

Preface.....	i
Public Health Nursing Protocol Ageement.....	ii
Table of Contents.....	iii

SECTION I: EMERGENCY MANAGEMENT

ACUTE ASTHMA ATTACK.....	1.010
ACUTE POISONING.....	1.020
ANAPHYLAXIS.....	1.030
Emergency Drug Chart	
ANIMAL BITES.....	1.040
BURN - FIRST DEGREE.....	1.050
CARDIAC EMERGENCIES.....	1.060
EMERGENCY CHILDBIRTH.....	1.070
Apgar Scoring System	
HEMORRHAGE/HEMORRHAGIC SHOCK.....	1.080
INSECT (NON SPIDER) BITES.....	1.090
LACERATION.....	1.100
PUNCTURE WOUND.....	1.110
RESPIRATORY EMERGENCY.....	1.120
SEIZURES.....	1.130
SHOCK.....	1.140
SYNCOPE/VASOVAGAL REACTION/COMMON FAINT.....	1.150
TICK BITE.....	1.160

SECTION II: FAMILY PLANNING

ALL METHODS, INITIAL AND/OR ANNUAL FAMILY PLANNING VISIT.....	2.010
CERVICAL CANCER SCREENING.....	2.020
COMBINED ORAL CONTRACEPTIVE PILLS.....	2.030
CONDOMS, SPONGE, AND SPERMICIDAL AGENTS.....	2.040
CONTRACEPTIVE PATCH.....	2.050
DIAPHRAGM.....	2.060
DYSMENORRHEA.....	2.070
EMERGENCY CONTRACEPTIVE PILLS (ECPS).....	2.080
FERTILITY AWARENESS-BASED METHODS (FAM).....	2.090
INTRAUTERINE CONTRACEPTIVE (IUC).....	2.100
PREGNANCY TEST.....	2.110
PROGESTIN-ONLY IMPLANT(S).....	2.120
PROGESTIN-ONLY INJECTABLE CONTRACEPTION.....	2.130
PROGESTIN-ONLY PILLS (MINIPILL).....	2.140
STERILIZATION.....	2.150
VAGINAL CONTRACEPTIVE RING.....	2.160
FAMILY PLANNING REFERENCE SECTION.....	2.170
Screening Criteria for Chlamydia and Gonorrhea	
Summary Chart of U.S. Medical Eligibility Criteria for Contraceptive Use	

SECTION III: GENERAL

ACNE.....	3.010
ACUTE UPPER RESIRATORY INFECTION (COMMON COLD).....	3.020
ANEMIA, IRON DEFICIENCY.....	3.025
ASCARIASIS (ROUNDWORMS).....	3.030
BLOOD PRESSURE, ELEVATED, ADULT.....	3.040
BLOOD PRESSURE, ELEVATED, CHILD.....	3.050
CERUMEN, IMPACTED (EAR WAX).....	3.060
CHIGGERS, (DEMATOPHILIS PENTRANS).....	3.07
RESCINDED FEBURARY 2013.....	3.080
CHOLESTEROL RISK ASSESSMENT.....	3.090
CONSTIPATION, ACUTE, CHILD.....	3.100
CONSTIPATION, ADULT.....	3.110
DIAPER DERMATITIS (DIAPER RASH).....	3.120
DIARRHEA.....	3.130
ENTEROBIUS VERMICULARIS (PINWORMS).....	3.140
FEVER, VACCINE ASSOCIATED.....	3.150
FLUORIDE DEFICIENCY.....	3.160
FLUORIDE VARNISH.....	3.170
FOLIC ACID PROPHYLACTIC THERAPY FOR WOMEN AGED 10-44.....	3.180
FOODBORNE OUTBREAK INVESTIGATION.....	3.190
HAEMOPHILUS MENINGITIS, CONTACT.....	3.200
HEPATITIS A, CASE OR PRESUMPTIVE.....	3.210
HEPATITIS A, POST EXPOSURE.....	3.220
HERPES SIMPLEX TYPE I (FEVER BLISTER).....	3.230
HERPETIC STOMATITIS (GINGIVOSTOMATITIS).....	3.240
HORDEOLUM (STY).....	3.250
IMPETIGO/BULLOUS IMPETIGO.....	3.260
RESCINDED.....	3.270
LEAD TOXICITY SCREENING.....	3.280
MENINGOCOCCAL MENINGITISS, CASE.....	3.290
MENINGOCOCCAL MENINGITIS, CONTACT.....	3.300
MILIARIA (PRICKLY HEAT, HEAT RASH).....	3.310
OBSTRUCTED NASOLACRIMAL DUCT.....	3.320
ORAL CANDIDIASIS/MONILIASIS (THRUSH).....	3.330
PEDICULOSIS CAPITIS (HEAD LICE).....	3.340
PERIODICITY SCHEDULE - INFANCY-ADOLESCENCE.....	3.350
PERIODICITY SCHEDULE - 22 YEARS & OVER.....	3.360
PITYRIASIS ROSEA.....	3.370
POISON IVY DERMATITIS.....	3.380
PREVENTION OF VITAMIN DEFICIENCY - PRENATAL.....	3.390
SARCOPTES SCABIEI (SCABIES).....	3.400
SEBORRHEIC DERMATITIS (CRADLE CAP).....	3.410
SMOKING CESSATION.....	3.420

Smoking Cessation Counseling & Treatment
 Patient Willing to Make Quit Attempt
 Patient Not Willing to Make Quit Attempt
 Pharmacotherapies for Smoking Cessation
 Patient Tobacco Survey
 Tobacco Cessation Clinical Form -Initial Clinical Visit
 Tobacco Cessation Clinical Form - Resupply Visit

TINEA CORPORIS (RINGWORM).....	3.430
TINEA CRURIS (JOCK ITCH, GYM ITCH)	3.440
TINEA VERSICOLOR	3.450
TESTING FOR TB INFECTION (TST OR IGRA).....	3.460
TUBERCULIN SKIN TESTING, TWO STEP PROCEDURE	3.470
TUBERCULOSIS, CASE OR SUSPECT (INITIAL VISIT)	3.480
TUBERCULOSIS, LATENT TUBERCULOSIS INFECTION (LTBI).....	3.490
URTICARIA (HIVES)	3.520
VARICELLA (CHICKENPOX)	3.530

SECTION IV: IMMUNIZATIONS

COMVAX (Combined HIB/Hep B).....	4.010
DIPHTHERIA, TETANUS TOXOID & ACELLULAR PERTUSSIS (DTaP)	4.020
DIPHTHERIA and TETANUS TOXOID, PEDIATRIC (DT Pediatric)	4.030
DIPHTHERIA, TETANUS TOXOID, ACELLULAR PERTUSSIS, INACTIVATED POLIO VACCINE (DTaP-IPV) (Kinrix)	4.040
DIPHTHERIA, TETANUS TOXOID and ACELLULAR PERTUSSIS, INACTIVATED POLIO, HAEMOPHILUS INFLUENZAE TYPE B COMBINATION VACCINE (DTaP-IPV-Hib)(Pentacel).....	4.050
GENERIC INJECTIONS.....	4.060
HAEMOPHILUS b CONJUGATE VACCINE (Hib).....	4.070
HEPATITIS A VACCINE.....	4.080
HEPATITIS A INACTIVATED, HEPATITIS B RECOMBINANT VACCINE ADULT (age 18 years and up)(Twinrix).....	4.090
HEPATITIS B RECOMBINANT VACCINE, Pre-Exposure (Birth - 18 years).....	4.100
HEPATITIS B RECOMBINANT VACCINE, Pre-Exposure Adult (19 years & Up)	4.110
HERPES ZOSTER (SHINGLES) VACCINE - LIVE VACCINE.....	4.115
HUMAN PAPILOMAVIRUS VACCINE (HPV).....	4.120
H1N1 INFLUENZA.....	4.125
H1N1 LIVE ATTENUATED INFLUENZA (LAIV).....	4.126
INFLUENZA VACCINE, LIVE ATTENUATED (LAIV)	4.130
INFLUENZA VACCINE, TRIVALENT INACTIVATED (TIV)	4.140
MEASLES, MUMPS, RUBELLA VACCINE (MMR)	4.150
MENINGOCOCCAL VACCINE (MENACTRA).....	4.160
MENINGOCOCCAL VACCINE (MENOMUNE)	4.170
PEDIARIX (DTaP/HEP B/IPV).....	4.180
PNEUMOCOCCAL CONJUGATE VACCINE (Prevnar).....	4.190
PNEUMOCOCCAL POLYSACCHARIDE VACCINE.....	4.200

POLIO VACCINE, INACTIVATED.....	4.210
RABIES VACCINE, POST-EXPOSURE.....	4.220
RABIES VACCINE, PRE-EXPOSURE	4.230
ROTAVIRUS VACCINE.....	4.240
TETANUS, DIPHTHERIA, AND ACELLULAR PERTUSSIS VACCINE (Tdap) (7 through 18 years, Adacel or Boostrix).....	4.250
TETANUS, DIPHTHERIA, AND ACELLULAR PERTUSSIS VACCINE (Tdap)..... (19 years and up, Adacel or Boostrix).....	4.260
TETANUS AND DIPHTHERIA TOXOID, ADULT TYPE (Td).....	4.270
TETANUS PROPHYLAXIS IN WOUND MANAGEMENT	4.280
VARICELLA VACCINE	4.290

SECTION V: SEXUALLY TRANSMITTED DISEASES

CHLAMYDIA TRACHOMATIS, CASE OR CONTACT.....	5.010
CHLAMYDIA TRACHOMATIS, PARTNER DELIVERED THERAPY	5.030
GONORRHEA, CASE OR CONTACT.....	5.040
HEPATITIS B, CASE OR PRESUMPTIVE.....	5.060
HEPATITIS B, INFANT CONTACTS	5.070
HEPATITIS B, ALL OTHER CONTACTS	5.080
HEPATITIS C, (NON - A, NON - B), CASE	5.090
HERPES SIMPLEX (GENITAL HERPES).....	5.100
HIV TESTING AND COUNSELING.....	5.110
PEDICULOSIS PUBIS (PUBIC LICE)	5.130
SYPHILIS, CASE OR CONTACT	5.140
TRICHOMONIASIS, CASE OR CONTACT.....	5.160

SECTION VI: DISASTER PREPAREDNESS AND BIOTERRORISM

ANTHRAX VACCINE	6.010
POTASSIUM IODIDE ADMINISTRATION	6.020
SMALLPOX VACCINE	6.030

APPENDICES

A. ADDITIONAL IMMUNIZATION INFORMATION	7.010
ADMINISTERING VACCINES: DOSE, ROUTE, SITE, AND NEEDLE SIZE	
HOW TO ADMINISTER INTRAMUSCULAR (IM) INJECTIONS	
HOW TO ADMINISTER SUBCUTANEOUS (SC) INJECTIONS	
MEDICATION ADMINISTRATION (How To Avoid Medication Errors)	
Follow The Five Rights of Medication Administration	
TIPS ON SAFEGUARDING YOUR VACCINE SUPPLY	
(Refer to Vaccine Storage and Handling Toolkit)	
VACCINES AND ROUTE OF ADMINISTRATION	
VACCINE ADVERSE EVENT REPORTING SYSTEM (VAERS)	

B. LIST OF STANDARD ABBREVIATIONS 7.020

REFERENCES 7.030

INDEX.....7.040

ALL METHODS, INITIAL AND/OR ANNUAL FAMILY PLANNING VISIT

GENERAL INFORMATION

A physical exam is not necessary to begin most methods of contraception. This protocol includes guidance for contraception to be provided via a “Quick Start” visit, without a physical exam (See Deferred Exam below). The PHN with Gyn Skills, RN-ES, APN, or Physician are all referred to as “examiner”.

“Quick Start” may be used when clinic staffing or other circumstances do not allow for an exam on the same day as the clinic visit or if the client request to delay or defer a physical examination.

SUBJECTIVE FINDINGS

Patient requests contraception

The medical history is reviewed

Complaints related to any previous or current contraceptive use are noted

All other complaints are noted

OBJECTIVE FINDINGS

Complete the following laboratory test and appropriate education as indicated.

- Height and weight for BMI
- Blood pressure
- Hemoglobin or Hematocrit*
- Vaginal wet mount*
- Pregnancy test*
- Urinalysis*
- Syphilis serology*
- Cholesterol and lipids*
- Hepatitis B testing*
- Rubella titer*
- HIV testing*
- Gonorrhea and chlamydia screening
- Diabetes testing*
- Pap smear (examiner) in accordance with current Pap smear guidelines (refer to PHN Protocol 2.020)

*These laboratory tests must be provided, either on-site or by referral, if required in the provision of a contraceptive method, and may be provided for the maintenance of health status and/or for diagnostic purposes

- Physical examination¹ performed annually by examiner
 - Thyroid
 - Heart
 - Lungs
 - Breast, including review and instruction of breast self exam (BSE)
 - Ages 20-39 perform every 1-3 years
 - Ages \geq 40 perform annually
 - Abdomen
 - Pelvic
 - Ages < 21 perform
 - external pelvic (inspection of external genitalia, urethral meatus, vaginal introitus, and perianal region)
 - internal pelvic (speculum and bimanual) if symptomatic
 - Ages \geq 21 perform external and internal exam annually
 - Digital prostate exam in males over age 50 with instruction in self-exam of the testes for males of any age
 - Rectum (colorectal screening begins at age 50 for males and females)
 - Extremities

Cervical cancer screening and/or the physical exam can be deferred for 3-6 months. Counseling regarding the importance of preventative services and the reason a recommended service was delayed or declined must **always** be documented in the chart.

Deferred exams and/or recommended laboratory testing should not be deferred for longer than 6 months without a referral to the APN or physician for further evaluation and appropriate written orders.

PLAN OF CARE FOR A DEFERRED EXAM VISIT

The plan of care for a deferred exam visit is considered preliminary or temporary and can be established by the PHN. Client history (initial or updated) must be negative for U.S. Medical Eligibility Criteria categories 3 and 4. The Summary chart of U.S. Medical Eligibility Criteria for Contraceptive Use is found in the Family Planning reference section 2.170.

This preliminary or temporary plan of care must address the following:

- An explanation for the deferral.
- A comprehensive medical history for the initial client or an updated medical history for the annual client

¹ If a TennCare child (under the age of 21) receives the major components of a Child Health/EPSTD exam through the health department's family planning clinic, she should also receive developmental screening and vision and hearing risk assessment/screening in order to complete the recommended AAP standards for preventive health care. REFER TO THE FAMILY PLANNING SECTION OF THE PTBMIS MANUAL FOR CORRECT CODING OF THIS TYPE VISIT.

- Consider a physician or APN consult for any category 2 findings and document appropriately.
- For annual visits (or supply visits), consult for method side effects that have not responded to standard treatments (i.e., recommend ways to reduce nausea), complications, or warning signs. Record consultant instructions in chart.
- Blood pressure measurement, weight, hemoglobin or hematocrit as indicated.
- Height for initial visit or annually for adolescents.
- Name, dosage, route, and frequency of the contraceptive chosen.
- The number of cycles given (up to 3 cycles).
- Informed consent form for an initial client or if giving the return client a new method.
- Necessary health teaching to use method correctly and consistently.
- Document health teaching/counseling on the history form table.
- Offer condoms and/or contraceptive foam or film for use as backup protection against unintended pregnancy and for improved STD protection.
- Date of the next exam appointment.

PLAN OF CARE FOR AN EXAM VISIT

An **ongoing plan of care** will be developed and signed at the **exam visit** by either the PHN with Gyn Skills, RN-ES, APN, or Physician (all referred to as “examiner”). The ongoing plan of care is developed in accordance with the protocol for the particular examiner (APN or physician). The ongoing plan of care written by the examiner must be reviewed by the PHN at each visit. Possible components of the ongoing plan of care can be found in The Family Planning Clinical Guidelines. (For APNs and the physician, see most current edition of Contraceptive Technology)

HEALTH TEACHING

Through the Title X Program Guidelines, the federal Office of Population Affairs requires that counseling about certain topics occur with family planning clients. Education provided should be appropriate to the client’s age, level of knowledge, language and socio-cultural background and be presented in an unbiased manner.

Required topics must be discussed with the client at least once during the time the client is in the Family Planning Program.

Provide instruction **on 3 or 4 of the required topics at each visit until instruction in all required topics is completed.** Topics do not need to be repeated unless the client request a review or the provider assesses that a review is needed. **Address client counseling at each visit and base counseling/education on client needs and program requirements.**

All providers **must** document education and counseling provided during each family planning visit on the health history form.

REQUIRED TOPICS: See required topics on the Health History form
Education services must provide clients with the information needed to:

- Make informed decisions about family planning;
- Use specific methods of contraception and identify adverse effects;

- Perform breast/testicular self-examination;
- Reduce risk of transmission of sexually transmitted diseases (STD) and Human Immunodeficiency Virus (HIV);
- The range of available services and the purpose and sequence of clinic procedures;
- The importance of recommended screening test and other procedures associated with the family planning visit;
- The importance of family involvement and how to recognize and resist sexual coercion is required for all adolescents on the first visit

Optional counseling topics:

- Basic female and male reproductive anatomy and physiology,
- Reproductive health and infertility in relation to the prevention of STDs.
- Health promotion/disease prevention including:
 - Smoking cessation, alcohol and drug abuse
 - Domestic violence, sexual abuse and suicide prevention
 - Seat belts, driving safety, helmets, gun safety etc.
 - Nutrition and exercise -
 - Instructions regarding calcium supplementation (adolescents and young adults, 1200-1500 mg day; adults aged 25-50, 1000 mg day; postmenopausal women, 1000-1500 mg day)
 - Instructions regarding folic acid supplementation (400 mcg daily)

Additional Information:

Tennessee Family Planning Clinical Guidelines:

- Client Instruction sheets in English and Spanish are in the appendix
- Contraceptive method education and counseling, use the Client Instruction Sheet
- The teaching method tool is on the reverse side of the method-specific consent form.
- “Get the Facts About HPV” - DH 0015 and DH 0015S
- “Family Planning is More Than You Think” - DH 0018 and DH 0018S
- “Welcome To Your County Health Department” is a “print your own” brochure. (Contact the regional family planning program administrator to obtain a copy of this pdf document.)

REFERENCES:

"Federal Program Guidelines for Project Grants for Family Planning Services, January 2001"

"Tennessee's Family Planning Clinical Guidelines January 2011, Visit Guidelines, Minimum Requirements".

American College of Obstetricians and Gynecologists. (2012). Well-woman visit. Committee Opinion No. 534. *Obstet Gynecol*, 120, 421-424.

Hatcher, R. A., Trussell, J., Nelson, A. L., Cates, W., Kowal, D., & Policar, M. S. (2011). *Contraceptive Technology* (20th ed.). New York: Ardent Media.

U.S. Department of Health and Human Services, Office of Public Health and Science, Office of Population Affairs, Office of Family Planning, *Program Guidelines for Project Grants for Family Planning Services*, January 2001

CERVICAL CANCER SCREENING PROCEDURE

The Tennessee Department of Health has several programs such as Family Planning, Breast and Cervical Cancer Screening and Women's Health that offer cervical cancer screening beginning at age 21.

Clients should be prepared for cervical cancer screening by being given the following information prior to the day of pap smear:

- Avoid douching for 2 days before the examination
- Avoid putting **ANYTHING** into the vagina for 2 days before the exam
- Make appointment for Pap test 1-2 weeks after the end of menses
- Whenever possible, have abnormal vaginal secretions treated before a Pap test is scheduled

SUBJECTIVE

The client reports to a program or service within the health department that could include cervical cancer screening.

OBJECTIVE

The client meets the screening criteria established by the health department. Refer to page 3 "Summary of Cervical Cancer Screening Guidelines"

ASSESSMENT

The client is appropriate for cervical cancer screening. The timing of her screening test is based upon her age and/or history and/or the results of her last Pap test.

PLAN

Review the Pap history in the chart.

Based on history, prepare the necessary materials for a Pap test. If a pap test is not done, document reason in the chart.

Explain to the client how she will receive her Pap results. Provide Reproductive Health Teaching (see below).

Schedule for next appointment

Complete follow-up for the Pap results as directed. (see written order of provider and Family Planning Guidelines)

HEALTH TEACHING

- Explain that nearly all sexually active individuals will be exposed to HPV sometime in their lifetime; 80% by age 50. Most women will have a natural immune response and clear the HPV on their own. Only a few at risk individuals will eventually develop

cervical cancer from HPV exposure. This process takes many years. Therefore, cervical cancer screening must continue throughout a woman's life.

- Assess client's current immunization status including HPV vaccine. Offer vaccine(s) based on current vaccine guidelines.
- Provide an overview of all sexually transmitted infections.
- Promote and instruct in the correct use of condoms.
- Review the risks associated with the following high-risk sexual behaviors:
 - Unprotected intercourse, including oral and anal sex
 - Early onset of sexual intercourse (i.e., first sexual intercourse before the age of 18) including increased likelihood of exposure to STDs and the increased risk of teen pregnancy and unintended pregnancy. Both teen pregnancy and unintended pregnancy are associated with infant mortality and morbidity.
 - Multiple sexual partners.
 - Having a sexual partner who has multiple partners.
 - Numerous sexual partners in a lifetime (serial monogamy).
- Review the increased risk of cervical cancer in women who smoke cigarettes.
- Review the risk to daughters of women who took the hormone diethylstilbestrol (DES) during their pregnancies (for clients born before 1970, DES was used primarily to prevent repeat miscarriages). These daughters are at greater risk for developing vaginal and cervical cancers.

FAMILY PLANNING GUIDELINES GENERAL INFORMATION

How Do We Screen For Cervical Cancer?

The Tennessee Department of Health screens women for cervical cancer using liquid-based cytology (Pap) testing. While both the conventional Pap smear and the liquid-based Pap test are equally effective, liquid-based allows for a single specimen to be used for both cytology and Human papilloma virus (HPV) testing. The main benefit of liquid-based testing is to allow for triage of atypical squamous cells of undetermined significance (ASCUS) for presence of HPV without having to bring the client back in to collect another sample.

What is HPV Testing?

Human papilloma virus (HPV) testing refers to the identification of high-risk (oncogenic) HPV strains that can become precursors to cervical cancer. HPV testing is a tool used to determine the need for a colposcopy in women with atypical squamous cells, undetermined significance (ASC-US) results and is referred to as reflex testing. HPV testing is also used in women aged 30-65 as an adjunct to cytology for cervical cancer screening to lengthen the screening interval (if both test are negative); this is referred to as co-testing.

Indications for HPV testing include the following:

- Reflex testing – to determine the need for colposcopy in women with ASC-US cytology result.
- Co-testing – use as an adjunct to cytology for cervical cancer screening in women aged 30 years and older.

Who and When Do We Screen For Cervical Cancer?

Cervical cancer screenings should begin at 21 years old. While a pap test may not be necessary at all Family Planning Program visits, an annual physical exam including but not limited to breast exam and pelvic (visual and bimanual) exam is still required.

Cervical cancer screening and/or the physical exam can be deferred for 3-6 months. Counseling regarding the importance of preventative services and the reason a recommended service was delayed or declined must **always** be documented in the chart.

Deferred exams and/or recommended laboratory testing should not be deferred for longer than 6 months without a referral to the APN or physician for further evaluation and appropriate written orders.

Refer to PHN Protocol 2.010 for necessary components of the initial/annual exam and required health teaching. Document education and counseling provided during each family planning visit on the health history form.

Summary of Cervical Cancer Screening Guidelines

Population	Recommended Screening Method
Age under 21	Do not screen
Age 21-29	Cytology (Pap smear) every 3 years
Age 30-64	Cytology every 3 years or Co-testing (cytology & HPV) every 5 years Note: Clients must be offered both options and allowed to choose based on their preference.
Age 65 and up	Discontinue screening if, since age 55, patient has had 2 consecutive negative HPV tests or 3 consecutive negative cytology results
Hysterectomy with removal of cervix	Do not screen if no history of CIN2+ in the past 20 years or cervical cancer ever
Vaccinated against HPV	Follow age-specific recommendations (same as unvaccinated women)

Please note these guidelines do not apply to the following high-risk populations:

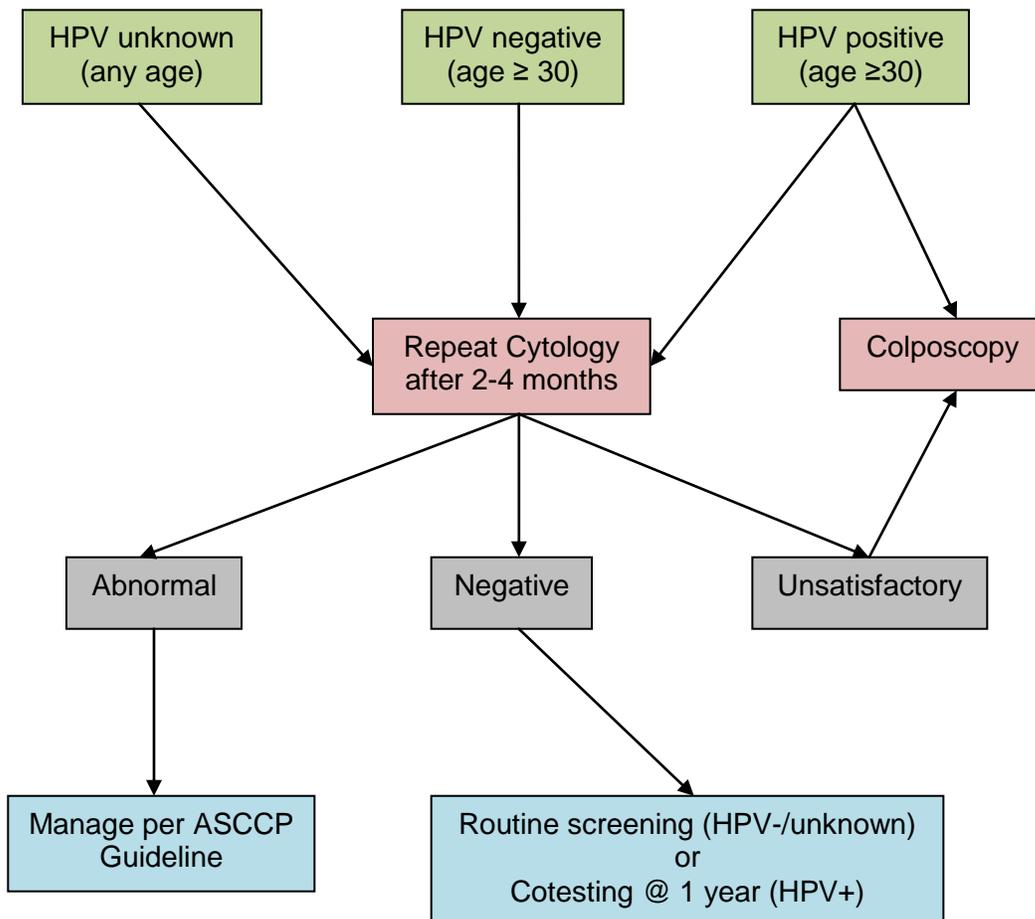
- HIV positive: CDC recommends that women with HIV have cervical cytology screening twice in the first year after diagnosis and annually thereafter. Screening should be initiated at the age when diagnosed with HIV even if younger than 21 years old.

- Immunosuppressed: ACOG recommends annual cytology screening starting at age 21, No recommendation exist from the ASCCP.
- Exposure to diethylstilbestrol (DES) in utero: No recommendation exists from ACOG or ASCCP
- Previous treatment for CIN2 or higher: Continue routine age-based screening for 20 years after the initial post treatment surveillance period, even if screening continues past age 65.

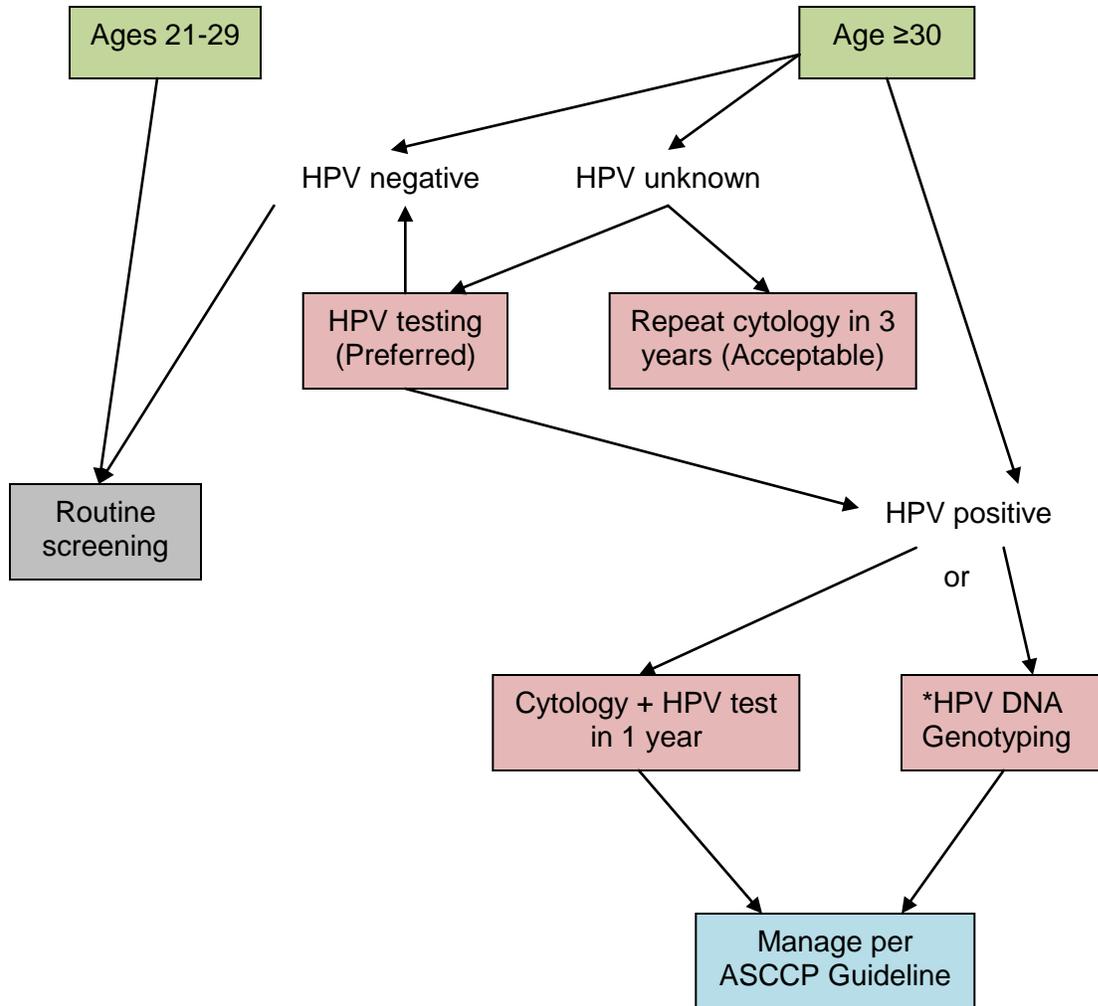
Management of Abnormal Cervical Cancer Screening Tests

Refer to the following algorithms from American Society for Colposcopy and Cervical Pathology (ASCCP). Full details of these guidelines may be reviewed at ASCCP’s website <http://www.asccp.org/ConsensusGuidelines/UpdatedConsensusGuidelinesAlgorithms/tabid/14410/Default.aspx>

Unsatisfactory Cytology

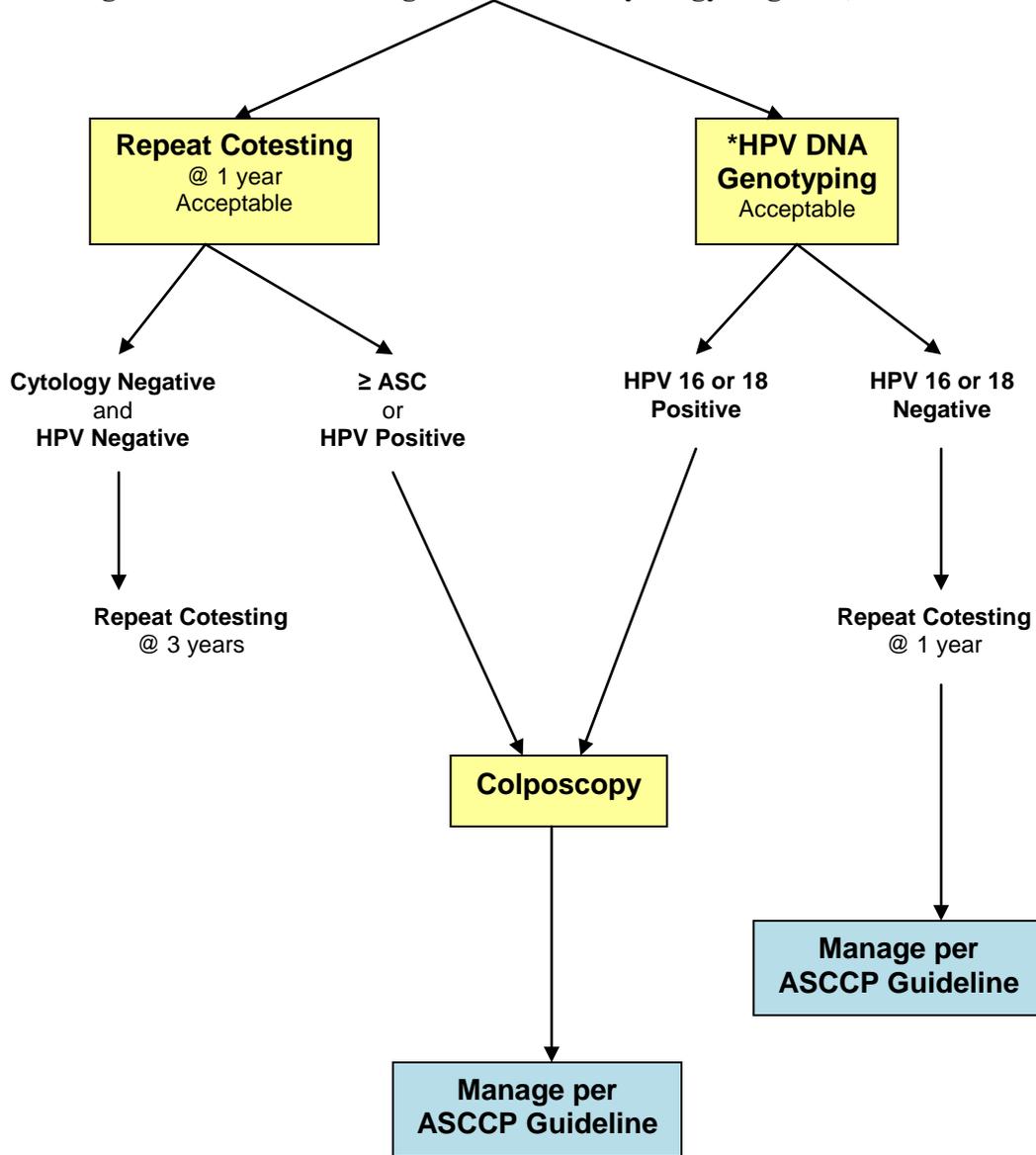


**Cytology Negative for Intraepithelial Lesion or Malignancy (NILM)
but Endocervical/Transformation (EC/TZ) Absent/Insufficient**



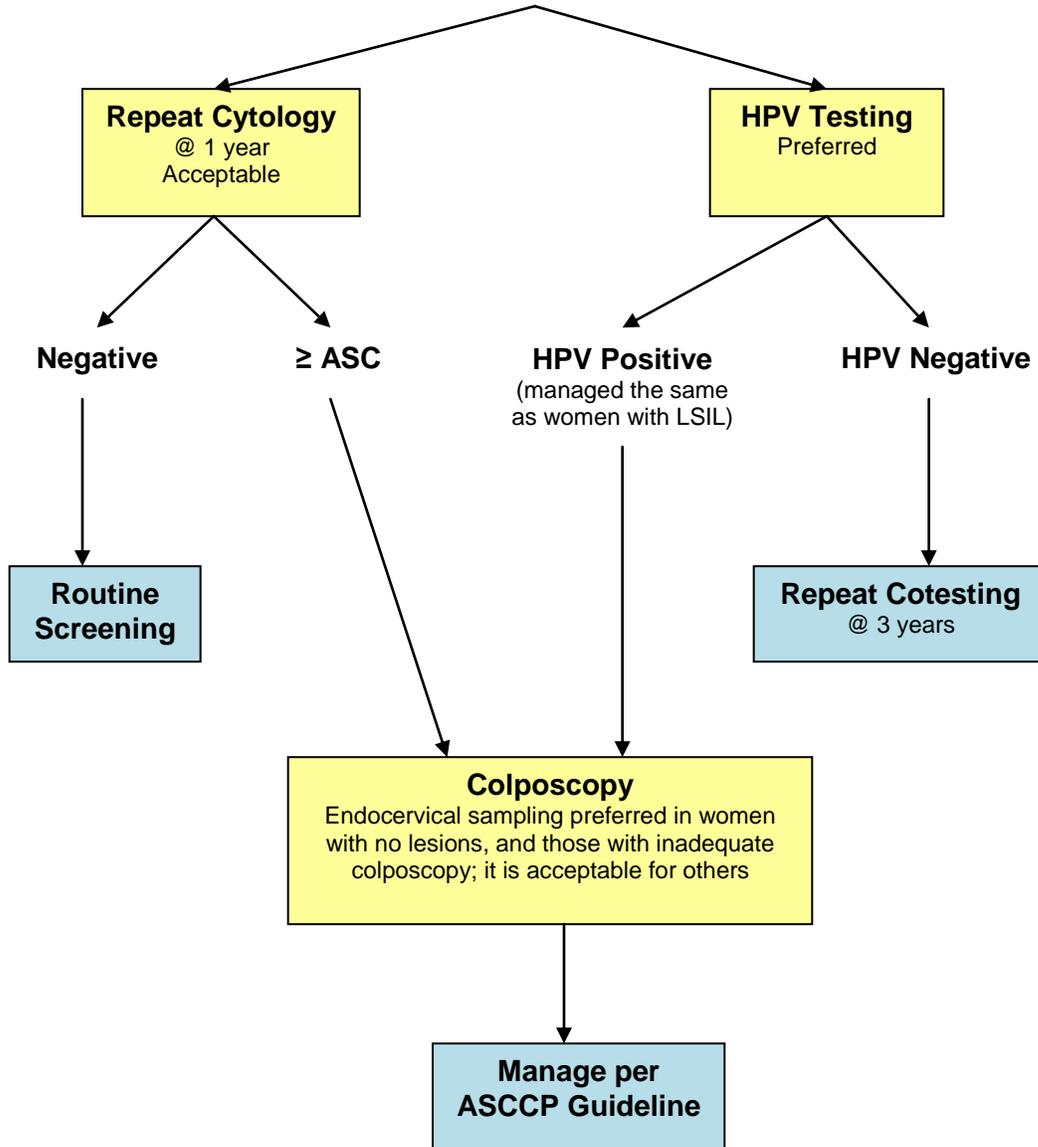
***Family Planning and Breast and Cervical Screening Programs do not currently pay for HPV DNA Genotyping.**

Management of Women \geq Age 30, who are Cytology Negative, but HPV Positive

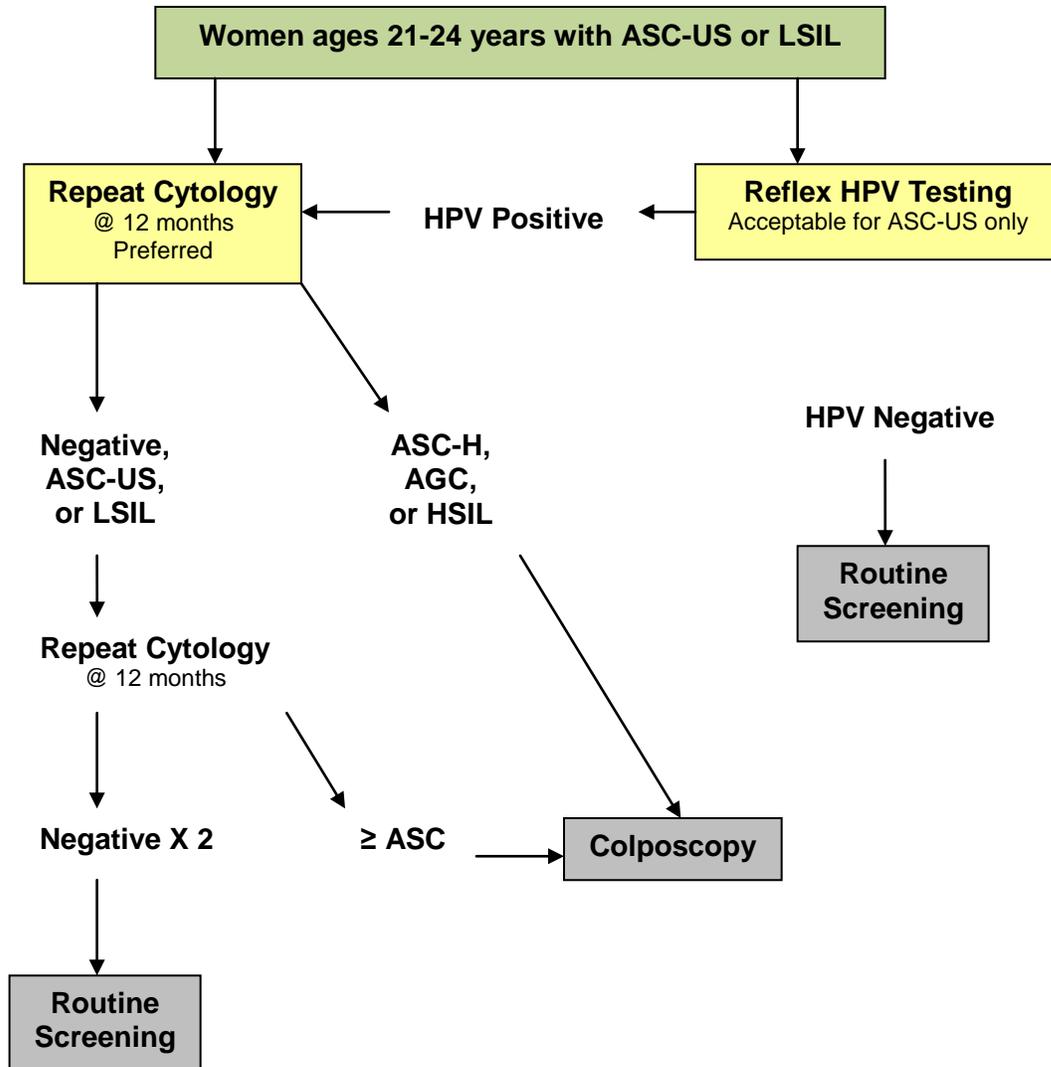


***Family Planning and Breast and Cervical Screening Programs do not currently pay for HPV DNA Genotyping.**

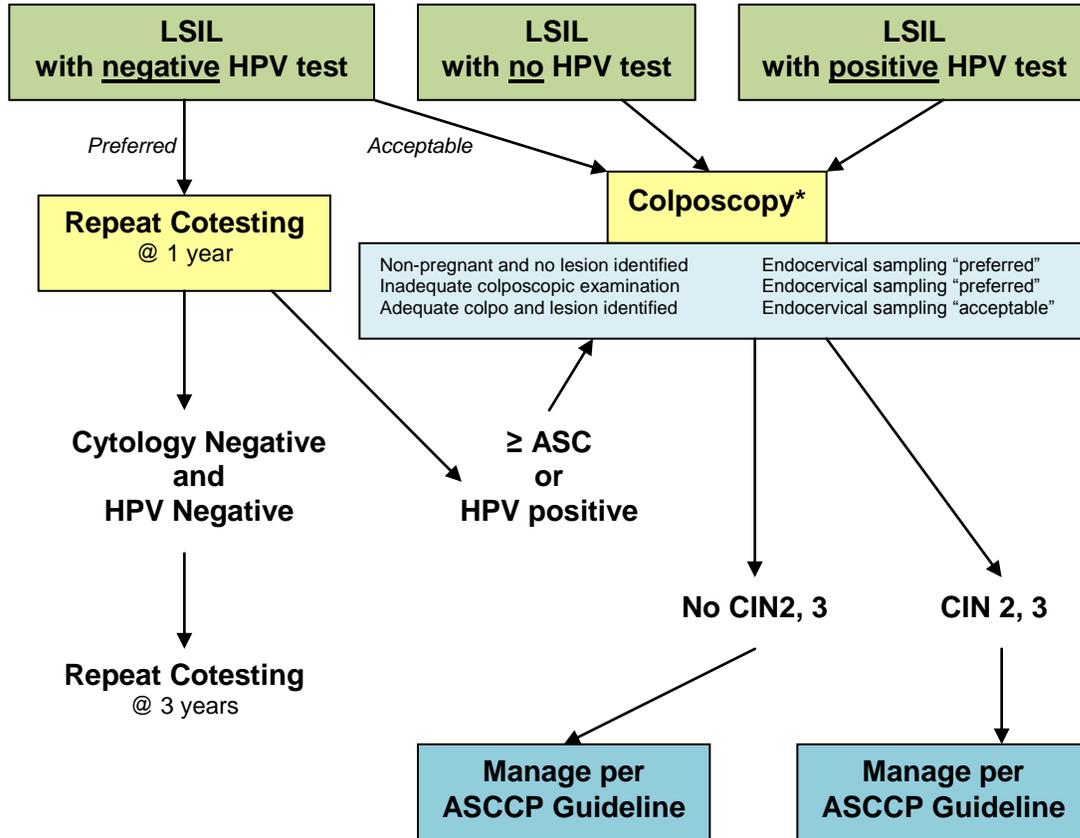
Management of Women > 25 years with Atypical Squamous Cells of Undetermined Significance (ASC-US) on Cytology
 (For women between 21-24 years, see following algorithm.)



Management of Women Ages 21-24 years with either Atypical Squamous Cells of Undetermined Significance (ASC-US) or Low-grade Squamous Intraepithelial Lesion (LSIL)

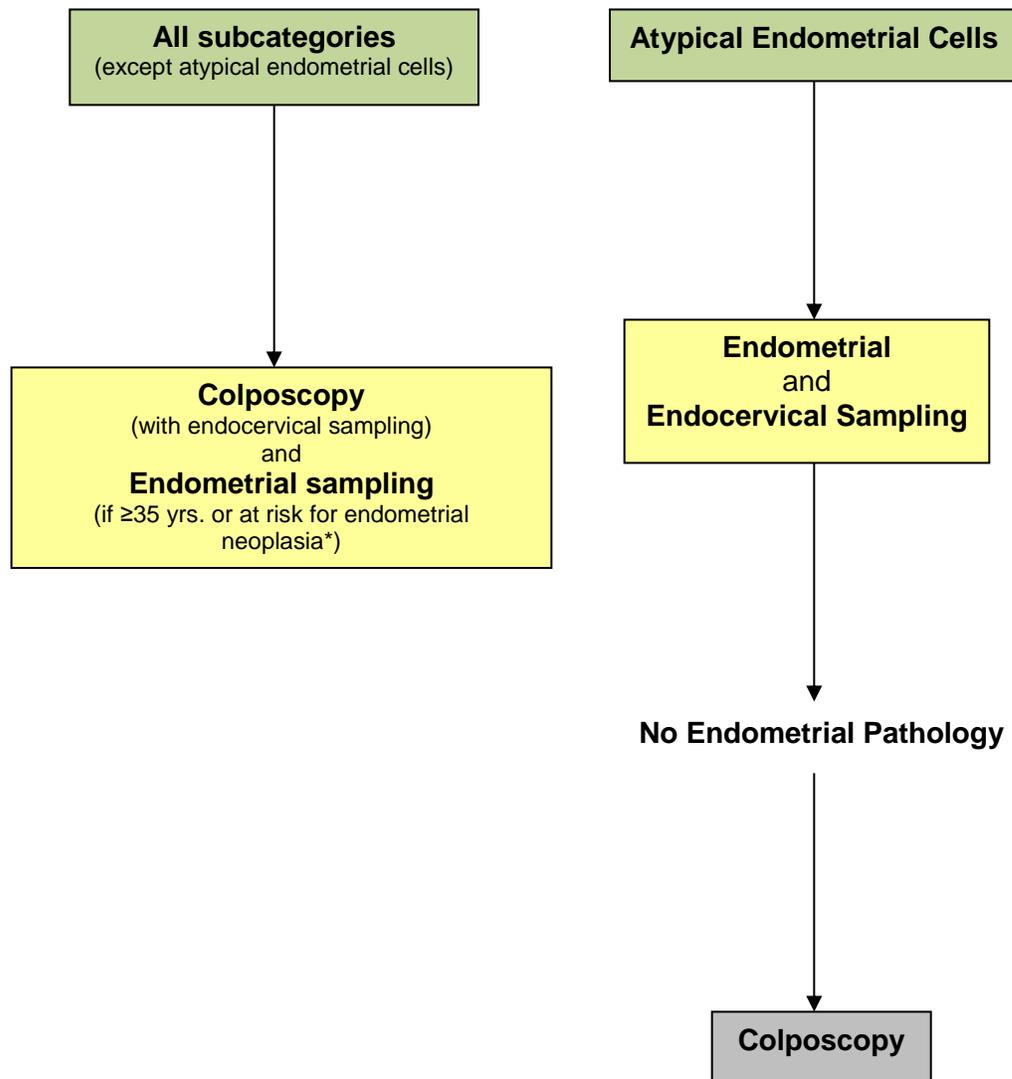


Management of Women >25 years with Low-grade Squamous Intraepithelial Lesions (LSIL)
 (For women between 21-24 years, see previous algorithm.)



***After colposcopy, management is directed by the colposcopist. Refer to the ASCCP algorithm booklet April 2013 for further guidelines.**

Initial Workup of Women with Atypical Glandular Cells (AGC)



*Includes unexplained vaginal bleeding or conditions suggesting chronic anovulation.

After colposcopy, management is directed by the colposcopist. Refer to the ASCCP algorithm booklet April 2013 for further guidelines.

REFERENCES

1. American College of Obstetricians and Gynecologists. (2012). Screening for Cervical Cancer. Practice Bulletin, No. 131. *Obstet Gynecol*, 120(5), 1222-1238.
2. American College of Obstetricians and Gynecologists. (2012). Well-woman visit. Committee Opinion No. 534. *Obstet Gynecol*, 120, 421-424.
3. American Society for Colposcopy and Cervical Pathology. (2013). Algorithms updated consensus guideline for managing abnormal cervical cancer screening tests and cancer precursors.
4. Massad, L. S., Einstein, M. H., Huh, W. K., Katki, H. A., Kinney, W. K., Schiffman, M., ... for the 2012 ASCCP Consensus Guidelines Conference. (2013). 2012 updated consensus guidelines for the management of abnormal cervical cancer screening tests and cancer precursors. *J Low Genit Tract Dis*, 17(5), S1-S27.
5. Moyer, V. A. on behalf of the U.S. Preventive Services Task Force. (2012). Screening for cervical cancer: U.S. Preventive Services Task Force recommendation statement. *Annals of Internal Medicine*, 156 (12), 880-891.
6. Saslow, D., Solomon, D., Lawson, H. W., Killackey, M., Kulasingam, S. L., Cain, J., . . . the ACS-ASCCP-ASCP Cervical Cancer Guideline Committee. (2012). American Cancer Society, American Society for Colposcopy and Cervical Pathology, and American Society for Clinical Pathology screening guidelines for the prevention and early detection of cervical cancer. *J Low Genit Tract Dis*, 16 (3), 175-204.
7. Solomon, D., Davey, D., Kurman, R., Moriarty, A., O'Connor, D., Prey, M.,... for the Forum Group Members and Bethesda 2001 Workshop. (2002). The 2001 Bethesda system terminology for reporting results of cervical cytology. *JAMA*, 287(16), 2114-2119.
8. U.S. Department of Health and Human Services, Office of Public Health and Science, Office of Population Affairs, Office of Family Planning, *Program Guidelines for Project Grants for Family Planning Services*, January 2001.

TESTING FOR TB INFECTION: Tuberculin Skin Testing (TST) or Interferon-gamma Release Assay (IGRA)

GENERAL INFORMATION

Refer to **World Health Organization (WHO) list of TB Incidence by Country, 2012** (Adapted from WHO website, 07/16/2013) at the end of this protocol for identification of TB-endemic countries.

Routine testing for TB infection with either TST or IGRA should not be performed for patients who are assessed to be at “LOW RISK” for tuberculosis.

IGRA is the preferred test for persons who have been previously vaccinated with Bacillus Calmette-Guérin (BCG); however, TST is not contraindicated for BCG-vaccinated individuals.

Targeted testing for TB infection may be performed to identify persons with increased risk of having TB infection who would benefit from treatment.

NOTE: A decision to test is a decision to treat. Consult Tennessee Tuberculosis Elimination Program (TTBEP) Central Office staff prior to starting a targeted testing initiative.

SUBJECTIVE

Evaluate/Document TB Risk Status:

Complete the “***TB Risk Assessment Tool***” (**TB RAT**) for all persons (child, adolescent or adult) who meet one or more of the following criteria:

- Being considered for TB infection testing, **OR**
- Had a cough \geq 2-3 weeks **AND** at least one of the following additional symptoms: fever, night sweats, weight loss, or hemoptysis; **OR**
- “High- risk” for TB (*see TABLE 1*); **OR**
- Responds “YES” to any of the questions on the “***TB Risk Assessment Questionnaire***” (*see TABLE 2*)

Pregnant women should be considered for TB infection testing only if they have a specific risk factor for TB infection (Note: There is no evidence that the TST or IGRA have adverse effects on the pregnant mother or fetus).

TABLE 1. Groups at High Risk for TB Infection (Immediate test for TB infection required)

1. Close contacts of a person known or suspected to have TB disease (i.e., those sharing the same household or other enclosed environments)
2. Foreign-born persons from TB-endemic countries (see **WHO list**)§
3. Health care workers who serve high-risk clients (use TST for annual testing)§
4. Mycobacterial laboratory workers (use TST for annual testing)
5. Persons with HIV infection or AIDS (in adults, use IGRA if possible)*
6. Persons with medical conditions or treatments that place them at high risk for progression to TB disease if infected with *M. tuberculosis* (includes diabetes, silicosis, leukemia or lymphoma, cancer of the head and neck or lung, immunosuppressive condition or therapy, end-stage kidney disease, gastrectomy or jejunioileal bypass, weigh < 90% of ideal body weight, pre/post-transplant (all tissue/solid organs requiring current anti-rejection medication), untreated/inadequate TB treatment [without a documented positive TB test result], diagnosed with TB infection within the past 2 years [without a documented positive TB test result], and smoking)**
7. Persons who inject or use illicit drugs§
8. Residents, staff, or volunteers who work or have ever worked in high-risk congregate settings (e.g., homeless shelters or correctional facilities)***§
9. Children under 18 years of age exposed to adults in high-risk categories
10. Persons who are currently or have ever been homeless§
11. Persons with radiographic or clinical findings suggesting TB disease
12. Residence or prolonged travel in a TB-endemic country (see **WHO list**)§
13. Other high-risk populations as locally defined by the Department of Health (designation as a locally-defined high-risk population will be based on the incidence of TB disease and infection for that specific area or population, and may include some medically underserved populations)

* All persons newly diagnosed with HIV infection should be tested for TB infection as soon as possible. Annual testing for TB infection is recommended only for HIV-infected patients who are at high risk of repeated or ongoing exposure to those with active TB.

** Once a negative test is documented for patients in this group, no repeat testing is necessary unless the patient has a new risk factor for TB exposure.

*** Residents, staff, or volunteers who work or have ever worked in a high-risk congregate setting are at high-risk for TB infection. TST should be used as the method of testing for any persons required to have annual testing. Children/youth in DCS custody residing in a congregate care setting (i.e., where testing for TB infection is required as long as the child/youth remains in the congregate care setting) should receive a TST (not IGRA) for the annual testing.

§Patients in these groups should receive initial testing for TB. Patients should be screened for symptoms and NEW risk factors for exposure or progression upon subsequent visits. If no new risk factors are present, testing for TB should not be done.

If a patient comes to the health department requesting a TST for employment, administer the TB RAT. If the patient is determined to be “low risk,” provide documentation that they do not need a skin test. If the TB RAT identifies an additional high risk factor, (for example, travel to a TB endemic country, has been homeless, etc.) then the health department may test using the TST method.

Uninsured and/or health department patients who are identified as “high risk” according to PHN Protocol 3.460, Table 1, #6, including patients needing TB testing prior to implementation of a medication or treatment, should be tested at the health department for TB infection using the IGRA. However, insured patients who have been referred to the health department by their private provider for TB testing with an IGRA prior to implementation of a medication or treatment should be referred back to their providers for the IGRA. The health department does not function as an outside lab.

Consult with the Regional Health Officer, Regional TB physician or staff at the TB Elimination Program Central Office for clarification or questions.

TABLE 2. TB Risk Assessment Questionnaire (Administer to Children & Adolescents)

1. Are you or your child in close contact of a person with TB?
2. Are you or your child foreign-born or an immigrant or refugee from a country where TB is common (refer to **WHO list**)
3. Have you, your child, or any household member traveled to a country where TB is common (refer to **WHO list**) in the last 12 months?
4. Do you or your child have a medical condition or treatment of a medical condition that suppresses the immune system?
5. Do you or your child have HIV infection, or is he/she considered at risk for HIV infection?
6. Are you or your child exposed to the following individuals?
 - HIV-infected, homeless individuals, residents of nursing homes, institutionalized adolescents or adults, users of illicit drugs, incarcerated adolescents or adults, or migrant farm workers

If respondent reports “YES” to any of the above, you must complete a “*TB Risk Assessment Tool*” (TB RAT).

For **children and adolescents** who present for an EPSDT, administer the “***TB Risk Assessment Questionnaire***” (see **TABLE 2** above). If testing for TB infection is indicated, use the TST method.

OBJECTIVE

TST may be given on the same day as live virus vaccines (e.g., MMR and Varicella); however, if not given on the same day, TST should be delayed **at least 4 weeks** (28 days) after administration of a live virus vaccine (Note: Delaying the TST will remove the concern of any theoretical suppression of PPD reactivity from the vaccine).

Inject 0.1 ml PPD intradermally into the volar (palm side) surface of the left forearm; the scapula area may be used as an alternative site for persons who cannot receive the TST in the lower arm.

Two-step TST (initial visit) all persons who are required to receive serial testing for TB infection (e.g., health care or correctional facility workers) in order to ascertain a reliable baseline. Refer to “*TST Two-Step Protocol 3.470*”

NOTE: IGRA is not recommended by CDC for serial testing (those who require annual testing for TB infection).

TABLE 3. TTBEF Recommendations for TST for Infants, Children and Adolescents^{§§}**Children for whom immediate TST or IGRA is indicated:**

- Contacts of persons with confirmed or suspected contagious TB (contact investigations)
- Children with radiographic or clinical findings suggesting TB disease
- Children immigrating from countries with endemic TB (see **WHO list**), including international adoptees
- Children with travel histories to countries with endemic TB (see **WHO list**) and substantial contact with indigenous people from such countries

Children who should have annual TST:

- Children infected with HIV (TST only)

Children at increased risk of progression to active TB disease:

- Children with other medical conditions, including diabetes mellitus, chronic renal failure, malnutrition, congenital or acquired immunodeficiencies, and children receiving tumor necrosis factor (TNF) antagonist deserve special consideration. Without recent exposure, these children are not at increased risk of acquiring TB infection. Underlying immune deficiencies associated with these conditions theoretically would enhance the possibility for progression to severe TB disease. Initial histories of potential exposure to TB should be included for all of these patients. If these histories or local epidemiologic factors suggest a possibility of TB exposure, immediate and periodic TST or IGRA should be considered.
- An initial TST or IGRA should be performed before initiation of immunosuppressive therapy, including prolonged steroid administration, use of TNF-alpha antagonists, or other immunosuppressive therapy in any child requiring these treatments.

^{§§} Adapted from AAP Tuberculin Skin Test (TST) Recommendations for Infants, Children, and Adolescents (2012 Red Book, Table 3.76, page 740)

IGRA blood samples should be collected per TB Elimination Program guidelines and laboratory protocol.

Refer to TB Elimination Program guidelines and Lab Manual for QuantiFERON[®]-TB Gold In-Tube assay collection and processing procedures.

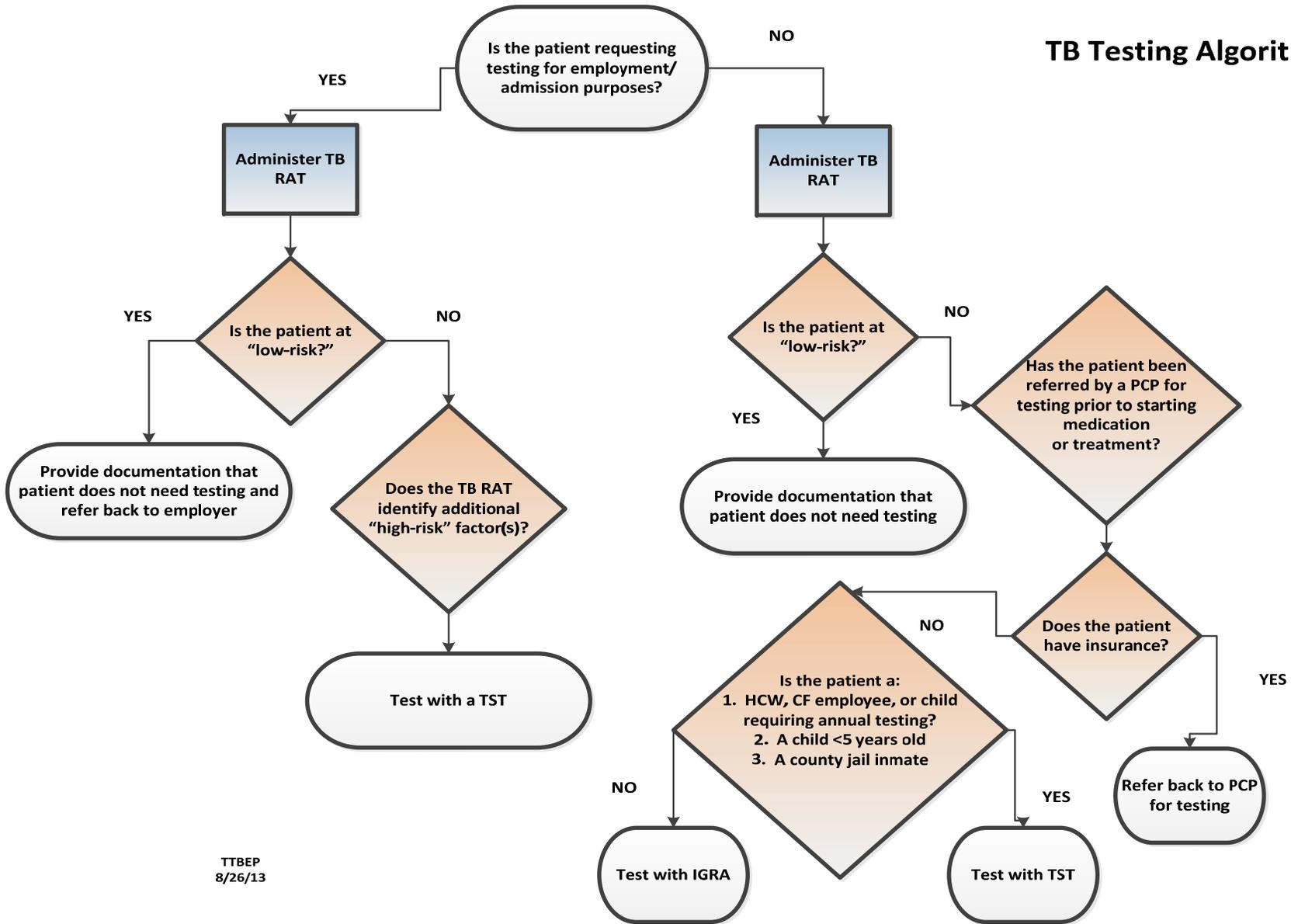
IGRA method should **NOT** be used for the following patients:

- a) Children <5 years of age
- b) Any child, regardless of age, requiring TB testing as part of the EPSDT exam
- c) Any person disposition as “low-risk” through the TB Risk Assessment Tool (TB RAT)
- d) Health Care Workers (HCWs) and those who require annual testing
- e) Persons requesting TB testing for employment purposes (excludes eligible health department employees)

EXCEPTION: An IGRA may be used for testing persons meeting criteria “b” “c” or “d” above *IF* identified during a contact investigation as at risk for recent TB exposure.

FIGURE 1: Testing for TB Infection

TB Testing Algorithm



TTBEP
8/26/13

ASSESSMENT

Read TST results within 48-72 hours. Palpate with the pads of fingertips for the presence or absence of induration (i.e., a hard, dense, raised formation); **do not measure any soft swelling or redness** that may be present at the site. The transverse diameter of the induration is measured across the forearm from the “thumb side” of the arm to the “little finger side” of the arm.

Record TST measurement in millimeters (mm) only

Interpret TST results (i.e., “positive” vs “negative”) in accordance with **TABLE 4, “Interpretation of TST results by Risk Group”**

A “**negative**” TST result (i.e., no induration present) in a person who returns for TST reading and interpretation more than 72 hours after placement **is not** considered valid; a repeat TST placement is required.

A “**positive**” TST result (i.e., induration is present) in a person who returns for TST reading and interpretation more than 72 hours after placement should be measured and documented in millimeters. A repeat TST is not necessary as a positive reaction may persist for up to one week after placement.

For persons with TST results interpreted as “**negative**” who undergo repeat TST placement, **an increase in induration diameter of ≥ 10 mm within a period of 2 years** should be considered a “**TST conversion**” indicative of recent infection with *M. tuberculosis*; such persons should be clinically evaluated for TB infection or active TB disease.

NOTE: As long as there is no history of prior severe reaction or allergy to the TB skin test, the TST may be repeated if the initial results are questionable or if there is no documentation of a prior result measured in millimeters (mm).

IGRA

Receipt of an IGRA result (i.e., QFT-GIT) can take between 3-5 days. The qualitative result will be indicated on the laboratory form as “**Positive**,” “**Negative**” or “**Indeterminate**.” Patients for whom the IGRA result is “Indeterminate” should have an IGRA of the same type repeated within 1-2 weeks.

1. IGRA:

- A “**Positive**” qualitative result noted on the laboratory form is an indication of infection with *M. tuberculosis*. It does not indicate when the infection occurred nor does it indicate if the infection has progressed to active TB disease.
- A “**Negative**” qualitative result indicates the person’s immune system did not detect the presence of *M. tuberculosis* when the specimen was drawn. If TB exposure has been recent, a repeat IGRA is indicated 8-10 weeks after he/she no longer has contact with the active case of TB, or 8-10 weeks after the person with active TB is no longer considered contagious.
- TST is preferred/recommended for children <5 years of age

2. TST Reaction ≥5 mm of induration – Interpret as “Positive**” if:**

- HIV-infected persons
- Recent contacts of persons with TB disease
- Fibrotic changes on chest radiograph consistent with prior TB
- Immunosuppressed patients, including those with organ transplants, those receiving the equivalent of ≥15 mg per day of prednisone for at least 1 month, chemotherapy, TNF-alpha antagonists, etc.*

3. TST Reaction ≥10 mm of induration – Interpret as “Positive**” if:**

- All foreign-born persons (recent immigrants within past 5 years) from high- prevalence countries
- Injection drug users
- Residents and employees of the following high-risk congregate settings: Prisons and jails, nursing homes and other long-term care facilities, hospitals and other health care facilities, residential facilities for patients with acquired immunodeficiency syndrome (AIDS), or homeless shelters
- Mycobacteriology laboratory personnel
- Persons with the following clinical conditions: silicosis, diabetes mellitus, chronic renal failure, some hematologic disorders (e.g., leukemias and lymphomas), other specific malignancies (e.g., carcinoma of the head or neck and lung), weight loss of ≥10% of ideal body weight, history of gastrectomy or jejunioileal bypass surgery
- Children younger than 4 years of age
- Infants, children, and adolescents exposed to adults at high-risk

4. TST reaction ≥15 mm of induration – Interpret as “Positive**” if:**

- Person with no risk factors for TB[†]

* The risk of TB in patients treated with corticosteroids increases with higher dose and longer duration.

[†] For persons who are otherwise at low risk and are tested at the start of employment, a reaction of ≥ 15mm induration is considered “positive.”

PLAN

Children < 4 years of age who are exposed to a person with active TB and have a negative initial TST must be:

- **Referred** promptly to the TB clinic for evaluation and possible treatment of LTBI, regardless of the TST result. Treatment can be stopped if, upon re-testing at 8-10 weeks after last exposure to the infectious TB case, the child's second TST remains negative.
- **Re-tested** with TST 8-10 weeks after he/she no longer has contact with the active case of TB, or 8-10 weeks after the person with active TB is no longer considered contagious.

If a TB test is “positive” (TST with induration present) or “Positive” (IGRA), refer the child promptly to the medical provider or regional TB clinic for evaluation to rule out active TB disease and consideration of treatment for TB infection.

Repeat TST as indicated (see **TABLE 3: Recommendations for Serial TST in Children**).

Adults who are exposed to a person with active TB and have a negative initial TST/IGRA must be

- **Referred** to the TB clinic for evaluation by medical provider if patient is immunocompromised or has symptoms of TB
- **Re-Tested** with same method initially used for testing (TST or IGRA) 8-10 weeks after last exposure

If a TB test is “positive” (TST with induration present) or “Positive” (IGRA), refer the patient promptly to the medical provider or regional TB clinic for evaluation to rule out active TB disease and consideration of treatment for TB infection.

REFERENCES:

American Academy of Pediatrics, 2012:736-759.

American Academy of Pediatrics. Tuberculosis. In: Pickering LK, Baker C, Kimberlin DW, Long SS, eds. 2012 Red Book.

CDC. A New Approach for Tuberculosis Disease Screening and Diagnosis in People with HIV/AIDS (adapted). <http://www.cdc.gov/hiv/resources/factsheets/hivtb.htm>

CDC. Controlling Tuberculosis in the United States. Recommendations from the American Thoracic Society, CDC, and the Infectious Diseases Society of America. *MMWR* 2005; 54 (No. RR-12, 33, Table 5)

CDC. Core Curriculum on TB: What the Clinician Should Know, 5th Ed., 2011.

CDC. [Guidelines for Using the QuantiFERON–TB Gold Test for Detecting *Mycobacterium tuberculosis* Infection, United States](#) *MMWR* 2005; 54 (No. RR–15, 1–37)

CDC. [Guidelines for the Investigation of Contacts of Persons with Infectious Tuberculosis: Recommendations from the National Tuberculosis Controllers Association and CDC](#) *MMWR* 2005; 54 (No. RR-15, 1-37)

CDC. Mantoux Tuberculosis Skin Testing Facilitator Guide. <http://www.cdc.gov/tb/education/Mantoux/part2.htm>

CDC. Targeted tuberculin testing and treatment of latent tuberculosis infection. *MMWR* 2000;49:1-51.

CDC. [Updated Guidelines for Using Interferon Gamma Release Assays to Detect *Mycobacterium tuberculosis* Infection — United States, 2010](#)
MMWR 2010; 59 (RR-5); 1-25

Panel on Antiretroviral Guidelines for Adults and Adolescents. Guidelines for Prevention and Treatment of Opportunistic Infections in HIV-Infected Adults and Adolescents. Department of Health and Human Services. Available at http://aidsinfo.nih.gov/contentfiles/lvguidelines/glchunk/glchunk_325.pdf. Section accessed 07/05/2013, p. F-2.

Report of the Committee on Infectious Diseases. Elk Grove Village, IL, 2012

WHO List: TB Incidence by Country, 2012 (Adapted from WHO website, 07/16/2013)

	COUNTRY	PTBMIS Code	INCIDENCE
A	Afghanistan	001	High
	Albania	002	Low
	Algeria	003	High
	American Samoa	004	Low
	Andorra	005	Low
	Angola	006	High
	Anguilla	007	High
	Antarctica	008	No data
	Antigua and Barbuda	009	Low
	Argentina	010	High
	Armenia	224	High
	Aruba	251	Low
	Australia	011	Low
	Austria	012	Low
	Azerbaijan	225	High
B	Bahamas	013	Low
	Bahrain	014	Low
	Bangladesh	015	High
	Barbados	016	No data
	Belarus	226	High
	Belgium	017	Low
	Belize	018	High
	Benin	019	High
	Bermuda	020	Low
	Bhutan	021	High
	Bolivia (Plurinational State of)	022	High
	Bonaire, Saint Eustatius and Saba	253	Low
	Bosnia and Herzegovina	227	High
	Botswana	023	High
	Bouvet Island	024	No data
	Brazil	025	High
	British Indian Ocean Territories	026	No data
	British Virgin Islands	027	Low
	Brunei Darussalam	028	High
	Bulgaria	029	High
	Burkina Faso (Upper Volta)	247	High
	Burma (Myanmar)	030	High
	COUNTRY	PTBMIS Code	INCIDENCE
	Burundi	031	High

C	Cambodia (Kampuchea)	228	High	
	Cameroon	032	High	
	Canada	033	Low	
	Cape Verde	034	High	
	Cayman Islands	035	Low	
	Central African Republic	036	High	
	Chad	037	High	
	Chile	038	High	
	China	039	High	
	China (Taiwan)	040	No data	
	China, Hong Kong SAR	087	High	
	China, Macao SAR	116	High	
	Christmas Island	041	No data	
	Cocos (Keeling) Islands	042	No data	
	Colombia	043	High	
	Comoros	044	High	
	Congo	045	High	
	Cook Islands	046	Low	
	Costa Rica	047	Low	
	Cote d'Ivoire (Ivory Coast)	098	High	
	Croatia	229	Low	
	Cuba	048	Low	
	Curacao	255	Low	
	Cyprus	049	Low	
	Czech Republic	230	Low	
	Czechoslovakia	050	No data	
	D	Democratic People's Republic of Korea (North Korea)	106	High
		Democratic Republic of the Congo	257	High
		Denmark	051	Low
		Djibouti	052	High
		Dominica	053	Low
		Dominican Republic	054	High
		E	East Germany	071
Ecuador	055		High	
Egypt	056		Low	
El Salvador	057		High	
England (United Kingdom of Great Britain and Northern Ireland)	204		Low	
COUNTRY	PTBMIS Code		INCIDENCE	
Equatorial Guinea	058		High	
Eritrea	259		High	
Estonia	231		High	
Ethiopia	059		High	

F	Falkland Islands	060	No data
	Faroe Islands	061	No data
	Federated States of Micronesia	245	High
	Fiji	062	High
	Finland	063	Low
	France	064	Low
	French Guiana	065	No data
	French Polynesia	066	High
	French Southern and Antarctic Lands	067	No data
G	Gabon	068	High
	Gambia	069	High
	Georgia	232	High
	Germany	246	Low
	Germany (East)	071	Low
	Germany (West)	072	Low
	Ghana	073	High
	Gibraltar	074	No data
	Gilbert Islands (Kiribati)	105	No data
	Great Britain (United Kingdom of Great Britain and Northern Ireland)	204	Low
	Greece	075	Low
	Greenland	076	High
	Grenada	077	Low
	Guadeloupe	078	No data
	Guam	079	High
	Guatemala	080	High
	Guinea	081	High
	Guinea-Bissau	082	High
	Guyana	083	High
H	Haiti	084	High
	Heard and McDonald Islands	085	No data
	Honduras	086	High
	Hong Kong (China, Hong Kong SAR)	087	High
	Hungary	088	Low
I	Iceland	089	Low
	India	090	High
	COUNTRY	PTBMIS Code	Incidence
	Indonesia	091	High
	Iran (Islamic Republic of)	092	High
	Iraq	093	High
	Iraq-Sauid Arabia Neutral Zone	094	No data
	Ireland	095	Low
	Israel	096	Low
	Italy	097	Low

	Ivory Coast (Cote d'Ivoire)	098	High
J	Jamaica	099	Low
	Japan	100	High
	Johnston Atoll	101	No data
	Jordan	102	Low
K	Kazakhstan	233	High
	Kenya	104	High
	Kiribati (Gilbert Islands)	105	High
	Korea, Democratic People's Republic of (North Korea)	106	High
	Korea, Republic of (South Korea)	107	High
	Kosovo	248	No data
	Kuwait	108	High
	Kyrgyzstan	234	High
L	Lao People's Democratic Republic (Laos)	109	High
	Laos (Lao People's Democratic Republic)	109	High
	Latvia	235	High
	Lebanon	110	Low
	Lesotho	111	High
	Liberia	112	High
	Libya (Libyan Arab Jamahiriya)	113	High
	Libyan Arab Jamahiriya	113	No data
	Liechtenstein	114	No data
	Lithuania	236	High
	Luxembourg	115	Low
M	Macao (China, Macao SAR)	116	High
	Macedonia (The Former Yugoslav Republic of Macedonia)	219	High
	Madagascar	117	High
	Malawi	118	High
	Malaysia	119	High
	Maldives	120	High
	Mali	121	High
	COUNTRY	PTBMIS Code	Incidence
	Malta	122	Low
	Marshall Islands	261	High
	Martinique	123	No data
	Mauritania	124	High
	Mauritius	125	High
	Mexico	126	High
	Micronesia (Federated States of)	245	High
	Midway Islands	127	No data
	Moldova (Republic of Moldova)	238	High
	Monaco	128	Low

	Mongolia	129	High
	Montenegro	239	Low
	Montserrat	130	Low
	Morocco	131	High
	Mozambique	132	High
	Myanmar (Burma)	030	High
N	Namibia	133	High
	Nauru	134	High
	Navassa Island	135	No data
	Nepal	136	High
	Netherlands	137	Low
	Netherlands Antilles	138	No data
	New Caledonia	139	High
	New Hebrides	140	No data
	New Zealand	141	Low
	Nicaragua	142	High
	Niger	143	High
	Nigeria	144	High
	Niue	145	High
	Norfolk Island	146	No data
	North Korea (Democratic People's Republic of Korea)	106	High
	Northern Ireland (United Kingdom of Great Britain and Northern Ireland)	204	Low
	Northern Mariana Islands	147	High
	Norway	148	Low
O	Oman	149	Low
P	Pakistan	150	High
	Palau	263	High
	Panama	151	High
	COUNTRY	PTBMIS Code	Incidence
	Papua New Guinea	152	High
	Paracel Islands	153	No data
	Paraguay	154	High
	Peru	155	High
	Philippines	156	High
	Pitcairn Islands	157	No data
	Poland	158	High
	Portugal	159	High
	Puerto Rico	160	Low
Q	Qatar	161	High
R	Refused Information	998	
	Republic of Korea (South Korea)	107	High
	Republic of Moldova	238	High

	Reunion	162	No data	
	Romania	163	High	
	Russian Federation (Russia)	240	High	
	Rwanda	164	High	
S	Saint Christopher and Nevis (Saint Kitts and Nevis)	165	Low	
	Saint Kitts and Nevis (Saint Christopher and Nevis)	165	Low	
	Samoa (Western Samoa)	216	High	
	San Marino	170	Low	
	Sao Tome and Principe	171	High	
	Saudi Arabia	172	Low	
	Senegal	173	High	
	Serbia	241	Low	
	Seychelles	174	High	
	Sierra Leone	175	High	
	Singapore	176	High	
	Sint Maarten (Dutch part)	265	Low	
	Slovakia	267	Low	
	Slovenia	242	Low	
	Solomon Islands	177	High	
	Somalia	178	High	
	South Africa	179	High	
	South Korea (Republic of Korea)	107	High	
	South Sudan	183	High	
	Spain	180	Low	
	Spratly Islands	181	No data	
	Sri Lanka	182	High	
		COUNTRY	PTBMIS Code	Incidence
		St. Helena	166	No data
		St. Lucia	167	Low
	St. Pierre and Miquelon	168	No data	
	St. Vincent and the Grenadines	169	High	
	Sudan	183	High	
	Suriname	184	High	
	Svalbard and Jan Mayen	185	No data	
	Swaziland	186	High	
	Sweden	187	Low	
	Switzerland	188	Low	
	Syria (Syrian Arab Republic)	189	Low	
	Syrian Arab Republic (Syria)	189	Low	
T	Taiwan	040	Low	
	Tajikistan	243	High	
	Tanzania (United Republic of Tanzania)	190	High	
	Thailand	191	High	

	The Former Yugoslav Republic of Macedonia	219	High
	Timor-Leste	269	High
	Togo	192	High
	Tokelau	193	High
	Tonga	194	Low
	Trinidad and Tobago	195	High
	Trust Territory of the Pacific Islands	196	No data
	Tunisia	197	High
	Turkey	198	High
	Turkmenistan	244	High
	Turks and Caicos Islands	199	High
	Tuvalu	200	High
U	Uganda	201	High
	Ukraine	223	High
	Union of Soviet Socialist Republics	202	No data
	United Arab Emirates	203	Low
	United Kingdom of Great Britain and Northern Ireland	204	Low
	United Republic of Tanzania	190	High
	United States Mis Pacific islands	206	No data
	United States of America	205	Low
	Unknown	999	
	Upper Volta	207	High
	Uruguay	208	High
	COUNTRY	PTBMIS Code	Incidence
	US Virgin Islands	212	Low
	Uzbekistan	246	High
V	Vanuatu	271	High
	Vatican City	209	No data
	Venezuela	210	High
	Viet Nam	211	High
W	Wake Island	213	No data
	Wallis and Futuna Islands	214	High
	West Bank and Gaza Strip	070	Low
	West Germany	072	Low
	Western Sahara	215	No data
	Western Samoa (Samoa)	216	High
Y	Yemen (Aden)	217	High
	Yemen (Sana)	218	High
	Yugoslavia	219	No data
Z	Zambia	221	High
	Zimbabwe (S. Rhodesia)	222	High

HEPATITIS A VACCINE

GENERAL INFORMATION

Hepatitis A disease is a serious liver infection caused by the Hepatitis A virus (HAV). HAV is found in the stool of persons with Hepatitis A. It is not often fatal, but is highly contagious with transmission occurring primarily by the fecal-oral route.

Hepatitis A vaccine is inactivated and contains no live organisms. Hepatitis A vaccine is not licensed for children younger than 1 year of age. Hepatitis A vaccine may be administered simultaneously with other vaccines.

To determine if a patient in an ACIP-recommended group is eligible for free, Federal vaccine, please see the current Tennessee Immunization Program Policy on the use of Federal vaccine.

Recommended Populations who should be vaccinated include:

- All children 12-23 months
- Previously unvaccinated children 23 months through 18 years of age
- Any person requesting protection from Hepatitis A virus infection
- Members of households planning to adopt a child, or care for a newly arriving adopted child, from a country where hepatitis A is common (see www.cdc.gov/travel).
- People who use street drugs.
- Men who have sex with men

- International travelers (refer)
- Persons working with hepatitis A-infected non-human primates (refer)
- Persons who work with hepatitis A in research laboratories (refer)

- ❖ Persons who have blood clotting-factor disorders or chronic liver disease (MD or APN order)

Contraindications to giving the vaccine include the following:

Persons with a history of severe reaction to a prior dose of hepatitis A vaccine or to any hepatitis A vaccine component

Precautions (risks and benefits of vaccination should be carefully evaluated for individuals under the following circumstances):

Moderate to severe acute illness (defer until illness resolves)

Adverse Reactions:

Severe allergic reaction to vaccine (rare)
 Injection site soreness, tenderness, redness, swelling (common)
 Fatigue, fever, malaise, anorexia, nausea, headache (systemic)

PLAN

1. Ask patient/guardian about contraindications
2. Have patient/guardian read Vaccine Information Statement
3. Administer the appropriate pediatric or adult formulation of the vaccine according to manufacturer instructions
4. Counsel regarding side effects of vaccine
5. Advise patient or parent/guardian to return for the second dose in 6-12 months
6. Advise to wait in clinic for 20 minutes after injection
7. Document vaccine administration on the immunization clinic record
8. Instruct patient/guardian to contact Health Department if adverse reaction occurs

Dosage:

VAQTA (Merck) **or** HAVRIX (GlaxoSmithKline) hepatitis A vaccines:

Pediatric Formulation (ages 12 mos. to 19 years), 2 doses required

Administer 0.5 cc IM

Administer second dose 6-12 months later.

Adult Formulation (≥ 19 years), 2 doses required

Administer 1.0 cc IM

Administer second dose 6-12 months later.

TWINRIX Combination Hepatitis A and B vaccine (GlaxoSmithKline):

(Licensed for adults ≥ 18 years only, 3 doses required)

Administer 1.0 cc IM,

Administer second dose 1 month after the first dose.

Administer third dose 6 months after the first dose.

Referral Indicators:

If vaccine is indicated for liver disease or blood clotting factor disorder¹, written order from MD or APN is needed

Severe reaction to previous vaccine (consult MD)

REFERENCES

CDC. Epidemiology and Prevention of Vaccine-Preventable Diseases. 12th edition, May 2012:pp 101-114.

<http://www.cdc.gov/vaccines/hcp/vis/vis-statements/hep-a.html#who>

CDC. Advisory Committee on Immunizations Practices (ACIP) Recommended Immunization Schedule for Adults Aged 19 years and older - United States, 2013. MMWR, February 1, 2013/62(01);9-19.

<http://www.cdc.gov/mmwr/preview/mmwrhtml/su6201a3.htm>

¹ Per Advisory Committee on Immunization Practices (ACIP) guidelines, hemophilia is not a contraindication for any vaccination, but administration should be done in consultation with a physician to minimize the risk of hematoma formation

**(STREP) PNEUMOCOCCAL CONJUGATE VACCINE – 13
VALENT (PREVNAR 13® BY PFIZER)
(PCV-13)**

GENERAL INFORMATION

Pneumococcal conjugate vaccine (PCV-13) helps to prevent invasive diseases caused by 13 strains of *Streptococcus pneumoniae* (including bloodstream infections, meningitis and ear infections).

The vaccine is approved by the Federal Food and Drug Administration (FDA) for use in infants and children at least six (6) weeks of age through 17 years and in adults aged 50 or older. Where the recommendations of the federal Advisory Committee on Immunization Practices (ACIP) differ from FDA labels, ACIP recommendations should be followed.

PCV-13 may be administered simultaneously with other vaccines.

Persons who need both PPSV23 and PCV-13 should receive PCV-13 first and PPSV23 at least 8 weeks later. If such a child aged 6 through 18 years has already received PPSV23, administer the PCV-13 at least 8 weeks later; if such an adult 19 or older has already received PPSV23, administer the PCV-13 at least 1 year later.

PCV-13 IS RECOMMENDED FOR:

All children who have not reached their 5th birthday.

Children aged 60 through 71 months (until 6th birthday) who have not had PCV-13 (“PCV-13 naïve”) with underlying medical conditions that increase their risk for invasive pneumococcal disease (IPD) – **Table 2.**

Certain PCV-13 naïve persons age 6 years and older and who have specific medical Conditions (Table 2)

Contraindications to giving the vaccine include the following:

An immediate anaphylactic reaction to the vaccine or a constituent of the vaccine, such as diphtheria toxoid

Acute, moderate, or severe illnesses with or without fever (defer until resolution).

Note: Mild illness with or without fever is NOT a contraindication.

Note: The product packaging does not contain latex.

Adverse events:

Swelling, redness and/or pain at site of administration

Low-grade fever

Systemic reactions infrequent, serious adverse reactions rare

PLAN

Have accompanying adult read “Vaccine Information Statement” (VIS)
Counsel regarding benefits, side effects, and management

ADMINISTRATION OF VACCINE:

- The routine pediatric immunization schedule consists of three (3) doses at approximately two (2) month intervals (ages 2, 4, and 6 months), followed by a fourth dose at 12-15 months of age. (See **Table 1** for dosing schedule)
- The usual age for the first dose is 2 months, but it can be given as young as six (6) weeks of age
- The recommended dosing interval is 4-8 weeks
- The fourth dose should be administered at age 12-15 months, and at least 8 weeks after the third dose
- For children who have received at least one previous dose of PCV-7, complete series with PCV 13
- For a list of high risk medical conditions for which a single dose of PCV-13 is recommended in PCV13-naïve patients aged 5 years or older, see **Table 2**.
- The dose is 0.5 ml to be given intramuscularly
- Shake vigorously immediately prior to administration of vaccine in order to obtain a uniform suspension

Table 1: Routine Schedule (under 5 years of age)

Recommended routine vaccination schedule for PCV13 among infants and children who have not received previous doses of PCV-7 or PCV-13, by age at first dose. A series begun with PCV-7 should simply be completed with PCV-13.

<u>Age at first dose (mos.)</u>	<u>Primary PCV13 series*</u>	<u>PCV13 booster dose†</u>
2–6	3 doses (ideally age 2, 4, 6 mos.)	1 dose at age 12–15 mos.
7–11	2 doses	1 dose at age 12–15 mos
12–23	2 doses	—
24–59 (Healthy children)	1 dose	—
24–71 (Children with certain chronic diseases or immunocompromising conditions§)	2 doses	—

* Minimum interval between doses is 8 weeks except for children vaccinated at age <12 months for whom minimum interval between doses is 4 weeks. Minimum age for administration of first dose is 6 weeks.

† Given at least 8 weeks after the previous dose.

§ For complete list of conditions, see **Table 2**.

Table 2: Medical Conditions that Increase Risk of Invasive Pneumococcal Disease

Underlying medical conditions that are indications for PCV-13 use in PCV-13 naïve persons, by risk Group

Risk group	Condition
Immunocompetent Persons	<i>Chronic heart disease*</i> [60 through 71 months only] <i>Chronic lung disease†</i> [60 through 71 months only] <i>Diabetes mellitus</i> [60 through 71 months only] Cerebrospinal fluid leaks [<u>all ages</u>] Cochlear implant [<u>all ages</u>]
<u>All ages</u> with functional or anatomic asplenia	Sickle cell disease and other hemoglobinopathies Congenital or acquired asplenia, or splenic Dysfunction
<u>All ages</u> with immunocompromising condition	HIV infection Chronic renal failure and nephrotic syndrome Diseases treated with immunosuppressive drugs or radiation therapy, including malignant neoplasms, leukemias, lymphomas, and Hodgkin disease; or solid organ transplant Congenital immunodeficiency§

* Particularly cyanotic congenital heart disease and cardiac failure.

† Including asthma if treated with prolonged high-dose oral corticosteroids.

§ Includes B- (humoral) or T-lymphocyte deficiency; complement deficiencies, particularly C1, C2, C3, and C4 deficiency; and phagocytic disorders (excluding chronic granulomatous disease).

NOTE:

The use of PCV-13 does not replace the use of 23-valent pneumococcal polysaccharide vaccine (PPSV23) in children ≥ 24 months of age or adults with the underlying medical conditions listed in **Table 2**.

If a patient will need PPSV23 and PCV-13, administer PCV-13 *before* the PPSV23 (at least 8 weeks apart). If such a child aged 6 through 18 years has already received PPSV23, administer the PCV-13 at least 8 weeks later; if such an adult 19 or older has already received PPSV23, administer the PCV-13 at least 1 year later.

Post Immunization Administrative Issues:

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 parent to contact Health Department if adverse reaction occurs (complete appropriate Vaccine Adverse Event Report [VAERS] Form)

Referral Indicators:

A history of anaphylactic hypersensitivity to any component of the vaccine

Follow-up:

Return for next pneumococcal vaccine dose at appropriate interval

REFERENCES:

- CDC. Licensure of a 13-Valent Pneumococcal Conjugate Vaccine (PCV13) and Recommendations for Use Among Children — Advisory Committee on Immunization Practices (ACIP), 2010. MMWR. <http://www.cdc.gov/mmwr/pdf/wk/mm5909.pdf>
- CDC. Use of 13-Valent Pneumococcal Conjugate Vaccine and 23-Valent Pneumococcal Polysaccharide Vaccine for Adults with Immunocompromising Conditions: Recommendations of the Advisory Committee on Immunization Practices (ACIP). MMWR, October. <http://www.cdc.gov/mmwr/pdf/wk/mm6140.pdf>
- CDC. Use of 13-Valent Pneumococcal Conjugate Vaccine and 23-Valent Pneumococcal Polysaccharide Vaccine Among Children Aged 6–18 Years with Immunocompromising Conditions: Recommendations of the Advisory Committee on Immunization Practices (ACIP), 2013. MMWR June 28, 2013. <http://www.cdc.gov/mmwr/pdf/wk/mm6225.pdf>
- PREVNAR 13 (Pneumococcal 13-valent Conjugate Vaccine [Diphtheria CRM197Protein]) Prescribing Information: <http://labeling.pfizer.com/showlabeling.aspx?id=501>

PNEUMOCOCCAL VACCINATION RECOMMENDATIONS for Children¹ and Adults by Age and/or Risk Factor

Risk Group	Underlying medical condition or other risk factor	Recommendations for Vaccination with Pneumococcal Conjugate Vaccine (PCV13)			Recommendations for Vaccination with Pneumococcal polysaccharide vaccine (PPSV23)		
		Administer doses needed to complete schedule to children through age 71 months	Administer 1 dose to PCV13-naïve children age 6–18 years	Administer 1 dose to PCV13-naïve adults age 19 years and older	Administer 1 dose at age 2 through 64 years	Administer second dose 5 years after first dose if age <65 years	Administer 1 dose at age 65 years (Wait 5 years from any prior dose given at age <65 years.)
Immuno-competent	Healthy adult, non-smoker						X
	Chronic heart disease ²	X			X		X
	Chronic lung disease ³	X			X		X
	Diabetes mellitus	X			X		X
	Cerebrospinal fluid leak	X	X	X	X		X
	Cochlear implant	X	X	X	X		X
	Alcoholism				X		X
	Chronic liver disease, cirrhosis				X		X
Cigarette smoking (≥19 yrs)				X		X	
Functional or anatomic asplenia	Sickle cell disease/other hemoglobinopathy	X	X	X	X	X	X
	Congenital or acquired asplenia	X	X	X	X	X	X
Immuno-compromised	Congenital or acquired immunodeficiency ⁴	X	X	X	X	X	X
	HIV	X	X	X	X	X	X
	Chronic renal failure	X	X	X	X	X	X
	Nephrotic syndrome	X	X	X	X	X	X
	Leukemia	X	X	X	X	X	X
	Lymphoma	X	X	X	X	X	X
	Hodgkin disease	X	X	X	X	X	X
	Generalized malignancy	X	X	X	X	X	X
	Iatrogenic immunosuppression ⁵	X	X	X	X	X	X
	Solid organ transplant	X	X	X	X	X	X
Multiple myeloma	X	X	X	X	X	X	

Technical content reviewed by the Centers for Disease Control and Prevention

Immunization Action Coalition

1573 Selby Avenue - St. Paul, MN 55104 - 651 647-9009 - www.immunize.org - www.vaccineinformation.org
www.immunize.org/catg.d/p2016.pdf.

1. For PCV13 vaccination of healthy children, see "Recommendations for Pneumococcal Vaccine Use in Children" at www.immunize.org/catg.d/p2016.pdf.
 2. Particularly cyanotic congenital heart disease and cardiac failure in children; excluding hypertension in adults.
 3. Including asthma in children if treated with high-dose oral corticosteroid therapy; including asthma in adults.
 4. Includes B- (humoral) or T-lymphocyte deficiency, complement deficiencies (particularly C1, C2, C3, and C4 deficiencies), and phagocytic disorders (excluding chronic granulomatous disease).
 5. Diseases requiring treatment with immunosuppressive drugs, including long-term systemic corticosteroids and radiation therapy.

GONORRHEA

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 in”

Pain, tenderness in pelvic organs

Sexual contact to confirmed or suspected case of gonorrhea

Private physician or other health care provider referral

OBJECTIVE

Purulent discharge from urethra or cervix noted on exam

Laboratory positive for *Neisseria gonorrhoeae*

ASSESSMENT

Confirmed or suspected case of *Neisseria gonorrhoeae*

Contact to confirmed or suspected case of *Neisseria gonorrhoeae*

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.

¹ Several studies of different test technologies have shown various post-treatment intervals wherein a false positive test result may occur. Repeat testing for *N. gonorrhoeae* should not be performed less than 1 week after appropriate treatment, and repeat testing for *C. trachomatis* should not be performed less than 3 weeks after appropriate treatment. Patients that have been exposed to an infected person within these intervals treatment should be re-treated, but not re-tested.

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.

TREATMENT

It is recommended that all patients being treated for gonorrhea receive dual treatment for both gonorrhea and chlamydia regardless of Chlamydia testing or results.²

Dual therapy, administered concurrently, is considered the only adequate therapy, regardless of the chlamydia results.

Treatment for Gonorrhea and Chlamydia **(regardless of site of infection OR Chlamydia results)**

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 days^{3,4}

Non-allergic Pregnant Adult/Adolescent or Breastfeeding Mothers:

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

Ceftriaxone 250 mg IM 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 days⁴

² Dual treatment is recommended because patients infected with *N. gonorrhoeae* frequently are co-infected with *C. trachomatis*. Additionally, the use of a second antimicrobial is recommended for use with ceftriaxone to theoretically improve treatment efficacy and delay emergence and spread of resistance to *N. gonorrhoeae* to cephalosporins.

³ Doxycycline is contraindicated in pregnancy and nursing mothers

⁴ Because of resistance concerns among Gonococcal Isolate Surveillance Project isolates, the use of azithromycin as the second antimicrobial is preferred to doxycycline (and, among pregnant or nursing mothers, to amoxicillin).

Allergic Adult/Adolescent (regardless of pregnancy or breastfeeding status):

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

PLUS

Test-of-cure in 1 week

If the patient has no clinical symptoms of persistent infection, the DNA-Probe specimen collection may be used for testing.

OR

If the patient has persistent symptoms, a culture plate with antimicrobial susceptibility should be performed.

The decision to re-treat at the test-of-cure visit will be based on nursing judgment and/or consultation with the APN or physician.

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 of allergic response to determine if there is a history of a severe 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.⁵ If history indicates a severe reaction such as anaphylaxis, or the nurse is unable to gain a reliable history consistent with a non-anaphylactic reaction, the patient should be treated with azithromycin 2 grams followed by a test-of-cure 1 week after treatment.

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, gonococcal 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 from front to back and avoid feminine hygiene sprays and deodorants.

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

⁵ Studies indicate that only 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.

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)

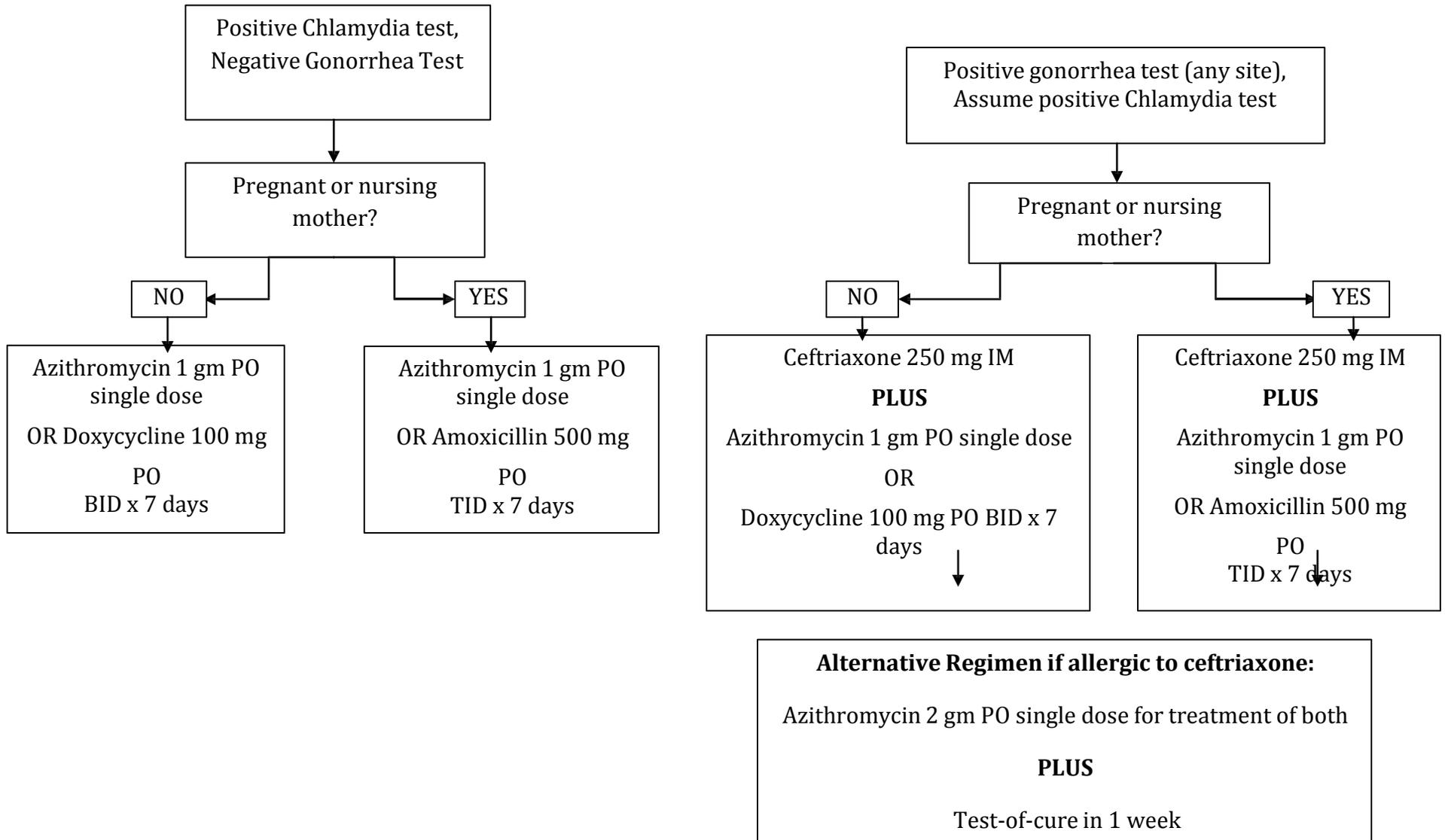
Follow-Up

Counsel all infected clients, regardless of treatment regimen, to return 1 week after treatment **if they experience persistent clinical symptoms**.
 In the absence of persistent clinical symptoms, counsel all infected patients to return for retesting of gonorrhea 3 months after completion of treatment or 1 week after treatment if not treated with ceftriaxone. If this does not occur, retest all persons treated for infection if they present for care within 12 months following treatment.
 Treatment failure should be considered in all patients with clinical or laboratory evidence of persistent infection after treatment. In all cases of suspected treatment failure, consult with nurse practitioner or physician and obtain a culture with antimicrobial susceptibility testing on specimens from relevant anatomic sites.
 Suspected treatment failures should be reported within 24 hours.
 Report all cases to Sexually Transmitted Disease Program representative

REFERENCE

- Centers for Disease Control and Prevention Update to CDC's Sexually Transmitted Diseases Treatment Guidelines, 2010: Oral Cephalosporins No Longer a Recommended Treatment for Gonococcal Infections. *MMWR* 2012; 61(31);590-594.
- Centers for Disease Control and Prevention Sexually Transmitted Diseases Treatment Guidelines, 2010. *MMWR* 2010; 59 (No. RR-12).
- Lyss SB, Kamb ML, Peterman TA, et al. *Chlamydia trachomatis* among patients infected with and treated for *Neisseria gonorrhoeae* in sexually transmitted disease clinics in the United States. *Ann Intern Med* 2003;139:178–85.
- Sathia L, Ellis B, Phillip S, et al. Pharyngeal gonorrhoea—is dual therapy the way forward? *Int J STD AIDS* 2007;18:647–8.
- Golden M, Kerani R, Shafii T, Whittington W, Holmes K. Does azithromycin co-treatment enhance the efficacy of oral cephalosporins for pharyngeal gonorrhea? Presented at: 18th International Society for STD Research (ISSTDR) Conference, London, UK, June 2009.

Gonorrhea and Chlamydia Treatment Decision Tree



LIST OF STANDARD ABBREVIATIONS

Revised November 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
NV&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 gonorrhea
 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
~	approximate	#	number
b $\sqrt{\quad}$	breast check	\ominus	negative
$\sqrt{\quad}$	check, checked	/	per
Δ	change	%	percent
$^\circ$	degree	1 $^\circ$	primary
=	equal	+ or $\textcircled{+}$	positive
q	every	?	question
\textcircled{f}	female	\textcircled{R}	right
'	foot	2 $^\circ$	secondary
>	greater than	\bar{c}	with
\geq	greater than or equal to	\bar{s}	without
\uparrow	high, elevated, above, increase	X	times
"	inches	\therefore	therefore
\textcircled{L}	left		
<	less than		
\leq	less than or equal to		

INDEX

-A-

Abbreviations, 7.020
 Acne, 3.010
 Acute Asthma Attack, 1.010
 Acute Poisoning, 1.020
 Acute Upper Respiratory Infection
 (Common Cold), 3.020
 Administering Vaccines:
 Dose, Route,
 Site, and Needle Size,
 7.010
 All Methods, Initial and/or Annual
 Family Planning Visit, 2.010
 Anaphylaxis, 1.030
 Anemia, Iron Deficiency, 3.025
 Animal Bites, 1.040
 Anthrax Vaccine, 6.010
 Apgar Scoring System, 1.070
 Ascariasis (Roundworms), 3.030

-B-

Blood Pressure, Elevated, Adult, 3.040
 Blood Pressure, Elevated, Child, 3.050
 Burn, First Degree, 1.050

-C-

Cardiac Emergencies, 1.060
 Cerumen Impacted (Ear Wax), 3.060
 Cervical Cancer Screening, 2.020
 Chickenpox, 3.530
 Chiggers (Dematophilis Pentrans), 3.070
 Chlamydia Trachomatis, Case or
 Contact, 5.010
 Chlamydia Trachomatis, Case or Contact,
 Opt-out HIV Testing (Metro Areas Only),
 5.020
 Chlamydia Trachomatis, Contact Partner
 Delivered Therapy, 5.030
 Cholesterol Risk Assessment, 3.090

Combined Oral Contraceptive Pills, 2.030
 Common Cold, 3.020
 Common Faint, 1.150
 Comvax Vaccine (Hib/Hep B), 4.010
 Condoms, Sponge and Spermicidal
 Agents, 2.040
 Constipation, Acute, Child, 3.100
 Constipation, Adult, 3.110
 Contraceptive Patch, 2.050
 Cradle Cap in Infants, 3.410

-D-

Dematophilis Pentrans (Chiggers), 3.070
 Diaper Dermatitis (Diaper Rash), 3.120
 Diaphragm, 2.060
 Diarrhea, 3.130
 Diphtheria, Tetanus Toxoid and Acellular
 Pertussis Vaccine (DTaP), 4.020
 Diphtheria and Tetanus Toxoid, Pediatric
 Vaccine (DT), 4.030
 Diphtheria, Tetanus Toxoid, Acellular
 Pertussis,
 Inactivated Polio Vaccine
 (DTaP-IPV) (Kinrix), 4.040
 Diphtheria, Tetanus Toxoid, Acellular
 Pertussis, Inactivated Polio,
 Haemophilus
 Influenzae Type B Combination
 Vaccine
 (DTaP-IPV-Hib) (Pentacel), 4.050
 Dysmenorrhea, 2.070

-E-

Emergency Childbirth, 1.070
 Emergency Contraceptive Pills (ECPs),
 2.080
 Emergency Drug Chart, 1.030
 Enterobius Vermicularis (Pinworms), 3.140

-F-

Family Planning Reference Section 2.170
 Fertility Awareness-Based Methods (FAM),
 2.090
 Fever Blister, 3.230
 Fever, Vaccine Associated, 3.150
 Five Rights of Medication Administration,
 7.010
 Fluoride Deficiency, 3.160
 Fluoride Varnish, 3.170
 Folic Acid Prophylactic Therapy for Women
 Aged 10-44, 3.180
 Foodborne Outbreak Investigation, 3.190

-G-

Generic Injections, 4.060
 Genital Herpes, 5.100
 Gingivostomatitis, 3.240
 Gonorrhea, Case or Contact, 5.040
 Gonorrhea, Case or Contact, Opt-out HIV
 Testing (Metro Areas Only), 5.050

-H-

Haemophilus b Conjugate Vaccine
 (Hib), 4.070
 Haemophilus Meningitis, Contact, 3.200
 Head Lice, 3.340
 Hemorrhage/Hemorrhagic Shock, 1.080
 Hepatitis A, Case or Presumptive, 3.210
 Hepatitis A, Post Exposure, 3.220
 Hepatitis A Vaccine, 4.080
 Hepatitis A Inactivated , Hepatitis B
 Recombinant Vaccine (Twinrix),
 4.090
 Hepatitis B, Case or Presumptive, 5.060
 Hepatitis B, Infant Contact, 5.070
 Hepatitis B, Other Non-Occupational
 Contacts, Post-Exposure, 5.080
 Hepatitis B Recombinant Vaccine,
 Pre-exposure
 (Birth through 18 years), 4.100

Hepatitis B Recombinant Vaccine,
 Pre-exposure Adult (19 years and up),
 4.110
 Hepatitis C (Non-A, Non-B), Case, 5.090
 Herpes Simplex - Type I (Fever Blister),
 3.230
 Herpes Simplex (Genital Herpes), 5.100
 Herpes Zoster Vaccine, 4.115
 Herpetic Stomatitis, 3.240
 Hives, 3.520
 HIV Testing and Counseling, 5.110
 HIV Testing and Counseling,
 Opt-out HIV Testing for STD Program
 (Metro Areas Only), 5.120
 H1N1 Influenza, 2009
 (Information and Guidance), 4.125
 H1N1 LAIV (Flumist), 4.126
 H1N1 Inactivated Influenza, 4.127
 Hordeolum (Sty), 3.250
 How to Administer
 Intramuscular (IM) Injections, 7.010
 Subcutaneous (SC) Injections, 7.010
 Human Papillomavirus (HPV)
 Vaccine, 4.120

-I-

Immune Globulin Hepatitis A Prophylaxis
 Dosage Chart, 3.220
 Impetigo/Bullous Impetigo, 3.260
 Influenza Vaccine, Live Attenuated (LAIV),
 4.130
 Influenza Vaccine, Trivalent Inactivated
 (TIV), 4.140
 Insect Bites, 1.090
 Intrauterine Contraceptive (IUC), 2.100

-J-

Jock Itch, Gym Itch, 3.440

-K-

Kinrix®, 4.040

-L-

Laceration, 1.100
 Lead Toxicity Screening, 3.280
 List of Standard Abbreviations, 7.020

-M-

Measles, Mumps, Rubella Vaccine (MMR),
 4.150
 Medication Administration, 7.010
 Meningococcal Meningitis, Case, 3.290
 Meningococcal Meningitis, Contact, 3.300
 Meningococcal Vaccine (Menactra), 4.160
 Meningococcal Vaccine (Menomune), 4.170
 Miliaria, 3.310

-N-

Nasolacrimal Duct, Obstructed, 3.320

-O-

Obstructed Nasolacrimal Duct, 3.320
 Oral Candidiasis/Moniliasis, 3.330

-P-

Pediarix (DTaP/Hep B/IPV), 4.180
 Pediculosis Capitis, 3.340
 Pediculosis Pubis, 5.130
 Periodicity Schedule (Infancy-
 Adolescence), 3.350
 Periodicity Schedule
 (22 years and over), 3.360
 Pinworms, 3.140
 Pityriasis Rosea, 3.370
 Pneumococcal Conjugate Vaccine
 (PCV13), 4.190
 Pneumococcal Vaccine, 4.200
 Poison Ivy Dermatitis, 3.380
 Poisoning, Acute, 1.020
 Poison Oak, 3.380
 Poison Sumac, 3.380
 Polio Vaccine, Inactivated (IPV), 4.210

Potassium Iodide (KI) Administration, 6.020
 Pregnancy Test, 2.110
 Prevention of Vitamin Deficiency - Prenatal,
 3.390
 Preventive Health Care, Children, 3.350
 Preventive Health Care, Adults, 3.360
 Prickly Heat, 3.310
 Progestin-only Implants, 2.120
 Progestin-only Injectable Contraception,
 2.130
 Progestin Only Pills (Minipill), 2.140
 Pubic Lice, 5.130
 Puncture Wound, 1.110

-Q-**-R-**

Rabies Vaccine, Post-Exposure, 4.220
 Rabies Vaccine, Pre-Exposure, 4.230
 References, 7.030
 Respiratory Emergency, 1.120
 Ringworm, 3.430
 Rotavirus Vaccine, 4.240
 Roundworms, 3.030

S-

Sarcoptes Scabiei, 3.400
 Scabies, 3.400
 Seborrheic Dermatitis, 3.410
 Seizures, 1.130
 Shingles Vaccine, 4.115
 Shock, 1.140
 Smallpox Vaccine (Vaccinia), 6.030
 Smoking Cessation, 3.420
 Sterilization, 2.150
 Sty, 3.250
 Syncope/Vasovagal Reaction
 /Common Faint, 1.150
 Syphilis, Case or Contact, 5.140
 Syphilis, Case or Contact
 Opt-out HIV Testing
 (Metro Areas only), 5.150

-T-

Tetanus, Diphtheria and Acellular
 Pertussis Vaccine (Tdap)
 (7 through 18 years), 4.250

Tetanus, Diphtheria and Acellular
 Pertussis Vaccine (Tdap)
 (19 through 64 years), 4.260

Tetanus and Diphtheria Toxoid,
 Adult Type (Td), 4.270

Tetanus Prophylaxis in Wound
 Management, 4.280

Thrush, 3.330

Tick Bite, 1.160

Tinea Corporis, 3.430

Tinea Cruris, 3.440

Tinea Versicolor, 3.450

Tips on Safeguarding Your
 Vaccine Supply, 7.010

Tobacco Cessation, 3.420

Trichomoniasis, Case or Contact, 5.160

Testing for TB Infection, 3.460

Tuberculosis, Case or Suspect,
 (Initial Visit) 3.480

Tuberculosis, Initial Visit, 3.480

Tuberculosis, Treatment of Latent TB
 Infection, 3.490

Tuberculin Skin Testing, Two Step
 Procedure, 3.470

-U-

Upper Respiratory Infection, Acute, 3.020

Urticaria, 3.520

-V-

Vaccine Adverse Event Reporting System
 (VAERS), 7.010

Vaccines and Route of Administration,
 7.010

Varicella, 3.530

Varicella Vaccine, 4.290

Vasovagal Reaction, 1.150

Vaginal Contraceptive Ring, 2.160

-W-

Wound, Puncture, 1.110

-X-**-Y-****-Z-**