STDs: Drug resistance demands dual therapy

As a professor of public health and a medical consultant for a state-run STD clinic, I greatly appreciated Dr. Campos-Outcalt's article addressing the recently updated STD treatment guidelines (CDC update: Guidelines for treating STDs. *J Fam Pract*. 2011:60;143-146). The author correctly points out the dosage change recommended for treating uncomplicated gonorrheal infections (increasing the dose of ceftriaxone from 125 to 250 mg) and the rationale for this change (to help combat emerging antibiotic-resistant strains). He also states that dual therapy (azithromycin plus ceftriaxone) is still recommended, both because of the high rate of co-infection with *Chlamydia trachomatis* and the potential for azithromycin to help eradicate gonorrhea with decreased susceptibility to ceftriaxone.

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However, one important change from the 2006 treatment guidelines was not addressed—that dual treatment of gonorrhea (the addition of 1 g oral azithromycin) is now recommended, *whether or not a chlamydial infection has been ruled out*.[1] The 2006 treatment guidelines recommended dual treatment (azithromycin plus a cephalosporin) to cover the possibility of co-infection with *C trachomatis*, but noted that if chlamydia had been ruled out by a sensitive test such as a nucleic acid amplification test, the azithromycin was unnecessary.[2]

The continued increase in antibiotic-resistant gonococci is the driving force behind 3 new gonorrhea treatment recommendations: (1) injectible ceftriaxone should be used rather than oral cefixime; (2) the ceftriaxone dose should be doubled from 125 to 250 mg; and (3) 1 g oral azithromycin should be administered (in addition to ceftriaxone), whether or not a chlamydial infection has been ruled out.

Attacking gonorrheal infections with a multidrug regimen will cover the possibility of co-infection with chlamydia, but even if chlamydial co-infection is absent, this strategy will help to decrease the emergence of cephalosporin-resistant isolates. A multidrug therapeutic approach to address the emergence of antimicrobial resistance is similar to the strategy currently used for the treatment of tuberculosis and HIV/AIDS.

Alan R. Katz, MD, MPH
Honolulu

1. Centers for Disease Control and Prevention. Sexually transmitted diseases treatment guidelines, 2010. *MMWR Recomm Rep*. 2010;59(RR-12):50.
2. Centers for Disease Control and Prevention. Sexually transmitted diseases treatment guidelines, 2006. *MMWR Recomm Rep*. 2006;55(RR-11):42-49.

Doctors applaud call for diversity

We read with interest Dr. Susman's editorial (Who should be admitted to medical school? *J Fam Pract.* 2011;60:179). It is refreshing to have a medical school dean recognize that medical board scores have never been correlated to practice performance and that multiple choice exams have nothing to do with success in daily practice. Further, we applaud Dr. Susman for recognizing and pursuing diversity as a goal in medical school education. It is well documented that medical students of color or students raised in urban, inner city, or rural communities are more likely to practice in underserved communities.[1] As physicians in the US Navy, we experience the benefits of a diverse patient population and diverse medical corps daily.

We think it important to clarify that the primary stewardship role of a medical school is to train well-rounded physicians who are prepared to practice in any setting—ie, to identify and train people who will be good doctors. Diversity is a necessary and beneficial contribution to good medicine after the primary goal is met.

Robert P. Lennon, MD, JD, LT, MC, USN; Nadine Tassin, MD, LT, MC, USN; Vanessa McNair, MD, MPH*
Jacksonville, Fla

1. Mullan F, Chen C, Petterson S, et al, The social mission of medical education: ranking the schools. *Ann Intern Med.* 2010;152:804-811.

*The views expressed here are those of the authors and do not reflect the official policy or position of the US government, Department of the Navy, or Department of Defense.