Gonorrhea and Chlamydia trachomatis infections

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**Background and Treatment of Gonorrhea**

AfterChlamydia trachomatis, gonococcal infections are considered as the second most prevalent bacterial foundation of sexually transmitted infections (STIs) (Piszczek, St. Jean, & Khaliq, 2015). Neisseria gonorrhoeae can develop resistance against multiple antibiotic classes. There are different risk factors for gonorrhea such as sexual contact with an infected person, previous gonorrhea, human immunodeficiency virus (HIV) as well as being a sex worker. Moreover, it is asymptomatic in females and symptomatic in males. Antimicrobial therapy is used to treat the disease.

Its ideal treatment must cure it at least 95% of infections (Piszczek et al., 2015). In the United States, there is Gonococcal Isolate Surveillance Project (GISP) that observers drifts in antimicrobial susceptibilities of N. gonorrhoeae with the purpose of guiding its treatment. In order to treat the rapid rise of resistance to N. gonorrhoeae currently, cotreatment with azithromycin for C. trachomatis is recommended. Furthermore, there is the use of ceftriaxone and cefixime to guarantee an effective cure.

**Background and Treatment of Chlamydia Trachomatis Infections**

C trachomatis is among the most commonly reported STI in Canada (Allen, MacDonald, Society, & Committee, 2014). It affects women having age 15 to 24 years of age and men having age 20 to 29 years. Its transmission occurs during sexual activity and the birth process. Nearly 50% of infants develop the infection when they are born vaginally to mothers with untreated chlamydia (Allen et al., 2014). However, the infection can be transmitted at any time during pregnancy or delivery.

The risk for the disease can be lessened with primary and secondary prevention strategies. Primary prevention strategies consist of vaccination against hepatitis B virus, condom use as well as behavioral change. Secondary preventive strategies consist of partner notification in addition to screening for STIs in asymptomatic young adults. Its preferred treatment includes the use of Ceftriaxone, azithromycin, and Cefixime (Allen et al., 2014).

References

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