COUNTY OF LOS ANGELES
Public Health

LOS ANGELES COUNTY HEALTH AGENCY

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April 23, 2020

Dear Los Angeles County STD Prevention and Care Champions,

The coronavirus (COVID-19) pandemic has thrust our community into unknown territory. We recognize this is a challenging time, with many clinics having to make considerable changes to clinical operations. In recent weeks, both the Centers for Disease Control and Prevention (CDC) and the California Department of Public Health (CDPH) issued guidance regarding how best to manage patients in need of STD services during the current phase of the COVID-19 crisis, when in-person patient-clinician contact may be limited. Please take a moment to review these brief documents which are attached to this letter for your review and reference.

We want to highlight the CDPH's "Interim STD Treatment Recommendations During COVID-19 for Symptomatic Patients," which provides recommendations for the syndromic treatment of STDs when treating presumptively or if only oral treatments are available. A few key points are summarized here:

- For patients with diagnosed or presumptive diagnosis of gonorrhea, when only oral treatment is available, **use of Cefixime is an acceptable substitute for Ceftriaxone, but at 800 mg orally**. This differs from the 2015 CDC STD treatment guidelines and is based on recent pharmacokinetic and resistance data.
- Patients receiving alternative oral regimens should be counseled that if their symptoms do not improve or resolve within 5-7 days and they should follow-up with the clinic or a medical provider.
- Patients treated presumptively for STDs without testing should be counseled of the importance of being tested for STDs once more routine clinical care can be safely resumed in Los Angeles County.
- Patients receiving regimens other than Benzathine penicillin for syphilis treatment should have repeat serologic testing performed 3-months post-treatment.

Please call the Division of HIV and STD Programs (DHSP) Clinical Consultation warmline at 213-368-7441, with clinical questions related to the care and treatment of patients with STDs. Staff continue to be available Monday through Friday, from 8am to 5pm. In addition, DHSP has the capacity to deliver Bicillin to providers treating pregnant patients with syphilis.

DHSP appreciates all that you do to combat STDs and HIV. Please feel free to reach out to us with any questions.

Sincerely,

Sonali P. Kulkarni, MD, MPH
Medical Director

Monica Munoz, RN, MPH
Nurse Manager

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Centers for Disease Control and Prevention

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 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
Male urethritis syndrome	Ceftriaxone 250mg intramuscular (IM) in a single dose **PLUS** 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 **PLUS** azithromycin 2 g orally in single dose is recommended.	Cefixime 800 mg orally in a single dose **PLUS** 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). **OR** Cefpodoxime 400 mg orally q12 hours x 2 doses **PLUS** 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. All patients receiving regimens other than Benzathine penicillin for syphilis treatment should have repeat serologic testing performed 3 months post-treatment.
Genital ulcer disease (GUD) Suspected primary or secondary syphilis[++]	Benzathine penicillin G, 2.4 million units IM in a single dose.	Males and non-pregnant females: Doxycycline 100 mg orally twice a day for 14 days. Pregnant: Benzathine penicillin G, 2.4 million units IM in a single dose.	
Vaginal discharge syndrome in women without lower abdominal pain, dyspareunia or other signs concerning for pelvic inflammatory disease (PID)	Treatment guided by examination and laboratory results.	**Discharge suggestive of bacterial vaginosis or trichomoniasis (frothy, odor):** Metronidazole 500 mg orally twice a day for 7 days. **Discharge cottage cheese-like with genital itching:** Therapy directed at candida.	
Proctitis syndrome#	Ceftriaxone 250mg IM in a single dose **PLUS** 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 **PLUS** doxycycline 100 mg orally bid for 7 days (if doxycycline not available or the patient is pregnant, azithromycin 1g orally in single dose recommended). **OR** Cefpodoxime 400 mg orally q12 hours x 2 doses **PLUS** 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
[++]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

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
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**	Patients treated for syphilis with non-benzathine penicillin regimens should have serologic testing done 3 months after treatment
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 patient 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.

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