STD Treatment Guidelines 2010

Recommended Regimens

Ceftriaxone 250 mg IM in a single dose
OR
Cefixime 400 mg orally in a single dose
PLUS
Metronidazole 2 g orally in a single dose
PLUS
Azithromycin 1 g orally in a single dose OR **Doxycycline** 100 mg orally twice a day for seven days

For those requiring alternative treatments, refer to the Center for Disease Control website, www.CDC.gov. Clinicians should counsel patients regarding the possible benefits and toxicities associated with these treatment regimens; gastrointestinal side effects can occur with this combination.

Hepatitis B Prophylaxis

Postexposure hepatitis B vaccination, without HBIG. This vaccine should be administered to sexual assault survivors at the time of the initial examination if they have not been previously vaccinated. Follow-up doses of vaccine should be administered at 1-2 and 4-6 months after the first dose.

Risk for Acquiring HIV Infection

HIV seroconversion has occurred in persons whose only known risk factor was sexual assault or sexual abuse, but the frequency of this occurrence is probably low. In consensual sex, the risk for HIV transmission from vaginal intercourse is 0.1% to 0.2% and for receptive rectal intercourse, 0.5% to 3%. The risk for HIV transmission from oral sex is substantially lower. Specific circumstances of an assault (e. g., Bleeding, which often accompanies trauma) might increase risk for HIV transmission in cases involving vaginal, anal, or oral penetration. Site of exposure to ejaculate, viral load in ejaculate, and the presence of an STD or genital lesions in the assailant or survivor also might increase the risk for HIV.

Children might be at higher risk for transmission, because the sexual abuse of children is frequently associated with multiple episodes of assault and might result in mucosal trauma.

Postexposure therapy with zidovudine was associated with a reduced risk for acquiring HIV in a study of healthcare workers who had percutaneous exposures to HIV infected blood. On the basis of these results and the results of animal studies, postexposure prophylaxis (PEP) has been recommended for health care workers who have occupational exposures to HIV. These findings have been extrapolated to other types of HIV exposure, including sexual assault. If HIV exposure has occurred, initiation of PEP as soon as possible after the exposure likely increases benefit. Although a definitive statement of benefit cannot be made regarding PEP after sexual assault, the possibility of HIV exposure from the assault should be assessed at the time of the post assault examination. The possible benefit of postexposure prophylaxis in preventing HIV infection also should be discussed with the assault survivor if the assault poses a risk for HIV exposure.

Several factors impact the medical recommendation for PEP and affect the assault survivor's acceptance of that recommendation, including 1) the likelihood of the assailant having HIV, 2) any exposure characteristics that might increase the risk for HIV transmission, 3) the time elapsed after the event, and 4) the potential benefits and risks associated with the PEP. Determination of the assailants HIV status at the time of the assault examination usually is not possible. Therefore, the healthcare provider should assess any available information concerning 1) characteristics and risk behaviors of the assailant (e. g., a man who has sex with other men and persons who use injection drugs or crack cocaine), 2) local epidemiology of HIV/AIDS, and 3) exposure characteristics of the assault. When assailants HIV status is unknown, factors that should be considered in determining whether an increased risk for HIV transmission exists include 1) whether vaginal or anal penetration occurred; 2) whether ejaculation occurred on mucous membranes; 3) whether multiple assailants were involved; 4) whether mucosal lesions are present in the assailant or survivor; and 5) any other characteristics of the assault, survivor, or assailant that might increase risk for HIV transmission.

If PEP is offered, the following information should be discussed with the patient: 1) the unproven benefit and known toxicity of antiretrovirals; 2) the importance of close follow-up; 3) the benefit of adherence to recommended dosing; and 4) the necessity of early initiation of PEP to optimize potential benefits (i.e., as soon as possible after and up to 72 hours after the assault). Providers should emphasize that PEP appears to be well tolerated in both adults and children and that severe adverse effects are rare. Clinical management of the survivor should be implemented according to the following guidelines. Specialist consultation on PEP regimens is recommended if HIV exposure during the assault was possible and if PEP is being considered. The sooner PEP is initiated after the exposure, the higher the likelihood that it will prevent HIV transmission if HIV exposure occurred; however, distress after an assault also might prevent the survivor from accurately weighing exposure risks and benefits of PEP and from making an informed decision to start such therapy. If use of PEP is judged to be warranted, the survivor should be offered a 3 to 5 day supply of PEP, and a follow-up visit should be scheduled several days later to allow for additional counseling.

Recommendations for Postexposure Assessment of Adolescent and Adult Survivors within 72 Hours of Sexual Assault

- Assess risk for HIV infection in the assailant
- Evaluate characteristics of the assault of that that might increase risk for HIV transmission
- Consult with specialists in HIV treatment, if PEP is being considered
- If the survivor appears to be at risk for HIV transmission from the assault, discuss anti-retroviral prophylaxis, including toxicity and lack of proven benefit.
- If the survivor chooses to start anti-retroviral PEP, provided enough medication to last until the next return visit; reevaluate the survivor 3 to 7 days after the initial assessment and assess tolerance of medications.
- If PEP is started, perform CBC and serum chemistry at baseline (initiation of PEP should not be delayed, pending results).
- Perform HIV antibody test and original assessment; repeated six weeks, three months, and six months.

Source: Center for Disease Control Morbidity and Mortality Weekly Report, December 17, 2010, volume 59/No. RR-12. www.CDC.gov/MMWR