

**STANDARD
NURSE PROTOCOLS
FOR
SEXUALLY TRANSMITTED
DISEASES (STD)**

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2014-2015 STD CLINICAL REVIEW TEAM

**Olugbenga O. Obasanjo MD
Health Director
District 4, Georgia Department of Public
Health**

**Pradnya B. Tambe, MD
Physician Consultant**

**Keisha Lewis-Brown, RN, BSN, MSN
Assistant Director of Nursing
Gwinnett, Newton and Rockdale Health
Depts.**

**Dawn Krahwinkel RN,BSN
Cobb & Douglas Public Health
Women's Health Coordinator
STI Program Director**

**Meshell McCloud, RN, APRN, WHNP-BC
Deputy Chief Nurse**

**Michelle Allen, BA
STD Unit Director**

**Greg French RD, LD, CPT
WIC Nutrition Program Consultant**

**Donelle Humphrey-Franklin RPh, MBA
Assistant Pharmacy Director**

**Gregory S. Felzien, MD, AAHIVS
Georgia Department of Public Health
Medical Advisor**

**Kimberly Brown, RN
STD Nurse Consultant**

**Rebecca Kershner, RN, CCP
District 6 STD Coordinator
General Medical/ID Supervisor, Laney
Walker
East Central Public Health District**

**Karen Schreppe, PharmD.
Director of Pharmacy
Gwinnett, Newton, & Rockdale County
Health Dept.**

**Kimberley Hazelwood, PharmD
Pharmacy Director**

**Tonia Parrott, Ph.D., M.T. (ASCP)
Clinical Microbiology Services Director**

**Penny Conner, BSN, RN
PHSO Nurse Consultant-Immunization
Unit**

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GENERAL INFORMATION

The completion of a **sexual history and health assessment** is to be conducted on all patients who are referred to the health department by an epidemiologist, communicable disease specialist, or disease investigative specialist, hospital or private provider referred, or a contact to an established health department infected patient. Assessments will vary according to each patient circumstance. Documentation is required to validate rationale for treatment and/or other care provided according to the nursing protocols.

SEXUALLY TRANSMITTED DISEASE PRESENTATIONS:

Lesions: Primary Syphilis, Genital Herpes (HSV), Lymphogranuloma Venereum(LGV)

Discharge: Bacterial Vaginosis (BV), Vulvovaginal Candidiasis, Gonorrhea (GC), Chlamydia (CT), Pelvic Inflammatory Disease (PID), Epididymitis, Nongonococcal Urethritis (NGU), Mucopurulent Cervicitis (MPC), Trichomoniasis

Rashes: Secondary Syphilis, Scabies, Pediculosis Pubis, Gonorrhea (Disseminated Gonococcal Infection), Genital Herpes

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**STANDARD NURSE PROTOCOL FOR
GONORRHEA
Uncomplicated Urethral, Endocervical, Rectal or Pharyngeal**

- DEFINITION** A sexually transmitted infection caused by infection with the **Neisseria gonorrhoeae bacterium that infects the mucous membranes of the reproductive tract**, anorectal, ocular or pharyngeal that may be symptomatic or asymptomatic **in both men and women. Gonorrhea is the 2nd most commonly reported communicable disease. Georgia ranks 8th nationally for most reported cases.**
- Incubation for gonorrhea is between 1-14 days. Generally in men symptoms develop within 2-5 days and in women within 10 days.**
- ETIOLOGY** Neisseria gonorrhoeae, an intracellular Gram-negative diplococcus. Infections caused by antibiotic resistant strains are clinically indistinguishable from drug-sensitive infections.
- SUBJECTIVE** 1. May be asymptomatic at any infected site, especially females.
2. Males frequently have purulent urethral discharge (generally within 24 hours) followed by dysuria.
3. Females may notice increase discharge from the vagina, intermenstrual uterine bleeding and dysuria.
4. Rectal discharge, pain, purities and/or scant bleeding with history of rectal sex.
5. Sore throat, with history of oral sex.
6. May have history of sexual contact to an individual with gonorrhea.
- OBJECTIVE**
1. Females commonly have no clinical signs.
2. Mucoid, mucopurulent or purulent discharge from the infected site **in both females and males.**
3. **Erythema and edema of the cervix and/or intermenstrual bleeding in females or urethral meatus in males.**
4. **Anorectal infections are commonly asymptomatic. When symptoms are present can include but not limited to: erythema, mucopurulent discharge, and/or scant bleeding.**

5. Pharyngeal inflammation (**mostly asymptomatic**).

LABORATORY FINDINGS

NOTE: Nonculture, nonamplified probe tests should not be used for diagnosing preadolescent children. GC culture or amplified DNA Probe remains the preferred method for diagnosis.

1. Adult Endocervical, Urethral, Rectal, or Pharyngeal Infection
 - a. Nonculture detection of *N. gonorrhoeae* (e.g., DNA probe, nucleic acid amplification test).
 - b. Culture positive for *N. gonorrhoeae*, with or without confirmatory tests.
 - c. Gram-negative intracellular diplococci seen on a smear of male urethral discharge. Gram stains are to be done in-house on symptomatic male patients in an effort to make a diagnosis and treat the patient on the same day.

NOTE: You must perform either “a” or “b” in female patients. In male patients, you must perform “a” or “b” and when available “c”; however, you can treat the male patient based on diagnostic criteria “c” alone.

NOTE: If the criteria for gonorrhea are not present, treatment should be deferred pending the results of the diagnostic studies. Empiric treatment for gonorrhea should be given in the following cases:

- a. Contact to Gonorrhea
 - b. Documented or contact to PID
 - c. Documented or contact to Epididymitis
 - d. **Visible discharge in males on examination** (in cases where Gram stain is not available).
2. Genital Infection in a child with positive culture for *N. gonorrhoeae*, confirmed by two different acceptable methods.

ASSESSMENT Gonorrhea [specify exposed site(s): by clinical assessment].

PLAN **The desired outcomes of treatment are: biologic cure, prevention of transmission to sex partners, prevention of pelvic inflammatory disease (PID) and resulting ectopic pregnancy or infertility, and, for pregnant women, prevention of transmission to infants during birth. Treatment of sex partners helps to prevent reinfection of the index patient and infection of other partners.**

DIAGNOSTIC STUDIES

1. Gonorrhea test should be performed: nucleic acid amplification test (NAAT), culture or DNA probe
2. Amplification or DNA probe test for Chlamydia should always be done when gonorrhea is suspected.
3. Gram Negative intracellular diplococci on gram stain.
4. Gonorrhea agar culture plate, when indicated, examples are:
 - a. **Gonococcal Isolate Surveillance Project (GISP)** study if ongoing
 - b. Suspected therapeutic failure after Gonorrhea treatment.
 - c. Symptomatic adults with oral and/or rectal exposure should have cultures done at the exposed site.
 - d. In children with suspected sexual abuse, do oral and rectal cultures regardless of history exposure.
 - e. As requested by a physician or supervisor when a Nucleic Hybridization test is not available

NOTE: Gen-Probe NAAT can be used for the above example listed as “c” if agar culture plate is not available.

NOTE: If suspected therapeutic failure after GC treatment, an agar culture plate must be used for specimen collection.

5. Children with gonorrhea should also be tested for **chlamydia, syphilis and HIV**. Sexual abuse is the most frequent cause of gonococcal infection in preadolescent children.

THERAPEUTIC

PHARMACOLOGIC

Empiric treatment for gonorrhea must be given in the following cases

- a. Contact to Gonorrhea
- b. Documented or contact to PID
- c. Documented or contact to Epididymitis
- d. Symptoms of discharge in males with visible discharge on examination (in cases where Gram stain is not available).

NOTE: Prior to treatment of children, consult with delegating physician or refer to primary care provider.

NOTE: If allergic to cephalosporins or penicillins, consult with delegating physician for referral for penicillin or cephalosporin desensitization.

NOTE: Any patients who test positive for gonorrhea should be tested for chlamydia, syphilis, and HIV.

- A. Cervical, Urethral, or Rectal Infection of non-pregnant adults/adolescents or children weighing at least 45 kilograms (kg) (99 pounds (lbs.)):

Ceftriaxone 250 mg IM, single dose,
PLUS,
Azithromycin 1 gm PO once, **administered on the same day, preferably under direct observation**

Alternative Regimen ONLY IF allergic to azithromycin:

Ceftriaxone 250 mg IM, single dose, PLUS, Doxycycline 100 mg PO, 2 times a day for 7 days (must be at least 8 years of age)

NOTE: Do not give Doxycycline to pregnant or lactating patient(s); patient(s) must be advised to discontinue breastfeeding or receive alternative regimen. Breastfeeding can be restarted 2 days after completion of treatment.

- B. Cervical, Urethral, or Rectal Infection of Pregnant adult/adolescent or children weighing at least 45 kg (99 lbs.):

Ceftriaxone 250 mg IM, single dose,
PLUS,
Azithromycin 1 gm PO, single dose,

- C. Pharyngeal Infection of adults/adolescents or children weighing at least 45 kg (99 lbs.):

Ceftriaxone 250 mg IM, single dose,
PLUS,
Azithromycin 1 gm PO once.

**NOTE: If allergic to cephalosporins or penicillins,
consult with delegating physician.**

- D.** Genital, rectal or pharyngeal infections in children weighing less than 45 kg (99lbs):

Ceftriaxone **25-50 mg/kg IM in a single dose,**
not to exceed 125 mg IM

NOTE: Children with gonorrhea should also be tested for chlamydia, syphilis **and HIV.**

NOTE: Culture testing should be done on children.

Co-treatment for Gonorrhea and Chlamydia, with appropriate drugs and dosage, reduces antimicrobial resistance and enhances pharyngeal treatment of Gonorrhea.

- E.** HIV infected patients should receive the same treatment regimen as those who are HIV negative.

NOTE: Due to the high prevalence of tetracycline resistance among Gonococcal Isolate Surveillance Project isolates the use of azithromycin is preferred instead of doxycycline as the second antimicrobial.

PATIENT EDUCATION/COUNSELING

(Reinforce pertinent information with handouts)

1. The name/significance of the infection. **Educate for sequelae and complications of untreated infection** (<http://www.cdc.gov/std/gonorrhea/gon-factsheet-july-2014.pdf>)
2. Directions for taking medication and management of potential side effects.
3. All sex partners from 60 days prior to the onset of symptoms or positive test should be referred for examination and treatment. Avoid sex until partner has been treated. Refer the last known sex partner if the last sexual contact was greater than 60 days

before onset of symptoms or diagnosis. Provide written note(s) to give to partners to refer them in for exam and treatment.

4. Education and counseling of the correct usage of protective barriers (condoms, dental dams, etc.).
5. **Educate patients who receive Azithromycin about adverse effects (QT Prolongation, torsades de pointes, etc.) and document the patient's understanding.**
<http://www.fda.gov/downloads/Drugs/DrugSafety/UCM343347.pdf>.
6. Assist patient(s) in developing a personalized STD/HIV risk reduction plan and document patient(s) plan. Abstain from sex until all the symptoms are resolved and partner(s) are tested and treated.
7. If patient is of childbearing age, counsel on the use of contraceptives to reduce the risk of unintended pregnancy.
8. Advise the patient to return to clinic for all lab results even if presumptively treated at initial visit. Inform patient if lab results are positive additional treatment may be needed.
9. Advise patient to return to clinic in 7 days or less if symptoms do not resolve.
10. Inform patient if additional lab(s) is/are positive, partner(s) will also need additional treatment.
11. If the patient is diabetic, received ceftriaxone therapy, and is using the ACCU-CHEK Compact Plus system, they should stop using the ACCU-CHEK Compact Plus system and begin using an alternate blood glucose monitoring system for the duration of this therapy and for 2 full days after the last treatment because it may lead to incorrect low glucose results.
12. Women who are breastfeeding should not receive Doxycycline. If Doxycycline is given to breastfeeding women they should discontinue breastfeeding throughout treatment and for two days after completion of treatment. If breastfeeding women are pumping during treatment, they should not provide pumped breast milk to infant throughout treatment and for two days after completion of treatment.
13. HIV antibody test to determine HIV status, if unknown.

14. Hepatitis A, Hepatitis B and/or HPV vaccine if patient is unvaccinated. To verify eligibility criteria for state supplied vaccines go to:
<http://dph.georgia.gov/sites/dph.georgia.gov/files/Immunizations/Publications-GA-Imm-Manual-Complete.pdf> and
http://dph.georgia.gov/sites/dph.georgia.gov/files/photo_gallery/February%202015%20Vaccine%20Eligibility%20table_0.pdf.

MANAGEMENT OF SEX PARTNERS

1. All sex partners from 60 days prior to onset of symptoms or positive test should be referred for examination and treatment. Refer the last **known** sex partner if the last sexual contact was greater than 60 days before **onset** of symptoms or diagnosis. Provide written note(s) to give to partners to refer them in for exam and treatment.
2. All sex partners, as defined above, should be examined and promptly treated with one of the above regimens for **gonorrhea**.

FOLLOW-UP

1. Patients who have uncomplicated gonorrhea and are treated with the recommended treatment regimen **or alternative treatment regimen** need not return for **test of cure** unless symptoms are unresolved. If **test of cure** is positive for Gonorrhea and reinfection is ruled out, consult with **delegating physician and contact STD Nurse Consultant**.
2. Test-of-cure is not routinely recommended unless therapeutic failure is suspected. **Question carefully about the possibility of reinfection if there is suspected treatment or therapeutic failure.** A patient with symptoms that persist after treatment and reinfection is ruled out, should have a gonorrhea culture done with anti-microbial sensitivity testing on positive cultures. If gonorrhea culture is not available, a second NAAT test can be performed 7 days after treatment. The Gen-Probe APTIMA 2 test is a dual performance test but GC results should be the **only test result assessed if the test was done within two weeks of when the patient was adequately treated for positive Chlamydia**. When a patient is adequately treated for positive chlamydia and a second test is conducted within two weeks of treatment, the Gen-Probe APTIMA 2 chlamydia lab results may return positive.

3. *N. gonorrhoeae* infection is prevalent among patients who have been diagnosed with and treated for gonorrhea in the preceding several months. Most infections result from reinfection rather than treatment failure, indicating a need for improved patient education and referral of sex partners. Clinicians should advise patients with gonorrhea to be retested three months after treatment. If patients do not seek medical care for retesting in three months, providers are encouraged to test these patients whenever they next seek medical care within the following 12 months, regardless of whether the patient(s) believe that their sex partners were treated. Retesting is distinct from test-of-cure to detect therapeutic failure, which is not recommended if the patient receives first line of treatment.

CONSULTATION/REFERRAL

1. **Treatment failure due to cephalosporin resistant gonorrhea should be considered in 1) persons whose symptoms do not resolve within 3-5 days after appropriate treatment and report no sexual contact during the post treatment follow-up period, 2) persons with a positive test of cure when no sexual contact is reported during the post-treatment follow-up period, 3) persons with a positive N gonorrhoeae culture within 30-60 days (but >72 hours) after treatment for gonorrhea regardless of whether sexual contact is reported during the post-treatment follow-up period. If cephalosporin resistant gonorrhea is suspected consult with delegating physician and contact STD nurse consultant.**
2. Refer to a District Communicable Disease Specialist for prevention counseling and assistance with partner referral.
2. **Consult with delegating physician if signs of Bartholin's gland or Skene's gland abscess or cyst are present.**
3. Consult with delegating physician if patient cannot tolerate cephalosporins, penicillins, or azithromycin.
4. **If patient with pharyngeal gonorrhea is treated with an alternative regimen and has a positive test of cure consult with delegating physician and contact STD Nurse Consultant.**
5. Consult with delegating physician concerning children allergic to cephalosporins or penicillins for desensitization or alternate treatment.

- 6. Hospitalization and consultation with an infectious disease specialist are recommended for initial therapy, of patients diagnosed with disseminated gonococcal infection (DGI). Disseminated gonococcal infection occurs when gonorrhea is not treated and spreads to distant parts of the body beyond the portal of entry. DGI can manifest as rash, arthritis, or flu-like symptoms.**

- 7. Public Health Employees must be familiar with procedures for reporting possible sexual or physical abuse of children if encountered through history or physical. All suspected sexual or physical abuse of children must be reported to the county Department of Family and Children Services office as per Guidelines for Mandatory Reporting of Suspected Child Abuse for Public Health Personnel**
<http://www.dphphil.org/DPH/Policy/Health%20Protection/Child%20Abuse%20Reporting%20Guidelines%20October%202013%20FINAL.pdf>.

- 8. Gram stains are inadequate to evaluate prepubertal children for gonorrhea and should not be used to diagnose or exclude gonorrhea. Specimens from the vagina, urethra, pharynx, or rectum should be streaked onto selective media for isolation of *N. gonorrhoeae*. Consultation with an expert is necessary before using NAATs.**

- 9. Infants exposed to infected mothers during vaginal delivery must be referred to pediatrician for evaluation and possible treatment.**

- 10. Patients with acute arthritis, skin pustules, meningitis or eye infection should be referred immediately for emergency evaluation, treatment and follow up. Delegating physician should be notified of referral.**

- 11. Consult delegating physician when further medical guidance is needed and STD nursing protocol is not applicable for therapeutic treatment of patient.**

REFERENCES

1. **Centers for Disease Control and Prevention, *Sexually Transmitted Diseases Treatment Guidelines 2015*, Vol. 64, No. RR-3, June 5, 2015.**
2. GUIDELINES FOR MANDATORY REPORTING OF SUSPECTED CHILD ABUSE for PUBLIC HEALTH PERSONNEL. (2013, October 1). Retrieved April 1, 2014, from <http://www.dphphil.org/DPH/Policy/Health%20Protection/Child%20Abuse%20Reporting%20Guidelines%20October%202013%20FINAL.pdf>
3. CDC, "Notice to Readers: Discontinuation of Spectinomycin," MMWR, Vol. 55, No. 13, April 7, 2006. <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5513a5.htm>
4. Centers for Disease Control and Prevention, *Update to CDC's Sexually Transmitted Diseases Treatment Guidelines, 2010: Oral Cephalosporins No Longer a Recommended Treatment for Gonococcal Infections*, MMWR, Vol. 61(31), 590-594, August 10, 2012.
5. Medscape: Dr. Robert Kircaldy, M.D., MPH, New Treatment Guidelines for Gonorrhea Antibiotic Change: CDC Expert commentary 201208-13
6. **Holmes, K. K. (2008). *Sexually transmitted diseases*. New York: McGraw-Hill Medical.**
7. **American Academy of Pediatrics., In Pickering, L. K., In Baker, C. J., In Kimberlin, D. W., In Long, S. S., & American Academy of Pediatrics. (2012). Red book: 2012 report of the Committee on Infectious Diseases**

STANDARD NURSE PROTOCOL FOR CHLAMYDIA URETHRITIS/CERVICITIS

- DEFINITION** **Chlamydia is a common sexually transmitted disease caused by bacteria. A sexually transmitted infection that is often asymptomatic in both males and females. Chlamydia is the most commonly reported STD in the United States. Georgia ranks 9th nationally for most reported cases.**
- ETIOLOGY** **Chlamydia trachomatis is an obligate intracellular bacterial agent with at least 18 serologic variants (serovars), which includes LGV. Chlamydia generally infects the columnar epithelial cells and often becomes chronic, lasting months to more than a year if untreated. Incubation is poorly defined but usually at least 1 week. The life cycle of chlamydia is 72 hours.**
- SUBJECTIVE**
1. Frequently asymptomatic in both men and women, **also known as the “silent infection”.**
 2. Sexually acquired chlamydial conjunctivitis can occur through contact with infected genital secretions
 3. Females may have a history of:
 - a. Abnormal discharge from vagina.
 - b. Bleeding after intercourse.
 - c. Dysuria, pyuria, urinary frequency
 4. Males may have a history of:
 - a. Mucoïd or watery urethral discharge
 - b. Itching of urethral meatus.
 - c. Dysuria.
 - d. Pain or swelling of testicles
 - e. Pyuria or urinary frequency
 5. Anal symptoms
 - a. Rectal pain
 - b. Discharge or bleeding
- OBJECTIVE**
1. Many show no clinical signs.
 2. Females
 - a. Mucoïd to mucopurulent endocervical discharge.
 - b. Cervical ectopy/friability.
 3. Males
 - a. Mucoïd to mucopurulent urethral discharge.

- b. Redness at urethral meatus.
- 4. Anal symptoms
 - a. Pain
 - b. Discharge or bleeding
- 5. Positive urethral, endocervical, anal, oral, or urine test (amplification, culture, DNA probe) for *Chlamydia trachomatis*.
NOTE: Nonculture, nonamplified probe tests should not be used for diagnosing preadolescent children.

ASSESSMENT Chlamydia – Urethritis or Cervicitis

PLAN **The desired outcomes of treatment of infected patients are: biologic cure, prevention of pelvic inflammatory disease (PID), ectopic pregnancy and infertility, prevention of transmission to sex partners, and prevention of transmission from infected females to infants during birth. Treatment of sex partners helps to prevent reinfection and sequelae of Chlamydia in the index patient and infection of other partners.**

Chlamydia screening of sexually active women less than 26 years of age is recommended. The primary focus of screening is to detect the infection and prevent complications.

DIAGNOSTIC STUDIES

- 1. Chlamydia test (nucleic acid amplification test (NAAT) or DNA probe.
- 2. Gonorrhea test (nucleic acid amplification test (NAAT), culture, or DNA probe) should always be done when chlamydia is suspected.

THERAPEUTIC

PHARMACOLOGIC

NOTE: Prior to treatment of children, less than 45 kg (**99lbs**), consult with or refer to primary care provider.

NOTE: Any patients who test positive for chlamydia should be tested for gonorrhea, syphilis, and HIV.

RECOMMENDED REGIMEN

- 1. Nonpregnant adults, adolescents, and children who are at least 8 years old:

- a. Azithromycin 1 gm PO, single dose,
OR
- b. Doxycycline 100 mg PO, 2 times a day for 7 days.

NOTE: Do not give Doxycycline to lactating patient(s); patient(s) must be advised to discontinue breastfeeding throughout treatment or receive alternative regimen. If breastfeeding women are pumping during treatment, they should not provide pumped breast milk to infant throughout treatment and for two days after completion of treatment. Do not give Doxycycline to children under the age of 8.

ALTERNATIVE REGIMEN

- a. Erythromycin base 500 mg PO, 4 times a day for 7 days,
OR
- b. Erythromycin Ethylsuccinate 800 mg PO, 4 times a day for 7 days,
OR
- c. Levofloxacin 500 mg once daily for 7 days.
OR
- d. Ofloxacin 300 mg twice daily for 7 days

RECOMMENDED REGIMEN

- 2. If pregnant:
 - a. Azithromycin 1 gm PO, single dose,
OR
 - b. Amoxicillin 500 mg PO, 3 times a day for 7 days,

ALTERNATIVE REGIMEN

- a. Erythromycin base 500 mg PO, 4 times a day for 7 days,
OR
- b. Erythromycin base 250 mg PO, 4 times a day for 14 days,
OR
- c. Erythromycin Ethylsuccinate 800 mg PO, 4 times a day for 7 days,
OR
- d. Erythromycin Ethylsuccinate 400 mg PO, 4 times a day for 14 days.

NOTE: The frequent gastrointestinal side effects associated with erythromycin can result in non-adherence with the alternative regimens. The lower dose 14-day erythromycin regimens can be considered if gastrointestinal tolerance is a concern.

3. Treatment of children under 8 years of age and who weigh less than 45 kg (**99 lbs**):
Erythromycin base or ethylsuccinate 50 mg/kg/day orally divided into 4 doses daily for 14 days.
4. Treatment of children under 8 years of age and who weigh greater than or equal to 45 kg (**99 lbs**):
Azithromycin 1 gm orally in a single dose.
5. HIV infected patients should receive the same treatment regimen as those who are HIV negative.

PATIENT EDUCATION/COUNSELING

(Reinforce pertinent information with handouts)

1. **The name of the infection and its significance. Educate for sequelae and complications of the untreated infection.** (<http://www.cdc.gov/std/chlamydia/chlamydia-factsheet-june-2014.pdf>).
2. Directions for taking medication and management of potential side effects.
3. All sex partners from 60 days prior to the onset of symptoms or diagnosis should be referred for examination and treatment. Refer the last known sex partner if the last sexual contact was greater than 60 days before onset of symptoms or diagnosis. Provide written note(s) to give to partners to refer them in for exam and treatment.
4. Women who are breastfeeding should not receive Doxycycline. If Doxycycline is given to breastfeeding women they should discontinue breastfeeding throughout treatment and for two days after completion of treatment. If breastfeeding women are pumping during treatment, they should not provide pumped breast milk to infant throughout treatment and for two days after completion of treatment.

5. Counsel the patient about high risk of reinfection if patient's partner(s) is not tested and treated. The usages of protective barriers (diaphragm, condoms, etc.) are not a substitute for protection during sexual intercourse for an untreated partner(s).
6. Educate patients who receive Azithromycin about adverse effects (QT Prolongation, torsades de pointes, etc.) and document the patient's understanding.
<http://www.fda.gov/downloads/Drugs/DrugSafety/UCM343347.pdf>
7. Abstain from intercourse until 7 days after taking azithromycin or until the 7 days Doxycycline regimen has been completed. Abstain from sex till sex partner(s) have been treated.
8. Advise the patient(s) to return to clinic for all lab results. Inform patient(s) if lab results are positive additional treatment may be needed.
9. Education and counseling on the correct usage of protective barriers (condoms, dental dams, etc.).
10. If patient is of childbearing age, counsel on the use of contraceptives to reduce the risk of unintended pregnancy.
11. Assist patient in developing a personalized STD/HIV risk reduction plan and document patients plan. Abstain from sex until all the symptoms are resolved and partner(s) are tested and treated.
12. Hepatitis A, Hepatitis B and/or HPV vaccine if patient is unvaccinated. To verify eligibility criteria for state supplied vaccines go to:
<http://dph.georgia.gov/sites/dph.georgia.gov/files/Immunizations/Publications-GA-Imm-Manual-Complete.pdf> and
http://dph.georgia.gov/sites/dph.georgia.gov/files/photo_gallery/February%202015%20Vaccine%20Eligibility%20table_0.pdf
13. HIV antibody test to determine HIV status, if unknown.

MANAGEMENT OF SEX PARTNERS

1. **All sex partners from 60 days prior to symptoms or diagnosis should be referred for examination and treatment. Refer the last sex partner if the last sexual contact occurred prior to 60 days. Provide written note(s) to give to partners to refer them in for exam and treatment.**

2. All sex partners, as defined above, should be examined and promptly treated with one of the above regimens for chlamydia.

FOLLOW-UP

1. Non-pregnant adults/adolescents do not require a test-of-cure unless therapeutic compliance is in question, symptoms persist, or reinfection is suspected.
2. Children should receive follow-up cultures to ensure that treatment has been effective.
3. Pregnant females should be retested 3-4 weeks after completing therapy, and rescreened near time of delivery.
4. Chlamydia infected women (nonpregnant or pregnant) and men should be retested approximately 3 months after treatment, regardless of whether they believe that their sex partners were treated. If retesting at 3 months is not possible, clinicians should retest the next time the patient(s) presents for medical care in the 12 months following initial treatment.

CONSULTATION/REFERRAL

1. If pregnant patient cannot tolerate medication refer to OB/GYN or OB provider.
2. Consult with delegating physician if signs of Bartholin's gland **or Skene's gland abscess or cyst are present.**
3. Signs and symptoms of prostatitis (blood in the urine, painful ejaculation or sexual dysfunction)
4. Signs and symptoms of reactive arthritis. People who have chlamydia are at higher risk of developing reactive arthritis, **formerly** known as Reiter's syndrome. This condition typically affects the joints, eyes and urethra.
5. Prior to treatment of children, less than 45 kg (**99 lbs**) consult with or refer to primary care provider.
6. Public Health Employees must be familiar with procedures for reporting possible sexual or physical abuse of children if encountered through history or physical.

All suspected sexual or physical abuse of children must be reported to the county Department of Family and Children Services office as per Guidelines for Mandatory Reporting of Suspected Child Abuse for Public Health Personnel, which may be viewed on the Public Health Information Library (PHIL) at <http://www.dphphil.org/DPH/Policy/Health%20Protection/Child%20Abuse%20Reporting%20Guidelines%20October%202013%20FINAL.pdf>.

7. Consult delegating physician when further medical guidance is needed and STD nursing protocol is not applicable for therapeutic treatment of patient.

REFERENCES

1. **Centers for Disease Control and Prevention, Sexually Transmitted Diseases Treatment Guidelines 2015, Vol. 64, No. RR-3, June 5, 2015.**
2. GUIDELINES FOR MANDATORY REPORTING OF SUSPECTED CHILD ABUSE for PUBLIC HEALTH PERSONNEL. (2013, October 1). . Retrieved April 1, 2014, from <http://www.dphphil.org/DPH/Policy/Health%20Protection/Child%20Abuse%20Reporting%20Guidelines%20October%202013%20FINAL.pdf>
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STANDARD NURSE PROTOCOLS FOR BACTERIAL VAGINOSIS (BV)

- DEFINITION** **An infection caused when too much of certain bacteria change the normal balance of bacteria in the vagina.** The clinical result of the replacement of the normal *Lactobacillus* species in the vagina with high concentrations of anaerobic bacteria. This polymicrobial clinical syndrome is the most prevalent cause of vaginal discharge or malodor; however, half of the women whose illnesses meet the clinical criteria for BV are asymptomatic. Though associated with having multiple sex partners, it is unclear whether BV results from acquisition of a sexually transmitted pathogen. Treatment of male sex partners has not been beneficial in preventing recurrences.
- BV has been associated with adverse pregnancy outcomes (e.g., premature rupture of membranes, preterm labor, and preterm birth). Some specialists recommend the screening of high-risk pregnant women (i.e., those who have previously delivered a premature infant) for BV at the first prenatal visit.
- ETIOLOGY** High concentrations of anaerobic bacteria (e.g., Prevotella species and Mobiluncus species), Gardnerella vaginalis, and Mycoplasma hominus, **Ureaplasma species, and anaerobic bacteria and decrease in concentration of Lactobacillus species. Incubation period is unknown.**
- SUBJECTIVE** 1. **Frequently asymptomatic.**
2. **White or gray vaginal discharge.**
3. **A strong, offensive, fish-like odor that is often most noticeable after intercourse.**
4. **Pain, itching, or burning in the vagina may occur.**
5. **Dysuria.**
- OBJECTIVE** The following criteria are used to diagnose bacterial vaginosis.
1. At least 3 of the following 4 are present (Amsel's Diagnostic Criteria):
- a. Homogeneous, white, non-inflammatory discharge that smoothly coats the vaginal walls.
- b. The pH of vaginal secretions is higher than 4.5.

- c. A "fishy" odor of vaginal discharge, before or after mixing it with 10% KOH (positive "whiff" test).
- d. "Clue cells" (epithelial cells with a granular appearance caused by adherent bacteria) on microscopic wet mount of vaginal discharge.

ASSESSMENT Bacterial Vaginosis

PLAN **The desired outcomes of treatment of non-pregnant females with BV are: relief of vaginal symptoms and signs of infection, reduce the risk for infectious complications after abortion or hysterectomy, and reduce the risk of getting an STD.**

DIAGNOSTIC STUDIES

1. Amsel's Diagnostic Criteria (observation for classic discharge, clue cells, "whiff" test and vaginal pH).
2. Check history for possible pregnancy.

THERAPEUTIC

Treatment is only recommended for women with symptoms.

PHARMACOLOGIC

NOTE: Metronidazole is a FDA Category B drug. Metronidazole should only be used in confirmed 2nd and 3rd trimester of pregnancy. Lactating women taking metronidazole should withhold breastfeeding during treatment and for 24 hours after last dose to reduce infant's exposure to drug.

Clindamycin is distributed into milk following systemic administration; it is not known if it is distributed into milk following intravaginal application but, because of the potential for adverse effects/reactions to clindamycin in nursing infants, a decision should be made whether to discontinue breastfeeding or to discontinue the drug, taking into account the importance of the drug to the woman.

NOTE: HIV infected patients who are diagnosed with BV should receive the same treatment regimen as those who are not HIV infected.

RECOMMENDED REGIMEN

If patient is not pregnant,

- a. Metronidazole 500 mg PO, 2 times a day for 7 days,
OR
- b. Metronidazole gel, 0.75%, one full applicator (5 gm),
intravaginally, once a day for 5 days,
OR
- c. Clindamycin cream, 2%, one full applicator (5 gm),
intravaginally, at bedtime for 7 days,

ALTERNATIVE REGIMEN

- a. Clindamycin 300 mg PO, 2 times a day for 7 days.

RECOMMENDED REGIMEN

NOTE: Refer pregnant women in their 1st trimester to their OB/GYN or OB provider.

If patient is pregnant beyond 1st trimester,

- a. Metronidazole 250 mg PO, 3 times a day for 7 days
(during 2nd or 3rd trimesters only).

ALTERNATIVE REGIMEN

- a. Clindamycin 300 mg PO, 2 times a day for 7 days.

PATIENT EDUCATION/COUNSELING

(Reinforce pertinent information with handouts)

1. **The name/significance of the infection. Educate for sequelae and complications of the untreated infection (<http://www.cdc.gov/std/bv/bv-fact-sheet-march-2014.pdf>).**
2. Directions for taking medication and management of potential side effects (e.g., to avoid alcoholic beverages and other alcohol-containing products until 24 hours following completion of metronidazole therapy); instructions to lactating patients regarding discontinuance of breastfeeding for the same length of time.
3. The infection is generally not considered to be sexually transmitted, so sex partners should be referred for examination only if they are symptomatic of possible STD. Otherwise no treatment is necessary for sex partners.

4. Education and counseling of the correct usage of protective barriers (condoms, dental dams, etc.).
5. BV is associated with high recurrence placing women at higher risk of other STDs.
6. Advise the patient to return to clinic for all lab results. Inform patient if lab results are positive additional treatment may be needed.
7. Instruct patient to return for reevaluation if symptoms persist.
8. Assist patient in developing a personalized STD/HIV risk reduction plan and document patient's plan. Abstain from sex until all the symptoms are resolved and partner(s) are tested and treated.
9. If patient is of childbearing age, counsel on the use of contraceptives to reduce the risk of unintended pregnancy.
10. HIV antibody test to determine HIV status, if unknown.
11. Hepatitis A, Hepatitis B and/or HPV vaccine if patient is unvaccinated. To verify eligibility criteria for state supplied vaccines go to:
<http://dph.georgia.gov/sites/dph.georgia.gov/files/Immunizations/Publications-GA-Imm-Manual-Complete.pdf> and
http://dph.georgia.gov/sites/dph.georgia.gov/files/photo_gallery/February%202015%20Vaccine%20Eligibility%20table_0.pdf

FOLLOW-UP

Patient should return only if symptoms persist after treatment, or recur. Use an alternative treatment regimen for recurrent disease.

Note: Clinical cure is the resolution of all symptoms (Amsel's Diagnostic Criteria) 21-30 days after treatment.

CONSULTATION/REFERRAL

1. Refer to OB/GYN or OB provider if (three or more) recurrences within 6 months that do not respond to alternative treatment regimens.
2. Public Health Employees must be familiar with procedures for reporting of possible sexual abuse of children if encountered through history, physical.

All suspected sexual abuse of children must be reported to the county Department of Family and Children Services office as per Guidelines for Mandatory Reporting of Suspected Child Abuse for Public Health Personnel, which may be viewed on the Public Health Information Library (PHIL) at

<http://www.dphphil.org/DPH/Policy/Health%20Protection/Child%20Abuse%20Reporting%20Guidelines%20October%202013%20FINAL.pdf>.

3. Consult delegating physician for repeated visit for BV for long term therapy.
4. Consult delegating physician when further medical guidance is needed and STD nursing protocol is not applicable for therapeutic treatment of patient.

REFERENCES

1. **Centers for Disease Control and Prevention, Sexually Transmitted Diseases Treatment Guidelines 2015, Vol. 64, No. RR-3, June 5, 2015..**
2. U.S. Preventive Services Task Force. Screening for bacterial vaginosis in pregnancy to prevent preterm delivery: recommendation statement. *Ann Intern Med* 2008; 148:214–9.
3. Myer L, Kuhn L, Stein ZA, et al. Intravaginal practices, bacterial vaginosis, and women’s susceptibility to HIV infection: epidemiological evidence and biological mechanisms. *Lancet Infect Disease* 2005; 5:786–94.
4. Guidelines Burke A. Cunha, M.D., *Antibiotic Essentials*, 8th edition, Physician’s Press, Royal Oak, Michigan, 2009
5. GUIDELINES FOR MANDATORY REPORTING OF SUSPECTED CHILD ABUSE for PUBLIC HEALTH PERSONNEL. (2013, October 1). . Retrieved April 1, 2014, from <http://www.dphphil.org/DPH/Policy/Health%20Protection/Child%20Abuse%20Reporting%20Guidelines%20October%202013%20FINAL.pdf>
6. **Holmes, K. K. (2008). Sexually transmitted diseases. New York: McGraw-Hill Medical.**
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STANDARD NURSE PROTOCOL FOR TRICHOMONIASIS

DEFINITION

A sexually transmitted infection of the urogenital tract, most commonly found in the urethra and the vagina in women. Trichomoniasis is considered the most common curable STD.

Vaginal trichomonas has been associated with adverse pregnancy outcomes, particularly premature rupture of the membranes, preterm delivery, and low birthweight. High risk populations include (1) those with multiple sex partners, (2) those with a history of STDs, (3) those that exchange sex for payment and use injecting drugs.

ETIOLOGY

Trichomonas vaginalis, a **flagellated** protozoan with an undulating membrane and flagella. **The incubation period averages one week but ranges from 5 to 28 days.**

SUBJECTIVE

1. May be asymptomatic, especially in males. In males, may present as Non Gonococcal Urethritis
2. **Male symptoms may include:**
 - a. **Itching and irritation inside the penis.**
 - b. **Dysuria or burning after ejaculation.**
 - c. **Penile discharge.**
3. **Female symptoms may include:**
 - a. **Itching, soreness and burning in vaginal area.**
 - b. **Dysuria.**
 - c. **Discharge with an offensive odor.**
 - d. **Vulvar irritation.**

OBJECTIVE

1. **May be asymptomatic in both females and males.**
2. Profuse, yellow-green malodorous vaginal discharge.
3. Vulvar inflammation with edema or excoriations.
4. Cervix may have a granular appearance with punctate hemorrhages ("strawberry cervix").

LABORATORY FINDINGS (with or without objective findings)

1. Typical motile trichomonads seen on wet mount of vaginal discharge. (wet mount sensitivity: **51% to 65%**)

OR

2. Identification of *T. vaginalis* on culture.

OR

3. Identification of Trichomonas on Pap smear.

NOTE: If Trichomonas is identified on Pap smear, may treat presumptively or refer to PMD.

NOTE: NAATs transcription-mediated amplification (TMA) or PCR are diagnostic options for testing men. Consult with your District Administration and GPLH about the availability of testing and processing. This diagnostic test option is not available through the STD **Program**.

ASSESSMENT

Trichomoniasis

PLAN

The desired outcomes of treatment for patients and sex partners are: relief of symptoms, microbiologic cure, and reduction of transmission and potential infection with other STDs.

DIAGNOSTIC STUDIES

1. Wet Preparation (saline, 10% KOH).

THERAPEUTIC

NOTE: Any patients who test positive for trichomoniasis should be tested for gonorrhea, chlamydia, syphilis, and HIV.

PHARMACOLOGIC

1. If patient is not pregnant
 - a. Metronidazole 2 gm PO, in a single dose.

OR

 - b. Metronidazole 500 mg PO, 2 times a day for 7 days.
2. If patient is pregnant (confirmed second and third trimester only)
Metronidazole 2 gm PO, in a single dose.
3. If patient is HIV infected treat with Metronidazole 500 mg PO, 2 times a day for 7 days.

NOTE: Metronidazole is a FDA Category B drug. Metronidazole should only be used in confirmed 2nd and 3rd trimester of pregnancy (see Consultation/Referral). Lactating women taking metronidazole should withhold breastfeeding during treatment and for 12-24 hours after

the last dose to reduce infant's exposure to the drug.

PATIENT EDUCATION/COUNSELING

(Reinforce pertinent information with handouts)

1. **The name/significance of the infection. Educate for sequelae and complications of the untreated infection**
<http://www.cdc.gov/std/trichomonas/trich-fact-sheet-aug-2012.pdf>.
2. Directions for taking medication and list of possible side effects.
3. Avoid alcohol-containing products within 24 hours of treatment.
4. Refer all sex partner(s) from within 60 days prior to the onset of symptoms or diagnosis of trichomoniasis for examination and treatment. Refer the last sex partner if the last sexual contact occurred prior to 60 days. Provide written note(s) to give to partners to refer them in for exam and treatment.
5. Advise the patient to return to clinic for all lab results even if presumptively treated at initial visit. Inform patient if lab results are positive additional treatment may be needed.
6. Education and counseling of the correct usage of protective barriers (condoms, dental dams, etc.).
7. If patient is of childbearing age, counsel on the use of contraceptives to reduce the risk of unintended pregnancy.
8. Avoid sex until partner(s) has been treated.
9. Assist patient in developing a personalized STD/HIV risk reduction plan and document patient's plan. Abstain from sex until all the symptoms are resolved and partner(s) are tested and treated.
10. Women who are breastfeeding should withhold breastfeeding during treatment and for 12-24 hours after the last dose to reduce child's exposure to the drug.
11. HIV antibody test to determine HIV status, if unknown.

12. Hepatitis A, Hepatitis B and or HPV vaccine if patient is unvaccinated. To verify eligibility criteria for state supplied vaccines go to:
<http://dph.georgia.gov/sites/dph.georgia.gov/files/Immunizations/Publications-GA-Imm-Manual-Complete.pdf> and
http://dph.georgia.gov/sites/dph.georgia.gov/files/photo_gallery/February%202015%20Vaccine%20Eligibility%20table_0.pdf

MANAGEMENT OF SEX PARTNERS

All sex partners (asymptomatic and symptomatic) from 60 days prior to onset of symptoms or diagnosis should be examined and treated promptly with one of the above regimens.

FOLLOW-UP

Patient should return only if symptoms persist after treatment, or recur. Re-treat with the 7-day regimen of metronidazole if 4-6 weeks have elapsed since previous treatment and presence of trichomonads has been reconfirmed (see medication package insert).

CONSULTATION/REFERRAL

1. Refer pregnant patients in first trimester who have tested positive for trichomoniasis to their OB/GYN or OB provider.
2. Consult with delegating physician if patient is allergic to metronidazole for desensitization referral.
3. Consult with delegating physician of repeated treatment failure. (Assure that partner(s) have been treated, to rule out reinfection).
4. Public Health Employees must be familiar with procedures for reporting possible sexual or physical abuse of children if encountered through history or physical. All suspected sexual or physical abuse of children must be reported to the county Department of Family and Children Services office as per Guidelines for Mandatory Reporting of Suspected Child Abuse for Public Health Personnel, which may be viewed on the Public Health Information Library (PHIL) at
<http://www.dphphil.org/DPH/Policy/Health%20Protection/Child%20Abuse%20Reporting%20Guidelines%20October%202013%20FINAL.pdf>.
5. Consult delegating physician when further medical guidance is needed and STD nursing protocol is not applicable to treat patient.

REFERENCES

1. **Centers for Disease Control and Prevention, Sexually Transmitted Diseases Treatment Guidelines 2015, Vol. 64, No. RR-3, June 5, 2015.**
2. **GUIDELINES FOR MANDATORY REPORTING OF SUSPECTED CHILD ABUSE for PUBLIC HEALTH PERSONNEL. (2013, October 1). . Retrieved April 1, 2014, from <http://www.dphphil.org/DPH/Policy/Health%20Protection/Child%20Abuse%20Reporting%20Guidelines%20October%202013%20FINAL.pdf>**
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4. **American Academy of Pediatrics., In Pickering, L. K., In Baker, C. J., In Kimberlin, D. W., In Long, S. S., & American Academy of Pediatrics. (2012). Red book: 2012 report of the Committee on Infectious Diseases.**

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**STANDARD NURSE PROTOCOL FOR
UNCOMPLICATED VULVOVAGINAL CANDIDIASIS (VVC)
(Yeast infection)**

DEFINITION	A common vulvo vaginal infection that may occasionally also cause cutaneous penile lesions in male sex partners (ex. Candidal balanitis), but is not always considered to be an STD. An estimated 75% of women will experience at least one episode of VVC during their life-time, and 40-45% will have two or more episodes.
ETIOLOGY	Most infections are caused by <i>Candida albicans</i> which grows as oval budding yeast cells and pseudohyphae and thrives best when the vaginal pH is 4.5 to 5. Other <i>Candida</i> species or yeasts may occasionally cause similar symptoms. The incubation period is unknown.
SUBJECTIVE	<ol style="list-style-type: none">1. Vulvovaginal itching.2. Thick, curdy vaginal discharge.3. May have vaginal soreness, pain with intercourse, vulvar burning and external dysuria.4. Redness and swelling of the vulva.
OBJECTIVE	DIAGNOSTIC CRITERIA NOTE: Many women are asymptomatic. Symptoms are caused by overgrowth of normally occurring yeast forms. Contributing factors, which disrupt the normally protective vaginal flora include: medications, diabetes, HIV, pregnancy, and other immuno-suppressive conditions. <ol style="list-style-type: none">1. Pruritis and erythema in the vulvovaginal area. A thick white, cottage cheese like vaginal discharge may be present. AND/OR2. Vaginal pH less than 4.5. AND/OR3. Identification of typical budding yeast or pseudohyphae on microscopic exam of vaginal discharge, by saline or adding 10% KOH solution to wet mount.
ASSESSMENT	Vulvovaginal Candidiasis (VVC)

PLAN

The desired outcome of treatment is the relief of symptoms, microbiologic cure, and reduction of transmission and potential infection with other STDs.

DIAGNOSTIC STUDIES

NOTE: Vulvovaginal candidiasis is an important concern for women with HIV infection. The colonization rates of candida have shown to be higher in HIV-infected women than HIV negative women, although the relationship of vulvovaginal candidiasis to HIV infection remains unclear.

1. Wet preparation (10% KOH, saline)

THERAPEUTIC

PHARMACOLOGIC

1. Intravaginal agents

Non-pregnant patients:

- a. *Butoconazole 2% cream, 5 gm, one applicatorful intravaginally for 3 days,
OR
- b. *Clotrimazole 1% cream, 5 gm, one applicatorful intravaginally for 7-14 days,
OR
- c. *Miconazole 100 mg vaginal suppository, one suppository for 7 days,
OR
- d. *Miconazole 200 mg vaginal suppository, one suppository for 3 days,
OR
- e. *Miconazole 2% cream, 5 gm, one applicatorful intravaginally for 7 days,
OR
- f. Nystatin 100,000-unit vaginal tablet, one tablet intravaginally for 14 days,
OR
- g. *Tioconazole 6.5% ointment, 5 gm, intravaginally in a single application,
OR
- h. Terconazole 0.4% cream 5 gm, one applicatorful intravaginally for 7 days,
OR
- i. Terconazole 80 mg vaginal suppository, one suppository for 3 days,

OR

- j. Terconazole 0.8% cream 5 gm, one applicatorful, intravaginally for 3 days.

*Available without a prescription.

OR

- 2. Oral agent:

Non-pregnant patients:

- a. Fluconazole (Diflucan) 150 mg PO, once.

NON-PHARMACOLOGIC MEASURES

Keep irritated vulvovaginal area as clean and dry as possible.

PATIENT EDUCATION/COUNSELING

(Reinforce pertinent information with handouts)

- 1. **The name/significance of the infection. Educate for sequelae and complications of untreated infection:**
<http://www.cdc.gov/fungal/diseases/candidiasis/genital/index.html>
- 2. Directions for treatment.
- 3. Although many preparations of intravaginal agents are available without a prescription, self-medication is advised only for women who have been previously diagnosed with VVC and who experience a recurrence of the same symptoms.
- 4. Butoconazole and clotrimazole cream, tioconazole ointment, and miconazole creams and suppositories are oil-based and may weaken latex condoms and diaphragms, therefore other methods of contraception should be used.
- 5. If taking fluconazole (Diflucan), noticeable improvement in symptoms may not occur for a few days. Even with a single dose, nausea, vomiting, diarrhea, abdominal pain and headache may occur.
- 6. Education and counseling of the correct usage of protective barriers (condoms, dental dams, etc.).
- 7. If patient is of childbearing age, counsel on the use of contraceptives to reduce the risk of unintended pregnancy

8. Assist patient in developing a personalized STD/HIV risk reduction plan and document patient's plan. Abstain from sex until all the symptoms are resolved.
9. Advise the patient to return to clinic for all lab results even if presumptively treated at initial visit.

Inform patient if lab results are positive additional treatment may be needed.
10. HIV antibody test to determine HIV status, if unknown.
11. Hepatitis A, Hepatitis B and/or HPV vaccine if patient is unvaccinated. To verify eligibility criteria for state supplied vaccines go to:
<http://dph.georgia.gov/sites/dph.georgia.gov/files/Immunizations/Publications-GA-Imm-Manual-Complete.pdf> and
http://dph.georgia.gov/sites/dph.georgia.gov/files/photo_gallery/February%202015%20Vaccine%20Eligibility%20table_0.pdf

MANAGEMENT OF SEX PARTNERS

No routine exam and/or treatment is necessary, but may be considered in females with recurrent infections. A minority of male sex partners who have balanitis, characterized by erythematous areas on the glans of the penis in conjunction with pruritus or irritation, can benefit from treatment with over-the-counter topical antifungal agents to relieve symptoms.

FOLLOW-UP

Only if symptoms persist or recur within 2 months of the initial symptoms.

CONSULTATION/REFERRAL

1. Consult delegating physician for referral of patients with frequent recurrent episodes not responding to usual therapy. Women who experience four (4) or more episodes of VVC within a year are described as having Recurrent Vulvovaginal Candidiasis (RVVC). Risk factors include uncontrolled diabetes mellitus, immunosuppression, and corticosteroid use, but most women who have RVVC have no apparent predisposing conditions. HIV status of the patient, if known, needs to be provided to the consulting delegating physician.
2. Refer pregnant and/or lactating women to their OB/GYN or OB provider for treatment.

3. Public Health Employees must be familiar with procedures for reporting possible sexual or physical abuse of children if encountered through history or physical. All suspected sexual or physical abuse of children must be reported to the county Department of Family and Children Services office as per Guidelines for Mandatory Reporting of Suspected Child Abuse for Public Health Personnel, which may be viewed on the Public Health Information Library (PHIL) at:
<http://www.dphphil.org/DPH/Policy/Health%20Protection/Child%20Abuse%20Reporting%20Guidelines%20October%202013%20FINAL.pdf>.
4. Consult delegating physician when further medical guidance is needed and STD nursing protocol is not applicable for therapeutic treatment of patient.

REFERENCES

1. **Centers for Disease Control and Prevention, Sexually Transmitted Diseases Treatment Guidelines 2015, Vol. 64, No. RR-3, June 5, 2015.**
2. GUIDELINES FOR MANDATORY REPORTING OF SUSPECTED CHILD ABUSE for PUBLIC HEALTH PERSONNEL. (2013, October 1). . Retrieved April 1, 2014, from <http://www.dphphil.org/DPH/Policy/Health%20Protection/Child%20Abuse%20Reporting%20Guidelines%20October%202013%20FINAL.pdf>
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STANDARD NURSE PROTOCOL FOR PELVIC INFLAMMATORY DISEASE (PID)

DEFINITION **An infection of a woman’s reproductive organs and a complication caused by untreated STDs, like chlamydia and gonorrhea.** The clinical syndrome resulting from the ascending spread of microorganisms from the vagina and endocervix to the endometrium, the fallopian tubes or to contiguous structures.

If untreated, acute infections may result in peritonitis caused by rupture of a tubo-ovarian abscess, and acute or subclinical infections may result in chronic pain, pelvic adhesions, involuntary infertility or ectopic pregnancy.

The intensity of symptoms may vary widely, from mild to acute. Many episodes of PID go unrecognized. Although some women may have asymptomatic PID, many have mild or non-specific symptoms or signs such as abnormal bleeding, dyspareunia or vaginal discharge. Experts recommend that providers maintain a low threshold of diagnosis for PID and recognize when PID should be suspected.

ETIOLOGY Sexually transmitted organisms, especially *Neisseria gonorrhoeae* and *Chlamydia trachomatis* are implicated in most cases of PID; however, organisms not usually associated with sexual transmission, such as anaerobes, Gram-negative facultative bacteria and streptococci may also be involved. **The incubation period for PID is undefined.**

SUBJECTIVE **SYMPTOMS**

1. Mild to moderate lower abdominal pain or tenderness.
2. **Vaginal discharge with or without a bad odor from vagina.**
3. **Dyspareunia** and/or bleeding after sex.
4. Fever and chills.
5. Anorexia, nausea.
6. **Bleeding between periods.**

HISTORY

1. May have a history of exposure to gonorrhea or chlamydia.

2. May have a history of previous PID, recent insertion of an IUD, or onset of symptoms during the first 5-10 days of the menstrual cycle.

OBJECTIVE

The following criteria are used to diagnose pelvic inflammatory disease:

1. A high index of suspicion must be kept in sexually active females. Minimum criteria to institute empiric treatment in sexually active young females and other females at risk for STDs:

Cervical motion tenderness,
AND/OR
Uterine/adnexal tenderness.
2. Additional criteria that support a diagnosis of PID include:
 - a. Abnormal cervical or vaginal mucopurulent discharge.
 - b. Presence of white blood cells (WBCs) on saline microscopy of vaginal secretions.
 - c. Laboratory documentation of cervical infection with *N. gonorrhoeae* or *C. trachomatis*.
 - d. Oral temperature may be 101° F (38.3° C) or higher.

NOTE: If the cervical discharge appears normal and no white blood cells are found on the wet prep, the diagnosis of PID is unlikely and an alternative diagnosis needs to be considered.
3. Wet prep of vaginal fluid to detect presence of concomitant infection (e.g., BV and Trichomonas).

ASSESSMENT

Pelvic Inflammatory Disease (PID)

PLAN

The desired outcome of treatment is: to demonstrate substantial clinical improvement within 3 days after initiation of therapy, with subsequent resolution of all signs and symptoms, prevention of formation of scar tissue both outside and inside the fallopian tubes that can lead to tubal blockage, ectopic pregnancy, infertility and long-term pelvic/abdominal pain.

DIAGNOSTIC STUDIES

1. Tests for gonorrhea and chlamydia.
2. Pelvic examination for cervical motion tenderness, uterine tenderness, or adnexal tenderness.
3. Pelvic examination for cervical exudates or cervical friability.

4. Wet Preparation (saline, 10% KOH).
5. Pregnancy test if there is a possibility that patient may be pregnant (see Consultation/Referral).

THERAPEUTIC

PHARMACOLOGIC

NOTE: Any patients who test positive for gonorrhea or chlamydia should be tested for syphilis and HIV.

NON-PREGNANT OR HIV INFECTED ADULT/ADOLESCENT:

RECOMMENDED REGIMEN

Ceftriaxone 250 mg IM, single dose,

PLUS

Doxycycline 100 mg PO, 2 times a day for 14 days
(only if at least age 8),

PLUS

Metronidazole 500 mg PO, 2 times a day for 14 days may be added for coverage of anaerobic organisms. It will also effectively treat bacterial vaginosis (BV), which is frequently associated with PID.

NOTE: Do not give Doxycycline to lactating patient(s); patient(s) must be advised to discontinue breastfeeding or receive alternative regimen. If breastfeeding women are pumping during treatment, they should not provide pumped breast milk to infant throughout treatment and for two days after completion of treatment. Breastfeeding can be restarted 2 days after completion of treatment. Do not give to children under the age of 8.

ALTERNATIVE REGIMEN

Cefoxitin 2g IM and Probenecid 1g

PLUS

Doxycycline 100 mg PO twice a day for 14 days

PLUS

Metronidazole 500 mg PO twice a day for 14 days may be added for coverage of anaerobic organisms. It will also effectively treat bacterial vaginosis (BV), which is frequently associated with PID.

OR

Ceftriaxone 250 mg IM, single dose,

PLUS

Azithromycin 1g PO once and repeat Azithromycin 1 gm in 1 week,

PLUS

Metronidazole 500 mg PO, 2 times a day for 14 days may be added for coverage of anaerobic organisms. It will also effectively treat bacterial vaginosis (BV), which is frequently associated with PID.

NOTE: Metronidazole is a FDA Category B drug. Metronidazole should only be used in confirmed 2nd and 3rd trimester of pregnancy. Metronidazole should not be used for treatment during the first trimester of pregnancy. **If metronidazole is given to breastfeeding women they should discontinue breastfeeding until two days after treatment is completed. If breastfeeding women are pumping during treatment, they should not provide pumped breast milk to infant throughout treatment and for two days after completion of treatment to reduce child's exposure to metronidazole and Doxycycline.**

PATIENT EDUCATION/COUNSELING

(Reinforce pertinent information with handouts)

1. **The name/significance of the infection. Educate for sequelae and complications of the untreated infection (<http://www.cdc.gov/std/pid/pid-fact-sheet-july-2014.pdf>).**
2. Directions for taking medication and what to do about potential side effects.
3. Return appointment for evaluation in 3 days.
4. Refer all sex partner(s) within 60 days prior to the onset of symptoms for examination and treatment. Avoid sex until partner has been treated. Refer the last known sex partner if the last sexual contact was greater than 60 days before the onset of symptoms or diagnosis.
5. Counsel to avoid sex with untreated partners.
6. **Women who are breastfeeding should not receive Doxycycline. If Doxycycline is given to breastfeeding women they should discontinue breastfeeding throughout treatment and for two days after completion of treatment.**

If breastfeeding women are pumping during treatment, they should not provide pumped breast milk to infant throughout treatment and for two days after completion of treatment.

7. If the patient is diabetic, received ceftriaxone therapy, and is using the ACCU-CHEK Compact Plus system, they should stop using the ACCU-CHEK Compact Plus system and begin using an alternate blood glucose monitoring system for the duration of this therapy and for 2 full days after the last treatment because it may lead to incorrect low glucose results.
8. Assist patient in developing a personalized STD/HIV risk reduction plan and document patients plan. Abstain from sex until all the symptoms are resolved and partner(s) are tested and treated.
9. Education and counseling of the correct usage of protective barriers (condoms, dental dams, etc.).
10. If patient is of childbearing age, counsel on the use of contraceptives to reduce the risk of unintended pregnancy.
11. Instruct patient to go to Emergency Room if symptoms worsen.
12. Advise the patient to return to clinic for all lab results even if presumptively treated at initial visit. Inform patient if lab results are positive additional treatment may be needed.
13. HIV antibody test to determine HIV status, if unknown.
14. Hepatitis A, Hepatitis B and or HPV vaccine if patient is unvaccinated. To verify eligibility criteria for state supplied vaccines go to:
<http://dph.georgia.gov/sites/dph.georgia.gov/files/Immunizations/Publications-GA-Imm-Manual-Complete.pdf> and
http://dph.georgia.gov/sites/dph.georgia.gov/files/photo_gallery/February%202015%20Vaccine%20Eligibility%20table_0.pdf

MANAGEMENT OF SEX PARTNERS

All sex partners from 60 days prior to the onset of symptoms or diagnosis should be examined for STDs and promptly treated with a regimen effective against both gonorrhea and chlamydia, regardless of symptoms or Gram stain or other test results. Male sex partners of females with PID caused by chlamydia or gonorrhea often are asymptomatic

FOLLOW-UP

1. Evaluation, by bimanual examination, within 72 hours after initiation of therapy for symptomatic improvement. Also discuss medication compliance and stress importance of completing therapy.
2. Suggest repeat examination, and rescreening tests for patients diagnosed with gonorrhea and chlamydia, 3-6 months after completing therapy.

CONSULTATION/REFERRAL

1. Treatment must be instituted as soon as possible. If a referral is made to an APRN or **physician** to confirm the diagnosis, begin treatment before the referral is made, unless the APRN or **physician** is on-site and can see the patient immediately.
2. Consult with delegating physician immediately, for possible hospitalization and/or parenteral treatment when:
 - a. Surgical emergencies such as appendicitis cannot be excluded.
 - b. The patient is pregnant.
 - c. The patient has failed to respond clinically to oral therapy.
 - d. The patient is unable to follow or tolerate an outpatient oral regimen.
 - e. The patient has signs of a severe illness, nausea and vomiting, or a high fever.
3. **If a patient with an IUD does not respond to treatment of clinical improvement within 48-72 hours of initiating treatment** consult with delegating physician for possible IUD removal and contraceptive counseling.
4. Public Health Employees must be familiar with procedures for reporting possible sexual or physical abuse of children if encountered through history or physical. All suspected sexual or physical abuse of children must be reported to the county Department of Family and Children Services office as per Guidelines for Mandatory Reporting of Suspected Child Abuse for Public Health Personnel, which may be viewed on the Public Health Information Library (PHIL) at <http://www.dphphil.org/DPH/Policy/Health%20Protection/Child%20Abuse%20Reporting%20Guidelines%20October%202013%20FINAL.pdf>.
5. Consult delegating physician when further medical guidance is needed and STD nursing protocol is not applicable for therapeutic treatment of patient.

REFERENCES

1. **Centers for Disease Control and Prevention, Sexually Transmitted Diseases Treatment Guidelines 2015, Vol. 64, No. RR-3, June 5, 2015.**
2. GUIDELINES FOR MANDATORY REPORTING OF SUSPECTED CHILD ABUSE for PUBLIC HEALTH PERSONNEL. (2013, October 1). . Retrieved April 1, 2014, from <http://www.dphphil.org/DPH/Policy/Health%20Protection/Child%20Abuse%20Reporting%20Guidelines%20October%202013%20FINAL.pdf>
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STANDARD NURSE PROTOCOL FOR EPIDIDYMITIS, SEXUALLY TRANSMITTED

DEFINITION	A clinical syndrome characterized by inflammation of the epididymis causing pain and tenderness, associated with urethritis that may be asymptomatic, usually occurring in men less than 35 years of age. (Epididymitis occurring in men over 35 years of age is usually nonsexual and may be associated with urinary tract infections, systemic disease and immunosuppression).
ETIOLOGY	Common causes are Chlamydia trachomatis or Neisseria gonorrhoeae, Escherichia coli and Pseudomonas spp. Infection can occur in males who are the insertive partners during anal intercourse. Sexually transmitted acute epididymitis usually is accompanied by urethritis, which frequently is asymptomatic.
SUBJECTIVE	<ol style="list-style-type: none">1. Scrotal pain and swelling, usually unilateral.2. May have dysuria and/or urethral discharge.3. No history of trauma to the area.
OBJECTIVE	<ol style="list-style-type: none">1. Scrotal tenderness and swelling observed during assessment. Inability to differentiate epididymis from testicle during palpation (see consultation and referral) AND2. Gram-stain smear is positive for urethritis (i.e., smear contains more than 5 polymorphonuclear leukocytes per oil immersion field). The smear may or may not be positive for Neisseria gonorrhoeae. OR3. Microscope examination of first-void urine sediment demonstrating more than 10 polymorphonuclear leukocytes per high power field, OR4. Positive leukocyte esterase test on first-void urine.
ASSESSMENT	Epididymitis, sexually transmitted
PLAN	The desired outcomes of treatment are microbiologic cure, alleviation of signs and symptoms, prevention of transmission of infection to others, and prevention of potential complications (e.g., infertility or chronic pain).

DIAGNOSTIC STUDIES

1. Tender scrotal swelling and on palpation cannot distinguish epididymis from testicle (see consultation and referral).
2. When available, gram-stain smear from urethra in males for Gonorrhea and for presumptive diagnosis of gonococcal infection.
3. Laboratory tests for gonorrhea and chlamydia, Nucleic Acid hybridization tests and/or gonorrhea culture.
4. If the gram-stain is negative or unavailable, positive leukocyte esterase test or microscopic examination of first-void uncentrifuged urine for leukocytes.

THERAPEUTIC

PHARMACOLOGIC

NOTE: Any patients who test positive for gonorrhea or chlamydia should be tested for syphilis and HIV.

NOTE: HIV infected patients with uncomplicated epididymitis can receive the same treatment regimen as those who are not HIV infected.

1. If most likely due to gonococcal or chlamydial infection:

Ceftriaxone 250 mg IM, single dose,

PLUS

Doxycycline 100 mg PO, 2 times a day for 10 days, (if patient is 8 years of age or older)

NOTE: If allergic to cephalosporins or tetracyclines, refer for desensitization.

NOTE: Do not give Doxycycline to lactating patient(s); patient(s) must be advised to discontinue breastfeeding throughout treatment or receive alternative regimen. If breastfeeding women are pumping during treatment, they should not provide pumped breast milk to infant throughout treatment and for two days after completion of treatment . Do not give to children under the age of 8.

2. **If most likely due to gonococcal or chlamydial infection and enteric organisms (men who practice insertive anal sex):**

**Ceftriaxone 250 mg IM, single dose,
PLUS**

**Ofloxacin 300 mg PO, 2 times a day for 10 days
(if patient is at least age 18),**

OR

**Levofloxacin 500 mg PO, once daily for 10 days (if
patient is at least age 18).**

3. **If most likely due to enteric organisms (men who practice insertive anal sex) or with negative gonococcal culture or nucleic acid amplification test:**

Ofloxacin 300 mg PO, 2 times a day for 10 days
(if patient is at least age 18),

OR

Levofloxacin 500 mg PO, once daily for 10 days (if
patient is at least age 18).

4. Over-the-counter oral analgesics for pain.

NON-PHARMACOLOGIC MEASURES

Patient recommended bed rest, scrotal elevation and support to relieve swelling and pain.

PATIENT EDUCATION/COUNSELING

(Reinforce pertinent information with handouts)

1. **The name/significance of the infection. Educate for sequelae and complications of the untreated infection (<http://www.ashasexualhealth.org/stdsstis/pid/>).**
2. Directions for taking medication and potential side effects and what to do about them.
3. Comfort measures.
4. To seek emergency medical care promptly if symptoms do not get noticeably better, or worsen. Patient (s) symptoms should start improving within 48 hours of the initiation of treatment.

5. If infection with gonorrhea and/or chlamydia is known or suspected, refer sex partners for examination and treatment. Avoid sex until treatment is completed and patient and partner(s) no longer have symptoms.
6. If the patient is diabetic, received ceftriaxone therapy, and is using the ACCU-CHEK Compact Plus system, they should stop using the ACCU-CHEK Compact Plus system and begin using an alternate blood glucose monitoring system for the duration of this therapy and for 2 full days after the last treatment because it may lead to incorrect low glucose results.
7. **Women who are breastfeeding should not receive Doxycycline. If Doxycycline is given to breastfeeding women they should discontinue breastfeeding throughout treatment and for two days after completion of treatment. If breastfeeding women are pumping during treatment, they should not provide pumped breast milk to infant throughout treatment and for two days after completion of treatment.**
8. Assist patient in developing a personalized STD/HIV risk reduction plan and document patients plan. Abstain from sex until all the symptoms are resolved and partner(s) are tested and treated.
9. Education and counseling on the correct usage of protective barriers (condoms, dental dams, etc.).
10. If patient is of childbearing age, counsel on the use of contraceptives to reduce the risk of unintended pregnancy.
11. Emphasize patient follow up in 3 days for re-evaluation (if date of follow up falls on a weekend, have patient return for re-evaluation the next open clinic day).
12. Emphasize the importance for patient to return to clinic for all lab results even if presumptively treated at initial visit. Inform patient if lab results are positive and additional treatment will be needed.
13. If additional laboratory tests are positive for STI (e.g. gonorrhea), partners also need treatment.
14. HIV antibody test to determine HIV status, if unknown.
15. Hepatitis A, Hepatitis B and or HPV vaccine if patient is unvaccinated.

To verify eligibility criteria for state supplied vaccines go to:
<http://dph.georgia.gov/sites/dph.georgia.gov/files/Immunizations/Publications-GA-Imm-Manual-Complete.pdf> and
http://dph.georgia.gov/sites/dph.georgia.gov/files/photo_gallery/February%202015%20Vaccine%20Eligibility%20table_0.pdf

MANAGEMENT OF SEX PARTNERS

If gonorrhea and/or chlamydial infection is known, or suspected, in the index patient, all sex partners from 60 days prior to the onset of symptoms or diagnosis should be examined and receive appropriate treatment for gonorrhea and chlamydia.

FOLLOW-UP

Re-evaluate in 2-3 days. Failure to improve means the diagnosis and therapy should be reevaluated and hospitalization may be indicated.

CONSULTATION/REFERRAL

1. Consult immediately the delegating physician if unable to perform the necessary diagnostic testing or patient cannot be treated with recommended drugs. **Refer immediately for emergency evaluation for testicular torsion.**
2. **If the diagnosis is questionable refer to an urologist. If the patient has intense pain, refer immediately for emergency evaluation even when urethritis is documented by gram stain.**
3. If no improvement in 3 days refer to an urologist or primary care physician.
4. Public Health Employees must be familiar with procedures for reporting possible sexual or physical abuse of children if encountered through history or physical. All suspected sexual or physical abuse of children must be reported to the county Department of Family and Children Services office as per Guidelines for Mandatory Reporting of Suspected Child Abuse for Public Health Personnel, which may be viewed on the Public Health Information Library (PHIL) at <http://www.dphphil.org/DPH/Policy/Health%20Protection/Child%20Abuse%20Reporting%20Guidelines%20October%202013%20FINAL.pdf>.

REFERENCES

1. **Centers for Disease Control and Prevention, Sexually Transmitted Diseases Treatment Guidelines 2015, Vol. 64, No. RR-3, June 5, 2015.**
2. GUIDELINES FOR MANDATORY REPORTING OF SUSPECTED CHILD ABUSE for PUBLIC HEALTH PERSONNEL. (2013, October 1). . Retrieved April 1, 2014, from <http://www.dphphil.org/DPH/Policy/Health%20Protection/Child%20Abuse%20Reporting%20Guidelines%20October%202013%20FINAL.pdf>
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NURSE PROTOCOL FOR MUCOPURULENT CERVICITIS (MPC)

DEFINITION	Clinical syndrome characterized by yellow or green mucopurulent exudate visible in the endocervical canal or an endocervical swab specimen and/or easily induced endocervical bleeding.
ETIOLOGY	Chlamydia trachomatis and Neisseria gonorrhoeae may cause MPC, but most women infected with either do not have MPC. In most cases, neither organism can be isolated. In some cases the condition persists despite repeated courses of antimicrobial therapy; therefore alternative diagnoses need to be considered.
SUBJECTIVE	<ol style="list-style-type: none">1. Frequently asymptomatic.2. Discharge from the vagina.3. Abnormal vaginal bleeding (e.g., after intercourse).
OBJECTIVE	<ol style="list-style-type: none">1. Presence of a purulent or mucopurulent exudate visible in the endocervical canal or in an endocervical swab specimen (positive swab test). <p style="text-align: center;">AND/OR</p> <ol style="list-style-type: none">2. Easily-induced bleeding occurs with insertion of the first endocervical swab (cervical friability).
ASSESSMENT	Mucopurulent Cervicitis (MPC)
PLAN	The desired outcomes of treatment are microbiologic cure, alleviation of signs and symptoms, prevention of transmission of infection to others, and treatment of sex partners.

DIAGNOSTIC STUDIES

1. Gonorrhea and chlamydia tests.
 2. Presence of a purulent or mucopurulent exudate visible in the endocervical canal or an endocervical swab specimen (positive swab test).
- AND/OR**
3. Easily-induced bleeding occurs with insertion of the first endocervical swab (cervical friability).
 4. Wet Preparation (saline, 10%KOH).

THERAPEUTIC

NOTE: Any patients who test positive for gonorrhea or chlamydia should be tested for syphilis and HIV.

1. The results of the chlamydia and gonorrhea tests should be used to determine the need for treatment, unless the patient is unlikely to be located for treatment when test results are available.
2. If the patient is unlikely to be easily located for treatment when the test results are available, empiric treatment to cover gonorrhea and/or chlamydia may be given. (See gonorrhea and chlamydia protocols for treatment choices.)

PATIENT EDUCATION/COUNSELING

(Reinforce pertinent information with handouts)

1. **The name/significance of the syndrome. Educate for sequelae and complications of the untreated infection.**
2. Advise the patient to return to clinic for all lab results even if presumptively treated at initial visit. Inform patient if lab results are positive additional treatment may be needed.
3. Directions for taking medication and what to do about potential side effects.
4. Encourage self-referral of recent sex partner(s) for examination and possible treatment. Avoid sex until partner has been treated.
5. Abstain from sex for 7 days after therapy is begun.
6. Assist patient in developing a personalized STD/HIV risk reduction plan and document patients plan. Abstain from sex until all the symptoms are resolved and partner(s) are tested and treated.
7. Education and counseling of the correct usage of protective barriers (condoms, dental dams, etc.).
8. If patient is of childbearing age, counsel on the use of contraceptives to reduce the risk of unintended pregnancy.
9. HIV antibody test to determine HIV status, if unknown.
10. Hepatitis A, Hepatitis B and or HPV vaccine if patient is unvaccinated. To verify eligibility criteria for state supplied vaccines go to:

<http://dph.georgia.gov/sites/dph.georgia.gov/files/Immunizations/Publications-GA-Imm-Manual-Complete.pdf> and
http://dph.georgia.gov/sites/dph.georgia.gov/files/photo_gallery/February%202015%20Vaccine%20Eligibility%20table_0.pdf

MANAGEMENT OF SEX PARTNERS

1. All self-referred sex partners should be treated on the basis of their examination and test results, or the test results of the index patient.
2. Partners of females who are treated for MPC before test results are available should receive treatment for the same suspected infection(s) as the female partner.

FOLLOW-UP

1. If symptoms persist, patients should return for re-evaluation. However, after the possibilities of relapse and reinfection have been excluded, management of persistent MPC is unclear.
2. If the chlamydia or gonorrhea test is positive, patients should be retested approximately 3 months after treatment, regardless of whether they believe that their sex partners were treated. If retesting at 3 months is not possible, clinicians should retest whenever patient(s) next present for medical care in the 12 months following initial treatment.

CONSULTATION/REFERRAL

1. Consult with or refer to primary care provider for additional evaluation if symptoms persist after relapse and reinfection have been excluded.
2. Public Health Employees must be familiar with procedures for reporting possible sexual or physical abuse of children if encountered through history or physical. All suspected sexual or physical abuse of children must be reported to the county Department of Family and Children Services office as per Guidelines for Mandatory Reporting of Suspected Child Abuse for Public Health Personnel, which may be viewed on the Public Health Information Library (PHIL) at <http://www.dphphil.org/DPH/Policy/Health%20Protection/Child%20Abuse%20Reporting%20Guidelines%20October%202013%20FINAL.pdf>.
3. Consult delegating physician when further medical guidance is needed and STD nursing protocol is not applicable for therapeutic treatment of patient.

REFERENCES

1. **Centers for Disease Control and Prevention, Sexually Transmitted Diseases Treatment Guidelines 2015, Vol. 64, No. RR-3, June 5, 2015.**
2. **GUIDELINES FOR MANDATORY REPORTING OF SUSPECTED CHILD ABUSE for PUBLIC HEALTH PERSONNEL. (2013, October 1).** . Retrieved April 1, 2014, from <http://www.dphphil.org/DPH/Policy/Health%20Protection/Child%20Abuse%20Reporting%20Guidelines%20October%202013%20FINAL.pdf>
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STANDARD NURSE PROTOCOL FOR NONGONOCOCCAL URETHRITIS (NGU)

- DEFINITION** Sexually transmitted clinical syndrome in men, usually characterized by a mucoid-to-purulent urethral discharge and often accompanied by dysuria or urethral itching. It is diagnosed if urethritis is present and Gram-negative intracellular organisms cannot be identified on Gram stains. May progress to epididymitis or reactive arthritis if untreated.
- ETIOLOGY** Chlamydia trachomatis causes 15%-40% of cases, with lower prevalence occurring in older men. The etiology of many cases of nonchlamydial NGU is unknown. Ureaplasma urealyticum and possibly Mycoplasma genitalium are implicated in as many as one third of cases (15%-25%). Trichomonas vaginalis and herpes simplex virus occasionally cause NGU.
- SUBJECTIVE**
1. Urethral discharge, especially in the morning.
 2. Itching or burning of the urethra.
- OBJECTIVE** The following criteria are used to diagnose nongonococcal urethritis (NGU).
1. Documentation of urethritis by:
 - a. Mucopurulent or purulent discharge,
OR
 - b. Gram stain of urethral secretions demonstrating more than 5 WBCs per oil immersion field.
OR
 - c. Positive leukocyte esterase test in a first void urine sediment demonstrating greater than 10 WBCs per high power field.
AND/OR
 2. When available a Gram stain that is negative for Gram-negative intracellular diplococci.
 2. If the criteria for urethritis are not present, treatment should be deferred pending the results of the diagnostic studies. Empiric treatment of symptoms without documentation of urethritis is recommended only for patients at high risk for infection who are unlikely to return for a follow-up evaluation (e.g. Adolescents who have multiple partners, non-compliance for follow up of previous positive results, etc.).

NOTE: If the patient has urinated within 2 hours before obtaining a specimen in which less than five (5) white blood cells (WBCs) per high power field are seen, may need to examine another specimen two hours after urination and before patients urinates again.

ASSESSMENT Nongonococcal Urethritis (NGU)

PLAN **The desired outcome of treatment is alleviation of symptoms and microbiologic cure of infection.**

DIAGNOSTIC STUDIES

1. Gonorrhea and Chlamydia tests.
2. Documentation of urethritis by:
 - a. Mucopurulent or purulent discharge,
OR
 - b. Gram stain of urethral secretions demonstrating more than 5 WBCs per oil immersion field.
OR
 - c. Positive leukocyte esterase test in a first void urine sediment demonstrating greater than 10 WBCs per high power field.
AND/OR
3. When available a Gram stain that is negative for gram-negative intracellular diplococci.

THERAPEUTIC

NOTE: Any patients who test positive for gonorrhea or chlamydia should be tested for syphilis and HIV.

NOTE: HIV infected patients with NGU can receive the same treatment regimen as those who are not HIV infected.

PHARMACOLOGIC

RECOMMENDED REGIMEN

1. Azithromycin 1 gm PO, single dose,
OR
2. Doxycycline 100 mg PO, 2 times a day for 7 days if at least age 8.

NOTE: Do not give Doxycycline to lactating patient(s); patient(s) must be advised to discontinue breastfeeding throughout treatment or receive alternative regimen.

If breastfeeding women are pumping during treatment, they should not provide pumped breast milk to infant throughout treatment and for two days after completion of treatment. Do not give Doxycycline to children under the age of 8.

ALTERNATIVE REGIMEN

1. Erythromycin base 500 mg orally 4 times a day for 7 days,
OR
2. Erythromycin ethylsuccinate 800 mg orally 4 times a day for 7 days,
OR
3. Levofloxacin 500 mg orally, once daily for 7 days (if patient is at least age 18),
OR
4. Ofloxacin 300 mg orally, 2 times a day for 7 days (if patient is at least age 18).

PATIENT EDUCATION/COUNSELING

(Reinforce pertinent information with handouts)

1. **The name/significance of the syndrome. Educate for sequelae and complications of untreated infection (<http://www.ashasexualhealth.org/stdsstis/ngu/>).**
2. Directions for taking medication and what to do about potential side effects.
3. **Women who are breastfeeding should not receive Doxycycline. If Doxycycline is given to breastfeeding women they should discontinue breastfeeding throughout treatment and for two days after completion of treatment. If breastfeeding women are pumping during treatment, they should not provide pumped breast milk to infant throughout treatment and for two days after completion of treatment.**
4. Referral, for evaluation and treatment, of all sex partners within the preceding 60 days.
5. Education and counseling of the correct usage of protective barriers (condoms, dental dams, etc.).
6. Educate patients who receive Azithromycin about adverse effects (QT Prolongation, torsades de pointes, etc.) and document the patient's understanding.
<http://www.fda.gov/downloads/Drugs/DrugSafety/UCM343347.pdf>

7. If patient is of childbearing age, counsel on the use of contraceptives to reduce the risk of unintended pregnancy.
8. Advise the patient to return to clinic for all lab results even if presumptively treated at initial visit. Inform patient if lab results are positive additional treatment may be needed.
9. Assist patient in developing a personalized STD/HIV risk reduction plan and document patients plan. Abstain from sex until all the symptoms are resolved and partner(s) are tested and treated.
10. Instruct patient to abstain from sexual intercourse until at least 7 days after therapy has started. The partner(s) must be adequately treated and the treated patient's symptoms completely resolved and sex partners have been adequately treated.
11. Hepatitis A, Hepatitis B and or HPV vaccine if patient is unvaccinated. To verify eligibility criteria for state supplied vaccines. To access most current version, go to <http://dph.georgia.gov/sites/dph.georgia.gov/files/Immunizations/Publications-GA-Imm-Manual-Complete.pdf> and http://dph.georgia.gov/sites/dph.georgia.gov/files/photo_gallery/February%202015%20Vaccine%20Eligibility%20table_0.pdf
12. HIV antibody test to determine HIV status, if unknown.

MANAGEMENT OF SEX PARTNERS

All sex partners from the 60 days prior to the onset of symptoms or diagnosis should be examined and promptly treated with one of the recommended regimens.

FOLLOW-UP

1. Advise the patient to return to clinic for all lab results even if presumptively treated at initial visit. Inform patient if lab results are positive additional treatment will be needed.
2. Inform patient if additional lab(s) is/are positive, partner(s) will need additional treatment also.
3. The patient should return if symptoms persist or return within three month of treatment. Patient(s) with persistent or recurrent urethritis should be retreated with the initial regimen if they have failed to comply with the regimen, or if they have been re-exposed to an untreated sex partner. Otherwise, refer to delegating

physician.

4. Clinicians should advise patients with positive chlamydia or gonorrhea tests to be retested three months after treatment. If patients do not seek medical care for retesting in three months, providers are encouraged to test these patients whenever they next seek medical care within the following 12 months, regardless of whether the patients believe that their sex partners were treated. Retesting is distinct from test-of-cure to detect therapeutic failure, which is not recommended if patient receives first line of treatment.

CONSULTATION/REFERRAL

1. If not compliant to previous treatment and instructions retreat and refer to Communicable Disease Specialist for counseling.
2. Refer to urologist or primary care physician for evaluation and treatment of 3 or more recurrent urethritis within three months. Referral should also be considered if patient is experiencing pain for more than 3 months within a 6-month period.
3. Public Health Employees must be familiar with procedures for reporting possible sexual or physical abuse of children if encountered through history or physical. All suspected sexual or physical abuse of children must be reported to the county Department of Family and Children Services office as per Guidelines for Mandatory Reporting of Suspected Child Abuse for Public Health Personnel. which may be viewed on the Public Health Information Library (PHIL) at <http://www.dphphil.org/DPH/Policy/Health%20Protection/Child%20Abuse%20Reporting%20Guidelines%20October%202013%20FINAL.pdf>.
4. Consult delegating physician when further medical guidance is needed and STD nursing protocol is not applicable for therapeutic treatment of patient.

REFERENCES

1. **Centers for Disease Control and Prevention, Sexually Transmitted Diseases Treatment Guidelines 2015, Vol. 64, No. RR-3, June 5, 2015.**
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STANDARD NURSE PROTOCOL FOR LYMPHOGRANULOMA VENEREUM (LGV)

DEFINITION

LGV is a systemic, sexually transmitted disease (STD) or infection caused by a type of *Chlamydia trachomatis* (serovars L1, L2, L3). The incidence is highest among sexually active people living in tropical or subtropical climates. It is rarely diagnosed in the United States or other industrialized countries. **LGV is more common in men who have sex with men than women or heterosexual men. LGV** has three clinical stages:

1. **First stage: Often unrecognized due to rapid healing.** A **painless** papule at the site of infection, which ulcerates and then heals rapidly. Mild urethritis may also occur. The patient rarely presents for examination at this stage.
2. **Secondary Stage:** Usually occurring **14-45** days after the **first** stage, it is characterized by **painful** increasing inguinal lymphadenopathy or, in patients exposed by receptive anal intercourse, acute hemorrhagic proctitis. The lymphadenopathy is usually unilateral; less than 20% have the “groove sign” showing involvement of the femoral nodes. Diagnosis and treatment during this stage can have the desired outcome of curing infection and prevention of ongoing tissue destruction.
3. **Third stage: This stage can occur years after** denoted by chronic inflammation of the lymph nodes, ulceration and fistula formation. Patients, especially those who have engaged in unprotected anal sex, may present with an atypical presentation. Symptoms could include proctitis or proctocolitis with rectal discharge, bleeding, pain on defecation or tenesmus.

ETIOLOGY

Chlamydia trachomatis is an **obligate intracellular bacterial agent with at least 18 serologic variants divided between biologic variants. LGV is serologic variant (serovars) L1, L2, and/or L3.**

SUBJECTIVE

1. With or without tender, (typically) unilateral, swollen glands (lymph nodes/bubo) in the groin.
2. May have history of briefly occurring painless papule/ulcer in the genital area.
3. Proctitis or proctocolitis with rectal discharge, tenderness and bleeding, with history of rectal sex. May complain of constipation, pain on defecation and tenesmus.

OBJECTIVE

NOTE: Diagnosis of LGV can be complicated. Diagnosis should be made considering a thorough sexual history, travel history, clinical findings and several laboratory tests including Chlamydia serology and Chlamydia serotyping of specimens.

1. Patient history and clinical findings consistent with LGV. One or more tender, progressively enlarging, fluctuant inguinal lymph nodes,
OR
Characteristic signs of hemorrhagic proctitis in a patient with history of rectal sex. May be accompanied by fever, malaise and myalgias.
AND
2. Positive microimmunofluorescent (MIF) serologic test titer more than 1:128, for a lymphogranuloma venereum strain of *Chlamydia trachomatis* (serum).
AND
Isolation/culture of *Chlamydia trachomatis*, LGV serotypes L1, L2 or L3 from clinical specimen (rectal swab).

ASSESSMENT

Lymphogranuloma Venereum (LGV)

PLAN

DIAGNOSTIC STUDIES

NOTE: MIF and LGV serotype are to be submitted to a private laboratory for processing. Georgia Public Health Laboratory does not conduct testing to diagnose LGV. The STD Office provides only treatment and the cost for the MIF and LGV lab should be discussed with administration prior to collection of specimens.

1. **Gonorrhea and chlamydia testing.**
2. Positive microimmunofluorescent (MIF) (titer more than 1:128) serologic test for a lymphogranuloma venereum strain of *Chlamydia trachomatis* (serum).
3. Isolation/culture of *Chlamydia trachomatis*, LGV serotype L1, L2 or L3 from a clinical specimen (rectal swab).
4. Serology for HIV and for syphilis (RPR).
5. If ulcer(s) present: darkfield exam, if available and herpes culture.

THERAPEUTIC

PHARMACOLOGIC

NOTE: Any patients who test positive for LGV should be tested for syphilis and HIV.

1. If patient is not pregnant **and 8 years of age or older:**
 - a. Doxycycline 100 mg PO, 2 times a day for 21 days, **NOTE: Do not give Doxycycline to lactating patient(s); patient(s) must be advised to discontinue breastfeeding throughout treatment and for two days after treatment is completed or receive alternative regimen. If breastfeeding women are pumping during treatment, they should not provide pumped breast milk to infant throughout treatment and for two days after completion of treatment. Do not give to children under the age of 8.**

OR
 - b. If patient cannot take Doxycycline, Erythromycin base 500mg PO, 4 times a day for 21 days.
2. If patient is pregnant **and/or lactating:** Erythromycin base 500 mg PO, 4 times a day for 21 days.
3. Patients with both LGV and HIV infection should receive the same regimens as those who are HIV-negative.

PATIENT EDUCATION/COUNSELING

(Reinforce pertinent information with handouts)

1. **The name/significance of the infection. Educate for sequelae and complications of the untreated infection:**
<http://www.cdc.gov/std/treatment/2010/genital-ulcers.htm#a4>
2. **Give directions for taking the medication and potential side effects and what to do about them. Stress the importance of finishing medications. Advise to abstain from sexual contact until treatment is completed and until partners have finished all their medication.**
3. **Women who are breastfeeding should not receive Doxycycline. If Doxycycline is given to breastfeeding women they should discontinue breastfeeding throughout treatment and for two days after completion of treatment. If breastfeeding women are pumping during treatment, they should not provide pumped breast milk to infant throughout treatment and for two days after completion of treatment.**

4. All sex partners from 60 days prior to the onset of symptoms should be referred for examination and treatment with a chlamydia regimen. Avoid sex until partner has been treated.
5. Stress safe sex practices among men who have sex with men (MSM) and bisexual men. Emphasize the importance of using condoms and avoiding penetrating sex. Limiting the number of sex partners and regular use of protective barriers can also reduce risk.
6. Counsel patient on individualized STD/HIV risk reductions and incorporate reduction plan.

NOTE: LGV can facilitate the spread of other STDs including HIV because of the disease's ulcers. Keep acute HIV infection and syphilis in mind as well as LGV when patients present with symptoms. HIV and syphilis are more prevalent than LGV in Georgia and patients should be screened for all STDs.

7. Advise the patient to return to clinic for all lab results even if presumptively treated at initial visit. Inform patient if lab results are positive additional treatment may be needed.
8. Education and counseling of the correct usage of protective barriers (condoms, dental dams, etc.).
9. If patient is of childbearing age, counsel on the use of contraceptives to reduce the risk of unintended pregnancy.
10. Assist patient in developing a personalized STD/HIV risk reduction plan and document patients plan. Abstain from sex until all the symptoms are resolved and partner(s) are tested and treated.
11. HIV antibody test to determine HIV status, if unknown.
12. Emphasize the importance of regular health screenings among high-risk populations.
13. Hepatitis A, Hepatitis B and or HPV vaccine if patient is unvaccinated. To verify eligibility criteria for state supplied vaccines go to:
<http://dph.georgia.gov/sites/dph.georgia.gov/files/Immunications/Publications-GA-Imm-Manual-Complete.pdf> and
http://dph.georgia.gov/sites/dph.georgia.gov/files/photo_gallery/February%202015%20Vaccine%20Eligibility%20table_0.pdf

MANAGEMENT OF SEX PARTNERS

All sex partners from 60 days prior to the onset of symptoms should be referred for examination and treatment with a chlamydia regimen. Avoid sex until partner has been treated.

FOLLOW UP

See every 1-2 weeks until all lesions have healed. Clinical response is the best gauge of therapy.

CONSULTATION/REFERRAL

1. Consult with delegating physician when inadequate response to treatment (continued signs and symptoms of LGV in the absence of possible reinfection).
2. Consult with delegating physician if lymph node enlargement continues to the point where rupture seems possible; refer for aspiration **or incision and drainage** (Blue color of overlying skin shows that rupture is imminent.)
3. If patient presents to the health department with history and signs/symptoms that are suggestive of LGV consult with the delegating physician. Notify STD Nurse Consultant of suspected or confirmed LGV case.
4. Public Health Employees must be familiar with procedures for reporting possible sexual or physical abuse of children if encountered through history or physical. All suspected sexual or physical abuse of children must be reported to the county Department of Family and Children Services office as per Guidelines for Mandatory Reporting of Suspected Child Abuse for Public Health Personnel, which may be viewed on the Public Health Information Library (PHIL) at <http://www.dphphil.org/DPH/Policy/Health%20Protection/Child%20Abuse%20Reporting%20Guidelines%20October%202013%20FINAL.pdf>.
5. Refer to a District Communicable Disease Specialist for prevention counseling and assistance with partner referral.
6. Consult delegating physician when further medical guidance is needed and STD nursing protocol is not applicable for therapeutic treatment of patient.

REFERENCES

1. **Centers for Disease Control and Prevention, Sexually Transmitted Diseases Treatment Guidelines 2015, Vol. 64, No. RR-3, June 5, 2015.**
2. CDC, "MMWR Weekly", *Lymphogranuloma Venereum Among Men Who Have Sex with Men-Netherlands*, Article, 53 (42) pp. 985-988 October 29, 2004.
3. CDC, "Sexually Transmitted Diseases" *Lymphogranuloma Venereum (LGV) Project*, n.d., <<http://cdc.gov/std/lgv/default.htm>> (April 4, 2005).
4. Georgia Department of Human Services, *Appearance of Rare Form of Chlamydia (LGV) in Atlanta. Health Officials stress safe sex practices among gay and bisexual men.* < <https://dhs.georgia.gov/appearance-rare-form-chlamydia-lgv-atlanta>> (February 18, 2005).
5. GUIDELINES FOR MANDATORY REPORTING OF SUSPECTED CHILD ABUSE for PUBLIC HEALTH PERSONNEL. (2013, October 1). . Retrieved April 1, 2014, from <http://www.dphphil.org/DPH/Policy/Health%20Protection/Child%20Abuse%20Reporting%20Guidelines%20October%202013%20FINAL.pdf>
6. **Holmes, K. K. (2008). Sexually transmitted diseases. New York: McGraw-Hill Medical.**
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STANDARD NURSE PROTOCOL FOR GENITAL/PERIANAL WARTS

DEFINITION	Infection of the genital and/or anal areas with the human papillomavirus (HPV). It is usually sexually transmitted, and the viral strains causing anogenital warts are not usually found on other areas of the body. Asymptomatic genital HPV infection is common and usually self-limited. While intra-anal warts are seen predominately in patients who have receptive anal intercourse, perianal warts can occur in males and females who do not give a history of anal sex.
ETIOLOGY	Member of the Papillomavirus family and are DNA virus. There are more than 100 types identified. More than 40 HPV types can infect the genital tract. The larger, fleshy warts are usually caused by HPV types 6 or 11; flat warts are caused by HPV types 16, 18, 31 and others. HPV 16 and 18 are considered to be the cause of cervical cancers. The higher-numbered types are the ones associated with cervical and other anogenital cancers. Regardless of type, most HPV infections are subclinical. However, depending on the size and anatomic location, genital warts can be painful, friable and pruritic. Incubation period is unknown but is estimated to range from 3 months to several years.
SUBJECTIVE	<ol style="list-style-type: none">1. May have no noticeable symptoms.2. Bumps/growths in the genital or anal areas.3. May be painful or pruritic.
OBJECTIVE	The following criteria are used to diagnose genital/perianal warts: <ol style="list-style-type: none">1. Single or multiple typical soft, fleshy growths on the skin or mucous membranes around the vulvovaginal area, anal area, penis, urethra or perineum. They may be like cauliflower, with a stalk-like base, or have a broad base.2. Demonstration of typical cytologic changes on a Pap smear is suggestive of subclinical HPV infection. HPV is associated with higher grade intraepithelial neoplasia.
ASSESSMENT	Genital and/or Perianal Warts (specify site)
PLAN	The desired outcome of treatment is the removal of symptomatic warts. Treatment can induce wart-free periods in most patients.

DIAGNOSTIC STUDIES

1. RPR titer, if not already done.
2. HIV antibody test to determine HIV status, if unknown.
3. Darkfield Exam of any open moist lesions to rule out primary syphilis or condylomata lata of secondary syphilis, if available.
4. A biopsy referral may be indicated if the wart(s) does not respond to therapy or gets worse during treatment.
5. Recommendation: HPV specific tests detect viral nucleic acid (i.e. DNA or RNA) capsid protein. Approved FDA Tests: HC II High-Risk HPV test (Quiagen), HC II Low-Risk HPV test (Quiagen), Cervista HPV 16/18 test and Cervista HPV High Risk Test (Hologics) **(cannot be used on males)**.

THERAPEUTIC

NOTE: Treatment of genital warts is optional, and the warts may spontaneously regress. Many patients will require a course of therapy rather than a single treatment. Treatment is not indicated in the absence of lesions.

PHARMACOLOGIC

NOTE: Any patient who is positive for HPV should be tested for gonorrhea, chlamydia, syphilis and HIV.

NOTE: For patient-applied therapy, clinicians must educate and demonstrate, to the patient, proper application technique of the initial treatment before dispensing medication to the patient.

1. Patient-Applied:
NOTE: For genital warts only. Patient must be able to identify and reach warts to be treated; the clinician should demonstrate the proper application technique and identify which warts should be treated.

NOTE: Podofilox or Imiquimod should not be used in children, pregnant or nursing patients.

- a. Podofilox 0.5% solution or gel. Apply solution with a cotton swab, or gel with a finger or swab, twice a day for 3 days, followed by 4 days of no therapy. Wash hands after applying medication. This cycle may be repeated, as necessary, for a total of 4 cycles. The total area treated should not exceed 10 cm², and no more than 0.5 mL of podofilox used per day. Nurse should apply the initial treatment to demonstrate to patient proper application technique.

OR

- b. If 12 years of age or older, Imiquimod 5% cream, (i.e., Aldara). Apply cream with a finger or cotton swab at bedtime, three times a week until warts are cleared, for up to 16 weeks. Wash hands after applying the medication. Wash the treatment area with mild soap and water 6-10 hours after the application. Educate patient about local inflammatory reaction.

2. Provider-Administered

NOTE: Trichloroacetic acid, bichloroacetic acid or Podophyllin should not be used in children, pregnant or nursing patients.

NOTE: Refer to the product package insertion prior to administration.

- a. Trichloroacetic acid (TCA) or bichloroacetic acid (BCA) 80-90% solution applied sparingly to warts and allowed to dry to a white "frosting" before the patient sits or stands. If an excess amount is applied, powder the treated area with liquid soap preparation, talc or sodium bicarbonate to remove unreacted acid. May repeat weekly as necessary.

NOTE: Treatment outlined is not for individuals with lesions in the urethra, vagina, anal, or cervical areas.

OR

- b. Podophyllin 10-25% in compound tincture of benzoin, applied topically and allowed to air dry. Limit each treatment to less than 0.5 mL applied to an area of less than 10 square cm of warts per session. Repeat weekly if necessary, up to 4 (four) applications. Do not use Podophyllin during

pregnancy or on open lesions and wounds.

PATIENT EDUCATION/COUNSELING

(Reinforce pertinent information with handouts)

1. **The name/significance of the infection. Educate for sequelae and complications of the untreated infection:**
<http://www.cdc.gov/std/hpv/hpv-factsheet-march-2014.pdf>
2. For the fleshy warts, stress that these are not usually caused by the same strains that are associated with cancer, but it is possible that other strains are also present. Treatment of external warts is not likely to influence the development of cervical cancer.
3. Directions for care of the treated area. To reduce local irritation, patient should wash off podophyllin in 1-4 hours after application.
3. No treatment, even laser **or liquid nitrogen (cryotherapy)**, is known to eradicate the virus, and recurrences are common. Recurrences occur most frequently during the first 3 months, and are usually due to reactivation of latent virus rather than reinfection by a sex partner.
4. Most HPV infections can clear spontaneously. However, some infections do get worse.
5. Infected females should undergo regular cervical Pap screening as recommended for females without genital warts.
6. Partners may be infected with HPV even if they have no visible warts. The use of condoms may reduce transmission to new partners.
7. HPV infection may persist lifelong in a dormant state and become infectious intermittently.
8. Correct and consistent condoms use may lower transmission and contact of HPV, but may not provide full protection based upon location(s) of HPV not covered by condom.
9. For patient-applied treatment:
 - a. Do not use more often than directed or on any other area of the body. Wash hands immediately after applying medication.
 - b. Report problems with application or side-effects, such as bleeding or severe swelling of tissue. Mild to moderate pain or local irritation is common with podofilox.

Mild to moderate local inflammatory reactions (**E.g. irritation, ulceration/erosions, vesicles, hypopigmentation**) are common with imiquimod.

- c. Do not share the medication with anyone else.
 - d. Do not have intercourse during the days when warts are being treated with podofilox or when imiquimod cream is on the skin.
 - e. Females should avoid getting pregnant.
10. Assist patient in developing a personalized STD/HIV risk reduction plan and document patients plan. Abstain from sex until all the symptoms are resolved and partner(s) are tested and treated.
 11. Education and counseling of the correct usage of protective barriers (condoms, dental dams, etc.).
 12. If patient is of childbearing age, counsel on the use of contraceptives to reduce the risk of unintended pregnancy.
 13. **Pregnant women should be educated and counseled concerning the low risk for warts on the larynx of their infants or children**
(<http://www.nidcd.nih.gov/health/voice/pages/laryngeal.aspx/#3> or <http://www.rpf.org/whatisRRP.html>).
 14. HIV antibody test to determine HIV status, if unknown.
 15. Hepatitis A, Hepatitis B and or HPV vaccine if patient is unvaccinated. To verify eligibility criteria for state supplied vaccines go to:
<http://dph.georgia.gov/sites/dph.georgia.gov/files/Immunizations/Publications-GA-Imm-Manual-Complete.pdf> and
http://dph.georgia.gov/sites/dph.georgia.gov/files/photo_gallery/February%202015%20Vaccine%20Eligibility%20table_0.pdf

MANAGEMENT OF SEX PARTNERS

1. Examine all referred sex partners for genital warts and other STDs.
2. Recommend a Pap smear for female partners who have not had one in the past year.

FOLLOW-UP

1. If desired, patients using self-administered treatment may return in a few weeks for assessment of treatment response.

2. For provider-administered topical treatment, apply weekly as needed. If no significant improvement in four weeks, or if warts have not completely cleared after six weeks, alternative therapy should be used.

CONSULTATION/REFERRAL

1. Refer patient(s) to a dermatologist or primary care provider if requests are made for treatment of lesions not located in the vulvovaginal area, anal area, penis, urethra or perineum. In addition, refer patient(s) who may require or request cryotherapy or surgical removal.
2. For Pap smear recommendations follow Georgia Breast and Cervical Cancer Program Cervical Screening Guidelines.
3. If patient is pregnant, consult with delegating physician for possible referral to OB/GYN or OB provider.
4. **For additional information and psychological support, refer to: Local HELP line (678-561-4377 in Atlanta) or the National Herpes and HPV and Cervical Cancer Prevention Hotline, 919-361 8488, 1-800-CDC-INFO, or <http://www.ashasexualhealth.org/stdsstis/hpv/>**
5. Public Health Employees must be familiar with procedures for reporting of possible sexual abuse of children if encountered through history, physical. All suspected sexual abuse of children must be reported to the county Department of Family and Children Services office as per Guidelines for Mandatory Reporting of Suspected Child Abuse for Public Health Personnel, which may be viewed on the Public Health Information Library (PHIL) at <http://www.dphphil.org/DPH/Policy/Health%20Protection/Child%20Abuse%20Reporting%20Guidelines%20October%202013%20FINAL.pdf>.
6. Consult with or refer to primary care provider if warts are not responding to treatment.
7. Consult delegating physician when further medical guidance is needed and STD nursing protocol is not applicable for therapeutic treatment of patient.

REFERENCES

1. **Centers for Disease Control and Prevention, Sexually Transmitted Diseases Treatment Guidelines 2015, Vol. 64, No. RR-3, June 5, 2015.**
2. **GUIDELINES FOR MANDATORY REPORTING OF SUSPECTED CHILD ABUSE for PUBLIC HEALTH PERSONNEL. (2013, October 1).** . Retrieved April 1, 2014, from <http://www.dphphil.org/DPH/Policy/Health%20Protection/Child%20Abuse%20Reporting%20Guidelines%20October%202013%20FINAL.pdf>
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STANDARD NURSE PROTOCOL FOR GENITAL HERPES

DEFINITION

A sexually transmissible viral infection characterized by recurring vesicular blisters resulting in ulcerative lesions on the genitals or adjacent areas that heal spontaneously without scarring. However, typical lesions are absent in many infected patients.

Some severe cases of first episode infection last an average of 12 days and aseptic meningitis or generalized symptoms due to viremia may occur. Subsequent milder recurrent infections do not last as long. During latency between clinical episodes, viral shedding occurs intermittently and individuals may transmit the virus to partners with asymptomatic viral shedding..

Most people with HSV-II (genital herpes infection) do not know they have it. Most infected patients never recognize signs suggestive of genital herpes; some will have symptoms shortly after infection and then never again. Many cases are acquired from patients who do not know that they are infected.

Persistent infection (lesions more than 4 weeks) or extensive anogenital ulceration and proctitis occur in immunocompromised patients. Lesions caused by HSV are common among HIV-infected patients. These individuals may experience increased viral shedding, have more prolonged episodes, and may experience more severe and atypical symptoms. HSV is an AIDS defining illness with: chronic ulcers (greater than 1 month's duration) or bronchitis, pneumonitis, or esophagitis (onset at age greater than 1 month).

ETIOLOGY

HSVs are enveloped, double-stranded, DNA viruses. Herpes simplex virus (HSV), type 1 or type 2. **HSV-I usually involves the face and skin above the waist and HSV-II usually involves below the waist. However at least 20% of genital herpes are caused by HSV-I. Most genital infections are with HSV-II, which is most apt to cause recurrences. Presence of type 2 antibodies implies anogenital infection. Incubation period ranges from 2 days to 2 weeks.**

SUBJECTIVE

1. Single or multiple blisters and/or shallow ulcers, usually painful, anywhere on the genitals.
2. May have swollen tender lymph nodes in the groin.
3. **Fever, headache, or malaise or myalgias.**

4. **Pruritic lesions.**
5. **Dysuria.**
6. **Vaginal or urethral discharge.**

OBJECTIVE

PHYSICAL/LAB FINDINGS

1. Typical vesicular lesions and/or shallow ulcers.
2. May have atypical papular lesions and no ulcers.
3. May have enlarged, tender inguinal lymph nodes.
4. Identification of herpes simplex virus type 1 and/or 2 in lesion scrapings, by cell culture,
OR
5. A clinical diagnosis is made based on the presence of characteristic single or multiple blisters and/or shallow painful ulcers that are typical for herpes, but not for syphilis or chancroid. Herpetic lesions are darkfield negative unless a co-existing syphilis lesion is present.
6. Suspicious genital papules, vesicles or ulcers, with a history of episode(s) of similar symptoms or sexual exposure to a patient with HSV are suggestive.
7. In the setting of HIV infected patient, a large non-healing genital ulceration may be HSV.

ASSESSMENT

Genital Herpes

PLAN

The desired outcome of treatment with systemic antiviral drugs is to minimize the signs and symptoms of herpes episodes.

DIAGNOSTIC STUDIES

1. Herpes culture to confirm diagnosis of typical lesions. **Sensitivity of viral culture is low and as healing begins culture sensitivity declines rapidly.** Positive culture gives a definitive diagnosis. Absence of a positive culture however, does not mean the patient does not have herpes because the virus may not be always cultured from the lesion if not present in adequate amount.
2. Type-specific HSV serologic assays might be useful in the following scenarios:

NOTE: Herpes culture should be performed first when noticeable symptoms are present. Serology should be done in conjunction with herpes culture in the below scenarios.

- a. If patient has a history of recurring genital or atypical lesions but obtaining an adequate specimen for a culture is not possible, order type-specific serologic antibody tests for HSV 1 and 2.
- b. A clinical diagnosis of genital herpes without laboratory confirmation.
- c. A partner with genital herpes.
- d. A patient with a history of multiple sex partners.
- e. Patients with HIV infection.
- f. MSM at increased risk for HIV acquisition.

NOTE: Screening for HSV-1 and HSV-2 in the general population is not indicated.

3. If available, darkfield exam of lesion fluid and/or Rapid Plasma Reagin (RPR) to rule out syphilis. Unless co-existing with syphilis, lesions will be darkfield negative.

THERAPEUTIC

PHARMACOLOGIC

NOTE: Any patients who test positive for HSV should be tested for gonorrhea, chlamydia, syphilis and HIV.

Systemic antiviral drugs partially control the symptoms and signs of herpes episodes when used to treat first clinical episodes and recurrent episodes or when used as daily suppressive therapy. However, these drugs neither eradicate latent virus nor affect subsequent risk, frequency, or severity of recurrences after the drug is discontinued.

NOTE: Pregnant females must be referred to an OB/GYN or OB provider for treatment. Lactating patients must discontinue breastfeeding while receiving treatment.

1. First genital episode
NOTE: Treatment may be extended if healing is incomplete after 10 days of therapy.
 - 1) Acyclovir 400 mg PO, 3 times a day for 7-10 days,

OR

2) Acyclovir 200 mg PO, 5 times a day for 7-10 days,

OR

3) Famciclovir 250 mg PO, 3 times a day for 7-10 days,

OR

4) Valacyclovir 1 gm PO, 2 times a day for 7-10 days.

NOTE: Valacyclovir has enhanced absorption after oral administration.

b. Episodic recurrent episodes

NOTE: Effective episodic treatment of recurrent herpes requires initiation of therapy within 1 day of lesion onset, or during the prodrome that precedes some outbreaks. The patient should be provided with a supply of medication with instructions to self-initiate treatment immediately when symptoms begin and to contact health department for follow-up **visit** to assess of current symptoms.

1) Acyclovir 400 mg PO, 3 times a day for 5 days,

OR

2) Acyclovir 800 mg PO, 2 times a day for 5 days,

OR

3) Acyclovir 800 mg PO, 3 times a day for 2 days,

OR

4) Famciclovir 125 mg PO, 2 times a day for 5 days,

OR

5) Famciclovir 500 mg PO, once followed by 250 mg 2 times a day for 2 days,

OR

6) Famciclovir 1000 mg PO, 2 times a day for 1 day,

OR

7) Valacyclovir 500 mg PO, 2 times a day for 3 days,

OR

8) Valacyclovir 1 gm PO, once a day for 5 days.

c. Daily suppressive therapy

- 1) Acyclovir 400 mg PO, 2 times a day,
OR
- 2) Famciclovir 250 mg PO, 2 times a day,
OR
- 3) Valacyclovir 500 mg PO, once a day, use only if 9 or fewer recurrences per year
OR
- 4) Valacyclovir 1 gm PO, once a day.

NOTE: The use of Valacyclovir may be less effective than other dosing regimens in patients who have more than 9 episodes per year.

- d. HIV-infected patients
 - 1) Episodic treatment:
 - a) Acyclovir 400 mg PO, 3 times a day, for 5-10 days,
OR
 - b) Famciclovir 500 mg PO, 2 times a day for 5-10 days,
OR
 - c) Valacyclovir 1 gm PO, 2 times a day for 5-10 days.
 - 2) Daily suppressive therapy:
 - a) Acyclovir 400 - 800 mg PO, 2-3 times a day,
OR
 - b) Famciclovir 500 mg PO, 2 times a day,
OR
 - c) Valacyclovir 500 mg PO, 2 times a day.

2. Over-the-counter oral analgesic of patient's choice (e.g., acetaminophen or ibuprofen) as needed **for pain related to outbreak and prodrome syndrome.**

NON-PHARMACOLOGIC MEASURES

1. Keep affected areas as clean and dry as possible. Pat lesions dry; avoid rubbing the area. (The use of ointments will retain moisture and may delay healing.)
2. Encourage increased intake of fluids (e.g., water) to dilute urine if it burns the affected area.

PATIENT EDUCATION/COUNSELING (Reinforce pertinent information with handouts)

Counseling of infected patients and their sex partners is critical to help the patient cope with the infection and to prevent sexual and perinatal transmission.

Although initial counseling is important, many patients benefit more from counseling about the chronic aspects of the disease after the acute illness subsides.

1. **The name/significance of the infection. Educate for sequelae and complications of the untreated infection.**
<http://www.cdc.gov/std/herpes/herpes-factsheet-july-2014.pdf>
2. Educate about the natural history of the disease, the potential for recurrent episodes, and the risks of asymptomatic viral shedding between episodes.
3. Give clear directions for taking medication and management of potential side effects.
4. Advise patients experiencing a first episode that suppressive and episodic antiviral therapy is available to prevent or shorten the duration of recurrent episodes.
5. Discuss comfort and pain-relieving measures.
6. Encourage patients to inform their current sex partners about the infection and inform future partners before initiating a sexual relationship. Inform sex partners of infected patients that they might be infected even if they have no symptoms.
7. Sexual transmission can occur during asymptomatic periods.
8. Avoid sexual activity with uninfected partners when lesions or prodromal symptoms are present. At other times, correctly-used latex condoms may reduce the risk of transmission when the infected areas are covered.
9. Prodrome occurs before recurring episodes. A day or two before an outbreak occurs; the genital skin gets sensations such as itching, tingling or pain. This period is called prodrome phase. The skin also sheds virus during this phase. Therefore, it is important to have no sexual relation during this period. If your partner has herpes, ask them to keep you informed about their prodrome phase.

10. Explain the risk for neonatal infection to all patients, including men. Advise infected women of child-bearing age to inform health-care providers who care for them during pregnancy and those who will care for their newborn infant.
11. Patients should refer all symptomatic sex partner(s) for evaluation. Asymptomatic sex partners may be referred for evaluation and counseling.
Sex partners of infected person should be advised that they may be infected even if they have no symptoms.
12. Discuss resources available for further information and psychological support including availability of latex condoms.
13. Risk of neonatal HSV should be discussed with females and males.
14. Refer all pregnant patients who are infected or exposed to herpes to obstetrician.
15. Episodic treatment does not reduce risk of transmission.
16. Recurrence of lesions does not mean that the patient has been reexposed.
17. **Recurrences and subclinical shedding are much more frequent for genital HSV-II than for genital HSV-I infection.**
18. **When exposed to HIV, HSV-II seropositive persons are at increased risk for HIV acquisition.**
19. **Pregnant women or women who conceive while taking daily suppressive should consult with their OB/GYN or OB provider for treatment regimen guidance.**
20. Education and counseling of the correct usage of protective barriers (condoms, dental dams, etc.).
21. If patient is of childbearing age, counsel on the use of contraceptives to reduce the risk of unintended pregnancy.
22. Assist patient in developing a personalized STD/HIV risk reduction plan and document patients plan. Abstain from sex until all the symptoms are resolved and partner(s) are tested and treated.

23. Hepatitis A, Hepatitis B and or HPV vaccine if patient is unvaccinated. To verify eligibility criteria for state supplied vaccines go to:
<http://dph.georgia.gov/sites/dph.georgia.gov/files/Immunizations/Publications-GA-Imm-Manual-Complete.pdf>
http://dph.georgia.gov/sites/dph.georgia.gov/files/photo_gallery/February%202015%20Vaccine%20Eligibility%20table_0.pdf
24. Women without symptoms or signs of genital herpes or prodrome can deliver vaginally. Women with recurrent genital herpetic lesions near or at the onset of delivery should deliver by C-section to prevent transmission to infant during vaginal delivery.
25. Advise the patient to return to clinic for all lab results even if presumptively treated at initial visit. Inform patient if lab results are positive additional treatment may be needed.
26. HIV antibody test to determine HIV status, if unknown.

MANAGEMENT OF SEX PARTNERS

1. Symptomatic sex partners should be managed the same as any patient with genital lesions. Educate to understand the natural history of HSV including possibility of asymptomatic shedding of virus and lesions reappearing without sexual re-exposure.
2. Ask asymptomatic partners about a history of typical or atypical genital lesions and encourage examining themselves for lesions in the future. Counsel about the possibility of being infected even if they have never been symptomatic. Order type-specific serologic antibody testing to determine whether the risk for HSV acquisition exists.

FOLLOW-UP

1. Schedule an appointment with the patient when culture results are available. Individualize counseling according to clinical progress and apparent emotional impact where further education and counseling for patient and sex partners may be indicated. Assist patient to develop a personalized STD/HIV risk reduction plan.
2. If the patient did not have a positive herpes culture, order type-specific serologic antibody testing to confirm the clinical diagnosis of genital herpes and determine the type of antibodies present. This has important counseling implications, since HSV-I genital infection is less likely to cause asymptomatic shedding or to recur than HSV-II.

3. For patients on continuous daily suppressive therapy, discuss therapy after one year, to assess the patient's psychological adjustment to genital herpes, rate of recurrent episodes, and the need to continue or discontinue therapy.

CONSULTATION/REFERRAL

1. **If signs or symptoms of meningitis present refer immediately for emergency evaluation.** Consult delegating physician if symptoms of meningitis (e.g., headache, nausea, vomiting, stiff neck) during first or with recurrent episode(s).
2. **For additional information and psychological support, refer to: Local HELP line (678-561-4377 in Atlanta) or the National Herpes and HPV and Cervical Cancer Prevention Hotline, 919-361 8488, 1-800-CDC-INFO, or <http://www.ashasexualhealth.org/stdsstis/herpes/>**
3. Consult with delegating physician for referral of the following types of patients:
 - a. Pregnant women. OB/GYN or OB provider must be given full information including copy of laboratory slips to ensure that the patient is treated adequately.
 - b. With history of renal impairment.
 - c. With persistent lesions.
4. In HIV infected patients, if receiving antiviral treatment and lesions persist or recur refer to Infectious Disease specialist for evaluation of possible resistance.
5. Consult delegating physician when further medical guidance is needed and STD nursing protocol is not applicable for therapeutic treatment of patient.
6. Public Health Employees must be familiar with procedures for reporting possible sexual or physical abuse of children if encountered through history or physical. All suspected sexual or physical abuse of children must be reported to the county Department of Family and Children Services office as per Guidelines for Mandatory Reporting of Suspected Child Abuse for Public Health Personnel, which may be viewed on the Public Health Information Library (PHIL) at <http://www.dphphil.org/DPH/Policy/Health%20Protection/Child%20Abuse%20Reporting%20Guidelines%20October%202013%20FINAL.pdf>.

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STANDARD NURSE PROTOCOL FOR GENITAL ULCER, POSSIBLE PRIMARY SYPHILIS

DEFINITION

The possibility of syphilis should be investigated for all genital ulcers. “Possible Primary Syphilis” is a tentative assessment based on the clinical findings of an ulcerated lesion, typical of the classic ulcer associated with primary syphilis, appearing in the genital area of a sexually active adult. The patient is not a known contact to early syphilis, and laboratory diagnostic criteria for primary syphilis (positive darkfield exam or newly-reactive Rapid Plasma Reagin [RPR] serology) are unable to be immediately met.

Factors in deciding to give treatment for possible primary syphilis before RPR results are available include **potential: patient unreliability, possible non-compliance with avoiding sexual contact, difficulty contacting and/or non-compliance with keeping follow-up appointment(s).**

If a primary syphilis ulcer has been present for less than a week, the RPR may be nonreactive, and treatment at this point could mask the diagnosis. In some cases, a Fluorescent Treponemal Antibody Absorption (FTA-ABS) but not an Enzyme Immunoassay (EIA) may be reactive prior to the RPR becoming reactive.

ETIOLOGY

Treponema pallidum, a spirochete, is the causative organism for syphilis. There are many causes of genital ulcers, but the most common sexually-transmitted etiology in the United States is herpes simplex virus, for which testing should also be done on all genital ulcers

SUBJECTIVE

1. Painless open sore in the genital area.
2. May have non-tender, swollen glands in the groin.
3. No definitive history of contact to a known case of early syphilis, though patient may have noticed a suspicious lesion or rash on a sex partner.

OBJECTIVE

1. Painless ulcer with an indurated border and relatively clear base, in the genital area.
2. May have firm, non-tender, and modestly enlarged inguinal lymph node(s), frequently bilateral.

ASSESSMENT

Genital Ulcer, Possible Primary Syphilis

PLAN

DIAGNOSTIC STUDIES

1. Rapid Plasma Reagin (RPR), with titer. Obtain history of past syphilis serologic results.
2. Enzyme Immunoassay (EIA) and Fluorescent Treponemal Antibody Absorption (FTA-ABS) if no history of previous syphilis; if the ulcer has been present for less than a week, order FTA regardless of RPR or EIA results.
3. Herpes culture.
4. Painless ulcer (chancre) with an indurated border and relatively smooth base, at a site of sexual exposure, e.g., genitals, anus, mouth.
5. Localized firm, non-tender, enlarged lymph nodes.

THERAPEUTIC

NOTE: The delegating physician should be consulted when presumptive treatment is being considered and pending laboratory findings does not support clinical finding.

NOTE: Any patients who test positive for syphilis should be tested for gonorrhea, chlamydia and HIV.

PHARMACOLOGIC

1. If patient is neither pregnant nor HIV-infected
 - a. Benzathine Penicillin G, 2.4 million units (mu) IM, once,

OR

 - b. If history of allergy to penicillin, Doxycycline 100 mg PO, 2 times a day for 14 days ,(if patient is 8 years of age or older).

NOTE: Do not give Doxycycline to lactating patient(s); patient(s) must be advised to discontinue breastfeeding or receive alternative regimen. If breastfeeding women are pumping during treatment, they should not provide pumped breast milk to infant throughout treatment and for two days after completion of treatment. Do not give to children under the age of 8.

2. If patient is pregnant
 - a. Benzathine Penicillin G, 2.4 mu IM, once, after (see consultation/referral),

OR

- b. If patient is allergic to penicillin, await lab results and consult delegating physician.
- 3. If patient is HIV-infected
 - a. Benzathine Penicillin G, 2.4 mu IM, once,
OR
 - b. Doxycycline 100 mg PO, 2 times a day for 14 days.
NOTE: Do not give Doxycycline or Tetracycline to lactating patient(s); patient(s) must be advised to discontinue breastfeeding or receive alternative regimen. If breastfeeding women are pumping during treatment, they should not provide pumped breast milk to infant throughout treatment and for two days after completion of treatment. Do not give to children under the age of 8.

PATIENT EDUCATION/ COUNSELING

(Reinforce pertinent information with handouts)

1. **The name/significance of the infection. Educate for sequelae and complications of the untreated infection (<http://www.cdc.gov/std/syphilis/syphilis-factsheet-july-2014.pdf>).**
2. If given oral medication, directions for taking it and what to do about potential side effects. Importance of follow up should be discussed, especially if first line drug (Benzathine Penicillin G) is not used.
3. **The possibility of a Jarisch-Herxheimer (e.g. fever, chills, headache, myalgia, and exacerbation of cutaneous lesions) reaction and what to do about it. (If pregnant, seek medical care immediately if notice a change in fetal movement or uterine contractions.) Jarisch-Herxheimer Reaction may occur within 12 hours after treatment of early syphilis. Local reaction may consist of intensification of lesions (e.g., a chancre may become edematous or a faint secondary rash may become prominent). Systemic reaction may consist of a rise in temperature of 101-102 degrees Fahrenheit. The self-limiting reaction usually only lasts a few hours, but may be up to 24 hours. Antipyretic may be taken as needed. Pregnant women may have more severe reactions and should contact their prenatal care provider at the first sign or symptoms. (If pregnant, seek medical care immediately if notice a change in fetal movement or uterine contractions.)**

4. The need to refer sex partners from within the previous three months to be examined and treated as soon as possible after the diagnosis is established.
5. Avoid sex until infection status of self and partner(s) is known.
6. **Women who are breastfeeding should not receive Doxycycline. If Doxycycline is given to breastfeeding women they should discontinue breastfeeding throughout treatment and for two days after completion of treatment. If breastfeeding women are pumping during treatment, they should not provide pumped breast milk to infant throughout treatment and for two days after completion of treatment.**
7. **If patient is of childbearing age, counsel on the use of contraceptives to reduce the risk of unintended pregnancy.**
8. Education and counseling of the correct usage of protective barriers (condoms, dental dams, etc.).
9. Assist patient in developing a personalized STD/HIV risk reduction plan and document patients plan. Abstain from sex until all the symptoms are resolved and partner(s) are tested and treated.
10. HIV antibody test to determine HIV status, if unknown.

Hepatitis A, Hepatitis B and or HPV vaccine if **patient** is unvaccinated. To verify eligibility criteria for state supplied vaccines go to;

<http://dph.georgia.gov/sites/dph.georgia.gov/files/Immunizations/Publications-GA-Imm-Manual-Complete.pdf> and
http://dph.georgia.gov/sites/dph.georgia.gov/files/photo_gallery/February%202015%20Vaccine%20Eligibility%20table_0.pdf

MANAGEMENT OF SEX PARTNERS

1. Do thorough history and examination for signs of syphilis; draw blood for RPR **and confirmatory test**.
2. Counsel patient that he/she may need treatment for syphilis, depending on test results on partner or self.

FOLLOW-UP

1. **If diagnosis of syphilis is made and District Communicable Disease Specialist is not on-site, document thorough information to identify and locate patient and partner(s) for District Communicable Disease Specialist's follow-up.**
2. Give the patient an appointment to return to the clinic in one week, no matter what the lab results are. Examine lesion for response to treatment. If the original RPR, EIA and FTA were negative and the lesion was highly suspicious for syphilis, but present for a week or less, order repeat tests.
3. If a diagnosis of primary syphilis is made, do follow-up per syphilis nurse protocol. Do a repeat RPR in one month regardless of the diagnosis to ensure that a syphilis diagnosis is not missed.

CONSULTATION/REFERRAL

1. Notify immediately, District Communicable Disease Specialist for partner services and case management.
2. Consult/refer to delegating physician or primary care physician if lesion does not improve in one week.
3. Consult with delegating physician if patient is pregnant and allergic to penicillin for desensitization referral.
4. Refer all pregnant women to OB/GYN or OB provider for prenatal care.
5. Consult delegating physician when further medical guidance is needed and STD nursing protocol is not applicable for therapeutic treatment of patient.
6. Public Health Employees must be familiar with procedures for reporting possible sexual or physical abuse of children if encountered through history or physical. All suspected sexual or physical abuse of children must be reported to the county Department of Family and Children Services office as per Guidelines for Mandatory Reporting of Suspected Child Abuse for Public Health Personnel, which may be viewed on the Public Health Information Library (PHIL) at <http://www.dphphil.org/DPH/Policy/Health%20Protection/Child%20Abuse%20Reporting%20Guidelines%20October%202013%20FINAL.pdf>.

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STANDARD NURSE PROTOCOL FOR SYPHILIS, EARLY SYMPTOMATIC (PRIMARY and SECONDARY)

DEFINITION The symptomatic stages occurring during the first year of untreated syphilis infection.

The primary stage is characterized by a painless, indurated ulcer (chancre) that appears at the site(s) of sexual exposure in about 21 days (range of 10-90 days) and lasts from 1 to 5 weeks before spontaneously healing.

The secondary stage, which usually appears 1 to 5 weeks after the primary chancre is healed, is characterized by a variety of skin or mucous membrane rashes or other type lesions. They will disappear spontaneously within 2 to 6 weeks, but may recur within the year.

ETIOLOGY Treponema pallidum, a spirochete. The primary chancre and certain moist lesions (condyloma lata or mucous patches) of secondary syphilis are very contagious, and sexual contact when such lesions are present is the usual mode of transmission.

SUBJECTIVE

A. Primary Syphilis:

1. Painless open sore, at a site of sexual exposure.
2. Localized, non-tender swollen glands.

B. Secondary Syphilis: Has one or more of the following:

NOTE: Symptomatic neurosyphilis can rarely occur in the secondary stage and should be considered if signs and/or symptoms of meningitis are present.

1. **Rough, red, or reddish brown** rash on the body and/or extremities. **Rash usually does not itch.**
2. Growths/lesions in the anogenital region.
3. Hair falling out.
4. Swollen glands.
5. Sores in the mouth, **vagina, or anus.**

6. Fever, malaise.

OBJECTIVE

- A. Primary Syphilis:
 1. **Firm, round**, painless ulcer (chancre) with an indurated border and relatively smooth base, at a site of sexual exposure, e.g., genitals, anus, mouth.
 2. Localized firm, non-tender, enlarged lymph nodes.
- B. Secondary Syphilis (one or more of the following is present):
 1. Bilaterally symmetrical macular or papular, nonpruritic rash on body and/or extremities. May be only on the palms and soles (palmar/plantar).
 2. Condyloma lata (large, **raised, gray or white lesions**, usually in the genital and/or anal region or mouth).
 3. Patchy hair loss on scalp, eyebrows or eyelashes.
 4. Generalized enlarged lymph nodes.
 5. Mucous patches in the mouth or on the cervix.

PHYSICAL EXAM/ LAB FINDINGS

- A. Primary Syphilis
 1. Identification of *T. pallidum* on darkfield microscopic exam of serum from a chancre is definitive.
OR
 2. Typical ulcer (chancre),
AND
 - a. A newly-reactive RPR, confirmed by a reactive treponemal EIA, FTA-ABS or TPPA,
OR
 - b. A four-fold or greater increase over the last known RPR titer in a patient with a previous history of syphilis is presumptive.

NOTE: Patients with a typical ulcer, a newly-reactive RPR or STAT POSITIVE RPR card test and no history of previous syphilis may be treated for primary syphilis prior to the results of the treponemal test being available.

3. A typical ulcer and exposure to a known case of early syphilis in the previous 10-90 days is suggestive of primary syphilis.
- B. Secondary Syphilis
1. Identification of *T. pallidum* on darkfield microscopic exam of lesion material is definitive.
OR
 2. Typical signs (e.g., rash, mucous patches)
AND
 - a. Newly-reactive RPR, confirmed by a treponemal test,
OR
 - b. A four-fold increase over the last known titer in a patient with a previous history of syphilis is presumptive.
- NOTE:** Patients with secondary typical signs, a newly-reactive RPR or STAT POSITIVE RPR and no history of previous syphilis may be treated for secondary syphilis prior to the results of the treponemal test being available.
3. Typical dermatologic signs and exposure to a known case of early syphilis in the past six months is suggestive of secondary syphilis.
- C. HIV-infected patients
When clinical findings are suggestive of syphilis but serologic tests are nonreactive or their interpretation is unclear, alternative tests may need to be considered. Neurosyphilis should be considered in HIV-infected patients with neurologic symptoms.

ASSESSMENT Primary Syphilis
OR
Secondary Syphilis

PLAN The desired outcome of case management is to ensure infection cure in the patient, prevention of infection in sexual partners exposed within the preceding 90 days, and congenital infection.

DIAGNOSTIC STUDIES

1. RPR titer, if not already done. **False-positive nontreponemal test results can be associated with various medical conditions and factors unrelated to syphilis, including other infections (e.g., HIV), autoimmune conditions (e.g., Lupus), immunizations, pregnancy, IV drug use and older age.**

2. Repeat RPR, if lab results are equivocal or indeterminate in two to four weeks.
 - a. Interpretation of Syphilis EIA or FTA results
 1. Reactive means a diagnosis of syphilis is confirmed
 2. Minimal reactive or equivocal means the test could not be called either reactive or non-reactive and a second specimen should be submitted for repeat testing in two to four weeks.
 3. Non-reactive means a diagnosis of syphilis is not confirmed.
3. Confirmatory test by a reactive treponemal EIA, FTA-ABS, or TPPA.
4. **If confirmatory test is reactive and the RPR (nontreponemal) is non-reactive, redraw the RPR (nontreponemal) within two to four weeks.**
5. Recommendation: RPR STAT Card, if available. Must be able to titer out results if RPR STAT card report indicates positive findings, confirmed by a reactive treponemal EIA, FTA-ABS, or TPPA. If RPR card test is negative, titer out results to rule out prozone phenomenon (false negative test).
6. Recommendation: Darkfield microscopic exam if resources are available.

THERAPEUTIC

PHARMACOLOGIC

NOTE: Any patients who test positive for syphilis should be tested for gonorrhea, chlamydia and HIV.

NOTE: If Benzathine Penicillin G is in short supply, reserve existing penicillin for pregnant and HIV- infected patients.

NOTE: Do not give Doxycycline or Tetracycline to lactating patient(s); patient(s) must be advised to discontinue breastfeeding throughout treatment and for two days after treatment or receive alternative regimen. If breastfeeding women are pumping during treatment, they should not provide pumped breast milk to infant throughout treatment and for two days after completion of treatment. Do not give to children under the age of 8.

NOTE: Patients with a positive treponemal screening test should receive a nontreponemal test to confirm the screening test. If the nontreponemal test is negative, another type of treponemal test, different from the initial treponemal test (FTA-ABS, TPPA, or EIA), should be done.

RECOMMENDED REGIMEN

NOTE: Empiric treatment for primary or secondary syphilis can be given if clinical manifestations (i.e., chancre, skin rash, lymphadenopathy) of primary or secondary are identified and the patient is unlikely to be located for treatment when test results are available. If empiric treatment is provided see patient education section for required education.

1. If patient is neither pregnant nor HIV-infected
 - a. Benzathine Penicillin G, 2.4 million units (mu) IM, once.
OR
 - b. If history of allergy to penicillin, Doxycycline 100 mg PO, 2 times a day for 14 days (if patient is 8 years of age or older).

ALTERNATIVE REGIMEN

1. Tetracycline 500mg PO, 4 times a day for 14 days if patient is 8 years of age or older.
2. If patient is pregnant or HIV-infected,
 - a. Benzathine Penicillin G, 2.4 million units IM, once.
OR
 - b. If history of allergy to penicillin, the **patient** must be referred for skin testing and possible desensitization and subsequent treatment with penicillin.

PATIENT EDUCATION/COUNSELING

(Reinforce pertinent information with handouts)

1. **The name/significance of the infection. Educate for sequela and complications of the untreated infection (<http://www.cdc.gov/std/syphilis/syphilis-factsheet-july-2014.pdf>).**
2. If given oral medication, directions for taking it, possible side effects, and what to do about them. Patients receiving oral treatment must report noncompliance due to any reason for corrective actions.
3. **The possibility of a Jarisch-Herxheimer (e.g. fever, chills, headache, myalgia, and exacerbation of cutaneous lesions) reaction and what to do about it. (If pregnant, seek medical care immediately if notice a change in fetal movement or uterine contractions.) Jarisch-Herxheimer Reaction may occur within 12 hours after treatment of early syphilis. Local reaction may consist of intensification of lesions (e.g., a chancre may become edematous or a faint secondary rash may become prominent). Systemic reaction may consist of a rise in temperature of 101-102 degrees Fahrenheit. The self-limiting reaction usually only last a few hours, but may be up to 24 hours. Antipyretic may be taken as needed. Pregnant women may have more severe reactions and should contact their prenatal care provider at the first sign or symptoms. (If pregnant, seek medical care immediately if notice a change in fetal movement or uterine contractions.)**
4. Signs and symptoms of neurosyphilis (see attached Appointment Card 7.101 & 7.102). If neurologic or ophthalmic disease is suspected patient should be referred for CSF analysis, otologic and ophthalmologic examination.
5. The need for, and schedule of, follow-up blood tests at 3, 6, and 12 months.
6. **Patients treated during the primary stage of syphilis may revert to being serologically nonreactive after 2-3 years.**
7. **Patients who receive positive treponemal screening test should have a standard nontreponemal test with titer preformed to guide patient management decisions.**

8. Counseling regarding abstinence until therapy is completed for the patient.
9. The need for examination and treatment of sex partners and avoidance of sex with untreated partners. Introduce them to the Communicable Disease Specialist who will assist them.
10. Assist patient in developing a personalized STD/HIV risk reduction plan and document patients plan. Abstain from sex until all the symptoms are resolved and partner(s) are tested and treated.
11. Refer all pregnant patients to OB/GYN or OB provider to seek prenatal care and/or fetal evaluation.
12. Education and counseling of the correct usage of protective barriers (condoms, dental dams, etc.).
13. **If patient is of childbearing age, counsel on the use of contraceptives to reduce the risk of unintended pregnancy.**
14. **If empiric treatment is provided, patient education must include:**
 - a. **Information of presumptive therapy with pending lab results.**
 - b. **Patient option to consent to treatment or refusal of treatment prior to lab results due to the high suspicion of syphilis.**
 - c. **Patient must return for lab results.**
 - d. **Patients should be referred to a Communicable Disease Specialist (CDS) for further counseling.**
 - e. **Updated demographics (current locating information, phone number, emergency contact, etc.) collected on patient and provided to CDS.**
15. Hepatitis A, Hepatitis B and or HPV vaccine if patient is unvaccinated. To verify eligibility criteria for state supplied vaccines go to:
<http://dph.georgia.gov/sites/dph.georgia.gov/files/Immunizations/Publications-GA-Imm-Manual-Complete.pdf> and
http://dph.georgia.gov/sites/dph.georgia.gov/files/photo_gallery/February%202015%20Vaccine%20Eligibility%20table_0.pdf

MANAGEMENT OF SEX PARTNERS

1. Contacts to Primary Syphilis
Examine and treat, with one of the regimens listed above, all referred partners exposed within 3 months of onset, or since

- onset, of symptoms.
2. Contacts to Secondary Syphilis
 - a. Examine all referred partners exposed within 6 months of onset, or since onset, of symptoms.
 - b. Treat (with one of the regimens listed above):
All those exposed within the preceding 3 months, regardless of examination and serologic test results, and those exposed more than 3 months ago if serologic test results are not immediately available and follow-up is uncertain.

FOLLOW-UP

1. Monitor compliance if taking Doxycycline.
2. Schedule a routine appointment for a clinical evaluation and repeat RPR in 3 to 6 months, and then at 12 months.
3. If pregnant, clinical evaluation and RPRs should be done at least once during the third trimester and at delivery. Monthly RPR titers may be indicated for women at high risk for reinfection.
4. HIV infected patients should be managed in the same manner as HIV-negative patients with the exception of monitoring RPR titers at 3-month intervals for a year, and then at 24 months after therapy.
5. Clinical and RPR titer response should be appropriate for the stage of disease. RPR titers may decline more slowly for patients that previously had syphilis.
6. Seek medical consultation from delegating physician if a, b and/or c occurs:
 - a. If signs or symptoms persist or recur, or if a sustained four-fold increase in titer compared to the baseline or maximum titer occurs, the patient probably failed treatment or was reinfected. The patient should be re-treated and reevaluated for HIV infection and/or re-exposure. A cerebral spinal fluid (CSF) exam also should be performed.
 - b. If titers have not declined fourfold by 6 months, the patient should be reevaluated for HIV infection. If further clinical and serologic follow up cannot be assured, re-treatment should be given.

- c. In either instance above, re-treatment should consist of three weekly doses of benzathine penicillin 2.4 million units IM, unless CSF exam indicates that neurosyphilis is present.

CONSULTATION/REFERRAL

1. Consult delegating physician when further medical guidance is needed and STD nursing protocol is not applicable for therapeutic treatment of patient.
2. Probable or suspected cases of syphilis with clinical magnifications or reactive RPR titer should receive delegating physician consultation immediately while pending confirmatory for possible presumptive treatment.
3. If signs or symptoms of neurologic or ophthalmic disease present refer immediately for emergency evaluation and consult delegating physician.
4. Consult delegating physician of patients with penicillin-allergy skin testing and desensitization, as necessary.
5. For CSF exam in instances noted previously.
6. All primary and secondary syphilis cases should be referred to a Communicable Disease Specialist for further counseling and sex partner referral.
7. Public Health Employees must be familiar with procedures for reporting possible sexual or physical abuse of children if encountered through history or physical. All suspected sexual or physical abuse of children must be reported to the county Department of Family and Children Services office as per Guidelines for Mandatory Reporting of Suspected Child Abuse for Public Health Personnel, which may be viewed on the Public Health Information Library (PHIL) at <http://www.dphphil.org/DPH/Policy/Health%20Protection/Child%20Abuse%20Reporting%20Guidelines%20October%202013%20FINAL.pdf>.

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3. Confirmatory test by a reactive treponemal EIA, FTA-ABS, or TPPA.
4. Review Appointment Card Signs/Symptoms of Neurosyphilis with patient, if any found, refer immediately for emergency evaluation and notify delegating physician.

THERAPEUTIC

Note: After the completion of neurosyphilis treatment, benzathine penicillin 2.4 million units IM X 3 can be considered to provide total duration of therapy.

PHARMACOLOGIC

1. Early Latent Syphilis
 - a. If patient is not pregnant, allergic to penicillin, or HIV-infected and neurosyphilis (see appointment card on page 7.101 & 7.102) is ruled out:
 - 1) Benzathine Penicillin G, 2.4 million units IM, once.
 - OR
 - 2) If allergic to penicillin, Doxycycline 100 mg PO, 2 times a day for 14 days, with careful monitoring for compliance, (if patient is 8 years of age or older).

NOTE: Do not give Doxycycline to lactating patient(s); patient(s) must be advised to discontinue breastfeeding throughout treatment and for two days after treatment is completed or receive alternative regimen. If breastfeeding women are pumping during treatment, they should not provide pumped breast milk to infant throughout treatment and for two days after completion of treatment. Do not give to children under the age of 8.

- b. If patient is pregnant and neurosyphilis (see appointment card on page 7.101 & 7.102) is ruled out treat with Benzathine Penicillin G, 2.4 million units IM, once.

If patient is pregnant and allergic to penicillin refer to allergist for desensitization with subsequent treatment with penicillin.

- c. If patient is HIV infected and neurosyphilis (see appointment card on page 7.101 & 7.102) is ruled out treat with Benzathine Penicillin G, 2.4 million units IM, once.

If patient is HIV infected and allergic to penicillin refer to allergist for desensitization with subsequent treatment with penicillin.

NOTE: If patient is pregnant, and/or HIV infected, or has signs and symptoms of neurosyphilis, refer immediately for emergency evaluation. Delegating physician, Allergist and Infectious Disease specialist should be consulted.

2. Late Latent Syphilis or Latent Syphilis of Unknown Duration

- a. If patient is not pregnant, allergic to penicillin, nor HIV-infected and does not have neuropsychiatric signs and/or symptoms:

- 1) Benzathine Penicillin G, 2.4 million units IM, weekly for 3 doses (7.2 million units total).

NOTE: An interval of up to 10-14 days between doses may occur without re-starting the sequence of injections

OR

- 2) If patient has a history of allergy to penicillin, refer for skin testing and possible desensitization, with subsequent treatment with benzathine penicillin

OR

- 3) If allergic to penicillin, and neurosyphilis has been ruled out, Doxycycline 100 mg PO, 2 times a day for 28 days, with careful monitoring for compliance ,(if patient is 8 years of age or older).

NOTE: Do not give Doxycycline to HIV infected patient(s) or lactating patient(s); patient(s) must be advised to discontinue breastfeeding throughout treatment and for two days after treatment is completed or receive alternative regimen.

If breastfeeding women are pumping during treatment, they should not provide pumped breast milk to infant throughout treatment and for two days after completion of treatment. Do not give to children under the age of 8.

ALTERNATIVE REGIMEN

Tetracycline 500 mg PO, 4 times a day for 28 days, (if patient is 8 years of age or older)

OR

If patient has a history of allergy to penicillin, refer for skin testing and possible desensitization, with subsequent treatment with benzathine penicillin.

NOTE: Do not give Doxycycline or Tetracycline to lactating patient(s); patient(s) must be advised to discontinue breastfeeding throughout treatment and for two days after treatment is completed or receive alternative regimen. If breastfeeding women are pumping during treatment, they should not provide pumped breast milk to infant throughout treatment and for two days after completion of treatment. Do not give to children under the age of 8.

REMINDER: If Benzathine Penicillin G is in short supply, reserve existing penicillin for pregnant and HIV-infected patients.

- b. If patient is pregnant and does not have neuropsychiatric signs and/or symptoms:
 - 1) Benzathine Penicillin G, 2.4 million units IM, weekly for 3 doses (7.2 million units total).

NOTE: Pregnant patients who miss any dose of therapy, scheduled at 7-day intervals, must restart the sequence of injections.

OR

- 2) If patient has a history of allergy to penicillin, refer for skin testing and possible desensitization, with subsequent treatment with Benzathine Penicillin G, 2.4 million units IM, weekly for 3 doses (7.2 million units total).
- c. If patient is HIV infected and does not have neuropsychiatric signs and/or symptoms:
- 1) Benzathine Penicillin G, 2.4 million units IM, weekly for 3 doses (7.2 million units total).
- NOTE: Patient(s) who miss any dose of therapy, scheduled at 7-day intervals, must restart the sequence of injections.
- OR**
- 2) If patient has a history of allergy to penicillin, refer for skin testing and possible desensitization, with subsequent treatment with Benzathine Penicillin G, 2.4 million units IM, weekly for 3 doses (7.2 million units total).

PATIENT EDUCATION/COUNSELING

(Reinforce pertinent information with handouts.)

1. **The name/significance of the infection. Educate for sequela and complications of the untreated infection (<http://www.cdc.gov/std/syphilis/syphilis-factsheet-july-2014.pdf>).**
2. If given oral medication, directions for administration and management of possible side effects.
3. **The possibility of a Jarisch-Herxheimer (e.g. fever, chills, headache, myalgia, and exacerbation of cutaneous lesions) reaction and what to do about it. (If pregnant, seek medical care immediately if notice a change in fetal movement or uterine contractions.) Jarisch-Herxheimer Reaction may occur within 12 hours after treatment of early syphilis. Local reaction may consist of intensification of lesions (e.g., a chancre may become edematous or a faint secondary rash may become prominent). Systemic reaction may consist of a rise in temperature of 101-102 degrees Fahrenheit. The self-limiting reaction usually only last a few hours, but may be up to 24 hours. Antipyretic may be taken as needed.**

Pregnant women may have more severe reactions and should contact their prenatal care provider at the first sign or symptoms. (If pregnant, seek medical care immediately if notice a change in fetal movement or uterine contractions.)

4. The need for, and schedule of, follow-up blood tests.
5. For early latent syphilis and syphilis of unknown duration, the need for examination of sex partners and avoidance of sex with untreated partners. Introduce patients to the communicable disease specialist who will assist them with partner notification.
6. For late latent syphilis and syphilis of unknown duration without neuropsychiatric signs/symptoms, give patient appointment card containing signs and symptoms of neurosyphilis with instructions on when to return.
7. Seropositive pregnant women should be considered infected unless adequate documentation of treatment history in medical records and titers has declined.
8. Pregnant women diagnosed for syphilis in 2nd trimester, should be referred to OB/GYN or OB provider for sonographic fetal evaluation for congenital syphilis.
9. Assist patient in developing a personalized STD/HIV risk reduction plan and document patients plan. Abstain from sex until all the symptoms are resolved and partner(s) are tested and treated.
10. Education and counseling of the correct usage of protective barriers (condoms, dental dams, etc.).
11. **Women who are breastfeeding should not receive Doxycycline. If Doxycycline is given to breastfeeding women they should discontinue breastfeeding throughout treatment and can resume breastfeeding two days after completion of treatment. If breastfeeding women are pumping during treatment, they should not provide pumped breast milk to infant throughout treatment and for two days after completion of treatment.**
12. If patient is of childbearing age, counsel on the use of contraceptives to reduce the risk of unintended pregnancy.
13. Review Appointment Card Signs/Symptoms of Neurosyphilis with patient.

14. HIV antibody test to determine HIV status, if unknown.
15. Refer pregnant patients to OBGYN or OB provider for prenatal care.
16. Hepatitis A, Hepatitis B and or HPV vaccine if patient is unvaccinated. To verify eligibility criteria for state supplied vaccines go to:
<http://dph.georgia.gov/sites/dph.georgia.gov/files/Immunizations/Publications-GA-Imm-Manual-Complete.pdf> and
http://dph.georgia.gov/sites/dph.georgia.gov/files/photo_gallery/February%202015%20Vaccine%20Eligibility%20table_0.pdf

MANAGEMENT OF SEX PARTNERS

1. Contacts to Early Latent Syphilis and Latent Syphilis of Unknown Duration
 - a. Examine all referred partners from the previous year.
 - b. Treat (with one of the above single dose or 14 day regimens) all those exposed within the preceding 3 months, regardless of examination and serologic test results, and those exposed more than 3 months ago if serologic test results are not immediately available and follow-up is uncertain.
2. Contacts to Late Latent Syphilis
 - a. Evaluate steady (e.g., marital) sex partners. No treatment is needed unless the partner is shown to be infected.
 - b. Children born to an infected female within the past few years should also be evaluated.

FOLLOW-UP (All latent syphilis)

1. Repeat RPR at 6, 12, and 24 months. If titers increase fourfold, if an initially high titer (at least 1:32) fails to decline at least fourfold within 12 to 24 months, or if the patient develops signs or symptoms attributable to syphilis, evaluate for possible neurosyphilis and re-treat appropriately.
2. If the patient is HIV-infected, repeat RPR at 6, 12, 18 and 24 months. If signs or symptoms of syphilis recur, if signs or symptoms of neurosyphilis develop, or if titers rise fourfold, refer patient for CSF (cerebrospinal fluid) exam and re-treat accordingly.

3. If pregnant, clinical evaluation and RPRs should be done at least once during the third trimester and at delivery.

CONSULTATION/REFERRAL

1. Consult delegating physician when further medical guidance is needed and STD nursing protocol is not applicable for therapeutic treatment of patient.
2. Refer all patients who have neuropsychiatric signs and/or symptoms immediately for emergency evaluation and notify delegating physician.
3. All HIV-infected patients in late latent syphilis and/or syphilis of unknown duration to a delegating physician.
4. Pregnant women diagnosed for syphilis in 2nd trimester, should be referred to OB/GYN or OB provider for sonographic fetal evaluation for congenital syphilis.
5. Refer to a primary care physician or dermatologist for skin testing for penicillin allergy, and possible desensitization, as necessary.
6. All latent syphilis cases should be referred to a Communicable Disease Specialist for further counseling and sex partner referral.
7. Public Health Employees must be familiar with procedures for reporting possible sexual or physical abuse of children if encountered through history or physical. All suspected sexual or physical abuse of children must be reported to the county Department of Family and Children Services office as per Guidelines for Mandatory Reporting of Suspected Child Abuse for Public Health Personnel, which may be viewed on the Public Health Information Library (PHIL) at <http://www.dphphil.org/DPH/Policy/Health%20Protection/Child%20Abuse%20Reporting%20Guidelines%20October%202013%20FINAL.pdf>.
8. Refer pregnant patients to OB/GYN or OB provider for prenatal care.

NOTE: The following appointment card depicts some of the symptoms and signs of Neurosyphilis. Patient Health Information:

You have been treated for Syphilis. This infection is curable if treated properly. It is very important that you return for treatment as discussed by the doctor or nurse to cure the infection and prevent progression of the infection. To ensure the infection has been cured, it is important that you repeat blood work every:

- 6 months (after initial treatment)
- 12 months (for follow-up)
- 24 months (for further follow-up)

Return to:

PLACE HEALTH CLINIC LABEL HERE
ABC Health Dept
123 Health Way
Treat Infection, State 12345

On the following Dates:

Date	Treatment

If you are having complications, have been re-exposed to this infection or feel you are having signs and symptoms, please return as soon as possible.

If you or someone else notices you are having any of these signs and/or symptoms, you should return to the clinic or report to your primary care physician right away.

- Memory Loss
- Problems with Mental Function
- Unsteady Walking
- Balance Problems (Dizziness or Faint)
- Urinary Problems (Can't Hold Pee)
- Bowel Problems (Can't hold bowel movements)
- Vision Problems (Blurred vision, loss of vision)
- Eye Pain
- Problems Having Sex
- Numbness or Loss of Feeling in Legs
- Stiff Neck
- Headache
- Fever
- Loss of Hearing
- Persistent Nausea and Vomiting (Always throwing up)
- Seizures
- Stroke
- Unexplained Episodes of Severe Pain

Appointment Card



PLACE HEALTH CLINIC LABEL HERE
ABC Health Dept
123 Health Way
Treat Infection, State 12345
(404) 555-1212

REFERENCES

1. **Centers for Disease Control and Prevention, Sexually Transmitted Diseases Treatment Guidelines 2015, Vol. 64, No. RR-3, June 5, 2015.** CDC, "Case Definitions for Infectious Conditions under Public Health Surveillance," *Morbidity and Mortality Weekly Report*, Vol. 46, No. RR-10, May 2, 1997. (Current)
2. GUIDELINES FOR MANDATORY REPORTING OF SUSPECTED CHILD ABUSE for PUBLIC HEALTH PERSONNEL. (2013, October 1). . Retrieved April 1, 2014, from <http://www.dphphil.org/DPH/Policy/Health%20Protection/Child%20Abuse%20Reporting%20Guidelines%20October%202013%20FINAL.pdf>
3. **Holmes, K. K. (2008). Sexually transmitted diseases. New York: McGraw-Hill Medical.**
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STANDARD NURSE PROTOCOL FOR PEDICULOSIS PUBIS (Crabs/pubic lice)

DEFINITION	Infestation of the pubic hair, although pubic louse may also infest facial hair or eyelashes. Lice deposit eggs (nits) on the hair shaft; nits hatch in one week. The desired outcome of treatment is to eliminate lice and nits from patients and their clothing and bedding. Keep a high index of suspicion of sexual molestation in children with pubic lice.
ETIOLOGY	Crab louse, <i>Phthirus pubis</i> , typically spread by sexual contact or sleeping in the same bed. Nymphs and adult lice feed on human blood. Incubation period is approximately 6-10 days.
SUBJECTIVE	<ol style="list-style-type: none">1. Itching in the pubic area.2. "Bugs" or "crabs."
OBJECTIVE	The following criteria are used to diagnose pediculosis pubis: <ol style="list-style-type: none">1. Identification of lice, larvae, or nits attached to genital hairs. OR2. History of exposure to pubic lice AND pruritic, reddened macules or papules or secondary excoriations are observed in the genital area.
ASSESSMENT	Pediculosis Pubis (Crab or Pubic Lice)
PLAN	DIAGNOSTIC STUDIES <ol style="list-style-type: none">1. Identification of lice, larvae, or nits attached to genital hairs. OR2. History of exposure to pubic lice AND pruritic, reddened macules or papules or secondary excoriations are observed in the genital area. THERAPEUTIC PHARMACOLOGIC NOTE: Any patients who test positive for pubic lice/crabs should be tested for gonorrhea, chlamydia, syphilis and HIV. NOTE: Prior to treatment of children, consult with or refer to primary care provider. Keep a high index of suspicion of sexual molestation in children with pubic lice.

1. Either of these over-the-counter preparations:
 - a. Permethrin 1% cream rinse (e.g., NIX) applied to the affected area and washed off after 10 minutes, may repeat in one week if live lice are still found;
NOTE: Patients who are breastfeeding should discontinue throughout treatment and can resume breastfeeding two days after completion of treatment. If breastfeeding women are pumping during treatment, they should not provide pumped breast milk to infant throughout treatment and for two days after completion of treatment. Do not give to ragweed sensitized patients.

NOTE: Must be at least 2 months of age.
OR
 - b. Pyrethrins with Piperonyl Butoxide (e.g., RID) applied to the affected area and washed off after 10 minutes.
NOTE: Patients who are breastfeeding should discontinue during the duration of treatment and can resume breastfeeding two days after completion of treatment. If breastfeeding women are pumping during treatment, they should not provide pumped breast milk to infant during duration of treatment nor two days after completion of treatment. Do not give to ragweed or chrysanthemums sensitized patients.
2. Mild topical antipruritic/anti-inflammatory cream or ointment may be obtained over-the-counter for itching.
3. Alternative Regimens (Consult delegating physician prior to administering or dispensing to patient)
 - a. If age is equal or greater than two years of age, weigh at least 15 kg, and patient is not pregnant give Ivermectin
250 mcg/kg orally, repeat in two weeks.

NOTE: Patients who are breastfeeding should discontinue throughout treatment and can resume breastfeeding two days after completion of treatment.

If breastfeeding women are pumping during treatment, they should not provide pumped breast milk to infant throughout treatment and for two days after completion of treatment. .

OR

- b. If age is equal or greater than six years of age give Malathion 0.5% lotion applied for 8-12 hours and then washed off. May reapply in 7-9 days if needed.

NOTE: Malathion lotion is flammable; patients must avoid heat sources (fire, hair, dryers, curling irons, etc.

NON-PHARMACOLOGIC MEASURES

Bedding and clothing should be decontaminated (i.e., either machine-washed with hot water, or machine-dried using the heat cycle or dry-cleaned) or removed from body contact for at least 72 hours (clean clothing should be worn after treatment).

PATIENTS EDUCATION/COUNSELING

(Reinforce pertinent information with handouts)

1. **The name/significance of the infection. Educate for sequelae and complications of the untreated infection (<http://www.ashasexualhealth.org/stdsstis/crabs/>).**
2. How to apply prescribed medication and decontaminate clothing and bedding. Fumigation of living areas is not necessary.
3. Tell all sex/bed partners from within the preceding month to obtain over the counter medication and complete treatment as soon as possible. Avoid sex or sleeping with untreated partners.
4. Education and counseling of the correct usage of protective barriers (condoms, dental dams, etc.).
5. **If patient is of childbearing age, counsel on the use of contraceptives to reduce the risk of unintended pregnancy.**
6. Assist patient in developing a personalized STD/HIV risk reduction plan and document patients plan. Abstain from sex until all the symptoms are resolved.
7. HIV antibody test to determine HIV status, if unknown.

8. Hepatitis A, Hepatitis B and or HPV vaccine if patient is unvaccinated. To verify eligibility criteria for state supplied vaccines go to:
<http://dph.georgia.gov/sites/dph.georgia.gov/files/Immunizations/Publications-GA-Imm-Manual-Complete.pdf> and
http://dph.georgia.gov/sites/dph.georgia.gov/files/photo_gallery/February%202015%20Vaccine%20Eligibility%20table_0.pdf

FOLLOW-UP

1. Reevaluate in one week if symptoms persist.
2. Re-treatment may be necessary if lice or eggs are found. If no response to initial treatment, re-treatment with another regimen is recommended.

CONSULTATION/REFERRAL

1. Consult with delegating physician regarding any question of management.
2. Consult delegating physician for referral of pediculosis pubis of the eyelashes/eyebrows.
3. Consult with delegating physician for treatment of patients related to pediculosis pubis outbreak (e.g. nursing homes, jails, schools, and other communities).
4. Consult delegating physician when further medical guidance is needed and/or STD nursing protocol is not applicable for therapeutic treatment of patient.
5. Public Health Employees must be familiar with procedures for reporting possible sexual or physical abuse of children if encountered through history or physical. All suspected sexual or physical abuse of children must be reported to the county Department of Family and Children Services office as per Guidelines for Mandatory Reporting of Suspected Child Abuse for Public Health Personnel, which may be viewed on the Public Health Information Library (PHIL) at
<http://www.dphphil.org/DPH/Policy/Health%20Protection/Child%20Abuse%20Reporting%20Guidelines%20October%202013%20FINAL.pdf>.

REFERENCES

1. **Centers for Disease Control and Prevention, Sexually Transmitted Diseases Treatment Guidelines 2015, Vol. 64, No. RR-3, June 5, 2015.**
2. *Mark Lebwohl, Lily Clark and Jacob Levitt, "Therapy for Head Lice Based on Life Cycle, Resistance, and Safety Considerations," Pediatrics, 2007, 119: 965-974.*
3. **GUIDELINES FOR MANDATORY REPORTING OF SUSPECTED CHILD ABUSE for PUBLIC HEALTH PERSONNEL. (2013, October 1).** . Retrieved April 1, 2014, from <http://www.dphphil.org/DPH/Policy/Health%20Protection/Child%20Abuse%20Reporting%20Guidelines%20October%202013%20FINAL.pdf>
4. **Holmes, K. K. (2008). Sexually transmitted diseases. New York: McGraw-Hill Medical.**
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2. Burrows in the skin or characteristic pruritic, erythematous, papular eruptions, and other causes of dermatitis are excluded.
3. Diagnosis is suggestive in a patient who has had sexual or other close physical contact to a patient infested with scabies and has compatible skin lesions.

ASSESSMENT Scabies

PLAN The desired outcome of treatment is to eliminate the mites and relieve symptoms.

DIAGNOSTIC STUDIES

NOTE: If the patient is symptomatic for scabies and denies sexual (vaginal, penile, oral or anal) intercourse in the past 60 days, Scabies can be treated as per protocols without STI screening (CT, GC, RPR, HIV). Documentation of assessment must be completed. Patient should be educated regarding the missed opportunity of screening for other STIs and possibility of asymptomatic infections.

1. Gross or microscopic identification of mites, larva or eggs on scraping from papules or burrows.
OR
2. Burrows in the skin or characteristic pruritic, erythematous, papular eruptions, and other causes of dermatitis are excluded.
3. Diagnosis is suggestive in a patient who has had sexual or other close physical contact to a patient infested with scabies and has compatible skin lesions.

THERAPEUTIC

PHARMACOLOGIC

NOTE: Any patients who test positive for scabies related to sexual transmission should be tested for gonorrhea, chlamydia, syphilis and HIV.

RECOMMENDED REGIMEN

1. Nonpregnant, nonlactating patient
 - a. Permethrin 5% Cream (i.e., Elimite), single application. Thoroughly massage into all skin from the neck down to the soles of the feet, avoiding contact with mucous membranes, eyes and mouth. Remove by washing after 8-14 hours.

NOTE: Must be at least 2 months of age or older.

OR

- b. If age is equal or greater than 2 years of age and weigh at least 15 kg. Ivermectin 200 mcg/kg orally, repeated in 2 weeks.

NOTE: Patients who are breastfeeding will need to discontinue until 72 hours after last treatment.

ALTERNATIVE REGIMEN

- a. Lindane 1% lotion (1 oz.) or cream (30 gm), single application to all skin areas from neck down and thoroughly washed off in 8 hours.
NOTE: Lindane is not recommended as first-line therapy because of toxicity. Consult delegating physician prior to admitting or dispensing to patient due to toxicity. Use only as an alternative due to inability to tolerate other therapies or if other therapies have failed. All patients must be provided a medication guide. Do not use Lindane:
- Immediately after bath or shower,
 - If patient has extensive dermatitis,
 - In pregnant women or lactating women,
 - In children less than 2 years of age,
 - In those who weigh less than 110 pounds,
 - If patient has uncontrolled seizures.
2. Pregnant or lactating females
(Treat only if clearly indicated; **they should discontinue breastfeeding throughout treatment and can resume breastfeeding two days after completion of treatment. If breastfeeding women are pumping during treatment, they should not provide pumped breast milk to infant throughout treatment and for two days after completion of treatment**).
- Permethrin 5% Cream, as above.
3. For relief of itching, suggest an over the counter oral antihistamine such as Benadryl tablets or liquid, with dosage appropriate to age.
4. Bacitracin ointment (OTC) for mild secondary infection.

NON-PHARMACOLOGIC MEASURES

1. Bedding and clothing should be decontaminated (i.e., either dry cleaned or machine-washed and dried using the hot cycle) or removed from body contact for at least 72 hours. Fumigation of living areas is unnecessary.
2. Keep fingernails clean and well-trimmed to minimize secondary infection from scratching.
3. Bathe in cool water using a mild soap.

PATIENT EDUCATION/COUNSELING

(Reinforce pertinent information with handouts.)

1. **The name/significance of the infection. Educate for possible sequelae and complications of the untreated infection (<http://www.ashasexualhealth.org/stdsstis/scabies/>).**
2. Directions for use of medication **and management of possible side effects.**
3. Itching may persist for up to two weeks even after successful treatment. Over the counter, Hydrocortisone cream (only use after diagnosis has been made) or Benadryl cream may relieve persistent itching.
4. Education and counseling of the correct usage of protective barriers (condoms, dental dams, etc.).
5. **If patient is of childbearing age, counsel on the use of contraceptives to reduce the risk of unintended pregnancy.**
6. Assist patient in developing a personalized STD/HIV risk reduction plan and document patients plan. Abstain from sex until all the symptoms are resolved.
7. HIV antibody test to determine HIV status, if unknown.

8. Hepatitis A, Hepatitis B and or HPV vaccine if patient is unvaccinated. To verify eligibility criteria for state supplied vaccines go to:
<http://dph.georgia.gov/sites/dph.georgia.gov/files/Immunizations/Publications-GA-Imm-Manual-Complete.pdf>
<http://dph.georgia.gov/sites/dph.georgia.gov/files/Immunizations/Publications-GA-Imm-Manual-Complete.pdf> and
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MANAGEMENT OF PARTNERS

Those that have had close personal, household contacts, or sexual partners within the preceding month need examination and treatment.

FOLLOW-UP

Reexamine in 1 week. Retreatment can be considered after 1–2 weeks for patients who are still symptomatic or if live mites are present. Treatment with an alternative regimen (i.e., Lindane) is recommended for patients who do not respond to the recommended treatment. If alternative regimen is contraindicated refer patient to primary care physician or dermatologist.

CONSULTATION/REFERRAL

1. Refer to Child Health Scabies Protocol when infection can be ruled out acquired through sexual transmission.
2. **Consult with delegating physician of repeated failure to respond to treatment.**
3. **Refer Infants younger than 2 months of age to primary care physician or pediatrician for evaluation and treatment or refer to the Standard Nurse Protocol for Scabies in Infants, Children and Adolescents.**
4. **Consult with delegating physician of severe secondary infection.**
5. Consult with delegating physician for treatment of patients related to scabies outbreak (nursing homes, jails, schools, and other communities).

6. Public Health Employees must be familiar with procedures for reporting possible sexual or physical abuse of children if encountered through history or physical. All suspected sexual or physical abuse of children must be reported to the county Department of Family and Children Services office as per Guidelines for Mandatory Reporting of Suspected Child Abuse for Public Health Personnel which may be viewed on the Public Health Information Library (PHIL) at <http://www.dphphil.org/DPH/Policy/Health%20Protection/Child%20Abuse%20Reporting%20Guidelines%20October%202013%20FINAL.pdf>.
7. Consult delegating physician when further medical guidance is needed and STD nursing protocol is not applicable for therapeutic treatment of patient.

REFERENCES

1. **Centers for Disease Control and Prevention, Sexually Transmitted Diseases Treatment Guidelines 2015, Vol. 64, No. RR-3, June 5, 2015.**
2. GUIDELINES FOR MANDATORY REPORTING OF SUSPECTED CHILD ABUSE for PUBLIC HEALTH PERSONNEL. (2013, October 1). . Retrieved April 1, 2014, from <http://www.dphphil.org/DPH/Policy/Health%20Protection/Child%20Abuse%20Reporting%20Guidelines%20October%202013%20FINAL.pdf>
3. **Holmes, K. K. (2008). Sexually transmitted diseases. New York: McGraw-Hill Medical.**
4. **American Academy of Pediatrics., In Pickering, L. K., In Baker, C. J., In Kimberlin, D. W., In Long, S. S., & American Academy of Pediatrics. (2012). Red book: 2012 report of the Committee on Infectious Diseases.**