DISEASE	RECOMMENDED RX	DOSE/ROUTE	ALTERNATIVES
LYMPHOGRANULOMA VENEREUM	doxycycline[3]	100 mg orally 2x/day for 21 days	erythromycin base 500 mg orally 4x/day for 21 days
NONGONOCOCCAL URETHRITIS (NGU)[20, 21]	azithromycin **OR** doxycycline	1 g orally in a single dose 100 mg orally 2x/day for 7 days	erythromycin base[5] 500 mg orally 4x/day for 7 days **OR** erythromycin ethylsuccinate[6] 800 mg orally 4x/day for 7 days **OR** levofloxacin 500 mg 1x/day for 7 days **OR** ofloxacin 300 mg 2x/day for 7 days
PEDICULOSIS PUBIS	permethrin 1% cream rinse **OR** pyrethrins with piperonyl butoxide	Apply to affected area, wash off after 10 minutes Apply to affected area, wash off after 10 minutes	malathion 0.5% lotion, apply to affected area and wash off after 8-12 hours OR ivermectin 250 µg/kg, orally repeated in 2 weeks
PELVIC INFLAMMATORY DISEASE[22, 23] Non-pregnant patients	**Parenteral Regimens** **EITHER** cefotetan **OR** cefoxitin **PLUS** doxycycline [3] **OR** clindamycin **PLUS** gentamicin **Recommended Intramuscular/Oral Regimens** **EITHER** ceftriaxone **OR** cefoxitin **WITH** probenecid **PLUS** doxycycline[3] **WITH** metronidazole if BV is present or cannot be ruled out	 2 g IV every 12 hours 2 g IV every 6 hours 100 mg orally or IV every 12 hours 900 mg IV every 8 hours 2 mg/kg IV or IM followed by 1.5 mg/kg IV or IM for 8 hours 250 mg IM in a single dose 2 g IM in a single dose 1 g orally administrated concurrently in a single dose 100 mg orally 2x/day for 14 days 500 mg orally 2x/day for 14 days	**Parenteral Regimens** ampicillin/sulbactam 3 g IV every 6 hours **PLUS** doxycycline 100 mg orally or IV every 12 hours The complete list of recommended regimens including regimens for pregnant women can be found in CDC's 2015 STD Treatment Guidelines
SCABIES	permethrin 5% cream **OR** ivermectin	Apply to all areas of body from neck down, wash off after 8-14 hours 200 µg/kg orally, repeated in 2 weeks	lindane 1%[24, 25] 1 oz. of lotion or 30 g of cream, applied thinly to all areas of the body from the neck down, wash off after 8 hours
SYPHILIS Primary, secondary, or early latent <1 year	benzathine penicillin G	2.4 million units IM in a single dose	doxycycline[3] 100 mg 2x/day for 14 days **OR** tetracycline[3] 500 mg orally 4x/day for 14 days
Latent >1 year, latent of unknown duration	benzathine penicillin G	2.4 million units IM in 3 doses each at 1 week intervals (7.2 million units total)	doxycycline[3] 100 mg 2x/day for 28 days **OR** tetracycline[3] 500 mg orally 4x/day for 28 days
Neurosyphilis and ocular[26] syphilis	aqueous crystalline penicillin G	18–24 million units per day, administered as 3–4 million units IV every 4 hours or continuous infusion, for 10–14 days	procaine penicillin G 2.4 million units IM 1x daily **PLUS** probenecid 500 mg orally 4x/day, both for 10-14 days
Pregnancy Primary, secondary, or early latent<1 year	benzathine penicillin G	2.4 million units IM in a single dose	None[27]
Pregnancy Latent>1 year, latent of unknown duration	benzathine penicillin G	2.4 million units IM in 3 doses each at 1 week interval (7.2 million units total)	None[27]
Pregnancy Neurosyphilis and ocular syphilis	aqueous crystalline penicillin G	Same info as above under neurosyphilis	procaine penicillin G, 2.4 million units IM 1x/day
TRICHOMONIASIS	metronidazole[29] **OR** tinidazole[28]	2 g orally in a single dose 2 g orally in a single dose	metronidazole[28] 500 mg 2x/day for 7 days
Persistent or recurrent trichomoniasis	metronidazole[29] If this regimen fails: metronidazole[29] **OR** tinidazole[28] If this regimen fails, susceptibility testing is recommended.	500mg orally 2x/day for 7 days 2 g orally for 7 days 2 g orally for 7 days	

1. The recommended regimens are equally efficacious.
2. These creams are oil-based and may weaken latex condoms and diaphragms. Refer to product labeling for further information.
3. Should not be administered during pregnancy, lactation, or to children <8 years of age.
4. If patient lives in community with high GC prevalence, or has risk factors (e.g. age <25 years, new partner, partner with concurrent sex partners, or sex partner with a STD), consider empiric treatment for GC.
5. If patient cannot tolerate high-dose erythromycin base schedules, change to 250 mg 4x/day for 14 days.
6. If patient cannot tolerate high-dose erythromycin ethylsuccinate schedules, change to 400 mg orally 4 times a day for 14 days.
7. Contraindicated for pregnant or lactating women.
8. Erythromycin estolate is contraindicated during pregnancy.
9. Patients who do not respond to therapy (within 72 hours) should be re-evaluated.
10. For patients with suspected sexually transmitted epididymitis, close follow-up is essential.
11. No definitive information available on prenatal exposure.
12. Treatment may be extended if healing is incomplete after 10 days of therapy.
13. Consider discontinuation of treatment after one year to assess frequency of recurrence.
14. Vaginal, cervical, urethral meatal, and anal warts may require referral to an appropriate specialist.
15. CDC recommends that treatment for uncomplicated gonococcal infections of the cervix, urethra, and/or rectum should include dual therapy, i.e., both a cephalosporin (e.g., ceftriaxone) plus azithromycin.
16. CDC recommends that cefixime in combination with azithromycin or doxycycline be used as an alternative when ceftriaxone is not available. Oral cephalosporins give lower and less-sustained bactericidal levels than ceftriaxone 250 mg; limited efficacy for treating pharyngeal GC.
17. Only ceftriaxone is recommended for the treatment of pharyngeal infection. Providers should inquire about oral sexual exposure.
18. Dual therapy with gemifloxacin 320 mg po plus azithromycin 2 g po or gentamicin 240 mg IM plus azithromycin 2 g po are potential alternatives. ID specialist consult may be prudent. Azithromycin monotherapy is no longer recommended due to resistance concerns and treatment failure reports. Pharyngeal GC patients treated with an alternative regimen should have a test of cure (with culture or nucleic acid amplification test) 14 days after treatment.
19. Every effort should be made to use a recommended regimen. Test-of-cure follow-up (preferably by NAAT) 3-4 weeks after completion of therapy is recommended in pregnancy. In case of allergy to both alternative and recommended regimens, consult with the STD Clinical Consultation Network at www.stdccn.org.
20. Mycoplasma genitalium is the most common cause of recurrent/persistent NGU. Men initially treated with doxycycline should be treated with azithromycin 1g orally. Men who fail a regimen of azithromycin should be treated with moxifloxacin 400mg orally 1x/day for 7 days (effective against M. genitalium)."
21. In areas of high trichomonas prevalence, men who have sex with women should also be treated with metronidazole OR tinidazole 2 g orally in a single dose. MSM are unlikely to benefit from the addition of nitroimidazoles.
22. Testing for gonorrhea and chlamydia is recommended because a specific diagnosis may improve compliance and partner management because these infections are reportable by state law.
23. Evaluate for bacterial vaginosis and trichomonas. Even if bacterial vaginosis is present or cannot be ruled out, treatment with parenteral therapy for the first 24 hours followed by 14 days of therapy is sufficient as described above. If trichomonas is also present, treat per above guidelines.
24. Contraindicated for pregnancy or lactating women, or children <10 years of age.
25. Do not use after a bath; should not be used by persons who have extensive dermatitis.
26. Some specialists recommend 2.4 million units of benzathine penicillin G once weekly for up to 3 weeks after completion of neurosyphilis treatment.
27. Pregnant patients allergic to penicillin should be treated with penicillin after desensitization.
28. Randomized controlled trials comparing single 2 g doses of metronidazole and tinidazole suggest that tinidazole is equivalent to, or superior to, metronidazole in achieving parasitologic cure and resolution of symptoms.
29. Pregnant patients can be treated with 2 g single dose.

★ Indicates update from the 2010 CDC Guidelines for the Treatment of Sexually Transmitted Diseases.

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