DST-1002 Treatment of STI Contacts

This decision support tool (DST) provides RN(C)s[1] with clinical guidance for treatment of clients who are contacts to an STI and require treatment with schedule 1 medications. STIs described in both the certified practice and non-certified practice DSTs are included in this DST.

Refer to the corresponding infection-specific certified and/or non-certified practice *STI DST* to ensure the client has received the recommended sexual health history/risk assessments, education and, if appropriate, screening. For symptomatic clients who are contacts to an STI, refer to the appropriate *STI DST* to determine if consultation with or referral to a physician or nurse practitioner (NP) is required based on DST recommendations, assessment and diagnostic findings.

Consultation with or referral to a physician or NP is required for all pregnant clients and may be required for breast-/chest-feeding clients depending upon the recommended treatment. Refer to the specific *STI DST* for further information.

BCCNP *STI DSTs* are not indicated for clients who are less than 12 years old and RN(C)s must follow the *PHSA Pelvic Exam DST* (indicated for clients aged 14 years and up) when providing STI care (see the *STI Assessment DST* for further screening and treatment recommendations). Clients 12-13 years of age who are symptomatic require consultation with or referral to a physician or NP.

DEFINITION

The process of offering testing and treatment to the sexual contacts of a person diagnosed with an STI or STI syndrome.

POTENTIAL CAUSES

Bacterial:

- Neisseria gonorrhoeae (GC)
- Chlamydia trachomatis (CT)
- Bacterial Vaginosis (BV)
- Treponema pallidum (syphilis)

Protozoan:

- Trichomonas vaginalis (TV)

Syndromes:

- urethritis
- mucopurulent cervicitis (MPC)
- pelvic inflammatory disease (PID)
- epididymitis
- proctitis

PREDISPOSING RISK FACTORS

- sexual contact with someone with an STI
- vaginal, anal or oral sexual contact

[1] Note: RN(C) is an authorized title recommended by BCCNP that refers to BCCNP-certified RNs, and is used throughout this Decision Support Tool (DST).

STI CONTACT ASSESSMENT

Offer full comprehensive STI assessment and screening. If declined, provide treatment appropriate to the type of contact and/or symptoms. See the *STI Assessment DST* for further information.

Sexual Health History

- complete a sexual health history and risk assessment – typical findings include:
  - sexual contact with at least one partner
  - identified as a sexual contact to someone with confirmed positive laboratory test for STI
  - identified as a sexual contact to STI syndrome (e.g., urethritis NYD)

Physical Assessment

- offer focused physical assessment
- if symptoms present, refer to the corresponding *STI DST*, and consult with or refer to physician or NP as needed

SCREENING DIAGNOSTIC TESTS

- provide screening and diagnostic testing for STI contact based on the type of exposure and presenting symptoms

MANAGEMENT AND INTERVENTIONS

Goals of Treatment

- treat potential infection
- prevent potential complications due to untreated or undiagnosed infection
- prevent the spread of infection

TREATMENT OF CHOICE FOR STI CONTACTS

The treatment required for an STI contact may differ from treatment provided for the index case. When recommended treatment for the contact is the same as the index, refer to the specific *STI DST* for information regarding treatment options including pharmaceutical and therapeutic suitability.

STI or Syndrome	Contact Management and Trace Back Period	Treatment of Contact	Notes
Bacterial Vaginosis (BV)	• offer assessment to all applicable contacts • treatment of male contacts is not indicated and does not prevent recurrence	See *Bacterial Vaginosis DST*.	1. There may be an increased incidence of concordant BV infection in sexual partnering and/or sexual behaviours where BV could flourish. 2. Where relevant, sexual partners of people diagnosed with BV may benefit from assessment and testing for BV. If clinical assessment and/or lab testing results are positive for BV, then treat as per the *BV DST*. 3. Refer to the *BV DST* for client education, screening recommendations, alternate treatments and further medication information.
Chlamydia (CT)	60 days • test and treat all contacts in the last 60 days • if there are no sexual contacts in the last 60 days, then recommend testing and treatment for the last sexual contact	See *Chlamydia DST*.	1. Advise to abstain from sexual activity during the 7-day course of treatment or for 7 days post-single-dose therapy. 2. Refer to the *CT DST* for client education, screening recommendations, alternate treatments and further medication information.
Lympho-granuloma venereum (LGV)	60 days • test and treat all contacts in the last 60 days • if there are no sexual contacts in the last 60 days, then recommend testing and treatment for the last sexual contact	**First Choice:** doxycycline 100 mg PO BID for 21 days **Alternate Choice:** Consult with or refer to physician or NP.	1. Empiric LGV treatment is recommended for all partners of confirmed or probable cases. Completion of treatment is recommended regardless of results. 2. Contacts should abstain from sexual activity for 7 days after initiation of treatment. 3. Testing of all exposed sites (e.g., throat, suspicious lesions, urine, vagina, cervix, rectum) is recommended. Indicate "contact to LGV" on requisition. 4. Consult with or refer to physician or NP if client is symptomatic, and all confirmed cases. 5. For confirmed LGV cases, please contact the Provincial STI Clinic's syphilis/LGV nursing desk (604.707.5607) for further management.

STI or Syndrome	Contact Management and Trace Back Period	Treatment of Contact	Notes
Gonorrhea (GC)	60 days • test and treat all contacts in the last 60 days • if no sexual contacts in the last 60 days then recommend testing and treating the last sexual contact	**First Choice:** cefixime 800 mg PO in a single dose and azithromycin 1 gm PO in a single dose OR ceftriaxone 250 mg IM in a single dose and azithromycin 1 gm PO in a single dose **Second Choice:** cefixime 800 mg PO in a single dose and doxycycline 100 mg PO BID for 7 days OR ceftriaxone 250 mg IM in a single dose and doxycycline 100 mg PO BID for 7 days **Third Choice** azithromycin 2 gm PO in a single dose	**General:** 1. Treatment covers both gonorrhea and chlamydia. 2. *Canadian Guidelines for STI* (CGSTI, PHAC, 2013) recommend ceftriaxone IM and azithromycin PO for the treatment of uncomplicated anogenital and pharyngeal infection; however BC surveillance patterns of GC resistance suggest that both cefixime and ceftriaxone are appropriate choices for the treatment of GC. 3. Future GC Treatment regimens will continue to reflect national recommendations in association with local GC antimicrobial resistance trends (AMR) trends. 4. Retreatment is indicated if the client has missed 2 consecutive doses of doxycycline or has not completed a full 5 days of treatment. 5. Consult a physician or NP if client is unable to use cefixime, ceftriaxone, or azithromycin. 6. See BCCDC *STI Medication Handouts* for further medication reconciliation and client information. 7. See *Monitoring and Follow-up* section for test-of-cure (TOC) requirements. **Allergy and Administration:** 8. DO NOT USE ceftriaxone or cefixime if history of allergy or anaphylaxis to cephalosporins. Consult with or refer to a physician or NP if history of anaphylaxis or immediate reaction to penicillins. 9. DO NOT USE azithromycin if history of allergy to macrolides. 10. DO NOT USE doxycycline if pregnant and/or allergic to doxycycline or other tetracyclines. 11. If an azithromycin or doxycycline allergy or contraindication exists, consult with or refer to a physician or NP for alternate treatment. 12. Azithromycin and doxycycline are sometimes associated with gastrointestinal adverse effects. Taking medication with food and plenty of water may minimize adverse effects. 13. The preferred diluent for ceftriaxone IM is 0.9 mls lidocaine 1% (without epinephrine) to minimize discomfort.

STI or Syndrome	Contact Management and Trace Back Period	Treatment of Contact	Notes
			14. DO NOT USE lidocaine if history of allergy to lidocaine or other local anaesthetics. Use cefixime PO as alternate treatment. 15. For IM injections of ceftriaxone the ventrogluteal site is preferred. 16. Advise client to remain in the clinic for at least 15 minutes post-IM injection in case of anaphylactic reaction to treatment. Provide anaphylaxis treatment as required, using BCCDC Immunization Manual- Section V- Management of Anaphylaxis in a Non-Hospital Setting BCCDC, April 2013. 17. If serious allergic reaction develops including difficulty breathing and/or severe itchiness, have the client inform clinic staff immediately. If symptoms develop after leaving the clinic, advise the client to seek immediate emergency care. 18. Advise client they may experience pain, redness and swelling at the injection site. If any of these effects persist or worsen advise to contact health care provider. 19. Recent data has emerged regarding azithromycin and QT prolongation. Although rare, it is more significant in older populations, those with pre-existing heart conditions, arrhythmias or electrolyte disturbances. It is unclear how significant these findings are in young to mid-age healthy adults consuming a one-time dose of azithromycin; however, please use the following precautions: Consult with or refer to an NP or physician if the client: ○ has a history of congenital or documented QT prolongation. ○ has a history of electrolyte disturbance in particular hypokalemia, hypomagnesaemia. ○ has clinically relevant bradycardia, cardiac arrhythmia or cardiac insufficiency. ○ is on any of the following medications: ○ Antipsychotics: pimozide (Orap®), ziprasidone (Zeldox®) ○ Cardiac: dronedarone (Multaq®)

STI or Syndrome	Contact Management and Trace Back Period	Treatment of Contact	Notes
			○ Migraine: dihydroergotamine (Migranal®), ergotamine (Cafergot®) 20. Refer to the *GC DST* for client education, screening recommendations, alternate treatments and further medication information.
Epididymitis **Mucopurulent Cervicitis (MPC)** **Pelvic Inflammatory Disease (PID)** **Proctitis**	**60 days** • test and treat all contacts in the last 60 days • if no sexual contacts in the last 60 days then testing and treatment of the last sexual contact is recommended	See *Treatment for Contacts to Gonorrhea* section within this DST.	1. Treatment covers potential gonorrhea and chlamydia infection. 2. See *Notes* section under *Contacts to Gonorrhea* section within this DST. 3. Refer to the relevant DST (e.g., *Epididymitis DST*, *MPC DST*, *PID DST*, *Proctitis DST*) for client education, screening recommendations, alternate treatments and further medication information.
Early Syphilis: **Primary Syphilis** **Secondary Syphilis** **Early Latent Syphilis (asymptomatic infection of < one year's duration)**	**For contacts to Primary Syphilis:** • test and treat all contacts within last 90 days **For contacts to Secondary Syphilis:** • test all contacts within last 6 months • test and treat all contacts within last 90 days **For contacts to Early Latent Syphilis:** • test all contacts within last 12 months or as directed by BCCDC physician • test and treat all contacts within 90 days	**First Choice:** benzathine penicillin G (Bicillin LA®) 2.4 MU prepared as 2 separate intramuscular injections (IM) 1.2 MU each **Second Choice:** **Consider for clients with penicillin allergy or who require alternate treatment (e.g., Bicillin L.A.® is unavailable and client follow-up is not assured).* doxycycline 100 mg PO BID for 14 days	**General:** 1. Contact the BCCDC CPS STI nurse responsible for contact follow-up strategy. Syphilis case management is centralized through the BCCDC. 2. Advise clients to abstain from sexual contact for the duration of oral therapy or for 14 days post-treatment for single-dose therapy. 3. If syphilis serology confirms infection, refer to *Syphilis DST* and contact the BCCDC CPS STI nurse responsible for syphilis contact follow-up strategy. 4. If the client declines treatment and initial testing is negative, repeat syphilis screening in 3 months. 5. Refer to the *Syphilis DST* for client education, screening recommendations, alternate treatments and further medication information. **Allergy and Administration:** 6. DO NOT USE Bicillin LA® if history of allergy, anaphylaxis or immediate reaction to penicillins.

STI or Syndrome	Contact Management and Trace Back Period	Treatment of Contact	Notes
Late Latent Syphilis **(asymptomatic infection > one year's duration)**	**Test (do not treat) contacts to latent syphilis:** all long term sexual contacts; and children whose mother has a late latent syphilis diagnosis	Treat only if serology is reactive.	7. Administer Bicillin LA® into the ventral (preferred) or dorsal gluteal sites on the same visit, at 2 separate sites. (See here) 8. Provide client education about the potential for a Jarisch-Herxheimer reaction which may occur soon after treatment and is expected to resolve within 24 hours. This is not a sign of a drug allergy. 9. If syphilis serology is confirms infection, refer to *Syphilis DST* and contact the BCCDC CPS STI nurse responsible for syphilis contact follow-up strategy. Syphilis case management is centralized in BC through the BCCDC. 10. Refer to the *Syphilis DST* for client education, screening recommendations, alternate treatments and further medication information.
Trichomoniasis	**60 days** • treat all contacts in the last 60 days • testing is also offered to certain contacts within the past 60 days as per *Trichomoniasis DST* • if no sexual contacts in the last 60 days then recommend treatment of the last sexual contact	See *Trichomoniasis DST*.	1. Advise to abstain from sexual contact until completion of multi-dose treatment or for 7 days after single-dose therapy. 2. Refer to the *Trichomoniasis DST* for client education, screening recommendations, alternate treatments and further medication information.
Urethritis – presumptive Gonorrhea	**60 days** • test and treat all contacts case in the last 60 days • if no sexual contacts, then testing and treatment of the last sexual contact is recommended	See *Treatment for Contacts to Gonorrhea* section within this DST.	1. Treatment covers potential gonorrhea and chlamydia infection. 2. See *Notes* section under *Contacts to Gonorrhea* section within this DST. 3. Refer to the *GC DST* for client education, screening recommendations, alternate treatments and further medication information.
Non-gonococcal Urethritis (NGU)	**60 days** • test and treat all contacts in the last 60 days • if no sexual contacts then testing and treatment of the last sexual contact is recommended	See *Treatment for Contacts to Chlamydia* section within this DST.	1. Treatment covers potential chlamydia infection. 2. See *Notes* section under *Contacts to Chlamydia* section within this DST. 3. Refer to the *CT DST* for client education, screening recommendations, alternate treatments and further medication information.

CLIENT EDUCATION

Counsel client regarding:

- returning for follow-up assessment if symptoms occur.
- the appropriate use of medications (dosage, side effects, and need for re-treatment if dosage not completed, or symptoms do not resolve).
- avoiding sexual contact until treatment is completed as indicated in the treatment table.
- harm reduction (condom use significantly reduces the risk of transmission).
- cleaning sex toys between use and using condoms if sharing sex toys
- the benefits of routine STI screening.
- the potential complications of untreated STI.
- co-infection risk for HIV when another STI is present.
- the asymptomatic nature of STI.

DOCUMENTATION

- as per agency policy

REFERENCES

More recent editions of any of the items in the reference list may have been published since this DST was published. If you have a newer version, please use it.

Australasian Sexual Health Alliance (ASHA). (n.d.). *Australian STI management guidelines for use in primary care*.

British Association for Sexual Health and HIV (BASHH). (n.d.). *BASHH guidelines*.

Barbee, L.A., Kerani, R.P., Dombrowski, J.C., Soge, O. & Golden, M.R. (2013). A retrospective comparative study of 2-drug oral and intramuscular cephalosporin treatment regimens for pharyngeal gonorrhea. *Clinical Infectious Diseases*, 56(11), pp.1539-1545.

British Columbia Centre for Disease Control (BCCDC). (2014). *British Columbia treatment guidelines: Sexually transmitted infections in adolescent and adults*. STI/HIV Prevention and Control Division, BCCDC.

BCCDC Public Health Laboratory (BCCDC PHL). (2016). *Laboratory trends*. Vancouver, BC.

Briggs, G.G., Freeman, R.K. & Yaffe, S.J. (2001). *Drugs in pregnancy and lactation: A reference guide to fetal and neonatal risk*. 6th ed. Philadelphia: Lippincott Williams & Wilkins.

Centers for Disease Control and Prevention (CDC). (2015). *2015 Sexually transmitted diseases treatment guidelines*.

Forcey, D.S., Vodstrcil, L.A., Hocking, J.S., Fairley, M.L., McNair, R.P. & Bradshaw, C.S. (2015). Factors associated with bacterial vaginosis among women who have sex with women: A systematic review. *PLoS One* **10**(12): e0141905-e0141905.

Holmes, K., Sparling, P., Stamm, W., Piot, P., Wasserheit, J., Corey, L., Cohen, M. & Watts, H. (2008). Sexually transmitted disease (4th ed). Toronto, ON: McGraw Hill Medical.

Hottes, T.S., Lester, R.T., Hoang, L., McKay, R., Gilbert, M., Patrick, D.M., Wong, T., Martin, R. & Ogilvie, G. (2013). Cephalosporin and azithromycin susceptibility in *Neissieria gonorrheoeae* isolates by site of infection, British Columbia, 2006 to 2011. *Sexually Transmitted Diseases*, 40(1), pp.46-51.

Public Health Agency of Canada (PHAC). (2012). *Canadian guidelines on sexually transmitted infections*.

PHAC. (2017). 2016 Updates summary. In: *Canadian guidelines on sexually transmitted infections*.

PHAC. (2017). Supplementary statement for the management of Lymphogranuloma venereum (LGV) cases and contacts. In: *Canadian guidelines on sexually transmitted infections*.

Society of Obstetricians and Gynecologists. (SOGC). (2008). Screening and management of bacterial vaginosis in pregnancy. *JOGC*, 211, pp.702-708.