

PUBLIC HEALTH

NURSING PROTOCOL

Tennessee Department of Health
Bureau of Health Services
Patient Care Services
Revised 12/10

PREFACE

A protocol represents delegated medical management. The Public Health Nursing (PHN) Protocols, establish standard of care for the general Public Health Nurse practicing at the local level in rural and Metro Public Health Departments. The PHN Protocol was developed, and is maintained, by the Public Health Nursing Practice Committee. These Protocols represent an enormous amount of work from a variety of nurses, physicians and other staff throughout the State. They have been reviewed by the State Medical Director, State Nursing Director, Medical Services Evaluation Committee, and specific individuals that are involved in developing Program guidelines that impact nursing practice.

The manual is divided into seven distinct sections. **Section I.** includes those protocols related to **Emergency Management.** **Section II.** includes those protocols related to **Family Planning.** **Section III.** is the **General section.** It covers treatments for various conditions that are not included in the other distinct sections. This section also includes recommended periodicity schedules for maintenance of health for both adults and children. **Section IV.** includes the **Immunization** protocols. **Section V.** includes those protocols related to **Sexually Transmitted Diseases.** **Section VI.** includes protocols related to **Disaster Preparedness and Bioterrorism.** Finally, an **Appendix** section (**section VII.**), includes additional program specific information and the **List of Standard Abbreviations.**

As always, we welcome your comments and suggestions with regards to additions, revisions, format changes etc. It is our goal to maintain an accurate, viable, and user friendly document.

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Staff Support
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PUBLIC HEALTH NURSING PROTOCOL AGREEMENT

Region _____

County/Site _____

This protocol has been jointly prepared by public health nurses and physicians and is approved for use by all licensed nurses. The health providers whose names are signed below agree that this protocol establishes the standard for public health nursing practice for those conditions included in the protocol. This protocol expires one year from the date of signatures. It shall be renewed, or revised, and signed annually and more frequently as deemed necessary.

Name	Date		
_____	_____	Regional Medical Director	Date
_____	_____		
_____	_____	Regional Nursing Director	Date
_____	_____		
_____	_____	County Health Officer	Date
_____	_____		
_____	_____	County Nursing Supervisor	Date
_____	_____		
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Screening Criteria for Chlamydia and Gonorrhea, Effective September 1, 2010

The screening criteria for chlamydia and gonorrhea have been revised based on risk criteria, national recommendations, and availability of funds. The screening criteria for Tennessee are:

1. Family Planning:

- Screen at the routine initial/annual exam:
 - all clients **less than age 26**
 - all clients **ages 26-29** who receive family planning services in a county with a chlamydia positivity rate of 3 percent or higher for 2009. (***See below for these counties.**)
- For clients ages **26 and over** (regardless of county where family planning services are received), only screen the following:
 - a client being prepared for IUD insertion;
 - a client with documented NEW signs or symptoms;
 - a client named as a contact;
 - a client using drugs;
 - a client exchanging sex for money or drugs.
- Regardless of age, a female client who has been treated for a positive chlamydia test should be retested 3 months after treatment or whenever she next seeks medical care within the following 3-12 months regardless of whether the client believes her partner was treated.

2. STD:

- **Test all STD clients:**
 - if contact to any STD;
 - symptomatic for any STD;
 - who request an examination for any STD.
- Notable exception:** Chlamydia testing is not required but *should be offered* to clients requesting only an HIV test and who are asymptomatic for any other STD.

3. EPSDT:

- All sexually active clients **11 years and older** should be screened for sexually transmitted diseases (STDs) during routine EPSDT visits.

4. Adult Health/Other:

- Offer testing to any sexually active client **less than age 26**.
- Test clients with signs or symptoms suggestive of gonorrhea or chlamydia.

5. Pregnancy Testing:

- **All women under age 30** reporting to clinic for a urine pregnancy test should be offered chlamydia and gonorrhea screening from their pregnancy test urine sample. Considering the sequelae that might occur in the mother and neonate if the infection persists, repeat testing is recommended 4 - 6 weeks after completion of therapy for all pregnant women to ensure therapeutic cure.

***The counties with positivity rates of 3 percent or higher in women ages 26 – 29 for 2009 are:**

Northeast Region – Johnson and Unicoi

East Tennessee Region – Anderson, Jefferson, Campbell, Cocke, Grainger and Sevier

Southeast – Franklin and Marion

Upper Cumberland – Overton and Smith

Mid Cumberland – Sumner, Cheatham and Dickson

South Central – Giles, Lawrence and Marshall

West Tennessee – Chester, Crockett, Dyer, Fayette, Gibson, Hardeman, Haywood, Henry, Lake,
Lauderdale, Obion, Tipton, and Weakley

Memphis/Shelby County – Health department clinics; Memphis Planned Parenthood

Nashville/Davidson

Knoxville/Knox

Jackson/Madison

CHLAMYDIA TRACHOMATIS, Case (0798), Contact (V016)

SUBJECTIVE

Symptoms may include:

FEMALES-

Vaginal discharge
Dysuria, pelvic pain
Changes in menses
Intermenstrual spotting, postcoital bleeding
Commonly asymptomatic

MALES -

Dysuria
Penile discharge
Commonly asymptomatic

“A friend told me to come in”

Sexual contact to confirmed or suspected case of chlamydia, gonorrhea, NGU, or non-specific cervicitis
Private physician or other health care provider referral

OBJECTIVE

Muco-purulent discharge from urethra or cervix
Laboratory positive for *Chlamydia Trachomatis*

ASSESSMENT

Confirmed or suspected case of *Chlamydia Trachomatis*
Contact to confirmed or suspected case of *Chlamydia Trachomatis*
Last menstrual period
Assess sites exposed (vaginal, oral, rectal, and urethral)

PLAN

Screen for Chlamydia according to the current available criteria (See attached criteria)
Screen¹ for chlamydia and gonorrhea using currently available test; refer to “*Laboratory Policies and Procedures Manual for Local Health Departments*” for information on specimen storage and mailing
Draw blood for syphilis serology
Consider need for hepatitis B vaccination and provide (if available) or refer as indicated
Offer HIV counseling and literature for all clients; offer testing for high-risk individuals or those requesting service
Interview patient for sexual contacts and encourage all contacts to obtain treatment:
Obtain name, address, phone number, age, sex, race, and date of exposure of all contacts within the last 60 days; do not write the information in the patient’s record; if a contact to confirmed case, do not write the original case name in the contact’s chart
Notify the public health representative of the original positive case name and contact information
Counsel, examine, and test all persons exposed

¹ Several studies of different test technologies have shown various post-treatment intervals wherein a false positive test result may occur. Therefore, repeat testing should not be performed within 3 weeks of appropriate treatment. Patients that have been exposed to an infected person within 3 weeks of treatment should be re-treated, but not re-tested.

TREATMENT

Use **dual treatment** for suspected chlamydia and gonorrhea if you do not have a confirmed negative test for gonorrhea (see protocol for gonorrhea):

Patients and/or sex partners presenting for treatment of laboratory confirmed gonorrhea, and known to have a negative chlamydia test, are to be treated for gonorrhea only

Patients and/or sex partners presenting for treatment of laboratory confirmed chlamydia, and known to have a negative gonorrhea test, are to be treated for chlamydia only

In those instances when it cannot be determined to which disease an individual has been exposed, or when the laboratory results for both diseases are not available, dual treatment (for chlamydia and gonorrhea) should be administered

If the chlamydia test is positive, refer to the treatment guidelines found in the PHN Protocol for **Chlamydia Partner Delivered Treatment**

CEFTRIAZONE (ROCEPHIN) is the drug of choice for GONORRHEA (if allergic to penicillin or cephalosporin, do not give Rocephin) If the patient alleges an allergy to penicillin or cephalosporins, the nurse should take a thorough history of allergic response to determine if there is a history of anaphylactic reaction. If history indicates a non-anaphylactic reaction (i.e. rash, itching, etc.), the patient should be treated with ceftriaxone. If history indicates a history of anaphylaxis, or nurse is unable to gain a history consistent with a non-anaphylactic reaction; the patient should be treated with 2 grams Azithromycin (ZITHROMAX).² Since there is little to no incidence of ceftriaxone resistant gonorrhea reported in the United States, all patients returning with gonorrhea with persistent or recurring symptoms should be considered reinfection and retreated with ceftriaxone.³

AZITHROMYCIN (ZITHROMAX) is the drug of choice for CHLAMYDIA

DILUENT- Use 1% lidocaine solution, sterile water for injection, or 0.9% Sodium Chloride Solution and **document** accordingly (if allergic to lidocaine, mix with sterile water or normal saline) Lidocaine allergy includes allergies to local anesthesia such as Nupercaine, Xylocaine, Carbocaine, Marcaine or Atanert; there has been no cross sensitivity shown to para-aminobenzoic derivatives such as procaine, tetracaine, and benzocaine

²Studies indicate that 10% of patients alleging an allergy to PCN are actually allergic when testing is done. Only 5-10% of patients allergic to PCN will have a cross reaction/sensitivity to cephalosporins; therefore, only 0.5-1% of patients that allege an allergy to PCN would actually be allergic to a cephalosporin. With a thorough history taken on those patients alleging PCN allergy, a risk of an allergic reaction to ceftriaxone will be extremely rare.

³There is no need for the laboratory to perform sensitivity testing on isolates unless CDC begins reporting an increased incidence of ceftriaxone-resistant gonorrhea from their Gonorrhea Isolate Surveillance Program (GISP).

Treatment for Chlamydia Only⁴

Non-Pregnant Individuals:

Azithromycin 1 gm po in a single dose

OR

Doxycycline 100 mg po BID x 7 days⁵

OR if allergic to doxycycline

OR if occupation requires working in the sun then use

Erythromycin base 500 mg po qid x 7 days

Pregnant Individuals (if unprotected coitus since LMP, suspect pregnancy and treat accordingly)/ Nursing Mothers:

Azithromycin 1 gm po in a single dose

OR

Erythromycin base 500 mg po qid x 7 days

OR

Amoxicillin 500 mg po TID x 7 days

OR

Erythromycin base 250 mg po qid x 14 days

OR

Erythromycin ethylsuccinate (liquid) 800 mg po qid x 7 days

OR

Erythromycin thylsuccinate (liquid) 400 mg po qid x 14 days

Allergic Pregnant Individuals:

Consult with physician regarding choice of above antibiotics

Dual Treatment for Chlamydia and Gonorrhea⁶

Non-Allergic Adult/Adolescent:

Ceftriaxone (Rocephin) 125 mg IM

PLUS ONE OF THE FOLLOWING:

Azithromycin 1 gm po in a single dose

OR

Doxycycline 100 mg po BID x 7 days⁵

Non-Allergic Pregnant Adult/Adolescent/ Nursing Mothers:

Ceftriaxone (Rocephin) 125 mg IM STAT dose

PLUS ONE OF THE FOLLOWING:

Azithromycin 1 gm po in a single dose

OR

Amoxicillin 500 mg po TID x 7 days

OR

Erythromycin base 500 mg po qid x 7 days

⁴Patients and/or sex partners presenting for treatment of laboratory confirmed chlamydia, and are known to have a negative gonorrhea test, are to be treated for chlamydia only.

⁵Doxycycline is contraindicated in pregnancy and nursing mothers.

⁶In those instances when it cannot be determined to which disease an individual has been exposed, or when the laboratory results for both diseases are not available, dual treatment (for chlamydia and gonorrhea) should be administered. Do not refer for desensitization treatment in absence of lab confirmed gonorrhea.

Allergic Adult/Adolescent:

Azithromycin 2 grams (tablet not suspension or capsule) po in a single dose⁷

Allergic Adult/ Adolescent/ MSM:

Azithromycin (Zithromax) 2 grams (tablets not suspension or capsule) po as a single dose⁷

Allergic Pregnant Adult/Adolescent/Nursing Mothers :

Azithromycin 2 grams (tablets not suspension or capsule) po as a single dose⁷

OR

Administer Azithromycin (Zithromax) 1 gm po as a single dose for Chlamydia and refer to physician for cephalosporin desensitization and treatment (An infectious disease physician experienced in the procedure should be selected)⁶

Health Teaching:

Offer condoms and encourage use during any sexual activity

Encourage all sexual contacts to obtain care

Stress completion of all medicines and advise to avoid intercourse until patient and their sex partner(s) have completed treatment; including 7 days after single-dose therapy or completion of 7 or 14-day treatment regimen

Warn patient that until medication is completed and all sex partners are treated, chlamydial infection can be transmitted and reinfection is likely

If using oral contraceptive, encourage use of barrier method until two weeks following completion of treatment; offer condoms

Discuss AIDS prevention

Encourage voiding before and after intercourse

Increase water intake with medications

Avoid antacids and exposure to sun when taking Doxycycline

Stress hygiene including cotton underwear, loose clothing, avoidance of underpants while sleeping, wipe front to back; avoid feminine hygiene sprays and deodorants

Stress need for follow-up exam if symptoms persist, recur, or exacerbate

Referral Indicators:

Pregnant individuals with **significant** medical issues (consultation with private physician or Health Officer prior to treatment)

Prepubertal children as indicated (refer to HSA Child Abuse Policy)

No response to treatment

⁷Studies have indicated increase frequency of gastrointestinal problems with a 2 gram dose of azithromycin. According to the PDR, azithromycin tablets, but not capsules and oral suspension, can be taken with food that may lessen the occurrence of GI symptoms. Patients should be advised to return for repeat treatment if vomiting occurs.

Dyspareunia and /or moderate to severe abdominal pain
Complications (i.e., PID, postpartum infection, abnormal Pap)

Follow-Up:

Return if no improvement after treatment

In cases of treatment failure, consult with nurse practitioner or physician

Report all cases to Sexually Transmitted Disease program representative

Counsel infected women to return for retesting in 3 months after treatment; also retest all women treated for chlamydia infection if they present for care within 12 months following treatment

Test of cure is not appropriate within 3-4 weeks following treatment

REFERENCE

- 2006 Sexually Transmitted Diseases, Treatment Guidelines, U.S. Department of Health and Human Services, Public Health Service, Centers for Disease Control and Prevention, Atlanta**
June 22, 2001 Memorandum from Dr. Moore and Dr. Hagstrom, “Alternative to Spectinomycin for the Treatment of *Neisseria gonorrhoeae*”
April 12, 2007 Centers for Disease Control and Prevention , “Update on the Management of Gonorrhea in Adults in the United States”

Protocol 5.020 - Chlamydia Trachomatis, Case, Contact, Opt-Out HIV Testing (Metros Areas Only)

Removed from manual on December 9, 2010

CHLAMYDIA TRACHOMATIS, CONTACT PARTNER DELIVERED THERAPY

NOTE: *In 2002 the Board of Medical Examiners and the Board of Osteopaths adopted an amendment to the medical practice act allowing providers and those who provide medical services under their responsibility and control to use partner delivered therapy.*

The following protocol should be implemented as an important DISEASE CONTROL STRATEGY and in accordance with CDC recommendations.

SUBJECTIVE

Partner delivered therapy is for those contacts to index cases of chlamydia who are unlikely to seek medical care.

OBJECTIVE

A laboratory confirmed Chlamydia infection without evidence of co-infection with gonorrhea or other complications suggestive of a relationship to Chlamydia infection

Provision of treatment of the (index) patient for Chlamydia

An attempt to persuade the infected patient to have all partners evaluated and treated and indication from the patient that partner(s) would not comply

PLAN

Document objective findings in index patient's record.

Provide a Chlamydia fact sheet to the patient with copies for all partners.

<http://www.cdc.gov/std/chlamydia/chlamydia-fact-sheet.pdf>

<http://www.nlm.nih.gov/medlineplus/druginfo/meds/a697037.html>

Counsel the patient on sexual abstinence for seven days after treatment and until seven days after partners have been treated.

Provide to the treated patient a non-named signed (MD or NP) prescription(s) or a signed, name-specific prescription(s) **OR**

Dispense to the treated patient 1 gram of azithromycin for each of the unnamed sex partners or for each of the total number of known sex partners named by the patient.

Contacts who present to the health department requesting treatment for Chlamydia will be given the following:

1 gram azithromycin

Opportunity for a full STD examination

Opportunity for questioning about other STD symptoms and encouragement to have HIV testing

GONORRHEA, Case (098); Contact (V016)

SUBJECTIVE

Symptoms may include:

FEMALES – (a large percentage of infected women are asymptomatic in the early stages of disease)

Early Symptoms

Dysuria
Leukorrhea, change in vaginal discharge
Unilateral labial pain and swelling
Lower abdominal discomfort
Pharyngitis

Later Symptoms

Purulent, irritating vaginal discharge
Fever (possibly high)
Rectal pain and discharge
Abnormal menstrual bleeding
Increased dysmenorrhea
Nausea, vomiting
Lesions in genital area
Joint pain and swelling
Upper abdominal pain

"A friend told me to come"

Pain, tenderness in pelvic organs

Sexual contact to confirmed or suspected case of gonorrhea

Private physician or other health care provider referral

MALES – (usually symptomatic)

Early Symptoms

Dysuria with frequency
Whitish discharge from penis
Pharyngitis

Later Symptoms

Yellow/greenish discharge from penis
Epididymitis
Proctitis

OBJECTIVE

Purulent discharge from urethra or cervix noted on exam

Laboratory positive for *Neisseria gonorrhoeae*

ASSESSMENT

Confirmed or suspected case of gonorrhea

Contact to confirmed or suspected case of gonorrhea

Last menstrual period

Assess sites exposed (vaginal, oral, rectal, and urethral)

PLAN

Screen for Chlamydia according to the current available criteria (See criteria)

Screen¹ for gonorrhea and chlamydia using test that is currently available; refer to “*Laboratory Policies and Procedures Manual for Local Health Departments*” for information on specimen storage and mailing (genital, pharyngeal, and rectal culture according to history)

Draw blood for syphilis serology

Consider need for Hepatitis B vaccination and provide (if available) or refer as indicated

Offer HIV confidential counseling/testing for high-risk individuals or those requesting services

Interview patient for sexual contacts:

Obtain name, address, phone number, age, sex, race, and date of exposure of all contacts within the last 60 days; do not write the information in the patient’s record; if a contact to confirmed case, do not write the original case name in the contact’s chart

Notify the public health representative of the original positive case name and contact information

Counsel, examine, and test all persons exposed

TREATMENT

Treatment with any other than the recommended regimen is not acceptable

Use dual treatment (for suspected gonorrhea and chlamydia) if you do not have a confirmed negative test for chlamydia (see protocol for chlamydia):

Patients and/or sex partners presenting for treatment of laboratory confirmed gonorrhea, and known to have a negative chlamydia test, are to be treated for gonorrhea only

Patients and/or sex partners presenting for treatment of laboratory confirmed chlamydia, and known to have a negative gonorrhea test, are to be treated for chlamydia only

In those instances when it cannot be determined to which disease a person has been exposed, or when the laboratory results for both diseases are not available, treatment for both gonorrhea and chlamydia should be administered

If the chlamydia test is positive, refer to the treatment guidelines found in the PHN Protocol for chlamydia and **Chlamydia Partner Delivered Treatment**

CEFTRIAXONE (ROCEPHIN) is the drug of choice for GONORRHEA (*if allergic to penicillin or cephalosporin, do not give Rocephin*) If the patient alleges an allergy to penicillin or cephalosporins, the nurse should take a thorough history of allergic response to determine if there is a history of anaphylactic reaction. If history indicates a non-anaphylactic reaction (i.e. rash, itching, etc.), the patient should be treated with ceftriaxone. If history indicates a history of anaphylaxis, or nurse is unable to gain a history consistent with a non-anaphylactic reaction; the patient should be treated with 2 grams Azithromycin (ZITHROMAX).²

¹Several studies of different test technologies have shown various post-treatment intervals where a false positive test result may occur; repeat testing should not be performed within 3 weeks of appropriate treatment. Patients that have been exposed to an infected person within 3 weeks of treatment should be re-treated, but not re-tested.

²Studies indicate that 10% of patients alleging an allergy to PCN are actually allergic when testing is done. Only 5-10% of patients allergic to PCN will have a cross reaction/sensitivity to cephalosporins; therefore, only 0.5-1% of patients that allege an allergy to PCN would actually be allergic to a cephalosporin. With a thorough history taken on those patients alleging PCN allergy, a risk of an allergic reaction to ceftriaxone will be extremely rare.

Since there is little to no incidence of ceftriaxone resistant gonorrhea reported in the United States, all patients returning with gonorrhea with persistent or recurring symptoms should be considered reinfection and retreated with ceftriaxone.³
AZITHROMYCIN (ZITHROMAX) is the drug of choice for CHLAMYDIA

DILUENT - Use 1% lidocaine solution, sterile water for injection, or 0.9% Sodium Chloride Solution and document accordingly (if allergic to lidocaine, mix with sterile water or normal saline) Lidocaine allergy includes allergies to amide local anesthesia such as Nupercaine, Xylocaine, Carbocaine, Marcaine or Atanert; there has been no cross sensitivity shown to para-aminobenzoic derivatives such as procaine, tetracaine, and benzocaine

Treatment for Gonorrhea Only⁴

Non-allergic Adult/Adolescent:

Ceftriaxone (Rocephin) 125 mg IM

Non-allergic Pregnant Adult/Adolescent:

Ceftriaxone (Rocephin) 125 mg IM

Allergic Adult/Adolescent:

Azithromycin (Zithromax) 2 grams (tablets not suspension or capsule) po as a single dose⁵

Allergic Pregnant Adult/Adolescent:

Azithromycin 2 grams (tablets not suspension or capsule) po as a single dose⁵

OR

Refer to physician for cephalosporin desensitization and treatment (An infectious disease physician experienced in the procedure should be selected)

Dual Treatment for Gonorrhea and Chlamydia⁶

Non-allergic Adult/Adolescent:

Ceftriaxone (Rocephin) 125 mg IM

PLUS ONE OF THE FOLLOWING:

Azithromycin (Zithromax) 1 gm po in a single dose

OR

³There is no need for the laboratory to perform sensitivity testing on isolates unless CDC begins reporting an increased incidence of ceftriaxone-resistant gonorrhea from their Gonorrhea Isolate Surveillance Program (GISP).

⁴Patients and/or sex partners presenting for treatment of laboratory confirmed gonorrhea, and known to have a negative chlamydia test, are to be treated for gonorrhea only.

⁵Studies have indicated increase frequency of gastrointestinal problems with a 2 gram dose of azithromycin. According to the PDR, azithromycin tablets, but not capsules and oral suspension, can be taken with food that may lessen the occurrence of GI symptoms. Patients should be advised to return for repeat treatment if vomiting occurs.

⁶In those instances when it cannot be determined to which disease a person has been exposed, or when the laboratory results for both diseases are not available, treatment for both gonorrhea and chlamydia should be administered. Do not refer for desensitization treatment in absence of lab confirmed gonorrhea.

⁷Doxycycline is contraindicated in pregnancy and nursing mothers.

Doxycycline 100 mg po BID x 7 days⁷

Non-allergic Pregnant Adult/Adolescent/: Nursing Mothers

Ceftriaxone (Rocephin) 125 mg IM STAT dose

PLUS ONE OF THE FOLLOWING:

Azithromycin (Zithromax) 1 gm po in a single dose

OR

Amoxicillin 500 mg po TID x 7 days

OR

Erythromycin base 500 mg po qid x 7 days

Allergic Adult/Adolescent:

Azithromycin (Zithromax) 2 grams (tablets not suspension or capsule) po in a single dose⁵

Allergic Adult/Adolescent/MSM:

Azithromycin (Zithromax) 2 grams (tablets not suspension or capsule) po as a single dose⁵

Allergic Pregnant Adult/Adolescent/ Nursing Mothers

Azithromycin 2 grams (tablets not suspension or capsule) po as a single dose⁵

OR

Administer Azithromycin (Zithromax) 1 gm po as a single dose for Chlamydia and refer to physician for cephalosporin desensitization and treatment (An infectious disease physician experienced in the procedure should be selected)⁶

Health Teaching:

Offer condoms and encourage use during any sexual activity

Encourage all sexual contacts to obtain care

Stress completion of all medicines and advise to avoid intercourse until patient and their sex partner(s) have completed treatment (including 7 days after single-dose therapy or completion of 7-day regimen)

Warn patient that until medication is completed and all sex partners are treated, gonococcal infection can be transmitted and reinfection is likely

If using oral contraceptive, encourage use of barrier method until two weeks following completion of treatment; offer condoms

Discuss AIDS prevention

Encourage voiding before and after intercourse

Increase water intake with medications

Avoid antacids and exposure to sun when taking doxycycline

Stress hygiene including cotton underwear, loose clothing, avoidance of underpants while sleeping, wipe front to back; avoid feminine hygiene sprays and deodorants

Stress need for follow-up exam if symptoms persist, recur, or exacerbate

Referral Indicators:

Pregnant individuals with **significant** medical issues (consultation with private physician or Health Officer prior to treatment)
Prepubertal children as indicated (refer to HSA Child Abuse Policy)
No response to treatment
Dyspareunia and/or moderate to severe abdominal pain
Complications (i.e., PID, postpartum infection, abnormal Pap)

Follow-Up:

Return if no improvement after treatment
Counsel infected women to return for retesting in 3 months after treatment; also retest all women treated for chlamydia infection if they present for care within 12 months following treatment
In cases of treatment failure, consult with nurse practitioner or physician
Report all cases to Sexually Transmitted Disease program representative
Test of cure is not appropriate within 3-4 weeks following treatment

REFERENCES

- 2006 Sexually Transmitted Diseases, Treatment Guidelines, U.S. Department of Health and Human Services, Public Health Service, Centers for Disease Control and Prevention, Atlanta Current PDR
June 22, 2001 Memorandum from Dr. Moore and Dr. Hagstrom, "Alternative to Spectinomycin for the Treatment of *Neisseria gonorrhoeae*"
2004 Morbidity and Mortality Weekly Report, Increases in fluoroquinolone-Resistant *Neisseria gonorrhoeae* – United States, 2003, and Revised Recommendations for Gonorrhea Treatment, 2004
April 12, 2007 Centers for Disease Control and Prevention, "Update on the Management of Gonorrhea in Adults in the United States"

**Protocol 5.050 - Gonorrhea, Case or Contact Opt-Out HIV
Testing (Metro Areas Only)**

Removed from manual on December 9, 2010

**Protocol 5.120 - HIV Opt-Out HIV Testing
(Metro Areas Only)**

Removed from manual on December 9, 2010

**Protocol 5.150 - Syphilis, Case or Contact Opt-Out HIV
Testing (Metro Areas Only)**

Removed from manual on December 9, 2010