Interim STD Treatment Recommendations During COVID-19 for Symptomatic Patients

This table summarizes interim CDC guidance from April 2020 for scenarios when in-person clinical exams are limited. In-person examination for symptomatic patients is preferred when possible.

Syndrome	Preferred Treatments (In clinic or other settings where IM route feasible[1])	Alternative Treatments (when only oral regimens are feasible[2])	Follow-up
Penile discharge or urethritis syndrome **(presumptive treatment for GC and CT)**	**Ceftriaxone[3] 250 mg IM PLUS Azithromycin 1 gm PO** (If azithromycin not available and patient is not pregnant, can use Doxycycline 100 mg PO twice a day for 7 days)	**Cefixime[4] 800 mg PO PLUS Azithromycin 1 gm PO** **OR** **Cefpodoxime[4] 400 mg PO Q 12 hr X 2 doses PLUS Azithromycin 1 gm PO** (If azithromycin not available and patient is not pregnant, can use Doxycycline 100 mg PO twice a day for 7 days)	If treated with alternative oral regimens, counsel patients to seek follow-up in 5-7 days if symptoms do not improve. Counsel patients to be tested for STIs/HIV once in-person clinical care resumes. Health departments should make efforts to assist with: - Follow-up reminders for comprehensive STI testing/screening for clients who received alternative oral regimens - Linkage to services when open Patients treated for syphilis with non-benzathine penicillin regimens should have serologic testing done 3 months after treatment
Vaginal discharge without suspected pelvic inflammatory disease (PID)[5]	Treatment guided by exam and laboratory results	Discharge/odor suggestive of bacterial vaginosis or trichomoniasis: **Metronidazole 500 mg PO twice a day for 7 days** Discharge (cottage cheese-like) with genital itching: **Fluconazole 150 mg PO**	
Genital Ulcer Disease (GUD), Suspected Primary or Secondary Syphilis[6]	**Benzathine penicillin G 2.4 million units IM**	Males and non-pregnant females: **Doxycycline 100 mg PO twice a day for 14 days** _____ Pregnant patients: **Benzathine penicillin G 2.4 million units IM**	
Proctitis Syndrome[7]	**Ceftriaxone 250 mg IM PLUS Doxycycline 100 mg PO twice a day for 7 days** (If doxycycline is not available or patient is pregnant use azithromycin 1 gm PO)	**Cefixime 800 mg PO PLUS Doxycycline 100 mg PO twice a day for 7 days** **OR** **Cefpodoxime 400 mg PO Q 12 hr X 2 doses PLUS Doxycycline 100 mg PO twice a day for 7 days** (If doxycycline is not available or patient is pregnant use azithromycin 1 gm PO)	
Expedited Partner Therapy	If patient diagnosed w/CT: **Azithromycin 1 gm PO** If patient diagnosed w/GC or presumptively treated: **Cefixime[4] 800 mg PO PLUS Azithromycin 1 gm PO OR Cefpodoxime[4] 400 mg PO Q 12 hr X 2 doses PLUS Azithromycin 1 gm PO** (If azithromycin not available and partner is not pregnant, can use Doxycycline 100 mg PO twice a day for 7 days)		

1. When possible, clinics should make arrangements for patients to receive injections at local pharmacies/clinics that remain open.
2. Consider alternative regimens when CDC 2015 STD Treatment Guidelines recommended regimens are not available.
3. If cephalosporin allergy, treat with gentamicin 240 mg IM plus azithromycin 2 gm orally.
4. If oral cephalosporins not available or allergy to cephalosporins then azithromycin 2 gm orally can be used as alternative treatment.
5. Symptoms of PID can include lower abdominal pain, dyspareunia, fever; patients with symptoms of PID should have in-person evaluation.
6. All pregnant patients with syphilis **must receive** benzathine penicillin G. If signs of neurosyphilis are present (e.g., cranial nerve dysfunction, auditory/ophthalmic abnormalities, meningitis, acute or chronic altered mental status, loss of vibration sense), conduct in-person evaluation.
7. Consider adding therapy for herpes simplex virus if painful ulcers are present.