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August 30, 2011

**Clinical Alert:**  
**Gonorrhea Dual Therapy Treatment Recommendations**

Dear Colleague:

In an effort to prevent the emergence of cephalosporin-resistant gonorrhea, the CDC is currently recommending the following dual therapy as the most effective treatment for uncomplicated gonorrhea:

**Ceftriaxone 250 mg intramuscularly once plus azithromycin 1 g orally once.<sup>1</sup>**

An oral regimen with single dose **cefixime** 400 mg once plus **azithromycin** 1 g once is recommended when treatment with ceftriaxone is not an option. Cefixime (or other oral cephalosporins) is not the preferred treatment due to poor pharyngeal penetrance as well as more rapidly decreasing susceptibility. Azithromycin is currently the preferred dual therapy agent over doxycycline due to the frequency of tetracycline resistance in recent gonorrhea isolates.

Cephalosporins remain an effective treatment for gonococcal infections. Treatment recommendations will likely change, however, if patterns of *Neisseria gonorrhoeae* cephalosporin susceptibility decreases further. Please visit our website for the most current information on the management of gonorrhea as well as other STDs:  
[www.lapublichealth.org/std/providers.htm](http://www.lapublichealth.org/std/providers.htm).

On the opposite page, please find a review of key steps that will help with both the care of your sexually active patients and with the control of gonorrhea.

Thank you for your continued assistance in the control of gonorrhea infection in Los Angeles County.

Sincerely,



Peter R. Kerndt, M.D., M.P.H.

Director

Los Angeles County Sexually Transmitted Disease Program

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<sup>1</sup> Cephalosporin Susceptibility among *Neisseria gonorrhoeae* Isolates---United States, 2000-2010. Morbidity and Mortality Weekly Report, July 8, 2011/ 60(26); 873-877.

# Ten Steps to Help Control Gonorrhea

- 1. Take Sexual Histories Routinely** as part of the clinical interview to determine the patient's risk for gonorrhea (GC) and other STDs, and to guide which anatomic sites to screen. Briefly assess the number and gender of sex partners, history of STDs, prevention of STDs/pregnancy, and sexual practices (i.e. vaginal, anal, oral sex).
- 2. Screen Individuals at Risk:** Screen sexually active women  $\leq 25$  years of age annually for GC and chlamydia. Target screening in other populations according to risk factors such as: history of GC, new or multiple sex partners, partner with other partner(s), men who have sex with men, and commercial sex workers. Men reporting receptive rectal sex and/or oral sex with men should be screened for rectal and/or pharyngeal GC at least annually.
- 3. Use the Best Test Available:** Nucleic acid amplification tests (NAATs) are recommended for screening due to their superior performance over culture and other non-amplified tests. Rectal and pharyngeal GC NAATs are not FDA approved but have been validated by many laboratories. If your laboratory does not offer these tests, ask them to do so.
- 4. Treat Gonorrhea Infections Promptly and Appropriately:**

## **Recommended therapy:**

- Ceftriaxone 250 mg intramuscularly once  
*plus*
- Azithromycin 1g orally once\*

## **Alternative therapy if ceftriaxone cannot be given:**

- Cefixime\*\* 400 mg orally once  
*plus*
- Azithromycin 1g orally once\*

\* Doxycycline 100 mg orally twice daily for 7 days may be used however azithromycin is preferred.

\*\*Cefixime is not recommended for pharyngeal infections. Ceftriaxone is the treatment of choice.

## **Cephalosporin allergy or other contraindications to cephalosporin regimens:**

- Azithromycin 2 g orally once

- 5. Re-screen all patients with gonorrhea 3 months after treatment** to detect re-infections.
- 6. Treat all sexual contacts from last 60 days:** It is the responsibility of the diagnosing physician to make reasonable attempts to ensure that all partners are treated. Offer expedited partner therapy (EPT) for partners (particularly heterosexuals) unable to seek prompt care. Advise patient to abstain or use condoms for 7 days after patient and partner(s) are treated to prevent re-infection.
- 7. Perform test-of-cure (TOC) in the following:** Suspected treatment failures, pregnant women, pharyngeal GC infections not treated with ceftriaxone, and any GC infections not treated with cephalosporins. The ideal TOC method is culture approx. 1 week after treatment. If using a NAAT, testing prior to 3 weeks may result in a false-positive result.
- 8. Report suspected treatment failure:** If providers suspect treatment failure, in the absence of re-exposure, take all necessary steps to culture the organism and contact the STD Program Nursing Unit (213) 744-3106.
- 9. Report GC to Public Health Department** within 7 working days by completing an STD Confidential Morbidity Report (CMR) form, available at <http://publichealth.lacounty.gov/std/cmr.htm> or by calling (213) 741-8000.
- 10. Visit our Provider Webpage for the most up-to date information:** <http://lapublichealth.org/std/providers.htm>