TREATMENT OF STDs IN HIV-INFECTED PATIENTS

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This resource is intended to assist clinicians in managing STDs in HIV-infected patients. (p. 2) This resource provides guidance, algorithms, and recommendations for the treatment of selected STDs. Please see the STD guidelines for additional information including diagnostic considerations and management of six partners with each other and other STDs.

Information adapted from:


The information contained in this publication is intended for medical professionals as a quick reference to the national guidelines. This resource does not replace nor represent the comprehensive nature of the published guidelines. In making decisions regarding the use of non-penicillin regimens, clinicians are encouraged to consult with their local experts and research the literature themselves. Consultation with the Florida/Caribbean AETC for urgent PEP decision-making is available to clinicians in Florida, Puerto Rico, and the U.S. Virgin Islands.

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GONORRHEA

Combination therapy with azithromycin (preferred) or doxycycline is recommended to hinder the development of antimicrobial-resistant N. gonorrhoeae and treat for presumed gonococcal infection.

Ceftriaxone 250 mg IM for 1 dose
• Ceftriaxone 250 mg IM (for 1 dose)
• Clindamycin 300 mg po bid for 7 days or
• Clindamycin 100 mg IV or po every 12 hours

Chlamydia

Recommended Treatment
• Azithromycin 1 g po for 1 dose
• Ceftriaxone 250 mg intramuscularly (IM) for 1 dose
• Clindamycin 500 mg po bid
• Doxycycline 100 mg po for 7 days

Alternative Treatment
• Tinidazole 2 g po once daily for 2 days
• Tindazole 1 g po once daily for 5 days
• Clindamycin 300 mg po twice daily for 7 days
• Clindamycin 100 mg IV or po for 1 dose

PELVIC INFLAMMATORY DISEASE (PID)

Inpatient Treatment
• Doxycycline 100 mg IV or po every 12 hours
• Clindamycin 100 mg IV or po every 12 hours

Outpatient Treatment
• Doxycycline 100 mg po bid for 14 days
• Clindamycin 500 mg po bid for 14 days
• Metronidazole 500 mg po bid for 14 days

SYPHILIS

See STD Guidelines for treatment of penicillin-allergic pts as the efficacy of non-penicillin regimens has not been well evaluated in HIV-infected pts.

Primary, Secondary, Early Latent Infection Treatment
• Benzathine penicillin G 2.4 million units IM

Comments
• Role of neurosyphilis; early latent infection defined as <1 year

Tertiary, Late Latent Infection Treatment
• Benzathine penicillin G 2.4 million units IM

Comments
• Role of neurosyphilis; late latent infection defined as >1 year of unknown duration

Neurosyphilis, Otic, or Ocular Disease Treatment
• Aqueous crystalline penicillin G 3-4 million units IV every 4 or 8 or 12 units per day as continuous infusion

Alternative
• Procaine penicillin G 2.4 million units IM

Comments (for recommended and alternative)
• Consider benzathine penicillin G 2.4 million units IM weekly for 3 weeks after completion of IV therapy (CIII)
• Procaine penicillin G is not recommended in sufla allergic pts since probenecid cannot be used with sulfa allergy

TRICHOMONIASIS

Recommended Treatment
• Metronidazole 500 mg po bid

Comments
• Avoid consuming alcohol during metronidazole therapy and for 24 hours after completion

VULVOVAGINAL CANDIDIASIS

Recommended Treatment
• Multiple OTC products as directed (see STD Guidelines) or
• Fluconazole 150 mg po for 1 dose