STI Treatment & Partner Notification

First-line regimens, counselling & notification duties

CLINICAL PATHWAY

Check the current dose before you prescribe. Gonorrhoea ceftriaxone dosing, the syphilis benzathine penicillin supply, and the HPV vaccine schedule have all changed recently — this sheet reflects current ASHM guidance, not the doses many of us learned.

FIRST-LINE TREATMENT REGIMENS

- **Chlamydia (genital):** doxycycline 100mg BD for 7 days; pregnancy — azithromycin 1g PO stat; symptomatic rectal infection — doxycycline for 21 days
- **Gonorrhoea (genital/anorectal):** ceftriaxone 500mg IM (with lignocaine) stat + azithromycin 1g PO stat
- **Gonorrhoea (pharyngeal):** same ceftriaxone 500mg IM, but azithromycin increases to 2g PO (1g stat then 1g 6–12 hours later); test of cure at 2 weeks
- **Genital herpes:** valaciclovir 500mg BD for 5–10 days (first episode) or 3 days (recurrence, self-initiated); suppression 500mg daily, reviewed 6-monthly
- **Genital warts:** patient-applied podophyllotoxin or imiquimod 5% cream are both first-line; cryotherapy is the clinician-applied alternative

SYPHILIS — DOSE & CURRENT SUPPLY ALERT

Early syphilis: benzathine penicillin 1.8g (2.4 million units) IM as a single dose (two injections). Late/unknown duration: same dose weekly for 3 doses; neurosyphilis is specialist-led. Bicillin L-A is currently in shortage (both syringe strengths) — a TGA-approved overseas product is available, and a doxycycline-based alternative exists for non-pregnant patients who cannot access benzathine penicillin. Confirm current status and the alternative regimen at sti.guidelines.org.au before prescribing.

HSV & HPV — COUNSELLING

- Asymptomatic HSV shedding is common — most transmission happens between recognised episodes; daily suppression reduces partner transmission
- HSV in pregnancy: start suppression from 36 weeks in those with known recurrent HSV; a primary infection in the third trimester needs urgent specialist input
- HPV vaccine: Gardasil 9 is now a single dose on the National Immunisation Program (age 12–13), with catch-up to 25 — any age if HIV-positive or immunocompromised
- Cervical screening: 5-yearly HPV test from age 25–74 (self-collection now available); annual if HIV-positive

CONTACT TRACING & NOTIFIABLE DUTY

- Trace sexual contacts of the last 6 months for chlamydia/gonorrhoea; for syphilis the window is stage-dependent (commonly 3 months primary, 6 months secondary, 12 months early latent) — confirm via sti.guidelines.org.au
- Let Them Know (letthemknow.org.au) supports anonymous SMS/email partner notification
- Chlamydia, gonorrhoea, syphilis and HIV are all notifiable — in Victoria, in writing within 5 days; confirm your own state's process
- Consider presumptive treatment of a recent, known sexual contact of confirmed chlamydia/gonorrhoea, particularly if follow-up is uncertain

■ SAFETY

- Confirm current ceftriaxone/azithromycin doses before prescribing — gonorrhoea dosing has changed; don't rely on memory
- Check the live syphilis-treatment supply alert at sti.guidelines.org.au before assuming benzathine penicillin is available
- Don't delay empirical treatment of a high-risk symptomatic contact while awaiting results

■ RED FLAGS / REFER

- Pregnancy with a new STI diagnosis, primary genital herpes in the third trimester, or syphilis in pregnancy → urgent specialist/obstetric co-management
- Neurosyphilis, disseminated gonococcal infection, or treatment failure → sexual health physician or infectious diseases
- Possible doxy-PEP candidate (e.g. recurrent bacterial STIs in GBMSM) → discuss with a sexual health physician — the 2023/24 ASHM consensus statement supports selective, time-limited use, reviewed periodically