

Health Advisory: Gonorrhea and Syphilis

DATE: September 24, 2012

TO: Medical Providers

FROM: Cora Hoover, MD, MPH, Assistant Health Officer

Gonorrhea: New treatment guidelines from the CDC

As of August 2012, the CDC has changed its recommendation for gonorrhea treatment. Cefixime is no longer a recommended treatment for gonorrhea, due to concerns of development of antibiotic resistance. The CDC's current recommendation is that health care providers treat uncomplicated gonorrhea infections with dual antibiotic therapy: ceftriaxone 250 mg IM *plus either* azithromycin 1 g orally in a single dose *or* doxycycline 100 mg orally BID for 7 days regardless of chlamydia test result.

So far, in the United States, cefixime resistance has been encountered *in vitro* only. However, cefixime-resistant *N. gonorrhoeae* leading to treatment failure has been observed in Asia and Europe. Please see www.cdc.gov/std/treatment for more information.

Gonorrhea--what medical providers should do:

- Screen at-risk patients for gonorrhea (women under 25, pregnant women, HIV positive patients, and men who have sex with men (MSM)). MSM should be screened at rectal and pharyngeal sites if they have had sexual exposure at those sites. All patients treated for gonorrhea should routinely be offered condoms, given risk-reduction counseling, and retested for gonorrhea 3 months later.
- When possible, treat gonorrhea with a combination of ceftriaxone 250 mg IM *plus either* azithromycin 1 g *or* doxycycline 100 mg for 7 days regardless of chlamydia test result.
- Obtain a test of cure to assess for treatment failure if an alternative treatment regimen such as cefixime is used. Please contact PHS or review the CDC guidance document (www.cdc.gov/std/treatment) for more information concerning test of cure.

Please distribute to all providers and relevant medical staff in your office.

- Advise infected patients that partners in the last 60 days need treatment and testing.
- Report all gonorrhea cases to public health within seven days of identification. For a fillable copy of the Confidential Morbidity Form, go to <http://www.sjcphs.org>. Click on the "For Providers" tab and then "Disease Reporting."
- If treatment failure with either the recommended or an alternative regimen is suspected, contact PHS STD program immediately for guidance concerning antibiotic susceptibility testing and follow up. Ideally a culture should be obtained and the patient should be retreated with ceftriaxone 500 mg IM *plus* azithromycin 2 g.

Please contact Public Health to confirm history of prior syphilis treatment or with any questions concerning syphilis or gonorrhea testing, diagnosis, and treatment. You can also schedule an "STD Update" presentation for your facility.

STD program phone 209-468-3845

Fax CMR to 209-468-3495

Public Health Services website <http://www.sjcphs.org/>

Syphilis: Increased cases in San Joaquin County

In 2011 and 2012, San Joaquin County has experienced a marked increase in early syphilis cases, mirroring increases throughout the state and approaching disease levels seen in the 1990s. From January 1, 2012 through September 1, 2012, 44 primary and secondary syphilis cases have been confirmed; in contrast, there were 44 cases in all of 2011 and 33 cases in all of 2010. Most of these early syphilis cases have been in young men who have sex with men, but heterosexual men and young women have also been affected. This increase is concerning because of the potential complications and sequelae of syphilis infection, including congenital syphilis and increased risk of HIV transmission.

Key facts about syphilis:

- Sexual transmission of syphilis occurs during the highly infectious primary and secondary stages via oral, vaginal, or anal sex.
- Primary syphilis is characterized by an ulcer (chancre) in the genital, oral, or anal area that appears 10-90 days after sexual exposure. Because these are typically painless, they often go unnoticed.
- Secondary syphilis can mimic many other conditions. Signs generally appear 3-6 weeks after the primary chancre. Manifestations include rash (often but not always on the palms and soles), condylomata lata (moist, wart-like lesions in the genital area), mucous patches in the mouth, generalized lymphadenopathy.
- Syphilis serology can be negative in up to 25% of primary syphilis cases, but will be positive by the time signs and symptoms of secondary syphilis are present.
- Maternal-fetal transmission can lead to congenital syphilis. **Please contact PHS directly for consultation on all primary/ secondary/ early latent cases in pregnant women.**
- Neurosyphilis can occur at any stage of syphilis. If clinical evidence of neurologic involvement is present, a CSF examination (LP) should be performed. Please consider consultation with ID or PHS for neurosyphilis cases.

Syphilis--what medical providers should do:

Screen, test, and report

- Report all confirmed and suspected syphilis cases to public health within one working day of identification. For a fillable copy of the Confidential Morbidity Form, go to <http://www.sjcphs.org>. Click on the "For Providers" tab and then "Disease Reporting."
- Men who have sex with men and HIV positive patients should be screened for syphilis at least yearly; those with multiple sexual partners should be screened every 3-6 months.
- Prenatal patients should be screened routinely. Pregnant women at higher risk for STDs should be rescreened for syphilis at 28 weeks of pregnancy and at delivery.
- Genital ulcers, new "warts," or a new rash in a sexually active patient could be signs of primary or secondary syphilis. Order an RPR/EIA on patients with suspected primary or secondary syphilis. Consider presumptive treatment on the day of testing if follow-up is uncertain. PHS

STD Clinic may be able to do a darkfield exam of a suspected chancre; please call for availability.

Treat cases, suspected cases, and contacts appropriately

- Appropriate treatment for primary, secondary, and early latent syphilis is Bicillin Long-Acting (LA) 2.4 million units IM once. Appropriate treatment for late latent syphilis and latent syphilis of unknown duration is Bicillin LA 2.4 million units x 3 doses one week apart. If Bicillin LA is not available in your practice setting, please refer patients to the Public Health Services STD Clinic for treatment.
- Alternative treatment regimens such as doxycycline have a higher risk of treatment failure and should be used only if TRUE penicillin allergy is present. **Penicillin is the only acceptable treatment for pregnant patients.**
- Patients must be advised of the Jarisch-Herxheimer reaction, a flu-like syndrome which may occur within 24 hours of penicillin treatment and usually resolves within 24 hours. This syndrome may cause fetal distress or early labor in pregnant patients, but this risk should not prevent or delay treatment.
- An RPR titer should be re-ordered on the day of treatment so that the response to treatment can be accurately measured by following RPR titers.
- If a patient reports having been exposed to syphilis, order an RPR/EIA and treat presumptively on the same day.
- All patients who have had sexual contact with a primary syphilis case in the prior 3 months or a secondary syphilis case in the prior 6 months should be treated presumptively while awaiting serology results.
- For HIV negative patients, reassess clinically and recheck RPR at 6, 12, and 24 months to assess for treatment failure and reinfection. For HIV positive patients, reassess clinically and recheck RPR at 3, 6, 9, 12, and 24 months.

Online STD resources for providers:

2010 CDC STD Treatment Guidelines:

<http://www.cdc.gov/std/treatment/2010/default.htm>

STD Screening Guidelines for MSM:

<http://stdcheckup.org/>

California Department of Public Health STD Control Branch:

<http://www.cdph.ca.gov/programs/std/Pages/default.aspx>