**STANDING ORDER POLICIES:**

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| **POLICY:** | **STANDING ORDER FOR STD TESTING AND TREATMENT** |

All registered nurses and other trained and approved personnel are authorized to collect specimens and administer treatment for each STD Test as outlined in the STD Testing and Treatment processes, and each specific disease policy within his or her scope of practice. These personnel are hereby authorized to inform the patients of their test results. The patient’s results and any treatment administered shall be documented on the STD Panel form.

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| Medical Director Signature |  | Date |  |

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| **PROCEDURE:** | **STD TESTING AND TREATMENT** |

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|  | **Disease** | **Method** | **Treatment** |
|  | HIV | Blood test: Lab send-off | **No Treatment.** Patient will be referred to own physician or a treatment center from referral list. |
|  | Hepatitis A | Blood test: Lab send-off | **No Treatment**. Patient will be referred to own physician or Monroe County STD Clinic. |
|  | Hepatitis B | Blood test: Lab send-off | **No Treatment.** Patient will be referred to own physician or Monroe County STD Clinic. |
|  | Syphilis | Blood test: Lab send-off | **No Treatment.** Patient will be referred to own physician or Monroe County STD Clinic.  |
|  | HSV | Blood Test: Lab send-off + visual inspection | **No Treatment.** Patient will be referred to own physician or Monroe County STD Clinic.  |
|  | HPV | NONE | **No Treatment.** Patient will be referred to patient’s own OB/GYN for testing/treatment. |
|  | Gonorrhea | Swab/Culture: In-house lab diagnosis + Lab send-off | **CEFTRIAXONE** (Rocephin) 250mg IM in a single dose **AND** either **AZITHROMYCIN** 1 g orally in a single dose OR **DOXYCYCLINE** 100mg orally twice a day for 7 days |
|  | Chlamydia | Swab/Culture: In-house lab diagnosis + Lab send-off | **AZITHROMYCIN** 1 g orally in a single dose OR **DOXYCYCLINE** 100 mg (for non-pregnant patients) orally twice a day for 7 days  |
|  | Trichomonas | Swab/Culture: In-house lab diagnosis | **METRONIDAZOLE** 2 g orally in a single dose OR **TINIDAZOLE** 2 g orally in a single dose OR **METRONIDAZOLE** 500 mg, orally twice a day for 7 days (Alternative Regimen) |
|  | Bacterial Vaginosis | Swab/Culture: In-house lab diagnosis | **METRONIDAZOLE** 500mg orally twice a day for 7 days OR **METRONIDAZOLE** gel, 0.75%, one full applicator (5g) intravaginally, once a day for 5 days OR **CLINDAMYCIN** cream 2%, one full applicator (5g) intravaginally at bedtime for 7 days |
|  | Yeast | Visual Inspection | **FLUCONAZOLE** 200 mg oral tablet, one tablet in single dose OR OTC **MICONAZOLE** 100mg vaginal suppository, one suppository for 7 days |
|  | Scabies | Swab/Culture: In-house lab diagnosis | **PERMETHRIN** 5% crème (1 60-gm tube) Apply to all areas of the body from neck down, wash off after 8-14 hours OR **Ivermectin** 200 mg/kg orally, repeated in 2 weeks |
|  | Pediculosis Pubis | Visual Inspection | **PERMETHRIN** 1% crème rinse Apply to affected area, wash off after 10 minutes OR **PERMETHRIN W/ PIPERONY BUTOXIDE**. Apply to affected area, wash off after 10 minutes |
|  | Non-Gonococcal Urethritis (NGU) | Visual Inspection | **AZITHROMYCIN** 1 g orally in a single dose OR **DOXYCYCLINE** 100mg orally twice a day for 7 days |
|  | Epididymitis | Visual Inspection | **No Treatment.** Patient will be referred to own physician or a treatment center from referral list |
| **Physician Signature** |  | **Date** |  |

**DISEASE –SPECIFIC PROCEDURES**

# BACTERIAL VAGINOSIS — BV

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| 1. **PRESUMPTIVE DIAGNOSTIC CRITERIA** | Three of the following four criteria are necessary:1. Observation of thin, homogenous discharge adhering to vaginal walls
2. Positive sniff/whiff test
3. Wet smear demonstrating the presence of clue cells

4. pH >than or equal to 4.5 |
| 2. **TREATMENT****If symptoms of discharge or odor are present** | **PRIMARY:****Metronidazole 500 mg po bid x 7** **days****OR****SECONDARY:****Metronidazole gel .75%. 1 applicator intravaginally qd x 5 days****OR****Clindamycin cream 2%, 1 applicator intravaginally hs x 7 days** |
| **Consideration:** The recommended regimens are equally effective. Alternative regimens are less efficacious |
| **Alternative regimens:** | **Clindamycin** 300 mg po bid x 7 days**OR****Clindamycin ovules** 100 mg intravaginally q hs x 3 **days** |
| **If persistent BV or recurrent BV** | **Refer patient to PCP/Referral Net** |
| **If nursing** | **Metronidazole gel or Clindamycin cream**No apparent contraindication |
| **If pregnant\*** | **Metronidazole** 500 mgpo BID x 7 daysOR **Metronidazole** 250 mg po TID x 7 daysOR **Clindamycin** 300 mg po BID x 7 days |
| **\*Consideration:** BV during pregnancy may be associated with adverse pregnancy outcomes (premature rupture of membrane, preterm labor, and preterm birth), and the organisms found in BV are also associated with postpartum, post caesarean, post abortion, or post hysterectomy infections.Because treatment of BV in high risk pregnant women who are asymptomatic might reduce premature delivery, some experts recommend screening and treatment of BV during the first trimester of pregnancy, as well as prior to the other gynecologic surgeries mentioned above. |
| **If Metronidazole allergy** | **Clindamycin** 300 mg po bid x 7 **days****OR****Clindamycin cream** 2%, one full applicator (5gm) intravaginally q hs x 7 days**Clindamycin cream should not be used after 20 weeks gestation.** |
| **Consideration:** Topical metronidazole ***(Metrogel)*** should not be prescribed for patients with metronidazole allergy. It may be prescribed for those who have GIintolerance to Metronidazole |
| 3. **PATIENT EDUCATION** | Present a Drug Fact Sheet to all patients requiring treatment, prior to administration of any drug.Do not drink alcoholic beverages while taking Metronidazole and 24 hours after completing Treatment. (Antabuse effect) |
| 4. **FOLLOW-UP** | None |
| 5. **SEXUAL PARTNER(s)** | **Refer (Schedule)** for STDexam and treat accordingly |

# CHLAMYDIA TRACHOMATIS

**CONSULT NOT NEEDED —** for positive laboratory test and uncomplicated urethral or cervical Chlamydia.

**CONSULT NEEDED** for all other CT — (e g, ophthalmic infection, infant infection)

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| **NOTE: A PRESUMPTIVE DIAGNOSIS OF CHLAMYDIA OR GONORRHEA INDICATES THAT PATIENTS SHOULD BE PRESUMPTIVELY CO-TREATED FOR BOTH CHLAMYDIA AND GONORRHEA AT THE TIME OF THE PRESUMPTIVE DIAGNOSIS.** |
| **1a. PRESUMPTIVE DIAGNOSTIC CRITERIA** | 1. **Observation of purulent discharge (uretheral or cervical) during physical exam**
2. **Known or suspected contact with an infected partner.**
 |
| **1b**. **DIAGNOSTIC CRITERIA** | Positive Chlamydia test by culture, NAAT, DFA, EIA, DNA probe, or other FDA approved test |
| **1c. CRITERIA FOR SCREENING** | **All Patients:*** Receive cervical or uretheral swab

**Selective Criteria:**Rectal and pharyngeal gonorrhea cultures will be performed for the following patients:• a history of sex for drugs/moneyOR• a history of rectal or oral sex with a partner who is suspected of positive CT/GC OR• Signs/symptoms of pharyngitis (throat culture only) or proctitis (rectal culture only). |
| 2. **TREATMENT** | **PRIMARY:****Azithromycin 1 gm. PO STAT** |
| **If Azithromycin intolerant :** | **SECONDARY:****Doxycycline 100 mg po bid x 7days****OR****Levofloxacin** 500 mg po qd x 7 days**OR****Erythromycin base** 500 mg po qid x 7 day. |
| **Consideration:** Levofloxacin and other quinolones may be prescribed for adolescents under 18 years of age, weighing more than 100 pounds. Doxycycline should not be given if TCN intolerant |
| **If Pregnant:** | **Azithromycin 1gm po STAT****OR****Amoxicillin** 500 mg po tid x 7 days |
| **Considerations in Pregnancy:** Doxycycline, Levofloxacin, and Erythromycin estolate are contraindicated during pregnancy. |
| 3. **PATIENT EDUCATION** | * Present a Drug Fact Sheet to all patients requiring treatment, prior to administration of any drug.
* Doxycycline can reduce the effectiveness of OCs during the cycle in which it is taken — OC users should be advised to use condoms during the entire cycle in which Doxycycline is taken.
* Doxycycline can cause photosensitivity — patients should be advised to reduce sun exposure and avoid tanning beds or wear sun block during treatment.
 |
| 4. **FOLLOW UP** | * Due to high rates of re-infection, patients with documented chlamydial infection should be advised to return for repeat STD screening in 3 months.
* Patient should return for a test of cure (TOC) in 2 weeks, at which time a repeat culture will be sent for lab results confirming a negative test following treatment.
 |
| **5. SEXUAL PARTNER(s)**For all sexual contacts of cases occurring within the previous 60 days or the most recent sexual partner if >60 days. Test and treat partners.  | **Azithromycin 1 gm po STAT****OR****Doxycycline 100 mg po bid x 7 days****I**F Partner is PREGNANT, PCN/CEPH ALLERGIC, or INTOLERANT — See Section 2. TREATMENT for Chlamydia trachomatis |
| **6. CHLAMYDIA CONJUNCTIVITIS** | Refer to ophthalmology |
| **Chlamydia Therapy for Infants and Children** | Children under 15 years will generally not be evaluated or treated. If the symptoms are urgent, referral to an urgent care center or pediatric emergency department should be arranged. Refer to Pediatrics Clinic, PCP or Referral Net Pediatrician or Family Doctor |

# EPIDIDYMITIS

**REFERRAL NEEDED: No** treatment may be administered. Patient should be referred to a Urologist. If an immediate referral to a Urologist is not possible, patient should be referred to Emergency Department.

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| 1. **PRESUMPTIVE DIAGNOSTIC CRITERIA** | Presence of pain and edema on palpation of epididymis. |
| **Etiology:** | * Epididymitis caused by STDs (GC or CT) is usually associated with urethritis and is more common in men < 35 years old.
* Epididymitis caused by enteric organisms (e.g. E coli) is not typically associated with urethritis and is more common in men > 35 years and in men with underlying structural urologic abnormalities.
 |
| 2. **TREATMENT** | **Refer to Urologist/Emergency Department/PCP.**  |
| ***Etiology likely due to STD*** | ***Ceftriaxone 250 mg IM STAT*** *FOLLOWED* ***BY******Doxycychne 100 mg po bid x 10 days*** |
| ***If the patient is allergic to penicillin or cephalosporins******OR******If etiology likely due to enteric organism*** | ***Ofloxacin*** *300 mg orally twice a day for 10 days if available****OR******Levofloxacin*** *500 mg orally once daily for 10 days* |
| ***Considerations:**** *Quinolone-resistant GC is occurring in the County. Check GC and resistance reports. If GC positive and quinolone resistance, consult with Medical Director*
* *Levofloxacin and other quinolones may be prescribed to adolescents less than 18 years of age weighing more than 100 pounds.*
 |
| *3.* ***PATIENT EDUCATION*** | * *Patient should be advised to be on bed rest with scrotal elevation, and cold packs until fever and local inflammation have subsided.*
* *Doxycycline can cause photosensitivity — patients should be advised to reduce sun exposure, avoid tanning booths and/or wear sun block during treatment*
 |
| *4.* ***FOLLOW-UP*** | *Re-evaluate in 2-3 days. Evaluation by PCP or Urologist should have been completed. If not, re-emphasize the importance of follow-up. If no significant improvement, refer to urologist (immediately) or ED for possible hospitalization.* |
| **5. SEXUAL PARTNER(s)**Sexual partners within the preceding 60 days | Examine for STDs and treat with a regimen effective against uncomplicated gonococcal and chlamydial infections. |

# GONORRHEA

**REFERRAL NOT NEEDED —** for positive laboratory test, uncomplicated GC: cervicitis, urethritis, pharyngitis, and proctitis.

**REFERRAL NEEDED** if complicated GC: PID, epididtis, ophthalmia, disseminated infection.

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| **NOTE: A PRESUMPTIVE DIAGNOSIS OF CHLAMYDIA OR GONORRHEA INDICATES THAT PATIENTS SHOULD BE PRESUMPTIVELY CO-TREATED FOR BOTH CHLAMYDIA AND GONORRHEA AT THE TIME OF THE PRESUMPTIVE DIAGNOSIS.** |
| **1a. PRESUMPTIVE DIAGNOSTIC CRITERIA** | * **Observation of purulent discharge (uretheral or cervical) during physical exam**
* **Known or suspected contact with an infected partner.**
 |
| **1b. DEFINITIVE DIAGNOSTIC CRITERIA** | * Positive laboratory test for *N. gonorrhoeae*including culture, DNA probe, NAAT (gram stain of urethra or cervix with intra-cellular, gram negative diplococci, if available)
 |
| **1c. CRITERIA FOR SCREENING** | **All Patients:*** Receive cervical or uretheral swab

**Selective Criteria:**Rectal and pharyngeal gonorrhea cultures will be performed for the following patients:• a history of sex for drugs/moneyOR• a history of rectal or oral sex with a partner who is suspected of positive CT/GC OR• Signs/symptoms of pharyngitis (throat culture only) or proctitis (rectal culture only). |
| 2. **TREATMENT** 1. **UNCOMPLICATED GONORRHEA FOR PERSONS OVER AGE 12:**

(cervical, urethral, rectal) | **PRIMARY:****Ceftriaxone** 250 mg **IM STAT****OR****SECONDARY:****Cefixime 400 mg po STAT****[Consult Medical Director if patient is contraindicated for primary treatment prior to providing a secondary treatment]****AND** **1 g Azithromycin po STAT** |
| **Considerations:*** Persons diagnosed with GC with negative test results for C. ***trachomatis*** by a NAAT (nucleic **acid based test** such as LCR, Probe-tec, PCR) **do** not require co-treatment for chlamydial infection.
* Quinolone-resistant GC is occurring in the County. Testing done in the 2007, showed that quinolone resistance was present in 5.5% of isolates **tested.**

**Most cases were in MSM. Routine testing** for quinolone resistance is occurring for STD Clinic patients. |
| **If Pregnant or Breastfeeding:** | **PRIMARY:****Ceftriaxone** 250 mg **IM STAT****OR****SECONDARY:****Cefixime 400 mg po STAT****[Consult Medical Director if patient is contraindicated for primary treatment prior to providing a secondary treatment]****AND** **1 g Azithromycin po STAT** |
| **If pregnant and PCN or cephalosporin allergic** | Consult with Medical Director |
| If PCN or cephalosporin allergic, and over 18 years — OR — if less than 18 but weighing more than 100 lbs | **Levofloxacin** 250mg po STAT FOLLOWED BY**Doxycycline** 100 MG po bid X 7 days |
| Consideration: Check result of GC resistance testing |
| If PCN or cephalosporin allergic and under 18 years and weighing less than 100 lbs | Consult with Medical Director |
| 1. **PHARYNGEAL GONORRHEA**

**Pharyngeal culture (+) and no prior treatment:** | **PRIMARY:****Ceftriaxone 125 mg IM STAT** FOLLOWED BY**Doxycycline 100 mg po bid x 7 days**ORAzithromycin 1gm po STAT |
| Alternate treatment | Ciprofloxacin 500 mg po STAT. |
| **Consideration:** Often if a pharyngeal GC culture result is back, the CT **result is also known. If the CT is negative, no co‑ treatment is necessary** |
| If pregnant | **Ceftriaxone** 125 mg IM STAT FOLLOWED BYAzithromycin lgm po STAT |
| If pregnant or under 18 years and PCN or cephalosporin allergic. | **Consult with STD** Medical Director |
|  **PREVIOULSY TREATED** |  |
| **Patients who were previously treated** for uncomplicated gonorrhea and subsequently found to have positive **pharyngeal** culture for *N.* ***gonorrhoeae* at the time of treatment** |
| If treated with Ciprofloxacin | **Check** GC **resistance report.** If no resistance, no action necessary |
| If treated with Ceftriaxone | No action necessary |
| If treated with Cefixime or other quinolone antibiotics (e.g. Levofloxacin) | **Recall, re-culture and treat with**PRIMARY:Ceftriaxone 125 mg IM STAT IF ABLEORSECONDARY:Ciprofloxacin 500 mg po STAT (if isolate was not resistant to quinolones),  |
| If unable to use a cephalosporin or ciprofloxacin | Notify Medical Director if culture is positive |
| **D. OPHTHALMIC GONOCOCCAL CONJUNCTIVITIS** | Refer immediately to Opthomalogist |
| **E. PELVIC INFLAMMATORY DISEASE** | Refer to section "Pelvic Inflammatory Disease" |
| **F. EPIDIDYMITIS** | Refer to section "Epididymitis" |
| **G**. **DISSEMINATED GONORRHEA** | Consult with Medical Director |
| 3. **PATIENT EDUCATION** | * Present a Drug Fact Sheet to all patients requiring treatment, prior to administration of any drug.
* Doxycycline can reduce the effectiveness of Oral Contraceptives during the cycle in which it is taken — OC users should be advised to use condoms during the entire cycle in which Doxycycline is taken.
* Doxycycline can cause photosensitivity — patients should be advised to reduce sun exposure or wear sun block during treatment.
 |
| 4. **FOLLOW-UP** | * Patient should return for a test of cure (TOC) in 2 weeks, at which time a repeat culture will be sent for lab results confirming a negative test following treatment.
 |
| **5.SEXUAL PARTNER(s)*** For all sexual contacts to cases of gonorrhea occurring within the previous**60** days:
 | **PRIMARY:****Ceftriaxone 125 mg IM STAT****OR****SECONDARY:****Cefixlme 400 mg po STAT****FOLLOWED BY****(for possible co-infection with C.T.)****Doxycycline 100 mg po bid X 7 days****OR****Azithromycin 1 gram po STAT** |
| **Note:** If chlamydial infection is ruled out by a negative NAAT (nucleic acid test such as *ProbeTec,* LCR, PCR), co-treatment for chlamydia is not recommended |
| **IF partner is PREGNANT, PCN/CEPH ALLERGIC OR INTOLERANT OR UNDER 18 YEARS, SEE ABOVE SECTION 2. TREATMENT** |

# HERPES SIMPLEX (GENITAL) VIRAL INFECTION

**CONSULT NEEDED:** Treatment will be referred to physician or MC STD Clinic in the case of a positive lab result AND symptoms. Asymptomatic patients with a positive result will not be referred for treatment or evaluation.

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| **PRESUMPTIVE DIAGNOSTIC CRITERIA** | Observation of painful, characteristic Vesicular, pustular, or ulcerative lesions (see GUD protocol |
| **DEFINITIVE DIAGNOSIS** | Positive lab result **for HSV (Type I or II)** from blood specimen.(A patient with a lab result reported as “Equivocal” should be retested for HSV I & II. If a second “Equivocal” result is reported, patient should be referred for further evaluation regardless of symptoms.) |
| *2.* ***TREATMENT******For first clinical episodes:*** | ***Acyclovir 400 mg po tid x 7-10 days******OR******Famciclovir 250 mg po tid x 7-10 days******OR******Valacyclovir 1 gm po bid x 7-10 days*** |
| ***For Recurrent episodes:*** | ***Acyclovir 400 mg po tid x 5 days****OR****Acyclovir 800 mg po tid x 2 days******OR******Famciclovir 1 gm po bid x 1 day******OR******Valacyclovir 500 mg. po bid x 3 days******OR******Valacyclovir 1gm po qd x 5 days*** |
| ***Consideration:*** *The clinical benefit of treating recurrent* ***HSV episodes*** *is limited to those patients who initiate therapy during the prodrome or first 24 hours and benefit may be only a half day less of symptoms.* |
| ***If Pregnant:*** | *Consult with STD Medical Director.* |
| ***IF HIV (****+)* | ***Acyclovir*** *400 mg po tid x 5-10 days**OR****Famciclovir*** *500 mg po bid x 5-10 days**OR****Valacyclovir*** *1 gm po bid x 5-10 days* |
| *3.* ***PATIENT EDUCATION*** | * *Suppressive antiviral therapy has been shown to decrease the frequency of clinical outbreaks, the rate of asymptomatic viral shedding and the transmission of genital HSV to an uninfected partner. Primary care providers are able to provide prescriptions for suppressive therapy in patients with frequent outbreaks or patients with regular sexual partners who do not have HSV themselves.*
 |
| *4.* ***FOLLOW-UP*** | *None* |
| ***5. SEXUAL PARTNER(s)*** | * *Sexual partners should be interviewed for past symptoms that may be suggestive of genital herpes infection and/or advised to return for diagnosis and treatment if genital lesions appear.*
 |
| *6.* ***TYPE SPECIFIC HSV ANTIBODY SCREENING*** | *Sensitive and specific HSV antibody screening\* is now available. Patients should be referred* ***to*** *a private provider. Tests detect:*1. *Glycoprotein G2 is specific for Type 2*
2. *Glycoprotein GI is specific for Type 1*

*There are currently two FDA approved serology tests:**(a) HerpeSelect 1 and 2 by Focus Technologies and**(b) POCkit Test by Diagnology for HSV Type 2.* |

# HUMAN PAPILLOMA VIRUS (HPV) - VENEREAL WARTS

**CONSULT NEEDED:** No screening or treatment of HPV will be done at CompassCare. All suspected or known cases of HPV must be referred to patient’s own physician.

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| *1.* ***DIAGNOSTIC CRITERIA*** | *Observation of flat or exophytic verrucous lesions which appear whitish or pinkish on genital skin or mucous membrane surfaces* |
| *2.* ***TREATMENT*** | *Specific referrals will be provided for patients with and without insurance..Most should be referred to a Gynecologist**Patients with perianal warts will be give a referral list for colorectal specialists for possible anoscopy/proctoscopy* |
| ***If Pregnant:*** | *Recommend treatment with cryotherapy. Refer to private Gynecologist, or Gyn Clinic* |
| ***If HIV Infected*** | *In general, HIV infected patients should be referred to their HIV provider as they require close follow-up over the long term.* |
| ***FOLLOW*** *UP* | *Exceptions may be made on a case by case basis.* |
| *3.* ***PATIENT EDUCATION*** | *Treatment of the wart lesions does not eradicate the HPV infection. Recurrences are frequent. Patient should use condoms and continue to inspect self for new lesions for a minimum period of 6 months. If new lesions are seen, seek re-treatment.**Even after removal of warts, patients may harbor HPV in surrounding normal tissue. The use of condoms may reduce transmission to partner likely to be uninfected, such as new partners. Recent studies indicate that genital HPV infections are self-limited in many patients and often resolve within 6 months However, the persistence of infection in an individual is not predictable.* |
| *4.* ***FOLLOW-UP*** | *None* |
| ***5. SEXUAL PARTNER(s)*** | *The partner should be examined thoroughly for wart lesions. If lesions are found, treatment may be prescribed as described above. If lesions are not present, the partner should be advised that they may be infected, even without visible lesions and they should also be advised to inspect self for wart lesion and seek treatment if lesions appear* |

# PELVIC INFLAMMATORY DISEASE

**CONSULT NEEDED:** No screening or treatment of PID will be done at CompassCare. All suspected or known cases of PID must be referred to patient’s own physician.

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| 1. **PRESUMPTIVE DIAGNOSTIC CRITERIA**

**Note:** GC isolates of STD clinic patients **are** routinely tested for resistance. | Uterine/adnexal tenderness**OR**Cervical motion tenderness**AND**Negative pregnancy test |
| *2.* ***TREATMENT*** | ***Ceftriaxone 250 mg IM STAT*** ***FOLLOWED BY******Doxycycline 100 mg po bid x 14 days******Levofloxacin 500 mg po qd x 14 days****With or Without****Metronidazole 500 mg po bid*** *x* ***14 days*** |
| ***Consideration:*** *If TCN intolerant, substitute Erythromycin* ***base****500 mg po qid x 14 days for Doxycycline**Adolescents under 18 years of age weighing more than 100 pounds may* ***be*** *treated with quinolones**Quinolone resistance GC is occurring in the County. Check patient's resistance report. If quinolone resistance, consult with Medical Director.**Would consider addition of Metronidazole in patients with coexisting BV due to increased concern for anaerobic infection* |
| ***If PCN or cephalosporin allergic and under 18 years of age and weighing less than 100 lbs:*** | *Consult with Medical Director* |
| ***If PCN or cephalosporin allergic and over 18 years or if under 18 and weighs more than 100 lbs:*** | ***Levofloxacin*** *500 mg po qd x 14 days* *With or Without****Metronidazole500 mg po*** *bid x 14 days* |
| ***If Pregnant:*** | *Patient should be evaluated by her obstetrical provider if available or at an ED. Consult with Medical Director if these evaluations cannot be obtained.* |
| *3.* ***PATIENT EDUCATION*** | *1. Patients should be advised that the following measures may help to alleviate pain:** + *complete rest for 48-72 hours*
	+ *avoid heavy work, lifting, prolonged standing for 48-72 hours*
	+ *discontinue athletic/exercise activities for 7-10 days*
	+ *avoid penile/vaginal intercourse for 2 weeks and/or the sexual partner is treated*

*2. Doxycycline can reduce the effectiveness of OCs during the cycle in which it is taken — OC users should be advised to use condoms during the entire cycle in which Doxycycline is taken.**3. Doxycycline can cause photosensitivity — patients should be advised to reduce sun exposure or wear sun block during treatment* |
| *4.* ***FOLLOW-UP*** | *All patients presumptively treated for PID must be scheduled to return for follow-up within 48-72 hours. Failure to respond to treatment requires consideration for hospitalization* |
| 1. ***SEXUAL PARTNER(s)***

*(sexual contact within the previous 60 days)* | *All sexual partners to cases of PID should be referred for STD screening and empirically treated with a regimen effective against N.* ***gonorrhoeae and*** *C.* ***trachomatis*** |

# PROCTITIS

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| 1. **PRESUMPTIVE DIAGNOSTIC CRITERIA**
2. Proctitis is inflammation of the rectum. Sexually transmitted proctitis is generally associated with receptive anorectal intercourse and may be due to syphilis, gonorrhea, *Chlamydia trachomatis* (including LGV serovars) or herpes simplex virus.

**II.** Anoscopic examination is required, so the patient should be referred to PCP or Gastroenterologist. A STAT **RPR** should be performed as well. | Symptoms of anorectal pain, tenesmus, or rectal discharge*OR*Anorectal discharge on anoscopic examinationORPresence of pmns on gram stain of anorectal discharge |
| 2. **TREATMENT** | **Treatment should not be attempted, but the patient should be referred out.** |
| **3. SEXUAL PARTNER(s)** | Partners should have an STD evaluation. Epidemiologic treatment of the sexual partner should be based on test results of the index patient. |

# PUBIC LICE

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| **1. DIAGNOSTIC CRITERIA** | Presence of pubic lice and/or nits seen in area of pubic hair on visual examination |
| 2. **TREATMENT** | **PRIMARY:****a. NIX** (Permethrin 1%) creme rinse (no prescription necessary): Wash infested area with shampoo and warm water. Towel dry. Saturate infested area with undiluted solution for 10 minutes. Rinse with warm water. Remove dead lice and eggs (nits) with the fine tooth comb provided in the package. Single application should be sufficient.Probably safe for pregnant and breast-feeding women.**OR****SECONDARY:****b. RID** (no prescription necessary): Apply undiluted solution to infested area for 10 minutes. Afterwards, wash thoroughly with soap or shampoo and warm water. Remove dead lice and eggs (nits) with fine tooth comb provided in the package. It may be necessary to repeat the treatment in7 days if lice are found or eggs are seen at the hair-skin junction.Probably safe for pregnant and breast-feeding women.ORc. **KWELL** (lindane 1%) shampoo 2 ounce bottle (prescription only): Shower or bathe. Apply to infested area and work shampoo into hair and skin until a good lather forms. Shampoo for 4 minutes. Rinse thoroughly and towel dry. Remove dead lice and eggs (nits) with the fine tooth comb provided in the package. May be repeated in 7 days.NOT safe for pregnant or breast-feeding women |
| 3. **PATIENT EDUCATION** | Provide Drug Fact Sheet to every patient requiring treatment, prior to administrering any medication.Advise patient to wash all bedding and clothing to prevent re-infestation. Items can also be placed in a sealed plastic bag for 10-14 days. |
| 4. **FOLLOW-UP** | None |
| 5. **SEXUAL PARTNER(s** | Treat as above |

# SCABIES

**CONSULT NEEDED:** Treatment may be administered only after consultation with STD clinician.

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| 1. **PRESUMPTIVE DIAGNOSTIC CRITERIA** |  |
| **2. TREATMENT** | PRIMARY:a. **Elimite** (Permethrin 5%) cream one 60 gm tube. After bath or shower, towel dry, and then apply cream to entire skin surface from the chin to the toes, including all folds and creases. Wash off in **8-14** hours**Considerations:** Probably safe for pregnant or breast-feeding women.**OR****SECONDARY:****b. KWELL** (lindane 1%) 2 oz. bottle (prescription only). After bath or shower, towel dry, and then apply lotion to entire skin surface from the chin to the toes, including all folds and creases. Apply a thin layer and wash off in 8 hours. May be repeated in 7 daysNOT safe for pregnant or breast-feeding women.**c. Ivermectin** 200 mcg/kg single dose po and repeat in 2 weeks. Advise patient regarding possibility of rare GI side effects, nausea anorexia.NOT safe for pregnant or breast-feeding women. |
| 3. **PATIENT EDUCATION** | Provide Drug Fact Sheet to every patient requiring treatment, prior to administrering any medication.Advise patient to wash all bedding and clothing to prevent re-infestation. Items can also be placed in a sealed plastic bag for 10 days. |
| 4. **FOLLOW-UP** | None |
| **5. SEXUAL PARTNER(s) and Household Contacts** | Treat as above |

# SYPHILIS

**CONSULT NEEDED:** All lab-confirmed positive Syphilis patients will be referred for follow-up and treatment with their own physician, or at the MC STD Clinic.

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| 1. **DIAGNOSTIC CRITERIA** | Confirmed lab serology is positivive. |
| *2.* ***TREATMENT******EARLY SYPHILIS (includes Primary. Secondary and Early Latent Syphilis:*** *(less than 1 year duration)* | *LA* ***Bicillin 2.4 million units IM STAT*** |
| ***Note:*** *Bicillin, or benzathine penicillin, is made as CR crystalline or LA — long acting.* ***Syphilis is only treated with the LA version.*** *Make sure the Bicillin is labeled with LA.* |
| ***If PCN allergic*** | ***Doxycycline*** *100 mg po bid x 14 days* |
| ***Note:*** *If patient is judged very likely to be non-adherent with Doxycycline therapy or if patient has already failed to complete a course of Doxycycline for the diagnosis of syphilis, contact the Medical Director regarding the possible use of Azithromycin 2 gm po STAT as directly**observed therapy* |
| ***If Pregnant:*** | *LA* ***Bicillin*** *2.4 million units IM STAT* |
| ***If Pregnant and PCN allergic:*** | ***Refer for PCN skin testing:****• If history of PCN allergy is ambiguous and skin testing is negative — treat in clinic with LA Bicillin 2.4 million units IM STAT**• If history of PCN allergy is clear, and skin testing is negative, or if skin testing is positive, arrange for desensitization and treatment in an ED.* |
| ***If HIV positive (including preliminary positive)*** | ***LA Bicillin*** *2.4 million units IM x 3 at weekly intervals (re-evaluate as soon as HIV confirmatory test results are available)* |
| ***If HIV positive and PCN allergic:*** | *CONSULT with Medical Director.* |
| ***2a. TREATMENT FOR LATE LATENT SYPHILIS****(More than 1 year's duration)* | *Obtain rapid HIV testing. Not likely to present to the clinic. Need referral for lumbar puncture and CSF examination to rule out neurosyphilis (see General Medical Policies, Syphilis). No clinic treatment or follow-up will be undertaken.* |
| ***5a. SEXUAL PARTNER(s) whose last******sexual exposure with the early syphilis case was within the previous 90 days:*** *Perform STAT RPR , rapid HIV antibody test, and provide preventive treatment* | *LA* ***Bicillin*** *2.4 million units IM STAT.* *If PCN allergic:**—* ***Doxycycline*** *100 mg po bid x 14 days* *If pregnant:* *—* ***LA Bicillin*** *2.4 million units IM STAT* *If pregnant and PCN allergic:* *— consult with STD Medical Director* |
| ***5b. SEXUAL PARTNER(s) whose last sexual exposure with the early syphilis case was more than 90 days previous:*** *Perform STAT RPR, rapid HIV antibody test, and treat based on result.* | *•* ***If STAT RPR is reactive,*** *consult with STD clinician for staging and treatment.* *•* ***If RPR non-reactive, no*** *treatment necessary* |

# TRICHOMONAS VAGINITIS

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| **1. DIAGNOSTIC CRITERIA:** | Presence of motile trichomonads seen on vaginal wet smear |
| 2. **TREATMENT** | **PRIMARY:****Metronidazole** *(Flagyl)* 2 gm po STATOR**SECONDARY:****Metronidazole** *(Flagyl)* 500 mg po bid x 7 days |
| **IF no response to treatment (based on patient still experiencing symptoms and returning for retest after 14 days):** | Assure that sexual partner has been adequately Treated• Retreat with Metronidazole 500 mg po bid x 7 days• If there is still no response, treat with Metronidazole 2 gm po qd x 5 daysIf there is still no response, contact medical director to assess for need for resistance testingTopical therapies (see metronidazole allergy section) may be effective in —50% of cases |
| **If pregnant and symptomatic, or nursing:** | **Metronidazole** *(Flagyl)* 2 gm po STAT. |
| **If allergic to Metronidazole:** | **PRIMARY:****Clotrimazole cream** 1% intravaginally bid x 2 weeksOR**SECONDARY:****Semicid cream** intravaginally bid x 2 weeksORDesensitization to metronidazole followed by treatment with metronidazole as above |
| **Consideration:** Topical therapies have only had —50% success rates**Consideration:** Persons with true allergy to metronidazole cannot be treated with the topical preparation *(Metrogel)* |
| **If patient has been treated with Metronidazole within the previous 30 days and has not had repeat sexual exposure:** | Consult with clinician |
| **3. PATIENT EDUCATION** | Provide Drug Fact Sheet to every patient requiring treatment, prior to administrering any medication.Patients should be advised that alcohol & Metronidazole may cause an Antabuse-like effect including headache, nausea and vomiting. Patients are to be advised to avoid all alcoholic beverages the day(or days) of treatment and for 24 hours after completion of treatment.**If nursing:** Do not breast feed for 24 hours during this time. Breast milk can be expressed and discarded. |
| 4. **FOLLOW-UP** | None |
| **5. SEXUAL PARTNER(s)**For all sexual contacts to cases of trichomoniasis occurring within the Previous 30 days. | a. **Metronidazole** 2 gm po STAT |

# URETHRITIS - MALE (NGU)

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| 1. **PRESUMPTIVE DIAGNOSTIC CRITERIA** | • Presence of urethral discharge seen on exam, either spontaneously or after urethral stripping. **OR**• Presence greater than or equal to 5 pmns/hpf and no gram-negative diplococci on gram-stained urethral smear. |
| **Consideration:** For males with symptoms of urethritis but no discharge on exam and no pmns on gram stain, screen for GC and CT and treat accordingly. |
| 2. **TREATMENT** | **PRIMARY:****Azithromycin 1 gm po STAT** **OR****SECONDARY:****Doxycycline** 100 mg po bid x 7 days |
| **Consideration:** for patients with frequently recurring NGU or poor response to treatment for NGU, **consider** **referral** for prostatitis evaluation. |
| **If history of persistent NGU within the past year:** | **Doxycycline** 100 mg po bid x 14 days. |
| **If history of NGU Rx within the previous 3 months** | **Erythromycin base** 500 mg po qid x 14 days |
| **2a. FOLLOW-UP TREATMENT** | Consult with Medical Director for Treatment Options: |
| **If incomplete response to treatment within 1 month of Initial treatment:** | **Consideration:** for patients with frequently recurring NGU or poor response to treatment for NGU, consider referral for prostatitis evaluation. |
| **If trichomoniasis cannot be ruled out** | **PRIMARY:****Doxycycline** 100 mg po bid x 14 days OR**SECONDARY:****Erythromycin** base 500 mg po qid x 14 days**AND****Add Metronidazole 2 gin po STAT**• Patients given STAT Metronidazole should avoid alcohol the day of treatment and for the next 24 hours. |
| 4. **FOLLOWUP** | If symptoms resolve after 14 days— no F/U. If symptoms persist, patient should return for re-evaluation at the end of his treatment |
| 5. **SEXUAL PARTNER(s)** sexual contact within the previous 60 days should receive preventive treatment | Sexual partners to men with NGU should have a complete STD evaluation and treatment with**PRIMARY:****Azithromycin** 1 gm po STATOR**SECONDARY:****Doxycycline** 100 mg po bid x 7 days |
| If pregnant: | **Erythromycin** 500 mg po qid x 7 days**Or if GI intolerant:****Erythromycin** 250 mg po qid x 14 days |
| **Algorithm for Diagnosis of Urethritis in Males****RN/NP performs examination including observation of urethral discharge without and with urethral stripping, and erythema of uro-genital epithelium inside urethra. RN assessment is normal vs abnormal discharge: If urine or sexual arousal fluid is seen, this is WNL and not charted as discharge. If abnormal discharge is seen, chart amount and type. Note only presence of erythema (bright, cherry red).**Abnormal discharge is seen either before or after stripping or pt is contact to GC or CT Pt c/o symptoms of urethritis — dysuria or discharge Await GC and CT results**A Urethral specimen swab is sent for Gram Stain and Culture** |
| Greater than or equal to 5 pmns/hpf is NOT seen on gram stain of urethra | If NO Abnormal discharge is charted but patient has symptoms — advise to return in 1-2 days in AM for repeat evaluation |
| Greater than or equal to 5 pmns/hpf is seen on gram stain of urethra | Treat for urethritis and refer to PCP or Urologist to R/O prostatitis, genital dermatitis |

# VAGINAL CANDIDIASIS

**(Yeast Infection)**

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| **1. DIAGNOSTIC CRITERIA** | Presence of budding yeast cells and/or pseudohyphae seen on vaginal wet smear |
| 2. **TREATMENT** | PRIMARY:a. **Fluconazole** *(Diflucan)* **200** mg po STAT (AVOID WITH PREGNANCY)SECONDARY:**b. Miconazole** *(Monistat)* Vaginal Suppository q hs x 3 days or Vaginal Cream q hs x 7 days (no prescription necessary)c. **Clotrimazole** *(Lotrimin)* Vaginal Suppository q hs x 3days or Vaginal Cream qhs x 7 days (no prescription necessary)d. **Butoconazole** *(Femstat)* Vaginal Suppository or Cream qhs x 3 dayse. **Teraconazole** *(Terazole)* Vaginal Suppository q hs x 3 days or Vaginal Cream qhsx7days |
| **Considerations:**• If vulvitis component, prescribe/advise cream• N Ystatin vaginal tablets bid x 2 weeks could be prescribed if cost is a factor |
| **If Pregnant:** | **Miconazole** *(Monistat)* Vaginal Suppository or Vaginal Cream q hs x 7 days (no prescription necessary) |
| 3. **PATIENT EDUCATION** | Provide Drug Fact Sheet to every patient requiring treatment, prior to administrering any medication.Candidiasis is not usually sexually transmitted; however, some male partners may develop balanoposthitis. |
| 4. **FOLLOW-UP** | None |
| **5. SEXUAL PARTNER(s)** | Refer for STD evaluation and treat accordingly. |