6 Sexual health

STI checks for women

- If under 18 years — consent and child protection issues
  - If 14–18 years — first see *STI checks for young people* (*p243*)
  - If under 14 years — see *Child sexual abuse* (*CARPA STM p146*)

- STIs under-diagnosed — often missed as may have no symptoms or minor symptoms that clear quickly
- Times to do an STI check include
  - As part of another consultation (opportunistic), if 15–35 years
  - As part of Adult Health Check (*CPM p123*)
  - Community-wide screening
  - If symptoms and/or risk factors suggest STI
  - If asked for by person — even if not long since last check
  - All pregnant women
- Aim for 2 standard STI checks a year — use recall system
- STI checks routinely recommended in 15–35 year age group

Risk factors for STIs

- Living in community with high STI rates
- Age
  - High risk — sexually active under 35 years
  - Highest risk — sexually active under 19 years
- STI or PID in past 12 months
- New sexual partner in past 3 months, more than 1 partner in past 6 months
- Drug or alcohol use — increase of high-risk behaviours (eg multiple sexual partners, unsafe sex)
- Recent travel

Additional risk factors for HIV

- Existing STI
- Person or their partner is man who has sex with men, transgender/ sistergirl, from overseas, person who injects drugs

Standard STI check

Full pathology testing, no detailed history or examination. Standard STI check replaces Brief STI check.

- Indications
  - Opportunistic
  - Adult Health Check (*CPM p123*), yearly STI check, community screening
  - 3 month re-test following a positive test result
  - 6 week postnatal check
- Ask about symptoms — abnormal vaginal discharge (*p253*), lower abdominal pain (*CARPA STM p24*), abnormal vaginal bleeding (*p301*), sores/ulcers (*p256*)
  - If symptoms — see relevant protocol

Sometimes there is not enough time or only some samples can be collected. It is still useful to do some tests from standard STI check.

Check

- Collect
  - Self-collected lower vaginal swabs x 2 (*p264*)
  - *OR* first-void urine (*CPM p393*)
  - *OR* if cervical screening due and/or doing speculum exam (*p272*) — endocervical swabs x 2 (*p274*)
- Request
  - NAAT for chlamydia, gonorrhoea, trichomonas. If swab — *Aptima* or dry
  - Gonorrhoea culture. If swab — amies transport medium
- Take blood for HIV serology, syphilis serology
- If hepatitis B status unknown or not immune (no evidence of previous infection or immunisation) — HBsAg, Anti-HBc, Anti-HBs

Do

- Tell woman to come back for results

Follow-up

- If any positive result — do rest of full STI check (*below*) including history, examination, treatment, contact tracing
- When giving results for STI check — be very clear about what has been tested for and what conditions the results relate to
  - Do not say things like “You have the all-clear” or “You don't have an STI”

Full STI check

- Symptoms — vaginal discharge, pain on passing urine, lower abdominal pain
- Asks for check
- If positive result from standard STI check (*p238*) — for additional assessment
- Contact (partner) of someone with an STI (*p250*)

Check file notes

- Date and results of last STI check
- Treatment offered and completed
- Hepatitis B status
- Date and result of last cervical screening
- Contraception use

Ask

- Last menstrual period, any abnormal bleeding
- Lower abdominal pain, pain with sex
- Vaginal discharge, itching, soreness
- Pain on passing urine

- Sore/s, rash, lump/s on genitals
- Sexual partners
  - Regular/casual partners, do partners have other partners
  - New partner in past 3 months
  - Number of partners in past 6 months

Check

- Rash (including hands and feet), hair loss
- Mouth for ulcers
- Groin for enlarged or tender lymph nodes
  - If present — check lymph nodes at other sites
- Groin, vulva, anus for sores, other lesions, rashes
  - If present — see *Genital ulcers and lumps* (*p256*)
- Offer urine pregnancy test (*p279*), especially if no record of contraceptive use
  - If positive and woman has symptoms of STI — **medical consult**, see *STI management for women* (*p245*)

Collect

- All women
  - Self-collected lower vaginal swabs x 2 (*p264*)
  - *OR* first-void urine (*CPM p393*)
  - *OR* if cervical screening due and/or doing speculum exam (*p272*) — endocervical swabs x 2 (*p274*)
  - Send for
    - NAAT for chlamydia, gonorrhoea, trichomonas. If swab — *Aptima* or dry
    - Gonorrhoea culture. If swab — amies transport medium
    - If abnormal discharge — MC&S from low or high vaginal swab
- All women — take blood for HIV serology, syphilis serology
- If genital sore — swab base of ulcer (sore, scab, lump) or fluid from blister (*CPM p391*)
  - Request — NAAT for herpes, syphilis, donovanosis
- If hepatitis B status unknown or not immune (no evidence of previous infection or immunisation) *AND* all pregnant women — HBsAg, Anti-HBc, Anti-HBs

Do

- If symptoms of STI — offer immediate syndromic treatment
  - If discharge — see *Abnormal vaginal discharge* (*p253*)
  - If sores, ulcer — see *Genital ulcers and lumps* (*p256*)
- In communities with high STI rates — consider immediate treatment even if no symptoms. Presumptive treatment. Treat for gonorrhoea (*p245*) (will also treat chlamydia) if
  - Woman asks for treatment or thinks she has put herself at risk

  - 15–25 years with other risk factor/s (p238) and not treated in last 12 months
  - At high risk and unlikely to return for results
- If symptoms of PID (eg lower abdominal pain, deep pain with sex) — see *Pelvic inflammatory disease* (p260)
- Offer STI and safer sex education (p252)
- Consider talking about contraception (p335)
- Tell woman to come back for results
- Ask for name/s of partner/s for contact tracing if pathology positive (p250)

Follow-up

- If positive results — see *STI management* (p245)
- When giving results for STI check — be very clear about what has been tested for and what conditions results relate to
  - Do not say things like "You have the all-clear" or "You don't have an STI"

Pregnancy and postnatal STI checks

- STIs in pregnancy can have serious consequences for mother and baby, including miscarriage, neonatal illness and death
- Testing, prompt management, and prioritised contact tracing are important

Table 6.1: Pregnancy and postnatal STI checks

Timing	Check	Comment
First antenatal visit	Pregnancy STI check	• Add hepatitis B serology, regardless of recorded status • If history of preterm birth — add MC&S for BV
28 weeks	Pregnancy STI check	If HIV tested earlier in pregnancy — don't repeat unless risk factors
36 weeks	Pregnancy STI check	Add GBS swabs
Birth	Syphilis serology	If STI status unknown — do pregnancy STI check
6 weeks postnatal	Standard STI check	Always include syphilis serology

Pregnancy STI check

Ask

- Always ask about symptoms — abnormal vaginal discharge (p253), lower abdominal pain (*CARPA STM p24*), abnormal vaginal bleeding (p301), sores/ulcers (p256)
  - If symptoms — see relevant protocols
- If history of herpes — see *Genital herpes – Do in pregnancy* (p258)

Check

- If speculum exam not being done — check vulva and vagina for sores, scars, abnormalities at first visit
- Collect
  - Lower vaginal swabs x 2. Best collected by clinician at first visit, otherwise self-collected (*p264*)
  - *OR* first-void urine (*CPM p393*)
  - *OR* if cervical screening due and/or doing speculum exam (*p272*) — endocervical swabs x 2 (*p274*)
- Request
  - NAAT for chlamydia, gonorrhoea, trichomonas. If swab — *Aptima* or dry
  - Gonorrhoea culture. If swab — amies transport medium
- Take blood for HIV serology, syphilis serology
- If genital sore/s —
  - Dry swab base of ulcer (sore, scab, lump) or fluid from blister
    - Request — NAAT for herpes, syphilis, donovanosis
  - Treat straight away — could be syphilis. See *Genital ulcers and lumps* (*p256*)

Do

- If any positive results from pregnancy STI check — do rest of full STI check (*p239*)

STI checks for young people

Sexually-active young people are at high risk of STIs and generally under tested.

- Actively screen sexually active young people for STIs, even in consensual relationship with 1 partner
- If under 18 years — you must be aware of child protection reporting requirements in your state or territory before testing. See Flowchart 2.4 (*CARPA STM p149*)

- If you suspect sexual abuse or reportable sexual activity, as defined by your state/territory legislation — **medical consult**
  - You **must** notify child protection
  - Doctor will advise about STI testing. Doctor may talk with child protection service or sexual assault referral centre

- **Before testing**
  - If under 16 years — you must obtain consent from parent/carer or assess whether to treat as competent minor (*CPM p102*)
  - Explain importance of doing STI test
    - Most STIs are easily treatable
    - Health consequences of STIs
  - Explain need to report to child protection service if
    - Under certain age (defined by state/territory legislation)
    - Positive result depending on age (defined by state/territory legislation)
    - Safety concerns
- Young person often presents with incomplete history
  - Sexual activity, consensual relationships, age of partner/s may not be revealed until later consults or as you build a relationship

Check

- If 14 years or over and issues of consent and child protection have been addressed — offer standard STI check (*p238*)
  - If not able to obtain consent, or unresolved child protection issues — **medical consult** before testing
- If under 14 years — **medical consult**

Do

- After doing STI check
  - Tell young person to come back for results
  - Discuss
    - Safer sex (*p252*) and offer condoms
    - Contraception (*p335*)
    - Treatment if positive result
- Report any identified issues to child protection service
  - **Do not** wait for STI results before you report

Follow-up

- If under 14 years and positive STI result —
  - Repeat notification to child protection service
  - **Medical consult** about
    - Contraception (*p335*)
    - Treatment
    - Contact tracing — may find other young people at risk of STIs, child protection issues
- If 14 years or over and positive STI result —
  - May need to report depending on state/territory requirements — if not sure, talk with more experienced staff member, doctor or child protection service
  - Do full STI check (*p239*)
  - See *STI management* (*p245*)

- Get help and advice from local ATSIHPs, health council, respected community members about doing STI work in culturally sensitive way
- Offer treatment as soon as possible to prevent complications, stop spread
- If person has symptoms/syndromes likely to be caused by STI, or has put themself at risk — treat straight away. **Do not** wait for laboratory or POC test results. See individual protocols
  - *Genital ulcers and lumps* (*p256*)
  - *Abnormal vaginal discharge* (*p253*)
  - *Pelvic inflammatory disease* (*p260*)
- Treat people with positive pathology and named partners/contacts as soon as possible
- If positive result on standard STI check or individual test — do remaining checks to complete full STI check (*p239*)
- If pregnant woman has positive STI test *AND* previous premature rupture of membranes, preterm labour, or low birth weight baby (under 2.5kg) — refer to obstetrician as soon as possible
  - May need additional monitoring, tests, treatment

Positive pathology results

Chlamydia

- Notifiable disease. Follow local protocols, check with sexual health unit if more information needed
- If woman has positive test result — always ask about symptoms of PID
  - Lower abdominal pain not a normal symptom of uncomplicated chlamydia

Do

- Give **azithromycin** oral single dose – adult 1g
- Contact trace (*p250*) and give partner/s same treatment
- Offer condoms but advise better not to have sex for 7 days after person and partner/s treated
- STI and safer sex education (*p252*)
- Consider talking about contraception (*p335*)

Follow-up

- Re-test in 3 months — standard STI check (*p238*)
- Check HIV and syphilis serology done

Pregnancy considerations

- Re-test after 4 weeks — send urine or low vaginal swab for NAAT
- High priority for contact tracing and treatment of woman and partner/s

Gonorrhoea

- Notifiable disease. Follow local protocols, check with sexual health unit if more information needed

►

- If woman has positive test result/s — always ask about symptoms of PID (*p260*)
  - Lower abdominal pain not a normal symptom of uncomplicated gonorrhoea

Do

- If person and **all** partners for last 3 months from geographical area with penicillin sensitive gonorrhoea (Table 6.2) —
  - Give **azithromycin** oral single dose – adult 1g
  - *AND* **amoxicillin** oral single dose – adult 3g
  - *AND* **probenecid** oral single dose – adult 1g
  - If allergic to penicillin — **sexual health consult**
- If person and/or **any** partner for last 3 months from geographical area with penicillin resistant gonorrhoea (Table 6.2) *OR* partners unknown —
  - Give **azithromycin** oral single dose – adult 1g
  - *AND* **ceftriaxone** IM single dose – adult 500mg mixed with 2mL **lidocaine (lignocaine) 1%**
- If oropharyngeal or anal gonorrhoea — regardless of geographical area
  - Give **azithromycin** oral single dose – adult 1g
  - *AND* **ceftriaxone** IM single dose – adult 500mg mixed with 2mL **lidocaine (lignocaine) 1%**
- Contact trace (*p250*) and give partner/s same treatment
- Offer condoms but advise better not to have sex for 7 days after person and partner/s treated
- STI and safer sex education (*p252*)
- Consider talking about contraception (*p335*)

Table 6.2 Geographical treatment areas for gonorrhoea

Type of gonorrhoea	Geographical area
Penicillin sensitive	• All of the NT outside of Darwin • The Kimberley, Goldfields, Midwest and Pilbara regions of WA
Penicillin resistant	• Darwin • All other areas except those mentioned above
NT communicable disease bulletins will advise if changes to these areas.	

Follow-up

- Re-test in 3 months — standard STI check (*p238*)
- Check HIV and syphilis serology done

Pregnancy considerations

- Re-test after 4 weeks — send urine or low vaginal swab for NAAT
- High priority for contact tracing and treatment of woman and partner/s

Genital herpes

- See *Genital ulcers and lumps* (*p256*)

Donovanosis

- Notifiable disease. Follow local protocols, check with sexual health unit if more information needed

Donovanosis sores

- Usually red, beefy, raised, raw, painless ulcer
- In early stages, small sore may look like primary syphilis
- Sores won't go away without treatment, will slowly get larger

Do

- Give **azithromycin** oral once a week for 4 weeks – adult 1g
- Check sore/s each week when giving medicine
  - If not healed after 4 weeks — **medical consult**
    - Continue **azithromycin** oral once a week until healed – adult 1g
  - If not improving — may need biopsy for cancer
- Contact trace (*p250*) and treat partner/s with same treatment
- Offer condoms but advise better not to have sex for 7 days after person and partner/s treated
- STI and safer sex education (*p252*)
- Consider talking about contraception (*p335*)

Follow-up

- Check 3 months after sore/s completely healed — to make sure sore/s haven't come back

Pregnancy considerations

- **Medical consult**

Syphilis

- Notifiable disease. Follow local protocols, check with sexual health unit if more information needed
- If ever had syphilis — positive result for life. Check for reinfection by comparing new and past results
- Syphilis diagnosed by
  - Positive test with no history of previous treatment
  - *OR* 4-fold (2 titre) increase in RPR level (eg 1:4 to 1:16)
- Syphilis serology can be hard to understand. Talk with sexual health unit or syphilis register
- If pregnant — can cause miscarriage, stillbirth, congenital syphilis in baby

Primary syphilis

- 1 or 2 painless ulcers — called chancres
- Usually red, round with firm rolled edge, base clean
- Sore goes away in 4–6 weeks without treatment, but syphilis still in blood

Secondary syphilis

- Fleshy, moist, wart-like lesions in genital or perianal area — called condylomata lata
- May also have
  - Skin rashes, especially palms of hands, soles of feet
  - Hair loss including outer eyebrow, beard
  - Swollen lymph glands all over body

Tertiary syphilis

- Dementia, change in personality
- Shooting pain, numbness, pins and needles
- Weakness of hands, arms, legs, unusual way of walking (gait)
- Problems with nerves of head and face (cranial nerve palsy), abnormal pupil reactions
- Deafness that is new
- Eye problems (eg retinal disease, uveitis, iritis)
- Heart valve weakness (aortic incompetence)
- Widening (dilation) of ascending aorta on x-ray or echocardiogram

Check

- Take blood for syphilis serology just before starting treatment so accurate pre-treatment/baseline RPR level

Do

Syphilis treatment depends on how long person has been infected. Sexual health unit or syphilis register can give history and advice on management.

- If known to be less than 2 years —
  - Give **benzathine penicillin (penicillin G)** IM single dose – adult 1.8g (2 x 900mg vials)
  - If allergic to penicillin — **sexual health consult**
- If unknown or known to be more than 2 years —
  - Give **benzathine penicillin (penicillin G)** IM once a week for 3 weeks – adult 1.8g (2 x 900mg vials)
    - If more than 7 days between injections — talk with sexual health unit or syphilis register. May need to start course again
  - If allergic to penicillin — **sexual health consult**
- If neurosyphilis or cardiovascular syphilis —
  - Talk with specialist, sexual health unit, syphilis register
  - Usually needs to go to hospital for more tests

- Contact trace (*p250*) and give partner/s same treatment. Very important if newly infected, get advice from sexual health unit
- Offer condoms but advise better not to have sex for 7 days after person and partner/s treated
- STI and safer sex education (*p252*)
- Consider talking about contraception (*p335*)

If recent syphilis — often harmless febrile reaction to treatment (Jarisch-Herxheimer). Starts in 3–4 hours, gets better within 24 hours.

- Give **paracetamol** up to 4 times a day (qid) – adult 1g (*CARPA STM p380*)

Follow-up

- Check syphilis serology again 6 months and 12 months after base line RPR and first treatment
- Advise syphilis register of treatment given — ask local PHU for number

Pregnancy considerations

Medical consult. This is an STI emergency.

- If woman has had syphilis for less than 2 years — high risk of transmission to baby. Must treat woman as soon as possible.
- High priority for contact tracing (*p250*) and coordinated treatment for woman and her contact/s

Trichomonas

- Notifiable disease in the NT. Follow local protocols, check with sexual health unit if more information needed

Do

- Give **metronidazole** oral single dose – adult 2g
- *OR* **metronidazole** oral twice a day (bd) for 5 days – adult 400mg. Best for breastfeeding, take after baby fed
- *OR* **tinidazole** oral single dose – adult 2g. Not if pregnant or breastfeeding
- Contact trace (*p250*) and give partner/s same treatment
- Offer condoms but advise better not to have sex for 7 days after person and partner/s treated
- STI and safer sex education (*p252*)
- Consider talking about contraception (*p335*)

Follow-up

- Re-test in 3 months — standard STI check (*p238*)
- Check HIV and syphilis serology done

Pregnancy considerations

- If asymptomatic consider delaying treatment until after first trimester
- Treatment same as for non-pregnant women

HIV

- Notifiable disease. HIV management always directed by sexual health or infectious diseases unit
- HIV treatment can now keep people healthy and prevent transmission to others — especially if started as soon as possible

Do

- Follow advice from sexual health unit and local protocols where appropriate
- Continued involvement of primary care services is important — usually involves
  - Managing and monitoring antiretroviral medicines
  - Contact tracing and management of contacts (*below*)
  - STI and safer sex education (*p252*)

Pregnancy considerations

- Anti-HIV treatment can
  - Keep woman healthy during pregnancy, and afterwards
  - Reduce risk of transmission to baby almost completely if started early enough
- If woman HIV positive —
  - **Medical consult** straight away. **Urgent referral** to HIV/AIDS specialist
  - Maintain confidentiality
  - Develop comprehensive management plan
  - Provide education and support about lifestyle factors such as diet, exercise, and stopping smoking, alcohol and use of other substances
- Elective Caesarean section may be recommended
- Talk with HIV/AIDS specialist at CDC/PHU about individual breastfeeding plan

Non STI results

- If MC&S results report thrush (candida) or BV — see *Abnormal vaginal discharge* (*p253*)

Contact tracing

- Person initially diagnosed with infection is referred to as the index case
- All sexual partners are referred to as contacts
- If contact has a positive result they will then become an index case
- All index cases need contact tracing

- Contacts have the right to STI check and treatment
- Untreated contacts can re-infect the index and also infect other people
- Give yourself enough time to talk with person about issues
- Ensure process is kept confidential (private)
  - Contact must never be made aware of name of index
  - **Do not** write name of contact in index file notes

- No sex or use condoms for 7 days after index and contact/s treated
- If contact treated more than 7 days after index and reinfection possible — retreat index if possible
- While contact tracing is important to manage all STIs, it is critical for syphilis, HIV, and any infection during pregnancy

Contact tracing – asking about partners

- Ask about all sexual partners in last 3 months
- Explain if partner/s not treated they may get infected again and there can be serious effects of ongoing infection — miscarriages, infertility, ectopic pregnancy, babies can become sick or die
- If person prefers they can write down name/s of sexual contact/s
- Make sure you know how to find the person again if needed

Do

- Document details of contact/s (DOB or approximate age, address) using appropriate confidential process for your area
- Hand over contact information confidentially to staff member who can begin treatment of contact, as this needs to occur quickly

Contact tracing – follow-up of partners

- Talk with ATSIHPs about best way/s in your community
- Tell person they have been in contact with someone who has an infection and it is best that they have both a check and treatment today
- Advise that most people with STIs don't know they have one

Check

- Do full STI check – men (*CARPA STM p272*), women (*p239*)

Do

- Treat straight away as per Table 6.3 without waiting for laboratory or POC test results — even if STI check declined
- STI and safer sex education (*p252*)

Table 6.3: Treatment of contacts

Index case infection/syndrome	Contact treatment
Gonorrhoea, chlamydia, trichomonas, syphilis	Same treatment as index
PID	Treat for gonorrhoea and chlamydia
Painful scrotum	Treat for gonorrhoea and chlamydia
All other conditions	See protocols for contact treatment if needed

Education

- Not needed with every sexual health check
- Best for people asking for test, or with STI needing treatment

STIs

Tell person

- What STIs are, why they matter, how to protect themself
- How you get one, signs and symptoms, asymptomatic infection
- Need to test for reinfection in 3 months
- Get STI check
  - If under 35 years — aim for 2 standard STI checks a year
  - Straight away if they have unsafe sex, symptoms of an STI
- Important to treat sexual partner/s from past 3 months
  - To prevent reinfection — no sex or use condoms for 7 days after person and partner/s treated
- Complications of STIs
  - Infertility
  - Increased risk of HIV
  - PID in women
  - Problems in pregnancy — ectopic pregnancy, miscarriage, preterm labour, infections in newborn baby

Safer sex

- If person has safer sex — less chance of an STI
  - Make sure they know what this means, don't just think they will know
- Safer sex is
  - Using a condom properly every time
  - *OR* having sex with just 1 partner after both have 'clear' STI check

Condoms

- Only contraceptive method that protects against STIs
- Show them how to use a condom (*p356*)
- Offer condoms to take away, talk about where they can get more

Abnormal vaginal discharge

- Vaginal discharge can be normal
- Abnormal when increased amount, changed colour, smell, soreness, itch
  - Caused by range of infectious and non-infectious conditions
  - Common — gonorrhoea, chlamydia, trichomonas, thrush (candida), bacterial vaginosis, atrophic vaginitis
  - Less common — *Mycoplasma genitalium*, herpes simplex, foreign body (eg retained tampon), cancer
- STIs common in women with risk factors (*p238*)
- If pregnant — consider ruptured membranes, intrauterine infection

Ask

- Discharge — amount, colour, smell, how long
- Itchy, sore
- Pain on passing urine. Urinary symptoms can be caused by STIs or UTIs
- Pregnant
- Last menstrual period
- Lower abdominal pain, pain deep inside with sex. If present — see *Pelvic inflammatory disease* (*p260*)
- Other STI symptoms — swollen lymph nodes, genital lumps, ulcers, sore throat, rash, hair loss
- Sexual partner/s — any from geographical area with penicillin-resistant gonorrhoea (Table 6.2 *p246*)

Check

- Do full STI check (*p239*)
- Urine pregnancy test if not sure (*p279*)
- pH test if available — before putting into transport medium, touch sample on swab onto pH paper
  - Test unreliable if woman post-menopausal, semen or blood present

Do

- If pH 4.5 or more (high) or pH test not done — treat for trichomonas and bacterial vaginosis straight away. **Do not** wait for test result
  - Give **metronidazole** oral single dose – adult 2g
  - *OR* **tinidazole** oral single dose – adult 2g. **Not** if pregnant or breastfeeding
  - *OR* **metronidazole** oral twice a day (bd) for 5 days – adult 400mg. Best for breastfeeding, take after baby fed
- Contact tracing — telling partners (*p250*)
- STI and safer sex education (*p252*)
- Consider talking about contraception (*p335*)
- Consider thrush (*p254*)

Do — if high risk of STI

High risk of STI
- Women with abnormal vaginal discharge and 35 years or under
- Women with cervical discharge or inflamed/friable (bleeds easily) cervix on speculum examination

- Treat for both gonorrhoea and chlamydia. Presentations very similar — syndromic management. **Do not** wait for laboratory or POC test results if not immediately available
  - If woman and **all** sexual partners in last 3 months from geographical area with penicillin-sensitive gonorrhoea (Table 6.2 *p246*) —
    - Give **azithromycin** oral single dose – adult 1g
    - *AND* **amoxicillin** oral single dose – adult 3g
    - *AND* **probenecid** oral single dose – adult 1g
  - If woman and/or **any** sexual partner in last 3 months from geographical area with penicillin-resistant gonorrhoea (Table 6.2 *p246*) *OR* partners unknown —
    - Give **azithromycin** oral single dose – adult 1g
    - *AND* **ceftriaxone** IM single dose – adult 500mg mixed with 2mL **lidocaine (lignocaine) 1%**
  - If allergic to penicillin or pregnant — **medical/sexual health consult**

Follow-up

- Review after 1 week — test results, response to treatment, further education
- If no improvement with treatment —
  - Consider foreign body (eg tampon, condom)
  - **Medical/sexual health consult**
- If STI results positive — see *STI management* (*p245*)
  - Check HIV and syphilis serology done
- Any woman who has had an STI is at high risk of getting more STIs
  - If positive test result — re-test in 3 months *OR* in 4 weeks if pregnant
    - Standard STI check (*p238*)

Thrush (candidiasis)

- Usually caused by *Candida albicans*
- Not sexually transmitted, contact tracing not needed
- Often found in vagina without causing any problems (asymptomatic)
  - More common if pregnant, weakened immune system, diabetes, long course of broad-spectrum antibiotics
  - Only treat if causing problems
- Thrush can cause
  - Vulval itch or burning
  - White, thick curd-like discharge that sticks to vagina walls
  - Very red inflamed vulva and vagina

Do

- Talk with woman about keeping genital area clean and dry, salt water washes, wearing cotton underwear
- Give **clotrimazole** vaginal pessary single dose – 500mg
- *OR* **miconazole 2%** cream for 7 days
  - If pregnant — put in with finger not applicator
- If not better — **medical consult** about **fluconazole** oral single dose – adult 150mg. **Not** if pregnant or breastfeeding
- If woman has diabetes — try to improve blood glucose control

Follow-up

Some women get recurrent thrush even when well *BUT* if recurrent or persistent thrush — important to check for diabetes, weakened immune system.

- Do BGL
- Offer HIV serology
- **Medical consult** about further tests. Consider *Candida glabrata*

Woman with recurrent discharge caused by thrush needs management plan in file notes to stop repeated, unnecessary treatment for STIs.

Bacterial vaginosis (BV)

- Due to change in vaginal bacteria — causes high pH
- Can cause abnormal vaginal discharge and unpleasant odour
- Not sexually transmitted, contact tracing not needed
- Often found in vagina without causing any problems (asymptomatic)

Do

- If MC&S result shows 'clue cells' or other findings consistent with BV —
  - If symptomatic —
    - Give **metronidazole** oral single dose – adult 2g
    - Make sure standard STI check done (*p238*)
  - If asymptomatic —
    - *AND* not pregnant or pregnant with no history of preterm labour — **do not** treat
    - *AND* pregnant with history of preterm labour — **medical consult** about management plan
- If still symptoms after initial single dose treatment —
  - Give **metronidazole** twice a day (bd) for 5 days – adult 400mg
  - Advise women to avoid douching (cleaning inside vagina)
- No follow-up needed

Genital ulcers and lumps

Causes

- Herpes — most common
- Syphilis
- Donovanosis — rare
- Genital warts
- Bartholin's cyst (*p306*)
- Molluscum contagiosum (*CARPA STM p391*)
- Local injury from scratching (eg scabies, lice, bad thrush)
- Cancer
  - If not better after 4 weeks — medical review, may need biopsy to exclude cancer

Ask

- How long have they had sores, are they getting worse
- Sores like these before
- Are sores painful
- Does sexual partner/s have sores

Check

- Do full STI check – women (*p239*), young person (*p243*). Must include syphilis serology
- If woman with no reliable contraception — do urine pregnancy test (*p279*)
- Swab sores (*CPM p391*) — NAAT for herpes, syphilis, donovanosis
- Type of sore

Do

- Treat straight away — **do not** wait for test results
  - If multiple, recent small painful blisters (vesicles) — treat as herpes (*p257*)
  - All other genital sores or ulcers — treat as syphilis and donovanosis (*p257*)
- STI and safer sex education at first visit (*p252*)
- Consider discussing contraception (*p335*)
- Explain that having sex before sores healed completely may delay healing and give infection to partner/s
  - Offer condoms but advise better not to have sex

Follow-up

- Review at 1 week
  - Check if symptoms resolved
  - If sore/s not healed, no cause found — **medical consult**, add recall for 4 week review

Syphilis and donovanosis

Check

- Take blood for syphilis serology just before starting treatment so accurate pre-treatment/baseline RPR level

Do

- Give **benzathine penicillin (penicillin G)** IM single dose – adult 1.8g (2 x 900mg vials) — to start treatment for syphilis
  - If allergic to penicillin — **sexual health consult**
- *AND* **azithromycin** oral single dose – adult 1g — to start treatment for donovanosis
- Contact tracing (*p250*). Very important if you suspect new syphilis infection, get advice from sexual health unit
- STI and safer sex education (*p252*)

If recent syphilis — often get harmless febrile reaction to treatment (Jarisch-Herxheimer). Starts in 3–4 hours, gets better within 24 hours.

- Give **paracetamol** up to 4 times a day (qid) – adult 1g (*CARPA STM p380*)

Do — if pregnant

- **Medical consult**. This is an STI emergency

Follow-up

- Review at 1 week
  - Check test results. If any positive — see *STI management for women* (*p245*)
  - If ulcer not healing and tests negative — **medical consult**, add recall for 4 week review
  - If you suspect donovanosis but tests negative — **sexual health consult**

Genital herpes

- Herpes simplex virus (HSV) causes genital and oral herpes (cold sores)
- Antiviral treatment reduces risk of spreading infection, duration and severity of symptoms, but doesn't cure
- Lifelong risk of recurrent episodes and shedding of herpes virus

Do

- Keep sores clean with **normal saline** washes
- Give **pain relief** (*CARPA STM p377*), can put **lidocaine (lignocaine) gel** on sores
- If kidney disease — **medical consult**. May need lower doses of antivirals

First episode

Can be severe, last 2–3 weeks.

- Medicines most helpful if blisters present for 3 days or less
  - Give **valaciclovir** oral twice a day (bd) for 5–10 days – adult 500mg

►

- Review at 1 week
  - Positive herpes NAAT confirms genital herpes. Negative herpes NAAT doesn't exclude genital herpes — ask to return for another swab if sores come back

Recurrent episodes

Usually less severe, last 1 week or less.

- Medicines most helpful if given before or on first day blisters appear
  - Give **valaciclovir** oral twice a day (bd) for 3 days – adult 500mg
  - *OR* **famciclovir** oral twice a day (bd) for 1 day – adult 1g
- If getting sores often and/or causing a lot of trouble — **medical consult** about having tablets at home to take as soon as sores start

Do — if pregnant

- **Medical/specialist consult** about management of pregnant woman if
  - First presentation of herpes in pregnancy
  - History of herpes, previously or in current pregnancy
    - Some women need prophylactic antiviral treatment
  - Woman or her partner had blood test in past showing positive herpes serology
- If first clinical episode —
  - Do herpes serology
  - Give **aciclovir** oral 3 times a day (tds) for 5–10 days – adult 400mg
- If recurrent episode — give **aciclovir** oral 3 times a day (tds) for 5 days – adult 400mg
- If severe episode — **medical consult**, send to hospital for **aciclovir** IV
- Advise woman with no history of herpes but whose partner has history of herpes to avoid sex in third trimester of pregnancy
- **At time of birth**
  - Women with herpes lesions need **obstetrician/gynaecology consult** about possible Caesarean section
  - If vaginal birth — avoid invasive fetal monitoring and instrument delivery

Genital warts

- Painless, solid lumps with hard smooth surface or cauliflower-like appearance. May look like secondary syphilis (condylomata lata)

Do not

- **Do not** treat as genital warts until secondary syphilis excluded
- **Do not** give podophyllotoxin if woman is or could be pregnant, is breastfeeding

Do

- Give **podophyllotoxin 0.5% solution** or **0.15% cream** to apply twice a day (bd) for 3 days — then no treatment for 4 days. Repeat cycle up to 4 times
  - **Do not** use if pregnant
  - Always show how to put on medicine
    - Use cotton swab or applicator for lotion
    - Glove best for cream but can use finger
    - Wash hands straight away
  - Only put on wart, can burn skin and cause ulcers
- *OR* give **imiquimod 5% cream** to apply once a day at night, 3 times a week for up to 16 weeks
  - OK to use if pregnant
  - Always show how to put on medicine
    - Use cotton swab or applicator
    - Wash hands straight away
    - Wash off with soap and water in morning or 6–10 hours after applying
    - Review weekly
- If not improving — **medical/sexual health consult** about other treatments
- If warts large, inside vagina, lot of warts — refer for freezing (cryotherapy)

Pelvic inflammatory disease

Inflammation of part or all of female upper genital tract.

- Diagnosed through clinical history and examination
- Always suspect if new onset pain and young age
- Unlikely after 12 weeks pregnant, but can cause miscarriage if not treated

Common cause of lower abdominal pain in non-pregnant women at high risk of STIs (15–35 years). Often missed. Can cause serious problems.

Decision to manage as PID is based on clinical assessment even if laboratory or POC test results negative.

Ask and check file notes

- Age — higher risk if 15–35 years
- History of STIs, PID, ectopic pregnancy, urinary infections
- Recent operations on genital tract
- Recent childbirth
- Date and results of last STI check, cervical screening

Ask

- Abdominal pain — where, when, how long, what makes worse or better
  - Can stay as ongoing mild pain or get worse
  - Often starts with period
- Menstrual periods
  - Last normal period
  - Change — more or less bleeding, bleeding between periods, pain with period, ongoing pain
- Fever, nausea, vomiting, feeling generally unwell
- Sexually active
  - Pain deep inside when having sex
  - Bleeding after sex
- Vaginal discharge — amount, colour, smell, how long
- Urinary problems — pain, frequency, blood in urine
- IUD

Check

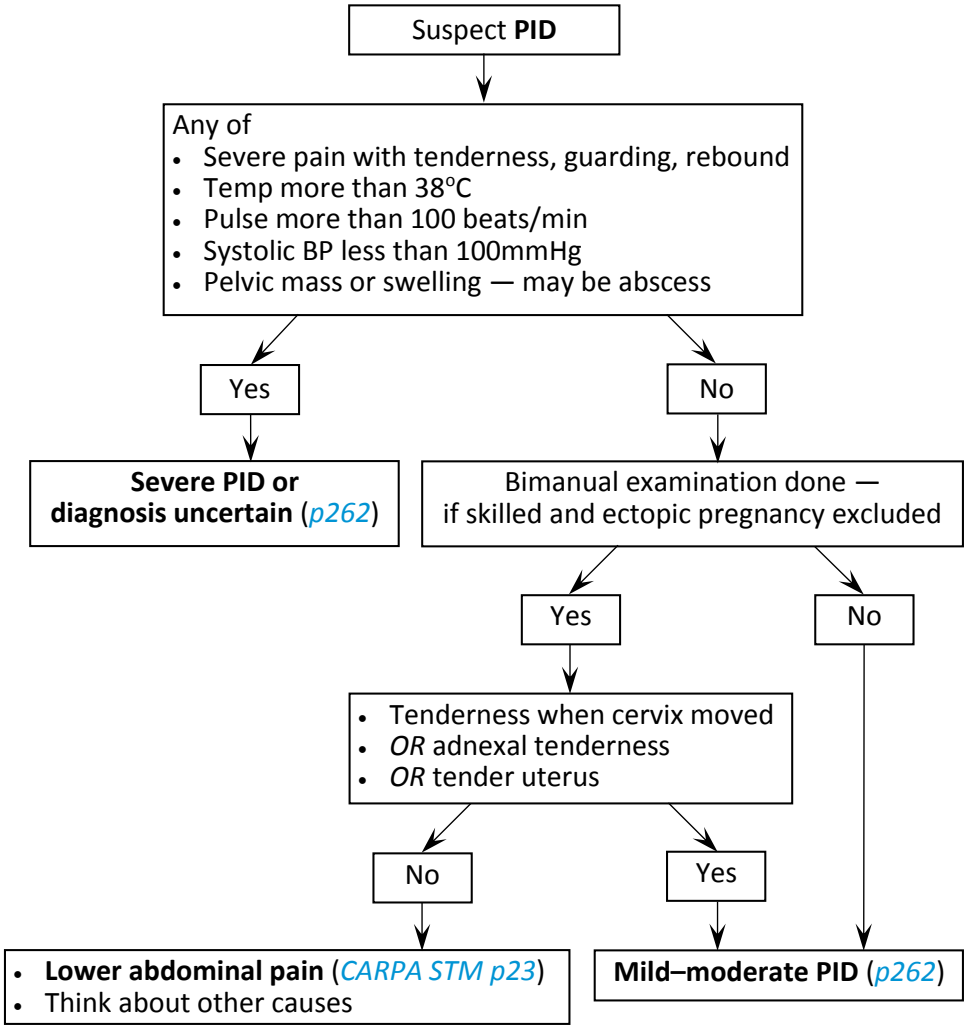
- Temp, pulse, RR, BP, O_2 sats — work out REWS (*p8*)
- Do full STI check (*p239*)
- Urine pregnancy test (*p279*)
- If urinary symptoms or pregnant — midstream urine for MC&S
- If pregnant but gestation unknown — feel for uterus above pubic bone
  - If not felt, usually less than 12 weeks pregnant — consider ectopic pregnancy (*p16*)
- See *Lower abdominal pain* (*CARPA STM p24*) for other causes of pain

- Bimanual exam, if skilled and ectopic pregnancy excluded (*p278*)
  - If pregnant — **medical consult** first

Do

- If pregnant — **medical consult** about diagnosis, treatment, sending to hospital
- If not pregnant — follow Flowchart 6.1

Flowchart 6.1: Suspected PID in non-pregnant woman



Do — if severe PID or diagnosis uncertain

- **Medical consult**, send to hospital
- Put in IV cannula (*CPM p84*)
  - Start **normal saline** 1L at 125mL/hour or as directed by doctor
  - Take blood for FBC and blood culture, send in with woman
- Give **ceftriaxone** IV single dose – adult 2g. If no IV access give IM — 2 x 1g vials, each mixed with 3.5mL **lidocaine (lignocaine) 1%** and injected into separate buttocks, not more than 1g in each buttock
- *AND* **azithromycin** oral single dose – adult 1g
- *AND* **metronidazole** IV single dose – adult 500mg
- **Do not** let woman eat or drink anything — may need operation
- Ask about names of contacts if possible (*p250*)

Do — if mild–moderate PID

- If not pregnant — treat and follow-up in community
- Start treatment straight away — do not wait for STI results

Day 1

- Give **ceftriaxone** IM single dose – adult 500mg mixed with 2mL **lidocaine (lignocaine) 1%**
- *AND* **doxycycline** oral twice a day (bd) for 14 days – adult 100mg. **Do not** use if pregnant
  - *OR* **azithromycin** oral single dose – adult 1g — second dose 1 week later
- *AND* **metronidazole** oral twice a day (bd) for 14 days – adult 400mg
- If pain relief needed — give
  - **Paracetamol** up to 4 times a day (qid) – adult 1g (*CARPA STM p380*)
  - *OR* **paracetamol-codeine** oral up to 4 times a day (qid) – adult 500+30mg (*CARPA STM p381*)
- Contact trace (*p250*) and give partner/s syndromic treatment for gonorrhea and chlamydia – men (*CARPA STM p286*), women (*p254*)
- STI and safer sex education (*p252*)
- Consider discussing contraception (*p335*)

Day 3

- Examine woman, ask if symptoms improving
- If improving — PID likely. Explain important to finish treatment, do contact tracing (*p250*)
- If not improving — **medical consult**, send to hospital

Day 8

- If using azithromycin — give **azithromycin** oral single dose – adult 1g

Day 14

- Reassess woman
- If still has symptoms, tenderness on abdominal or bimanual exam (do if skilled) — **medical consult**

Do also — if IUD

- **Medical consult**. Doctor should talk with gynaecologist
  - Mild PID can be managed in community without removing IUD
  - Very careful follow-up, **must** be seen daily for 3 days
  - If not improving — **medical consult**
- **If IUD removed**
  - Take 2 swabs of IUD for MC&S, NAAT for gonorrhoea, chlamydia, trichomonas
  - Put IUD in yellow-top jar and send for MC&S

Follow-up

- Check that partner/s have been treated
- If woman treated in hospital — check if follow-up needed (eg pelvic ultrasound)
- If positive test result — re-test in 3 months – standard STI check (*p238*)

Self-collected lower vaginal swabs (LVS)

Attention

- Used to test for
  - STIs
  - Vaginal infections such as thrush (candida)
  - Group B Streptococcus (GBS) in pregnancy
  - HPV for cervical screening in certain circumstances (*p290*)

What you need

- See Table 6.3 for swab types used for various samples and tests
- pH paper

Table 6.3: Sample and swab types for self-collected lower vaginal swabs

Sample type	Test (request)	Swab type
Lower vaginal swab	NAAT — chlamydia, gonorrhoea, trichomonas	• *Aptima* swab and tube • *OR* dry swab — flocked if available
Lower vaginal swab	Gonorrhoea culture	• Amies transport medium swab ◦ If delay in transport — use charcoal medium
Lower vaginal swab	MC&S — thrush, BV	• Amies transport medium swab
Lower vaginal swab	HPV test	• Swab supplied by laboratory
Combined lower vaginal and anal swab	MC&S — GBS	• Amies transport medium swab

What you do

General procedure

- If more than one test being done (eg STI, vaginal infections, HPV) — number the swab packets/containers. STI swab is collected first
  - 1 = *Aptima* or dry swab (STI)
  - 2 = amies transport medium swab (STI and other infections)
  - 3 = swab for HPV test
- Have woman wash her hands, then give her the required swabs
  - Swab with transport medium (eg *Aptima*, amies)
    - Remove container, leave swab in original packet
    - **Do not** give container to woman
  - Dry swab — leave swab in original container, break seal
- Explain to woman she needs to
  - Have her legs apart — either
    - Sitting on toilet — F 6.1
    - Standing with 1 foot on toilet seat — F 6.2

6.1

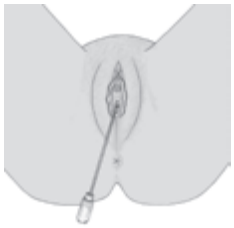
- Give woman specific instructions for swabs needed
  Note: Small difference in method used for collecting STI and HPV swabs
- Put swabs on small tray or in paper bag — easier to manage and reduces environmental contamination

6.2

LVS for STI and other vaginal infections

Instructions for the woman

- Take first swab out of packet/container (numbered 1)
  - Put tip of *Aptima* or dry swab about 2–4cm (length of 1–2 finger joints) inside vagina — F 6.3
    - If *Aptima* swab — do not touch notched handle below groove
    - Turn swab around once, leave in vagina, count to 10, remove
  - Put *Aptima* swab back into packet *OR* dry swab back into container
- Take second swab out of packet (numbered 2)
  - Repeat collection procedure as for first swab
  - Put swab back into packet
- Use third swab if needed (numbered 3) — see *LVS for HPV test* (*below*)
- Wash hands, return swabs to nurse or ATSIHP



6.3

When woman returns swabs

- Swab 1 (*Aptima* or dry swab)
  - Take *Aptima* swab out of packet and put into *Aptima* tube. Break off handle at groove, **do not** touch section below groove. Put on cap
  - *OR* make sure dry swab in transport tube and cap on
  - Request 'LVS – chlamydia, gonorrhoea, trichomonas NAAT'
- Swab 2 (amies transport medium swab)
  - Take swab out of packet
  - If doing pH test for trichomonas — touch swab on pH paper
    - Test unreliable if woman post-menopausal, semen or blood present
  - Put swab into amies transport medium tube
  - If only doing STI check — request 'LVS – gonorrhoea culture'
  - *OR* if also testing for vaginal infection (eg thrush, BV) — request 'LVS – MC&S and gonorrhoea culture'
- Make sure swab containers correctly labelled, closed tightly
- Store and transport at room temperature

LVS for HPV test for cervical screening

Use swab provided by laboratory. Swab must be turned multiple times to collect an adequate sample.

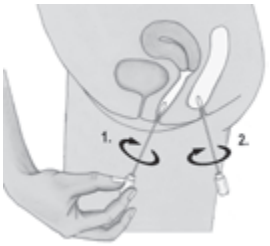
Instructions for woman

- Take swab out of packet/container (numbered 3 if multiple tests)
- Put tip of swab about 2–4cm (length of 1–2 finger joint) inside vagina — F 6.3
  - Turn swab around vagina 6–8 times, remove
- Put swab back into packet/container
- Wash her hands, return swab to nurse or ATSIHP

When woman returns swab

- If swab given to woman in packet — take out and put into transport medium tube
- If swab given to woman in container — make sure swab in tube and cap on
- Request 'HPV test'
  - Write 'for cervical screening' and give clinical indication (eg never screened, screening overdue by more than 2 years)
- Make sure swab container correctly labelled, closed tightly
- Store and transport at room temperature

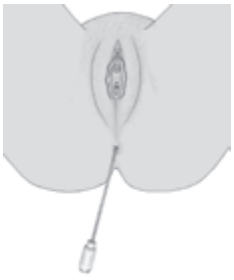
Combined lower vaginal and anal swab for GBS



6.4

Instructions for woman

- Take swab out of packet
- Put tip of swab about 2cm (length of 1 finger joint) inside vagina — F 6.3
  - Turn swab around once, leave in vagina, count to 10, remove
- Put same swab about 2cm inside anus — F 6.4, F 6.5
  - Turn swab around once, leave in anus, count to 10, remove
- Put swab back into packet
- Wash her hands, return swab to nurse or ATSIHP



6.5

When woman returns swab

- Take swab out of packet, put into amies transport medium tube
- Request 'LVS/anal – MC&S for GBS'
- Make sure swab container correctly labelled, closed tightly
- Store and transport at room temperature