### Cystitis
- **Risk factors:** sex, spermicide, diaphragms, DM, h/o recurrent UTIs, recent abx. **Agents:** usually *E. coli* or *Staph saprophyticus*, also *Proteus*, *Klebsiella*, enterococci

### Symptoms
- Lower UTI: dysuria with muscle spasm, frequency with small vol, urgency, suprapubic pain, ± hematuria - Upper UTI: lower symptoms + fever > 100.4, flank pain, CVA tenderness, nausea, vomiting
- Elderly may have AMS only

### Work up
- Uncomplicated = healthy young nonpregnant female → proceed to empiric treatment
- Complicated = UA with microscopy (look for pyuria, bacteriuria, varying hematuria), culture, wet prep - Hematuria will not be present in cervicitis or urethritis but is common in UTI

### Treatment
- Uncomplicated: 3-5 days of bactrim or FQ if more severe symptoms, Septra alternative
- Complicated: 7-14 days of FQ or Septra OK, send to ED if N/V
- Preventive cranberry juice acidifies urine and prevents pathogens from binding to urinary epithelia
- Short-term phenazopyridine for dysuria

### Prophylaxis
- Consider prophylaxis for women with > 2 UTIs in last 6 mo or > 3 UTIs in last year: clean UA followed by 6 months of Septra, nitrofurantoin, cefaclor, cephalexin, or FQ
- Postmenopausal women may benefit from vaginal estrogen cream

### UTI/Pyelonephritis
- **Sx:** dysuria, frequency, urgency +/- hematuria, suprapubic pain (Pyelo = UTI sx + fever, chills, flank pain, CVA tenderness)
- **Dx:** UA → pyuria (>10 WBC/hpf), bacteriuria, leukocyte esterase (reflects pyuria), nitrates (reflect Enterobacteria)
- **Cipro** → 500mg BID x 3-7d (1 week for elderly, complicated)
- **Bactrim (TMP-SMX)** → one double strength tablet [160/800 mg] BID x3-7d
- **Macrobid (Nitrofurantoin)** = 100mg PO BID x5-7d
- **Yeast infection** → Diflucan 150mg PO 1x dose (Fluconazole)
- **Pyelo** → do urine cx & susceptibility testing to determine best regimen
  - Empiric = FQ i.e. Cipro 500 BID x7d or Levo 750mg once daily x 5-7d
- **Urethritis** → discharge & dysuria, typically d/t gonorrhea, chlamydia, or trich, dx with gram stain
  - Tx: ceftriaxone (G), doxy (C), flagyl (T)

### Balanitis
- Important to distinguish from SCC
- Pinpoint red papules evolving into umbilicated pustules on the glans and coronal sulcus with pasty macerated debris under the foreskin (more common in uncircumcised men)
- Edema & pain can cause difficulty retracting foreskin
- Topical treatment for 10d is usually sufficient
- If it doesn’t clear → biopsy for SCC

### Prostatitis
- **⇒ m/c d/t E. coli, constitutional sx + LUTS, pyuria, bacteriuria, elevated PSA**
  - Do a urine gram stain & culture
  - Tx empirically with Bactrim or FQ
- **Acute Bacterial Prostatitis**
  - **Etiology:** gram negative rods (*E. coli*, pseudomonas), sometimes gram + enterococci
  - **S/Sx:** PAIN, fever, irritative voiding symptoms
    - obstruction indicates more serious infx
    - FEVER, TENDERNESS if severe
    - Any pt with back pain should have this on their differential
  - Usually infects via ascending route (urethra to prostatic ducts)
  - **Lab evaluation:** leukocytosis, pyuria, bacteruria, +/- hematuria, urine culture
  - **DDx:** pyelonephritis, epididymitis, diverticulitis, urinary retention from BOO
  - **Treatment:** abx, NO catheterization, f/u culture and exam of secretions
  - **Prognosis:** good!
  - **Referrals:** urinary retention, chronic prostatitis
  - **Admissions:** sepsis, surgical drainage

### Chronic Bacterial Prostatitis
- **Etiology:** gram negative rods, can be questionable
- **S/Sx:** asymptomatic, irritative voiding sx, perineal or suprapubic discomfort, low back pain, hx UTIs
  - Prostate may feel normal, boggy, indurated
  - **Lab eval:** U/A, prostatic secretions → culture, sometimes pelvic radiology
    - >10 WBCs/HPF (esp. macrophages) is consistent with chronic prostatitis
  - **DDx:** chronic urethritis, cystitis, anal disease
  - **Tx:** antibiotics (given 6-12wks), NSAIDs, hot sitz baths
  - **Prognosis:** difficult to cure
  - **Referrals:** for persistent symptoms

### Orchitis
- → testicular swelling and pain commonly d/t systemic infx (mumps) → urology consult

### Epididymitis
- **⇒ unilateral testicular pain, dysuria, freq & urgency, fever, + Prehn’s sign**
  - Can be infectious or non-infectious (prolonged sitting, vigorous exercise)
  - **Dx:** CBC, UA, urethral cx & gram stain → *chlamydia***, *gonorrhea, E. coli, pseudomonas*
  - **Tx:** ice, elevation, NSAIDs
    - <35yo: ceftriaxone 250mg IM x1 + doxycycline 100mg PO BID x10d
    - >35yo: ofloxacin 300mg PO BID x10d OR levofloxacin 500mg PO QD x10d
### Infectious Diseases

#### HIV
- Heterosexual contact is the most commonly reported risk factor.
- Candida vaginitis and HSV are more persistent and severe in HIV infected women.
- HIV infected women have an increased risk for cervical dysplasia and cervical cancer.
- Choice of contraception is complex (drug interactions and risk of transmission).
- Progresses from primary infection with seroconversion → clinical latency → early symptomatic disease → AIDS.
- Transmission is mostly heterosexual in developing countries while both MSM and heterosexual in the US.
- Patients are most infectious during primary infection.

#### Signs & symptoms
- Only lymphadenopathy during asymptomatic disease.
- May have mononucleosis-like syndrome during primary infection.
- Febrile illness.
- Aseptic meningitis.

#### Workup
- Serologies are + 3 - 7 weeks after infection.
- Drug resistance testing.
- Definition of AIDS is when CD4 count drops to < 200.

#### Management
- Large debate about aggressive treatment of primary infection vs waiting until disease is symptomatic.

#### Toxoplasmosis
- **Toxoplasma gondii**
- Acquired via ingestion of contaminated meat or cat poop, through vertical transmission, or via blood transfusion or organ transplantation.
- High amount of seroprevalence in US as 30-40% of household cats are infected.

#### Prevention
- AIDS pts should be given prophylaxis.

#### Signs & symptoms
- Majority of adult infections are asymptomatic.
- Fevers, chills, sweats.
- Cervical lymphadenopathy.
- Can have reactivation illness during times of immunosuppression.
- In HIV can have encephalitis.
- With vertical transmission, there is congenital toxoplasmic syndrome.

#### Workup
- Serology (IgM will be + within 1 week and may persist for years, IgG persists for lifetime).
- Brain MRI for HIV patients showing ring-enhancing lesions.

#### Management
- Pyrimethamine + sulfadiazine for cerebral toxoplasmosis.

#### Pneumocystis (Pneumocystis jiroveci)
- It’s actually a fungus → leads to pneumonia in HIV patients.
- Immunocompromised = PCP, most common opportunistic infection (CD4<200).
- Dry cough, SOB, fever.
- Tx = Bactrim.

#### Cytomegalovirus (CMV)
- Transmission may be sexual, close contact, or blood and tissue exposure.
- HIV patients and transplant patients are at increased risk of reactivation disease.

#### Signs & symptoms
- Generally asymptomatic or nonspecific in immunocompetent host.
- Can have CMV mononucleosis with fever (distinguish from EBV by absence of lymphadenopathy and pharyngitis).
- Rare associations with colitis, encephalitis, myocarditis.
- Can have reactivation in critically ill patients.

#### Workup
- CBC shows lymphocytosis.
- PCR test.
- Serologies.
- Viral culture.

#### Management
- Antivirals only for immunocompromised with severe manifestations.

#### Lyme disease
- Tick bite → find out how long tick was embedded! how many days since bite found?
  - Within 2d of bite → can give 2 tabs of doxy 100mg for prophylactic tx.
  - Check labs in 6 weeks.
- Early localized (~1-2wks): erythema migrans, flu-like systemic sx, lyme arthralgia.
  - If really high fever ~104 or severe sx, consider co-infection Anaplasmosis/Ehrlichia.
- Early Disseminated (~1-2mo): cranial neuropathy (facial n. / CN 7), lyme carditis (heart block / conduction delay), rash.
- Late Disseminated: monoarticular arthritis, cognitive effects.

#### Diagnosis
- Serology = ELISA (indirect) for antibodies IgG & IgM, if positive → Western Blot (direct).
- IgG indicates prior/late infections (requires 5 antibodies present).
- IgM indicates current infection (requires 2 abs present).

#### Treatment
- Doxycycline 100mg BID x10-21d.
- Alternatives: Amoxicillin 500mg TID x14-21d OR Cefuroxime 500 BID x14-21d.
- Lyme meningitis, carditis: IV ceftriaxone x28d.
**Rocky Mountain Spotted Fever**
- Most cases are in NC, SC, TN, OK, and AR
- *Rickettsia rickettsii*
- Transmitted by *dermacentor variabilis* (dog tick)
- Most cases in NC, SC, Tennessee, Oklahoma, and Arkansas
- Agent in US is *Rickettsia rickettsia*
- Transmitted by *Dermacentor variabilis* (dog tick)
- **Symptoms**
  - Chills, fever, headache, nausea, vomiting, myalgias, restlessness, insomnia, and irritability
  - Rash begins as macules then progresses to maculopapules and petechiae, beginning on wrists and ankles, spreading to arms, legs, and trunk, also soles and palms
  - Facial flushing, conjunctival injection, and hard palate lesions may occur
  - Splenomegaly, hepatomegaly, jaundice, and myocarditis may occur
  - Possible delirium
  - Pneumonitis with respiratory failure
- **Workup**
  - PCR of skin lesions
  - Serology will not be positive until 2nd week of disease
- **Treatment**
  - Doxycycline (even in kids)
- **Prognosis**  
  → High mortality rate if untreated

**Methicillin Resistant Staphylococcus Aureus (MRSA)**
- Healthcare-associated MRSA (HA-MRSA) is associated with severe, invasive disease in hospitalized patients
- Community-acquired MRSA (CA-MRSA) can occur in skin and soft tissue infection in young healthy adults with no recent healthcare exposure
- **Management**
  - Invasive infections → vancomycin or daptomycin
  - Osteomyelitis → vancomycin or daptomycin
  - Outpatient management of MRSA skin and soft tissue infection → clindamycin, Septra, or doxycycline
  - Inpatient treatment of severe MRSA skin and soft tissue infection → vancomycin, linezolid, or daptomycin

**Salmonellosis**
- Enteric fever is caused by *Salmonella typhi* and *Salmonella paratyphi*
- Other *Salmonella* serotypes are collectively known as nontyphoidal salmonellae and are frequently isolated from the stool of patients with gastroenteritis
- Associated with poultry, eggs, and milk products, but many other food products and animal contacts are also sources of infection

**Tetanus**
- Caused by the soil anaerobe *Clostridium tetani*
- **Signs & Symptoms**
  - Muscle spasms, Inadequate vaccination history
- **Workup**
  - Diagnosis is clinical
- **Management**
  - Neutralize unbound toxin using tetanus Ig
  - Metronidazole to eradicate remaining *Clostridia*
  - Benzos to control spasms
  - Labetalol for autonomic hyperactivity

**Pertussis**
- Whooping cough
- *Bordetella pertussis* = gram neg coccobacillus
- **Symptoms**
  - Whooping cough spells (paroxysms) w/ post-tussive emesis
  - Catarrhal phase = mild URI sx
  - Paroxysmal stage = whooping cough
  - Convalescent stage = mild cough continues
- **Treatment**
  - Usually 12wk duration
  - Abx helpful if in catarrhal phase
  - Azithromycin x5d (500 mg for the first dose, then 250 mg daily for the next 4d)
  - Isolate for 5d
  - Bactrim if pt cannot tolerate macrolides

**Influenza**
- Influenza A/B virus
- **Symptoms**
  - Abrupt onset (worsens over 3-6hrs)
  - Fever, headache, myalgia, malaise
  - DRY cough, sore throat, rhinitis sometimes
- **Treatment**
  - Antipyretics / Analgesics
  - Albuterol SABA Neb
  - Antivirals WITHIN 48hrs OF SX ONSET
    - Tamiflu/Oseltamivir 75mg BID x5d (PO)
    - Ralenza/Zanamivir 10mg BID x5d (IH)

**Diphtheria**
- Patient will be complaining of URI-like illness, sore throat, low fever
- PE will show bull neck, cervical adenopathy, “pseudomembrane” on pharynx and “grains of salt” on tonsils
- Most commonly caused by *corynebacterium diphtheria* (anaerobic Gram positive)

**Rabies**
- Patient with a history of exposure to raccoons, bats, or skunks
- Complaining of hydrophobia, agitation, spasms
- Treatment is wound care (scrubbing), Ig at wound site, vaccination
## Epstein Barr Virus Infections (EBV)/Mononucleosis
- **Epstein Barr virus**
  - Other viruses like CMV can cause mono-like syndrome
- **Symptoms**
  - Fever, fatigue, malaise
  - Pharyngitis (for 10-14d)
  - Tonsillar edema, erythema
  - Exudative tonsillitis (shaggy white-purple)
  - LAD, hepatosplenomegaly
- **Diagnosis**
  - Monospot test (detects heterophile Abs), LFTs, CBC w/ platelets, Coombs test
- **Treatment**
  - Avoid contact sports & heavy lifting first 2-3wks
  - AVOID AMPICILLIN / AMOXICILLIN → If provider mistakes this for strep and gives these, mono pt can get RASH
- **Complications**
  - Ruptured spleen, hepatitis, low blood cell counts, CNS infx

## Cryptococcosis
- **Cryptococcus neoformans**
- **Meningitis, CD4 <100:** Cryptococcus
- **Signs & symptoms**
  - Pulmonary infections → solitary, non-calcified nodules
  - Meningoencephalitis: seen in HIV, sx occur over 1-2 weeks
- **Workup**
  - Must culture organism from CSF for definitive dx of meningitis but can presumptively ID with CSF Ag testing
- **Treatment**
  - Amphotericin B and flucytosine for meningitis

## Histoplasmosis
- Patient with a history of travel to Ohio/Mississippi river valleys and exposure to bird/bat droppings
- X-ray will show solitary pulmonary calcification, hilar and mediastinal adenopathy
- Diagnosis is made by culture
- Treatment is **itraconazole** or amphotericin B

## Botulism
- Infantile, foodborne, and wound types
  - Infantile = MC (honey or corn syrup)
  - Food borne = undercooked foods, canned foods
  - Wound = spores
- > 70% of cases are infantile
- > 20% linked to honey exposure, not ingestion
- Toxin secretion causes illness by acting on pre-synaptic nerves to block the release of acetylcholine
- **Symptoms:**
  - Descending, symmetric, flaccid paralysis
  - Cranial nerve deficits
  - Bulbar palsy
  - Hypotonia
  - Respiratory failure
- Diagnosis made with stool culture and toxin assay, no blood tests available
- Antibiotics are contraindicated (except for wounds)

## Malaria
- **P. falciparum** (deadliest), P. ovale, P. vivax, P. malariae
- **P. ovale, P. vivax:** hepatic phase
- Anopheles mosquito
- Immigrant, traveler
- Irregular fevers, diaphoresis
- P. falciparum: cerebral malaria, Blackwater fever
- Uncomplicated, no resistance areas Rx: chloroquine
- Complicated, P. falciparum rx: quinidine + doxycycline

## Shigellosis
- Transmitted by direct person-to-person spread, less commonly, through contaminated food and water
- The incubation period = 1-7 days
- **Symptoms**
  - High fever, abdominal cramps, and bloody, mucoid diarrhea; tenesmus is common
  - Generally self-limited, lasting no more than seven days in an untreated immunocompetent host
- Patient will be complaining of fever, bloody, mucoid diarrhea and seizures (more common in children)
- Labs will show RBCs and WBCs
- Treatment is ciprofloxacin
- Complications: HUS, Reiters syndrome

## Cholera
- Patient with a history of drinking contaminated water
- Complaining of severe, watery diarrhea flecked with mucus “rice water”
- PE will show dehydration
- Diagnosis is made by stool culture or darkfield microscopy
- Most commonly caused by *Vibrio cholerae*
- Treatment is supportive. Moderate to severe - fluoroquinolones, macrolides, and tetracyclines

## Varicella zoster
- Age, immunodeficiency
- Reactivation of latent VZV in dorsal root ganglion
- Grouped vesicles on an erythematous base, dermatomal
- Postherpetic neuralgia, Ramsay Hunt syndrome, zoster opthalmicus
- Acyclovir
<table>
<thead>
<tr>
<th>Disease</th>
<th>Description</th>
<th>Etiology Pathophys</th>
<th>Clinical Presentation</th>
<th>Dx Tests Work Up</th>
<th>Treatment Management</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Trichomonas</strong></td>
<td>The most common curable STD</td>
<td>Protozoan <em>Trichomonas vaginalis</em></td>
<td>Inflammation (vaginitis) pH = 5-6 <em>Frothy</em> thin gray-yellow discharge Vulvular irritation, erythema, edema Dyspareunia Dysuria <strong>Strawberry cervix</strong></td>
<td>Motile trichomonads seen on wet mount confirmatory tests include NAAT (gold standard) – reverse transcriptase PCR microscopy only shows organism 60% of time</td>
<td>Metronidazole (Flagyl) PO Treat partners! Complications: pre-term delivery increased susceptibility to other STDs</td>
</tr>
<tr>
<td><strong>Chlamydia</strong></td>
<td>Most frequent reportable bacterial STD in US 14-25 y/o most affected Causes mucopurulent cervicitis</td>
<td>Bacterial <em>Chlamydia trachomatis</em></td>
<td>Asymptomatic (most common, 50% of women) Slight clear white discharge Dysuria (burning possible) Vague pelvic pain Abnormal bleeding Urethritis/cervicitis or normal appearance, vaginal discharge reinfection is common</td>
<td>Screening: –sexually active + &lt;25yo should have annual screening -MSMs should be screened yearly and every 3-6 mo if multiple partners Cell culture NAAT from urine or vaginal swab</td>
<td>Azithromycin 1mg PO x1d or Doxycycline 100mg x1wk Treat partners! Complications: cervicitis/urethritis, perihepatitis, perihepatitis (Fitzhugh-curtis syndrome), PID 30%, pregnancy (low birth weight, premature rupture of membranes), ectopic pregnancy, infertility</td>
</tr>
<tr>
<td><strong>Gonorrhea</strong></td>
<td>2nd most common reportable STD (1/5 as often as chlamydia)</td>
<td>Bacterial <em>Neisseria gonorrhoeae</em></td>
<td>Asymptomatic most common (50% F, 10%M) <em>Purulent</em> discharge Women: dysuria, discharge, abnormal bleeding, pharyngitis, mucopurulent cervicitis Men: thick white or yellow-green discharge, dysuria, urethral itch &amp; pain, inflamed testes or prostate Can also infect mucous membranes of mouth, eyes</td>
<td>Cx on Thayer-Martin media (sn 72-95%) NAAT – urine, urethral, vagina, oral, rectal (sn. 98-100%) Gram stain for intracellular gram (-) diplococci For disseminated infx → arthrocentesis</td>
<td>Ceftriaxone !M x1d + Azithromycin PO or doxy +/- cipro Ceftriaxone alone no longer recommended d/t increasing resistance - 1% of chlamydia is resistant to ceftriaxone – use azithro Treat partners! Complications: pharyngitis, perihepatitis, PID, ectopic pregnancy, infertility, disseminated infx (joint)</td>
</tr>
<tr>
<td><strong>Syphilis</strong></td>
<td>Ulcerative lesion Estimated 55k new infx yearly “the great pretender” – variable presentation Disproportionately affects MSMs</td>
<td><em>Treponema pallidum</em> (spirochete bacteria)</td>
<td>Painless ulcer “raised, rolled border” Primary = painless lesion at site of infection (“chancre”) – easily missed, heals in few wks w/o tx Typically appears 3wks post infx Secondary = systemic dissemination, occurs 25% of time, maculopapular rash on palms &amp; soles, conjunctivitis, lymphadenopathy, fever, malaise, arthralgias, pharyngitis, condyloma lata (wart-like) Typically appears 6-8wks post infx</td>
<td>Gold standard = darkfield microscopy Nonspecific tests = RPR, VDRL (high rate of false positives) →successful tx should show 4-fold reduction in titer at 6-12mo Specific tests = FTA-ABS, TP-PA, EIA, MHA-TP, HATTS = direct test for Abs to treponemal antigens, “reactive” or “nonreactive” results, remains positive even after treatment PCR Lumbar puncture Cannot grow in cx Cannot view w/ light microscopy</td>
<td>Penicillin G* Allergies: tetracycline (doxy) or ceftriaxone Neurosyphilis = Pen G Resolves spontaneously in 3-8wks</td>
</tr>
<tr>
<td>Disease</td>
<td>Mode of transmission</td>
<td>Symptoms</td>
<td>Diagnosis and Treatment</td>
<td>Prevention</td>
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<tr>
<td><strong>Chancroid</strong></td>
<td>Bacterial (pathogen)</td>
<td>Herpesvirus type 1 and 2, genital and perianal ulcerations, painful pustular lesions</td>
<td>Clinical diagnosis: Tzanck smear → multinucleate giant cells. Viral Culture (sn 50%)</td>
<td>No cure</td>
<td></td>
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<tr>
<td><strong>Herpes</strong></td>
<td>HSV-1, HSV-2: commonly genital, HSV-3: commonly lip/oral mucosa, both can affect</td>
<td>Painful vesicles around genital, rectum, or mouth</td>
<td>Screening not done routinely - done if recurrent sx, partner with genital herpes, individuals who present for STD eval, pts with HIV, at-risk MSM</td>
<td>Abstinence, condoms Abstain during outbreaks Inform partners</td>
<td></td>
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<td></td>
<td>either site</td>
<td>Reactions with latent virus: lack of symptoms, asymptomatic shedding</td>
<td>Acyclovir, foscavir, valacyclovir (PO) - for primary or recurrent episodes - reduces viral shedding &amp; shortens clinical course - can be used prophylactically for pts with frequently recurring episodes IV acyclovir for severe disease or in immunocompromised patients not effective</td>
<td>Complications: encephalitis, meningitis, ocular</td>
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<td></td>
<td>Transmitted via contact w/ lesions, mucosal surfaces, genital &amp; oral secretions</td>
<td>Recurrence with latent virus: lack of symptoms, asymptomatic shedding</td>
<td>All sex partners should be evaluated for infx</td>
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<td></td>
<td>High risk when symptomatic (lesions), but can still asymptptomatically shed virus</td>
<td>Reactivation/Recurrence: reactivation of latent virus</td>
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<td>Harder to get subseq HSV-2 infx after having HSV-1</td>
<td>Reactivation: reactivation of latent virus</td>
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<td></td>
<td>Incubation period: 2-12d</td>
<td>Triggers: stress, fever, menses, trauma, immunodeficiency, nerve damage</td>
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<td>Precipitating factors for recurrent outbreaks: stress, fever, menses, trauma,</td>
<td>Less painful, shorter duration</td>
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<tr>
<td><strong>Lymphogranuloma Venereum</strong></td>
<td><strong>Granuloma inguinale</strong> - Rare in US, common in developing world</td>
<td>Large, painless, spreading ulcers, raised rolled margins bleed easily, Exude malodorous discharge</td>
<td>Clinical diagnosis: Serologic test for IgG Abs. Viral Culture (sn 50%)</td>
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<td><strong>Chlamydia trachomatis</strong> - Serotypes L1, L2, L3 are most common</td>
<td>4 types of presentation: Ulcerogeniculomatomatous (beefy red, bleed to touch)</td>
<td>PCR-based genotyping can differentiate LGV from non-LGV chlamydia trachomatis</td>
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<td>Risk from travel &amp; unprotected sex in Africa, SE Asia, India</td>
<td>Stage 1 - small, painless papules / shallow ulcerations typically on vaginal wall</td>
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<td>Groove sign = pathognom = inguinal buboes with nonsignificant ulcers</td>
<td>Stage 2 - painful unilateral inguinal adenopathy → grove sign</td>
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<td><strong>Donovanosis</strong> - Rare in US, common in developing world</td>
<td>Stage 3 - rupture of budo → genitoanorectal syndrome</td>
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<td><strong>Infect the lymphatic tissue in the genital region</strong></td>
<td>Strictures, tissue strictures, tissue ischemia &amp; necrosis, elephantiasis of female genitalia</td>
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<td></td>
<td><strong>Groove sign = pathognom = inguinal buboes with nonsignificant ulcers</strong></td>
<td><strong>Comparison:</strong> Donovan bodies (intracytoplasmic safety pin shaped organisms) on Giems or Wright stain</td>
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<td></td>
<td><strong>Inguinal buboes</strong></td>
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<tr>
<td>Condition</td>
<td>Description</td>
<td>Symptoms</td>
<td>Diagnosis/Treatment</td>
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<tr>
<td>HPV</td>
<td>The most common STD of all. 75-85% of all sexually active individuals will get at some point</td>
<td>Most people don’t know they are infected. Causes plantar warts, common warts, anogenital warts. Infects squamous cells and may cause them to mutate. Genital warts can cause itching, burning, pain, and/or bleeding. Can occur as condyloma acuminate (cauliflower like), keratotic, flat topped papules, papular warts.</td>
<td>Clinical dx HPV testing Biopsy/colposcopy Pap smears/cytology Most HPV warts clear in 6-12 months</td>
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<tr>
<td>Molluscum Contagiosum</td>
<td>Benign infx of vulva. Pox virus usually asymptomatic Small, white/pink/flesh colored dome-shaped papules w/ central umbilication.</td>
<td>Usually clinical dx Excisional bx → shows intracytoplasmic inclusions</td>
<td>Usually self-limiting Curettage or cryotherapy Topical imiquimod</td>
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<tr>
<td>Scabies</td>
<td>Parasite. Sarcoptes scabiei (mite) Transmitted by sexual contact / skin-to-skin contact or fomites. Pruritus (worse at night, spares the head) Polymorphic papules may be seen. Scabies prep: mineral oil over burrow → burrow scraped off onto slide.</td>
<td>Visualization of parasites or nits/eggs Scabies prep: mineral oil over burrow → burrow scraped off onto slide.</td>
<td>Permethrin cream (1-5%) applied neck down and washed off after 8-14hrs (91% cure rates after one use)</td>
<td></td>
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<tr>
<td>Pubic Lice</td>
<td>Parasite. Pediculus pubis (crab louse) Transmitted by sexual contact / skin-to-skin contact or fomites. 30d incubation period. Very itchy (worse at night) Possible low grade fever &amp; malaise.</td>
<td>Visualization of lice or nits/eggs</td>
<td>Permethrin cream Nix Wash all linens Treat family/close contacts</td>
<td></td>
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