CDC 2020 Gonorrhea Treatment Update:
Single 500 mg IM Dose of Ceftriaxone Recommended

This table summarizes the Centers for Disease Control and Prevention (CDC) "Update to CDC's Treatment Guidelines for Gonococcal Infection, 2020" published December 18th, 2020. This guidance updates the 2015 CDC STD Treatment Guidelines and reflects changes expected in the forthcoming CDC 2021 STI Treatment Guidelines.

The new gonorrhea treatment regimens have shifted to monotherapy with a higher dose due to the following reasons:

1. Increasing concern for antimicrobial stewardship and the potential impact of dual therapy on commensal organisms and concurrent pathogens
2. Continued low incidence of gonorrhea isolate strains with ceftriaxone resistance
3. Increased incidence of azithromycin resistance

Disease	Recommended Regimen	Alternative Regimen	Follow-up
Uncomplicated Urogenital and Rectal Gonorrhea (GC)	**Ceftriaxone 500 mg IM for persons weighing <150 kg (330 lb)[1]** **If chlamydia has not been excluded with a negative test result, then treat for chlamydia with doxycycline 100 mg PO BID for 7 days. (*During pregnancy use azithromycin 1 gm orally for chlamydia treatment)***	**Cefixime[2] 800 mg orally** **OR** **Gentamicin[3] 240 mg IM PLUS** **Azithromycin 2 gm orally** **If chlamydia has not been excluded with negative test result, then treat for chlamydia with doxycycline 100 mg PO BID for 7 days. (*During pregnancy use azithromycin 1 gm orally for chlamydia treatment)***	Retest[5] all patients for reinfection 3 months after treatment (even if all sex partners were treated). If retesting[5] at 3 months is not possible, retesting can be performed at any time within 1-12 months after treatment.
Uncomplicated Pharyngeal Gonorrhea (GC)	**Ceftriaxone 500mg IM for persons weighing <150 kg (330 lb)[1]** **If chlamydia coinfection is identified during testing for pharyngeal GC then add treatment for chlamydia with doxycycline 100 mg PO BID for 7 days. (*During pregnancy use azithromycin 1 gm orally for chlamydia treatment)***	No reliable alternative treatments are available. If history of beta-lactam allergy, a thorough assessment of the allergic reaction is recommended.[4] If history of anaphylactic or other severe reaction (e.g., Stevens Johnson syndrome) to ceftriaxone, consult an Infectious Disease specialist or www.STDCCN.org for advice.	A test-of-cure is recommended using culture or nucleic acid amplification test 7–14 days after initial treatment. Retest[5] all patients for reinfection 3 months after treatment (even if all sex partners were treated). If retesting[5] at 3 months is not possible, retesting can be performed at any time within 1-12 months after treatment.

Citation

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1. For persons weighing ≥150 kg (330 lb), 1 g of ceftriaxone should be administered IM.
2. Oral cefixime can be used if administration of ceftriaxone is not available. Cefixime does not provide as high, or as sustained bactericidal levels as ceftriaxone. Cefixime has limited efficacy for pharyngeal infection.
3. If the patient has a cephalosporin allergy, gentamicin plus azithromycin regimen can be used for treatment.
4. Information about assessing prior history of allergy is described in the CDC 2015 STD Treatment Guidelines gonorrhea section. (https://www.cdc.gov/std/tg2015/gonorrhea.htm)
5. Retesting assesses for reinfection; reinfection is common within 12 months of diagnosis/treatment for gonorrhea.

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