

CHANCROID:

OVERVIEW:	CLINICAL:	TREATMENT:
<ul style="list-style-type: none"> Caused by <i>Haemophilus ducreyi</i> Rare in Canada/US Difficult to diagnose; usually based on clinical grounds Treat empirically Incubation period ~ 7 days (range 1-35 days) 	<p>Papule(s) → pustule(s) → ulcer(s)</p> <p>Painful, red base with exudate overlying</p> <p>Inguinal lymphadenopathy in 50%</p>	<ul style="list-style-type: none"> Azithromycin 1000 mg PO x 1 dose Ceftriaxone 250 mg IM x 1 dose Equivalent efficacy

SYPHILLIS:

SYPHILLIS 101:	SYPHILLIS DIAGNOSIS:																	
<ul style="list-style-type: none"> Caused by spirochete, <i>Treponema pallidum</i> Sexual acquisition (mostly) <ul style="list-style-type: none"> Via infectious lesions (genital secretions are “infectious” likely due to contact with lesions) Vertical transmission (mother → baby) Blood (less common/rare) <ul style="list-style-type: none"> Transfusion blood is screened, organism can’t survive long 20-30% transmission efficiency 	<table border="1"> <tr> <td data-bbox="695 468 797 493">SEROLOGY</td> <td colspan="2" data-bbox="883 468 1531 548"> <ul style="list-style-type: none"> Enzyme-linked immunoassay (EIA) Rapid plasma regain (RPR) <i>Treponema pallidum</i> particle agglutination (TPPA) </td> </tr> <tr> <td data-bbox="695 554 818 579">DIRECT TESTS</td> <td data-bbox="883 554 1003 634">Anal/genital lesions</td> <td data-bbox="1008 554 1531 634"> <ul style="list-style-type: none"> Darkfield microscopy Direct fluorescent antibody (DFA) Polymerase chain reaction (PCR) </td> </tr> <tr> <td></td> <td data-bbox="883 640 1003 699">Oral lesions</td> <td data-bbox="1008 640 1531 699"> <ul style="list-style-type: none"> PCR only With other direct tests, risk of false positives due to endogenous oral treponemes </td> </tr> <tr> <td data-bbox="695 716 797 741">CLINICALLY</td> <td colspan="2" data-bbox="883 716 1531 741"> <ul style="list-style-type: none"> Symptoms + right epidemiological picture + correct risk profile </td> </tr> </table>		SEROLOGY	<ul style="list-style-type: none"> Enzyme-linked immunoassay (EIA) Rapid plasma regain (RPR) <i>Treponema pallidum</i> particle agglutination (TPPA) 		DIRECT TESTS	Anal/genital lesions	<ul style="list-style-type: none"> Darkfield microscopy Direct fluorescent antibody (DFA) Polymerase chain reaction (PCR) 		Oral lesions	<ul style="list-style-type: none"> PCR only With other direct tests, risk of false positives due to endogenous oral treponemes 	CLINICALLY	<ul style="list-style-type: none"> Symptoms + right epidemiological picture + correct risk profile 					
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OCULAR SYPHILLIS:	PROPHYLAXIS WITH DOXYCYCLINE:																	
<ul style="list-style-type: none"> New onset eye symptoms in anyone (especially HIV + MSM) are potential RED FLAGS Early referral to ID and ophthalmology is critical Lumbar puncture to rules CNS involvement 	<ul style="list-style-type: none"> PEP with doxycycline reduced overall incidence of bacterial STIs by 47% in MSM on PrEP No effect on gonorrhea, but strong reduction (70-73%) in chlamydia & syphilis incidence Acceptable safety profile with mild/moderate GI AEs <ul style="list-style-type: none"> D/C in only 7% of participants No evidence of risk compensation Analysis of antibiotic resistance pending Long-term benefit of PEP yet unknown <ul style="list-style-type: none"> More research needed in field of STIs Antibiotic prophylaxis for STIs still <u>NOT recommended</u> 																	
OTHER THAN THE RATES, SYPHILLIS INCREASES DUE TO:	SOME KEY POINTS TO REMEMBER:																	
<ul style="list-style-type: none"> Increased testing Changes in behavior <ul style="list-style-type: none"> Effective HIV therapies HIV PrEP What else can be done? PrEP and PEP 	<ul style="list-style-type: none"> Syphilis is not called “the great pretender” for nothing <ul style="list-style-type: none"> Multiple, diverse clinical manifestations Can affect essentially ANY organ system Neurosyphilis ≠ tertiary syphilis Those living with HIV are at increased risk for: <ul style="list-style-type: none"> More unusual/severe manifestations Earlier complications PrEP and PEP with doxycycline looks promising 																	

NEISSERIA GONORRHOEAE:

LOCAL BC EPIDEMIOLOGY:	MANAGEMENT:						
<ul style="list-style-type: none"> Early 1990s: “safer sex” amongst gbMSM = lower rates of GC, including rectal GC More recently, infection in gbMSM = increased proportion of cases <ul style="list-style-type: none"> Increasing rates of antibiotic resistance than heterosexual counterparts Key HIV association <ul style="list-style-type: none"> Increases transmission and susceptibility “Syndromic STI treatment” is an HIV prevention modality 	<ul style="list-style-type: none"> Cefixime 800 mg PO OR ceftriaxone 250 mg IM PLUS azithromycin 1 g PO OR doxycycline 100 mg PO BID x 7 days <ul style="list-style-type: none"> Chlamydia co-infection is common AND incubation period is longer so may be missed by test early on Theoretical that if you treat gonorrhea with a drug with different MOA, you may reduce risk of resistance development at population level No sex x 1 week (of starting treatment) Partner notification & partner treatment 						
CLINICAL MANIFESTATION: majority are asymptomatic	ALTERNATIVE TREATMENTS:						
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COMPLICATIONS	Infertility, ectopic pregnancy, PID						
RECENT TRENDS IN GC AMR:							
<ul style="list-style-type: none"> Progressive resistance to penicillin, tetracyclines, quinolones and 3rd gen cephs 							

CHLAMYDIA:**EPIDEMIOLOGY:**

- Caused by *Chlamydia trachomatis* (serovars D-K)
- In many parts of the Western world, most commonly reported bacterial infection
- Women >> men

RISK FACTORS:

- Young age = partial immunity?
- Previous CT = the "network" effect
- Sexual history over last 2-3 months
- Lower SES

TREATMENT OPTIONS:

PREFERRED	<ul style="list-style-type: none"> • Azithromycin 1000 mg PO once • Doxycycline 100 mg PO bid x 7 days
ALTERNATE	<ul style="list-style-type: none"> • Levofloxacin 500 mg PO daily x 7 days

CLINICAL FEATURES:

WOMEN	Features	<ul style="list-style-type: none"> • Most are asymptomatic • Incubation period 7-14 days
	Symptoms	<ul style="list-style-type: none"> • Cervicitis (mucopurulent discharge, friability, edematous ectopy) • +/- urethritis • Proctitis
	Complications	<ul style="list-style-type: none"> • PID → tubal infertility • Ectopic pregnancy • Chronic pelvic pain • Perihepatitis
MEN	Features	<ul style="list-style-type: none"> • Incubation period 5-10 days
	Symptoms	<ul style="list-style-type: none"> • Urethritis (mucoid, watery discharge, dysuria) • Prostatitis (dysuria, painful ejaculation, generalized pain) • Epididymitis (pain) • Proctitis (pain, discharge, bleeding) • Reactive arthritis