

# ADVANCING STI CARE

Epidemiology, Communication, and Updated  
Treatment Guidelines

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(She, her)

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Division of ID



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# DISCLOSURES

- No relevant financial disclosures



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# OBJECTIVES

Describe the regional prevalence of STI

Identify sub-populations at risk for STI

Discuss STI and Treatment updates

Review STI Prophylaxis

# ACCELERATING PROGRESS

## A MESSAGE FROM THE CDC

- Increase awareness of STIs
- Collective public health efforts for prevention and control
- Increased use of innovation
  - STI self-tests
  - Newer point-of-care tests
  - Doxy PEP
- Empowering communities to prioritize STI control
  - Modernizing our systems
  - Advancing research
  - Support the public health workforce

CDC Releases 2024 National STI Data

# OBJECTIVES

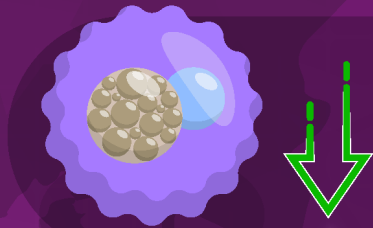
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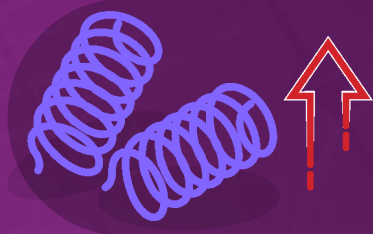
# The State of STIs in the U.S. in 2024



**1.5 million** cases of **CHLAMYDIA**;  
**4% decrease** since 2020.



**543,409** cases of **GONORRHEA**;  
**20% decrease** since 2020.



**190,242** cases of **SYPHILIS**;  
**42% increase** since 2020.

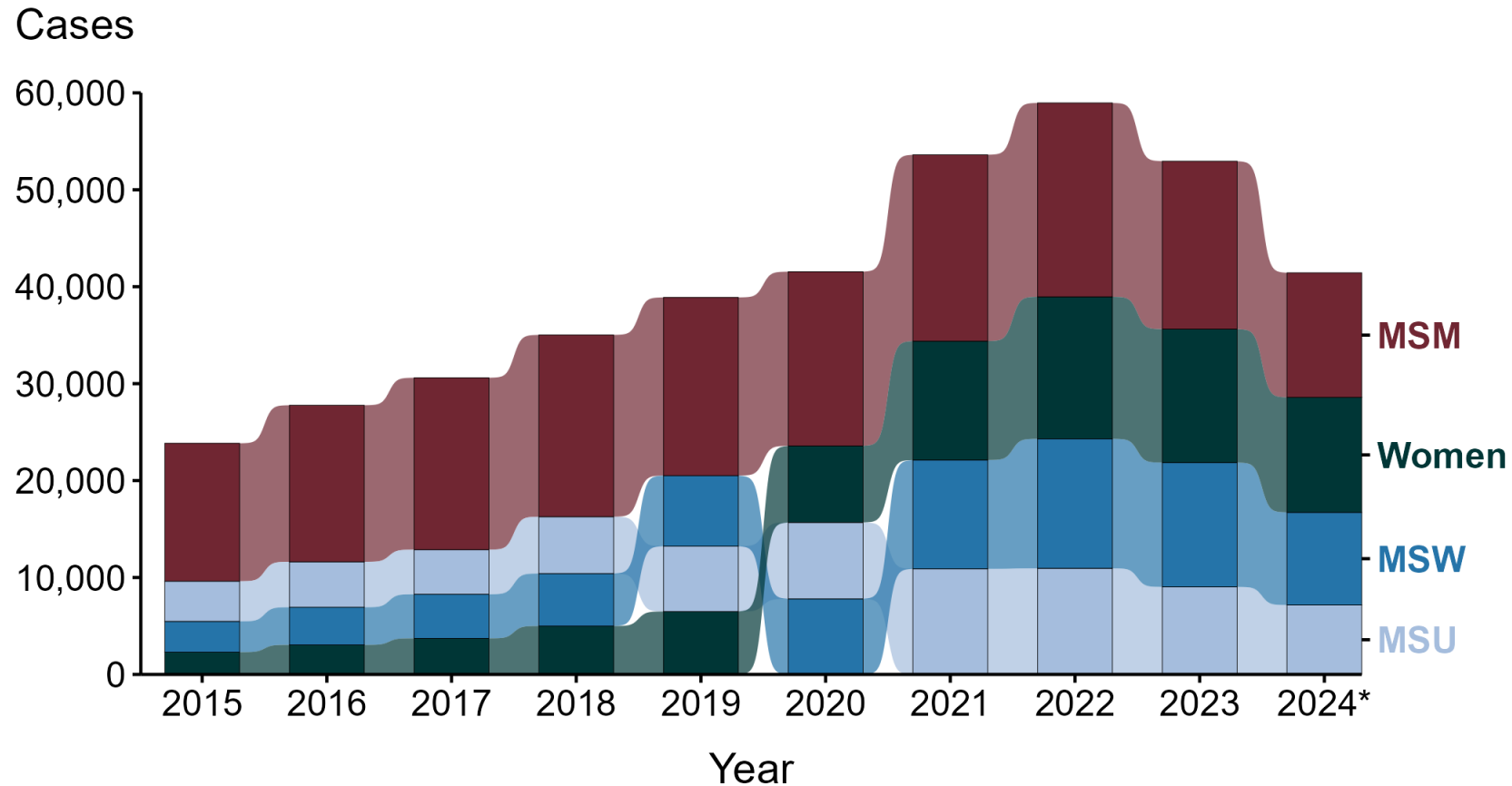


**3,941** cases of **SYPHILIS AMONG NEWBORNS**;  
**82% increase** since 2020.

Data are provisional. Details:  
[www.cdc.gov/sti-statistics](http://www.cdc.gov/sti-statistics)



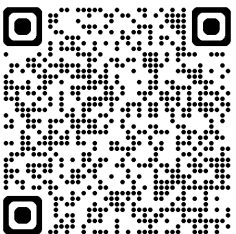
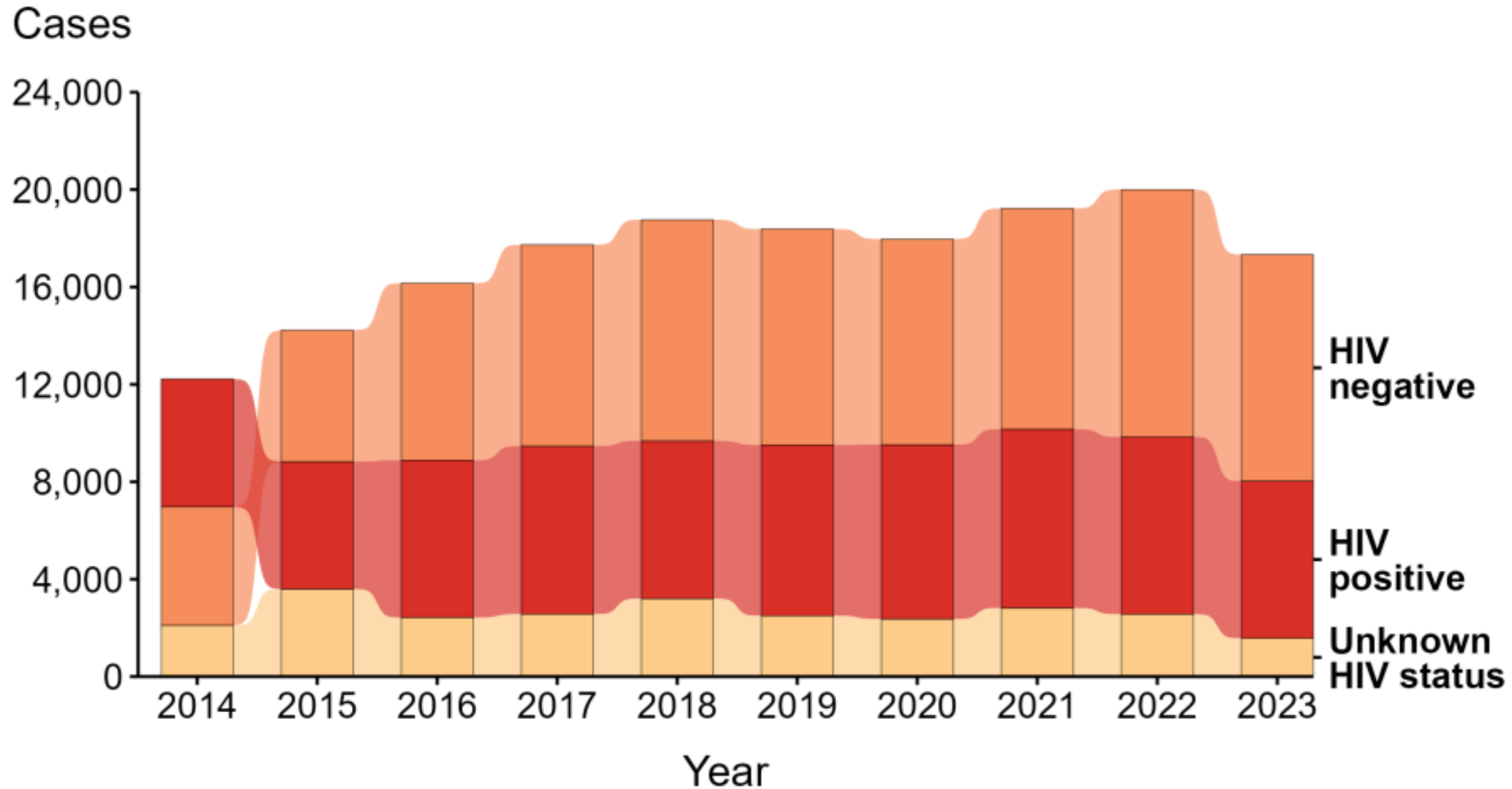
# Primary and Secondary Syphilis — Reported Cases by Sex and Sex of Sex Partners and Year, United States, 2015–2024



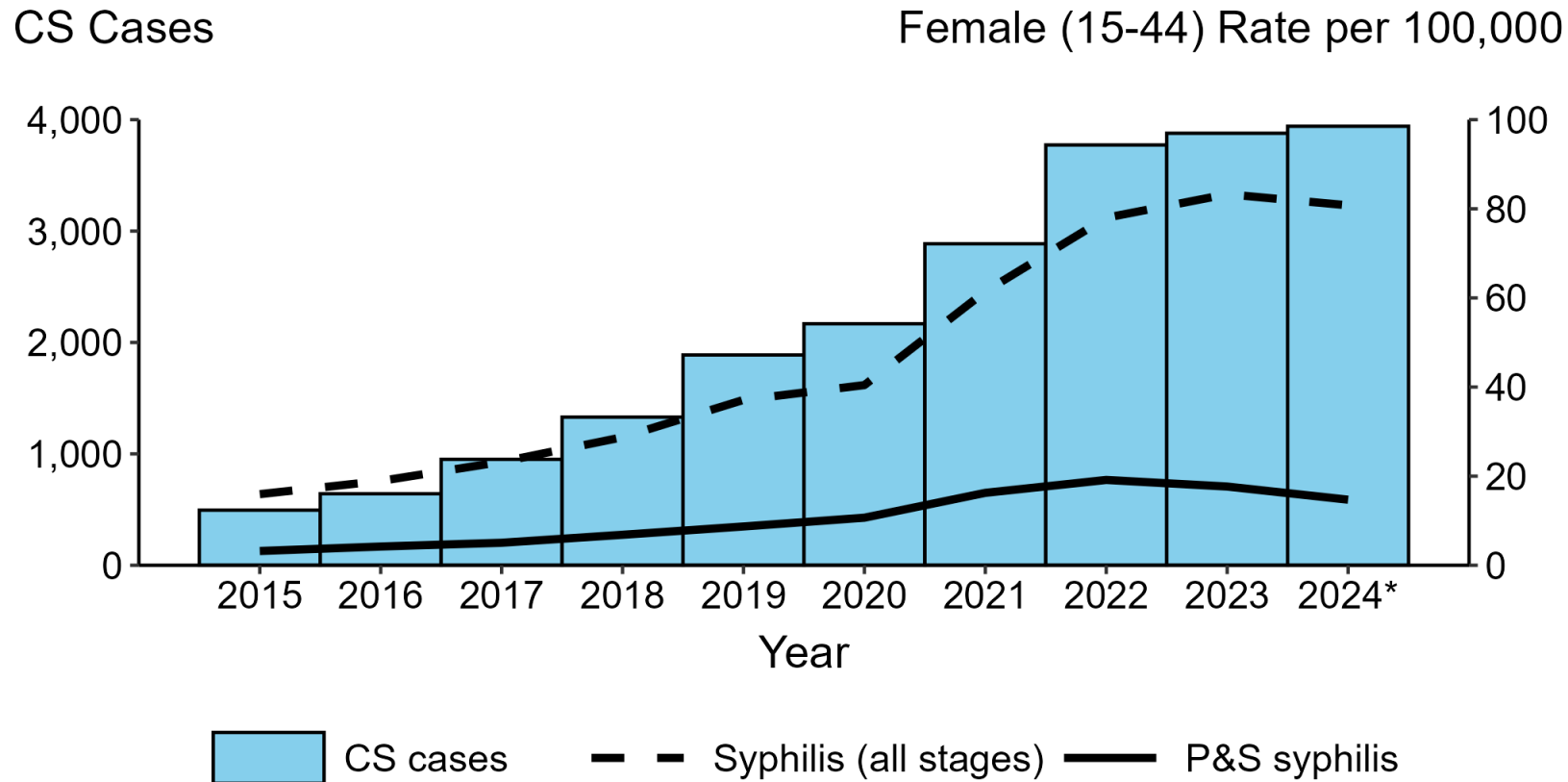
\* 2024 data are provisional as of August 14, 2025.

**ACRONYMS:** MSM = Men who have sex with men; MSU = Men with unknown sex of sex partners; MSW = Men who have sex with women only

# Primary and Secondary Syphilis — Reported Cases Among Men Who Have Sex with Men by HIV Status and Year, United States, 2014–2023



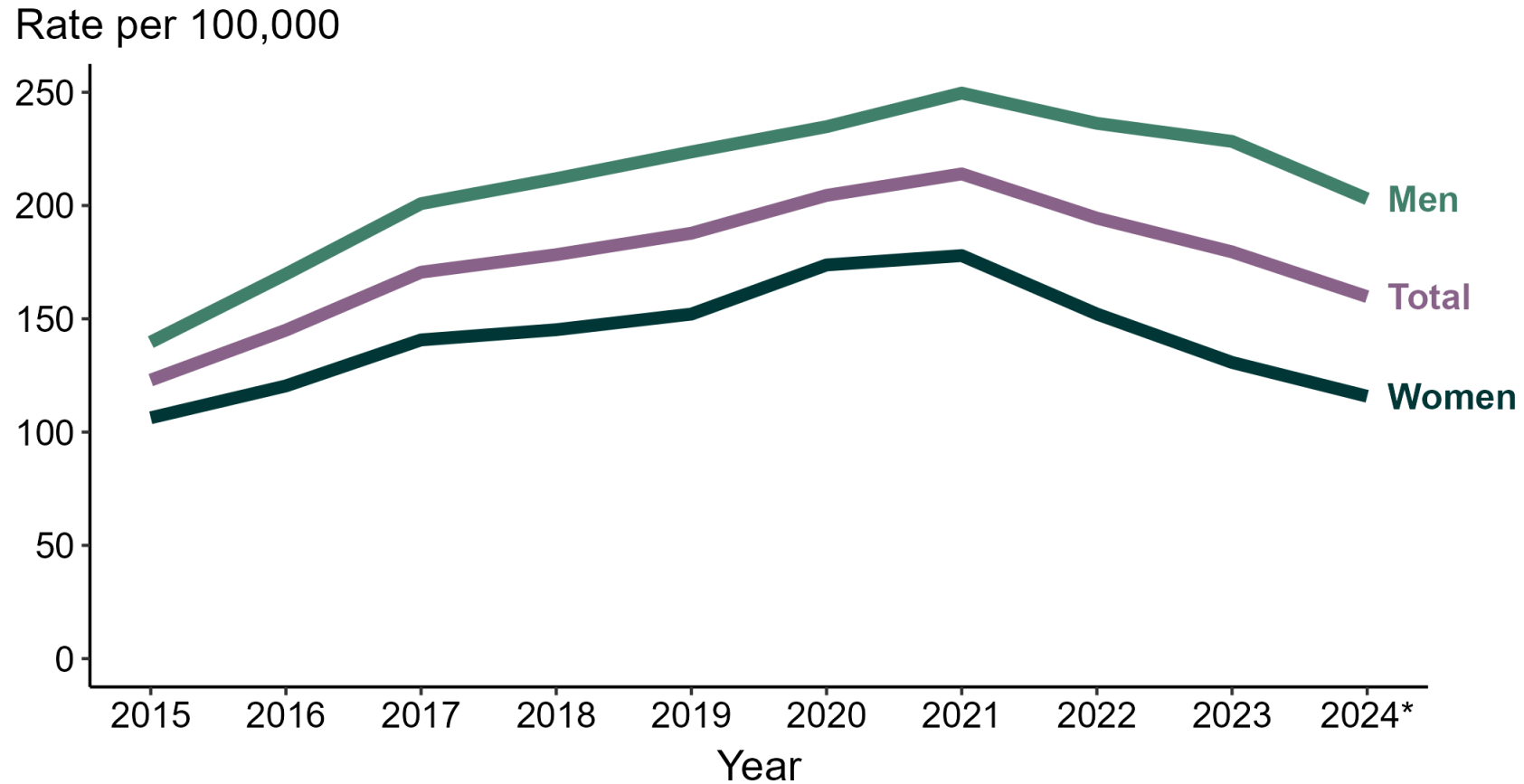
# Congenital Syphilis — Reported Cases by Year of Birth and Rates of Reported Cases of Primary and Secondary Syphilis and Syphilis (All Stages) Among Women Aged 15–44 Years, United States, 2015–2024



\* 2024 data are provisional as of August 14, 2025.

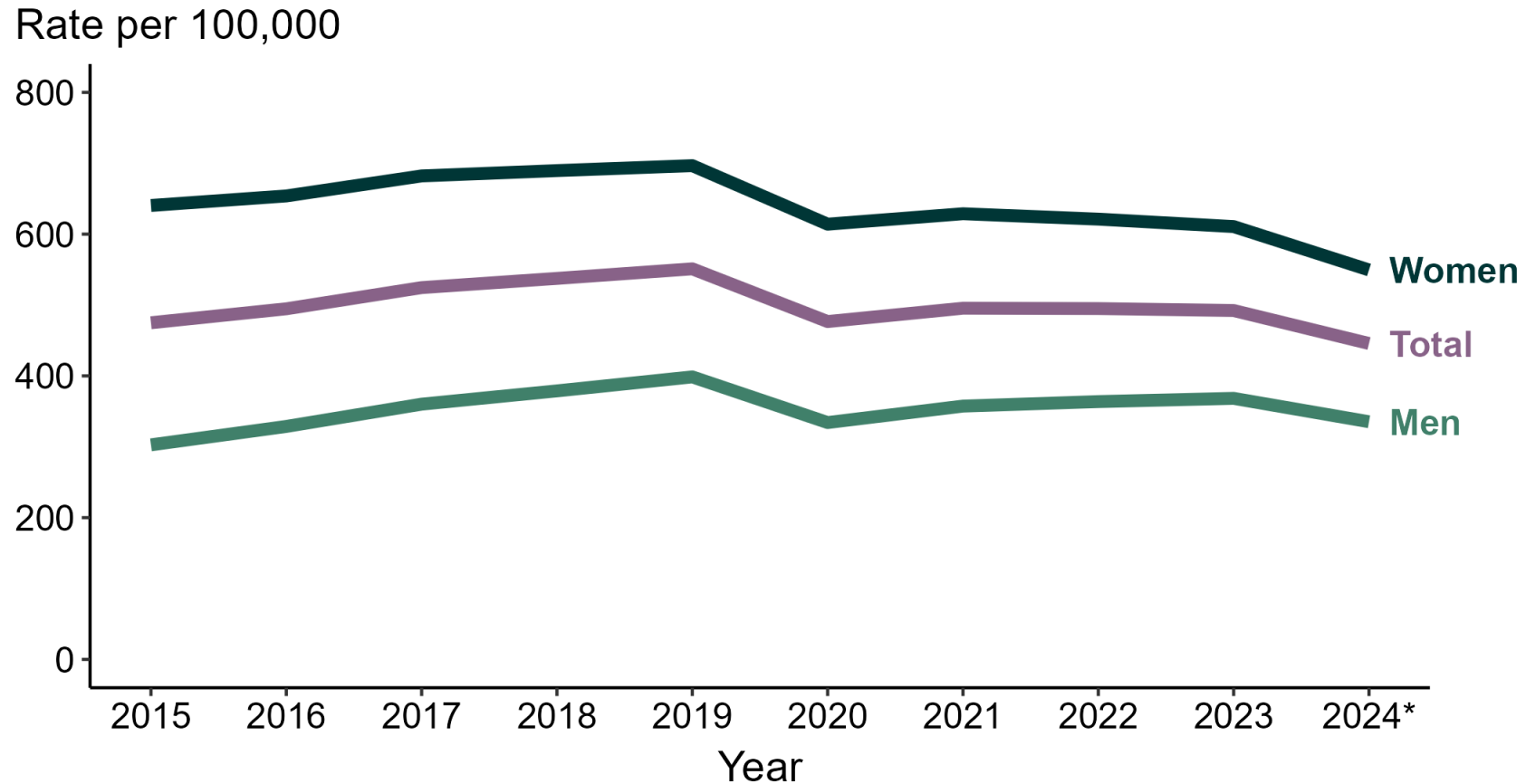
**ACRONYMS:** CS = Congenital syphilis; P&S Syphilis = Primary and secondary syphilis

# Gonorrhea — Rates of Reported Cases by Sex and Year, United States, 2015–2024



\* 2024 data are provisional as of August 14, 2025.

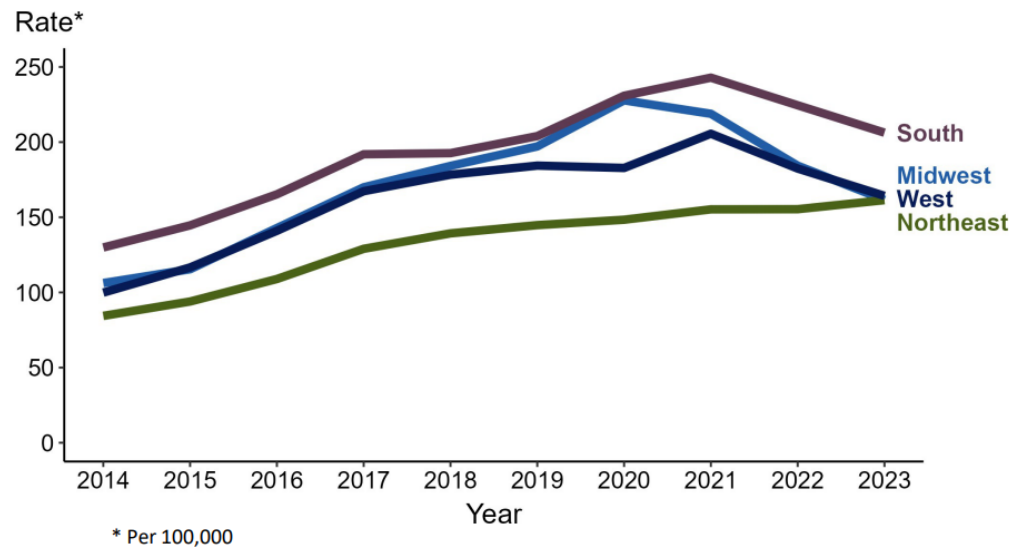
# Chlamydia — Rates of Reported Cases by Sex and Year, United States, 2015–2024



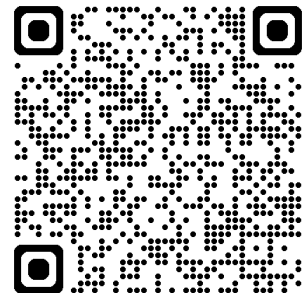
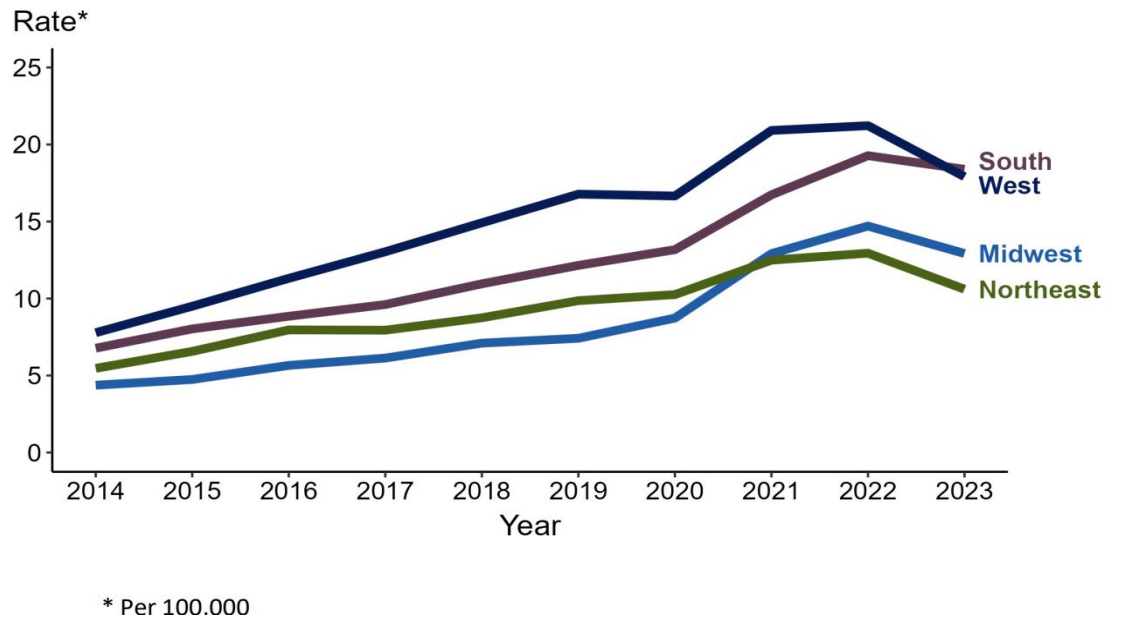
\* 2024 data are provisional as of August 14, 2025.

# STI by Region

Gonorrhea — Rates of Reported Cases by Region and Year, United States, 2014–2023

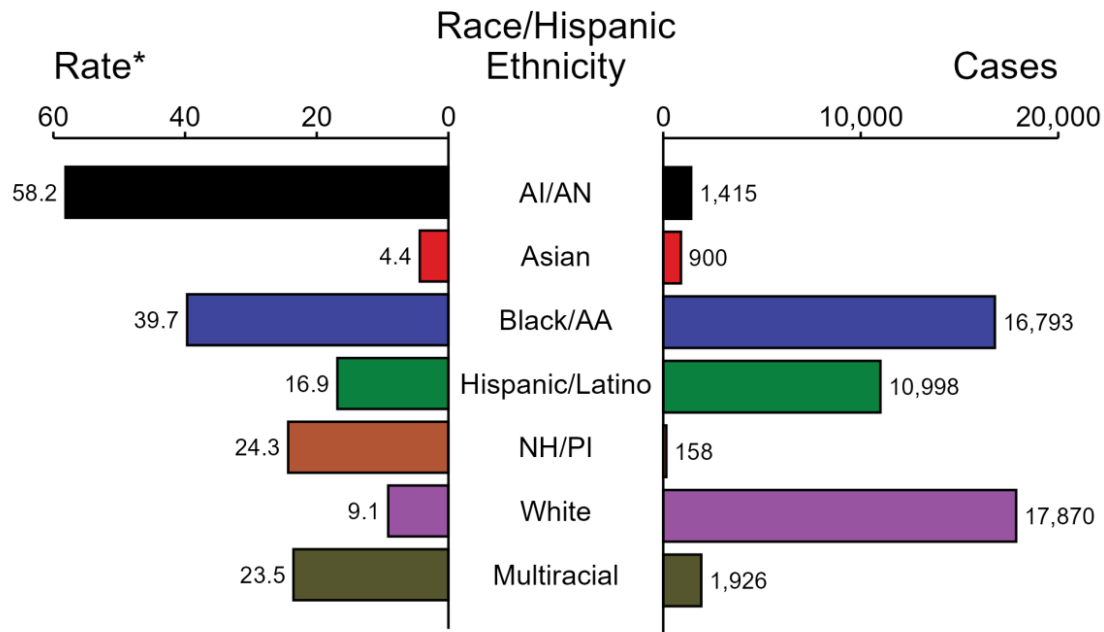


Primary and Secondary Syphilis — Rates of Reported Cases by Region and Year, United States, 2014–2023



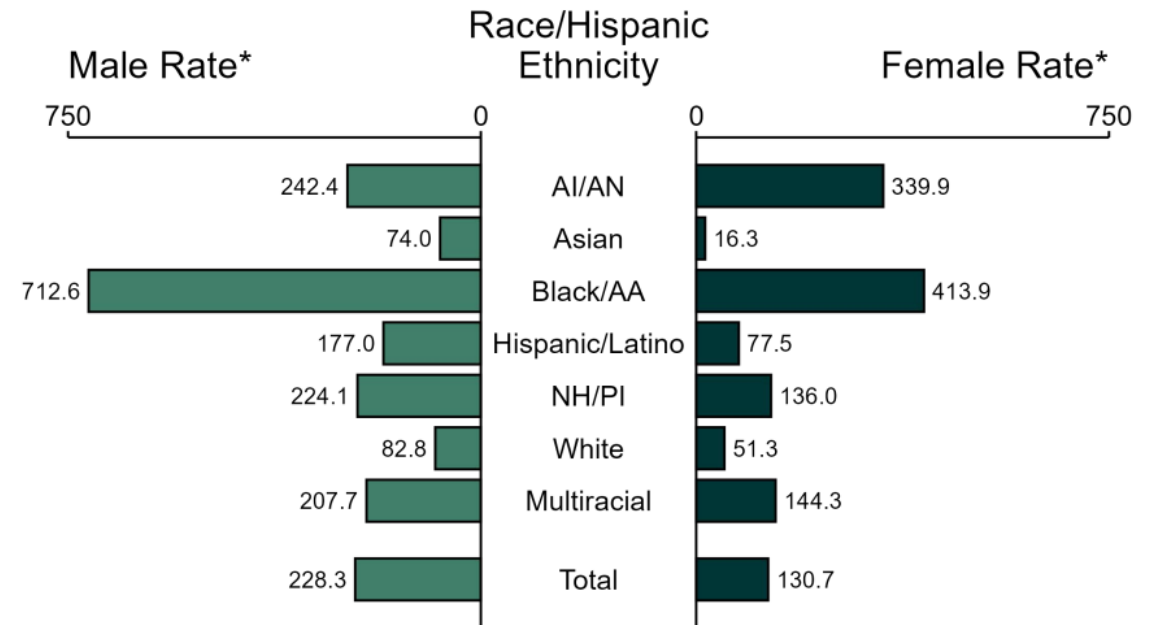
# STI by Race/Ethnicity

Primary and Secondary Syphilis — Case Counts and Rates of Reported Cases by Race/Hispanic Ethnicity, United States, 2023



\* Per 100,000

Gonorrhea — Rates of Reported Cases by Race/Hispanic Ethnicity and Sex, United States, 2023



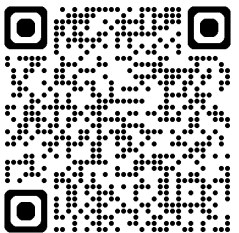
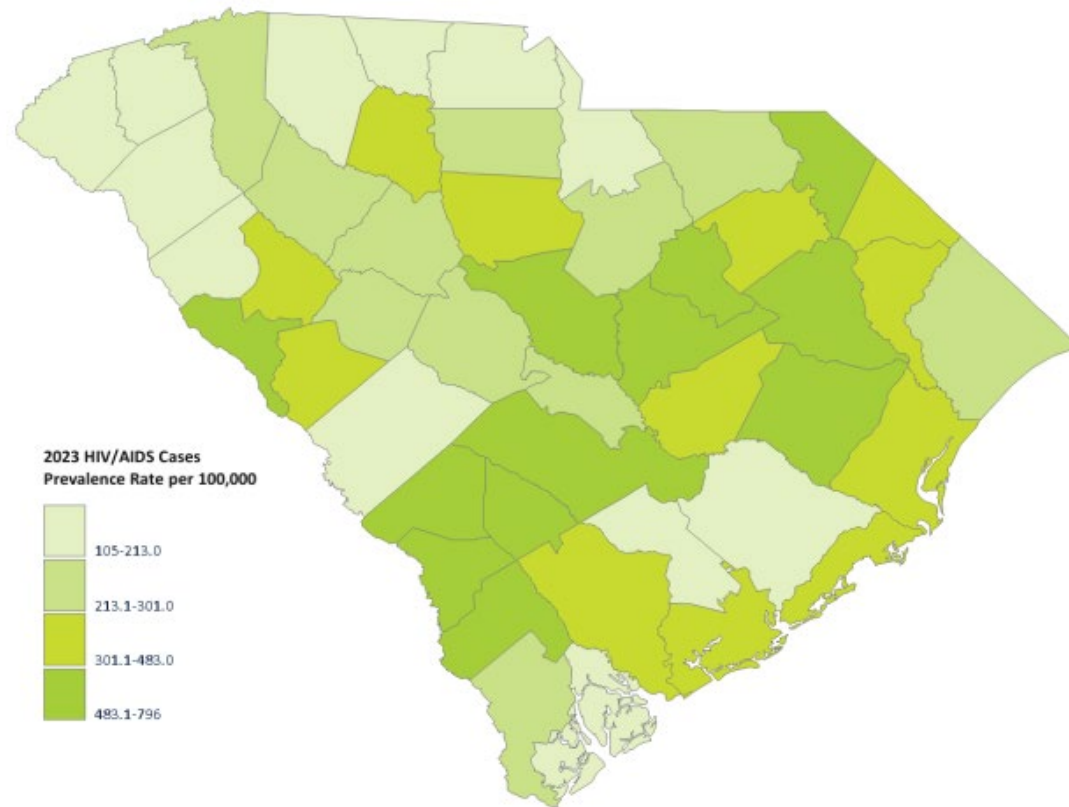
\* Per 100,000



# SUBGROUPS FOR HIV TESTING AND PREP FOCUS

- HIV/AIDS Prevalence by county in SC (n=20,266)

South Carolina HIV/AIDS Prevalence Rate



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# OBJECTIVES

Describe the regional prevalence of STI

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Anyone who has sex could get an STI, **but some groups are more affected:**

- ✓ young people aged 15-24
- ✓ gay & bisexual men
- ✓ pregnant women
- ✓ racial & ethnic minority groups

Untreated STIs can lead to **serious health problems:**



increased risk of transmitting or getting HIV



long-term pelvic/abdominal pain



inability to get pregnant or pregnancy complications



Prevent the spread of STIs with three simple steps:

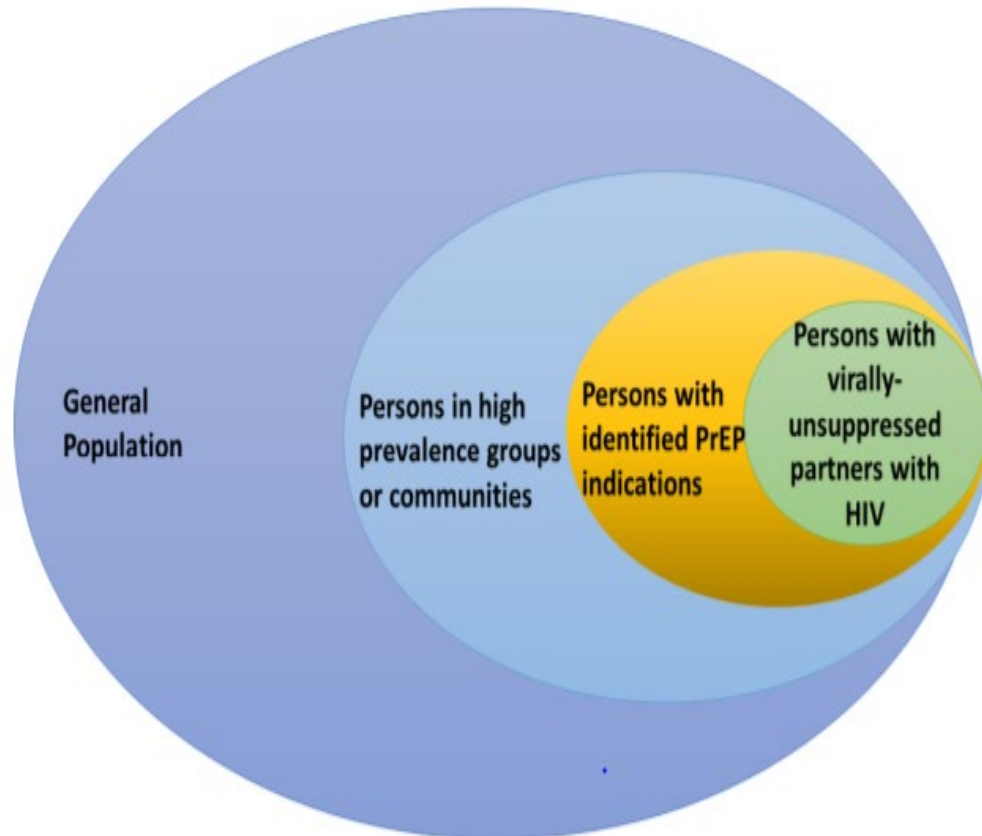
**talk } test } treat**



U.S. CENTERS FOR DISEASE CONTROL AND PREVENTION

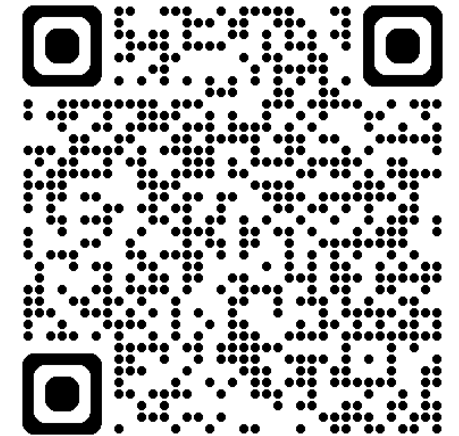
# WHO IS AT RISK FOR HIV ?

Figure 1 Populations and HIV Acquisition Risk



- The conversation
- How to save time and identify?
  - Add to general screening questionnaires
  - Ask with intake/Bp
  - Flyers

## PrEP Resources



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# OBJECTIVES

Describe the regional prevalence of STI

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# QUESTION













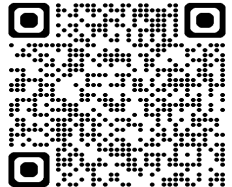
- How often should a versatile cis-gender MSM with multiple partners and prior STI be tested for Gonorrhea
  - a. Q 6 months
  - b. Q 3 months
  - c. Once per year
  - d. Wait on symptoms to develop



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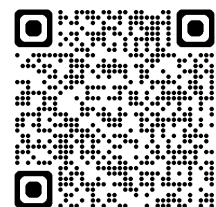
# FREQUENCY OF SCREENING

	Chlamydia	Gonorrhea	Syphilis		
CDC	<p> <ul style="list-style-type: none"> <li>&lt;25 yo</li> <li>&gt;25 yo if increased risk*</li> </ul>  as above</p> <p> (all sites) <ul style="list-style-type: none"> <li>High prevalence</li> <li>MSM: Q 3–6 mo</li> </ul>  <ul style="list-style-type: none"> <li>Baseline, at least annual, risk based</li> </ul> </p>	<p> <ul style="list-style-type: none"> <li>&lt; 25 yo</li> <li>&gt; 25 yo increased risk* (no condom, \$ for sex)</li> </ul>  as above</p> <p> (all sites) <ul style="list-style-type: none"> <li>MSM: annually</li> <li>Q 3–6 mo, high risk</li> </ul>  <ul style="list-style-type: none"> <li>Baseline, at least annual, risk based</li> </ul> </p>	<p></p> <p> All at first visit <ul style="list-style-type: none"> <li>○ Early 3rd trimester</li> <li>○ @delivery if risk</li> </ul> <p> (all sites) <ul style="list-style-type: none"> <li>MSM: annually</li> <li>Q 3–6 mo, high risk</li> </ul>  <ul style="list-style-type: none"> <li>Baseline, at least annual, risk based/ local epi</li> </ul> </p></p>	<p><b>*Increased risk:</b>  New partner  &gt;1 partner  Partner with partners  Partner with STI</p>	<p>Adopting a Sexual Health Paradigm  2021 NIH</p> 

# FREQUENCY OF SCREENING

Body	Chlamydia	Gonorrhea	Syphilis
USPSTF	<p>♀ (Grade B)</p> <ul style="list-style-type: none"> <li>&lt;24 yo</li> <li>&gt;24 yo at increased risk</li> </ul> <p>♂ evidence insufficient ( 2021)</p>	<p>♀ (Grade B)</p> <ul style="list-style-type: none"> <li>&lt;24 yo</li> <li>&gt;24 yo at increased risk</li> </ul> <p>♂ evidence insufficient ( 2021)</p>	<p>👤 (Grade A)</p> <ul style="list-style-type: none"> <li>Early screening</li> <li>🔄 early 3rd trimester and @delivery if at risk</li> </ul>
AAFP	<p>♀</p> <ul style="list-style-type: none"> <li>&lt;25</li> <li>Older or 👤 if at risk</li> </ul> <p>♂ MSM if at risk#</p> <p>👤 +people</p>	<p>♀</p> <ul style="list-style-type: none"> <li>&lt;25</li> <li>Older or 👤 if at risk</li> </ul> <p>♂ MSM if at risk#</p> <p>👤 +people</p>	<p>♀</p> <ul style="list-style-type: none"> <li>👤</li> </ul> <p>♂ MSM and other adults/ado at risk</p> <p>👤 +people</p>
AAP	<p>♀</p> <ul style="list-style-type: none"> <li>&lt;25 (annual)</li> <li>Older women/👤 if at risk+</li> </ul> <p>♂</p> <ul style="list-style-type: none"> <li>MSM: Q3-6mo (partners drugs)</li> <li>Hetero- annual</li> </ul>	<p>♀</p> <ul style="list-style-type: none"> <li>&lt;25 (annual)</li> <li>Older women/👤 if at risk+</li> </ul> <p>♂</p> <ul style="list-style-type: none"> <li>MSM: Annual and Q3-6mths (at risk)</li> <li>Hetero- annual</li> </ul> <p>🔄 @ 3 mo; TOC: Pharyngeal only @14 days</p>	<p>Based on individual risk</p> <ul style="list-style-type: none"> <li>MSM annually or every 3–6 months if high risk</li> <li>Pregnant people</li> </ul>
ACOG	<p>♀</p> <ul style="list-style-type: none"> <li>&lt;25 annual</li> <li>&gt;25 – risk based</li> <li>👤-routine</li> <li>👤 + annual</li> </ul>	<p>♀</p> <ul style="list-style-type: none"> <li>&lt;25 annual</li> <li>&gt;25 – risk based</li> <li>👤 - &lt;25 yo or prevalent area</li> <li>👤 + annual</li> </ul> <p>🔄 @ 3 mo /3rd trimester</p> <p>TOC: Pharyngeal and alternative rx @14 days</p>	<p>♀</p> <ul style="list-style-type: none"> <li>No recommendation for non-👤</li> <li>👤-1st visit; later in preg and @delivery if at risk</li> <li>👤 + annual</li> </ul>

Adopting a Sexual Health Paradigm  
2021 NIH



# STI TESTING WHILE ON HIV PREP

Timing of Oral PrEP-associated Laboratory Tests

Test	Screening/Baseline Visit	Q 3 months	Q 6 months	Q 12 months	When stopping PrEP
HIV Test	X*	X			X*
eCrCl	X		If age $\geq 50$ or eCrCl $< 90$ ml/min at PrEP initiation	If age $< 50$ and eCrCl $\geq 90$ ml/min at PrEP initiation	X
Syphilis	X	MSM /TGW	X		MSM/TGW
Gonorrhea	X	MSM /TGW	X		MSM /TGW
Chlamydia	X	MSM /TGW	X		MSM /TGW
Lipid panel (F/TAF)	X			X	
Hep B serology	X				
Hep C serology	MSM, TGW, and PWID only			MSM, TGW, and PWID only	

\* Assess for acute HIV infection (see Figure 4)

Timing of CAB PrEP-associated Laboratory Tests

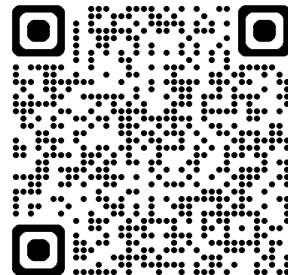
Test	Initiation Visit	1 month visit	Q2 months	Q4 months	Q6 months	Q12 months	When Stopping CAB
HIV*	X	X	X	X	X	X	X
Syphilis	X			MSM^/TGW <sup>-</sup> only	Heterosexually active women and men only	X	MSM/TGW only
Gonorrhea	X			MSM/TGW only	Heterosexually active women and men only	X	MSM/TGW only
Chlamydia	X			MSM/TGW only	MSM/TGW only	Heterosexually active women and men only	MSM/TGW only

\* HIV-1 RNA assay

X all PrEP patients

^ men who have sex with men

<sup>-</sup> persons assigned male sex at birth whose gender identification is female



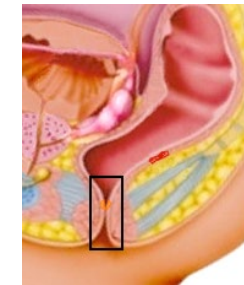
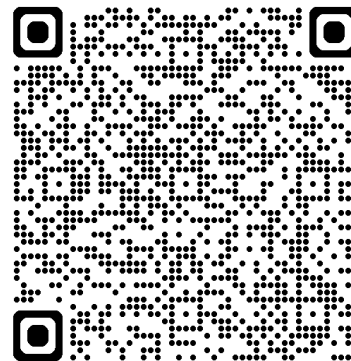
US Public Health Service

**PREEXPOSURE PROPHYLAXIS FOR THE PREVENTION OF HIV INFECTION IN THE UNITED STATES – 2021 UPDATE**

A CLINICAL PRACTICE GUIDELINE

# STI SCREENING

- Blood – syphilis or Hep C
- GC and chlamydia by NAAT (all sites)
  - Pharyngeal
  - Rectal
  - Urine
- Self-collected specimen has equivalent performance<sup>1-3</sup>
- Specimen collection resource:



1. Barbee *J Acquir Immune Defic Syndr.* 2016  
2 Freeman *Chlamydia /GC pharyngeal infection STD.* 2011  
3. Lunny *PloS One.* 2015  
<http://www.cdc.gov/hiv/pdf/prepguidelines2017.pdf>



# CASE



- Oral and Perianal lesions

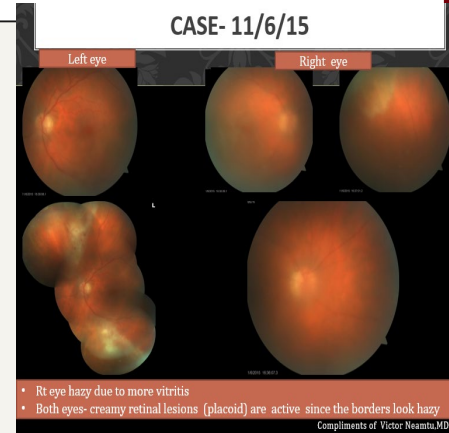
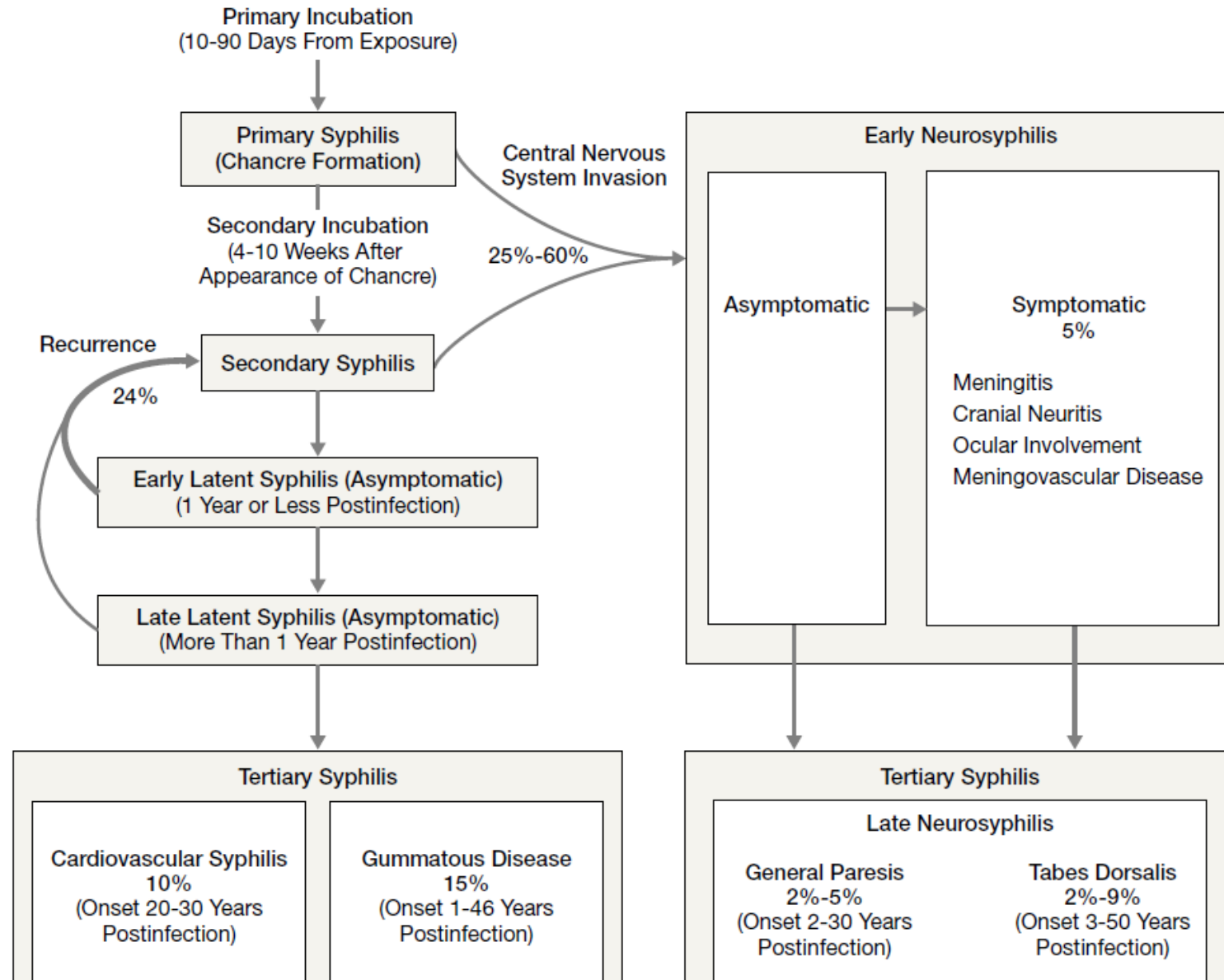
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# SYPHILIS CLINICAL PRESENTATION: STAGES



# OBJECTIVES

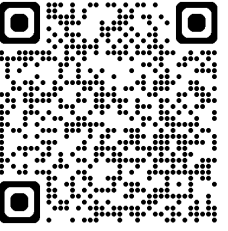
Describe the regional prevalence of STI

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# TREATMENT



	Preferred	Alternative	Allergic	Pregnant
Gonorrhea	Ceftriaxone <b>500 mg IM*1</b>	If unavailable, Cefixime 800 mg PO, single dose	Gentamicin 240 mg IM*1 <b>PLUS</b> Azithro 2 gm PO*1	Ceftriaxone 500 mg IM in a single dose
DGI	Ceftriaxone 1 gm IM or by IV Q24 hr	Cefotaxime 1 gm by IV Q8 rs OR Ceftizoxime 1 gm Q8 hr		
Chlamydia	Doxycycline 100 mg PO BID for 7 days	<ul style="list-style-type: none"> <li>• Azithromycin 1 gm PO*1 OR</li> <li>• Levofloxacin 500 mg PO 1x/day* 7 days</li> </ul>		<ul style="list-style-type: none"> <li>• Azithromycin 1 gm PO*1</li> <li>• Amoxicillin 500 mg PO TID*7 dy</li> </ul>
LGV	Doxycycline 100 mg orally 2x/day for 21 days	Azithromycin 1 gm orally 1x/week for 3 weeks		

# GC EASILY TREATED, CONSIDERATIONS?

- Sequelae: Infertility, rectal stenosis
- Disseminated GC
  - Septic joints
  - Endocarditis
- Cost
- Microbiome
- Antimicrobial Stewardship

While international resistance is high, the US has low rates of ceftriaxone resistance, with less than 0.1% of isolates showing "alert" levels.

[Neisseria gonorrhoeae Antimicrobial Resistance: The Future of Antibiotic Therapy - PMC](#)



## Antibiotic-Resistant Gonorrhea



Basic Information

LITTLE NOW STANDS BETWEEN US & UNTREATABLE GONORRHEA

Laboratory Information

NEW DRUGS

COMBATING THE THREAT

Gonorrhea has progressively developed resistance to the antibiotic drugs prescribed to treat it. Following the spread of gonococcal fluoroquinolone resistance, the cephalosporin antibiotics have been the foundation of recommended treatment for gonorrhea. The emergence of cephalosporin-resistant gonorrhea would significantly complicate the ability of providers to treat gonorrhea successfully, since we have few antibiotic options left that are simple, well-studied, well-tolerated and highly effective. It is critical to continuously monitor antibiotic resistance in *Neisseria gonorrhoeae* and encourage research and development of new treatment regimens.

Updates

[Antibiotic Resistance Threats in the United States 2019 and Drug-resistant \*N. gonorrhoeae\* pathogen page](#) (November 13, 2019)



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# NEW AGENTS FOR GONORRHEA

- Gepotidacin (Blujepa) approved early December 2025
  - First in class- triazaacenaphthylene: inhibits DNA replication via DNA gyrase and topoisomerase IV
  - Previously approved for UTI
  - 3000 mg PO q12hr \*2 doses (1tab=750mg)
  - QTc prolongation and DDI
- Zoliflodacin (Nuzolvence) approved mid-December 2025
  - First in class- spiropyrimidinetrione: disrupts bacterial DNA replication via DNA gyrase and topoisomerase IV
  - 3g \*1 dose – granules
  - Fetal harm and pregnancy loss, testicular toxicity

CDI risk



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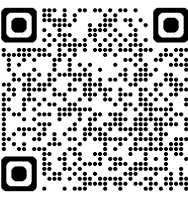
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# TREATMENT

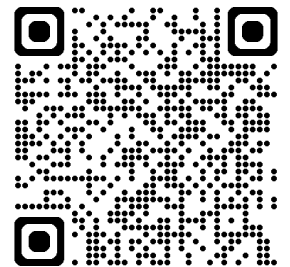
	Preferred	Alternative	Alternative	Pregnant
<b>Nongonococcal Urethritis</b>	Doxycycline 100 mg PO BID *7 dy	Azithromycin 1 gm *1 OR Azithro 500 mg *1, then 250mg QD* 4 dy		
Persistent/ Recurrent NGU: test mycoplasma genitalium	Doxycycline 100 mg PO BID* 7 dy, then Moxifloxacin 400 mg PO QD* 7 dy			
<b>Syphilis</b>				
Primary/Sec/ Early latent	<b>Benzathine penicillin G 2.4</b> million units IM *1 (Bicillin L-A)	<ul style="list-style-type: none"> <li>• <b>Doxycycline (100 mg PO BID*14 dy)</b></li> <li>• Ceftriaxone 1g IM/IV QD*10-14dy – optimal unknown</li> <li>• Procaine PCN 600000U IM QD* 10-14 dy (European 2000)</li> </ul>	<p>Amoxil 3g/24hr + probenecid 720mg/24hr (divided tid)*14 dys *Japanese 286 HIV pt –95.5% efficacy (CID 2015)</p> <p>Amoxil 1.5 g/24 hrs similar efficacy (STI 2022)</p>	Benzathine penicillin G 2.4 million units IM*1



# TREATMENT

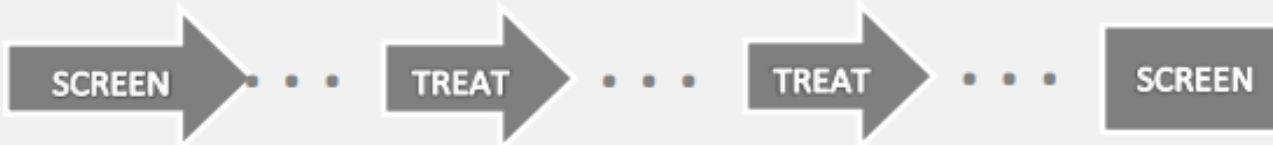


	Preferred	Alternative	Alternatives	Pregnant
<b>Syphilis</b>				
Late latent	3 doses of 2.4 million units IM Q wk <b>(10-14 dy interval acceptable)</b>	<b>Doxycycline (100 mg PO BID for 28 dy)</b>  Procaine PCN 600000U IM qdaily 17-21 days (European 2000)	Amoxil 3g qd with probenecid 750mg qd (divided tid)* 28 dy  Ceftriaxone 1g IM/IV QD (10-14dys) –optimal unknown	If interval >9 days start over
Neuro	Penicillin G 18–24 million units /day, *10–14 dy	Procaine penicillin G 2.4 MU IM QD PLUS probenecid 500 mg orally 4x/day* 10–14 days	Ceftriaxone 1-2g IM/IV qdaily (10-14days) – French study lancet ID 2021 (European 2000)	



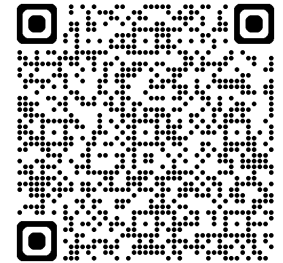
# TEST OF CURE/REPEAT SCREENING

## Chlamydia and Gonorrhea Clinical Management in a Nutshell:



- **Screen** all appropriate patients for chlamydia and gonorrhea;
- **Treat** all infected patients promptly;
- **Treat** all or their recent partners; and
- **Screen** all treated patients again three months after treatment (retest)

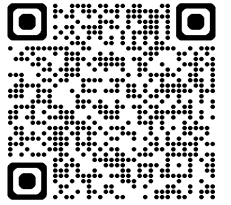
- Rx all partners from last 60 days
- No test of cure for non-pregnant, if SOC used
- Pregnancy – test of cure s/p 3 wk after rx then q 3 mo /close to delivery



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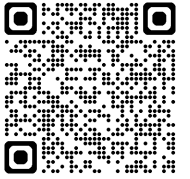
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# TEST OF CURE/REPEAT TESTING



Body	Chlamydia	Gonorrhea	Syphilis
CDC	<p>♀</p> <ul style="list-style-type: none"> <li>&lt; 25 yr of age</li> <li>&gt;25 yr if increased risk</li> </ul> <p> 3 months s/p rx</p>	<p>♀</p> <ul style="list-style-type: none"> <li>&lt; 25 yr of age</li> <li>&gt;25 yr if increased risk</li> </ul> <p> 3 mo s/p rx</p>	<p>♀</p>
	<p>👤 as above</p> <ul style="list-style-type: none"> <li> 3<sup>rd</sup> trimester</li> <li>TOC: 3–4 wk</li> </ul>	<p>👤 as above</p> <ul style="list-style-type: none"> <li> 3 mo s/p rx</li> </ul>	<p>👤 First visit</p> <ul style="list-style-type: none"> <li> Early 3rd trimester and @ delivery if at risk</li> </ul>
	<p>♂ (all sites)</p> <ul style="list-style-type: none"> <li>All in high prevalence local</li> <li>MSM: Q3–6 mo</li> </ul>	<p>♂ (all sites)</p> <ul style="list-style-type: none"> <li>MSM: annually</li> <li>Q:3–6 mo in high risk</li> </ul>	<p>♂ (all sites)</p> <ul style="list-style-type: none"> <li>MSM: annually</li> <li>Q: 3–6 mo in high risk</li> </ul>
	<p></p> <ul style="list-style-type: none"> <li>Baseline and at least annual, risk dependent</li> </ul>	<p></p> <ul style="list-style-type: none"> <li>Baseline and at least annual, risk dependent</li> </ul>	<p></p> <ul style="list-style-type: none"> <li>Baseline and at least annual, risk dependent/ local epi</li> </ul>

# TEST OF CURE/REPEAT SCREENING



Body	Chlamydia	Gonorrhea	Syphilis
AAP	<p>♀</p> <ul style="list-style-type: none"> <li>&lt;25 (annual)</li> <li>Older women or 🧑 if at risk+</li> </ul> <p>♂</p> <p><b>MSM: Q3-6mo (partners and drugs)</b> Hetero- annual</p>	<p>♀</p> <ul style="list-style-type: none"> <li>&lt;25 (annual)</li> <li>Older women or pregnant women if at risk+</li> </ul> <p>♂</p> <p><b>MSM: Annual and Q3-6mths (at risk)</b> Hetero- annual</p> <p>🔄 @ 3 mo</p> <p><b>TOC: Pharyngeal only @14 days</b></p>	<p>Based on individual risk</p> <ul style="list-style-type: none"> <li>MSM annually or every 3–6 months if high risk</li> <li>Pregnant people</li> </ul>
ACOG	<p>♀</p> <ul style="list-style-type: none"> <li>&lt;25 annual</li> <li>&gt;25 – risk based</li> <li>🧑-routine</li> <li>💊+ annual</li> </ul>	<p>♀</p> <ul style="list-style-type: none"> <li>&lt;25 annual</li> <li>&gt;25 – risk based</li> <li>🧑 &lt;25 yo or prevalent area</li> <li>💊+ annual</li> </ul> <p>🔄 @ 3 mo /3rd trimester</p> <p><b>TOC: Pharyngeal and alternative rx @14 days</b></p>	<p>♀</p> <ul style="list-style-type: none"> <li>No recommendation for non 🧑</li> <li>🧑-1st visit; later in preg and @delivery if at risk</li> <li>💊+ annual</li> </ul>

# SYPHILIS RPT TESTING AND INTERPRETATION

- Rpt testing at 3, 6, 12 mo
  - Primary/Secondary expect:
    - 4 fold (2 tubes) decline @ 6 mo
    - 6 fold (3 tubes) decline @ 12 mo
    - 8 fold (4 tubes) decline @24 mo
  - Primary syphilis
    - 50% RPR sero-ve at 12mo  
(Romanowski AIM 1991)
    - 24% -ve FTA/ABS at 2-3 yo  
(Romanowski AIM 1991)



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# SYPHILIS RPT TESTING AND LP

- Prior recommendation, if failure to respond (< 4fold decline) consider CSF
  - If positive rx as neurosyphilis
  - If negative, rx as latent syphilis
- 15-20% remain serofast = no change or 2 fold down
- Current CDC expert opinion away from CSF and just close monitoring (MMWR 2021)
  - Neuro exam and titers
  - If follow up unlikely or RPR >1:32 with no response- Consider retreatment with 3 doses

# OBJECTIVES

Describe the regional prevalence of STI

Identify sub-populations at risk for STI

Discuss STI treatment updates

Review STI Prophylaxis

# DOXY PEP






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# DOXY-PEP: IPERGAY SUB-STUDY (FRANCE)

## Study Design

- : MSM on PrEP
- Design: Open-label, randomized (1:1)
- :
  - Doxy-PEP: doxy 200mg <24 hr after sex
  - Control: No PEP


- : 232 total
  - 116 Doxy-PEP
  - 116 Control
- Follow-up: Median 8.7 mo (IQR 7.8–9.7)

- : Any new STI
  - 22% with dPEP
  - 42% without PEP (p = 0.007)
-  Risk Reduction
  - Hazard Ratio: 0.53 (95% CI 0.33–0.85)

# DOXY-PEP: IPERGAY SUB STUDY (FRANCE)







- Doxy-PEP significantly reduced first STI episode:
  - Chlamydia
    - HR 0.30; 95% CI 0.13-0.70; p=0.006
  - Syphilis
    - HR 0.27; 0.07-0.98; p=0.047
- No significant reduction in gonorrhoea
  - HR 0.83; 0.47-1.47; p=0.52

-  GI AE in 53% participants in dPEP group (p=0.05)

# DOXY PEP WORKFLOW

## Postexposure Prophylaxis for HIV and STIs

Guidelines for using PEP aimed at preventing HIV and other STIs as a result of sexual exposure are available at <https://www.cdc.gov/hiv/pdf/programresources/cdc-hiv-npep-guidelines.pdf> . Sexually active persons seeking HIV PEP should be evaluated for PrEP after completing their PEP course and testing negative for HIV. HIV PEP is also discussed elsewhere in this report (see Sexual Assault and Abuse and STIs). Genital hygiene methods (e.g., vaginal washing and douching) after sexual exposure are ineffective in protecting against HIV and STIs and might increase the risk for bacterial

- : Gay and bisexual men and trans women
- : Doxy 200mg \*1 dose; within 24-72 hrs of condomless sex
  - Give 30 pills
- : Phototoxicity, GI upset, more rarely esophageal ulceration
- : SOC--- triple site q 3 months

- Doxycycline 200 mg administered within 24-72 hours of condomless sex was the regimen evaluated in this study. Other antibiotics should not be considered for PEP.
- In addition to informing patients about the potential STI prevention benefits of doxy as PEP, providers should also counsel patients about potential adverse side effects of doxycycline including phototoxicity, gastrointestinal symptoms, and more rarely esophageal ulceration.
- Providers should continue to screen, test, and treat for bacterial STIs in accordance with [CDC's STI Treatment Guidelines](#) and [CDC's PrEP for the Prevention of HIV guidelines](#) , even among people who may be using doxycycline as PEP or PrEP.

<https://www.cdc.gov/std/treatment-guidelines/clinical-primary.htm#CautionsForDoxPEP>

<https://www.cdc.gov/hiv/pdf/programresources/cdc-hiv-npep-guidelines.pdf>



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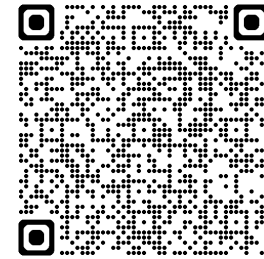
# DOXY PEP AND REAL WORD EXPERIENCE



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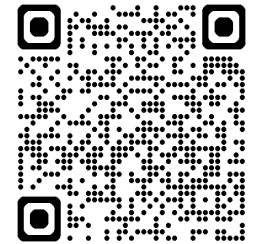
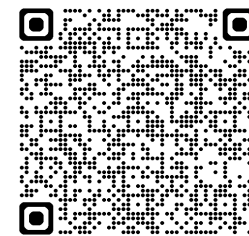
- **Gonorrhea**

- Less effective for gonorrhea, lower protection rates (12-55%) compared to other STIs
  - Harvard Pilgrim Health Care Institute: 12% reduction in gonorrhea and 79–80% reduction in chlamydia/syphilis



- **Antibiotic Resistance (2025)**

- DoxyPEP usage is linked to higher rates of:
  - Tetracycline-resistant gonorrhea
  - Greater prevalence of antibiotic-resistant staph/strep bacteria in the throat




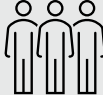






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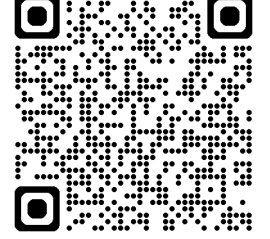
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# HIV PREP OPTIONS

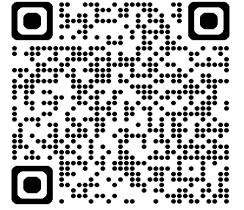
Effectiveness estimate : ~99% if used as directed

	Route	Population	Cost	Renal CrCL	SE
TDF/F			\$	>60	GI, Renal, 1% BMD
TAF/F			\$\$	>30	GI, Weight gain, Lipid
Cabotegravir	IM 		\$\$\$		Local pain
Lenacapavir	SC 		\$\$\$\$		Injection site reaction

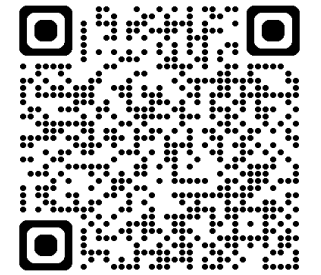
2021 guidelines



CDC PrEP



2025 update



# ENDING THE EPIDEMICS: ALL THE CROSSROADS



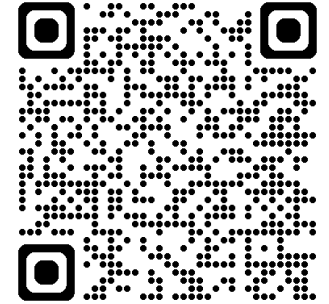
- Conversations

Sexual health “requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination, and violence. (WHO)

- Condoms:

- 52% of high school students **did not** use a condom @ last sexual intercourse (2023)

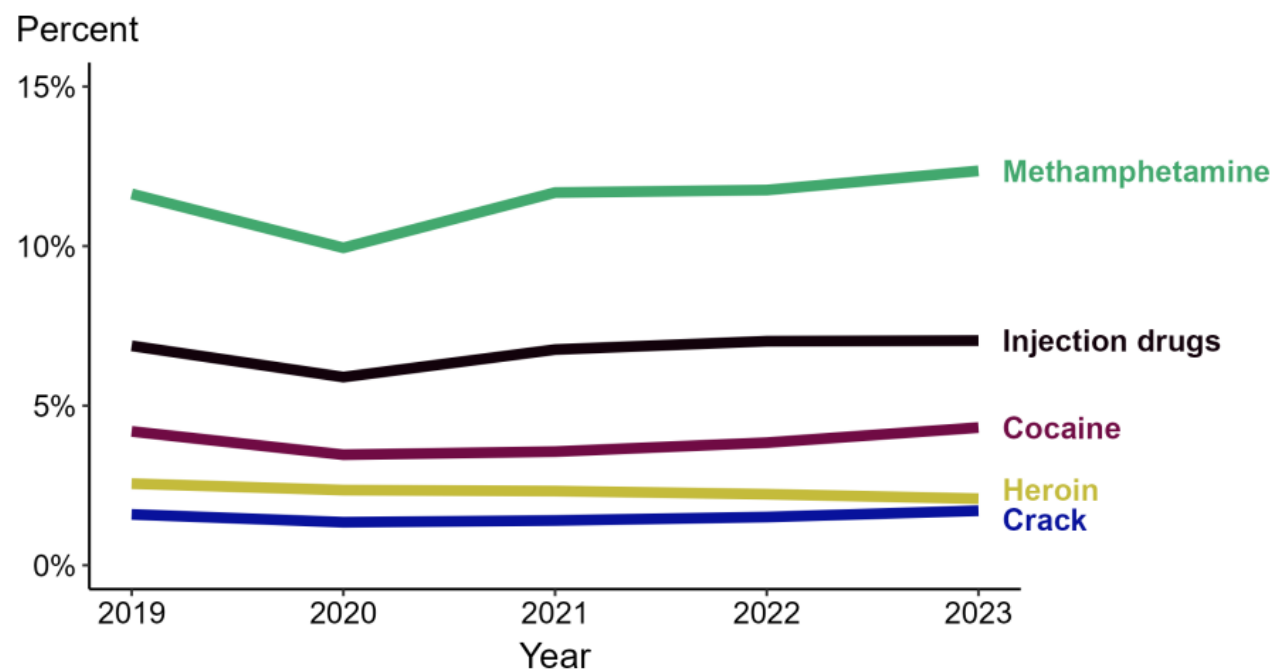
- Intersection of SUD and STI



Strategies: Condom Availability Programs (CAPs)

# SUD AMONG PERSONS WITH SYPHILIS

Primary and Secondary Syphilis — Percentage of Cases Reporting Selected Substance Use Behaviors\* by Year, United States, 2019–2023



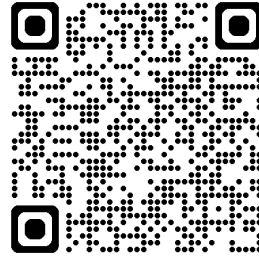
- Talk chem sex
- Screen SUD

\* Percentage reporting injection drug use, methamphetamine use, heroin use, crack use, or cocaine use within the last 12 months calculated among cases with known data (cases with missing or unknown responses were excluded from the denominator)

# OTHER STI TO THINK ABOUT

- MPOX

- Prevention - Vaccine -->



- HPV

- Vaccine

- Catch up Age 13-26
- Shared decision making 27-45 -->

- Anal paps

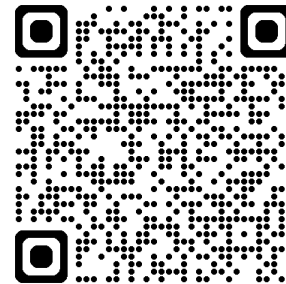


FIGURE. Characteristic monkeypox lesions\* — United States, May 2022



\* The rash associated with monkeypox involves firm, deep-seated, and well-circumscribed vesicles or pustules, which might umbilicate or become confluent. Lesions progress over time to scabs.

\* Photo used with patient's permission.



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# HONORABLE MENTION: TRICHOMONAS VAGINALIS



## Adverse outcomes

- Abnormal PAP and ?risk of Ca, pregnancy complications, risk of HIV and STI, infertility, PID

## Treatment

- Metronidazole 500mg po bid\*7 days
  - 2g for any partners within 60 days
- Metronidazole allergy
  - Metronidazole desensitization
  - Cross reactivity with Tinidazole

## Treatment failure

- Non-adherence
- Sex with untreated partner
- Retreatment

## Management of resistant trich

- Sample sent to CDC
- Tinidazole PO + topical paramomycin \*2 weeks (Workowski et al)
  - \$\$
- Rx partner with Tinidazole



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# ADVANCING STI CARE QUESTIONS

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