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PUNCTURE WOUND

SUBJECTIVE

History of recent injury

Assess the following:

- When and where the injury occurred
- Circumstances of injury (if animal- see Animal Bites)
- Description of the penetrating object
- Date of last tetanus vaccine
- Depth of penetration
- Footwear at the time of injury (if plantar wound)

OBJECTIVE

Determination if a retained foreign body is present

Medical history of the patient (especially diabetes mellitus, neuropathy, or vascular disease)

Presence or absence of pain, bleeding, discharge, edema and/or inflammation

Clean or dirty wound

ASSESSMENT

Puncture wound

PLAN

Cleanse with iodophor, other antiseptic solution, or use antibacterial soap and water.

Use tweezers to remove splinter/foreign body if easily accessible; if deep, do not attempt removal. **DO NOT** attempt to remove splinter/foreign body in, or around, eye

Apply thin layer of antibiotic ointment and sterile dressing

Teach signs and symptoms of infection (redness, heat, swelling)

Refer to PHN Protocol 4.280, Tetanus Prophylaxis in Wound Management, for administration of tetanus prophylaxis.

Referral Indicators:

Consult with nurse practitioner or physician if:

- Removal of foreign body
- Signs or symptoms of infection are present
- All eye injuries

Follow-up:

As recommended by provider

Return to clinic PRN

Reference

Mayo Clinic, Guide To Self-Care, Fifth Edition 2006

<http://www.uptodate.com/contents/overview-of-puncture-wounds>

TETANUS AND DIPHTHERIA TOXOID, ADULT TYPE

Td (Adult Type)

GENERAL INFORMATION

Tdap is recommended for most persons age 11 years and older who have not yet received it (see Tdap protocol for adolescents 11 through 18 years or the protocol for adults ≥ 19). Subsequent routine Td boosters are recommended every 10 years.

SUBJECTIVE

Patient reports needs Tetanus booster

OBJECTIVE

Appropriate candidates for Td include the following:

- At least seven years of age and older and requiring tetanus immunization for whom Tdap is not recommended (e.g., medical contraindication, previous dose of Tdap, or child 7-9 years of age who had a complete DTaP vaccination series)
- No previous dose of Td, or at least 4-8 weeks after Td #1 or 6 months after Td #2
- Ten years since last tetanus-containing vaccine (DTP, DTaP, Tdap or Td)

ASSESSMENT

Contraindications include the following:

History of severe allergic reaction (i.e., anaphylaxis) to a previous dose of any tetanus- or diphtheria-containing vaccine or component of the vaccine

Precautions include the following:

- Defer vaccination until resolution of moderate to severe acute illness
- History of Arthus-type hypersensitivity reactions (extensive painful limb swelling within hours of injection) following tetanus vaccination administered <10 years previously; such patients should not be given any tetanus-containing vaccine more frequently than every 10 years
- Guillain-Barre syndrome (GBS) within 6 weeks after a previous dose of a tetanus toxoid-containing vaccine
- Severe (anaphylactic) latex allergy; vial stopper and pre-filled syringes may contain latex (see package insert of specific product)

PREGNANCY: Pregnancy is not a contraindication to Td or Tdap; if tetanus vaccination during pregnancy is indicated, Tdap is preferred. Unless contraindicated, pregnant women who have not completed their primary series should do so before delivery if possible. If there is insufficient time, 2 doses of Td should be administered at least 4 weeks apart and the second dose should be given at least 2 weeks before delivery. Tdap should be substituted for the first Td dose if Tdap has not been administered previously.

Tdap should be given to each pregnant woman, preferably during the third trimester, during EACH pregnancy, regardless of her history of Tdap vaccination). See protocol 4.260.

PLAN

Have patient or accompanying adult read Vaccine Information Statement/Vaccine Information Material

Counsel regarding benefits, side effects, and management

Administer 0.5 cc of Td INTRAMUSCULARLY

Advise to wait in clinic 20 minutes after injection

Record manufacturer and lot number of the vaccine administered, date of administration and provision of VIS, name, address, and title of person administering vaccine (National Childhood Vaccine Injury Act)

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

Referral Indicators:

History of severe reaction to previous dose of tetanus- or diphtheria-containing vaccine (DTP / DTaP / DT / Td)

History of severe latex allergy (if Td vial stopper or pre-filled syringe contains latex, see package insert)

Needs tetanus immune globulin (TIG) for wound management

If severe reaction is identified following vaccine administered by health department personnel, VAERS Report Form must be completed

Follow-Up:

If no primary series, return for Td #2 in 4-8 weeks or for Td #3 in 6-12 months [use Tdap for one of the doses if not previously administered]

Return for Td booster in 10 years, according to current immunization schedule

Return for wound management as required (see Protocol 4.280, Tetanus Prophylaxis in Wound Management).

REFERENCES

Packet Insert: <http://www.fda.gov/downloads/BiologicsBloodVaccines/UCM152826.pdf> last accessed March 21, 2012.

Current Vaccine Information Statement: <http://www.cdc.gov/vaccines/pubs/vis/downloads/vis-td-tdap.pdf> last accessed March 21, 2012.

Centers for Disease Control and Prevention, Updated Recommendations for Use of Tetanus Toxoid, Reduced Diphtheria Toxoid and Acellular Pertussis (Tdap) Vaccine from the Advisory Committee on Immunization Practices, 2010. MMWR. <http://www.cdc.gov/mmwr/pdf/wk/mm6001.pdf> Last accessed January 14, 2011.

Centers for Disease Control and Prevention. FDA Approval of Expanded Age Indication for a Tetanus Toxoid, Reduced Diphtheria Toxoid and Acellular Pertussis Vaccine. MMWR 2011;60(No. 37): pp. 1279-1280.

Centers for Disease Control and Prevention. Updated Recommendations for Use of Tetanus Toxoid, Reduced Diphtheria Toxoid and Acellular Pertussis Vaccine (Tdap) in Pregnant Women and Persons Who Have or Anticipate Having Close Contact with an Infant Aged <12 Months — Advisory Committee on Immunization Practices (ACIP), 2011

ACIP provisional recommendations for adults aged 65 years and older on use of tetanus toxoid, reduced diphtheria toxoid and acellular pertussis vaccine (Tdap) and guidance on use of Tdap products for adults aged 65 years and older.

<http://www.cdc.gov/vaccines/recs/provisional/Tdap-feb2012.htm>. Last accessed March 22, 2012.

TETANUS PROPHYLAXIS IN WOUND MANAGEMENT

GENERAL INFORMATION

Tetanus is an acute, often fatal, disease characterized by muscle stiffness usually involving the jaw (lockjaw) and neck that becomes generalized rigidity and convulsive spasms of skeletal muscles. Transmission is primarily by contaminated minor or major wounds. The incubation period ranges from 3 to 21 days, usually about 8 days. In general the further the injury site is from the central nervous system, the longer the incubation period. The shorter the incubation period, the higher the chance of death.

SUBJECTIVE

Patient reports recent wound (could be skin burn, deep puncture wound, crush wound, otitis media (ear infections), dental infection, animal bite)

OBJECTIVE

Patient needs tetanus prophylaxis

ASSESSMENT

Review patient immunization history

PLAN

Teach wound care

Have patient or accompanying adult read Vaccine Information Statement/Vaccine Information Material

Counsel regarding benefits, side effects, and management

Administer IM 0.5cc DTaP, DT, Tdap or Td vaccine using the following schedule:

Guide to tetanus prophylaxis in routine wound management.

History of adsorbed tetanus toxoid (doses)	Clean minor wounds Tdap or Td†	Clean minor wounds TIG§	All other wounds* Tdap or Td†	All other wounds* TIG§
less than 3 or unknown	Yes	No	Yes	Yes
3 or more doses¶	No if <10 years since last tetanus containing vaccine dose	No	No if <5 years since last tetanus containing vaccine dose	No
	Yes if >10 years since last tetanus containing vaccine dose	No	Yes if ≥ 5 years since last tetanus containing vaccine dose	No

* Such as (but not limited to) wounds contaminated with dirt, feces, soil, and saliva; puncture wounds; avulsions; and wounds resulting from missiles, crushing, burns, and frostbite.

† DtaP is the recommended and preferred vaccine for children less than 7 years of age, (or DT if pertussis component is contraindicated)

Do not give DTaP if:

- a) The total number of DTaP immunizations would be in excess of the number recommended for the child's age
- b) They have not reached the minimum age for the next dose due

† For persons age 7 and up with unknown or <3 doses, Tdap is preferred if the patient has not previously received Tdap (if so, Td is preferred)
For persons 7–9 years of age who have previously completed the series, Td is recommended

¶ If patient records indicate that only three doses of fluid tetanus toxoid have been received, a fourth dose of a tetanus toxoid, preferably adsorbed, should be given. Although licensed, fluid tetanus toxoid is rarely used. Children 7-10 years with incomplete pertussis immunization may receive Tdap, see Tdap protocol for children and adolescents.

For persons >10 years, Tdap is preferred to Td if the patient has never received Tdap and has no contraindication to pertussis vaccine. For persons 7 years of age or older, if Tdap is not available or not indicated because of age, Td is preferred to TT.

§ Patients with wounds that are neither clean nor minor, AND who have had 0-2 prior doses of tetanus toxoid or have an uncertain history of prior doses should be referred for Tetanus Immune Globulin (Human) referred to as TIG. Equine tetanus antitoxin should be used when TIG is not available.

NOTE: For non-pregnant persons 11 or older (including those over age 64), Tdap should be used instead of Td if the recipient has not previously received Tdap. If Tdap is not available or was administered previously, Td should be administered.

Pregnancy:

PREGNANCY: Pregnancy is not a contraindication to Td or Tdap; if tetanus vaccination during pregnancy is indicated, Tdap is preferred, unless contraindicated. Pregnant women who have not completed their primary series should do so before delivery if possible. If there is insufficient time, 2 doses of Td should be administered at least 4 weeks apart and the second dose should be given at least 2 weeks before delivery. Tdap should be substituted for the first Td dose if Tdap has not been administered previously.

Tdap should be given to each pregnant woman, preferably during the third trimester, during EACH pregnancy, regardless of her history of Tdap vaccination. See protocol 4.260.

Referral Indicators:

Needs TIG

History of severe reaction (e.g., anaphylaxis) to DTP/DTaP/DT/Td

If a severe reaction is reported as occurring within 30 days following vaccine administered by health department personnel, VAERS Report Form must be completed.

Follow-Up:

Persons whose immunizations are incomplete should be scheduled for the remainder of the recommended series.

REFERENCES

MMWR, Vol. 40, No. RR-10, August 1991.

MMWR, Vol. 55, No. RR-3, March 24, 2006

Advisory Committee on Immunization Practice (ACIP) Votes to Recommend Use of Combined Tetanus, Diphtheria and Pertussis (Tdap) Vaccines for Adults, U.S. Department of Health and Human Services, Centers for Disease Control and Prevention (CDC), Atlanta, GA 30333, March 2, 2006 http://www.cdc.gov/nip/vaccine/tdap/tdap_adult_recs.pdf Last accessed May 12, 2006

Centers for Disease Control and Prevention, Updated Recommendations for Use of Tetanus Toxoid, Reduced Diphtheria Toxoid and Acellular Pertussis (Tdap) Vaccine from the Advisory Committee on Immunization Practices, 2010. MMWR. <http://www.cdc.gov/mmwr/pdf/wk/mm6001.pdf> Last accessed January 14, 2011.

<http://www.cdc.gov/vaccines/pubs/pinkbook/tetanus.html#wound>

Red Book, Report of the Committee on Infectious Diseases, 29th Edition. 2012

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.
Refer to PHN Protocol 5.010 for Chlamydia Case or Contact for treatment and counseling.

HEPATITIS B

Other Non-Occupational Contacts POST-EXPOSURE

GENERAL INFORMATION

Hepatitis B (HBV) is transmitted through infected blood or body fluids. Common modes of transmission include exposure to infectious body fluids through sexual contact, household exposure or through the sharing of needles or syringes. The incubation period for acute infection is 60 to 150 days, with an average of 90 days.

SUBJECTIVE

History of sexual contact, needle sharing, or household exposure to blood or body fluids. Complaint of serum sickness-like prodrome (skin eruptions, urticaria, arthralgias, arthritis), fatigue, anorexia, nausea, vomiting, headache.

OBJECTIVE

Symptoms may include dark urine, jaundice, and moderate liver enlargement with tenderness. Diagnosis cannot be made on basis of clinical symptoms alone. Most will need testing for markers of hepatitis B infection and vaccination, if susceptible

ASSESSMENT

Perform serologic testing

Evaluate need for pre- and post-vaccination serologic testing.

PLAN

Notify Regional Communicable Environmental Disease & Emergency Preparedness (CEDEP) Director

If patient is pregnant, notify Regional Perinatal Hepatitis B Coordinator

Table 1. Guidelines for **Pre-Vaccination** Testing and Interpretation of Results for non-Occupational Contacts of HBsAg Positive Persons

Exposure	Testing	Timing of test	
All household, needle-sharing, sexual contacts	HBsAg and anti-HBs	Before administering PEP (at same visit)	
Test Results	HBsAg positive	HBsAg negative, anti-HBs positive	HBsAg negative, anti-HBs negative
Next Steps	Patient is infected. Discontinue vaccination, refer for medical follow-up, refer to Regional CEDP Director for case investigation, contact management	Patient immune, discontinue vaccination	Patient is susceptible, complete vaccine series

Use Table 2 below to evaluate need for Hepatitis B Immune Globulin (HBIG) and Hepatitis B

Vaccine (HBV) (percutaneous or mucosal exposure) based on the HBsAg status of the source and the HBV immunization and vaccine-response status of the person exposed.

Refer to packet insert for administration instructions and guidelines on the use of HBIG

Table 2. Guidelines for **Postexposure Prophylaxis (PEP)** of susceptible persons with non-occupational discrete exposures to blood or body fluids that contain blood by exposure type and vaccination status**:

Exposure	Treatment	
HBsAG positive source		
	Unvaccinated (or incompletely vaccinated)	Previously vaccinated (without prior serologic confirmation of immunity)*
Percutaneous (e.g., bite or needle stick) or mucosal exposure (within 7 days)	Administer HBIG and initiate HBV series	Administer one HBV booster dose
Sex or needle-sharing contact (within 14 days)	Administer HBIG and initiate HBV series	Administer one HBV booster dose
Victim of sexual assault/abuse (within 14 days)	Administer HBIG and initiate HBV series	Administer one HBV booster dose
Source with <u>unknown</u> HBsAg status		
Percutaneous (e.g., bite or needle stick) or mucosal exposure (within 7 days)	Initiate HBV series	No treatment
Sex or needle sharing contact (within 14 days of last contact)	Initiate HBV series	No treatment
Victim of sexual assault/abuse (within 14 days)	Initiate HBV series	No treatment

*Persons who have ever had laboratory confirmation of immunity (e.g., positive for anti-HBs) do not require a booster dose or HBIG.

**Administer PEP as soon as possible, preferably within 24 hours. PEP should not be given after the maximum number of days specified in the exposure category, because it is not expected to be protective. Vaccine may still be appropriate to protect from future exposure.

Federally funded vaccine may be used for all HBV vaccine used as PEP and to complete immunization series of all at risk contacts, regardless of age.

Refer to most recent “Federally Funded Vaccines for Adults” guidance

Certain contacts should receive post-vaccination testing to document immunity.

Table 3. Guidelines for **Post-Vaccination Testing of Certain Contacts** of HBsAg positive persons.

Type of exposure	Test needed	Test timing (never earlier than 1 month after vaccination)
Ongoing sexual partner of infected person	Anti-HBs	At least 1 month after vaccination
Ongoing needle-sharing partner of infected person	Anti-HBs	At least 1 month after vaccination
Children <5 years in household of an infected person (not offspring of case)*	Anti-HBs	At least 1 month after vaccination
Fully immunized children of woman with chronic hepatitis B: considered perinatal contacts	Anti-HBs and HBsAg (if not previously tested)	At least 1 month after vaccination: see detailed information below

* Children under 5 years are at high risk of chronic infection if they remain susceptible following vaccination and are exposed to the virus. This risk declines with age. If HBIG has been given in past 4 months, consult with Health Officer.

For fully immunized children of a woman who is HBsAg+, where there is any possibility that she was HBsAg+ during her pregnancy with them: these children are not simply household contacts, but should be considered incompletely evaluated perinatal contacts that are overdue for post-vaccination testing. Like younger perinatal contact infants, these children are still due to have serology done for both **HBsAg and anti-HBs**.

Testing should **not** be done if there is documentation that the child has ever had serology proving they were immune or proving they were already infected. **If they are fully immunized, HBsAg negative and anti-HBs negative, a single challenge dose of vaccine** should be given and the patient should have an anti- HBs drawn 1 month later. This will stimulate a positive antibody response in the vast majority of children who are immune but whose antibody levels had dropped.

For patients that test negative for anti-HBs following three doses of vaccine, **repeat the vaccine series of 3 doses** in accordance with the routine vaccination schedule and re-test for anti-HBs at least 1 month after the second series. If the patient remains non-immune, they are a vaccine **non-responder** and no further vaccination will be of benefit. Educate about risk behaviors and their ongoing risk of HBV infection if exposed. HBIG will be needed for protection if an exposure occurs in the future.

Health Teaching:

Encourage HBV vaccine and the importance of testing, where relevant.

Avoid sharing needles with others.

Diabetic patients should not share personal glucose monitors or lancets with others.

Abstain from sexual contact with infected partners.

Use condoms for each sexual encounter to prevent exchange of body fluids or skin contact.

Use only water based lubricants (such as K-Y) during sexual encounter. Do not use oil-based products.

Avoid donating blood or organs if test positive for hepatitis B.

REFERENCES

“Epidemiology and Prevention of Vaccine-Preventable Diseases”, Centers for Disease Control and Prevention, DHHS, 12th Edition, May 2011

Red Book, Report of the Committee on Infectious Diseases, 29th Edition. 2012

MMWR, A Comprehensive Immunization Strategy to Eliminate Transmission of Hepatitis B Virus Infection in the United States. Recommendations of the Advisory Committee on Immunization Practices (ACIP) Part II: Immunization of Adults. December 8, 2006. Vol. 55 Number RR-16.

MMWR, Recommendations for Identification and Public Health Management of Persons with Chronic Hepatitis B Virus Infection. September 19, 2008 / Vol. 57 / No. RR-8.

HIV TESTING AND COUNSELING

GENERAL INFORMATION

Human immunodeficiency virus (HIV) is the virus that can lead to acquired immunodeficiency syndrome, or AIDS. In the United States, HIV is spread mainly by having unprotected sex (sex without a condom) with someone who has HIV or sharing needles/syringes, or other equipment used to prepare injection drugs with someone who has HIV. For transmission to occur, fluids (blood, semen, pre-seminal fluid, rectal fluids, vaginal fluids, or breast milk) from a HIV infected person must come in contact with a mucous membrane (rectum, vagina, opening of the penis, or mouth) of an uninfected person.

SUBJECTIVE

Patient seeking evaluation and/or treatment for STDs

Patient request HIV testing or counseling

Patient identified as high risk

OBJECTIVE

Encourage testing for all person ages 13 to 64 years in health-care settings.

Persons at high-risk for HIV infection should be screened at least annually, including:

- Men who have sex with men (MSM) who themselves or their sex partners have had more than one sex partner since their most recent HIV test
- Heterosexuals who themselves or their sex partners have had more than one sex partner since their most recent HIV test
- Sex partners of HIV-infected persons
- Injection drug users and their partner(s)
- Anyone seeking STD evaluation/treatment
- Individuals with syphilis
- Individuals with tuberculosis

ASSESSMENT

Assess client's individual risk status

Determine client's needs (testing, level of counseling)

PLAN

- Screen for HIV using currently available test (serologic, oral¹ rapid); refer to "*Laboratory Policies and Procedures Manual for Local Health Departments*" for information on specimen storage and handling
- Draw blood for syphilis serology on all STD patients examined in clinic, and when appropriate during outreach activities
- Offer testing/counseling for other STDs (gonorrhea, chlamydia)

¹ The use of Oral/Rapid testing is not a routine clinic procedure, at this time. These testing modalities should be used in outreach activities, or on a case-by-case basis in extraordinary clinic circumstances, with prior Supervisor approval.

- Evaluate patient immunization status including Hepatitis A, Hepatitis B, HPV and according to current CDC recommendations.
- Provide immunization(s) per PHN Protocol and current funding guidelines or refer as indicated
- Advise/provide HIV risk reduction counseling
- Offer condoms and encourage consistent use during all sexual activity.
- Instruct to use only water based lubricants such as KY Jelly or glycerin.
- Spermicides containing nonoxynol-9 are not recommended for STD/HIV prevention. Frequent use of spermicides containing N-9 has been associated with disruption of the genital epithelium, which might be associated with an increased risk for HIV transmission
- Encourage contacts to obtain testing/care
- Provide follow-up, e.g., test results, counseling as indicated, information relative to services available, and future opportunity for testing/counseling

Health Teaching:

Counseling should focus on the following:

- Unprotected intercourse increases the risk of HIV transmission
- Correct and consistent use of the male latex condom is an effective method of reducing the risk of HIV infection
- Anal sex is the highest-risk sexual behavior. Receptive anal sex (bottoming) is riskier than insertive anal sex (topping). Vaginal sex is the second highest-risk sexual behavior.
- Having multiple sex partners can increase the risk of HIV infection
- Sexually transmitted diseases (STD) have been long known to increase the risk of both acquiring and transmitting HIV infection.
- HIV can be passed from mother to child during pregnancy, birth, or breastfeeding.
- Contraceptive methods that are not mechanical barriers do not protect against HIV or other STDs.
- HIV transmission rates among uncircumcised males are higher than for circumcised males.

REFERENCES

CDC. HIV Basics: Risk Behaviors accessed September 6, 2013.
<http://www.cdc.gov/hiv/risk/index.html>

CDC. HIV Basics. Prevention research, accessed September 6, 2013
<http://www.cdc.gov/hiv/prevention/index.html>

Morbidity and Mortality Weekly Report, *Sexually Transmitted Diseases Treatment Guidelines*.
 Released by Centers for Disease Control and Prevention (CDC) December 17, 2010 /
 Vol. 59 / No. RR-12

SYPHILIS, CASE OR CONTACT

BACKGROUND

Syphilis is a STD that is transmitted from person to person by direct contact with syphilis sores. Sores occur mainly on the external genitals, vagina, anus, or in the rectum. They may also occur on the lips and in the mouth. Syphilis can be transmitted during vaginal, anal, or oral sexual contact. Syphilis can cause long-term complications and/or death if not adequately treated.

Pregnant women with the disease can pass it to their unborn children.

The average time between infection with syphilis and appearance of the first symptom is 21 days, but it can range from 10 to 90 days.

SUBJECTIVE

Previous history of syphilis infection

History of **symptoms suggestive of syphilis:**

Painless indurated lesion on genitalia or adjacent areas or other mucous membranes such as lip, vulva, labia, cervix, or anus

Body rash or spots on palms of hands or soles of feet

Sore throat, fever, headaches, or general malaise

Sexual contact to serology proven or physician verified case

Referral from private physician

Person at risk of syphilis as identified through the course of case investigation

“My partner told me he/she has syphilis”

OBJECTIVE

Report of reactive Captia Syphilis-G test (from Blood Bank) or EIA

Primary Syphilis:

One or more sores (also called chancres) at the location where syphilis entered the body. The sores are usually firm, round and painless and therefore may go unnoticed. These sores may appear on the genitalia, anus, fingers, tongue, nipples, tonsils, or eyelids. They last 3 to 6 weeks and will heal regardless of treatment.

Regional lymphadenopathy (unilateral or bilateral)

Secondary syphilis:

Rash is the most characteristic finding of secondary syphilis and can take any form except vesicular lesions. The rash is classically uniform, well defined, and generalized on trunk, extremities including the palms and soles, face, and scalp

Lesions enlarge and erode producing highly contagious sores that are pink or grayish-white

Reactive RPR and positive TP-PA¹ (sometimes RPR may be false positive)

Regional lymphadenopathy (unilateral or bilateral)

Alopecia, hair may have "moth eaten look"

¹ The TP-PA (Treponemal pallidum-particle agglutination) test has replaced the MHA-TP test, which is no longer available

ASSESSMENT

Confirmed or suspected syphilis, syphilis contact, or person identified through the course of syphilis case investigation

PLAN**NOTE**

If there has been an exposure within 90 DAYS prior to the exam, all known contacts to cases of syphilis, or persons identified through case investigation as being at risk for syphilis should be preventively treated. Contacts are treated with the same regimens as infected patients according to the following recommendations from the 2010 CDC guidelines on the treatment of STDs:

- Persons who were exposed within 90 days preceding the diagnosis of primary, secondary or early latent (acquired within the past 1 year) syphilis in a sex partner might be infected even if seronegative; therefore, such persons should be treated presumptively.
- Persons who were exposed >90 days before the diagnosis of primary, secondary or early latent syphilis in a sex partner should be treated presumptively if follow-up is uncertain.
- Long-term sex partners of patients who have latent syphilis should be evaluated clinically and serologically for syphilis and treated on the basis of the evaluation.

If a report is received of an individual with a reactive Captia Syphilis-G test, an attempt should be made to locate the person to inform him or her of the test result. It is important to inform the individual that the Captia Syphilis-G tests are used for screening purposes and that further tests (RPR and TP-PA) are needed for confirmation of a current syphilis infection.

Obtain specimen from lesion(s), if present, for darkfield examination (if available) by Public Health Representative or physician.

For persons with a positive Captia Syphilis-G test, question regarding a previous history of syphilis infection, recall of symptoms suggestive of syphilis, sexual exposure to someone with symptoms, or known exposure to a confirmed case in order to make a more clear diagnosis.

After obtaining a specimen on individuals with only a positive Captia Syphilis-G test, both the RPR and the TP-PA should be concurrently ordered on the syphilis serology form (i.e. lab slip). Also indicate that it is a re-test of a Captia Syphilis-G test per State Lab protocols.

Obtain blood specimen for serologic test for syphilis. Request TP-PA if reactive RPR.

Refer all patients with syphilis for HIV counseling and testing.

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

Perform gonorrhea and chlamydia screening.

Ask whether patient has any drug sensitivities, especially to penicillin.

Report all prepubertal children to the Department of Human Services.

Report all cases to the STD Representative or Regional CEDEP Supervisor **immediately**.

Consult physician as needed.

TREATMENT

Early Syphilis (primary, secondary, or early latent syphilis). Contacts to a case should be treated with this same regimen. Subsequent and/or additional treatment will be based on results of lab test.

Non-pregnant, Non-allergic Adult/Adolescent:

Benzathine penicillin G 2.4 million units IM (give 1.2 million units in each buttock)

Non-pregnant, Penicillin Allergic Adult/Adolescent:

Doxycycline², 100 mg orally BID x 14 days

Non-tolerance to Doxycycline:

If follow-up or compliance cannot be assured, the patient should be referred for skin testing for penicillin allergy and undergo desensitization, if necessary. With careful follow-up and permission obtained from regional health officer, may give ceftriaxone 1gm IM once a day for 10-14 days. Caution must be used as patients who are allergic to penicillin may also be allergic to cephalosporins.

Late Latent Syphilis (over one year's duration) AND Latent Syphilis of Unknown Duration

Non-pregnant, Non-allergic Adult/Adolescent:

Benzathine penicillin G 7.2 million units total, administered as one dose of 2.4 million units (1.2 million units IM in each buttock IM) at one week intervals for 3 consecutive weeks

Non-pregnant, Penicillin Allergic Adult/Adolescent:

If patient is allergic to penicillin and there are no clinical signs of neurological involvement (see next section on Neurosyphilis), the following regimen may be used following consultation with Regional CEDEP Director and/or Regional Health Officer

Doxycycline, 100 mg orally BID x 28 days

Neurosyphilis (central nervous system disease may occur during any stage of syphilis)

With any clinical evidence of neurological involvement (e.g. optic and auditory symptoms, cranial nerve palsies or signs or symptoms of meningitis), consult with Regional CEDEP Director and/or Regional Health Officer and refer as recommended. Neurosyphilis can occur in any stage of syphilis. Treatment should be based on the stage of syphilis. Treatment should not be withheld pending evaluation.

Syphilis in Pregnancy

All pregnant women should be screened early in pregnancy.

Seropositive pregnant women should be considered infected unless treatment history and sequential serologic antibody titers are showing an appropriate response. In areas in which the prevalence of syphilis is high, or for patients at high risk, testing should be repeated at 28 weeks and at delivery.

² Doxycycline is contraindicated in pregnancy and nursing mothers

Tetracycline and doxycycline are contraindicated in pregnancy and nursing mothers. Erythromycin is not to be used due to high risk of failure to cure infection in fetus.

All Stages of Pregnancy, Non-allergic:

Benzathine penicillin G in dosage schedules appropriate for the stage of syphilis, as recommended for treatment of non-pregnant patients (see above).

All Stages of Pregnancy, Penicillin Allergic:

Contact Regional CEDEP Director and/or Regional Health Officer and refer as recommended.

Syphilis and HIV

All syphilis patients should be screened for HIV.

HIV, Non-allergic

Benzathine Penicillin G in dosage schedules appropriate for the stage of syphilis, as recommended for treatment of non-HIV patients (see above).

Congenital Syphilis

Contact Regional CEDEP Director and/or Regional Health Officer and refer according to CED guidelines.

Health Teaching

Offer condoms and encourage use during any sexual activity. The use of condoms is effective, but only protects the parts covered.

Wash exposed parts with soap and water as soon after contact as possible.

Advise regular check-ups when patient has more than one sexual partner or if sex partner has more than one partner.

Counsel regarding HIV and other STDs. Offer testing as indicated.

Advise women taking oral contraceptives to use condoms during, and for 2 weeks after, antibiotic treatment.

Counsel that RPR may stay reactive after treatment.

Instruct regarding potential Jarisch-Herxheimer Reaction (in 50% of cases, 6-12 hours after any therapy for syphilis, patient may develop high fever, malaise, exacerbation of symptoms lasting 24 hours and pregnant women may experience pre-term labor).

Encourage to return if primary syphilis lesion has not healed within a week

Referral Indicators

Pregnant and penicillin allergic

Continued elevated antibody titers after treatment

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

A primary lesion that is not healing one week after treatment

Follow-Up

Return for repeat RPR tests at 6 and 12 months after conclusion of treatment or until 4 fold decrease (2 dilutions) (i.e., 128 dilutions to 32 dilutions) in titer is observed.

HIV infected persons should return for repeat tests at 3, 6, 9, 12 and 24 months after conclusion of treatment.

Careful follow-up serologic testing is particularly important in patients treated with antibiotics other than penicillin.

If less than 4 fold (2 dilutions) decrease in RPR (i.e. 128 dilutions to 64 dilutions) after 6 months (3 months for HIV infected patients) refer to STD/CEDS supervisor and/or clinic Regional Health Officer for evaluation of treatment or reinfection.

Counsel regarding HIV and other STDs. Offer testing as indicated.

If using oral contraceptives, counsel patient to use condoms during, and for 2 weeks after, antibiotic treatment.

Counsel that RPR may stay reactive after treatment.

Reference

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

CDC. Sexually Transmitted Diseases. Syphilis – CDC Fact Sheet
<http://www.cdc.gov/std/syphilis/STDFact-Syphilis.htm>

Hicks CB, Sparling PF, Pathogenesis, clinical manifestations and treatment of early syphilis uptodate

LIST OF STANDARD ABBREVIATIONS

Revised December 2013

NOTE:

Region specific abbreviations may be used as long as they are approved by the region and are attached to the following list of approved standard abbreviations.

The use of abbreviations in standard program and laboratory manuals and Patient Tracking and Billing Management Information System (PTBMIS) are allowed.

The following Joint Commission on Accreditation of Healthcare Organization (JCAHO) prohibited abbreviations should not be used because potential for provider error:

qd /every day; qod / every other day; and U/ units

-A-

A & O	alert and oriented
Ab	abortion
Abd	abdominal, abdomen
Abn	abnormal
ac	before meals
ACHES	abdominal pain, chest pain, headaches, eye problems and severe leg pain
ADD	attention deficit disorder
ADHD	attention deficit hyperactive disorder
ad lib	as desired
ADL	activities of daily living
adm	admission, admit
AIDS	acquired immunodeficiency Syndrome
AKA	above knee amputation
ALT	anterio lateral thigh
Am	morning
AMA	against medical advice
amb	ambulatory
Amox	Amoxocillin
amp	amputation
amt	amount
ant	anterior
ant font	anterior fontanelle
appt	appointment
ARDS	Acute Respiratory Distress Syndrome

ASA	aspirin
ASAP	as soon as possible
ASHD	arteriosclerotic heart disease
AUB	abnormal uterine bleeding
auth #	authorization number
AV	anteverted

- B -

BC	birth control
BCP	birth control pills
B/F	black female
BF	breastfeeding
BID	two times daily
Bil	bilateral
BKA	below knee amputation
BM	bowel movement
B/M	black male
BMR	basal metabolic rate
B/P or BP	blood pressure
BOM	bilateral otitis media
BS or BG	blood sugar or glucose
BSE	breast self exam
BSO	bilateral salpingo oophorectomy
BTB	break through bleeding
BTL	bilateral tubal ligation
BUM	back up method
BV	bacterial vaginosis
BW	birth weight
BX	biopsy

- C -

C	centigrade/ Celsius
Ca	cancer
Ca+	calcium
CABG	coronary artery bypass with graft
CAD	coronary artery disease
Cal	calorie
cap	Capsule
Carb	carbohydrate
cath	catheterization
cc	cubic centimeter
CC	chief complaint
CCLG	Creative Curriculum Learning Games
CCU	Coronary Care Unit
CD	communicable disease
CEDEP	Communicable Environmental Disease & Emergency Preparedness
Cert	certify
CHA	Community Health Agency
CHF	congestive heart failure
Chol	cholesterol
CID	correction in documentation
Cigs	cigarettes
Circ	circumcision
ck	check
cm	centimeter
CMT	cervical motion tenderness
CMV	cytomegalovirus
CNS	central nervous system
c/o	complains of
Co	county
CO ₂	carbon dioxide
comp	comprehensive
colpo	colposcopy
cont	continue
COPD	chronic obstructive pulmonary disease
CPAP	continuous positive airway pressure
cryo	cryosurgery
C-section	cesarean section
CTA	clear to auscultation
CV	cardiovascular
CVA	cerebral vascular accident

CVAT	costo vertebral angle tenderness
Cx	cervix
CXR	chest x-ray

- D -

D & C	dilatation and curettage
dc, D/C	discontinue, discharge
DCS	Department of Children's Services
Del	delivery, delivered
delt	deltoid
dept	department
dev	development
DHS	Department of Human Services
diaph	diaphragm
diff	differential
Dir	Director
disc	discussed
disp	dispensed
DM	Diabetes Mellitus
DMPA, Depo	Depo-Medroxyprogesterone (Depo-Provera)
DOE	dyspnea on exertion
Doxy	Doxycycline
DTR	Deep tendon reflex
DTs	Delirium tremors
DVT	deep vein thrombosis
Dx	diagnosis
DZ	disease

- E -

ECC	endocervical curettage
ED	Emergency Department
edu/ed	education
EDC	estimated date of confinement
EDD	estimated date of delivery
EES, E-mycin	Erythromycin
EMS	Emergency Medical Services
enc	encourage
ENT	ear, nose, throat
Env	environment
ER	emergency room
eRx	e prescribe
esp	especially
etc	and so on
ETOH	alcohol

eval evaluate
 ex example
 ext external

- F -

F, Fa father
 FA Folic Acid
 FBD fibrocystic breast disease
 FBS, FBG fasting blood sugar or glucose
 fe female
 Fe iron
 FeSO₄ ferrous sulfate
 FM fetal movement
 font fontanel
 FH fundal height
 FHR fetal heart rate
 FHT fetal heart tone
 Fl fluoride
 freq frequent
 ft foot
 FTT failure to thrive
 f/u follow-up
 FUO fever of undetermined origin
 FVA Fluoride Varnish Application
 Fx fracture

- G -

GB gall bladder
 GC gonorrhea
 GERD gastro esophageal reflux disease
 GF grandfather
 GI gastrointestinal
 glu glucose
 Gm gram
 GM grandmother
 Gr grade
 gr grain
 GSE genital self-exam
 gtt drops
 G_P_A_ gravida _, para _, abortion_
 GYN gynecology

- H -

H₂O water
 H₂O₂ hydrogen peroxide

HOH hard of hearing
 HA headache
 HBV hepatitis B virus
 HC head circumference
 HCTZ hydrochlorothiazide
 HCV hepatitis C virus
 HCW health care worker
 HD health department
 HDV hepatitis D virus
 HEENT head, eyes, ears, nose, throat
 HH Home Health
 HMB heavy menstrual bleeding
 hosp hospital
 hr hour
 HR heart rate
 HRT hormone replacement therapy
 HS night, bedtime
 HSV herpes simplex virus
 ht height
 HTN hypertension
 Hx history
 hyst hysterectomy

- I -

IBW ideal body weight
 IBS irritable bowel syndrome
 ICU Intensive Care Unit
 I&D incision and drainage
 ID intradermal or identification
 IDDM insulin dependent diabetes mellitus
 i.e. such as
 IG immune globulin
 imm immunization
 in inches
 info information
 inj injection
 Ins insurance
 inst instruct, instructed, instructions
 IP intestinal parasite
 irreg irregular
 ISG immune serum globulin
 IUB Irregular uterine bleeding
 IUGR intrauterine growth retardation
 IUP intrauterine pregnancy
 IV intravenous
 IVDU IV Drug Use

- J -

(none)

- K -

K+	potassium
Kcal	kilo calorie
KCL	potassium chloride
kg	kilogram
KUB	kidneys, ureters, bladder

- L -

L&D	labor and delivery
LAC	left antecubital
Lap	laparotomy
lat	lateral
lb	pound
LBW	low birth weight
LD	left deltoid
LE	lower extremity
LEEP	Laser Electrosurgical Excision Procedure
LFA	left forearm
lg	large
LG	left gluteus
LGA	large for gestational age
LGM	left gluteus maximus
liq	liquid
LLE	left lower extremity
LLL	Left Lower Lobe
LLQ	left lower quadrant
LNMP	last normal menstrual period
LSB	left sternal border
LSC	last sexual contact
LT	left thigh
LUA	left upper arm
LUE	left upper extremity
LUQ	left upper quadrant
LHD	local health department

- M -

m	male
M, Mo	mother
Max	maximum
mcg	microgram
mcg/dl	micrograms per dilution

MCO	Managed Care
MDI	Metered Dose Inhaler
med	medication
mg	milligram
MGF	maternal grandfather
MGR	murmur, gallop, rub
MGM	maternal grandmother
mgt/mgmt	management
MH	Mental Health
MI	myocardial infarction
min	minute
misc	miscellaneous
ml	milliliter
mm	millimeter
MNT	medical nutrition therapy
mo	month
mod	moderate
mono	mononucleosis
MRSA	methicillin resistant staph aureus
mtg	meeting
MVA	motor vehicle accident
MVI	multivitamin
MVP	mitral valve prolapse
MTZ	metronidazole

- N -

Na	sodium
N/A	not applicable
NaCl	sodium chloride
NAS	intranasal
N&V	nausea and vomiting
N&V&D	nausea and vomiting and diarrhea
NAD	no apparent distress
NFP	natural family planning
NGU	nongonococcal urethritis
	NICU neonatal intensive care unit
NIDDM	non insulin dependent diabetes mellitus
NKA	no known allergies
NKDA	no known drug allergies
nl	normal
NN	nurses notes
NOS	not otherwise specified
NPO	nothing by mouth
NRF	no refills
NRT	nicotine replacement therapy

NSAIDS non-steroidal anti-inflammatory drugs
 Nsg nursing
 NSR normal sinus rhythm
 NSSC normal size, shape, and contour
 N/T non tender
 nutr, nutria nutrition

- O -

O₂ oxygen
 O & P ova and parasites
 OB obstetric
 oc oral contraceptive
 occ occasional
 OCP oral contraceptive pill
 OD overdose or right eye
 OM otitis media
 ortho orthopedic
 OS left eye
 OT Occupational Therapy
 OTC over the counter
 OU both eyes
 OV office visit
 oz ounce

- P -

P pulse
 palp palpable
 PAP Patient Assistant Program
 PC Primary Care
 phone conference/call
 pc after meals
 PCN penicillin
 PE physical examination
 ped pediatric
 peri perineum
 PERRLA pupils equal, round, reactive to light and accommodation
 PGF paternal grandfather
 PGM paternal grandmother
 PHBC "Partners for Healthy Babies" curriculum
 PID pelvic inflammatory disease
 pk pack
 pkg package
 pm afternoon

PMH past medical history
 PMI point of maximum impulse
 PMS premenstrual syndrome
 pneu pneumonia
 PNV prenatal vitamins
 POC plan of care
 po by mouth
 post posterior
 pp post partum
 PPBS, PPBG post prandial blood sugar or glucose
 ppd packs per day
 PPNG penicillinase producing neisseria gonorrhoea
 preg pregnant
 prep preparation
 Pres Elig presumptive eligibility
 PRN as needed
 Prog program
 PROM premature rupture of membranes
 PSVT paroxysmal supraventricular tachycardia
 PT physical therapy or pregnancy test
 Pt patient
 p/u pick up
 PUD peptic ulcer disease
 Pul pulmonary
 pvt private
 psych psychiatric

- Q -

q every
 q ___ h every ___ hours
 QID four times a day
 qt quart

- R -

R or RR respirations
 RA rheumatoid arthritis
 RAC right antecubital
 RD right deltoid
 RDS respiratory distress syndrome
 re regarding
 Re re-check
 Rec recommend

rec'd	received
rev'd	reviewed
recert	recertify, recertification
ref	referral, refer
reg	regulation, regular
rehab	rehabilitation
resp	respiratory
req	request
RF	refill
RFA	right forearm
RG	right gluteus
RGM	right gluteus maximus
Rh	serological blood grouping factor
RLE	right lower extremity
RLL	Right Lower Lobe
RLQ	right lower quadrant
r/o	rule out
ROI	release of information
ROM	range of motion
ROS	Review of Systems
R/R	reactive reparative changes
Rpt	repeat
RRR	regular rate rhythm
R/S	resupply
RSB	right sternal border
r/t	related to
RT	Right Thigh
RTC	return to clinic
RUA	right upper arm
RUE	right upper extremity
RUQ	right upper quadrant
RV	retroverted
Rx	prescribed, prescription, treatment
RxAP	prescription assistance program

- S -

SAB	spontaneous abortion
SBE	self breast exam
SCJ	squamocolumnar junction
SE	side effects
SGA	small for gestational age
SIDS	Sudden Infant Death Syndrome
sl	slight
sm	small
SOB	shortness of breath
SOM	serous otitis media

s/p	status post
spec	specimen
sq	squamous
SQ/SC	subcutaneous
s/s	signs and symptoms
ST	Speech Therapy
STAT	immediately
SVD	spontaneous vaginal delivery
SVT	supraventricular tachycardia

T -

T/ temp	temperature
T & A	tonsillectomy and adenoidectomy
tab	tablet
TAH	total abdominal hysterectomy
Tbsp	tablespoon TC
	throat culture
TCA	trichloroacetic acid
TIA	transient ischemic attack
TID	three times a day
TM	tympanic membrane
TNTC	too numerous to count
TOC	test of cure
TNCare	TennCare
tol	tolerated
tr	trace
trach	tracheostomy
trich	trichomoniasis
TSE	testicular self exam
tsp	teaspoon
TTQL	Tennessee Tobacco Quit Line
Tx	treatment

- U -

umb	umbilicus
UNK	unknown
UOQ	upper outer quadrant
URI	upper respiratory infection
US	ultrasound
UTD	up to date
UTI	urinary tract infection
UTV	unable to void

- V -

VA	Veterans Administration
vag	vaginal
VBAC	vaginal birth after caesarian section
VCF	vaginal contraceptive film
VE	vaginal exam
vit	vitamin
VO	verbal orders
Vo	vouchers only
Voc. Rehab	Vocational Rehabilitation
Vol	volume
VP	venipuncture
VS	vital signs
vtx	vertex
VU	verbalized understanding

VACCINE MANUFACTURERS

CHI	Chiron
CSL	Commonwealth Serum Laboratories
GSK	GlaxoSmithKline
MBL	Massachusetts Biologic Labs
MI	MedImmune
MSD	Merck
NOV	Novartis
SP	sanofi pasteur
WL	Wyeth/ Lederle

- W -

W/F	white female
W/M	white male
w/c	wheel chair
wk	week
WNL	within normal limits
w/o	without
wt	weight

- X -

(none)

- Y -

y/o	year old
yd	yard
yr	year

- Z -

(none)

CREDENTIALS/PERSONNEL

APN	Advanced Practice Nurse	MSN	Master of Science in Nursing
BA	Bachelor of Arts	MSW	Masters in Social Work
BFPC/BFC	Breast Feeding Pear Counselor	NA	Nursing Assistant
BS	Bachelor of Science	NE	Nutrition Educator
BSN	Bachelor of Science in Nursing	NUTR	Nutritionist
BSW	Bachelor of Social Work	OT	Occupational Therapist
CA	Counseling Assistant	PA	Physician Assistant
CC	Care Coordinator	PCP	Primary Care Physician/Provider
CDA	Child Development Aide	PHN	Public Health Nurse
CNA	Certified Nursing Assistant	PHOA	Public Health Office Assistant
CNM	Certified Nurse Midwife	PHR	Public Health Representative
DA	Dental Assistant	PHOS	Public Health Office Supervisor
DDS	Dentist	PMD	Private Medical Doctor
DH	Dental Hygienist	PMP	Private Medical Provider
DIS	Disease Intervention Specialist	PTA	Physical Therapy Assistant
DO	Doctor of Osteopath	RD	Registered Dietitian
Dr.	Doctor	RN	Registered Nurse
EMT	Emergency Medical Technician		
HE	Health Educator	RN,C or	Registered Nurse, Certified
IBCLC	International Board Certified Lactation Consultant	RN-BC	
LC	Lactation Consultant	RN-ES	Registered Nurse with Expanded Skills
LCSW	Licensed Clinical Social Worker	RPh	Registered Pharmacist
LDN	Licensed Dietitian/Nutritionist	RPT	Registered Physical Therapist
LPN	Licensed Practical Nurse	SC	Social Counselor
LMSW	Licensed Medical Social Worker	ST	Speech Therapist
MD	Medical Doctor	SW	Social Worker
MHA	Masters in Health Administration		
MPA	Masters in Public Administration		
MPH	Masters in Public Health		
MS	Master of Science		
MSSW	Master of Science in Social Work		

SYMBOLS

\bar{p}	after	\downarrow	low, decreased, below
\bar{a}	before	$\♂$	male
&	and	\textcircled{M}	murmur
@	at	\emptyset or O	no or normal
\sim	approximate	#	number
b $\sqrt{\quad}$	breast check	\ominus	negative
$\sqrt{\quad}$	check, checked	/	per
Δ	change	%	percent
	degree	1°	primary
=	equal	+ or $\textcircled{+}$	positive
q	every	?	question
\textcircled{L}	left	\textcircled{R}	right
\textcircled{L}	left	2°	secondary
<	less than	\bar{c}	with
\leq	less than or equal to	\bar{s}	without
\uparrow	high, elevated, above, increase	X	times
"	inches		therefore

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