Canadian Family Medicine Clinical Card

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Sexually Transmitted Infections

⚠ **When working up any patient for STI, it is important to identify other STIs through serologic and other appropriate testing.**

GENITAL ULCERS (consider non-infxs cause, e.g. autoimmune, fixed-drug eruption)

	Presentation	Investigations	Treatment
Herpes (HSV-1, -2)	- Grouped vesicles that rupture and become shallow/painful ulcers - Inguinal lymphadenopathy - Fever, malaise, pharyngitis	- Scrape multiple ulcers/vesicles for PCR/culture	- HSV primary infection is a much rarer presentation than recurrent infection - Treatment varies; see guidelines for primary/recurrent/ suppressive management
Syphilis (notifiable disease)	- +ve serology found screening high-risk populations - Secondary stage rash (systemic illness + copper macular rash → symmetric papules including palms/soles) -Painless well-demarcated ulcer (chancre) that resolves	Options: - PCR for *T. pallidum* - Serologic tests for syphilis as per local lab (each lab has a different algorithm, much variation across Canada)	- Benzathine Penicillin G 2.4MU IM once **(if pregnant, administer a 2nd dose 1wk apart)** - Same regimen for HIV +ve patients - Test and treat all sexual contacts - Late neurosyphilis requires alternative treatment (consult ID)
Chancroid	- Painful; necrotizing/ purulent ulcers - Inguinal lymphadenopathy	- Gram stain lesion - *H. ducreyi* PCR/culture	- Single dose of Azithromycin 1g PO or Ciprofloxacin 500mg PO or Ceftriaxone 250mg IM
Lymphogran. venereum	- Painless genital/rectal papule/ulcer (resolves) - Inguinal/femoral lymphadenopathy - Urethritis or prostatitis	- NAAT**/culture for *C. trachomatis*; if +ve perform serovar testing	- Doxycycline 100mg PO BID x 21d - Treat sexual contacts (from within 60d) x 7d
Granuloma inguinale	- *K. granulomatis* - Painless anogenital papules/ulcers - Highly vascular, bleed easily on contact	- Difficult to culture - Consult microbiologist	- Azithromycin 1g PO q1wk for at least 1wk until lesions clear - Treatment halts progression, but often relapse in 6-18m

GENITAL GROWTHS

	Presentation	Diagnosis	Treatment
Warts	- Soft, smooth or lobular anogenital papules or plaques (cauliform common color and appearance vary) - Painless +/- pruritis	- Clinical - Can consider biopsy if unclear	- May increase in # and size or spontaneously regress, typically resolve in 4 months - Cryotherapy (liquid nitrogen) - Topical Imiquimod or Podophyllotoxin
Molluscum Contagiosum	- Small, raised, pink, or flesh-colored with central dimple or pit - Anywhere, incl. genitals	- Clinical - Can consider skin scraping/ biopsy if unclear	- Self-limited, but may take months to resolve - Cryotherapy and curettage - Lim. efficacy with topical tx

** NAAT: Nucleic acid amplification test

VULVOVAGINITIS

	Presentation	Investigations	Treatment
Bacterial Vaginosis	- Thin whitish-grey d/c - Organic amine vaginal odor	- Clue cells on microscopy - Vaginal fluid pH >4.5 - Fishy odor with addition of potassium hydroxide	- Metronidazole 500mg PO BID x 7d (avoid EtOH until 24hrs post-treatment) - Treat asymptomatic patients if any of: ❑ Pregnant with history of previous preterm delivery ❑ Prior to IUD insertion, gynecologic surgery or genitourinary procedure ❑ Prior to therapeutic abortion
Candidiasis	- White, cottage-cheese d/c - Inflamed vulva - Pruritus - Dysuria	- pH 4-4.5 - Yeast hyphae visible on wet mount, Gram stain and PAP	- **Non-pregnant:** Fluconazole 150mg PO once or intravaginal -azole cream/tablet x 1-3d - **Pregnant:** any intravaginal -azole cream x 7d (Fluconazole PO contraindicated) - **Balanitis (♂):** Topical -azole cream x 7d
Trich.	- Yellow frothy d/c - Odor, pruritus, dysuria	- NAAT** - Flagellated motile organisms on wet mount	- Metronidazole 2g PO once (avoid EtOH until 24hrs post-treatment) - Treat sexual partners

GONORRHEA AND CHLAMYDIA (notifiable disease)

Presentation	Investigations	Treatment
- Asymptomatic or as cervicitis/urethritis - ♀: vaginal pruritus, mucopurulent d/c, dysuria, +/- abdominal pain, +/- dyspareunia - ♂: dysuria, +/- pruritus or d/c at urethral meatus - 40% of patients with *N. gonorrhoeae* also have *C. trachomatis* co-infection	- Culture (endocervical or urethral swab) - NAAT** (first catch urine or endocervical, vaginal or urethral swab)	- **Gonorrhea:** [Cefixime 800mg PO or Ceftriaxone 250mg IM once] + [Chlamydia treatment] - Alternative regimen for pharyngeal infection - **Chlamydia:** - **♂ or non-pregnant ♀:** Azithromycin 1g PO once or Doxycycline 100mg PO BID x 7d - **Pregnant:** Amoxicillin 500mg PO TID x 7d (Azithromycin if compliance can't be assured) - Treat recent partners (last 60d) - No intercourse until 7d post-tx

PUBIC LICE AND SCABIES

Presentation	Treatment
- **Lice:** small insects on any part of body with hair, itchy all of the time, nits on hair shaft - **Scabies:** mites that dig under skin, head and neck-sparing, more itchy at night, red papules/crusts, curvy red burrow lines; pruritus may persist after eradication	- **Lice:** Permethrin 1% cream rinse applied for 10mins, then rinse, repeat q3-7d - **Scabies:** Permethrin 5% cream applied from neck down (including fingernails) overnight, rinse in AM, repeat q7d - Wash all clothes and bedding in hot water (>50°C) or place in plastic bag for 7d - Treat all household contacts and recent partners (last month)

Key References: 1) Public Health Agency of Canada. (2017). Canadian Guideline on Sexually Transmitted Infections. Retrieved from https://www.canada.ca/en/public-health/services/infectious-diseases/sexual-health-sexually-transmitted-infections/canadian-guidelines/sexually-transmitted-infections.html#toc 2) Centers for Disease Control and Prevention. (2015). 2015 Sexually Transmitted Diseases Treatment Guidelines. Retrieved from: https://www.cdc.gov/std/tg2015/default.htm