5 Sexual health

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STI checks for men

- If woman — see *STI checks for women* (*WBM p238*)
- If under 18 years — consent and child protection issues
  - If 14–18 years — first see *STI checks for young people* (*p276*)
  - If under 14 years — see *STI testing in children* (*p150*)

- 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 risk factors suggest STI
  - If asked for by person — even if not long since last check
- Aim for 2 standard STI checks a year — use recall system
- STI checks are 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 in past 12 months
- New sexual partner in past 3 months, more than 1 partner in past 6 months
- Drug or alcohol use — increases 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
- Ask about symptoms — discharge from penis or pain on passing urine (*p286*), sores/ulcers (*p288*)
  - If symptoms — see relevant protocols

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

- First-void urine (*CPM p393*) — request
  - NAAT for chlamydia, gonorrhoea *AND* if in NT — trichomonas
  - Gonorrhoea culture
- 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 man 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 STI check results — 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 — discharge, pain on passing urine, sores
- Asks for check
- If positive result from standard STI check (*p272*) — for additional assessment
- Contact (partner) of someone with an STI (*p283*)

Check file notes

- Date and results of last STI check
- Treatment offered and completed
- Hepatitis B status

Ask

- Discharge from penis
- Pain on passing urine
- Sore/s, rash, lump/s on genitals
- Sexual partners
  - Regular/casual partners, do they have other partners
  - Other men
  - 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
- Penis, scrotum, anus for sores, other lesions, rashes
  - If present — see *Genital ulcers and lumps* (*p288*)

Collect

- All men
  - First-void urine (*CPM p393*)
  - *AND* if discharge — penile swabs x 2 (*CPM p391*)
  - Request
    - NAAT for chlamydia, gonorrhoea, trichomonas. If swab — *Aptima* or dry
    - Gonorrhoea culture. If swab — amies transport medium
- All men — take blood for HIV serology, syphilis serology
- If urinary symptoms and 45 years or over —
  - Mid-stream urine (*CPM p393*)
  - *OR* first catch urine if can't get second sample
  - Request — MC&S for UTI
- 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) — take blood for HBsAg, Anti-HBc, Anti-HBs
- If man has sex with men —
  - Anal swab x 2 (*CPM p391*) *AND* throat swab x 2 (*CPM p390*)
  - Request —
    - NAAT for chlamydia, gonorrhoea — *Aptima* or dry swab
    - Gonorrhoea culture — amies transport medium swab

Do

- If symptoms of STI — offer immediate syndromic treatment
  - If pain or discharge — see *Discharge from penis or pain on passing urine* (*p286*)
  - If sores, ulcer — see *Genital ulcers and lumps* (*p288*)
- In communities with high STI rates — consider immediate treatment even if no symptoms. Presumptive treatment. Treat for gonorrhoea (*p279*) (will also treat chlamydia) if
  - Man asks for treatment or thinks he has put himself at risk
  - 15–25 years with other risk factor/s (*p272*) and not treated in last 12 months
  - At high risk and unlikely to return for results

  - 15–35 years with leukocytes 1+ or more in urine
- Offer STI and safer sex education (*p285*)
- Tell man to come back for results
- Ask for name/s of partner/s, for contact tracing if pathology positive (*p283*)

Follow-up

- If positive results — see *STI management* (*p278*)
- 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”

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 (*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 – men (*p272*), women (*WBM 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 (*p285*) and offer condoms
    - Contraception (*WBM 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 (*WBM 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 – men (*p273*), women (*WBM p239*)
  - See *STI management* – men (*p278*), women (*WBM p245*)

STI management

- 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* (*p288*)
  - *Discharge from penis or pain on passing urine* (*p286*)
  - *Painful scrotum* (*p384*)
  - *Abnormal vaginal discharge* (*WBM p253*)
  - *Pelvic inflammatory disease* (*WBM 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 – men (*p273*), women (*WBM p239*)
- If pregnant woman has positive STI test *AND* previous premature rupture of membranes, preterm labour, 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 (*WBM p260*)
  - Lower abdominal pain not a normal symptom of uncomplicated chlamydia

Do

- Give **azithromycin** oral single dose – adult 1g
- Contact trace (*p283*) 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 (*p285*)
- Consider talking about contraception (*WBM p335*)

Follow-up

- Re-test in 3 months — standard STI check – men (*p272*), women (*WBM 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 (*WBM 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 5.1) —
  - 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 area with penicillin resistant gonorrhoea (Table 5.1) *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 (*p283*) 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 (*p285*)
- Consider talking about contraception (*WBM p335*)

Table 5.1 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 – men (*p272*), women (*WBM 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 coordinated treatment of woman and partner/s

Genital herpes

- See *Genital ulcers and lumps* (*p288*)

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 (*p283*) 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 (*p285*)
- Consider talking about contraception (*WBM 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**

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- If neurosyphilis or cardiovascular syphilis —
  - Talk with specialist, sexual health unit, syphilis register
  - Usually needs to go to hospital for more tests
- Contact trace (*p283*) 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 (*p285*)
- Consider talking about contraception (*WBM 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 (*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 (*p283*) and coordinated treatment of 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 (*p283*) and give partner/s same treatment
- Advise no sex or use condoms for 7 days after person and partner/s treated
- STI and safer sex education (*p285*)
- Consider talking about contraception (*WBM p335*)

Follow-up

- Re-test in 3 months — standard STI check – men (*p272*), women (*WBM 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 (*p283*)
  - STI and safer sex education (*p285*)

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* (*WBM 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

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- 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 (*p273*), women (*WBM p239*)

Do

- Treat straight away as per Table 5.2 without waiting for laboratory or POC test results — even if STI check declined
- STI and safer sex education (*p285*)

Table 5.2: 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-up
- 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-up

Condoms

- Only contraceptive method that protects against STIs
- Show them how to use a condom (*CPM p209*)
- Offer condoms to take away, talk about where they can get more

Discharge from penis or pain on passing urine

- Urethral discharge is almost always caused by STI
- Pain on passing urine is most likely due to STI in young men and often in older men, especially if a recent new partner
- Could be gonorrhoea, chlamydia, trichomonas or less commonly mycoplasma genitalium, herpes or other viral infections

Ask

- How long has he had problem, has he had it before
- Pain when passing urine, discharge from penis
- Sores, blisters, lumps, rashes in private parts (genitals) (*p288*)
- Scrotum painful (*p384*) or swollen
- Other STI symptoms — swollen lymph nodes, sore throat, rash, hair loss
- About sexual partners — any from geographical area with penicillin resistant gonorrhoea (Table 5.1 *p279*)

Check

- If sores, blisters, lumps, painful or swollen scrotum — check genitals, back passage (anal area)
- Skin, mouth
- Lymph nodes in neck, armpits, groin
- Do full STI check (*p273*)

Do

- 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 man and **all** partners in last 3 months from geographical area with penicillin sensitive gonorrhoea (Table 5.1 *p279*) —
    - Give **azithromycin** oral single dose – adult 1g
    - *AND* **amoxicillin** oral single dose – adult 3g
    - *AND* **probenecid** oral single dose – adult 1g
  - If man and/or **any** partner in last 3 months from geographical area with penicillin resistant gonorrhoea (Table 5.1 *p279*) *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 — **sexual health consult**
- Contact tracing (*p283*)
- STI and safer sex education (*p285*)

Follow-up

- If positive test result — re-test in 3 months – standard STI check (*p272*)
- **If re-presents with ongoing symptoms** — check STI test results
  - If full STI check not done — collect remaining samples (*p273*)
  - If another STI — see *STI management* (*p278*)
  - If trichomonas not tested for (*p282*) — treat presumptively
    - Give **metronidazole** oral single dose – adult 2g
  - If no STI — do U/A and send urine for MC&S. **Medical consult**
  - If positive for gonorrhoea and/or chlamydia —
    - Was all first round of treatment taken. If not — repeat
    - Did symptoms get better and then come back (reinfection) or never get better at all (resistant)
    - Did sexual partner/s all get treated
  - If reinfection likely —
    - Repeat STI check (*p272*) and treatment for man and partner/s

    Remember: Can take up to a month for NAAT tests to become negative after successful treatment.
  - If resistance likely —
    - Check test results for antibiotic sensitivities
    - Repeat STI check (*p272*). Make sure MC&S for gonorrhoea included
    - Give **ceftriaxone** IM single dose if not given in first treatment – adult 500mg mixed with 2mL **lidocaine (lignocaine) 1%**
- There are other causes of discharge or urine symptoms. If persisting symptoms despite all of the above — **medical consult**

Genital ulcers and lumps

Causes

- Herpes — most common
- Syphilis
- Donovanosis — rare
- Genital warts
- Bartholin's cyst (*WBM p306*)
- Molluscum contagiosum (*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 — men (*p273*), women (*WBM p239*), young person (*p276*). Must include syphilis serology
- If woman with no reliable contraception — do urine pregnancy test (*WBM 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 (*p289*)
  - All other genital sores or ulcers — treat as syphilis and donovanosis (*p289*)
- STI and safer sex education at first visit (*p285*)
- Consider discussing contraception (*WBM 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 (*p283*). Very important if you suspect new syphilis infection, get advice from sexual health unit
- STI and safer sex education (*p285*)

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 (*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* (*p278*)
  - 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** (*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

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- 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)