

PREGNANCY TEST

GENERAL INFORMATION

Patients requesting pregnancy tests at the Health Department should be tested on that day and only deferred if absolutely necessary. Pregnancy testing must be performed according to the *Pregnancy Testing Guidelines* contained in the Family Planning Clinical Guidelines

Chlamydia and gonorrhea are STDs that can affect long term fertility and the health of any current pregnancy. Early detection and treatment can preserve fertility and improve pregnancy outcome.

Tennessee STD Program standards regarding the chlamydia/gonorrhea test at the time of the pregnancy test are as follows:

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.

If the gonorrhea/chlamydia test is positive, refer to the treatment guidelines found in the PHN Protocol for Chlamydia and Gonorrhea and Chlamydia, Partner Delivered Treatment. Obtain informed consent and forward the record to the prenatal care provider. The prenatal care provider is responsible for the test of cure.

SUBJECTIVE FINDINGS

Date of LMP

History of unprotected coitus since LMP

Symptoms of pregnancy and date symptoms appeared:

- Breast tenderness
- Fatigue
- Nausea
- Urinary frequency

History of STDs

Current family planning method if any

Any over-the-counter and/or prescription drug use

Any alcohol use and/or substance abuse

Is she smoking cigarettes?

Does she want to be pregnant now? Does she want to be pregnant in the future? If so, when?

OBJECTIVE FINDINGS

Positive or negative pregnancy test

ASSESSMENT

Pregnancy test positive, pregnancy intended
 Pregnancy test positive, pregnancy unintended
 Pregnancy test negative, pregnancy desired
 Pregnancy test negative, pregnancy not desired

PLAN OF CARE

- Inform client that pregnancy cannot be accurately diagnosed, nor gestational age determined, through laboratory testing alone; that pregnancy diagnosis consists of a history, pregnancy test, and physical examination, including pelvic examination
- Discuss test results clearly and objectively
- Complete relevant forms and document counseling in chart
- Dispense Family Planning Required Client Instruction Sheets
- If pregnancy test is negative, repeat the pregnancy test if no menses in two weeks
- Compile and keep current a county specific resource list for referrals
- Inform the client that chlamydia and gonorrhea are STDs that can affect long term fertility and the health of any current pregnancy. Early detection and treatment can preserve fertility and improve pregnancy outcome.

If the pregnancy test is negative and pregnancy is not desired:

- Explore the client's feelings about the pregnancy test result
- Discuss contraception
- Discuss emergency contraception
- Provide condoms
- Offer the client a brochure on family planning program services and/or explain program services
- If the client is an adolescent, encourage her to discuss contraceptive use with parent(s) or another responsible family member
- If possible, admit the client to the family planning program that day, especially if she is an adolescent. If a clinic opening is not available that day, waive the physical exam and if there are no contraindications in her medical history, give 3 months supply of birth control method. Schedule a physical exam within 3 months. See PHN Protocol for the method of choice.
- Consider creating a tickler file (manual or PTBMIS) for this at risk client and follow-up as may be needed for an appropriate period of time (nursing judgment).

If the pregnancy test is negative and pregnancy is desired:

- Explore the client's feelings about the pregnancy test result
- Discuss the menstrual cycle and fertile days
 - Provide pre-conception counseling including:
 - Nutrition and the importance of folic acid
 - The importance of dental care to good pregnancy outcomes
 - The impact of smoking during pregnancy and after pregnancy
 - The importance of early prenatal care

- The impact of alcohol, medications, and substance abuse during pregnancy
- The impact of sexually transmitted diseases on pregnancy
- Review services available at the local health department including WIC, presumptive eligibility for TennCare, and the HUGS home visiting program
- Encourage an adolescent to discuss their desire for pregnancy with a parent or another responsible family member; explore why they want to be pregnant
- Consider creating a tickler file (manual or PTBMIS) for the at-risk adolescent and follow-up as needed for an appropriate period of time (nursing judgment).

If the pregnancy test is positive and the pregnancy is desired:

- Discuss the importance of early prenatal care
- Offer prenatal provider resource list
- Enroll and Ensure completion of presumptive eligibility for TennCare clients
- If client is under 21 years of age, offer assistance with scheduling an appointment to a prenatal provider.
- If client is under 21 years of age and deemed eligible for TennCare prenatal presumptive eligibility and declines assistance with scheduling an appointment, provide to the client a prenatal provider resource list.
- Find a prenatal care resource if no private insurance and not TennCare eligible
- Enroll eligible clients to WIC
- Refer eligible clients to HUGS
- Discuss nutrition, prenatal vitamins, and the importance of folic acid
- Discuss the importance of dental care to good pregnancy outcomes
- Make a dental referral
- Discuss the impact of smoking during pregnancy and after pregnancy
- Discuss the impact of alcohol, medications, and substance abuse during pregnancy
- Discuss the impact of sexually transmitted diseases on pregnancy

If the pregnancy test is positive and the pregnancy is not desired:

- Explore the client's feelings about the pregnancy test result
- Discuss termination options and review resources in the local area
- Discuss adoption as an option and review resources in the local area
- Discuss parenting as an option
- All clients need the information regarding good health practices in pregnancy (listed under test positive/pregnancy desired) until their decision regarding the pregnancy is made. Give as complete information as seems appropriate for the given client. Offer her the opportunity to return for further counseling; discuss the possibility of her bringing in her partner, a friend, or a family member.
- Encourage adolescents to speak with a parent or other responsible family member as soon as possible
- Consider whether or not a mental health referral is needed
- Consider creating a tickler file (manual or PTBMIS) for these at risk clients and follow-up for an appropriate period of time (nursing judgment)
- Make a HUGS referral if this pregnancy is continued

REFERENCES

- Tennessee Department of Health, "Family Planning Clinical Guidelines", January 2011
- U.S. Department of Health and Human Services, Public Health Service, Health Service Administration, Bureau of Community Health Services Program, *Program Guidelines For Project Grants For Family Planning*, 2001
- U.S. Department of Health and Human Services, Public Health Service, Standards of Compliance for Abortion-Related Services in Family Planning Service Projects, *Federal Register* 58(23), February 5, 1993.

Options Counseling Guide

Explore the patient's feelings about the pregnancy. If the patient is unsure of how to proceed with the pregnancy, it is the nurse's responsibility to explore all available options with the client. Assist the client in identifying health, social, and economic consequences of each option. It is important to introduce all options even if the client does not mention each one. Avoid personal biases.

Prenatal care and delivery

- Explain health promotion, disease prevention services through the Health Department
- Refer to HUGS home visiting program
- Refer to WIC
- Ensure completion of presumptive eligibility for TennCare clients
- If client is under 21 years of age, offer assistance with scheduling an appointment to a prenatal provider
- Explain the system for prenatal care in the private sector
- Review danger signs of pregnancy, including signs and symptoms of a threatened miscarriage or ectopic pregnancy
 - Bleeding
 - Spotting
 - Lower abdominal pain
- Discuss nutrition, prenatal vitamins, and the importance of folic acid
- Discuss the importance of dental care to good pregnancy outcomes
- Make a dental referral
- Discuss the impact of smoking during pregnancy and after pregnancy
- Discuss the impact of alcohol, medications, and substance abuse during pregnancy
- Discuss the impact of sexually transmitted diseases on pregnancy

Infant care

- Discuss day care needs if returning to school or employment
- Explore family support system
- Explore the daily needs of a newborn and its impact on lifestyle

Foster Care or Adoption

- Refer to Department of Human Services
- Refer to local private agencies
- Offer to meet again to discuss further as questions may develop later

Pregnancy termination

- Answer patient's questions. Avoid personal biases.
- Remember that abortion is a legal option
- Remember that no state or federal funds are available
- Have a list of providers available
- Discuss the timetable for decision-making (obtaining pregnancy termination during the first trimester)
- Do not give specific facility brochures
- Do not make appointments for the patient (the patient should be given sufficient information to make her own appointment)
- Do not provide transportation

PREGNANCY TEST (continued)

- **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 3 - 4 weeks after completion of therapy for all pregnant women to ensure therapeutic cure.

LIVE ATTENUATED SEASONAL INFLUENZA VACCINE (LAIV) (FluMist® by MedImmune)

GENERAL INFORMATION

General Recommendations for Influenza Vaccination:

Seasonal influenza vaccine comes in two forms: trivalent inactivated vaccine (TIV) administered by injection and live-attenuated, intranasally-administered vaccine (LAIV). See TIV protocol for persons who prefer it or who are ineligible for LAIV.

It is recommended that all persons aged ≥ 6 months be vaccinated each influenza season. No preference between TIV and LAIV is expressed for persons eligible to receive either.

New this season: During the 2011-2012 season, **all** children aged 6 months through 8 years *who did not receive a dose of influenza vaccine last season (2010-11)* should receive *2 doses this season*, regardless of previous influenza vaccination history, in order to assure adequate immunity to the 2009 H1N1 strain of influenza.

The 2011-2012 seasonal trivalent influenza vaccine is composed of the same 3 strains as the 2010-11 vaccine: A/California/7/2009 (H1N1)-like, A/Perth/16/2009 (H3N2)-like, and B/Brisbane/60/2008-like (B/Victoria lineage).

Because immunity levels wane over time, vaccination is recommended every season, even when the vaccine strains do not change from the previous season. It is appropriate to begin vaccinating patients as soon as vaccine arrives for the season; delaying vaccination is not recommended.

Seasonal LAIV indication:

LAIV is approved by the Food and Drug Administration (FDA) for use in healthy persons aged 24 months through 49 years who are not known to be pregnant.

Special situations:

LAIV may be co-administered with any other vaccine at the same visit. Live vaccines that are not given on the same day (e.g., varicella, MMR) should be administered at least 4 weeks apart.

Patients < 9 years of age who require 2 doses of vaccine this season do not have to use the same type of vaccine (TIV or LAIV) for both doses

LAIV may be given to breastfeeding women, close contacts of pregnant women, infants or to contacts of persons with mild to moderate immunocompromise. It should not be administered to close contacts of severely immunocompromised persons who reside in a protective environment (such as a bone marrow transplant unit).

Do not administer LAIV < 48 hours after a dose of antiviral (anti-influenza) medication, such as oseltamivir or zanamivir. Because antiviral medication may interfere with LAIV, recipient should not use an antiviral medication within 2 weeks after LAIV administration unless medically necessary.

Contraindications and precautions:

People less than 2 years of age or age 50 years or older

Persons with egg allergy [may be eligible for TIV, see TIV protocol]

People with a medical condition that places them at high risk for complications from influenza [e.g., chronic heart or lung disease, asthma, diabetes, kidney disease, hemoglobinopathies, any condition that compromises the ability to handle respiratory secretions, pregnant women, or persons with a weakened immune system]
 Children aged 2 through 4 years with a diagnosis of asthma or history of wheezing in the past 12 months (parent answers “yes” when asked “In the past 12 months, has a health care provider ever told you your child had wheezing or asthma?”)
 Children or adolescents receiving aspirin therapy
 People with a history of Guillain-Barré syndrome

Common Adverse Reactions (≥10% of patients)

Nasal congestion
 Sore throat in adults
 Fever >100°F in children ages 2-6 years

PLAN

Have recipient, parent, or guardian read Vaccine Information Statement (VIS)
 Counsel regarding benefits, side effects, and management
 Administer vaccine intranasal spray (0.1 ml in each nostril) according to manufacturer's recommendation
 Remind that influenza vaccine is recommended annually (advise parent or guardian of recipients less than 9 years of age to return for a second dose in 1 month if the child did not receive a dose of influenza vaccine during the 2010-2011 season)
 Because antiviral medication, such as oseltamivir (Tamiflu) may interfere with LAIV, advise that recipient should not use an antiviral medication within 2 weeks after LAIV administration unless medically necessary.
 Advise to wait in clinic 20 minutes after intranasal administration
 Record manufacturer and lot number of the vaccine administered, date, name, address, and title of person administering vaccine
 Instruct patient to contact Health Department if adverse reaction occurs (complete appropriate VAERS form: <http://vaers.hhs.gov>)

Recommended Schedule and Dosage of LAIV (FluMist®):

Age Group	Influenza Vaccination Status	Dosage Schedule
Children 24 months through 8 years	A) Not previously vaccinated against influenza <i>or</i> B) Did not receive at least 1 dose of influenza vaccine last season (2010-11)	2 doses (each dose 0.1ml per nostril) given at least 1 month apart
Children 24 months through 8 years	Not in category A or B above	1 dose (0.1 ml per nostril)
Other persons aged 9-49 years	n/a	1 dose (0.1 ml per nostril)

Referral Indicators:

Persons with allergy to components of vaccine (gelatin, gentamicin, arginine) or who have had a severe allergic reaction to a previous dose of influenza vaccine.

Persons who report egg allergy. Evaluate them for administration of TIV using the assessment tool in the TIV protocol.

Persons with history of Guillain-Barré syndrome

Persons having moderate to severe acute febrile illness or illnesses with significant nasal congestion (until illness resolves)

REFERENCES

Prevention and Control of Influenza with Vaccines, Recommendations of the Advisory Committee on Immunization Practices (ACIP), 2011. U.S. Department of Health and Human Services, Public Health Service, Centers for Disease Control, August 18, 2011. Available at <http://www.cdc.gov/mmwr/pdf/wk/mm60e0818.pdf>. Last accessed August 18, 2011.

FluMist® Influenza Vaccine, Live Intranasal Vaccine Prescribing Information for 2011-2012 (MedImmune). http://www.medimmune.com/pdf/products/flumist_pi.pdf. Last accessed August 19, 2011.

TRIVALENT INACTIVATED SEASONAL INFLUENZA VACCINE (TIV)

GENERAL INFORMATION

General Recommendations for Influenza Vaccination:

Seasonal influenza vaccine comes in two forms: trivalent inactivated vaccine (TIV) administered by injection and live-attenuated, intranasally-administered vaccine (LAIV). See LAIV protocol for healthy persons 24 months and up who choose LAIV, where available.

It is recommended that all persons aged ≥ 6 months be vaccinated each influenza season.

New this season: During the 2011-2012 season, **all** children aged 6 months through 8 years *who did not receive a dose of influenza vaccine last season (2010-11)* should receive *2 doses this season*, regardless of previous influenza vaccination history, in order to assure adequate immunity to the 2009 H1N1 strain of influenza.

The 2011-2012 seasonal trivalent influenza vaccine is composed of the same 3 strains as the 2010-11 vaccine: A/California/7/2009 (H1N1)-like, A/Perth/16/2009 (H3N2)-like, and B/Brisbane/60/2008-like (B/Victoria lineage).

Because immunity levels wane over time, vaccination is recommended every season, even when the vaccine strains do not change from the previous season. It is appropriate to begin vaccinating patients as soon as vaccine arrives for the season; delaying vaccination is not recommended.

Licensed TIV formulations by Manufacturer (not all are available in health departments):

Manufacturer (Brand)	Product Formulation	FDA-licensed ages
Sanofi Pasteur TIV (Fluzone®)	0.25 ml preservative-free, pre-filled syringe (PFS)	6-35 months only
	0.5 ml PFS or single dose vial	≥ 36 months
	5 ml multidose vial	≥ 6 months
Novartis TIV (Fluvirin®)	5 ml multidose vial	≥ 4 years
	0.5 ml PFS	
CSL, distributed by Merck (Afluria®)	0.5 ml PFS	9 years and up
	5 ml multidose vial	9 years and up
GSK TIV (Fluarix®)	0.5 ml PFS	≥ 3 years
GSK TIV (Flulaval®)	5 ml multidose vial	≥ 18 years
Sanofi Pasteur TIV High Dose (Fluzone High-Dose®)	0.5 ml PFS	≥ 65 years
Sanofi Pasteur TIV Intradermal (Fluzone Intradermal®)	0.1ml prefilled microinjection system	18-64 years

Centers for Disease Control and Prevention (CDC) recommendations:

CDC recommends annual influenza vaccine for ALL persons without medical contraindications, aged 6 months or older.

Persons who should not receive the influenza vaccine include the following:

(See Referral Indicators for precautions)

Persons with a severe allergy (i.e., anaphylactic allergic reaction) to a previous dose of influenza vaccine or its components

Children less than 6 months of age

PLAN

Have recipient, parent, or guardian read Vaccine Information Statement (VIS)

Counsel regarding benefits, side effects, and management (see figure below for assessment of persons who report egg allergy)

Administer vaccine injection according to manufacturer's recommendation

Remind that seasonal influenza vaccine is recommended annually. Advise the parent or guardian of recipients less than 9 years of age to return for a second dose in 1 month if the child did not receive at least 1 dose of influenza vaccine during the 2010-11 season.

Advise to wait in clinic 20 minutes after injection

Record manufacturer and lot number of the vaccine administered, date, name, address, and title of person administering vaccine

Instruct patient to contact Health Department if adverse reaction occurs (complete appropriate VAERS form)

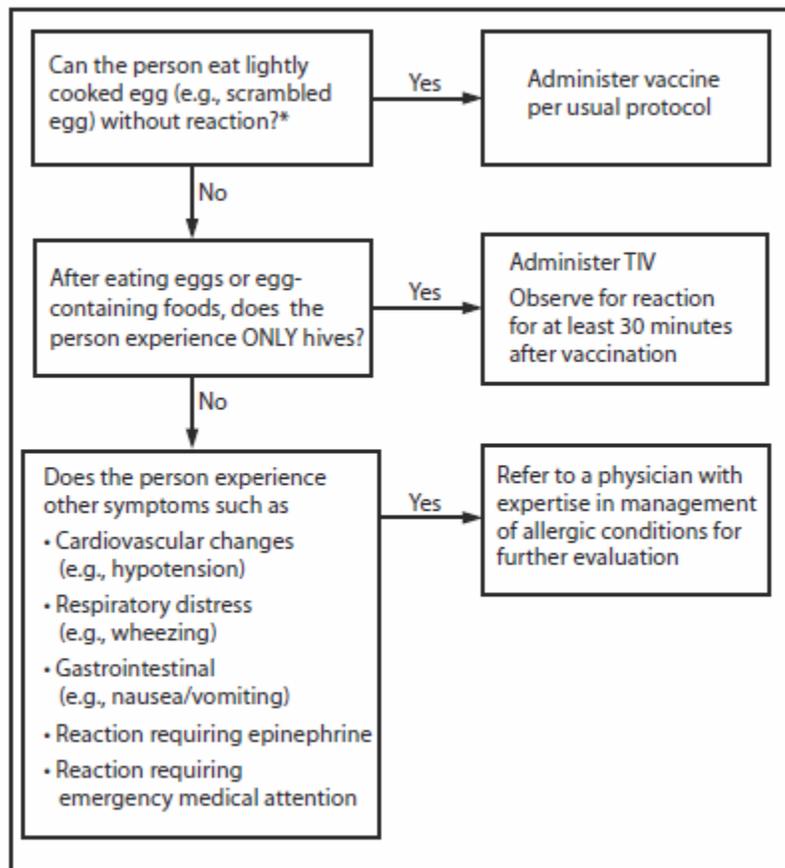
Recommended Schedule and Dosage of Seasonal Trivalent Inactivated Vaccine (TIV):

Age Group	Influenza Vaccination Status	Dosage Schedule
Children 6 months through 35 months	A) Not previously vaccinated against influenza <i>or</i> B) Did not receive at least 1 dose of influenza vaccine last season (2010-11)	2 doses (each dose 0.25 ml, IM) given at least 1 month apart*
	Not in category A or B above	1 dose (0.25 ml, IM)
Children 36 months through 8 years	A) Not previously vaccinated against influenza <i>or</i> B) Did not receive at least 1 dose of influenza vaccine last season (2010-11)	2 doses (each dose 0.5 ml, IM) given at least 1 month apart*
	Not in category A or B above	1 dose (0.5 ml, IM)
All other persons aged 9 years and up	n/a	1 dose (0.5 ml, IM)

*TIV or LAIV may be used interchangeably for either dose, if appropriate.

Use the following table to screen all patients who report allergy to egg:

FIGURE 2. Recommendations regarding influenza vaccination for persons who report allergy to eggs — Advisory Committee on Immunization Practices (ACIP), 2011–12 influenza season



* Persons with egg allergy might tolerate egg in baked products (e.g., bread or cake). Tolerance to egg-containing foods does not exclude the possibility of egg allergy.

Referral Indicators:

- Persons with severe allergy to eggs (not only hives, as defined in the figure above) or components of vaccine (see prescribing information)
- Persons with history of Guillain-Barré syndrome
- Persons having moderate to severe acute febrile illness (until illness resolves)

REFERENCES

Prevention and Control of Influenza with Vaccines, Recommendations of the Advisory Committee on Immunization Practices (ACIP), 2011. U.S. Department of Health and Human Services, Public Health Service, Centers for Disease Control, August 18, 2011. Available at <http://www.cdc.gov/mmwr/pdf/wk/mm60e0818.pdf>. Last accessed August 18, 2011.

MENINGOCOCCAL VACCINE

MENINGOCOCCAL CONJUGATE VACCINE (MCV4)

(MENACTRA™, MENVEO™)

GENERAL INFORMATION

Meningococcal disease is caused by bacteria (*Neisseria meningitidis*) that infect the bloodstream and the linings of the brain and spinal cord, causing serious illness. Meningococcal disease is rare in the United States, but is now the leading cause of bacterial meningitis in children. Of people with meningococcal disease, 10% die and 11-19% of survivors have permanent disabilities (such as mental retardation, hearing loss, and loss of limbs). Meningococcal disease is most likely to occur in infants and toddlers, although the type (serogroup B) that causes most disease in this age group is not preventable by vaccine. After infancy, the next period of increased risk is from 16-21 years. Infection is spread by direct contact with infected individuals (e.g., sharing a glass or cigarette, or kissing), or via droplets of respiratory secretions (e.g., coughing or sneezing). Symptoms include the sudden onset of fever, chills, severe headache, stiff neck, rash, nausea, vomiting and lethargy.

Meningococcal vaccine is inactivated and contains no live organisms. The vaccine is designed to prevent infections from serogroups A, C, Y and W-135. Protective antibody levels may be achieved within 7-10 days after vaccination. Meningococcal vaccine may be given at the same time as other immunizations, if needed.

Meningococcal Conjugate Vaccine (MCV4)

There are 2 MCV4 vaccines: Menactra™ by Sanofi Pasteur (licensed age 9 months through 55 years) and Menveo™ by Novartis (licensed age 24 months through 55 years)

Immunity is expected to last 3-5 years following a single dose.

MCV4 is recommended for routine use in preteens and certain individuals who are at elevated risk for meningococcal disease and are between 2 and 55 years of age

Where MCV4 is not available, Meningococcal Polysaccharide Vaccine (MPSV4, Menomune™) is an acceptable substitute for some, not all, persons for whom MCV4 is recommended; refer to Meningococcal Polysaccharide vaccine (MPSV4, Menomune) protocol as needed for additional information. MCV4 is always preferred to MPSV4.

ACIP Recommended Populations include the following:

Adolescents (First dose routinely for children 11 through 12 years and as catch up for any children 13 through 18 years not previously vaccinated with MCV4)

College freshmen in dormitories, including those through age 21 who enroll in college and present for vaccine before moving on campus, if not previously vaccinated or booster indicated

Persons age 2 through 55 years who have anatomic or functional asplenia or terminal complement component deficiencies, including such persons who had received one dose of MPSV4 three (3) or more years earlier (with physician order)

Persons age 2 through 55 years who travel to, or reside in, countries in which *N. meningitidis* is hyperendemic or epidemic, particularly if contact with local populations is prolonged

Military recruits (Health departments should refer)

Microbiologists routinely exposed to isolates to *N. meningitidis* (Health departments refer)

(continued on next page)

Contraindications to giving the vaccine include the following:

- Persons under 2 years or over 55 years of age
- If known to be pregnant, consult with health officer or refer to medical provider
- Hypersensitivity to any component of the vaccine, including diphtheria toxoid
- Menactra only: hypersensitivity to dry natural latex (contained in vaccine vial stopper)
- Note: Menveo packaging does not contain latex.

Precautions include the following:

- Immunization should be deferred during the course of any moderate to severe illness
- Anyone who has ever had Guillain-Barre Syndrome

Adverse Reactions include the following:

COMMON

- Mild injection site pain and redness (within 1 -2 days of vaccination)
- Mild systemic reactions such as headache and malaise (within 7 days of vaccination)

RARE

- Fever (within 7 days of vaccination) or severe systemic reaction

PLAN

ADMINISTRATION OF VACCINE:

Vaccinate according to the following table [Use federally-funded vaccine, in accordance with current guidance for its use (see cover letter). If state or locally-purchased vaccine is available, persons ineligible for federally-funded vaccine may be vaccinated in accordance with local policy]:

Risk group	First dose (age in years)	Booster dose (age in years)§
Persons aged 11 through 18 years	11 through 12	16 (catch up dose through age 18)*
	13 through 15	16 through 18*
	16 or older	-none-
HIV-infected persons age 11 through 18 years	11 through 12 (primary 2-dose series, at least 8 weeks apart*)	16 (catch up dose through age 18)* ¥
	13 through 15 (primary 2-dose series, at least 8 weeks apart*)	16 through 18*¥
	≥16 (primary 2-dose series, at least 8 weeks apart*)	-none-
Persons aged 2 through 55 years with persistent complement component deficiency (such as C5-C9, properidin or factor D) or asplenia (functional or anatomic)	At earliest opportunity (primary 2-dose series, at least 8 weeks apart)	Every 5 years following the second primary series dose.
Persons age 2-55 years with prolonged increased risk for exposure to N. meningitidis**	1 dose	If aged 2 through 6 years, after 3 years, <i>if still at increased risk</i> If aged 7 years or older, after 5 years <i>if still at increased risk</i>
§ Minimum interval between primary and booster doses of vaccine is 8 weeks		
*Students enrolling in college aged 19 through 21 may be administered a dose of vaccine, if they have not had a dose since turning age 16, if local or state-purchased vaccine is available.		
¥Calculate need for booster dose based upon age at receipt of the second dose in the primary 2-dose series.		
**Microbiologists routinely working with Neisseria meningitidis and travelers or residents of countries where meningococcal disease is hyperendemic or epidemic.		

If using Menveo, reconstitute product according to manufacturer package insert prior to administration.

Administer a single dose of vaccine, 0.5 ml **INTRAMUSCULARLY**

Health Teaching:

Provide current Vaccine Information Sheet (VIS) about meningococcal disease and the benefits of vaccination

If the vaccine is used in persons receiving immunosuppressive therapy, the expected immune response may not be obtained

Counsel regarding side effects of vaccine

Educate recipients for whom a booster dose is recommended about the timing and importance of the booster dose

Referral:

Pregnancy

Military recruits

Microbiologists occupationally exposed to isolates of *N. meningitidis*

Travelers (to a travel clinic)

REFERENCES

Menactra® [Meningococcal (Groups A, C, Y and W-135) Polysaccharide Diphtheria Toxoid Conjugate Vaccine] package insert, Sanofi Pasteur (Aventis Pasteur), April 2008

MENVEO® [Meningococcal (Groups A, C, Y and W-135) Oligosaccharide Diphtheria CRM197 Conjugate Vaccine] package insert, Novartis, January 2011

MMWR, Prevention and Control of Meningococcal Disease, Recommendations of the Advisory Committee on Immunization Practices (ACIP), U.S. Department of Health and Human Services, Centers for Disease Control and Prevention (CDC), Atlanta, GA 30333, May 27, 2005/Vol.54/No. RR-7

MMWR, Notice to Readers: Recommendation from the Advisory Committee on Immunization Practices (ACIP) for Use of Quadrivalent Meningococcal Conjugate Vaccine (MCV4) in Children Aged 2--10 Years at Increased Risk for Invasive Meningococcal Disease. December 7, 2007 / 56(48);1265-1266

MMWR, Updated Recommendations for the Use of Meningococcal Conjugate Vaccines – Advisory Committee on Immunization Practices (ACIP) 2010, January 28, 2011. <http://www.cdc.gov/mmwr/pdf/wk/mm6003.pdf>

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

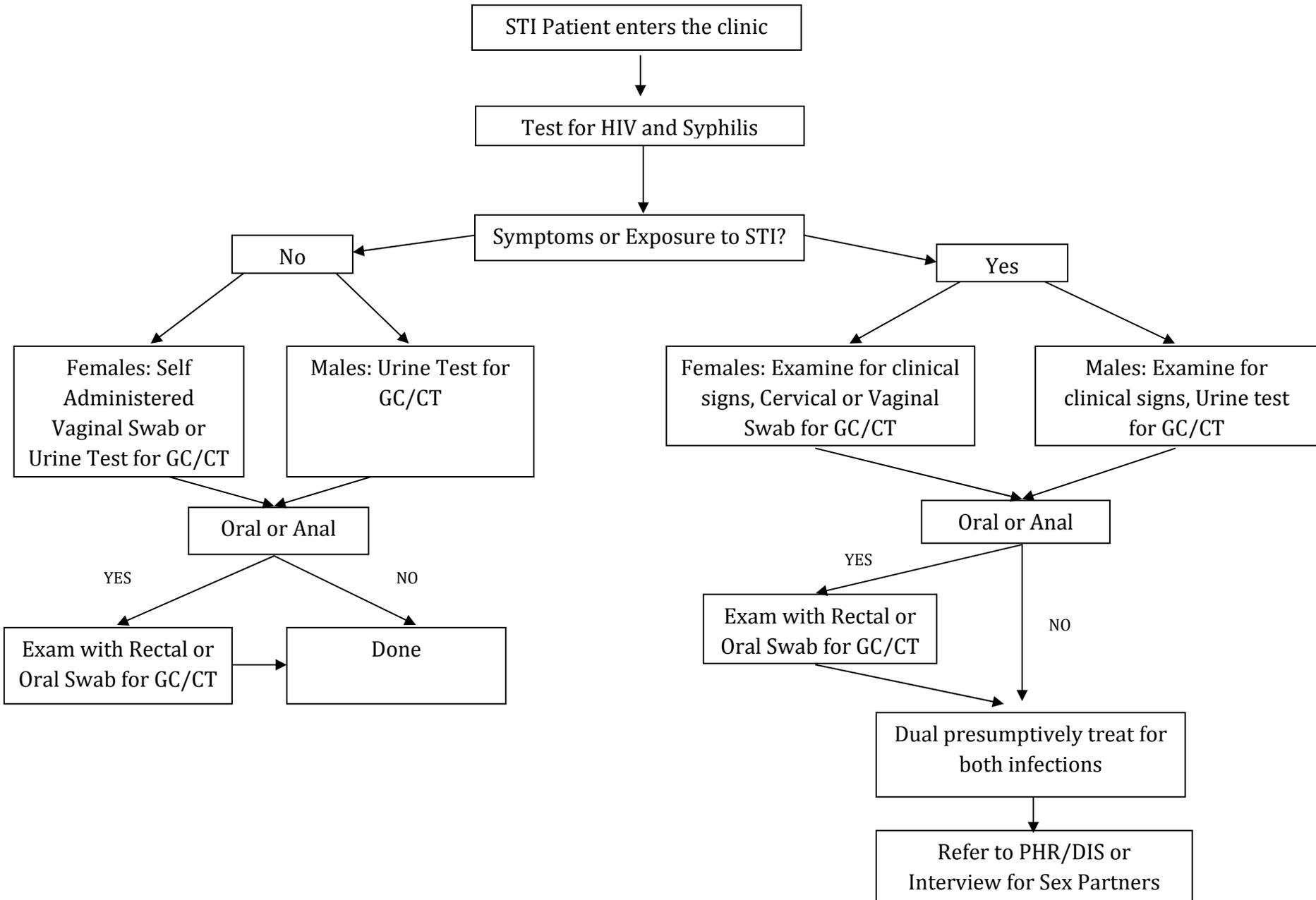
Memphis/Shelby County – Health Department clinics, Memphis Planned Parenthood

Nashville/Davidson

Knoxville/Knox

Jackson/Madison

Decision Tree for Examination of STI Patients



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

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.

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 retreated, but not retested.

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.

TREATMENT

Use dual treatment on the person to be treated, unless you have a confirmed negative test for gonorrhea (see protocol for gonorrhea).

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

AZITHROMYCIN is the drug of choice for chlamydia.

Treatment for Chlamydia Only²

Adult/Adolescent:

Azithromycin 1 gm orally as a single dose

OR

Doxycycline 100 mg orally BID x 7 days³

Pregnant Adult/Adolescent or Nursing Mothers:

(if unprotected coitus since LMP, suspect pregnancy and treat accordingly):

Azithromycin 1 gm orally as a single dose

OR

Amoxicillin 500 mg orally TID x 7 days

Allergic Pregnant Individuals:

Consult with physician regarding choice of above antibiotics

Dual Treatment for Chlamydia and Gonorrhea (regardless of site of exposure)⁴

² Patients 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.

³ Doxycycline is contraindicated in pregnancy and nursing mothers.

Non-Allergic Adult/Adolescent:

Ceftriaxone 250 mg IM as a single dose

PLUS ONE OF THE FOLLOWING:

Azithromycin 1 gm orally as a single dose

OR

Doxycycline 100 mg orally BID x 7 days⁵

Non-Allergic Pregnant Adult/ Adolescent/ Nursing Mothers:

Ceftriaxone 250 mg as a single dose

PLUS ONE OF THE FOLLOWING:

Azithromycin 1 gm orally as a single dose

OR

Amoxicillin 500 mg orally TID x 7 days

Allergic Adult/Adolescent:

Azithromycin 2 grams (tablets only) orally as a single dose⁶

Allergic Pregnant Adult/Adolescent/Nursing Mothers :

Azithromycin 2 grams (tablets only) orally as a single dose

OR

Azithromycin 1 gm orally 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)

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.

Penicillin or Cephalosporin Allergies: Ceftriaxone is the drug of choice for gonorrhea. If the patient alleges an allergy to penicillin or cephalosporins, the nurse should take a thorough history

⁴ When the laboratory results for both diseases are not available on the person being treated, dual treatment (for chlamydia and gonorrhea) should be administered. Do not refer for desensitization treatment in absence of lab confirmed gonorrhea.

⁵ Doxycycline is contraindicated in pregnancy and nursing mothers.

⁶ Studies have indicated increase frequency of gastrointestinal problems with a 2 gram dose of azithromycin. According to the PDR, azithromycin tablets can be taken with food to lessen the occurrence of GI symptoms. Patients should be advised to return for repeat treatment if vomiting occurs.

of allergic response to determine if there is a history of severe allergic reaction such as anaphylaxis or Stevens Johnson syndrome. If the history indicates a non-anaphylactic reaction, (i.e. mild to moderate rash, itching, etc.), the patient should be treated with ceftriaxone. If history indicates a severe reaction such as anaphylaxis, or nurse is unable to gain a history consistent with a non-anaphylactic reaction the patient should be treated with 2 grams azithromycin.⁷ Since there is little to no incidence of ceftriaxone resistant gonorrhea reported in the United States, all patients returning with gonorrhea and persistent or recurring symptoms should be considered reinfected and retreated with ceftriaxone.⁸

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 may 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 HIV and STD prevention.
- Encourage voiding before and after intercourse.
- Increase water intake with medications.
- Avoid antacids and exposure to sun when taking doxycycline.
- Stress hygiene, including wearing cotton underwear, loose clothing, avoidance of underpants while sleeping, wiping front to back, and 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)

⁷ Studies 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.

⁸ There is no need for the laboratory to perform sensitivity testing on isolates unless the CDC begins reporting an increased incidence of ceftriaxone-resistant gonorrhea from their Gonorrhea Isolate Surveillance Program GISP).

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 patient to return for retesting 3 months after completion of treatment. If this does not occur, retest all persons 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 except in pregnant women who should be tested 4-6 weeks after completing therapy.

REFERENCE

Centers for Disease Control and Prevention Sexually Transmitted Diseases Treatment Guidelines, 2010. MMWR 2010; 59(No. RR-12).

Chlamydia and Gonorrhea Treatment Decision Tree

