CLINICAL MANAGEMENT OF STDS

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Outline
- Essential components of STD care management
  - Sexual History
  - Risk Assessment
  - Clinical evaluation
  - Diagnosis and Treatment
  - Partner management
  - Prevention Education/Counseling
- STD Cases

Components of STD Care management.

The Importance of a Comprehensive Sexual History
- Establish patient’s STD/HIV risk
- Guides Physical exam
- Guides screening activities
- Clarify partner management issues
- Establish patient’s pregnancy risk and contraceptive needs
- Provide relevant risk reduction counseling

Risk Assessment

The (Five) Ps
- Partners
- Practices
- Protection
- Pregnancy
- Past History of STIs

Clinical Evaluation

- Males
  - Skin (all exposed areas)
  - Mouth/Throat
  - External Genitalia
  - Circumcision status
  - Urethral meatus
  - Genital lesions
  - Testicular/scrotal palpation
  - Lymphadenopathy
  - Ano-rectal

- Females
  - Skin (all exposed areas)
  - Mouth/Throat
  - External Genitalia
  - Vulva, Labia, introitus, perineum
  - Genital Lesions
  - Vagina and vaginal secretions
  - Pelvic exam
  - Cervix
  - Bimanual exam
  - Lymphadenopathy
  - Ano-rectal

www.cdc.gov/STD/treatment
Diagnostic Tests

- **Microscopy and Rapid tests**
  - Gram stain
  - Vaginal fluid tests
    - Wet-mount microscopy for clue cells, trichomonas (saline), fungi (10% KOH)
  - pH
  - Amine odor test (KOH “sniff” test)
  - Darkfield microscopy
  - Rapid plasma reagin (rapid syphilis test)
  - Rapid pregnancy test
  - Leukocyte esterase
  - Urinalysis

- **Microbiology**
  - NAAT tests for all sites*
  - Cultures
  - Urine culture

- **Blood tests**
  - Syphilis serology
  - Rapid HIV test
  - HSV type-specific serology
  - Viral hepatitis-A,B,C

- **Cytology**
  - Cervical PAP (HPV)
  - Anal PAP

- **Other**
  - Skin scraping for scabies

*Oral and Rectal- Not FDA-approved; requires local lab validation

**CDC STD Treatment Guidelines, 2010**

- Clinical guidance for the screening, diagnosis and treatment of STDs.


**CDC STD Treatment Guidelines Mobile App**

- Diagnostic information and current STD Treatment Guidelines.
- Quick access to information about the diagnosis and treatment of 21 STDs.
- Access to booklet “A Guide to Taking a Sexual History.”
- Available for both Apple and Android devices.
- Download for free from the iTunes and Google Play stores.

**Follow up**

**Follow up:**
- Patients treated for uncomplicated GC/CT infections do not need a test of cure.
- TOC in 1 week if alternate treatment regime used – GC.
- Retest 3 months after treatment - GC/CT.
- Monitor RPR post treatment (6, 12 mos.), more frequently if at high risk.
- HIV test

**Partner management**

**Partner management:**
- Partners of those infected with STDs should be evaluated, tested and treated presumptively
- Infected persons should abstain from sexual intercourse until their treatment is completed and their partners are treated
- Partner notification
- Insplot.org –
  - anonymous partner notification
- Expedited Partner Therapy(EPT)
Prevention Education/Counseling

Nature of infection
- Commonly asymptomatic in men and women.
- In women, increased risk of upper reproductive tract complications and squealea from STDs with re-infections

Transmission issues
- Effective treatment reduces HIV transmission and acquisition with certain STDs
- Abstaining from sex until partner treated prevents re-infection

Risk reduction counseling
- Discuss prevention strategies (abstinence, monogamy, condoms, limit number of sex partners, etc.).
- Vaccine preventable STDs – Hep A, Hep B, HPV

STD CASES

Case Questions
- What questions should be asked?
- What do you expect to find?
- What tests should you order?
- What treatment is recommended?
- What follow up is required?

Case 1
A 17 year-old female presents with increased vaginal discharge and intermittent burning with urination x 10 day. Discharge is whitish to yellow with no odor. She denies abdominal pain.

She states that she has been using a condom with her new male partner of 2 weeks.

How would you manage this patient?

a) Treat with Azithromycin 1g PO x 1
b) Treat with Azithromycin 1g PO x 1 and Ceftriaxone 250mg IM x 1
c) Tell her to abstain from sex and to call you in 3 days for test results
d) Treat with Azithromycin 1g PO x 1, Ceftriaxone 250 IM x 1 and Metronidazole 500mg BID x 7 days
**Cervicitis - Management**

**Treatment Options:**
- Treat presumptively for Ct:
  - Young (<25), new or multiple sex partners, hx of unprotected sex
  - If follow-up is uncertain
- Treat presumptively for GC and Ct:
  - If risk factors as above and/or high local prevalence (>5%)
- Await results of diagnostic tests:
  - Low-risk, good follow-up, sensitive tests used (NAATs)

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**Case 2**

*Alternate scenario for Case 1:*

Physical exam reveals mild yellowish discharge from the os and easily-induced cervical bleeding. Cervical motion tenderness is equivocal—patient says, “that’s a little uncomfortable”—but she winces when you examine the R adnexa. You do not palpate any masses, and there is no rebound or guarding on abdominal exam.

**Case 2**

*How would you manage this patient?*

a) Send her to the Emergency Room
b) Treat her with Ceftriaxone 250mg IM x 1, Doxycycline 100mg BID x 14 days and Metronidazole 500mg PO BID x 14 days, and tell her to return to clinic if she does not tolerate the medications at home
c) Tell her to abstain from sex and to call you in 3 days for her test results
d) Treat with Ceftriaxone, Doxycycline and Metronidazole and give her an appointment to see you in 3 days.

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**PID Diagnosis**

**Minimum Criteria:**
- Cervical motion tenderness OR uterine tenderness OR adnexal tenderness
- No single historical, physical or lab finding is both sensitive and specific for diagnosis of acute PID

**Additional Criteria:**
- Temp > 38.3 C (101 F)
- Abnormal discharge; abundant WBCs on wet mount
- Elevated ESR/C-reactive protein
- + GC/Ct laboratory test

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**Case 3**

A 26 year-old male presents with a 1-week history of intermittent burning with urination. He also describes an “itchy” feeling inside of his penis. He denies urethral discharge.

He has had a steady girlfriend for the past 6 months, with whom he does not use condoms, and 3 “1 night stands” with women over the past 3 months.

You treat empirically with Doxycycline 100mg BID x 7 days.

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**Case 3**

Physical exam reveals a mucoid discharge from the urethra, no penile lesions and a normal testicular exam.
Case 3

The patient returns 2 weeks later with persistent dysuria and discharge. Ct and GC urine NAATs from the last visit were negative. Physical exam is unchanged.

He states that he completed the course of doxycycline, and that his girlfriend was treated as well. He did not know how to contact the other 3 partners. He has not had sex with anyone other than his girlfriend since being treated.

Case 3

How would you manage this patient?

a) Treat with another course of Doxycycline
b) Treat with Azithromycin 1g PO x 1
c) Treat with Metronidazole 2g PO x 1 plus Azithromycin 1g PO x 1
d) Refer to a urologist

Recurrent and Persistent Urethritis

Differential Diagnosis:
- Re-exposure to untreated partner
- Incomplete treatment
- Persistent infection:
  - Mycoplasma
  - Ureaplasma
  - Trichomoniasis
- Non-infectious causes: chronic prostatitis(referral to Urology)

Case 4

A 30 year-old male presents with a 2-day history of greenish urethral discharge and burning with urination. 5 days ago, he had unprotected receptive oral intercourse and receptive and insertive anal intercourse with a condom.

He reports 7 male partners over the past 3 months. Always uses a condom for anal sex, almost never for oral sex.

Case 4

Physical exam:
- Copious, yellow/white urethral discharge.
- No lesions
- Skin, testicular and anal exam normal

What diagnostic tests would you order in this patient?

Case 4

How would you treat this patient?

a) Ciprofloxacin 500mg PO x 1
b) Ceftriaxone 250mg IM x 1
c) Doxycycline 100mg BID x 7 days
d) Tell him to abstain from sex and to call for results in 3 days
e) Ceftriaxone 250mg IM x 1 plus Azithromycin 1g PO x 1
Case 4

**What would you tell this patient about his partners?**

a) He should only notify his partner from 5 days ago

b) He should tell all partners from the past year to be tested for HIV and other STDs

c) He should notify partners from the past 60 days that they should be evaluated and treated for GC

d) The health department will be contacting his partners because “We know who they are.”

Case 5

A 24 year-old male comes to see you because he wants to be “tested for everything.” He has had 3 sexual partners over the past 3 months, including 2 males. He practices oral, anal and vaginal sex with his partners. He states that he uses condoms “most of the time.”

**STD screening reveals:**
- Rapid HIV EIA: negative
- Urine GC/Ct NAAT: negative
- Pharyngeal GC culture: negative
- Anal GC cultures: positive
- Anal Ct NAAT: positive

Case 5

When he returns for treatment, he describes recent symptoms of intermittent rectal pain, bleeding after bowel movements, and tenesmus.

**How would you treat his infection?**

a) Ceftriaxone 250mg IM x 1 plus Azithromycin 1g PO x 1

b) Ceftriaxone 250mg IM x 1 plus Doxycycline 100mg BID x 21 days

c) Azithromycin 2g PO x 1

d) Ceftriaxone 250mg IM x 1 plus Doxycycline 100mg BID x 7 days

Proctitis

- Inflammation of the rectal mucosa
- Associated with rectal anal intercourse
- Symptoms: rectal pain, tenesmus, constipation, mucopurulent discharge, hematochezia
- Etiology:
  - Neisseria gonorrhea
  - Chlamydia trachomatis (including LGV strains)
  - Trepomena pallidum
  - Herpes simplex virus

Case 6

Alternate scenario to #5

Patient returns to your clinic in 4 months. He states he last had sex at a sex party 3 weeks ago with three male partners. Now complaining of a painless lesion on penis x 1 week, no other genital complaints or symptoms.

**Physical exam:**
- 5x5 round ulcer on shaft
- Bilateral inguinal lymphadenopathy
- Normal perianal exam
- No mouth lesions
- No rash on trunk or palms/soles

Case 6

**Test results**
- RPR is 1:64, FTA Reactive
- Anorectal NAAT test is negative for GC and chlamydia.
- Urine NAATs are negative for GC and chlamydia
- Herpes cx negative
- Acute HIV testing was negative

**What are your next steps?**
Case 6

- The patient returns at 3 month intervals for titer checks:
  - 3 months  RPR 1:16
  - 6 months  RPR 1:4
  - 9 months  RPR 1:4
  - 12 months RPR 1:2
  - 15 months RPR 1:32
- How do you interpret these results?
- His female partner is 10 weeks pregnant, next steps?

Response to Therapy by Syphilis Stage

* Primary, Secondary Syphilis
  Resolution of symptoms
  By 6-12 months- Fall in RPR titer by 2 titers

* Early Latent, Late Latent Syphilis
  If RPR titer $\leq 1:32$
  Fall in RPR titer by 2 titers within 12-24 months

??? HIV-infected Patients

*Test persons with syphilis for HIV

THANK YOU!