WOLVERTON CENTRE FOR SEXUAL HEALTH

Treatment of Sexually Transmitted Infections

Wolverton Centre Guidelines

Updated Jan 2018

Please ensure that you have the latest version.
V: Department Folder/Standard Operating Guides/Clinical Governance/Treatment of Sexually Transmitted infections – updated Jan 2018.doc

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Distribution list:

- *Wolverton Centre Staff*
- *Clinical rooms*
- *Laboratory*
- *Website*
- *Induction*

Contents Page:

TREATMENT OF SEXUALLY TRANSMITTED INFECTIONS
SUMMARY (January 2018)

CONDITION	1st line treatment	2nd line treatment or for penicillin allergy	Comments
SYPHILIS			
Epidemiological treatment	Benzathine penicillin 2.4 MU IM – single dose	Doxycycline 100mg PO BD for 14 days OR Azithromycin 1G PO stat	Treatment not essential. Please discuss indication for epidemiological treatment with Consultant
Early Syphilis including primary, secondary & early latent (less than 2yrs)	Benzathine penicillin 2.4 MU IM – single dose OR Procaine penicillin G 600,000 units IM daily for 10 days – 17 days	Doxycycline 100mg PO BD for 14 days OR Azithromycin 2G PO single dose OR Azithromycin 500mg PO for 10 days	All cases of early Syphilis must be referred to a Consultant. Resistance to macrolides – thus caution in using. Follow up serology for 1 year required (at 3,6 and 12 months) to check 4 fold reduction in RPR or becomes serofast Advise no SI for 2 weeks from completion of treatment in patient and partner.
Late Latent Syphilis	Benzathine penicillin 2.4 MU IM 3 doses at day 1, 8 & 15 OR Procaine penicillin G 600,000 units IM daily for 17 days	Doxycycline 100mg PO BD for 28 days	Follow up is needed to ensure completion of Rx but repeat RPR is not required if the pre-treatment RPR is negative.
Neuro / Cardiovascular Syphilis Including Neurological / Ophthalmic involvement in early Syphilis	Procaine penicillin G 2.4 MU IM daily for 14 days **Plus** Probenecid 500mg PO for 14 days **Plus** prednisolone 50mg PO OD for 3 days OR Benzylpenicillin 18 – 24MU daily IV (3 –4MU 4 hourly) 17 days **Plus** prednisolone as above	**Penicillin allergy** Doxycycline 200mg BD 28 days	All cases of neurosyphilis must be referred to a consultant. Consider treatment as an inpatient
Syphilis in HIV positive patients	Same treatment as in HIV negative patients, assuming regular long term follow up	If follow up unreliable, treat as for neurosyphilis	All cases of syphilis in HIV patients must be referred to a Consultant

CONDITION	Ist line treatment	2nd line treatment	Comments
GONORRHOEA			
Uncomplicated urethral, cervical, rectal GC and epidemiological treatment	Ceftriaxone 500mg IM single dose* **plus** Azithromycin 1G PO single dose	Cefixime 400mg PO single dose **plus** Azithromycin 1G PO single dose In severe penicillin allergy or Cephalosporin hypersensitivity: Spectinomycin 2G IM single dose	**Send Cultures prior to all GC treatment** **Test of cure** required for all gonococccal infections. **Asymptomatic** – NAATS 2 weeks after completion of treatment **Symptomatic** – culture 72hrs after completion of treatment
Throat GC	Ceftriaxone 500mg IM single dose* **plus** Azithromycin 1G PO oral single dose	Ciprofloxacin 500mg PO single dose **plus** Azithromycin 1G PO single dose Only prescribe in cases of severe penicillin allergy or Cephalosporin hypersensitivity where culture has confirmed sensitivity to ciprofloxacin	**Do not use Cefixime / Spectinomycin for pharyngeal GC due to poor penetration of the drug in the throat.** **Discuss multi resistant strains with consultant**
GC in pregnancy or breast feeding All trimesters – (unlicensed)	Ceftriaxone 500mg IM single dose* **plus** Azithromycin 1G PO single dose		Ceftriaxone, Cefixime, Spectinomycin are all safe in pregnancy – avoid ciprofloxacin or tetracycline
Ophthalmia neonatorum (gonococcal)	Ceftriaxome 25 – 50mg / Kg IV or IM single dose, not to exceed 125mg daily for 3 days		Refer to Consultant. Mother needs testing and treating.
Ophthalmia neonatorum (gonococcal)	Ceftriaxone 25 – 50mg / Kg IV or IM single dose, not to exceed 125mg daily for 3 days		Refer to Consultant. Mother needs testing and treating.

CONDITION	Ist line treatment	2nd line treatment	Comments
CHLAMYDIA			
Asymptomatic Chlamydia **Cervix / urethra and epidemiological treatment**	Azithromycin 1G PO single dose	Doxycycline 100mg PO BD for 7 days	Do not give Doxycycline in pregnancy. Treat partners with Azithromycin 1G PO single dose **Re-test at 3 months in all <25 years**
Throat Chlamydia	Azithromycin 1G PO single dose	Doxycycline 100mg PO BD for 7 days	Treat partners with Azithromycin 1G PO single dose
Rectal Chlamydia	Doxycycline 100mg PO BD for 7 days	In case of allergy, discus with Consultant	Treat partners with Azithromycin 1G PO single dose
Rectal Chlamydia in all MSM	Doxycycline 100mg PO BD for 21 days *Request LGV in all MSM with rectal chlamydia*		TOC if patient remains symptomatic - not needed if 3 weeks doxycycline completed & patient is asymptomatic.
Adult Chlamydia conjunctivitis	Azithromycin 1G PO single dose		Needs STI screen and PN
Chlamydia Ophthalmia neonatorum	Erythromycin 50mg / kg / day PO into 4 doses daily for 14 days		Refer to Consultant. Mother needs testing and treating.
Lymphogranuloma venereum (LGV)	Doxycycline 100mg PO BD for 21 days	Erythromycin 500mg PO QDS for 21 days	Discuss all cases with Consultant. **Ensure HIV test is performed.** Follow up all patients to ensure symptoms have resolved. *TOC 2 weeks after completion of treatment if patient remains symptomatic adherence was poor or treated with erythromycin.*

CONDITION	Ist line treatment	2nd line treatment	Comments
NSU			
Uncomplicated NSU	Doxycycline 100mg PO BD for 7 days	Azithromycin 500mg stat then 250mg OD for 4 days Or Ofloxacin 400mg OD for 7 days	Partners of NSU patients should be treated with Doxycycline 100mg PO BD for 1 week (not in pregnancy)or same medication that was successful in index case
Persistent NSU	*If treated with Doxycycline 1st line:* Azithromycin 500mg PO single dose, then 250mg PO daily for next 4 days **plus** Metronidazole 400mg PO BD for 5 days *If treated with Azithromycin first line:* Doxycycline 100mg PO BD for 7 days **plus** Metronidazole 400mg PO BD for 5 days	Moxifloxacin* 400mg OD 14 days **plus** Metronidazole 400mg PO BD for 5 days *Discuss with consultant first as should only be used in pts at high risk of macrolide resistant MG - potential severe liver reactions.	Refer to CPC if symptoms persist. Ensure that partner is treated with the same antibiotic regime that was successful in the index case. NB. Mycoplasma genitalium causes 10-20% NSU and 40% organisms may be resistant to macrolides.
Mycoplasma genitalium (MG)	No routine testing available in SWLP at present however patients may present as contacts if their partners have been tested elsewhere. *Confirmed contacts should be treated:* Azithromycin 500 mg stat then 250 mg daily for next 4 days		
EPIDIDYMO-ORCHITIS			
	Doxycycline 100mg PO BD for 14 days **Plus** Ceftriaxone 500mg IM single dose **Plus** Azithromycin 1G single dose	Ofloxacin* 200mg PO BD for 2 weeks (*Do not use if GC is suspected due to high rates Quinolone resistance)	Use Ofloxacin if enteric organisms most likely, i.e. >35 years and low risk for STI Treat partners with Azithromycin 1G PO single dose

CONDITION	I[st] line treatment	2[nd] line treatment	Comments
PID			
	Ceftriaxone 500mg IM single dose **Plus** Doxycycline 100mg PO BD for 14 days **Plus** Metronidazole 400mg PO BD for 14 days *(plus Azithromycin 1G single dose if GC positive on microscopy, contact of GC or high risk for GC)* *If GC positive on NAATs take a culture swab and retreat with Ceftriaxone and Azithromycin)*	Discuss with Consultant: Ofloxacin* 400mg PO BD for 14 days **Plus** Metronidazole 400mg PO BD for 14 days OR Moxifloxacin 400mg OD 14 days *Do not prescribe if GC is suspected due to high rates quinolone resistance	Not in pregnancy – discuss treatment options with Consultant. Treat partner with Doxycycline 100mg BD 7 days
TRICHOMONAS			
Uncomplicated	Metronidazole 2G oral single dose	Metronidazole 400mg oral BD 5 days	Metronidazole – antabuse effect during and for 48hrs after treatment - avoid alcohol Treat male partners epidemiologically TOC after 1 week
Relapsing / recurrent	Discuss with Consultant Metronidazole 400mg PO TDS **plus** MTZ suppository 1G PV for 7 days	Tinidazole PO 2G BD 10 days	Consider TV culture for sensitivity to Metronidazole
GENITAL WARTS			
	Treatment depends on morphology, number and distribution: • **Soft / exophytic:** cryotherapy stat plus Warticon cream TTA (**Warticon cream** apply x 2 per day for 3 consecutive days for 4 weeks). Review after 4 weeks if not cleared • **Keratinised / single or few:** As above • **Keratinised / extensive:** Clinic based treatment with cryotherapy and Warticon ream or 5% Imiquimod cream or 25% podophyllin. Review with consultant to optimise treatment.	2[nd] line treatment for both keratinised and non-keratinised warts: **Imiquimod 5% cream** nocte x 3 times (M, W, F) a week. Wash off next morning.	If warts persist after 2 months of treatment, refer to CPC for review. Note: Do not use Podophyllin or Warticon or Imiquimod in pregnancy. All damage latex condoms.

CONDITION	Ist line treatment	2nd line treatment	Comments
BACTERIAL VAGINOSIS			
	Metronidazole 2G PO single dose	Metronidazole 400mg PO BD for 5 days **or** Clindamycin cream 2% PV OD for 7 days **Clindamycin cream damages latex condoms**	**Pregnancy 1st trimester:** Amoxicillin 500mg oral TDS 7 days **or** Metronidazole 400mg PO BD for 5 days **2nd and 3rd trimester:** Metronidazole 2G PO single dose. Refer to CPC if frequent recurrences.
CANDIDA			
Female: uncomplicated	Clotrimazole pessary 500mg PV single dose **or** Ecostatin pessary 150mg PV single dose **plus** Clotrimazole 1% cream **plus** Aqueous cream as a soap substitute	Fluconazole 150mg PO single dose **plus** Clotrimazole 1% cream	Do not use Fluconazole in pregnancy **Pessaries damage latex condoms**
Female: Complicated/recurrent	Clotrimazole pessaries 100mg PV for 6 – 12 days **or** Fluconazole 150mg PO single dose - two doses 72hrs apart **plus** Clotrimazole 1% cream **plus** Aqueous cream as a soap substitute		Refer recurrent or persistent candida to CPC. Request Candida spp. identification & sensitivities in advance.
Male: uncomplicated / balanitis	Clotrimazole 1% cream Or Canesten HC **plus** Aqueous cream as a soap substitute	Fluconazole 150mg PO single dose	Refer to CPC if persistent symptoms Test urine for glucose

CONDITION	I[st] line treatment	2[nd] line treatment	Comments
GENITAL HERPES			
Primary episode	Aciclovir 400mg PO TDS for 5 days OR Aciclovir 200mg PO x 5 per day for 5 days **Plus, if indicated for pain** 2% Lidocaine gel topically and oral analgesia	Valaciclovir 500mg PO BD for 5 days Consider IV treatment in severe cases	Continue treatment until new lesions have ceased to appear **Severe cases may need 10 days of treatment**
Immunosuppressed patients	Aciclovir 800mg PO TDS for 5 – 10 days OR Aciclovir 400mg PO x 5 per day for 5 – 10 days	Consider IV treatment in severe cases	If severe, discuss with Consultant
Recurrent episodes	Not usually necessary to treat unless frequent or severe Advise salt water bathing		If frequent recurrences (>6 – 8 per year) or severe symptoms, refer to CPC for review & consideration of prophylaxis: Aciclovir 400mg twice daily OR valaciclovir 500mg OD
Herpes in pregnancy, 1[st], 2[nd] or 3[rd] trimester Primary / recurrent episode	Treat as for non-pregnant women Aciclovir 400mg PO TDS x 5 days OR 200mg PO x 5 per day for 5 days Prophylactic Aciclovir 400mg PO TDS from 36 weeks gestation until delivery		Aciclovir is not licensed in pregnancy, but there is substantial evidence supporting its safety. **Refer all pregnant women with known or suspected HSV to CPC.**
MOLLUSCUM CONTAGIOSUM			
	In immune-competent patients this is a self- limiting condition so treatment may not be required. If immunosuppressed and/or treatment is required: 5% Warticon cream applied topically on 3 consecutive days each week for maximum of 4 weeks OR gentle single treatment cryotherapy.		Immunosuppressed patients or those with facial lesions to be reviewed by senior clinician

CONDITION	Ist line treatment	2nd line treatment	Comments
SCABIES AND PUBIC LICE			
Scabies	Permethrin 5% cream. (Supply 30 – 60g per adult) *OR* Malathion 0.5% Aqueous lotion (Derbac-M). Supply 100ml (2 bottles) per adult. Apply from head down, leave on at least 12hrs, re-apply to hands after washing, wash bed clothes at 50^{o}C	Repeat treatment may be required one week later	Permethrin cream safe in pregnancy and breastfeeding. All partners and household contacts need treating (including children). Antihistamine or Crotamiton cream to control itch.
Pubic lice	Malathion 0.5% Aqueous lotion (Derbac-M). Apply to damp hair and wash out after 12hrs *OR* Permethrin 1% cream rinse (Lyclear). Apply to dry hair and wash out after 10 minutes. Repeat application after 3 – 7 days Eyelash infestation: smear with Derbac-M or Lyclear whilst keeping eye closed for 10 minutes, then wash off.	Re-treat with different product, in case of failure	Screen and treat all sexual partners
URINARY TRACT INFECTION			
	Cephalexin 500mg TDS for 3 – 5 days Pregnant women need 7 days of treatment. Ideally, treat according to culture & sensitivity on MSU	Treat according to culture and sensitivity Trimethoprim 200mg PO BD for 3 – 5 days	Refer women with recurrent UTIs to CPC Refer all men with a documented UTI to Urology Trimethoprim contraindicated in pregnancy

Appendix 1

Reconstitution of Ceftriaxone 250mg powder in Lignocaine 1%

Ceftriaxone may be administered by deep intramuscular injection into the buttock

For intramuscular injection:
Using two vials of 250mg ceftriaxone powder for solution, dissolve the contents of each 250mg vial in 1ml of 1 % Lidocaine solution, discard immediately if solution is not clear and deposit free. 2ml of the resulting solution provides 500mg ceftriaxone.

Warning

Solutions reconstituted with Lidocaine Hydrochloride BP solution should not be administered intravenously**.**

Reference

Ceftriaxone 250mg Rocephin (Roche) SmPC updated May 2017.
Accessed via https://www.medicines.org.uk/emc/ 08/01/18

Appendix 2

Reconstitution Benzathine penicillin powder with lidocaine (unlicensed)

Reconstitute the vial with 8ml of 1% Lidocaine Hydrochloride BP solution. Split the resultant suspension into two equal volumes.

The suspension should be administered by deep intramuscular injection in two different sites.

Administration:

1. Add solvent to vial and turn the vial gently whilst warming it in your hands

2. Extract the suspension with a needle different from the one you will use for injection

3. To inject, insert an “empty” 0.9 calibre needle into the patient

4. Place the syringe and aspirate to check that no blood comes out.

5. Inject by deep intramuscular injection.

Warning

Solutions reconstituted with Lidocaine Hydrochloride BP solution should not be administered intravenously**.**

Reference

Lentocilin S Benzathine Benzyl Penicillin – Patient information leaflet –revision of text 2012

Appendix 3

Procaine penicillin

Reconstitute two 1.2 mega unit vials with 4ml of 1% lidocaine hydrochloride BP solution each. The required volume should be administered by deep intramuscular injection into two different sites.

Inadvertent intravenous administration of Lidocaine can cause bradycardia (which may lead to cardiac arrest), fitting and/or sedation. Use the “aspiration technique" of injection to minimise the risk of this happening.

Contraindications

- Allergy to penicillin or lidocaine
- Concomitant anticoagulant therapy
- Bleeding diathesis (eg. Haemophilia)

Precautions

- Patients with penicillin allergy, cross reactivity to other beta-lactams such as cephalosporins should be taken into account.

Warning

Solutions reconstituted with Lidocaine Hydrochloride BP solution should not be administered intravenously.

Appendix 4

Spectinomycin

BASHH CEG statement

Spectinomycin has been in short supply for some time in the UK. The main wholesalers of non-licensed medicines in the UK are IDIS and Durbin.

Durbin import it from an EU source (Trobicin® 2g injection - Pfizer).

The information supplied with Trobicin® may not be in English. English translation is available on the BASHH website.

Please seek advice from pharmacy if alternative brand has been supplied.