

TREATMENT PROCTITIS, PROCTOCOLITIS, ENTEROCOLITIS, AND ENTERITIS

Acute proctitis in persons who have practiced receptive anal intercourse is usually sexually acquired. Such patients should undergo anoscopy to detect rectal ulcers or vesicles and petechiae after swabbing of the rectal mucosa; to examine rectal exudates for PMNs and gram-negative diplococci; and to obtain rectal swab specimens for testing for rectal gonorrhea, chlamydial infection, herpes, and syphilis. Pending test results, patients with proctitis should receive empirical syndromic treatment—e.g., with ceftriaxone (a single IM dose of 250 mg for gonorrhea) plus doxycycline (100 mg by mouth twice daily for 7 days) for possible chlamydial infection plus treatment for herpes or syphilis if indicated. If LGV proctitis is proven or suspected, the recommended treatment is doxycycline (100 mg by mouth twice daily for 21 days); alternatively, 1 g of azithromycin once a week for 3 weeks is likely to be effective but is little studied.

PREVENTION AND CONTROL OF STIs

Prevention and control of STIs require the following:

1. Reduction of the average rate of sexual exposure to STIs through alteration of sexual risk behaviors and behavioral norms among both susceptible and infected persons in all population groups. The necessary changes include reduction in the total number of sexual partners and the number of concurrent sexual partners.
2. Reduction of the efficiency of transmission through the promotion of safer sexual practices, the use of condoms during casual or commercial sex, vaccination against HBV and HPV infection, male circumcision (which reduces risk of acquisition of HIV infection, chancroid, and perhaps other STIs), and a growing number of other approaches (e.g., early detection and treatment of other STIs to reduce the efficiency of sexual transmission of HIV). Longitudinal studies have shown that consistent condom use is associated with significant protection of both males and females against all STIs that have been examined, including HIV, HPV, and HSV infections as well as gonorrhea and chlamydial infection. The only exceptions are probably sexually transmitted *Pthirus pubis* and *Sarcoptes scabiei* infestations.
3. Shortening of the duration of infectivity of STIs through early detection and curative or suppressive treatment of patients and their sexual partners.

Financial and time constraints imposed by many clinical practices, along with the reluctance of some clinicians to ask questions about stigmatized sexual behaviors, often curtail screening and prevention services. As outlined in Fig. 163-8, the success of clinicians' efforts to detect and treat STIs depends in part on societal efforts to teach young people how to recognize symptoms of STIs; to motivate individuals with symptoms to seek care promptly; to educate persons who are at risk but have no symptoms about what tests they should undergo routinely; and to make high-quality, appropriate care accessible, affordable, and acceptable, especially to the young indigent patients most likely to acquire an STI.

Because many infected individuals develop no symptoms or fail to recognize and report symptoms, clinicians should routinely perform an STI risk assessment for teenagers and young adults as a guide to selective screening. As stated earlier, U.S. Preventive Services Task Force Guidelines recommend screening sexually active female patients ≤ 25 years of age for *C. trachomatis* whenever they present for health care (at least once a year); older women should be tested if they have more than one sexual partner, have begun a new sexual relationship since the previous test, or have another STI diagnosed. In women 25–29 years of age, chlamydial infection is uncommon but still may reach a prevalence of 3–5% in some settings; information provided by women in this age group on a sex partner's concurrency (whether

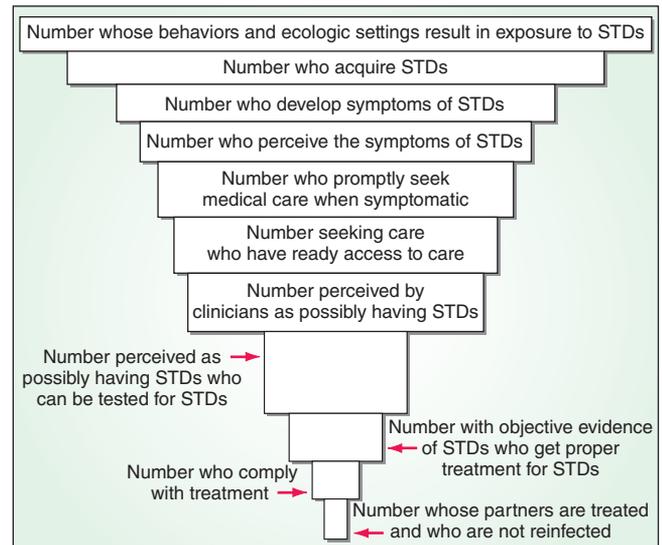


FIGURE 163-8 Critical control points for preventive and clinical interventions against sexually transmitted diseases (STDs).

(Adapted from HT Waller and MA Piot: *Bull World Health Organ* 41:75, 1969 and 43:1, 1970; and from "Resource allocation model for public health planning—a case study of tuberculosis control," *Bull World Health Organ* 48 [Suppl], 1973.)

a male partner has had another sex partner during the time they have been together) is helpful in identifying women at increased risk. In some regions of the United States, widespread selective screening and treatment of young women for cervical *C. trachomatis* infection have been associated with a 50–60% drop in prevalence. Such screening and treatment also protect the individual woman from PID. Sensitive urine-based genetic amplification tests permit expansion of screening to men, teenage boys, and girls in settings where examination is not planned or is impractical (e.g., during preparticipation sports examinations or during initial medical evaluation of adolescent girls). Vaginal swabs—collected either by the health care provider at a pelvic examination or by the woman herself—are highly sensitive and specific for the diagnosis of chlamydial and gonococcal infection; they are now the preferred type of specimen for screening and diagnosis of these infections.

Although gonorrhea is now substantially less common than chlamydial infection in industrialized countries, screening tests for *N. gonorrhoeae* are still appropriate for women and teenage girls attending STD clinics and for sexually active teens and young women from areas of high gonorrhea prevalence. Multiplex NAATs that combine screening for *N. gonorrhoeae* and *C. trachomatis*—and, more recently, for *T. vaginalis*—in a single low-cost assay now facilitate the prevention and control of these infections for populations at high risk.

All patients who have newly detected STIs or are at high risk for STIs according to routine risk assessment as well as all pregnant women should be encouraged to undergo serologic testing for syphilis and HIV infection, with appropriate HIV counseling before and after testing. Randomized trials have shown that risk-reduction counseling of patients with STIs significantly lowers subsequent risk of acquiring an STI; such counseling should now be considered a standard component of STI management. Preimmunization serologic testing for antibody to HBV is indicated for unvaccinated persons who are known to be at high risk, such as MSM and people who use injection drugs. In most young persons, however, it is more cost-effective to vaccinate against HBV without serologic screening. It is important to recognize that, while immunization against HBV has contributed to marked reductions in the incidence of infection with this virus, the majority of new cases that do occur are acquired through sex. In 2006, the Advisory Committee on Immunization Practices (ACIP) of the CDC recommended the following: (1) Universal hepatitis B vaccination should be implemented for all unvaccinated adults in