



April 6, 2020

Dear Colleagues,

This letter offers guidance to STD prevention programs, including STD clinics, on providing effective STD care and prevention when facility-based services and in-person patient-clinician contact is limited. Many health care settings have expanded phone triage and telehealth services, and some clinics that provide STD services have had to temporarily close.

During this time, a flexible and pragmatic approach that minimizes reductions in STD care and treatment is needed in areas where clinical services are at risk of being, or have been, disrupted. If STD clinic services have not been disrupted, providers should continue to follow recommendations in the [2015 STD Treatment Guidelines](#) and the [Recommendations for Providing Quality STD Clinical Services, 2020](#) with appropriate precautions to prevent SARS-CoV-2 transmission to patients and providers (see [CDC Guidance for Healthcare Providers](#)).

For jurisdictions that are experiencing disruption in STD clinical services, CDC offers the following guidance for STD programs and clinics to consider in the local context of resources and staff.

1. STD clinics that remain open but are limiting the number of patients seen should prioritize patients with STD symptoms, those reporting STD contact, and individuals at risk for complications (i.e. women with vaginal discharge and abdominal pain, pregnant women with syphilis, individuals with symptoms concerning for neurosyphilis). Routine screening visits should be deferred until the emergency response is over.
2. Phone or telemedicine-based triage, including syndromic management of male urethritis, suspected primary or secondary syphilis, vaginal discharge and proctitis, could be implemented (see Table 1 below). A triage protocol that includes identification and referral for additional evaluation of individuals at risk for complications is essential.
3. If an STD program is considering closing clinics, STD programs should try to establish relationships with other clinics and/or pharmacies that can provide preferred treatments (e.g., injections of ceftriaxone, penicillin G benzathine [Bicillin L-A® or BIC], or gentamicin). Symptomatic patients and their known contacts could be referred to these sites for syndromic treatment (See Table 1 below). Some STD programs have already implemented home or non-clinic-based testing programs. CDC encourages development of innovative testing protocols for self-collected clinical laboratory specimens.

Lastly, we have received some reports of shortages of cefixime, azithromycin and gentamicin in some clinic settings. In our discussions with FDA, they are not aware of any shortages of cefixime and azithromycin in nationwide supply chains. The problem seems to be within some local distribution

chains. We are currently investigating a potential gentamicin shortage and we will keep you updated. If you are experiencing any medication shortages, please contact your DSTDP prevention specialist.

We, at CDC, appreciate all that you do to combat STDs including HIV, and even more so as our nation faces the COVID-19 pandemic. The situation is evolving, new challenges and questions are arising daily as well as new science and guidance becoming available. We will keep in touch with you during the coming days. Please feel free to reach out to us with any questions and stay safe.

Sincerely,

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**Table 1. Therapeutic options to consider for symptomatic patients and their partners when in person clinical evaluation is not feasible:**

Syndrome	Preferred Treatments In clinic, or other location where injections can be given*	Alternative Treatments When only oral medications are available&	Follow-up
<b>Male urethritis syndrome</b>	Ceftriaxone 250mg intramuscular (IM) in a single dose <b>PLUS</b> Azithromycin 1g orally in a single dose (If azithromycin is not available and patient is not pregnant, then doxycycline 100 mg orally twice a day for 7 days is recommended).  If cephalosporin allergy is reported, gentamicin 240 mg IM in a single dose <b>PLUS</b> azithromycin 2 g orally in single dose is recommended.	Cefixime 800 mg orally in a single dose <b>PLUS</b> Azithromycin 1g orally in a single dose (If azithromycin is not available and the patient is not pregnant, doxycycline 100 mg orally twice a day for 7 days is recommended). <b>OR</b> Cefpodoxime 400 mg orally q12 hours x 2 doses <b>PLUS</b> Azithromycin 1g orally in a single dose (If azithromycin is not available and the patient is not pregnant, doxycycline 100 mg orally twice a day for 7 days is recommended).  If oral cephalosporin is not available or cephalosporin allergy is reported, azithromycin 2g orally in a single dose.	For alternative oral regimens, patients should be counseled that if their symptoms do not improve or resolve within 5-7 days, they should follow-up with the clinic or a medical provider.  Patients should be counseled to be tested for STIs once clinical care is resumed in the jurisdiction. Health departments should make an effort to remind clients who have been referred for oral treatment to return for comprehensive testing and screening and link them to services at that time.
<b>Genital ulcer disease (GUD) Suspected primary or secondary syphilis<sup>++</sup></b>	Benzathine penicillin G, 2.4 million units IM in a single dose.	<u>Males and non-pregnant females:</u> Doxycycline 100 mg orally twice a day for 14 days.	All patients receiving regimens other than Benzathine penicillin for syphilis treatment should have repeat serologic testing performed 3 months post-treatment.
		<u>Pregnant:</u> Benzathine penicillin G, 2.4 million units IM in a single dose.	
<b>Vaginal discharge syndrome in women without lower abdominal pain, dyspareunia or other signs concerning for pelvic inflammatory disease (PID)</b>	Treatment guided by examination and laboratory results.	<b>Discharge suggestive of bacterial vaginosis or trichomoniasis (frothy, odor):</b> Metronidazole 500 mg orally twice a day for 7 days.	
		<b>Discharge cottage cheese-like with genital itching:</b> Therapy directed at candida.	
<b>Proctitis syndrome#</b>	Ceftriaxone 250mg IM in a single dose <b>PLUS</b> doxycycline 100 mg orally twice a day for 7 days. If doxycycline not available or the patient is pregnant, azithromycin 1g orally in single dose recommended.	Cefixime 800 mg orally in a single dose <b>PLUS</b> doxycycline 100 mg orally bid for 7 days (if doxycycline not available or the patient is pregnant, azithromycin 1g orally in single dose recommended). <b>OR</b> Cefpodoxime 400 mg orally q12 hours x 2 doses <b>PLUS</b> doxycycline 100 mg orally bid for 7 days (if doxycycline not available or the patient is pregnant, azithromycin 1g orally in single dose recommended).	

\*When possible, clinics should make arrangements with local pharmacies or other clinics that are still open and can give injections

&Alternative regimens should be considered when recommended treatments from the 2015 CDC STD Treatment Guidelines are not available

<sup>++</sup>All pregnant women with syphilis must receive Benzathine penicillin G. If clinical signs of neurosyphilis present (e.g. cranial nerve dysfunction, auditory or ophthalmic abnormalities, meningitis, stroke, acute or chronic altered mental status, loss of vibration sense), further evaluation is warranted

#Consider adding therapy for herpes simplex virus if pain present