rupture, peripheral neuropathy, and CNS effects. Discontinue levofloxacin and avoid use of fluoroquinolones in patients with these serious adverse reactions. Reserve use of levofloxacin for patients with no alternative treatment options for an uncomplicated UTI, acute bacterial exacerbation of chronic bronchitis, or acute bacterial sinusitis. Fluoroquinolones, including levofloxacin, may exacerbate muscle weakness in persons with myasthenia gravis. Avoid in patients with known history of myasthenia gravis.</strong></td>
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</tr>
<tr>
<td>Renal Impairment:</td>
<td>- Usual dose of 500 mg orally every 24 hours (FDA-approved labeling)</td>
<td>Drug Interactions: Bepidril, dronedarone, halofantrine, pimozide and thioridazine are contraindicated. Aluminum, calcium, magnesium, and zinc containing products, QT interval prolonging drugs, NSAIDS. <strong>Contraindications:</strong> Hypersensitivity to levofloxacin, or any other quinolone antibiotic including ofloxacin or any component of the product. Concomitant use with bepridil, dronedarone, halofantrine, pimozide or thioridazine. <strong>Caution in the following:</strong> Dehydration, renal impairment, arrhythmias, QT prolongation or history of, patients at risk for aortic dissection, history of aneurysm of aorta or any other blood vessels, peripheral atherosclerotic vascular diseases, congenital long QT syndrome, bradycardia, AV block, heart failure, stress-related cardiomyopathy, MI, stroke, hypomagnesemia, hypokalemia, hypocalcemia, concomitant use with NSAIDS, anti-diabetic agents, medications known to prolong the QT interval or cause electrolyte imbalances, hepatic disease, myasthenia gravis, pregnancy, breastfeeding, the elderly. <strong>NOTE:</strong> While levofloxacin may be used to treat certain sexually transmitted diseases (STD), the drug may mask or delay the symptoms of incubating syphilis when given as part of an STD treatment regimen. All patients with a diagnosed or suspected STD should be tested for other STDs, which may include HIV, syphilis, chlamydia, and gonorrhea, at the time of diagnosis. Initiate appropriate therapy and perform follow-up testing as recommended based upon sexually transmitted disease diagnosis.</td>
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<tr>
<td></td>
<td>- CrCl ≥ 50 mL/min: No dosage adjustment needed.</td>
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<td></td>
<td>- CrCl 20 to 49 mL/min: 500 mg orally once, then 250 mg orally every 24 hours.</td>
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<td></td>
<td>- CrCl 10 to 19 mL/min: 500 mg orally once, then 250 mg orally every 48 hours.</td>
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</tbody>
</table>

*Bold = Formulary*  
*See prescribing information for complete description of dosing, adverse effects, drug interactions, precautions and contraindications.*  
The cost scale $$$$$ represents the relative cost of acquisition of medication only. Frequency and complexity of medication administration (institution workload, effect on adherence) should be considered when determining overall cost-effectiveness of treatment.
### Antibiotics

<table>
<thead>
<tr>
<th>DRUG CLASS / MEDICATION</th>
<th>DOSING*</th>
<th>ADVERSE EFFECTS / INTERACTIONS*</th>
<th>COMMENTS*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Moxifloxacin (Avelox®)</td>
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<td></td>
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<tr>
<td>Tablet: 400 mg</td>
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</table>

**M. genitalium:**
- Resistance testing is available:
  - Macrolide resistant: Doxycycline 100 mg orally twice daily for 7 days followed by moxifloxacin 400 mg orally once daily for 7 days.
  - If *M. genitalium* is detected by an FDA-cleared NAAT and resistance testing is NOT available: Doxycycline 100 mg orally twice daily for 7 days followed by moxifloxacin 400 mg orally once daily for 7 days.

**Hepatic Impairment:** No dose adjustment needed. Caution should be used, however, due to metabolic alterations associated with hepatic impairment, which may lead to QT prolongation.

**Renal Impairment:** No dose adjustment needed.

- Adverse Reactions: Abdominal pain, constipation, cough, diarrhea, dysgeusia, dizziness, fever, headache, infection, insomnia, nausea, pharyngitis, rash, rhinitis, vomiting, agitation, anemia, angina, anorexia, edema, QT prolongation, torsade de points, photosensitivity, tendinitis, tendon rupture, rash, pruritus, dehydration, candidiasis, dyspnea, palpitations, syncope, ventricular arrhythmia/tachycardia, urticaria, *C. diff.* colitis, gastritis, arthralgia, muscle spasms, hepatic failure, elevated hepatic enzymes, seizures, peripheral neuropathy, toxic epidermal necrolysis, Stevens-Johnson syndrome, hyper/hypoglycemia

- Drug Interactions: Bepridil, dronedarone, halofantrine, levomethadyl, mesoridazine, pimozide, thioridazine, and ziprasidone are contraindicated. Aluminum, calcium, magnesium, and zinc containing products, QT interval prolonging drugs, NSAIDS, atenolol

**Black Box Warning:** Fluoroquinolones, including moxifloxacin, are associated with disabling and potentially irreversible serious adverse reactions that have occurred together, including tendinitis and tendon rupture, peripheral neuropathy, and CNS effects. Discontinue moxifloxacin and avoid use of fluoroquinolones in patients with these serious adverse reactions. Reserve use of moxifloxacin for patients with no alternative treatment options for acute bacterial sinusitis or acute bacterial exacerbation of chronic bronchitis. Fluoroquinolones, including moxifloxacin, may exacerbate muscle weakness in persons with myasthenia gravis. Avoid in patients with known history of myasthenia gravis

- Contraindications: Hypersensitivity to moxifloxacin, or any other quinolone antibiotics including ofloxacin or any component of the product. Concomitant use with bepridil, dronedarone, pimozide, halogantrene, levomethadyl, mesoridazine, thioridazine, and ziprasidone

- Caution in the following: Dehydration, renal impairment, arrhythmias, QT prolongation or history of patients at risk for aortic dissection, history of aneurysm of aorta or any other blood vessels, peripheral atherosclerotic vascular diseases, congenital long QT syndrome, bradycardia, AV block, heart failure, stress-related cardiomyopathy, MI, stroke, hypomagnesemia, hypokalemia, hypocalcemia, concomitant use with NSAIDS, antiadibetic agents, medications known to prolong the QT interval or cause electrolyte imbalances, hepatic disease, myasthenia gravis, pregnancy, breastfeeding, the elderly

**NOTE:** While moxifloxacin may be used to treat certain sexually transmitted diseases (STD), the drug may mask or delay the symptoms of incubating syphilis when given as part of an STD treatment regimen. All patients with a diagnosed or suspected STD should be tested for other STDs, which may include HIV, syphilis, chlamydia, and gonorrhea, at the time of diagnosis. Initiate appropriate therapy and perform follow-up testing as recommended based upon sexually transmitted disease diagnosis.

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## Summary

### Medication Tables

### Antbiotics

<table>
<thead>
<tr>
<th>Drug Class / Medication</th>
<th>Dosing*</th>
<th>Adverse Effects / Interactions*</th>
<th>Comments*</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Penicillin G</strong>&lt;br&gt;Aqueous Crystalline&lt;br&gt;(Pfizer®)<strong>&lt;br&gt;Injectable: 5 million unit powder for injection</strong>&lt;br&gt;$$$$$</td>
<td>Neurosyphilis, Ocular Syphilis, or Otosyphilis:&lt;br&gt;• 18 to 24 million units per day, administered as 3 to 4 million units IV every 4 hours or continuous infusion, for 10-14 days.&lt;br&gt;NOTE: Penicillin G Benzathine 2.4 million units IM in a single dose once a week (every 7 days) for up to 3 weeks can be considered after IV therapy to provide a comparable duration of treatment to latent syphilis.&lt;br&gt;Hepatic Impairment: No dose adjustment needed. However, dose adjustments may be needed in patients with both hepatic and renal impairment.&lt;br&gt;Renal Impairment:&lt;br&gt;• Manufacturer recommends:&lt;br&gt;  - CrCl ≥ 10 mL/min/1.73m² in patients with uremia: A full loading dose then 50% of the usual dose given every 4 to 5 hours.&lt;br&gt;  - CrCl &lt; 10 mL/min/1.73m²: A full loading dose then 50% of the usual dose given every 8 to 10 hours.&lt;br&gt;• Other guidelines recommend:&lt;br&gt;  - CrCl 10 to 50 mL/min/1.73m²: 75% of the usual dose.&lt;br&gt;  - CrCl &lt; 10 mL/min/1.73m²: 20 to 50% of the usual dose.&lt;br&gt;Adverse Reactions: Rash, fever, drug-induced eosinophilia, urticaria, nausea, vomiting, arthralgia, Jarisch-Herxheimer reaction, hyperkalemia, injection site reaction&lt;br&gt;Drug Interactions: Tetracyclines, warfarin, methotrexate, donepezil, live vaccines, bupropion, oral contraceptives, aminoglycosides, sodium picosulfate, ethacrynic acid&lt;br&gt;Contraindications: Hypersensitivity to penicillin(s) or any component of the product&lt;br&gt;Caution in the following: Electrolyte imbalance, renal impairment, cephalosporin or carbapenem hypersensitivity, allergies or allergic conditions, asthma, ulcerative colitis or other GI disease, pregnancy, breastfeeding, the elderly</td>
<td><strong>Black Box Warning</strong> Intramuscular (Suspension) - Not for intravenous use. Do not inject intravenously or admix with other intravenous solutions. There have been reports of inadvertent intravenous administration of penicillin G benzathine which has been associated with cardiorespiratory arrest and death.&lt;br&gt;<strong>Contraindications</strong> Hypersensitivity to penicillin(s) or any component of the product&lt;br&gt;<strong>Caution in the following</strong> Seizure disorders, renal impairment, congenital syphilis or neurosyphilis, cephalosporin or carbapenem hypersensitivity, allergies or allergic conditions, asthma, ulcerative colitis or other GI disease, pregnancy, breastfeeding, the elderly</td>
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</tbody>
</table>

| Penicillin G Benzathine<br>(Bicillin LA®)**<br>Injectable: 2.4 million units/4 mL**<br>$$$$$ | Syphilis:<br>• Primary, secondary, or early latent < 1 year: 2.4 million units IM in a single dose.<br>• Latent > 1 year, or of unknown duration: 2.4 million units IM in a single dose once a week (every 7 days) for 3 doses (7.2 million units total).<br>• Tertiary with normal CSF examination: 2.4 million units IM in a single dose once a week (every 7 days) for 3 doses (7.2 million units total).<br>Hepatic Impairment: No dose adjustment needed. However, dose adjustments may be needed in patients with both hepatic and renal impairment.<br>Renal Impairment: Clearance is significantly delayed in patients with decreased renal function. Specific dose adjustment recommendations are not available; use with caution. | Adverse Reactions: Rash, urticaria, nausea, vomiting, increased eosinophil count, fatigue, fever, Jarisch-Herxheimer reaction, arthralgia, chills, edema, dizziness, headache, drowsiness<br>Drug Interactions: Tetracyclines, warfarin, methotrexate, donepezil, live vaccines, bupropion, oral contraceptives, aminoglycosides, sodium picosulfate | **Comments** |

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### Antiviral - Genital Herpes

<table>
<thead>
<tr>
<th>DRUG CLASS / MEDICATION</th>
<th>DOISING*</th>
<th>ADVERSE EFFECTS / INTERACTIONS*</th>
<th>COMMENTS*</th>
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<tbody>
<tr>
<td>Acyclovir (Zovirax)</td>
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<tr>
<td>Tablets: 200 mg 400 mg 800 mg $</td>
<td>Genital Herpes Simplex:</td>
<td>Adverse Reactions: Malaise, nausea, vomiting, abdominal pain, elevated hepatic enzymes, dizziness, drowsiness, fatigue, hepatitis, nephrotoxicity, hyperbilirubinemia, jaundice, rash, urticaria, erythema multiforme, Stevens-Johnson syndrome, toxic epidermal necrolysis, myalgia, elevated serum creatinine, elevated BUN.</td>
<td>Contraindications: Hypersensitivity to acyclovir, valacyclovir, or any component of the formulation. Due to similar chemical structures and possible cross-sensitivity, acyclovir should not be used in patients with famciclovir, ganciclovir, penciclovir, or valganciclovir hypersensitivity. Caution in the following: Dehydration, renal impairment, concurrent use with nephrotoxic drugs, seizure disorder, electrolyte imbalance, significant hypoxemia, significant hepatic disease, pregnancy, breastfeeding, the elderly.</td>
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<tr>
<td></td>
<td>- First clinical episode of genital herpes: 400 mg orally 3 times daily for 7 to 10 days.</td>
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<td>- Episodic therapy for recurrent genital herpes: 800 mg orally twice daily for 5 days OR 800 mg orally 3 times daily for 2 days.</td>
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<td>- Suppressive therapy for recurrent genital herpes: 400 mg orally twice daily.</td>
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<td></td>
<td>- Recommended regimen for episodic infection in persons with HIV infection: 400 mg orally 3 times daily for 5 to 10 days.</td>
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<td></td>
<td>- Recommended regimen for daily suppressive therapy in persons with HIV infection: 400 mg orally every 2 to 3 times a day.</td>
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<td></td>
<td>- Recommended regimen for suppressive therapy of pregnant women with recurrent genital herpes (recommend starting at 36 weeks gestation through delivery): 400 mg orally 3 times daily.</td>
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<td></td>
<td>Hepatic Impairment: No dose adjustment provided in the manufacturer’s labeling; use caution in patients with severe impairment.</td>
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<td>Renal Impairment:</td>
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<td>- CrCl 11 to 25 mL/min/1.73m²: No dose adjustment needed for patients receiving 400 mg orally every 12 hours.</td>
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<td>- CrCl ≤10 mL/min/1.73m²: Patients receiving 400 mg orally every 12 hours, reduce dose to 200 mg orally every 12 hours.</td>
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</table>

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**Antiviral - Genital Herpes**

<table>
<thead>
<tr>
<th>DRUG CLASS / MEDICATION</th>
<th>DOSING*</th>
<th>ADVERSE EFFECTS / INTERACTIONS*</th>
<th>COMMENTS*</th>
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<tbody>
<tr>
<td>Famciclovir (Famvir®)</td>
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<tr>
<td>Tablets:</td>
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<tr>
<td>125 mg</td>
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<td>250 mg</td>
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</table>

**Genital Herpes Simplex:**
- First clinical episode of genital herpes: 250 mg orally 3 times daily for 7 to 10 days.
- Epidemic therapy for recurrent genital herpes: 1 g orally twice daily for 1 day OR 500 mg orally once followed by 250 mg orally twice daily for 2 days.
- Suppressive therapy for recurrent genital herpes: 250 mg orally twice daily.
- Recommended regimen for episodic infection in persons with HIV infection: 500 mg orally twice daily for 5 to 10 days.
- Recommended regimen for daily suppressive therapy in persons with HIV infection: 500 mg orally twice daily.

**Hepatic Impairment:**
- Mild to moderate: No dose adjustment needed
- Severe: No dosage adjustment provided in manufacturer’s labeling; has not been studied.

**Renal Impairment:**
- Epidemic therapy for recurrent genital herpes:
  - CrCl $\geq$ 80 mL/min: no dosage adjustment needed.
  - CrCl 40 to 59 mL/min: 500 mg orally every 12 hours for 1 day.
  - CrCl 20 to 39 mL/min: 500 mg orally as a single dose.
  - CrCl < 20 mL/min: 250 mg orally as a single dose.
  - Hemodialysis: Administer 250 mg as a single dose after a dialysis session.
- Suppressive therapy for recurrent genital herpes:
  - CrCl $\geq$ 40 mL/min: no dosage adjustment needed.
  - CrCl 20 to 39 mL/min: 125 mg orally every 12 hours.
  - CrCl < 20 mL/min: 125 mg orally every 24 hours.
  - Hemodialysis: 125 mg after each dialysis session.
- Recurrent orolabial and genital herpes in persons with HIV infection:
  - CrCl $\geq$ 40 mL/min: no dosage adjustment needed.
  - CrCl 20 to 39 mL/min: 500 mg orally every 24 hours.
  - CrCl < 20 mL/min: 250 mg orally every 24 hours.
  - Hemodialysis: 250 mg orally after each dialysis session.

**Adverse Reactions:** Headache, nausea, vomiting, abdominal pain, diarrhea, flatulence, migraine, pruritus, dysmenorrhea, fatigue, elevated hepatic enzymes, neutropenia, anemia, dizziness, drowsiness, angioedema, anaphylaxis, jaundice, rash, urticaria, erythema multiforme, Stevens-Johnson syndrome, toxic epidermal necrolysis, paresthesia

**Drug Interactions:** Varicella-zoster virus vaccine live, measles/mumps/rubella/varicella virus vaccine-live, talimogene laherparepvec, probenecid

**Contraindications:** Hypersensitivity to famciclovir, penciclovir or any component of the formulation. Due to similar chemical structures and possible cross-sensitivity, famciclovir should not be used in patients with acyclovir, ganciclovir, valacyclovir or valganciclovir hypersensitivity

**Caution in the following:** Dialysis, renal failure/impairment, pregnancy, breastfeeding, the elderly, efficacy has not been established in the following: ophthalmic or disseminated zoster or immunocompromised patients with herpes zoster

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## Medication Tables

### Antiviral - Genital Herpes

<table>
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<tr>
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<th>ADVERSE EFFECTS / INTERACTIONS*</th>
<th>COMMENTS*</th>
</tr>
</thead>
</table>
| Valacyclovir (Valtrex®)  | Genital Herpes Simplex:  
  - First clinical episode of genital herpes: 1 g orally twice daily for 7 to 10 days.  
  - Episodic therapy for recurrent genital herpes: 500 mg orally twice daily for 3 days OR 1 g orally once daily for 5 days.  
  - Suppressive therapy for recurrent genital herpes: 500 mg orally once daily OR 1 g orally once daily.  
  - Recommended regimen for episodic infection in persons with HIV infection: 1 g orally twice daily for 5 to 10 days.  
  - Recommended regimen for daily suppressive therapy in persons with HIV infection: 500 mg orally once daily OR 1 g orally once daily.  
  - Recommended regimen for suppressive therapy of pregnant women with recurrent genital herpes (recommend starting at 36 weeks gestation through delivery): 500 mg orally twice daily.  
Hepatic Impairment: No dose adjustment needed.  
Renal Impairment:  
  - CrCl ≥ 50 mL/min: No dosage adjustment needed.  
  - CrCl 30 to 49 mL/min: For regimens of - 1 g orally every 8 hours, change to 1 g orally every 12 hours. - Other regimens do not require a dosage adjustment.  
  - CrCl 10 to 29 mL/min: For regimens of - 1 g orally every 8 to 12 hours, reduce dose to 1 g orally every 24 hours. - 1 g orally once daily or 500 mg orally every 12 hours, reduce dose to 500 mg orally once daily. - 500 mg orally once daily, change dose to 500 mg orally every 48 hours.  
  - CrCl < 10 mL/min: For regimens of - 1 g orally every 8 to 24 hours or 500 mg orally every 12 hours, reduce dose to 500 mg orally once daily. - 500 mg orally once daily, change dose to 500 mg orally every 48 hours.  
Adverse Reactions: Headache, nausea, vomiting, abdominal pain, elevated hepatic enzymes, dizziness, arthralgia, fatigue, neutropenia, pharyngitis, alopecia, depression, anemia, fever, dysmenorrhea, rhinorrhea, sinusitis, thrombocytopenia, hepatitis, acute renal failure, rash, urticaria, elevated serum creatinine  
Drug Interactions: Cidofovir is contraindicated; varicella-zoster virus vaccine-live, measles/mumps/rubella/varicella virus vaccine-live, talimogene laherparepvec, leflunomide, teriflunomide, valproic acid, phenytoin, fosphenytoin, dichlorphenamide, cimetidine, lithium, emtricitabine, entecavir, mycophenolate, probenecid  
Contraindications: Hypersensitivity to valacyclovir, acyclovir or any component of the formulation. Due to similar chemical structures and possible cross-sensitivity, valacyclovir should not be used in patients with famciclovir, ganciclovir, penciclovir, or valganciclovir hypersensitivity  
Caution in the following: Dehydration, renal impairment/failure, concurrent use with nephrotoxic drugs, pregnancy, breastfeeding, the elderly |

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## Medication Tables

### Antiviral - Genital Warts

<table>
<thead>
<tr>
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<th>DOSING*</th>
<th>ADVERSE EFFECTS / INTERACTIONS*</th>
<th>COMMENTS*</th>
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</thead>
<tbody>
<tr>
<td>Podofilox Topical solution: 0.5%</td>
<td>Anogenital Warts: Using a cotton swab, apply topically to the anogenital wart twice daily for 3 days followed by 4 days of no therapy. May repeat this cycle, as necessary, for up to 4 cycles. Total wart area treated should not exceed 10 cm² and total volume of podofilox should be limited to 0.5 mL per day.</td>
<td>Adverse Reactions: Local skin reactions (burning, pain, inflammation, erosion and itching, bleeding), headache, dizziness, nausea, vomiting, insomnia Drug Interactions: No known significant interactions</td>
<td>Contraindications: Hypersensitivity or intolerance to podofilox, podophyllum, or any component of the formulation, pregnancy Caution in the following: Breastfeeding, use in perianal area (solution has not been evaluated for use in the treatment of warts occurring in this area), unhealed skin due to previous drug or surgical treatments (use not recommended until healed) Appropriate use: For cutaneous use only; avoid contact with eyes. If product comes in contact with the eyes, flush with water and seek medical attention. Not intended for treatment of mucous membrane warts. Avoid accidental exposure to healthy skin areas.</td>
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<tr>
<td>Imiquimod (Aldara®) Topical Cream: 5%</td>
<td>External Genital and Perianal Warts: Apply a thin layer to the affected areas once daily 3 times per week (on nonconsecutive nights) just prior to sleep. The cream should be left on the skin for 6 to 10 hours and then washed off with mild soap and water. Continue therapy until there is a total clearance of warts or for a maximum of 16 weeks (median time to complete wart clearance is about 10 weeks).</td>
<td>Adverse Reactions: application site reaction, erythema, infection, pruritus, skin erosion, skin ulcer, xerosis, burning sensation, peeling of skin, influenza-like symptoms, headache, upper respiratory infection, nausea, vomiting, diarrhea, dyspepsia, anorexia, cough, new primary malignancy, genital edema (female), hypopigmentation Drug Interactions: No known significant interactions</td>
<td>Contraindications: Hypersensitivity to imiquimod or any component of the formulation Caution in the following: autoimmune disorders, unhealed skin due to previous drug or surgical treatments (use not recommended until healed), human papilloma viral disease, pregnancy, breastfeeding</td>
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</tbody>
</table>

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<th>COMMENTS*</th>
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<tbody>
<tr>
<td>Metronidazole (Flagyl®)</td>
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<tr>
<td>Tablets: 250 mg</td>
<td>Oral: 500 mg orally twice daily for 7 days.</td>
<td>Adverse Reactions: Candidiasis</td>
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<tr>
<td></td>
<td>Topical: One 5 g applicator intravaginally</td>
<td>of the genital region, headache,</td>
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<td></td>
<td>once daily for 5 days.</td>
<td>nausea, vaginal discharge,</td>
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<td></td>
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<td>vaginitis, abdominal pain,</td>
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<td></td>
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<td>diarrhea, abnormal taste in</td>
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<td></td>
<td></td>
<td>mouth, dysuria, discolored</td>
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<td></td>
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<td>urine, toxic epidermal</td>
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<td></td>
<td></td>
<td>necrolysis, Stevens-Johnson</td>
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<td></td>
<td></td>
<td>Syndrome, hypersensitivity</td>
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<td>reaction</td>
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<td>Trichomoniasis:</td>
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<td></td>
<td>In Women: 500 mg orally twice daily for</td>
<td>Drug Interactions: Disulfiram,</td>
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<td></td>
<td>7 days.</td>
<td>ethanol, propylene glycol,</td>
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<td>drounedarone, xabepilone,</td>
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<td>pimozide, and thioridazine are</td>
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<td>all contraindicated; warfarin,</td>
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<td>live vaccines, mebendazole,</td>
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<td>mycophenolate, droperidol,</td>
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<td>amiodarone, any other drug that</td>
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<td>may prolong QT interval,</td>
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<td>fluorouraclid</td>
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<td></td>
<td>Hepatic Impairment: Decrease systemic dose</td>
<td>Black Box Warning: Metronidazole</td>
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<td></td>
<td>by 50% in severe hepatic impairment (Child-</td>
<td>has been shown to be carcinogenic</td>
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<td></td>
<td>Pugh C).</td>
<td>in mice and rats. Unnecessary</td>
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<td>Renal Impairment:</td>
<td></td>
<td>use of the drug should be</td>
<td></td>
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<td></td>
<td>No dosage adjustment needed. Monitor for</td>
<td>avoided. Its use should be</td>
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<td></td>
<td>adverse effects in patients with end stage</td>
<td>reserved only for conditions</td>
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<td>renal disease because metabolite</td>
<td>for which it is approved.</td>
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<td>accumulation may occur.</td>
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<td>Vaginal Gel: 0.75%</td>
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*See prescribing information for complete description of dosing, adverse effects, drug interactions, precautions and contraindications.

The cost scale $-$$$$$ represents the relative cost of acquisition of medication only. Frequency and complexity of medication administration (institution workload, effect on adherence) should be considered when determining overall cost-effectiveness of treatment.
REFERENCES


WHAT IS A SEXUALLY TRANSMITTED INFECTION?
⇒ The term sexually transmitted infections (STIs) refers to a group of clinical illnesses and diseases that you can get or can give to someone else through sexual activity.

HOW ARE STIs SPREAD?
⇒ You can get an STI by direct contact during vaginal, anal, or oral sex.
⇒ You can also get certain STIs through contact with the rectum, the lips, or the mouth.
⇒ Multiple STIs can spread from an infected mother to her unborn baby.

HOW CAN I REDUCE MY RISK OF GETTING AN STI?
⇒ The only way to avoid getting a STI is to not have vaginal, anal or oral sex.
⇒ If you have sex:
  ◦ Being in a long-term relationship with one partner who has been tested and is negative for STIs can help reduce your risk of getting an STI.
  ◦ Using latex condoms the right way every time you have sex can help as well. Condoms limit transfer of STIs, but cannot fully protect you for some STIs.

STIs: KNOW YOUR RISK
⇒ Any sexually active person can get STIs through unprotected vaginal, anal, or oral sex.
⇒ Have an honest and open talk with your health care provider. Ask if you should be tested for STIs.
  ◦ All pregnant patients should be tested as part of their first prenatal visit.
  ◦ You should get tested regularly for STIs if you are sexually active and/or:
    ‣ You are a man who has sex with men.
    ‣ You are living with HIV.
    ‣ You have partner(s) who have tested positive for STIs.

WHAT ARE THE SIGNS AND SYMPTOMS OF STIs?
⇒ Sores or bumps on the genitals or in the mouth or rectal area.
⇒ Painful or burning urination
⇒ Painful, sore, or burning mouth or throat
⇒ Discharge from the penis
⇒ Unusual or odd-smelling vaginal discharge
⇒ Unusual vaginal bleeding
⇒ Pain during sex
⇒ Sore, swollen lymph nodes, in the groin but sometimes more widespread
⇒ Lower abdominal pain
⇒ Fever
⇒ Rash over the trunk, hands, or feet

HOW DO I FIND OUT IF I HAVE AN STI?
⇒ Most of the time, a simple blood or urine test is used to test for STIs.
⇒ In some instances, a cotton swab may be used in the rectum or mouth for collection (this may be done by your health care provider or yourself).
⇒ Health care providers will choose the appropriate tests to diagnose the specific STI.
CCHCS Care Guide: Sexually Transmitted Infections

**WHAT YOU SHOULD KNOW: THE 5 Ps (IMPORTANT INFORMATION ABOUT YOUR HEALTH)**

**WHAT ARE THE 5 Ps?**
- The Centers for Disease Control and Prevention (CDC) has a list of questions health care providers should ask every patient to help find and also prevent sexually transmitted infections (STIs).
- They have divided these questions into 5 important areas (the 5 Ps):
  - **Sex Partners**, **Sex Practices**, **Protection from STIs**, **Past STIs**, and **Pregnancy intentions**

**WHY IS IT IMPORTANT TO HAVE THIS ASSESSMENT?**
- Some of these questions may seem very personal and maybe even embarrassing at first, but the CDC has determined they are needed to help your health care provider find, treat, and prevent STIs.
- These questions are standard and are asked of ALL patients.
- Knowing your sexual history and current sexual practices can help your health care provider talk with you on how to lower your risk of getting an STI.

**WHAT TYPES OF QUESTIONS ARE IN THE 5 Ps?**

**PARTNERS**
- “In the past 12 months, how many different people have you had sexual encounters with?”
- “Are the people you have had sexual encounters with:
  - Men
  - Women
  - Both men and women
  - Other gender identifying persons such as transgender persons or persons identifying as non-binary.”

**PRACTICES**
- “I need to ask about specific sex practices to help us know if there is any testing you might need. In the past 12 months, what kind of sexual contact have you had?
  - Vaginal sex (penis in the vagina)
  - Anal sex (penis in the anus)
  - Oral sex (mouth on penis, vagina or anus)”

**PROTECTION FROM STIs**
- “Do you and your partner(s) use any protection against STIs such as condoms? If so, how often?”
  - All of the time
  - Some of the time
  - Rarely

**PAST HISTORY OF STIs**
- “Have you ever been diagnosed with a sexually transmitted infection?
  - If so, which STI?
  - Around when were you diagnosed?
  - Did you get treatment?”

**PREGNANCY INTENTIONS**
- “Are you aware of the CDCR Condom Program?”
WHAT IS THE CDCR CONDOM PROGRAM?

⇒ State law requires the CDCR make condoms available in all state prisons. Condoms are made available free of charge to inmates. Inmates will be allowed to possess up to three condoms at any given time. This law does not change the fact that sexual activity between inmates is illegal and will be addressed according to California Code of Regulations, Title 15, and California Penal Code.

CORRECT USE OF CDCR ISSUED CONDOMS

Proper use of condom:

⇒ Getting Rid of Used Condoms
The recommended method of disposal is flushing down the toilet.

⇒ Expired Condoms
Expired condoms should be kept in the packaging and disposed of in the trash.

WHY SHOULD I USE A CONDOM DURING SEXUAL INTERCOURSE?

⇒ Using condoms during sex can decrease the risk of becoming infected with a sexually transmitted infection (STI), including HIV, chlamydia, gonorrhea, syphilis, and hepatitis.

⇒ The most effective way to avoid an STI is to not have sex while in prison. If you choose to have sex, condoms may decrease your risk of STI. Many people who have STIs have no symptoms and may not know they are infected.

HOW DO I KNOW IF I HAVE AN STI?

⇒ Any sexually active person can get STIs through unprotected vaginal, anal, or oral sex. Have an honest and open talk with your health care provider and ask whether you should be tested for STIs.

⇒ If you agree with any of the following statements, we recommend you get tested:

  ◦ I have had unprotected sex recently.
  ◦ It burns or hurts when I urinate or have sex.
  ◦ I have had multiple sex partners.
  ◦ I have had unprotected sex with an HIV positive partner.
  ◦ I had sex under the influence of alcohol and/or other substances.
  ◦ I have shared my drug injection equipment or snorting equipment.
  ◦ I have received a tattoo while in prison.
  ◦ I have come in contact with someone else’s blood, semen, and/or vaginal fluids.
  ◦ I have a sexual partner with an STI.
WHAT IS SYPHILIS?
Syphilis (pronounced si-fuh-luhs) is a sexually transmitted infection (STI) that can cause serious health problems if it is not treated.

HOW DOES SYPHILIS SPREAD?
- You can get syphilis from having vaginal, anal, or oral sex with a partner who has syphilis.
- Syphilis can also spread from a mother to her unborn baby.

WHAT ARE THE SIGNS AND SYMPTOMS OF SYPHILIS?
Syphilis has many “Stages”:

<table>
<thead>
<tr>
<th>Stage</th>
<th>Symptoms</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>First (Primary Stage)</strong></td>
<td>Sore on the penis, vagina, anus or mouth. Sores are usually, but not always, firm, round, and painless. Because the sore is painless, it can easily go unnoticed.</td>
</tr>
<tr>
<td><strong>Second Stage</strong></td>
<td>Can have a number of symptoms including a rash (sometimes on palms or soles), warty growths on the genitals or in the mouth, white patches inside the mouth, swollen lymph nodes or hair loss.</td>
</tr>
</tbody>
</table>
| **Third Stage**                | Very serious and can occur 10 to 30 years after your infection starts if you do not get treatment. In this stage the disease damages your internal organs and can result in death.◊ Syphilis can also show no symptoms at all
◊ Syphilis can go to the brain or eyes and cause damage if not treated

WHO SHOULD GET TESTED FOR SYPHILIS?
- All patients entering CDCR are offered testing for syphilis, so you likely had a test when you arrived – that test is done on blood and is called an rapid plasma reagin (RPR).
- You should get tested regularly for syphilis if you are sexually active and/or:
  ◊ You are a man who has sex with men; or
  ◊ You are living with HIV; or
  ◊ You have a partner who has tested positive for syphilis.
- All pregnant women should be tested for syphilis at their first prenatal appointment.

CAN SYPHILIS BE TREATED?
- Yes, in most people syphilis can be treated and cured with penicillin or other antibiotics.
  ◊ However, if damage has already been done the antibiotics cannot make that better.
- Having syphilis once does not protect you from getting syphilis again. You can easily get the infection again if you have sex with someone who has syphilis.
WHAT IS CHLAMYDIA?
⇒ Chlamydia (pronounced kluh-mi-dee-uh) is a common sexually transmitted infection (STI) that can infect people who have sex.
⇒ It can cause serious, permanent damage to the reproductive system. This can make it difficult or impossible for a pregnancy to occur later in life.

HOW IS CHLAMYDIA SPREAD?
⇒ You can get chlamydia by having vaginal, anal, or oral sex with someone who has chlamydia.
⇒ If your sex partner is male, you can still get chlamydia even if he does not ejaculate (cum).
⇒ If you have had chlamydia and were treated in the past, you can get infected again. This can happen if you have unprotected sex with someone who has chlamydia.
⇒ If you are pregnant, you can give chlamydia to your baby during childbirth.

WHAT ARE THE SIGNS AND SYMPTOMS OF CHLAMYDIA?
⇒ Most people who have chlamydia have no symptoms.
⇒ If you do have symptoms, they may not appear until weeks after you have sex with an infected partner.

MALE:
⇒ Discharge from their penis.
⇒ Burning sensation with urination.
⇒ Pain and swelling in one or both testicles (although less common).

FEMALE:
⇒ Abnormal vaginal discharge.
⇒ Burning sensation with urination.

RECTAL INFECTIONS (ANYONE WHO BOTTOMS DURING ANAL SEX):
⇒ People can also get infected with chlamydia in their rectum. This happens by either having receptive anal sex, or being spread from another infected site (such as the vagina). While these infections often cause no symptoms, they can cause:
  ◦ Rectal pain
  ◦ Discharge
  ◦ Bleeding

CHLAMYDIA: KNOW YOUR RISK
⇒ Anyone who has sex can get chlamydia through unprotected vaginal, anal, or oral sex.

HOW DO I FIND OUT IF I HAVE CHLAMYDIA?
⇒ Have an open and honest talk with your health care provider and ask whether you should be tested for chlamydia.
⇒ Laboratory tests can diagnose chlamydia.
⇒ Your health care provider may ask you to provide a urine sample, or may use (or ask you to use) a cotton swab to get a sample from your vagina or rectum to test for chlamydia.
WHAT IS GONORRHEA?

- Gonorrhea (pronounced gaa-nr-ee-uh) is a sexually transmitted infection (STI) that can infect people who have sex.
- It can cause infections in the genitals, rectum, and throat.
- Gonorrhea is a very common infection, especially among young people ages 15 to 24 years.

HOW DOES GONORRHEA SPREAD?

- You can get gonorrhea through vaginal, anal, or oral sex with a person who has gonorrhea.
- A pregnant person with gonorrhea can give the infection to the unborn baby during childbirth.

GONORRHEA: KNOW YOUR RISK

- Any sexually active person can get gonorrhea through vaginal, anal, or oral sex. Have an honest and open talk with your health care provider and ask whether you should be tested for gonorrhea or other STIs.

WHAT ARE THE SIGNS AND SYMPTOMS OF GONORRHEA?

### MALE:

- Some have no symptoms at all. However, some who do have symptoms may have:
  - Burning sensation with urination.
  - Burning and soreness in the mouth.
  - White, yellow, or green discharge from the penis.
  - Painful or swollen testicles (not very common).

### FEMALE:

- Most females with gonorrhea do not have any symptoms. Even when symptoms are present, they are often mild and can be mistaken for a bladder or vaginal infection.
- Gonorrhea increases the risk of developing serious complications from the infection, even if they do not have any symptoms.
- Symptoms can include:
  - Pain or burning with urination.
  - Increased vaginal discharge.
  - Vaginal bleeding between periods.
  - Burning or soreness in the mouth.

### RECTAL INFECTIONS (ANYONE WHO BOTTOMS DURING ANAL SEX):

- Rectal infections may either cause no symptoms or cause symptoms which may include:
  - Discharge
  - Anal Itching
  - Soreness
  - Bleeding
  - Painful bowel movements

HOW DO I FIND OUT IF I HAVE GONORRHEA?

- Speak with your health care provider about being tested.
- Most of the time, a urine test is used to test for gonorrhea.
- However, if you have had oral and/or anal sex, swabs may be used to collect samples from your throat and/or rectum.
WHAT IS EPIDIDYMITIS & NON-GONOCOCCAL URETHRITIS?

- Epididymitis (pronounced ep-ih-did-uh-MY-tis) and non-gonococcal urethritis (pronounced non-gon-uh-koh-ul yr-e-thrai-tuhs) also known as NGU are sexually transmitted infections (STIs).
- Epididymitis is swelling of the tube at the back of the testicle that carries sperm. The swelling can cause intense pain in the testicle.
  - Epididymitis is caused by bacteria from STIs such as chlamydia and gonorrhea.
  - Men at any age can get epididymitis, but it happens most often in men between 14-35 years old.
- NGU is swelling of the tube that carries urine out of the body.
  - NGU is most often caused by chlamydia and is more common in men than women.

HOW DO THEY SPREAD?

- You can get epididymitis through vaginal or anal sex with a person who is infected.
- You can get NGU through vaginal, anal, or oral sex with a person who is infected.

KNOW YOUR RISK

- Any sexually active person can get epididymitis through vaginal or anal sex or NGU through vaginal, anal, or oral sex. Have an honest and open talk with your health care provider and ask whether you should be tested.

WHAT ARE THE SIGNS AND SYMPTOMS?

<table>
<thead>
<tr>
<th>EPIDIDYMITIS - MALES ONLY:</th>
</tr>
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<tbody>
<tr>
<td>⇒ Some symptoms of epididymitis can include:</td>
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<tr>
<td>◦ Swollen, red, or warm scrotum.</td>
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<tr>
<td>◦ Testicle pain, usually on one side.</td>
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<tr>
<td>◦ Pain while urinating.</td>
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<tr>
<td>◦ Discharge from penis.</td>
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<tr>
<td>◦ Blood in semen.</td>
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<thead>
<tr>
<th>NON-GONOCOCCAL URETHRITIS - MALE:</th>
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<tbody>
<tr>
<td>⇒ Some symptoms of NGU can include:</td>
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<tr>
<td>◦ Discharge from penis.</td>
</tr>
<tr>
<td>◦ Burning or pain while urinating.</td>
</tr>
<tr>
<td>◦ Itching, irritation, or tenderness.</td>
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<tr>
<th>NON-GONOCOCCAL URETHRITIS - FEMALE:</th>
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<tr>
<td>⇒ Some women have no symptoms at all. However, some who do have symptoms may have:</td>
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<tr>
<td>◦ Discharge from vagina.</td>
</tr>
<tr>
<td>◦ Burning or pain while urinating.</td>
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<tr>
<td>◦ Stomach pain.</td>
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<tr>
<td>◦ Abnormal vaginal bleeding.</td>
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</table>

HOW DO I FIND OUT IF I HAVE EPIDIDYMITIS OR NGU?

- Speak with your health care provider about being tested.
- Testing for epididymitis and NGU can include a urine test or a swab test from your urethra.
WHAT IS GENITAL HERPES?

Genital herpes is a life-long sexually transmitted infection (STI) that can infect people who have sex. Genital herpes is caused by two types of viruses: herpes simplex virus type 1 (HSV-1) and herpes simplex virus type 2 (HSV-2).

HOW DOES GENITAL HERPES SPREAD?

You can get genital herpes by having vaginal, anal, or oral sex with a person who has herpes. If you come into contact with a herpes sore. It can be spread from the mouth to the genitals through oral sex. You will not get herpes from toilet seats, bedding, or swimming pools, or from touching objects around you.

GENITAL HERPES: KNOW YOUR RISK

Anyone who has sex can get genital herpes through unprotected vaginal, anal, or oral sex.
- Sexually active young people are at a higher risk of getting genital herpes. This is due to behaviors and biological factors common in young people.
- Gay, bisexual, and other men who have sex with men, and transgender women are also at risk since genital herpes can spread through oral and anal sex.
- Have an honest and open talk with your health care provider. Ask whether you should be tested for genital herpes or other STIs.

WHAT ARE THE SIGNS AND SYMPTOMS OF GENITAL HERPES?

**Men and Women:**

- Most people who have genital herpes do not have symptoms.
- You may not notice mild symptoms or you may mistake them for another skin condition, such as a pimple or ingrown hair. Because of this, most people who have herpes do not know it.
- Symptoms of herpes include:
  - Blisters on or around the genitals, rectum, or mouth.
    - The blisters break and leave painful sores that may take a week or more to heal.
    - These symptoms are called “having an outbreak.”
  - Fever
  - Body aches
  - Swollen glands

HOW DO I FIND OUT IF I HAVE GENITAL HERPES?

- Speak with your health care provider about being tested.
- Herpes testing is not recommended for people without symptoms.

CAN GENITAL HERPES BE CURED?

- There is no cure for herpes.
- There are medicines that can prevent or shorten outbreaks and can make it less likely that you will pass the infection on to your sex partner(s).
WHAT IS HUMAN PAPILLOMAVIRUS (HPV)?
- Most sexually active persons become infected with HPV at least once in their lifetime.
- In most cases, HPV goes away on its own and does not cause any health problems.
- There are many different types of HPV. Some types can cause health problems, including genital and/or oral warts and cancers.

HOW DOES HPV SPREAD?
- You can get HPV by having vaginal, anal, or oral sex with someone who has the disease through skin to skin contact.
- HPV can infect areas not covered by a condom, so condoms may not fully protect against getting HPV.

SHOULD I GET VACCINATED FOR HPV?
- It is advised that everyone through age 26 years, if not vaccinated already, should be vaccinated for HPV.
- It is not recommended to get the vaccination for everyone older than age 26 years.
- However, some adults age 27 through 45 who are not already vaccinated may decide to get the HPV vaccine after speaking with their doctor about their risk for new HPV infections and the possible benefits of vaccination.
- Have an honest and open talk with your doctor. Ask whether you should be tested for HPV or other STIs.

WHAT ARE THE SIGNS AND SYMPTOMS OF HPV?

PEOPLE WITH HPV INFECTION:
- Most people who have HPV do not know they are infected and never develop symptoms or health problems from it.
- Some symptoms of HPV can include:
  - Genital and oral warts — may appear as a small bump or group of bumps in the genital or oral areas. They can be small or large, raised or flat, or shaped like a cauliflower.
  - Cancer of the:
    - Vulva
    - Vagina
    - Penis
    - Anus
    - Throat
    - Tongue
    - Tonsils
- There is no way to know why people who have HPV will develop cancer or other health problems. The types of HPV that cause genital warts are not the same as the types of HPV that can cause cancers.

HOW DO I FIND OUT IF I HAVE HPV?
- There are HPV tests that can be used to screen for cervical cancer; these tests are only recommended for screening in women aged 30 years and older.
- There is no approved HPV test to find HPV in the mouth or throat.
- HPV tests are not recommended to screen males, or women under the age of 26 years.
CCHCS Care Guide: Sexually Transmitted Infections

STI Prevention
CALIFORNIA CORRECTIONAL HEALTH CARE SERVICES

TEST YOURSELF
Self-collected Throat Swab

1. Wash your hands with soap and water for at least 20 seconds.
2. Remove the tube and pink swab from packaging.
3. Place your label on the tube.
4. Firmly hold the swab far enough from the tip.
5. Open your mouth wide and reach the swab into your mouth to touch your throat.
6. Gently rub the swab tip on your throat side to side, up and down at least 5 times.
7. Unscrew the cap from the transport tube.
8. Place the swab into the transport tube. Snap the swab at the dashed line.
9. Place the cap back on the transport tube and twist it closed.
10. Wash your hands with soap and water and return to lab.
CCHCS Care Guide: Sexually Transmitted Infections

STI Prevention
CALIFORNIA CORRECTIONAL HEALTH CARE SERVICES

TEST YOURSELF
Self-collected Rectal Swab

1. Wash your hands with soap and water for at least 20 seconds.
2. Remove the tube and pink swab from packaging.
3. Place your label on the tube.
4. Firmly hold the swab above the dashed line (near the swab tip).
5. Get into a comfortable position that allows you to access your anus.
6. Gently insert the swab 1.5-2 inches into the rectum and twirl the swab in a circle 5 times.
7. Unscrew the cap from the transport tube.
8. Place the swab into the transport tube. Snap the swab at the dashed line.
9. Place the cap back on the transport tube and twist it closed.
10. Wash your hands with soap and water and return to lab.
¿QUÉ ES UNA INFECCIÓN DE TRANSMISIÓN SEXUAL?
⇒ El término infecciones de transmisión sexual (ITS) se refiere a un grupo de enfermedades e infecciones clínicas que se pueden contraer o transmitir a otra persona a través de las relaciones sexuales.

¿CÓMO SE TRANSMITEN LAS ITS?
⇒ Puede contraer una ITS por contacto directo durante las relaciones sexuales vaginales, anales u orales.
⇒ También puede contraer ciertas ITS al hacer contacto con el recto, los labios o la boca.
⇒ Se pueden transmitir varias ITS de una madre infectada a su recién nacido.

¿CÓMO PUEDO REDUCIR EL RIESGO DE CONTRAER UNA ITS?
⇒ La única forma de evitar contraer una ITS es no tener relaciones sexuales vaginales, anales u orales.
⇒ Si tiene relaciones sexuales:
  ◦ Estar en una relación a largo plazo con una pareja que se ha hecho la prueba y cuyo resultado es negativo para las ITS puede ayudar a reducir el riesgo de contraer una ITS.
  ◦ Usar preservativos de látex de la manera correcta cada vez que tenga relaciones sexuales también puede ayudar. Los preservativos limitan la transferencia de las ITS, aunque para algunas no pueden protegerlo completamente.

LAS ITS: CONOZCA SU RIESGO
⇒ Cualquier persona sexualmente activa puede contraer una ITS a través las relaciones sexuales vaginales, anales u orales sin protección.
⇒ Tenga una conversación honesta y abierta con su proveedor de atención médica. Pregunte si debe hacerse pruebas para las ITS.
  ◦ Todas las pacientes embarazadas deben ser examinadas como parte de su primera visita prenatal.
  ◦ Debería hacerse pruebas regularmente para detectar las ITS si es sexualmente activo o si:
    ▶ Es un hombre que tiene relaciones sexuales con hombres.
    ▶ Vive con el VIH.
    ▶ Tiene pareja(s) que ha(n) dado positivo en las pruebas de las ITS.

¿CUÁLES SON LOS SIGNOS Y SÍNTOMAS DE LAS ITS?
⇒ Llagas o bultos en los genitales, la boca o el área rectal.
⇒ Dolor o ardor al orinar.
⇒ Dolor o ardor en la boca o la garganta.
⇒ Secrección del pene.
⇒ Flujo vaginal inusual o de olor extraño.
⇒ Hemorragia vaginal inusual.
⇒ Dolor durante las relaciones sexuales.
⇒ Ganglios linfáticos doloridos e hinchados, en la ingle pero a veces más extenso.
⇒ Fiebre.
⇒ Erupción en el tronco, las manos o los pies.
⇒ Dolor en la zona abdominal inferior.

¿CÓMO PUEDO SABER SI TENGO UNA ITS?
⇒ La mayoría de las veces, se utiliza un simple análisis de sangre u orina para detectar las ITS.
⇒ En algunos casos, se puede utilizar un bastoncillo de algodón en el recto o en la boca para la recolección (esto lo puede hacer su proveedor de atención médica o usted mismo).
⇒ Los proveedores de atención médica elegirán las pruebas apropiadas para diagnosticar la ITS específica.
Guía de cuidados de CCHCS: Enfermedades de transmisión sexual

Diciembre de 2021

¿Qué son las 5 áreas importantes?

⇒ Los Centros para el Control y la Prevención de Enfermedades (Centers for Disease Control and Prevention, CDC) tienen una lista de preguntas que los proveedores de atención médica deben hacer a cada paciente para ayudar a encontrar y también prevenir las enfermedades de transmisión sexual (ETS).
⇒ Han dividido estas preguntas en 5 áreas importantes:
  ⇒ Parejas sexuales, prácticas sexuales, protección contra las ETS, las ETS pasadas y intención de embarazos.

¿Por qué es importante tener esta evaluación?

⇒ Algunas de estas preguntas pueden parecer muy personales e incluso vergonzosas al principio, pero los CDC han determinado que son necesarias para ayudar a su provedor de atención médica a encontrar, tratar y prevenir las ETS.
⇒ Estas preguntas son estándar y se hacen a TODOS los pacientes.
⇒ Conocer su historial sexual y sus prácticas sexuales actuales puede ayudar a su proveedor de atención médica a hablar con usted sobre cómo reducir el riesgo de contraer una ETS.

Resumen

Parejas
⇒ "¿En los últimos 12 meses, con cuántas personas diferentes ha tenido encuentros sexuales?"
⇒ "¿Las personas con las que ha tenido encuentros sexuales son:
  Hombres?
  Mujeres?
  Tanto hombres como mujeres?
  Personas que se identifican con otro género, como los transexuales o las personas que se identifican como no binarias?"

Prácticas
⇒ “Necesito preguntar sobre prácticas sexuales específicas para ayudarnos a saber si hay alguna prueba que pueda necesitar. ¿En los últimos 12 meses, qué tipo de contacto sexual ha tenido?
  Sexo vaginal (pene en la vagina)
  Sexo anal (pene en el ano)
  Sexo oral (boca en el pene, la vagina o el ano)"

Protección contra las ETS
⇒ "¿Usted y su(s) pareja(s) utiliza(n) alguna protección contra las enfermedades de transmisión sexual, como preservativos? ¿Si es así, con qué frecuencia?"
  Todo el tiempo
  Algunas veces
  Casi nunca

Las ETS Pasadas
⇒ "¿Alguna vez se le ha diagnosticado una enfermedad de transmisión sexual?
  ¿Si es así, cuál ETS?
  ¿Alrededor de cuándo fue diagnosticado?
  ¿Recibió tratamiento?"

Intención de embarazos
⇒ "¿Conoce el programa de preservativos del Departamento Correccional y de Rehabilitación de California (California Department of Corrections and Rehabilitation, CDCR)"
¿QUÉ ES EL PROGRAMA DE PRESERVATIVOS DEL CDCR?

⇒ La ley estatal requiere que el CDCR proporcione preservativos en todas las prisiones estatales. Estos se proporcionan a los reclusos de forma gratuita. A los reclusos se les permitirá poseer hasta tres (3) preservativos en cualquier momento. Esta ley no cambia el hecho de que las relaciones sexuales entre reclusos es ilegal y será tratada de acuerdo con el Título 15 del Código de Regulaciones de California y el Código Penal de California.

USO CORRECTO DE LOS PRESERVATIVOS EMITIDOS POR EL CDCR

Uso adecuado del preservativo:

⇒ Deshacerse de los preservativos usados
El método recomendado de eliminación es tirarlo por el inodoro.

⇒ Preservativos vencidos
Los preservativos vencidos deben permanecer en su empaque y desecharse en la basura.

¿POR QUÉ DEBO USAR UN PRESERVATIVO DURANTE LAS RELACIONES SEXUALES?

⇒ El uso de preservativos durante las relaciones sexuales puede disminuir el riesgo de infectarse con una enfermedad de transmisión sexual (ETS), incluyendo el VIH, la clamidia, la gonorrea, la sífilis y la hepatitis.

⇒ La forma más efectiva de evitar una ETS es no tener relaciones sexuales mientras está en prisión. Si decide tener relaciones sexuales, los preservativos pueden disminuir el riesgo de contraer una ETS. Muchas personas que tienen una ETS no tienen síntomas y pueden no saber que están infectadas.

¿CÓMO SÉ SI TENGO UNA ETS?

⇒ Cualquier persona sexualmente activa puede contraer una ETS a través de las relaciones sexuales vaginales, anales u orales sin protección. Tenga una conversación honesta y abierta con su proveedor de atención médica y pregúntele si debe hacerse pruebas para las ETS.

⇒ Si está de acuerdo con alguna de las siguientes afirmaciones, le recomendamos que se haga una prueba:
  ◦ He tenido relaciones sexuales sin protección recientemente.
  ◦ Me arde o me duele cuando orino o tengo relaciones sexuales .
  ◦ He tenido varias parejas sexuales.
  ◦ He tenido relaciones sexuales sin protección con una pareja seropositiva.
  ◦ Tuve relaciones sexuales bajo la influencia del alcohol u otras sustancias.
  ◦ He compartido mi equipo de inyección de drogas o de inhalación.
  ◦ He recibido un tatuaje mientras estaba en prisión.
  ◦ He tenido contacto con la sangre, el semen o los fluidos vaginales de otra persona.
  ◦ Tengo una pareja sexual que tiene una ETS.
¿QUÉ ES LA SÍFILIS?
⇒ La sífilis es una infección de transmisión sexual (ITS) que puede causar problemas de salud graves si no se trata.

¿CÓMO SE TRANSMITE LA SÍFILIS?
⇒ Puede contraer la sífilis a través de las relaciones sexuales vaginales, anales u orales con una pareja que tiene sífilis.
⇒ También se puede transmitir de la madre al bebé nonato.

¿CUÁLES SON LOS SIGNOS Y SÍNTOMAS DE LA SÍFILIS?
La sífilis tiene muchas “etapas”:

Primera etapa
⇒ Llagas en el pene, la vagina, el ano, o la boca.
⇒ Las llagas suelen ser, aunque no siempre, firmes, redondas y sin dolor. Debido a que las llagas no duelen, pueden pasar fácilmente desapercibidas.

Segunda etapa
⇒ Puede tener una serie de síntomas como un sarpullido (a veces en las palmas de las manos o las plantas de los pies), verrugas en los genitales, manchas blancas en el interior de la boca, inflamación de los ganglios linfáticos o pérdida de cabello.

Tercera etapa
⇒ Es muy grave y puede ocurrir de 10 a 30 años después del comienzo de la infección si no recibe tratamiento. En esta etapa, la enfermedad daña sus órganos internos y puede resultar en la muerte.

◊ La sífilis también puede no mostrar ningún síntoma.
◊ La sífilis puede llegar al cerebro o a los ojos y causar daños si no se trata.

¿QUIÉN DEBERÍA HACERSE UNA PRUEBA PARA LA SÍFILIS?
⇒ A todos los pacientes que entran al CDCR se les ofrece la posibilidad de hacerse una prueba de sífilis, por lo que es probable que se le haya hecho una prueba al llegar, esa prueba se realiza en la sangre y se llama reagina plasmática rápida (RPR).
⇒ Debería realizarse la prueba de sífilis regularmente si es sexualmente activo o:
◊ Es un hombre que tiene relaciones sexuales con hombres; o
◊ Vive con el VIH; o
◊ Tiene una pareja que ha dado positivo en la prueba de sífilis.
⇒ A todas las mujeres embarazadas deben hacérselas la prueba de la sífilis en su primera cita prenatal.

¿SE PUEDE TRATAR LA SÍFILIS?
⇒ Sí, en la mayoría de las personas la sífilis se puede tratar y curar con penicilina u otros antibióticos.
⇒ Sin embargo, si el daño ya está hecho, los antibióticos no pueden mejorarlo.
⇒ Tener sífilis una vez no le protege de contraerla otra vez. Puedes contraer fácilmente la infección de nuevo si tiene relaciones sexuales con alguien que tenga sífilis.
### ¿QUÉ ES LA CLAMIDIA?

- La clamidia es una infección de transmisión sexual (ITS) común que puede infectar a las personas que tienen relaciones sexuales.
- Puede causar daños graves y permanentes en el sistema reproductivo. Esto puede hacer que sea difícil o imposible que un embarazo ocurra más adelante en la vida.

### ¿CÓMO SE TRANSMITE LA CLAMIDIA?

- Puede contraer la clamidia al tener relaciones sexuales vaginales, anal u orales con alguien que la tenga.
- Si su pareja sexual es hombre, aún puede contraer clamidia aunque no eyacule.
- Si ha tenido clamidia y fue tratado en el pasado, puede infectarse de nuevo. Esto puede suceder si tiene relaciones sexuales sin protección con alguien que tiene clamidia.
- Si está embarazada, puede transmitirle clamidia a su bebé durante el parto.

### ¿CUÁLES SON LOS SIGNOS Y SÍNTOMAS DE LA CLAMIDIA?

- La mayoría de las personas que tienen la clamidia no tienen síntomas.
- Si tiene síntomas, es posible que no aparezcan hasta semanas después de tener relaciones sexuales con una pareja infectada.

### LA CLAMIDIA: CONOZCA SU RIESGO

- Cualquier persona que tenga relaciones sexuales puede contraer la clamidia a través de las relaciones sexuales vaginales, anal u orales sin protección.

### ¿CÓMO PUEDO SABER SI TENGO LA CLAMIDIA?

- Tenga una conversación honesta y abierta con su proveedor de atención médica y pregúntele si debe hacerse la prueba para la clamidia.
- Las pruebas de laboratorio pueden diagnosticar la clamidia.
- Es posible que su proveedor de atención médica le pida que proporcione una muestra de orina o que utilice (o le pida que Ud. utilice) un bastoncillo de algodón para obtener una muestra de la vagina o el recto para detectar la clamidia.

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### RESUMEN

- **¿QUÉ ES LA CLAMIDIA?**
- **¿CÓMO SE TRANSMITE LA CLAMIDIA?**
- **¿CUÁLES SON LOS SIGNOS Y SÍNTOMAS DE LA CLAMIDIA?**
- **LA CLAMIDIA: CONOZCA SU RIESGO**
- **¿CÓMO PUEDO SABER SI TENGO LA CLAMIDIA?**
¿QUÉ ES LA GONORREA?
⇒ La gonorrea es una infección de transmisión sexual (ITS) común que puede infectar a las personas que tienen relaciones sexuales.
⇒ Puede causar infecciones en los genitales, el recto y la garganta.
⇒ La gonorrea es una infección muy común, especialmente entre los jóvenes de 15 a 24 años.

¿CÓMO SE TRANSMITE LA GONORREA?
⇒ Puede contraer la gonorrea a través de las relaciones sexuales vaginales, anales u orales con una persona que tenga gonorrea.
⇒ Una persona embarazada con gonorrea puede pasar la infección al bebé nonato durante el parto.

LA GONORREA: CONOZCA SU RIESGO
⇒ Cualquier persona sexualmente activa puede contraer gonorrea a través de las relaciones sexuales vaginales, anales u orales. Tenga una conversación honesta y abierta con su proveedor de atención médica y pregúntele si debe hacerse la prueba para la gonorrea u otra ITS.

¿CUÁLES SON LOS SIGNOS Y SÍNTOMAS DE LA GONORREA?

HOMBRES:
⇒ Algunos no tienen ningún síntoma. Sin embargo, algunos que sí tienen síntomas pueden tener:
   ◊ Sensación de ardor al orinar.
   ◊ Secreción blanca, amarilla o verde del pene.
   ◊ Dolor o inflamación de los testículos (no muy común).
   ◊ Ardor y dolor en la boca.

MUJERES:
⇒ La mayoría de las mujeres con gonorrea no tienen ningún síntoma. Incluso cuando los síntomas están presentes, a menudo son leves y pueden confundirse con una infección de vejiga o vaginal.
⇒ La gonorrea aumenta el riesgo de desarrollar complicaciones graves de la infección, incluso si no tienen ningún síntoma.
⇒ Las síntoma pueden incluir:
   ◊ Dolor o ardor al orinar.
   ◊ Aumento de la secreción vaginal.
   ◊ Hemorragia vaginal entre períodos.
   ◊ Ardor y dolor en la boca.

INFECCIONES RECTALES (CUALQUIER PERSONA QUE SEA PENETRADAA DURANTE LAS RELACIONES SEXUALES ANALES):
⇒ Las infecciones rectales pueden no causar ningún síntoma o causar síntomas que pueden incluir:
   ◊ Secreción
   ◊ Comezón anal
   ◊ Dolor
   ◊ Hemorragia
   ◊ Deposiciones dolorosas

¿CÓMO PUEDE SABER SI TENGO LA GONORREA?
⇒ Hable con su proveedor de atención médica sobre la posibilidad de hacerse una prueba.
⇒ La mayoría de las veces, se utiliza un análisis de orina para detectar la gonorrea.
⇒ Sin embargo, si ha tenido relaciones sexuales orales o anales, se pueden utilizar bastoncillos de algodón para recoger muestras de la garganta o el recto.
¿QUÉ ES LA EPIDIDIMITIS Y LA URETRITIS NO GONOCÓCICA?

- La epididimitis y la uretritis no gonocócica, también conocida como UNG, son enfermedades de transmisión sexual (ETS).
- La epididimitis es la inflamación del tubo que se encuentra en la parte posterior del testículo y que transporta el esperma. Esta inflamación puede causar dolor intenso en el testículo.
  - La epididimitis es causada por bacterias presentes en ETS como la clamidia y la gonorrea.
  - Los hombres pueden contraer epididimitis a cualquier edad, pero se ve con más frecuencia en hombres de 14 a 35 años de edad.
- La UNG es la inflamación del tubo que transporta la orina fuera del cuerpo.
  - La causa más frecuente de la UNG es la clamidia y es más común en hombres que en mujeres.

¿CÓMO SE TRANSMITEN?

- Puede contraer epididimitis mediante el sexo vaginal o anal con una persona infectada.
- Puede contraer UNG mediante el sexo vaginal, anal u oral con una persona infectada.

CONOZCA SU RIESGO

- Cualquier persona sexualmente activa puede contraer epididimitis mediante el sexo vaginal o anal, o UNG mediante el sexo vaginal, anal u oral. Tenga una conversación honesta y abierta con su proveedor de atención médica y pregunte si debería hacerse una prueba.

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<tr>
<th>EPIDIDIMITIS SOLO EN HOMBRES:</th>
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<tr>
<td>Algunos de los síntomas pueden incluir:</td>
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<tr>
<td>- Escroto hinchado, enrojecido o que irradiad calor</td>
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<tr>
<td>- Dolor en el testículo, generalmente de un lado</td>
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<tr>
<td>- Dolor al orinar</td>
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<tr>
<td>- Secreción del pene</td>
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<td>- Sangre en el semen</td>
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<tr>
<th>URETRITIS NO GONOCÓCICA EN HOMBRES:</th>
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<tr>
<td>- Ardor o dolor al orinar</td>
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<tr>
<td>- Picazón, irritación o sensibilidad</td>
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<tr>
<th>URETRITIS NO GONOCÓCICA EN MUJERES:</th>
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<tr>
<td>Algunas mujeres no presentan síntomas. Sin embargo, las que sí los presentan pueden tener:</td>
</tr>
<tr>
<td>- Secreción vaginal</td>
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<tr>
<td>- Ardor o dolor al orinar</td>
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<tr>
<td>- Dolor de estómago</td>
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<tr>
<td>- Sangrado vaginal anormal</td>
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¿CÓMO SABER SI TENGO EPIDIDIMITIS O UNG?

- Hable con su proveedor de atención médica sobre hacerse una prueba.
- La prueba para detectar la epididimitis y la UNG puede incluir una prueba de orina o prueba de hisopado de uretra.
¿QUÉ ES EL HERPES GENITAL?
⇒ El herpes genital es una infección de transmisión sexual (ITS) de por vida que puede infectar a las personas que tienen relaciones sexuales.
⇒ El herpes genital es causado por dos tipos de virus: el virus del herpes simple tipo 1 (VHS-1) y el virus del herpes simple tipo 2 (VHS-2).

¿CÓMO SE TRANSMITE EL HERPES GENITAL?
⇒ Puede contraer el herpes genital a través de las relaciones sexuales vaginales, anales u orales con una persona que tenga herpes.
⇒ Si entra en contacto con una llaga de herpes.
⇒ Se puede transmitir de la boca a los genitales a través de las relaciones sexuales orales.
⇒ No se contagiará de herpes por los asientos de los inodoros, la ropa de cama o las piscinas, ni por tocar objetos a su alrededor.

EL HERPES GENITAL: CONOZCA SU RIESGO
⇒ Cualquier persona que tenga relaciones sexuales puede contraer el herpes genital a través de las relaciones sexuales vaginales, anales u orales sin protección.

Los jóvenes sexualmente activos corren un mayor riesgo de contraer el herpes genital. Esto se debe a comportamientos y factores biológicos comunes en los jóvenes.

Los hombres homosexuales, bisexuales y otros hombres que tienen relaciones sexuales con hombres, así como las mujeres transgénero, también están en riesgo ya que el herpes genital puede propagarse a través de las relaciones sexuales orales y anales.

⇒ Tenga una conversación honesta y abierta con su proveedor de atención médica. Pregúntele si debe hacerse la prueba para el herpes genital u otra ETS.

¿CUÁLES SON LOS SIGNOS Y SÍNTOMAS DEL HERPES GENITAL?

Hombres y mujeres:
⇒ La mayoría de las personas que tienen el herpes genital no presentan síntomas.
⇒ Es posible que no note los síntomas leves o que los confunda con otra afección de la piel, como un grano o un pelo encarnado. Por esto, la mayoría de las personas que tienen el herpes genital no saben que lo tienen.
⇒ Los síntomas del herpes incluyen:
   ◊ Ampollas en o alrededor de los genitales, el recto o la boca.
      ‣ Las ampollas se rompen y dejan llagas dolorosas que pueden tardar una semana o más en sanar.
      ‣ Estos síntomas se denominan "tener un brote."
◊ Fiebre
◊ Dolores corporales
◊ Ganglios inflamados

¿CÓMO PUEDO SABER SI TENGO EL HERPES GENITAL?
⇒ Hable con su proveedor de atención médica sobre la posibilidad de hacerse la prueba.
⇒ No se recomienda la prueba de herpes para las personas que no tienen síntomas.

¿SE PUEDE CURAR EL HERPES GENITAL?
⇒ No hay cura para el herpes.
⇒ Hay medicamentos que pueden prevenir o acortar los brotes y pueden hacer que sea menos probable que transmita la infección a su(s) pareja(s) sexual(es).
¿QUÉ ES EL VIRUS DEL PAPILOMA HUMANO (VPH)?
⇒ La mayoría de las personas sexualmente activas se infectan con VPH al menos una vez en su vida.
⇒ En la mayoría de los casos, el VPH desaparece por sí solo y no causa ningún problema de salud.
⇒ Hay muchos tipos diferentes de VPH. Algunos tipos pueden causar problemas de salud, incluyendo verrugas genitales y cáncer.

¿CÓMO SE TRANSMITE EL VPH?
⇒ Puede contraer el VPH al tener relaciones sexuales vaginales, anales u orales con alguien que tenga la enfermedad a través del contacto con la piel del individuo.
⇒ El VPH puede infectar áreas no cubiertas por un preservativo, por lo que es posible que los preservativos no protejan completamente contra el VPH.

¿DEBERÍA VACUNARME CONTRA EL VPH?
⇒ Se recomienda que todas las personas hasta los 26 años de edad, si no están vacunadas ya, deberían vacunarse contra el VPH.
⇒ No se recomienda vacunar a todas las personas mayores de 26 años.
⇒ Sin embargo, algunos adultos de 27 a 45 años de edad que aún no están vacunados pueden decidir vacunarse contra el VPH después de hablar con su médico sobre el riesgo de nuevas infecciones de VPH y los posibles beneficios de la vacunación.
⇒ Tenga una conversación honesta y abierta con su médico. Pregúntele si debe hacerse la prueba para el VPH u otra ITS.

¿CUÁL ES LA PRUEBA PARA EL VPH?
⇒ Existen pruebas para el VPH que pueden utilizarse para detectar el cáncer de cuello uterino; estas pruebas solo se recomiendan para la detección en mujeres de 30 años o más.
⇒ No hay ninguna prueba para el VPH aprobada para encontrar el virus en la boca o la garganta.
⇒ Las pruebas para el VPH no se recomiendan para los hombres o las mujeres menores de 26 años.
PRUEBA PERSONAL
Hisopo de recolección personal para la garganta

1. Lávese las manos con agua y jabón por al menos 20 segundos.
2. Retire el tubo y el hisopo color rosa del empaque.
3. Coloque su etiqueta en el tubo.
4. Sostenga el hisopo con tiempo lo suficientemente lejos del extremo.
5. Abra bien la boca e inserte el hisopo hasta tocar su garganta.
6. Frote suavemente la punta del hisopo en su garganta de lado a lado, hacia arriba y hacia abajo, al menos 5 veces.
7. Desenrosque la tapa del tubo de traslado de la muestra.
8. Inserte el hisopo dentro del tubo de traslado. Rómpalo por la línea punteada.
9. Tape de nuevo el tubo de traslado de la muestra girando la tapa.
10. Lave sus manos con agua y jabón. Envíe al laboratorio.
1. Lávese las manos con agua y jabón por al menos 20 segundos.

2. Retire el tubo y el hisopo color rosa del empaque.

3. Coloque su etiqueta en el tubo.

4. Sostenga el hisopo sobre la línea punteada (cerca del extremo).

5. Colóquese en una posición cómoda, que le permita acceder a su ano.

6. Inserte suavemente el hisopo entre 1.5 y 2 pulgadas en el recto y gírelo 5 veces.

7. Desenrosque la tapa del tubo de traslado de la muestra.

8. Inserte el hisopo dentro del tubo de traslado. Rómpalo por la línea punteada.

9. Tape de nuevo el tubo de traslado de la muestra girando la tapa.

10. Lave sus manos con agua y jabón. Envíe al laboratorio.

Gírelo 5 veces