FIRST LINE COMPREHENSIVE MANAGEMENT AND CONTROL OF SEXUALLY TRANSMITTED INFECTIONS (STIs)

Protocol for the management of a person with a Sexually Transmitted Infection

According to the Essential Drug List

“Edited” MARCH 2008
IMPROVE THE QUALITY OF STI SERVICES

Make services accessible and user friendly

- All PHC facilities should offer STI services during normal working times of the facility.
- Address the problem of long waiting times.
- Utilize waiting time for creative health promotion techniques.
- Consider extended hours if needed for your community so that patients can come after work or weekends.
- Promote integrated and comprehensive “one stop” services.
- Avoid stigmatizing patients with STIs: Avoid having services in a particular room or only on specific days or certain times.
- Ensure confidentiality at the point of registration. There is no need for disclosure at registration.
- Ensure positive and friendly attitude of all staff towards all patients/clients coming to your facility.
- Aim for adolescent friendly services where adolescents also receive education and counseling on life skills.
- Address barriers to attending your facility related to sex, race or age group.
- Public services at PHC level are free of charge.

Ensure regular supply of drugs and consumables, availability of equipment and improved infrastructure

- Avoid stock outs of essential drugs at any time: Cefixime, Ciprofloxacin, Doxycycline, Metronidazole, Benzathine-penicillin, erythromycin, Ceftriaxone, Clotrimazole, and Amoxicillin.
- Avoid stock out of condoms at any time.
- Avoid stock out of partner notification slips (English and Local language) at any time.
- Ensure availability of couch and couch covers (paper roll), examination light, examination torch, clinical thermometer, wash basing with running water and soap, specula sizes “small”, “medium”, “large”, gloves, condom box with condom, dildo (if female condom site: condom demonstrator and pamphlets, EDL PHC book, National Guidelines for First Line Comprehensive Management and Control of STIs, client education material (English and local language) and STI wall charts with treatment flow charts in each consultation room.
- Ensure privacy, consultation room to have doors and sufficient ventilation.
- Have access to equipment to sterilize speculae.

Ensure access to and availability of laboratory services and access control

- Avoid stocks out of on site or rapid test kit in use at your facility: for example HIV test, RPR test, new Treponema pallidum specific rapid test (if approved).
- Have standard operation manual available to all staff for each test kit available at your facility.
- Keep a record in a laboratory book of each test conducted at including result, unique laboratory number, date and name of person who has conducted the test.
- Agree and implement with the NHLS a regular scheme for external quality control of laboratory tests conducted at your facility.
- Routinely document and archive results of each round of external quality control, implement and document measures of improvement if recommended.
- Ensure regular transport to external laboratories and prompt communication to receive results
- Develop and make accessible to all staff standard operation manual for procedures to take specimen, to store them (if necessary), to send them out to external laboratories, to receive results, to follow up patients and to document.
- Document routinely turn-around time of laboratory results, agree with NHLS and local laboratories on turn-around targets for each test conducted externally and monitor the implementation of the targets.
Ensure well-functioning patient referral systems

- Strengthen your contact with the consulting doctor at your facility or at the next referral facility
- Establish and strengthen teamwork with the referral to (from) lay counselors, community health worker and other external service provider from the public and private sector
- Make referral criteria and procedure available to staff and ensure implementation
- Strengthen the routine of “in house” documentation of referrals and professional referral letters.
- Have national guidelines in place and develop “in-house” procedures for the management and referral of sexual violence, rape and child abuse
- Insist on report-back from all referral sites, follow up if necessary.
- Conduct team meetings with consulting doctors and all referral sites at regular intervals and ensure implementation of recommendation for improvement.
- Care and advocate for your patient and insist on good quality from all referral sites.

Develop communication skills and gain the trust of your patient

- Realise that the patient has come up with a problem which is of a very sensitive nature
- Welcome your patient, greet and offer him/her a seat
- Ensure privacy: make sure that the door is closed and that nobody enters during consultation. Sit at an appropriate distance to enable comfortable and private communication.
- Assure the patient that all information will be kept confidential
- Make eye contact, listen to and look at your patient as he/she speaks
- Manage patient in a caring, non-judgmental way
- Ask questions to understand the specific problems of the individual patient
- Be patient and remember that patients with an STI are often anxious and afraid due to the way in which STIs are acquired, because of the problems it might raise within his/her relationship and because of the risk of HIV infection
- Realise that for most patients it was not an easy decision to come by to you for help. Your attitude will determine to a great extent whether his/her visit was helpful

Monitor and evaluate your work

- Ensure proper record keeping (patient records, daily and month health statistics, store and drug management).
- Ensure timely submission (latest 7th day of following month) of monthly PHC form for the District Health Information System (DHIS).
- Display graphs of key performance indicators (incidence of STI treated new episode partner notification rate, STI partner tracing rate, condom distribution rate) at your facility.
- Discuss and agree on target for these indicators with all staff at your facility and with your district/sub-district coordinators. Monitor those targets on your graph with a target line
- Conduct quality assessment at your facility at regular intervals using the DISCA+ tool.
- Ensure that you receive performance summaries from all other facilities of your sub-district at regular intervals and discuss them amongst your staff.
- Listen to and address comments of patients and community members on their perception of the of your services.
- Conduct patient satisfaction surveys using standardized questionnaires at regular intervals and discuss results with community members and clinical staff
- Develop and agree with all staff an action plan based on you statistics and assessment in order to improve performance on a continuous basis and to achieve target
IDENTIFICATION & COMPREHENSIVE MANAGEMENT OF A PATIENT WITH A SYMPTOMATIC STI

Identification of a patient with an STI

- Patients with an STI are not always aware of their infection even when there are symptoms and/or signs
- Others might be aware, but are not concerned and would not visit a health facility specifically for this reason.

Given the high prevalence of STIs in the community and even more amongst the clients attending your facility, it is important for the control and appropriate management of STIs that symptoms and signs are actively identified amongst all clients in the sexually active age groups attending your facility. History taking and examination of all clients in the sexually active age group attending your facility should therefore include checking symptoms and signs of STI, irrespective of whether they come for antenatal care, family planning, VCT or other services!

Steps involved in the comprehensive management of a patient with an STI

Comprehensive Management of a patient with a symptomatic STI (overview)
- History taking
- Physical examination
- Screening of cervical cancer according to protocol
- Correct diagnosis
- Treatment using the syndromic approach or referral if indicated
- Health education
- Counseling
- VCT
- Partner notification and treatment
- Condom promotion, demonstration and provision
- Referral to other services as indicated (family planning, antenatal care, PMTCT, TB, HIV treatment and care etc.)
- Documentation (patient record, daily statistics)

Take a good history from your patient

- Good history is your guide for health education and counseling
- Add your communications skills
- Good history taking lest the patient talk, but without loosing focus
- Your structured approach and guiding questions will help you to achieve success with the 3 goals of history taking
  * To gain the patient's trust
  * To develop an initial understanding about the person and his or her problems
  * To gain specific information relevant for the diagnosis, therapy, assessment of potential complications and assessment of risk factors including risk behaviour.

Remember that the patient coming to your clinic may not spontaneously report STI symptoms. Also remember that a patient can have more than one STI at the same time.

- Include an assessment of the risk of exposure to an STI. There may be some other cause of the symptoms and signs
- It is important to find about:
  * The presenting complaint
  * Past STIs and if there has been any treatment recently
  * Other illness and drug allergies
  * Contraception, menstruation and symptoms of pregnancy
  * Risk factors
Physical examination: gently and with respect

Always examine your patient

- Conduct a bimanual examination in women to exclude cervical motion tenderness. Whenever possible do a speculum examination. Feel and view the cervix. If an abnormality is suspected, refer
- Identify one or more of the syndromes based on symptoms and signs and treat patients according to the appropriate protocol(s)
- Encourage the patient to return if the STI does not get better. If the full course has not been completed or if the re-infection is possible, treat once again before referring the patients
- Use this opportunity for the further prevention and control of the STIs

Laboratory examinations

All pregnant women are screened for syphilis during their first antenatal visit. The test most widely used in the RPR test. HIV testing should be promoted among all patients at your facility. Patients with a symptomatic STI who have a negative HIV result should have the test repeated after 3 months.

For all laboratory tests performed at your facility, a quality assurance schemes should be in place in collaboration with the NHLS. For CD4 count testing, consult the national VCT And HIV treatment guidelines. In case of symptoms and/or signs of any disease other than STI’s consult the appropriate guidelines.

Since the treatment of STIs is based on the syndromic approach, there is no need for any further routine laboratory tests for STIs as part of the first line management.

Diagnosis – The time for your decision

Good history taking is one half and good physical examination the other half of deciding the right diagnosis, it is now time for your decision. In the vast majority of clinical situation this decision will be straight forward.

Syndromic management of symptomatic STIs

The following (see next pages) national flow charts for the syndromic management of symptomatic STIs are based on the clinical, microbiological and epidemiological evidence from data available in South Africa, from international studies and recommendations of the WHO. The goal of the recommended first line treatment is to achieve a cure rate of 90%. Ongoing studies, clinical and microbiological surveillance as well as monitoring of drug resistance pattern will provide the basis for any future review as necessary.

All first line health service providers in public and private sector should adhere to these guidelines.
- It is the most feasible and cost effective first line management of STIs.

It is therefore important that all first line health service providers are familiar with the following flow chart. They provide an easy to use guide and should be available in each consultation room. They also provide clear indications when to refer to a doctor for second line STI treatment or other reasons.
MALE URETHRITIS SYNDROME (MUS)

Patient complains of urethral discharge or dysuria

- Take history and examine
- Milk urethra, if no visible discharge
- Emphasise HIV testing

Discharge and/or dysuria present?

- YES
  
  Treat with
  
  Cefixime, oral. 400 mg single dose**
  AND
  Doxycycline, oral. 100mg twice daily for 7 days

  Ask patient to return in 7 days if symptoms persist

- NO
  
  If symptoms persist

  Unprotected intercourse? Poor adherence?

- NO
  
  Ask patient to return in 7 days if symptoms persist

- YES
  
  Repeat treatment

  Improved?

- NO
  
  Treatment failure: Refer!

- YES
  
  Discharge patient

People who are penicillin allergic may also react to cephalosporins.

**If severe penicillin allergic, i.e. angioedema, anaphylactic shock or bronchospasm

Ciprofloxacin, oral, 500 mg single dose
If no response after 48 hours - refer
VAGINAL DISCHARGE SYNDROME (VDS)

Patients complain of abnormal vaginal discharge / dysuria or vulval itching / burning

Sexually active within the last 3 months?

- NO
- YES

Abnormal discharge or vulval itching / burning confirmed?

- NO
- YES

- Lower abdominal pain or pain on moving the cervix?

- NO
- YES

Use lower abdominal pain flowchart

Consider vaginal candidiasis and/or bacterial vaginosis.

- Metronidazole, oral, 2g immediately as single dose
  AND
- Clotrimazole vaginal pessary 500 mg inserted immediately as a single dose
  OR
- Clotrimazole vaginal cream, with applicator for 7 days, twice daily

Treat with

- Cefixime, oral, 400 mg single dose**
  AND
- Doxycycline, oral, 100mg 12 hourly for 7 days
  AND
- Metronidazole 2g immediately as a single dose

In pregnancy / during breast feeding

- Cefixime, oral, 400 mg single dose
  AND
- Amoxicillin, oral 500 mg 8 hourly for 7 days
  AND
- Metronidazole 2g immediately as a single dose

If Vulval oedema / curd-like discharge, erythema, excoriations present, treat for candidiasis by adding:

- Clotrimazole vaginal pessary 500 mg inserted immediately as a single dose
  AND
  - If Vulval irritation
    - Clotrimazole vaginal cream applied thinly to vulva twice daily and continue for 3 days after symptoms resolve. (Maximum 2 weeks)

Ask patient to return in 7 days if symptoms persist

Patient comes back after 7 days

- Unprotected intercourse?
- Poor adherence?

- NO
- YES

Repeat treatment

Treatment failure: Refer!

People who are penicillin allergic may also react to cephalosporins.

**If severe penicillin allergic, i.e. angioedema, anaphylactic shock or bronchospasm
Ciprofloxacin, oral, 500 mg single dose
If no response after 48 hours - refer

Pregnant and penicillin allergic: Replace Amoxicillin, oral with Erythromycin, oral, 500mg qid x 7 days.
LOWE ABDOMINAL PAIN (LAP)

Sexually active patient complains of lower abdominal pain with or without vaginal discharge

Take history (including gynaecological) and examine (abdominal and vaginal). Emphasise HIV testing

Any of the following present?
- Pregnancy
- Missed/Overdue period
- Recent delivery, abortion or miscarriage
- Abdominal guarding and/or rebound tenderness
- Abnormal vaginal bleeding
- Abdominal mass
- Fever > 38°C

Refer all patients for gynaecological or surgical assessment

SEVERELY ILL PATIENTS
Set up an IV line and treat shock if present. If referral is delayed > 6 hours give:
- Ceftriaxone, IV, 1 g PLUS
- Metronidazole, oral 400 mg.

Lower abdominal tenderness with or without vaginal discharge

Nitrites in urine and no cervical motion tenderness?

YES → Treat as a UTI

NO → Treat with:
- Ceftriaxone, IM, 250 mg single dose**
  AND
- Doxycycline, oral, 100 mg 12 hourly for 14 days
  AND
- Metronidazole, oral, 400 mg 12 hourly for 14 days

Review in 2 to 3 days or earlier if no improvement

Improved?

YES: Complete treatment

People who are penicillin allergic may also react to cephalosporins.

**If severe penicillin allergic, i.e. angioedema, anaphylactic shock or bronchospasm
Ciprofloxacin, oral, 500 mg 12 hourly for 3 days.

Advise patient to return if no improvement within 2 to 3 days referral

Pregnant / Breastfeeding, refer.
Patient complains of genital sore or ulcer with/without pain.

Take sexual history and examine. Emphasise HIV testing

Sexually active within the last 3 months?

YES

Consider genital herpes. Emphasise HIV testing

Treat with:

- Acyclovir, oral, 400 mg 8 hourly for 7 days

NO

Treat with:

- Benzathine, Penicillin**, im, 2.4 MU immediately as a single dose
- Erythromycin, oral 500 mg 6 hourly for 7 days
- Acyclovir, oral, 400 mg 8 hourly for 7 days
- Pain relief if indicated
- Review after 7 days or earlier if necessary

Ulcer(s) healed or clearly improving?

NO

Re-emphasise HIV testing if no improvement, refer!

YES

Discharge patient

People who are penicillin allergic.

**If severe penicillin allergic, i.e. angioedema, anaphylactic shock or bronchospasm.

Non Pregnant females and males: Replace Benzathine Penicillin with doxycycline 100mg b.d x 14 days

Pregnant women: Increase to Erythromycin 500mg qid x 14 days
Sexually active patient complains of scrotal swelling/pain

Take history and examine. Emphasize HIV testing.

Scrotal swelling or pain confirmed?

YES

Testes rotated and elevated or history of trauma or other nontender swelling not thought to be due to sexual activity?

YES

Refer for surgical opinion

Refer urgently if suspected torsion!

NO

Treat with:
- Ceftriaxone, im, 250 mg single dose** AND
- Doxycycline, oral, 100 mg 12 hourly for 14 days

Review after 7 days or earlier if necessary

NO

Improved?

YES

Complete treatment and discharge patient

NO

People who are penicillin allergic may also react to cephalosporins.

**If severe penicillin allergic, i.e. angioedema, anaphylactic shock or bronchospasm
Ciprofloxacin, oral, 500 mg 12 hourly for 3 days
If no response after 48 hours - refer
BALANITIS / BALANOPOSTHITIS (BAL)

- Patient complains of soreness/itching of glans, inability to retract foreskin, malodour

  - Take history and examine
  - Emphasise HIV testing

  - Foreskin cannot be retracted
    - Complicated case: Refer!

  - Retract foreskin, clean with water filled syringe and dry

  - Re-examine

  - Symptoms confirmed?
    - YES
      - Treat with:
        - Instruct on retraction of foreskin when washing
        - Wash daily with water avoid soap while inflamed
        - Clotrimazole cream 2x daily for 7 days
        - Perform urinalysis for glycosuria. If positive, refer.
        - Ask patient to return in 7 days if symptoms persist

    - NO
      - Treatment failure: Refer!

  - Patient comes back after 7 days

    - Poor adherence to clotrimazole?
      - NO
        - Treatment failure: Refer!
      - YES
        - Repeat treatment
BUBO

Patient complains of hot tender inguinal swelling with surrounding erythema and/or oedema

Take history and examine. Encourage HIV testing. Exclude hernia or femoral aneurysm.

Bubo confirmed?

YES

Treat with

- **Doxycycline**, oral, 100 mg 12 hourly for 14 days
  
- **Ciprofloxacin**, oral, 500 mg 12 hourly for 3 days

IN PREGNANCY/DURING BREAST FEEDING, replace the above with:

- **Erythromycin**, oral, 500 mg 6 hourly for 14 days

If bubo is fluctuant:

Aspirate pus in a sterile manner. (Check policy) Repeat every 72 hours as necessary

If ulcer also present:

Add Acyclovir, Oral, 400mg 8 hourly for 7days
Perform RPR/VDRL if indicated
sexual assault case
suspected secondary syphilis
suspected tertiary syphilis
3 months follow-up of recently treated early syphilis case

RPR/VDRL positive

RPR/VDRL negative

YES

YES

NO

NO

YES

Discharge

symptoms/signs of gential ulcer or secondary syphilis present?

YES

NO

Last RPR/VDRL less than 2 years ago?

YES

NO

Current RPR/VDRL is 4 fold or more higher than the previous RPR/VDRL e.g. was 1:8 now 1:32 or higher

Current RPR/VDRL is 4 fold lower, or in a known serofast patient, is the same, lower or no more than 2 fold higher than the previous RPR/VDRL, e.g. was 1:4 now no more than 1:8

Treat as early syphilis
Benzathine penicillin 2.4 MU im immediately as a single dose

Treat as late syphilis
Benzathine penicillin 2.4 MU im once weekly for 3 weeks

Treat as early syphilis
Benzathine penicillin 2.4 MU im immediately as a single dose

Treat as late syphilis
Benzathine penicillin 2.4 MU im once weekly for 3 weeks

rules out secondary/tertiary syphilis
repeat RPR/VDRL in 3 months only in sexual assault cases
indicates cure in previously treated syphilis case

YES

NO

YES

NO

YES

NO

YES

NO

YES

NO

YES

NO
**Drug Treatment of more than one STI syndrome**

<table>
<thead>
<tr>
<th>STI Syndromes</th>
<th>Drug Treatment</th>
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</thead>
<tbody>
<tr>
<td><strong>MUS + SSW</strong></td>
<td>Treat according to SSW flow chart</td>
</tr>
</tbody>
</table>
| **MUS + BAL**                  | Treat according to MUS flow chart  
Plus  
Clotrimazole cream 2 x daily for 7 days                                        |
| **MUS + GUS**                  |  
- Cefixime 400mg p.o. stat plus  
- Benzathine penicillin* 2.4 mu im stat plus  
- Erythromycin, oral, 500mg 6 hourly for 7 days plus  
- Acyclovir, oral, 400mg 8 hourly for 7 days                                        |
| **VDS + LAP**                  | Treat according to LAP flow chart  
Plus  
Treat for candidiasis, if required                                                |
| **VDS + GUS (non-pregnant)**   |  
- Cefixime 400mg p.o. stat plus  
- Metronidazole 2g p.o. stat plus  
- Benzathine penicillin* 2.4 MU imi stat plus  
- Erythromycin, oral, 500mg 6 hourly for 7 days plus  
- Acyclovir, oral, 400mg 8 hourly for 7 days plus  
- treat for candidiasis, if required                                               |
| **VDS + GUS (pregnant, breastfeeding)** |  
- Cefixime 400mg p.o. stat plus  
- Metronidazole 2g stat plus  
- Benzathine penicillin* 2.4 MU imi stat plus  
- Erythromycin, oral, 500mg 6 hourly for 7 days plus  
- Acyclovir, oral, 400mg 8 hourly for 7 days plus  
- treat for candidiasis, if required                                               |
| **SSW / LAP + GUS**            |  
- Ceftriaxone 250mg imi stat plus  
- Metronidazole 400mg 2 daily x for 14 days plus  
- Erythromycin, oral, 500mg 6 hourly for 14 days plus  
- Acyclovir, oral, 400mg 8 hourly for 7 days                                        |

**Penicillin allergic men and non pregnant women, replace benzathine penicillin with:**
- Doxycycline, oral, 100mg 12 hourly for 14 days

**Penicillin allergic pregnant or breast feeding women, replace benzathine penicillin and amoxicillin with:**
- Erythromycin, oral 500mg 6 hourly for 14 days

**NB:** Erythromycin covers Chancroid / LGV, Chlamydial Urethritis and Cervicitis
Genital Warts (code GW): Condylomata Acuminata

Description
The clinical signs are:
- Warts on the ano-gential areas, vagina, cervix, meatus or urethra
- They can be soft or hard

Non-drug treatment
RPR to exclude secondary syphilis which may present with similar lesions
Encourage HIV testing

Treatment
Soft warts (<10mm)
- Tincture of podophyllin solution 20%, applied at weekly intervals to the lesions at the clinic by a health care professional until lesions disappear.
- Apply petroleum jelly to the surrounding skin for protection.
- Wash the solution off after 4 hours.
- If lesions do not improve after 5 treatments, refer.
- Podophyllin is cytotoxic agent. Avoid systematic absorption.
- Contraindicated in pregnancy. Exclude pregnancy before using podophyllin.

Referral
All patients with:
- Hyper-keratinised wart warts
- Warts larger than 10mm
- Inaccessible warts, e.g. intra vaginal or cervical warts
- Pregnant women
- Non-responding soft warts

Pubic Lice (code PL)

Description
Infestation of lice mostly confined to pubic and peri-anal areas, and occasionally involves eyelashes. The bites cause intense itching which often result in scratching with bacterial super infection

Non-drug Treatment:
Clothing and bed linen that may have been contaminated by the patient in the 2 days prior to start of treatment should be thoroughly washed in hot water and then ironed.

Drug treatment
- Benzyl benzoate 25%, applied to affected area
- Leave this on for 24 hours, then wash thoroughly
  Repeat in days

Pediculosis of the eyelashes or eyebrows
- Petroleum jelly applied to the eyelid margins daily for 10 days to smother lice and nits
  Do not apply to eyes

Referral
- All children with lice on eyelashes to exclude sexual abuse

Genital MOLLUSCUM CONTAGIOSUM (code MC)

Description
This viral infection can be transmitted sexually and non-sexually.
It is usually self limiting but can be progressive in an advance stage of immunodeficiency.
Clinical signs are papules at the genitals or other parts of the body
Usually, the papules have a central dent (umbilicated papules)

Drug treatment
Tincture of iodine, apply with an applicator to the core of lesions
# TREATMENT OF ASYMPTOMATIC PARTNERS

<table>
<thead>
<tr>
<th>Female Patient</th>
<th>Male Partner</th>
<th>Male Patient</th>
<th>Female Partner</th>
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<tbody>
<tr>
<td>VDS</td>
<td>MUS plus metronidazole 2 g stat</td>
<td>MUS</td>
<td>VDS</td>
</tr>
<tr>
<td>LAP</td>
<td>MUS plus metronidazole 2 g stat</td>
<td>SSW</td>
<td>VDS</td>
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<tr>
<td>GUS</td>
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<td>BAL</td>
<td>Cotrimazole vaginal pessary 500mgs inserted stat 2</td>
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<tr>
<td>GW</td>
<td>GW if signs</td>
<td>GUS</td>
<td>GUS</td>
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<tr>
<td>PL</td>
<td>PL</td>
<td>GW</td>
<td>GW if signs</td>
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<tr>
<td>MC</td>
<td>MC if signs</td>
<td>PL</td>
<td>PL</td>
</tr>
<tr>
<td>RPR+</td>
<td>Benzathine Penicillin 2.4mu im stat in addition RPR test</td>
<td>MC</td>
<td>MC if signs</td>
</tr>
</tbody>
</table>

_In addition:_ treat any symptomatic STI

RPR+ Benzathine Penicillin 2.4mu im stat in addition to RPR test
SYPHILIS SCREENING OF PREGNANT WOMEN

All pregnant women at first antenatal visit

Take history and examine, explain need for syphilis screening, do pre-test counselling for HIV

Take blood for RPR test (always), for HIV test (if consent), and for other ANC routines

- Any STI syndrome or illness
- Syphilis test positive?
- HIV test positive?

YES

YES

NO

YES

Repeat HIV test after 3 months

Use appropriate flowchart, manage appropriately

Post test counselling, PMTC

Treat pregnant woman with:

- Benzathine Penicillin 2.4 MU imi once weekly for 3 weeks
- Erythromycin 500 mg 4 x daily for 4 weeks (28 days)

Treat all symptomatic newborns of mothers with positive RPR test during pregnancy with:

- Benzathine Penicillin 50 000 IU / kg imi stat
- Symptomatic newborns (congenital syphilis):
  - Notify (Notification of Medical conditions Form GW17/5)
  - Refer to doctor

ALL PREGNANT WOMEN:

- Educate, ensure compliance and counsel; promote couple-counselling if applicable
- Explain the risk of vertical transmission
- Promote consistent condom use particularly during pregnancy, demonstrate condom use, provide condoms
- Stress the importance of partner treatment, issue one notification slip for each sexual partner
- Promote HIV counselling and testing of partner
**NEONATAL CONJUNCTIVITIS**

Neonate with eye discharge

Take history and examine

Swollen eyelid(s) with purulent discharge?

- **YES**
  - Treat baby with:
    - Ceftriaxone 50 mg/kg imi stat (maximum 125 mg)
    - Erythromycin Syrup 50 mg/kg/day in four divide doses for 14 days
  - Treat with:
    - Mother: Cefixime, oral, 400 mg stat AND Erythromycin, oral, 500 mg 4 x daily for 7 days
    - Father/Partner: Cefixime, oral, 400 mg stat, Doxycycline, oral, 100 mg 2 x daily for 7 days
  - Review baby in 2 days (or earlier if necessary)

- **NO**
  - Reassure mother
  - Advise to return if necessary

Improved?

- **YES**
  - Finalise treatment
  - Reassure mother
- **NO**
  - Complicated case: Refer to doctor!
    - Reassure mother

**PARENTS OF BABY WITH CONFIRMED NEONATAL CONJUNCTIVITIS**

- Educate, ensure compliance and counsel; promote couple-counselling if applicable
- Promote abstinence from penetrative sex during the course of treatment
- Promote and demonstrate condom use, provide condoms
- Stress the importance of partner treatment, issue one notification slip for each sexual partner follow up partner treatment during review visit!
- Promote HIV counselling and testing, for negative results repeat test after 3 months
ANAPHYLAXIS PROTOCOL

Before administrating drugs or injections, ask your patients about previous allergies to drugs. A rash after previous treatment may be a warning sign.

Signs of possible anaphylaxis:
- Shock
- Difficulty in breathing
- Rash (may be present)

If signs of anaphylaxis confirmed, do the following:

1. Call for help – preferably a doctor

2. Check ABC

- Airway
- Breathing: give mouth to mouth respiration
- Circulation: do CPR if necessary

3. If anaphylaxis give adrenaline subcutaneously

- Site
- Dosage: Adult 0.5 ml
  Children over 3 years 0.2 – 0.3 ml
  Children under 3 year 0.1 ml
  Elderly 0.3 ml

4. Put up an intravenous infusion as soon as possible

- Normal saline run in according to blood pressure response
- Give Adrenaline diluted in 10 ml sterile water slowly
- Dosage: Adult 5 ml
  Children over 3 years 2 – 3 ml
  Children under 3 years 1 ml
  Elderly 3 ml

Heart rate not to exceed 160 beats per minute