

**SEXUALLY TRANSMITTED DISEASES (STD)
PROGRAM MANUAL**



GEORGIA DEPARTMENT OF HUMAN RESOURCES

DIVISION OF PUBLIC HEALTH

EPIDEMIOLOGY AND PREVENTION BRANCH

STD/HIV SECTION

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GEORGIA STD PROGRAM MANUAL

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INTRODUCTION

This manual is prepared as a guide and resource for use by district and county public health personnel to establish standards and maintain up-to-date policies and procedures for STD clinical and disease intervention services within local jurisdictions. It replaces the manual issued in 1991 and any revised pages issued since that time.

The Georgia STD Program standards are based on current Centers for Disease Control and Prevention (CDC) guidelines for STD diagnostic, treatment and disease intervention services. It is expected that district programs will attain these standards whenever possible.

This manual can not cover all potential situations arising in day-to-day STD Program activities. When questions arise, consultation is available from the Georgia STD Program Office at (404) 657-3100.

I. STANDARDS FOR STD MEDICAL RECORDS

The STD medical record should be designed to organize the necessary patient information in a clear and logical manner. A "check-off" design is suggested to provide a fairly complete set of symptoms, history and physical exam and lab test categories to cover the common STDs. "Other" spaces and areas for detailed descriptions of symptoms and abnormal physical findings should augment the check-off format.

The clinical evaluation and laboratory items should be designed so that each must be marked whether it is done or not done, positive or negative, normal or abnormal, etc., so that a quality assurance record audit can determine whether or not clinician performance meets established guidelines and clinic protocols. Enough information should be included in all clinical evaluation categories so that others using the record will understand the examining clinician's assessment.

While a district or clinic may design a record to meet their own specific needs, an STD Medical Record (Form 3164, Revised 7/92) may be ordered from State Central Supply. A sample of the record is on page 3. Each form has space for two patient visits plus a follow-up laboratory results record at the bottom of the back side. It may be folded or kept flat, depending on the local record filing system.

Medical records should be stored in a secured area where they can be easily located by clinic personnel but are not accessible to unauthorized persons. Medical records stored on computer need to have rigorous protection procedures to prevent unauthorized entry into the file, as well as a back-up filing process to prevent any loss of information.

INFORMATION TO BE INCLUDED ON STD MEDICAL RECORDS

A. Identifying Information (Update at each visit)

1. Name - Complete name, including maiden name if applicable. Also note aliases used by patient.
2. Address - Complete with apartment number and zip code.
3. Phone Number - Note where and when patient prefers to be called.
4. Date of Birth.

5. Sex; Marital Status, Race/Ethnic Origin.
6. Employer/School.
7. Emergency Contact Person - Name, phone.

B. Basic Medical History and Risk Assessment

Information collected should accurately define the problem(s), determine risk for STD/HIV infection and lead to successful patient management.

1. Reason for Visit - Note whether patient is a volunteer, has been referred or needs followup.
2. Symptom History - Onset; duration; character; frequency; if patient has had similar problems before or sex partner has symptoms.
3. Sexual History - Last exposure; sexual partners (male/female/both); exposure sites (oral/genital/anal); number of recent (1-2 months) partners; recent new partner; frequency of condom use/if use with all partners.
4. Medication History - Recent use of antibiotics; other current medications; known drug allergies, including name of drug and type of reaction.
5. History of Drug Use and Needle-Sharing Practices - In self and/or sex partners. Includes oral, inhaled or injected “street” drugs and alcohol.
6. Past History of STDs - Gonorrhea, chlamydia, any blood tests for syphilis and HIV infection. Also, history of Hepatitis B infection or immunizations.
7. Females: Contraception, Date of Last Menses, Last Pap Smear - Note any unusual aspects of last menses (e.g., change in duration or amount of flow, pain), likelihood of pregnancy.
8. Review of General Health - As appropriate. Note recent pulmonary infections or breathing problems; frequency and type of bacterial infections in the past year; unexplained weight loss, night sweats, fatigue, depressed appetite, unexplained diarrhea.

C. Physical Examination - Per standards; describe abnormal findings.

D. Laboratory - List all tests done onsite and those sent to an outside lab, including tests for HIV.

- E. **Assessment/Diagnosis** - Based on history, exam and laboratory findings.
- F. **Management Plan** - Medication, referral(s), education and use of handouts, partner referral, prevention/risk reduction counseling, HIV pretest or posttest counseling, follow-up appointments.
- G. **Signatures** - Clinician and, as needed, Communicable Disease Specialist.

(state STD Medical Record)

GUIDELINES FOR COMPLETION OF STD MEDICAL RECORD
(Form 3164, Revised 7/92)

Guidelines/suggestions for areas that may cause questions:

A. Patient Demographic Information

1. Codes for RACE: A = Asian; B = Black; AI = American Indian; AN = Alaska Native; M = Multiracial; PI = Pacific Islander; W = White
2. MARITAL STATUS: N = Never married (not just Single now)

B. HIV Information

Per the current Georgia Division of Public Health HIV/AIDS Policy Manual, "Information regarding a patient's HIV status shall be noted in the patient's medical record---." HIV information is included in the following areas:

1. PRIOR STD, for previous HIV test results;
2. DELAYED LAB TESTS, for test ordered that day; and,
3. COUNSELING/EDUCATION/REFERRAL, for (pretest or posttest) HIV prevention counseling performed that day.

C. For efficient use of space, the following areas contain more than one word or abbreviations divided by a slanted line(/) where a choice must be made by circling the applicable part:

1. PRIOR STD -- MPC/NGU
2. PHYSICAL EXAM -- Cx/Vag/Ureth. discharge
3. STAT LAB TESTS -- Gram stain U/Cx --GmNegDip Intra/Extracell
4. DELAYED LAB TESTS -- (GC CULTURES) Cx/Urethra
5. COUNSELING/EDUCATION/REFERRAL -- HIV Pretest/Posttest

D. In the PHYSICAL EXAM and LAB TEST areas, there must be **X**'s in the boxes to show whether no exam or lab tests were done/ordered or exactly what was examined and which lab tests were done/ordered. Categories to **X** are also listed for COUNSELING/EDUCATION/REFERRAL.

- E. SEXUAL HISTORY -- For both males and females, mark an **X** if condoms are used: Always; Some (sometimes); or, No (never).
- F. OTHER MEDS/DRUGS --Record "street drug" use in addition to any prescribed and over-the-counter medications.
- G. The INTERVIEWER space is for the Communicable Disease Specialist's signature, for those patients who are referred for an interview (e.g., syphilis cases/contacts).

II. STANDARDS FOR BASIC STD PHYSICAL EXAMINATION

MALE AND FEMALE

1. Inspect skin of face, trunk, forearms and legs, palms and soles for lesions, rashes, nodules or discoloration.
2. Inspect oral cavity and mucosal surfaces for lesions, blisters, discoloration.
3. Palpate inguinal and femoral areas for lymphadenopathy.
(Also palpate cervical, supraclavicular, epitrochlear and axillary areas for lymphadenopathy if systemic disease suspected.)
4. Inspect pubic hair for lice and nits.
5. FEMALE -- Complete pelvic exam:
 - a. Inspect perineum and external genitalia for discharge, redness, masses, lesions, etc.
 - b. Palpate Bartholin's and Skene's glands.
 - c. Inspect cervix, with attention to the amount, color and character of any discharge. Note presence of ectopy, edema, friability or lesions.
 - d. Inspect vaginal mucosa. Note any lesions and the amount, character and color of any discharge.
 - e. Perform bimanual examination. Note any cervical motion tenderness, uterine enlargement, adnexal tenderness or pelvic masses.
 - f. Rectovaginal exam to palpate uterus, adnexae and rectum, if indicated.

MALE -- Genital examination:

- a. Inspect penis, with attention to the meatus, retraction of the foreskin and discharge from the urethra--note color, amount and character of discharge.
- b. Inspect scrotum and palpate contents. Note any testicular masses or

- tenderness.
- c. Inspect anorectal area if symptoms or history of sexual exposure.

III. STANDARDS FOR ROUTINE LABORATORY TESTS

MALES AND FEMALES

1. Serologic test for syphilis at every visit unless known to have a negative test within the past month (30 days). Immediate RPR (rapid plasma reagin) card test, if possible, when a suspicious lesion or rash is present and for any sex partner of a confirmed or suspected syphilis case.
2. HIV prevention counseling and offering HIV antibody testing. Encourage testing if there is evidence of genital lesions, after suspected exposure, before pregnancy and during early pregnancy.
3. Darkfield examination, if possible, of serous fluid from any lesion thought to be a primary syphilis ulcer or moist lesion thought to be due to secondary syphilis.

MALES

1. Urethral Gram stain smear for gonorrhea and/or urethritis.
2. Culture(s) or other acceptable test for gonorrhea:
 - a. Urethral, if Gram stain smear is negative for gonorrhea, or not done.
 - b. Oropharyngeal and/or rectal if history indicates exposure or symptoms.

FEMALES

1. Culture(s) or other acceptable test for gonorrhea:
 - a. Endocervical on all patients.
 - b. Urethral if discharge is present or cervix is absent.
 - c. Oropharyngeal and/or rectal if history indicates exposure or symptoms.

2. Endocervical nonculture chlamydia test (e.g., GenProbe) per selective criteria, if available.
3. Tests of vaginal discharge:
 - a. "Whiff test" with KOH, for fishy odor, and elevated pH to support diagnosis of bacterial vaginosis.
(These are actually clinician observations, not laboratory tests.)
 - b. Saline wet mount for trichomonas, "clue cells" and evidence of yeast.
 - c. KOH wet mount for yeast.
4. Pap smear, if not done within past year. Refer if unable to do onsite.
5. Pregnancy test, if pregnancy suspected.

IV. STANDARDS FOR MEDICAL CONSULTATION AND REFERRAL

- A. Physician consultation is indicated when:
 1. Pelvic examination could not be done satisfactorily.
 2. Other pelvic abnormalities are found, e.g., uterine enlargement, adnexal masses.
 3. Tender or enlarged Bartholin glands are present in a female patient.
 4. Tender or enlarged epididymis or testicles are present in a male patient.
 5. Diagnosis is uncertain or disease is severe.
 6. Appropriate treatment is not covered by a nurse protocol.
 7. There is any sign of an adverse reaction to treatment, e.g., anaphylaxis, skin rash or severe anxiety.
 8. Local regulations dictate, e.g., young age of patient.
- B. Referral to a specialist is indicated when:
 1. The patient with acute salpingitis may need inpatient care.
 2. A severe drug reaction requires further treatment or observation.
 3. A pregnant patient is not receiving prenatal care.

4. The patient is at risk for unwanted pregnancy and requests contraception.
5. IUD removal is medically indicated, e.g., PID.
6. The patient shows side effects of her current contraceptive.
7. Urethritis does not respond to therapy or symptoms suggesting urinary tract infections recur.
8. Other urological/prostatic disorders are recognized.
9. A general surgery evaluation is desired for such findings as inguinal hernia, hemorrhoids or extensive warts.
10. An HIV-infected patient is not being followed clinically.

V. STANDARDS FOR COUNSELING AND PATIENT EDUCATION

The purpose of patient education is to stimulate behaviors that will contribute to successful therapy and prevention. Although handouts are an efficient way of giving the patient basic information, they do not replace individualized counseling to personalize the messages and allow for discussion.

The following topics need to be discussed with all patients, at their level of understanding:

A. Laboratory results, diagnosis and treatment information.

1. Results of all tests.
2. The name of the disease and its importance.
3. Treatment information to include:
 - The name of all medications and why they are used.
 - How much medicine to take and when to take it.
 - What to do if doses are missed, if applicable.
 - Potential side effects and what to do about them.
 - Any special instructions to maximize efficacy or minimize side effects.
4. Expected outcome of treatment.

B. The importance of evaluating sexual partners.

1. How the disease is transmitted, its incubation period and time of infectiousness.
2. The likelihood of asymptomatic infection and health consequences if partner(s) not evaluated/treated.
3. Information that the sexual partner(s) need to obtain appropriate medical evaluation/treatment.

- C. When applicable, necessary followup examination/tests.
1. Specific date to return.
 2. The purpose of the exam/tests and potential consequences of not returning.
- D. How to prevent infection or respond if symptoms occur.
1. The proper use of condoms, if not in a mutually monogamous relationship.
 2. Other STD and HIV prevention measures.
 3. Recognition of major STD symptoms.
 4. The need for pregnant women to receive prenatal care, including syphilis testing and HIV antibody testing.

VI. STANDARDS FOR REFERRAL FOR INTERVIEWING

The following categories of patients need to be referred to a Communicable Disease Specialist (CDS):

1. Primary, secondary and early latent syphilis cases, for interviewing and contact followup.
2. Contacts to primary, secondary and early latent syphilis, for cluster interviewing.
3. HIV-infected patients, for interviewing and partner follow up.
4. Other patients with priority STDs who need additional counseling or assistance with notifying their partners. While local availability of CDS staff may be limited, every attempt should be made to assure that patients with gonorrhea, chlamydia and PID receive the assistance they need to refer partners. If a CDS is not immediately available, the clinician may need to interview the patient for the identifying and locating information the CDS needs for field follow-up of the partner(s).

VII. DRUG SIDE EFFECTS AND REACTIONS

- A. Side Effects
Clinicians should be knowledgeable about possible side effects of all medications administered, dispensed or prescribed for STD treatment, so appropriate counseling of the patient can be done.
- B. Vasovagal Syncope (Fainting) and Hyperventilation

Either of the above may occur when the patient is anxious about having blood drawn or receiving an injection. The patient should be observed until recovered, and ideally should be accompanied when leaving the clinic.

C. Jarisch-Herxheimer Reaction

This may occur within 12 hours after treatment of early syphilis. Local reaction may consist of intensification of lesions (e.g., a chancre may become edematous or a faint secondary rash may become prominent). Systemic reaction may consist of a rise in temperature of 101-102 degrees Fahrenheit. The self-limiting reaction usually only lasts a few hours, but may be up to 24 hours. Antipyretics may be taken as needed. Pregnant women may have more severe reactions and should contact their prenatal care provider at the first sign of premature labor or possible fetal distress.

D. Anaphylactic (Allergic) Reactions

The following pages contain the Georgia Division of Public Health guidelines for handling these rare, but possible reactions to antibiotics given to treat STDs.

**STANDARDS FOR MANAGEMENT OF DRUG REACTIONS
IN PUBLIC HEALTH CLINICS***

1. Every clinic site will have up-to-date written plans and protocols for handling anaphylactic (allergic) reactions to medication or immunizations, as well as anxiety or fainting reactions to injections and/or blood-drawing. Plans will include designating the length of time patients will be told to remain in the clinic after receiving an injection.
2. Every clinic site will have appropriate emergency equipment and supplies readily available.
3. Every clinic site will have an emergency alert communication system that is known by all staff.
4. Every clinic site will have posted for easy access local emergency telephone numbers, e.g. EMS, hospital, etc.
5. All staff will have current CPR certification.
6. All new staff will receive orientation/training in emergency procedures within one month of employment.
7. All staff will participate in training updates as needed and in mock emergency drills at least once a year.
8. One person will coordinate the maintenance of up-to-date plans, protocols,

equipment and supplies.

9. One person will coordinate training and scheduling, implementation and evaluation of practice drills.
10. Every drug reaction will be appropriately documented. Copies of records on anaphylactic reactions will be distributed as follows:
 - a. sent with patient to emergency room, if applicable
 - b. retained by the clinic for patient record
 - c. sent to District office, with incident report
 - d. sent to designated State office.
11. District Health Director/Clinical Coordinator will arrange for an annual review and completion of an emergency preparedness checklist for each clinic.

*Other drug reactions/side effects may occur after the patient has left the clinic, e.g. Jarisch-Herxheimer reaction to syphilis treatment. Clinicians are expected to counsel patients about possible reactions and how to handle them.

SUPPLIES FOR TREATMENT OF ANAPHYLAXIS

Local factors such as anticipated EMS response time, the availability of a physician and the ability of personnel to start IVs, etc. will determine the need for supplies beyond the minimum and expanded protocols for some clinics. **Emergency preparedness should be coordinated with the local Emergency Medical System.**

All supplies should be kept together in a kit or cart that is easily moveable and readily accessible/visible during clinic service hours. Inventory should be checked monthly, with careful attention to medication expiration dates and the working condition of equipment.

MINIMUM SUPPLIES

Blood pressure cuff	*Epinephrine 1:1000, 1 cc
Stethoscope	2 ampules
Flashlight/extra batteries	*Diphenhydramine HCl, (e.g., Benadryl)
Oral airways (adult,child)	50 mg/cc, 2 ampules
AMBU bag and/or mask for mouth-to-mouth resuscitation	Syringes, 1 cc
Copy of protocol	Needles, subQ and IM
Acute anaphylaxis records	Swabs, alcohol and dry

Pens
Copy of inventory list of supplies

OPTIONAL SUPPLIES (for use where additional protocols and trained personnel are available)

Portable oxygen/masks	Diphenhydramine HCl capsules, 25 mg and 50 mg
IV needles/infusion sets	Diphenhydramine liquid susp. 12.5 mg/5cc
Tourniquet	
Gauze pads, tape	Epinephrine 1:10,000, for IV use
IV fluids (consult local emergency care experts for suggested type)	

*Available from Office of Pharmaceutical Services, Atlanta

PROTOCOL FOR TREATMENT OF ACUTE ANAPHYLAXIS

A. Assessment:

1. When they occur, anaphylactic reactions after injection of medication usually are immediate or within a few minutes, but occasionally may be delayed for several hours. Patients will be told to stay in the clinic for a designated length of time (usually up to 30 minutes) after receiving an injection. The speed of onset of the reaction means increasing severity and **prompt treatment is imperative.**
2. Any, or all, of the following symptoms may be present: swelling, shortness of breath, wheezing, generalized itching, itching of eyes, nausea, vomiting, diarrhea, rash, weakness, tingling of the extremities, flushing or pallor, tightness in chest, choking sensation, fall in B/P, weak pulse, loss of consciousness.

B. Treatment:

Step 1 Call for HELP - have EMS or physician called

Step 2 Place patient in supine POSITION, legs elevated

Step 3 Assure AIRWAY and begin CPR if indicated
Begin monitoring VITAL SIGNS every 5 minutes

Step 4 EPINEPHRINE (for hypotension/breathing trouble/loss of consciousness)

ADULT: 0.5 cc of 1:1000 subcutaneously (SQ)
 CHILD: 8-22 lbs, give 0.1 cc of 1:1000 SQ
 23-66 lbs, give 0.2 cc of 1:1000 SQ
 67-110 lbs, give 0.3 cc of 1:1000 SQ
 Over 110 lbs, give adult dose

May repeat every 5 -15 minutes as necessary.

Step 5 DIPHENHYDRAMINE, e.g. Benadryl, (for itching/urticaria/nausea)

ADULT: 50 mg IM

CHILD: 25 mg IM

INFANT: (1-10 lbs) 5 mg IM (11-20 lbs) 10 mg IM

Step 6 Assure that treatment worksheet is completed and a copy ready for EMS or physician.

(Appropriate additions to the protocol regarding oxygen equipment and IV infusions would be included when applicable.)

ACUTE ANAPHYLAXIS RECORD

(Example)

District/Clinic Site _____

Date _____ Patient _____ DOB _____

1. Call for HELP

Have EMS called

Injection(s)/treatment which preceded reaction:

2. Patient supine, legs elevated

3. Assure AIRWAY
 Check VITAL SIGNS
 CPR, if necessary

Time given: _____

Time reaction began: _____

4. EPINEPHRINE 1:1000
 (for hypotension, breathing trouble)

Describe signs/symptoms: _____

ADULT: 0.5 cc SQ

Vital Signs

CHILD:

110+ lbs, 0.5 cc SQ

Time: _____ BP _____ P _____ R _____

67-110 lbs, 0.3 cc SQ

23-66 lbs, 0.2 cc SQ

8-22 lbs, 0.1 cc SQ

May repeat every

5 -15 minutes PRN

Emergency Drugs

5. DIPHENHYDRAMINE
(for itching,
urticaria, nausea)

EPINEPHRINE 1:1000 SQ:

Dose: _____ Time: _____

ADULT: 25 mg IM

CHILD:

>20 lbs, 25 mg IM

11-20 lbs, 10 mg IM

1-10 lbs, 5 mg IM

DIPHENHYDRAMINE IM:

Dose: _____ Time: _____

Time EMS/physician arrived _____

Other observations/comments:

Signature of RN/PA _____

Disposition _____ Reviewer _____

VIII. STANDARDS FOR FOLLOW-UP VISITS

A. History

1. Changes in previous symptoms or presence of new symptoms.
2. Adverse reaction to drug treatment.
3. Compliance with previous instructions.
4. Sexual exposure since therapy, including exposure using a condom.
5. Treatment status of sex partner(s).

B. Physical Examination

Reassess the positive physical findings of the previous examination and evaluate any new complaints.

C. Laboratory Tests

According to previous findings and any new complaints.
(See specific follow-up requirements in the diagnostic and treatment guideline for each disease.)

D. Counseling

Review disease prevention measures.

IX. DIAGNOSTIC AND MANAGEMENT GUIDELINES

A. **Scope of Guidelines**

The guidelines on the following pages are for those infections or syndromes most apt to be diagnosed in teenagers and adults being evaluated for STDs in Georgia public health clinics. For other conditions, including infections in children, other reference documents should be consulted.

B. **Reference Documents**

CDC's 1998 Guidelines for Treatment of Sexually Transmitted Diseases; CDC's 1991 Sexually Transmitted Disease Clinical Practice Guidelines; and King K. Holmes, et. al., Sexually Transmitted Diseases, McGraw Hill, 2nd edition, 1990.

C. **Laboratory Tests**

Information on laboratory tests for diagnosis, and how to request those available from a DHR State or Regional Lab, is included after the protocol page(s) for each specific infection or syndrome. Also refer to the Georgia Public Health

D. Diagnostic Criteria

Some CDC documents refer to "levels" of diagnostic criteria:

1. Definitive - This reflects the highest level of confidence based on laboratory identification of the causative organism, or detection of antigen or nucleic acid.
2. Presumptive - This reflects a sufficient level of confidence to warrant full treatment and follow-up based on clinical findings and laboratory testing.
3. Suggestive - The criteria do not confirm the diagnosis, but the potential benefit of treatment must be weighed against the risk of withholding or delaying it.

The diagnostic criteria listed on the following pages will not differentiate between definitive and presumptive, but will include what is expected to be attained in Georgia public health clinics. Suggestive criteria will be noted when it seems most appropriate that treatment be given when only that level is met, for patient management and disease intervention purposes.

E. Treatment Regimens

There are many acceptable treatment regimens for some diseases. Unless there is no other alternative, drugs that are not available through the State Pharmaceutical Supply are not included on the following pages. For conditions where no appropriate drug for treatment is available from the State, arrangements to obtain drugs must be made by local clinics.

Some medications are contraindicated during pregnancy. The prenatal care provider should be informed when a pregnant woman is treated for any STD.

F. Counseling and Routine Screening

It is assumed that all patients will be given appropriate educational information about their diagnosis and its management and prevention measures, and will have routine screening tests done per STD patient evaluation standards. Therefore this general information is not repeated on each individual guideline.

G. Sex Partners

When treatment of sex partners is specified, it should be presumed that the patients have not been adequately managed until all recent sex partners are treated. For syphilis and HIV infection, a CDS is usually responsible for partner referral. For other STDs, the clinician is responsible for counseling patients about how to refer their partners for examination and treatment. Printed referral notes for them to give to the partners should be provided. A CDS may be asked to assist in partner notification for gonorrhea, chlamydia or PID, when indicated.

Clients who voluntarily come to the clinic without a referral note, but give a history of having been told by a sex partner that they need treatment for a specific STD (e.g., gonorrhea, chlamydia) for which the partner has been treated, should be given appropriate treatment for that infection and examination/lab testing for STDs per clinic standards. Confirmation that the partner has been treated is not necessary; the clinician should chart that the patient states he/she is a contact to the named STD.

H. Revisions to Diagnostic and Management Guidelines

Information on the following pages is current as of April 1998, and consistent with the 1998 STD Nurse Protocols. When revisions are necessary, replacement pages will be dated and distributed appropriately.

PRIMARY SYPHILIS

<u>Symptoms/Signs</u>	<u>Diagnostic Criteria</u>	<u>Management</u>
<p>Painless ulcer (chancre) with an indurated border and relatively smooth base, at a site of sexual exposure, e.g., genitals, anus, mouth.</p> <p>Ulcer is usually singular, but there may be more than one.</p> <p>Localized firm, nontender, enlarged lymph nodes.</p>	<p>1. Identification of <u>T. pallidum</u> on darkfield microscopic or DFA (direct fluorescent anti-body) exam of serum from a lesion.</p> <p style="text-align: center;">OR</p> <p>2. Typical ulcer</p> <p style="text-align: center;">AND</p> <p>a. Newly reactive RPR or VDRL,</p> <p style="text-align: center;">OR</p> <p>b. Four-fold or more increase over the last known titer in a person with a history of previous syphilis.</p> <p>Typical ulcer(s) and exposure to a known case of early syphilis in the previous 10-90 days is suggestive of primary syphilis.</p>	<p>A. <u>Treatment</u></p> <p><u>If not HIV-infected:</u></p> <ol style="list-style-type: none"> 1. Benzathine penicillin G, 2.4 mu IM, once, <p style="text-align: center;">OR</p> <ol style="list-style-type: none"> 2. If allergic to penicillin and not pregnant: Doxycycline 100 mg PO, b.i.d. for 14 days. <p style="text-align: center;">OR</p> <ol style="list-style-type: none"> 3. If cannot take penicillin <u>or</u> doxycycline: Erythromycin 500 mg PO, q.i.d. for 14 days. <p>NOTE: If pregnant, this is an interim measure only. See page 22.</p> <p><u>If HIV-infected, and neurosyphilis is ruled out:</u> Benzathine Penicillin G, 2.4 mu IM.</p> <p>B. <u>Counseling/Referral</u></p> <ol style="list-style-type: none"> 1. Explain the possible occurrence of the Herxheimer reaction and how to handle it. 2. Encourage HIV antibody testing. 3. Refer to a Communicable Disease Specialist for an interview. <p>C. <u>Follow-up</u></p> <ol style="list-style-type: none"> 1. Monitor compliance if taking oral medication. 2. Unless HIV-infected or pregnant and more frequent follow up is indicated, examine and repeat RPR/VDRL at 6 and 12 months. 3. For signs/symptoms of possible treatment failure, follow the latest CDC STD Treatment Guidelines. <p>D. <u>Sex Partners</u></p> <p>Examine and treat, with one of the above regimens, all partners exposed within 3 months of onset, or since onset, of symptoms.</p>
17	4/98	

SECONDARY SYPHILIS

<u>Symptoms/Signs</u>	<u>Diagnostic Criteria</u>	<u>Management</u>
<p>One or more may be present:</p> <p>Bilaterally symmetrical macular or papular, non-pruritic rash on body/extremities. May only be on palms and soles.</p> <p>Condyloma lata (moist papules) usually in the anogenital region or mouth.</p> <p>Patchy hair loss on scalp or eyebrows and eyelashes.</p> <p>Generalized enlarged lymph nodes.</p> <p>Mucous patches in mouth or on cervix.</p> <p>Fever and malaise.</p> <p>Splenomegaly.</p> <p>Iritis.</p>	<ol style="list-style-type: none">1. Identification of <u>T. pallidum</u> on darkfield microscopic or DFA (direct fluorescent anti-body) exam of serum from a lesion. OR2. Typical signs AND<ol style="list-style-type: none">a. Newly reactive RPR or VDRL, titer $\geq 1:8$ ORb. Four-fold or more increase over the last known titer in a person with a history of syphilis. <p>Typical lesions and exposure to a known case of early syphilis in the previous six months is suggestive of secondary syphilis.</p>	<ol style="list-style-type: none">A. <u>Treatment</u> <u>If not HIV-infected:</u><ol style="list-style-type: none">1. Benzathine penicillin G, 2.4 mu IM, once, OR2. If allergic to penicillin and not pregnant: Doxycycline 100 mg PO, b.i.d. for 14 days. OR3. If cannot take penicillin OR doxycycline: Erythromycin 500 mg PO, q.i.d. for 14 days. NOTE: If pregnant, this is an interim measure only. See page 22.<u>If HIV-infected, and neurosyphilis is ruled out:</u> Benzathine Penicillin G, 2.4 mu IM, once.B. <u>Counseling/Referral</u><ol style="list-style-type: none">1. Explain the possible occurrence of the Herxheimer reaction and how to handle it.2. Encourage HIV antibody testing.3. Refer to a Communicable Disease Specialist for an interview.C. <u>Follow-up</u><ol style="list-style-type: none">1. Monitor compliance if taking oral medication.2. Unless HIV-infected or pregnant and monthly followup is indicated, examine and repeat RPR/VDRL at 3 and 6 months.3. For signs/symptoms of possible treatment failure, follow according to the latest CDC STD Treatment Guidelines.D. <u>Sex Partners</u><ol style="list-style-type: none">1. Routine <u>examination</u> of all exposed within 6 months of onset, or since onset, of symptoms.2. <u>Treatment</u> (as above) of all exposed within the preceding 3 months, and those exposed more than 3 months ago if serologic test results are not immediately available and followup is uncertain.

EARLY LATENT SYPHILIS

<u>Symptoms/Signs</u>	<u>Diagnostic Criteria</u>	<u>Management</u>
<p>NONE.</p> <p>May have a history of prior genital lesion, rash, or other symptom of primary or secondary syphilis.</p>	<p>No clinical symptoms or signs,</p> <p style="text-align: center;">AND</p> <p>Reactive RPR/VDRL,</p> <p style="text-align: center;">AND</p> <p>Reactive EIA/FTA-ABS/MHA-TP</p> <p style="text-align: center;">AND</p> <p>Has had, within the past year:</p> <p>a. A nonreactive serologic test,</p> <p style="text-align: center;">OR</p> <p>b. Symptoms highly suggestive of primary or secondary syphilis,</p> <p style="text-align: center;">OR</p> <p>c. A four-fold increase in titer on serial RPR or VDRL tests.</p> <p>A reactive RPR or VDRL and sexual exposure to a known case of early</p>	<p>A. <u>Treatment</u></p> <p><u>If not HIV-infected:</u></p> <ol style="list-style-type: none"> 1. Benzathine penicillin G, 2.4 mu IM, once, <p style="text-align: center;">OR</p> <ol style="list-style-type: none"> 2. If allergic to penicillin and not pregnant: Doxycycline 100 mg PO, b.i.d. for 14 days. If pregnant, as an <u>interim measure only</u>: Erythromycin 500 mg PO, q.i.d. for up to 14 days. (See page 22.) <p><u>If HIV-infected, and neurosyphilis is ruled out:</u> Benzathine Penicillin G, 2.4 mu IM, once.</p> <p>B. <u>Counseling/Referral</u></p> <ol style="list-style-type: none"> 1. Explain the possible occurrence of the Herxheimer reaction and how to handle it. 2. Encourage HIV antibody testing. 3. Refer to a Communicable Disease Specialist. <p>C. <u>Follow-up</u></p> <ol style="list-style-type: none"> 1. Monitor compliance if taking oral medication. 2. Unless HIV-infected or pregnant and monthly followup is indicated, repeat RPR/VDRL at least at 6 and 12 months. 3. For signs/symptoms of possible treatment failure, follow according to the latest CDC STD Treatment Guidelines. <p>D. <u>Sex Partners</u></p> <ol style="list-style-type: none"> 1. Routine <u>examination</u> of all exposed within

<p>19</p> <p>4/98</p>	<p>syphilis within the past year is <u>suggestive</u> of early latent syphilis.</p>	<p>the previous year.</p> <p>2. <u>Treatment</u> (as above) of all exposed within the preceding 3 months, and those exposed more than 3 months ago if serologic test results are not immediately available and followup is uncertain.</p>
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<p>LATE LATENT SYPHILIS</p>		
<p><u>Symptoms/Signs</u></p>	<p><u>Diagnostic Criteria</u></p>	<p><u>Management</u></p>
<p>None.</p>	<p>No clinical symptoms or signs,</p> <p style="text-align: center;">AND</p> <p>Reactive RPR/VDRL,</p> <p style="text-align: center;">AND</p> <p>Reactive EIA/FTA-ABS/MHA-TP</p> <p style="text-align: center;">AND</p> <p>Does not meet the other criteria for <u>early latent syphilis</u>.</p> <p>NOTE: A cerebrospinal fluid (CSF) exam to rule out neuro-syphilis should be done in the following instances: --Neurologic signs or symptoms;</p>	<p>A. <u>Treatment</u></p> <p><u>If not HIV-infected:</u></p> <p>1. Benzathine penicillin G, 2.4 mu IM, weekly for 3 doses (7.2 mu total),</p> <p style="text-align: center;">OR</p> <p>2. If allergic to penicillin and not pregnant: Doxycycline 100 mg PO, b.i.d. for 28 days.</p> <p>3. If allergic to penicillin and pregnant: See page 22.</p> <p><u>If HIV-infected, and neurosyphilis is ruled out:</u> Benzathine Penicillin G, 2.4 mu IM, weekly for 3 doses (total of 7.2 mu).</p> <p>B. <u>Follow-up</u></p> <p>1. Monitor compliance if taking oral medication. 2. Unless HIV-infected or pregnant and monthly followup is indicated, repeat RPR/VDRL at 6, 12 and 24 months to establish stable titer level.</p> <p>C. <u>Sex Partners</u></p>

<p>20</p> <p>4/98</p>	<p>--Apparent treatment failure; --HIV infection; --Non-penicillin therapy planned; --RPR <u>≥</u>1:32.</p>	<ol style="list-style-type: none">1. Examine steady (e.g., marital) sex partners.2. Children of infected women may also need an examination, since the fetus may be infected if the mother had untreated syphilis, for even a few years' duration, when pregnant.
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OTHER SYPHILIS

A. Neurosyphilis

Neurosyphilis may occur as a late manifestation, as a complication in early syphilis or in congenital syphilis. When symptomatic, it is manifested by a variety of neurologic symptoms/signs, depending on the actual site of involvement. Diagnosis is made from a Venereal Disease Research Laboratory test (VDRL) and cellular examination of cerebrospinal fluid (CSF). Suggested drug regimens are described in the CDC Guidelines.

B. Response to Treatment and Need for Retreatment

To assure that treatment was adequate, serologic titer follow-up, as noted on the previous pages, is mandatory. If the titer fails to decline fourfold (two dilutions) by 6 months after treatment for primary or secondary syphilis, treatment failure should be considered. In most cases of adequately treated primary syphilis the titer will be nonreactive by the end of one year and for secondary syphilis by the end of two years. Latent syphilis titers will decrease more slowly and may remain reactive in low titers even with adequate treatment. The possibility of reinfection should always be considered when the titer does not decrease as expected. A CSF examination is recommended unless reinfection and diagnosis of early syphilis can be established.

Retreatment is needed when:

1. Clinical signs or symptoms persist or recur.
2. There is a fourfold (two tube) increase in titer of a nontreponemal test (RPR/VDRL), without evidence of reinfection.
3. An initially high-titer nontreponemal test fails to decrease at least four-fold within a year.

Re-treat with a regimen effective against late latent syphilis unless CSF exam shows neurosyphilis.

C. Diagnosing and Treating Syphilis in HIV-Infected Patients

Since clinical manifestations, serologic responses, efficacy of treatment and occurrences of complications of syphilis may be altered in patients coinfecting with HIV, consultation should be obtained to evaluate unusual serologic test results in patients suspected of having syphilis or in those being followed for response to treatment. Careful medical follow up of co-infected patients must occur.

SYPHILIS IN PREGNANCY

A. Maternal Screening Serologies

The August 1990 Revised Department of Human Resources Rules, Chapter 290-5-21, "Serologic Test for Syphilis for Pregnant Women" mandates that such tests be performed:

1. At the initial prenatal care visit;
2. During the third trimester; and
3. At delivery, if the delivering physician cannot confirm that the previous testing was done.

It further states that reports of reactive serologies must be given to DHR within 24 hours of their receipt.

B. Evaluation of Seroreactive Women

Seroreactive women must be medically evaluated promptly and thoroughly. The evaluation should include a history and physical examination, a quantitative nontreponemal test and a confirmatory treponemal test unless there is documentation of a previous diagnosis of syphilis.

If a prompt and thorough evaluation of the cause of seroreactivity cannot be ensured, such as delay in obtaining confirmatory test results, the woman should be treated at the first evaluation visit. In general, delay in treatment of a seroreactive pregnant woman beyond two weeks should not be allowed.

If the patient has a reactive RPR or VDRL, a nonreactive confirmatory test, such as fluorescent treponemal antibody absorption (FTA-ABS), microhemagglutination assay for antibodies to *Treponema pallidum* (MHA-TP), or enzyme immunoassay (EIA), and no clinical or epidemiologic evidence of syphilis, no treatment is necessary. However, both the quantitative RPR/VDRL and the confirmatory test should be repeated within four weeks. If clinical or serologic evidence of syphilis is found, or if diagnosis of syphilis cannot be excluded with reasonable certainty, the patient should be treated.

Patients who have documented adequate treatment for syphilis in the past need not be retreated unless clinical, serologic or epidemiologic evidence of reinfection exists.

C. Treatment of Syphilis in Pregnancy

Pregnant women should be treated with the penicillin regimen appropriate for the diagnosed stage of syphilis. Tetracycline and doxycycline are contraindicated during pregnancy and erythromycin should not be used because of the high risk of failure to cure infection in the fetus.

Because of its failure to cure some adult infection, and most fetal infection, erythromycin treatment should not be considered except as an interim measure, for women with a history of allergy to penicillin, until skin testing can be performed, desensitization done if necessary and penicillin treatment is given.

If necessary, make arrangements to have the skin/testing desensitization done at a Regional Perinatal Center according to the following guidelines established in December 1995:

Standards for Referral of Penicillin-allergic Pregnant Women with Syphilis for Appropriate Treatment

- A. Referring Agency/Health Department
 - 1. Will arrange for services at the local level, if available.
 - 2. Will make the appointment for the client.
 - 3. Will have the client sign a Release of Information Form and give the referral agency as much information about the client's current medical history and previous reaction to penicillin as possible, at the time of making the appointment . A copy of the information will be given to the client and FAXed to the contact person at the Regional Center.
 - 4. Will clarify, with the agency and client, the expected method of payment for services with the referral agency when the appointment is made (e.g., Medicaid, referral agency paying under high risk pregnancy program, private insurance).
 - 5. Will assist the client to obtain transportation to and from the appointment, as needed.

- B. Participating Perinatal Center (see next page)
 - 1. Will assure that an alternate contact person is available to take a referral when the listed contact person is not available.
 - 2. Will schedule an appointment for the client as soon as possible, considering the ability of the client to receive transportation to the

- facility.
3. Will clarify the expected method of payment for services with the client/referral agency when the appointment is made.
 4. Will retain the prerogative to decide, based on the history of the client's previous reaction to penicillin and any other pertinent history, whether skin testing should be done prior to desensitization and subsequent treatment with penicillin.
 5. Will use the CDC 1998 STD Treatment Guidelines, or subsequent revisions, as a guide to treatment of penicillin-allergic clients.

REGIONAL PERINATAL CENTERS

Grady Memorial Hospital
Atlanta
Dr. Luella Klein, Director
Contact: Diane Kelly
(404)616-4936

Medical College of Georgia
Augusta
Dr. Bruce Work, Director
Contact: Kathy Leopard
(706)721-4959, Option 2, Option 3

Memorial Medical Center
Savannah
Dr. Gary Oakes, Director
Contact: Jane Miller
(912)350-5993

Medical Center of Central Georgia
Macon
Dr. Mark Boddy, Director
Contact: Debra Kimsey
(912) 738-0404

The Medical Center
Columbus
Dr. Robert Stauffer, Director
Contact: Dr. Stauffer
(706)572-1112

Phoebe Putney Hospital
Albany
Dr. Michael Edwards, Director
Contact: Dr. Edwards
(912)889-2557

If unable to make an appointment, contact Dianne Norris, RNC, at the Women's Health Unit, Atlanta, (404)657-3143.

In the event a mother receives only erythromycin treatment, she must have careful follow-up to assure response to treatment. It must also be assured that the neonate receives penicillin treatment at birth, even if asymptomatic.

Women who are treated in the second half of pregnancy are at risk for premature labor and/or fetal distress if the treatment precipitates a Jarisch-Herxheimer reaction. They should be advised to seek medical attention

if they notice any change in fetal movements or begin to have any contractions.

Monthly serologic follow-up is mandatory, so that retreatment can be given if needed. The antibody response should be appropriate for the stage of disease.

D. Transmission of Syphilis to the Fetus

The chances of a fetus becoming infected depend on the duration of the disease in the mother and the stage of pregnancy during which she is treated.

A mother with untreated primary or secondary syphilis represents a greater hazard to the fetus than if she had latent or late syphilis. The possibility of fetal infection is never entirely eliminated.

Spirochetes from an infected mother are transmitted via the maternal circulation, through the placenta, to the fetal circulation. The fetus receives a transfusion of spirochetes, with the result that the symptoms of early congenital syphilis resemble those of acquired secondary syphilis. If the fetus is infected during the first trimester, miscarriage may occur. Stillbirth is another possible outcome. The later the fetus becomes infected, the better its chances are for survival.

E. The Infected Neonate

The prognosis is poor for infants with symptoms at birth. However, most infected newborns appear healthy at birth, with signs/symptoms beginning to appear in a week or more. Those infected late in the third trimester may have a negative blood at birth and may not show signs/symptoms until at least the eighth week after birth.

F. Evaluation, Diagnosis and Treatment of the Neonate

Guidelines for infant evaluation, diagnosis and treatment may be found in the latest CDC [STD Treatment Guidelines](#), or other guidelines from CDC.

Syphilis Laboratory Tests

A. Type of test: Darkfield microscopic identification of *T. pallidum*.

Specimen: Abrade lesion to remove exudate, epithelium and crusts. Collect serum on slide. Use coverslip. Examine immediately.

Interpretation of results:

Motile spirochetes observed means a diagnosis of primary or secondary syphilis, depending on the type of lesion(s).

B. Type of test: STAT RPR card test, qualitative (undiluted serum)

Specimen: Serum from 5-10 ml. whole blood. Perform test per kit instructions, including use of control cards to test antigen daily.

Interpretation of results:

Positive test may support diagnosis of syphilis when other criteria are met for stage suspected.

(Send remainder of specimen to the Public Health Microbial Immunology Lab in Decatur, DHR Regional Lab or local lab for quantitative RPR or VDRL .)

C. Type of test: Quantitative RPR (or VDRL) nontreponemal serologic test (serially diluted to an endpoint)

Specimen: 5-10 ml whole blood (or serum, as above) in serologic outfit, with Serologic Test for Syphilis and Rubella form.

Send to: State Microbial Immunology Lab, DHR Regional Lab, or local lab.

Interpretation of results:

1. More than a reactive test is needed to justify a diagnosis of syphilis.

2. A negative test does not rule out syphilis.

a. The RPR or VDRL may not be reactive in primary syphilis until at

least one week after appearance of the chancre.

- b. In 1-2% of cases of secondary syphilis an initially negative test may be due to the "prozone phenomenon". In these cases, an initially nonreactive but "rough" pattern will become reactive upon further dilution. The lab should be asked to dilute an initially negative serum and continue titration in all cases where suspicious lesions are present. (If blood tube and upper right corner of lab form are marked with a red dot the state labs will do this.)
 - c. The nontreponemal tests may also be negative in congenital or late symptomatic syphilis.
3. A reactive nontreponemal test (titer usually 1:8 or less) may be a false positive. Though most remain unexplained, some causes are:

Acute False Positives (up to 6 months duration)

Various viral and bacterial infections
Immunizations
Drug use
Pregnancy

Chronic False Positives

Various autoimmune diseases, e.g., rheumatoid arthritis, systemic lupus erythematosus
Other conditions with abnormal globulins
Cancer chemotherapy
Chronic infections
Narcotic addiction
Genetic factors
Aging (over age 60)

A negative treponemal test (FTA-ABS/MHA-TP/EIA) will rule out a diagnosis of syphilis in a person with a false positive nontreponemal test.

4. Depending at the stage when treatment is given, the RPR or VDRL may remain positive in low titer, or even in relatively high pre-treatment titer, for life after adequate treatment. Follow-up tests, per protocol, are important to establish the stable titer level to facilitate evaluation of future test results. The patient should be given a written record of the results and encouraged to take it to future health care visits.

5. A sustained 4-fold (two dilution) rise in titer, such as 1:2 to 1:8, performed by the same lab indicates probable need for retreatment. The only exception is adequately treated congenital syphilis where the titer may fluctuate without particular significance.
 6. On occasion, such things as drug use, and possibly pregnancy, may produce unusual titer patterns.
- D. Type of test: Enzyme immunoassay (EIA) serology, for antitreponemal IgG antibody. Confirmatory test for syphilis.

Specimen: Same as for RPR.

This test will automatically be performed on all reactive RPRs sent to the Public Health Microbial Immunology Lab in Decatur, and DHR Regional Labs, unless there is a notation on the lab form that it is not needed.

To avoid unnecessary testing, the "No confirmatory test needed" box on the lab form should be marked when the patient has:

1. A history of a previous reactive treponemal test, such as an FTA-ABS, MHA-TP or EIA; or
2. A history of a previous diagnosis of syphilis; or
3. A darkfield positive lesion of primary or secondary syphilis; or
4. A newly reactive RPR and symptoms of primary or secondary syphilis.

NOTE: There are occasional instances when confirmatory test results may be needed on patients with negative RPR results (e.g., when a very early ulcer typical of primary syphilis is present or for newborn reactor follow-up).
 To request that the state Public Health or Regional lab perform an EIA when RPR results are negative, highlight, in green, the right edge of the Syphilis and Rubella Form (#3432).

Interpretation of results:

Reactive means confirmation for a diagnosis of syphilis.

Reactive, equivocal means that the test could not be called either reactive or nonreactive. The specimen was tested two more times and repeat test results were still equivocal. In these cases, the lab will also do an FTA-

ABS (see next page) on the specimen before reporting the results.

Nonreactive means no confirmation for a diagnosis of syphilis.

E. Type of test: FTA-ABS for treponemal antibody.

Specimen: Same as for RPR and EIA.

This test will only be done on specimens that have repeatedly equivocal EIA results or have an RPR \geq 1:16 and the EIA is negative.

Interpretation of results:

Reactive means confirmation for a diagnosis of syphilis.

Minimal reactive means that the test repeatedly showed minimally reactive results. If there are still concerns about a possible diagnosis of syphilis in the patient, another specimen may be submitted.

Nonreactive means no confirmation for a diagnosis of syphilis.

CHANCROID

<u>Symptoms/Signs</u>	<u>Diagnostic Criteria</u>	<u>Management</u>
<p>Tender papule, surrounded by erythema, becoming pustular and eroded over 24-48 hours.</p> <p>Ulcer has ragged, undermined, non-indurated edges. Base may be necrotic.</p> <p>Ulcer is usually painful in males, but not in females.</p> <p><50% have more than one ulcer.</p> <p><50% have painful, unilaterally enlarged inguinal lymph nodes (bubo) with redness of the overlying skin.</p>	<p>1. One or more typical genital ulcers, with or without inguinal lymphadenopathy,</p> <p style="text-align: center;">AND</p> <p>Exclusion of syphilis by negative darkfield exam or negative serology performed at least 7 days after the onset of ulcers</p> <p style="text-align: center;">AND</p> <p>A test for herpes simplex is negative.</p> <p style="text-align: center;">OR</p> <p>2. The combination of a painful ulcer and tender, suppurative (pus-filled) inguinal adenopathy is almost</p>	<p>A. <u>Treatment</u></p> <p>1. Ceftriaxone 250 mg IM, single dose,</p> <p style="text-align: center;">OR</p> <p>2. Azithromycin 1 Gm. PO, single dose,</p> <p>B. <u>Lesion Management</u></p> <p>Fluctuant lymph nodes may need to be incised and drained or aspirated to prevent rupture.</p> <p>C. <u>Follow-up</u></p> <p>Examine 3-7 days after initiation of therapy. If ulcers are not improving by 7 days, consider: alternative diagnosis; drug resistance; or possibility of coinfection with another STD or HIV. Lymph node resolution takes place slowly.</p> <p>D. <u>Sex Partners</u></p> <p>Examine and treat (as above) all partners from within 10 days before onset of the patient's symptoms.</p>

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pathognomonic.

LYMPHOGRANULOMA VENEREUM (LGV)

<u>Symptoms/Signs</u>	<u>Diagnostic Criteria</u>	<u>Management</u>
<p><u>Primary Stage</u> Small, inconspicuous genital papule or ulcer that heals rapidly.</p> <p><u>Secondary Stage</u> (10-30 days after the primary stage)</p> <p>Acute inflammation and swelling of inguinal lymph nodes, usually unilateral. The increasingly painful "bubo" enlarges over 2 weeks. Blue color of overlying skin precedes rupture.</p> <p><20% have a "groove sign", showing involvement of the femoral nodes also.</p> <p>May have hemorrhagic proctitis (with history of rectal sex), or fever, malaise, myalgias.</p>	<p>1. One or more tender, progressively enlarging, fluctuant inguinal lymph nodes, OR Signs of hemorrhagic proctitis,</p> <p style="text-align: center;">AND</p> <p>2. A single <i>C. trachomatis</i> complement-fixation serologic titer (sometimes called an "LGV titer") of 1:64 or above.</p> <p>Other causes of ulcers and/or lymphadenopathy (e.g., chancroid, herpes and syphilis) should be ruled out.</p>	<p>A. <u>Treatment</u></p> <p>1. Doxycycline 100 mg PO, b.i.d. for 21 days, OR 2. Erythromycin base 500 mg PO, q.i.d. for 21 days.</p> <p>B. <u>Lesion Management</u></p> <p>Fluctuant lymph nodes (buboes) may need to be aspirated or incised and drained to prevent rupture.</p> <p>C. <u>Follow-up</u></p> <p>Clinical assessment every 1-2 weeks until all signs/symptoms are resolved.</p> <p>D. <u>Sex Partners</u></p> <p>Examine and treat (as above) all partners who have had sexual contact with the patient within a month prior to the onset of symptoms.</p>

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CHANCROID and LGV LABORATORY TESTS

A. CHANCROID

Type of test: Identification of Gram-negative bacilli typical of *Haemophilus ducreyi* on stained slide.

[This test is not included in current CDC criteria for diagnosis of chancroid.]

B. LGV

Type of test: Complement-fixation serologic *Chlamydia trachomatis* antibody detection.
The test is not specific for LGV serotypes and should not be used for screening purposes.

Specimen: 5-10 ml. whole blood or serum.

Submission: Serology outfit with Virology Request Form.

Send to: State Public Health Microbial Immunology Lab.

Interpretation of results:

An antibody titer of 1:64 or greater supports a presumptive diagnosis of LGV in a symptomatic patient when other causes of ulcers/ lymphadenopathy have been excluded. Lower titers show only that infection with one or more serotypes of *C. trachomatis* has occurred at some point in the person's life.

GENITAL HERPES

<u>Symptoms/Signs</u>	<u>Diagnostic Criteria</u>	<u>Management</u>
<p>Vesicular lesions and/or painful, shallow ulcers on the genitals or adjacent areas.</p> <p>Enlarged, tender inguinal lymph nodes.</p> <p>May have a history of previous episodes of similar lesions.</p> <p>The first occurrence may last 2-3 weeks and recurrent episodes 1-2 weeks.</p> <p>May have prodromal symptoms of itching or tingling at site of lesions a few days before recurrences.</p>	<p>1. Identification of herpes simplex virus in lesion scrapings, by cell culture or antigen detection test.</p> <p style="text-align: center;">OR</p> <p>2. Typical painful lesions,</p> <p style="text-align: center;">AND</p> <p>a. Detection of multinucleated giant cells on a Tzanck or Pap smear of lesions scrapings,</p> <p style="text-align: center;">OR</p> <p>b. Exclusion of chancroid and syphilis.</p> <p>Clinical symptoms, with a history of similar symptoms <u>OR</u> sexual exposure to a person with HSV, is suggestive.</p>	<p>A. <u>Treatment</u></p> <p>1. <u>First clinical episode</u> Treat for 7-10 days, or until clinical resolution occurs with:</p> <p>a. Acyclovir 400 mg PO, 3 times a day or 200 mg PO, 5 times daily, OR</p> <p>b. Famciclovir 250 mg PO, 3 times a day, OR</p> <p>c. Valacyclovir 1 gram PO, 2 times a day.</p> <p>2. <u>Recurrent episode</u> Begin at start of prodrome or within 2 days of onset and treat for 5 days with:</p> <p>a. Acyclovir 200 mg PO, 5 times daily <u>OR</u> 400 mg t.i.d. <u>OR</u> 800 mg PO b.i.d., OR</p> <p>b. Famciclovir 125 mg PO, b.i.d., OR</p> <p>c. Valacyclovir 500 mg PO, t.i.d.</p> <p>3. <u>Suppressive therapy, for patients with 6 or more recurrences a year:</u></p> <p>a. Acyclovir 400 mg PO b.i.d. <u>OR</u> 200 mg 2-5 times daily, OR</p> <p>b. Famciclovir 250 mg PO, b.i.d., OR</p> <p>c. Valacyclovir 250 mg PO, b.i.d., <u>OR</u> 500 mg PO, once daily, <u>OR</u> 1,000 mg PO, once daily.</p>

GENITAL HERPES, continued

Management, continuedB. Counseling/Follow-up

1. Individualize; assess the emotional impact of the disease and refer for counseling, (e.g., to local HELP line or national Herpes Hotline) PRN.
2. Treatment is palliative, not curative. At the time of the first episode, options for treatment of recurrent episodes and suppressive therapy should be discussed.
3. The risk for neonatal infection should be explained to all patients, including men. Pregnant women should inform the prenatal care provider of herpes history in self or partner.
4. For patients on continuous daily suppressive therapy, discontinuation of therapy should be discussed after one year, to assess the patient's psychological adjustment to genital herpes and the rate of recurrent episodes.

C. Sex Partners

Routine exam and counseling as needed.

HERPES SIMPLEX LABORATORY TESTS

A. Type of test: Viral Isolation (culture)

- Specimen: 1. Clean area of any topically applied agents. For cervical lesions, remove mucus with swab and discard swab. Do not prepare site with disinfectants such as alcohol or betadine--they may inactivate the virus.
2. Open vesicular lesion, if necessary. Swab open lesions with a dry sterile cotton swab to obtain fluid and cells from the base of the lesions. Do not use a calcium alginate swab. Promptly place swab in tube of transport medium, break off stem where handled and discard, and cap tube. Refrigerate promptly at 2-6 degrees Celsius for no longer than three days prior to transporting to the lab.

Submission: Securely pack Viral Single Swab Outfit, with Virology Request Form, on wet ice in an insulated container for transport. **Do not freeze!**

Send to: Public Health Virology Lab, Decatur. (Turn-around time is 3 weeks)

Interpretation of results:

Isolation of the virus (with confirmation by enzyme immunoassay) means a definitive diagnosis of herpes simplex.

Inability to isolate the virus does not rule out a diagnosis of herpes. (After the lesion has been present for a few days, the chance of isolating the virus decreases rapidly.)

B. Type of test: Serologic enzyme immunoassay (ELISA), antibody testing.

[These tests are seldom helpful for diagnostic purposes. Detection of antibodies usually only indicates infection at some point in time with HSV-1, HSV-2 or both. Paired sera (acute and convalescent) with dates and date of onset of illness is needed for proper interpretation of results.]

Specimen: 5-10 ml. of whole blood.

Form: Virology Request Form, #3595.

Send to: Public Health Microbial Immunology Lab, Decatur.

Interpretation of results:

Information on interpretation will be sent with results.

GONORRHEA

Uncomplicated Urethral, Endocervical or Rectal Infection

<u>Symptoms/Signs</u>	<u>Diagnostic Criteria</u>	<u>Management</u>
<p>Mucoid, mucopurulent, or purulent discharge from the infected site.</p> <p>Dysuria.</p> <p>May have no symptoms or signs.</p> <p>May have a history of contact to a case of gonorrhoea.</p>	<p>A. <u>Urethral or endocervical</u></p> <p>1. Culture positive for <u>Neisseria gonorrhoeae</u>, with or without confirmatory tests.</p> <p>OR</p> <p>2. Gram-negative intracellular diplococci seen on smear of discharge. (Must also do culture if endocervical discharge)</p> <p>OR</p> <p>3. Nonculture identification of <u>N. gonorrhoeae</u>, e.g., DNA probe (Gen-Probe) or enzyme immunoassay.</p> <p>B. <u>Rectal infection</u></p> <p>Culture positive</p>	<p>A. <u>Treatment</u></p> <p>1. Ceftriaxone 125 mg IM, single dose,</p> <p>OR</p> <p>2. If not pregnant, lactating, or under age 18, Ofloxacin 400 mg PO, single dose,</p> <p>PLUS, unless a test for chlamydia is negative, <u>either of the above is followed by</u></p> <p>Azithromycin 1 gm. PO, single dose</p> <p>OR</p> <p>Doxycycline 100 mg PO, b.i.d., for 7 days (do not use if pregnant.)</p> <p>3. If the patient cannot take cephalosporins <u>or</u> quinolones, Spectinomycin 2 g IM, single dose, <u>followed by</u> azithromycin or doxycycline regimen, as needed.</p> <p>B. <u>Follow-up</u></p> <p>1. Persons treated with one of the above regimens do not need a test-of-cure culture.</p> <p>2. If symptoms persist or return, do a culture and test positives for antibiotic sensitivity. Question carefully about the possibility of reinfection by an untreated partner.</p> <p>C. <u>Sex Partners</u></p> <p>1. Counsel patients to refer all sex partners from within <u>60</u> days prior to onset of symptoms, or of testing, for evaluation and treatment appropriate to exposure site(s).</p> <p>2. Refer the <u>last</u> sex partner if last sexual</p>

36	4/98	for <u>N. gonorrhoeae</u> , confirmed by an acceptable method.	contact occurred prior to 60 days.
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<p style="text-align: center;">GONORRHEA Pharyngeal (Throat) Infection</p>			
<u>Symptoms/Signs</u>	<u>Diagnostic Criteria</u>	<u>Management</u>	
<p>Usually none, but throat may be sore and inflamed.</p> <p>May have a history of oral sexual exposure to a case of gonorrhoea.</p>	<p>Culture positive for <u>Neisseria gonorrhoeae</u>, confirmed by an acceptable method.</p>	<p>A. <u>Treatment</u></p> <ol style="list-style-type: none"> 1. Ceftriaxone 125 mg IM, single dose, followed by <u>Azithromycin</u> 1 Gm. PO, single dose, OR Doxycycline 100 mg PO, 2 times a day for 7 days. 2. If the patient cannot take cephalosporins <u>AND</u> if not pregnant, lactating, or under age 18, Ofloxacin 400 mg PO, single dose, followed by azithromycin or doxycycline. <p>B. <u>Follow-up</u></p> <ol style="list-style-type: none"> 1. If treated with ciprofloxacin, schedule the patient for test-of-cure culture 4-7 days after treatment. 2. <u>Apparent treatment failure</u>: Question carefully about possibility of reinfection. Antibiotic sensitivity studies should be done. Unless contraindicated, re-treat with ceftriaxone. <p>C. <u>Sex Partners</u></p> <p>Counsel patient to refer all partners from within</p>	

37	4/98	60 days prior to onset of symptoms, or of testing, for examination and treatment appropriate to exposure site(s). Refer the <u>last</u> sex partner if last sexual contact occurred prior to 60 days.
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GONORRHEA LABORATORY TESTS

A. Type of test: Identification of Gram-negative intracellular diplococci on stained smear.

- Specimen:
1. Male urethra -- If not doing a Gen-Probe test, obtain discharge on cotton swab, or on calcium alginate swab inserted 2-3 cm. into the anterior urethra if discharge cannot be expressed. If doing a Gen-Probe test, use the provided swab per manufacturer's instructions.
Roll a thin smear on to a slide and air dry. Perform the proper Gram stain procedure and microscopic exam with oil immersion lens.
 2. Female endocervix -- Obtain secretions by inserting sterile cotton or Gen-Probe swab into the endocervical canal and rotating slightly for at least 10 seconds. Prepare and examine slide the same as for a male specimen.

Interpretation of results:

1. The presence of Gram-negative intracellular diplococci means a presumptive diagnosis of gonorrhea.
2. If no Gram-negative intracellular diplococci are seen, gonorrhea is not ruled out until culture results are obtained. See page 47 for interpretation of Gram stain results in diagnosing nongonococcal urethritis (NGU).

B. Type of test: Gonorrhea Culture

Specimen: Discharge obtained on swab from exposed site inoculated on Martin-Lewis culture medium. (See Performance Standards on page 40.)

Urethral and endocervical specimens should be obtained as above for the Gram stain. The same sterile swab used for the Gram stain smear, or to clean the endocervix before obtaining a chlamydia test specimen, may be used to inoculate the culture medium. The female urethra should be the source of the specimen when the patient has had a hysterectomy.

Rectal specimens are obtained by inserting a cotton-tipped swab 2-3 cm. into the anal canal. If the tip is inadvertently pushed into feces, use another swab to obtain the specimen. Move swab from side to side; allow several seconds for secretions to be absorbed.

Specimens collected from prepubertal females should be obtained from the vaginal vault by separating the labia manually, exposing the introitus, and gently inserting and rotating a cotton-tipped swab.

Oropharyngeal specimens are obtained by swabbing the posterior pharynx and tonsillar crypts with a sterile cotton-tipped applicator.

Form: Gonorrhea Submission Form, #3568, Rev. 2/97-- **until replaced by Chlamydia and Gonorrhea Submission Form, #3568, Rev. 9/98**

Send to: Appropriate local lab, DHR Regional Lab or State Lab.

Interpretation of reported results

Unconfirmed positive = presumptive diagnosis of gonorrhea

Confirmed positive = definitive diagnosis of gonorrhea

The State and Regional Public Health Labs perform confirmation testing on specimens from all anatomical sites in adults; specimens from children, and specimens obtained for legal reasons from persons of any age, receive confirmation testing with two different tests.

Antibiotic sensitivity testing of positive isolates is performed on a selected number of specimens each month. Results will be reported to the provider only if they may impact on patient therapy.

C. Type of test: Nucleic acid probe (Gen-Probe)

[This test is available to clinics which are approved to submit one cervical or urethral specimen to test for both gonorrhea and *Chlamydia trachomatis*. For further information on this test, see page 44.]

PERFORMANCE STANDARDS for GONORRHEA CULTURES

1. Store fresh culture plates in a refrigerator* at 2-8 degrees C, agar side up, away from the freezer.
2. Bring culture plates to room temperature before inoculating.
3. Do not use plate if medium appears dry, cracked or pulled away from the edges, if it appears to have been frozen or if it is past the expiration date on the label.
4. Fill in the patient's name and date of inoculation on label.
5. Complete a separate information form for each plate.
6. Roll specimen swab in a "Z" pattern on the surface of medium. Cross-streak with the same swab, sterile stick end of another swab, sterile wire or plastic loop.
7. Place inoculated plate in carbon dioxide (CO²) atmosphere within 15 minutes.
 - a. When using a candle jar, relight the candle each time the lid is opened. Place candle in the bottom of the jar and do not stack more than 12 plates along side of it.
 - b. With the bag/pill CO² system, tear foil pack to expose pill and place pack in bag. Do not moisten pill!
8. Place plates in an incubator* (35-36 degrees C) within 2 hours of inoculating, and overnite before sending by courier or mail to an off-site lab. If no incubator is available, send plates to the lab the day of inoculation.
9. Mark the number of hours of pre-incubation on the lab form before shipping. If it is not appropriately marked, or if the specimen has not been preincubated a minimum of 18 hours, a report of "unsatisfactory" could result.
10. Pack plates and forms in a sturdy box, with sufficient padding. Padded bags are usually safe; manila envelopes are unacceptable.
11. First class, special handling, is the most economical and fastest method for mailing specimens to the lab (up to 2 pounds weight).
12. Specimens collected on Friday or the day before a holiday should be incubated over the weekend or holiday and mailed on the next appropriate mail service date.

* Refrigerator and incubator temperatures must be checked and recorded on a log each work

day.

(Test form)

Instructions for Chlamydia and Gonorrhea Test Form (#3568 Rev. 9/98)

- A. All submitter and patient information on the Laboratory Copy must be completed thoroughly. Make sure the correct clinic code numbers are used.
- B. Only one test form is needed for endocervical or urethral specimens for Gen-Probe testing, even if testing will be done for both chlamydia and gonorrhea. A separate form is needed for each gonorrhea culture specimen.

C. Reason for Test

This should be checked by the clinician.

Only one reason should be marked, as follows:

1. Routine Screen - test is part of a routine physical examination.
 2. Contact to Chlamydia - patient is a sex partner of a person with chlamydia.
 3. Contact to GC - patient is a sex partner of a person with gonorrhea.
 4. Medical-Legal - test is being done as part of a legal action.
 5. Other - test is being done for any other reason.
- D. Information on the Submitter and Program copies (yellow and pink copies) is to be completed per Chlamydia Program Protocol instructions, to assist in:
 1. Obtaining data from Chlamydia Project sites;
 2. Follow-up of positive chlamydia and gonorrhea tests; and
 3. Reporting the treatment of positives to the State STD Surveillance Unit.

CHLAMYDIA

(Urethral, Endocervical or Pharyngeal)

Symptoms/Signs

Female Endocervical and/or Urethral

Most have no signs or symptoms.

Mucoid to mucopurulent cervical discharge; may have cervical ectopy that bleeds easily; may have dysuria or pain with intercourse.

Male Urethral

May have no signs or symptoms.

Mucoid to mucopurulent urethral discharge; dysuria. Symptoms usually milder than for GC.

Pharyngeal

Occurrence of signs or symptoms is not well-described. May have a history of oral sexual exposure to chlamydia.

Diagnostic Criteria

Urethral/endocervical

Positive culture for ***C. trachomatis***.

OR

Positive non-culture test such as: DNA probe (Gen-Probe available at Public Health labs);

direct fluorescence antibody; antigen detection; or nucleic acid amplification

for

C. trachomatis.

Pharyngeal

Positive culture or nucleic acid amplification test.

(Not available

at Public Health laboratories)

Management

A. Treatment (Adult/adolescent/child at least age 8) (Should be effective against pharyngeal infection if present)

1. Azithromycin 1 Gm PO, single dose,

OR

2. Doxycycline 100 mg PO, b.i.d. for 7 days.

3. If pregnant, give azithromycin, as above,

OR

Amoxicillin 500 mg PO, t.i.d. for 7-10 days.

B. Counseling/Follow-up

1. Abstain from sex until 7 days after treatment has been completed.

2. Advise the patient to return if symptoms persist or recur.

C. Sex Partners

1. Refer all sex partners from within 60 days of the onset of symptoms, or of testing, for evaluation and treatment as above.

2. Refer the last sex partner if the last sexual contact occurred prior to 60 days.

**GEN-PROBE TESTS for *Chlamydia trachomatis*
and *Neisseria gonorrhoeae***

Type of test: Nucleic acid probe (Gen-Probe)

Specimen: Endocervix

Collect specimens for Gram stain and/or gonorrhea culture before collecting Gen-Probe specimen. Pap smear specimen should be collected last.

1. Remove excess mucus from the cervical os and surrounding mucosa using one of the swabs provided in the kit. DISCARD CLEANING SWAB.
2. Insert second swab from collection kit one to one and a half centimeters into the endocervical canal.
3. Rotate swab slowly 180° for at least 10 seconds to ensure adequate sampling.
4. Withdraw swab carefully; avoid any contact with the vaginal mucosa.
5. Insert ONE collection swab into the Gen-Probe transport tube.
6. Snap off shaft at score line, or cut shaft to fit tube. Cap tube.
7. Label tube with patient's name and specimen number.

Urethra (Patient should not have urinated for at least one hour)

1. Insert swab from urethral collection kit 2-4 centimeters into the urethra.
2. Rotate swab gently at least one full rotation to ensure that it comes into contact with all urethral surfaces. Allow swab to remain inserted for 2-3 seconds.
3. Withdraw swab and follow steps 5, 6 and 7 above. (May use swab first to prepare slide for Gram stain.)

Form: Form or computer diskette, as designated

Send to: Designated laboratory, in specified container

Interpretation of Results:

Positive -- nucleic acid for the specified organism was detected in the specimen and was confirmed by probe competition assay.

Indeterminate -- the specimen initially tested positive for the specified organism but did not confirm by probe competitive assay. Submission of another specimen is desirable.

Negative -- no evidence of nucleic acid of specified organism was found in the specimen.

Unsatisfactory -- specimen was unsatisfactory as described. Submission of another specimen is desirable.

MUCOPURULENT CERVICITIS (MPC)

<u>Symptoms/Signs</u>	<u>Diagnostic Criteria</u>	<u>Management</u>
<p>Frequently asymptomatic.</p> <p>Yellow or green exudate observed in endocervical canal or in an endocervical swab specimen.</p> <p>Easily induced cervical bleeding.</p> <p>Abnormal vaginal bleeding (e.g., after intercourse).</p> <p>This clinical syndrome may be caused by <i>C. trachomatis</i> and/or <i>N. gonorrhoeae</i>, but in most cases, neither can be detected.</p>	<ol style="list-style-type: none">1. Presence of yellow exudate on a white cotton-tipped swab of endocervical secretions (positive swab test). <p style="text-align: center;">AND/OR</p> <ol style="list-style-type: none">2. Bleeding occurs with insertion of the first endo-cervical swab (cervical friability).3. Tests for both gonorrhoea and chlamydia should be ordered.	<ol style="list-style-type: none">A. <u>Treatment</u><ol style="list-style-type: none">1. If the patient is likely to return for treatment, the results of gonorrhoea and chlamydia tests should be used to determine the need for treatment.OR,<ol style="list-style-type: none">2. If clinic-based prevalence of chlamydial infection or gonorrhoea is known to be high (>15-20%) and the patient is unlikely to be easily located for treatment when test results are available, then appropriate treatment to cover possible gonorrhoea and/or chlamydia may be given.B. <u>Follow-up</u><p>Advise the patient how/when to call for test results. She must return for treatment of any untreated gonorrhoea or chlamydial infection as soon as possible.</p>C. <u>Sex Partners</u><p>Recent sex partners should be examined and treated for the STD identified or suspected in the index patient.</p>

PELVIC INFLAMMATORY DISEASE (PID)

<u>Symptoms/Signs</u>	<u>Diagnostic Criteria</u>	<u>Management</u>
<p>May have no symptoms, mild or acute symptoms.</p> <p>Lower abdominal tenderness, bilateral or unilateral.</p> <p>Cervical motion tenderness.</p> <p>Adnexal tenderness on bimanual exam, with or without palpable mass(es).</p> <p>Purulent endocervical discharge.</p> <p>Fever and chills.</p> <p>Anorexia, nausea.</p> <p><u>Associated Factors</u></p> <p>Previous PID.</p>	<p>1. <u>Minimum criteria for treatment:</u> Lower abdominal tenderness, AND Cervical motion tenderness, AND Adnexal tenderness.</p> <p>2. Additional clinical criteria that support the diagnosis in women with more severe clinical signs are: Fever >38.3 C; Abnormal cervical or vaginal discharge; Gonorrhoea or chlamydial infection; Elevated erythrocyte</p>	<p>A. <u>Treatment</u></p> <p>1. Ceftriaxone 250 mg IM, single dose, followed by Doxycycline 100 mg PO, b.i.d. for 14 days. OR 2. Ofloxacin 400 mg PO, b.i.d. for 14 days, PLUS Metronidazole 500 mg PO, b.i.d. for 14 days.</p> <p>B. <u>Follow-up/Referral</u></p> <p>1. Re-examine in 2-3 days to assess progress and medication compliance. 2. IUD removal after medication has begun. 3. Refer for possible hospitalization or parenteral treatment when: a. Surgical emergencies such as appendicitis cannot be excluded; b. The patient is pregnant; c. The patient has failed to respond clinically to oral therapy; d. The patient is unable to follow or tolerate an outpatient/oral regimen; or e. The patient's presentation is severe (e.g., high fever, nausea and vomiting, tubo-ovarian abscess) or the patient is immunodeficient.</p> <p>C. <u>Sex Partners</u></p>

PELVIC INFLAMMATORY DISEASE (PID)

<p>Recent insertion of an IUD.</p> <p>First 5-10 days of menstrual cycle.</p> <p>46 4/98</p>	<p>sedimentation rate; and</p> <p>Elevated C-reactive protein.</p>	<p>Examine and treat (with a regimen effective against gonorrhoea and chlamydia) all partners from within 60 days prior to the onset of symptoms to the current date, or the last partner if last sexual contact was prior to that.</p>
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NONGONOCOCCAL URETHRITIS (NGU)

<u>Symptoms/Signs</u>	<u>Diagnostic Criteria</u>	<u>Management</u>
<p>May be asymptomatic.</p> <p>Mucoid to mucopurulent urethral discharge, especially in the morning before voiding.</p> <p>Itching or burning of the urethra.</p> <p><i>Chlamydia trachomatis</i> causes from 23- 55% of cases, with lower prevalence in older men. The etiology of most cases is unknown.</p> <p><i>Ureaplasma urealyticum</i> and <i>Mycoplasma genitalium</i> cause up to 33% of cases.</p>	<p>Documentation of urethritis by:</p> <p>Mucopurulent or purulent urethral discharge,</p> <p>OR</p> <p>Detection of at least 5 PMN leukocytes per oil immersion field on Gram-stained smear of discharge.</p> <p>AND</p> <p>Exclusion of a diagnosis of gonorrhea by Gram stain and/or culture.</p> <p>Testing for chlamydia should be done.</p>	<p>A. <u>Treatment</u></p> <ol style="list-style-type: none">1. Azithromycin 1 Gm PO, single dose,OR2. Doxycycline 100 mg PO, b.i.d. for 7 days. <p>B. <u>Follow-up</u></p> <ol style="list-style-type: none">1. Advise the patient how/when to call for gonorrhea and chlamydia test results and that he and his partners will need additional treatment if the gonorrhea test is positive.2. Patients with persistent or recurrent urethritis should be retreated with the initial regimen if they have failed to comply with the regimen, or if they have been re-exposed to an untreated sex partner. Otherwise, refer. <p>C. <u>Sex Partners</u></p> <p>Refer all sex partners from within <u>60</u> days of onset of symptoms for evaluation and treatment.</p>

EPIDIDYMITIS

<u>Symptoms/Signs</u>	<u>Diagnostic Criteria</u>	<u>Management</u>
<p>Scrotal pain and swelling of gradual onset, usually unilateral.</p> <p>On palpation, cannot distinguish epididymis from the testicle.</p> <p>May have dysuria.</p> <p><50% have urethral discharge.</p> <p>No history of trauma to the area.</p> <p>In males <age 35, cause is usually a sexually transmitted infection, frequently caused by <i>C. trachomatis</i> or <i>N. gonorrhoeae</i>. <i>E. coli</i> infection can occur in</p>	<p>1. Tender scrotal swelling and on palpation cannot distinguish epididymis from testicle,</p> <p style="text-align: center;">AND</p> <p>2. Positive Gram-stained smear for urethritis (≥ 5 PMN leukocytes per oil immersion field.)</p> <p>Smear may or may not be positive for <i>N.gonorrhoeae</i>.</p> <p>Tests for gonorrhea and chlamydia should be done.</p> <p>A culture and smear of uncentrifuged urine should also be done.</p>	<p>A. <u>Treatment</u></p> <ol style="list-style-type: none"> 1. If most likely due to gonococcal or chlamydial infection: Ceftriaxone 250 mg IM, single dose, followed by Doxycycline 100 mg PO, b.i.d. for 10 days. 2. If most likely to be due to enteric organisms, or if allergic to cephalosporins or tetracyclines: Ofloxacin 300 mg PO, b.i.d for 10 days. 3. Bedrest and scrotal elevation to reduce swelling; careful use of ice packs, and oral analgesics to relieve pain. <p>B. <u>Counseling/Follow-up</u></p> <ol style="list-style-type: none"> 1. If possible, send uncentrifuged urine for culture and smear to detect Gram-negative bacteria. 2. Reevaluate in 2-3 days; if not improved, refer to a urologist or hospital. 3. If symptoms worsen, patient should promptly seek medical care. <p>C. <u>Sex Partners</u></p>

<p>homosexual men who are the insertive partners during anal intercourse.</p> <p>48 4/98</p>		<p>If gonorrhea or chlamydia is known or suspected, partners from within 60 days of onset of symptoms should be examined and receive appropriate treatment.</p>
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GENITAL/PERIANAL WARTS

[Human Papilloma Virus (HPV) Infection; Condylomata Acuminata]

<u>Symptoms/Signs</u>	<u>Diagnostic Criteria</u>	<u>Management</u>
<p>Soft, painless fleshy growths around the vulvo-vaginal area, anal area, penis, urethra or perineum.</p> <p>Base of lesion(s) may be stalk-like or broad.</p> <p>May be single or multiple lesions.</p> <p>Subclinical infection (inconspicuous flat lesions) may occur, especially on the cervix.</p> <p>Perianal warts can occur in both males and females who do not have a history of anal sex.</p>	<p>Typical growths visible on skin or mucous membranes.</p> <p>When appropriate, exclude diagnosis of condyloma lata by darkfield exam or serologic test for syphilis.</p>	<p>A. <u>Treatment</u> - optional, per decision of patient.</p> <ol style="list-style-type: none">1. <u>External genital/perianal- not too extensive</u> <u>Patient-applied:</u><ol style="list-style-type: none">a. Podofilox 0.5% solution or gel, ORb. Imiquimod 5% cream, per package directions. (Provider should demonstrate proper technique and identify which warts should be treated.) OR2. <u>Provider administered:</u><ol style="list-style-type: none">a. Trichloroacetic acid (80-90%). Apply only to warts; powder with talc or sodium bicarbonate to remove unreacted acid, as needed. ORb. Podophyllin 10-25% in compound tincture of benzoin. Limit each treatment to <0.5 ml. applied to <10 square cm. only. Wash off thoroughly in 1-4 hours. <p>2. For <u>extensive external genital/perianal warts</u>, or if cervical, vaginal, anal or urethral warts are present, refer to a physician.</p> <p>B. <u>Counseling/Follow-up</u></p> <ol style="list-style-type: none">1. Inform patient that no treatment is know to eradicate the virus, and recurrences are common.2. Repeat topical treatment weekly, PRN.3. Self-treatment should be done only as directed.4. If no significant improvement over a few weeks, consider alternative therapy.

49	4/98	<p>5. Females should have annual Pap smears.</p> <p>C. <u>Sex Partners</u> Examine symptomatic partners.</p>
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MOLLUSCUM CONTAGIOSUM		
<u>Symptoms/Signs</u>	<u>Diagnostic Criteria</u>	<u>Management</u>
<p>Smooth, firm, shiny, single or multiple papules with umbilicated centers, found on the genitals and/or on adjacent skin. Nonsexual spread and lesions on the face, extremities and trunk are common in children. Recurrences often occur in HIV-infected persons.</p> <p>The 3-5 mm. papules contain a core of caseous material.</p> <p>Lesions are usually flesh colored, but may be yellow, pink or gray-white.</p> <p>Individual lesions may resolve,</p>	<p>Typical papules.</p> <p>(For atypical lesions, must rule out other causes)</p>	<p>A. <u>Treatment</u></p> <p>Treatment is elective, as lesions will eventually resolve without treatment; client may choose to go to a private physician if treatment is desired.</p> <p>B. <u>Counseling/Follow-up</u></p> <ol style="list-style-type: none"> 1. The patient should understand that lesions are almost always self-limited and cause no medical problems. 2. Encourage HIV antibody testing if the patient has repeated recurrences, extensive lesions or lesions appearing on the face or upper trunk. <p>C. <u>Sex Partners</u></p> <p>Routine STD exam only if symptomatic.</p>

without treatment
within 2 months;
more extensive
outbreaks last an
average of 2 years
without treatment.

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TRICHOMONIASIS

<u>Symptoms/Signs</u>	<u>Diagnostic Criteria</u>	<u>Management</u>
<p>Profuse, frothy vaginal discharge with an offensive odor.</p> <p>Onset of discharge often associated with menses.</p> <p>External genitalia may be edematous, reddened and/or excoriated.</p> <p>"Strawberry cervix" --granular appearance with punctate hemorrhages, may be present.</p>	<p>1. Typical motile trichomonads seen on wet mount of vaginal discharge.</p> <p>OR</p> <p>2. Identification of <u>T. vaginalis</u> by microscopic exam of Gram stain or Pap smear.</p>	<p>A. <u>Treatment</u></p> <p>1. Metronidazole 2 g PO in a single dose, OR 2. Metronidazole 500 mg PO b.i.d. for 7 days.</p> <p>NOTE: Use single dose treatment if pregnant.</p> <p>B. <u>Counseling/Follow-up</u></p> <p>1. Alcohol should be avoided for at least 24 hours following treatment with metronidazole. 2. Reevaluate only if symptoms do not subside or recur. Retreatment with the 7 day regimen of metronidazole may be given as necessary.</p> <p>C. <u>Sex Partners</u></p> <p>Examine and treat (as above) all recent partners. Male partners are usually asymptomatic, but may have urethritis or balanitis.</p>

VULVOVAGINAL CANDIDIASIS (VVC)

<u>Symptoms/Signs</u>	<u>Diagnostic Criteria</u>	<u>Management</u>
<p>Vulvar itching, usually with premenstrual onset.</p> <p>Reddened, edematous and/or excoriated vulvar tissue.</p> <p>Thick white vaginal discharge, which may be of "cottage cheese" consistency.</p> <p>Symptoms are caused by overgrowth of normally occurring yeast forms, and may be associated with:</p> <p>Use of antibiotics or corticosteroids; Pregnancy; or Diabetes.</p>	<p>Clinical symptoms</p> <p>AND</p> <p>Identification of typical budding yeast forms or pseudohyphae on microscopic exam of discharge by: KOH wet mount; saline wet mount; or Gram stain.</p>	<p>A. <u>Treatment</u></p> <ol style="list-style-type: none"> 1. <u>Miconazole</u>: 200 mg vaginal suppository inserted at bedtime for 3 days; or 2% cream, 5 gm, intra-vaginally at bedtime for 7 days. OR 2. <u>Clotrimazole</u>: 200 mg vaginal tablet inserted at bedtime for 3 days; or 100 mg vaginal tablet or 1% cream, 5 gm, inserted at bedtime for 7 days. OR 3. <u>Butaconazole</u>: 2% cream, 5 gm, intravaginally at bedtime for 3 days (6 days in second or third trimester of pregnancy). OR 4. <u>Terconazole</u>: 80 mg vaginal suppository or 0.8% cream, 5 gm, inserted at bedtime for 3 days; or 0.4% cream, 5 gm, at bedtime for 7 days. OR 5. If age 18 or over and not pregnant or lactating, Fluconazole 150 mg PO, once. <p>B. <u>Counseling/Follow-up</u></p> <p>Women who experience 4 or more episodes of VVC within a year, that cannot be explained by use of antibiotics or corticosteroids, should be evaluated for possible intensive and/or maintenance therapy.</p>

<p>52</p> <p>4/98</p>		<p>C. <u>Sex Partners</u></p> <p>Male partners who have balanitis or penile dermatitis may benefit from treatment with over-the-counter topical antifungal agents to relieve symptoms.</p>
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<p>BACTERIAL VAGINOSIS</p>		
<p><u>Symptoms/Signs</u></p>	<p><u>Diagnostic Criteria</u></p>	<p><u>Management</u></p>
<p>Thin, homogeneous, adherent white vaginal discharge with an offensive odor that is often more noticeable after intercourse.</p> <p>Symptoms are due to alterations in the vaginal flora due to replacement of the normal lactobacilli, with high concentrations of anaerobic bacteria.</p>	<p>1. Complaint of vaginal malodor or discharge, AND</p> <p>2. <u>At least 3</u> of the following:</p> <p>a. Homogeneous white, adherent vaginal discharge;</p> <p>b. Vaginal pH >4.5;</p> <p>c. Fishy amine odor, stronger when vaginal fluid is mixed with 10% KOH;</p> <p>d. Presence of "clue cells" on a wet mount of vaginal discharge.</p>	<p>A. <u>Treatment</u></p> <p>1. <u>If not pregnant:</u></p> <p>a. Metronidazole 500 mg PO, b.i.d. for 7 days, OR</p> <p>b. Metronidazole gel, 0.75%, one applicatorful (5g) intravaginally, 2 times a day for 5 days, OR</p> <p>c. Clindamycin cream, 2%, one applicatorful (5g) intravaginally at bedtime for 7 days.</p> <p>2. <u>For high-risk pregnant women (who have previously delivered a premature infant),</u></p> <p>a. <u>Second or third trimester:</u> Metronidazole 250 mg PO, t.i.d. for 7 days, or 2 grams PO, single dose, OR</p> <p>b. Clindamycin 300 mg PO, b.i.d. for 7 days.</p> <p>3. <u>For pregnant women not at high risk,</u> Oral regimen as for high risk, OR Metronidazole gel, 0.75%, one applicatorful (5g) intravaginally, 2 times a day for 5 days.</p>

<p>53</p> <p>4/98</p>		<p>B. <u>Counseling/Follow-up</u></p> <ol style="list-style-type: none">1. Counsel to avoid alcohol until 24 hours following completion of metronidazole therapy.2. The patient should return if symptoms persist after treatment or recur. <p>C. <u>Sex Partners</u></p> <p>Examine if symptomatic of possible STD; otherwise no examination or treatment is necessary, as this syndrome is not considered to be an STD.</p>
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STAT LABORATORY TESTS for VAGINAL INFECTIONS

- A. Type of test: Microscopic identification of trichomonads, yeast forms or "clue cells" on a saline wet mount.

Specimen: Obtain vaginal wall material on a swab; prepare a turbid solution in 0.5 ml saline in a test tube; place a drop of the suspension on a slide* and use a coverslip; examine immediately on the high dry objective.

*May also place a drop of saline on a slide and roll the swab in it to make the suspension.

Interpretation of results:

1. Motile trichomonads seen = trichomoniasis.
2. Yeast cells with pseudo-hyphae seen = candidiasis.
3. "Clue cells" seen = support for a diagnosis of bacterial vaginosis only if other criteria are met.

- B. Type of test: Microscopic identification of budding yeast or hyphae on KOH wet mount.

Specimen: Obtain material from the inflamed vaginal wall on a swab; prepare a solution in 0.5 ml 10% KOH in a test tube; place a drop of the suspension on a slide* and use a coverslip; examine under the high dry objective immediately. Take care not to get any KOH on the objective-- it may cause damage!

*May also place a drop of KOH on a slide and roll the swab in it to make the suspension.

Interpretation of results: positive slide = candidiasis

- C. Type of test: Microscopic identification of yeast forms or "clue cells" by Gram stain.

Specimen: Obtain material from vaginal wall on a swab and roll a thin smear on a slide. Air dry and stain.

Interpretation of results:

1. Budding yeast = candidiasis (may also see WBCs)
2. "Clue cells" = support for a diagnosis of bacterial vaginosis, if other criteria are also met.

SCABIES

<u>Symptoms/Signs</u>	<u>Diagnostic Criteria</u>	<u>Management</u>
<p>Severe itching associated with reddened papular eruptions with linear burrows.</p> <p>Lesions are commonly found on the genitals and inner thighs when scabies is spread sexually. Lesions may also be found in the axillae, fingerwebs, beltline and other areas of the body.</p> <p>Secondary excoriations due to scratching of the infested area(s) are common.</p>	<p>1. Gross or microscopic identifications of mite, larva or eggs on scraping from papules or burrows.</p> <p style="text-align: center;">OR</p> <p>2. Burrows in the skin or characteristic pruritic, erythematous, papular eruptions and other causes of dermatitis are excluded.</p> <p>Compatible or atypical skin lesions and sexual or other close physical contact to a person infested with scabies is suggestive.</p>	<p>A. <u>Treatment</u></p> <p>1. Permethrin 5% Cream (Elimite), massaged into all skin areas from the neck down, avoiding contact with mucous membranes, eyes and mouth. Remove by washing after 8-14 hours. (One application)</p> <p style="text-align: center;">OR</p> <p>2. Lindane 1% lotion (1 oz) or cream (30 gm), applied once to all skin areas from the neck down and washed off in 8 hours. <u>Do not use after a bath or if have extensive dermatitis. Do not use if pregnant, lactating or a child.</u></p> <p>B. <u>Counseling/Follow-up</u></p> <p>1. All clothes, towels and bed linens used during the past few days need to be laundered or dry cleaned.</p> <p>2. Reexamine in a week. May re-treat once if there is no improvement.</p> <p>3. Use nonprescription oral or topical Benadryl or hydrocortisone cream for persistent itching.</p> <p>C. <u>Sex Partners</u></p> <p>Examine and treat (as above) all sex partners and close household contacts.</p>

PEDICULOSIS PUBIS
("Crab" Lice)

<u>Symptoms/Signs</u>	<u>Diagnostic Criteria</u>	<u>Management</u>
<p>Adult louse and/or nits (egg cases) observed on pubic hair.</p> <p>Lice may appear as scabs/crusts over "scratch papules."</p> <p>Characteristic blue spots on skin due to bite of louse.</p> <p>Sensitivity reaction to louse bite: Itching, with secondary erythema and irritation due to scratching, may begin after a few days.</p>	<p>1. Identification of lice, larvae or nits attached to genital hairs.</p> <p style="text-align: center;">OR</p> <p>2. History of recent exposure to pubic lice and pruritic, reddened macules or papules or secondary excoriations are observed in the genital area.</p>	<p>A. <u>Treatment</u></p> <p>1. Permethrin 1% cream (NIX) applied to the affected area and washed off after 10 minutes, OR</p> <p>2. Pyrethins with piperonyl butoxide (e.g., RID) applied to the affected area and washed off after 10 minutes, OR</p> <p>3. Lindane 1% shampoo, left on for 4 minutes and then washed off. <u>Do not use if pregnant or lactating.</u></p> <p>B. <u>Counseling/Follow-up</u></p> <p>1. All clothes, towels and bed linens used during the past few days need to be decontaminated (either machine-washed or machine-dried using the heat cycle, or dry cleaned) or removed from body contact for at least 72 hours. Fumigation of living areas is not necessary.</p> <p>2. Mild topical antipruritic/anti-inflammatory cream or ointment may be obtained over-the-counter to use for itching.</p> <p>3. Re-treat if lice or nits are still seen after 7 days.</p>

56	4/98	C. <u>Sex/bed partners</u> All sex and bed partners from within the preceding month should obtain one of the over-the-counter medications listed above and complete treatment as soon as possible.
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HUMAN IMMUNODEFICIENCY VIRUS (HIV) INFECTION

Because of the uniqueness of diagnosis and management of HIV infection, please see the HIV/HBV Policy Manual, HIV Prevention Counseling training material, and other appropriate guidelines for more detailed information on pre/posttest counseling and case management of clients who test positive for HIV antibody.

<u>Symptoms/Signs</u>	<u>Diagnostic Criteria</u>	<u>Management</u>
<p>May or may not have signs or symptoms related to HIV disease.</p> <p>May give a history of suspected exposure.</p> <p>All patients being seen for other STD services in Public Health clinics will be offered HIV antibody testing.</p> <p>Informed consent is required; those refusing to give signed consent may be tested anonymously.</p> <p>Appropriate pretest HIV Prevention Counseling will be done before testing.</p>	<p>Positive serologic tests for HIV antibody: Repeat reactive EIA/ELISA (enzyme-linked immunosorbent assay) and positive Western Blot.</p>	<p>A. <u>Treatment</u></p> <p>After full evaluation of health status by a trained clinician, antiretroviral therapy may be considered. It will be strongly encouraged in pregnant women.</p> <p>B. <u>Counseling/Referral</u></p> <ol style="list-style-type: none"> 1. Provide posttest counseling per HIV Prevention Counseling guidelines. 2. Refer for case management, as needed. 3. Refer to communicable disease specialist for assistance with partner notification, as indicated. 4. Refer for other needs (e.g., substance abuse services), as indicated. <p>C. <u>Follow up</u></p> <p>As needed. Offer testing for other STDs, if not done previously.</p> <p>D. <u>Partners</u></p> <ol style="list-style-type: none"> 1. Assistance with sex and needle-sharing partner referral will be offered during posttest counseling and at other appropriate times in

the case management process.
2. Partners may be referred to the clinic for appropriate counseling and testing.

HUMAN IMMUNODEFICIENCY VIRUS (HIV) ANTIBODY TESTING

Types of tests: Qualitative Enzyme Linked Immunosorbant Assay (EIA or ELISA)
Qualitative Western Blot

Specimen: 5-10 milliliters of blood in a red-top tube, without additive.

Form: Virology Request Form, #3605.

Submission: Use red address label.

Send to: Microbial Immunology Lab, Decatur.

Interpretation of results:

1. EIA Negative/Repeat Negative, Western Blot not performed means no HIV antibodies detected
2. EIA Repeat Reactive, Western Blot Negative means no HIV antibodies detected
3. EIA Repeat Reactive, Western Blot Positive means HIV antibodies detected
4. EIA Repeat Reactive, Western Blot Indeterminate means no HIV antibodies confirmed

NOTE: When no antibodies are detected, or confirmed, either no infection has occurred or there were not sufficient HIV antibodies to be detected. Another test is suggested if risk of exposure to infection occurred in the previous six months.

STD PROGRAM ORIENTATION FOR PUBLIC HEALTH NURSES

NAME _____ COUNTY _____

Education and training for minimum competence as an STD nurse clinician:

- | <u>A. Didactic/Formal Courses</u> | <u>Date Completed</u> |
|--|-----------------------|
| 1. Pelvic Exam | _____ |
| 2. Basic STD information, including signs/symptoms, diagnostic criteria, treatment, client counseling/education | _____ |
| 3. Use and Care of the Microscope & Advanced Microscopy (or equivalent) | _____ |
|
 | |
| <u>B. Self-Study</u> | |
| 1. <u>A Guide to Physical Examination</u> by Barbara Bates, M.D. (or equivalent text) Male & Female Genitalia; Anus/Rectum | _____ |
| 2. Male & Female Exam video(s) | _____ |
|
 | |
| <u>C. Program Guidelines</u> | |
| 1. State STD Manual | _____ |
| 2. Georgia Laws for Control of Venereal Disease | _____ |
| 3. DHR Rules - Notifiable Diseases | _____ |
| 4. District STD Standards and Protocols | _____ |
|
 | |
| <u>D. District/State Program Orientation</u> | |
| 1. Funding Sources | _____ |
| 2. Organizational Charts | _____ |
| 3. Goals and Objectives | _____ |
| 4. Evaluation Mechanisms | _____ |
| 5. Role of Communicable Disease Specialist | |
| a. Referral priorities and system | _____ |
| b. Interview and field records | _____ |
| c. Observe fieldwork | _____ |
|
 | |
| <u>E. Clinical Orientation</u> | |
| 1. Forms and Reports | |
| a. Patient medical record | _____ |
| b. Laboratory test forms | _____ |
| c. Morbidity report forms | _____ |

Date completed

- d. Clinic logs _____
- e. Other: _____

- 2. STD Drugs
 - a. Availability/storage/dispensing _____
 - b. Handling reactions and side effects _____

- 3. Patient Management
 - a. Observe clerical intake. _____
 - b. Observe preceptor: obtain history; perform physical exam; obtain lab specimens; determine diagnosis and provide treatment according to nurse protocol; do appropriate counseling and referral; and, complete medical record, for a total of at least six (6) male and female patients. _____
 - c. Preceptor observes the nurse perform all activities under b. above, for a total of at least ten (10) male and female patients. _____

- 4. Laboratory
 - a. Observes performance of:
 - 1) Gram stain procedure and reading stained slides. _____
 - 2) Reading wet mount slides (saline and KOH). _____
 - b. Observes QA procedures for GC cultures _____
 - c. If available, observes darkfield exam and RPR card test. _____
 - d. Preceptor observes the nurse correctly perform all of the above for which he/she is responsible. _____
 - e. Nurse demonstrates knowledge of CLIA requirements. _____
 - f. Nurse demonstrates proper infection control procedures while handling specimens and performing lab tests. _____

- 5. Written evaluation of patient management and laboratory performance discussed by nurse and supervisor. _____

- F. STD Program Orientation Completed _____

Signature of Preceptor/Supervisor:

Signature of Public Health Nurse:

STD CLINICIAN TRAINING

Training in STD patient care is available to Georgia Public Health Nurses from:

CDC STD/HIV Prevention/Training (P/T) Centers

Though there are many P/T Centers nationwide, it is most convenient for Georgia nurses to attend the center in Birmingham, Alabama. A one-week "Intensive" STD Clinician Training course is available, consisting of lectures, clinical practice and laboratory practice. A three day laboratory course is also taught.

Arrangements to attend a CDC course can be facilitated by calling the State Office STD Nurse Consultant at the Georgia STD/HIV Section, (404) 657-3100. If participants prefer to make their own arrangements with the Birmingham staff, they should inform the Nurse Consultant when they are going, and send her a copy of their registration forms. This is so follow-up evaluation of the training can occur.

STD clinicians should also be trained as HIV Prevention counselors. This training is coordinated by the STD/HIV Section, but may be provided at the district level.

STD CLINIC ASSESSMENT

Formal quality assurance reviews of district/county public STD clinical services may be conducted by State Office staff, upon request. A complete STD clinic assessment consists of reviewing four components. They are:

1. Clinic Structure and Management
2. Patient Evaluation, Diagnosis and Management
(observation of patient care)
3. Laboratory Quality Assurance
4. Medical Record Audit

Standards by which the structure and management components are evaluated can be found on the following pages. Specific aspects of the clinic in each category are rated according to the following terms:

EXCEPTIONAL -- Exceeds expectations.

ACCEPTABLE -- Meets expectations.

BORDERLINE ACCEPTABLE -- The clinic only partially meets expectations. This is accompanied by an explanation of the degree of deficiency observed and a recommendation for becoming acceptable.

NEEDS IMPROVEMENT -- The clinic does not meet expectations. This assessment is accompanied by an explanation of the observed deficiency and a practical recommendation for improvement.

NOT EVALUATED -- The reviewers either could not review this aspect or were unable to make sufficient observations to justify a rating or recommendation.

The standards are applicable to STD clinical services in all health departments, whether there is a separate STD Clinic or not. Clinical supervisors are encouraged to regularly use these standards to evaluate STD services in their own settings. The following formats may be obtained from the STD State Office Nurse Consultant to assist in the evaluation:

STD Clinic Assessment Worksheet
Exam Room Equipment and Supplies Checklist
STD Laboratory Quality Assurance Worksheet
STD Clinician Evaluation Form
STD Medical Record Audit Worksheet

STANDARDS FOR STD CLINICAL SERVICES

I. STRUCTURE AND MANAGEMENT

A. ACCESSIBILITY

1. Clinic Schedule

- Clinic hours should meet the needs of the community, and be long enough to reasonably accommodate the average daily patient load.
- Evening hours should be available at least once a week.
- STD services should be offered at least three days a week to allow flexibility in scheduling return visits and sufficient opportunity for symptomatic patients to attend.

2. Physical Location

- Clinics, particularly new ones, should be located near residential areas of high STD prevalence and be readily accessible to public and private transportation.

3. Cost to Patient

- Fees, if charged, should be minimal or on a sliding scale. Services and/or medications must never be withheld because patients cannot pay a fee.
- Fees should not be assessed for examining persons referred to the clinic by a Communicable Disease Specialist (CDS) or by another health professional.

B. CLINIC ENVIRONMENT

1. Clinic Directions

- The building that houses an STD clinic should have easily readable signs that clearly direct patients.

2. Waiting Areas

- Waiting areas should be clean, maintained at a comfortable temperature and large enough to accommodate all patients.
- Waiting areas should contain appropriate patient educational

materials.

- Except in facilities where the STD patients wait in a common area with patients attending clinics other than the STD clinic, confidentiality should be promoted by calling patients by numbers, not by names.

3. Examination Room

- Exam rooms should be clean and private, so it is not possible to overhear patients who are being examined.
- The number of exam rooms should be adequate to have at least one room per clinician.
- Rooms should have adequate equipment and supplies for physical exams and specimen collection for both male and female patients.

4. Patient Consideration

- All interactions with patients and other staff should be courteous and respectful.
- Cross-cultural awareness and bilingual fluency (where appropriate) should be promoted as crucial elements in establishing a positive clinic-patient relationship.

C. REGISTRATION PROCESS

- Clerks need to obtain complete and accurate identifying and locating information. Positive identification (e.g., driver's license) may be requested at registration. However, services must not be denied because a client does not show identification, and a waiver of identification for those seeking only anonymous HIV antibody counseling and testing should be advertised.
- Registration interviewing should not be overheard by other patients.
- Where privacy is a problem, the clinic should consider a self-registration process where little information is exchanged verbally.
- Sufficient clerical staff should be available to register patients expeditiously and continuously.
- Walk-in clinics should have special, rapid registration procedures for follow-up visits, sex partners and other high priority referrals.
- The "expected in" file for referrals by a CDS will be checked for every patient.

D. MEDICAL RECORDS

- Records should have a mostly "check-off" design with sufficiently complete sets of symptoms, history, examination and lab tests categories to cover most STDs. Additional space should be adequate for necessary narrative description of findings.
- Medical records should contain sufficient information in all clinical evaluation categories so that any clinician, or other authorized person, who looks at a record will understand the examining clinician's findings and assessment. These categories include: the reason for the visit; medical/sexual history; physical exam findings; laboratory tests ordered and performed; diagnosis; treatment; counseling; and plans for follow-up or referral.
- The clinical evaluation and laboratory items should be designed so that clinicians must mark each as to whether it is positive or negative, done or not done, normal or abnormal, etc., so that a quality assurance audit of records can determine if clinician performance is consistent with established guidelines and protocols.
- Medical records should be stored in locked files where they can be easily located by authorized medical/clerical personnel but are inaccessible to unauthorized persons.
- Medical records stored on computer need to have rigorous access protection procedures to prevent unauthorized entry into the file, as well as a back-up filing process to prevent any loss of information.

E. CLINIC FLOW

- Patients are required to make a maximum of four stops (registration, clinical care, phlebotomy and interviewing/counseling).
- The next available clinician should see the next patient in order, regardless of gender or complaint.
- Initial patient visits should take no more than an hour from registration to treatment.
- Expedited care should be accorded to follow-up and patients referred by a Communicable Disease Specialist.
- Any clinic with an average patient volume exceeding 3 patients per clinician per operating hour should adopt a combined appointment and walk-in system to smooth out patient flow.

F. CLINIC MANAGEMENT

Manager Qualifications and Responsibilities

- Job qualifications for clinic managers should include:
 - a. Adequate medical knowledge about STDs to make valid comparisons between the clinic protocols and directly observed quality of care;
 - b. Adequate management training to operate the clinic effectively; and,
 - c. Adequate knowledge of STD disease intervention concepts and activities to judge the needs and performance of Communicable Disease Specialists.

- Management responsibilities should include:
 - a. Maintain an accessible clinic manual containing updated clinic protocols, policies, procedures and performance standards.
 - b. Ensure that the clinic facility, equipment and supplies are adequate.
 - c. Ensure that medication available from the State Pharmacy is obtained to distribute to patients for the appropriate conditions. Through other sources, obtain medication to treat other STDs of significant morbidity.
 - d. Ensure that morbidity reporting is accurate and timely.
 - e. Oversee quality assurance procedures.

- Personnel responsibilities should ensure that:
 - a. The clinic has adequate staff.
 - b. All staff have appropriate job descriptions and know what is expected.
 - c. All staff are adequately trained and regularly updated .
 - d. All staff follow protocols and meet performance standards.
 - e. Input from staff is encouraged and frequent staff meetings are held.
 - f. Universal blood and body fluid precautions are observed by all personnel.

G. CLINICIAN ROLES AND TRAINING

- Nurses should function as clinicians responsible for the entire clinical care stop.
- Nurses should receive appropriate training, including preceptorship, to diagnose and treat all STDs for which model protocols are available from the Division of Public Health.
- Physician back-up should be readily available on- site or on-call.
- All clinicians should be trained as HIV prevention counselors and have additional training, as appropriate, about signs/symptoms of HIV-related illness and case management.

H. STANDARDS AND PROTOCOLS FOR PATIENT MANAGEMENT

- The clinic manual should contain written standards and protocols, to be used by all clinicians, that comply with CDC and Georgia STD Program guidelines.
- Standards should include:
 - a. Routine history, physical examination and laboratory specimens;
 - b. Additional evaluation of specific problems;
 - c. Physician consultation and referral guidelines;
 - d. Counseling and patient education guidelines;
 - e. Priorities for referral to a CE; and,
 - f. Emergency procedures for handling drug reactions.
- Nurse protocols for specific STDs should include criteria for:
 - a. Diagnosis;
 - b. Treatment and followup;
 - c. Treatment of sex partners;
 - d. Physician consultation and/or referral; and,
 - e. Specific counseling/patient education messages.

I. CLINIC STAT LABORATORY

- Each clinic should have an on-site stat laboratory.
- The stat lab, at a minimum, should perform the following tests: Gram

stain of urethral discharge, saline and KOH wet mounts of vaginal discharge, and urine pregnancy tests.

[At least one health department lab per district should be able to perform the Gram stain, RPR and darkfield exam.]

- The lab should, at a minimum, have the following properly maintained equipment, along with the appropriate controls and supplies:
 - a. Brightfield microscope for Gram stain and wet mounts;
 - b. Incubator for inoculated gonorrhea (GC) cultures; and,
 - c. Refrigerator for unused GC culture medium.
- Labs performing RPRs need a card test rotator, centrifuge, antigen kits and control kits.
- Labs performing darkfield exams need a darkfield (or convertible brightfield) microscope.
- The stat lab should have the accessible back-up of a reference lab for performance of other procedures necessary for STD diagnosis.
- The stat lab should maintain complete and current logs/records of testing activities, results, and results of back-up/confirmation testing.
- CLIA requirements for staff training, proficiency testing and procedure manuals must be met.
- All staff performing lab tests must be trained in, and follow, universal precautions and biosafety standards.

J. DISEASE INTERVENTION OUTREACH STAFF

- Communicable Disease Specialists (CDS) are available on-site or on-call to provide disease intervention services during hours of clinic operation.
- CDS staff is provided with an adequate number of private rooms to ensure that confidential STD interviews and HIV counseling sessions can be conducted without interruption.
- Procedures are established so all relevant disease intervention information is smoothly exchanged between CDS and other clinic staff.
- CDS/clinician communication is maintained to ensure consistency between messages given to the patient.

K. FORMAL QUALITY ASSURANCE PROCEDURES

- The STD clinic has quality assurance procedures in place for:

- a. The periodic auditing of medical records to determine the appropriateness of diagnosis and treatment and completeness of documentation;
- b. Regular direct observation of clinic staff (clerks, clinicians and CDS) performance during interactions with patients;
- c. Regular monitoring of the quality of GC culturing and stat lab procedures, such as Gram stain/culture correlation of male urethral discharges, STAT RPR/backup lab results, etc.
- d. Monitoring customer satisfaction and receiving and management of significant complaints of patients about clinical services.
- e. Dispensing medication and monitoring its usage.

II. STANDARDS FOR PATIENT EVALUATION, DIAGNOSIS AND MANAGEMENT

- Medical records should be complete and legible.
- Clinicians should respond sensitively to patient concerns.
- Patient history and physical exam should be thorough and adequate, according to established standards.
- Appropriate specimens for laboratory testing are collected, according to established standards.
- Clinicians should be skilled in specimen collection and performance of stat laboratory procedures.
- Diagnosis should be accurate and based on established criteria.
- Treatment should be appropriate and according to established protocols.
- Medical consultation and referral to other health services, or a communicable disease specialist, should be accomplished according to established criteria.
- Counseling and patient education should be thorough and appropriate to diagnosis, treatment and necessary followup.
- Appropriate handouts should be given to patients to reinforce educational messages.

- STD and HIV risk reduction/prevention messages should be appropriate to the individual patient situation.
- If the patient is to refer his/her own sex partner(s) for examination and treatment, the clinician should give him/her adequate information reinforced by written notes to give to the partner(s), to accomplish this in a timely manner.

DISEASE INTERVENTION SECTION
(Formerly called “Epidemiology” Section)

It is of the utmost importance that STD workers create an atmosphere in the sexual partner referral and follow-up process which will enhance the relationship between health departments, private physicians and all clients. Many people are very impressionable and one or two negative experiences with representatives of the health department can do a great deal of harm to the STD prevention effort. In the investigative process, one should always exercise discretion and diplomacy to avoid embarrassment or discomfort.

All medical and epidemiologic facts are obtained as confidential information. Therefore, the identities of persons giving this information cannot be revealed. Because the communicable disease specialist is an official representative of a public agency and is entrusted with extremely confidential information, it is of the utmost importance that his or her responsibilities be tempered with understanding, tact, tolerance and, most importantly, good sound judgement.

See the Table of Contents in front of the manual for page numbers of disease-specific information.

**I. COMPLETION OF THE INTERVIEW RECORD (CDC 73.54)
AND
FIELD RECORD (CDC 73.2936S)**

Interview Records (CDC 73.54) and Field Records (CDC 73.2936S) may be used for monitoring and case management of any STD or HIV disease intervention and prevention activity. For detailed information on the correct way to complete the 73.54, refer to the CDC Interview Record instructions. For the correct way to complete the 73.2936S, see CDC Field Record instructions. **(NOTE: See exception in item B-3 on page 73.)**

The notes below serve as additional explanation and clarification on some of the most frequent concerns in completing the Interview Record and Field Record, and apply to any disease for which these records are used. **For specific instructions on how to submit syphilis Interview Records and Field Records to the State STD Surveillance Unit, see the Syphilis section beginning on page 83.**

A. INTERVIEW RECORD

1. Informant Identity

Remember to complete "Informant Identity" when the case has been brought to treatment through disease intervention.

2. Dual Dispositions on 73.54 (See Examples on page 74)

- a. Dual dispositions should appear on the 73.54 when "ping-pong" infections are involved. For example, when an individual is both the source and spread, enter the name of the contact on two lines, as though he were two different persons. The first line should show the appropriate disposition for the first infection (when he/she was the source or spread, whichever is the case). The other line should show the current disposition and whether he/she is the source or a spread.
- b. For a previously diagnosed and treated partner who is related to the case (either source or spread), and has been located, examined again and receives epidemiologic treatment, show this partner as the source or spread with the appropriate dates, disposition and diagnosis applicable to the previous infection. Show this partner as a current record closure. Put an asterisk by the partner's name, and indicate on the bottom of the 73.54 that this partner was treated prophylactically and the date of

treatment.

In contrast, if a previously treated partner is unrelated (not a source or spread), but is re-examined and receives epidemiologic treatment, show the current examination and treatment (disposition "A") information, put an asterisk by the partner's name and indicate on the bottom of the 73.54 that this partner was previously treated, showing the stage and date of diagnosis. (An "F" disposition would be handled the same as an "A".)

3. Patient Address

List complete address including house or apartment number, street, city and zip code.

4. Supervisor/Investigative Agency Codes

Enter codes in the 3 digit code blocks for each district/unit as listed below. DO NOT use county code for Investigative Agency Code.

<u>DISTRICT/UNIT</u>	<u>CODE</u>	<u>DISTRICT/UNIT</u>	<u>CODE</u>
1/1 Rome	110	5/1 Dublin	510
1/2 Dalton	120	5/2 Macon	520
2 Gainesville	200	6 Augusta	600
3/1 Marietta	310	7 Columbus	700
3/2 Fulton County	320	8/1 Valdosta	810
3/3 Clayton County	330	8/2 Albany	820
3/4 Lawrenceville	340	9/1 Savannah	910
3/5 DeKalb County	350	9/2 Waycross	920
4 LaGrange	400	9/3 Brunswick	930
		10 Athens	100

5. Dates of Events

Assure that all dates entered on the 73.54 are accurate and logical. For instance, "date interviewed" cannot be prior to "date assigned".

6. Date Assigned

The date assigned is the date the Communicable Disease Specialist (CDS)

becomes aware that the person was diagnosed as a case.

7. Intrastate Morbidity Assignment

When morbidity is assigned from one district to another district within the state, photocopies of Interview Records and relevant Field Records will be sent to the other involved district. Confidentiality of information must be assured.

8. Notation of Out-of-State Morbidity Assignment

If morbidity is being assigned to another state, please specify by writing at the very top of the 73.54 "**MORBIDITY TO _____**". List patient's complete address. Remember, **MORBIDITY IS BASED ON PATIENT'S USUAL STATE OF RESIDENCE AT TIME OF TREATMENT AND DIAGNOSIS.**

B. FIELD RECORD

1. Original Patient ID Number

Assure that the local patient ID/case number is written in the relevant box on the Field Record, especially if it is being sent to another district.

2. Brought To Treatment/Previous Treatment Dispositions

An "infected, brought to treatment" disposition (disposition "C") is used when the partner, cluster or reactor was examined and treated (for the suspected infection) as a direct result of this field investigation. If the individual was treated prior to the initiation of this Field Record, the disposition should be "previously treated for this infection" (disposition "E"). See an example of "E" disposition on Page 75.

3. Disposition Date

Date of disposition in the partner/cluster section of the Interview Record (and in the "disposition date" box on the Field Record) should be the **date the investigation or record search was completed**. This should be immediately after the completion of the activity. **DISREGARD ITEM 31-F ("DISPO DATE") ON PAGE 5 OF THE CDC FIELD RECORD INSTRUCTIONS AND ITEM 46 ("DISP. DATE") ON PAGE 9 OF THE CDC INTERVIEW RECORD INSTRUCTIONS.**

II. ROUTING OF FIELD RECORD (FORM 73.2936S)

Below is the policy for interstate and intrastate routing of Field Records (Form 73.2936S) for investigation of the following sexually transmitted diseases, partners and clusters:

- ◆ Syphilis reactors
- ◆ Partners and clusters to primary, secondary, and early latent syphilis
- ◆ Gonorrhea cases and partners
- ◆ Chlamydia cases and partners
- ◆ PID partners
- ◆ HIV positives and partners

A. Out-of-Jurisdiction Investigations Within Georgia

The initiating district should thoroughly complete a four-part 73.2936S and mail three copies (including the green copy) to the investigating district, retaining one copy for control purposes. The initiating district may call the investigating district prior to mailing the 73.2936S. The investigating district should provide a preliminary disposition to the initiating district within 5 workdays after receipt. This preliminary disposition should, at a minimum, verify the address, name, locating information, etc. In the event that additional information is needed, the original patient can then be reinterviewed.

Within 14 calendar days of receiving the 73.2936S, the investigating district should send a dispositioned copy back to the initiating district so that case analysis may be completed. The investigating district also should forward the **white** copy to the STD/HIV Section for data entry. NOTE: The 73.54 should not be closed until final dispositions are recorded.

B. Out-of-State Investigations

Except for Fulton County, which handles its own out-of-state transmissions, all transmissions must be handled by the Georgia STD/HIV Section ICCR Clerk. **No one else is to communicate directly with another state without clearance from the STD/HIV Section.** If paperwork or phone calls are received in a local clinic directly from another state, please contact the Georgia STD/HIV Section.

1. Epidemiologic information originating in Georgia:

Information on contacts/clusters to early syphilis or HIV infection and persons who have reactive syphilis tests with titers $\geq 1:8$ will be phoned. Information on HIV positives, syphilis reactors with titers $<1:8$, chlamydia/gonorrhea cases/contacts and PID contacts, will be mailed, with one exception. If a

person is pregnant, the information will be phoned.

- a. Phone information on syphilis/HIV contacts, priority syphilis reactors and other contacts/reactors known to be pregnant to the Georgia STD/HIV Section on the date initiated. Buff copies of the 73.2936S should be used for syphilis and HIV contacts as a control measure, with no paperwork being sent to the STD/HIV Section.
- b. Mail a four-part Field Record (73.2936) to the STD/HIV Section for low priority syphilis reactors, contacts to gonorrhea/chlamydia and HIV positives on the date initiated. For HIV positives, include a copy of the test report.
- c. Upon receiving the information, the STD/HIV Section ICCR Clerk will appropriately either telephone the state in which the investigation is to be performed or forward the four-part Field Record to the other state.
- d. A disposition within 14 days for early syphilis contacts (30 days for HIV contacts) will be requested by the ICCR clerk. When a disposition is received from the investigating state, results will be called to the initiating district.

2. Epidemiologic information originating in another state:

- a. All epidemiologic information received from other states relative to Georgia residents will be called to the investigating district by the Georgia STD/HIV Section ICCR Clerk.
- b. The investigating district will initiate a four part 73.2936S. The investigating district should provide a preliminary disposition to the STD/HIV ICCR clerk within 5 working days after receipt. A final disposition should be called to the Georgia STD/HIV Section ICCR Clerk by the investigating district as soon as possible, but no later than 14 days from the initiation date. If a final disposition has not been reported within 14 calendar days (on the "Disposition Due Date"), the responsible district CDS must report the status of the investigation to the Georgia STD/HIV Section.
- c. The **white** copy of the closed Field Record should be forwarded to the Georgia STD/HIV Section for inclusion in data processing reports.

C. HIV Infection

1. Out-of-jurisdiction (intrastate or interstate) HIV partner notifications will be

handled as described above.

2. When a copy of the patient/client's HIV positive laboratory report is sent to an out-of-jurisdiction area for posttest prevention counseling of an infected patient/client, ensure that it is sent to the correct person and address, so that confidentiality of the information is maintained.

D. Military

Any domestic military installation that initiates STD intervention information for investigation anywhere within the United States or its territories should forward forms through the local district health office. The district offices must screen these forms for accuracy and transmit to the appropriate district if the investigation is within Georgia, or to the Georgia STD/HIV Section ICCR Clerk if the investigation is to be performed in another state.

III. LOCATION OF COMMUNICABLE DISEASE SPECIALISTS

(ALL CAPITAL LETTERS DENOTE CITY OF DISTRICT HEADQUARTERS)

District 1 Unit 1 ROME	Northwest Health District N.W. Georgia Regional Hospital 1305 Redmond Circle, Building 614 Rome, GA 30165	706-295-6656 FAX: 706-295-6015
District 1 Unit 1 DALTON	Northwest Health District 100 West Walnut Avenue Suite 92 Dalton, GA 30720	706-272-2342 FAX: 706-272-2221
District 2 GAINESVILLE	North Health District 1131 Vine Street P.O. Box 1295 Gainesville, GA 30501	770-718-5093 Sec'y 770-531-5606 FAX: 770-531-6035
District 3 Unit 1 MARIETTA	Cobb County Health Department 1650 County Services Parkway Marietta, GA 30008	770-514-2335 FAX: 770-514-2414
District 3 Unit 2 ATLANTA	Fulton County Health Department ATTN: STD Clinic 99 Butler Street, S.E. Atlanta, GA 30303	404-730-1401 -1402 FAX: 404-730-1499
District 3 Unit 3 MORROW	Clayton County Health Department Administrative Office 1380 Southlake Plaza Drive Morrow, GA 30260	770-961-1330 FAX: 770-961-8370
District 3 Unit 4 LAWRENCEVILLE	Office of Infectious Disease 324 W. Pike Street PO Box 897 Lawrenceville, GA 30045-0897	770-339-4260 FAX: 770-339-4265
District 3 Unit 5 DECATUR	DeKalb County Board of Health STD/HIV Program, Suite 354 445 Winn Way Decatur, GA 30031	404-294-3762 FAX: 404-508-7879
District 4-A LAGRANGE	District 4 Health Office 122 Gordon Commercial Drive Suite B LaGrange, GA 30240	706-845-4035 FAX: 706-845-4038

District 4-B Griffin	District 4 Health Services 1435 North Expressway, Suite 604 Griffin, GA 30223-1783	770-229-3116
District 5 Unit 1 DUBLIN	South Central Health District 2121-B Bellevue Road Dublin, GA 31021	912-275-6556 FAX: 912-275-6575
District 5 Unit 2 MACON	Epidemiology, North Central Health District 811 Hemlock Street Macon, GA 31201	912-751-6214, 6329 -6326 FAX: 912-752-1710
District 6 AUGUSTA	East Central Health District Attn: Willa Mitchell 1916 Northleg Road Augusta, GA 30909	706-667-4342 FAX: 706-667-4728
District 7-A COLUMBUS	West Central Health District Office of Communicable Disease 2100 Comer Avenue P.O. Box 2299 Columbus, GA 31902	706-321-6411 FAX: 706-321-6409
District 7-B Americus	Community Epidemiologist P.O. Box 1302 Americus, GA 31709	912-931-2403, 2514 FAX: 912-931-2448
District 8 Unit 1-A VALDOSTA	South Health District 312 North Patterson Street P.O. Box 5147 Valdosta, GA 31601	912-333-5290 FAX: 912-333-7822
District 8 Unit 1-B Tifton	Tift County Health Dept. 305 East 12th Street P.O. Box J Tifton, GA 31794	912-386-8373
District 8 Unit 1C Fitzgerald	Ben Hill County Health Dept. P.O. Box 88 Fitzgerald, GA 31750	912-426-5288
District 8 Unit 2-A ALBANY	Dougherty County Health Dept. 1710 South Slappy Boulevard P.O. Box 3048 Albany, GA 31706	912-430-6250 FAX: 912-430-6340

District 8 Unit 2-B Thomasville	Epidemiology Office P.O. Box 471 Thomasville, GA 31792	912-225-5035
District 8 Unit 2-C Bainbridge	Decatur County Health Dept. P.O. Box 417 Bainbridge, GA 31718	912-248-3055, 2682 928 West St. 31717
District 8 Unit 2-D Camilla	Mitchell County Health Dept. P.O. Box 283 Camilla GA 31730	912-336-2055
District 9 Unit 1 SAVANNAH	Chatham County Health Dept. 2011 Eisenhower Drive P.O. Box 14257 Savannah, GA 31416	912-356-2157 FAX: 912-353-3121
District 9 Unit 2-A WAYCROSS	Southeast Health District 1115 Church Street, Suite A Waycross, GA 31501-3525	912-285-6022 FAX: 912-284-2522
District 9 Unit 2-B Lyons	Toombs County Health Dept. P.O. Box 308 Lyons, GA 30436	912-526-8108 FAX: 912-526-6504
District 9 Unit 2-C Statesboro	Bulloch County Health Dept. P.O. Box 666 Statesboro, GA 30458-0666	912-764-3800
District 9 Unit 2-D Douglas	Coffee County Health Dept. 1111 W. Baker Highway Douglas, GA 31533	912-389-4458 FAX: 912-389-6326
District 9 Unit 2-E Jesup	Wayne County Health Dept. P.O. Box A Jesup, GA 31545	912-427-2042
District 9 Unit 3-A BRUNSWICK	Glynn County Health Dept. 1609 Newcastle Street Brunswick, GA 31520	912-264-3907 FAX: 912-262-2315
District 9 Unit 3-B Hinesville	Liberty County Health Dept. P.O. Box 231 Hinesville, GA 31313	912-876-2713, 5085 FAX: 912-368-8033
District 10 ATHENS	District Health Office 468 N. Milledge Avenue Athens, GA 30601	706-542-9612 FAX: 706-542-9754

IV. USE OF THE NOTIFIABLE DISEASE REPORT FORM (FORM 3095)

All licensed physicians, laboratories, hospitals, military installations and other health care providers should report on the Notifiable Disease Report Form (3095). Only one disease per card should be reported on the Notifiable Disease Report Form with the exception of gonorrhea and chlamydia, which are frequently tested for and reported together.

The Notifiable Disease Report Form is used to report “**positive results**” or **diagnosed disease**. This form should not be used to report “**pending**,” “**non-reactive**,” “**ruled-out**” or “**possible**” results.

All health care providers using the Notifiable Disease Report Form are required to report the minimum information: the disease or condition, client’s name (except for HIV), address, telephone number, date of birth, pregnancy status and treatment status. Treatment should be indicated in the “comment” section of the original version of the form (10/96) or in the specifically-designated section on the revised form.

NOTE: It is important that the name, facility and telephone number of the reporting physician be included on the form.

1. Districts receiving gonorrhea, chlamydia, chancroid or LGV morbidity information on a Notifiable Disease Report Form directly from county/private laboratories, hospitals, military installations, physicians and other reporting agencies will forward the form to the State STD Surveillance Unit.
2. A Field Record should be initiated from a Notifiable Disease Report Form from a private/military provider only if assistance with getting a patient treated for one of the above infections is requested, or for a syphilis reactor (see next page).
3. Upon completion of an investigation, the District will mail the **white** copy of the Field Record, attached to the Notifiable Disease Report Form, to the State STD Surveillance Unit for processing.
4. The State STD Surveillance Unit will process Form **3095** morbidity information into the STD/MIS system. Districts may request that data from the State STD Surveillance Unit be downloaded monthly.

V. EARLY SYPHILIS, Primary and Secondary (P&S) and Early Latent (EL)

Screening

The State STD/HIV Section STD Surveillance Unit is responsible for processing, maintaining and forwarding reports of positive syphilis serologies to public health districts for follow-up. This ensures that the State STD Surveillance Unit maintains a quality assurance system to monitor all open reactors.

A. Procedures for Follow-up of Reactive Serologies

1. Positive laboratory serologies that are not closed by the State STD Surveillance Unit as administrative closure (A/C) or out-of-jurisdiction (OOJ) will be record searched. If a reactive serology cannot be record-search closed (R/C) by the STD Surveillance Unit, a laboratory log reactor sheet will be generated and, along with the laboratory report, forwarded to the appropriate district for follow-up according to the standards for investigation found on page 87. The receiving district will return disposition information to the STD Surveillance Unit **within 30 days**.

NOTE: Record-search closures and administrative closures will be forwarded to districts only at a district's request.

2. When follow-up has been completed on positive laboratory serologies, districts will mail a copy of the completed field records, along with the laboratory log reactor sheet to the STD Surveillance Unit.

NOTE: If a reactor Field Record is dispositioned "K" (out-of-jurisdiction), the district will initiate a new Field Record to the appropriate district. The log reactor number must be placed on the new Field Record. A copy of the completed "K" Field Record and a copy of the positive reactor laboratory serology will be mailed back to the State STD surveillance unit to update the reactor log file. The receiving district will report the final results of the investigation back to the initiating district and to the State STD Surveillance Unit.

B. Reactive Serology Resolutions

Reactive serologies should have Field Records initiated as high priority or priority, or may be administratively closed, according to the **reactor grid** on the following page.

It is the responsibility of the communicable disease specialist supervisor in each district to initiate a Field Record on any reactor needing further investigation to rule out a new infection.

MALE SYPHILIS REACTOR GRID					
TEST/AGE	0-39	40-49	50-59	>60	AGE UNK
VDRL/RPR - NR or UNKNOWN FTA, MHA, EIA - REACTIVE or UNK	P	AC	AC	AC	P
VDRL/RPR - REACTIVE FTA, MHA, EIA - NONREACTIVE	AC	AC	AC	AC	AC
VDRL/RPR - REACTIVE or 1:1 FTA, MHA, EIA - REACTIVE or UNK	P	AC	AC	AC	P
VDRL/RPR - 1:2 FTA, MHA, EIA - REACTIVE or UNK	P	P	P	AC	P
VDRL/RPR - 1:4 FTA, MHA, EIA - REACTIVE or UNK	HP	P	P	AC	P
VDRL/RPR - 1:8 FTA, MHA, EIA - REACTIVE or UNK	HP	P	P	AC	HP
VDRL/RPR - 1:16/1:32 FTA, MHA, EIA - REACTIVE or UNK	HP	P	P	AC	HP
VDRL/RPR > 1:32 FTA, MHA, EIA - REACTIVE or UNK	HP	HP	P	P	HP

FEMALE SYPHILIS REACTOR GRID					
TEST/AGE	0-39	40-49	50-59	>60	AGE UNK
VDRL/RPR NR or UNKNOWN FTA, MHA, EIA - REACTIVE or UNK	HP	AC	AC	AC	P
VDRL/RPR - REACTIVE FTA, MHA, EIA - NONREACTIVE	AC	AC	AC	AC	AC
VDRL/RPR - 1:1/1:2 FTA, MHA, EIA - REACTIVE or UNK	HP	P	P	AC	HP
VDRL/RPR - 1:4/1:8 FTA, MHA, EIA - REACTIVE or UNK	HP	P	P	AC	HP
VDRL/RPR - 1:16/1:32 FTA, MHA, EIA - REACTIVE or UNK	HP	HP	P	AC	HP
VDRL/RPR > 1:32 FTA, MHA, EIA - REACTIVE or UNK	HP	HP	P	P	HP

NOTE: Initiate all public/non-public high priority (HP) reactive serologies immediately and begin investigation within 24 hours of initiation. Priority (P) reactors may demand the same standards based on epidemiologic information. At a minimum, these reactors should be investigated within 3 to 5 days.

Interviewing/Counseling

Submission of Syphilis Cases to the State STD Surveillance Unit

1. For **all diagnosed early syphilis cases**, districts should mail an initial **yellow** copy of the Interview Record (CDC 73.54) to the State STD/HIV Section STD Surveillance Unit **within 72 hours** of the interview.
2. After the case is closed, a **photocopy** (from the white copy) of the closed Interview Record should be forwarded to the State STD Surveillance Unit **at the end of the month after the month the interview was done, (e.g., cases interviewed in January are due before March 1.) All patient information, laboratory work and the disposition of contacts/clusters must be complete at that time.** The white copy of closed partner/cluster Field Records should also be included.
3. The State STD Surveillance Unit will process all syphilis Interview Records into the STD/MIS system. Districts may request that data from the STD Surveillance Unit be downloaded monthly.

Minimum process performance standards:

1. Interview **at least 75%** of all early syphilis cases **within 3 workdays** of becoming aware of a case.
2. Reinterview selected patients relative to epidemiologic intelligence obtained through additional case analysis and field investigations. If it is determined that a patient needs to be reinterviewed, **the initial reinterview should occur within 5 workdays of the original interview at least 75% of the time.**
3. During the interview, obtain a **complete description and two items of locating information** at least **75%** of the time on each partner Field Record initiated.

Investigation

Minimum process performance standards:

1. Initiate all public and non-public high priority reactive serologies **immediately**. Begin investigation **within 24** hours of initiation and accomplish proper follow-up (e.g., examination of patient, closure information obtained from physician) on **at least 80% within 3 work days**. Lower priority reactors may demand the same standards based on epidemiologic information.
2. Examine **at least 65%** of partners of primary and secondary syphilis cases within **3 workdays**.
3. Examine at least **60%** of partners of early latent syphilis cases **within 3 workdays**.
4. Thoroughly **document all investigative activities** (dates and times of phone calls, field visits, failed appointments, etc.) on the back of the cardboard copy of **all** Field Records.

Additional program expectations:

1. Interview **100% of locatable early syphilis cases** for partners and cluster suspects, and **selected partners** for associates, with emphasis on S-1's, S-2's, A-1's and A-2's. (See CDC Interview Record Instructions for definitions of S-1, S-2, etc. See section entitled "Completion of the Interview Record and Field Record" on pages 70-72 of this manual for further instructions on completion of the Interview Record.)
2. Begin all partner/cluster field investigations **immediately** upon completion of the interview; all available pre-investigative materials such as telephone directories, city directories and closed Field Records should be utilized prior to initiating follow-up.
3. Epidemiologically treat examined seronegative partners to early (P&S and EL) syphilis who were exposed **within the previous 90 days** (3 months).
4. Perform **ongoing source/spread analysis** during the entire course of syphilis case management.
5. Assure that **any public laboratories not reporting directly to the State Office** report syphilis reactors to the district program daily.

6. Assure that **private laboratories** report syphilis reactors to the district program or to the Epidemiology and Prevention Branch daily on the Notifiable Disease Report Form (3095).
7. **Visit private laboratories** within the district **at least annually**. Visits should be made more frequently if problems arise.
8. Supervisors should maintain quality assurance by performing **routine reviews of employee work, depending on employee experience and identified problems**. This may start with at least one review of open field work (pouch review), case review, interview audit and field audit per month for new employees or after problems have been identified, and progress to quarterly reviews for veteran employees for whom no recent problems have been identified.
9. Complete and **submit monthly** (by the 15th of the following month) to the STD/HIV Section the **STD Program Indicators form**.

Criteria for Requesting State Office Record Searches

1. Attempt to talk with the patient to obtain specifics before calling for a record search. To assist the STD/HIV Section in performing a more accurate record search, try to have as much of the following information as possible:
 - a. Patient's full name. This might include: middle name or initials used; nickname; a.k.a.; female's maiden name, names by former marriages or husband's first name.
 - b. Patient's age/date of birth, sex and race.
 - c. Year and age when treated.
 - d. Where treated (name of clinic, doctor or prison) and/or who performed the serology.
2. When calling the State Office for a record search, have recent information (such as current titer) available so if a record is found, it can be updated.

VI. LATE LATENT AND LATE SYPHILIS

Marital or steady sex partners of all patients diagnosed with late latent or late syphilis should be referred for a serologic test for syphilis. Infants of women diagnosed with late latent syphilis must also be evaluated.

VII. CONGENITAL SYPHILIS

Measures which have successfully led to control of congenital syphilis have been well-studied and extensively practiced. Contributing to control are a range of public health activities which integrate service delivery with community outreach: comprehensive prenatal care, strategically targeted STD educational programs and responsive, high-quality diagnostic and treatment services. Equally crucial is a well-managed syphilis prevention/intervention component.

The control of early syphilis is essential for the prevention of congenital syphilis and is the primary reason for the investment of staff and funds in that effort. The traditional strategies of early syphilis control include an original interview of the patient to elicit information on sex partners, rapid notification of partners, selective reinterviewing, and selective clustering around the patient and his/her examined sex partners to obtain information on other persons who may be at risk of infection. These procedures have been well established in the state of Georgia for many years.

In addition to the performance of traditional epidemiology of early adult syphilis, the communicable disease specialist must also serve as the focal point for newborn reactor epidemiology. The CDS is responsible for initiating the follow-up of congenital syphilis suspects and for subsequent data collection from physicians and hospitals, field investigations, clinical referral and reporting.

Interviewing/Counseling

Successful interviewing of early syphilis cases should impart accurate information about the medical and social aspects of congenital syphilis to the patient. The communicable disease specialist should attempt to convince the patient of the importance of congenital syphilis control and of the key role the patient can play. When interviewing men or women diagnosed with syphilis, the CDS should attempt to elicit names of acquaintances (i.e., clusters) who may be pregnant. Women, especially pregnant women, may be more aware of other pregnant women than men might be.

Program expectations:

1. Female Cases:

- a.** All females should be asked if they have delivered an infant during the preceding year. If so, serologies should be obtained on any infant born during the time the mother was likely to have been infected. If delivery has been during the past three months, treatment of the infant would also be indicated.

- b. If the female case is currently pregnant, the prenatal care provider should be contacted to assure follow-up of the mother and infant according to established guidelines.

2. Male Cases:

All males should be asked if any of their female contacts are pregnant or delivered an infant during the past year. If so, these contacts should be considered of the highest priority so as to be examined as soon as possible.

3. Clustering:

Cluster interviewing should stress the identification of women who are pregnant or who have recently delivered, to assure their examination.

Investigation

Minimum process performance standard:

- All newborn reactive serologies should be immediately and thoroughly investigated. A Congenital Syphilis Follow-up worksheet should be completed on all newborn reactors who meet the surveillance case definition for reporting congenital syphilis. This should be forwarded to the STD/HIV Section within **21 days** of becoming aware of the reactor.

NOTE: See previous pages for additional interviewing and investigation standards for early syphilis.

VIII. GONORRHEA

Screening

An estimated one million new infections with *N. gonorrhoeae* occur in the United States each year. Many infections among women do not produce recognizable symptoms until complications such as PID have occurred. Because gonococcal infections among women are often asymptomatic, a primary measure for controlling gonorrhea has been the screening of high-risk women. Through selective screening at public and private clinics, each district has the ability to identify and bring to treatment individuals who have a gonococcal infection or its complications. All screening sites which send specimens to the State Lab, a Regional Lab or a local Public Health Lab, should be routinely visited in order to assess quality control standards. Written records of these visits should be kept.

The STD/HIV Section provides quarterly data to each district showing volume and yield from its gonorrhea screening sites so that overall cost effectiveness can be determined. Efforts should be made to increase the overall yield by redirecting or discontinuing provider sites based on analysis of the data.

Procedures for Follow-up of Positive Gonorrhea Tests

1. Positive gonorrhea test results received at the STD Surveillance Unit that need to be followed outside of Georgia will be mailed to the appropriate other state immediately.
2. For in-state positive gonorrhea test results reported to the STD Surveillance Unit, from both private and public laboratories, morbidity information will be processed into the STD/MIS system.
3. Field Records will be initiated on untreated positives reported to the districts from the State/Regional/Local Public Health laboratories.
4. When follow-up, including verification of treatment, has been completed on positive gonorrhea tests reported to the districts, the **white copy of the dispositioned Field Record** will be mailed to the State STD Surveillance Unit. Treatment information will be added to the morbidity record already in the STD/MIS system.

Interviewing/Counseling

All Public Health clinic patients diagnosed with gonorrhea should receive counseling about their infection and partner notification by the clinician, (see page 8 in the Clinical Section) including discussion of consequences to partners if not treated, and consequences to themselves from reinfection if partners are not treated before further sexual contact. They should emphasize that patients must have their sex partners evaluated and treated as soon as possible. Based upon local priorities and availability of CDS staff, certain gonorrhea patients may be referred to a communicable disease specialist for an interview. These may include STD repeaters and women with pelvic inflammatory disease. All patients should be offered partner notification assistance according to their specific needs.

Sex partners of all patients with gonorrhea should be evaluated and appropriately treated if their last sexual contact with the patient was within **60 days** prior to the patient's symptoms or positive test. Women diagnosed with pelvic inflammatory disease, with gonorrhea test results pending, should also be interviewed for sex partners from a period of **60 days** prior to treatment. The most recent sex partner should be treated if the last exposure was prior to 60 days.

Minimum process performance standards for CDS:

- 1. Interview at least 70% of all public uncomplicated gonorrhea cases referred for interview, within 3 workdays** of receiving the referral, with notification of sex partners from the above time periods.
- 2. During the interview, obtain a complete description and two items of locating information** at least **75%** of the time on each partner Field Record initiated through interviewing.

Investigation

Partner notification by the health department staff should be performed if requested by the patient or if patient referral is inappropriate.

Minimum process performance standards:

- 1. Initiate a Field Record on all reported public untreated positives, and non-public positives when the provider has requested assistance, immediately.** Begin investigation **within 24 hours** of receiving test results.
- 2. Bring to treatment at least 70% of public and 65% of referred non-public untreated positives within 3 workdays** of initiation.

3. Examine and treat at least **65%** of initiated partners **within 3 workdays** of interview.
4. Thoroughly **document all investigative activities** (phone calls, field visits, failed appointments, etc.) on the back of the cardboard copy of **all** Field Records.

Additional program expectations:

1. Ensure adequate treatment of **at least 90%** of all public cases and referred non-public cases of gonorrhea.
2. For patients interviewed, begin all partner/cluster field investigations **immediately** upon completion of the interview; all available pre-investigative materials such as telephone directories, city directories and closed Field Records should be utilized prior to initiating follow-up.
3. Assure that **public state/regional/county laboratories** appropriately report gonorrhea screening positives daily.
4. Assure that **private laboratories** report gonorrhea screening positives to the district program or to the Epidemiology and Prevention Branch daily on the Notifiable Disease Report Form (3095).
5. **Visit private laboratories** within the district **at least annually**. Visits should be made more frequently if problems arise.
6. Supervisors should maintain quality assurance by performing **routine reviews of employee work, depending on employee experience and identified problems**. This may start with at least one review of open field work (pouch review), case review, interview audit and field audit per month for new employees or after problems have been identified, and progress to quarterly reviews for veteran employees for whom no recent problems have been identified.
7. Complete and **submit monthly** (by the 15th of the following month) to the STD/HIV Section the **STD Program Indicators**

IX. CHLAMYDIA

Infections caused by *Chlamydia trachomatis* are recognized as the most prevalent and among the most damaging of all STDs. More than 4 million chlamydial infections occur annually. Adolescents and young adults are at substantial risk of becoming infected with chlamydia, and symptoms are often absent or minor among most infected women and many men. This large group of asymptomatic and infectious persons sustains transmission within a community.

Every effort should be made to ensure that infected persons are adequately treated and that the sex partners of women, especially those diagnosed with PID, are followed and treated. Field follow-up may be needed to motivate asymptomatic women and their partners to be treated.

Screening

Various tests are available for diagnosis of chlamydial infection. However, many tests are not available in all public health clinics. Since many cases of the syndromes of non-gonococcal urethritis (NGU), pelvic inflammatory disease (PID) and epididymitis are probably caused by *Chlamydia trachomatis*, those syndromes may be diagnosed on clinical grounds and treatment to cover *C. trachomatis* given accordingly.

Procedures for Follow-up of Positive Chlamydia Tests

1. Positive chlamydia test results received at the STD Surveillance Unit that need to be followed outside of the state will be mailed to the appropriate other state immediately.
2. For in-state positive chlamydia test results from private laboratories, the STD Surveillance Unit will process morbidity information into the STD/MIS system. No information will be forwarded to the districts.
3. For in-state positive chlamydia tests reported from State/Regional laboratories, the STD Surveillance Unit will forward the results to the districts.
4. Districts will initiate Field Records for all positive chlamydia test results forwarded to them.
5. When follow-up, including verification of treatment, has been completed on positive chlamydia tests, districts should mail the **white copy of the dis positioned Field Record** to the STD Surveillance Unit. Morbidity and treatment information will be processed into the STD/MIS system.

Interviewing/ Counseling

Besides giving infected patients information about chlamydia and its treatment (see Clinical Section, page 8), clinicians should discuss the management of their sex partners, including consequences to partners if not treated, and consequences to themselves from reinfection if partners are not treated before further sexual contact. They should emphasize that patients must have their sex partners evaluated and treated as soon as possible. Based upon availability of CDS staff and the need for assistance with partner referral, patients may be referred to a CDS for an interview.

For all patients with diagnosed genitourinary chlamydial infections the referral period for partners is **60 days** before the date of the patient's examination/test. For those women diagnosed with PID, the interview period is **60 days** prior to the date of treatment. If no exposure has occurred within these specified periods, the most recent sex partner should be evaluated and treated.

Minimum process performance standards:

1. Interview **at least 70% of all chlamydia cases referred for interview, within 3 workdays** of receiving the referral, with notification of sex partners from the above time period.
2. During the interview, obtain a **complete description and two items of locating information** at least **75%** of the time on each partner Field Record initiated.

Investigation

A. Follow-up of positive test results:

Chlamydia Program Protocols state that screening sites must have a written plan for follow-up of positive chlamydia test results. Plans will include a provision for a minimum of two documented attempts to be made to contact the client, by telephone or mail, for all positive test results. The first attempt must be initiated within one working day of receipt of test results. If attempts to reach the client by telephone and mail are unsuccessful in bringing her to treatment, and communicable disease specialists are available, it is strongly urged that clients be notified in person.

Minimum process performance standards:

1. Initiate a Field Record on all reported **public** untreated positives, and **non-public positives when the provider has requested assistance, immediately**. Begin investigation **within 24 hours** of receiving test results.

2. Bring to treatment at least **70% of untreated public positives** and **65% of referred non-public positives within 3 workdays** of receiving test results.
3. Thoroughly **document all investigative activities** (dates and times of phone calls, field visits, failed appointments, etc.) on the back of the cardboard copy of **all** Field Records.

B. Follow-up of partners:

Minimum process performance standards:

1. Examine and treat at least **65%** of initiated partners **within 3 workdays** of the interview.
2. Thoroughly **document all investigative activities** (dates and times of phone calls, field visits, failed appointments, etc.) on the back of the cardboard copy of **all** Field Records.

Additional program expectations:

1. Ensure adequate treatment of **at least 90%** of public and referred non-public cases of chlamydia.
2. For patients interviewed, begin all partner/cluster field investigations **immediately** upon completion of the interview; all available pre-investigative materials such as telephone directories, city directories and closed Field Records should be utilized prior to initiating follow-up.
3. Assure that **private laboratories** report chlamydia screening positives to the district program or to the Epidemiology and Prevention Branch daily on the Notifiable Disease Report Form (3095).
4. **Visit private laboratories** within the district **at least annually**. Visits should be made more frequently if problems arise.
5. Supervisors should maintain quality assurance by performing **routine reviews of employee work, depending on employee experience and identified problems**. This may start with at least one review of open field work (pouch review), case review, interview audit and field audit per month for new employees or after problems have been identified, and progress to quarterly reviews for veteran employees for whom no recent problems have been identified.

6. Complete and **submit monthly** (by the 15th of the following month) to the STD/HIV Section the **STD Program Indicators form**.

X. OTHER STDs

Preventing the spread of STDs requires that persons at risk for transmitting or acquiring infections change their behaviors. The health care provider has an opportunity to assist the client in identifying risks and in making a realistic plan, with incremental steps if necessary, to avoid acquiring or transmitting STDs.

The disease intervention methodologies and standards for the screening, interviewing/counseling and epidemiologic field investigation described for syphilis, gonorrhea and chlamydia may be utilized for outbreaks of any of the other sexually transmitted diseases. It is the prerogative and responsibility of the State STD/HIV Section and each district to devise and implement surveillance and control procedures for any STD when it is deemed appropriate.

The guidelines for identification, treatment and counseling of patients with other STDs are found in the preceding Clinical Section of this manual. See the Table of Contents for specific page numbers.

XI. HIV INFECTION

This section contains standards for HIV Prevention Counseling and investigation activities as they relate to HIV partner notification services. For additional information and discussion, see Chapter V of the Division's Human Immunodeficiency Virus (HIV) and Hepatitis B Virus (HBV) Policy manual.

Partner notification and provider referral of partners will be offered to both anonymous and confidentially tested HIV positive clients. However, the Division of Public Health will not initiate follow-up or make contact with an HIV positive person reported by a private physician or laboratory without first obtaining the physician's permission.

I. HIV Prevention Counseling and Partner Elicitation

- A. Partner notification services will be offered to every client on the initial and subsequent post-test positive counseling sessions or clinic visits. During each session, all feasible options should be explored with the client to ensure that **all** at-risk sex and/or needle-sharing partners are identified, located and offered an HIV test.

While the timing of an initial partner elicitation interview should allow the client sufficient time to deal with his/her positivity status, receive a clinical evaluation/referral and a psychosocial needs assessment, the welfare of partners needing notification must also be considered. Because the emotional status of clients will vary, a specific time frame is impossible to define. However, the interview should occur as soon as reasonably possible.

NOTE: If the client claims to be positive from a previous test that cannot be documented, he/she should be retested before being interviewed and receiving partner notification assistance.

NOTE: When a minor, or an adult in the care of a guardian of the state, tests positive, the counselor will discuss with the client the desirability of informing his/her parent or guardian.

- B. In order to maintain consistency of counseling messages, the post-test positive counseling session must be conducted by staff trained to perform HIV prevention counseling. In order to be trained in HIV prevention counseling, staff must attend and satisfactorily complete DHR approved training courses. All district CDS staff (HIV, STD, and TB) should be cross-trained in HIV prevention counseling.

- C. During the post-test prevention counseling session, the counselor should provide the HIV seropositive client with a copy of his/her positive laboratory report if it is available. If the client has been tested in another district or state (intrastate or interstate out-of-jurisdiction) and if a copy of the positive laboratory report is sent to the area providing the client's prevention counseling, the outer envelope should be marked "CONFIDENTIAL--OPEN BY COMMUNICABLE DISEASE SPECIALIST SUPERVISOR OR ADDRESSEE ONLY"
- D. Because of the seriousness of the disease and the fact that it is not clear when someone might have become infected with the virus, communicable disease specialists must attempt to elicit **all** sex and needle-sharing partners for whom locating information is available. Regardless of the client's current marital status, state law mandates that all exposed spouses within the past seven years be notified. Per Ryan White funding requirements, all spouses from within ten years of the diagnosis of HIV infection must be notified.
- E. An Interview Record (CDC 73.54) will be completed for all HIV positive clients who receive prevention counseling **and** partner notification services. The interview record will serve as an evaluation tool for prevention, early intervention and partner notification actions per program standards.

NOTE: A 73.54 that omits demographic information such as name, address, telephone number, etc. should be completed on anonymously tested clients receiving prevention counseling **and** partner notification services.

Field Records will be initiated for all partners and clusters needing investigation (see Section III, "Investigation Activities" below).

- F. During the interviewing and investigative phases, individuals who are not partners, but may be at high risk, should be identified through the clustering process. Priority should be given to those individuals who have symptoms associated with HIV disease (S1 or A1) and those individuals who have been, or may have been, exposed to HIV positive persons (S2 or A2). Additional individuals who may be at risk for exposure to HIV positive persons (S3 or A3), especially pregnant women or women who have given birth within the past two years, should be considered for investigation and referral.

II. Seropositive clients not returning for test results

- A. If the seropositive client does not return for his/her test result within 3 work days of his/her scheduled appointment, an investigation is necessary for posttest HIV prevention counseling. A Field Record (CDC 73.2936) will be initiated by the testing site and assigned for follow-up. If the HIV positive client lives in, or has relocated to, another district and posttest counseling is needed, a copy of the positive laboratory report will be forwarded to the district responsible for providing the HIV counseling and follow-up prior to that district performing the counseling.
- B. In order to schedule a new appointment for test results, the client may be contacted by field visit, telephone or mail. Since the investigator has the least amount of control over confidentiality when using the mail, field visits and telephone calls should be performed whenever possible.
1. When a field visit is conducted, every effort should be made to establish face-to-face contact with the client to give him/her the appointment to return for "test results". If an appointment notice is left in the field for the client (residence, workplace, etc.), a generic referral slip **which does not make any reference to HIV** should be left in a plain, sealed envelope marked "confidential". The referral slip should list the investigator's name and phone number.
 2. When the client is contacted by telephone, he/she should be requested to return to the clinic for his/her "test results". **No reference to HIV or AIDS will be made over the telephone. Test results will not be given over the telephone.**
 3. When an appointment notification is mailed to the client, the generic referral slip **which does not make any reference to HIV or AIDS** should be sent in a plain, sealed envelope marked "confidential". The referral slip should list the investigator's name and phone number.
- C. It is highly recommended that all post-test positive prevention counseling be conducted in the clinic. This allows the counselor ready access to support resources should the client have difficulty coping with his/her positivity status. However, the CDS must be prepared to provide post-test positive prevention counseling in the field as necessary. HIV seropositive prevention counseling and partner notification performed in the field must occur in a private and confidential setting.

III. Partner notification activities

- A. Priority should be given to the following sex and/or needle-sharing partners when conducting notification activities:
1. Pregnant females and women of child-bearing age
 2. Spouses of HIV seropositives (legally mandated)
 3. Victims of AIDS-transmitting crimes (legally mandated)
- B. Field Records will be initiated for all partners and clusters needing notification and sufficient locating or identifying information is available. The original seropositive client's name will not be documented on the Field Record of any partner/cluster. All investigations for referral of HIV clients, partners and clusters will be conducted in such a way as to be indistinguishable from traditional STD investigations.
- C. The client who wishes to notify his/her own partners should be encouraged to do so. The HIV counselor should provide referral cards/notes and negotiate a contract with the client which defines the following:
- When and how the client will notify each partner/cluster
 - What the client will say to each partner/cluster
 - When and where each partner/cluster will be referred
 - That a field worker will contact a partner/cluster who does not respond to an agreed-upon referral to the public health clinic within three workdays
- D. If the client-referred partner/cluster fails to keep an agreed-upon appointment within three workdays of the interview, then the communicable disease specialist (or other field worker) will attempt to contact the partner/cluster by field visit, telephone or mail. Since the investigator has the least amount of control over confidentiality when using the mail, field visits and telephone calls should be performed whenever possible.
1. When a field visit is conducted, every effort should be made to establish face-to-face contact with the partner/ cluster. If an appointment notice is left in the field for the partner/cluster (residence, workplace, etc.), a generic referral slip **which does not make any reference to HIV** should be left in a plain, sealed envelope marked "confidential". The referral slip should list the investigators's name and phone number only.
 2. When the partner or cluster is contacted by telephone, arrangements should be made for the investigator and the partner/cluster to meet to discuss "an important health matter" or that the partner/cluster has been

exposed to an infectious disease. **No reference to HIV or AIDS will be made over the telephone. Face-to-face notification is required to acknowledge specific exposure to HIV.**

3. When an appointment notice is mailed to the partner or cluster, the generic referral slip **which does not make any reference to HIV or AIDS** should be sent in a plain, sealed envelope marked “confidential”. The referral slip should list the investigator’s name and phone number only.
- E.** Once located, the partner or cluster will be counseled about his/her exposure to HIV and encouraged to be tested. A specific appointment should be given for testing. If this individual fails to keep the appointment, a second visit should be made to reinforce the importance of being tested. If the partner/cluster fails to keep two appointments, it will be the responsibility of the communicable disease specialist supervisor (or other designated person) to determine if further follow-up should be attempted.
- F.** The investigator may provide confidential pretest counseling and draw the blood specimen in the field as an alternative to a clinic appointment for HIV testing. However, a clinic appointment for post-test counseling should be given to the partner/cluster whenever possible.
- G.** When talking with the partner/cluster, the identity of the infected original client, the date of exposure to that client, or the location of the exposure cannot be revealed or acknowledged by the investigator. The following specific messages should be delivered to the partner/cluster:
- His/her possible exposure to an HIV infection and the meaning of the exposure.
 - Actions that can be taken to reduce the risk of exposure or infecting others in the future.
 - Motivations to seek further counseling and HIV antibody testing.
 - If he/she refuses testing, it is in his/her best interest, as well as the community’s best interest, to practice safe behavior as though seropositive.

Appropriate written information should be given to the partner/cluster to reinforce the above messages.

- H.** A partner or cluster who cannot be located after every reasonable attempt, including field investigation, may be dispositioned as “H” (unable to locate) following consultation with the communicable disease specialist supervisor (or other designated person).

- I. All investigative activities (dates and times of phone calls, field visits, failed appointments, client's refusal of testing, etc.) must be thoroughly documented on the back of the green cardboard copy of the field record. The documentation should clearly and accurately reflect what has occurred.
- J. Out-of-jurisdiction (intrastate or interstate) HIV partner notification will be handled in the same manner as out-of-jurisdiction syphilis investigations. (See pages 75 through 77, Routing of Field Record.)

IV. Syphilis/HIV coinfecting clients

Persons diagnosed with early syphilis should be informed of their increased risk of HIV infection and strongly encouraged to be tested. Individuals diagnosed with syphilis who choose HIV testing should be informed that if the HIV test result is positive, then partners named during the original syphilis interview may be notified of their exposure to HIV. Every attempt will be made to notify the original patient of his/her positive HIV results prior to notifying the partners. However, if the seropositive client cannot be located, HIV partner notification will take place without further delay.

Consideration might be given to using a one year interview period for individuals diagnosed with primary or secondary syphilis who choose HIV testing. If the original syphilis patient's HIV test results are positive, the one-year interview period may identify additional partners of the seropositive patient who would need notification of exposure to HIV.

Interviewing/Counseling

Minimum process performance standards:

1. Counsel **at least 70%** of **public** HIV seropositives **within 3 workdays** of Field Record initiation (3 workdays after failure to keep appointment for test results). Counsel at least **65% of non-public positives within 3 work days** of the provider's request.
2. For program expectations regarding original interviewing of HIV seropositives for partner notification, see item #1 under "Additional program expectations" below.
3. Reinterview selected seropositive patients relative to epidemiologic intelligence obtained through field investigations. If it is determined that a patient needs to be reinterviewed, **the initial reinterview should occur within 5 workdays of the original interview at least 75% of the time.**

4. During the interview, obtain a **complete description and two items of locating information** at least **75%** of the time on each partner Field Record initiated.

Investigation

Minimum process performance standards:

1. Initiate Field Records on public seropositive clients who do not return for test results **within 3 workdays** after their appointments. Begin investigation **within 24** hours of initiation.
2. Bring to counseling at least **70% of public and 65% of referred non-public HIV seropositive clients within 3 work days** of Field Record initiation.
3. Provide counseling/testing to at least **60%** of partners **within 3 workdays** of the **interview** (provider-referred partners) or **failure to keep the appointment** (client-referred partners).
4. Thoroughly **document all investigative activities** (dates and times of phone calls, field visits, failed appointments, etc.) on the back of the cardboard copy of **all** Field Records.

Additional program expectations:

1. Interview **all locatable public and referred non-public HIV seropositives** for partners and cluster suspects, and **selected partners** for associates, with emphasis on S-1's, S-2's, A-1's and A-2's. (See 73.54 instructions for definition of S-1, S-2, etc.) **The original interview should take place only after the client has had sufficient time to deal with his or her positivity status, but as soon as he/she is able to participate in a productive interview.**
2. Begin all provider-referral partner/cluster field investigations **immediately** upon completion of the interview; begin client-referral field investigations **after the partner/cluster has failed to appear at the clinic within 3 workdays of the original interview.** All available pre-investigative materials such as telephone directories, city directories and closed Field Records should be utilized prior to initiating follow-up.

3. Supervisors should maintain quality assurance by performing **routine reviews of employee work, depending on employee experience and identified problems.** This may start with at least one review of open field work (pouch review), case review, interview audit and field audit per month for new employees or after problems have been identified, and progress to quarterly reviews for veteran employees for whom no recent problems have been identified.
4. Complete and **submit monthly** (by the 15th of the following month) to the STD/HIV Section the **Results Of HIV Prevention Counseling and Partner Notification form.**

XII. PROCESS EVALUATION OF DISEASE INTERVENTION ACTIVITY

The following pages contain an audit format to allow for in-depth analysis of Individual or programmatic disease intervention activity for priority STDs. The audit format is divided into components of the program with each component listing process performance standards. Interview Records (73.54) and Field Records (73.2936) should be utilized on all interviewed cases of syphilis, HIV infection, gonorrhea and chlamydia. These records should be retained for a minimum of one year, to allow for evaluation and quality control.

It is recommended that the communicable disease specialist supervisor do periodic appraisals of various program components and individual communicable disease specialists utilizing the format and methods contained herein. This will allow for frequent and timely program evaluation and planning.

For additional program expectations see each specific disease section on previous pages.

I. INTERVIEWING

COMPONENT # 1

TIME FRAME TO INTERVIEWING OR COUNSELING	Process Performance Standards (All within 3 workdays)	Achievement
Syphilis (interview)	≥ 90%: Far Exceeds Expectations 85-89%: Exceeds Expectations 75-84%: Meets Expectations < 75%: Does Not Meet Expectations	Syphilis interviewed: _____% within 3 workdays
Gonorrhea and Chlamydia (interview of referred cases) HIV (counseling, public cases)	≥ 95%: Far Exceeds Expectations 85-94%: Exceeds Expectations 70-84%: Meets Expectations < 70%: Does Not Meet Expectations	Gonorrhea interviewed: _____% within 3 workdays Chlamydia interviewed: _____% within 3 workdays HIV counseled: _____% within 3 workdays
HIV (counseling, referred non-public cases)	≥ 90%: Far Exceeds Expectations 85-89%: Exceeds Expectations 65-84%: Meets Expectations < 65%: Does Not Meet Expectations	HIV counseled: _____% within 3 workdays

Disease intervention begins with the interview. Unless there are unusual circumstances, all diagnosed cases of public and non-public syphilis should be interviewed for partners and clusters. Based upon local priorities and availability of CDS staff, certain gonorrhea and chlamydia patients may be referred for an interview by a CDS.

Speed of investigation, which must begin with the interview, is crucial to effective case prevention. The sooner partners and clusters are identified and examined/counseled, the more likely that the chain of infection will be interrupted. Every effort should be made to interview diagnosed syphilis cases as soon as possible. Completed copies of Interview Records and Field Records should be provided to the district STD program supervisor within 24 hours. This component is measured from the date assigned to the date interviewed or counseled.

SOURCE DOCUMENTS: Syphilis and HIV...Interview Record (73.54); Gonorrhea and Chlamydia...STD clinic record, Interview Record, or case log.

COMPONENT # 2

<u>PERCENT OF INITIAL REINTERVIEWS WITHIN 5 WORKDAYS</u>	<u>Process Performance Standards</u>	<u>Achievement</u>
Syphilis and HIV	100%: Far Exceeds Expectations 90-99%: Exceeds Expectations 75-89%: Meets Expectations < 75%: Does Not Meet Expectations	Syphilis: _____% within 5 workdays HIV: _____% within 5 workdays

Reinterviews are additional exchanges of information with selected patients occurring after the original interview. They are conducted for the purpose of eliciting additional information, confronting conflicting information and confirming new information. These should be based on an analysis of epidemiologic intelligence obtained through field investigations. There is a direct correlation between the time lapse from original interview to reinterview. The sooner the reinterview, the more productive it is likely to be.

SOURCE DOCUMENT: Interview Record (73.54)

COMPONENT # 3

<p><u>QUALITY OF IDENTIFYING AND LOCATING INFORMATION</u> (Percent of partner Field Records including: A complete description and at least two items of locating information.)</p>	<p><u>Process Performance Standards</u></p>	<p><u>Achievement</u></p>
<p>Syphilis, HIV, Gonorrhea, and Chlamydia</p>	<p>> 95% : Far Exceeds Expectations 85-94%: Exceeds Expectations 75-84%: Meets Expectations < 75%: Does Not Meet Expectations</p>	<p>Syphilis: _____ % HIV: _____ % Gonorrhea: _____ % Chlamydia: _____ %</p>

During the interview, it is important to gather as much information as possible to facilitate rapid investigation and examination. Field Records should be documented with a complete description (physical appearance items, such as height, weight, hair style and complexion) and at least two items of locating information.

SOURCE DOCUMENT: Field Record (73.2936)

II. INVESTIGATION

COMPONENT # 4

<p align="center"><u>ADEQUACY OF DOCUMENTATION OF INVESTIGATIONS</u> (Work copies of all Field Records should be fully documented to indicate all investigative activities.)</p>	<p align="center"><u>Process Performance Standard</u></p>	<p align="center"><u>Achievement</u></p>
<p>Syphilis, HIV, Gonorrhea, and Chlamydia</p>	<p>100%: Meets Expectations < 100%: Does Not Meet Expectations</p>	<p>Syphilis:_____ % HIV:_____ % Gonorrhea:_____ % Chlamydia:_____ %</p>

Documentation of Field Records should be written in such a way that if the Field Record is reassigned or reinitiated the new CDS can proceed with minimal difficulty. In addition, the Field Record serves as a quasi-medical record, a worker activity/quality assurance document, a potential legal document (non-HIV/AIDS-related records are subpoenaable) and a historic locator.

SOURCE DOCUMENT: Interview Record (73.54)

COMPONENT # 5

<u>PERCENT PARTNER EXAMINATIONS (new investigations) WITHIN 3 WORKDAYS</u>	<u>Process Performance Standards</u>	<u>Achievement</u>
Syphilis Gonorrhea Chlamydia	<u>Partners to P&S, Gonorrhea/Chlamydia</u> ≥ 90%: Far Exceeds Expectations 80-89%: Exceeds Expectations 65-79%: Meets Expectations < 65%: Does Not Meet Expectations <u>Partners to Early Latent Syphilis</u> ≥ 80%: Far Exceeds Expectations 70-79%: Exceeds Expectations 60-69%: Meets Expectations < 60%: Does Not Meet Expectations	<u>Partners to P&S Syphilis</u> _____% within 3 workdays <u>Partners to Gonorrhea/Chlamydia</u> _____% within 3 workdays <u>Partners to EL Syphilis</u> _____% within 3 workdays
HIV (Client-referred partners should be initiated and investigated if failing to appear within 3 work days of the original interview.)	<u>Counseling/Testing:</u> ≥ 80%: Far Exceeds Expectations 70-79%: Exceeds Expectations 60-69%: Meets Expectations < 60%: Does Not Meet Expectations	<u>Counseling/Testing:</u> _____% within 3 workdays

Speed of investigations is imperative in a disease control program. CDS should evaluate and prioritize investigations where infections most probably will occur. Partners to infectious syphilis (primary and secondary) should command a higher priority than partners to early latent. For HIV, this component refers to counsel/testing rather than examination.

SOURCE DOCUMENT: Interview Record (73.54)

COMPONENT # 6

<p><u>TIME FROM INITIATION TO DOCUMENTATION OF 1st INVESTIGATION (Positive Tests)</u> Field investigations of positive tests for priority STDs should commence within 24 hours of Field Record initiation (or receipt date if initiated out of jurisdiction).</p>	<p><u>Process Performance Standards</u></p>	<p><u>Achievement</u></p>
<p>Syphilis, HIV (Field Records should be initiated if the HIV seropositive client does not return for test result within 3 workdays), Gonorrhea, Chlamydia</p>	<p><u>Investigations begun in:</u> ≤ 24 hours: Meets Expectations > 24 hours: Does Not Meet Expectations</p>	<p>Syphilis: _____ % ≤ 24 hrs. HIV: _____ % ≤ 24hrs Gonorrhea: _____ % ≤ 24hrs Chlamydia: _____ % ≤ 24hrs</p>

See discussions of Components # 4 and # 5.

SOURCE DOCUMENT: Field Record (73.2936)

COMPONENT # 7A (Public Health Clinic Patients)

PERCENT POSITIVE TESTS WITH PROPER FOLLOW-UP WITHIN 3 WORKDAYS OF INITIATION	Process Performance Standards	Achievement
Syphilis (subsequent exam, contact with physician, etc.)	≥ 95%: Far Exceeds Expectations 90-94%: Exceeds Expectations 80-89%: Meets Expectations < 80%: Does Not Meet Expectations	_____ % within 3 workdays
HIV (counseling, and referral to a medical provider) Gonorrhea and Chlamydia (treatment)	≥ 95%: Far Exceeds Expectations 85-94%: Exceeds Expectations 70-84%: Meets Expectations < 70%: Does Not Meet Expectations	HIV: _____ % within 3 workdays Gonorrhea: _____ % within 3 workdays Chlamydia: _____ % within 3 workdays

Proper follow-up for public syphilis reactors would include subsequent exam, and for public HIV positives, counseling and referral to a medical provider. Follow-up of women who have tested positive for either gonorrhea or chlamydia, and are untreated, should be a high priority because of the likelihood of PID.

SOURCE DOCUMENT: Field Record (73.2936)

COMPONENT # 7B (Non-Public Health Clinic Patients)

<u>PERCENT POSITIVE TESTS WITH PROPER FOLLOW-UP WITHIN 3 WORKDAYS OF INITIATION</u>	<u>Process Performance Standards</u>	<u>Achievement</u>
Syphilis (contact with physician, subsequent exam, etc.)	≥ 95%: Far Exceeds Expectations 90-94%: Exceeds Expectations 80-89%: Meets Expectations < 80%: Does Not Meet Expectations	_____ % within 3 workdays
HIV (counseling, and referral to a medical provider) Gonorrhea and Chlamydia, if assistance requested by private provider (treatment)	> 90%: Far Exceeds Expectations 85-89%: Exceeds Expectations 65-84%: Meets Expectations < 65%: Does Not Meet Expectations	HIV: _____ % within 3 workdays Gonorrhea: _____ % within 3 workdays Chlamydia: _____ % within 3 workdays

Proper follow-up for non-public syphilis reactors would include subsequent exam, contact with physician, etc. For non-public HIV positives, proper follow-up of referred patients would include counseling and necessary referrals. Follow-up of women who have tested positive for either gonorrhea or chlamydia, and are untreated, should be a high priority because of the likelihood of PID.

SOURCE DOCUMENT: Field Record (73.2936)

REFERENCE SECTION

This section is designed to provide essential reference information on a variety of topics that do not specifically apply to clinical and epidemiologic services. This includes administrative processes/forms and laws pertaining to sexual activity and sexually transmitted (venereal) diseases. For page numbers of specific items, refer to the Table of Contents in the front of the manual.

ORDERING STD FORMS

The following forms are to be ordered directly from Central Supply (see requisition on the next page):

CDC 73.2936 S	Field Record
CDC 73.2936 S	Buff Field Record
CDC 73.54	Interview Record
Form 3164 (Rev. 7-92)	STD Treatment and Medical Record

ORDERING PHARMACEUTICAL SUPPLIES

The following may be ordered from Public Health Pharmaceutical Supply:

<u>ITEM NUMBER</u>	<u>UNIT OF ISSUE</u>	<u>DESCRIPTION</u>
0500	EA	RPR Kits #115. Shipped each/by the kit.
0507	SR	Penicillin G Benzathine 1,200,000 U/ml Syringe Shipped by the syringe.
0514	PK	RPR Card Test Control, 10's. Shipped by the package.
0516	EA	RPR Antigen, 3 ml ampule. Shipped each.
0546	BT	Doxycycline capsules 100 mg, 14/BT, 250 BT/Case. Shipped by the bottle.
0560	VL	Ceftriaxone 250 mg/vial, 10 VL/box. Shipped by the vial. Requires <u>0.9 ml</u> of Lidocaine 1% or Bacteriostatic water per vial for reconstitution of powder. Provides two (125 mg) doses.
0561	VL	Bacteriostatic water for injection, <u>30 ml</u> multi-dose vial. Shipped by the vial. For use as a diluent.
0562	VL	Ceftriaxone 1 Gm/vial, 10 vials/box. Shipped by the vial. Requires <u>3.6 ml</u> of Lidocaine 1% or Bacteriostatic water per vial for reconstitution of powder. Provides eight (125 mg) doses.
0563	VL	Lidocaine 1% solution, <u>30 ml</u> multi-dose vial. Shipped by the vial. For use as a diluent.
0564	PK	Ofloxacin Tablets 400 mg, 100/pk, 10 strips of 10 unit dose tablets. Shipped by the pk.
0565	BX	Azithromycin single dose, 10/bx. Shipped by box of 10 doses only.

INSTRUCTIONS FOR ORDERING:

The items on the previous page must be ordered on a Public Health Pharmaceutical Supply Requisition (see next page) and mailed to:

Attn: Pharmacist
Division of Public Health
2 Peachtree Street, Room 7.205
Atlanta, Georgia 30303

For questions, please call: 404/657-2557

Please follow the GENERAL INSTRUCTIONS FOR ORDERING in the Pharmaceutical Supply catalog. Do not order the above items with other supplies.