Spectrum Community Health CIC

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BASHH publishes UK-first guidelines on doxyPEP for the prevention of syphilis
The UK becomes one of the first countries in the world to issue a national evidence-based doxyPEP guideline.
The new guidelines offer clear direction for healthcare professionals and marks a landmark step in targeted STI prevention.
Read the guidelines over on the BASHH website
BASHH
British Association for Sexual Health and HIV

DoxyPEP (Doxycycline post-exposure prophylaxis)

- New guideline published June 2025 (“informal use” before this, not being prescribed here yet)

- Aim is to reduce syphilis acquisition in those at increased risk:
  - Cisgender gay, bisexual and other men who have sex with men
  - Trans women
  - Case by case for people at risk of reproductive health sequelae from acquiring syphilis (e.g. trans men, sex workers, those with partners from higher risk groups)
  - People at increased risk of syphilis presenting within 72hours of sexual assault
  - Bacterial STI in last 12 months
  - Multiple new partners in last 3 months/group sex/chemsex

Potential benefits?

- Reduction of infection acquisition – syphilis (chlamydia/?LGV)
- Improved quality of life
  - reduction of anxiety about acquiring/transmitting STIs
  - giving more control over sexual health
- Low cost, widely available medication

What concerns might there be about this?

- Safety/tolerability
- Side effects – short/long term
- Antimicrobial resistance
- Effect on microbiome
- Reduction of other means to prevent STIs

Data from 4 RCTs

- Efficacy ✓ for reducing syphilis + chlamydia in GBMSM and TGW
- Safety/tolerability ✓ safe and well tolerated, small numbers discontinued
- Side effects – short/long term ✓
  - nausea/vomiting/photosensitivity
  - benign intracranial hypertension/liver toxicity (rare)

- Antimicrobial resistance ✓? – not seen in STS/CT, “limited understanding”
- Effect on microbiome ✓? – “inconsistent findings”
- Reduction of other means to prevent STIs – part of a comprehensive approach

What other approaches are there for STI risk reduction?

What other approaches are there for STI risk reduction?

- condom use
- HIV prevention interventions (HIV PrEP)
- vaccinations
- STI testing, treatment and management
- appropriate risk reduction advice and psychological interventions

What and how?

Single dose of 200mg (2x 100mg) doxycycline, within 24 hours and no later than 72 hours after sex.

Maximum of 200mg doxycycline in 24 hours.

If several episodes over 72hours can take at the end (may reduce side effects, no evidence)

Pregnancy and lactation

- Use of doxyPEP supported up to 15 weeks gestation
- Contraindicated in breastfeeding in doxycycline SmPC but short term use unlikely to cause harm

Baseline and follow up

- Testing/screening for asymptomatic STIs in line with current guidance
- Treatment/management of incident STIs in line with current guidance
- Offer epidemiological Rx to doxyPEP users who are contacts of syphilis
  - Although they may choose not to have Rx
- Encourage syphilis contacts to attend and have out of window screening

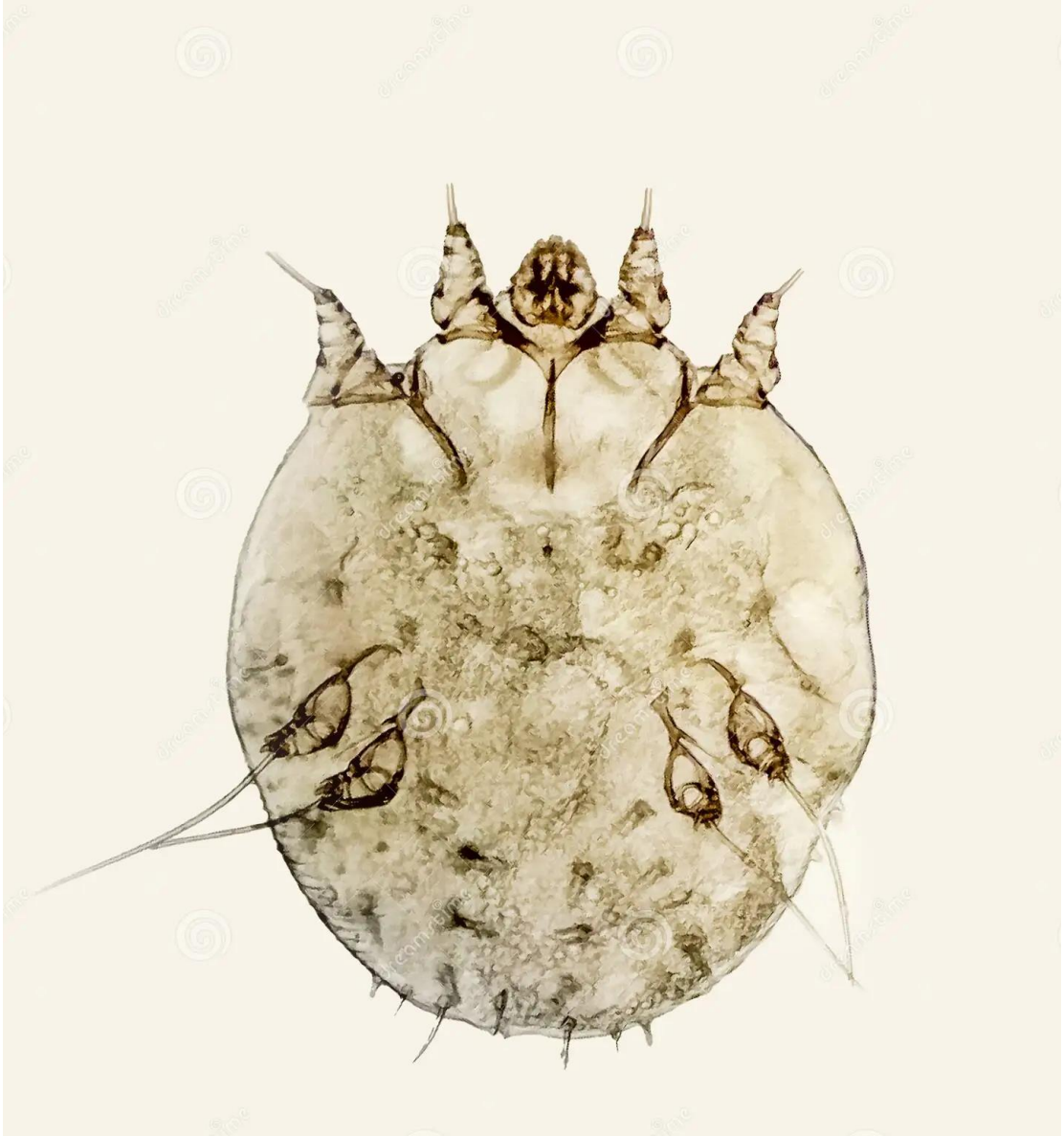
- Chlamydia contacts using doxy PEP do not need additional Rx (if correct dose taken within 72 hours)
- Report use for public health surveillance (GUMCAD)
- No additional monitoring required in DoxyPEP users

Explain DoxyPEP

- not 100% effective at preventing bacterial STIs and should seek advice if signs/symptoms
- effective at reducing chlamydia and syphilis but unlikely to prevent gonorrhoea
- does not prevent HIV or non-bacterial infections e.g. HSV
- users may also benefit from HIV PrEP if not taking already
- users should share information with other healthcare providers

Cautions

- Chronic/heavy alcohol consumption (may reduce effectiveness)
- Absorption problems
- Current long term use of tetracyclines
- Myasthenia gravis
- SLE
- Oesophagitis/oesophageal ulceration
- Porphyria
- Hepatic impairment
- Interacting medication e.g. antacids
- Allergies/intolerance to ingredients



GPs advise not to ignore scabies symptoms

Scabies can lead to secondary skin infections, if not treated.

Sharon Barbour
Health correspondent

24 October 2024

People are being told not to ignore an itchy rash, with GPs in England reporting a spike in scabies - the highly infectious skin infestation.

- British Association for Sexual Health and HIV National Guideline on the Management of Scabies in adults 2025

- Intended for adults attending specialist sexual health services (but can be applied to other situations where appropriate and to children over 13 years old)

- Replaces 2016 guideline. Authors reviewed 64 articles (from 366)

- Updated information about biology/diagnosis
- 2 first line treatments (topical 5% permethrin/oral ivermectin)
- Evidence base for drug Rx and non-pharmacological interventions
- Malathion now alternative Rx (not first line)
- Management of follow up/contacts/ post-scabetic itch
- Management of suspected treatment failure

Epidemiology

- Common, any age/socioeconomic status
- Risk increased in crowded conditions
- Prevalence estimates 0.2-71% worldwide
- Highest in Pacific region and Latin America
- Complex – depends on region. In UK mostly sporadic with occasional outbreaks in institutions

Pathogen

- Scabies mite (females 0.3-0.4mm, 2 x size of males)
- Male dies after mating, female digs burrows (0.5-5mm/day for whole lifespan of 4-6 weeks, laying 1-3 eggs/day (about 25 total)

- Eggs hatch after 3-4 days
- Mature into adults after 10-15 days
- Fewer than 10% eggs become mature adults

- Initial infestation 10-15 mites on average (can penetrate skin within 30 mins)

Transmission

- Skin to skin contact – extended (unlikely through handshake etc)
- Heat and body odour attractive
- Can be sexually acquired
- Crowded conditions/malnutrition increase risk
- More common in first 4-6 weeks (before symptoms develop)
- Fomite transmission uncommon but can happen – sharing clothing/beds

- Mite survival depends on temperature and humidity (24 hours – 19 days)

Clinical Features

- Symptoms from 3-6 weeks after primary infestation
- Intense itch, worse at night (although lack of itch does not exclude it)
- Itchy household/family/sexual contacts
- ? Caused by host-mite interaction+/- delayed type IV hypersensitivity
- Scratching may allow strep/staph infection (causing other skin or systemic complications)
- Can have atypical presentations e.g. scabies incognito after steroid use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- Zoonotic scabies, self limiting, no burrows, sites of animal contact, cannot pass to other humans.

- Treat the animal only.

Diagnosis

- Clinical – symptoms/signs/risk factors
- Excoriated papules/burrows/nodules at typical sites
- Needs visualisation of mites/eggs/faeces for diagnostic certainty

- Differentials for scabies: impetigo, folliculitis/urticarial reactions/dermatitis (atopic/contact/seborrhoeic), dermatitis herpetiformis/psoriasis/pityriasis rosea, secondary syphilis, lymphoma, pseudolymphoma

- Differential for crusted scabies: psoriasis/eczema/Darier's disease/pityriasis rubra pilaris/palmo-plantar keratoderma/cutaneous lymphoma

Management

- Explain transmission route
- Coordinate treatment with contacts where possible (even if no symptoms)
- Offer screening for STIs, avoid sex (min 24 hrs after first dose completed)
- Decontamination of clothes/bedlinen/towels (on the 1st day of treatment)
  - Machine wash 35 mins at ≥50^{o} (will kill eggs and mites)
  - And/or tumble dry on high (50-120^{o} for 10-35 mins)
  - Or seal clothes in plastic bags for 4 days at room temperature
  - Or freeze at -10^{o} for at least 5 hours
  - Crusted scabies may need more thorough cleaning – carpets/soft furnishings etc

What is close contact?

- People who sleep in the same dwelling
- People who share a bed
- Sexual partners
- Children in the same classroom or who play closely together
- Adults with known skin to skin contact

Treatment (1st options licensed for scabies)

- Permethrin 5% to whole body, wash off after 12 hours, repeat after 7-14 days.
  - Second dose increases success rate as may have missed some areas with first application

- Oral ivermectin 200µg/kg x 2 doses repeated after 7 days (or up to 15 days).
  - Second dose increases success rate as cream does not kill eggs
  - Discuss with pharmacy/microbiology if patient > 120kg

Topical Rx

- Application of topical Rx must include ankles/under fingernails/between toes/sacral region (may need assistance)
- Skin should be clean, dry and cool
- Remove jewellery or apply underneath
- Include scalp and face, avoiding area around eyes
- Leave 10-15 mins before dressing and leave product on at least 12 hours
- Reapply to hands after washing
- Repeat treatment after 7 days and advise symptoms may last > 4 weeks
- Written advice: Scabies - BAD Patient Hub

	Ivermectin	
Body weight (kg)	Single oral dose (mg)	Number of 3 mg tablet
15 to 24	3	1
25 to 35	6	2
36 to 50	9	3
51 to 65	12	4
66 to 79	15	5
80 to 99	18	6
≥100	21	7

Discuss with pharmacy/microbiology if body weight >120 kg

Alternative treatment options

- Malathion 0.5% liquid emulsion (licensed in UK for scabies but no RCTs)
- Benzyl benzoate 25% emulsion (not licensed in UK)
- Topical ivermectin 1% (not licensed or recommended by BASHH)
- Sulphur preparations may be used in other countries
- Spinosad cream, not recommended in UK
- Tea tree oil 5% (used as additional agent in parts of Australia)

- Involve dermatology/ID for treatment of crusted scabies, avoid admission

Pregnancy/lactation

- Permethrin 5% cream
- Malathion 0.5% liquid if permethrin not suitable
- Not licensed but systemic exposure extremely low, no evidence of harm
- Oral ivermectin not recommended

Side effects

- All topical treatments may cause skin reactions
- Paraesthesia recognised side effect of permethrin- usually mild
- Contact dermatitis from Rx or ongoing scabies??

Side effects - Ivermectin

- Neurological symptoms reported
- Nausea
- Headache
- Slightly higher reported side effects compared to permethrin
- Likely to be lower risk than once thought

Follow up

- Review at 4-6 weeks after last Rx may be helpful
- Itching >4 weeks after second dose can be a diagnostic challenge
- If new burrows > 7 days after second dose, need retreating
- If itch gets worse despite Rx consider re-infection/alternative diagnosis

Post scabetic itch

- Expect improvement 2-4 weeks after Rx
- But 1/3 patients may itch for 1-3 months
- Psychological impact - can lead to excessive cleaning/overuse of Rx

- Can try crotamiton 10% cream bd/tds, emollients, steroid (if eczematous areas despite adequate treatment), antihistamines, treatment of bacterial infection

Treatment failure

- Incorrect diagnosis
- Dermatitis
- Incorrect treatment use/prescription
- No repeat dose
- Immunosuppression
- Re-infestation from untreated contacts/fomites
- Drug resistance (?)