Sexually Transmitted Infections Care Guide

March 2025

CALIFORNIA CORRECTIONAL HEALTH CARE SERVICES

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.

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CCHCS Care Guide: Sexually Transmitted Infections

TABLE OF CONTENTS

Stakeholders and Reviewers

The Sexually Transmitted Infections (STI) Care Guide has been revised, and feedback was solicited and incorporated from the following stakeholders:

- The California Department of Public Health STD Control Branch
- CCHCS Public Health Medical Services
- CCHCS Public Health Nurse Consultants Program Review, Nursing Services

Record of Changes (January 2025)

- Added a new section, Section 2—Public Health Reporting and Response. This section details what should happen when STIs are diagnosed to include investigation, education, and response campaigns.
- Added additional STI prevention discussion including a prevention table and screening table to assist providers as they care for diverse patient populations with differing sexual health needs (e.g., men who have sex with men, transgender persons, etc.)—Section 6 subsection D, Table 1 Prevention Services that Should be Considered for Certain Populations and Table 2 Screening and Testing for STI Outside of the Reception Center.
- Expanded discussion of HIV PrEP in Section 6 B.
- Added discussion of doxycycline PEP to Section 6 C.
- Streamlined disease specific discussion to just one section—removed prior overview of selected STI and instead provide in one section only, Section 7 -- Clinical Presentation, Testing, and Management of Selected STIs.
- Updated the references, Section 9.

Section 1. Overview

The terms STDs and STIs refer to a variety of clinical syndromes and infections caused by pathogens acquired and transmitted through sexual activity. STIs are typically transmitted via contact with mucous membranes, secretions, and blood.

A. 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 most 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 Centers for Disease Control and Prevention (CDC) is currently defining these new recommendations in the "Sexually Transmitted Infections (STI) Treatment Guidelines, 2021."

B. Prevention and Control of STIs

The prevention and control of STIs is based on the following 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,
- Access to other prevention services like condoms and pre-exposure prophylaxis,
- Identification of asymptomatic infected persons and persons with symptoms associated with STIs,
- Effective diagnosis, treatment, counseling, and follow up of infected persons, and
- 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** (e.g., 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.

C. Effective techniques for facilitating rapport with patients

Effective interviewing and counseling skills, which are characterized by respect, compassion, and a nonjudgmental attitude toward all patients. These characteristics 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. Using these skills will help put patients at ease and let them know obtaining a sexual history is an important part of a complete medical exam or physical history. Additionally, counsel the patient that sexual activity will not be shared with custody and is for health purposes only, nothing punitive will occur from the discussion.

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 should be reported.)
- 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.

D. 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.

E. Population-based Reception Center Opt-out testing:

Patients entering CDCR are given the following diagnostic screening tests and assessments at the Reception Centers based on the Opt-Out screening method (Health Care Department of Operations Manual 3.1.8):

- Serum pregnancy test (persons with a uterus less than 60 years old)
- HCV ab w/reflex to HCV viral load w/reflex to HCV Genotype
- HBV surface antigen, surface antibody, and core antibody
- HIV antibody screening
- Reactive Plasmin Reagin (RPR) with reflex to TP-PA syphilis confirmatory test
- Gonorrhea/chlamydia urine (all incarcerated persons ≤ 44 years old)
- Trichomonas vaginalis (all persons with a vagina ≤ 44 years old)

F. Additional Individual Testing

The California Department of Public Health (CDPH) now recommends that all individuals between the ages of 18 and 44 who are sexually active are offered annual syphilis testing because of the increase in syphilis and congenital syphilis cases in California.

The term, 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.

Tests for common STIs (e.g., genital herpes, *Mycoplasma genitalium*, and HPV) are available when indicated.

Section 2. Public Health Reporting and Response

A. Reporting:

All patients who are diagnosed with a reportable STI should be reported to the local health department as per Title 17. In addition, for patients with STI diagnosed outside the reception center, the Public Health Nurse (PHN) should submit a Public Health Outbreak Response System (PORS) report to the CCHCS Headquarters PH team. Additional information regarding public health reporting and response can be found in HCDOM Section 3.8.1, Public Health Disease Reporting.

For patients in whom prior syphilis titers or treatment records are needed, PHNs and providers may reach out to the local health department. If additional help is needed the STD Control Branch of the California Department of Public Health at stdsurv@cdph.ca.gov may also be available to retrieve those records. See Section 7. A. Syphilis.

B. Investigation and Response:

Case Patient:
The case patient should be referred to a provider for treatment. Additionally, all patients with a newly diagnosed STI should be offered appropriate preventive services, including testing for additional STIs, HIV, HBV/HCV, and if indicated, rectal infection screening and an anal pap smear. They should also be offered mpox vaccine, HPV vaccination, and HIV PrEP or doxy PEP as indicated.

Within the reception center, diagnosis of HIV, HCV, HBV, syphilis, chlamydia, or gonorrhea should trigger a report to the PHN who coordinates with the local health department. Patients should be referred to a provider for treatment and completion of the STI risk assessment/sexual history form within Cerner. For cases deemed potentially infectious while residing in CDCR, an interview by the provider should be conducted to determine whether there were any exposures at CDCR (including cases of possible victimization) and assess the risk of additional cases/an outbreak.

The role of the PHN when a patient tests positive for a STI includes:

1. Notify and send reports to the CCHCS Headquarters Public Health and the Local Health Department.
2. Conduct a contact investigation that includes review of patient's movement and programming.
3. Review the patient's medical record for prior STI treatment and history.
4. Distribute community education materials that include education on symptoms, how to request testing, STI risk factors, and the importance of 'Knowing your Status' if an STI campaign is conducted.
5. Collaborate with PCP to review information obtained to help determine potential exposures and contacts.
6. Collaborate with the PCP to notify and educate named contacts and assist with linking contacts to testing and treatment.

In a prison setting, it may be challenging for patients to disclose their partners. Providers may develop a good rapport with the patient and may be able to help the patient notify partners if safe or assist in ensuring partners are tested and treated if needed. However, there are some situations where it may be very difficult to perform such an investigation given the difficulty in keeping the identity of the case patient private and protecting them from harm. Patients should be invited to participate in partner notification if this is something that they feel comfortable doing or is important to them. Please note contact investigations are not recommended for HPV or HSV due to high levels of asymptomatic transmission of these viruses.

Providers are not required by law to notify partners regarding HIV exposure. Physicians will not be held criminally or civilly liable for disclosing to a patient's partner provided the notification is done in collaboration with the patient and ensuring confidentiality and privacy of the patient (California Health and Safety Code 121015). Providers should never put patient safety at risk by disclosing HIV status, an STI diagnosis, or non-allowed

Investigation and Response, Cont'd

behaviors. However, providers should endeavor to ensure that partners are tested and treated. The local health department can assist for patients with partners outside of CDCR.

Case Patient Interview:

It is very important to establish rapport with the patient and ensure that outside of some circumstances regarding mandatory reporting (i.e., Section 3 Prison Rape Elimination Act) answers will be kept confidential.

Examples of open-ended interview questions:

- "You have … infection. One way that a person can become infected is through close contact with another person. Anyone who might have this infection should be treated and cured."
- "Do you know how you may have become infected?"
- "Is there anyone in the last few months who you have come into contact with who may have become infected?"
- "How can we get these individuals treated?"

For patients, regardless of whether they disclose sexual activity, you may want to ask in general, whether sexual activity between incarcerated persons is something that they have witnessed or heard about.

Public Health Campaigns:

Institutions should use community health education and awareness public health campaign strategies if there is a suspicion for STI transmission in CDCR. These education and awareness strategies should be used to encourage individuals to opt in for screening, testing, and other sexual health services. Public health campaigns may be used as a response to risk behaviors that are identified in the patient population, or if there is concern of gaps in access to STI, HIV, or viral hepatitis services. These specific campaigns could be considered even if partners are tested and treated. Especially, where there is concern about illicit sexual behaviors or anecdotal reports received about sex trafficking or concern partner notification is not safe, these more generalized campaigns may be beneficial and do not single out any one person or group. can increase access to services needed in a non-stigmatizing way. Armed with the knowledge they will be empowered to use those services to protect themselves and their partners. This approach is superior to a narrowly focused investigation which might miss the larger opportunities for promoting sexual health and preventive services. These campaigns can be promoted across housing units and discuss risk factors for STI, HIV, Hepatitis B and Hepatitis C. Patients should be encouraged to submit a 7362 to come in for testing.

When patients present for testing, they do not need to disclose any risk factors. Patients should also be educated and offered additional appropriate preventative services as indicated (e.g., condoms, mpox vaccine or other vaccinations, doxycycline PEP, PrEP, etc.).

Section 3. Prison Rape Elimination Act (PREA)

CCHCS, under the PREA, 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 HCDOM Section 4.1.6, Prison Rape Elimination Act.

Section 4. California Department of Public Health 340B Program

CCHCS has partnered with the CDPH Sexually Transmitted Diseases (STD) 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.

To participate in this program, a patient should be "enrolled" for care by a "covered entity." Each of our institutions is 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 currently limited to HIV and HBV patients. However, any provider may use the STI Screening/Education PowerForm for patients diagnosed with STI or to conduct a sexual history.

Section 5. Education and Prevention

A. 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 to screen for certain STIs. A complete sexual history should be obtained at least annually, e.g., a patient's initial visit or during annual health prevention exams, and when signs of STIs are present, or when a patient complains of symptoms that are suggestive of an STI. The STI Screening/Education PowerForm (located in EHRS Ad Hoc forms) may be utilized to help capture this history.

The "Five Ps" approach to obtaining a sexual history is one strategy for eliciting information concerning the following five key areas of interest.

- **P**artners
- **P**ractices
- **P**rotection from STIs
- **P**ast history of STIs
- **P**regnancy Intention

Section 5 Table 1. "Five Ps" of Sexual Health

	CDC Language	Suggested CDCR Language for Incarcerated Patients
Partners	• Are you currently sexually active (or are you having sex)? If the patient answers no, have you ever been sexually active? • In recent months, how many sex partners have you had? • In the past 12 months, how many sex partners have you had? • What is the gender of your partner? Tell me about your sex partner. • 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?	Without making assumptions about the patient's sexual orientation determine the number of your patient's different sexual encounter contacts. • In the past 12 months, how many different people have you had sex with? • Tell me about your sex partners

Practices	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.
	• Have you had vaginal sex, meaning 'penis in vagina sex'? If yes, do you use condoms: never, sometimes, or always?
	• Have you had anal sex, meaning 'penis in rectum/anus sex'? If yes, do you use condoms: never, sometimes, or always?
	• Have you had oral sex, meaning 'mouth on penis/vagina'?
	• For condom answers:
	  ○ If "never", why don't you use condoms?
	  ○ If "sometimes", in what situations (or with whom) do you use condoms?
		Different sex practices require specific STI testing/guidance.
		• 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	Determine the appropriate level of risk-reduction counseling for each patient. What do you do to protect yourself from STIs and HIV? • Do you and your partner(s) use any protection against STIs? If not, could you tell me the reason? • If so, what kind of protection do you use? • How often do you use this protection? If sometimes, in what situations or with whom do you use protection?	See Prevention of Pregnancy below • Are you aware of the condom program?

Past history of STIs	A history of prior STIs may place your patient at greater risk now and require more frequent testing.
	• Have you ever had an STI?
	• Have any of your partners had an STI?
	• Have you ever been diagnosed with an STI? When? How were you treated? Pre-exposure prophylaxis (PrEP), post-exposure prophylaxis (PEP)?
		• Have you ever been diagnosed with an STI?
		  ○ If so, which STI?
		  ○ Approximate date?
		  ○ Was it treated? PrEP, PEP?

Pregnancy intention	Based on partner information from the prior section, you may determine that the patient is at risk of becoming pregnant or of impregnating a partner. If so, first determine if a pregnancy is desired. Questions should be appropriate based on the patient's history.
	• Are you currently trying to conceive a child?
	• Are you concerned about getting pregnant or getting your partner pregnant?
	• What are you doing to prevent pregnancy?
	• Are you using contraception or practicing any form of birth control? Do you need any information on birth control?
		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.
		• Do you and your partner(s) use any protection against STIs or preventing pregnancy, such as condoms? If so, how often?
		  ○ All of the time
		  ○ Some of the time
		  ○ Rarely

Behavioral Risk Assessment, cont'd

Providers should be mindful of cultural competency and recognize that patients in carceral settings may have particular concerns regarding privacy and safety that are compounded by the setting.

B. Prevention Counseling

Providers can encourage risk reduction by providing prevention counseling after obtaining a sexual history from their patient. 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. Within CDCR/CCHCS, it may be most useful to tailor prevention messages, screening and testing recommendations based on consideration of sexual practices/anatomy instead of sexual orientation or gender identification. A discussion of different populations is provided in Section 6 Prevention: Condoms, pre- and post-exposure prophylaxis, and vaccines.

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.

Pre-release planning for incarcerated patients should include a risk assessment and offering of sexual health services near the time of release as risk for HIV, STI, and mpox transmission increases when patients re-enter the general community (Section 6 Prevention: Condoms, Pre- and Post-exposure prophylaxis and vaccines).

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 at all institutions and the following are a sample of the groups available.

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

Section 6. Prevention: Condoms, Pre and Post-Exposure Prophylaxis and Other Preventive Measures

A. Condoms

The California state law requires CDCR to make condoms available in all state prisons in within dispensers even though sexual activity between incarcerated persons is illegal according to California Code of Regulations, Title 15 and the California Penal Code. The dispensers are supposed to be kept stocked and located in a public but relatively discreet locations. Condoms are made available free of charge to incarcerated persons. Incarcerated persons are allowed to possess up to 3 condoms at any given time. The role of medical staff is the health and welfare of patients. Providers should not get involved in legality issues and rules violations regarding sexual activities within CDCR institutions.

B. HIV Pre-exposure Prophylaxis (PrEP)

HIV PrEP would benefit certain individuals who are at increased risk for HIV acquisition. These include men who have sex with men (MSM). Risk for HIV transmission is low within CDCR as patients within CDCR have high HIV viral suppression rates. However, patients may be at risk during conjugal visits, if they exchange sex for money or drugs, are MSM, or share needles with persons who have unsuppressed HIV. Providers are encouraged to consult the HIV team if there are questions regarding PrEP prescriptions.

C. Post-exposure Prophylaxis (PEP)

Doxycycline PEP (doxy PEP): Is dispensed as a single 200 mg doxycycline dose given within 72 hours after condomless oral, anal, or insertive vaginal sex. The Centers for Disease Control and Prevention (CDC) and CDPH recommend doxy PEP for certain individuals, including cisgender men who have sex with men and transgender women with a history of bacterial STIs or condomless sex in the past year, to help prevent chlamydia, gonorrhea, and syphilis. Doxy PEP may also be offered to other non-pregnant sexually active individuals who are interested in taking it, after having a conversation discussing the benefits and risks with their health care provider.

Patients should receive counseling that doxy PEP can be used as postexposure prophylaxis to prevent chlamydia, gonorrhea, and syphilis.

Following shared decision-making with their provider, CDPH recommends that providers offer a prescription for doxy PEP to be self-administered within 72 hours after having oral, vaginal, or anal sex, to all non-pregnant people who have had a bacterial STI within the past 12 months.

Persons who request doxy PEP but have not had a diagnosis of a bacterial STI may also receive doxy PEP after shared decision making. The recommended dose of doxy PEP is 200 mg and should not exceed a maximum dose of 200 mg every 24 hours.

Persons who are prescribed doxy PEP should undergo bacterial STI testing at anatomic sites of exposure at baseline and every 3–6 months thereafter. Ongoing need for doxy PEP should be assessed every 3–6 months as well. HIV screening should be performed for HIV-negative persons according to current recommendations as well.
When prescribing doxy PEP, providers should counsel on comprehensive preventative sexual health and education. In general, transmission of bacterial STI within institutions is very low.

D. Prevention Practices and Vaccination for Various Patient Groups

Recommendations for sexual health services vary based on sex, age, anatomy, gender identity, sexual orientation, HIV status and reported risk behavior. Please see Table 1. Prevention Services Recommended for Certain Populations.

Men Who Have Sex with Men

The term MSM describes a heterogeneous group with varied behaviors, identities, and health-care needs. MSM often refers to sexual behaviors and is separate from sexual orientation as individuals may identify as heterosexual but based on sexual practice considered MSM.

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 may 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 for these patients: PrEP as needed for HIV prevention, doxy PEP, rectal/pharyngeal testing, digital anorectal exam, checking for enteric pathogens, counseling and education. HIV screening should be completed at least annually. Consider more frequent screening based on risk behavior. These patients should also be offered the following vaccinations: mpox, Hepatitis A, Hepatitis B, meningococcal vaccine (MenACWY), and consideration for HPV (offer to all <27 years of age, shared decision making for persons who are between 27 and 45 years of age).

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.

Prevention Practices and Vaccination for Various Patient Groups Cont'd

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.
As noted above, HPV vaccination should be offered to persons <27 and can be offered with shared decision making to persons between 27 and 45 years of age.

Transgender, Gender Diverse and Non-binary People

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 should 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. Patients under age 27 may be offered the HPV vaccine if they have not previously received that vaccination—for patients between 27 and 45, patients may elect to be vaccinated based on shared decision making.

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, please see the Transgender Care Guide for more detail.

Women who have sex with men: Incarcerated women who have sex with men should have intake screening and additional screening for bacterial STIs, including syphilis based on risk. Women experiencing incarceration have high rates of victimization and exploitation and high rates of STI in the community.

Men who have sex with women: Incarcerated men who have sex with women should have intake screening and additional screening for bacterial STIs based on risk. In the general population, screening is generally not recommended for gonorrhea and chlamydia, however, in carceral settings risk for these bacterial STIs is higher.

Section 6, Subsection D, Table 1: Prevention Services Recommended for Certain Populations

Population	HIV PrEP	Doxy PEP	Vaccines as Prevention	Condoms
MSM	X	X	Hepatitis A, hepatitis B, HPV*, MenACWY, Mpox	X
Women who have sex with women	X	X†	Hepatitis B, HPV*	
Transgender Women	X	X	Hepatitis B, HPV*, Mpox‡	X
Transgender Men	X	X†	Hepatitis B, HPV*, Mpox‡	X
Women who have sex with men	X	X†	Hepatitis B, HPV*	X
Men who have sex with women	X		Hepatitis B, HPV*	X

*For HPV vaccine, shared decision making can be used for patients between ages 27-45, patients <27 should be offered if previously unvaccinated.

† Currently there is limited data for use of doxy PEP in transgender men and cis-gender women so shared decision making should be used.

‡Patients at increased risk should be offered the mpox vaccine.

Additional STI screening may be offered to individuals at increased risk for STI including individuals with:

- A new partner
- More than one sex partner
- A sex partner with concurrent partners
- A sex partner with STI
- Inconsistent condom use
- History of transactional sex (exchanging sex for money or drugs or protection)

Additionally, individuals who are pregnant should be screened for gonorrhea, chlamydia, syphilis, HIV, hepatitis B and C, and trichomonas. This is in addition to diagnostic testing for individuals presenting with symptoms.

Section 6, Subsection D, Table 2: Screening and Testing for STI Outside of the Reception Center

Screening and Testing for STI Outside of the Reception Center							
Risk Group	**Chlamydia and gonorrhea genital***	**Chlamydia and gonorrhea extragenital***	**Syphilis***	**Trichomonas**	**HSV**	**HIV***	**Hepatitis B and C**
Persons with penis	X	X	X		†	X	X
Persons who engage in receptive anal intercourse	X	X	X		†	X	X
Persons who engage in receptive oral intercourse	X	X	X		†	X	X
Persons with a cervix	X	X	X	X	†	X	X
Persons who engage in receptive vaginal intercourse	X	X	X	X	†	X	X
Pregnant Persons	X	X	X	X	†	X	X

*Persons who have ongoing risk factors should be screened every three to six months; this includes screening for HIV for persons on HIV PrEP. Three site testing for GC/CT should be considered for persons with those exposures.

†Type-specific HSV-2 serologic assays for diagnosing HSV-2 are useful in the following scenarios: recurrent or atypical genital symptoms or lesions with a negative HSV PCR or culture result, clinical diagnosis of genital herpes without laboratory confirmation, and a patient's partner has genital herpes. HSV-2 serologic screening among the general population is not recommended. Patients who are at higher risk for infection (e.g., those presenting for an STI evaluation, especially for persons with ≥10 lifetime sex partners, and persons with HIV infection) might need to be assessed for a history of genital herpes symptoms, followed by type-specific HSV serologic assays to diagnose genital herpes for those with genital symptoms.

Section 7. Clinical Presentation, Testing, and Management of Selected STIs

For additional STI not covered in this guide, please see the CDC STI Guidelines. In addition, for management for complicated patients or other clinical questions, providers may consult the National Network of STD Clinical Prevention Training Centers offers a clinical consultation service STD CCN.

A. Syphilis

Patients with documentation of syphilis (e.g., a positive RPR and confirmatory treponemal test) should be offered treatment unless written documentation is uploaded to the medical record, showing 1) prior treatment appropriate to staging, and 2) an appropriate decline in titer on follow up testing.

If prior treatment cannot be documented, and patient declines to be treated, a treatment refusal form should be signed by the patient.

Obtaining syphilis treatment history: public health officials collect and compile syphilis treatment data at the state and local level. The data are held in state and local health jurisdiction case registries that are accessible only to public health officials. Primary care providers should work with institutional PHNs to request prior treatment and testing information on any patients with lab-confirmed syphilis.

Overview

Syphilis is an STI caused by *Treponema pallidum*. Untreated syphilis in pregnancy can cause miscarriage, stillbirth, and preterm birth. Screening all pregnant people for syphilis and providing early treatment for those with syphilis and their sexual partner(s) during prenatal care could completely prevent congenital syphilis.

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

- Primary syphilis infection presents with painless or painful ulcer(s) or chancre(s) at the infection site including the lips, tongue, and other oral structures.
- Secondary syphilis manifestations include maculopapular skin rash which may involve palms and soles, mucocutaneous (including oral) lesions, condyloma lata, patchy alopecia, and lymphadenopathy.
- Latent infections do not have clinical manifestations and are detected by serologic testing.
  - Early latent syphilis is defined as syphilis acquired within the preceding year.
  - Late latent syphilis or syphilis of unknown duration include all those acquired at least 12 months prior to diagnosis.
- Tertiary syphilis may present with various disease manifestations including cardiac and gummatous disease such as granulomatous disease of skin, bones, viscera, as well as neurologic manifestations including tabes dorsalis, and general paresis).
- Neurosyphilis, ocular and otic syphilis: *T. pallidum* may infect the nervous system and may cause disease at any time and during 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—patients may present with headache, difficulty or instability walking, weakness in arms or legs, paresthesias, shooting pain in extremities, and decreased patellar or Achilles reflexes.
  - Otic symptoms may include trouble with hearing, vertigo and tinnitus.
  - Ocular symptoms may include visual changes (blurry or double vision, decreased vision), eye pain or redness, or Argyle Robertson pupil.

Syphilis Cont'd

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 blood tests. They are often used for screening, but they are not specific for syphilis and, by themselves, are insufficient for diagnosis.

- When reactive, an RPR result should have an antibody titer reported quantitatively.
- Titers usually decline after treatment and might become nonreactive with time. A fourfold decline in titer after adequate treatment indicates a serologic cure, which can take up to 24 months depending on the stage of disease. Resolution of titers may also be delayed in HIV disease.
- 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, it is important to obtain an RPR prior to the first treatment dose, which may be a repeat assay. For a person who was previously treated for syphilis whose RPR/VDRL has not yet declined or become non-reactive, a fourfold increase in RPR/VDRL titer is evidence of reinfection.
- Atypical nontreponemal serologic test results (i.e., unusually high, unusually low, or fluctuating titers) might occur regardless of HIV-infection status

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

- These antibodies appear earlier than nontreponemal antibodies and usually remain detectable for life, even after successful treatment. If positive, they indicate either past or present syphilis infection. 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, in the third trimester and at delivery. Syphilis in pregnancy can have devastating consequences and requires timely treatment starting at least 30 days before delivery 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, though patients may take up to 24 months to decrease titers fourfold depending on stage of disease. 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.

Syphilis Cont'd

Neurosyphilis: All patients diagnosed with syphilis should receive a neurological examination inclusive of cranial nerve testing, hearing and vision tests 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 such as cranial nerve deficits are present, a cerebrospinal fluid (CSF) evaluation is indicated. A CSF evaluation may not always be indicated in ocular syphilis. Please consult an ophthalmologist or infectious disease physician. Additionally, it is not necessary to obtain CSF analysis for auditory abnormalities. If there are questions, consult an infectious diseases physician. If there are significant delays in consultation, consider treating for neurosyphilis pending consult. 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 white blood 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.

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.
- The penicillin regimen for primary, secondary, and early latent stage syphilis is Benzathine penicillin G 2.4 million units IM in a single dose
    - For non-pregnant patients, a non-penicillin alternative regimen is doxycycline 100 mg PO BID for 14 days
- The penicillin regimen for late-latent and unknown duration stage syphilis is Benzathine penicillin G 7.2 million units total, administered as 3 doses of 2.4 million units IM each at 1-week intervals
    - For non-pregnant patients, a non-penicillin alternative regimen is doxycycline 100 mg PO BID for 28 days
- The penicillin regimen for neurosyphilis is Aqueous crystalline penicillin G 18–24 million units per day, administered as 3–4 million units IV every 4 hours or continuous infusion for 10–14 days

If aqueous crystalline penicillin G IV is unavailable, an alternative treatment is ceftriaxone: 1 g daily IM or IV for at least 14 days, or 2 g daily IM or IV for at least 10 days

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.

Syphilis Cont'd

Alternative regimens may be utilized for non-pregnant patients including doxycycline.

- Primary, secondary and early latent syphilis: doxycycline 100 mg po BID x 14 days.
- Late latent syphilis: doxycycline 100 mg po BID x 28 days.

Please see Section 7, Subsection A table: Recommended Syphilis Regimens for Adults for more detail.

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 might cause early labor or fetal distress in pregnant patients; this should not prevent or delay therapy.

Pregnancy: Syphilis screening during pregnancy is important. There has been a 10-fold increase in congenital syphilis in the United States, including California from 2012 to 2022, and increases are ongoing. 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. Multiple sex partners, having an STI during pregnancy, or having a partner with an STI all increase one's risk for prenatal syphilis. 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. For those who require a 3-dose regimen for late latent/unknown duration stage, intervals should be as close to 7 days as possible, and not outside of 6-8 days per the CDPH.

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 non-pregnant patients: For non-pregnant patients the alternatives include doxycycline (100 mg orally twice 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 1:1 – 1:32, though serofast titers can present higher (e.g. 1:128). Patients who have a very low titer at diagnosis may not decline despite adequate treatment and may be serofast. If the patient is treated and titer does not improve in the appropriate timespan, 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.

Section 7, Subsection A, Table: Recommended Syphilis Treatment in Adults

Stage of Syphilis	Drug	Dose	Duration
Primary, secondary, and early latent (including HIV patients)	Benzathine penicillin G	2.4 million units IM	Single dose
	Doxycycline (excluding pregnant patients)	100 mg po BID	14 days
Late Latent (including people with HIV infection)	Benzathine penicillin G	7.2 million units total, administered as 3 doses of 2.4 million units IM each at 1-week intervals	3 weeks
	Doxycycline (excluding pregnant patients)	100 mg po BID	28 days
Neurosyphilis, Ocular Syphilis, and Otosyphilis	Aqueous crystalline penicillin G*	18–24 million units per day, administered as 3–4 million units IV every 4 hours or continuous infusion.	10-14 days
Tertiary	Benzathine penicillin G	7.2 million units total, administered as 3 doses of 2.4 million units IM each at 1-week intervals	3 weeks
	Doxycycline (excluding pregnant patients)	100 mg po BID	28 days

*Alternative Regimen: If aqueous crystalline penicillin G IV is unavailable, an alternative treatment is ceftriaxone: 1 g daily IM or IV for at least 14 days, or 2 g daily IM or IV for at least 10 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 - 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.

Syphilis Cont'd

Latent syphilis:

- Patients should be followed up clinically and **serologically at 6, 12, and 24 mos**. (Quantitative 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 cell count 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. However, HIV patients, or those with late latent syphilis may resolve more slowly, up to 24 months. 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 1:1 to 1:32 (but can be higher, such as 1:128). 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.

B. 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 (PID), 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 cis women under the age of 25 years have the highest burden of chlamydia. All people 44 years and younger are screened at entry via opt-out screening within CDCR.

Type of tests: There are several 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.

- Urogenital testing for gynecologic patients (cis women/transgender men): Self-collected swabs are the optimal specimen to screen for genital chlamydia using NAATs; urine is an effective alternative specimen type.
- Urogenital testing for penile infections (cis men/transgender women): Urine is the specimen of choice.
- Rectal testing: self-collected swabs should be collected for persons who engage in anal sex.
- Oropharyngeal testing: oropharyngeal swabs should be collected for persons who engage in oral sex.

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.

Section 7, Subsection B, Table: Chlamydia Infection sites, Complications, Testing, Treatment, and Follow-up

	People with a penis	People with a cervix
Genital infections, uncomplicated	Urethritis	Cervicitis, Urethritis
Reproductive tract complications	Epididymitis, accessory gland infection/abscess, inguinal lymphadenitis, penile edema, balanitis, prostatitis	Pelvic inflammatory disease, endometritis, salpingitis, perihepatitis, infertility, accessory gland infection/abscess, chronic pelvic pain
Other sites of infection	Conjunctivitis, Pharyngitis, Proctitis, Proctocolitis	
Test specimens, genital	Urine (alternative urethral)	Urine (alternatives vaginal, cervical swab can be self-collected by the patient)
Test specimens, extragenital	Rectal swab, throat swab (both can be self-collected by patient)	
Diagnostic tests	NAAT combo test 11363 for *Chlamydia trachomatis/Neisseria gonorrhoeae*	SureSwab test 16492 for *Chlamydia trachomatis/Neisseria gonorrhoeae/T. vaginalis*
Treatment, chlamydia Non-pregnant adults and adolescents, including patients living with HIV Pregnant patients	**Doxycycline 100 mg orally twice a day for 7 days** **Alternatives: Azithromycin 1 g orally in a single dose** [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.] **Azithromycin 1 g orally in a single dose OR amoxicillin 500 mg orally 3x/day for 7 days**	
Partner treatment	Refer all sex partners in preceding 60 days for evaluation and presumptive treatment	
Follow-up	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.	

C. Gonorrhea

Overview

Gonorrhea is an STI caused by infection with the bacteria *Neisseria 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.

- **Penile infections (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.
- **Gynecologic infections (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 can be infected during childbirth via the birth canal if a gonorrhea infection is present. In babies, gonorrhea most commonly affects the eyes but rarely can cause disseminated gonorrhea causing sepsis, arthritis and meningitis. It can also cause scalp abscess from fetal monitoring.
- 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 polyarthralgia, tenosynovitis, or oligoarticular septic arthritis, sepsis, endocarditis, and meningitis.

Assessment

Screening: In the community screening 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 up to 44 years old 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: NAAT testing is available for the detection of genitourinary infection with *N. gonorrhoeae*.

- NAAT can be done on endocervical swabs, vaginal swabs, and urine (any gender) Urethral swabs (penile) may be considered but urine is preferred. Assessment of risk will dictate whether additional swab testing is needed for rectal, or oropharyngeal, or conjunctival infections.
- 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 STIs, including chlamydia, syphilis, and HIV if HIV status is not known.

Culture may be considered but requires swab specimens.

Penile/Rectal/Pharyngeal: NAAT combo test 11363 for *Chlamydia trachomatis/Neisseria gonorrhoeae*

Gynecologic Testing: SureSwab test 16492 for *Chlamydia trachomatis/Neisseria gonorrhoeae/T. vaginalis*

Gonorrhea Cont'd

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.
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 no longer 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	Medications	Alternative Regimens and Notes
Uncomplicated Gonococcal Infections of the Cervix, Urethra, Rectum, and Pharynx	Adults < 150 kg Ceftriaxone 500 mg IM in a single dose* Adults ≥ 150 kg Ceftriaxone 1 g IM in a single dose*	If cephalosporin allergy: gentamicin 240 mg IM in a single dose **PLUS** azithromycin 2 g orally in a single dose If ceftriaxone administration is not available or not feasible: cefixime 800 mg orally in a single dose
Disseminated Gonococcal Infection - Arthritis and Arthritis-Dermatitis Syndrome	Ceftriaxone 1 g IM or IV every 24 hours*	Alternatives: Cefotaxime 1 g IV every 8 hours **OR** ceftizoxime 1 g IV or IM every 8 hours When treating for the arthritis-dermatitis syndrome, the provider can switch to an oral agent guided by antimicrobial susceptibility testing 24–48 hours after substantial clinical improvement, for a total treatment course of at least 7 days.
Disseminated Gonococcal Infection - Gonococcal Meningitis and Endocarditis	Ceftriaxone 1–2 g IV every 12-24 hours*	Treatment for DGI should be guided by the results of antimicrobial susceptibility testing. Therapy for meningitis should be continued with recommended parenteral therapy for 10–14 days. Parenteral antimicrobial therapy for endocarditis should be administered for at least 4 weeks.
Conjunctivitis	Ceftriaxone 1 g IM in a single dose	Consider one-time lavage of the infected eye with saline solution.
Pregnancy	Ceftriaxone 500 mg IM in a single dose	Gentamicin use is cautioned during pregnancy because of risk for neonatal birth defects, nephrotoxicity, or ototoxicity

*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).

Post-Treatment Monitoring

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

Gonorrhea Cont'd

Repeat testing: Retest patients 3 months after gonorrhea treatment to screen for reinfection, 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. For criteria for suspected gonorrhea treatment failure, refer to CDPH Gonorrhea Treatment Failure Protocol for Local Health Departments

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

D. Epididymitis

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 spermatic cord (testicular) torsion should be maintained among patients 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 those who are the insertive partner during anal sex.

Assessment

Patients 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 penile infections.

Treatment

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

Infection Type - Acute Epididymitis	Medication	Notes
Acute epididymitis most likely caused by chlamydia and gonorrhea (and enteric organisms are unlikely)	Ceftriaxone 500 mg IM in a single dose **PLUS** doxycycline 100 mg orally 2x/day for 10 days.	For patients ≥ 150 kg, increase dose of ceftriaxone to 1 g
Acute epididymitis most likely caused by chlamydia, gonorrhea, or enteric organisms (men who practice insertive anal sex)	Ceftriaxone 500 mg IM in a single dose **PLUS** levofloxacin 500 mg orally 1x/day for 10 days.	For patients ≥ 150 kg, increase dose of ceftriaxone to 1 g
Acute epididymitis likely caused by enteric organisms only	Levofloxacin 500 mg orally 1x/day for 10 days.	

E. Non-Gonococcal Urethritis (NGU)

Overview

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

Assessment

Clinical presentations include penile urethral discharge, irritation, dysuria, or meatal pruritus. NGU is confirmed for symptomatic patients when diagnostic evaluation of penile 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.

Recommended Treatment	Doxycycline 100 mg orally 2x/day for 7 days
Alternative Regimens:	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

F. Genital Lesions: Herpes and Human Papillomavirus

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 commonly, 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.
  - **Transmission:** mainly occurs during asymptomatic shedding of genital HSV infections.
  - **Presentation:** Herpes Simplex lesions typically appear as one or more vesicles on or around the genitals, rectum or mouth. Lesions typically progress from papules to vesicles with clear fluid to shallow wet ulcers to crusted dry healing lesions.
  - **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 and shedding decreases after the first two years of 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 pregnancy can be passed to a fetus before birth, or to a neonate at delivery and can be deadly to the baby.

Genital Lesions: Herpes and Human Papillomavirus Cont'd

Assessment

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

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.

Treatment

- There is no cure for genital herpes.
- Oral antiviral medications (e.g., acyclovir, valacyclovir) can prevent or shorten outbreaks while the patient takes the medication. Topical therapy with antiviral drugs offers minimal clinical benefit and is discouraged.
- 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.

Genital Lesions: Herpes and Human Papillomavirus Cont'd

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 – but does not eliminate – the risk of transmission. Suppression is recommended prior to delivery in a pregnant patient if primary or recurrent episode of genital HSV occurs in the late third trimester, or those with frequent lesions.
  - Safety and efficacy have been documented among patients receiving daily therapy with acyclovir for as long as six years.
- **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.

Human Papillomavirus (HPV)

Overview

Over 200 types of HPV infections have been identified, 40 of which can infect the anogenital mucosa. Most are self-limited and are asymptomatic or go unrecognized. HPV is highly transmissible. Most sexually active individuals become infected with HPV at least once in their lifetime. Treatment of warts or HPV-related dysplasia 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 anogenital and oral warts and recurrent respiratory papillomatosis.
- **Pregnancy**: Although rare, genital HPV infection can be transmitted from to a newborn during vaginal delivery.
- **Vaccine**: 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 9 and may be provided up to age 45 for males and females. Patients under age 27 should be offered the vaccine, and patients between ages 27 and 45 may be offered the vaccine based on shared decision making.

Assessment

Genital warts usually appear as a small bump or group of bumps in the anogenital area. Warts can also appear in the oral cavity or pharynx. They can be small or large, raised, or flat, or verrucous / cauliflower-like in appearance. 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 with bowel movement.

- **Most 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 condyloma lata lesions can be easily mistaken for anogenital warts but are more likely to be raised flat lesions as opposed to verrucous/cauliflower-like lesions more common in appearance of HPV.

Human Papillomavirus (HPV) Cont'd

Lab Testing: There are HPV tests to detect high risk 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 and anal cancer screening and management or follow-up of abnormal cervical or anal cytology or histology.

- HPV tests are not recommended to screen men, adolescents, or women under the age of 30 years.
- Anal cancer screening for people living with HIV over the age of 35 is strongly recommended. Please see the HIV Care Guide for more details.

Treatment

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 one 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.
- Within CCHCS, Imiquimod is available on formulary.

G. Trichomonas Vaginalis

Overview

Trichomonas vaginalis is the most common non-viral STI worldwide. Gynecologic infections are more common than penile infections. *T. vaginalis* is one of the three common infectious causes of vaginal complaints, along with bacterial vaginosis and candida vulvovaginitis, and is also a cause of penile urethritis. However, the infection is often asymptomatic. *T. vaginalis* is a relatively common infection among women who have sex with women (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 *T. 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 empirically treated. Any person who has a positive test for *T. 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*.

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

Trichomonas Vaginalis Cont'd

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 performed for persons with *T. vaginalis*.

	Recommended Regimen	Alternative Regimen
Women	metronidazole 500 mg orally 2x/day for 7 days	tinidazole 2 g orally in a single dose
Men	metronidazole 2 g orally in a single dose	tinidazole 2 g orally in a single dose

Section 8. Antimicrobial Therapy

Antibiotics

DRUG CLASS / MEDICATION	DOSING*	ADVERSE EFFECTS / INTERACTIONS*	COMMENTS*
Amoxicillin **Capsule:** **250 mg** **500 mg** **$** Chewable Tablet: 125 mg 250 mg $ Tablet: 500 mg 875 mg $ Powder for Suspension: 125 mg/5 mL 200 mg/5 mL 250 mg/5 mL 400 mg/5 mL $	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, typhoid 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

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

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Antibiotics, cont'd

DRUG CLASS / MEDICATION	DOSING*	ADVERSE EFFECTS / INTERACTIONS*	COMMENTS*
Azithromycin (Zithromax®) **Tablets:** **250 mg** **500 mg** **600 mg** **$**	Chlamydia (Pregnancy OR Alternative Treatment): 1 g orally as a single dose. Gonorrhea (Alternative Treatment): Guideline Dosage • Uncomplicated infection of cervix, urethra, or rectum: 2 g orally as a single dose in combination with gentamicin 240 mg IM as a single dose. • Nongonococcal Urethritis: 1 g orally as a single dose OR 500 mg orally as a single dose, then 250 mg orally once daily for 4 days. *M. genitalium* (If resistance testing is available and macrolide sensitive): Doxycycline 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). Hepatic Impairment: Not studied in patients with impaired hepatic function. Recommendations not available. Renal Impairment: CrCl < 10 mL/min: use with caution.	Adverse Reactions: Abdominal pain, diarrhea, nausea, vomiting, flatulence, increased liver enzymes, headache, abnormal vision Drug Interactions: Dronedarone, pimozide, 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, levalbuterol, aluminum or magnesium containing products, carbamazepine	Contraindications: Hypersensitivity to azithromycin or any component of the product, erythromycin, any macrolide or ketolide 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

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Antibiotics, cont'd

DRUG CLASS / MEDICATION	DOSING*	ADVERSE EFFECTS / INTERACTIONS*	COMMENTS*
Ceftriaxone (Rocephin®) **Injectable:** **250 mg vial** **1 g vial** **$**	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 IV every 12-24 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: Doxycycline 100 mg orally twice daily for 10 days PLUS ceftriaxone 500 mg IM as a single dose. - ≥ 150 kg: Doxycycline 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

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Antibiotics, cont'd

DRUG CLASS / MEDICATION	DOSING*	ADVERSE EFFECTS / INTERACTIONS*	COMMENTS*
Doxycycline Hyclate (Vibramycin® Vibra-Tabs®) **Capsule/Tablet:** **100 mg** **$-$$$**	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. Doxy PEP: 200 mg po within 72 hours of oral, vaginal, or anal sex. No more than 200 mg per 24 hours. 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

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Antibiotics, cont'd

DRUG CLASS / MEDICATION	DOSING *	ADVERSE EFFECTS / INTERACTIONS*	COMMENTS*
Levofloxacin Tablet: 250 mg 500 mg 750 mg $ Oral Solution 25 mg/mL $$$$$	Acute Epididymitis • Most likely caused by chlamydia, gonorrhea, or enteric organisms (men who practice insertive anal sex): - < 150 kg: 500 mg orally once daily for 10 days PLUS ceftriaxone 500 mg IM once as a single dose. - ≥ 150 kg: 500 mg orally once daily for 10 days PLUS ceftriaxone 1 g IM once as a single dose. • Most likely caused by enteric organisms only: 500 mg orally once daily for 10 days. Chlamydia (Alternative Treatment): 500 mg orally once daily for 7 days. Hepatic Impairment: No dose adjustment needed. Renal Impairment: • Usual dose of 500 mg orally every 24 hours (FDA-approved labeling) - CrCl ≥ 50 mL/min: No dosage adjustment needed. - CrCl 20 to 49 mL/min: 500 mg orally once, then 250 mg orally every 24 hours. - CrCl 10 to 19 mL/min: 500 mg orally once, then 250 mg orally every 48 hours.	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 pointes, photosensitivity, tendinitis, tendon rupture, rash, pruritus, vaginitis, candidiasis, dyspnea, palpitations, syncope, ventricular arrhythmia/tachycardia, urticaria, C. diff. colitis, gastritis, pancreatitis, arthralgia, myalgia, hepatotoxicity, elevated hepatic enzymes, seizures, peripheral neuropathy, toxic epidermal necrolysis, Stevens-Johnson syndrome, hyper/hypoglycemia Drug Interactions: Bepridil, dronedarone, halofantrine, pimozide and thioridazine are contraindicated. Aluminum, calcium, magnesium, and zinc containing products, QT- interval prolonging drugs, NSAIDS	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. Contraindications: Hypersensitivity to levofloxacin, or any other quinolone antibiotics including ofloxacin or any component of the product. Concomitant use with bepridil, dronedarone, halofantrine, pimozide or thioridazine 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, antidiabetic agents, medications known to prolong the QT interval or cause electrolyte imbalances, hepatic disease, myasthenia gravis, pregnancy, breastfeeding, the elderly NOTE: 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.

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Antibiotics, cont'd

DRUG CLASS / MEDICATION	DOSING*	ADVERSE EFFECTS / INTERACTIONS*	COMMENTS*
Moxifloxacin (Avelox®) Tablet: 400 mg $	*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 pointes, 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, halogantrine, 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, antidiabetic 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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Antibiotics, cont'd

DRUG CLASS / MEDICATION	DOSING*	ADVERSE EFFECTS / INTERACTIONS*	COMMENTS*
Penicillin G Aqueous Crystalline (Pfizerpen®) **Injectable: 5 million unit powder for injection** **$$$$$**	Neurosyphilis, Ocular Syphilis, or Otosyphilis: • 18 to 24 million units per day, administered as 3 to 4 million units IV every 4 hours or continuous infusion, for 10-14 days. NOTE: Penicillin G Benzathine 2.4 million units IM in a single dose once a week (every 7 days) for up to 3 weeks can be considered after IV therapy to provide a comparable duration of treatment to latent syphilis. Hepatic Impairment: No dose adjustment needed. However, dose adjustments may be needed in patients with both hepatic and renal impairment. Renal Impairment: • Manufacturer recommends: - CrCl ≥ 10 mL/min/1.73m2 in patients with uremia: A full loading dose then 50% of the usual dose given every 4 to 5 hours. - CrCl < 10 mL/min/1.73m2: A full loading dose then 50% of the usual dose given every 8 to 10 hours. • Other guidelines recommend: - CrCl 10 to 50 mL/min/1.73m2: 75% of the usual dose. - CrCl < 10 mL/min/1.73m2: 20 to 50% of the usual dose.	Adverse Reactions: Rash, fever, drug-induced eosinophilia, urticaria, nausea, vomiting, arthralgia, Jarisch-Herxheimer reaction, hyperkalemia, injection site reaction. Drug Interactions: Tetracyclines, warfarin, methotrexate, donepezil, live vaccines, bupropion, oral contraceptives, aminoglycosides, sodium picosulfate, ethacrynic acid.	Contraindications: Hypersensitivity to penicillin(s) or any component of the product Caution in the following: Electrolyte imbalance, renal impairment, cephalosporin or carbapenem hypersensitivity, allergies or allergic conditions, asthma, ulcerative colitis or other GI disease, pregnancy, breastfeeding, the elderly.
Penicillin G Benzathine (Bicillin LA®) **Injectable: 2.4 million units/4 mL** **$$$$$**	Syphilis • Primary, secondary, or early latent < 1 year: 2.4 million units IM in a single dose. • 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). 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). Hepatic Impairment: No dose adjustment needed. However, dose adjustments may be needed in patients with both hepatic and renal impairment. Renal Impairment: Clearance is significantly delayed in patients with decreased renal function. Specific dose adjustment recommendations are not available; use with caution. **DO NOT USE BICILLIN CR**	Adverse Reactions: Rash, urticaria, nausea, vomiting, increased eosinophil count, fatigue, fever, Jarisch Herxheimer reaction, arthralgia, chills, edema, dizziness, headache, drowsiness. Drug Interactions: Tetracyclines, warfarin, methotrexate, donepezil, live vaccines, bupropion, oral contraceptives, aminoglycosides, sodium picosulfate.	Black Box Warning: 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. Contraindications: Hypersensitivity to penicillin(s) or any component of the product. Caution in the following: 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.

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DRUG CLASS / MEDICATION	DOSING*	ADVERSE EFFECTS /INTERACTIONS*	COMMENTS*
Acyclovir (Zovirax) **Tablets:** **200 mg** **400 mg** **800 mg** **$**	Genital Herpes Simplex: • First clinical episode of genital herpes: 400 mg orally 3 times daily for 7 to 10 days. • Episodic therapy for recurrent genital herpes: 800 mg orally twice daily for 5 days OR 800 mg orally 3 times daily for 2 days. • Suppressive therapy for recurrent genital herpes: 400 mg orally twice daily. • Recommended regimen for episodic infection in persons with HIV infection: 400 mg orally 3 times daily for 5 to 10 days. • Recommended regimen for daily suppressive therapy in persons with HIV infection: 400 to 800 mg orally 2 to 3 times a day. • 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. Hepatic Impairment: No dose adjustment provided in the manufacturer's labeling; use caution in patients with severe impairment. Renal Impairment: • CrCl 11 to 25 mL/min/1.73m2: No dose adjustment needed for patients receiving 400 mg orally every 12 hours. • CrCl ≤10 mL/min/1.73m2: Patients receiving 400 mg orally every 12 hours, reduce dose to 200 mg orally every 12 hours.	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. 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, clofarabine, lithium, emtricitabine, entecavir, mycophenolate, probenecid, theophylline, aminophylline, tizanidine	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.

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

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Antiviral - Genital Herpes, cont'd

DRUG CLASS / MEDICATION	DOSING*	ADVERSE EFFECTS /INTERACTIONS*	COMMENTS*
Valacyclovir (Valtrex®) Tablets: 500 mg 1 g $	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 twice 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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Antiviral - Genital Warts

DRUG CLASS / MEDICATION	DOSING*	ADVERSE EFFECTS /INTERACTIONS*	COMMENTS*
Podofilox Topical solution: 0.5% $$	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. Hepatic Impairment: No dose adjustment needed. Renal Impairment: No dose adjustment needed.	Adverse Reactions: Local skin reactions (burning, pain, inflammation, erosion and itching, bleeding), headache, dizziness, nausea, vomiting, insomnia. Drug Interactions: No known significant interactions	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.
Imiquimod (Aldara®) **Topical Cream: 5%** **$**	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). NOTE: Do not apply an occlusive dressing to the treatment area. Non-occlusive dressings such as cotton gauze or cotton underwear may be used in the management of skin reactions. Hepatic Impairment: Specific guidelines not available; it appears that no dose adjustments are needed. Renal Impairment: Specific guidelines not available; it appears that no dose adjustments are needed.	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.	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.

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Antibacterial/Antiprotozoal

DRUG CLASS / MEDICATION	DOSING*	ADVERSE EFFECTS /INTERACTIONS*	COMMENTS*
Metronidazole (Flagyl®) **Tablets:** **250 mg** **500 mg** **$** Vaginal Gel: 0.75% $$$	Bacterial Vaginosis: • Oral: 500 mg orally twice daily for 7 days. • Topical: One 5 g applicator intravaginally once daily for 5 days. Trichomoniasis: • In Women: 500 mg orally twice daily for 7 days. • In Men: 2 g orally in a single dose. Hepatic Impairment: Decrease systemic dose by 50% in severe hepatic impairment (Child-Pugh C). Renal Impairment: No dosage adjustment needed. Monitor for adverse effects in patients with end stage renal disease because metabolite accumulation may occur.	Adverse Reactions: Candidiasis of the genital region, headache, nausea, vaginal discharge, vaginitis, abdominal pain, diarrhea, abnormal taste in mouth, dysuria, discolored urine, toxic epidermal necrolysis, Stevens-Johnson Syndrome, hypersensitivity reaction. Drug Interactions: Disulfiram, ethanol, propylene glycol, dronedarone, xabepilone, pimozide, and thioridazine are all contraindicated; warfarin, live vaccines, mebendazole, mycophenolate, droperidol, amiodarone, any other drug that may prolong QT interval, fluorouracil.	Black Box Warning: Metronidazole has been shown to be carcinogenic in mice and rats. Unnecessary use of the drug should be avoided. Its use should be reserved only for conditions for which it is approved. Contraindications: Hypersensitivity to metronidazole, nitroimidazole derivatives, or any component of the formulation; pregnant patients (first trimester) with trichomoniasis; breastfeeding (systemic products), use of disulfiram during therapy or within the past 2 weeks; use of alcohol or products containing propylene glycol during therapy or within 3 days of therapy discontinuation. Caution in the following: Known or history of blood dyscrasias, hepatic impairment, Cockayne syndrome, renal impairment, seizure disorder, cardiac disease, heart failure, edema, QT prolongation or history of, MI, stroke, bradycardia, hypomagnesemia, hypokalemia, hypocalcemia, alcoholism, Crohn's disease, Cockayne syndrome, pregnancy (avoid if possible, contraindicated during 1st trimester for treatment of trichomoniasis), breastfeeding (avoid if possible, contraindicated for systemic products), the elderly.

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

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CCHCS Care Guide: Sexually Transmitted Infections

Patient Education

What You Should Know: Sexually Transmitted Infections

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.

<u>These include gonorrhea, chlamydia, syphilis, trichomonas, HIV and Hepatitis B and C.</u>

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

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

Patient Education

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 **P**artners, Sex **P**ractices, **P**rotection from STIs, **P**ast STIs, and **P**regnancy 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?"

CCHCS Care Guide: Sexually Transmitted Infections

Patient Education

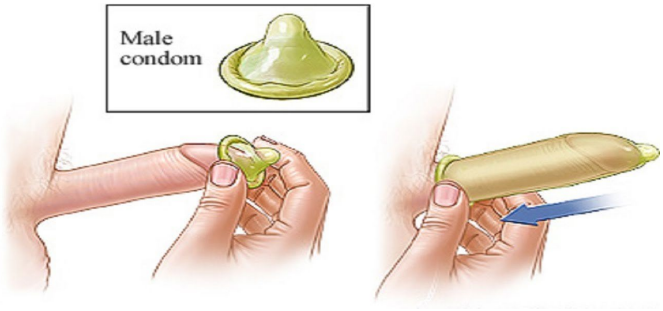
What You Should Know: CDCR Condom Program

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.

CCHCS Care Guide: Sexually Transmitted Infections

Patient Education

What You Should Know: SYPHILIS

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 pregnant person to the unborn baby.

WHAT ARE THE SIGNS AND SYMPTOMS OF SYPHILIS?

Syphilis has many "Stages":

First (Primary Stage)
➢ Sore on the penis, vagina, anus, or mouth. ➢ Sores are usually, but not always, firm, round, and painless. Because the sore may be painless, it can easily go unnoticed.
Second Stage
➢ 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.
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

Persons who are pregnant and have syphilis can give syphilis to their unborn baby which can cause very serious illness or even stillbirth.

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.

GYT
GET YOURSELF
TESTED
TREATED
TALKING

⇒ All pregnant persons 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.

CCHCS Care Guide: Sexually Transmitted Infections

Patient Education

What You Should Know: CHLAMYDIA

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.

CCHCS Care Guide: Sexually Transmitted Infections

Patient Education

What You Should Know: GONORRHEA

WHAT IS GONORRHEA?

⇒ Gonorrhea (pronounced gah-nor-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, but can infect anyone who is sexually active.

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

CCHCS Care Guide: Sexually Transmitted Infections

Patient Education

What You Should Know: EPIDIDYMITIS & NON-GONOCOCCAL URETHRITIS

WHAT IS EPIDIDYMITIS & NON-GONOCOCCAL URETHRITIS?

⇒ Epididymitis (pronounced ep-ih-did-uh-MY-tis) and non-gonococcal urethritis (pronounced non-gon-uh-kok-uhl yur-ee-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?

EPIDIDYMITIS – Persons with penises ONLY:

➢ Some symptoms of epididymitis can include:
- ✓ Swollen, red, or warm scrotum
- ✓ Testicle pain, usually on one side
- ✓ Pain while urinating
- ✓ Discharge from penis
- ✓ Blood in semen

NON-GONOCOCCAL URETHRITIS – Persons with penises:

➢ Some symptoms of NGU can include:
- ✓ Discharge from penis
- ✓ Burning or pain while urinating
- ✓ Itching, irritation, or tenderness

NON-GONOCOCCAL URETHRITIS –Persons with vaginas:

➢ Some women have no symptoms at all. However, some who do have symptoms may have:
- ✓ Discharge from vagina
- ✓ Burning or pain while urinating
- ✓ Stomach pain
- ✓ Abnormal vaginal bleeding

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.

Patient Education

What You Should Know: GENITAL LESIONS – HERPES (HSV-1 and HSV-2)

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?

SIGNS AND SYMPTOMS:

- 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).

CCHCS Care Guide: Sexually Transmitted Infections

Patient Education

What You Should Know: GENITAL LESIONS – HUMAN PAPILLOMAVIRUS

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

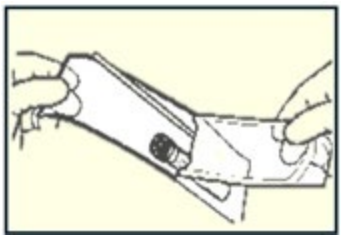
- Most people who have HPV do not know they are infected and never develop symptoms or health problems from it.
- Some symptoms of HPV can include:
  - ✓ Genital and oral warts – may appear as a small bump or group of bumps in the genital or oral areas. They can be small or large, raised or flat, or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

HOW DO I FIND OUT IF I HAVE HPV?

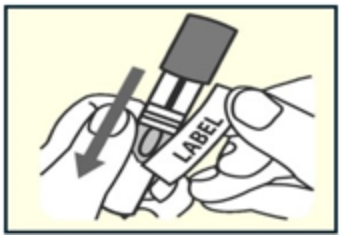
⇒ There are HPV tests that can be used to screen for cervical cancer; these tests are only recommended for screening in women aged 30 years and older.
⇒ There is no approved HPV test to find HPV in the mouth or throat.
⇒ HPV tests are not recommended to screen males, or women under the age of 26 years.

CCHCS Care Guide: Sexually Transmitted Infections

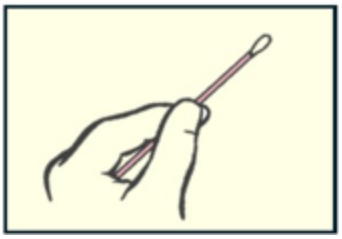
1. Wash your hands with soap and water for at least



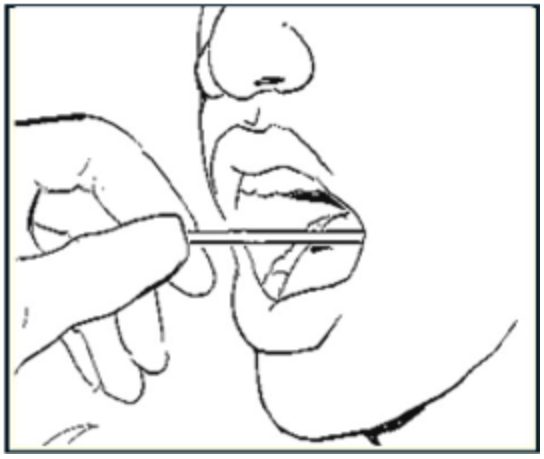
2. Remove the tube and pink swab from packaging



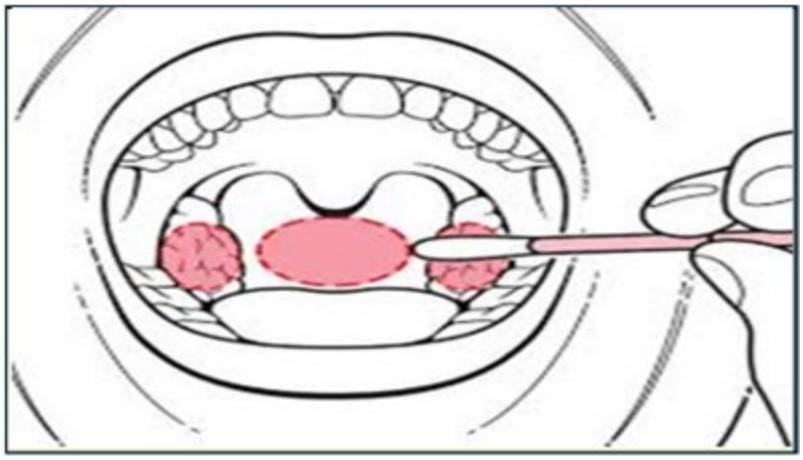
3. Place your label on the tube



4. Firmly hold the swab far enough from the tip

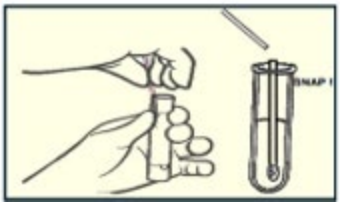


5. Open your mouth wide and reach the swab into your mouth to touch

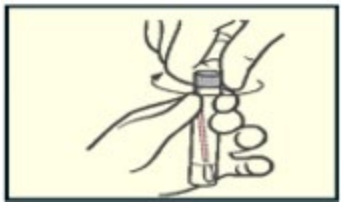


6. Gently rub the swab tip on your throat side to side, up and down at least 5 times

7. Unscrew the cap from the transport tube



8. Place the swab into the transport tube. Snap the swab at the dashed line

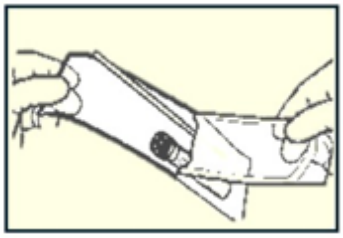


9. Place the cap back on the transport tube and twist it closed

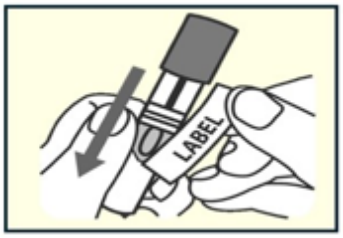
10. Wash your hands with soap and water and return to lab

CCHCS Care Guide: Sexually Transmitted Infections

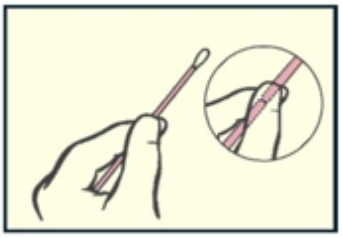
1. Wash your hands with soap and water for at least 20 seconds



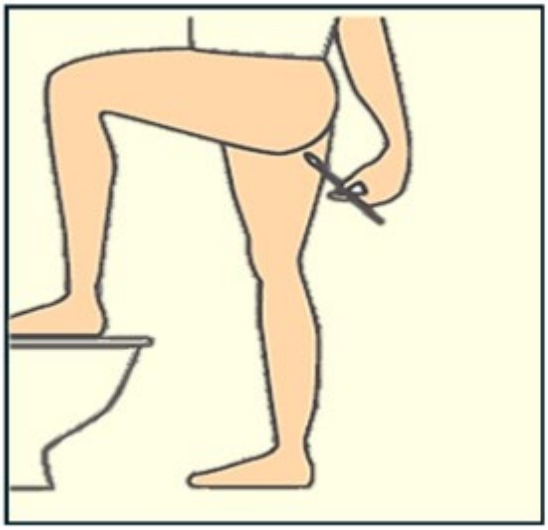
2. Remove the tube and pink swab from packaging



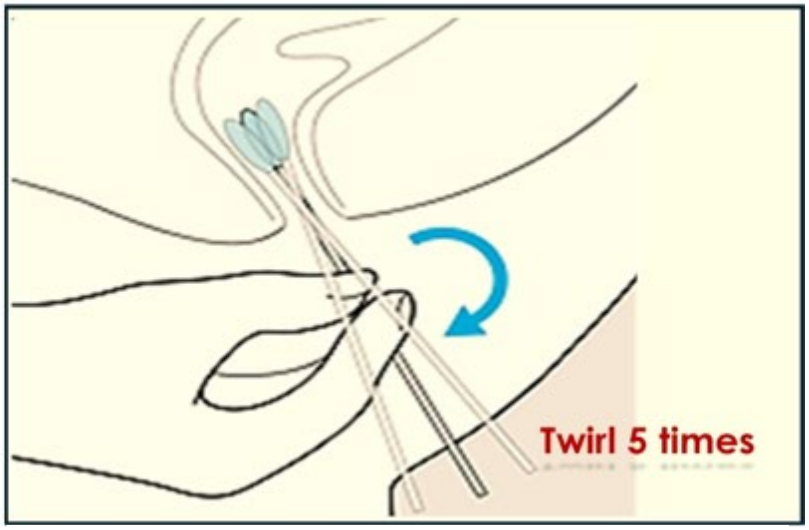
3. Place your label on the tube



4. Firmly hold the swab above the dashed line (near the swab tip)

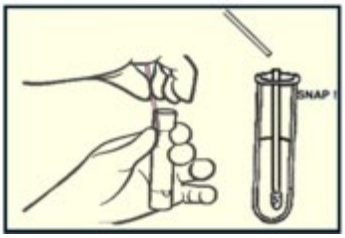


5. Get into a comfortable position that allows you to access your anus

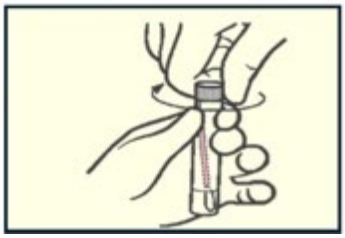


6. Gently insert the swab 1.5 – 2 inches into the rectum and twirl the swab in a circle 5 times

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 the lab

EDUCACIÓN PARA PACIENTES

Qué debes saber: Infecciones de Transmisión Sexual

¿QUÉ ES UNA INFECCIÓN DE TRANSMISIÓN SEXUAL?

⇒ El término infecciones de transmisión sexual (ITS) se refiere a un grupo de enfermedades clínicas que se pueden contraer o contagiar a otra persona a través de la actividad sexual.

Entre ellas se incluyen la gonorrea, la clamidia, la sífilis, las tricomonas, el VIH y las hepatitis B y C.

¿CÓMO SE PROPAGAN LAS ITS?

⇒ Se puede contraer una ITS por contacto directo durante el sexo vaginal, anal u oral.

⇒ También se pueden contraer ciertas ITS por contacto con el recto, los labios o la boca.

⇒ Una madre infectada puede transmitir varias ITS al feto.

¿CÓMO PUEDO REDUCIR EL RIESGO DE CONTRAER UNA ITS?

⇒ La única forma de evitar contraer una ITS es no tener sexo vaginal, anal u oral.

⇒ Si tienes relaciones sexuales:

- Para reducir el riesgo de contraer una ITS, mantén una relación duradera con una pareja que se haya sometido a pruebas y haya dado negativo.
- Utilizar preservativos de látex de la forma correcta cada vez que tengas relaciones sexuales también puede ayudar. Los preservativos limitan la transmisión de ITS, pero no protegen totalmente de algunas ITS.

ITS: CONOCE TU RIESGO

⇒ Cualquier persona sexualmente activa puede contraer ITS a través del sexo vaginal, anal u oral sin protección.

⇒ Habla honesta y abiertamente con tu médico. Pregunta si debes hacerte pruebas de ITS.

- ◊ Todas las pacientes embarazadas deben hacerse la prueba como parte de su primera visita prenatal.
- ◊ Debes someterte a pruebas periódicas de ITS si eres sexualmente activo o:
  - Eres un hombre que tiene relaciones sexuales con hombres.
  - Eres portador del VIH.
  - Tienes parejas que dieron positivo en las pruebas de ITS.

¿CUÁLES SON LOS SIGNOS Y SÍNTOMAS DE LAS ITS?

⇒ Llagas o protuberancias en los genitales o en la zona bucal o rectal.
⇒ Dolor o ardor al orinar
⇒ Dolor o ardor en la boca o garganta
⇒ Secreción del pene
⇒ Flujo vaginal inusual o de olor extraño
⇒ Sangrado vaginal inusual

¿CÓMO PUEDO SABER SI TENGO UNA ITS?

⇒ La mayoría de las veces, se realiza un simple análisis de sangre u orina para detectar una ITS.

⇒ En algunos casos, se puede utilizar un hisopo de algodón en el recto o la boca para la recolección (esto lo puede hacer su médico o usted mismo).

⇒ Los profesionales médicos elegirán las pruebas adecuadas para diagnosticar la ITS específica.

Educación para pacientes

Qué debes saber: Las 5 P (Información importante sobre su salud)

¿QUÉ SON LAS 5 P?

⇒ Los Centros para el Control y la Prevención de Enfermedades (CDC, por sus siglas en inglés) tienen una lista de preguntas que los proveedores de atención médica deben hacer a cada paciente para ayudar a detectar y prevenir las infecciones de transmisión sexual (ITS).

⇒ Han dividido estas preguntas en 5 áreas importantes (las 5 P):

⇒ **P**arejas sexuales, **P**rácticas sexuales, **P**rotección frente a las ITS, ITS **P**asadas e **P**retensiones de embarazo.

¿POR QUÉ ES IMPORTANTE REALIZAR 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 médico a detectar, tratar y prevenir las ITS.

⇒ Estas preguntas son estándar y se hacen a TODOS los pacientes.

⇒ Conocer tu historia sexual y tus prácticas sexuales actuales puede ayudar a tu médico a hablar contigo sobre cómo reducir el riesgo de contraer una ITS.

¿QUÉ TIPO DE PREGUNTAS HAY EN LAS 5 P?

Parejas

- "En los últimos 12 meses, ¿con cuántas personas diferentes has tenido encuentros sexuales?"
- "¿Las personas con las que has tenido encuentros sexuales son:
  - ✓ Hombres
  - ✓ Mujeres
  - ✓ Hombres y mujeres
  - ✓ Otras personas que se identifican con el género, como personas transgénero o personas que se identifican como no binarias".

Prácticas

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

Protección frente a las ITS

- "¿Utilizan usted y sus parejas algún tipo de protección contra las ITS como el preservativo? En caso afirmativo, ¿con qué frecuencia?"
  - ✓ Todo el tiempo
  - ✓ Algunas veces
  - ✓ Rara vez

Antecedentes de ITS.

- "¿Le han diagnosticado alguna vez una infección de transmisión sexual?
  - ✓ En caso afirmativo, ¿qué ITS?
  - ✓ ¿Cuándo se la diagnosticaron?
  - ✓ ¿Recibió tratamiento?"

Pretensiones de embarazo

- "¿Conoce el Programa de preservativos del CDCR?"

Educación para pacientes

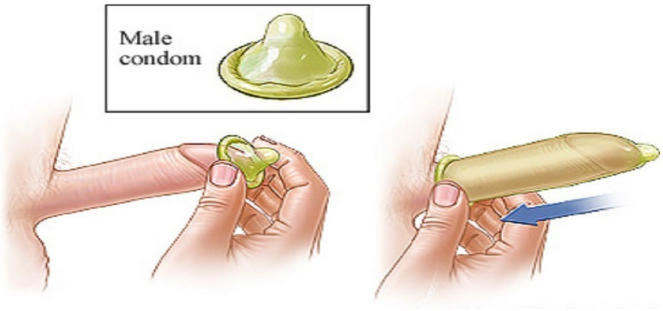
Qué debes saber: Programa de preservativos del CDCR

¿QUÉ ES EL PROGRAMA DE PRESERVATIVOS DEL CDCR?

⇒ La ley estatal requiere que el CDCR tenga condones disponibles en todas las prisiones del estado. Los preservativos están disponibles de forma gratuita para los reclusos. Se les permitirá a los reclusos poseer hasta tres condones a la vez. Esta ley no cambia el hecho de que la actividad sexual entre reclusos es ilegal y se abordará de acuerdo con el Código de Reglamentos de California, Título 15, y el Código Penal de California.

USO CORRECTO DE LOS CONDONES EXPEDIDOS POR EL CDCR

Uso correcto del preservativo:



⇒ **Cómo deshacerse de los condones usados**
El método recomendado de eliminación es tirarlo por el inodoro.

⇒ **Preservativos caducados**
Los condones vencidos deben guardarse en el empaque y desecharse en la basura.

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

⇒ El uso del preservativo durante las relaciones sexuales puede disminuir el riesgo de contraer una Infección de Transmisión Sexual (ITS), como el VIH, la clamidia, la gonorrea, la sífilis y la hepatitis.

⇒ La forma más eficaz de evitar una ITS es no tener relaciones sexuales mientras te encuentras en la prisión. Si decides tener relaciones sexuales, los preservativos pueden disminuir el riesgo de contraer una ITS. Muchas personas que tienen ITS no presentan síntomas y pueden no saber que están infectadas.

¿CÓMO SÉ SI TENGO UNA ITS?

⇒ Cualquier persona sexualmente activa puede contraer ITS a través del sexo vaginal, anal u oral sin protección. Habla sincera y abiertamente con tu médico y pregúntale si deberías someterte a una prueba de ITS.

⇒ Si estás de acuerdo con alguna de las siguientes afirmaciones, te recomendamos que te hagas la prueba:

◊ He tenido relaciones sexuales sin protección recientemente.

◊ Me arde o me duele al orinar o al tener relaciones sexuales.

◊ He tenido varias parejas sexuales.

◊ He tenido relaciones sexuales sin protección con una pareja seropositiva.

◊ He tenido relaciones sexuales bajo los efectos del alcohol u otras sustancias.

◊ He compartido mi equipo de inyección o esnifado de drogas.

◊ Me he hecho un tatuaje estando en prisión.

◊ He estado en contacto con sangre, semen o fluidos vaginales de otra persona.

◊ Tengo una pareja sexual con una ITS.

Educación para pacientes

Qué debes saber: SÍFILIS

¿QUÉ ES LA SÍFILIS?

⇒ La sífilis es una Infección de Transmisión Sexual (ITS) que puede causar graves problemas de salud si no se trata.

¿CÓMO SE CONTAGIA LA SÍFILIS?

⇒ Se puede contraer sífilis al tener sexo vaginal, anal u oral con una pareja que tiene sífilis.

⇒ La sífilis también puede contagiarse de una persona embarazada al feto.

¿CUÁLES SON LOS INDICIOS Y SÍNTOMAS DE LA SÍFILIS?

La sífilis tiene muchas "Fases":

Primera (Fase inicial)

- Úlcera en el pene, la vagina, el ano o la boca.
- Las úlceras suelen ser, aunque no siempre, firmes, redondas e indoloras. Como la úlcera puede ser indolora, es fácil que pase desapercibida.

Segunda fase

- Puede presentar una serie de síntomas, como erupción cutánea (a veces en las palmas de las manos o en las plantas de los pies), tumores verrugosos en los genitales o en la boca, manchas blancas en el interior de la boca, inflamación de los ganglios linfáticos o caída del cabello.

Tercera fase

- Muy grave y puede aparecer entre 10 y 30 años después del inicio de la infección si no se recibe tratamiento. En esta fase, la enfermedad daña los órganos internos y puede causar la muerte.

◊ La sífilis también puede ser asintomática

◊ La sífilis puede llegar al cerebro o a los ojos y causar daños si no se trata

Las personas embarazadas con sífilis pueden contagiar la enfermedad al feto, lo que puede provocar una enfermedad muy grave o incluso el nacimiento de un niño muerto.

¿QUIÉN DEBE HACERSE LA PRUEBA DE LA SÍFILIS?

⇒ Todos los pacientes que ingresan al CDCR se les ofrece una prueba para la sífilis, por lo que es probable que se le haya hecho una prueba cuando llegó - esa prueba se hace en la sangre y se llama una reagina plasmática rápida (RPR).

⇒ Debes someterte a pruebas periódicas de sífilis si eres sexualmente activo o:

◊ Eres un hombre que tiene relaciones sexuales con hombres; o

◊ Eres portador del VIH; o

◊ Tienes una pareja que dio positivo en la prueba de la sífilis.

⇒ Todas las embarazadas deben someterse a la prueba de la sífilis en su primera cita prenatal.

¿SE PUEDE TRATAR LA SÍFILIS?

⇒ Sí, en la mayoría de las personas la sífilis puede tratarse y curarse con penicilina u otros antibióticos.

◊ Sin embargo, si el daño ya se ha producido, los antibióticos no pueden mejorarlo.

⇒ Tener sífilis una vez no te protege de contraer sífilis de nuevo. Puedes volver a contraer la infección fácilmente si tienes relaciones sexuales con alguien que tiene sífilis.

Educación para pacientes

Qué debes saber: CLAMIDIA

¿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 aparato reproductor. Esto puede dificultar o imposibilitar un embarazo en etapas posteriores de la vida.

¿CÓMO SE CONTAGIA LA CLAMIDIA?

⇒ Se puede contraer clamidia teniendo relaciones sexuales vaginales, anales u orales con otra persona que padezca clamidia.

⇒ Si tu pareja sexual es hombre, puedes contraer clamidia aunque no eyacule (se corra).

⇒ Si has tenido clamidia y recibiste tratamiento en el pasado, puedes volver a infectarte. Esto puede suceder si tienes relaciones sexuales sin protección con alguien que tiene clamidia.

⇒ Si estás embarazada, puedes transmitir clamidia a tu bebé durante el parto.

¿CUÁLES SON LOS INDICIOS Y SÍNTOMAS DE LA CLAMIDIA?

⇒ La mayoría de las personas que tienen clamidia no presentan síntomas.

⇒ Si tienes síntomas, es posible que no aparezcan hasta semanas después de haber tenido relaciones sexuales con una pareja infectada.

HOMBRES:

- Secreción del pene
- Sensación de ardor al orinar
- Dolor e hinchazón en uno o ambos testículos (aunque es menos frecuente)

MUJERES:

- Flujo vaginal anormal
- Sensación de ardor al orinar

INFECCIONES RECTALES (CUALQUIER PERSONA QUE TENGA SEXO ANAL):

Las personas también pueden infectarse con clamidia en el recto. Esto ocurre por tener sexo anal receptivo o por contagio desde otro sitio infectado (como la vagina). Aunque estas infecciones no suelen provocar síntomas, pueden causar:

- dolor rectal
- secreción
- hemorragia

CLAMIDIA: CONOCE TU RIESGO

⇒ Cualquier persona que tenga relaciones sexuales puede contraer clamidia a través del sexo vaginal, anal u oral sin protección.

¿CÓMO PUEDO SABER SI TENGO CLAMIDIA?

⇒ Habla sincera y abiertamente con tu médico y pregúntale si deberías someterte a una prueba de clamidia.

⇒ Las pruebas de laboratorio pueden diagnosticar la clamidia.

⇒ Tu médico puede pedirte que proporciones una muestra de orina o puede usar (o pedirte que uses) un hisopo de algodón para obtener una muestra de tu vagina o recto para hacer la prueba de clamidia.

Educación para pacientes

Qué debes saber: GONORREA

¿QUÉ ES LA GONORREA?

⇒ La gonorrea es una Infección de Transmisión Sexual (ITS) 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 común, especialmente entre los jóvenes de 15 a 24 años, pero puede infectar a cualquier persona sexualmente activa.

¿CÓMO SE PROPAGA LA GONORREA?

⇒ Se puede contraer gonorrea al tener sexo vaginal, anal u oral con una persona que tiene gonorrea.

⇒ Una persona embarazada con gonorrea puede transmitir la infección al feto durante el parto.

GONORREA: CONOCE TU RIESGO

⇒ Cualquier persona sexualmente activa puede contraer gonorrea a través del sexo vaginal, anal u oral. Habla sincera y abiertamente con tu médico y pregúntale si deberías someterte a una prueba de gonorrea u otras ITS.

¿CUÁLES SON LOS INDICIOS 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
- ✓ Ardor y dolor en la boca
- ✓ Secreción blanca, amarilla o verde del pene
- ✓ Dolor o inflamación testicular (no tan frecuente)

MUJERES:

- La mayoría de las mujeres con gonorrea no presentan ningún síntoma. Incluso cuando los síntomas están presentes, a menudo son leves y pueden confundirse con una infección vaginal o de la vejiga.
- La gonorrea aumenta el riesgo de desarrollar complicaciones graves derivadas de la infección, aunque no presenten síntomas.
- Los síntomas pueden incluir:
- ✓ Dolor o ardor al orinar
- ✓ Aumento del flujo vaginal
- ✓ Sangrado vaginal entre periodos
- ✓ Ardor o dolor en la boca

INFECCIONES RECTALES (CUALQUIER PERSONA QUE TENGA SEXO ANAL):

- Las infecciones rectales pueden no causar síntomas o causar síntomas que pueden incluir:
- ✓ secreción
- ✓ picazón anal
- ✓ sensación de adolorido
- ✓ hemorragia
- ✓ evacuaciones intestinales dolorosas

¿CÓMO PUEDO SABER SI TENGO GONORREA?

⇒ Habla con tu médico para que te haga la prueba.

⇒ La mayoría de las veces, se utiliza un análisis de orina para detectar la gonorrea.

⇒ Sin embargo, si ha tenido sexo oral o anal, se pueden utilizar hisopos para recoger muestras de la garganta o el recto.

Educación para pacientes

Qué debe saber: EPIDIDIMITIS Y URETRITIS NO GONOCÓCICA

¿QUÉ ES LA EPIDIMITIS Y LA URETRITIS NO GONOCÓCICA?

⇒ La epididimitis (pronunciada e-pi-di-di-mi-tis) y la uretritis no gonocócica (pronunciada u-re-tri-tis no -go-no-có-ci-ca), también conocidas como UNG, son Infecciones de Transmisión Sexual (ITS).

⇒ La epididimitis es la inflamación del conducto situado en la parte posterior del testículo que transporta los espermatozoides. La inflamación puede provocar un dolor intenso en el testículo.

- La epididimitis está causada por bacterias de ITS como la clamidia y la gonorrea.
- Los hombres de cualquier edad pueden contraer epididimitis, pero ocurre con más frecuencia en hombres de entre 14 y 35 años.

⇒ El UNG es la inflamación del conducto que transporta la orina fuera del cuerpo.

- El UNG suele estar causada por la clamidia y es más frecuente en hombres que en mujeres.

¿CÓMO SE CONTAGIAN?

⇒ Puedes contraer epididimitis a través del sexo vaginal o anal con una persona infectada.

⇒ Puedes contraer UNG por sexo vaginal, anal u oral con una persona infectada.

CONOCE TU RIESGO

⇒ Cualquier persona sexualmente activa puede contraer epididimitis a través de sexo vaginal o anal o UNG a través de sexo vaginal, anal u oral. Habla sincera y abiertamente con tu médico y pregúntale si deberías someterte a una prueba.

¿CUÁLES SON LOS INDICIOS Y SÍNTOMAS?

EPIDIDMITIS - SÓLO personas con pene:

- Algunos síntomas de la epididimitis pueden incluir:
  - ✓ Escroto hinchado, enrojecido o caliente
  - ✓ Dolor testicular, generalmente de un lado
  - ✓ Dolor al orinar
  - ✓ Secreción del pene
  - ✓ Sangre en el semen

URETRITIS NO GONOCOCAL - Personas con pene:

- Algunos síntomas de la UNG pueden incluir:
  - ✓ Secreción del pene
  - ✓ Ardor o dolor al orinar
  - ✓ Picazón, irritación o sensibilidad

URETRITIS NO GONOCOCAL - Personas con vagina:

- Algunas mujeres no presentan ningún síntoma. Sin embargo, algunos que sí tienen síntomas pueden tener:
  - ✓ Secreción de la vagina
  - ✓ Ardor o dolor al orinar
  - ✓ Dolor de estómago
  - ✓ Hemorragia vaginal anormal

¿CÓMO PUEDO SABER SI TENGO EPIDIDIMITIS O UNG?

⇒ Habla con tu médico para que te haga la prueba.

⇒ La prueba de la epididimitis y la UNG puede incluir un análisis de orina o un hisopado de la uretra.

Educación para pacientes

Qué debes saber: LESIONES GENITALES - HERPES (VHS-1 y VHS-2)

¿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 mantienen relaciones sexuales.

⇒ El herpes genital está 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 CONTAGIA EL HERPES GENITAL?

⇒ Puedes contraer herpes genital al tener sexo vaginal, anal u oral con una persona que tiene herpes.

⇒ Si entras en contacto con una llaga herpética.

⇒ Se puede contagiar de la boca a los genitales a través del sexo oral.

⇒ No te contagiarás el herpes por los asientos de los inodoros, la ropa de cama o las piscinas, ni por tocar los objetos que te rodean.

HERPES GENITAL: CONOCE TU RIESGO

⇒ Cualquier persona que tenga relaciones sexuales puede contraer Herpes genita a través del sexo vaginal, anal u oral sin protección.

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

◊ Los homosexuales, bisexuales y otros hombres que tienen relaciones sexuales con hombres, así como las mujeres transexuales, también corren riesgo, ya que el herpes genital puede contagiarse a través del sexo oral y anal.

⇒ Habla honesta y abiertamente con tu médico. Consulta si debes someterte a pruebas de detección de herpes genital u otras ITS.

¿CUÁLES SON LOS INDICIOS Y SÍNTOMAS DEL HERPES GENITAL?

SEÑALES Y SÍNTOMAS:

- La mayoría de las personas que tienen herpes genital no presentan síntomas.
- Es posible que no notes síntomas leves, o que los confundas con otra afección cutánea, como un grano o un vello encarnado. Por este motivo, la mayoría de las personas que tienen herpes no lo saben.
- 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 curarse.
    - Estos síntomas se denominan "tener un brote".
  - ✓ Fiebre
  - ✓ Dolores en el cuerpo
  - ✓ Glándulas inflamadas

¿CÓMO PUEDO SABER SI TENGO HERPES GENITAL?

⇒ Habla con tu médico para que te haga la prueba.

⇒ No se recomienda la prueba del herpes en personas asintomáticas.

¿SE PUEDE CURAR EL HERPES GENITAL?

⇒ El herpes no tiene cura.

⇒ Existen medicamentos que pueden prevenir o acortar los brotes y reducir la probabilidad de que transmitas la infección a tus parejas sexuales.

Educación para pacientes

Qué debe saber: LESIONES GENITALES - VIRUS DEL PAPILOMA HUMANO

¿QUÉ ES EL VIRUS DEL PAPILOMA HUMANO (VPH)?

⇒ La mayoría de las personas sexualmente activas se infectan por el VPH al menos una vez en la vida.
⇒ En la mayoría de los casos, el VPH desaparece por sí solo y no causa ningún problema de salud.
⇒ Existen muchos tipos diferentes de VPH. Algunos tipos pueden causar problemas de salud, como verrugas genitales o bucales y cáncer.

¿CÓMO SE PROPAGA EL VPH?

⇒ Puedes contraer el VPH teniendo relaciones sexuales vaginales, anales u orales con alguien que tenga la enfermedad a través del contacto piel con piel.
⇒ El VPH puede infectar zonas no cubiertas por un preservativo, por lo que es posible que los preservativos no protejan totalmente contra el contagio del VPH.

¿DEBO VACUNARME CONTRA EL VPH?

⇒ Se recomienda vacunarse contra el VPH a todas las personas de hasta 26 años de edad, si aún no se han vacunado.
⇒ No se recomienda vacunarse a todas las personas mayores de 26 años.
⇒ Sin embargo, algunos adultos de 27 a 45 años que aún no están vacunados pueden decidir vacunarse contra el VPH después de hablar con su médico sobre su riesgo de nuevas infecciones por VPH y los posibles beneficios de la vacunación.
⇒ Habla honesta y abiertamente con tu médico. Consulta si debes someterte a pruebas de detección VPH u otras ITS.

¿CUÁLES SON LOS INDICIOS Y SÍNTOMAS DEL VPH?

Personas infectadas por el VPH

- La mayoría de las personas que tienen el VPH no saben que están infectadas y nunca desarrollan síntomas o problemas de salud por ello.
- Algunos síntomas del VPH pueden ser:
  - ✓ Verrugas genitales y orales: pueden aparecer como un pequeño bulto o grupo de bultos en las zonas genital u oral. Pueden ser pequeñas o grandes, elevadas o planas, o tener forma de coliflor.
  - ✓ Cáncer de:
    - vulva
    - vagina
    - pene
    - ano
    - garganta
    - lengua
    - amígdalas
- No hay forma de saber por qué algunas personas que tienen el VPH desarrollarán cáncer u otros problemas de salud. Los tipos de VPH que causan verrugas genitales no son los mismos que los tipos de VPH que pueden causar cáncer.

¿CÓMO PUEDO SABER SI TENGO EL VPH?

⇒ Existen pruebas del VPH que se pueden utilizar para detectar el cáncer de cuello uterino; estas pruebas sólo se recomiendan para el cribado en mujeres de 30 años o más.
⇒ No existe ninguna prueba del VPH aprobada para detectar el VPH en la boca o la garganta.
⇒ No se recomiendan las pruebas de detección del VPH en varones ni en mujeres menores de 26 años.

STI Prevention
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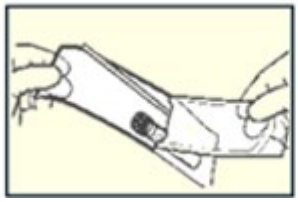
PONTE A PRUEBA

Hisopado faríngeo recogido por el propio paciente

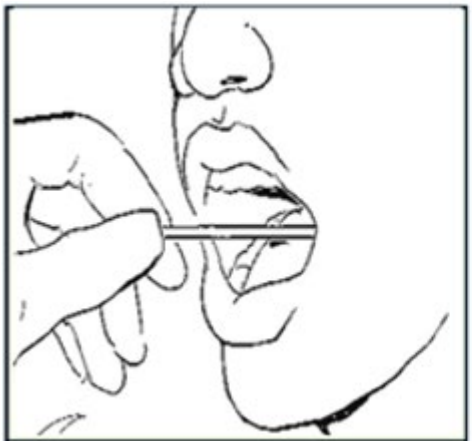
1. Lavarse las manos con agua y jabón durante al menos 20 segundos



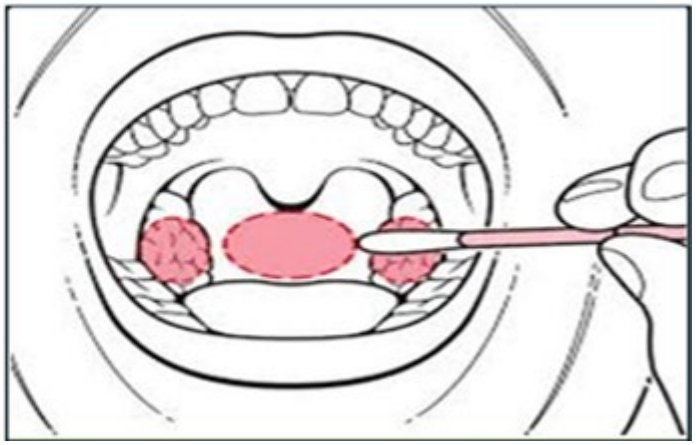
2. Sacar el tubo y la torunda rosa del envase

3. Coloque su etiqueta en el tubo

4. Sujetar firmemente el bastoncillo lo suficientemente lejos de la punta



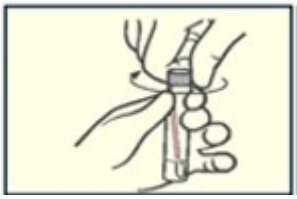
5. Abra bien la boca e introducir la torunda en la boca hasta tocarse la garganta



6. Frote suavemente la punta del hisopo en la garganta de lado a lado, de arriba y hacia abajo al menos 5 veces

7. Desenrosque la tapa de la tubo de transporte

8. Coloque el hisopo en el tubo de transporte. Golpee el hisopo en la línea discontinua



9. Vuelva a colocar la tapa en el tubo de transporte y gírelo para cerrarlo

10. Lavarse los manos con agua y jabón y volver al laboratorio

STI Prevention
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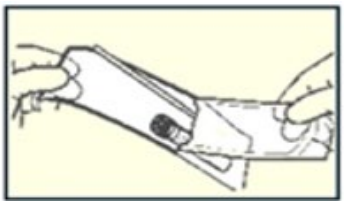
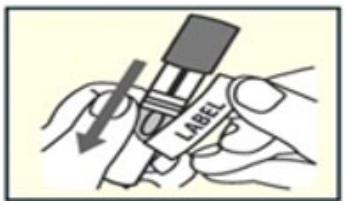
PONTE A PRUEBA

Hisopado rectal recogido por el propio paciente

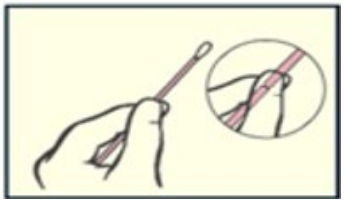
1. Lavarse las manos con agua y jabón durante al menos 20 segundos



2. Sacar el tubo y la torunda rosa del envase

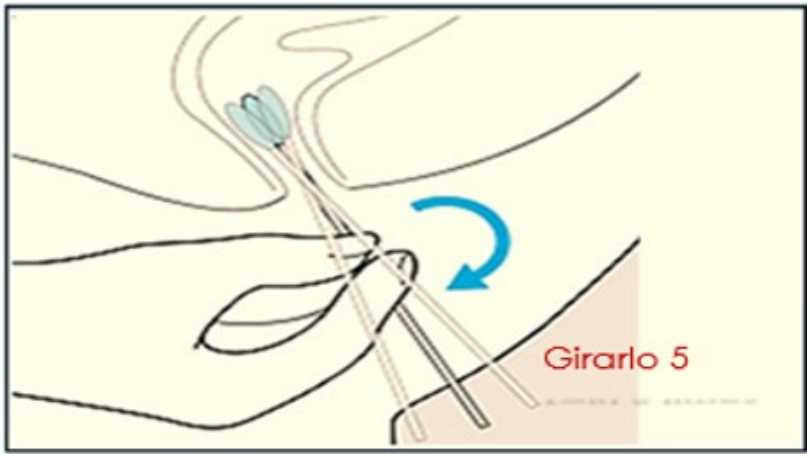


3. Coloque su etiqueta en el tubo



4. Sujetar firmemente el bastoncillo lo suficientemente lejos de la punta

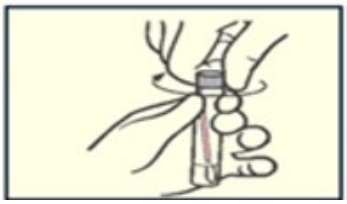
5. Colócate en una posición cómoda que te permita acceder a tu ano



6. Introducir suavemente la torunda 2.5 cm en el recto y girarla torunda en círculo 5 veces

7. Desenrosque la tapa de la tubo de transporte

8. Coloque el hisopo en el tubo de transporte. Golpee el hisopo en la línea discontinua



9. Vuelva a colocar la tapa en el tubo de transporte y gírelo para cerrarlo

10. Lavarse los manos con agua y jabón y volver al laboratorio