VII Jornada sobre aspectes rellevants de la infecció pel VIH.
Maneig a l'Atenció Primària i a l'hospital

MANEIG DE LA SÍFILIS
ACTUALITZACIÓ DOXI-PEP

Ricard Carrillo

Metge de MfiC. EAP Florida Sud (L'Hospitalet de Llobregat).

GdT VIH - CAMFiC

Barcelona, 24 d'octubre de 2024

Patrocina:

01 Sífilis

Sífilis

Una mica d'història

1493

Primera sospita. Procedent d' Amèrica. Ràpida extensió. Creixement tràfic marítim comercial, precarietat social i salut.

1521

Hieronymi Francastorii . Primer en nomenar-la sífilis al llibre *Syphilis. Sive Morbus Gaellicus* [Trad. Sífilis o malatía francesa]

1679

T. Sydenham. Evidència actual procedent d'Àfrica per contacte amb casos de pian.

1789

Marcello Cumano descripció relacionada amb ITS

Sífilis

Una mica d'història

1941

Primera inclusió vigilància epidemiològica

1998

Descens molt notable de casos.

OMS la va considerar quasi erradicada

2016

OMS. $12x10^6$ nous casos

2019

CDC. 86% afecta a homes sobre tot HSH i el 46% coinfecció amb VIH

2024

Brot als països de renda alta.

Afecten a homes i dones heterosexuals

La predominança de símptomes mucocutanis previs a l'afectació sistèmica ha fet que històricament la dermatologia fos la "encarregada" del diagnòstic i tractament → APiC, infeccioses, unitats VIH, ginecologia, entitats comunitàries...

REVIEW

Syphilis: a mini review of the history, epidemiology and focus on microbiota

Sífilis

Situació epidemiològica de la sífilis infecciosa a Catalunya

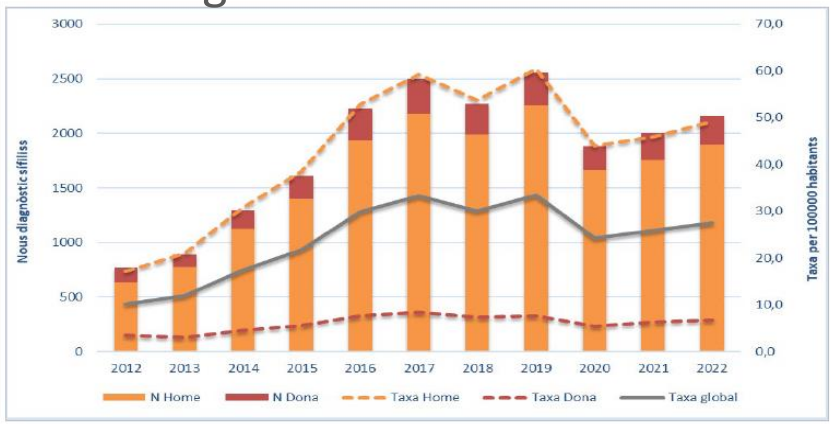


Figura 26. Evolució de la taxa per 100.000 de sífilis infecciosa segons el sexe. Catalunya, 2010-2022.

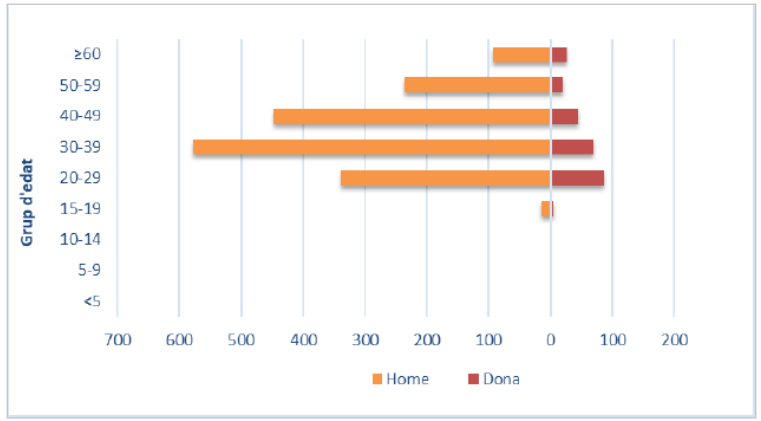


Figura 27. Distribució del nombre de casos de sífilis infecciosa per grup d'edat i sexe. Catalunya, 2022.

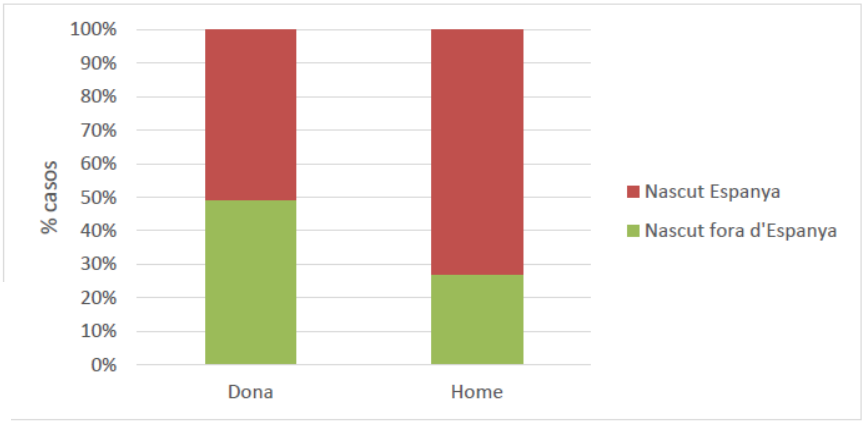


Figura 30. Percentatge de notificacions de sífilis segons el sexe i el país de naixement. Catalunya, 2022.

Vigilància epidemiològica de les ITS a Catalunya-Informe 2022

Informe anual 2022

Febrer 2024

Sífilis

Situació epidemiològica de la sífilis infecciosa a Catalunya

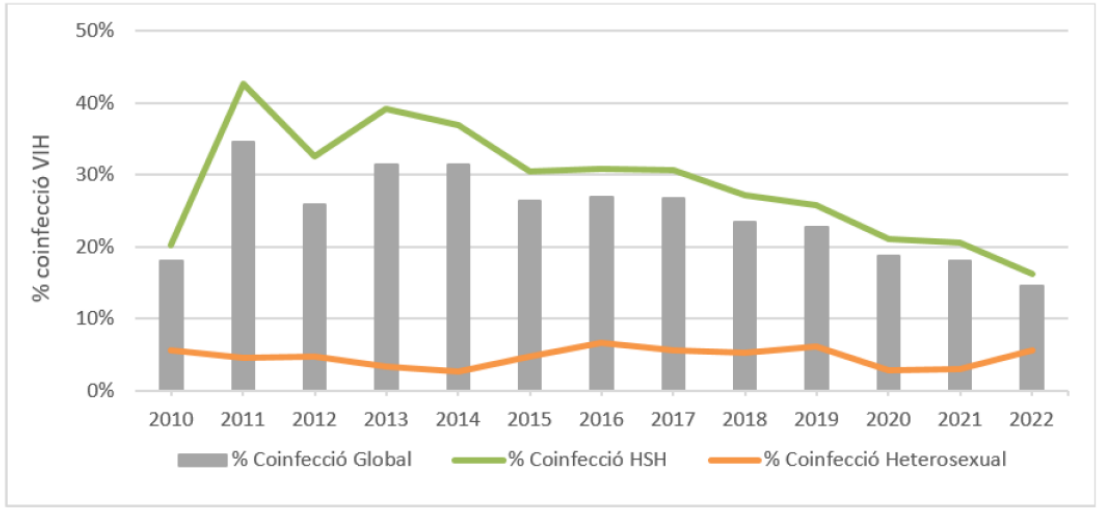


Figura 33. Evolució del percentatge de diagnòstics de sífilis infecciosa coinfectats per VIH. Catalunya, 2010-2020.

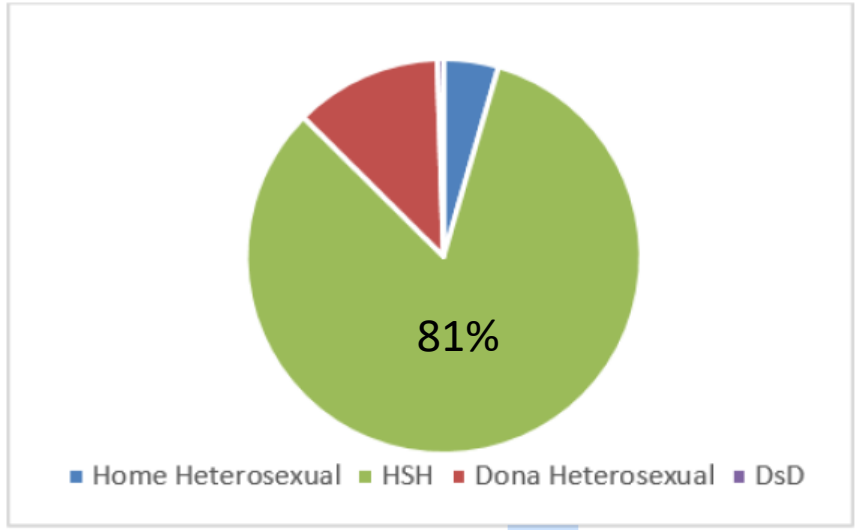
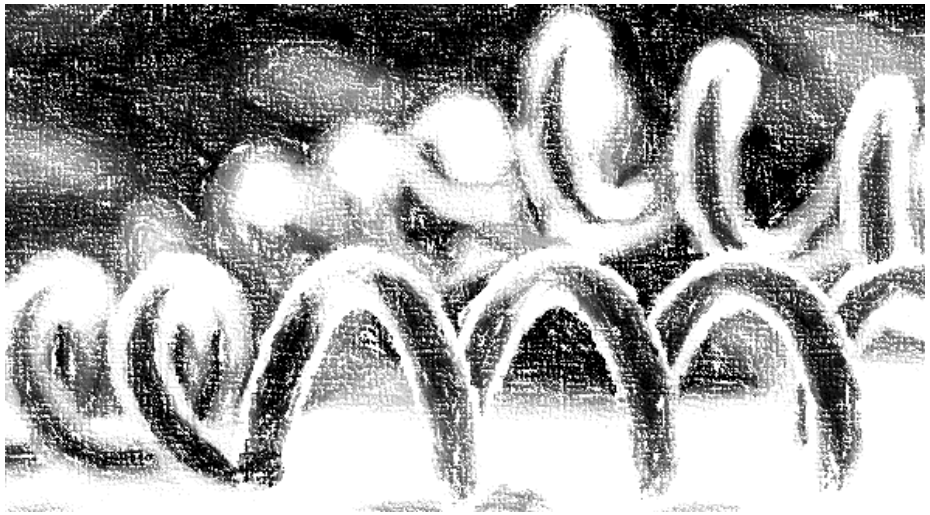


Figura 31. Distribució dels casos de sífilis infecciosa segons el grup de transmissió. Catalunya, 2022.

Treponema pallidum pallidum (ord. *Spirochaetalis*)



- Espiroqueta gram negativa
- Creixement lent
- Hoste: Únicament humans
- Transmissió sexual i vertical

MALALTIA INFECCIOSA SISTÈMICA

Treponema no ITS →

Malalties infeccioses tropicals de la pell

- Pian. *T. pallidum pertenue*
- Pinta. *T. catareum*

Sífilis endèmica

- Bejel. *T. pallidum endemicus*

Sapròfits

- *Treponema paraluiscuniculi, Treponema enticola, Treponema vincentii, Treponema scoliodontum, Treponema refringens, Treponema minutum, Treponema phagedenis, Treponema succinifaciens, Treponema bryantii,*

Sífilis

Risc de transmissió

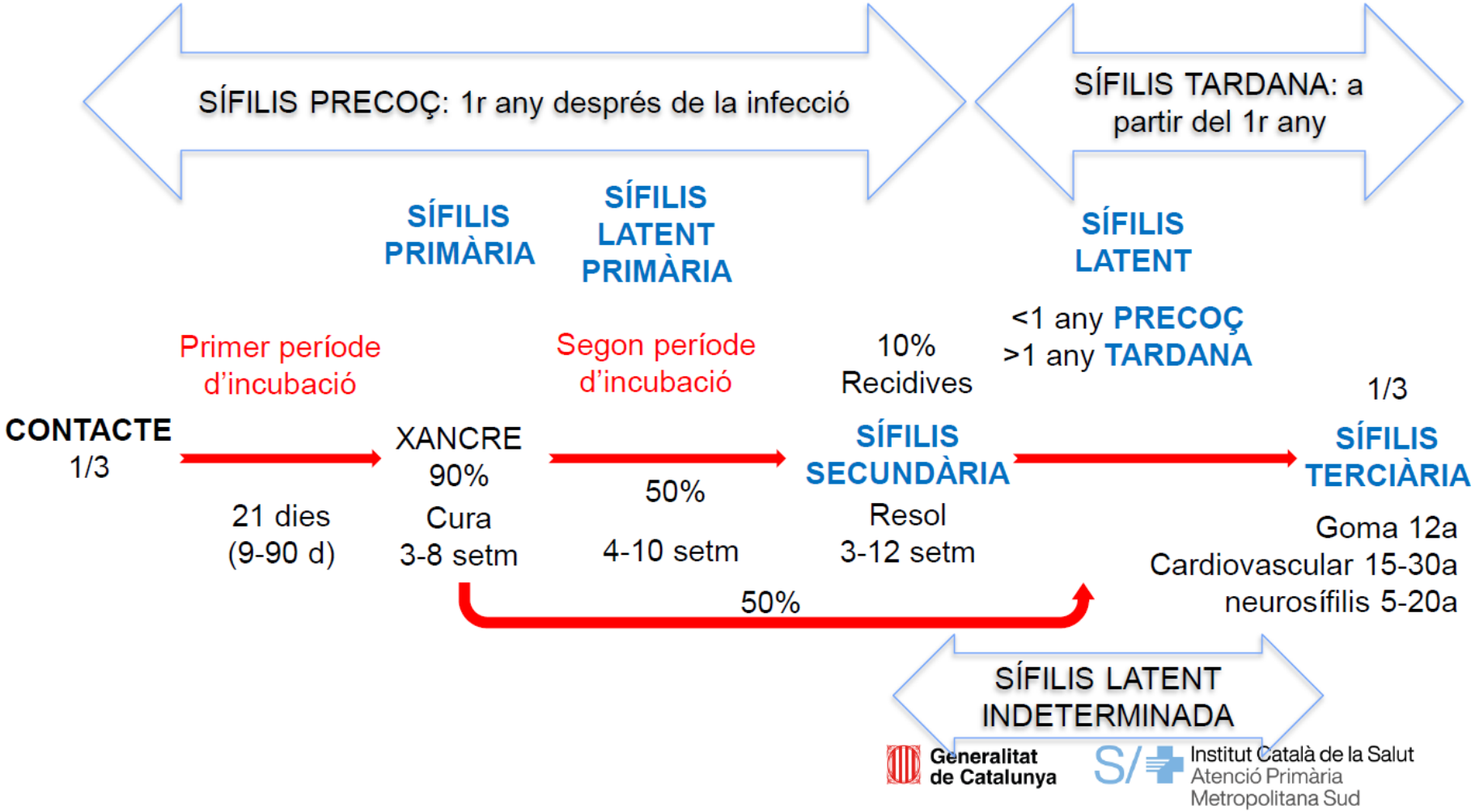
El risc per contacte sexual depèn de l'estadi de la malaltia. Estimació agrupada del 32,6% (Denman, 2022)

És més transmissible en la sífilis precoç (primària i secundària) sobre tot si són ulcerades i/o exsudatives

La sífilis terciària es considera no transmissible

Sífilis

Classificació

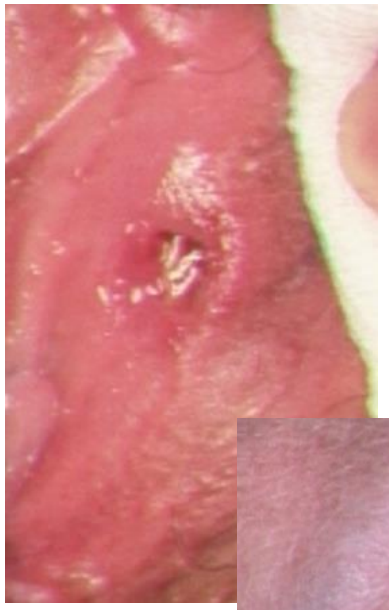


Sífilis primària

Sospita clínica. Signes i símptomes

Període d'incubació: 10-70 dies. Mediana 21 d.

- **Cap lesió és patognomònica. Cal fer diagnòstic diferencial**
- Pàpula d'1-2 cm a la zona d'inocul·lació. Previa al xancre
- Presentació típica. Xancre. Úlcera indolora, habitualment única (poden ser múltiples), indurada, bores sobre elevades i de base neta
- En dones pot passar desapercebut (vaginal o cervical)
- Adenopaties uni/bilaterals indolores i indurades
- Resolució espontània al cap d'unes setmanes.



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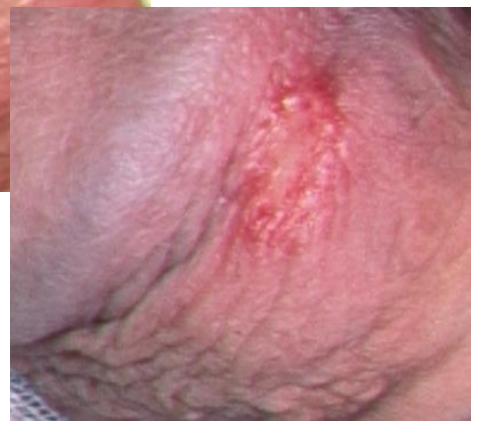

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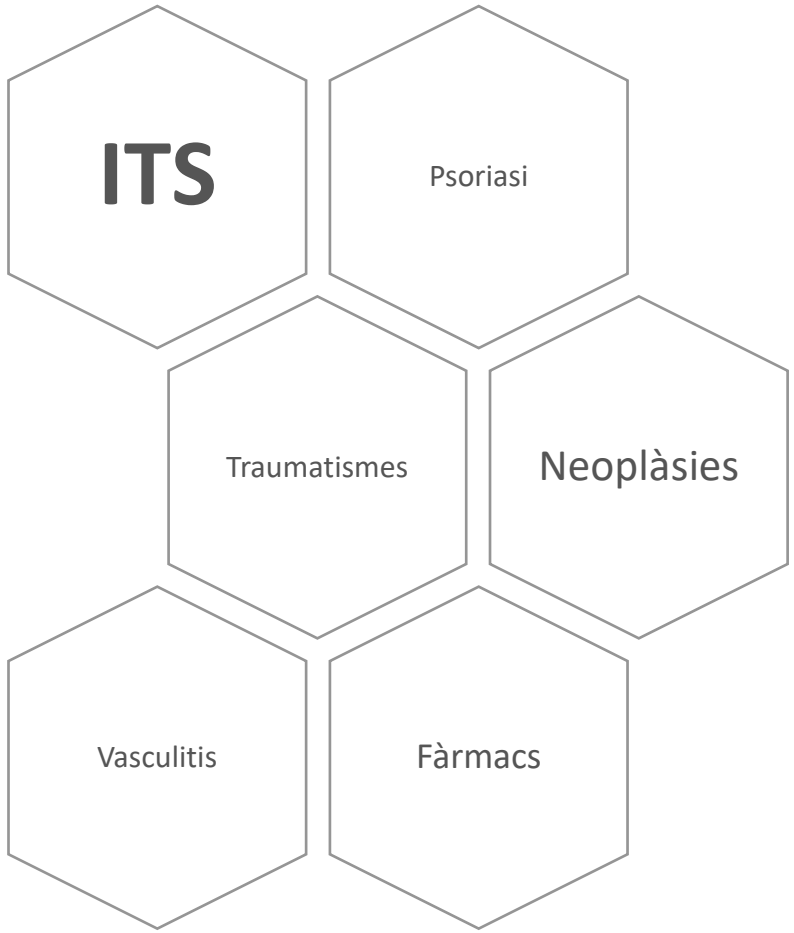
Sífilis primària

Diagnòstic diferencial lesió ulcerada



Estudis:

- Serologies sífilis, VIH, Hepatitis B
- PCR / Cultiu Clamídia, Gonocòccia, VHS 1 i 2
- A valorar Hepatitis A i C i verola del mico i tricomones

TABLA 2. Diagnóstico diferencial de las lesiones ulceradas

	Incubación	Lesión inicial	Características de la úlcera				Clínica general	Adenopatías
			Número de lesiones	Induración	Dolor	Tamaño		
* Herpes genital	2-10 días	Vesícula	Múltiples, superficiales lisas y eritematosas	No	Dolor y quemazón	1-3 mm	Mialgias, cefalea, fiebre, prurito	Bilaterales, dolorosas y recidivantes
* Sífilis primaria	2-4 semanas	Mácula, pápula	Única o múltiples, de bordes definidos, profunda, base lisa roja y brillante, limpia. Cura espontáneamente	Sí	No dolorosa	5-15 mm	Asintomática	Bilaterales duras, no dolorosas, eritema en la zona
* Chancro blando	4-7 días	Mácula, pápula, pústula	De una o tres úlceras profundas y base purulenta, amarillenta y friable	No	Dolorosa	2-20 mm		Unilateral habitualmente, dolorosa, adherida a la piel, blanda, puede fluctuar o supurar creando un cráter
* Linfogranuloma venéreo	3-30 días	Pústula	Única, plana, de bordes variables y de profundidad variable	Variable	No dolorosa	2-10 mm	Malestar, fiebre, artromialgias	Dolorosas, generalmente unilateral, inguinal o femoral adheridas entre sí y piel adyacente con supuración
Granuloma inguinal	7-180 días	Pápula, nódulo	Única o múltiples. Extensas, limpias y granulosas, de bordes marcados, sangra con facilidad	Sí	No dolorosa	Variable	Dolor si hay sobreinfección por anaerobios	Ausencia de adenopatías. A los 1-2 meses pueden aparecer seudobubones (granuloma inguinal subcutáneo)

* PCR Multitest

FMC. 2016;23(8):463-6

Sífilis secundària

Sospita clínica. Signes i símptomes

3-8 setmanes posteriors a l'aparició del xancre

Manifestacions dermatològiques

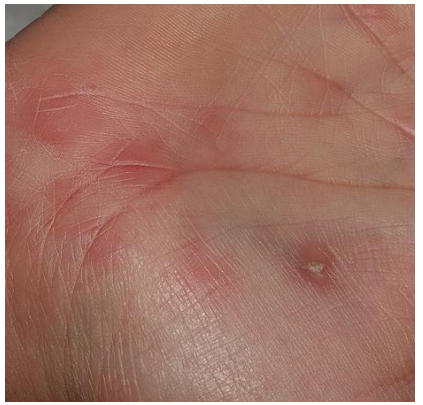
- Rash ("**roseola sifilítica**"): Macular, papular. Freqüentment descamatiu. Afectació de palmes de les mans i plantes dels peus. No pruriginós
- **Condiloma pla**. A zones humides. Molt infectiva

Altres manifestacions:

- Símptomes generals: Febre, MEG, artràlgies, limfadenopatia generalitzada, cefalea, astènia...
- Sistema nerviós: parestèsies, disminució agudesa visual, meningisme...
- Menys freqüents: afectació renal i hepàtica

Resolució espontània en poques setmanes → període de latència i en risc de sífilis terciària

A valorar PL en PVVIH



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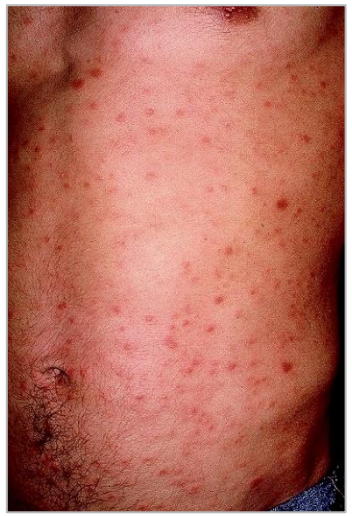

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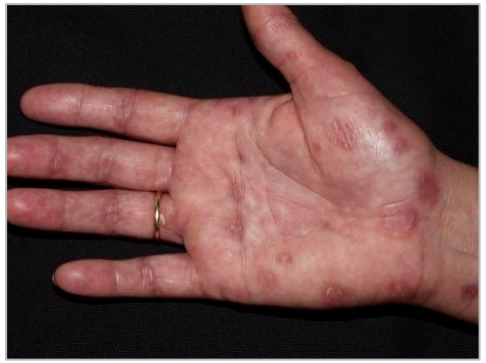

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Sífilis secundària

Diagnòstic diferencial rosèola sifilítica

TABLA 2. Diagnóstico diferencial del exantema en la sífilis secundaria

Pitiriasis rosada	Placa eritematosa con collarete descamativo central, frecuentemente localizada en el tronco (medallón herádico). Las lesiones desaparecen sin dejar cicatriz Tratamiento sintomático: corticoides tópicos y antihistamínicos
Eritema multiforme	Erupción simétrica en zonas de extensión de manos, codo, rodillas y pies de lesiones eritematoedematosas en forma de diana ("herpes virus Bateman" o lesión "en escarapela" con centro violáceo a veces ampolloso Tratamiento sintomático: corticoides tópicos y antihistamínicos
Erupción medicamentosa	Exantema maculopapular que suele comenzar a las 2 semanas de la administración del tratamiento. Generalmente recuerdan exantemas virales, acompañados de fiebre, prurito y eosinofilia. No suele afectar a la cara y compromete tronco y extremidades, en forma simétrica. Normalmente el exantema desaparece a las 2 semanas de suspendido el fármaco Los fármacos que con mayor frecuencia las producen son: ampicilina y penicilina, fenilbutazona, sulfonamidas, fenitoína, carbamazepina y gentamicina
Linfoma	*Micosis fungoide* (células T), inicialmente placas eritematosas de predominio troncular similares a un eccema crónico. Posteriormente placas eritematosas infiltrativas con histología característica: microabscesos de Pautrier intraepidérmicos
	Los *linfomas extracutáneos* con afectación secundaria de la piel suelen ser de células B y producen lesiones únicas, nodulares, monomorfas y asintomáticas
Síndrome mononucleósido	Exantema papular en brazos y tórax, sobre todo en pacientes que han recibido betalactámicos, generalmente fugaz y ocasionalmente asociado a enantema Adenopatías cervicales simétricas elásticas y sensibles a la palpación
Lupus eritematoso sistémico	*Lupus cutáneo agudo*. La lesión más reconocida es la erupción malar o "eritema en alas de mariposa" *Lupus cutáneo subagudo*: el término se refiere a distintas lesiones cutáneas, en general pápulas o placas, más difusas, fotosensibles, no induradas y que no dejan cicatriz. Un 90% de los pacientes con este tipo de afectación cutánea tiene anticuerpos anti-Ro *Lupus crónico*: El lupus discoide crónico es la forma más frecuente. Consiste en pápulas o placas eritematosas y descamativas o hiperqueratósicas, bien delimitadas, con tendencia a la cronicidad y crecimiento periférico, que dejan cicatrices atróficas, con pérdida de anejos y alteraciones de la pigmentación
Dermatofitosis	Tiña del cuerpo (herpes circinado o *tinea corporis*): placas eritematodescamativas circinadas, es decir con bordes más activos, pruriginosas que crecen de forma excéntrica con menor actividad en el centro y mayor en los bordes

FMC. 2017;24(1):5-11

Sífilis secundària

Diagnòstic diferencial condiloma pla

Condiloma acuminat

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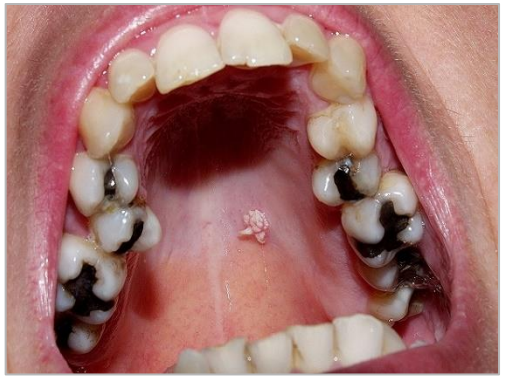

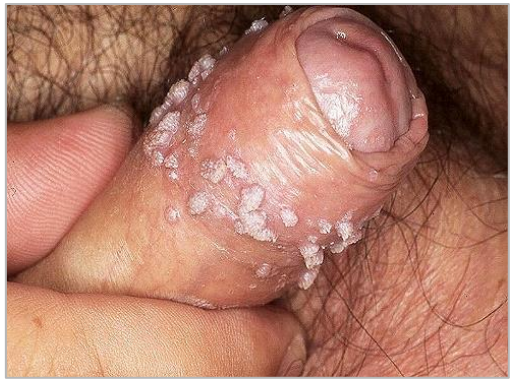

Condiloma pla

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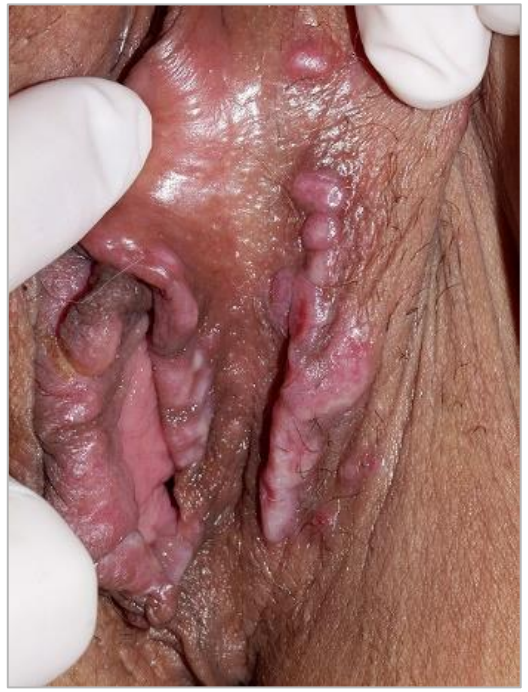

Moluscum contagiosum

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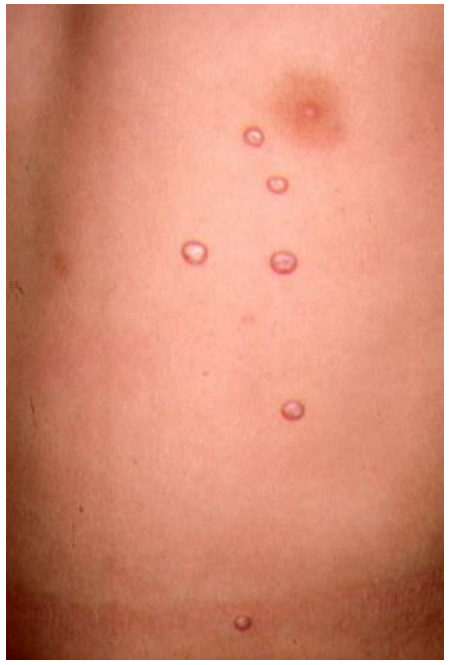
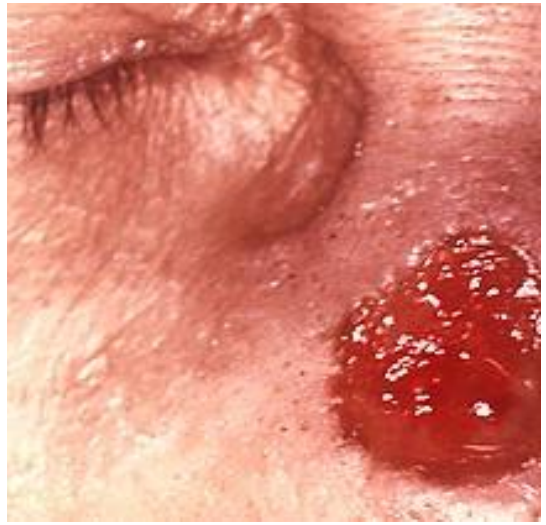


Sífilis terciària

Sospita clínica. Signes i símptomes

1/3 de les persones no tractades. Diagnòstic proves de laboratori + PL

- Asimptomàtica
  - Latent precoç. Evolució < 1a
  - Latent tardana. Evolució > 1a
- Lesions:
  - Goma (1-45a). No dolorosa. Escassa reacció inflamatòria. Freqüentment afecta la pell però també altres òrgans o als ossos.
  - Cardiovascular (10-30a). Aortitis, aneurisma aòrtic, valvulopatia aòrtica
  - Neurosífilis (2-20a).
    - Meningovascular → AVC (5-10 a. posteriors a la infecció)
    - *Tabes dorsalis* → Afectació espinal amb parèsia progressiva
    - Demència → Progressiva



Font: Wikipedia

Diagnòstic

Mètodes directes

Sífilis primària o secundaria precoces

No són d'elecció

- Microscopia en camp fosc
- Cultiu. Cèl·lules de conill
- PCR. Fals positiu treponematosis sapròfits

Diagnòstic

Mètodes indirectes. Ac anti-proteïnes *T. pallidum*

MOLT ESPECÍFICS

No distingeixen entre la sífilis i altres treponematosi no venèries

Generalment, **PERSISTEIXEN POSITIVES** de per vida independentment del tractament.

S'utilitzen com a test de cribratge i confirmació

No distingeixen malaltia activa, passada, o prèviament tractada.

- CLIA/EIA.
  - Detecta Ac anti treponema IgG i IgM. Molt sensible.
  - IgM: a partir de la 2ª semana. IgG a partir de la 5ª semana
- *Treponema Pallidun Particle Agglutination (TPPA)*
- *Treponema Pallidun Haemagglutination Assays* (TPHA)
- Inmunoblot (si TPHA negatiu)
- *Fluorescent Treponemal Antibodies Absorbed* (FTA-abs)

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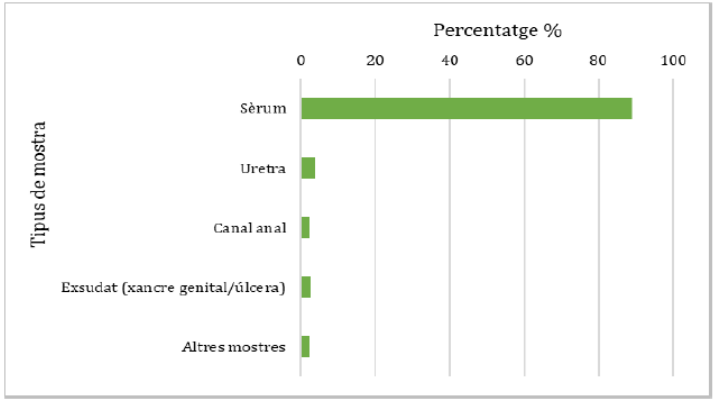


Figura 34. Tipus de mostra utilitzada per al diagnòstic de *Treponema pallidum*, SNMC. 2022.

Srm-Hepatitis B anticossos IgG (CLIA) (anti core)	Negatiu
Srm-Hepatitis B antigen superfície (HbsAg) (CLIA)	Negatiu
Srm-Hepatitis C anticossos IgG (CLIA)	Negatiu
Srm-Treponema pallidum anticossos especif. (CLIA)	Negatiu
Srm-VIH1 i VIH2 anticossos i antigen p24 (CLIA)	Negatiu

Sífilis. Diagnòstic

Mètodes indirectes. Proves reagíniques

Rapid Plasma Reagin Test (RPR)	L'antigen no és específic de *T pallidum* **Falsos positius:** - *Malalties febrils* agudes - Embaràs - Malalties cròniques: autoimmunes, hepatitis C o lepra. **Falsos negatius:** - Per excés d'anticossos (S. secundària) (efecte prozona).
Venereal Diseasis Reserach Laboratory (VDRL)	
Toluidine Red Unheated Serum Test (TRUST)	
Sensibilitat 85-100% / Especificitat 95-99%	
Es poden titular: Títols menors = menor activitat	Després del tractament els títols **generalment disminueixen i es tornen no reactius als 12 mesos** Un 10% de les de les persones amb sífilis continuen reactives (estat *serofast*).
No són útils per determinar l'estadi de la malaltia	
Punt de tal 1/16 encara que titulacions menors no la descarten	
Útils per la resposta al tractament	
Útils per detectar la reinfecció	

Sífilis

Proves serològiques ràpides

Point of Care

Sensibilitats del 76-86% i especificitats del 96-99% en comparació amb assajos de referència de laboratori com TPPA

Són assequibles, sensibles, específiques, fàcils d'utilitzar, ràpides i robustes, sense equips

Permetent el tractament immediat d'aquells que donen positiu.

Requereixen una gota de sang obtinguda d'una punxada al dit i poden donar un resultat en 15 minuts

Sífilis

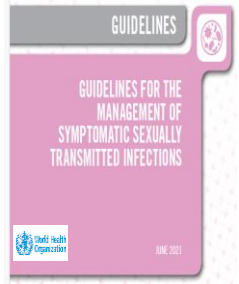
Interpretació dels resultats serològics segons estadi i efecte del tractament

	Early syphilis			Late syphilis	
	Primary	Secondary	Early latent	Late latent	Tertiary
Non-treponemal syphilis serology - Untreated	Negative becoming positive	Always positive	Usually positive	Usually positive	Usually positive, but becoming negative
Treponemal syphilis serology - Untreated	Negative becoming positive (EARLY)	Always positive	Always positive	Always positive	Usually positive, eventually becoming negative

Effect of treatment by stage of infection

Non-treponemal syphilis serology - Treated	Becomes negative	Becoming negative	Becoming negative	Remains positive	Results unchanged
Treponemal syphilis serology - Treated	Remains positive, if initially positive	Remains positive	Remains positive	Remains positive	Results unchanged

Negative serological test Positive serological test



Sífilis

Diagnòstic. Període finestra

- Proves treponèmiques.
  - IgM: 2 setmanes posteriors al xancre
  - IgG: 4-5 setmanes posteriors al xancre
- Proves reagíniques
  - 2-3 setmanes posteriors al xancre.
  - Baixa sensibilitat en el període de latència

Sífilis

Tractament

	Treatment option 1	Treatment option 2	Treatment option 3
Primary and secondary syphilis in non-pregnant adults, including adults with HIV	Penicillin G benzathine, 2·4 million units in a single intramuscular dose	Doxycycline, 100 mg orally twice a day for 14 days	Ceftriaxone, 1 g daily, intramuscular or intravenous, for 10–14 days
Early latent syphilis in non-pregnant adults, including adults with HIV	Penicillin G benzathine, 2·4 million units in a single intramuscular dose	Doxycycline, 100 mg orally twice a day for 28 days	..
Late latent syphilis in non-pregnant adults, including adults with HIV	Penicillin G benzathine, 7·2 million units total, administered in 3 intramuscular doses of 2·4 million units each at 1-week intervals	Doxycycline, 100 mg orally twice a day for 28 days	..
Late syphilis (gummas and cardiovascular manifestations) but not neurosyphilis	Penicillin G benzathine, 7·2 million units total, administered in 3 intramuscular doses of 2·4 million units each at 1-week intervals	..	..
Neurosyphilis and ocular syphilis	Aqueous crystalline penicillin G, 18–24 million units per day, administered in INTRAVENOUS doses of 3–4 million units every 4 h or as a continuous infusion, for 10–14 days	Penicillin G procaine, 2·4 million units in a single intramuscular dose daily, plus probenecid, 500 mg administered orally four times per day, both for 10–14 days	..
Primary and secondary syphilis in pregnancy	Penicillin G benzathine, 2·4 million units in a single intramuscular dose	..	..
Early latent syphilis in pregnancy	Penicillin G benzathine, 2·4 million units in a single intramuscular dose	..	..
Late latent syphilis in pregnancy	Penicillin G benzathine, 7·2 million units total, administered in 3 intramuscular doses of 2·4 million units each at 1-week intervals	..	..
Congenital syphilis	Aqueous crystalline penicillin G 100 000–150 000 units/kg per day, administered as 50 000 units/kg per dose intravenous every 12 h during the first 7 days of life and every 8 h thereafter for a total of 10 days	Procaine penicillin G 50 000 units/kg per dose intramuscular in a single daily dose for 10 days	..

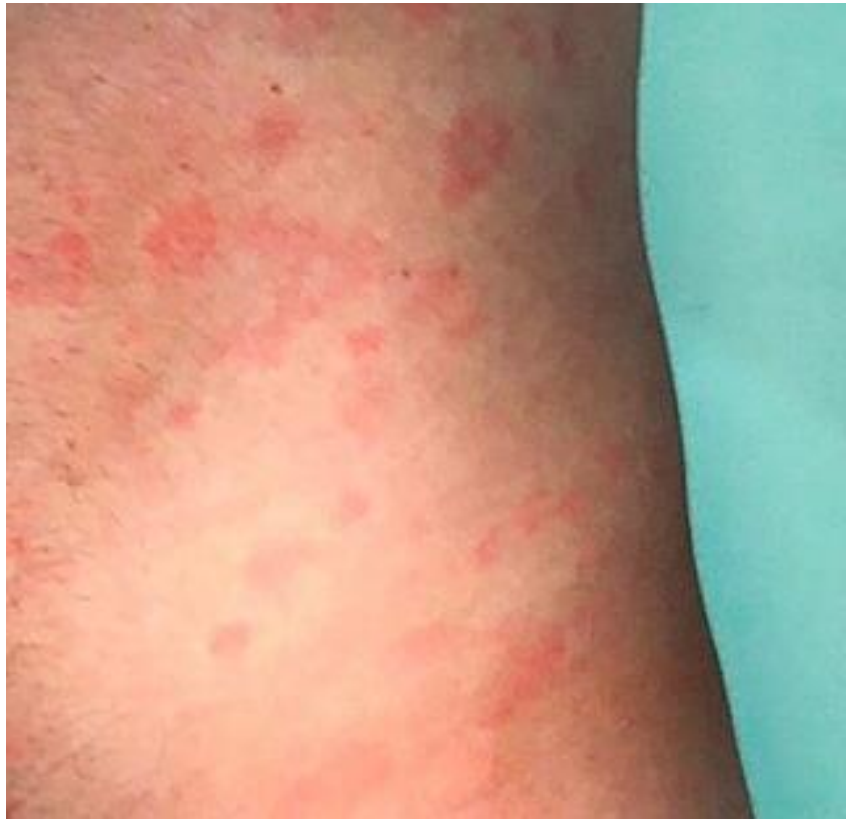
Table: Centers for Disease Control and Prevention Syphilis Treatment Guidelines[40]

Lancet 2023; 402: 336–46

Sífilis

Reacció Jarisch-Herxheimer

- Apareix a les 24 h post tractament per la destrucció de les espiroquetes
- Símptomes similars a una virasi (MEG, febre, artràlgies, cefalea, nàusees…)
- Tractament: repòs i antitèrmics
- La reacció en el segon trimestre de l'embaràs incrementa el risc de part prematur



Font: Wikipedia

Sífilis

Penicil·lina G benzatina, amb o sense lidocaïna?

Lidocaine as a diluent for administration of benzathine penicillin G

AMIR, JACOB MD; GINAT, SHARON MD; COHEN, YISHAI HAIMI MD; MARCUS, TALI EDLITZ MD; KELLER, NATAN MD; VARSANO, ITZHAK MD

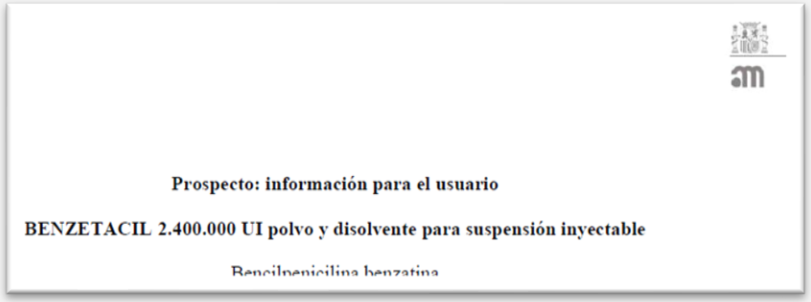
Author Information

The Pediatric Infectious Disease Journal 17(10):p 890-893, October 1998.

Conclusion.

Use of lidocaine hydrochloride as a diluent for benzathine penicillin G does not change the penicillin concentration in body fluids and significantly reduces the pain of injection. We suggest the use of lidocaine hydrochloride 1% as a diluent for benzathine penicillin G.

1998



Prospecto: información para el usuario

BENZETACIL 2.400.000 UI polvo y disolvente para suspensión inyectable

Bencilpenicilina benzatina

Local anaesthetic to reduce injection pain in patients who are prescribed intramuscular benzathine penicillin G: a systematic review and meta-analysis

Ferruccio Pelone,[a] Bessie Kwok,[b] Sabahat Ahmed,[b] Yakup Kilic,[c] Syed Ahsan Ali,[b] Nida Ahmed,[b] Mahmood Ahmad,[d] Jonathan JH. Bray,[e] Farhad Shokraneh,[a] Miryan Cassandra,[f] David S. Celermajer,[g] Eloi Marijon,[h] and Rui Providencia[a,b,]*

Interpretation In patients receiving intramuscular BPG injections, moderate quality quantitative evidence suggests that BPG injections diluted with lidocaine or mepivacaine may improve post-injection pain scores compared to BPG injections diluted with sterile water. Procaine may also have a benefit, but quality of evidence was lower. Most studies included small patient samples and assessed pain levels at different timepoints. Due to insufficient data we were not able to assess the impact of injection volume, and local anaesthetics' dose on pain intensity and duration of pain relief.

2024

Evaluation of Combined Strategy to Reduce the Pain of Penicillin G Benzathine Injection in Primary Syphilis

Yuxia Fang[1], Yilu Zhao[2], Lei Qin[1], Ziyue Song[1], Ruzhi Zhang[1]

Conclusion: The lidocaine + Z-track penicillin method can reduce delayed pain and induration reactions in patients with syphilis, and provides an additional approach to improving patient comfort beyond the standard use of lidocaine alone. This method merits clinical promotion.

2024

Sífilis

Estudi de contactes

Sífilis primària → 3 m

Sífilis secundaria → 6 mesos

Sífilis latent precoç → 12 mesos

Resultat negatiu. Repetir serologies als 2-3 mesos

Sífilis

Seguiment

- Als 3, 6 i 12 mesos
- Als 3, 6, 12, 18 i 24 mesos en persones que viuen amb el VIH, i fins a que es negativitzi
- Embaràs: 28-32 setmanes i en el moment del part, o cada mes fins al part si el risc de reinfecció és alt
- Absència de resposta serològica als 6-12 mesos (menor a 2 dilucions):
    - Descartar reinfecció
    - Valorar PL per descartar neurolues

Evitar exposicions de risc (RS) fins finalitzar tractament i millora de las proves

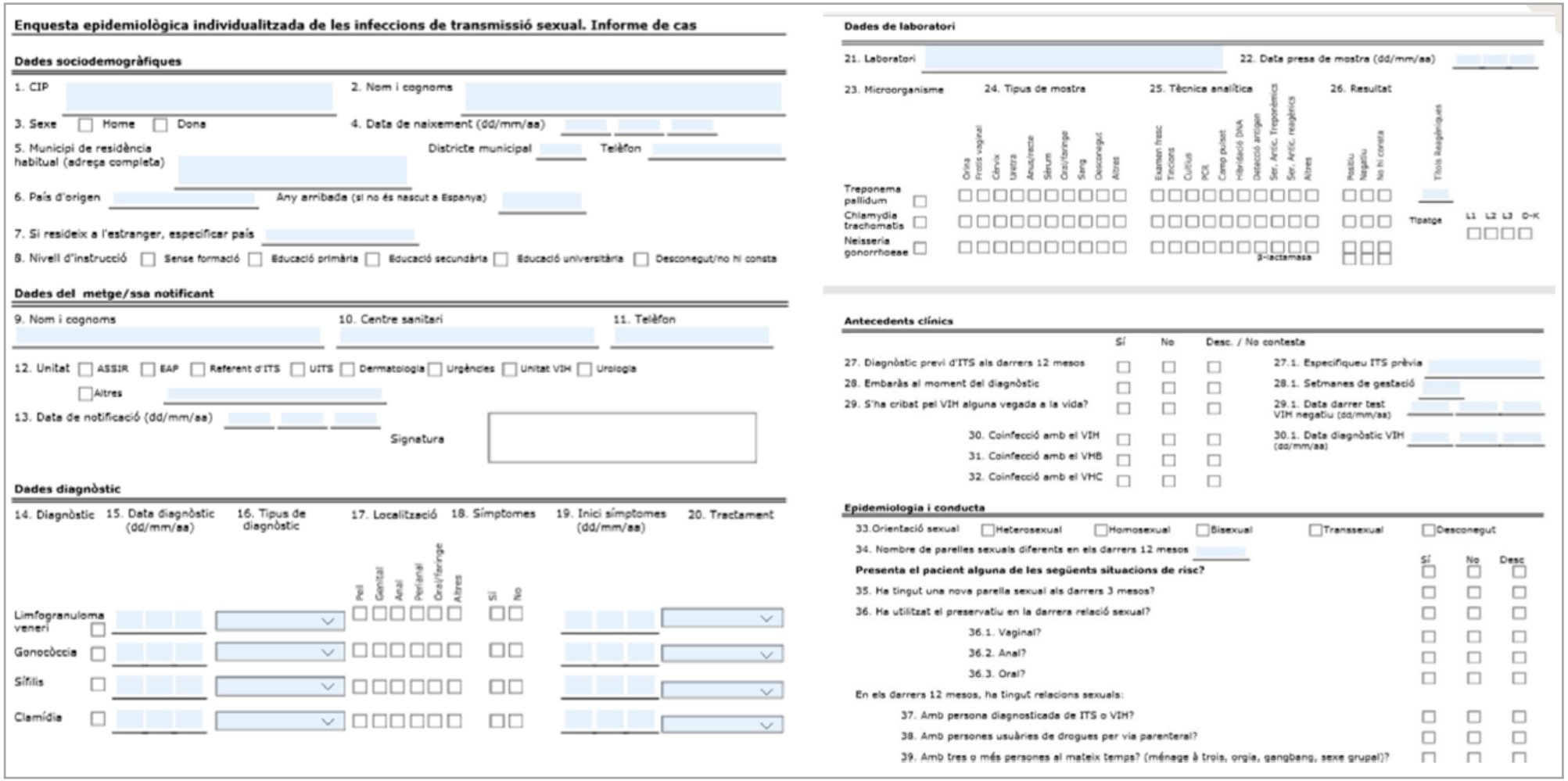
Vacunació hepatitis A i B / Educació sanitària disminució de riscos

Cribratge ITS periòdic si s'escau

La sífilis no deixa immunitat permanent. Elevació dels títols de l'RPR de dues dilucions (4x) → Valorar reinfecció.

Sífilis

Declaració individualitzada



Enquesta epidemiològica individualitzada de les infeccions de transmissió sexual. Informe de cas

Dades sociodemogràfiques

1. CIP
2. Nom i cognoms
3. Sexe ☐ Home ☐ Dona
4. Data de naixement (dd/mm/aa)
5. Municipi de residència habitual (adreça completa)
Districte municipal
Telèfon
6. País d'origen
Any arribada (si no és nascut a Espanya)
7. Si resideix a l'estranger, especificar país
8. Nivell d'instrucció ☐ Sense formació ☐ Educació primària ☐ Educació secundària ☐ Educació universitària ☐ Desconegut/no hi consta

Dades del metge/ssa notificant

9. Nom i cognoms
10. Centre sanitari
11. Telèfon
12. Unitat ☐ ASSIR ☐ EAP ☐ Referent d'ITS ☐ UITS ☐ Dermatologia ☐ Urgències ☐ Unitat VIH ☐ Urologia ☐ Altres
13. Data de notificació (dd/mm/aa)
Signatura

Dades diagnòstic

14. Diagnòstic	15. Data diagnòstic (dd/mm/aa)	16. Tipus de diagnòstic	17. Localització: Pell	Genital	Anal	Perianal	Oral/faringe	Altres	18. Símptomes: Sí	No	19. Inici símptomes (dd/mm/aa)	20. Tractament
☐ Limfogranuloma veneri			☐	☐	☐	☐	☐	☐	☐	☐		
☐ Gonocòccia			☐	☐	☐	☐	☐	☐	☐	☐		
☐ Sífilis			☐	☐	☐	☐	☐	☐	☐	☐		
☐ Clamídia			☐	☐	☐	☐	☐	☐	☐	☐		

Dades de laboratori

21. Laboratori
22. Data presa de mostra (dd/mm/aa)

23. Microorganisme	24. Tipus de mostra: Orina	Frotis vaginal	Cèrvix	Uretra	Anus/recte	Sèmen	Oral/faringe	Sang	Desconegut	Altres	25. Tècnica analítica: Examen fresc	Tinció	Cultiu	PCR	Camp pulsat	Hibridació DNA	Detecció antigen	Ser. Antic. Treponèmics	Ser. Antic. reagínics	Altres	26. Resultat: Positiu	Negatiu	No hi consta	Tipus Resgènics	Tipatge	L1	L2	L3	D-K
☐ Treponema pallidum	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐						
☐ Chlamydia trachomatis	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐						
☐ Neisseria gonorrhoeae	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐						

β-lactamasa

Antecedents clínics

	Sí	No	Desc. / No contesta	
27. Diagnòstic previ d'ITS als darrers 12 mesos	☐	☐	☐	27.1. Especifiqueu ITS prèvia
28. Embaràs al moment del diagnòstic	☐	☐	☐	28.1. Setmanes de gestació
29. S'ha cribat pel VIH alguna vegada a la vida?	☐	☐	☐	29.1. Data darrer test VIH negatiu (dd/mm/aa)
30. Coinfecció amb el VIH	☐	☐	☐	30.1. Data diagnòstic VIH (dd/mm/aa)
31. Coinfecció amb el VHB	☐	☐	☐	
32. Coinfecció amb el VHC	☐	☐	☐	

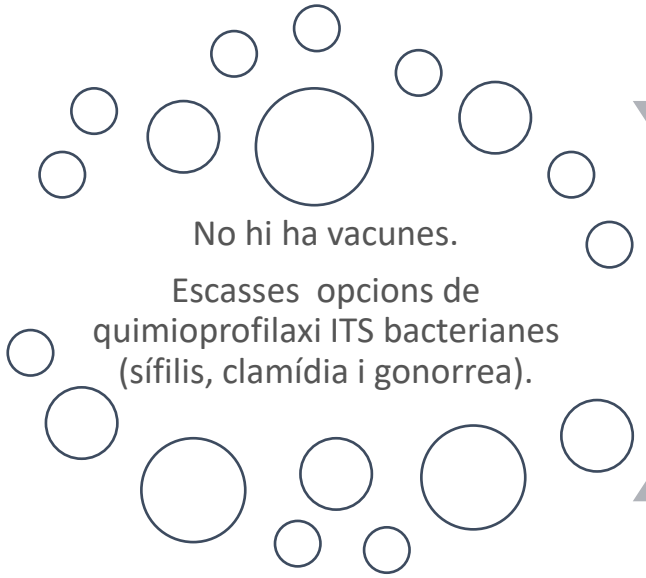
Epidemiologia i conducta

33. Orientació sexual ☐ Heterosexual ☐ Homosexual ☐ Bisexual ☐ Transsexual ☐ Desconegut
34. Nombre de parelles sexuals diferents en els darrers 12 mesos

Presenta el pacient alguna de les següents situacions de risc?	Sí	No	Desc
35. Ha tingut una nova parella sexual als darrers 3 mesos?	☐	☐	☐
36. Ha utilitzat el preservatiu en la darrera relació sexual?	☐	☐	☐
36.1. Vaginal?	☐	☐	☐
36.2. Anal?	☐	☐	☐
36.3. Oral?	☐	☐	☐
En els darrers 12 mesos, ha tingut relacions sexuals:			
37. Amb persona diagnosticada de ITS o VIH?	☐	☐	☐
38. Amb persones usuàries de drogues per via parenteral?	☐	☐	☐
39. Amb tres o més persones al mateix temps? (ménage à trois, orgia, gangbang, sexe grupal)?	☐	☐	☐

02 DOXI-PEP

En què es basa la Doxi-PEP?



No hi ha vacunes.

Escasses opcions de quimioprofilaxi ITS bacterianes (sífilis, clamídia i gonorrea).

Increment notable de la sífilis clamídia i gonorrea en col·lectius vulnerables gais, bisexuals, i altres HSH i dones transgènere (TGW).

200 mg de doxiciclina presa dins de les 72 hores posteriors a les relacions sexuals

⇩ Sífilis i clamídia >70%

⇩ Gonococ ± 50%

Doxi-PEP

Assaig clínic

Published in final edited form as:
N Engl J Med. 2023 April 06; 388(14): 1296–1306. doi:10.1056/NEJMoa2211934.

Postexposure Doxycycline to Prevent Bacterial Sexually Transmitted Infections

Volume **31** Issue **5** November/December **2023**

Invited Review

Doxycycline Postexposure Prophylaxis for Prevention of Sexually Transmitted Infections

Chase A. Cannon, MD, MPH[1,2]; Connie L. Celum, MD, MPH[1]

Doxycycline post-exposure prophylaxis among men who have sex with men and transgender women in Belgium: awareness, use and antimicrobial resistance concerns in a cross-sectional online survey

Thibaut Vanbaelen [1], Anke Rotsaert,[2] Irith De Baetselier [1], Tom Platteau [1], Bernadette Hensen,[2] Thijs Reyniers [2], Chris Kenyon [1]

Early adopters of doxycycline as post-exposure prophylaxis to prevent bacterial sexually transmitted infections in a real-world clinical setting

Philip A Chan [1,2], Yelena Malyuta [2], Hannah Parent [1], Jun Tao [1], Maximillian Erbe [2], Peter Salhaney [2], Michaela Maynard [2], William DeWitt [2], Antonio Reisopoulos [2], Amy Nunn [2,3]

Correspondence to Dr Philip A Chan, Department of Medicine, Brown University, Providence, Rhode Island, USA; Philip_Chan@brown.edu

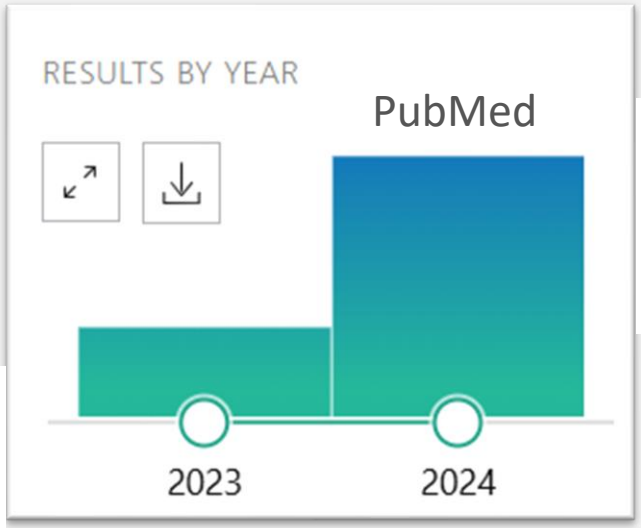
Clinical Infectious Diseases

REVIEW ARTICLE

IDSA Infectious Diseases Society of America · hivma hiv medicine association · OXFORD

Doxycycline Prophylaxis for Bacterial Sexually Transmitted Infections

Juliana S. Grant,[1] Chrysovalantis Staflis,[2] Connie Celum,[3,4] Troy Gronman,[5] Bridget Haire,[1] John Kaldor,[2] Anne F. Luetkemeyer,[6] John M. Saunders,[5] Jean-Michel Molina,[6,7] and Jeffrey D. Klausner[2,8,9]



RS i Metaanàlisis

Systematic review

Efficacy of postexposure prophylaxis with doxycycline (Doxy-PEP) in reducing sexually transmitted infections: a systematic review and meta-analysis

Paulo Roberto Sokoll [1], Celina Borges Migliavaca [2], Stephan Döring [1], Uschi Traub [1], Karlin Stark [1], Amanda Veiga Sardeli [3]

Doxycycline prophylaxis for the prevention of sexually transmitted infections: A systematic review and meta-analysis of randomized controlled trials

István Szondy [1,2], Fanni Adél Meznerics [1,2], Kende Lőrincz [1,2], Lajos Vince Kemény [1,2,3,4], Anna Walter [5], Alzahra Ahmed Mohammed [1,2,3], Péter Hegyi [2,5,6], Norbert Kiss [1,2], András Bánvölgyi [1,2,*]

META-ANALYSIS

Efficacy of Doxycycline as Pre-exposure and/or Post-exposure Prophylaxis to Prevent Sexually Transmitted Diseases: A Systematic Review and Meta-analysis

Boschiero, Matheus Negri MD[1,2,3,4,a]; Sansone, Nathália Mariana Santos MA[1,3,4,a]; Ribeiro, Laura Matos MD[3]; Marson, Fernando Augusto Lima Ph.D.[1,3,4,*]

Author Information

Sexually Transmitted Diseases ():10.1097/OLQ.0000000000002082, September 24, 2024. | *DOI:* 10.1097/OLQ.0000000000002082

Doxi-PEP

The NEW ENGLAND JOURNAL of MEDICINE

ORIGINAL ARTICLE

Postexposure Doxycycline to Prevent Bacterial Sexually Transmitted Infections

Anne F. Luetkemeyer, M.D., Deborah Donnell, Ph.D., Julia C. Dombrowski, M.D., M.P.H., Stephanie Cohen, M.D., M.P.H., Cole Grabow, M.P.H., Clare E. Brown, Ph.D., Cheryl Malinski, B.S., Rodney Perkins, R.N., M.P.H., Melody Nasser, B.A., Carolina Lopez, B.A., Eric Vittinghoff, Ph.D., Susan P. Buchbinder, M.D., Hyman Scott, M.D., M.P.H., Edwin D. Charlebois, Ph.D., M.P.H., Diane V. Havlir, M.D., Olusegun O. Soge, Ph.D., and Connie Celum, M.D., M.P.H., for the DoxyPEP Study Team*

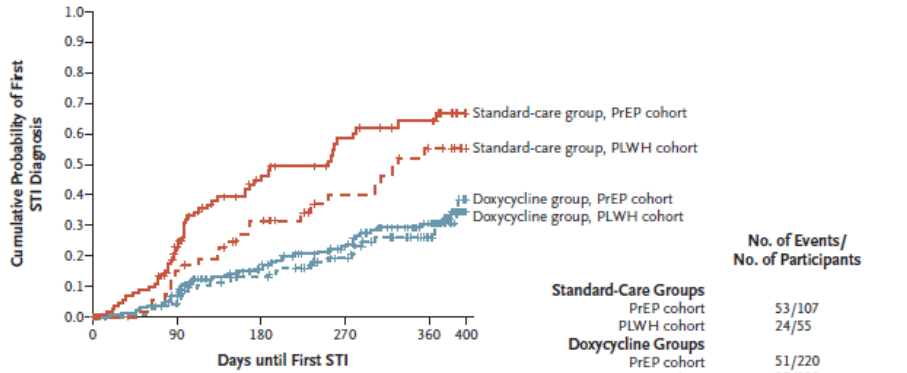


Figure 3. Kaplan–Meier Estimate of Time to First STI Diagnosis.
The cumulative probability of any incident bacterial STI (chlamydia, gonorrhea, or syphilis) is shown according to study group (doxycycline and standard care) and participant cohort (PrEP and PLWH).

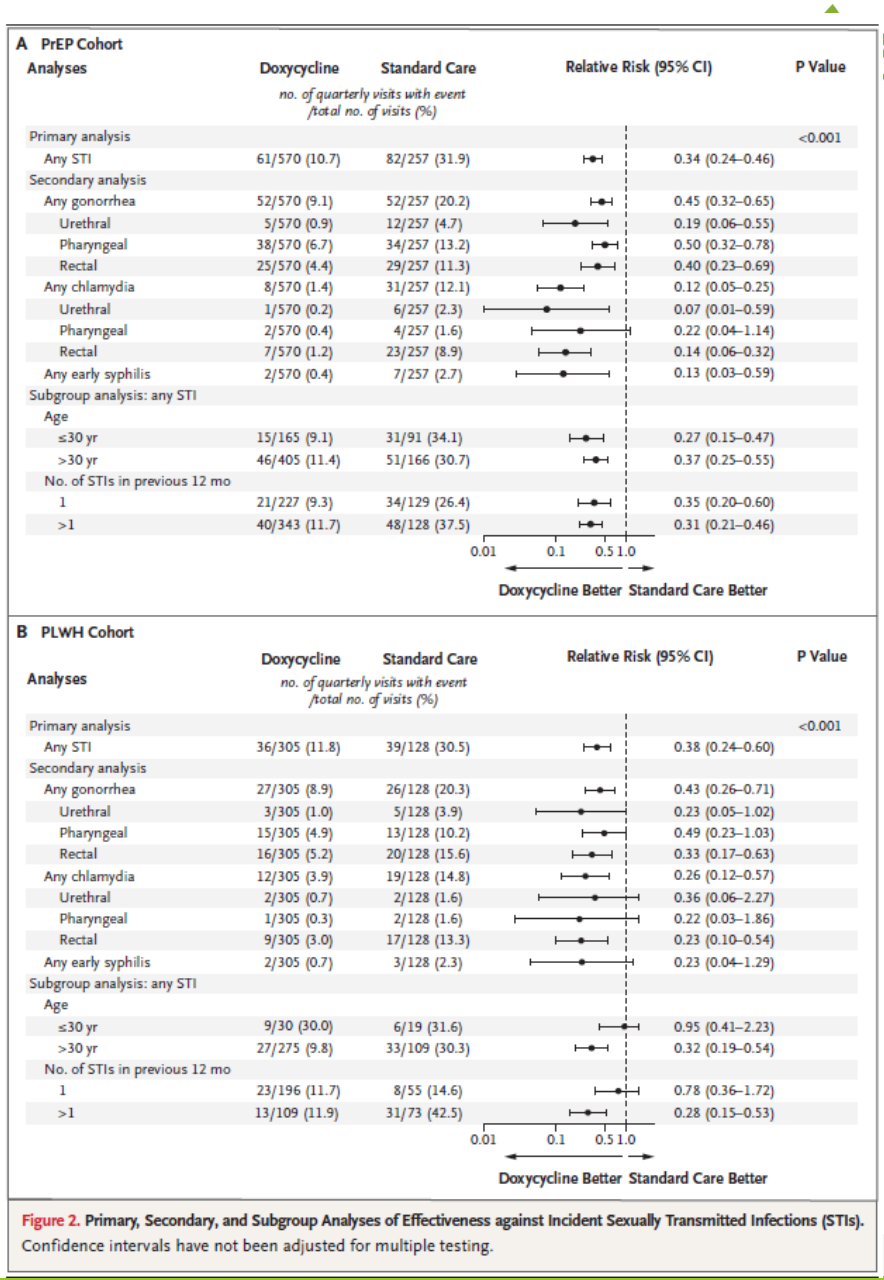
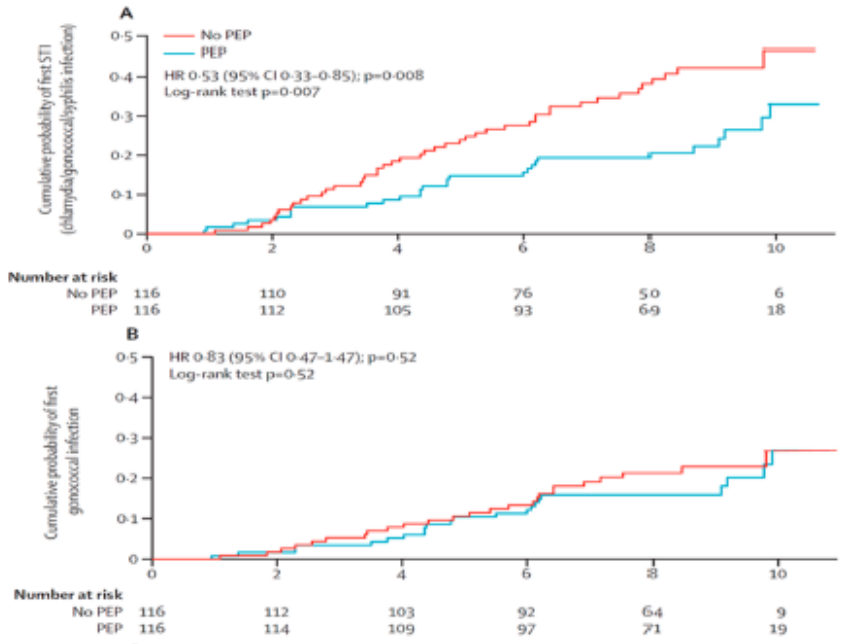


Figure 2. Primary, Secondary, and Subgroup Analyses of Effectiveness against Incident Sexually Transmitted Infections (STIs).
Confidence intervals have not been adjusted for multiple testing.

Doxi-PEP. Efectivitat

ACS Infectious Diseases Viewpoint



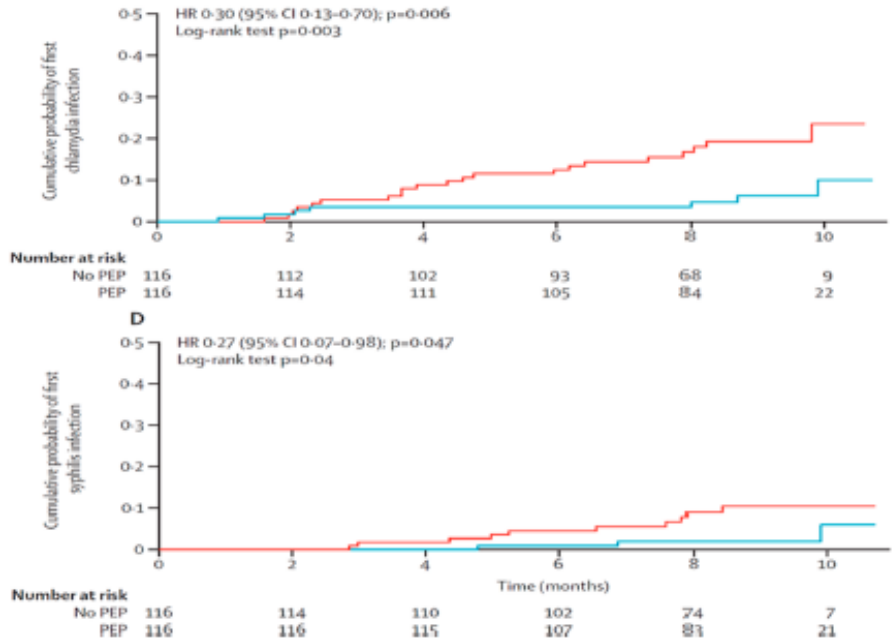


Figure 1. Kaplan–Meier estimates of time to first STIs in the intention-to-treat analysis of the IPERGAY substudy evaluating the doxycycline PEP of bacterial STIs.[8] (A) Time to first sexually transmitted infection (STI; chlamydia, gonorrhea, or syphilis). (B) Time to first gonorrheal infection. (C) Time to first chlamydial infection. (D) Time to first syphilis infection. Cumulative probabilities of acquisition are shown for the two study groups. Figure adapted with permission from Molina et al. (2018) Post-exposure prophylaxis with doxycycline to prevent sexually transmitted infections in men who have sex with men: an open-label randomised substudy of the ANRS IPERGAY trial. *Lancet Infect. Dis.* *18* (3), 308–317; DOI: 10.1016/S1473-3099(17)30725-9. Copyright 2018 Elsevier Ltd.

ACS Infectious Diseases Viewpoint
Cite This: ACS Infect. Dis. 2018, 4, 660−663
pubs.acs.org/journal/aidcbc

Doxycycline Prophylaxis for Bacterial Sexually Transmitted Infections: Promises and Perils

Martin Siguier and Jean-Michel Molina*

Doxy-PEP. Resistències bacterianes i efectes adversos

The NEW ENGLAND JOURNAL of MEDICINE

ORIGINAL ARTICLE

Postexposure Doxycycline to Prevent Bacterial Sexually Transmitted Infections

Anne F. Luetkemeyer, M.D., Deborah Donnell, Ph.D., Julia C. Dombrowski, M.D., M.P.H., Stephanie Cohen, M.D., M.P.H., Cole Grabow, M.P.H., Clare E. Brown, Ph.D., Cheryl Malinski, B.S., Rodney Perkins, R.N., M.P.H., Melody Nasser, B.A., Carolina Lopez, B.A., Eric Vittinghoff, Ph.D., Susan P. Buchbinder, M.D., Hyman Scott, M.D., M.P.H., Edwin D. Charlebois, Ph.D., M.P.H., Diane V. Havlir, M.D., Olusegun O. Soge, Ph.D., and Connie Celum, M.D., M.P.H., for the DoxyPEP Study Team*

Cap advers greu atribuït a la doxiciclina.

Gonorrea resistent a la tetraciclina:

- Grup doxa: 5 de 13
- Grup control 2 de 16

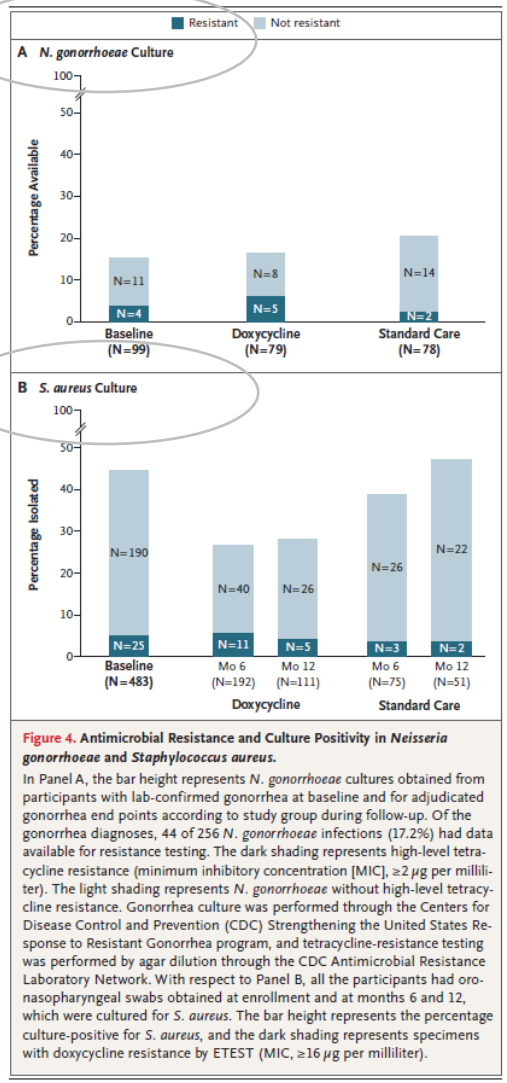


Figure 4. Antimicrobial Resistance and Culture Positivity in *Neisseria gonorrhoeae* and *Staphylococcus aureus*.

In Panel A, the bar height represents *N. gonorrhoeae* cultures obtained from participants with lab-confirmed gonorrhea at baseline and for adjudicated gonorrhea end points according to study group during follow-up. Of the gonorrhea diagnoses, 44 of 256 *N. gonorrhoeae* infections (17.2%) had data available for resistance testing. The dark shading represents high-level tetracycline resistance (minimum inhibitory concentration [MIC], ≥2 μg per milliliter). The light shading represents *N. gonorrhoeae* without high-level tetracycline resistance. Gonorrhea culture was performed through the Centers for Disease Control and Prevention (CDC) Strengthening the United States Response to Resistant Gonorrhea program, and tetracycline-resistance testing was performed by agar dilution through the CDC Antimicrobial Resistance Laboratory Network. With respect to Panel B, all the participants had oronasopharyngeal swabs obtained at enrollment and at months 6 and 12, which were cultured for *S. aureus*. The bar height represents the percentage culture-positive for *S. aureus*, and the dark shading represents specimens with doxycycline resistance by ETEST (MIC, ≥16 μg per milliliter).

Volume 31 Issue 5 November/December 2023

Invited Review

Doxycycline Postexposure Prophylaxis for Prevention of Sexually Transmitted Infections

Chase A. Cannon, MD, MPH[1,2]; Connie L. Celum, MD, MPH[1]

[1]University of Washington, Seattle; [2]Public Health Seattle & King County, Washington

Table 2. Number and Frequency of Reported Laboratory Abnormalities, Adverse Events, and Other Outcomes From Clinical Doxy-PEP Trials

Randomized clinical trial	Laboratory abnormalities	Adverse events	Discontinuations	Other outcomes
IPERGAY	Grade 4 transaminitis due to acute hepatitis C infection (n = 3)	Drug-related gastrointestinal adverse events (n = 29); more common in PEP group (*P* = .03)	29 (26%) for all reasons; 8 (7%) due to drug-related adverse events	No difference between groups in serious adverse events
DoxyPEP	Grade 2 transaminitis (n = 1)	Grade 3 diarrhea or headache (n = 5)	2%	No weight gain compared to standard of care
DOXYVAC	None as of July 2023	Gastrointestinal adverse events (n = 2)	3 (0.9%) due to gastrointestinal adverse events or fear of adverse events	Further data pending final review
dPEP (Kenya)	Not collected	7% (gastrointestinal side effects)	5%	Social harms related to PEP use among 3 participants

Abbreviations: DoxyPEP, Evaluation of Doxycycline Post-Exposure Prophylaxis to Reduce Sexually Transmitted Infections in PrEP Users and HIV-Infected Men Who Have Sex With Men; DOXYVAC, Combined Prevention of Sexually Transmitted Infections in Men Who Have Sex With Men and Using Oral Tenofovir Disoproxil Fumarate/Emtricitabine for HIV Pre-Exposure Prophylaxis; dPEP (Kenya), doxycycline postexposure prophylaxis trial (Kenya); IPERGAY, Intervention Préventive de l'Exposition aux Risques avec et pour les Gays; PEP, postexposure prophylaxis.

Note: Data obtained and compiled from Molina,[18] Luetkemeyer et al,[16] Molina,[19] and Stewart[20] (Jean-Michel Molina, MD, PhD, email, August 26, 2023; Jenell Stewart, DO, MPH, email, August 8, 2023).

Doxi-PEP. Efectivitat en dones

ORIGINAL ARTICLE

Doxycycline Prophylaxis to Prevent Sexually Transmitted Infections in Women

Jenell Stewart, D.O., M.P.H., Kevin Oware, M.A., Deborah Donnell, Ph.D.,

Table 3. Reported Adverse Effects.

Event	Doxycycline PEP*				Standard Care†			
	Month 3	Month 6	Month 9	Month 12	Month 3	Month 6	Month 9	Month 12
	number of participants (percent)							
Nausea	27 (12.4)	13 (6.1)	12 (5.7)	10 (4.7)	9 (4.1)	14 (6.3)	11 (5.0)	7 (3.2)
Vomiting	18 (8.3)	8 (3.7)	10 (4.7)	8 (3.8)	10 (4.6)	12 (5.4)	11 (5.0)	4 (1.8)
Diarrhea	9 (4.1)	8 (3.7)	3 (1.4)	1 (0.5)	8 (3.7)	5 (2.3)	6 (2.7)	6 (2.7)
Rash	8 (3.7)	5 (2.3)	6 (2.8)	8 (3.8)	13 (5.9)	13 (5.9)	13 (5.9)	8 (3.6)
Acne	1 (0.5)	0	1 (0.5)	0	0	1 (0.5)	0	1 (0.5)

* Among the participants in the doxycycline-PEP group, surveys were completed at the quarterly follow-up visit by 217 at month 3, by 214 at month 6, by 212 at month 9, and by 213 at month 12.

† Among the participants in the standard-care group, surveys were completed at the quarterly follow-up visit by 219 at month 3, by 221 at month 6, by 222 at month 9, and by 222 at month 12.

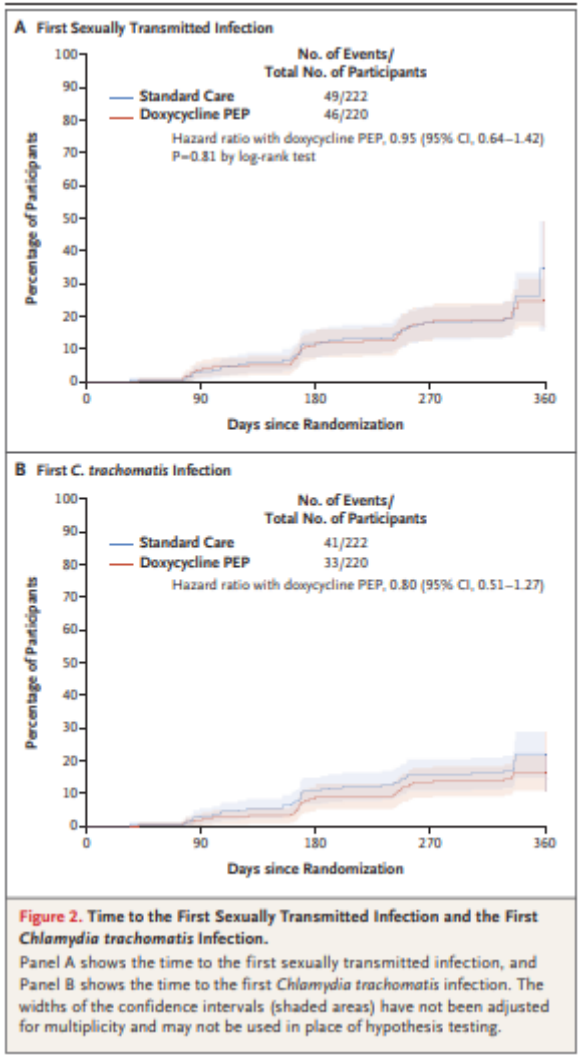


Figure 2. Time to the First Sexually Transmitted Infection and the First *Chlamydia trachomatis* Infection.

Panel A shows the time to the first sexually transmitted infection, and Panel B shows the time to the first *Chlamydia trachomatis* infection. The widths of the confidence intervals (shaded areas) have not been adjusted for multiplicity and may not be used in place of hypothesis testing.

CONCLUSIONS

Among cisgender women, the incidence of STIs was not significantly lower with doxycycline PEP than with standard care. According to hair-sample analysis, the use of doxycycline PEP among those assigned to receive it was low. (Funded by the National Institutes of Health; dPEP ClinicalTrials.gov number, NCT04050540.)

Doxi-PEP

DoxiPEP s'ha d'implementar en el context d'un enfocament integral de salut sexual, inclosa la reducció de riscos assessorament, detecció i tractament d'ITS, vacunació recomanada i vinculació amb la PrEP del VIH, atenció del VIH o altres serveis segons correspongui.

CDC Clinical Guidelines on the Use of Doxycycline Postexposure Prophylaxis for Bacterial Sexually Transmitted Infection Prevention, United States, 2024

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR DISEASE CONTROL AND PREVENTION

Australian consensus statement on doxycycline post-exposure prophylaxis (doxy-PEP) for the prevention of syphilis, chlamydia and gonorrhoea among gay, bisexual and other men who have sex with men

Vincent J Cornelisse[1,2], Benjamin Riley[3], Nicholas A Medland[2]

Main recommendations: There was broad agreement that doxy-PEP should be considered *primarily* for the prevention of syphilis in GBMSM who are at risk of this STI, with a secondary benefit of reductions in other bacterial STIs. At the end of the consensus process, there remained some disagreement, as some stakeholders felt strongly that doxy-PEP should be considered *only* for the prevention of syphilis in GBMSM, and that the risk of increasing antimicrobial resistance outweighed any potential benefit from reductions in other bacterial STIs in the target population. The national roundtable made several other recommendations for clinicians, community, researchers and policy makers, as detailed in this article. ASHM will support the development of detailed clinical guidelines and education materials on doxy-PEP (www.ashm.org.au/doxy-pep).

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GUIDELINE

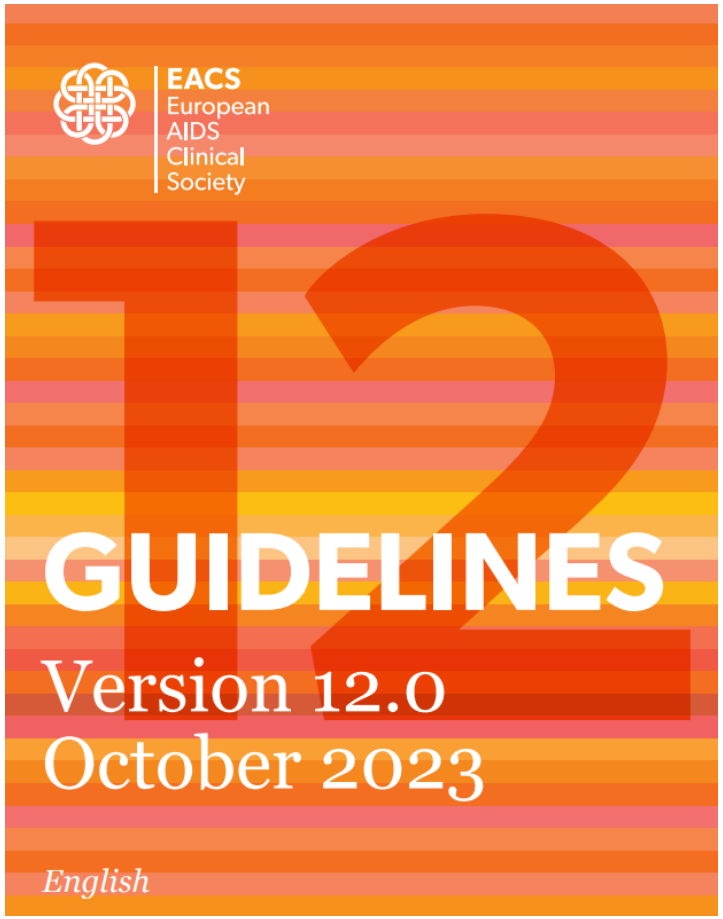
DDG

Position statement of the German STI Society on the prophylactic use of doxycycline to prevent STIs (Doxy-PEP, Doxy-PrEP)

Ricardo Niklas Werner[1] | Axel Jeremias Schmidt[2,3] | Anja Potthoff[4,5] |

- *Due to the unclear effects of such a strategy on antimicrobial resistance, DSTIG recommends against any broad implementation of antibiotic STI prevention, such as the general use of preventive doxycycline in sexually active individuals.*
- *The use of antibiotic STI post-exposure prophylaxis (Doxy-PEP, i.e., doxycycline 200 mg orally taken within 24 hours after sex) can be considered on a case-by-case basis. Criteria for making individual decisions and defining risk events or occasions for intake are outlined in Table 1 It is important to note that this is an off-label use outside the approved indication; in Germany the cost of the prescription is therefore to be borne by the individual concerned, and the prescribing physician bears the legal responsibility.*
- *DSTIG recommends against the continuous (daily) preventive intake of doxycycline (Doxy-PrEP) as a form of the antibiotic STI prevention.*
- *From the perspective of DSTIG, there is a need for research into the effects of antibiotic STI prevention on the spread of antibiotic resistance determinants and the development of antimicrobial effectiveness within bacterial pathogens. This includes pathogens such as Treponema (T.) pallidum and Chlamydia trachomatis (Serovars D-K and L1-L3), as well as bacterial pathogens outside the STI spectrum. Furthermore, potential changes in the microbiome at the individual patient level, taking into consideration the development of resistance, need to be investigated.*
- *The implementation of antibiotic STI prevention should not come at the expense of established preventive measures. In particular, regular syphilis testing, recommended at least every 6 months for MSM,[1,2] or every 3 months with increased risk,[3] remains crucial to effectively prevent long-term harm among at-risk groups and individuals.*

Doxi-PEP



Pre-exposure Prophylaxis (PrEP)

1. **PrEP** should be used in adults at high-risk of acquiring HIV infection when condoms are not used consistently. Before PrEP is initiated, HBV serology status should be documented

- Recommended in HIV-negative men who have sex with men (MSM) and transgender individuals when condoms are not used consistently with casual partners or with partners with HIV who are not virally suppressed on treatment. A recent STI, use of post-exposure prophylaxis or chem-sex may be markers of increased risk for HIV
- May be considered in HIV-negative heterosexual women and men who are inconsistent in their use of condoms and have multiple sexual partners where some may have untreated or inadequately suppressed HIV infection

2. **PrEP** is a medical intervention that provides a high level of protection against HIV acquisition but does not protect against other STIs or pregnancy and should be used in combination with other preventive interventions. PrEP should be supervised by a doctor, experienced with sexual health and use of HIV medicines, possibly as part of a shared care arrangement

The following procedures are recommended:

- Documented negative fourth generation HIV test a week prior to starting PrEP. In case of suspicion of acute HIV-infection, an RNA test on plasma should also be performed, page 15. During PrEP, a fourth generation HIV test should be repeated at one month and then every 3 months. In stable long-term users who are on 6 monthly prescriptions an interim fourth generation test that can be performed without a visit to clinic
- PrEP should be changed to triple-drug ART without interruption in case of early clinical signs of HIV seroconversion or a positive HIV diagnostic test which may necessitate referral for evaluation to an HIV unit, see ART initiation page 12
- PrEP may continue during pregnancy and breastfeeding if the risk of acquiring HIV persists
- Before PrEP is initiated, HBV serology status should be documented. If HBsAg positive, see Clinical Management and Treatment of HBV and HCV Co-infection
- Counsel that PrEP does not prevent other types of STIs; screen for STI (syphilis, chlamydia, gonorrhoeae, HAV, HCV) when starting PrEP and regularly during use of PrEP, pages 7-9
  All persons under PrEP should be offered vaccinations against HAV, HBV, HPV and monkeypox virus.
  Doxycycline post exposure prophylaxis, 200 mg within 24 to 72h after sexual intercourse, proved to be effective in preventing bacterial STIs in MSM with the caveat of the unknown long terms effects on microbiota and STIs resistance. It can be proposed to persons with repeated STIs on a case by case basis
- Counsel that TDF-based PrEP may rarely impact renal and bone health, see pages 78 and 80-82. Check renal function within the first 3 months of starting PrEP and check renal function and bone health during PrEP according to guidelines on TDF use
- Counsel that PrEP, like other prevention methods, only works when it is taken. An adherence check one month after starting is recommended, and counselling may be required in follow-up
- Counsel that PrEP can be prescribed long-term but that each consecutive PrEP prescription should cover the period to the next visit which will be every 3 months for the majority but could be a maximum of 6 months in stable long-term users (over one year of daily PrEP)

3. **PrEP** regimen

- The most common drug available is a generic version with 300mg of tenofovir (formulated as disoproxil fumarate/maleate/phosphate) combined with 200mg of emtricitabine (TDF/FTC). In certain countries, TDF is labelled as 245 mg rather than 300 mg to reflect the amount of the prodrug (tenofovir disoproxil) rather than the fumarate salt (tenofovir disoproxil fumarate)
- The effectiveness of daily and on-demand regimens of TDF/FTC has been extensively evaluated in clinical studies in men, but on demand has only been evaluated in pharmacokinetic/pharmacodynamic (PK/PD) studies for the female genital tract (FGT) and not at all for neovaginal/neopenile tissues
- TAF/FTC could be considered, if available, when creatinine clearance or bone mineral density preclude TDF/FTC. TAF/FTC has been evaluated as a daily regimen in comparison to TDF/FTC in men and transgender women. It was non-inferior, with a statistically significant benefit for renal and bone biomarkers
- Long-acting cabotegravir is available on application to compassionate release program, pending EMA approval, for individuals for whom TDF/FTC is contraindicated

- TDF/FTC 300*/200 mg 1 tablet qd. In both men and women PrEP should be taken for 7 days before the first exposure and stopped 7 days after the last exposure
- For men only, PrEP may be dosed 'on demand' (double dose of TDF/FTC 2-24 hours before each sexual intercourse, followed by two single doses of TDF/FTC, 24 and 48 hours after the first drug intake; no data for TAF/FTC so far). There are no efficacy data with on demand PrEP with TDF/FTC in women
- PK/PD studies comparing TAF/FTC to TDF/FTC suggest that the recommandations for starting and stopping TAF/FTC can be extrapolated from TDF/FTC
- Use of generic formulations of TDF/FTC, if and where available, may help to improve the cost-effectiveness of PrEP, which is essential for its use as public health approach
- Rates of adverse eGFR declines are generally low for those using TDF for PrEP, but PrEP users with the highest risk of adverse renal outcomes on TDF and most in need for systematic monitoring of renal function are older individuals and those with pre-existing renal impairment. Data on renal outcomes with use of TDF vs. TAF in those on PrEP with renal impairment is limited, recommendations to follow guidelines on TDF use in persons with HIV, see pages 81-83. Similarly, no data on use of "on demand" vs daily PrEP for renal outcomes
- Any person presenting with low PrEP adherence and a condomless at risk sexual intercourse should benefit from post exposure prophylaxis. Low adherence is defined :
  - For men and women on daily regimen: less than 4 pills a week, regardless of the distribution
  - For men on on demand regimen: less than 1 pill before and 1 pill after sexual intercourse

Doxi-PEP

DOCUMENTO DE POSICIONAMIENTO
SOBRE EL USO PROFILÁCTICO DE DOXICICLINA PARA PREVENIR LAS ITS (DOXI-PEP)
DE LA SOCIEDAD ESPAÑOLA DE ENFERMEDADES INFECCIOSAS Y MICROBIOLOGÍA CLÍNICA (SEIMC)
A TRAVÉS DEL GRUPO DE ESTUDIO EN INFECCIONES DE TRANSMISIÓN SEXUAL (GEITS), DEL GRUPO DE ESTUDIO DEL SIDA (GESIDA) Y DEL GRUPO DE ESTUDIO DE LOS MECANISMOS DE ACCIÓN Y DE LA RESISTENCIA A LOS ANTIMICROBIANOS (GEMARA)

Marzo, 2024

La doxiciclina no está aprobada para su uso en la prevención de las ITS. Se considera fuera de indicación.

Se valorará únicamente y de manera individualizada en HSH o MTG que tienen sexo con hombres y que han presentado reiteradas ITS en el último año.

La toma de doxi-PEP (200 mg/día) debe hacerse lo antes posible tras un contacto sexual oral, anal o vaginal sin preservativo, idealmente en las primeras 24 horas, y nunca después de las 72 horas.

La decisión sobre la prescripción de la doxi-PEP debe ser compartida con el paciente tras informarle de que su uso para la prevención de ITS está fuera de indicación y exponiéndole la efectividad, beneficios y riesgos que conlleva su administración.

La prevención de las ITS mediante la doxi-PEP no debe realizarse a expensas de las medidas preventivas establecidas, por lo cual es fundamental informar al paciente sobre la importancia y la necesidad de mantener relaciones sexuales con protección.

No se ha demostrado hasta el momento la eficacia de la doxi-PEP en mujeres cisgénero ni en hombres transexuales, por lo que no debe ser considerada en estos colectivos.

Se necesita información sobre la resistencia tetraciclinas u otras familias de antimicrobianos en microorganismos productores de ITS u otras patologías, así como en las alteraciones de la microbiota.

Los grupos de trabajo de SEIMC firmantes de este documento de posicionamiento, GEITS, GeSIDA y GEMARA, opinan que, **aunque existe evidencia científica sobre la eficacia de la doxi-PEP para prevenir ITS** (especialmente clamidiasis y sífilis) en HSH y MTG, **ésta es aún insuficiente para recomendar su utilización sistemática** en estos grupos.

LA VANGUARDIA

Dimarts, 22 d'octubre 2022

LA VANGUARDIA

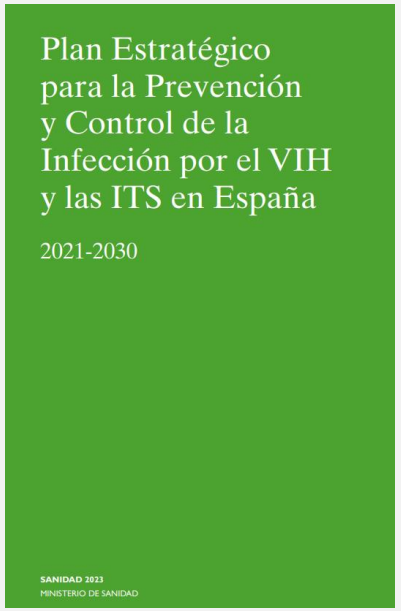
EN DOS AÑOS

La gonorrea crece casi un 43% y la sífilis un 24,1% por la resistencia al condón

• Las infecciones de transimisión sexual no cesan de aumentar en la última década en hombres y mujeres jóvenes

Sanidad puso en marcha el pasado mes de junio una campaña para frenar las ITS en menores de 25 años

ITS. Prevenció combinada



Decàleg de punts clau

Sífilis

- Important diagnòstic i tractament precoç
- Cal incloure-la en el diagnòstic diferencial de la úlcera genital i del rash generalitzat
- Cal fer controls post tractament per comprovar la curació
- Important cribratge ITS i VIH perquè comparteixen la mateixa via d'infecció
- És imprescindible fer estudi de contactes

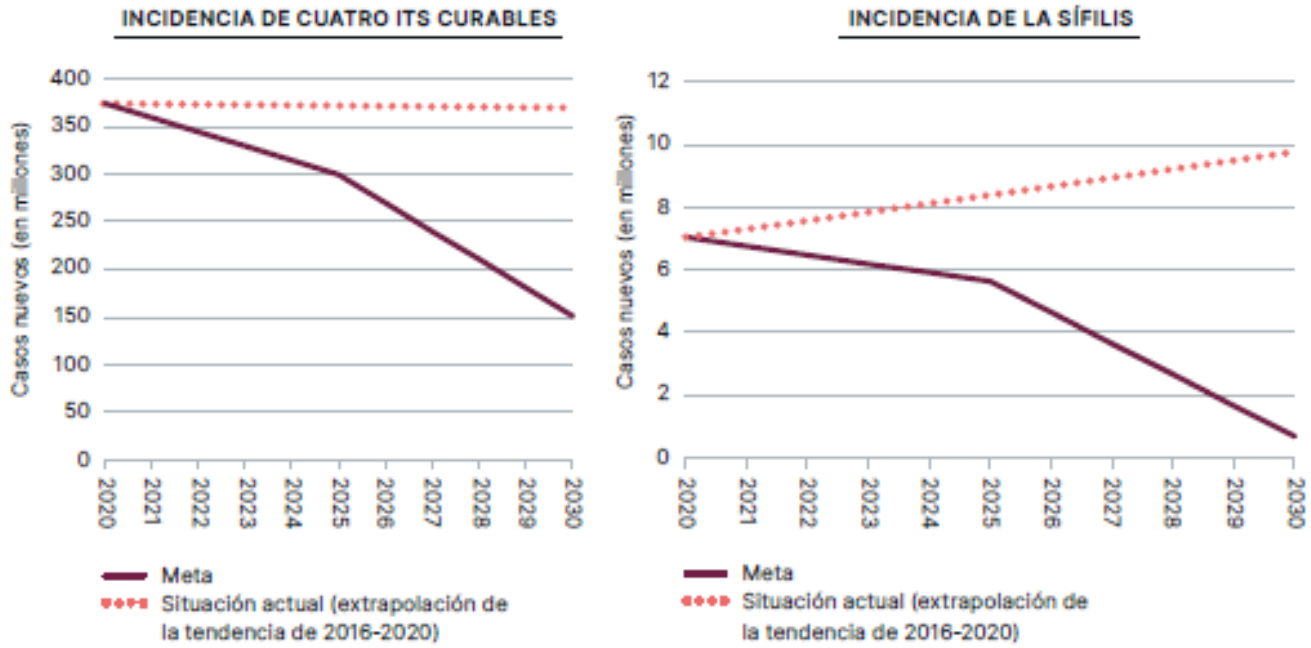
Doxi-PEP

- Ha demostrat disminuir la incidència de ITS (sífilis i clamídia) amb bona tolerància
- Alerta amb l'increment de resistències bacterianes
- La indicació ha de ser cas a cas en HSH i TGW que han tingut diverses ITS en el darrer any
- No està indicada en dones cis ni homes transgènere
- Cal avaluar la indicació cada 3 mesos.

L'educació sanitària i les mesures de reducció de riscos són fonamentals

OMS estratègies mundials ITS i hepatitis 2022-2030

Figura 2.5. Incidencia de cuatro infecciones de transmisión sexual curables y de la con las medidas propuestas en la estrategia y en ausencia de medidas (2020–2030)



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Moltes gràcies

CAMFiC
societat catalana de medicina familiar i comunitària