Dear Healthcare Providers: April, 5, 2021

According to the Center for Disease Control (CDC) Morbidity and Mortality Weekly Report (MMWR) from December 2020, "Sexually transmitted infections, (STIs) caused by the bacteria Neisseria Gonorrhoeae (gonococcal infections) have increased 63% since 2014 and are a cause of sequelae including pelvic inflammatory disease, ectopic pregnancy and infertility and can facilitate transmission of human immunodeficiency virus (HIV)." In November 2020, the California Department of Public Health (CDPH) released a "Dear Colleague" letter after receiving increasing reports of disseminated gonococcal infections (DGI), an uncommon but severe complication of untreated gonorrhea.

In response to increasing antibacterial resistance with azithromycin and the need to be good stewards of our antibiotics, CDC has changed the recommended treatment for uncomplicated gonococcal infection. Uncomplicated gonococcal infections of the urogenital, rectal or pharyngeal tracts are infections that are not associated with bacteremia (i.e. DGI) or ascending spread (i.e. PID) of the pathogen to other organs.

In December of 2020, the CDC released updated treatment guidance for gonococcal infection from dual therapy ceftriaxone and azithromycin to monotherapy using a higher dose of ceftriaxone. **The current treatment regimen for gonorrhea is now a single dose of ceftriaxone 500 mg IM. Dual therapy with azithromycin is no longer the recommended standard. When treating patients with gonorrhea in whom chlamydial infection has not been ruled out, empiric co-treatment with doxycycline should be given, unless tetracyclines are contraindicated.**

Summary of Recommendations

- *When treating for gonorrhea,* ***include screening for chlamydia, syphilis, HIV and Hepatitis C****.*
- Complete a sexual and medical history including history of STI testing/treatment.
- Assess for pregnancy in females
- Perform a thorough physical exam including genital exam
- Use a NAAT swab when testing for gonorrhea (pharyngeal, urogenital, and rectal)
- Obtain a partner history and refer all partners within the last 60 days for testing and treatment
- Educate the patient to abstain from sex for 1 week after treatment
- Encourage the use of condoms
- If HIV negative, offer HIV pre-exposure prophylaxis (PrEP)
- A test of cure in 7-14 days is recommended for patients with pharyngeal gonorrhea
- Because reinfection is common, rescreen your patient after 3 months
- Report all cases of suspected gonococcal treatment failures and suspected DGI to Humboldt County Public Health Communicable Disease by phone (707) 268-2182 or fax (707) 445-7346.

Treat gonococcal infection according to the new CDC guidelines:

Uncomplicated urogenital, rectal, and pharyngeal gonorrhea:

- Ceftriaxone 500 mg IM once in patients weighing < 150 kg
  OR
- Ceftriaxone 1 g IM once in patients weighing ≥ 150 kg

Co-treat for urogenital or rectal chlamydia* (if chlamydia infection has not been ruled out at these anatomic sites):

- Doxycycline 100 mg orally twice daily x 7 days
  OR
- Azithromycin 1 g orally once if the patient is pregnant, or pregnancy has not been ruled out in a patient biologically capable of pregnancy.

*Doxycycline is now favored over azithromycin for the treatment of uncomplicated chlamydia, particularly for rectal chlamydia and chlamydia urethritis. Updated guidance on the treatment of chlamydia will be included in the forthcoming 2021 CDC STI Treatment Guidelines.

Patients with urogenital or rectal gonorrhea who have a history of severe allergy to cephalosporins should receive:

- Gentamicin 240 mg IM once plus azithromycin 2 grams orally once
  - Counsel the patient that they may experience nausea, vomiting, or diarrhea with this dose of azithromycin.
  - Co-treatment with doxycycline is not necessary with this regimen, since it includes azithromycin.

Patients with pharyngeal gonorrhea who have a history of allergy to cephalosporins should receive*:*

- No reliable alternative treatments are available.

- If history of beta-lactam allergy, a thorough assessment of the allergic reaction is recommended.

- If history of anaphylactic or other severe reactive to ceftriaxone, consult an Infectious Disease specialist or www.STDCCN.org for advice.

Please post the attached PDF entitled "CDC Gonorrhea Treatment Update" for provider use in your facility. For any questions, call the Humboldt County Public Health Communicable Disease Program at (707) 268-2182.

The following team members are available via phone or email:

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Thank you for the excellent medical service you bring to this community.

Sincerely,

Ian Hoffman, MD, MPH

Health Officer Humboldt County

CDC 2020 Gonorrhea Treatment Update:
Single 500 mg IM Dose of Ceftriaxone Recommended

This table summarizes the Centers for Disease Control and Prevention (CDC) "Update to CDC's Treatment Guidelines for Gonococcal Infection, 2020" published December 18th, 2020. This guidance updates the 2015 CDC STD Treatment Guidelines and reflects changes expected in the forthcoming CDC 2021 STI Treatment Guidelines.

The new gonorrhea treatment regimens have shifted to monotherapy with a higher dose due to the following reasons:

1. Increasing concern for antimicrobial stewardship and the potential impact of dual therapy on commensal organisms and concurrent pathogens
2. Continued low incidence of gonorrhea isolate strains with ceftriaxone resistance
3. Increased incidence of azithromycin resistance

Disease	Recommended Regimen	Alternative Regimen	Follow up
Uncomplicated Urogenital and Rectal Gonorrhea (GC)	**Ceftriaxone 500 mg IM for persons weighing <150 kg (330 lb)[1]** **If chlamydia has not been excluded with a negative test result, then treat for chlamydia with doxycycline 100 mg PO BID for 7 days. (*During pregnancy use azithromycin 1 gm orally for chlamydia treatment)***	**Cefixime[2] 800 mg orally OR Gentamicin[3] 240 mg IM PLUS Azithromycin 2 gm orally** **If chlamydia has not been excluded with negative test result, then treat for chlamydia with doxycycline 100 mg PO BID for 7 days. (*During pregnancy use azithromycin 1 gm orally for chlamydia treatment)***	Retest[5] all patients for reinfection 3 months after treatment (even if all sex partners were treated). If retesting[5] at 3 months is not possible, retesting can be performed at any time within 1-12 months after treatment.
Uncomplicated Pharyngeal Gonorrhea (GC)	**Ceftriaxone 500mg IM for persons weighing <150 kg (330 lb)[1]** **If chlamydia coinfection is identified during testing for pharyngeal GC then add treatment for chlamydia with doxycycline 100 mg PO BID for 7 days. (*During pregnancy use azithromycin 1 gm orally for chlamydia treatment)***	No reliable alternative treatments are available. If history of beta-lactam allergy, a thorough assessment of the allergic reaction is recommended.[4] If history of anaphylactic or other severe reaction (e.g., Stevens Johnson syndrome) to ceftriaxone, consult an Infectious Disease specialist or www.STDCCN.org for advice.	A test-of-cure is recommended using culture or nucleic acid amplification test 7–14 days after initial treatment. Retest[5] all patients for reinfection 3 months after treatment (even if all sex partners were treated). If retesting[5] at 3 months is not possible, retesting can be performed at any time within 1-12 months after treatment.

Citation

St. Cyr S, Barbee L, Workowski KA, et al. Update to CDC's Treatment Guidelines for Gonococcal Infection, 2020. MMWR Morb Mortal Wkly Rep 2020;69:1911–1916. DOI: http://dx.doi.org/10.15585/mmwr.mm6950a6external icon

1. For persons weighing ≥150 kg (330 lb), 1 g of ceftriaxone should be administered IM.
2. Oral cefixime can be used if administration of ceftriaxone is not available. Cefixime does not provide as high, or as sustained bactericidal levels as ceftriaxone. Cefixime has limited efficacy for pharyngeal infection.
3. If the patient has a cephalosporin allergy, gentamicin plus azithromycin regimen can be used for treatment.
4. Information about assessing prior history of allergy is described in the CDC 2015 STD Treatment Guidelines gonorrhea section. (https://www.cdc.gov/std/tg2015/gonorrhea.htm)
5. Retesting assesses for reinfection; reinfection is common within 12 months of diagnosis/treatment for gonorrhea.

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