

Recommended Regimens for Chancroid

Azithromycin 1 g orally in a single dose
 or
 Ceftriaxone 250 mg IM in a single dose
 or
 Ciprofloxacin 500 mg orally 2 times/day for 3 days
 or
 Erythromycin base 500 mg orally 3 times/day for 7 days

Azithromycin and ceftriaxone offer the advantage of single-dose therapy (429). Worldwide, several isolates with intermediate resistance to either ciprofloxacin or erythromycin have been reported. However, because cultures are not routinely performed, and chancroid is uncommon, data are limited regarding prevalence of *H. ducreyi* antimicrobial resistance.

Other Management Considerations

Men who are uncircumcised and persons with HIV infection do not respond as well to treatment as persons who are circumcised or are HIV negative (430). Patients should be tested for HIV at the time chancroid is diagnosed. If the initial HIV test results were negative, the provider can consider the benefits of offering more frequent testing and HIV PrEP to persons at increased risk for HIV infection.

Follow-Up

Patients should be reexamined 3–7 days after therapy initiation. If treatment is successful, ulcers usually improve symptomatically within 3 days and objectively within 7 days after therapy. If no clinical improvement is evident, the clinician should consider whether the diagnosis is correct, another STI is present, the patient has HIV infection, the treatment was not used as instructed, or the *H. ducreyi* strain causing the infection is resistant to the prescribed antimicrobial. The time required for complete healing depends on the size of the ulcer; large ulcers might require >2 weeks. In addition, healing can be slower for uncircumcised men who have ulcers under the foreskin. Clinical resolution of fluctuant lymphadenopathy is slower than that of ulcers and might require needle aspiration or incision and drainage, despite otherwise successful therapy. Although needle aspiration of buboes is a simpler procedure, incision and drainage might be preferred because of reduced need for subsequent drainage procedures.

Management of Sex Partners

Regardless of whether disease symptoms are present, sex partners of patients with chancroid should be examined and treated if they had sexual contact with the patient during the 10 days preceding the patient's symptom onset.

Special Considerations**Pregnancy**

Data indicate ciprofloxacin presents a low risk to the fetus during pregnancy but has potential for toxicity during breastfeeding (431). Alternative drugs should be used if the patient is pregnant or lactating. No adverse effects of chancroid on pregnancy outcome have been reported.

HIV Infection

Persons with HIV infection who have chancroid infection should be monitored closely because they are more likely to experience chancroid treatment failure and to have ulcers that heal slowly (430,432). Persons with HIV might require repeated or longer courses of therapy, and treatment failures can occur with any regimen. Data are limited concerning the therapeutic efficacy of the recommended single-dose azithromycin and ceftriaxone regimens among persons with HIV infection.

Children

Because sexual contact is the major primary transmission route among U.S. patients, diagnosis of chancroid ulcers among infants and children, especially in the genital or perineal region, is highly suspicious of sexual abuse. However, *H. ducreyi* is recognized as a major cause of nonsexually transmitted cutaneous ulcers among children in tropical regions and, specifically, countries where yaws is endemic (433–435). Acquisition of a lower-extremity ulcer attributable to *H. ducreyi* in a child without genital ulcers and reported travel to a region where yaws is endemic should not be considered evidence of sexual abuse.

Genital Herpes

Genital herpes is a chronic, lifelong viral infection. Two types of HSV can cause genital herpes: HSV-1 and HSV-2. Most cases of recurrent genital herpes are caused by HSV-2, and 11.9% of persons aged 14–49 years are estimated to be infected in the United States (436). However, an increasing proportion of anogenital herpetic infections have been attributed to HSV-1, which is especially prominent among young women and MSM (186,437,438).

The majority of persons infected with HSV-2 have not had the condition diagnosed, many of whom have mild or unrecognized infections but shed virus intermittently in the anogenital area. Consequently, most genital herpes infections are transmitted by persons unaware that they have the infection or who are asymptomatic when transmission occurs. Management of genital HSV should address the chronic nature of the infection rather than focusing solely on treating acute episodes of genital lesions.