COMMONWEALTH of VIRGINIA

Department of Health

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Dear Healthcare Provider,

The Virginia Department of Health seeks your assistance in responding to concerning increases in sexually transmitted infections (STIs). From 2020 to 2024, total early syphilis (TES) cases increased 34%. Most TES cases are diagnosed among men (78% in 2024); however, cases among women are on the rise (107% increase from 2020-2024). Cases of congenital syphilis have also increased dramatically in the last decade. Preliminary data from 2025 and additional resources are available on our syphilis webpage. National and international reports also highlight the spread of antibiotic-resistant gonococcal infections.

Please review the following recommendations and prevention tools.

Consider Syphilis in Differential Diagnoses

a) **Stage cases of syphilis.** Consider syphilis for your differential diagnoses, as it can mimic many other conditions. **Ocular, otic, and neurological manifestations** can occur at any stage.

b) **Review the different signs and symptoms of each stage of syphilis**. This includes primary, secondary, latent, and tertiary syphilis. Earlier stages are considered the most infectious**.**

c) **Explore syphilis training opportunities**.

Screen for STIs

a) **Conduct thorough** sexual health histories with patients who are sexually active.

b) **Follow CDC's** screening recommendations. Testing patients for gonorrhea and chlamydia at all sites of exposure (vaginal/urine, anal, oral).

c) **Serologically screen all pregnant women for syphilis.** Screen pregnant women for syphilis at their first prenatal care visit, universally rescreen early in the third trimester (28-32 weeks), and rescreen again at delivery, regardless of risk (see updated recommendations from the American College of Obstetricians and Gynecologists).

d) **Screen for syphilis in all sexually active patients aged 15-44 living in a county with high incidence of syphilis.** For all other counties, assess risk factors to recommend testing. Test all symptomatic patients for syphilis, regardless of risk factors or where they live.

e) **Order both treponemal and nontreponemal serologic tests for accurate syphilis diagnosis** (e.g., reflex RPR and TPPA, or EIA reflex to RPR reflex to TPPA). Ordering only one test may delay identification and treatment of an active infection.

f) **Offer more frequent STI screenings** for patients who report having multiple sex partners, sex with anonymous partners, or sex under the influence of drugs or alcohol.

Treat STIs Promptly

a) **Follow CDC STI treatment guidelines**.

b) **Consider the use of expedited partner therapy** (EPT) for partners of patients diagnosed with gonorrhea and chlamydia who may not otherwise receive treatment.

c) **Contact your local health department if you have difficulty obtaining appropriate treatment for your patients** such as penicillin G benzathine (Bicillin L-A®) to treat syphilis. For pregnant patients in this situation Bicillin L-A is available through the VDH bicillin delivery program.

d) **Contact a Disease Intervention Specialist at a local health department to assist with syphilis staging, partner notification, and linkage to care**.

e) **Report suspected gonorrhea treatment failures to your local health department**. Obtain cultures to test for decreased antibiotic susceptibility from any patients with suspected gonorrhea treatment failure (see CDC information on antibiotic resistant gonorrhea and the VDH resistant gonorrhea fact sheet).

f) **Report confirmed or clinically suspected cases of disseminated gonococcal infection (DGI) to your local health department**.

Offer Doxycycline Post-Exposure Prophylaxis (DoxyPEP) for Bacterial STIs

a) **Doxycycline 200 mg within 24–72 hours of condomless sex** is proven to reduce significantly reduce syphilis, chlamydia, and gonorrhea among men who have sex with men and transgender women.

b) **Review VDH's patient factsheet (Español) and provider factsheet for DoxyPEP**.

c) **Review CDC guidance for DoxyPEP**.

Provide Comprehensive Sexual Health Services

a) **Counsel all HIV-negative patients on HIV Pre-Exposure Prophylaxis (PrEP)**, including daily oral PrEP and long-acting injectable PrEP.

b) **Evaluate patients for HIV Post-Exposure Prophylaxis (PEP)**.

c) **Ensure all people living with HIV are in care and aware of HIV treatment as prevention**. Maintaining a consistent, undetectable HIV viral load for at least six months ends the risk of transmitting HIV to sexual partners during sex.

d) **Recommend vaccines which protect against STIs and associated infections** according to local eligibility and Advisory Committee on Immunization Practices (ACIP) Guidance:
    i. Mpox vaccine (Jynneos)
    ii. Meningococcal vaccine (MenACWY)
    iii. Hepatitis A/Hepatitis B vaccines
    iv. Human papillomavirus (HPV) vaccine
e) **Refer individuals with substance use disorders to comprehensive harm reduction services**.

Please visit www.vdh.virginia.gov/disease-prevention/hcw/ or scan the QR code below for an electronic version of this letter to access the embedded links and electronic resources.

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STI Reporting Requirements for Physicians

This resource is intended for physicians who treat or examine any person who has or is suspected of having a reportable sexually transmitted infection (STI).

NOTE: Per Virginia's Regulations for Disease Reporting and Control https://law.lis.virginia.gov/admincodefull/title12/agency5/chapter90/, each physician who treats or examines any person who has or is suspected of having a reportable disease or condition is required to report. Directors of laboratories are also required reporters and must report any laboratory examination of any clinical specimen which yields evidence of a reportable disease or condition. ***Therefore, reporting by both laboratories and physicians* is required in cases where laboratory exams yield evidence of an STI.***

STIs Required to be Reported

Report Immediately	Report Within 3 Days
Suspected and confirmed cases of: • Congenital syphilis (*Treponema pallidum*) • Primary syphilis (*Treponema pallidum*) • Secondary syphilis (*Treponema pallidum*)	Suspected and confirmed cases of: • Chancroid *(Haemophilus ducreyi)* • *Chlamydia trachomatis* infection, including lymphogranuloma venereum • Gonorrhea *(Neisseria gonorrhoeae)* • Granuloma inguinale *(Calymmatobacterium granulomatis)* • All other stages of syphilis (*Treponema pallidum*)

Data Required to be Reported

The following data are required to be reported by you or your designee:

- The name of the suspected or confirmed disease, date of illness onset, and available lab tests and results
- Patient name, address, age, date of birth, race, sex, and pregnancy status (for females)
- Name, address, and phone number of the physician and medical facility where examination was made

Reporting of treatment and ethnicity category (Hispanic/not Hispanic) are also encouraged, but not required. Treatment should be reported with medication name, dose, route, frequency, and date treatment was administered or prescribed.

Reporting STIs

Reports should be submitted to your local health department through one of the following methods:

- Electronic Confidential Morbidity Report Portal (Form Epi-1)
  - The portal and a guide on how to use the portal can be found on the VDH Disease Reporting and Control Regulations webpage: https://www.vdh.virginia.gov/clinicians/disease-reporting-and-control-regulations/
- Paper Confidential Morbidity Report (Form Epi-1)
  - A copy of this form can also be found on the VDH Disease Reporting and Control Regulations webpage
- Computer-generated printout
- Telephone to local health department (*only* for immediately reportable conditions)

Additional Resources

Complete information on disease reporting can be found on the VDH Disease Reporting and Control Regulations webpage.

**Reporting requirements are not limited to laboratories and physicians. Other health care providers should reference the Regulations for Disease Reporting and Control for requirements related to their position/facility.*

VIRGINIA REPORTABLE DISEASE LIST

Reporting of the following diseases is required by state law (Sections 32.1-36 and 32.1-37 of the Code of Virginia and 12 VAC 5-90-80 of the Board of Health Regulations for Disease Reporting and Control). Report all conditions when suspected or confirmed to your local health department (LHD). Reports may be submitted by Confidential Morbidity Report Portal (Epi-1 form), computer-generated printout, CDC or VDH surveillance form, or upon agreement with VDH, by means of secure electronic submission.

REPORT IMMEDIATELY

- Anthrax *(Bacillus anthracis)*
- Botulism *(Clostridium botulinum)*
- Brucellosis *(Brucella* spp.)
- Cholera *(Vibrio cholerae* O1/O139)
- Coronavirus infection, severe (e.g., SARS-CoV, MERS-CoV)
- Diphtheria *(Corynebacterium diphtheriae)*
- Disease caused by an agent that may have been used as a weapon
- *Haemophilus influenzae* infection, invasive
- Hepatitis A
- Influenza-associated deaths if younger than 18 years of age
- Influenza A, novel virus
- Measles (Rubeola)
- Meningococcal disease *(Neisseria meningitidis)*
- Orthopoxviruses (e.g., Monkeypox virus, Variola virus/Smallpox, Vaccinia disease or adverse event)
- Outbreaks, all (including foodborne, healthcare-associated, occupational, toxic substance-related, waterborne, and any other outbreak)
- Pertussis/Whooping cough *(Bordetella pertussis)*
- Plague *(Yersinia pestis)*
- Poliovirus infection, including poliomyelitis
- Psittacosis *(Chlamydophila psittaci)*
- Q fever *(Coxiella burnetti)*
- Rabies, human and animal
- Rubella, including congenital rubella syndrome
- Syphilis *(Treponema pallidum)*, congenital, primary, and secondary
- Tuberculosis, active disease (*Mycobacterium tuberculosis* complex) [a]
- Tularemia *(Francisella tularensis)*
- Typhoid/Paratyphoid infection (*Salmonella* Typhi, *Salmonella* Paratyphi (all types))
- Unusual occurrence of disease of public health concern
- Vibriosis (*Vibrio* spp.) [b]
- Viral hemorrhagic fever
- Yellow fever

LEGEND

- Reportable by directors of laboratories. Additional condition-specific requirements for directors of laboratories available here. These and all other conditions listed must be reported by physicians and directors of medical care facilities.
- Laboratories must submit the initial isolate (preferred) within five days or the clinical specimen within two days of a positive result. All specimens must be identified with patient and physician information, and the LHD must be notified within the specified reporting timeframe.
- Include available antimicrobial susceptibility findings in report.

a Laboratories report acid-fast bacilli, *M. tuberculosis* complex or any other mycobacteria, and antimicrobial susceptibility for *M. tuberculosis* complex.
b Includes reporting of *Photobacterium damselae* and *Grimontia hollisae*.
c Includes submission of *Candida haemulonii* specimens to DCLS.
d By culture, antigen detection by direct fluorescent antibody (DFA), or nucleic acid detection. Influenza rapid antigen tests are not reportable.
e Laboratories that use enzyme immunoassay (EIA) without a positive culture should forward positive stool specimens or enrichment broth to DCLS.

REPORT WITHIN 3 DAYS

- Alpha-gal Syndrome (AGS)
- Amebiasis *(Entamoeba histolytica)*
- Arboviral infections (e.g., CHIK, dengue, EEE, LAC, SLE, WNV, Zika)
- Babesiosis *(Babesia* spp.)
- Campylobacteriosis *(Campylobacter* spp.)
- *Candida auris*, infection or colonization [c]
- Carbapenemase-producing organism, infection or colonization
- Chancroid *(Haemophilus ducreyi)*
- Chickenpox (Varicella virus)
- *Chlamydia trachomatis* infection
- Coronavirus disease 2019 (COVID-19 or SARS-CoV-2)
- Cryptosporidiosis *(Cryptosporidium* spp.)
- Cyclosporiasis *(Cyclospora* spp.)
- Ehrlichiosis/Anaplasmosis *(Ehrlichia* spp., *Anaplasma phagocytophilum)*
- Giardiasis *(Giardia* spp.)
- Gonorrhea *(Neisseria gonorrhoeae)*
- Granuloma inguinale *(Calymmatobacterium granulomatis)*
- Hantavirus pulmonary syndrome
- Hemolytic uremic syndrome (HUS)
- Hepatitis B (acute and chronic)
- Hepatitis C (acute and chronic)
- Hepatitis, other acute viral
- Human immunodeficiency virus (HIV) infection
- Influenza, laboratory-confirmed [d]
- Lead, reportable blood levels
- Legionellosis *(Legionella* spp.)
- Leprosy/Hansen's disease *(Mycobacterium leprae)*
- Leptospirosis *(Leptospira interrogans)*
- Listeriosis *(Listeria monocytogenes)*
- Lyme disease *(Borrelia* spp.)
- Lymphogranuloma venereum *(Chlamydia trachomatis)*
- Malaria *(Plasmodium* spp.)
- Mumps
- Neonatal abstinence syndrome (NAS)
- Ophthalmia neonatorum
- Rabies treatment, post-exposure
- Salmonellosis *(Salmonella* spp.)
- Shiga toxin-producing *Escherichia coli* infection [e]
- Shigellosis *(Shigella* spp.)
- Spotted fever rickettsiosis *(Rickettsia* spp.)
- Streptococcal disease, Group A, invasive or toxic shock
- *Streptococcus pneumoniae* infection, invasive if <5 years of age
- Syphilis *(Treponema pallidum)*, if not primary, secondary, or congenital
- Tetanus *(Clostridium tetani)*
- Toxic substance-related illness
- Trichinosis (Trichinellosis) *(Trichinella spiralis)*
- Tuberculosis infection
- Vancomycin-intermediate or vancomycin-resistant *Staphylococcus aureus* infection
- Yersiniosis *(Yersinia* spp.)

ALL REPORTS ARE CONFIDENTIAL AND SHOULD INCLUDE -

1. *the disease or condition diagnosed or suspected*
2. *patient's name, date of birth, age, sex, race/ethnicity, pregnancy status, address, and telephone number*
3. *physician's name, address, and telephone number*
4. *method of diagnosis, if available*

VDH VIRGINIA DEPARTMENT OF HEALTH

Bicillin L-A™ Available to Order

VDH has purchased a supply of Bicillin L-A™ to be made available to providers of pregnant patients with an identified syphilis infection. VDH pharmacy will dispense the medication and ship it directly to the provider.

Despite statewide efforts to combat the significant increase in cases of syphilis described in the July 2024 letter (https://www.vdh.virginia.gov/clinicians/syphilis-treatment-and-clinical-manifestations-updates-for-providers/), Virginia is on pace to exceed the number of congenital syphilis cases recorded in 2023. In an effort to avert cases of congenital syphilis, VDH has purchased a supply of Bicillin L-A™ to be made available to providers of pregnant patients with an identified syphilis infection.

If you are a provider who does not have access to Bicillin L-A™, or continue to experience a lack of Bicillin L-A™ resulting from the shortage which ended earlier this year, you can request VDH Bicillin L-A™ by accessing the VDH website, scanning the QR code below or by pasting this link into your web browser: https://redcap.link/vdhbic. VDH Pharmacy will dispense the medication and ship it directly to the provider for administration.

Order Bicillin L-A™ Now

Questions about requesting VDH Bicillin L-A™ can be directed to pharmacy@vdh.virginia.gov. Thank you for your continued partnership in STI prevention.

Syphilis Screening Recommendations in Virginia

VDH has released a list of cities and counties where providers should screen all sexually active people between the ages of 15-44 for syphilis.

Find this resource and others on the VDH syphilis resource page for healthcare providers:

vdh.virginia.gov/syphilis/healthcare-providers

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STI Screening Recommendations

This document has been adapted from *Screening Recommendations and Considerations Referenced in Treatment Guidelines and Original Sources*, U.S. Centers for Disease Control and Prevention.

Contents

1····· Chlamydia, Gonorrhea, Syphilis, and HIV

3····· Herpes, Trichomonas, HPV, Cervical Cancer, Anal Cancer, Hepatitis B, Hepatitis C

5····· References

Population	Chlamydia	Gonorrhea	Syphilis	HIV
Women	• Sexually active women under 25 years of age. [1] • Sexually active women aged 25 years and older if at increased risk. [1] • Retest approx. 3 months after treatment. (2) • Rectal chlamydial testing can be considered based on reported sexual behaviors and exposure. [3], [4]	• Sexually active women under 25 years of age. [1] • Sexually active women aged 25 years and older if at increased risk. [1] • Retest 3 months after treatment. (2) • Pharyngeal and rectal gonorrhea screening can be considered in females based on reported sexual behaviors and exposure. [3], [4]	• Screen asymptomatic sexually active women ages 15-44 living in counties with high incidence of syphilis. [5] • Screen persons at increased risk regardless of where they live (multiple partners, history of incarceration or commercial sex work, substance use). [2], [6]	• All women aged 13-64 years (opt-out). [7], [8] • All women who seek evaluation and treatment for STIs. [2], [8]
Pregnant Women	• All pregnant women under 25 years of age. [1] • Pregnant women aged 25 and older if at increased risk (new or multiple sex partners, sex partner with concurrent partners, sex partner with an STI). [1] • Retest during the third trimester for women under 25 years of age or at risk. [2] • Pregnant women with chlamydial infection should have a test-of-cure 4 weeks after treatment and be retested within 3 months. [2]	• All pregnant women under 25 years of age and older women if at increased risk. [1] • Retest during the 3rd trimester for women under 25 years of age or at risk. [2] • Pregnant women with gonorrhea should be retested within three months. [2]	• All pregnant women at the first prenatal visit, at 28 weeks gestation and at delivery regardless of risk. [9]	• All pregnant women at first prenatal visit (opt-out). [8] • Retest in third trimester if at high risk (using drugs, STIs during pregnancy, multiple or new sexual partners during pregnancy, live in areas with high HIV prevalence, has partners living with HIV). [10] • Perform rapid testing at delivery if not previously screened during pregnancy. [8]

Population	Chlamydia	Gonorrhea	Syphilis	HIV
Men Who Have Sex with Women	• Consider screening young men in high prevalence clinical settings (adolescent clinics, correctional facilities, STI clinic). [1], [11]	• Consider screening young men in high prevalence clinical settings (adolescent clinics, correctional facilities, STI clinic). [1], [11]	• Screen asymptomatic sexually active men ages 15-44 living in counties with high incidence of syphilis. (5) • Screen persons at increased risk regardless of where they live (history of incarceration or commercial sex work, race/ethnicity, and being a male younger than 29 years). [2], [6]	• All men aged 13-64 years (opt-out). [7] • All men who seek evaluation and treatment for STIs. [2]
Men Who Have Sex with Men (MSM)	• At least annually for sexually active MSM at sites of contact (urethra, rectum, pharynx) regardless of condom use. [2] • Every 3-6 months if at increased risk. [2]	• At least annually for sexually active MSM at sites of contact (urethra, rectum, pharynx) regardless of condom use. [2] • Every 3-6 months if at increased risk. [2]	• At least annually for sexually active MSM. [2] • Every 3-6 months if at increased risk. [2]	• At least annually for sexually active MSM if HIV status is unknown or negative and the patient himself or his sex partners have had more than one sex partner since the most recent HIV test. [2], [8], [12]
Transgender and Gender Diverse Persons	• Screening recommendations should be adapted based on anatomy, i.e. annual, routine screening for chlamydia in cisgender women <25 years old should be extended to all transgender men and gender diverse people with a cervix. [2] • Consider screening at the rectal site based on reported sexual behaviors and exposure. [2]	• Screening recommendations should be adapted based on anatomy, i.e. annual, routine screening for chlamydia in cisgender women <25 years old should be extended to all transgender men and gender diverse people with a cervix. [2] • Consider screening at the pharyngeal and rectal site based on reported sexual behaviors and exposure. [2]	• Consider screening at least annually based on reported sexual behaviors and exposure. [2]	• HIV screening should be discussed and offered to all transgender and gender diverse persons. Frequency of repeat screenings should be based on level of risk. [2], [12]
Persons with HIV	• For sexually active individuals, screen at first HIV evaluation, and at least annually thereafter. [2], [13] • More frequent screening depending on individual risk behaviors and local epidemiology. [2]	• For sexually active individuals, screen at first HIV evaluation, and at least annually thereafter. [2], [13] • More frequent screening depending on risk and local epidemiology. [2]	• For sexually active individuals, screen at first HIV evaluation, and at least annually thereafter. [14], [15] • More frequent screening depending on risk and local epidemiology. [2]	• Test appropriately according to established recommendations for managing HIV infection. (16)

STI Screening Recommendations

This document has been adapted from *Screening Recommendations and Considerations Referenced in Treatment Guidelines and Original Sources*, U.S. Centers for Disease Control and Prevention. See pages 5-6 for a list of references.

Population	Herpes	Trichomonas	HPV*, Cervical Cancer, Anal Cancer	Hepatitis B (HBV)	Hepatitis C (HCV)
Women	• Type-specific HSV serologic testing can be considered for women presenting for an STI evaluation (especially for women with multiple sex partners). [2], [15]	• Consider screening for women receiving care in high-prevalence settings (e.g., STI clinics and correctional facilities) and for asymptomatic women at high risk for infection (e.g., women with multiple sex partners, transactional sex, drug misuse, or a history of STI or incarceration). [2]	• Women 21-29 years of age every 3 years with cytology. [16], [17], [18] • Women 30-65 years of age every 3 years with cytology, or every 5 years with a combination of cytology and HPV testing. [16], [17], [18]	• Women at increased risk (having had more than one sex partner in the previous 6 months, evaluation or treatment for an STI, past or current injection-drug use, and an HBsAg-positive sex partner). [19]	• All adults over age 18 years should be screened for hepatitis C except in settings where the HCV infection (HCV positivity) is < 0.1%. [20]
Pregnant Women	• Evidence does not support routine HSV-2 serologic screening among asymptomatic pregnant women. However, type-specific serologic tests might be useful for identifying pregnant women at risk for HSV infection and guiding counseling regarding the risk for acquiring genital herpes during pregnancy. [2]	• No current screening recommendations.	• Pregnant Women should be screened at same intervals as nonpregnant cis-gender women. [16], [17], [18]	• Test for HBsAg at first prenatal visit of each pregnancy regardless of prior testing; retest at delivery if at high risk. [21]	• Pregnant women should be screened for hepatitis C except in settings where the HCV infection (HCV positivity) is < 0.1%. [20]
Men	• Type-specific HSV serologic testing can be considered for men presenting for an STI evaluation (especially for men with multiple sex partners). [2], [15]	• No current screening recommendations.	• No current screening recommendations.	• Men at increased risk. [19]	• All adults over age 18 years should be screened for hepatitis C except in settings where the HCV infection (HCV positivity) is < 0.1%. [20]

*Human Papillomavirus

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Population	Herpes	Trichomonas	HPV*, Cervical Cancer, Anal Cancer	Hepatitis B (HBV)	Hepatitis C (HCV)
Men Who Have Sex with Men (MSM)	• Type-specific serologic tests can be considered if infection status is unknown in MSM with previously undiagnosed genital tract infection. [2], [15]	• No current screening recommendations	• Digital anorectal exam. • Data is insufficient to recommend routine anal cancer screening with anal cytology. [2], [22]	• All MSM should be tested for HBsAg, HBV core antibody, and HBV surface antibody. [19]	• All adults over age 18 years should be screened for hepatitis C except in settings where the HCV infection (HCV positivity) is < 0.1%. [20]
Transgender and Gender Diverse Persons	• No current screening recommendations.	• No current screening recommendations.	• Screening for people with a cervix should follow current screening guidelines for cervical cancer. [2]	• No current screening recommendations.	• No current screening recommendations.
Persons with HIV	• Type-specific HSV serologic testing should be considered for persons presenting for an STI evaluation (especially for those persons with multiple sex partners), persons with HIV infection, and MSM at increased risk for HIV acquisition. [2]	• Recommended for sexually active women at entry to care and at least annually thereafter. (2), (14)	• Women with HIV should be screened within 1 year of sexual activity using conventional or liquid-based cytology; testing should be repeated 6 months later. With 3 normal and consecutive Pap tests, screening should be every 3 years. [22], [23]	• Test for HBsAg and anti-HBc and/or anti-HBs. [19]	• Serologic testing at initial evaluation. [2], [20] • Annual HCV testing in MSM with HIV infection. [2], [20]

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Summary of CDC STI Treatment Guidelines, 2021

This wall chart reflects recommended regimens found in CDC's Sexually Transmitted Infections Treatment Guidelines, 2021. This summary is intended as a source of clinical guidance. When more than one therapeutic regimen is recommended, the sequence is in alphabetical order unless the choices for therapy are prioritized based on efficacy, cost, or convenience. The recommended regimens should be used primarily; alternative regimens can be considered in instances of substantial drug allergy or other contraindications. An important component of STI treatment is partner management. Providers can arrange for the evaluation and treatment of sex partners either directly or with assistance from state and local health departments. Complete guidelines can be found online at www.cdc.gov/std/treatment.

DISEASE	RECOMMENDED REGIMEN	ALTERNATIVE REGIMEN
Bacterial Vaginosis	metronidazole 500 mg orally 2x/day for 7 days **OR** metronidazole gel 0.75%, one 5 gm applicator intravaginally, 1x/day for 5 days **OR** clindamycin cream 2%, one 5 gm applicator intravaginally, at bedtime for 7 days	clindamycin 300 mg orally 2x/day for 7 days **OR** clindamycin ovules 100 mg intravaginally at bedtime for 3 days[1] **OR** secnidazole 2 gm orally in a single dose[2] **OR** tinidazole 2 gm orally 1x/day for 2 days **OR** tinidazole 1 gm orally 1x/day for 5 days
Cervicitis[3]	doxycycline 100 mg orally 2x/day for 7 days	azithromycin 1 gm orally in a single dose
Chlamydial Infections		
Adults and adolescents	doxycycline 100 mg orally 2x/day for 7 days	azithromycin 1 gm orally in a single dose **OR** levofloxacin 500 mg orally 1x/day for 7 days
Pregnancy	azithromycin 1 gm orally in a single dose	amoxicillin 500 mg orally 3x/day for 7 days
Infant and children <45 kg[4] (nasopharynx, urogenital, and rectal)	erythromycin base, 50 mg/kg body weight/day orally, divided into 4 doses daily for 14 days **OR** ethylsuccinate, 50 mg/kg body weight/day orally, divided into 4 doses daily for 14 days	
Children who weigh ≥45 kg, but who are aged <8 years (nasopharynx, urogenital, and rectal)	azithromycin 1 gm orally in a single dose	
Children aged ≥8 years (nasopharynx, urogenital, and rectal)	azithromycin 1 gm orally in a single dose **OR** doxycycline 100 mg orally 2x/day for 7 days	
Neonates:[5] ophthalmia and pneumonia	erythromycin base, 50 mg/kg body weight/day orally, divided into 4 doses daily for 14 days **OR** ethylsuccinate, 50 mg/kg body weight/day orally, divided into 4 doses daily for 14 days	azithromycin suspension 20 mg/kg body weight/day orally, 1x/day for 3 days
Epididymitis		
For acute epididymitis most likely caused by sexually transmitted chlamydia and gonorrhea	ceftriaxone 500 mg IM in a single dose[6] **PLUS** doxycycline 100 mg orally 2x/day for 10 days	
For 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[6] **PLUS** levofloxacin 500 mg orally 1x/day for 10 days	
For acute epididymitis most likely caused by enteric organisms only	levofloxacin 500 mg orally 1x/day for 10 days	
Genital Herpes Simplex		
First clinical episode of genital herpes[7]	acyclovir 400 mg orally 3x/day for 7–10 days[8] **OR** famciclovir 250 mg orally 3x/day for 7–10 days **OR** valacyclovir 1 gm orally 2x/day for 7–10 days	
Suppressive therapy for recurrent genital herpes (HSV-2)	acyclovir 400 mg orally 2x/day **OR** valacyclovir 500 mg orally 1x/day[9] **OR** valacyclovir 1 gm orally 1x/day **OR** famciclovir 250 mg orally 2x/day	
Episodic therapy for recurrent genital herpes (HSV-2)[10]	acyclovir 800 mg orally 2x/day for 5 days **OR** acyclovir 800 mg orally 3x/day for 2 days **OR** famciclovir 1 gm orally 2x/day for 1 day **OR** famciclovir 500 mg once, **FOLLOWED BY** 250 mg 2x/day for 2 days **OR** famciclovir 125 mg 2x/day for 5 days **OR** valacyclovir 500 mg orally 2x/day for 3 days **OR** valacyclovir 1 gm orally 1x/day for 5 days	
Daily suppressive therapy for persons with HIV infection	acyclovir 400-800 mg orally 2x–3x/day **OR** famciclovir 500 mg orally 2x/day **OR** valacyclovir 500 mg orally 2x/day	
Episodic therapy for persons with HIV infection	acyclovir 400 mg orally 3x/day for 5–10 days **OR** famciclovir 500 mg orally 2x/day for 5–10 days **OR** valacyclovir 1 gm orally 2x/day for 5–10 days	
Daily suppressive therapy of recurrent genital herpes in pregnant women[11]	acyclovir 400 mg orally 3x/day **OR** valacyclovir 500 mg orally 2x/day	
Genital Warts (Human Papillomavirus)		
External anogenital warts[12]	**Patient-applied** imiquimod 3.75% or 5% cream[13] **OR** podofilox 0.5% solution or gel **OR** sinecatechins 15% ointment[13] **Provider–administered** cryotherapy with liquid nitrogen or cryoprobe **OR** surgical removal either by tangential scissor excision, tangential shave excision, curettage, laser, or electrosurgery **OR** trichloroacetic acid (TCA) or bichloroacetic acid (BCA) 80%–90% solution	
Urethral meatus warts	cryotherapy with liquid nitrogen **OR** surgical removal	
Vaginal warts,[14] Cervical warts,[15] Intra-anal warts[16]	cryotherapy with liquid nitrogen **OR** surgical removal **OR** TCA or BCA 80%–90% solution	
Gonococcal Infections		
Uncomplicated infections of the cervix, urethra, and rectum: adults and adolescents <150 kg[6]	ceftriaxone 500 mg IM in a single dose[17]	If cephalosporin allergy: gentamicin 240 mg IM in a single dose **PLUS** azithromycin 2 gm orally in a single dose If ceftriaxone administration is not available or not feasible: cefixime 800 mg orally in a single dose[17]
Uncomplicated infection of the pharynx: adults and adolescents <150 kg[6]	ceftriaxone 500 mg IM in a single dose[17]	
Pregnancy	ceftriaxone 500 mg IM in a single dose[17]	
Conjunctivitis	ceftriaxone 1 gm IM in a single dose[18]	
Disseminated gonococcal infections (DGI)[19]	ceftriaxone 1 gm IM or by IV every 24 hours[17]	cefotaxime 1 gm by IV every 8 hours **OR** ceftizoxime 1 gm every 8 hours
Uncomplicated gonococcal vulvovaginitis, cervicitis, urethritis, pharyngitis, or proctitis: infants and children ≤45 kg	ceftriaxone 25–50 mg/kg body weight by IV or IM in a single dose, not to exceed 250 mg IM	
Uncomplicated gonococcal vulvovaginitis, cervicitis, urethritis, pharyngitis, or proctitis: children >45 kg	Treat with the regimen recommended for adults (see above)	
Ocular prophylaxis in neonates	erythromycin (0.5%) ophthalmic ointment in each eye in a single application at birth	
Ophthalmia in neonates and infants	ceftriaxone 25–50 mg/kg body weight by IV or IM in a single dose, not to exceed 250 mg	For neonates unable to receive ceftriaxone due to simultaneous administration of intravenous calcium: cefotaxime 100 mg/kg body weight by IV or IM as a single dose

DISEASE	RECOMMENDED REGIMEN	ALTERNATIVE REGIMEN
Lymphogranuloma Venereum	doxycycline 100 mg orally 2x/day for 21 days	azithromycin 1 gm orally 1x/week for 3 weeks [20] **OR** erythromycin base 500 mg orally 4x/day for 21 days
Nongonococcal Urethritis (NGU)	doxycycline 100 mg orally 2x/day for 7 days	azithromycin 1 gm orally in a single dose **OR** azithromycin 500 mg orally in a single dose, **THEN** 250 mg 1x/day for 4 days
Persistent or Recurrent NGU: test for *Mycoplasma genitalium:*		
If *M. genitalium* resistance testing is unavailable but *M. genitalium* is detected by an FDA-cleared NAAT	doxycycline 100 mg orally 2x/day for 7 days, **FOLLOWED BY** moxifloxacin 400 mg 1x/day for 7 days	For settings without resistance testing and when moxifloxacin cannot be used: doxycycline 100 mg 2x/day for 7 days **PLUS** azithromycin 1 gm on first day **PLUS** azithromycin 500 mg 1x/day for 3 days and a test-of-cure 21 days after completion of therapy
If resistance testing is available, use resistance-guided therapy	**Macrolide sensitive** doxycycline 100 mg orally 2x/day for 7 days, **FOLLOWED BY** azithromycin 1 gm initial dose, **THEN** azithromycin 500 mg 1x/day for 3 additional days (2.5 gm total) **Macrolide resistance** doxycycline 100 mg orally 2x/day for 7 days, **FOLLOWED BY** moxifloxicin 400 mg 1x/day for 7 days	
Test for *Trichomonas vaginalis* in heterosexual men in areas where infection is prevalent	metronidazole 2 gm orally in a single dose **OR** tinidazole 2 gm orally in a single dose	
Pediculosis Pubis	permethrin 1% cream rinse applied to affected areas, wash after 10 minutes **OR** pyrethrin with piperonyl butoxide applied to affected areas, wash after 10 minutes	malathion 0.5% lotion applied to affected areas, wash after 8–12 hours **OR** ivermectin 250 µg/kg body weight repeated in 7–14 days
Pelvic Inflammatory Disease		
Parenteral treatment	ceftriaxone 1 gm by IV every 24 hours **PLUS** doxycycline 100 mg orally or by IV every 12 hours **PLUS** metronidazole 500 mg orally or by IV every 12 hours **OR** cefotetan 2 gm by IV every 12 hours **PLUS** doxycycline 100 mg orally or by IV every 12 hours **OR** cefoxitin 2 gm by IV every 6 hours **PLUS** doxycycline 100 mg orally or by IV every 12 hours	ampicillin-sulbactam 3 gm by IV every 6 hours **PLUS** doxycycline 100 mg orally or by IV every 12 hours **OR** clindamycin 900 mg by IV every 8 hours **PLUS** gentamicin 2 mg/kg body weight by IV or IM **FOLLOWED BY** 1.5 mg/kg body weight every 8 hours. Can substitute with 3–5 mg/kg body weight 1x/day
Intramuscular or oral treatment	ceftriaxone 500 mg IM in a single dose[6] **PLUS** doxycycline 100 mg orally 2x/day for 14 days **WITH** metronidazole 500 mg orally 2x/day for 14 days **OR** cefoxitin 2 gm IM in a single dose **AND** probenecid 1 gm orally, administered concurrently in a single dose **PLUS** doxycycline 100 mg orally 2x/day for 14 days **WITH** metronidazole 500 mg orally 2x/day for 14 days **OR** Other parenteral third-generation cephalosporin (e.g., ceftizoxime or cefotaxime) **PLUS** doxycycline 100 mg orally 2x/day for 14 days **WITH** metronidazole 500 mg orally 2x/day for 14 days	
The complete list of recommended regimens can be found in Sexually Transmitted Infections Treatment Guidelines, 2021.		
Scabies	permethrin 5% cream applied to all areas of the body (from neck down), wash after 8–14 hours[21] **OR** ivermectin 200ug/kg body weight orally, repeated in 14 days[22] **OR** ivermectin 1% lotion applied to all areas of the body (from neck down), wash after 8–14 hours; repeat treatment in 1 week if symptoms persist	lindane 1% 1 oz of lotion or 30 gm of cream applied thinly to all areas of the body (from neck down), wash after 8 hours[23]
Syphilis[24]		
Primary, secondary, and early latent: adults (including pregnant women and people with HIV infection)	benzathine penicillin G 2.4 million units IM in a single dose	
Late latent adults (including pregnant women and 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	
Neurosyphilis, ocular syphilis, and otosyphilis	aqueous crystalline penicillin G 18–24 million units per day, administered as 3–4 million units by IV every 4 hours or continuous infusion, for 10–14 days	procaine penicillin G 2.4 million units IM 1x/day **PLUS** probenecid 500 mg orally 4x/day, both for 10–14 days
For children or congenital syphilis	See Sexually Transmitted Infections Treatment Guidelines, 2021.	
Trichomoniasis[25]		
Women	metronidazole 500 mg orally 2x/day for 7 days	tinidazole 2 gm orally in a single dose
Men	metronidazole 2 gm orally in a single dose	tinidazole 2 gm orally in a single dose

1. Clindamycin ovules use an oleaginous base that might weaken latex or rubber products (e.g., condoms and diaphragms). Use of such products within 72 hours following treatment with clindamycin ovules is not recommended.
2. Oral granules should be sprinkled onto unsweetened applesauce, yogurt, or pudding before ingestion. A glass of water can be taken after administration to aid in swallowing.
3. Consider concurrent treatment for gonococcal infection if the patient is at risk for gonorrhea or lives in a community where the prevalence of gonorrhea is high (see Gonorrhea section).
4. Data are limited regarding the effectiveness and optimal dose of azithromycin for treating chlamydial infection among infants and children who weigh <45 kg.
5. An association between oral erythromycin and azithromycin and infantile hypertrophic pyloric stenosis (IHPS) has been reported among infants aged <6 weeks. Infants treated with either of these antimicrobials should be followed for IHPS signs and symptoms.
6. For persons weighing ≥150 kg, 1 gm ceftriaxone should be administered.
7. Treatment can be extended if healing is incomplete after 10 days of therapy.
8. Acyclovir 200 mg orally five times/day is also effective but is not recommended because of the frequency of dosing.
9. Valacyclovir 500 mg once a day might be less effective than other valacyclovir or acyclovir dosing regimens for persons who have frequent recurrences (i.e., ≥10 episodes/year).
10. Acyclovir 400 mg orally three times/day is also effective but is not recommended because of frequency of dosing.
11. Treatment recommended starting at 36 weeks' gestation. (Source: *American College of Obstetricians and Gynecologists. Clinical management guidelines for obstetrician-gynecologists. Management of herpes in pregnancy.* ACOG Practice Bulletin No. 82. Obstet Gynecol 2007;109:1489–98.)
12. Persons with external anal or peri-anal warts might also have intra-anal warts. Thus, persons with external anal warts might benefit from an inspection of the anal canal by digital examination, standard anoscopy, or high-resolution anoscopy.
13. Might weaken condoms and vaginal diaphragms.
14. The use of a cryoprobe in the vagina is not recommended because of the risk for vaginal perforation and fistula formation.
15. Management of cervical warts should include consultation with a specialist. For women who have exophytic cervical warts, a biopsy evaluation to exclude high-grade squamous intraepithelial lesion should be performed before treatment is initiated.
16. Management of intra-anal warts should include consultation with a specialist.
17. If chlamydial infection has not been excluded, treat for chlamydia with doxycycline 100 mg orally two times/day for 7 days.
18. Providers should consider one-time lavage of the infected eye with saline solution.
19. When treating for the arthritis-dermatitis syndrome, the provider can switch to an oral agent guided by antimicrobial susceptibility testing (AST) 24–48 hours after substantial clinical improvement, for a total treatment course of >7 days.
20. Because this regimen has not been validated rigorously, a test-of-cure with *Chlamydia trachomatis* nucleic acid amplification test (NAAT) 4 weeks after completion of treatment can be considered.
21. Infants and young children (aged <5 years) should be treated with permethrin.
22. Oral ivermectin has limited ovicidal activity; a second dose is required for cure.
23. Infants and children aged <10 years should not be treated with lindane.
24. The complete list of recommendations on treating syphilis among people with HIV infection and pregnant women, as well as discussion of alternative therapy in people with penicillin allergy, can be found in Sexually Transmitted Infections Treatment Guidelines, 2021.
25. For management of persistent or recurrent infection, refer to Sexually Transmitted Infections Treatment Guidelines, 2021.

Accessible version: https://www.cdc.gov/std/treatment-guidelines/default.htm

Centers for Disease Control and Prevention
National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention

National Network of STD Clinical Prevention Training Centers

CS325034-A

- Clinician DoxyPEP Factsheet -

DoxyPEP for STI Prevention

Background

DoxyPEP refers to the use of doxycycline for post-exposure prophylaxis (PEP) to prevent bacterial sexually transmitted infections (STIs). In June 2024, the Centers for Disease Control and Prevention (CDC) published clinical guidelines for the use of DoxyPEP for STI prevention in the United States. Sustained increases in STI incidence make the use of novel approaches to decrease STIs, especially for disproportionally affected populations, a public health priority in Virginia. DoxyPEP is the first biomedical prevention tool for bacterial STIs that has been shown to be effective and well-tolerated. While it remains an off-label indication, doxycycline is inexpensive and has a history of off-label long-term use for other conditions.

Clinical Recommendations

Conduct a thorough sexual health history with patients who are sexually active. Consider offering DoxyPEP using a shared decision-making model to adult **gay, bisexual, and other men who have sex with men** and **transgender women** who report having any of the following in the past year:

- ✓ a bacterial STI (specifically syphilis, chlamydia, or gonorrhea)
- ✓ condomless anal or oral sex with at least one male or transgender female partner
- ✓ multiple sex partners in the past year
- ✓ sex with anonymous partners or under the influence of drugs or alcohol

Consider prescribing DoxyPEP to adult men and transgender women who ask for it, even if they do not disclose any of the risks noted above. Stigma, distrust, or shame may prevent patients from talking about sex with you.

Note: Current efficacy data only applies to gay/bisexual men and transgender women. Clinical data to support DoxyPEP in other populations (*i.e.*, cisgender women, cisgender heterosexual men, transgender men, other queer and nonbinary people) are limited. Providers should use their clinical judgement and shared decision-making to inform use of DoxyPEP with populations that are not part of CDC recommendations. DoxyPEP should not be used for patients who are pregnant or whose medical history or current medications contraindicate the use of doxycycline.

Discuss: The CDC recommends that providers counsel eligible patients about the benefits and harms of using DoxyPEP. When considering DoxyPEP initiation, discuss the following key points with patients:

Efficacy Data

Researchers from the University of California recently conducted a randomized trial of DoxyPEP for the prevention of syphilis, chlamydia, and gonorrhea. Study participants included cisgender men who have sex with men (MSM) and transgender women who were either taking HIV pre-exposure prophylaxis (PrEP) or living with HIV (PLWH). All had been diagnosed with an STI in the past year. Participants in the intervention arm received a single dose of 200 mg doxycycline administered within 24–72 hours after condomless sex. The trial ended early due to the high efficacy observed, and no significant adverse reactions attributable to doxycycline were noted among trial participants.*

The efficacy of DoxyPEP against other bacterial STIs is not known. DoxyPEP does not prevent HIV, mpox, or other viral infections such as human papillomavirus (HPV) or herpes simplex virus (HSV).

* Source: Luetkemeyer et al. Postexposure Doxycycline to Prevent Bacterial Sexually Transmitted Infections. N Engl J Med 2023 Apr; 388:1296-1306.

- Clinician DoxyPEP Factsheet -

Dosing and Prescribing

- Providers should write the prescription for self-administration of the recommended dose of 200 mg of doxycycline (any formulation) to be taken as soon as possible within 72 hours (ideally within 24 hours) after having condomless oral, anal, or vaginal sex with a maximum dose of 200 mg every 24 hours.
- Either doxycycline hyclate delayed release 200 mg (one tablet) *OR* doxycycline hyclate or monohydrate immediate release 100 mg (two tablets taken at the same time) are acceptable options. Immediate release doxycycline may be less expensive than delayed release and should be equivalently bioavailable.
- Prescribe enough doses (or refills) of doxycycline to last until the next follow-up visit based on the person's anticipated sexual activity. This will increase the likelihood that patients can take a dose within 24 hours of having sex, reduce the number of trips to and potential questions from their local pharmacy, and still allow opportunities for STI screening. Ongoing need for DoxyPEP should be assessed every 3-6 months.
- Use ICD-10 diagnosis code Z20.2 "Contact with and (suspected) exposure to infections with a predominantly sexual mode of transmission." Another option is ICD-10 code Z79.2 "Long term (current) use of antibiotics."

Monitoring

- Monitor how frequently patients take DoxyPEP. For patients taking DoxyPEP for a prolonged period, clinicians may want to consider periodic or annual liver function tests (LFT), renal function tests, and complete blood count (CBC). No severe adverse events were noted in the DoxyPEP study.
- To identify and treat existing or breakthrough infections, patients on DoxyPEP should be screened at initiation and then every 3-6 months for gonorrhea and chlamydia at all anatomic sites of exposure (urogenital/urine, pharyngeal, and rectal), syphilis, and HIV (if not known to be living with HIV).
- Patients who get an STI while using DoxyPEP should be treated according to standard CDC STI Treatment Guidelines.

Counseling Messages

- Counsel patients about possible drug interactions, risk of sun sensitivity, remaining upright for 30 minutes after taking doxycycline to reduce the risk of pill esophagitis, and the (rare) risk of benign intracranial hypertension.
- Encourage patients to take doxycycline with a glass of water; take with food if gastric upset occurs. Avoid taking with antacids or dairy products. Gastrointestinal side effects were commonly reported in clinical trials of DoxyPEP.
- The impacts of long-term use of DoxyPEP for STI prevention are unknown, but doxycycline has been previously used safely for long-term prophylaxis of malaria and treatment for acne.
- The long-term impact of DoxyPEP on the gut microbiome and on antibiotic resistance at the individual and population level remains unknown. Some studies have associated changes in the gut microbiome with chronic illnesses such as diabetes and inflammatory bowel disease. The extent and clinical significance of any microbiome changes attributable to DoxyPEP requires more study.

Provide Comprehensive Sexual Health Services

- Counsel all HIV-negative patients on their HIV PrEP options, including daily oral PrEP and long-acting injectable PrEP (cabotegravir).
- Ensure PLWH are in care and inform patients that U=U (undetectable = untransmissible); maintaining a consistent, undetectable HIV viral load for at least six months prevents transmission of HIV to sexual partners during sex.
- Recommend and offer the following vaccines, which protect against sexually transmitted or sexually associated infections, based on local eligibility and ACIP Guidance: Mpox vaccine (Jynneos), meningococcal vaccine (MenACWY), Hepatitis A / Hepatitis B vaccines, and human papillomavirus (HPV) vaccine.
- Individuals who also have a substance use disorder should be referred to comprehensive harm reduction services.

Additional Resources

Centers for Disease Control and Prevention: Doxy PEP for Bacterial STI Prevention

Virginia Department of Health: Updates and Clinical Resources for Health Professionals

National Coalition of STD Directors: Doxycycline as STI PEP Implementation Toolkit

Centers for Disease Control and Prevention: PrEP for the Prevention of HIV Guidelines

- Quick Facts for Patients -

DoxyPEP for STI Prevention

What is DoxyPEP?

Doxycycline Post-Exposure Prophylaxis (DoxyPEP) means taking the antibiotic doxycycline after sex to prevent getting a sexually transmitted infection (STI). Recent studies have shown that taking DoxyPEP can reduce your chance of getting syphilis and chlamydia by about three-quarters (74-88%), and gonorrhea by about half (55-57%).

Who should take DoxyPEP?

DoxyPEP might be for you if you are an **adult man or transgender woman and have sex with men**. Talk to your doctor about DoxyPEP if you are living with HIV or are taking HIV pre-exposure prophylaxis (PrEP) and/or have had a bacterial STI in the past year (syphilis, chlamydia, gonorrhea).

There is not yet enough data to recommend DoxyPEP to other groups of people. However, you should discuss your individual situation with your doctor. People who have condomless sex, sex with multiple partners, sex with anonymous partners, or a recent bacterial STI may benefit from DoxyPEP. People who are already pregnant or may become pregnant should not take DoxyPEP.

When should I take DoxyPEP?

Take 200 mg (two 100 mg pills) of doxycycline within 24 hours (for greatest effect) but no later than 72 hours after condomless sex. Condomless sex means oral, anal, vaginal, or front-hole sex when a condom is not used for the entire time.

If you have sex again within 24 hours of taking doxycycline, you can take another dose 24 hours after your last dose. You can take doxycycline as often as once every day. However, do not take more than 200 mg (two 100 mg pills) per day.

How should I take DoxyPEP?

- ✓ Take doxycycline with a full glass of water or something else to drink so that it does not get stuck when you swallow. If your stomach is upset by doxycycline, taking it with food may help.
- ✓ Avoid dairy products (milk, cheese, etc.), calcium, antacids, or vitamins for 2 hours before and 2 hours after taking doxycycline.
- ✓ Some people are more sensitive to the sun when they take doxycycline, so wear sunscreen.
- ✓ Please do not share doxycycline with others.

What are we still learning about DoxyPEP?

- ○ When a drug is used to treat an infection, the bacteria can change over time, making the drug less effective. This is called resistance. We do not know if DoxyPEP could increase resistance.
- ○ Doxycycline use is very common. Neither chlamydia nor syphilis has shown resistance to doxycycline; however, about 25% of gonorrhea in the U.S. is already resistant to doxycycline.
- ○ We need more studies of DoxyPEP among other groups of people, including women.

What else should I know?

- ☑ You will still need to get tested for STIs every 3 months and whenever you have symptoms.
- ☑ DoxyPEP does not protect against viral infections such as HIV, Mpox (monkeypox), HPV, or herpes.
- ☑ If you have HIV, continue to take your HIV medications and see your doctor regularly.
- ☑ If you are HIV-negative, talk to your doctor about PrEP and/or post-exposure prophylaxis to prevent HIV.

VDH VIRGINIA DEPARTMENT OF HEALTH

Division of Disease Prevention
www.vdh.virginia.gov/disease-prevention/
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- información breve para pacientes -

DoxyPEP para la Prevención de ITS

¿Qué es la DoxyPEP?

La profilaxis (tratamiento preventivo) con doxiciclina conocido como DoxyPEP se refiere a tomarse el antibiótico doxiciclina después de tener relaciones sexuales para evitar el contagio de una infección de transmisión sexual (ITS). Estudios recientes han demostrado que tomar DoxyPEP puede reducir las probabilidades de contraer sífilis y clamidia en aproximadamente tres cuartas partes (entre el 74 % al 88 %), y la gonorrea en aproximadamente la mitad (entre el 55 % al 57 %).

¿Quién debe tomarse DoxyPEP?

Usted podría tomarse DoxyPEP si es un **hombre adulto o una mujer transgénero y tiene relaciones sexuales con hombres**. Si tiene el virus de la inmunodeficiencia humana (VIH) o toma PrEP (profilaxis antes de la exposición al VIH) y/o ha tenido una ITS bacteriana en el último año (sífilis, clamidia, gonorrea), converse con su médico acerca de la DoxyPEP.

Aún no contamos con información suficiente para recomendar la administración de DoxyPEP a otros grupos de personas. Sin embargo, debe conversar con su médico sobre su situación particular. Las personas que tienen relaciones sexuales sin condón, con múltiples parejas, con parejas anónimas o han tenido una ITS bacteriana reciente pueden beneficiarse de la DoxyPEP. Las personas que están embarazadas o que pueden quedar embarazadas no deben administrarse la DoxyPEP.

¿Cuándo debo tomarme la DoxyPEP?

Tome 200 mg (dos píldoras de 100 mg) de doxiciclina en un plazo de 24 horas (para un mayor efecto), pero a más tardar 72 horas, después de haber tenido relaciones sexuales sin condón. El sexo sin condón se refiere al sexo oral, anal, vaginal o por el orificio frontal cuando no usa un condón durante todo el acto sexual.

Si vuelve a tener relaciones sexuales después de 24 horas de haber tomado la doxiciclina, puede administrarse otra dosis 24 horas después de su última dosis. Puede tomarse doxiciclina hasta una vez al día. Sin embargo, no debe tomarse más de 200 mg (dos píldoras de 100 mg) al día.

¿Cómo debo tomar la DoxyPEP?

- ✓ Tome la doxiciclina con un vaso lleno de agua o algún otro líquido a fin de no atorarse al momento de tragarla. Si la doxiciclina le produce malestar estomacal, tomarla con alimentos puede ayudarle.
- ✓ Evite ingerir productos lácteos (leche, queso, etc.), calcio, antiácidos o vitaminas 2 horas antes y 2 horas después de administrarse la doxiciclina.
- ✓ Algunas personas son más sensibles al sol cuando se toman la doxiciclina, por lo que le recomendamos que use protector solar.
- ✓ No comparta la doxiciclina con otras personas.

¿Qué seguimos aprendiendo con relación a la DoxyPEP?

- ○ Cuando un medicamento se utiliza para tratar una infección, las bacterias pueden cambiar con el tiempo, lo que provoca que el medicamento sea menos efectivo. Esto se conoce como resistencia. No sabemos si la DoxyPEP podría aumentar la resistencia.
- ○ El uso de la doxiciclina es muy frecuente. Hasta el momento, ni la clamidia ni la sífilis han mostrado resistencia a la doxiciclina. Sin embargo, alrededor del 25 % de las personas con gonorrea en los Estados Unidos ya es resistente a la doxiciclina.
- ○ Necesitamos que se realicen más estudios de la DoxyPEP entre otros grupos de personas, incluidas las mujeres.

¿Qué más debo saber?

- ☑ Siempre deberá realizarse la prueba de ITS cada 3 meses y cada vez que presente síntomas.
- ☑ La DoxyPEP no protege contra infecciones víricas como el VIH, la viruela del mono, el virus del papiloma humano, o el herpes.
- ☑ Si tiene VIH, continúe administrándose sus medicamentos y visite a su médico con regularidad.
- ☑ Si es VIH negativo, converse con su médico sobre la PrEP y/o la profilaxis después de la exposición para prevenir el VIH.

VDH VIRGINIA DEPARTMENT OF HEALTH

Division of Disease Prevention
www.vdh.virginia.gov/disease-prevention/
Revised: January 2024

Expedited Partner Therapy (EPT) in Virginia
- Fact Sheet for Medical Providers -

What is EPT?

Expedited Partner Therapy (EPT) is the clinical practice of treating the sex partners of patients diagnosed with sexually transmitted infections (STIs) without an intervening medical evaluation. It is also sometimes referred to as patient-delivered partner therapy (PDPT). It is an evidence-based strategy targeting partners who are otherwise unlikely or unable to obtain a timely medical assessment. The ultimate goal of EPT is to reduce the likelihood of reinfection for the index patient, prevent sequelae, and halt the further spread of infection.

EPT in Virginia

As of July 1, 2021, the Code of Virginia [Section §54.1-3303.B] was revised to allow practitioners to prescribe antibiotic therapy for the sexual partner(s) of a patients diagnosed with a sexually transmitted disease, without first establishing the bona fide practitioner-patient relationship normally required, when providing EPT consistent with current Centers for Disease Control and Prevention (CDC) treatment recommendations.

EPT Best Practices

The CDC recommends dispensing medications directly to the patient for their partners when possible. However, clinicians should consider costs and patient/partner circumstances. EPT can be offered to patients/partners regardless of their age and gender. EPT may be offered to men who have sex with men (MSM), but should not be *routinely* offered to MSM because of a high risk for coexisting infections (especially undiagnosed HIV infection) in their partners.

Recommended Treatment Regimens for EPT

Index Patient Diagnosis	EPT Treatment Regimen
Chlamydia (only)	**Doxycycline** 100 mg twice daily for 7 days*
Gonorrhea (only)	**Cefixime** (e.g. Suprax) 800 mg orally once
Gonorrhea (with confirmed or suspected chlamydia co-infection)	**Cefixime** (e.g. Suprax) 800 mg orally once ***PLUS*** **Doxycycline** 100 mg twice daily for 7 days*

Substitute Azithromycin 1 gram orally as a single dose for partners who may be pregnant or unlikely to adhere to a 7-day regimen.

Tips for Writing EPT Prescriptions

- Write a separate prescription for each sex partner. Do not add additional doses to the index patient's prescription.
- Clearly write 'EPT' or 'expedited partner therapy' on the prescription.
- If known, write the partner's name, date of birth, and address on the prescription. Otherwise, just write 'EPT' or 'expedited partner therapy'.

Additional Considerations for EPT

Health care providers and pharmacists who prescribe or dispense EPT should counsel patients to encourage their partners to seek medical care and provide patients with written materials for each partner. These materials should include: information about chlamydia and gonorrhea infections and the importance of seeking a medical evaluation, especially for pregnant women and MSM; medication instructions; warnings about adverse allergic reactions; and advice to abstain from sexual activity for 7-10 days after single dose antibiotics (or to wear a condom with each sex act if assistance is not possible).

Clinician Resources

Written informational materials on EPT for patients and their sex partners are available for download on the VDH website (www.vdh.virginia.gov).

VDH VIRGINIA DEPARTMENT OF HEALTH

Updated August 2021

Expedited Partner Therapy (EPT) in Virginia
- Fact Sheet for Pharmacists -

What is EPT?

Expedited Partner Therapy (EPT) is the clinical practice of treating the sex partners of patients diagnosed with sexually transmitted infections (STIs) without an intervening medical evaluation. It is also sometimes referred to as patient-delivered partner therapy (PDPT). It is an evidence-based strategy for treating partners who are otherwise unlikely or unable to obtain a timely medical assessment.

EPT in Virginia

As of July 1, 2021, the Code of Virginia [Section §54.1-3303.B] was revised to allow practitioners to prescribe antibiotic therapy for the sexual partner(s) of a patients diagnosed with a sexually transmitted disease, without first establishing the bona fide practitioner-patient relationship normally required, when providing EPT consistent with current Centers for Disease Control and Prevention (CDC) treatment recommendations. EPT prescriptions in Virginia may be dispensed either with or without the partner's name on the prescription. Pharmacists can legally fill a prescription with the designation of 'EPT' even when the sex partner's name, address, and date of birth are not listed on the prescription.

Who is Eligible for EPT?

People are eligible for EPT when their sexual partner has a laboratory confirmed or clinical diagnosis of chlamydia or gonorrhea infection and they are unable or unlikely to see a doctor for testing and treatment. EPT is appropriate for the index patient's known sexual partners in the previous 60 days, or most recent sexual partners if there are no partners in the previous 60 days. There are no restrictions on the use of EPT based on patient/partner age or gender.

How should Pharmacists Fill EPT Prescriptions?

If the prescription is missing the partner's name, the pharmacists should affix 'EPT' or 'Expedited Partner Therapy' to the written prescription and the medication label. Medication costs may be self-pay (paid by the person who picks up the prescription) or paid by the sex partner's health insurance. EPT prescriptions without the partner's name cannot legally be billed to the index patients insurance or the partner's insurance, and should instead be billed as a cash only prescription. If the partner is unnamed, the practice in other states has been to create a unique identifier and use that instead of a name for both labeling and record keeping purposes. If known, the pharmacist may write the partner's name on the prescription and bill it to the partner's insurance.

Counseling for EPT

Pharmacists who dispense EPT should counsel partners to seek medical care and provide medication instructions; provide warnings about adverse allergic reactions; and advise to abstain from sexual activity for 7-10 days after single dose antibiotics (or to wear a condom with each sex act if assistance is not possible). In addition, pharmacists must ask whether the patient is allergic to the prescribed medication, and advise discontinuing the medication if the partner has a known allergy or develops signs of an allergic reaction after taking the medicine.

Expedited Partner Therapy (EPT) in Virginia
- Fact Sheet for Pharmacists -

Recommended Treatment Regimens for EPT

Index Patient Diagnosis	EPT Treatment Regimen
Chlamydia (only)	**Doxycycline** 100 mg twice daily for 7 days*
Gonorrhea (only)	**Cefixime** (e.g. Suprax) 800 mg orally once
Gonorrhea (with confirmed or suspected chlamydia co-infection)	**Cefixime** (e.g. Suprax) 800 mg orally once ***PLUS*** **Doxycycline** 100 mg twice daily for 7 days*

Substitute Azithromycin 1 gram orally as a single dose for partners who may be pregnant or unlikely to adhere to a 7-day regimen.

Adverse Reactions

While no adverse events and/or life threatening allergic reactions have been reported to date, report any EPT-related adverse events to the Virginia Department of Health at 1-800-533-4148 or email hiv-stdhotline@vdh.virginia.gov.

Pharmacist Resources

Additional EPT information and written material for patients and their sex partners are available for download on the VDH website under 'Clinical Resources'.

Expedited Partner Therapy (EPT) for Private Practitioners in Virginia
- Frequently Asked Questions -

Question: What is EPT?

Answer: Expedited Partner Therapy (EPT) is the clinical practice of treating the sex partners of patients diagnosed with sexually transmitted infections (STIs) without an intervening medical evaluation. It is sometimes referred to as patient-delivered partner therapy (PDPT). It is an evidence-based strategy in which antibiotic therapy (or a prescription for antibiotic therapy) is given to patients for them to deliver to any of their partners who are unlikely or unable to obtain a timely medical assessment. The ultimate goal of EPT is to reduce the likelihood of reinfection for the index patient, prevent sequelae, and halt the further spread of infection.

Question: Do I have to use EPT?

Answer: No. EPT is an optional tool to help with managing partner treatment. Medical practitioners should use their best clinical judgment to determine which patients and partners are good candidates for this treatment option.

Question: Can private medical practitioners use EPT in Virginia?

Answer: Yes. As of July 1, 2020, the Code of Virginia [Section §54.1-3303.B] was revised to authorize all practitioners in Virginia, regardless of employment with the Department of Health, to practice EPT.

Question: Is it better to dispense or prescribe EPT?

Answer: The Centers for Disease Control and Prevention (CDC) recommends dispensing medications directly to the index patient for their partner(s) when possible. However, clinicians should consider costs and patient/partner circumstances.

Question: If EPT is dispensed or prescribed, who is responsible for obtaining the medical and drug history for the partner(s)?

Answer: As of July 1, 2020, the requirement to obtain medical and drug history for the partner as part of establishing a bona fide practitioner-patient relationship is waived when a practitioner is providing EPT consistent with current CDC recommendations (Code of Virginia, Section §54.1-3303.B).

Question: Can EPT be offered to patients/partners younger than 18 years?

Answer: Yes, the CDC recommendations do not place any restrictions on the practice of EPT by age.

Question: Can EPT be offered to men?

Answer: Yes, EPT may be used regardless of the index patient's gender, or that of their partner(s). CDC has concluded that EPT may be a particularly useful option for treatment of male partners of women with chlamydial infection or gonorrhea.

Question: Can EPT be offered to men who have sex with men (MSM)?

Answer: Yes, but EPT should not be *routinely* offered to MSM because of a high risk for coexisting infections (especially undiagnosed HIV infection) in their partners.

Question: What are the recommended treatment regimens for EPT?

Answer: For **chlamydial infections** (without concurrent gonococcal infection), the partner may be treated with **Doxycycline** (e.g. Vibramycin) 100mg 2 times/day for 7 days, or with **Azithromycin** (e.g. Zithromax) 1 g orally in a single dose for partner who may be pregnant or when adherence to a multi-day dosing regimen is a considerable concern.

For **gonococcal infections**, the partner may be treated with **Cefixime** (e.g. Suprax) 800 mg orally in a single dose, provided that concurrent chlamydial infection in the patient has been excluded. Otherwise, the partner should also be treated with **Doxycycline** (e.g. Vibramycin) 100mg 2 times/day for 7 days (or with **Azithromycin** 1 g orally in a single dose for partner who may be pregnant or when adherence to a multi-day dosing regimen is a considerable concern). For additional information, see the CDC's treatment guidelines.

Question: Can EPT be used for gonorrhea? What about antibiotic resistance?

Answer: If a partner cannot be linked to evaluation and treatment in a timely fashion, EPT with either ceftriaxone (500 mg via single intramuscular dose) ***or*** cefixime (800mg orally in a single dose) should be considered. Dual treatment with either doxycycline (100 mg taken orally 2 times/day for 7 days) or azithromycin (1 g orally in a single dose) should be provided if chlamydial infection is also present or suspected. According to the CDC, not treating partners is significantly more harmful than is the use of EPT for gonorrhea.

Question: Can EPT be used for the management of Trichomoniasis?

Answer: Yes. According to the CDC, existing data indicate that EPT also might have a role in partner management for trichomoniasis; however, no partner management intervention has been reported to be more effective than any other in reducing trichomoniasis reinfection rates. The evidence supporting EPT use for chlamydia and gonorrhea is stronger.

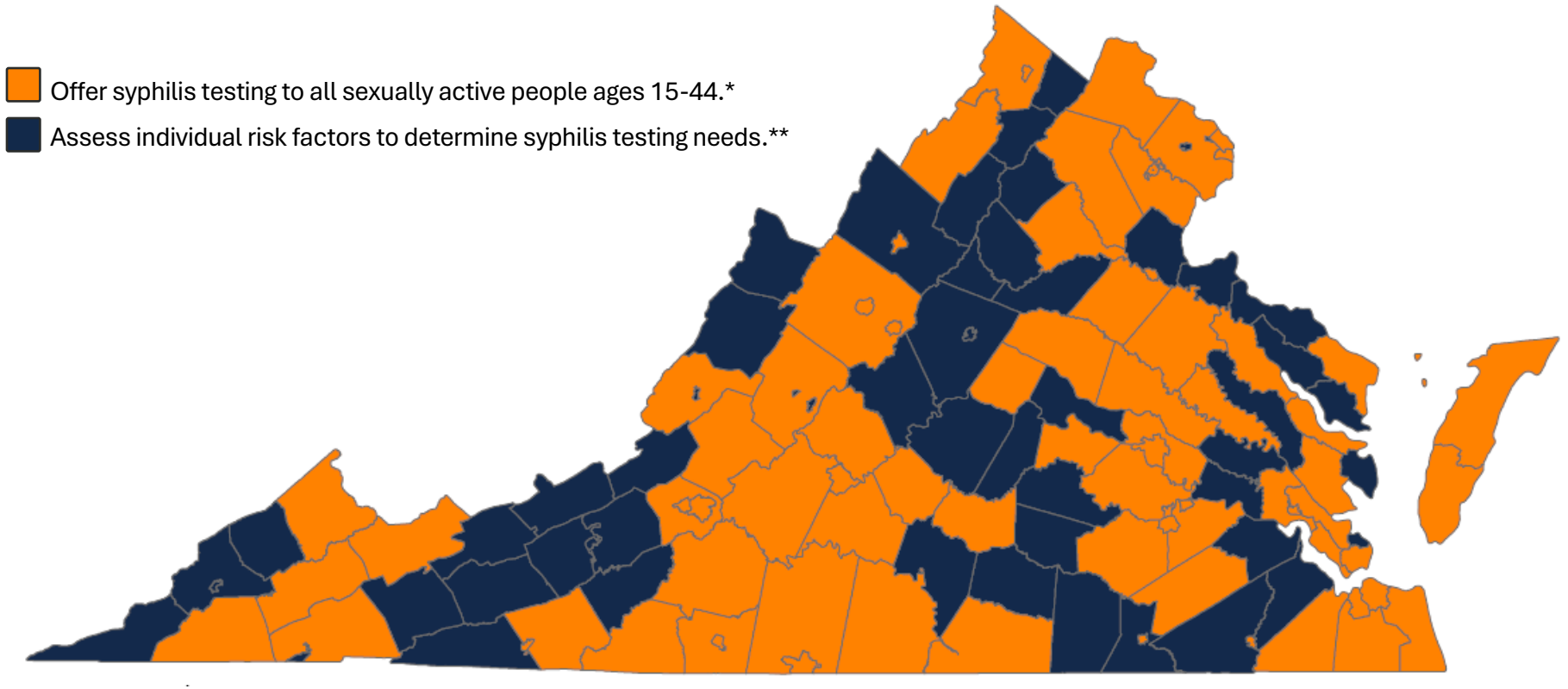
Question: Are EPT medications safe for people with penicillin allergies?

Answer: Serious adverse reactions, including anaphylaxis, with the recommended EPT treatment regimens are very rare. Furthermore, there is no evidence that cephalosporin use in penicillin-allergic patients results in an increased risk of anaphylaxis when using second- and third-generation cephalosporins (such as ceifixme). (More information: http://pediatrics.aappublications.org/content/115/4/1048.long)

Question: What is my legal liability if I dispense or prescribe EPT?

Answer: The legal liability for dispensing or prescribing EPT is no different than for dispensing or prescribing any other treatment. However, if EPT is provided consistent with CDC treatment recommendations, the practitioner's individual liability would be minimized in the event of an adverse drug reaction. According to a position statement from the Society for Adolescent Medicine, "In EPT programs in which adverse events have been monitored since 2001, no drug-related adverse effects or lawsuits arising from the type of care have been documented" (source: https://www.ncbi.nlm.nih.gov/pubmed/19699429)

2024 Virginia Syphilis Screening Guidelines by County/City



* In counties/cities where the rate of syphilis (all stages) among women aged 15-44 years was greater than 4.6 per 100,000 in 2024, providers should offer syphilis testing to all sexually active people aged 15-44 years.

** In counties/cities where the rate of syphilis (all stages) among women aged 15-44 years was less than or equal to 4.6 per 100,000 in 2024, providers should continue to assess individual risk factors to determine testing needs as outlined in the CDC screening guidelines.

Based on 2024 data, Virginia counties/cities where syphilis screening is recommended for all sexually active people aged 15-44 years:

Accomack County
Alleghany County
Amherst County
Appomattox County
Arlington County
Augusta County
Bedford County
Botetourt County
Buchanan County
Campbell County
Caroline County
Carroll County
Chesterfield County
Culpeper County
Dinwiddie County
Essex County
Fairfax County
Fauquier County
Fluvanna County
Franklin County
Frederick County
Gloucester County
Halifax County
Hanover County
Henrico County
Henry County
James City County
King William County
Loudoun County
Louisa County
Mecklenburg County
Middlesex County
Northampton County
Northumberland County
Patrick County
Pittsylvania County
Powhatan County
Prince Edward County
Prince George County
Prince William County
Roanoke County
Rockbridge County
Russell County
Scott County
Shenandoah County
Spotsylvania County
Sussex County
Tazewell County
Washington County
York County
Alexandria City
Chesapeake City
Colonial Heights City
Danville City
Emporia City
Franklin City
Fredericksburg City
Galax City
Hampton City
Harrisonburg City
Hopewell City
Lynchburg City
Manassas City
Manassas Park City
Martinsville City
Newport News City
Norfolk City
Petersburg City
Portsmouth City
Richmond City
Roanoke City
Salem City
Staunton City
Suffolk City
Virginia Beach City
Waynesboro City
Williamsburg City
Winchester City

Technical Note: Update to Syphilis Screening Recommendations in Virginia Based on 2024 Epidemiological Data

Overview:
The Virginia Department of Health (VDH) has updated its syphilis screening recommendations for reproductive-aged sexually active people (15-44 years) based on the most recent Virginia epidemiological data. The revised Virginia guidelines now reference using the rate of **syphilis of all stages** among women aged 15-44, rather than limiting analysis to **primary and secondary** syphilis cases.

Rationale for Change:
The Virginia syphilis screening guidelines aim to reduce syphilis and congenital syphilis rates. Congenital syphilis can result from maternal infection at any stage of syphilis during pregnancy, not just primary or secondary stages. In Virginia, women tend to be diagnosed later during the course of their syphilis infection. In 2024, only 21% of all syphilis diagnoses among women 15-44 were primary and secondary stages; 79% were diagnosed as later syphilis stages. Expanding the guidelines to include the rate of all stages of syphilis ensures a more accurate representation of counties with high syphilis rates among women, including counties with congenital syphilis diagnoses that would otherwise have been left out.

Antibiotic Resistant Gonorrhea: Clinical Guidance for Suspected Treatment Failure

Gonorrhea is a common sexually transmitted infection (STI) caused by *Neisseria gonorrhoeae* bacteria. This bacteria has rapidly acquired resistance to each class of antibiotics used for treatment, and the Centers for Disease Control and Prevention (CDC) has declared drug-resistant gonorrhea an urgent public health threat.

Reported cases of cephalosporin resistance have recently occurred in Europe, Asia, Australia, and Canada, and cases with reduced susceptibility have now been reported in the United States (in Nevada and Massachusetts).

Monotherapy with ceftriaxone (500 mg IM for persons weighing <150 kg) is now the only treatment regimen for gonorrhea recommended by the CDC.

Identifying Suspected Treatment Failure

Clinicians should be alert for potential treatment failures. Gonococcal treatment failure may be suspected in the following two situations:

Patients with **persistent symptoms** more than 3 days after recommended treatment, **with:**

- ✓ No sexual contact since treatment (reinfection unlikely), ***and***
- ✓ Other untreated infections have been excluded (*ex: chlamydia, mycoplasma genitalium, trichomoniasis*).

Patients with a **positive test-of-cure** (TOC), **with**:

- ✓ No sexual contact since treatment (reinfection unlikely), ***and***
- ✓ Positive culture at least 72 hours after appropriate treatment, ***or***
- ✓ Positive NAAT obtained more than 7 days after treatment for anogenital gonorrhea, ***or***
- ✓ Positive NAAT more than 14 days after treatment for pharyngeal gonorrhea.

Important Note: Most suspected treatment failures are likely due to reinfection rather than true treatment failures. It is crucial that clinicians **conduct a thorough sexual history** to evaluate for potential reinfection. Patients suspected of having a reinfection should be re-treated with the recommended antibiotic regimen.

Both **CDC** and **NCSD** have clinician guides on taking a comprehensive sexual health history.

Testing Suspected for Treatment Failure

For Private Clinicians:
If your practice does not have the capacity to conduct gonococcal culture for AST, reach out to your local health department to connect your patient for testing.

If reinfection has been ruled out, clinicians should repeat NAAT testing at all exposed anatomic sites, along with collection of specimens for gonococcal culture and **antimicrobial susceptibility testing** (AST). Note that NAATs alone cannot provide antimicrobial susceptibility results.

Treating clinicians can consult the STD Clinical Consultation Network or CDC for advice on obtaining cultures, antimicrobial susceptibility testing, and treatment regimens.

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Revised 3/10/2026

Clinical Management for Treatment Failures

The following steps should be taken to ensure adequate testing, treatment, partner management, and follow-up of suspected gonorrhea treatment failure when reinfection is unlikely.

Culture:	Obtain specimens for culture ***and*** NAAT **prior** to re-treatment. Positive cultures should undergo antimicrobial susceptibility testing (AST). If culture is not available on-site, coordinate with your local health department.
Repeat Treatment:	Treat suspected gonorrhea treatment failures with either: 1. Ceftriaxone 500 mg IM in a single dose for persons weighing <150 kg (1 g for persons weighing ≥ 150 kg), ***or*** 2. If cephalosporin allergy: Gentamicin 240 mg IM ***plus*** azithromycin 2 g orally. **Note:** Gentamicin has poor efficacy for pharyngeal infection. For suspected treatment failures of pharyngeal infections, ceftriaxone should be used whenever possible.
Report & Consult:	Report the case to your local health department within 24 hours. You may also reach out to the STD Prevention and Surveillance program for consultation or reporting assistance.
Test/Treat Partners:	Work with your assigned Disease Intervention Specialist (DIS). All sexual partners in the last 60 days should be tested at all sites of exposure and empirically treated with the same treatment as the index patient.
Test-of-Cure (TOC):	Counsel the patient to refrain from sex. TOC should be performed with ***both*** culture ***and*** NAAT after: ▪ 7 days for urogenital/rectal infection, or ▪ 14 days for pharyngeal infection. All positive cultures should have AST performed, and be held for further testing if needed.

Source: Workowski et al. Sexually Transmitted Treatment Guidelines, 2021. MMWR Recomm Rep 2021;70(4):71-80.

Reporting Presumptive Treatment Failures

Presumptive treatment failures should be **reported to VDH** as soon as possible after receiving a positive result for a repeat NAAT, or upon receipt of a positive culture test (assuming reinfection is unlikely).

- **Private clinicians:** report to your local health department.
- **Health department clinicians:** report to the STD Prevention and Surveillance (SPS) program. SPS staff will work with you to complete the CDC's Suspected Gonorrhea Treatment Failure Consultation Form.

If antibiotic resistance or decreased susceptibility to ceftriaxone is confirmed, SPS staff will coordinate case assignment to a Disease Intervention Specialist (DIS) for field follow up to conduct partner services.

Laboratory Resources for Antimicrobial Susceptibility Testing (AST)*

LabCorp: offers gonorrhea culture (Test Code 008128) with the possibility of adding antimicrobial susceptibility testing (Test Code 183130) as soon as the positive culture result is obtained. The add-on of the test 183130 needs to be requested verbally by phone to LabCorp customer service.

Quest Diagnostics: offers gonorrhea culture with reflex to antimicrobial susceptibility testing (Test Code 38404; CPT Code 87081). If gonorrhea is isolated, then antimicrobial susceptibility testing will be performed (CPT code(s): 87185, 87181(x4)). Contact Quest directly for more information on gonorrhea testing.

Maryland Public Health Laboratory (through CDC's ARLab Network) offers antimicrobial susceptibility testing for suspected gonorrhea treatment failures. Visit submission guidelines or contact mdphl.arln@maryland.gov for more information.

For VDH Clinicians:

Instructions for ordering gonococcal culture and AST testing from LabCorp are available in the VDH Laboratory Manual for Clinical Settings (pg. 11).

* Company and laboratory names are provided for informational purposes only. VDH does not endorse any company or its products.

Disseminated Gonococcal Infection

Fact Sheet

CDC has received increasing reports of DGI – an uncommon, but severe, complication of gonorrhea.

What is a DGI?

Disseminated gonococcal infection (DGI) occurs when the STD, *Neisseria gonorrhoeae*, invades the bloodstream and spreads to distant sites in the body. Infection leads to clinical manifestations like septic arthritis, polyarthralgia, tenosynovitis, petechial/pustular skin lesions, bacteremia, or, on rare occasions, endocarditis or meningitis. Cultures from disseminated sites of infection are often negative and mucosal sites of infection (e.g. urogenital, rectal, or pharyngeal) are often asymptomatic and not tested before empiric antimicrobial treatment is started despite having a higher diagnostic yield[1]. As a result, DGI is usually a clinical diagnosis without microbiologic confirmation, which likely contributes to underdiagnosis and delays in treatment and reporting.

What should be done if DGI is suspected?

1. Collect and process nucleic acid amplification test (NAAT) or culture specimens from all exposed urogenital and extragenital mucosal site(s).
2. Collect NAAT and culture specimens from disseminated sites of infection [e.g., skin, synovial fluid, blood, or cerebrospinal fluid (CSF)].
3. All N. gonorrhoeae isolates from suspected DGI case should be tested for antimicrobial susceptibility, which requires culture.
4. Manage DGI cases according to current CDC STD Treatment Guidelines, which can be found by going to http://www.cdc.gov/std/treatment-guidelines.
5. Hospitalization and consultation with an infectious disease specialist are recommended for initial therapy.
6. Instruct patients to refer all sex partners within the past 60 days for evaluation, testing, and presumptive treatment of gonorrhea.
7. Any laboratory confirmed or clinically suspected case of DGI, including those empirically treated without laboratory evidence of N. gonorrhoeae, should be reported to VDH within 24 hours by fax or through our electronic portal at https://www.vdh.virginia.gov/disease-prevention/disease-reporting/.

DGI Consultation

Clinical consultation for DGI management is available through the STD Clinical Consultation Network: **http://www.stdccn.org**.

CDC STD Treatment Guidelines

1) CDC Health Alert Template for Disseminated Gonococcal Infection (DGI): https://www.cdc.gov/std/program/outbreakresources/HANtemplate-dgi.htm

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