HIV GUIDELINES.ORG

ALL RECOMMENDATIONS (continued from P.1)

POST-TREATMENT FOLLOW-UP

• Clinicians should follow up with patients who have completed treatment for gonococcal and chlamydial infections as detailed in Tables 2 and 3, below. (A3)
• Clinicians should rescreen patients who have confirmed gonococcal or chlamydial infection at 3 months post-treatment for evidence of reinfection. (A2)

MANAGEMENT OF HIV EXPOSURE IN SEX PARTNERS

• Clinicians should educate patients with partners who do not have HIV or partners of unknown HIV status to be vigilant for any post-exposure acute HIV symptoms in their partners, such as febrile illness accompanied by rash, lymphadenopathy, myalgias, and/or sore throat. (A3)
• Partners who present within 36 hours of an HIV exposure should be evaluated as soon as possible for initiation of post-exposure prophylaxis therapy. (A3)

MANAGEMENT OF PARTNERS EXPOSED TO N. GONORRHOEAE OR C. TRACHOMATIS

• Clinicians should advise their patients that sex partners who were exposed up to 60 days before the source case’s onset of symptoms or diagnosis of gonococcal or chlamydial infection should seek evaluation and treatment and HIV testing. (A2)
• When a patient with HIV is diagnosed with gonorrhea or chlamydia, clinicians should advise the patient to encourage sex partners to seek medical care for possible exposure to HIV and gonorrhea and chlamydia and should inform the patient that NYSDOH Partner Services offers free, confidential partner notification assistance. (A2)

NEW YORK STATE REPORTING REQUIREMENTS:

• NYS Public Health Law mandates that medical providers report all suspected or confirmed HIV, gonorrhea, and chlamydia diagnoses to the local health department in the area where the patient resides.
• Clinicians must report cases of suspected gonorrhea treatment failure that are not due to reinfection:
  - New York State: Report suspected treatment failures to the local health department within 24 hours.
  - New York City: Call 866-692-3641 to notify the health department of suspected treatment failures.
• NYS Public Health Law mandates that medical providers talk with individuals with HIV infection about their options for informing their sexual partners that they may have been exposed to HIV.
• NYS Public Health Law mandates that expedited partner therapy not be used for sex partners of patients with gonorrhea, syphilis, and/or HIV.

HIV CLINICAL RESOURCE
1/4-FOLDED GUIDE

VISIT HIVGUIDELINES.ORG TO LEARN MORE OR VIEW COMPLETE GUIDE

MANAGEMENT OF GONORRHEA AND CHLAMYDIA IN PATIENTS WITH HIV INFECTION

COMMITTEE FOR THE CARE OF PATIENTS WITH STIs

3/2018

ALL RECOMMENDATIONS P.1

TRANSMISSION AND PREVENTION

• Clinicians should inform patients with HIV about the risk of acquiring or transmitting chlamydia, gonorrhea, and other STIs from close physical contact with all sites of possible exposure, including the penis, vagina, mouth, or anus. (A3)
• When patients with HIV are diagnosed with gonococcal or chlamydial infections, clinicians should educate patients about the following:
  - Risk-reduction strategies, including the value of correct condom use. (A2)
  - The potential for oral transmission of gonorrhea and chlamydia. (A3)
  - The benefits of identifying STIs early. (A3)
  - The need for prompt evaluation and treatment of partners. (A3)

SCREENING

• For MSM and transgender women who have sex with men, clinicians should perform three-site screening (genital, pharyngeal, rectal) at the following intervals:
  - At first visit and every 3 months thereafter if the patient is at low risk of infection. (A2)
  - At first visit and every 6 months thereafter if the patient is at high risk of infection. (A2)
  - High risk: Patient self-identifies as being at high risk of STIs and/or has sexual risk factors.
  - For patients who test positive for rectal chlamydial infection or who present with such signs and symptoms, clinicians should obtain samples for both culture/susceptibility and NAAT. (A1)
  - If a patient has a known exposure to a cephalosporin-resistant strain, clinicians should obtain NAAT on samples collected from genital and extragenital sites. (A2)
  - At first visit and every 3 months thereafter if the patient is at high risk of infection. (A2)
  - At first visit and every 6 months thereafter if the patient is at low risk of infection. (A2)
  - For patients with HIV infection, clinicians should obtain NAAT on samples collected from genital and extragenital sites. (A2)
  - At first visit and every 3 months thereafter if the patient is at low risk of infection. (A2)
  - At first visit and every 6 months thereafter if the patient is at high risk of infection. (A2)

Continued on P.2 →
TREATMENT, FOLLOW-UP, AND RE-TREATMENT

### TABLE 1: Recommended Treatment for Uncomplicated Chlamydial and LGV Infections [adapted from CDC, 2015]

<table>
<thead>
<tr>
<th>Infection</th>
<th>Regimen</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Uncomplicated cervical, urethral, rectal, or pharyngeal infection</td>
<td><strong>Recommended:</strong>&lt;br&gt;• Azithromycin 1 g by mouth as a single dose OR&lt;br&gt;• Doxycycline 100 mg by mouth twice daily for 7 days.&lt;br&gt;<strong>Alternatives:</strong>&lt;br&gt;• Erythromycin base 500 mg by mouth four times per day for 7 days OR&lt;br&gt;• Erythromycin ethylsuccinate 800 mg by mouth four times per day for 7 days OR&lt;br&gt;• Levofloxacin 500 mg by mouth once daily for 7 days OR&lt;br&gt;• Ofloxacin 300 mg by mouth twice per day for 7 days.</td>
<td>• Treat asymptomatic pharyngeal infection even if it is the only site of infection.&lt;br&gt;• Alternative regimens are NOT recommended for pharyngeal infections.</td>
</tr>
</tbody>
</table>

| Symptomatic proctitis | Doxycycline 100 mg by mouth twice daily for 21 days. | • Presumptively treat for LGV; if LGV is excluded by testing, then patients should complete the standard seven-day regimen for uncomplicated chlamydial infection. |

### TABLE 2: Recommended Follow-Up after Completion of Treatment for Uncomplicated Gonococcal Infection [adapted from CDC, 2015]

<table>
<thead>
<tr>
<th>Clinical Circumstance</th>
<th>Recommended Clinician Follow-Up</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asymptomatic after treatment with recommended regimen:</td>
<td>• Retest at 3 months (or as close to 3 months as possible) post-treatment to assess for reinfection.</td>
</tr>
<tr>
<td>Asymptomatic after possibly ineffective course of treatment:</td>
<td>• Assess for re-exposure and partner treatment.</td>
</tr>
<tr>
<td>Symptomatic post-treatment: Persistent symptoms post-treatment; infection at any site.</td>
<td>• Assess for re-exposure and partner treatment.</td>
</tr>
</tbody>
</table>

### TABLE 3: Recommended Follow-Up after Completion of Treatment for Uncomplicated Chlamydia Infection [adapted from CDC, 2015]

<table>
<thead>
<tr>
<th>Clinical Circumstance</th>
<th>Recommended Clinician Follow-Up</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asymptomatic after treatment with preferred or alternative regimen.</td>
<td>• Retest at 3 months (or as close to 3 months as possible) post-treatment to assess for reinfection.</td>
</tr>
</tbody>
</table>

### TABLE 4: Recommended Retreatment Regimens after Suspected Failure of Treatment for Uncomplicated Gonococcal Infection [adapted from CDC, 2015]

<table>
<thead>
<tr>
<th>Clinical Circumstance</th>
<th>Recommended Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Possible reinfection (most cases).</td>
<td>Ceftriaxone 250 mg by mouth in a single dose PLUS azithromycin 2 g by mouth in a single dose.</td>
</tr>
<tr>
<td>Low reinfection risk; initial treatment was incomplete or regimen administered was not preferred or alternative.</td>
<td>Ceftriaxone 250 mg by mouth in a single dose PLUS azithromycin 1 g by mouth in a single dose.</td>
</tr>
<tr>
<td>Low reinfection risk; initial treatment with cefixime and azithromycin.</td>
<td>Ceftriaxone 250 mg by mouth in a single dose PLUS azithromycin 2 g by mouth in a single dose.</td>
</tr>
<tr>
<td>Low reinfection risk; initial treatment with ceftriaxone 250 mg IM and azithromycin 1 g by mouth.</td>
<td>Gentamicin 240 mg IM or gemifloxacin 320 mg by mouth PLUS azithromycin 2 g by mouth in a single dose.</td>
</tr>
<tr>
<td>Reduced susceptibility to relevant antibiotics on antimicrobial susceptibility testing.</td>
<td>Consult local health department.</td>
</tr>
<tr>
<td>Patient cannot follow above regimens due to allergies.</td>
<td>Obtain clinical consultation with infectious disease specialist.</td>
</tr>
</tbody>
</table>

### KEY POINTS
- Because most gonorrheal and chlamydial infections are asymptomatic, regular screening is essential to protect patients’ health and prevent the spread of STIs. This is an essential component of patient education.
- People infected with N. gonorrhoeae are frequently coinfected with C. trachomatis.
- Although LGV occurs only sporadically in the United States, outbreaks of LGV have been reported in NYC and other cities among MSM, and many of these cases occurred in individuals with HIV.
- Gonococcal and chlamydial reinfection rates are high among people who have been successfully treated.