7. Quickie Gonorrhea Overview (Chapter 14)

The old testament book of Leviticus describes gonorrheal "urethral discharge" and the associated disgust, shame, and perceived uncleanliness. Flash forward to today: The biblical description still holds true! And recent internet headlines show gonorrhea is still all too "relevant."
Gonorrhea Rates Jump 67percent in US, Reach Record High.
Drug-Resistant Super–Gonorrhea Is Here – That Means an Antibiotic Crisis Is Here Too.

You get gonorrhea when an infected source — vagina, penile, rectum, throat, saliva or occasionally fingers — contacts a mucous membrane lining. Australian studies show some men spread gonorrhea via deep kissing or saliva without any sexual contact.

Men are more likely to get gonorrhea symptoms than women. Men often get a scant penile drip which intensifies over 24 hours to obvious pus. In women, silent infections are common and especially dangerous as treatment is typically delayed. Some women notice a thin, purulent, mildly foul-smelling vaginal discharge with some pain on urination. Throat and anal infections are most often asymptomatic but can show up with throat aches or rectal itchiness, mucous discharge and the urge to defecate. If you have atypical urinary or vaginal symptoms, don't live in denial! 40 percent of men and 50 percent of woman with gonorrhea at an STD clinic reported continuing to have sex despite suspicious complaints. That is how the disease spreads. In addition, silent gonorrhea infections are dangerous because treatment is delayed for months before the disease either spontaneously resolves (80 percent) or progresses up the reproductive tract (20 percent) to inflame, scar and permanently damage Fallopian tubes and internal reproductive organs.

Test for gonorrhea with accurate urine (or if appropriate throat, vagina, or rectal swabs) DNA assays that are positive within days of exposure. There is still a 100 percent cure rate but as noted above, antibiotic resistance has begun to emerge. Avoid sex for seven days after treatment. Inform all sex contacts and kissing partners from the last 60 days. Meningococcal B vaccination appears to be protective against future gonorrhea. Urinating after sex may also decrease infection (up to 30 percent effective). Condoms are also very helpful (80 percent effective).

Bottom line, get tested. Gonorrhea is curable. If you are sexually active, get regular screening tests to detect occult disease and prevent serious long-term reproductive complications.

Gonorrhea Summary:

Incidence (new U.S. cases/year): 820,000

Prevalence (total U.S. cases): 250,000 (The low number of total U.S. cases is because gonorrhea infection only lasts a few months - so there are more new cases (incidence) than the number of total cases (prevalence) at any single point in time.)

Initial symptoms: 50 percent of men present initially with abnormal penile discharge that intensifies over the ensuing 24 hours. Most women are asymptomatic but some report increasing vaginal discharge, pain on urination or pain with intercourse

Incubation period (time from infection to illness): 1-3 days

Window period (time from infection to blood tests turning "positive"): 1-2 days (genetic tests)

What happens if no treatment: Asymptomatic gonorrhea may go undetected for months before either spontaneously resolving (80 percent) or progressing up the reproductive tract (20 percent) to inflame, scar and permanently damage Fallopian tubes and internal reproductive organs

Source of infection: Infected saliva, throat, vaginal, penile and rectal secretions. There is increased risk with ejaculation and with menstruation

Infectivity (Risk of transmission after one condom-less sex act with untreated patient):

Very High: Vaginal sex from infected male – 60 percent risk transmission
Vaginal sex from infected female – 25 percent risk transmission
Anal sex from infected male – 80 - 90 percent risk transmission
Oral sex from infected male – 60 - 70 percent risk transmission

High: French kissing and use of saliva as sexual lubricant

Moderate: Sex toys

Low: Romantic touching (petting, hand job, fingering)

Negligible: Towels, especially damp; household transmission rare

Zero: Breast feeding, tears, hugs, shaking hands, food or water

Test (accuracy): DNA urine or vaginal/throat/rectal swab test (99 percent)

Curable? 100 percent

Treatment? Ceftriaxone 250 intramuscular injection plus azithromycin 1 gram orally

Prevention (percent risk reduction if known):

1. Testing, especially for those at highest risk (young women and MSM)
2. Mutual monogamy with uninfected (based on screening tests) partner (100)
3. Condom (80)
4. Meningococcal B vaccination (30)
5. Be alert for clues of atypical gonorrhea: Discharge, urinary discomfort, between cycle bleeding, heavy periods, pain with intercourse or joint/skin problems
6. STDs often travel in pairs! If you have a new case of chlamydia, Trich or HSV, don't forget to test for gonorrhea and HIV

8. Quickie Chlamydia Overview (Chapter 15)

Chlamydial is the gorilla in the room. At this very moment, nearly 3 million Americans are living with this STD – for many, infertility is the price to be paid.

Chlamydia is very common (4 times more common than gonorrhea). It's especially common in women under 25 - an immature cervix may be more susceptible to infection. It's very infectious — 650-fold more than HIV — via vaginal, oral, and rectal sex. It's hard to self-diagnose (70 percent of women and 50 percent of men with infections have no recognizable pelvic symptoms). Chlamydia is more dangerous than gonorrhea - occult chlamydia reproductive tract infections result in more scarring and complications than the more aggressive, symptomatic gonorrhea.

Thankfully, chlamydia is often a self-limiting disease: 80 percent spontaneously burn out and resolve after a year. However, up to 20 percent of the time, chlamydia scars uterine, tubal, and intra-abdominal surfaces, sometimes to the point of blocking the passage of a fertilized egg from the ovary to uterus implantation resulting in a life-threatening tubal pregnancy.

Whereas self-diagnosis is often near impossible, a screening urine (or if exposure dictates, a vaginal, anal or throat swab) DNA test is simple – and extremely accurate!

Antibiotic treatment is simple and 100 percent effective. The law now permits doctors to also give their patients extra antibiotic treatment for all recent at-risk partners. If your doctor is not offering this "expedited partner treatment", ask. It may be time to educate him or her!

Prevention includes mutual monogamy with uninfected (based on screening tests) partner (100 percent effective) condoms (80 percent effective) and pre-exposure treatment with daily doxycycline or post-exposure one time immediately after sex.

Bottom line, lack of symptoms is a curse; 130 *million* people worldwide wouldn't be blithely walking around with this infection if it were easy to self-diagnose! Be proactive. If you are sexually active — especially if you are a woman under 25 — get a yearly chlamydia test.

Chlamydia Summary:

Incidence (new U.S. cases/year): 2,900,000

Prevalence (total U.S. cases): 1,800,000 (If you are math oriented, the connection between incidence and prevalence is Prevalence = Incidence x Duration. When duration is less than 1 year, the prevalence will be less than the incidence. In this specifjc case, the duration for chlamydia is 4-6 months.)

Initial symptoms: Most cases are asymptomatic. 30 percent of women will have vaginal discharge or abnormal vaginal bleeding. Men may report scant thin penile discharge and or discomfort with urination

Incubation period (time from infection to illness): 1 to 4 weeks if symptoms do appear

Window period (time from infection to blood tests turning "positive"): 5 days (genetic tests)

What happens if no treatment: Many infections clear without consequence; however, 10 - 20

percent persist, proceeding to permanently damage pelvic organs leading to chronic pain or infertility. Chlamydia increases risk of contracting HIV 5-fold. It may rarely cause arthritis or even ovarian cancer.

Source of infection: Oral, vaginal, rectal (increased risk with ejaculation) sex or childbirth

Infectivity (Risk of transmission after one condom-less sex act with untreated patient):

High: Vaginal sex from infected male – 50 percent risk transmission
Vaginal sex from infected female –50 percent risk transmission
Anal sex

Moderate: Oral sex

Low: French kissing, sex toys

Zero: Breast feeding, tears, hugs, shaking hands, shared personal objects, food or water

Test (accuracy): DNA urine or vaginal/throat/rectal swab test (98 - 99 percent)

Curable? Yes

Treatment? Yes: Azithromycin 1 gram, one oral dose or Doxycycline 100 mg, twice a day for 7 days

Prevention (percent risk reduction if known):

1. Condoms (80)
2. Mutual monogamy with uninfected (based on screening tests) partner (100)
3. PrEP/PEP (pre- or post-exposure prophylaxis): 100 mg of doxycycline daily or 200 mg of doxycycline one time before or immediately after sex

9. Quickie Mycoplasma Overview (Chapter 16)

Mycoplasma is brand new to the top ten STD list. It's been an STD suspect for years, but tests were too insensitive to convict it. Just now, a new accurate DNA test has changed all of that. Researchers now realize this very infectious (560-times more contagious than HIV) STD was causing millions of silent (70 percent) or minimally symptomatic (30 percent) chlamydia-like urethral, testicular, cervical, and fallopian tube infections. To complicate matters, mycoplasma is often resistant to the antibiotics used for chlamydia, gonorrhea, or trichomonas. So symptomatic or not, in many instances mycoplasma stays in the genital tract undiagnosed and often inappropriately treated with antibiotics aimed at chlamydia, poised to inflame the urethra, cervix, or fallopian tubes, contributing to America's infertility problem. In America today, one in nine young couples are infertile! Spoiler alert: a real-life *Handmaid's Tale*?

There are no good studies yet, but mycoplasma appears to be as common as chlamydia, so our best estimates are about 2.8 million new cases of mycoplasma in the U.S. each year. You get mycoplasma by exposure during condom-less sex to infected penile, vaginal, or rectal secretions. Best case, untreated mycoplasma remains silent and after an uneventful year the infection burns out. On the other hand, mycoplasma can form cause painful inflammation and permanent scarring inside genital structures. Mycoplasma also scars the fallopian tubes and may cause tubal pregnancy when the fertilized egg cannot make it through the blocked passageway from the ovaries into the uterus. There are about 1,000 maternal deaths yearly in the U.S. About 15 percent (150 deaths) of those deaths are due to tubal pregnancies. On that basis, every year mycoplasma, chlamydia, and gonorrhea are each responsible for up to 50 deaths.

One of the unique current challenges in the treatment of STDs: Doctors typically do not test for mycoplasma – they're unaware of a new DNA urine, vaginal or anal swab test that just became available in 2016 that can identify this treatable cause of infertility. Mycoplasma treatment is tricky because antibiotics ordinarily given for gonorrhea, chlamydia and Trich (other common STD causes of vaginal discharge) are not especially effective.

Condoms work to prevent infection, but they must be used correctly.

Bottom line, mycoplasma is a newly discovered STD. Be pro-active and ask about mycoplasma and and make sure you are being screened with the correct diagnostic test.

PS, blame me if the doctor gives you attitude!

Mycoplasma Summary:

Incidence (new U.S. cases/yr.): 2,800,000

Prevalence (total U.S. cases): 1,700,000

Initial symptoms: The majority of people are asymptomatic. 30 percent get symptoms: males may complain of thin, slightly milky penile (or rectal) discharge. Females may have unusual vaginal discharge, pain with sex or vaginal bleeding.

What happens if no treatment: Similar to chlamydia – long term pelvic pain and infertility

Incubation period (time from infection to illness): 7 to 28 days if symptoms do appear

Window period (time from infection to tests turning "positive"): 2-5 days (genetic tests)

Incubation Period: 7 - 14 days

Source of infection: Oral, vaginal, penile or rectal secretions (an increased risk with ejaculation)

Infectivity (Risk of transmission after one condom-less sex act with untreated patient):

High: Vaginal sex from infected male – 40-50 percent risk transmission
Vaginal sex from infected female – 30-40 percent risk transmission
Anal sex

Moderate: Oral sex

Mild: French kissing, sex toys

Zero: Breast feeding, tears, hugs, shaking hands, shared personal objects, food or water

Test (accuracy): DNA urine or vaginal/throat/rectal swab test (98 - 99 percent)

Curable? Yes

Treatable (percent success)? Yes; Moxifloxacin 400 mg by mouth for 10 days (70 – 100) or Azithromycin 1.5 - 2.5 gram by mouth one time (40 - 85) or Doxycycline 100 mg twice daily for 7 days followed by Azithromycin 1.5 gram over 2 days (>90)

Prevention (percent risk reduction if known):

1. Testing, especially for those at highest risk
2. Be proactive – ask about the new mycoplasma diagnostic test - most doctors still don't include it in their "thorough" STD panels
3. Condoms (80)
4. Mutual monogamy with uninfected (based on screening test) partner (100)

10. Quickie Trichomonas Overview (Chapter 17)

Almost 4 million Americans are currently living with an active parasitic STD - Trichomonas vaginalis - contracted through vaginal sex. It's very infectious - a 40 percent catch rate with a single episode of condom-less sex. It can cause minor urinary irritation or penile or vaginal discharge. It can cause vaginal malodor. But most of the time (85 percent), it causes no symptoms and people carry it without knowing it.

"Trich" triples the risk of acquiring HIV. It increases baby mortality (3 percent of pregnant women have Trich). Trich doesn't scar up reproductive tubes (like gonorrhea, chlamydia or mycoplasma) and typically spontaneously resolves but can also persist for years.

Trich is easy to diagnose with a urine or vaginal swab DNA test (95 percent accurate).

Trich is also easy to treat with antibiotics. However, twenty percent of folks treated for trichomoniasis get reinfected within three months, so like with every other STD, please tell all recent (within the last 60 days) contacts to get treated. Condoms are 80 percent effective in preventing transmission.

Bottom line, Trich is a curable parasite that can cause irritating symptoms and rarely complications during pregnancy.

Trichomonas Summary:

Incidence (new U.S. cases/yr.): 1,100,000

Prevalence (total U.S. cases): 3,700,000

Initial symptoms: 85 percent are asymptomatic. Symptomatic men can get minor urinary symptoms or a thin penile discharge. Women can report minimal urinary discomfort or a thin vaginal discharge, yellow to green, and occasionally foul smelling

Incubation period (time from infection to illness): 5 to 28 days (if symptoms do appear)

Window period (time from infection to blood tests turning "positive"): 2-5 days (genetic tests)

Incubation Period: 5 - 28 days

What happens if no treatment: Even asymptomatic trichomonas infection can increase one's risk of contracting HIV or cause pregnancy complications like preterm delivery.

Source of infection: Vaginal, penile and anal secretions (increased risk with ejaculation)

Infectivity (Risk of transmission after one condom-less sex act with untreated patient):

High: Sex toys

Moderate: Vaginal/anal sex infectivity is unknown, but presumed at least moderate

Negligible: Oral sex, French kissing, romantic touching (petting, hand job, fingering), shared towels

Zero: Breast feeding, tears, hugs, shaking hands, shared personal objects, food or water

Test (accuracy): DNA urine or vaginal/rectal swab test (98 - 99 percent)

Curable? Yes

Treatable? Yes; Metronidazole, 500 mg twice daily for 7 days

Prevention (percent risk reduction if known):

1. Testing, especially for those at highest risk
2. Condom effectiveness (80)
3. Mutual monogamy with uninfected (based on screening test) partner (100)

11. Quickie Crabs (Pubic Lice) Overview (Chapter 18)

Pubic lice or "crabs" are different in three key ways from every other STD:

#1 You can see this STD -- the pubic lice (nits) and its eggs are visible to the naked eye.

#2 There are relatively few silent infections; Pubic crabs almost always cause an obvious symptom – itchiness.

#3 Pubic lice are the dinosaurs of STDs. From approximately 3 million new pubic lice infestations each year in the 1990's, there has been an unprecedented 95 plus percent drop. The near global adaptation of pubic hair removal techniques, especially the "Brazilian," may be pushing pubic lice -- which require pubic hair to survive — near extinction.

Public lice are spread to pubic hair via sexual contact. In rare instances, the infestation begins after contact with toilet seats, clothing, bed sheets and dirty towels used by an infected person.

Pubic itchiness begins approximately five to seven days after the initial pubic lice exposure. When skin is scratched hard enough, especially with long fingernails, bacterial boils or localized skin infection can result. Occasionally, the lice bites do not elicit an allergic response and itching never occurs. Rarely, individuals first see black residue (lice droppings) and miniscule white eggs in their underwear. Pubic lice do not spread any other disease or cause any internal medical complications.

The diagnosis of crabs is old-school: visual identification of lice (nits) and/or their eggs (with or without a magnifying glass).

Fortunately, effective treatment via creams or lotions (Nix, Rid) is available over the counter. The best prevention: Eliminate pubic hair. Condoms are of no benefit.

Bottom line, pubic lice — a nuisance parasite that carries no disease — is far less common now than just a decade ago. Nonetheless, if you have genital itchiness, look for the characteristic minute pubic crab and its eggs.

Pubic Lice Summary:

Incidence (new U.S. cases/yr.): 120,000

Prevalence (total U.S. cases): 60,000 (Pubic lice does not linger -- almost always itchiness is present, meaning infected persons go for treatment promptly. Therefore, the new cases (incidence) is larger than the total cases at any one time (prevalence).)

Initial symptoms: Itchiness

What happens if no treatment: Itchiness leading to severe scratching that can result in bacterial streptococcal or staphylococcal infection of the skin

Incubation period (time from infection to illness): 7 to 14 days

Window period (time from infection to blood tests turning "positive"): 7 to 14 days (visual)

Source of infection: Vaginal or anal sex. Rarely, pubic lice can be contracted from contact with toilet seats, clothing, bed sheets or dirty towels used by an infected person

Infectivity (Risk of transmission after *one* condom-less sex act with untreated patient):

High: Vaginal sex (partners have pubic hair), romantic touching (petting, hand job, fingering)

Low: Oral sex, French kissing (eyebrows), shared personal objects

Negligible: Sex toys

Zero: Breast feeding, tears, hugs, shaking hands, food or water

Test (accuracy): Visual (unknown)

Curable? Yes

Treatable? Yes; 1 percent permethrin cream rinse or pyrethins with piperonyl butoxide (RID, Nix). Repeat treatment in 9–10 days if live lice are still found.

To kill any lice or nits remaining on clothing, towels, or bedding, machine-wash and machine-dry those items that the infested person used during the 2–3 days before treatment. Use hot water (at least 130°F) and the hot dryer cycle. Items that cannot be laundered can be dry-cleaned or stored in a sealed plastic bag for 2 weeks. All sex partners from within the previous month should be informed that they are at risk for infestation and should be treated. Persons should avoid sexual contact with their sex partner(s) until both they and their partners have been successfully treated and reevaluated to rule out persistent infestation.

Prevention (percent risk reduction if known):

1. Condoms are of no benefit in decreasing pubic crab infection
2. Complete pubic hair removal (100)

Non-Sexually Transmitted Genital Infection Capsule Summaries

Quickie Bacterial Vaginosis (BV) Overview (Chapter 19)

BV is the most common vaginal infection by a long shot – 30 percent of sexually active women have it – half with and half without obvious symptoms. BV is a sex-related but not sexually transmitted disease: It can start after a new partner. Condoms can prevent it. Non-sexually active women are rarely affected. However, there is no known male counterpart. Males get no symptoms and no disease. Furthermore, treating the male partner doesn't affect the women's chance of BV cure – or future recurrence.

BV symptoms include a milky thin vaginal discharge sometimes with a slightly fishy smell or merely vague vaginal discontent. There is overgrowth of Gardnerella or other unusual bacteria in the face of diminished levels of normal healthy vaginal bacteria like lactobacillus. BV is an imbalance of the normal bacterial in the vagina.

Women with BV are more likely to get other STDs, especially HIV, gonorrhea, chlamydia and herpes. They get more complications after abortions or other gynecological surgery. They get more pregnancy complications. A word of caution: It's tricky discerning normal vaginal discharge (which increases in pregnancy) and vaginal yeast overgrowth (also common during pregnancy) from BV discharge. Currently the detection and treatment of asymptomatic BV in pregnancy is controversial.

In the real-world, docs begin BV treatment if you have an adherent milky discharge with or without malodor and your urine DNA tests for gonorrhea, chlamydia, mycoplasma and Trich are all negative and you have no yeast discharge (it's usually a thicker "cottage cheese" consistency, but it can be thin, making it tough to differentiate from BV).

Very effective antibiotic pills or vaginal creams exist which also fortunately happen to be safe for pregnant women too. Treatment includes stopping tobacco. There is a two-to-three-fold increased chance of BV in cigarette smokers. Alcohol and bacterial vaginosis antibiotics don't mix, so avoid booze while on treatment.

Probiotic preparations or intravaginal non-medical lactobacillus (or yogurt) do not work. Triple sulfa intravaginal creams are not effective. Sex partners need not be notified or treated. Follow-up visits are unnecessary if symptoms resolve. Unfortunately, recurrent BV is common, so other empiric approaches — like switching to vaginal estrogen supplementation like the NuvaRing for birth control or monthly metronidazole treatment are occasionally required.

Bottom line, BV is very common and occasionally leads to post-operative and pregnancy complications. Don't be intimidated by health care providers who shoulder-shrug subtle discharge and odor complaints. Those docs erroneously believe BV symptoms are trivial and its diagnosis questionable. This pervasive misconception results in delayed and inadequate treatment.

Quickie Urinary Tract Infection Overview (Chapter 20)

UTI's are the most common genitourinary infection by a long shot – by age 24, a third of American women will have had at least one UTI heralded by discomfort in the act of urination, unnaturally frequent urination, an unnaturally urgent desire to urinate and occasionally blood in the urine.

First timers freak out, logically fearing they have contracted a raging STD. But UTIs are sex-related, not sexually transmitted. Intercourse tends to cause vaginal bacteria to migrate up to the urethra then into the sterile bladder – and urine is a pretty good bacterial culture medium, especially in pregnancy. UTIs appear about two days after intercourse, the time it takes for rapidly dividing bacteria to gain a foothold into the bladder wall. UTIs are so common after weddings that there's a special name for it: Honeymoon Cystitis.

Females get thirty-fold more UTIs than men because of anatomical differences: the distance from the tip of the urethra to the bladder is considerably longer in men (inches) compared with women (fractions of an inch). UTI's are not caused by sexually transmitted bacteria – males do not seem to be the source of UTIs in women. Condoms and spermicides do not lower UTI risk. Lastly, treatment of the male partner doesn't affect the women's chance of UTI cure – or future recurrence.

UTIs occasionally ascend up from the bladder via the ureter to cause kidney infection. That potentially dangerous complication that can lead to life threatening bloodstream infection is signaled by flank pain along the back, fever, chills, and general malaise.

UTI's are diagnosed by detecting white blood cells and abnormal numbers of bacteria in mid-stream urine collections. Antibiotic treatment is empiric ("an estimate") until culture results return. An over the counter urethral numbing agent can also be added to reduce urinary burning if it's severe – but just for the first few days. You don't want that numbing medicine on board at day three when the antibiotics should have markedly lowered or eliminated symptoms. Residual symptoms mean the antibiotic you are on may be ineffective and treatment changes should be considered. There is lots of conflicting information regarding cranberry products, most of it suggesting they do not work. Don't depend on them.

A urine culture returns in 48 - 72 hours. Assuming the correct antibiotic was originally given, no more than the three originally prescribed days of antibiotics is usually required. If the microbe is resistant to the initially prescribed antibiotic (less than 10 percent of the time), the appropriate drug is prescribed.

Being well hydrated is the best initial approach to preventing UTI's – it's safe, cost effective and scientifically validated! Merely consume an extra 1.5 liter per day - 2 extra cups of water three times a day to reduce recurrent UTI's by 50 percent.

Bottom line, UTIs are common, easily treatable with antibiotic and extra water but can be very uncomfortable. Do not "ride it out." If you think you have an UTI, get treated.

Quickie Yeast Overview (Chapter 21)

At any one time, up to half of all women have at least some vaginal yeast, but only 5 percent have any symptoms consistent with an "infection."

Eventually, over their life time, over three quarters of women will have a yeast "infection" with some or all of the following symptoms: itching at outer edge of the vagina, white "cottage cheese" discharge, outer vaginal discomfort with urination, vaginal soreness, swelling, redness, and pain with intercourse. Woman often self-treat with over-the-counter anti-fungal creams but self-diagnosis is an iffy proposition: Only half of those women actually have a yeast infection. The main "complication" of vaginal yeast infections is in fact incorrect self-diagnosis – delaying treatment of other more troublesome and serious causes of vaginal discharge, including BV, gonorrhea, chlamydia, mycoplasma or Trich.

Candidiasis is typically also a sex-related, not a sexually transmitted disease. Oral or vaginal sex can introduce yeast into the vagina. Elevated estrogen — occurring naturally in pregnancy and from birth control pills (BCPs) — increases risk. Up to 10 percent of male sex partners have yeast balanitis (often confused with herpes), characterized by red patchy areas on the glans of the penis and under the foreskin in conjunction with itching or irritation. Those men benefit from treatment with topical antifungal agents to relieve symptoms. Other than that, no partner treatment recommended. Frequent sexual activity and having multiple different partners does not increase the risk for vaginal yeast infections.

Diagnosis is based on the characteristic vaginal discharge plus yeast seen by microscopic exam or culture of a sample of the discharge.

Very effective anti-fungal treatment exists over the counter. Anti-fungal prescription pills are sometimes required. Some anti-fungal creams are oil-based and might weaken latex condoms. Acidophilus or probiotic treatments do not work and should be avoided.

Bottom line, yeast infections are common, cause few if any serious complications, and can be simply treated by over the counter medication. But if this home therapy is not promptly successful, seek medical help. Yeast is a true sexually transmitted disease in less than 10 percent of cases so mention it to your partner.