

PUBLIC HEALTH

NURSING PROTOCOL

Tennessee Department of Health
Community Health Services
Patient Care Services

PREFACE

The Public Health Nursing (PHN) protocol represents a detailed written set of instructions to guide medical management of our patients, thereby establishing a standard of care for the Public Health Nurse's practice. The PHN Protocol was developed, and is maintained, by the Public Health Nursing Practice Committee. These Protocols represent an enormous amount of work from a variety of nurses, physicians and other staff throughout the State. They have been reviewed by the State Medical Director, State Nursing Director, Regional Nursing Directors, Medical Services Evaluation Committee, and specific individuals that are involved in developing program guidelines that impact nursing practice.

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

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

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Staff Support
PHN Practice Committee

PUBLIC HEALTH NURSING PROTOCOL AGREEMENT

Region _____

County/Site _____

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

| Name | Date |
|-------|--|
| _____ | _____ Regional Medical Director Date |
| _____ | |
| _____ | _____ Regional Nursing Director Date |
| _____ | |
| _____ | _____ County Health Officer Date |
| _____ | |
| _____ | _____ County Nursing Supervisor Date |
| _____ | |
| _____ | |
| _____ | |

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**EMERGENCY
MANAGEMENT**

1.010 – 1.160

ACUTE ASTHMA ATTACK

SUBJECTIVE

History of:

- Current/past medications and efficacy
- Recent contact with irritant
- Previous asthma attack Acute or chronic infection

Symptoms may include:

- Severe wheezing, difficulty breathing, chest tightness, coughing
- Anxiety, apprehension and breathlessness

OBJECTIVE

- Use of the neck, chest, or abdominal muscles in breathing
- Rapid pulse and respiration
- Systolic blood pressure usually rises
- Heavy perspiration
- Prolonged expiration with expiratory and occasionally inspiratory wheezes
- During severe distress, wheezing may be absent and breath sounds may be diminished and lip and fingernail cyanosis may be present

ASSESSMENT

Acute asthmatic attack

PLAN

- Call 911
- Assure adequate airway - administer CPR if indicated
- Question regarding most recent weight, medication use and allergies. Avoid Inhaler overuse.
- Locate and use Emergency Kit
- Keep patient's head/chest elevated
- Administer aqueous epinephrine 1:1000, subcutaneously according to Emergency Drug Chart (**Note** - epinephrine should be given with caution to persons taking beta blockers); may repeat epinephrine dosage in 15-20 minutes if necessary
- Observe closely for signs of Status Asthmaticus (cyanosis, confusion, and lethargy)
- Reassure and calm patient
- Administer oxygen, 4-6 liters per minute by nasal catheter or cannula, or 6-12 liters by mask
- Transfer to hospital as soon as possible and send report of care given to receiving providers.
- After transfer, document actions in patient record.

Reference

Mayo Clinic, Guide To Self -Care, Fifth Edition 2006
Ferri's Clinical Advisor 2008

ACUTE POISONING

SUBJECTIVE

History suggests:

Ingestion of non-food substance

Accidental or intentional ingestion of toxic amounts of a medication

Ingestion was witnessed, or empty container found

What, how much, and when swallowed?

OBJECTIVE

Symptoms may be absent if discovered soon after poisoning occurs

Abnormal odor to breath or clothes

Presence of burns on lips/tongue

Pain with, or difficulty in, swallowing

Central nervous system changes (e.g., convulsion, coma, dilated or pinpoint pupils)

Respiratory distress

ASSESSMENT

Poisoning or overdose

PLAN

Immediately contact physician or Poison Control Center

National Poison Control Hotline: 1-800-222-1222

Follow guidelines for emergency treatment as given per physician or Poison Control Center

Transfer patient to nearest medical provider or emergency care facility

Health Teaching:

Keep all potential poisons, household products, and medicines locked and out of reach of children

Keep medicines in child-resistant containers, and always replace cap after each use

Keep Poison Control Center and physician's phone numbers beside telephone Do not store non-drinkable/non-edible substances in drink/food containers Label all containers with contents

Referral Indicators:

All poisonings and overdoses

Follow-Up:

As suggested by consultant

ANAPHYLAXIS

SUBJECTIVE

History of:

Ingestion of medication or recent injection, often within minutes
Recent insect bite or sting Food
consumption Previous allergic reaction

Symptoms may include:

Headache
Anxiety/feeling of impending doom
Difficult breathing/tightness in throat and chest, wheezing
Feeling faint
Localized or generalized pruritis
Swelling of hands, feet, face and tongue

OBJECTIVE

Weak, irregular, and rapid pulse (above 100 beats per minute)
Rapid and shallow respirations
Fall in blood pressure
Patient apprehensive and perspiring heavily
Lips, tongue, and eyelids are frequently swollen
Hives, rash, erythema present on the upper chest and face
Cyanosis of the lips and nail beds
Labored breathing and wheezing (wheezes are heard throughout chest)

ASSESSMENT

Anaphylactic reaction

PLAN

Initiate emergency response system
Assure adequate airway - administer CPR if indicated
Question regarding most recent weight
Administer aqueous epinephrine 1:1000 SUBCUTANEOUSLY according to Emergency Drug Chart (**Note - epinephrine should be given with caution to persons taking beta blockers**)
May repeat epinephrine dosage every 5-15 minutes, if necessary
Administer Benadryl IM according to Emergency Drug Chart (See page 3)
Observe closely for signs of continuing shock, airway obstruction, convulsions, and coma
Administer oxygen, 4-6 liters per minute by nasal catheter or cannula, or 6-12 liters by mask
Transport via ambulance as soon as possible and send report of care given

References

Drug Interactions. Philip Hantsen 5th edition P. 32, 1985. Bureau of Health Services Policy 8.4.a

ANAPHYLAXIS

EMERGENCY DRUG CHART

1. Aqueous Epinephrine (Adrenalin) = 0.01 ml./kg. SQ

| WEIGHT | | AQUEOUS EPINEPHRINE (ADRENALIN) 1:1000 SQ |
|------------------|----------------|--|
| kg | lb | |
| Less than 5.0 | Less than 11 | 0.05 ml. |
| 5.0 - 11.5 | 11 - 25 | 0.10 ml. |
| 11.6 - 16.0 | 26 - 35 | 0.15 ml. |
| 16.1 - 20.5 | 36 - 45 | 0.20 ml. |
| 20.6 - 27.5 | 46 - 60 | 0.25 ml. |
| 27.6 and greater | 61 and greater | 0.30 ml. |

2. Diphenhydramine (Benadryl) = 1 mg./kg. IM

| WEIGHT | | DIPHENHYDRAMINE (prefilled syringes) 50 mg/ml IM |
|---------------|--------------|--|
| kg | lb | |
| Less than 5.0 | Less than 11 | Consult MD |
| 5.0 - 9.0 | 11 - 20 | Consult MD |
| 9.1 - 11.5 | 21 - 25 | 12.5 mg = 0.25 ml. |
| 11.6 - 16.0 | 26 - 35 | 15 mg = 0.30 ml. |
| 16.1 - 18.5 | 36 - 40 | 17.5 mg = 0.35 ml. |
| 18.6 - 20.5 | 41 - 45 | 20 mg = 0.40 ml. |
| 20.6 - 23.0 | 46 - 50 | 22.5 mg = 0.45 ml. |
| 23.1 - 27.5 | 51 - 60 | 25 mg = 0.50 ml. |
| 27.6 - 34.5 | 61 - 75 | 30 mg = 0.60 ml. |
| 34.6 - 39.0 | 76 - 85 | 35 mg = 0.70 ml. |
| 39.1 - 45.5 | 86 - 100 | 40 mg = 0.80 ml. |
| Over 45.5 | Over 100 | 50 mg = 1.00 ml. |

WEIGHT CONVERSION:

1 kg = 2.2 lbs

1 lb = 0.45 kg

ANIMAL BITES (EXCLUDING SNAKEBITES)

SUBJECTIVE

Bitten or attacked by animal, often owned by victim

History to include:

Species of biting animal; date and time of contact; circumstances of biting accident; whether provoked or not

Location of affected area(s)

Immunization history of patient; vaccination history of animal

OBJECTIVE

Puncture wounds, lacerations, contusions, avulsions (torn skin)

Teeth bites that result in broken skin

Open scratches, cuts, or torn skin

ASSESSMENT

Animal bite (with or without possible exposure to rabies or other diseases spread through animal bites/scratches which include rat bite fever, tetanus, and cat scratch fever)

PLAN

Wash the wound thoroughly with soap and water

Control bleeding

Apply antiseptic cream or ointment

Apply sterile dressing as needed

Assess need for tetanus prophylaxis and measures to control bacterial infection (refer to Tetanus Prophylaxis in Wound Management)

Consider exposure risk for rabies and need for immunoprophylaxis (refer to Rabies Vaccine, post-Exposure)

Advise confinement of animal until potential rabies exposure can be evaluated

Health Teaching:

Stress importance of maintaining annual rabies vaccination for all family cats/dogs

Avoid contact with certain wild animals, especially skunks, raccoons and bats

Warn that the practice of capturing stray or wild animals and keeping as pets without a special permit from the Tennessee Wildlife Resource Agency is against the law.

Referral Indicators:

All snake bites

Severe bites, bites over joints

Immunocompromized persons
Severe diabetic
Swelling, red streaks, redness, pus or severe pain in bite site

Reference:

Mayo Clinic, Guide To Self-Care, Fifth Edition 2006
Ferri's Clinical Advisor 2008

BURN - FIRST DEGREE

SUBJECTIVE

Burn or contact with fire, steam, hot liquid, ultraviolet rays of sun, tanning bed or chemicals
Painful affected area
Assess for date and time of injury; location of affected area(s) and tetanus vaccine status

OBJECTIVE

1st Degree - Erythema only
2nd Degree - Erythema with blister formation; peeling and weeping may or may not be present
3rd Degree - Areas that have charred or whitish appearance usually surrounded by erythema; areas of anesthesia may be present
4th Degree - Damage extends through subcutaneous tissue

ASSESSMENT

Burn - first degree

PLAN

Assess vital signs, especially respiration

Determine extent of injury

Refer all 2nd degree, 3rd degree and 4th degree burns, or if there is face or neck burns, singed nasal hairs, darkened sputum, burn or carbon marks on the oral or nasal membranes, or if the burn occurred in an enclosed space

FIRST DEGREE BURN:

If on an upper extremity, remove jewelry

Immerse burn area in clean cold water or if unable to immerse burn site, cover with a clean cloth and soak with cold water or normal saline for 15-20 minutes

Cover with sterile gauze dressing

For pain relief:

Children - Acetaminophen, dosage according to weight

Adults - Ibuprofen 600 mg po every 6 hours PRN

Increase fluid intake

Treat sunburns with OTC aloe vera type lotion or cream; teach gradual sun exposure and use of sun screen for prevention

Teach signs and symptoms of infection

Can use silver sulfadiazine cream as first aid if not allergic

Provide record of last tetanus immunization for other than first degree burn

Advise and/or administer tetanus prophylaxis

Prophylactic Antibiotics for first degree burns not recommended

Referral Indicators:

Burns over large body area Second,
third, fourth degree burns Suspected
child abuse or neglect Eye involvement
Chemical or electrical burns of uncertain severity

Follow-up:

Patient/parent will be asked to contact health provider if condition persists or
worsens

References:

Mayo Clinic, Guide To Self-Care, Fifth Edition 2006
Ferri's Clinical Advisor 2008

CARDIAC EMERGENCIES

SUBJECTIVE

Symptoms may include:

- Chest pain (may or may not radiate to the left arm, neck, back or jaw), pressure in chest and/or shortness of breath
- Apprehension
- History of coronary artery disease
- Currently taking cardiac medicines

OBJECTIVE

- Weak, irregular, rapid pulse, or no pulse
- Cyanosis (nail beds, lips, etc)
- Cold clammy skin
- Fall in blood pressure, or no pressure
- Labored respirations
- May or may not have distended neck veins when patient is at 45° angle

ASSESSMENT

Coronary Artery Disease/Angina

PLAN

- Initiate emergency response system
- Check vital signs
- Administer CPR if indicated
- Use automatic external defibrillator (AED) if available and indicated
- Give oxygen 4-6 liters/minute via mask, or nasal cannula
- After determining that patient is not allergic to aspirin, give 325 mg non-enteric coated aspirin, crushing tablet and adding to water. **DO NOT ADMINISTER UNLESS PATIENT IS FULLY CONSCIOUS**
- Observe closely for signs of continued decrease in blood pressure, arrhythmias, tachycardia or bradycardia
- If patient has nitroglycerin medication, instruct to take prescribed dosage sublingually; one tablet q 5 minutes x 3; hold if systolic blood pressure is less than 100
- Transport via ambulance as soon as possible and send report of care give

References:

- GIVING EMERGENCY CARE COMPETENTLY, Nursing Skills Books
 - “Cardiac arrest: When minutes count,” Romaine Hart, RN
 - “Myocardial Infarction: How to alleviate pain and anxiety: Catherine C. Manzi, RN
- TDH, Division of Emergency Medical Services, PARAMEDICAL PROTOCOL, “Symptomatic Chest Pain”, H. Lynn Massingale, M.D., Oct. 1, 1991
- Conn's Current Therapy, Edited by Robert E. Rakel, MD. W.B. Sanders Co., Philadelphia 1999. "Acute Myocardial Infarction" pp 324-329
- American Heart Association Guidelines CPR ECC, 2010, September 2011
- http://www.heart.org/idc/groups/heart-public/@wcm/@ecc/documents/downloadable/ucm_317350.pdf

EMERGENCY CHILDBIRTH

SUBJECTIVE

Urge to push, bear down, or have a bowel movement
Warns that "baby coming"
Reports "water broke"

OBJECTIVE

Contractions 2 minutes apart or less
Bulging perineum or crowning
Straining and pushing down with contractions

ASSESSMENT

Imminent birth

PLAN

Call for help and instruct someone to call 911 for ambulance
Reassure mother, provide for privacy, keep her informed of progress
Obtain pertinent medical and obstetrical history
Secure "Emergency Delivery Kit"

Allow delivery to progress spontaneously. Assist as follows:

Instruct mother to push with contractions and breathe between contractions

Support baby's head and body as delivery proceeds. Do not pull on baby. Suction baby's airway, both nose and mouth, with bulb syringe as soon as head is clear of birth canal (bulb should be in squeezed position before inserting).

Check for cord around neck. If present, gently bring the cord over the head or, if there is adequate slack in the cord, the cord may be pushed back over the shoulders. A tight cord around the neck will require clamping and cutting before the birth can be completed.

After the baby is born, hold infant with head in dependent position while suctioning oral pharynx again.

Immediately wipe the baby dry. Minimize heat loss. Wrap in dry blanket as soon as possible. Cover head.

While baby is the same level as the mother's vagina, after cord stops pulsating, clamp or tie umbilical cord approximately 6 inches from baby, place second clamp or tie approximately 2 inches closer to mother, and cut between clamps or ties. Work quickly. Have the baby wrapped in dry blanket(s) as soon as possible.

Stimulate cry by tapping soles of feet; if no spontaneous cry, begin resuscitation.

Assess Apgar score at 60 seconds and 5 minutes post-birth (see Apgar Scoring System chart on page 9A) Scores of 0-3 indicate need for immediate resuscitation. Scores of 4-6 indicate need for some resuscitative measures.

Again, wrap baby in dry blanket as quickly as possible, make sure head is covered to avoid excessive heat loss.

Allow baby to root or nurse at the breast/nipple. This will stimulate uterine contractions. Uterine contractions will encourage the delivery of the placenta and decrease blood loss.

Do not pull on the cord to force the delivery of the placenta. Let the placenta deliver spontaneously. The mother and infant may be transported with placenta undelivered. If placenta delivers prior to transport, massage fundus carefully as required for postpartum patients. Fundal massage produces a firm contracted uterus that minimizes blood loss. Place pad over vaginal opening, and take placenta to hospital.

Arrange transfer of mother and baby to hospital as quickly as possible.

Check and record mother's vital signs, condition of uterine fundus, and amount/quality of lochia every 15 minutes until EMS arrives.

Record time and date of delivery, baby's Apgar score, and any other pertinent information.

Notify County or Regional Health Officer as appropriate.

References

APGAR SCORING SYSTEM

Points Given According to
Status

| <u>Clinical Signs</u> | <u>0 Points</u> | <u>1 point</u> | <u>2 points</u> | <u>1 min.</u> | <u>5 min.</u> |
|---|-----------------|-----------------------------|--|---------------|---------------|
| HEART RATE | Absent | Below 100 | Over 100 | _____ | _____ |
| RESPIRATORY EFFORT | Absent | Slow, irregular | Strong and regular with good cry | _____ | _____ |
| MUSCLE TONE | Flaccid | Some flexion of extremities | Active motion | _____ | _____ |
| REFLEX IRRITABILITY (tap sole of foot) | No response | Grimace | Vigorous cry Or active withdrawal of foot | _____ | _____ |
| COLOR | Blue pale | Body pink Limbs blue | Completely pink | _____ | _____ |
| <u>TOTAL APGAR SCORE</u> | | | | _____ | _____ |

HEMORRHAGE/HEMORRHAGIC SHOCK

GENERAL INFORMATION

Hemorrhage refers to a significant loss of blood volume. Etiologies include trauma, ruptured aneurysm, gastrointestinal bleeding, injury to internal organs such as liver or spleen, or any vascular injury. Reproductive etiologies include ruptured ectopic pregnancy, postpartum hemorrhage, miscarriage, abruptio placenta, and placenta previa. Vaginal bleeding unrelated to pregnancy can be seen with coagulopathies, cervical infection, dysfunctional uterine bleeding, bleeding due to leiomyomata (fibroids), polyps endometrial hyperplasia or cancer, but rarely rises to the level of hemorrhage and shock. In cases of bleeding secondary to genital trauma, rape and/or abuse must be considered.

As blood loss increases shock may ensue due to loss of effective circulating blood volume and inadequate organ perfusion. Initially the body compensates for the loss. Decompensated shock occurs when there is a loss of circulating volume that overcomes the patient's physiologic percentage reserve. At this point, vital signs are altered.

SUBJECTIVE

Symptoms may include:

- Thirst - DO NOT GIVE FOOD; sips of water may be given if person able to converse
- Confusion, restlessness, anxiety
- Possibly nauseated
- Low abdominal pain or cramping and bleeding
- Rape
- Gather as much historical information as possible from patient, friends, or family

OBJECTIVE

- Overt or occult bleeding
- Decreasing level of consciousness
- Decreasing blood pressure
- Pulse becoming rapid, weak

ASSESSMENT

Hemorrhage, at risk for hemorrhagic shock

PLAN

- Initiate emergency response system (Call EMT/ 911)
- Monitor vital signs
- Control a bleeding wound by direct pressure, pressure point pressure, or pressure bandage
- Keep patient calm and in comfortable position
- If supine and no fracture or spinal trauma, elevate legs
- Prevent heat loss (cover with a blanket)

Provide high flow oxygen
Give report to EMT team upon arrival
Document the event per health department protocol

References

Rosen and Barkin's 5-Minute Emergency Medical Consult
Tennessee Pre-hospital Protocols and Standing Orders, TN Emergency Medical Services, 2004

INSECT (NON SPIDER) BITES

SUBJECTIVE

Skin that itches
Lump(s) on back of neck or other lymph node areas
Exposure to insects
Assess date and time of contact and location of affected area(s)

OBJECTIVE

Assess respiration to rule out hoarseness or wheezing
Solitary, multiple, or profuse lesions; if numerous, may cause adenopathy
Limited, localized swelling and/or redness
Lesions appear as erythematous wheel if recent exposure

ASSESSMENT

Insect bite

PLAN

Cool water compress to affected area(s)
Application of calamine lotion or a paste of baking soda and water
Application of topical OTC corticosteroid for control of persistent pruritis, 2-4 times daily
Recommend OTC oral antihistamine, such as diphenhydramine (Benadryl) if itching is extreme (according to package insert); warn regarding drowsiness effect of antihistamine therapy
Teach routine hygiene measures to prevent secondary infection, i.e., cut fingernails, keep hands and nails clean; keep the area clean and dry
Modify environment to prevent further exposure if applicable; consider use of insect repellents relative to level of risk
Observe for signs and symptoms of secondary infection, i.e., redness, drainage, fever, pain, spread of lesions
Educate regarding seasonal illness such as West Nile Virus

Referral Indicators:

Headache, confusion, light sensitivity
Severe inflammatory or systemic allergic (including respiratory difficulty) response (refer to emergency protocol)
Secondary infection with fever, lymphatic involvement
Necrosis of tissue
Suspected or known contact with poisonous insect or spider
Immunocompromised persons

Follow-up:

Patient/parent will be asked to contact health provider if condition persists or worsens
In severe reactions, desensitization and/or “emergency epinephrine” (epipen injector) availability can be advised

Reference

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

Ferri’s Clinical Advisor 2008

LACERATION

SUBJECTIVE

Cut, tear, scratch, scrape of skin surface

Pain

Assess date, time, and circumstances of injury; date of last tetanus vaccine

OBJECTIVE

Open, torn wound in which only a few layers of tissue may be involved

Bleeding, edema, erythema

ASSESSMENT

Small superficial laceration

PLAN

Control excessive bleeding by applying direct pressure over wound

Clean thoroughly with soap and warm water

Look for foreign body

Apply sterile dressing or Band-Aid if needed; apply antibiotic ointment

Give tetanus prophylaxis if indicated (refer to Tetanus Prophylaxis in Wound Management)

Health Teaching:

Discuss prevention of accidents and/or injuries

Advise regarding importance of infection prevention, i.e., keep wound clean and dry; antibiotic ointment, dressing changes as indicated; observe for redness, purulent drainage, fever, pain, significant/increasing soreness, and increased warmth

Discuss avoiding prolonged use of iodine or peroxide as these may delay healing

Explain need for adequate tetanus prophylaxis

Discuss importance of adequate protein and vitamin C to promote wound healing

Referral Indicators:

Unable to control bleeding

Laceration of face

Wound extending into subcutaneous tissue and/or requiring sutures

Signs of infection

Foreign material or object embedded in wound
Gross contamination of object causing wound
Functional loss resulting from injury

Follow-up:

Patient/parent will be asked to contact health provider if wound does not heal, or signs of infection develop

Reference

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

PUNCTURE WOUND

SUBJECTIVE

History of recent injury

Assess the following:

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

OBJECTIVE

- Determination if a retained foreign body is present
- Medical history of the patient (especially diabetes mellitus, neuropathy, or vascular disease)
- Presence or absence of pain, bleeding, discharge, edema and/or inflammation
- Clean or dirty wound

ASSESSMENT

Puncture wound

PLAN

- Cleanse with iodophor, other antiseptic solution, or use antibacterial soap and water.
- Use tweezers to remove splinter/foreign body if easily accessible; if deep, do not attempt removal. **DO NOT** attempt to remove splinter/foreign body in, or around, eye
- Apply thin layer of antibiotic ointment and sterile dressing
- Teach signs and symptoms of infection (redness, heat, swelling)
- Refer to PHN Protocol 4.280, Tetanus Prophylaxis in Wound Management, for administration of tetanus prophylaxis.

Referral Indicators:

Consult with nurse practitioner or physician if:

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

Follow-up:

As recommended by provider
Return to clinic PRN

Reference

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

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

RESPIRATORY EMERGENCY

SUBJECTIVE

Symptoms may include:

- Difficulty breathing due to choking
- Difficulty breathing with history of asthma
- Difficulty breathing with unknown cause

History to establish cause:

- Gather as much information as possible from patient, family/friends(s), or bystanders
- Signs and symptoms Allergies Medications
- Past medical history
- Last meal
- Events prior to episode

OBJECTIVE

Possible objective findings may include the following:

- Wheezing
- Stridor
- Rhonchi and/or rales on auscultation
- Difficulty speaking
- Decreasing level of consciousness (alert to anxious to confused to lethargic to unconsciousness)
- Cyanosis
- Diaphoresis
- Orthopnea
- Respiratory rate >25/minute

ASSESSMENT

- Respiratory distress of unknown cause
- Respiratory distress due to foreign body obstruction
- Respiratory distress due to a:
 - CV event as seen with, but not limited to, congestive heart failure, pulmonary embolus, dysrhythmia, etc.
 - Pulmonary event as seen with, but not limited to, asthma, pneumonia, COPD, etc.
 - Neuromuscular event as seen with, but not limited to, Guillain-Barre syndrome
 - Toxic event as seen with, but not limited to, poisoning or drug overdose, anaphylactic or septic shock
 - Psychogenic event as seen in, but not limited to, anxiety disorders

PLAN

- Initiate emergency response system (call EMS/911)
- For foreign body obstruction ONLY**, begin abdominal thrusts
- Assure airway, breathing, circulation
- Monitor vital signs
- Observe mental status, level of distress, work of breathing, skin color

Allow conscious patient to assume a position of comfort for breathing (most likely sitting)

Give high flow oxygen

Rescue breathing if apnea ensues

CPR if needed

May administer aqueous epinephrine 1:1000 SUBCUTANEOUSLY according to Emergency Drug Chart (**Note - epinephrine should be given with caution to persons taking beta blockers or with severe hypertension**)

Give report to EMT team upon arrival

Document event per health department protocol

References

Rosen and Barkin's 5-Minute Emergency Medicine Consult, 2003

Tennessee Pre-hospital Protocols and Standing Orders, TN Emergency Medical Services, 2004

SEIZURES

SUBJECTIVE

History of:

- Previous seizures or "fits" or positive family history
- Ingestion of drugs or poisons
- Previous head trauma
- High fever - infections
- CNS congenital abnormalities or neonatal insult
- Recent alcohol cessation

Symptoms may include:

- Sensory or motor disturbances, "Aura" Nausea

OBJECTIVE

- Localized or generalized rhythmic muscle jerking, clenched jaws
- Confusion, drowsiness (postictal state), unconsciousness;
- Eyes rolled upward or to one side
- Cyanosis of lips and nailbeds
- Urinary and fecal incontinence, vomiting

ASSESSMENT

Seizure

PLAN

During Seizure:

- Call 911
- Maintain an open airway by turning patient on side with head low; DO NOT try to pry clenched jaws apart; loosen clothing around neck
- Use oxygen if needed
- Place patient in a position to prevent injury; avoid physical restraint unless absolutely necessary to protect patient
- Note and record length of seizure and activity

After Seizure:

- Reorient patient and examine for associated injuries
- Refer to medical facility for evaluation and further treatment as appropriate

Reference

Ferri's Clinical Advisor 2008

SHOCK

SUBJECTIVE

Symptoms may include:

- Anxious
- Sense of impending doom
- Possibly difficulty breathing (seen with anaphylaxis) Possibly itching (seen with anaphylaxis)
- Possibly chest pain (seen with cardiogenic event)

History to establish cause:

An anaphylaxis or cardiogenic event is most likely cause in clinic setting
 Hemorrhagic shock could be seen in clinic in women who are pregnant or postpartum (as might be seen with ruptured ectopic pregnancy, spontaneous incomplete miscarriage, abruptio placenta, placenta previa, or postpartum hemorrhage (**See Hemorrhage Protocol**))
 Septic, neurogenic, and other hypovolemic shock are less likely to be a walk-in event in the health department setting though not impossible

Gather as much information as possible from patient, family/friend(s), or bystanders
 Signs and symptoms Allergies Medications
 Past medical history
 Last meal
 Events or treatments prior to episode

OBJECTIVE

Decreasing BP (systolic drops below 80-90 mm Hg or 20-30 mm Hg below normal baseline) Pulse pressure narrows (systolic pressure minus diastolic is less than 30 mm Hg)
 Rapid weak pulse
 Altered level of consciousness Cool, mottled extremities Diaphoresis
 Weak or absent peripheral pulses
 Stridor, wheezing with anaphylaxis

ASSESSMENT

Shock (cardiac, hemorrhage, septic, unknown origin)

PLAN

Initiate emergency response system (call EMT/911)
 Assure airway, breathing, and circulation
 Monitor vital signs
 Patient should lie down or if conscious and there are breathing difficulties, assume the position most comfortable for breathing (usually sitting)
 Elevate feet if client is supine
 Give high flow oxygen
 Begin CPR if needed
 Give report to EMT team upon arrival

REFERENCES

Rosen and Barkin's 5-Minute Emergency Medicine Consult, 2003
 Tennessee Pre-hospital Protocols and Standing Orders, TN Emergency Medical Services, 2004

SYNCOPE/VASOVAGAL REACTION/COMMON FAINT

GENERAL INFORMATION

Syncope is a transient loss of consciousness and postural tone due to inadequate cerebral blood flow with prompt recovery that does not require resuscitation.

Vasovagal reactions (referred to as common fainting) are autonomic nervous system responses to stressful, painful, fearful, or claustrophobic experiences.

Syncope may also be caused by cardiac disorders, cerebrovascular disorders, orthostatic hypotension, hypovolemia secondary to hemorrhage or dehydration, chronic diseases such as diabetes-related hypoglycemia or fasting for tests, and neurologic disorders such as transient ischemic attacks (TIAs).

SUBJECTIVE

Symptoms may include:

- Nausea
- Lightheadedness
- Roaring in ears sensation
- Dimming vision

History to establish cause:

- Gather as much information as possible from patient, family/friend(s), or bystanders
- What was the person doing prior to the episode?
- What were the prodromal symptoms (i.e., nausea, lightheadedness etc.)?
- Are there any predisposing factors (i.e., age, chronic disease, fasting, IUD insertion etc.)? Are there any precipitating factors (i.e., a painful or fearful procedure)?
- What did the passersby witness? Were there any signs of seizure?

OBJECTIVE

- Diaphoresis
- Loss of color (pale/ashen)
- Loss of consciousness and postural tone

ASSESSMENT

- Syncope – Possible Vasovagal Reaction

PLAN

- Assure airway, breathing, circulation
- Remove any inciting stimuli (stress, pain, fear etc.) Elevate legs, loosen tight clothing such as a tie or belt
- Monitor vital signs

When there is immediate recovery, review history and refer patients with any significant findings to a primary care provider
Give high flow oxygen if recovery is not immediate
Initiate emergency response (call EMT/911) if recovery is not complete within minutes
Continue to check vitals signs, assure airway, breathing, and circulation until EMT arrives
Give report to EMT team

References

Current Medical Diagnosis and Treatment, 2000
Handbook of Signs and Symptoms, 2006
Rosen and Barkin's 5-Minute Emergency Medicine Consult, 2003
Tennessee Pre-hospital Protocols and Standing Orders, TN Emergency Medical Services, 2004

TICK BITE

SUBJECTIVE

History of tick bite
 Recent outdoor exposure to tick-infected areas, note geographical site and time of year exposure occurred
 Document age of victim; location of affected area(s) and date and time of bite if known
 History of systemic response (i.e., fever $>100^{\circ}$; rash, headache, neck stiffness, confusion)

OBJECTIVE

Tick embedded in skin
 May present with rash, fever, swollen lymph nodes, conjunctival injection (red eyes)
May complain of headache, nausea, vomiting, abdominal pain, muscle pain, lack of appetite

ASSESSMENT

Embedded tick or recent history of tick removal

PLAN

Tick removal:

Grasp tick with fine-tipped tweezers (or fingers, protected with gloves or tissue paper) as close to skin's surface as possible
 Gently pull straight out without twisting motions.
 Wash tick down drain
 Wash hands and tick attachment site with soap and water
 Advise use of OTC antibiotic ointment at site of attachment

Avoid folklore remedies such as "painting" the tick with nail polish or petroleum jelly, or using heat to make the tick detach from the skin.

HEALTH TEACHING

- Avoidance of tick infected areas such as wooded and bushy areas with high grass and leaf litter.
- Wear light colored clothes that cover the arms, legs, and other exposed areas. Pants should be tucked into boots or socks and long sleeved shirts should be buttoned at the cuff.
- Use repellents that contain 20% or more DEET (N, N-diethyl-m-toluamide) on the exposed skin for protection that lasts up to several hours. Always follow product instructions.
- Insect repellents containing DEET should not be used on children under 2 months of age. Oil of lemon eucalyptus products should not be used on children under 3 years of age.
- When applying insect repellents to children, avoid their hands, around the eyes, and cut or irritated skin. Do not allow children to handle insect repellents. When using on

children, apply to your own hands and then put it on the child. After returning indoors, wash your child's treated skin or bathe the child. Clothes exposed to insect repellants should be washed with soap and water.

- Use products that contain permethrin to treat clothing and gear, such as boots, pants, socks and tents. It remains protective through several washings.

Find and Remove Ticks from Your Body

- Bathe or shower as soon as possible after coming indoors (preferably within two hours) to wash off and more easily find ticks that are crawling on you.
- Conduct a full body tick check upon return from tick-infested areas. Inspect children's bodies and clothing also. Special attention should be given to the exposed hairy regions of the body where ticks often attach. Parents should check their children for ticks, paying close attention to under the arms, in and around the ears, inside the belly button, behind the knees, between the legs, around the waist, and especially in their hair.
- Examine gear and pets. Ticks can ride into the home on clothing and pets, then attach to a person later, so carefully examine pets, coats, and day packs. Tumble clothes in a dryer on high heat for an hour to kill remaining ticks.

REFERRAL INDICATORS

Unable to remove tick

Seek medical attention promptly if symptoms of Rocky Mountain Spotted Fever (RMSF), Lyme disease or Ehrlichiosis occur. For information purposes, the incubation period and symptoms for these diseases are listed below:

Rocky Mountain Spotted Fever (RMSE)

Incubation: Approximately 1 week (range, 2-14 days)

Symptoms: typically begin 2-14 days after the bite of an infected tick and commonly include: sudden onset of fever and headache; nausea; vomiting; abdominal pain; muscle pain; lack of appetite; conjunctival injection (red eyes) and rash

About 90% of patients develop some type of rash about 2-5 days after fever, but sometimes not until late in the disease process. Approximately 10% of patients **never develop a rash.**

The classic rash may first appear 2-5 days after the onset of fever and present as small, flat, pink, non-itchy spots (macules) on the wrists, forearms, and ankles and spread to include the trunk and sometimes the palms and soles. Some people will have a rash that varies from this description and people who fail to develop a rash, or develop an atypical rash, are at increased risk of being misdiagnosed.

The red to purple, spotted (petechial) rash is usually not seen until the sixth day or later after onset of symptoms and occurs in 35-60% of patients with the infection and is indicative of progression to severe disease

Lyme Disease

Incubation: 1-32 days with a median, 11 days

Symptoms: Divided into 3 stages:

Stage One: Early localized stage (3-30 days post-tick bite)

Fatigue, chills, fever, headache, muscle and joint aches, and swollen lymph nodes

Red, expanding rash called erythema migrans (EM) or “bull’s-eye” rash occurs in approximately 70-80% of infected persons. It begins at the site of a tick bite on average about 7 days after the bite. Rash gradually expands over a period of several days, and can reach up to 12 inches (30 cm) across. Parts of the rash may clear as it enlarges, resulting in a “bull’s-eye” appearance.

Rash usually feels warm to the touch but is rarely itchy or painful.

EM lesions may appear on any area of the body.

Some people may get these general symptoms in addition to an EM rash, but in others, these general symptoms may be the only evidence of infection.



Stage 2: Early disseminated stage (days to weeks post-tick bite)

Untreated, the infection may spread from the site of the bite to other parts of the body, producing an array of specific symptoms that may come and go, including:

Additional EM lesions in other areas of the body

Facial or Bell's palsy (loss of muscle tone on one or both sides of the face)

Severe headaches and neck stiffness due to meningitis (inflammation of the spinal cord)

Pain and swelling in the large joints (such as knees)

Shooting pains that may interfere with sleep

Heart palpitations and dizziness due to changes in heartbeat

Many of these symptoms will resolve over a period of weeks to months, even without treatment². However, lack of treatment can result in additional complications, described below.

Stage 3: Late disseminated stage (months-to-years post-tick bite)

Approximately 60% of patients with untreated infection may begin to have intermittent bouts of arthritis, with severe joint pain and swelling. Large joints are most often affected, particularly the knees³. Arthritis caused by Lyme disease manifests differently than other causes of arthritis and must be distinguished from arthralgias (pain, but not swelling, in joints).

Up to 5% of untreated patients may develop chronic neurological complaints months to years after infection⁴. These include shooting pains, numbness or tingling in the hands or feet, and problems with short-term memory.

Ehrlichiosis

Incubation: 5 to 10 days after a tick bite, median, 9 days

Symptoms: Commonly occur 1-2 weeks following a tick bite; fever, headache, chills, malaise, muscle pain, nausea/vomiting/diarrhea, confusion, conjunctival injection (red eyes), rash (in up to 60% of children, less than 30% of adults)

It is important to note that the combination of symptoms varies greatly from person to person.

Erythroderma is a type of rash that resembles a sunburn and consists of widespread reddening of the skin that may peel after several days. Some patients may develop a rash that resembles the rash of Rocky Mountain spotted fever making these two diseases difficult to differentiate on the basis of clinical signs alone.

REFERENCES

2012 Red Book: Report of the Committee on Infectious Diseases, 29th Edition, Larry K. Pickering, MD, FAAP, Editor

<http://www.fda.gov/Drugs/EmergencyPreparedness/ucm085277.htm>

http://www.cdc.gov/lyme/signs_symptoms/index.html

<http://www.cdc.gov/rmsf/symptoms/index.html>

Information about insect repellents can be found at the following sites:

The Environmental Protection Agency (EPA) regulates all pesticides and provides extensive information about insect repellents:

[Environmental Protection Agency Home Page](#)

[How to Use Insect Repellents Safely](#)

The Centers for Disease Control and Prevention (CDC) offers information about mosquito repellents:

[Insect Repellent Use and Safety](#)

[Updated Information Regarding Insect Repellents](#)

The American Academy of Pediatrics (AAP) has information about the use of mosquito repellents in children:

[Follow Safety Precautions When Using DEET on Children](#)

[DEET Alternatives Considered to be Effective Mosquito Repellents](#)

[Insect Repellents](#)

SECTION III:
GENERAL

3.010 – 3.530

ACNE

SUBJECTIVE

Pimples, blackheads, whiteheads, bumps, "zits"

OBJECTIVE

Open comedones (blackheads) and closed comedones (whiteheads), papules, pustules, nodulocystic lesions

Scars usually distributed on face, neck, upper chest, back, and shoulders

Skin and hair are often oily

ASSESSMENT

Acne (85% of those aged 12 to 24 have acne to some extent)

PLAN

Wash gently with soap and hot water TID, rinse with cold water

Encourage to keep hands off face; especially refrain from squeezing or picking skin

Instruct to keep hair clean and off the face

Use waterbase cosmetics (or preferably none at all)

Apply OTC preparations of benzoyl peroxide cream (e.g., Clearasil), in a thin layer over entire area of involvement, not just on lesions; begin with once a day applications and after 3 days if no excess peeling or redness of skin, increase use to BID; reduce frequency if excessive dryness or irritation develops

Recommend NO dietary restrictions; eat a balanced diet

Teach precipitating factors which may cause exacerbations, (i.e., menses, oral contraceptives, emotional stress)

Counsel regarding danger of ACCUTANE use during pregnancy (high risk of malformations) and oral antibiotics if taking oral contraceptives (decreased effectiveness of oral contraceptives)

Referral Indicators:

Little or no response to treatment (topical antibiotics can be helpful in some cases)

Allergy or skin irritation from topical OTC medication

Extensive or widespread involvement Secondary bacterial infections

Potential facial scarring if untreated

Follow-Up:

Patient/parent will be asked to contact health provider in 2 weeks if not resolved

Reference:

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

Ferri's Clinical Advisor 2008

ACUTE UPPER RESPIRATORY INFECTION (COMMON COLD)

SUBJECTIVE

Sneezing, "stuffiness" of head
Malaise, fatigue Sore throat, cough Poor appetite
Low grade or no fever history

OBJECTIVE

Congested nasal passages
Serous nasal discharge, moist and boggy nasal mucous membranes
Lung fields clear
Low grade fever may be present

ASSESSMENT

Upper respiratory infection (common cold)

PLAN

Acetaminophen for pain or fever
May humidify the air (vaporizer or bathroom shower water) to relieve nasal and pharyngeal discomfort and cough; vaporizer should not be used if allergic to molds
Nasal congestion may be relieved as follows by normal saline nose drops. (1/4-1/2 teaspoon salt to 1 cup water) every 4 hours PRN; for infants to 2 years, recommend suction gently with infant syringe
OTC decongestant as appropriate and if not contraindicated (follow label directions)

Health Teaching:

Instruct patient to rest and force fluids
Teach proper hand washing technique, cover mouth while coughing, and tissue disposal to prevent spread of disease

Referral Indicators:

Purulent nasal discharge
Pharyngeal exudate and/or tender cervical nodes
Red and/or bulging tympanic membranes
Tender sinuses
Fever extending beyond 48 hours/antipyretic does not bring fever below 101° F Infants 0-12 months with fever 100.5° F rectally
Infants < 2 months with significant symptoms, with or without fever
Children under 2 years if no improvement in 24 hours, or signs and symptoms worsen

Follow-Up:

Patient/parent will be asked to contact health provider if condition persists or worsens

Reference:

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

ASSESSMENT OF IRON INTAKE AND MANAGEMENT OF IRON DEFICIENCY ANEMIA

Background

Childhood Anemia

Childhood anemia is a very common diagnosis and usually occurs due to an inadequate amount of dietary iron. Adequate iron storage is necessary to prevent anemia, but is also essential for brain development. In order to prevent iron-deficiency anemia, infants should be drinking either breast milk or iron-fortified formula. Toddlers and older children should eat a balanced, iron-rich diet.

Although iron deficiency is the most common etiology, anemia in childhood can be caused by a variety of conditions that are either congenital or acquired. Types of congenital anemia include sickle cell disease or thalassemia; acquired anemia includes such diagnoses as leukemia, gastrointestinal bleeding, and hemolytic disease. Congenital and acquired anemia generally is not iron-responsive. If a child presents with a pre-diagnosed anemia that is NOT iron-deficient, he/she should be referred to his/her provider for further management.

Sickle cell anemia can be easily ruled out by checking the status of the newborn screening. If sickle cell anemia is strongly suspected and an asymptomatic infant's disease status is unknown, refer to his/her provider, and delay replacement iron regimen until the results are available.

Adult Anemia

Anemia in adults is most commonly due to iron deficiency. In contrast to iron deficiency in childhood, which is most commonly caused by deficient dietary intake, the major cause of iron deficiency anemia is blood loss, which can be overt (trauma, hematemesis, melena, menorrhagia, etc.) or occult (e.g. via the gastrointestinal tract). Iron deficiency can also result from dietary deficiencies or reduced gastrointestinal absorption; however, blood loss should first be ruled out by the patient's primary care physician as a cause of iron deficiency before nutritional deficiency or malabsorption is assumed as a diagnosis.

Anemia Screening Procedure

Anemia screening is performed by checking hemoglobin levels. **Confirm abnormal/low hemoglobin levels with a second test at the same or a new site.** Make sure the skin is clean and dry before puncture. Avoid any squeezing of the digit after puncture. After the diagnosis of anemia, iron deficiency anemia is confirmed by administering a therapeutic regimen of iron and demonstrating a rise in hemoglobin of ≥ 1 g/dL after 4 weeks. If an infant fails to respond to therapy, referral shall be made to a physician or nurse practitioner for further evaluation.

SUBJECTIVE

Dietary assessment

- Inadequate consumption of dietary iron
- Consumption of whole cow's milk or formula with low iron or no iron
- Children > age 1 year: consumption of more than 24 ounces of milk daily

Menstrual history (if appropriate)

Patient reported history of gastrointestinal blood loss

Normal versus abnormal newborn state screen for sickle cell disease

Symptoms: Pallor, shortness of breath, tachycardia, decreased energy/fatigue/lethargy, dizziness

OBJECTIVE

Fatigued appearance

Pallor of skin and/or conjunctiva

Dyspnea

Tachycardia

Heart murmur

Abnormal/low hemoglobin (hgb), see chart below

| Age | Criteria for anemia (hemoglobin concentration in g/dL) | |
|------------------------------------|---|-------|
| | Female | Male |
| 6-12 months | <11.0 | <11.0 |
| 1-2 years | <11.0 | <11.0 |
| 2-5 years | <11.1 | <11.1 |
| 5-8 years | <11.5 | <11.5 |
| 8-12 years | <11.9 | <11.9 |
| 12-15 years (non-pregnant) | | |
| Nonsmoker | <11.8 | <12.5 |
| Smoke up to 1 pack/day | <12.1 | <12.8 |
| Smoke 1-2 packs/day | <12.3 | <13.0 |
| Smoke >2 packs/day | <12.5 | <13.2 |
| 15-18 years (non-pregnant) | | |
| Nonsmoker | <12.0 | <13.3 |
| Smoke up to 1 pack/day | <12.3 | <13.6 |
| Smoke 1-2 packs/day | <12.5 | <13.8 |
| Smoke >2 packs/day | <12.7 | <14.0 |
| >18 years (non-pregnant) | | |
| Nonsmoker | <12.0 | <13.5 |
| Smoke up to 1 pack/day | <12.3 | <13.8 |
| Smoke 1-2 packs/day | <12.5 | <14.0 |
| Smoke >2 packs/day | <12.7 | <14.2 |

| Age | Criteria for anemia (hemoglobin concentration in g/dL) | |
|---|---|------|
| | Female | Male |
| PREGNANT: 1st Trimester | | |
| Nonsmoker | <11.0 | N/A |
| Smoke up to 1 pack/day | <11.3 | N/A |
| Smoke 1-2 packs/day | <11.5 | N/A |
| Smoke >2 packs/day | <11.7 | N/A |
| PREGNANT: 2nd Trimester | | |
| Nonsmoker | <10.5 | N/A |
| Smoke up to 1 pack/day | <10.8 | N/A |
| Smoke 1-2 packs/day | <11.0 | N/A |
| Smoke >2 packs/day | <11.2 | N/A |
| PREGNANT: 3rd Trimester | | |
| Nonsmoker | <11.0 | N/A |
| Smoke up to 1 pack/day | <11.3 | N/A |
| Smoke 1-2 packs/day | <11.5 | N/A |
| Smoke >2 packs/day | <11.7 | N/A |

ASSESSMENT

Not at risk for iron depletion with normal hemoglobin

OR

At risk for iron depletion with normal hemoglobin

- Infant at risk: preterm, low birth weight, diet of non-iron fortified infant formula, introduction of cow's milk prior to 12 months of age, or breastfed infant who is receiving inadequate dietary iron after six months of age
- Toddler/child/adolescent at risk: consumption of more than 24 ounces of cow's milk daily, low dietary iron intake/picky eaters, previous history of iron deficiency

OR

Anemia, suspect iron-deficiency

PLAN

For those not at risk for iron depletion with a normal hemoglobin

Instruct in age appropriate diet high in iron

Certification for WIC if eligible

Educate regarding the importance of iron for both blood and brain development

For those at risk of iron depletion with a normal hemoglobin

Instruct in age appropriate diet high in iron

Issue age-appropriate multivitamin with iron or write prescription:

- Infant/toddler multivitamin with iron drops at dose of 1 ml daily **OR**
- Children's chewable multivitamin with iron at dose of one tablet daily per manufacturer's directions
- **NOTE:** If multivitamins with iron are used in an infant who is not anemic, the daily dose should not exceed 15 mg elemental iron daily or 2 mg/kg/day. Most infant/toddler *multivitamin* with iron drops contain 10 mg elemental iron per milliliter. Most chewable multivitamins with iron for toddlers and older children/adolescents contain 15-18 mg elemental iron per tablet. These should be administered according to package instructions.

Give iron-related pamphlet

Certification for WIC if eligible

Educate regarding the importance of iron for both blood and brain development

For those with suspected iron deficiency anemia, see table below and refer to the Iron replacement Dosing Chart:

| Age <6 months | Age 6-12 Months | Age 1-3 Years | Age 3-12 Years | Age 12-18 Years | >18 Years |
|--|--|--|---|---|---|
| Obtain dietary assessment | Obtain dietary assessment | Obtain dietary assessment | Obtain dietary assessment | Obtain dietary assessment | Evaluate for blood loss (history, physical, hemocult) |
| Instruct to use breast milk or iron fortified formula | Instruct in adequate consumption of dietary iron | Instruct in adequate consumption of dietary iron | Instruct in adequate consumption of dietary iron | Instruct in adequate consumption of dietary iron | Consider referral to MD or NP |
| Supplement with iron according to the dose based on body weight (see dosing chart) | Give iron-related pamphlet Refer to WIC if eligible | Decrease milk if necessary to 16 ounces or less daily Give iron-related pamphlet | Decrease milk if necessary to 16 ounces or less daily Give iron-related pamphlet | Decrease milk if necessary to 16 ounces or less daily Give iron-related pamphlet | Instruct in adequate consumption of dietary iron and Vitamin C |
| Refer to WIC if eligible | Supplement with iron according to dose based on body weight (see dosing chart) | Refer to WIC if eligible Supplement with iron according to dose based on body weight (see dosing chart) | Refer to WIC if eligible (< 5 yrs.) Supplement with iron according to dose based on body weight (see dosing chart) | Supplement with iron according to dose based on body weight (see dosing chart) | Dispense Ferrous Sulfate (FeSO ₄) 325mg by mouth three times per day. |

Health Teaching

Oral iron may cause constipation and turn stool black

Establish regular time for drug administration

Iron drops may harmlessly coat the teeth

Oral iron may interfere with absorption of tetracycline
 Vitamin C will enhance absorption
 Iron absorption is inhibited by antacids, Vitamin E, eggs, coffee, tea, and milk
 ORAL IRON IS A SERIOUS POTENTIAL POISON - Issue safely

Referral Indicators

Premature infant
 Poor weight gain/abnormal growth pattern
 Symptomatic anemia (see “objective” for list of possible symptoms)
 Heart murmur present
 Pregnancy
 Pre-diagnosed anemia that is NOT iron-deficient
 Sickle cell disease and other hemoglobinopathies
 Symptoms of gastrointestinal bleeding (dark tarry stools, blood in toilet bowl or on toilet paper, large amounts of blood passed from the rectum, vomiting blood)
 Special health needs that increase the risk of iron-deficiency (chronic infection, inflammatory disorders, chronic or acute blood loss, restricted diets, use of medications that interfere with iron absorption)
 Parent needs further guidance/education (subjective evaluation by RN/RD)
 Inadequate response to therapy

CRITICAL VALUES:

For ages <5: Refer immediately for hemoglobin of **8.5 or less** or if the patient is symptomatic

For ages 5 and up: Refer immediately for hemoglobin of **10 or less** or if the patient is symptomatic

*For all ages, if the patient is symptomatic, they should be referred to their primary care provider immediately

Follow-up

For individuals with normal hemoglobin or iron depletion with normal hemoglobin:

Screen for anemia at routine intervals during WIC visits and/or preventive care visits (EPSDT exams)

For individuals with suspected iron deficiency anemia:

Evaluate for compliance to dietary and iron therapy

Repeat hemoglobin in 4 weeks, confirm at least 1 g/dL increase in hemoglobin

- **If there less than a 1 g/dL increase in hemoglobin after 4 weeks of iron supplementation, confirm that the dose is appropriate, there is no dairy overconsumption, and that the patient is compliant. If there are no confounding factors and the hemoglobin has not gone up, refer to health care provider.**

- **If there is at least 1g/dL increase in hemoglobin, continue iron supplementation for 8 weeks after hemoglobin confirmed normal.**

Refer to health care provider if compliant infant shows inadequate response to therapy or hemoglobin remains below normal range despite 6-8 weeks of iron supplementation.

Iron Replacement Dosing Chart

All treatment of iron deficiency anemia is two-fold, a diet high in iron rich foods and therapeutic regimens of iron.

If concentrated iron drops, elixir or tablets are used in an infant or child that is anemic, the dose should not exceed 6 mg/kg of elemental iron daily to a maximum of the standard adult dose. Replacement iron doses may be divided into two or three daily doses. Liquid concentrated iron preparations are generally accepted but may not be palatable. If a child refuses to take the prescribed preparation, another may be used as long as the daily dose of elemental iron remains consistent.

All doses referenced in this protocol and on the dosing chart refer to either:

- **Concentrated ferrous sulfate drops that contain 15 mg/1.0 ml elemental iron.**
OR
- **Ferrous sulfate elixir that contain 44 mg/5.0 mL elemental iron.**
OR
- **325 mg ferrous sulfate tablets that contain 65 mg elemental iron per tablet.**

Instruct the caregiver regarding measurement using calibrated, oral medication syringes. Doses in milliliters require a precise dropper or oral syringe with well-marked increments of 0.1 ml.

Maximizing the dose for body weight is very important.

Iron Replacement Dosing Chart

| Weight | | Dosing Script (Write This on Prescription) | | |
|--------|------|--|--|--------------------------|
| Lbs | Kgs | IRON DROPS (15 mg / 1.0 ml) | ELIXIR (44 mg / 5.0 ml) | TABLETS (65 mg / tablet) |
| 10 | 4.5 | 10.2 mg elemental iron (0.7 ml) po bid | | |
| 11 | 5.0 | 11.3 mg elemental iron (0.8 ml) po bid | | |
| 12 | 5.5 | 12.3 mg elemental iron (0.8 ml) po bid | | |
| 13 | 5.9 | 13.3 mg elemental iron (0.9 ml) po bid | | |
| 14 | 6.4 | 14.3 mg elemental iron (1.0 ml) po bid | | |
| 15 | 6.8 | 15.3 mg elemental iron (1.0 ml) po bid | | |
| 16 | 7.3 | 16.4 mg elemental iron (1.1 ml) po bid | | |
| 17 | 7.7 | 17.4 mg elemental iron (1.2 ml) po bid | | |
| 18 | 8.2 | 18.4 mg elemental iron (1.2 ml) po bid | | |
| 19 | 8.6 | 19.4 mg elemental iron (1.3 ml) po bid | | |
| 20 | 9.1 | 20.5 mg elemental iron (1.4 ml) po bid | | |
| 21 | 9.5 | 21.5 mg elemental iron (1.4 ml) po bid | | |
| 22 | 10.0 | 22.5 mg elemental iron (1.5 ml) po bid | | |
| 23 | 10.5 | 23.5 mg elemental iron (1.6 ml) po bid | | |
| 24 | 10.9 | 24.5 mg elemental iron (1.6 ml) po bid | | |
| 25 | 11.4 | 25.6 mg elemental iron (1.7 ml) po bid | | |
| 26 | 11.8 | 26.6 mg elemental iron (1.8 ml) po bid | | |
| 27 | 12.3 | 27.6 mg elemental iron (1.8 ml) po bid | | |
| 28 | 12.7 | 28.6 mg elemental iron (1.9 ml) po bid | | |
| 29 | 13.2 | 29.7 mg elemental iron (2.0 ml) po bid | | |
| 30 | 13.6 | 30.7 mg elemental iron (2.0 ml) po bid | | |
| 31 | 14.1 | 31.7 mg elemental iron (2.1 ml) po bid | | |
| 32 | 14.5 | 32.7 mg elemental iron (2.2 ml) po bid | | |
| 33 | 15.0 | 33.8 mg elemental iron (2.3 ml) po bid | 33.8 mg elemental iron (3.8 ml) po bid | |
| 34 | 15.5 | 34.8 mg elemental iron (2.3 ml) po bid | 34.8 mg elemental iron (4.0 ml) po bid | |
| 35 | 15.9 | 35.8 mg elemental iron (2.4 ml) po bid | 35.8 mg elemental iron (4.1 ml) po bid | |
| 36 | 16.4 | 36.8 mg elemental iron (2.5 ml) po bid | 36.8 mg elemental iron (4.2 ml) po bid | |
| 37 | 16.8 | 37.8 mg elemental iron (2.5 ml) po bid | 37.8 mg elemental iron (4.3 ml) po bid | |
| 38 | 17.3 | 38.9 mg elemental iron (2.6 ml) po bid | 38.9 mg elemental iron (4.4 ml) po bid | |
| 39 | 17.7 | 39.9 mg elemental iron (2.7 ml) po bid | 39.9 mg elemental iron (4.5 ml) po bid | |
| 40 | 18.2 | 40.9 mg elemental iron (2.7 ml) po bid | 40.9 mg elemental iron (4.6 ml) po bid | |
| 41 | 18.6 | 41.9 mg elemental iron (2.8 ml) po bid | 41.9 mg elemental iron (4.8 ml) po bid | |
| 42 | 19.1 | 43.0 mg elemental iron (2.9 ml) po bid | 43.0 mg elemental iron (4.9 ml) po bid | |
| 43 | 19.5 | 44.0 mg elemental iron (2.9 ml) po bid | 44.0 mg elemental iron (5.0 ml) po bid | |
| 44 | 20.0 | | 45.0 mg elemental iron (5.1 ml) po bid | |

| Weight | | Dosing Script (Write This on Prescription) | | |
|------------|--------------|--|--|--|
| Lbs | Kgs | IRON DROPS (15 mg / 1.0 ml) | ELIXIR (44 mg / 5.0 ml) | TABLETS (65 mg / tablet) |
| 45 | 20.5 | | 46.0 mg elemental iron (5.2 ml) po bid | |
| 46 | 20.9 | | 47.0 mg elemental iron (5.3 ml) po bid | |
| 47 | 21.4 | | 48.1 mg elemental iron (5.5 ml) po bid | |
| 48 | 21.8 | | 49.1 mg elemental iron (5.6 ml) po bid | |
| 49 | 22.3 | | 50.1 mg elemental iron (5.7 ml) po bid | |
| 50 | 22.7 | | 51.1 mg elemental iron (5.8 ml) po bid | |
| 51 | 23.2 | | 52.2 mg elemental iron (5.9 ml) po bid | |
| 52 | 23.6 | | 53.2 mg elemental iron (6.0 ml) po bid | |
| 53 | 24.1 | | 54.2 mg elemental iron (6.2 ml) po bid | |
| 54 | 24.5 | | 55.2 mg elemental iron (6.3 ml) po bid | |
| 55 | 25.0 | | 56.3 mg elemental iron (6.4 ml) po bid | |
| 56 | 25.5 | | 57.3 mg elemental iron (6.5 ml) po bid | |
| 57 | 25.9 | | 58.3 mg elemental iron (6.6 ml) po bid | |
| 58 | 26.4 | | 59.3 mg elemental iron (6.7 ml) po bid | |
| 59 | 26.8 | | 60.3 mg elemental iron (6.9 ml) po bid | |
| 60 | 27.3 | | 61.4 mg elemental iron (7.0 ml) po bid | |
| 61 | 27.7 | | 62.4 mg elemental iron (7.1 ml) po bid | |
| 62 | 28.2 | | 63.4 mg elemental iron (7.2 ml) po bid | |
| 63 | 28.6 | | 64.4 mg elemental iron (7.3 ml) po bid | |
| 64 | 29.1 | | 65.5 mg elemental iron (7.4 ml) po bid | One tablet (65.0 mg elemental iron) po bid |
| 65 | 29.5 | | 66.5 mg elemental iron (7.6 ml) po bid | One tablet (65.0 mg elemental iron) po bid |
| 66 | 30.0 | | 67.5 mg elemental iron (7.7 ml) po bid | One tablet (65.0 mg elemental iron) po bid |
| 67 | 30.5 | | 68.5 mg elemental iron (7.8 ml) po bid | One tablet (65.0 mg elemental iron) po bid |
| 68 | 30.9 | | 69.5 mg elemental iron (7.9 ml) po bid | One tablet (65.0 mg elemental iron) po bid |
| 69 | 31.4 | | 70.6 mg elemental Iron (8.0 ml) po bid | One tablet (65.0 mg elemental iron) po bid |
| 70 | 31.8 | | 71.6 mg elemental iron (8.1 ml) po bid | One tablet (65.0 mg elemental iron) po bid |
| 71 | 32.3 | | 72.6 mg elemental iron (8.3 ml) po bid | One tablet (65.0 mg elemental iron) po bid |
| 72 | 32.7 | | 73.6 mg elemental iron (8.4 ml) po bid | One tablet (65.0 mg elemental iron) po bid |
| 73 | 33.2 | | 74.7 mg elemental iron (8.5 ml) po bid | One tablet (65.0 mg elemental iron) po bid |
| 73 - 95 | 33.2 43.2 | | 86.0 mg elemental iron (9.8 ml) po bid | One tablet (65.0 mg elemental iron) po bid |
| > 95 | > 43.2 | | 64.8 mg elemental iron (7.4 ml) po tid | One tablet (65.0 mg elemental iron) po tid |

Writing a Prescription for Iron Replacement **Provider and Pharmacist Prescription Guidance**

When writing a prescription for ferrous sulfate, the dosage should be based strictly on the exact weight of the child. Use the following format when writing prescriptions for iron replacement. This format will help to standardize the instructions given to pharmacists and should help minimize dosing errors if the pharmacy needs to provide the medication in another formulation.

| | |
|---|---|
| <i>For liquid iron preparations, write:</i> | <i>Example:</i> |
| Ferrous sulfate drops (15mg elemental iron/1.0 mL) Sig (insert dosing script from dosing chart) #QS 1 month, 3 refills | Ferrous sulfate drops (15 mg elemental iron/1.0 mL) Sig 10.2 mg elemental iron (0.7 mL) po bid #QS 1 month, 2 refills |
| Or | Or |
| Ferrous sulfate elixir (44mg elemental iron/5.0 mL) Sig (insert dosing script from dosing chart) #QS 1 month, 3 refills | Ferrous sulfate elixir (44 mg elemental iron/5.0 mL) Sig 66 mg elemental iron (7.5 mL) po bid #QS 1 month, 3 refills |
| <i>For iron tablets, write:</i> | <i>Example:</i> |
| Iron tablets (65 mg elemental iron/tablet) Sig (insert dosing script based from dosing chart) #QS 1 month, 3 refills | Iron tablets (65 mg elemental iron/tablet) Sig one tablet (65 mg elemental iron) po tid #QS 1 month, 3 refills |

REFERENCES

- Tennessee WIC Manual, Nutrition Risk Criteria section, revised 2012.
- Centers for Disease Control and Prevention. Recommendations to Prevent and Control Iron Deficiency in the United States. MMWR. April 03, 1998/47(RR-3); 1-36. Available at: <http://www.cdc.gov/mmwr/preview/mmwrhtml/00051880.htm>.
- Tennessee Laboratory Policy & Procedure Manual for Local Health Departments, revised 2000.
- Baker RD, Greer MD, AAP Committee on Nutrition. Clinical Report—Diagnosis and Prevention of Iron Deficiency and Iron-Deficiency Anemia in Infants and Young Children (0-3 Years of Age). Pediatrics. 2010; 126(5): 1-22.
- Segel GB, Hirsh MG, Feig SA. Managing anemia in pediatric office practice. Pediatrics in Review. 2002; 23(3): 75-84.
- Mahoney DH, et al. Iron deficiency in infants and young children: Treatment. In: UpToDate, Hoppin, AG (Ed), UpToDate, Waltham, MA, 2010.
- Schrier SL, Mentzer WC. Causes and diagnosis of anemia due to iron deficiency, In: UpToDate, SA (Ed), UpToDate, Waltham, MA, 2011.

ASCARIASIS (ROUNDWORMS)

SUBJECTIVE

History of passage of adult worm, round and pinkish-white, often no symptoms

May have symptoms of:

- Abdominal pain
- Nausea and vomiting
- Anorexia
- Weight loss
- Pica
- Persistent cough, fever, blood tinged sputum
- Choking

OBJECTIVE

Laboratory confirmation of roundworm infestation from stool specimen, OR visual observation of roundworm in stool or vomitus; There is no useful blood test.

ASSESSMENT

Ascariasis (Roundworms)

PLAN

Pyrantel Pamoate, 11mg base/kg, once daily for 3 consecutive days.

| Pyrantel Dosing - Single Dose | | | |
|--------------------------------------|---------------|---|---|
| Weight | | Chewable Tablets (250mg Pyrantel base/chewable tablet) | Suspension (50mg Pyrantel base/ml) |
| 25 to 37 lbs | 11 to 16 kg | <u>1/2</u> | 2.5 ml |
| 38 to 62 lbs | 17 to 28 kg | 1 | 5 ml |
| 63 to 87 lbs | 29 to 39 kg | 1 & 1/2 | 7.5 ml |
| 88 to 112 lbs | 40 to 50 kg | 2 | 10 ml |
| 113 to 137 lbs | 51 to 62 kg | 2 & 1/2 | 12.5 ml |
| 138 to 162 lbs | 63 to 73 kg | 3 | 15 ml |
| 163 to 187 lbs | 74 to 84 kg | 3 & 1/2 | 17.5 ml |
| 188 lbs or more | 85 kg or more | 4 | 20 ml |

NOTE: DO NOT GIVE TO CHILDREN UNDER TWO YEARS OLD, PREGNANT OR POSSIBLY PREGNANT, OR BREAST-FEEDING WOMEN WITHOUT SPECIFIC AUTHORIZATION OF A PHYSICIAN

Family members submit specimen and treat as indicated

Health Teaching

- Avoid contacting soil that may be contaminated
- Sanitary disposal of diapers and feces; cleaning of toilet seat; attention to children's play areas
- Wash hands before eating, preparing food, and after elimination; keep nails short
- Discourage eating food that has been dropped on the floor, or is unwashed from the garden; wash, peel or cook raw fruits and vegetables before eating.

Referral Indicators

- No response to treatment
- Children under two years of age
- Pregnant or breast-feeding women
- Pulmonary involvement
- Abdominal pain

Follow-Up

- Patient/parent will be asked to contact health provider if reoccurrence of symptoms after second treatment

Reference

- CDC.gov; Ascarius Infection; September 2012.
- UpToDate.com; Pyrantel Pamoate: pediatric drug information; September 2012.
- Quartzpharmaceuticals.com; Pin-x-overview; September 2012.

BLOOD PRESSURE, ELEVATED ADULTS 18 YEARS OF AGE AND OLDER

GENERAL INFORMATION

Classification of blood pressure is based on the average of two or more properly measured, seated BP readings on each of two or more clinic visits:

| | | |
|-----------------------|-----------------------|------------------------|
| Normal | systolic = <120 | diastolic = <80 |
| Prehypertension | systolic = 120-139 | diastolic = 80-89 |
| Hypertension, Stage 1 | systolic = 140-159 | diastolic = 90-99 |
| Hypertension, Stage 2 | systolic = \geq 160 | diastolic = \geq 100 |

Accuracy in blood pressure measurement is dependent on the following:

Persons should be seated quietly for at least 5 minutes in a chair, with feet on the floor, and arm supported at heart level

An appropriate sized cuff should be used (cuff bladder encircling at least 80 percent of the arm)

Equipment should be properly calibrated

At least two measurements should be made

The right arm is preferred in repeated measures of BP to provide consistency and comparison with standard tables; it is also important because of the possibility of coarctation of the aorta, which might lead to false (low) readings in the left arm

Risk factors for hypertension include the following:

Specific lifestyle factors (alcohol use, tobacco use, excess dietary sodium, lack of exercise, stress)

Medical conditions (obesity, sleep apnea, diabetes, kidney disease, hormonal disorders, thyroid or parathyroid disease, preeclampsia during pregnancy)

Certain medications (oral contraceptives, steroids, nonsteroidal anti-inflammatory drugs, decongestants, diet pills, antidepressants)

Age (35 and older)

Gender (men, post menopausal women)

Genetic factors (family history of hypertension, stroke, heart attack, heart disease, kidney disease, or diabetes)

Race (African-Americans are at higher risk)

PLAN

Obtain history, weight, height, urine dipstick, and blood pressure

Use a cuff appropriate to the size of the adult's upper arm – BP using auscultation is preferred

Have adult sit quietly for 5 minutes with feet and back supported

Check BP using the right arm

If BP is < 120/80, the BP is normal

If BP is 120-139/80-89, patient is prehypertensive and life style modifications should be strongly encouraged

If BP is \geq 140/90, repeat BP within one week

If BP continues to be elevated on the second visit, check BP again within one week

If the third BP check is still elevated and the average of the 3 BPs is \geq 140/90, **REFER**

Blood Pressure Screening Table for Persons 18 Years and Older (Non-Pregnant)

| CATEGORIES | READINGS* | | FOLLOW-UP RECOMMENDATIONS |
|-----------------------------|----------------|--------------------------|---|
| | Systolic | Diastolic | |
| Normal | Less than 120 | <u>AND</u> Less than 80 | <ul style="list-style-type: none"> • Recheck in 2 years • Encourage healthy lifestyle |
| Prehypertension | 120-139 | <u>OR</u> 80-89 | <ul style="list-style-type: none"> • Recommend lifestyle modifications • Recheck in one year • If under MD/NP care, urge to keep doctor's appointments and follow instructions |
| Hypertension Stage 1 | 140-159 | <u>OR</u> 90-99 | <ul style="list-style-type: none"> • Recheck within one week • If still elevated, recheck within one week • If still elevated and average of the 3 BPs is \geq140/90, refer for medical evaluation • If under MD/NP care, refer for reevaluation |
| Hypertension Stage 2 | 160 or greater | <u>OR</u> 100 or greater | <ul style="list-style-type: none"> • Refer for prompt medical evaluation • If under MD/NP care, refer for prompt reevaluation |
| | 180 or greater | <u>OR</u> 120 or greater | <ul style="list-style-type: none"> • Refer immediately • If under MD/NP care, refer for immediate reevaluation |

*Based on the average of two or more readings taken at each of two or more visits. When systolic and diastolic pressures fall into different categories, the higher category should be used to classify the individual's blood pressure

Health Teaching

Encourage healthy lifestyles for all individuals

Emphasize lifestyle modifications for all patient with prehypertension and hypertension in order to reduce blood pressure, enhance antihypertensive drug efficacy, and decrease cardiovascular risk

Components of lifestyle modifications include weight reductions, DASH eating plan, dietary sodium reduction, aerobic physical activity, and moderation of alcohol consumption

| Modification | Recommendation |
|-----------------------------------|--|
| Weight Reduction | Maintain normal body weight (BMI 18.5-24.9) |
| DASH eating plan* | Adopt a diet rich in fruits, vegetables, and lowfat dairy products with reduced content of saturated and total fat |
| Dietary sodium reduction | Reduce dietary sodium intake to ≤ 100 mmol per day (2.4 g sodium or 6 g sodium chloride) |
| Aerobic physical activity | Regular aerobic physical activity (e.g., brisk walking) at least 30 minutes per day, most days of the week |
| Moderation of alcohol consumption | Men: limit to ≤ 2 drinks** per day Women and lighter weight persons: limit to ≤ 1 drink* per day |

* Dietary Approaches to Stop Hypertension (DASH)

**1 drink = $\frac{1}{2}$ oz or 15 ml ethanol (e.g., 12 oz beer, 5 oz wine, 1.5 oz 80-proof whiskey)

Referral Indicators

Symptoms of elevated BP (headache, blurred vision, vertigo, chest pain, edema, nausea and vomiting, and alteration in consciousness)

BP $\geq 140/90$ (average of 3 BP readings)

Reference

The Seventh Report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of high Blood Pressure, US Department of Health and Human Services, National Institutes of Health, National Heart, Lung and Blood Institute, National High Blood Pressure Education Program, December 2003

BLOOD PRESSURE, ELEVATED CHILDREN 1-17 YEARS OF AGE

GENERAL INFORMATION

Based on the Fourth Report of the Joint National Committee on the Prevention, Detection, Evaluation, and Treatment of Hypertension in Children and Adolescents, the following definitions are provided:

Normal BP in children is defined as an average systolic and diastolic BP \leq 90th percentile for gender, age and height

Hypertension in children is defined as an average systolic BP and/or diastolic BP that is \geq 95th percentile for gender, age, and height on \geq 3 separate occasions

Prehypertension in children is defined as an average systolic BP or diastolic BP that are \geq 90th percentile but $<$ 95th percentile or a BP that exceeds 120/80 mmHg even if below the 90th percentile

In order to achieve an accurate blood pressure reading, it is recommended that:

The child be free of stimulant drugs or food AND

Have been sitting quietly for 5 minutes AND

Be seated with his or her back supported, feet on the floor, and right arm supported, cubital fossa at heart level

The right arm is preferred in repeated measures of BP for consistency and comparison with standard tables; it is also important because of the possibility of coarctation of the aorta, which might lead to false (low) readings in the left arm

PLAN

Obtain the child's height and age

Use a cuff appropriate to the size of the child's upper arm – BP using auscultation is preferred

Have child sit quietly for 5 minutes with feet and back supported

Check BP of any child over 3 years of age using the right arm

If BP is \leq 90th percentile, the BP is normal

If the BP is $>$ 5 mm Hg above the 99th percentile, REFER PROMPTLY

If the patient is symptomatic, REFER IMMEDIATELY

If automatic BP cuff is used and the child is found to have elevated BP \geq 90th percentile, repeat BP using auscultation after sitting quietly for 5 minutes

If BP found to be elevated (\geq 95th percentile) based on systolic and diastolic reading, age, gender and height (using attached chart), repeat BP in one week

If BP continues to be elevated on the second visit, check BP again in one week

If the third BP check is still elevated and the average of the 3 BPs is \geq 95th percentile,

REFER

Blood Pressure, Elevated Children 1-17 years of age

Using the BP Chart

1. Obtain height and age of child
2. Measure and record BP
3. Find correct gender chart
4. Find the child's age on the left side of the chart, follow the age row horizontally across the table to the intersection of the line for the height percentile (vertical column)
5. Find the 50th, 90th, and 99th percentiles for systolic and diastolic BP in the right columns

| | |
|--|-------------------------|
| BP < 90 th percentile | = Normal |
| BP between the 90 th and 95 th | = Prehypertensive |
| BP > 95 th percentile X 3 checks | = May Be Hypertensive |
| BP > 99 th percentile + 5 mm Hg | = Probably Hypertensive |

Health Teaching

Counsel the child on prevention and health related life-styles such as:

Weight reduction

Increased physical activity

Dietary modification such as decreased sugar, salt, and an increase in fresh fruits and vegetables, regular meals, and a healthy breakfast

If Prehypertensive counsel regarding the need for BP recheck in 6 months

Referral Indicators

BP > 99th percentile + 5 mm Hg (PROMPTLY, if symptomatic IMMEDIATE)

Average of 3 BP > 95th percentile

Symptoms of elevated BP (i.e. headache, blurred vision, vertigo, chest pain, edema, nausea and vomiting, and alteration in consciousness)

REFERENCE

The Fourth Report on the Diagnosis, Evaluation, and treatment of High Blood Pressure in Children and Adolescents, U.S. Department of Health and Human Services, National Institutes of Health, National Heart, Lung, and Blood Institute, May 2005

The Seventh Report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of high Blood Pressure, US Department of Health and Human Services, National Institutes of Health, National Heart, Lung and Blood Institute, National High Blood Pressure Education Program, December 2003

Blood Pressure, Elevated Children 1-17 years of age

Blood Pressure Levels for BOYS by Age and Height Percentile

| Age (Year) | BP Percentile ↓ | Systolic BP (mmHg) | | | | | | | Diastolic BP (mmHg) | | | | | | |
|---------------|-----------------------|--------------------------|------|------|------|------|------|------|--------------------------|------|------|------|------|------|------|
| | | ← Percentile of Height → | | | | | | | ← Percentile of Height → | | | | | | |
| | | 5th | 10th | 25th | 50th | 75th | 90th | 95th | 5th | 10th | 25th | 50th | 75th | 90th | 95th |
| 1 | 50th | 80 | 81 | 83 | 85 | 87 | 88 | 89 | 34 | 35 | 36 | 37 | 38 | 39 | 39 |
| | 90th | 94 | 95 | 97 | 99 | 100 | 102 | 103 | 49 | 50 | 51 | 52 | 53 | 53 | 51 |
| | 95th | 98 | 99 | 101 | 103 | 104 | 106 | 106 | 54 | 54 | 55 | 56 | 57 | 58 | 58 |
| | 99th | 105 | 106 | 108 | 110 | 112 | 113 | 114 | 61 | 62 | 63 | 64 | 65 | 66 | 66 |
| 2 | 50th | 84 | 85 | 87 | 88 | 90 | 92 | 93 | 39 | 40 | 41 | 42 | 43 | 44 | 44 |
| | 90th | 97 | 99 | 100 | 102 | 104 | 105 | 106 | 54 | 55 | 56 | 57 | 58 | 58 | 59 |
| | 95th | 101 | 102 | 104 | 106 | 108 | 109 | 110 | 59 | 59 | 60 | 61 | 62 | 63 | 63 |
| | 99th | 109 | 110 | 111 | 113 | 115 | 117 | 117 | 66 | 67 | 68 | 69 | 70 | 71 | 71 |
| 3 | 50th | 86 | 87 | 89 | 91 | 93 | 94 | 95 | 44 | 44 | 45 | 46 | 47 | 48 | 48 |
| | 90th | 100 | 101 | 103 | 105 | 107 | 108 | 109 | 59 | 59 | 60 | 61 | 62 | 63 | 63 |
| | 95th | 104 | 105 | 107 | 109 | 110 | 112 | 113 | 63 | 63 | 64 | 65 | 66 | 67 | 67 |
| | 99th | 111 | 112 | 114 | 116 | 118 | 119 | 120 | 71 | 71 | 72 | 73 | 74 | 75 | 75 |
| 4 | 50th | 88 | 89 | 91 | 93 | 95 | 96 | 97 | 47 | 48 | 49 | 50 | 51 | 51 | 52 |
| | 90th | 102 | 103 | 105 | 107 | 109 | 110 | 111 | 62 | 63 | 64 | 65 | 66 | 66 | 67 |
| | 95th | 106 | 107 | 109 | 111 | 112 | 114 | 115 | 66 | 67 | 68 | 69 | 70 | 71 | 71 |
| | 99th | 113 | 114 | 116 | 118 | 120 | 121 | 122 | 74 | 75 | 76 | 76 | 78 | 78 | 79 |
| 5 | 50th | 90 | 91 | 93 | 95 | 96 | 98 | 98 | 50 | 51 | 52 | 53 | 54 | 55 | 55 |
| | 90th | 104 | 105 | 106 | 108 | 110 | 111 | 112 | 65 | 66 | 67 | 68 | 69 | 69 | 70 |
| | 95th | 108 | 109 | 110 | 112 | 114 | 115 | 116 | 69 | 70 | 71 | 72 | 73 | 74 | 74 |
| | 99th | 115 | 116 | 118 | 120 | 121 | 123 | 123 | 77 | 78 | 79 | 80 | 81 | 81 | 82 |
| 6 | 50th | 91 | 92 | 94 | 96 | 98 | 99 | 100 | 53 | 53 | 54 | 55 | 56 | 57 | 57 |
| | 90th | 105 | 106 | 108 | 110 | 111 | 113 | 113 | 68 | 68 | 69 | 70 | 71 | 72 | 72 |
| | 95th | 109 | 110 | 112 | 114 | 115 | 117 | 117 | 72 | 72 | 73 | 74 | 75 | 76 | 76 |
| | 99th | 116 | 117 | 119 | 121 | 123 | 124 | 125 | 80 | 80 | 81 | 82 | 83 | 84 | 84 |
| 7 | 50th | 92 | 94 | 95 | 97 | 99 | 100 | 101 | 55 | 55 | 56 | 57 | 58 | 59 | 59 |
| | 90th | 106 | 107 | 109 | 111 | 113 | 114 | 115 | 70 | 70 | 71 | 72 | 73 | 74 | 74 |
| | 95th | 110 | 111 | 113 | 115 | 117 | 118 | 119 | 74 | 74 | 75 | 76 | 77 | 78 | 78 |
| | 99th | 117 | 118 | 120 | 122 | 124 | 125 | 126 | 82 | 82 | 83 | 84 | 85 | 86 | 86 |
| 8 | 50th | 94 | 95 | 97 | 99 | 100 | 102 | 102 | 56 | 57 | 58 | 59 | 60 | 60 | 61 |
| | 90th | 107 | 109 | 110 | 112 | 114 | 115 | 116 | 71 | 72 | 72 | 73 | 74 | 75 | 76 |
| | 95th | 111 | 112 | 114 | 116 | 118 | 119 | 120 | 75 | 76 | 77 | 78 | 79 | 79 | 80 |
| | 99th | 119 | 120 | 122 | 123 | 125 | 127 | 127 | 83 | 84 | 85 | 86 | 87 | 87 | 88 |
| 9 | 50th | 95 | 96 | 98 | 100 | 102 | 103 | 104 | 57 | 58 | 59 | 60 | 61 | 61 | 62 |
| | 90th | 106 | 110 | 112 | 114 | 115 | 117 | 118 | 72 | 73 | 74 | 75 | 76 | 76 | 77 |
| | 95th | 113 | 114 | 116 | 118 | 119 | 121 | 121 | 76 | 77 | 78 | 79 | 80 | 81 | 81 |
| | 99th | 120 | 121 | 123 | 125 | 127 | 128 | 129 | 84 | 85 | 86 | 87 | 88 | 88 | 89 |
| 10 | 50th | 97 | 98 | 100 | 102 | 103 | 105 | 106 | 58 | 59 | 60 | 61 | 61 | 62 | 63 |
| | 90th | 111 | 112 | 114 | 115 | 117 | 119 | 119 | 73 | 73 | 74 | 75 | 76 | 77 | 78 |
| | 95th | 115 | 116 | 117 | 119 | 121 | 122 | 123 | 77 | 78 | 79 | 80 | 81 | 81 | 82 |
| | 99th | 122 | 123 | 125 | 127 | 128 | 130 | 130 | 85 | 86 | 86 | 88 | 88 | 89 | 90 |

Blood Pressure, Elevated Children 1-17 years of age

Blood Pressure Levels for BOYS by Age and Height Percentile (Continued)

| Age (Year) | BP Percentile ↓ | Systolic BP (mmHg) | | | | | | | Diastolic BP (mmHg) | | | | | | |
|---------------|-----------------------|--------------------------|------|------|------|------|------|------|--------------------------|------|------|------|------|------|------|
| | | ← Percentile of Height → | | | | | | | ← Percentile of Height → | | | | | | |
| | | 5th | 10th | 25th | 50th | 75th | 90th | 95th | 5th | 10th | 25th | 50th | 75th | 90th | 95th |
| 11 | 50th | 99 | 100 | 102 | 104 | 105 | 107 | 107 | 59 | 59 | 60 | 61 | 62 | 63 | 63 |
| | 90th | 113 | 114 | 115 | 117 | 119 | 120 | 121 | 74 | 74 | 75 | 76 | 77 | 78 | 78 |
| | 95th | 117 | 118 | 119 | 121 | 123 | 124 | 125 | 78 | 78 | 79 | 80 | 81 | 82 | 82 |
| | 99th | 124 | 125 | 127 | 129 | 130 | 132 | 132 | 86 | 86 | 87 | 88 | 89 | 90 | 90 |
| 12 | 50th | 101 | 102 | 104 | 106 | 108 | 109 | 110 | 59 | 60 | 61 | 62 | 63 | 63 | 64 |
| | 90th | 115 | 116 | 118 | 120 | 121 | 123 | 123 | 74 | 75 | 75 | 76 | 77 | 78 | 79 |
| | 95th | 119 | 120 | 122 | 123 | 125 | 127 | 127 | 78 | 79 | 80 | 81 | 82 | 82 | 83 |
| | 99th | 126 | 127 | 129 | 131 | 133 | 134 | 135 | 86 | 87 | 88 | 89 | 90 | 90 | 91 |
| 13 | 50th | 104 | 105 | 106 | 108 | 110 | 111 | 112 | 60 | 60 | 61 | 62 | 63 | 64 | 64 |
| | 90th | 117 | 118 | 120 | 122 | 124 | 125 | 126 | 75 | 75 | 76 | 77 | 78 | 79 | 79 |
| | 95th | 121 | 122 | 124 | 126 | 128 | 129 | 130 | 79 | 79 | 80 | 81 | 82 | 83 | 83 |
| | 99th | 128 | 130 | 131 | 133 | 135 | 136 | 137 | 87 | 87 | 88 | 89 | 90 | 91 | 91 |
| 14 | 50th | 106 | 107 | 109 | 111 | 113 | 114 | 115 | 60 | 61 | 62 | 63 | 64 | 65 | 65 |
| | 90th | 120 | 121 | 123 | 125 | 126 | 128 | 128 | 75 | 76 | 77 | 78 | 79 | 79 | 80 |
| | 95th | 124 | 125 | 127 | 128 | 130 | 132 | 132 | 80 | 80 | 81 | 82 | 83 | 84 | 84 |
| | 99th | 131 | 132 | 134 | 136 | 138 | 139 | 140 | 87 | 88 | 89 | 90 | 91 | 92 | 92 |
| 15 | 50th | 109 | 110 | 112 | 113 | 115 | 117 | 117 | 61 | 62 | 63 | 64 | 65 | 66 | 66 |
| | 90th | 122 | 124 | 125 | 127 | 129 | 130 | 131 | 76 | 77 | 78 | 79 | 80 | 80 | 81 |
| | 95th | 126 | 127 | 129 | 131 | 133 | 134 | 135 | 81 | 81 | 82 | 83 | 84 | 85 | 85 |
| | 99th | 134 | 135 | 136 | 138 | 140 | 142 | 142 | 88 | 89 | 90 | 91 | 92 | 93 | 93 |
| 16 | 50th | 111 | 112 | 114 | 116 | 118 | 119 | 120 | 63 | 63 | 64 | 65 | 66 | 67 | 67 |
| | 90th | 125 | 126 | 128 | 130 | 131 | 133 | 134 | 78 | 78 | 79 | 80 | 81 | 82 | 82 |
| | 95th | 129 | 130 | 132 | 134 | 135 | 137 | 137 | 82 | 83 | 83 | 84 | 85 | 86 | 87 |
| | 99th | 136 | 137 | 139 | 141 | 143 | 144 | 145 | 90 | 90 | 91 | 92 | 93 | 94 | 94 |
| 17 | 50th | 114 | 115 | 116 | 118 | 120 | 121 | 122 | 65 | 66 | 66 | 67 | 68 | 69 | 70 |
| | 90th | 127 | 128 | 130 | 132 | 134 | 135 | 136 | 80 | 80 | 81 | 82 | 83 | 84 | 84 |
| | 95th | 131 | 132 | 134 | 136 | 138 | 139 | 140 | 84 | 85 | 86 | 87 | 87 | 88 | 89 |
| | 99th | 139 | 140 | 141 | 143 | 145 | 146 | 147 | 92 | 93 | 93 | 94 | 95 | 96 | 97 |

Blood pressure tables taken from the Fourth Report on the Diagnosis, Evaluation, and Treatment of High Blood Pressure in Children and Adolescents

BP standards based on sex, age, and height provide a precise classification of BP according to body size

Blood Pressure, Elevated Children 1-17 years of age

Blood Pressure Levels for GIRLS by Age and Height Percentile

| Age (Year) | BP Percentile ↓ | Systolic BP (mmHg) | | | | | | | Diastolic BP (mmHg) | | | | | | |
|---------------|-----------------------|--------------------------|------|------|------|------|------|------|--------------------------|------|------|------|------|------|------|
| | | ← Percentile of Height → | | | | | | | ← Percentile of Height → | | | | | | |
| | | 5th | 10th | 25th | 50th | 75th | 90th | 95th | 5th | 10th | 25th | 50th | 75th | 90th | 95th |
| 1 | 50th | 83 | 84 | 85 | 86 | 88 | 89 | 90 | 38 | 39 | 39 | 40 | 41 | 41 | 42 |
| | 90th | 97 | 97 | 98 | 100 | 101 | 102 | 103 | 52 | 53 | 53 | 54 | 55 | 55 | 56 |
| | 95th | 100 | 101 | 102 | 104 | 105 | 106 | 107 | 56 | 57 | 57 | 58 | 59 | 59 | 60 |
| | 99th | 108 | 108 | 109 | 111 | 112 | 113 | 114 | 64 | 64 | 65 | 65 | 66 | 67 | 67 |
| 2 | 50th | 85 | 85 | 87 | 88 | 89 | 91 | 91 | 43 | 44 | 44 | 45 | 46 | 46 | 47 |
| | 90th | 98 | 99 | 100 | 101 | 103 | 104 | 105 | 57 | 58 | 58 | 59 | 60 | 61 | 61 |
| | 95th | 102 | 103 | 104 | 105 | 107 | 108 | 109 | 61 | 62 | 62 | 63 | 64 | 65 | 65 |
| | 99th | 109 | 110 | 111 | 112 | 114 | 115 | 116 | 69 | 69 | 70 | 70 | 71 | 72 | 72 |
| 3 | 50th | 86 | 87 | 88 | 89 | 91 | 92 | 93 | 47 | 48 | 48 | 49 | 50 | 50 | 51 |
| | 90th | 100 | 100 | 102 | 103 | 104 | 106 | 106 | 61 | 62 | 62 | 63 | 64 | 64 | 65 |
| | 95th | 104 | 104 | 105 | 107 | 108 | 109 | 110 | 65 | 66 | 66 | 67 | 68 | 68 | 69 |
| | 99th | 111 | 111 | 113 | 114 | 115 | 116 | 117 | 73 | 73 | 74 | 74 | 75 | 76 | 76 |
| 4 | 50th | 88 | 88 | 90 | 91 | 92 | 94 | 94 | 50 | 50 | 51 | 52 | 52 | 53 | 54 |
| | 90th | 101 | 102 | 103 | 104 | 106 | 107 | 108 | 64 | 64 | 65 | 66 | 67 | 67 | 68 |
| | 95th | 105 | 106 | 107 | 108 | 110 | 111 | 112 | 68 | 68 | 69 | 70 | 71 | 71 | 72 |
| | 99th | 112 | 113 | 114 | 115 | 117 | 118 | 119 | 76 | 76 | 76 | 77 | 78 | 79 | 79 |
| 5 | 50th | 89 | 90 | 91 | 93 | 94 | 95 | 96 | 52 | 53 | 53 | 54 | 55 | 55 | 56 |
| | 90th | 103 | 103 | 105 | 106 | 107 | 109 | 109 | 66 | 67 | 67 | 68 | 69 | 69 | 70 |
| | 95th | 107 | 107 | 107 | 110 | 111 | 112 | 113 | 70 | 71 | 71 | 72 | 73 | 73 | 74 |
| | 99th | 114 | 114 | 116 | 117 | 118 | 120 | 120 | 78 | 78 | 79 | 79 | 80 | 81 | 81 |
| 6 | 50th | 91 | 92 | 93 | 94 | 96 | 97 | 98 | 54 | 54 | 55 | 56 | 56 | 57 | 58 |
| | 90th | 104 | 105 | 106 | 108 | 109 | 110 | 111 | 68 | 68 | 69 | 70 | 70 | 71 | 72 |
| | 95th | 108 | 109 | 110 | 111 | 113 | 114 | 115 | 72 | 72 | 73 | 74 | 74 | 75 | 76 |
| | 99th | 115 | 116 | 117 | 119 | 120 | 121 | 122 | 80 | 80 | 80 | 81 | 82 | 83 | 83 |
| 7 | 50th | 93 | 93 | 95 | 96 | 97 | 99 | 99 | 55 | 56 | 56 | 57 | 58 | 58 | 59 |
| | 90th | 106 | 107 | 108 | 109 | 111 | 112 | 113 | 69 | 70 | 70 | 71 | 72 | 72 | 73 |
| | 95th | 110 | 111 | 112 | 113 | 115 | 116 | 116 | 73 | 74 | 74 | 75 | 76 | 76 | 77 |
| | 99th | 117 | 118 | 119 | 120 | 122 | 123 | 124 | 81 | 81 | 82 | 82 | 83 | 84 | 84 |
| 8 | 50th | 95 | 95 | 96 | 96 | 99 | 100 | 101 | 57 | 57 | 57 | 58 | 59 | 60 | 60 |
| | 90th | 108 | 109 | 110 | 111 | 113 | 114 | 114 | 71 | 71 | 71 | 72 | 73 | 74 | 74 |
| | 95th | 112 | 112 | 114 | 115 | 116 | 118 | 118 | 75 | 75 | 75 | 76 | 77 | 78 | 78 |
| | 99th | 119 | 120 | 121 | 122 | 123 | 125 | 125 | 82 | 82 | 83 | 83 | 84 | 85 | 86 |
| 9 | 50th | 96 | 97 | 98 | 100 | 101 | 102 | 103 | 58 | 58 | 58 | 59 | 60 | 61 | 61 |
| | 90th | 110 | 110 | 112 | 113 | 114 | 116 | 116 | 72 | 72 | 72 | 73 | 74 | 75 | 75 |
| | 95th | 114 | 114 | 115 | 117 | 118 | 119 | 120 | 76 | 76 | 76 | 77 | 78 | 79 | 79 |
| | 99th | 121 | 121 | 123 | 124 | 125 | 127 | 127 | 83 | 83 | 84 | 81 | 85 | 86 | 87 |
| 10 | 50th | 98 | 99 | 100 | 102 | 103 | 104 | 105 | 59 | 59 | 59 | 60 | 61 | 62 | 62 |
| | 90th | 112 | 112 | 114 | 115 | 116 | 118 | 118 | 73 | 73 | 73 | 74 | 75 | 76 | 76 |
| | 95th | 116 | 116 | 117 | 119 | 120 | 121 | 122 | 77 | 77 | 77 | 78 | 79 | 80 | 80 |
| | 99th | 123 | 123 | 125 | 126 | 127 | 129 | 129 | 84 | 84 | 85 | 86 | 86 | 87 | 88 |

Blood Pressure, Elevated Children 1-17 years of age

Blood Pressure Levels for GIRLS by Age and Height Percentile (Continued)

| Age (Year) | BP Percentile ↓ | Systolic BP (mmHg) | | | | | | | Diastolic BP (mmHg) | | | | | | |
|---------------|-----------------------|--------------------------|------|------|------|------|------|------|--------------------------|------|------|------|------|------|------|
| | | ← Percentile of Height → | | | | | | | ← Percentile of Height → | | | | | | |
| | | 5th | 10th | 25th | 50th | 75th | 90th | 95th | 5th | 10th | 25th | 50th | 75th | 90th | 95th |
| 11 | 50th | 100 | 101 | 102 | 103 | 105 | 106 | 107 | 60 | 60 | 60 | 61 | 62 | 63 | 63 |
| | 90th | 114 | 114 | 116 | 117 | 118 | 119 | 120 | 74 | 74 | 74 | 75 | 76 | 77 | 77 |
| | 95th | 118 | 118 | 119 | 121 | 122 | 123 | 124 | 78 | 78 | 78 | 79 | 80 | 81 | 81 |
| | 99th | 125 | 125 | 126 | 128 | 129 | 130 | 131 | 85 | 85 | 86 | 87 | 87 | 88 | 89 |
| 12 | 50th | 102 | 103 | 104 | 105 | 107 | 108 | 109 | 61 | 61 | 61 | 62 | 63 | 64 | 64 |
| | 90th | 116 | 116 | 117 | 119 | 120 | 121 | 122 | 75 | 75 | 75 | 76 | 77 | 78 | 78 |
| | 95th | 119 | 120 | 121 | 123 | 124 | 125 | 126 | 79 | 79 | 79 | 80 | 81 | 82 | 82 |
| | 99th | 127 | 127 | 128 | 130 | 131 | 132 | 133 | 86 | 86 | 87 | 88 | 88 | 89 | 90 |
| 13 | 50th | 104 | 105 | 106 | 107 | 109 | 110 | 110 | 62 | 62 | 62 | 63 | 64 | 65 | 66 |
| | 90th | 117 | 118 | 119 | 121 | 122 | 123 | 124 | 76 | 76 | 76 | 77 | 78 | 79 | 79 |
| | 95th | 121 | 122 | 123 | 124 | 126 | 127 | 128 | 80 | 80 | 80 | 81 | 82 | 83 | 83 |
| | 99th | 128 | 129 | 130 | 132 | 133 | 134 | 135 | 87 | 87 | 88 | 89 | 89 | 90 | 91 |
| 14 | 50th | 106 | 106 | 107 | 109 | 110 | 111 | 112 | 63 | 63 | 63 | 64 | 65 | 66 | 66 |
| | 90th | 119 | 120 | 121 | 122 | 124 | 125 | 125 | 77 | 77 | 77 | 78 | 79 | 80 | 80 |
| | 95th | 123 | 123 | 125 | 126 | 127 | 129 | 129 | 81 | 81 | 81 | 82 | 83 | 84 | 84 |
| | 99th | 130 | 131 | 132 | 133 | 135 | 136 | 136 | 88 | 88 | 89 | 90 | 90 | 91 | 92 |
| 15 | 50th | 107 | 108 | 109 | 110 | 111 | 113 | 113 | 64 | 64 | 64 | 65 | 66 | 67 | 67 |
| | 90th | 120 | 121 | 122 | 123 | 125 | 126 | 127 | 78 | 78 | 78 | 79 | 80 | 81 | 81 |
| | 95th | 124 | 125 | 126 | 127 | 129 | 130 | 131 | 82 | 82 | 82 | 83 | 84 | 85 | 85 |
| | 99th | 131 | 132 | 133 | 134 | 136 | 137 | 138 | 89 | 89 | 90 | 91 | 91 | 92 | 93 |
| 16 | 50th | 108 | 108 | 110 | 111 | 112 | 114 | 114 | 64 | 64 | 65 | 66 | 66 | 67 | 68 |
| | 90th | 121 | 122 | 123 | 124 | 126 | 127 | 128 | 78 | 78 | 79 | 80 | 81 | 81 | 82 |
| | 95th | 125 | 126 | 127 | 128 | 130 | 131 | 132 | 82 | 82 | 83 | 84 | 85 | 85 | 86 |
| | 99th | 132 | 133 | 134 | 135 | 137 | 138 | 139 | 90 | 90 | 90 | 91 | 92 | 93 | 93 |
| 17 | 50th | 108 | 109 | 110 | 111 | 113 | 114 | 115 | 64 | 65 | 65 | 66 | 67 | 67 | 68 |
| | 90th | 122 | 122 | 123 | 125 | 126 | 127 | 128 | 78 | 79 | 79 | 80 | 81 | 81 | 82 |
| | 95th | 125 | 126 | 127 | 129 | 130 | 131 | 132 | 82 | 83 | 83 | 84 | 85 | 85 | 86 |
| | 99th | 133 | 133 | 134 | 136 | 137 | 138 | 139 | 90 | 90 | 91 | 91 | 92 | 93 | 93 |

Blood pressure tables taken from the Fourth Report on the Diagnosis, Evaluation, and Treatment of High Blood Pressure in Children and Adolescents

BP standards based on sex, age, and height provide a precise classification of BP according to body size

CERUMEN, IMPACTED (EAR WAX)

SUBJECTIVE

- Ear feels plugged
- Diminished hearing
- Itching may be present
- History is negative for:
 - Ear drainage
 - Perforation of ear drum(s)
 - Ear pain
 - Ear surgery, e.g., “tubes”

OBJECTIVE

- Hardened and packed cerumen
- Tympanic membrane not visible

ASSESSMENT

- Impacted cerumen

PLAN

- Hearing assessment according to age
- Recommend softening ear wax with the following warmed to body temperature:
 - Use 5-6 drops of glycerin or mineral oil in each ear b.i.d. or t.i.d. for 7 days or
 - recommend Debrox Drops 5-10 drops twice daily for 3-4 days
- Parent or guardian should be instructed in proper manipulation of ear lobe and cartilage to facilitate drops flowing into the ear
- Discourage the use of anything smaller than the finger tip for cleaning the ear canal, (i.e., Q-tips, bobby pins, toothpicks, match sticks, twigs or straw)

Referral Indicators:

- Earaches, ear pain
- Ear drainage
- Perforation of tympanic membrane
- Impacted cerumen that fails to respond to above management
- Impaired hearing or delayed and/or impaired speech
- Children less than 2 years of age
- Febrile (100.4° F rectally or greater)

Follow-Up:

- Inspect the ears with an otoscope 2-4 days after

Reference:

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

CHIGGERS (DEMATOPHILIS PENTRANS)

SUBJECTIVE

Intense itching and red raised wheels which increase in size and intensity over time
History of exposure to grasses and shrubs that may have harbored the mites

OBJECTIVE

Red raised wheels found especially in body creases and at edges of clothing
R/O insect bites/stings, scabies, varicella
Excoriations and 2° infections

ASSESSMENT

Chigger Bites

PLAN

Ice water compresses or gentle ice massage may help with itching
May obtain relief through application of OTC hydrocortisone preparation
If bites are extensive, an oral antihistamine may be beneficial

Health Teaching:

Avoid scratching to reduce risk of secondary bacterial infection
Future skin contact with the mites can be avoided by wearing long-sleeved shirts, long pants, and boots, and taping the clothing at the ankles, wrists, and waist, and using an insect repellent such as DEET

DEET **should be avoided** in infants under 2 months of age (follow label directions)

Wash clothing immediately after exposure

Shower well with soap after outdoors exposure

Referral Indicators:

Localized infection

Follow-Up:

Usually not necessary

Reference:

Medline Plus Medical Encyclopedia, "Chiggers" 10/17/06.

<http://www.nlm.nih.gov/medlineplus/ency/article/001333.htm>

CHOLESTEROL RISK ASSESSMENT (Child Health/EPSDT)

GENERAL INFORMATION

The following children are at **high risk** for developing coronary heart disease:

Children whose parent(s) have a total blood cholesterol level ≥ 240 mg/dL

Children whose parents or grandparents have had a documented myocardial infarction, positive coronary angiogram, or cerebrovascular or peripheral vascular disease before the age of fifty-five (55)

Children and adolescents with several risk factors for future coronary vascular disease (e.g., smoking, hypertension, physical inactivity, obesity, or diabetes mellitus), or whose family history cannot be ascertained (e.g., adopted, early parent death)

Assessment (see Plan for assessment questions):

"High risk cholesterol" assessment will be completed on all children two years of age and older who receive EPSDT services in local health departments

This assessment will be updated annually unless the cholesterol level has already been determined and a plan for treatment is in effect

PLAN

If the child is receiving a well child or an EPSDT exam, and is two years of age and older, assess the potential of being at high risk for elevated cholesterol levels by asking the following questions:

Is there a history of heart disease, heart attack or stroke with the child's parents or grandparents before these individuals turned fifty-five (55) years of age?

If the answer is **YES** -

Assess that it is a true diagnosis by asking questions regarding lab work, hospitalization and/or surgeries pertaining to the diagnosis

If the answer is still **YES** and the diagnosis is likely -

Counsel (nurse/nutritionist) regarding good eating habits and making good food choices (decreasing fat intake and increasing their diets with

more grain products, fruits, vegetables, low-fat milk, beans, lean meat, poultry and fish)

Document history and plan of action in the patient's chart

Refer the child to their PCP for evaluation

Do you know if the child's mother or father has a high cholesterol level over 240 mg/dL?

If the answer is **YES** -

Discuss child's existing risk factors and the value of referring to the PCP for cholesterol evaluation

CHOLESTEROL SCREENING

Counsel (nurse/nutritionist) regarding good eating habits and making good food choices (decreasing fat intake and increasing their diets with more grain products, fruits, vegetables, low-fat milk, beans, lean meat, poultry and fish)

Document history and plan of action in the patient's chart

If the answer to both questions is **NO**:

Counsel (nurse/nutritionist) regarding good eating habits and making good food choices (decreasing fat intake and increasing their diets with more grain products, fruits, vegetables, low-fat milk, beans, lean meat, poultry and fish)

Document "cholesterol assessment negative and counseled regarding good nutrition"

If the nurse is **UNABLE TO OBTAIN A HISTORY**:

Counsel (nurse/nutritionist) regarding good eating habits and making good food choices (decreasing fat intake and increasing their diets with more grain products, fruits, vegetables, low-fat milk, beans, lean meat, poultry and fish)

Encourage the child's parent to discuss with PCP the need for cholesterol screening

Document "Unable to obtain a cholesterol history; counseled parents regarding cholesterol evaluation and good eating habits "

If the child has **RISK FACTORS** and/or the **CHOLESTEROL HISTORY IS NOT OBTAINABLE**:

Document risk factors and/or cholesterol history not available

Counsel the family regarding risk factors and/or refer to the PCP for cholesterol evaluation

Counsel (nurse/nutritionist) regarding good eating habits and making good food choices (decreasing fat intake and increasing their diets with more grain products, fruits, vegetables, low-fat milk, beans, lean meat, poultry and fish)

Document plan of action in the patient's record

NOTE: If the patient does not have a PCP or the Health Department is the PCP consult with or refer to physician and/or nurse clinician for evaluation according to Physician/Nurse Clinician protocols

CONSTIPATION, ACUTE, CHILD

SUBJECTIVE

Malaise, headache, abdominal cramping
History of hard, dry, stools; may be history of fecal soiling in older child
History of infrequent passage of stools relative to the individual's usual habit
Pain and/or straining at defecation; reluctance to sit on toilet
Stool streaked with blood
Diet and medication history

OBJECTIVE

Signs of dehydration
Anal fissure or evidence of irritation
Mild abdominal distention with or without palpable firm mass
Stool streaked with bright blood

ASSESSMENT

Acute childhood constipation

PLAN

Encourage defecation when urge presents
Adjust diet to allow for adequate fluid and carbohydrate intake:
Young infants - Offer water 1-3 times daily between feedings; reduce intake of formula, if excessive
Older infants - increase fluid intake; increase amounts of pureed fruits in the diet, especially prunes and plums; the amount needed will vary with individual infants
Older children - Increase fluid intake; add prunes, apricots, and figs to the daily diet; include high-residue substances such as bran, whole wheat, oatmeal, and green leafy vegetables in daily diet
Discourage use of suppositories, laxatives, or enemas unless specifically ordered by physician
For minor anal irritation, advise warm sitz baths and use of petroleum jelly or ointment
For older child, support for feet when toileting

NOTE: HONEY SHOULD NOT BE USED AS OSMOTIC AGENT DUE TO DANGER OF BOTULISM

Referral Indicators:

Persistent, severe, or recurrent abdominal pain
Persistent fecal soiling
Persistent constipation despite adequate dietary intake
Vomiting, dehydration, fever

Severe breakdown of skin around anus
Blood streaked stool

Follow-Up:

Patient/parent will be asked to contact health provider if not resolved in 48-72 hours

Reference

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

CONSTIPATION, ADULT

SUBJECTIVE

Symptoms may include:

Headache, indigestion, nausea, fatigue; abdominal pain, spasm, or discomfort;
gas pain and flatulence

Abnormal color and/or odor of feces; quantity of stool less than normal

Decreased appetite; anorexia

Frequency of defecation less than normal, or less than every third day

Hard formed stool; strains at stool; feels pressure in rectum

Diet and medication history

OBJECTIVE

Bowel sounds diminished

Palpable mass in left lower quadrant

Distended abdomen

ASSESSMENT

Constipation

PLAN

Health Teaching:

Activity - increase daily activity level (example: walking 30-40 minutes daily)

Elimination patterns - set aside 30 minutes, preferably after breakfast, for defecation; pay attention to urge to defecate; instruct against habitual use of enemas and laxatives; avoid straining, ensure privacy, minimize distractions Hydration - drink 6 glasses of water daily in addition to any other beverage Nutrition - increase intake of fruit (raisins, dried apricots and plums), raw

vegetables, broccoli, bran cereals, and whole-grain breads; consider use of unprocessed wheat bran (6 teaspoons a day) in cereal or liquids

Medication - select one or more of the following as appropriate:

Bulk - Metamucil or generic brand, 1 tsp. stirred into 8 oz. cool water daily to t.i.d.; follow each dose with additional glass of water; optimal benefit 2-3 days

Laxative - Milk of Magnesia 2-4 tbsp followed by a glass of water for mild laxative

Stool softener - docusate sodium (Colace) 50-200 mg daily; adjust dose to individual response; effects noticed in 1-3 days

Lubricant - Glycerin Suppository at time bowel movement required

Referral Indicators:

Constipation not corrected with above management in 72 hours
Nausea and vomiting
Persistent, severe, or recurrent abdominal pain
Temperature above normal
Rectal bleeding or positive serocult
Abnormal color of stool

References

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

DIAPER DERMATITIS (DIAPER RASH)

SUBJECTIVE

Caretaker reports diaper rash
Irritability

OBJECTIVE

Contact dermatitis: Chafed, reddened, non-raised areas over genital and buttocks area

Infected dermatitis: Inflamed, bright red, indurated and tender skin; parched area
With satellite lesions; thick white plaques with an erythematous base may be present on oral mucus membrane (thrush), especially during or following antibiotic therapy (see also oral candidiasis/moniliasis)

ASSESSMENT

Contact or Infected Diaper Dermatitis

PLAN

For Contact Diaper Dermatitis:

Change diaper as soon as possible after it becomes wet or soiled; check diaper every hour in newborn

Dry diaper area gently and expose to air to dry completely after urination.

Clean diaper area with warm water and mild soap (ie. Dove or Basis) after each bowel movement and dry gently but thoroughly

Leave diaper off during nap time to allow drying of the area

A thin layer of protective ointment or cream or medicated powder may be applied to skin with each diaper change.

Do not overdress infant

Discourage use of waterproof pants, plastic covered diapers, tightly pinned or double diapers, scented diapers, and diaper wipes as many contain perfume or alcohol

DO NOT USE TALCUM POWDER, BAKING SODA, OIL, OR PETROLEUM JELLY

Provide laundry instructions for cloth diapers, if applicable:

Suggest laundering diapers in mild detergent (i.e. Dreft) and rinse thoroughly

Discourage use of fabric softener

Referral Indicators:

Infected diaper dermatitis

Suspicion of burn

No response to treatment within 2-3 days

Presence of systemic involvement (e.g., fever)

Follow up:

Parent will be asked to contact health provider in 48-72 hours if not improved

Reference:

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

Uphold and Graham, Fourth Edition 2003

American Academy of Pediatrics, Healthy Children

<http://www.healthychildren.org/English/ages-stages/baby/diapers-clothing/Pages/Diaper-Rash-Solution.aspx>

DIARRHEA

SUBJECTIVE

Loose, watery stools, increased frequency
Urgency for stool
Cramping abdominal pain
Decreased urination, strong colored urine

OBJECTIVE

Increased bowel sounds
Observe for signs of dehydration:
Sunken fontanelles
Dry mucus membranes
Sunken eyes Decreased
skin turgor Decreased
urination Fever
Grayish skin
Rapid breathing and pulse
Weight loss

ASSESSMENT

Diarrhea: Acute and Unaccompanied by Nausea/Vomiting

PLAN

Weigh patient

For infants older than 2 months, instruct parent to:

Increase liquids containing calories, sodium (Na), and potassium (K), example
Pedialyte, etc.

Discontinue solid foods but do not withhold formula milk/breast milk

After 24 hours if improvement, add semi-solids (e.g., cereal, applesauce,
bananas) if tolerated, and if infant was on semi-solids prior to diarrhea Slowly
advance diet to its previous level if semi-solids are well tolerated

Teach signs and symptoms of dehydration

For young child or adult:

Rehydrate with clear liquids (apple juice, gingerale, tea, broth) for 12 to 24
hours

Then try usual diet, avoid simple sugars and fats

Add soda crackers, toast, rice, cereal, yogurt, fruits, vegetables

Add soft foods as symptoms begin to improve

Referral Indicators:

- Infant less than 2 months old
- Preschool child with 9-10 stools per 24 hours
- Patients with lethargy, vomiting, or fever
- Patients with signs of severe dehydration (sunken eyes, dry mucus membranes, decreased skin turgor, decreased urination)
- Presence of abdominal tenderness
- Patients with no improvement after 24 hours on liquid diet
- Blood, pus, or mucus in stool
- Weight loss significant in relation to age
- Infants and children less than 4 years of age who fails to improve in 24 hours after clear liquids
- If infants/children are taking fluids poorly

References

- Mayo Clinic, Guide To Self-Care, Fifth Edition 2006
- Managing Acute Gastroenteritis Among Children, MMWR. November 21, 2003

ENTEROBIUS VERMICULARIS (PINWORMS)

SUBJECTIVE

Rectal itching, especially at night
 Heavy infestations may cause perianal pain and bleeding with defecation
 White threadlike worms may be seen in bowel movements
 Restlessness and irritability
 Nightmares

OBJECTIVE

Anal area shows evidence of scratching, may have perianal infection
 Using clear tape collection method, ova may be seen microscopically
 Laboratory confirmation of pinworm infestation from stool specimen
 Visual observation of pinworm

ASSESSMENT

Enterobius Vermicularis (Pinworms) or Enterobiasis

PLAN

Pyrantel Pamoate, 11 mg pyrantel base/kg, given as a single dose with a maximum of 1 gm/single dose.

| Pyrantel Dosing - Single Dose | | | |
|--------------------------------------|---------------|---|--|
| Weight | | Chewable Tablets (250 mg Pyrantel) | Suspension (50 mg Pyrantel) |
| 25 to 37 lbs | 11 to 16 kg | 1/2 | 2.5 ml |
| 38 to 62 lbs | 17 to 28 kg | 1 | 5 ml |
| 63 to 87 lbs | 29 to 39 kg | 1 & 1/2 | 7.5 ml |
| 88 to 112 lbs | 40 to 50 kg | 2 | 10 ml |
| 113 to 137 lbs | 51 to 62 kg | 2 & 1/2 | 12.5 ml |
| 138 to 162 lbs | 63 to 73 kg | 3 | 15 ml |
| 163 to 187 lbs | 74 to 84 kg | 3 & 1/2 | 17.5 ml |
| 188 lbs or more | 85 kg or more | 4 | 20 ml |

NOTE: DO NOT GIVE TO CHILDREN UNDER TWO YEARS OLD, PREGNANT OR POSSIBLY PREGNANT, OR BREAST-FEEDING WOMEN

The entire family (immediate household members) should be treated, even if asymptomatic, to prevent reinfestation.

A second treatment should be given in 2 weeks to eliminate possible reinfection.

Health Teaching

- Inform that reinfection and recurrence is common and will require retreatment
- Sanitary disposal of feces; cleaning of toilet seat
- Change bed linens and underwear of infected person daily
- Wash soiled laundry in hot water
- Wash hands before preparing food, eating, and after elimination; keep nails short
- Discourage habits of nail biting and scratching bare anal area

Referral Indicators:

- Secondary bacterial infection
- No response to treatment
- Children under 2 years of age
- Pregnant or breast-feeding women

Follow-Up:

Patient/parent will be asked to contact health provider if reoccurrence of symptoms after second treatment

Reference:

- cdc.gov; Enterobius Vericularis Infection – See Pinworm Infection
- UpToDate.com; Pyrantel Pamoate: pediatric drug information; September 2012.
- quartzpharmaceuticals.com; Pin-x-overview; September 2012.

FLUORIDE DEFICIENCY

NOTE:

- The use of dietary fluoride supplements is one alternative means of providing fluoride protection to the teeth of children 6 months old to 16 years of age who consume fluoride-deficient water with 0.6 ppm fluoride or less.
- Dietary fluoride supplements, in the form of daily tablets, lozenges, liquids, or vitamin-fluoride combinations, provide systemic benefits to developing teeth as well as topical benefits to erupted teeth. When practical, supplements should be prescribed as chewable tablets or lozenges to maximize the topical effects of fluoride.
- When prescribed and used appropriately, fluoride supplements provide benefits similar to those obtained from ingesting optimally-fluoride water over the same period of time.
- **When improperly prescribed, fluoride supplements may cause mild enamel fluorosis (white spots on teeth). Therefore, systemic fluoride supplements should never be prescribed to children in fluoridated communities who are already receiving optimally fluoridated water (0.7-1.2 ppm fluoride).**
- Because of an increase in the milder forms of dental fluorosis associated with fluoride ingestion in excess of that necessary to prevent tooth decay, a conservative approach to fluoride supplementation should be used and in accordance with the recently revised guidelines.
- If a child's primary drinking water source is a well, spring, or non-fluoridated community water system, a water sample must first be taken and analyzed to determine its fluoride content and what dosage of fluoride supplement, if any, is needed.

SUBJECTIVE

No other systemic source of fluoride besides that present in foods and beverages processed with fluoridated water
 Request for dietary fluoride supplement
 Age 6 months to 16 years

OBJECTIVE

Private community water supply with a fluoride content 0.6 ppm fluoride or below as confirmed by fluoride assay
 Dental caries are more common in areas of fluoride deficient water supply.

ASSESSMENT

Fluoride Deficiency

PLAN

Drinking water should be analyzed for fluoride content prior to supplementation in order to determine if supplements are necessary and how much to prescribe.

To determine the level of fluoride in the child's existing water supply:

1. Obtain water sample bottles from either Fluoridation Specialist (TDEC Nashville Env. Field Office, Division of Water Supply, 711 R.S. Gass Blvd, Nashville, TN 37216, Telephone 615-687-7037 or the Regional Dental Director.
2. Provide parent or guardian with 1 water sample bottle, request slip for fluoride determination.
3. Instruct patient on the correct procedure for collecting and handling of the water sample:
 - a. Using a kitchen or bathroom faucet allow cold water to run for at least 30 seconds.
 - b. Rinse out the sample bottle twice before filling.
 - c. Fill sample bottle with cold water and screw on cap firmly.
 - d. Mail the sample within 3 days.

Estimate an effective fluoride concentration as indicated (child is consuming water from multiple sources)

Example: If the home water supply is tested and the fluoride concentration is 0.2 ppm, but it only accounts for half of the child's daily water intake ($0.2 \text{ ppm} \times 0.50 = 0.1 \text{ ppm}$) and the day-care water supply has a known fluoride concentration of 1.0 ppm and it accounts for the remaining half of the child's daily intake ($1.0 \text{ ppm} \times 0.50 \text{ ppm}$) a dietary fluoride supplement (if prescribed) should be based on the effective fluoride concentration of 0.6 ppm and not 0.2 ppm

Dispense fluoride supplements according to the following dosage schedule:

Dietary Supplemental Fluoride Dosage Schedule in mg F/day
Revised, ADA Winter 1994

| Age of Child | ppm fluoride in water supply | | |
|---------------|------------------------------|-------------|----------|
| | 0-0.3 ppm | 0.3-0.6 ppm | >0.6 ppm |
| Birth to 6 mo | 0 | 0 | 0 |
| 6 mo to 3 yrs | 0.25 mg | 0 | 0 |
| 3 to 6 yrs | 0.5 mg | 0.25 mg | 0 |
| 6-16 yrs | 1.0 mg | 0.5 mg | 0 |

Dispense on a "one bottle at a time" basis

Each bottle should not exceed the recommended limit of 120 mgs of fluoride

Health Teaching:

There is a well-documented decline in dental caries in children in the United States which is due to widespread use of various forms of fluoride. Even people living in communities where water supplies are not fluoridated still benefit from exposure to fluorides found in toothpaste, mouth rinses, professionally applied fluorides and in foods processed in cities where water supplies are fluoridated (i.e., the “halo” phenomenon). In order to reduce risk of dental fluorosis, it is recommended that parents closely supervise tooth brushing by young children to prevent their ingestion of fluoride toothpaste and to ensure that only very small quantities (pea-sized amounts) are used. Careful use of fluoride is particularly appropriate during the time of anterior tooth enamel development (birth to 6 years).

Follow-Up:

The parent or guardian of the child will be asked to return for a refill when one bottle is near completion or if the fluoride status of the water supply changes.

Reference

MMWR August 17, 2001 / 50 (RR14) 1-42
MMWR “Achievements....etc.” October 22, 1999 / 48 (41); 933-940

FLUORIDE VARNISH

NOTE:

- The bacteria associated with dental caries have been identified as Streptococcus Mutans. The presence of these bacteria along with food and saliva allow the process of decay to begin on the tooth surface. Untreated decay progresses through stages of tooth destruction. As the decay progresses, the affected area becomes larger.
- There has been a well-documented decline in dental caries in children in the United States, which has been attributed to widespread use of various forms of fluoride. With the use of fluoride varnish, a high-concentration of fluoride in a small amount is painted directly onto the teeth.
- Even people living in communities where water supplies are not fluoridated still benefit from exposure to fluorides found in toothpaste, mouth rinses, professionally applied fluorides, and in foods processed in cities where water supplies are fluoridated (i.e., the “halo” phenomenon)
- The use of topical fluoride supplements is one alternative means of providing protection to the teeth of children 0 months old to 21¹ years of age who are at risk for dental caries.
- Proper application technique reduces the possibility that a patient will swallow varnish during its application and limits the total amount of fluoride swallowed as the varnish wears off the teeth over several hours.
- A combination of various types of fluoride use (e.g. optimally fluoridated water, prescription fluoride supplements, and professionally applied topical fluoride) reduces dental caries significantly more than any one method alone.
- No published evidence indicates that professionally applied fluoride varnish is a risk factor for enamel fluorosis, even among children aged <6 years.
- Applying the fluoride varnish to any and all tooth surfaces reduces the risk of decay.
- A helpful tip for applying fluoride varnish to the teeth of young children is to sit knee-to-knee with parent or caregiver, and have child lay in the health care provider’s lap

¹ Topical application of fluoride varnish is safe for the prenatal patient

SUBJECTIVE

Age 0 – 21 years of age

Target population age 0 - 5 years

Mother requests application of dental varnish for child

Health care provider recommends application of dental varnish

OBJECTIVE

White spot lesions may or may not be present on any teeth in the child's oral cavity

ASSESSMENT

Need for dental varnish application

PLAN

RN to apply dental fluoride varnish application according to package instructions

Health Teaching:

Instruct parent/guardian on the correct care of child's teeth until the next day

Provide parent/guardian with appropriate information sheet for care of child's teeth following fluoride varnish application

Instruct parent or guardian on the need for additional applications of fluoride varnish

Counsel parent/guardian to closely supervise tooth brushing by young children in order to prevent their ingestion of fluoride toothpaste and to ensure that only very small quantities (pea-sized amounts) are used (so as to reduce the risk of dental fluorosis)

Counsel parent/guardian regarding the risks that contributes to dental decay

Instruct parent/guardian about proper diet and feeding habits, as well as the daily care of the child's teeth to contribute to the prevention of dental decay

Follow-Up:

Fluoride varnish should be applied two times annually or according to manufacturer's instructions.

REFERENCE

Morbidity and Mortality Weekly Report, Recommendations and Reports, August 17, 2001, Vol. 50 No. RR-14; pages 18–19

FOLIC ACID PROPHYLACTIC THERAPY FOR WOMEN OF REPRODUCTIVE AGE

GENERAL INFORMATION

Folic acid is vital to the early development of the fetal brain and spinal cord. Brain and spinal cord development occur by the 5th week of pregnancy. This is only one week after the menstrual period has been missed. Some women will not yet know they are pregnant. Inadequate folic acid levels can lead to a defect in the developing fetal brain and spinal cord. This is called a neural tube defect. All women of reproductive age should consume 400mcg (0.4 mg) of folic acid daily in order to be prepared should a pregnancy occur. Folic acid prior to pregnancy is an important component of preconception care.

Supplementation with folic acid is recommended because it is difficult to eat a diet that contains adequate amounts of folic acid. Today, enriched grain products such as flour, cereal, bread, rice and pasta are fortified with folic acid. Other sources of folic acid include dark green leafy vegetables, dried beans, legumes oranges, and orange juice. Nevertheless supplementation is recommended.

SUBJECTIVE

- No medical history of intolerance to multivitamins with folic acid
- Negative obstetric history for a child with spina bifida or anencephaly
- Not currently taking a daily multivitamin with folic acid

OBJECTIVE

Woman of reproductive age (approximately 10 to 44 years of age)

ASSESSMENT

Client is appropriate for supplementation with a daily multivitamin with 400 mcg of folic acid.

PLAN

Educate the client about the importance of folic acid.

If the client already takes a multivitamin with folic acid, assure that she understands that she needs only one a day. She should complete what she has before beginning what is given to her at the clinic.

If there is an obstetric history of neural tube defects, consult for the proper dosage of folic acid. Women who have given birth to a child with a neural tube defect require higher doses of folic acid.

Give the client a supply of multivitamins with folic acid with the instructions to take one tablet orally daily.

Client may take the supplement with food if she has nausea when taking it on an empty stomach.

Provide client with any written materials you may have regarding folic acid.

The return appointment is scheduled as needed.

REFERENCES

<http://ods.od.nih.gov/factsheets/folate.asp>

www.cdc.gov/Features/FolicAcid/

www.marchofdimes.com

FOODBORNE OUTBREAK INVESTIGATION

GENERAL INFORMATION

A foodborne outbreak is defined as the occurrence of two or more cases of a similar illness resulting from the ingestion of a common food.

Exception: one case of botulism is considered a foodborne outbreak and is subject to notification and investigation

Complaints about taste, appearance or odor of food without illness are not considered outbreaks.

PLAN

Follow instructions in the following manual:

Foodborne Outbreak Investigation Manual
Tennessee Department of Health, January 2000

Report all foodborne outbreaks to the local health department as stated in the following document:

Rules and Regulations Governing Communicable Diseases in Tennessee
Chapter 1200-14-1-.02
Tennessee Department of Health

Notify according to the following document:

Foodborne Outbreak Investigation Manual
Tennessee Department of Health
January 2000

Note:

Important Telephone Numbers listed in Appendix A of the Foodborne Outbreak Manual

INVASIVE *HAEMOPHILUS INFLUENZA TYPE B*, DISEASE CONTACT

Background

Before the introduction of effective vaccines, *Haemophilus influenzae* type b (Hib) was the leading cause of bacterial meningitis in the United States among children younger than 5 years old. Widespread use of Hib conjugate vaccine has virtually eliminated invasive Hib disease in the United States and other countries where vaccination is routine. Hib is spread by direct contact with a patient's oral secretions. Hib can be spread by people who have the bacteria in their noses or throats but who do not show symptoms. The incubation period is unknown.

SUBJECTIVE

Referred to Health Department with history of recent (within 1 week) contact to confirmed case of invasive *Haemophilus influenzae* type B disease and other resources for patient to purchase medication is not available

OBJECTIVE

Chemoprophylaxis with Rifampin Recommended

For all household contacts in the following circumstances:

- Household with at least 1 contact younger than 4 years of age who is unimmunized or incompletely immunized

- Household with a child younger than 12 months of age who has not completed the primary Hib vaccine series

- Household with a contact who is an immunocompromised child, regardless of that child's Hib immunization status

For preschool and childcare center contacts when 2 or more cases of Hib invasive disease have occurred within 60 days

For the index patient, if younger than 2 years of age, or a member of a household with a susceptible contact and treated with a regimen other than cefotaxime or ceftriaxone.

Consult with Regional Health Officer as needed for further identification/clarification of contacts needing chemoprophylaxis

Chemoprophylaxis Not Recommended

For occupants of households with no children younger than 4 years of age other than the index patient

For occupants of households where all household contacts 12 through 48 months of age have completed their Hib immunization series and when household contacts younger than 12 months of age have completed their primary series of Hib immunization

For preschool or childcare contacts of one index case

For pregnant women

Observe for symptoms of fever, malaise, nausea, vomiting, severe headache, increased sensitivity to light, altered mental status or confusion.

IF SYMPTOMATIC DO NOT PROVIDE PROPHYLAXIS, REFER IMMEDIATELY FOR DEFINITIVE DIAGNOSIS AND TREATMENT

ASSESSMENT

Provide chemoprophylaxis and immunization as indicated

PLAN

Rifampin is the drug of choice for chemoprophylaxis

Obtain order from physician to dispense Rifampin (for individual with no known allergy to Rifampin)

Obtain Rifampin from regional pharmacy; ask regional pharmacist to re-package tablets for adults and mix suspension for children; if necessary, Rifampin may be provided to a local pharmacist for re-packaging

Rifampin Dosage:

Adults: 600 mg/day (single dose) x 4 days, by mouth

Children (1 month-12 years): 20 mg/kg/day (single dose) x 4 days,
not to exceed 600 mg per dose, by mouth

Infants (less than 1 month): 10 mg/kg/day (single dose) x 4 days, by mouth

Instruct patient regarding medication side effects and contraindications

Immunization

Children in the household and younger than age 5 years who are incompletely immunized against Hib disease according to the Hib immunization schedule should be administered a dose of Hib-containing vaccine and, if necessary, educated to return for the next dose when due. A single dose of Hib vaccine completes the series for any child age 15 months through 59 months.

Health Teaching

Advise barrier method (foam and condoms) for oral contraceptives

Advise contact lens wearers that tears will be orange and stain contacts; urine may be orange

Notify Regional Health Officer, Communicable Disease Director and Nursing Supervisor

Referral Indicators:

Symptomatic for meningitis

Unable to tolerate, or allergy to, Rifampin

REFERENCES

CDC. Meningitis – Bacterial

www.cdc.gov/meningitis/bacterial

American Academy of Pediatrics. Haemophilus influenzae infections. In: Pickering, LK, Baker CJ, Kimberlin DW, Long SS, eds. *Red Book: 2012 Report of the Committee on Infectious Diseases*. Elk Grove Village, IL: American Academy of Pediatrics; 2012:345-352.

Epidemiology and Prevention of Vaccine-Preventable Diseases, Department of Health and Human Services, Centers for Disease Control and Prevention, 12th Edition, May 2011

Manual for Surveillance of Vaccine-Preventable Diseases, Centers for Disease Control and Prevention, 5th Edition, 2012

Yeh, S. Prevention of Haemophilus influenza infection. In: UpToDate, Torchia, M (Ed), Waltham, MA, 2013

HEPATITIS A, CASE OR PRESUMPTIVE

BACKGROUND

Hepatitis A virus (HAV) is acquired primarily by mouth through fecal-oral transmission by either person-to-person contact or ingestion of contaminated food or water. Humans are the only natural reservoir of the virus. The incubation period is approximately 28 days with a range of 15-50 days. Blood test for HAV infection becomes positive about 5 days before symptoms appear and remains positive for about 6 months after infection. Once infected with hepatitis A virus, it is not possible to become infected again.

SUBJECTIVE

Initial symptoms of hepatitis A usually include:

| | |
|--|--------------------------------------|
| Fatigue | Malaise |
| Nausea | vomiting |
| Lack of appetite | Fever (greater than 100.4°F or 38°C) |
| Abdominal pain (right side under the ribs) | |

Other symptoms that may develop as illness progresses:

| | |
|------------|----------------------|
| Jaundice | Dark colored urine |
| Itchy skin | Light colored stools |

OBJECTIVE

Viral shedding persists for 1 to 3 weeks. Infected persons are most likely to transmit HAV 1 to 2 weeks before the onset of illness, up to 1 week after illness onset.

Symptoms usually last less than 2 months, although 10%–15% of symptomatic persons have prolonged or relapsing disease for up to 6 months.

Management should be considered for:

Hepatitis A confirmed by laboratory (note: hepatitis A IgM testing is not recommended for patients without symptoms of acute hepatitis illness due to the risk of false positive hepatitis A IgM test results).

If hepatitis A is strongly suspected

Epidemiological contact to confirmed case of Hepatitis A

Groups at increased risk for Hepatitis A or its complications include:

International travelers

Men who have sex with men

Users of injection and non-injection illegal drugs

Persons with clotting factor disorders

Persons working with nonhuman primates susceptible to HAV infection

ASSESSMENT

There is no specific treatment for hepatitis A virus infection. Treatment and management are supportive.

PLAN

Institute fecal-oral precautions

Determine if post-exposure prophylaxis is indicated (refer to PHN Protocol 3.220 Hepatitis A Post-exposure).

Hepatitis A is a reportable condition under Tennessee Reportable Disease Regulations. Notify nursing supervisor and communicable disease investigator; complete appropriate case investigation forms

Notify environmentalist if food or water borne transmission is suspected

Refer to the Summary Chart of U.S. Medical Eligibility Criteria for Contraceptive Use PHN Protocol 2.170 for contraceptive management during an acute illness,

Health Teaching

Instruct on proper hand washing techniques. Advise to wash for 15 to 20 seconds using antimicrobial soap and water. Rinse well and dry hands on a SINGLE USE TOWEL.

Hands should be washed before and after preparing food and eating, after going to the bathroom(or changing a diaper) and/or handling garbage, dirty laundry or any soiled item.

Wash raw fruits and vegetables thoroughly before eating

REFERENCES

CDC. Hepatitis A Information for Health Professionals, Centers for Disease Control and Prevention, Division of Viral Hepatitis, August 2011

<http://www.cdc.gov/hepatitis/HA/HAfaq.htm>

Cheney, CP, Patient Information: Hepatitis A (Beyond the Basics), In: UptoDate, Baron, EB(Ed.) Waltham, MA, 2013

Epidemiology and Prevention of Vaccine Preventable Diseases, Department of Health and Human Services, Centers for Disease Control and Prevention 12th Edition, May 2011

Ferri, FF. (2010), Ferri's Clinical Advisor, Philadelphia, PA: Mosby Elsevier

HEPATITIS A, POSTEXPOSURE

GENERAL INFORMATION

Hepatitis A virus (HAV) symptoms may appear two to seven weeks after exposure to the infected source, but usually occur about four weeks after exposure. However, people who have been infected are contagious from about two weeks before the symptoms appear and continue to be contagious for about one week after the onset of jaundice. After they recover from HAV they are immune to it for life and do not continue to carry the virus.

The recommendations for the use of hepatitis A vaccine after exposure to HAV have changed. People who recently have been exposed to HAV and who previously have not had hepatitis A vaccine should be given a single dose of hepatitis A vaccine (not the combination vaccine) **or** immune globulin (IG) as soon as possible and within 14 days of the last exposure. The effectiveness of postexposure prophylaxis declines over time. Decisions to use vaccine or IG should take into account which of them is readily available and patient characteristics associated with more severe manifestations of hepatitis A, including older age and chronic liver disease.

Federally funded vaccine and IG may be used for PEP. Federally funded vaccine is not available for second doses of vaccine unless the recipient would otherwise be provided the second dose as part of the routine hepatitis A immunization protocol.

Hepatitis A vaccine is preferred for:

Most people age 12 months through 40 years of age (exceptions below)

IG is preferred for:

People over 40 years of age (hepatitis A vaccine can be used if IG is unavailable)

Children younger than 12 months of age

Immunocompromised persons

Persons who have diagnosed chronic liver disease

Persons for whom vaccine is contraindicated

Contact to a known or suspected hepatitis A case is defined as follows:

Close personal contact (with not more than 14 days since last exposure to infectious case):

Household and sexual contacts

Persons who have shared illicit drugs

Close family and playmates

Ongoing personal contact (e.g., regular babysitting)

Daycare contact (with not more than 14 days since exposure)

Hepatitis A vaccine or IG should be administered to all previously unvaccinated staff members and attendees of child care centers or homes if:

1) one or more cases of hepatitis A are recognized in children or employees

OR

2) cases are recognized in two or more households of center attendees

In centers that do not provide care to children who wear diapers, hepatitis A vaccine or IG need be administered only to classroom contacts of the index patient.

When an outbreak occurs (i.e., hepatitis A cases in three or more families), hepatitis A vaccine or IG also should be considered for members of households that have children (center attendees) in diapers.

Common-source exposure

If case is a **food handler**, hepatitis A vaccine or IG should be given to other food handlers in the same establishment (if not more than 14 days since exposure)
- consult with communicable disease director and regional health officer before acting.

Recommended for patrons if

- 1) during the time when the food handler was likely to be infectious, the food handler both directly handled uncooked or cooked foods and had diarrhea or poor hygienic practices, **AND**
- 2) patrons can be identified and treated ≤ 2 weeks after the exposure. In settings in which repeated exposures to HAV might have occurred (e.g., institutional cafeterias), stronger consideration of hepatitis A vaccine or IG use could be warranted.

Schools, hospitals, and work settings

Hepatitis A postexposure prophylaxis is not routinely indicated when a single case occurs in an elementary or secondary school or an office or other work setting, and the source of infection is outside the school or work setting. Also, when a person who has hepatitis A is admitted to a hospital, staff members should not routinely be administered hepatitis A postexposure prophylaxis; instead, careful hygienic practices should be emphasized. Hepatitis A vaccine or IG should be administered to persons who have close contact with index patients if an epidemiologic investigation indicates HAV transmission has occurred among students in a school or among patients or between patients and staff members in a hospital.

PLAN

Report all know cases and suspects to the Communicable Disease Representative

For persons exposed to HAV within the past 14 days and who previously have not received hepatitis A vaccine, administer appropriate postexposure prophylaxis, according to guidelines above: **either**

a single dose of single-antigen vaccine (refer to the Hepatitis A Vaccine protocol for dosage and administration)

or IG (0.02mL/kg)

as soon as possible (and **only** within 14 days of exposure); see Dosage for IG Prophylaxis Chart.

The Tennessee Department of Health provides post-exposure prophylaxis with vaccine or immune globulin for contacts to hepatitis A cases who meet listed criteria

If using immune globulin, obtain order from public health or private physician to administer immune globulin

Delay administration of live virus vaccine(s) for at least 3 months after IG administration

If immune globulin is given within 14 days after a live virus vaccine has been given, the live virus vaccine should be repeated in 3 months

If immune globulin has been given in the previous 3 months, consult communicable disease director or public health physician prior to repeating

If the preferred postexposure prophylaxis (immune globulin or vaccine) for a particular patient is not readily available, but the alternative product is, consult with a public health physician or communicable disease director to determine acceptability of administering the alternative product.

Health Teaching:

Household and close contacts

Fecal/oral precautions

Wash hands after elimination, and before preparing food and eating; keep nails short

Daycare Facilities

Prompt and proper diaper changing

Proper disposal of diapers and disinfection of changing area

Hand washing after elimination, diaper changing, before eating, before food preparation

Disinfection of toys and play equipment in areas with diagnosed children

Educate that all children 12 months and up are now recommended to be vaccinated routinely against hepatitis A

Food Service Facilities

Environmental inspection and emphasis on personal hygiene, hand washing and sanitation

Remove food handler with diarrhea from direct food handling duties

Management to notify health department if secondary cases indicated in food handlers (fever, malaise, anorexia, abdominal pain, or nausea)

Contact health provider immediately if symptoms develop in coinfecting cases (similar time frame) or in secondary cases (within six weeks)

Follow-up

If hepatitis A vaccine is initiated for postexposure, instruct patient that they may obtain a second dose after 6 months or longer to complete the series for lifelong immunity. The second dose of vaccine is not necessary for post-exposure prophylaxis and is not provided by the health department to persons for whom the health department would not otherwise provide hepatitis A vaccine.

Referral Indicators:

Symptomatic for hepatitis A

REFERENCES

MMWR, Update: Prevention of Hepatitis A After Exposure to Hepatitis A...., October 19, 2007 /56 (41); 1080-1084

Red Book, 27th Edition 2006

“Federally Funded Vaccines for Adults” memo from Dr. Kelly Moore and Dr. Tom Jaselskis, July 8, 2009

DOSAGE OF IMMUNE GLOBULIN (IG) FOR PROPHYLAXIS OF HEPATITIS A**Dosage is 0.02 ml of IG/kg**

1 kg = 2.2 lbs

| <u>Weight</u> | <u>Immune Globulin</u> |
|---------------|------------------------|
| 11 lbs..... | .1 ml |
| 22 lbs..... | .2 ml |
| 33 lbs..... | .3 ml |
| 44 lbs..... | .4 ml |
| 55 lbs..... | .5 ml |
| 66 lbs..... | .6 ml |
| 77 lbs..... | .7 ml |
| 88 lbs..... | .8 ml |
| 99 lbs..... | .9 ml |
| 110 lbs..... | 1.0 ml |
| 121 lbs..... | 1.1 ml |
| 132 lbs..... | 1.2 ml |
| 143 lbs..... | 1.3 ml |
| 154 lbs..... | 1.4 ml |
| 165 lbs..... | 1.5 ml |
| 176 lbs..... | 1.6 ml |
| 187 lbs..... | 1.7 ml |
| 198 lbs..... | 1.8 ml |
| 209 lbs..... | 1.9 ml |
| 220 lbs..... | 2.0 ml |
| 231 lbs..... | 2.1 ml |
| 242 lbs..... | 2.2 ml |
| 253 lbs..... | 2.3 ml |
| 264 lbs..... | 2.4 ml |
| 275 lbs..... | 2.5 ml |

HERPES SIMPLEX TYPE I (Fever Blister)

SUBJECTIVE

Singular or grouped blisters around mouth (cold sores, fever blisters)
Sores may be preceded by irritation, a tingling sensation or burning at affected site and may appear following exposure to sun or tanning bed, and at times of stress

OBJECTIVE

Vesicular eruption and ulceration of mucous membranes of the lips, mouth and/or face
Initial case may have fever [Fever may reach 40-40.6°C (104-105°F)]
Tender, enlarged lymph nodes (submandibular, submaxillary)
Increased salivation, halitosis, and anorexia

ASSESSMENT

Herpes Simplex (Fever Blister)

PLAN

Inform that disease is usually self-limiting, lasting 1-2 weeks
Important to ensure adequate fluid intake (avoid acidic drinks)
Advise regarding temporary relief:
 Application of ice cube (1 hour duration) when lesions first suspected or within 24 hours of appearance may promote rapid healing
 Acetaminophen for fever or pain with generalized primary infection
 Local analgesics prior to feedings
 Local drying agents, i.e., Blistex, 3-4 times daily

Health Teaching:

Antibody studies indicate over 85% of all adults have had this exposure
Teach proper hand washing technique
Educate that recurrent infection may be reactivated by overexposure to heat (sunlight, ultraviolet light) or cold, emotional stress, fever, trauma, or menses; often returns in same location
Advise use of lip moisturizer containing sun screen
Advise to avoid kissing when lesion present
Encourage additional rest

Referral Indicators:

Newborn infants, severely malnourished infants or children, immunosuppressed patients, or in association with another disease (i.e., measles)
Generalized eruption or extensive mucosal involvement
Ocular or genital lesions
Secondary bacterial infection
Suspected dehydration

Signs of neurologic manifestation (i.e., headache, vomiting, photophobia, convulsions, or neurologic findings)

Follow-Up:

Contact health provider if blister not improving in 72 hours; may need reassessment for hydration status
Antiviral antibiotics can be effective if started early.

Reference:

Mayo Clinic, Guide To Self-Care, Fifth Edition 2006
Ferri's Clinical Advisor 2008

HERPETIC STOMATITIS (Gingivostomatitis)

SUBJECTIVE

Sores in mouth

Sudden onset of pain in mouth, drooling, bad breath, refusal to eat, and fever

Sores may be preceded by fever and irritability by 1-2 days

OBJECTIVE

Vesicular eruption and ulceration of gingival and oral mucosa

Fever may reach 40-40.6°C (104-105°F)

Tender, enlarged lymph nodes (submandibular, submaxillary)

Increased salivation, halitosis, and anorexia

Signs of dehydration

ASSESSMENT

Herpetic Stomatitis (usually Herpes Simplex type 1)

PLAN

Inform that disease is self-limiting, lasting 4-10 days

Important to ensure adequate fluid intake (avoid acidic drinks; offer children popsicles)

Acetaminophen for fever or pain Local analgesics prior to feedings

Teach proper hand washing technique

Health Teaching:

Avoid kissing when lesions are present

Referral Indicators:

Infants less than 2 months, severely malnourished infants or children, immunosuppressed patients, or in association with another disease (e.g. measles)

Secondary bacterial infection (i.e., suspected strep)

Suspected dehydration (i.e., no urinary output in 12 hours)

Signs of neurological manifestation (i.e., headache, vomiting, photophobia, convulsions or neurological findings)

Persistence or non-healing over 2 weeks

Follow-Up:

Patient/parent will be asked to contact health provider if the condition is not improving in 48-72 hours

Reference:

Ferri's Clinical Advisor 2008

STY (HORDEOLUM)

SUBJECTIVE

Tenderness at site of infection
Tearing

OBJECTIVE

Redness, swelling, and small, hard, red boil at base of eyelash

ASSESSMENT

Hordeolum (Sty)

PLAN

Advise warm, moist (water) compresses 5-15 minutes, 3-4 times daily

Health Teaching:

Instruct patient to keep hands away from eyes and wash hands after touching eyes
Systemic Antibiotics generally not necessary

Referral Indicators:

More than one sty
Redness of sclera
Exudate or swelling
Increasing redness of the eyelid margin
Marked pain
Discharge

Follow-Up:

Patient/parent will be asked to contact health provider if no improvement in 3-4 days

Reference:

Mayo Clinic, Guide To Self-Care, Fifth Edition. 2006
Ferri's Clinical Advisor, 2006

IMPETIGO/BULLOUS IMPETIGO

SUBJECTIVE

Often history of trauma, i.e., insect bites, abrasions or chronically wet skin from muggy weather or hot clothes (diapers), eczema or chickenpox
It can be spread by touch and by shared objects such as towels.
Sores that do not heal or are spreading
May complain of itching
Dysuria

OBJECTIVE

Impetigo: Seropurulent vesicles surrounded by an erythematous base; may be honey-colored crust present, especially around nose and mouth

Bullous Impetigo: Seropurulent or ruptured vesicles often on extremities; lesions vary in size; these lesions can form on face, trunk, limbs and diaper area

Blood pressure
Proteinuria
Swollen glands

ASSESSMENT

Impetigo or Bullous Impetigo

PLAN

Check blood pressure
Do urine dipstick for protein
Soak and then gently scrub lesions with warm water and antibacterial soap 2-3 times a day to soften and remove crusts
Apply thin coat of topical OTC antibacterial ointment (e.g., Bacitracin, Neosporin, Neomycin or generic equivalent) to affected area after each cleansing TID or QID

Teaching

Trim and clean fingernails to prevent spread of infection and teach children not to scratch
Counsel on treatment of other family members/contacts if applicable; impetigo is highly contagious. It can be spread by touch and by shared objects such as towels.
Don't share towels or clothing
Provide advice on school attendance
When cuts and scrapes occur, wash then with antibacterial soap and a dab of OTC ointment such as Neosporin

Referral Indicators:

- Three or more lesions greater than 1/2 inch in diameter
- Little or no response to treatment within 3 days
- Impetigo in conjunction with acute or chronic illness
- Any systemic symptoms, i.e., fever, regional adenopathy
- Signs or symptoms of complications, i.e., glomerulonephritis (dark colored urine, decreased urinary output, edema)
- Eye involvement or close to eye
- Hypertension
- Proteinuria
- Widely spaced lesions, such as face and buttocks (may need systemic treatment)

Follow-Up:

Patient/parent will be asked to contact health provider in 48-72 hours

Reference:

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

LEAD TOXICITY SCREENING

GENERAL INFORMATION

Children from 6 to 72 months may be at risk for lead poisoning (lead poisoning can affect any child regardless of race, economic status, or living conditions)

Children under the age of 6, living in older homes, and living in poverty have the highest risk for lead poisoning

Sources of lead exposure include:

- Housing built prior to 1978 with old chipping paint, lead water pipes, or lead soldered pipes
- Recently renovated home or frequently visited house/building built before 1978
- Close proximity (80 ft) to a heavily traveled highway (leaded gasoline) or near industrial site
- Work or hobbies involving paint, chemicals, battery, mining, lead smelting, leaded glass, lead sinkers, and lead glazed pottery
- Pewter or leaded crystal containers for storing, cooking, or eating food/drink
- Plastic or vinyl mini blinds, (purchased prior to 1996)
- Folk medicine such as Mexican, Asian, and Middle Eastern
- Sibling, housemate, frequent visitor, playmates of children with known lead toxicity

Effects of lead toxicity include:

- Very severe lead exposure in children can cause coma, convulsions, and even death
- Lower levels can affect the central nervous system and kidneys
- Very low levels are associated with decreased intelligence, behavior problems, decreased growth, and hearing difficulties

SUBJECTIVE

Have parent/guardian complete the **Blood Lead Risk Assessment Questionnaire** (see Table 1). Document all positive risk factors in the medical record. If the parent/guardian answers “yes” or “don’t know” to any of the questions, the child is considered to be at **high risk** and should be **screened with a finger stick BLL at that time.**

OBJECTIVE

Obtain a finger stick blood lead level at well child visit on all children **12 months and 24 months of age**

Obtain a finger stick blood lead level at well child visit on **children 36 to 72 months of age** **Who do not have a previously documented blood test**

Confirm all elevated blood lead levels (5 µg/dL or greater) using venous blood sampling in accordance with the **Recommended Schedule for a Confirmatory Venous Sample** (see Table 2)

Obtain a finger stick blood lead level for siblings (6-72 months of age) of children with a confirmed elevated blood lead level, and consult with parents regarding the need to test other frequent playmates, pregnant household members, and others

Consult parent(s) or caretaker regarding results and need for follow-up (document any parent/guardian refusal)

Comprehensive follow-up services must be based on the child's confirmed Blood Lead Level (BLL) and managed according to **Schedule for Follow-up Blood Lead Testing** (see Table 3)

ASSESSMENT

All children with a confirmed **BLL ≥ 5 $\mu\text{g}/\text{dL}$** should receive comprehensive follow-up services based on the confirmed Blood Lead Level(BLL) and managed according to **Schedule for Follow-up Blood Lead Testing** (see Table 3)

PLAN

Provide comprehensive follow-up services for confirmed **BLL ≥ 5 $\mu\text{g}/\text{dL}$** according to **Schedule for Follow-up Blood Lead Testing** (see Table 3)

Stress need for appropriate follow-up, testing, treatment, and intervention

Repeat blood lead level (BLL) according to guidelines

If developmentally delayed, refer to appropriate programs

Health Teaching (for confirmed cases of lead exposure of 5 $\mu\text{g}/\text{dL}$ or greater)

Provide anticipatory guidance during pregnancy, when children are 3-6 months of age, and again when they are 12 months of age (parental guidance during this time frame might prevent some lead exposure)

Provide lead poisoning prevention counseling to all children receiving child health exams

Educate about the effects/problems of lead poisoning, important sources of lead (be alert to parental occupations/hobbies), and discuss ways to prevent access to causative agents

Stress hand washing (especially before eating), showering, proper handling of soiled clothes, and frequent washing of toys and pacifiers

Educate about soil contaminated with lead (if soil near house is contaminated because of lead-based paint or near major highway, advise to plant shrubs near house to decrease play activity in that area)

Educate about miniblinds and possible lead contamination

Provide nutritional counseling regarding the need for 3 small meals and 3 snacks a day with adequate iron and calcium (iron deficiency can enhance lead absorption and empty stomach increases lead absorption)

Stress need to clean floors, window frames, windowsills, and other surfaces at least weekly with warm water and a general all-purpose cleaner or a cleaner made specifically for lead

Discuss the ineffectiveness of dry methods of cleaning, such as sweeping or vacuuming (unless a Hepavac is used) for lead removal

If drinking water has increased lead, use only fully flushed water (let water run one to two minutes) from cold-water tap for cooking, drinking, and making formula (encourage breast-feeding)

For cooking preparation and storage, use pottery that is labeled safe for cooking and/or storing food, and do not store food in open cans

Table 1: BLOOD LEAD RISK ASSESSMENT QUESTIONNAIRE

| |
|--|
| <p>Mandatory Questions:</p> <p>Does your child live in or regularly visit a house built before 1950? (This could include a day care center, home of a baby sitter, or a relative.)</p> <p>Does your child live in or regularly visit a house built before 1978 with recent, ongoing, or planned renovations or remodeling (within the past 6 months)?</p> <p>Does your child have a sibling or a playmate that has, or did have, lead poisoning?</p> |
| <p>Optional Questions (may be asked at the provider's discretion):</p> <p>Does your child frequently come in contact with an adult who works with lead? (Examples include construction, welding, pottery, etc.)</p> <p>Does your home contain any plastic or vinyl mini blinds made before July 1996?</p> <p>Have you ever been told that your child has low iron?</p> <p>Have you seen your child eating paint chips, crayons, soil, or dirt?</p> <p>Does your child live near or visit with someone who lives near a lead smelter, battery recycling plant or other industry that could release lead?</p> <p>Do you give your child any home or folk remedies that may contain lead? (such as moonshine, Azarcon, Greta, Paylooah)</p> <p>Does your child live within 80 feet (or one block) of areas with a constant flow of traffic, such as busy intersections and streets, highways and interstates? (The soil near heavily used streets and roads may contain lead as a result of past use of lead in gasoline; automobile exhaust from past leaded gasoline contributes to both air and soil lead pollution)</p> <p>Does your home's plumbing have lead pipes or copper pipes with lead solder joints?</p> <p>Does your family use pottery ware or leaded crystal for cooking, eating, or drinking?</p> |

Table 2: RECOMMENDED SCHEDULE FOR A CONFIRMATORY VENOUS SAMPLE

| Screening test result ($\mu\text{g}/\text{dL}$) | Time to confirmation testing: |
|---|-------------------------------|
| 5-9 | 1-3 months |
| 10-44 | 1 week - 1 month* |
| 45-59 | 48 hours |
| 60-69 | 24 hours |
| ≥ 70 | Urgently as emergency test |

* The higher the BLL on the screening test, the more urgent the need for confirmatory testing

Table 3: SCHEDULE FOR FOLLOW-UP BLOOD LEAD TESTING^a

Medical management includes follow-up blood lead testing. The following table (Table 3) presents the suggested frequency of follow-up tests and should be used as guidance. Case managers and PCPs should consider individual patient characteristics and caregiver capabilities and adjust the frequency of follow-up tests accordingly.

| Venous Blood Lead Level ($\mu\text{g}/\text{dL}$) | Early Follow-Up (first 2-4 tests after identification) | Late Follow-Up (after BLL begins to decline) |
|---|---|---|
| 5-9 | 3 months ^b | 6-9 months |
| 10-19 | 1-3 months ^b | 3-6 months |
| 20-24 | 1-3 months ^b | 1-3 months |
| 25-44 | 2 weeks-1 month | 1 month |
| ≥ 45 | As soon as possible | As soon as possible |

^a Seasonal variation of BLLs exists and may be more apparent in colder climate areas. Greater exposure in the summer months may necessitate more frequent follow-ups.

^b Some case managers or PCPs may choose to repeat blood lead tests on all new patients within a month to ensure that their BLL is not rising more quickly than anticipated.

Table 4: SUMMARY OF RECOMMENDED ACTIONS FOR CHILDREN BASED ON BLOOD LEAD LEVEL($\mu\text{g}/\text{dL}$) VALUES

| <5 | 5 - 44 | 45 – 69 | ≥ 70 |
|---|--|---|---|
| Lead education* -Dietary -Environmental | Lead education* -Dietary -Environmental | Lead education* -Dietary -Environmental | Hospitalize and commence chelation therapy (following confirmatory venous blood lead test) in conjunction with consultation from a medical toxicologist or a pediatric environmental health specialty unit. |
| Environmental assessment for pre-1978 housing | Follow-up blood lead monitoring (see guidelines) | Follow-up blood lead monitoring (see guidelines) | |
| Follow-up blood lead monitoring | Complete history and physical exam Lab work: -Iron status -Consider hemoglobin or hematocrit Environmental investigation** (BLL's ≥ 20 or persistently elevated levels) Lead hazard reduction Neurodevelopmental monitoring Abdominal X-ray (if particulate lead ingestion is suspected) with bowel decontamination if indicated | Complete history and physical exam Lab work: - Iron Status -Hemoglobin or hematocrit -Free erythrocyte protoporphyrin (FEP) Environmental investigation** Lead hazard reduction Neurodevelopmental monitoring Abdominal X-ray (if particulate lead ingestion is suspected) with bowel decontamination if indicated Oral Chelation therapy Consider hospitalization if lead-safe environment cannot be assured | Proceed according to actions for 45-69 $\mu\text{g}/\text{dL}$ |

*<http://pediatrics.aappublications.org/content/116/4/1036.full.pdf>

**Environmental investigations are requested by a Childhood Lead Prevention Nurse at the Central office .

If the child lives in Section 8 housing and has an elevated blood lead level, the Tennessee Housing Development Agency will be notified for environmental investigation, assessment, and correction of the problem. For certified inspection, assessment, and abatement firms in the area, call the Lead Line at 1-888-771-5323.

The following actions are **NOT** recommended at any blood lead level:

- Searching for gingival lead lines
- Testing of neurophysiologic function
- Evaluation of renal function
(except during chelation with EDTA)
- Testing of hair, teeth, or fingernails for lead
- Radiographic imaging of long bones
- X-ray fluorescence of long bones

REFERENCES

“Recommendations for Blood Lead Screening of Young Children Enrolled in Medicaid: Targeting a Group at High Risk”, MMR, December 8, 2000
Centers for Disease Control and Prevention. Managing Elevated Blood Lead Levels Among Young Children: Recommendations from the Advisory Committee on Childhood Lead Poisoning Prevention. Atlanta: CDC; 2002
http://www.cdc.gov/nceh/lead/ACCLPP/Final_Document_030712.pdf

MENINGOCOCCAL DISEASE (Case)

BACKGROUND

Meningococcal disease is an acute, severe illness caused by the bacterium *Neisseria meningitidis*. *Neisseria meningitidis* is rare, but is the leading cause of bacterial meningitis and is considered a medical emergency. About 1,000 cases occur in the U.S. each year. Meningococcal disease is spread person to person through exchange of respiratory and throat secretions such as coughing, kissing or sharing eating utensils. Household contacts living with a case in the week before illness onset are at the greatest risk of illness. The incubation period of meningococcal disease is 3–4 days, with a range of 2–10 days.

SUBJECTIVE

Meningococcal disease is a reportable condition under Tennessee Reportable Disease Regulations. Meningococcal disease may be reported to the health department by physician, physician's office or hospital
Meningococcal meningitis due to *Neisseria meningitidis* confirmed by laboratory results

OBJECTIVE

Symptoms include sudden onset of fever, headache, stiff neck often accompanied by nausea, vomiting, sensitivity to light and altered mental status. A non-blanching, red purpuric rash may be present on the skin.

PLAN

Determine if chemoprophylaxis is indicated for contacts. Consult Regional Medical Director and Regional Communicable Disease Director

Educate patients that all exposed close contacts who develop febrile illness should **receive prompt medical evaluation.**

Notify nursing supervisor

Complete Case Report in the National Electronic Disease Surveillance system (NEDSS).

REFERENCES

Immunization Action Coalition, Meningococcal: Questions and Answers Information about the disease and vaccines, March 2012

<http://www.immunize.org/catg.d/p4210.pdf>

CDC. Meningococcal Disease

www.cdc.gov/meningococcal/about/symptoms.html

Kaplan SL, & Pentima CD. Meningitis in Children Beyond the Basics, In: UpToDate, Torchia, MM (Ed), Waltham, MA, 2013

MENINGOCOCCAL, INVASIVE DISEASE, Contact

BACKGROUND

Invasive infections with *Neisseria meningitidis* may present as meningococemia (an infection of the bloodstream), meningococcal meningitis (inflammation of the protective membranes that cover the brain and spinal cord), or both. Invasive meningococcal disease is rare (about 1,000 cases occur in the United States each year) and serious. About 10% of cases die. Among survivors, 11-20% suffer neurologic damage or loss of limbs. Invasive meningococcal disease is spread person to person through exchange of respiratory and throat secretions such as coughing, kissing or sharing eating utensils. The incubation period of meningococcal disease is 1-10 days, usually less than 4 days. Meningococcal vaccines cannot prevent all cases of meningococcal disease and is not a factor in decisions concerning chemoprophylaxis of contacts.

SUBJECTIVE

Referred to Health Department with history of exposure to confirmed case of invasive meningococcal disease within 7 days of onset of disease in the index case and less than 2 weeks after exposure and other resources not available for patient to purchase medication.

OBJECTIVE

Chemoprophylaxis recommended (high risk)

Chemoprophylaxis is indicated for the following close contacts, ideally within 24 hours of diagnosis of *Neisseria meningitidis* invasive disease in the index case, but *not* more than 2 weeks after exposure.

- Household members, roommates, intimate contacts in the 7 days prior to disease onset
- Child care or preschool contacts any time during 7 days before onset of illness
- Direct exposure to index patient's oral secretions through kissing or through sharing toothbrushes, cigarettes, drinks or eating utensils, markers of close social contact, at any time during 7 days before onset of illness.
- Mouth-to-mouth resuscitation, *unprotected* endotracheal intubation or endotracheal tube management during 7 days before onset of illness
- People who frequently slept in the same dwelling as index patient during 7 days before onset of illness
- Passengers seated directly next to the index patient during airline flights lasting more than 8 hours

Consult with Regional Health Officer as needed for further identification/clarification of contacts needing chemoprophylaxis

Observe for symptoms of fever, malaise, nausea, vomiting, severe headache, increase sensitivity to light, altered mental status or confusion

IF SYMPTOMATIC, DO NOT PROVIDE PROPHYLAXIS, REFER IMMEDIATELY FOR DEFINITIVE DIAGNOSIS AND TREATMENT

ASSESSMENT

Provide chemoprophylaxis as indicated

PLAN

Obtain order from health care provider to dispense Rifampin (no known allergy to Rifampin)

Obtain Rifampin from regional pharmacy; ask regional pharmacist to repackage tablets for adults and mix suspension for children

Rifampin: **Adults:** 600 mg every 12 hours x 2 days
 Children: (1 month-12 years) 10 mg/kg/dose every 12 hours x 2 days not to exceed 600 mg/dose
 Infants: (less than 1 month) 5 mg/kg/dose every 12 hours x 2 days

Ciprofloxacin: 500 mg STAT dose may be dispensed or prescribed as an alternate treatment for persons **over age 18** years

Health Teaching

Counsel patient that chemoprophylaxis is not 100% protective, review the signs and symptoms of meningococcal disease (sudden onset of fever, chills, malaise, muscle pain or a rash), advise to seek immediate medical attention should these signs develop.

Instruct patient regarding side effects and contraindications of chemoprophylaxis

Advise barrier method (foam, film or condoms) for oral contraceptive clients

Advise that tears will be orange and stain contacts lenses; urine may be orange

Notify regional health officer, communicable disease director and nursing supervisor

Should check to see that index case received Rifampin post treatment to eradicate upper respiratory tract colonization of organism

Referral Indicators:

Symptomatic for meningitis

Unable to tolerate Rifampin

REFERENCES

American Academy of Pediatrics. Meningococcal infections. In: Pickering, LK, Baker CJ, Kimberlin DW, Long SS, eds. *Red Book: 2012 Report of the Committee on Infectious Diseases*. Elk Grove Village, IL: American Academy of Pediatrics; 2012:500-509.

CDC. Meningococcal Disease

www.cdc.gov/meningococcal/about/symptoms.html

Epidemiology and Prevention of Vaccine-Preventable Diseases, Department of Health and Human Services, Centers for Disease Control and Prevention, 12th Edition, May 2011

Immunization Action Coalition, Meningococcal: Questions and Answers Information about the disease and vaccines, March 2012

<http://www.immunize.org/catg.d/p4210.pdf>

Kaplan SL, & Pentima CD. Meningitis in Children Beyond the Basics, In: UpToDate, Torchia, MM (Ed), Waltham, MA, 2013

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

MILIARIA

(Prickly Heat, Heat Rash)

SUBJECTIVE

"Little pimples" on skin

May have history of recent elevated temperature, or exposure to hot, humid temperature

OBJECTIVE

Very small vesicles without erythema (miliaria crystallina) or erythematous papules (miliaria rubra) over the chest and neck

Vesicle fluid is clear, vesicles are extremely superficial, and no inflammation is present

Lesions are usually localized to sites of occlusion or to flexural areas where skin may become macerated and eroded

Infants may be overdressed

ASSESSMENT

Miliaria (Prickly Heat)

PLAN

Avoidance of overheating

Cool patient by regulation of environmental temperature

Remove excessive clothing

Discontinue inappropriate use of topical agents (powder, ointments, lotions)

Bath with tepid water with baking soda, no soap bath

Referral Indicators:

Secondary bacterial infection

Follow-Up:

Patient/parent will be asked to contact health provider if condition worsens

Reference:

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

OBSTRUCTED NASOLACRIMAL DUCT

SUBJECTIVE

Excessive tearing
Swollen inner eyelid

OBJECTIVE

Swelling over medial aspect of upper lid extending to the nose

ASSESSMENT

Obstructed nasolacrimal duct

PLAN

Instruct parent to wash hands prior to procedure and to massage the area by applying pressure from the inner canthus of the eye down the side of the nose 3-4 times daily

Referral Indicators:

Significant redness or swelling
Intermittent swelling past 6 months of age
Purulent discharge with reddened conjunctiva or sclera

Follow-Up:

Parent will be asked to contact health provider in 5-7 days

Reference:

Uphold and Graham, Clinical Guidelines in Family Medicine, Fourth Edition 2003

ORAL CANDIDIASIS/MONILIASIS (Thrush)

SUBJECTIVE

Inability of infant to breast or bottle feed due to discomfort in mouth;
older child may complain of painful or sore mouth or tongue
White rash in mouth
Infant/child unusually fussy

OBJECTIVE

Excessive drooling
Creamy white patches of exudate found on tongue or buccal mucosa
Occasional cracking and redness of skin at corners of mouth
Exudate cannot be removed when scraped with tongue blade

ASSESSMENT

Thrush

PLAN

Nystatin oral suspension 100,000 u./ml, quantity 60 ml with the following directions:

- Place 1 cc in each side of mouth four times a day

If infant is breastfed, mothers must also be treated, even if asymptomatic;

- Give Nystatin topical cream 15 gm Rx - advise to apply to breast TID

Wipe off breast prior to breast-feeding; change bra/nursing pads daily;
avoid use of excessive soap on breasts during treatment
Sterilize bottles and pacifiers used by infant

Referral Indicators:

Baby refuses to bottle or breast feed
No response to treatment within 2-3 days
Presence of systemic involvement, such as fever

Follow-Up

Contact health provider in 48-72 hours if no improvement

Reference:

Mayo Clinic, Guide To Self-Care, Fifth Edition 2006
Ferri's Clinical Advisor 2008
Medline Plus Medical Encyclopedia (online)

PEDICULOSIS CAPITIS (Head Lice)

POLICY STATEMENT

The following policy was adopted by the Medical Services Evaluation Committee July 22, 1998:

Local school authorities have the sole authority to implement a no-nit policy in a school. However, the Tennessee Department of Health encourages school officials to consult with the Regional Health Officer and the local health department prior to implementing such a policy. Scientific evidence for or against a no-nit policy is not available. Educational efforts directed toward local medical professionals, school officials, teachers, and parents should be at the center of control measures. The Health Department feels that only in special cases should any no-nit policy be attempted, and then for a limited period of time. In these cases, the problems accompanying the implementation of the policy should be understood and reviewed with all concerned.

SUBJECTIVE

Severe itching of scalp
Bugs on head or nits (eggs) on hair
Contact with infected individual
Rule out allergies to drug components

OBJECTIVE

Light, tan, or dark eggs firmly attached to hair shaft
May see lice in hair, especially at the back of the head in occipital region
Excoriation of scalp
Enlargement of occipital and cervical nodes

ASSESSMENT

Pediculosis Capitis (head lice)

PLAN

Advise Parents Regarding Appropriate Treatment:

Issue and/or advise to treat with OTC pediculocide shampoo or crème rinse according to specific product instructions
Nits should be removed with a fine tooth comb or fingernails
Treat all family members and other close contacts

Advise Parents How to Clean the Environment:

Soak all combs and brushes in hot water for 5 – 10 minutes.

Launder all washable clothing and bed linens used within previous 48 hours with hot water (130 degrees) and detergent, and dry at high heat for at least 20 minutes; dry clean clothing that is not washable, or place items that cannot be washed, including stuffed animals, in a heavy duty plastic bag, and securely seal for 10-14 days

Vacuum carpet, furniture, and car upholstery (throw away vacuum cleaner bag); if vacuum is not available use a pediculocide spray on such areas

Advise Parents How to Prevent Spread and Re-infestation:

Report case of head lice to school, day care, camp, church, and social groups so that other children in the facility can be checked

Strategy Regarding Persistent Infestation:

Question to assess reason for continued infestation (misdiagnosis, non-compliance, new infestation); have patient describe process used

Tell me step-by-step how you used the product

Tell me step-by-step how you cleaned the environment

How did you remove the nits? (assess for adequate eyesight/lighting and use of comb and fingernail)

Retreat all household members and close contacts if live lice are noted 7-10 days after initial treatment using OTC pediculocide shampoo or crème rinse or alternatively use a non-toxic, pesticide-free product.

Repeat questions to assess correct use of product and compliance with cleaning the environment

Retreat using a different OTC pediculocide shampoo or crème rinse in accordance with package instructions, if live lice are noted 7-10 days after second treatment, (a maximum of three treatments may be advised)

Health Teaching (in accordance with “Lice Advice” in the appendices):

Instruct parents to check child’s head daily for lice (this catches head lice early and thus prevents it from spreading in school/daycare and keeps child from missing school and parents from missing work)

Teach mode of transmission and prevention of spread (e.g., headphones in school, stuffed toys, auto upholstery, car seats, sharing of hats, hair scrunches, combs, and helmets)

Teach children to avoid sharing hats, sports headgear, combs and brushes, or borrowing clothing or other personal objects

Teach use and side effects of medications, and caution against overuse

Advise that rinsing the hair with a 1:1 vinegar/water rinse before treatment may help to loosen the nits. Advise that oil treatment (e.g., vegetable oil, olive oil) may be used as a last resort or as an interim treatment if live lice are noted prior to 7 days following a traditional treatment with pediculocide shampoo or crème rinse; the family should be told that there is no guarantee that this will work and that mechanical removal of the nits should still be performed

Massage oil into the child’s head and scalp

Cover with shower cap or plastic wrap for 30 to 60 minutes

Shampoo with liquid dish detergent (will require repeated shampooing)

Remove nits

Clean environment using traditional methods

Teach mother to wear gloves if they are shampooing the child's hair and especially if she is pregnant

Teach patients to shampoo their hair in the sink to prevent over absorption of medication due to contact on other body surfaces

Advise do not use conditioner or shampoo that contains conditioner when washing hair before treatment.

Advise to avoid shampooing the hair for 2 days after treatment and then to shampoo as infrequently as possible for the next two weeks using a mild shampoo.

Referral Indicators:

Children 2 years and under, refer to specific product instructions on the package insert for age appropriate use.

Pregnant women in their first trimester, or lactating women

Secondary bacterial infection

Those with a known sensitivity to pediculocide shampoo, crème rinse or chrysanthemums/ragweed sensitized persons

Nits present in eyelashes

Repeat infestations (greater than 3)

Neurological disorders

Raw or inflamed scalp

Follow-up:

Assessment after treatment

REFERENCE

Centers for Disease Control. <http://www.cdc.gov/parasites/lice/head/treatment.html>

PERIODICITY SCHEDULE INFANCY

Recommendations for preventive health care

The mission of the Tennessee Department of Health is to protect and promote the health of Tennesseans. In order to fulfill this mission, priority must be given to services that address disease prevention, health promotion, and health education.

By way of introduction to this section, the American Academy of Pediatrics (AAP)/Bright Futures periodicity tables for Infancy, Early Childhood, Middle Childhood, and Adolescence, as well as Preventive Health Care tables for Adults 22 through 49 years, and age 50 and older have been included. These tables identify recommended periodic health screening/examinations for child and adult health. The following should be noted:

- These tables provide **general recommendations for the provision of preventive health care**. In so doing they assume that the client is healthy and with no significant problems. However, once a problem has been identified through the periodic health screening, a plan of care should be determined which accurately reflects specific patient needs.
- It should be noted that **procedures** identified in the Children's table have been divided into those that are routine (general) and those screening procedures that are recommended for high-risk populations/individuals.
- The recommendations provided for **preventive pediatric health care** are designed for the care of children who are receiving competent parenting, have no manifestations of any important health problems, and are growing and developing in satisfactory fashion. Additional visits may become necessary if circumstances suggest variations from normal.
- The following guidelines include **recommendations** for preventive services that can be provided directly through the health department as well as those that may necessitate a referral.
- A patient may enter at any point in the health care continuum. At the discretion of the nurse practitioner and/or triage nurse, each patient must be evaluated in order to **identify those services that are required related to the patient's chief complaint or preventive health care needs**. A complete health history should be taken at the first comprehensive preventive screening visit. An updated health history should be taken at each subsequent visit (which may be as simple as asking the question "Have there been any health changes since your last visit?")
- These tables can also be used as **teaching tools** in order to educate patients as to the availability of, and recommended need for, specific services, as determined by age criteria.
- Distinction should be made between a **sick visit and a well visit**. For example, if a patient seeks services for a sore throat, it may not be advisable, or feasible, to provide all the services that are recommended for that particular visit according to age. The patient should be questioned as to his/her current status regarding those recommended services, and advised as to the need to schedule an appointment whereby such recommended services can be provided.
- It must be emphasized that **documentation** as to the specific services and patient information that was provided is essential.
- Although not specifically addressed in the list of recommended services for adults, **anticipatory guidance and preventive health counseling** are vital elements of public health. Each patient visit provides a valuable opportunity for education. The nurse should make efficient use of every chance to provide preventive health counseling on such topics as proper nutrition, exercise, alcohol/drug/tobacco use, safe sex, child safety, seatbelt use, violence prevention, cancer warning signs, and recommendations for self-examination.

INFANCY PERIODICITY TABLE

| AGE ¹ | Prenatal ² | Newborn ³ | 3-5d ⁴ | By 1 mo | 2 mo | 4 mo | 6 mo | 9 mo |
|--|-----------------------|----------------------|-------------------|---------|------|------|------|------|
| HISTORY | | | | | | | | |
| Initial/Interval | • | • | • | • | • | • | • | • |
| MEASUREMENTS | | | | | | | | |
| Length/Height and Weight | | • | • | • | • | • | • | • |
| Head Circumference | | • | • | • | • | • | • | • |
| Weight for Length | | • | • | • | • | • | • | • |
| Body Mass Index ⁵ | | | | | | | | |
| Blood Pressure ⁶ | | ★ | ★ | ★ | ★ | ★ | ★ | ★ |
| SENSORY SCREENING | | | | | | | | |
| Vision | | ★ | ★ | ★ | ★ | ★ | ★ | ★ |
| Hearing | | • ⁸ | ★ | ★ | ★ | ★ | ★ | ★ |
| DEVELOPMENTAL/ BEHAVIORAL ASSESSMENT | | | | | | | | |
| Developmental Screening ⁹ | | | | | | | | • |
| Autism Screening ¹⁰ | | | | | | | | |
| Developmental Surveillance | | • | • | • | • | • | • | |
| Psychosocial/Behavioral Assessment | | • | • | • | • | • | • | |
| Alcohol & Drug Use Assessment ¹¹ | | | | | | | | |
| Depression Screening ¹² | | | | | | | | |
| PHYSICAL EXAMINATION¹³ | | • | • | • | • | • | • | • |
| PROCEDURES¹⁴ | | | | | | | | |
| Newborn Blood Screening | | ←•→ | | | | | | |
| Critical Congenital Heart Defect Screening ¹⁶ | | • | | | | | | |
| Immunization ¹⁷ | | • | • | • | • | • | • | • |
| Hematocrit or Hemoglobin ¹⁸ | | | | | | ★ | | |
| Lead Screening ¹⁹ | | | | | | | ★ | ★ |
| Tuberculosis Testing ²¹ | | | | ★ | | | ★ | ★ |
| Dyslipidemia Screening ²² | | | | | | | ★ | |
| STI/HIV Screening ²³ | | | | | | | | |
| Cervical Dysplasia Screening ²⁴ | | | | | | | | |
| ORAL HEALTH²⁵ | | | | | | | ★ | ★ |
| ANTICIPATORY GUIDANCE | • | • | • | • | • | • | • | • |

AAP Recommendations for Preventive Pediatric Health Care/Bright Futures

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EARLY CHILDHOOD PERIODICITY TABLE

| AGE ¹ | 12 mo | 15 mo | 18 mo | 24 mo | 30 mo | 3 yr | 4 yr |
|--|----------------------|-------|--------|----------------------|--------|----------------|------|
| HISTORY | | | | | | | |
| Initial/Interval | • | • | • | • | • | • | • |
| MEASUREMENTS | | | | | | | |
| Length/Height and Weight | • | • | • | • | • | • | • |
| Head Circumference | • | • | • | • | | | |
| Weight for Length | • | • | • | | | | |
| Body Mass Index ⁵ | | | | • | • | • | • |
| Blood Pressure ⁶ | ★ | ★ | ★ | ★ | ★ | • | • |
| SENSORY SCREENING | | | | | | | |
| Vision | ★ | ★ | ★ | ★ | ★ | • ⁷ | • |
| Hearing | ★ | ★ | ★ | ★ | ★ | ★ | • |
| DEVELOPMENTAL/ BEHAVIORAL ASSESSMENT | | | | | | | |
| Developmental Screening ⁹ | | | • | | • | | |
| Autism Screening ¹⁰ | | | • | • | | | |
| Developmental Surveillance | • | • | | • | • | | • |
| Psychosocial/Behavioral Assessment | • | • | • | • | • | • | • |
| Alcohol & Drug Use Assessment ¹¹ | | | | | | | |
| Depression ¹² | | | | | | | |
| PHYSICAL EXAMINATION ¹³ | • | • | • | • | • | • | • |
| PROCEDURES ¹⁴ | | | | | | | |
| Newborn Blood Screening ¹⁵ | | | | | | | |
| Critical Congenital Heart Defect Screening ¹⁶ | | | | | | | |
| Immunization ¹⁷ | • | • | • | • | • | • | • |
| Hematocrit or Hemoglobin ¹⁸ | • | ★ | ★ | ★ | ★ | ★ | ★ |
| Lead Screening ¹⁹ | • or ★ ²⁰ | | ★ | • or ★ ²⁰ | | ★ | ★ |
| Tuberculosis Testing ²¹ | ★ | | | ★ | | ★ | ★ |
| Dyslipidemia Screening ²² | | | | ★ | | | ★ |
| STI/HIV Screening ²³ | | | | | | | |
| Cervical Dysplasia Screening ²⁴ | | | | | | | |
| ORAL HEALTH ²⁵ | • or ★ | | • or ★ | • or ★ | • or ★ | • | |
| ANTICIPATORY GUIDANCE | • | • | • | • | • | • | • |

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MIDDLE CHILDHOOD PERIODICITY TABLE

| AGE ¹ | 5 yr | 6 yr | 7 yr | 8 yr | 9 yr | 10 yr |
|--|------|------|------|------|------|-------|
| HISTORY | | | | | | |
| Initial/Interval | • | • | • | • | • | • |
| MEASUREMENTS | | | | | | |
| Length/Height and Weight | • | • | • | • | • | • |
| Head Circumference | | | | | | |
| Weight for Length | | | | | | |
| Body Mass Index ⁵ | • | • | • | • | • | • |
| Blood Pressure ⁶ | • | • | • | • | • | • |
| SENSORY SCREENING | | | | | | |
| Vision | • | • | ★ | • | ★ | • |
| Hearing | • | • | ★ | • | ★ | • |
| DEVELOPMENTAL/ BEHAVIORAL ASSESSMENT | | | | | | |
| Developmental Screening ⁹ | | | | | | |
| Autism Screening ¹⁰ | | | | | | |
| Developmental Surveillance | • | • | • | • | • | • |
| Psychosocial/Behavioral Assessment | • | • | • | • | • | • |
| Alcohol & Drug Use Assessment ¹¹ | | | | | | |
| Depression ¹² | | | | | | |
| PHYSICAL EXAMINATION ¹³ | • | • | • | • | • | • |
| PROCEDURES ¹⁴ | | | | | | |
| Newborn Blood Screening ¹⁵ | | | | | | |
| Critical Congenital Heart Defect Screening ¹⁶ | | | | | | |
| Immunization ¹⁷ | • | • | • | • | • | • |
| Hematocrit or Hemoglobin ¹⁸ | ★ | ★ | ★ | ★ | ★ | ★ |
| Lead Screening ¹⁹ | ★ | ★ | ★ | ★ | ★ | ★ |
| Tuberculosis Testing ²¹ | ★ | ★ | ★ | ★ | ★ | ★ |
| Dyslipidemia Screening ²² | | ★ | | ★ | ←•→ | |
| STI/HIV Screening ²³ | | | | | | |
| Cervical Dysplasia Screening ²⁴ | | | | | | |
| ORAL HEALTH ²⁵ | | | • | | | |
| ANTICIPATORY GUIDANCE | • | • | • | | • | • |

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ADOLESCENCE PERIODICITY TABLE

| AGE ¹ | 11yr | 12yr | 13yr | 14yr | 15yr | 16yr | 17yr | 18yr | 19yr | 20yr | 21yr |
|---|------|------|------|------|------|------|------|------|------|------|------|
| HISTORY | | | | | | | | | | | |
| Initial/Interval | • | • | • | • | • | • | • | • | • | • | • |
| MEASUREMENTS | | | | | | | | | | | |
| Length/Height and Weight | • | • | • | • | • | • | • | • | • | • | • |
| Head Circumference | | | | | | | | | | | |
| Weight for Length | | | | | | | | | | | |
| Body Mass Index ⁵ | • | • | • | • | • | • | • | • | • | • | • |
| Blood Pressure ⁶ | • | • | • | • | • | • | • | • | • | • | • |
| SENSORY SCREENING | | | | | | | | | | | |
| Vision | ★ | • | ★ | ★ | • | ★ | ★ | • | ★ | ★ | ★ |
| Hearing | ★ | ★ | ★ | ★ | ★ | ★ | ★ | ★ | ★ | ★ | ★ |
| DEVELOPMENTAL/ BEHAVIORAL ASSESSMENT | | | | | | | | | | | |
| Developmental Screening ⁹ | | | | | | | | | | | |
| Autism Screening ¹⁰ | | | | | | | | | | | |
| Developmental Surveillance | • | • | • | • | • | • | • | • | • | • | • |
| Psychosocial/Behavioral Assessment | • | • | • | • | • | • | • | • | • | • | • |
| Alcohol & Drug Use Assessment ¹¹ | ★ | ★ | ★ | ★ | ★ | ★ | ★ | ★ | ★ | ★ | ★ |
| Depression ¹² | | | | | | | | | | | |
| PHYSICAL EXAMINATION¹³ | • | • | • | • | • | • | • | • | • | • | • |
| PROCEDURES¹⁴ | | | | | | | | | | | |
| Newborn Blood Screening ¹⁵ | | | | | | | | | | | |
| Critical Congenital Heart Defect ¹⁶ | | | | | | | | | | | |
| Immunization ¹⁷ | • | • | • | • | • | • | • | • | • | • | • |
| Hematocrit or Hemoglobin ¹⁸ | ★ | ★ | ★ | ★ | ★ | ★ | ★ | ★ | ★ | ★ | ★ |
| Lead Screening ¹⁹ | | | | | | | | | | | |
| Tuberculosis Testing ²¹ | ★ | ★ | ★ | ★ | ★ | ★ | ★ | ★ | ★ | ★ | ★ |
| Dyslipidemia Screening ²² | ★ | ★ | ★ | ★ | ★ | ★ | ★ | • | • | • | • |
| STI/HIV Screening ²³ | ★ | ★ | ★ | ★ | ★ | ← | • | → | ★ | ★ | ★ |
| Cervical Dysplasia Screening ²⁴ | | | | | | | | | | | • |
| ORAL HEALTH²⁵ | | | | | | | | | | | |
| ANTICIPATORY GUIDANCE | • | • | • | • | • | • | • | • | • | • | • |

AAP Recommendations for Preventive Pediatric Health Care/Bright Futures

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FOOTNOTES FOR PERIODICITY TABLES INFANCY THROUGH ADOLESCENCE

1. If a child comes under care for the first time at any point on the schedule, or if any items are not accomplished at the suggested age, the schedule should be brought up to date at the earliest possible time.
2. A prenatal visit is recommended for parents who are at high risk, for first-time parents, and for those who request a conference. The prenatal visit should include anticipatory guidance, pertinent medical history, and a discussion of benefits of breastfeeding and planned method of feeding, per the 2009 AAP statement “The Prenatal Visit” (<http://pediatrics.aappublications.org/content/124/4/1227.full>).
3. Every infant should have a newborn evaluation after birth, and breastfeeding should be encouraged (and instruction and support should be offered).
4. Every infant should have an evaluation within 3 to 5 days of birth and within 48 to 72 hours after discharge from the hospital to include evaluation for feeding and jaundice. Breastfeeding infants should receive formal breastfeeding evaluation, and their mothers should receive encouragement and instruction, as recommended in the 2012 AAP statement “Breastfeeding and the Use of Human Milk” (<http://pediatrics.aappublications.org/content/129/3/e827.full>). Newborn infants discharged less than 48 hours after delivery must be examined within 48 hours of discharge, per the 2010 AAP statement “Hospital Stay for Healthy Term Newborns” (<http://pediatrics.aappublications.org/content/125/2/405.full>).
5. Screen, per the 2007 AAP statement “Expert Committee Recommendations Regarding the Prevention, Assessment, and Treatment of Child and Adolescent Overweight and Obesity: Summary Report” (http://pediatrics.aappublications.org/content/120/Supplement_4/S164.full).
6. Blood pressure measurement in infants and children with specific risk conditions should be performed at visits before age 3 years.
7. If the patient is uncooperative, rescreen within 6 months, per the 2007 AAP statement “Eye Examination in Infants, Children, and Young Adults by Pediatricians” (<http://pediatrics.aappublications.org/content/111/4/902.abstract>).
8. All newborns should be screened, per the AAP statement “Year 2007 Position Statement: Principles and Guidelines for Early Hearing Detection and Intervention Programs” (<http://pediatrics.aappublications.org/content/120/4/898.full>).
9. See 2006 AAP statement “Identifying Infants and Young Children with Developmental Disorders in the Medical Home: An Algorithm for Developmental Surveillance and Screening” (<http://pediatrics.aappublications.org/content/118/1/405.full>).
10. Screening should occur per the 2007 AAP statement “Identification and Evaluation of Children with Autism Spectrum Disorders” (<http://pediatrics.aappublications.org/content/120/5/1183.full>).
11. A recommended screening tool is available at <http://www.ceasar-boston.org/CRAFFT/index.php>.
12. Recommended screening using the Patient Health Questionnaire (PHQ)-2 or other tools available in the GLAD-PC toolkit and at http://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Mental-Health/Documents/MH_ScreeningChart.pdf
13. At each visit, age-appropriate physical examination is essential, with infant totally unclothed and older children undressed and suitably draped. See 2011 AAP statement “Use of Chaperones during the Physical Examination of the Pediatric Patient” (<http://pediatrics.aappublications.org/content/127/5/991.full>).
14. These may be modified, depending on entry point into schedule and individual need.
15. The Recommended Uniform Newborn Screening Panel (<http://www.hrsa.gov/advisorycommittees/mchbadvisory/heritabledisorders/recommendedpanel/uniformscreeningpanel.pdf>) as determined by The Secretary’s Advisory Committee on Heritable Disorders in Newborns and Children, and state newborn screening laws/regulations (<http://genes-r-us.uthscsa.edu/sites/genes-r-us/files/nbsdisorders.pdf>) establish the criteria for and coverage of newborn screening procedures and programs. Follow-up must be provided, as appropriate, by the pediatrician.
16. Screening for critical congenital heart disease using pulse oximetry should be performed in newborns, after 24 hours of age, before discharge from the hospital, per the 2011 AAP statement “Endorsement of Health and Human Services Recommendation for Pulse Oximetry Screening for Critical Congenital Heart Disease” (<http://pediatrics.aappublications.org/content/129/1/190.full>).
17. Schedules, per the AAP Committee on Infectious Diseases, are available at: <http://aapredbook.aappublications.org/site/resources/izschedules.xhtml>. Every visit should be an opportunity to update and complete a child’s immunizations.
18. See 2010 AAP statement “Diagnosis and Prevention of Iron Deficiency and Iron Deficiency Anemia in Infants and Young Children (0-3 Years of Age)” <http://pediatrics.aappublications.org/content/126/5/1040.full>

19. For children at risk of lead exposure, see the 2012 CDC Advisory Committee on Childhood Lead Poisoning Prevention statement “Low Level Lead Exposure Harms Children: A Renewed Call for Primary Prevention” (http://www.cdc.gov/nceh/lead/ACCLPP/Final_Document_030712.pdf).
20. Perform risk assessments or screenings as appropriate, based on universal screening requirements for patients with Medicaid or in high prevalence areas.
21. Tuberculosis testing per recommendations of the Committee on Infectious Diseases, published in the current edition of *AAP Red Book: Report of the Committee on Infectious Diseases*. Testing should be performed on recognition of high-risk factors
22. See AAP-endorsed 2011 guidelines from the National Heart Blood and Lung Institute, “Integrated Guidelines for Cardiovascular Health and Risk Reduction in Children and Adolescents” (http://www.nhlbi.nih.gov/guidelines/cvd_ped/index.htm).
23. Adolescents should be screened for sexually transmitted infections (STIs) per recommendations in the current edition of the *AAP Red Book: Report of the Committee on Infectious Diseases*. Additionally, all adolescents should be screened for HIV according to the AAP statement (<http://pediatrics.aappublications.org/content/128/5/1023.full>) once between the ages of 16 and 18, making every effort to preserve confidentiality of the adolescent. Those at increased risk of HIV infection, including those who are sexually active, participate in injection drug use, or are being tested for other STIs, should be tested for HIV and reassessed annually.
24. See USPSTF recommendations (<http://www.uspreventiveservicestaskforce.org/uspstf/uspscerv.htm>). Indications for pelvic examinations prior to age 21 are noted in the 2010 AAP statement “Gynecologic Examination for Adolescents in the Pediatric Office Setting” (<http://pediatrics.aappublications.org/content/126/3/583.full>).
25. Refer to a dental home, if available. If not available, perform a risk assessment (<http://www2.aap.org/oralhealth/docs/RiskAssessmentTool.pdf>). If primary water source is deficient in fluoride, consider oral fluoride supplementation. For those at high risk, consider application of fluoride varnish for caries prevention. See 2008 AAP statement “Preventive Oral Health Intervention for Pediatricians” (<http://pediatrics.aappublications.org/content/122/6/1387.full>) and 2009 AAP statement “Oral Health Risk Assessment Timing and Establishment of the Dental Home” (<http://pediatrics.aappublications.org/content/111/5/1113.full>)

PITYRIASIS ROSEA

SUBJECTIVE

Mild itching

Occasionally mild fever or malaise

Usually history of solitary oval lesion (herald patch) preceding a generalized rash by several days

OBJECTIVE

Initial lesion with central clearing and a scaly border (herald patch) may or may not be present

Symmetric maculopapular pink oval lesions with scaly appearance (collarette), usually located on trunk in caucasian or on extremities in black persons

Characteristic "Christmas tree" pattern may be evident on back with lesions aligned along cutaneous cleavage lines

ASSESSMENT

Pityriasis Rosea

PLAN

Reassurance that disease is not contagious, is self-limited, and will resolve without treatment in 6-8 weeks

Advise that artificial or natural sunlight may decrease severity

Soak in a tepid to cold Burrow solution (Domeboro), baking soda, or colloidal oatmeal (Aveeno bath) as needed for temporary relief of itching

An OTC oral antihistamine medication, e.g., diphenhydramine (Benadryl) may be necessary, especially at night, for sedation and relief of pruritis; Benadryl dosage according to package instructions

Recommend hydrocortisone OTC cream (e.g., Cort-aid, etc.) as per package instructions for itching

WARN REGARDING DROWSINESS EFFECT OF ANTIHISTAMINE THERAPY

Prevent secondary bacterial infection (clean, short nails)

Obtain syphilis serology if indicated by history

Referral indicators:

Evidence of secondary bacterial infection

Follow-Up:

As required for patient reassurance and/or with signs of complications

Reference:

Ferri's Clinical Advisor 2008

POISON IVY DERMATITIS

(Poison Oak, Poison Sumac)

SUBJECTIVE

Itching moderate to severe
Exposure to offending plant, contaminated clothing, smoke of burning plant, or to affected pet, commonly within preceding 24-48 hours

OBJECTIVE

Irregularly shaped, raised, erythematous lesions; vesicobullous and weeping, if severe
Linear streaks or scratch marks may be evident

ASSESSMENT

Contact Dermatitis Due to Poison Ivy, Poison Oak, Poison Sumac

PLAN

Soak affected area in colloidal oatmeal (Aveeno bath) for 20 minutes at least 4 times daily
Dry thoroughly and apply calamine lotion or OTC cortisone cream such as Cort-aid, etc. (as per package instructions), to lesions for itching
Discourage topical antihistamines
An OTC oral antihistamine medication, e.g., diphenhydramine, (Benadryl) may be judiciously used (according to package instructions) to interrupt the itch/scratch cycle and for sedation.

WARN REGARDING DROWSINESS EFFECT OF ANTIHISTAMINE THERAPY

Keep nails clean and short
Discourage scratching especially in mucosal areas to prevent secondary bacterial infection

HEALTH TEACHING:

Recognition of plants
Avoidance
Protect by wearing long sleeves and gloves
Cleansing of skin and clothing with soap and water within 5-30 minutes after suspected exposure
Warmth intensifies itching

Referral Indicators:

- Extensive involvement or uncontrollable discomfort
- Ingestion or inhalation of irritant
- Mucosal involvement (mouth, eyelid, conjunctiva, anus, vagina)
- Evidence of secondary bacterial infection (impetigo, pyoderma)

Follow-Up:

- Patient/parent will be asked to contact health provider in 48-72 hours

Reference:

Ferri's Clinical Advisor 2008

PREVENTION OF VITAMIN DEFICIENCY PRENATAL

PLAN

Recommend or provide an approved prenatal vitamin preparation that contains 27-30mg of elemental iron* and not exceeding 1 mg of folic acid.

(*Elemental iron is the absorbable portion of the iron salt. For example, 20% of ferrous sulfate is absorbable, thus a 325 mg tablet of ferrous sulfate provides 65 mg of elemental iron. 33% of ferrous fumarate is absorbable, thus a 300mg tablet of ferrous fumarate provides 100mg of elemental iron. Ferrous gluconate provides 12% elemental iron.)

Advise to take one vitamin tablet daily during pregnancy, for 6 weeks postpartum and during lactation.

Refer to local health department nutrition provider and WIC if appropriate.

Health Teaching

Instruct patient to take vitamin with food to avoid nausea and vomiting.

Vitamins with iron may cause stools to darken.

Counsel on the importance of iron-rich foods.

May require further iron supplementation via the obstetrical provider if iron deficiency anemia develops.

Referral Indicators

All pregnant women are to be assessed for presumptive eligibility for TennCare and referred to an obstetrical provider.

WIC if eligible HUGS

if eligible Dental if

eligible

Follow-up

Prenatal vitamins should be resupplied through the obstetric provider if possible.

TennCare will pay for prenatal vitamins with a prescription.

Reference

National Institute of Health website <http://ods.od.nih.gov/factsheets/iron.asp>

SARCOPTES SCABIEI (Scabies)

BACKGROUND

Scabies is found worldwide and affects people of all races and social classes. Scabies is an infestation of the skin by the human itch mite (*Sarcoptes scabiei* var. *hominis*). The microscopic scabies mite burrows into the upper layer of the skin where it lives and lays its eggs. The most common symptoms of scabies are intense itching and a pimple-like skin rash. The scabies mite usually is spread by direct, prolonged, skin-to-skin contact with a person who has scabies. The incubation period in a person who has never had scabies before is 4-6 weeks while in a person who has had scabies before, symptoms usually appear much sooner (1-4) days after exposure. It is important to remember that an infested person can spread scabies during this time, even if he/she does not have symptoms yet. Institutions such as nursing homes, extended-care facilities, and prisons are often sites of scabies outbreaks. Child care facilities also are a common site of scabies infestations.

SUBJECTIVE

Intense itching (pruritus) of affected area, especially at night
A pimple-like (papular) itchy rash that can include tiny blisters (vesicles) and scales.

The itching and rash each may affect much of the body or be limited to common sites such as:

- Fingers and webbing between the fingers
- Skin folds around the wrists, elbows, and knees
- Armpits
- Area surrounding the nipples (particularly in women)
- Waist
- Male genitalia (penis and scrotum)
- Lower buttocks and upper thighs
- Sides and bottoms of the feet

OBJECTIVE

Small vesicle may be visible at point of entrance of the mite
Tiny burrows sometimes are seen on the skin; these are caused by the female scabies mite tunneling just beneath the surface of the skin. These burrows appear as tiny raised and crooked (serpiginous) grayish-white or skin-colored lines on the skin surface. They are found most often in the webbing between the fingers, in the skin folds on the wrist, elbow, or knee, and on the penis, breast, or shoulder blades.
The head, face, neck, palms, and soles often are involved in infants and very young children, but usually not adults and older children.

ASSESSMENT

Sarcoptes Scabiei (scabies) – suspected

PLAN

Treatment of choice is Permethrin Cream 5%

Treatment is recommended for household members and sexual contacts, particularly those who have had prolonged direct skin-to-skin contact with the infested person within the preceding month. All members of the household should be treated at the same time to prevent reinfestation

Instruct children and adults

Read the package instructions carefully before use

Thoroughly wash and dry skin

Massage permethrin (Elimite 5% cream) into the skin from the head to the soles of the feet paying special attention to creases in the skin, hands, feet, between fingers and toes, underarms, and groin. Scabies rarely infests the scalp of adults

The hairline, neck, side of the head, and forehead may be infested in older people and in infants

Infants should be treated on the scalp, side of the head, and forehead. Do not use around eyes, including eyelashes or eyebrows

Leave the permethrin cream on the skin for 8 to 14 hours.

Wash off by taking a shower or bath.

Put on clean clothes.

Itching may continue for up to 4 weeks after treatment

Contraindications include:

Known hypersensitivity to Pyrethroid or pyrethrin or chrysanthemums

Precautions (requiring physician consultation or referral) include:

Infants under 2 months of age

Pregnant or nursing women

Adverse reactions include:

Mild and transient burning and stinging

Pruritus

Infrequent erythema, numbness, tingling and rash

Health Teaching:

Treatment may temporarily exacerbate pruritis, edema, and erythema

One application is usually curative but that itching may persist for several weeks post-treatment

An OTC oral antihistamine medication, diphenhydramine (Benadryl), may be judiciously used to interrupt the itch/scratch cycle, or for sedation; warn regarding drowsiness effect of antihistamine therapy

May need to apply topical corticosteroid preparation if itching persists

Skin sores that become infected should be assessed by a physician for treatment

Children should be allowed to return to childcare or school after treatment has been completed

Teach mode of transmission- prolonged direct skin-to-skin contact. Animals do not spread human scabies. Although very uncommon, scabies can be spread by sharing a towel or item of clothing that has been used by a person with scabies

Teach prevention of spread – environmental controls and personal hygiene
Scabies mites do not survive more than 2-3 days away from human skin. Bedding, clothing and towel used by a person with scabies can be decontaminate by machine washing in hot water and drying using the hot cycle. Items that can not be washed can be decontaminated by removing from any body contact for 72 hours.

Environmental treatment is unnecessary

Referral Indicators:

Infants under 2 months of age
Pregnant or nursing women

Follow-Up

Patient/parent will be asked to contact health provider if recurrence of symptoms after 2 weeks

REFERENCES

http://www.cdc.gov/parasites/scabies/gen_info/index.html

Goldstein, BG & Goldstein, AO, Patient Information: Scabies (Beyond the Basics), In: UpToDate, Ofori, AO (Ed), UpToDate, Waltham, MA 2013

Red Book, Report of the Committee on Infectious Diseases, 27th Edition. 2006

SEBORRHEIC DERMATITIS (Cradle Cap)

SUBJECTIVE

Family history of allergic conditions
Occurrence of scales on scalp

OBJECTIVE

Inflammation of forehead and face
Scaling, crusting of the scalp

ASSESSMENT

Seborrheic Dermatitis (Cradle Cap)

PLAN

Use Baby Oil immediately before shampooing to loosen crust
Wash scalp with antiseborrheic shampoo, (e.g., Head and Shoulders, Selsun Blue)
every 2 to 3 days (avoid contact with eyes)
Use a small soft brush to gently loosen crusts while shampooing

Referral Indicators:

No response to treatment in 7 days
Area other than scalp involved

Follow-Up:

Patient/parent will be asked to contact health provider if no improvement in one week

Reference:

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

SMOKING CESSATION COUNSELING AND TREATMENT PROTOCOL

General Information

All health department patients aged 13 or older receiving clinical services should be asked the basic tobacco data questions; if applicable, be asked to complete the Patient Tobacco Survey; and receive evaluation and smoking cessation counseling from a provider according to the 5 As or 5 Rs guideline and protocol. All patients to receive pharmaceutical treatment should be seen by an RN or referred to an APN or MD/DO.

SUBJECTIVE: Patient has completed the Patient Tobacco Survey and states a willingness to quit smoking. If patient does not state a desire to quit smoking today, counsel according to the **Patient Not Willing to Make Quit Attempt Protocol (5 Rs)**.

Contraindications:

See **Patient Willing to Make Quit Attempt Smoking Cessation Protocol** and **Pharmacotherapies for Smoking Cessation (Appendix A)**

OBJECTIVE: Blood
Pressure Pulse
Respirations
Weight
Date of last menstrual period (LMP)

ASSESSMENT: Desires smoking cessation
Has no contraindication to treatment
Assess history according to **Patient Willing to Make Quit Attempt Smoking Cessation Protocol** and **Pharmacotherapies for Smoking Cessation (Appendix A)**

PLAN:

- 1) Patient using tobacco and states willingness to quit, counsel according to **Patient Willing to Make Quit Attempt Smoking Cessation Protocol (5 As)**
 - a. For treatment with nicotine gum or nicotine lozenge, refer to **Patient Willing to Make Quit Attempt Smoking Cessation Protocol** and **Pharmacotherapies for Smoking Cessation (Appendix A)**

Note: Refer to Pharmacotherapies for Smoking Cessation (Appendix A) – for precaution/ contraindications, adverse effects, dosage/ directions, and duration of available therapies. Dosing for nicotine gum and lozenge vary. Only nicotine gum, nicotine lozenge, and Chantix[®] to be stocked at this time.

- b. RN may initiate an order for nicotine replacement therapy (NRT) products only

- c. Refer to APN or MD for questions or concerns related to issuing nicotine gum or nicotine lozenges
 - d. Refer to APN or MD for patient to be treated with Chantix[®]
 - e. Give appropriate smoking cessation counseling materials
 - f. Refer to 1-800-Quit Now (1-800-784-8669)
- 2) Patient uses tobacco but is not willing to quit, counsel according to **Patient Not Willing to Make Quit Attempt Smoking Cessation Protocol (5 Rs)**

Follow-up for re-supply visits:

At a minimum, assess and document the following:

- i. Assess Blood Pressure, Pulse, Respirations, Weight, and LMP
- ii. Assess pharmacotherapy use and screen for side effects
 - a. Any **significant** changes in mood or behavior including erratic or aggressive behavior
 Patients who experience **significant** side effects, in particular **significant** mood and/or behavior changes including erratic and/or aggressive, should be instructed to:
 - i. Stop the medication immediately
 - ii. Immediately contact the health care provider
 - b. Significant drowsiness due to quitting or medication
Patients should use caution when driving or operating machinery until they know how quitting smoking and the medication may affect them
 - c. Any other side effects or general concerns
 - d. Alcohol/illicit drug use

If **negative** for “**any significant changes in mood or behavior, including erratic or aggressive behavior,**” ~~Æ~~ the RN may re-supply the pharmacotherapy according to protocol for nicotine gum or nicotine lozenge, or following written order of APN or MD/DO for Chantix[®]

If **positive** for “**any significant changes in mood or behavior including erratic or aggressive behavior,**” ~~Æ~~ the RN must consult a physician immediately, either on-site or by phone, to determine current medical plan (including assessment for crisis intervention).

- e. For patients on Chantix[®] who are making reasonable progress toward quitting and are felt to be committed by the provider, it will be acceptable with provider discretion to continue these patients on another three months of pharmacotherapy, provided the patient is enrolled for counseling with the QuitLine
- iii. Repeat “**Patient Pharmacotherapy Counseling**” from **Section 4.f.v** of **Patient Willing to Make Quit Attempt Smoking Cessation Protocol**.

- iv. Provide Practical Counseling
 - a. Congratulate success and review benefits derived from cessation
 - b. If relapse, obtain recommitment to abstinence (learning experience – Average 6-10 quit attempts before successful)
 - c. Identify problems encountered (barriers or triggers) and anticipate future challenges
 - d. Help patient identify additional sources of support- Tennessee Tobacco Quit Line
 - e. Consider providing or referring to more intensive counseling:
 - i. Appropriate for those willing to participate
 - ii. May be group, individual, or telephone

- v. At the discretion of the provider, committed patients who are already in the program may be restarted on treatment if they previously failed to complete a three month treatment regimen, provided the patient is enrolled for counseling with the QuitLine

If no problems are identified during the assessment, the RN may re-supply the pharmacotherapy according to protocol for nicotine gum or nicotine lozenge, or following written order of APN or MD/DO for Chantix[®]

Problems will be referred to the APN or MD/DO.

Patient Willing to Make Quit Attempt Smoking Cessation Protocol

All health department patients aged 13 or older receiving clinical services should be asked the basic tobacco data questions. If applicable, patients will be asked to complete the Patient Tobacco Survey, and receive evaluation and smoking cessation counseling from their provider according to the 5 As or 5 Rs guideline and protocol. All patients to receive pharmacologic treatment should be seen by or referred to an RN, APN, or MD/DO.

1) ASK

“Do you use any kind of tobacco now?” (Asked by office assistant)

If Yes Æ give Patient Tobacco Survey to complete and discuss with nurse/provider

If No Æ second question by office assistant **“Have you ever used any kind of tobacco?”**

If Yes Æ give self-assessment form to complete and discuss with nurse/provider

If No Æ apply non-tobacco user identification to chart (blank sticker)

2) ADVISE – By RN, APN, MD/DO, or DDS/DMD

- a) Tell patient importance of stopping tobacco use now and that you want to help
- b) Emphasize that it is the most important health step that they can take
- c) Give reasons of improved health for self and loved ones (second-hand smoke):

Parents – increased respiratory infections in children; poor role model for health

New smokers – easier to stop now

Adolescents – decreased athletic performance

Pregnant women – preterm birth, low birth weight, reduced oxygen levels, respiratory problems, and increased hospital stays for infants while mother goes home

Asymptomatic – 2x risk of stroke, 6x risk of oral cancer, 10x risk of larynx cancer and COPD, 12x risk of lung cancer and CAD, 5-8 year shorter life span

Symptomatic – URIs, gum disease, dyspnea, ulcers, angina, claudication, osteoporosis, esophagitis, shortened enjoyment of life (e.g. retirement and grandchildren)

Negative social impact – costly, bad breath, stained teeth, facial wrinkles

3) ASSESS – By RN, APN, MD/DO, or DDS/DMD

Ask – “Are you thinking about quitting within the next 6 months?”

If Yes, ask if thinking about quitting within 30 days – if yes, start the “quit plan”

If No, continue to ask and offer assistance at every visit. Refer to “*Patient Not Willing to Make Quit Attempt Smoking Cessation Protocol*” (**5 Rs intervention**).

4) ASSIST – Provide counseling by RN, APN, MD/DO, or DDS/DMD and pharmacotherapy (when indicated) by RN, APN, or MD/DO.

a) Help with a **Quit Plan**

- Set a quit date (ideally within 2 weeks)
- Enlist support of family, friends, co-workers
- Identify smoking triggers/habits and ways to avoid or mitigate triggers
- Remove tobacco products from environment
- Anticipate challenges (nicotine withdrawal typically peaks within 1-3 weeks after quitting)

b) Provide Practical Counseling

- Encourage total abstinence as ultimate goal
- Anticipate set-backs (a “slip” is not a failure)
- Review past experience with quit attempts
- Advise limiting or stopping alcohol use (strongly associated with relapse)
- Encourage cessation in other household members

c) Advise that provider and staff are available for support

- Give patient information (available throughout office) and give Health Department number

d) Assist with outside support system

- Give patient Tennessee **Tobacco QuitLine number (1-800-784-8669)** and if patient willing, initiate Tennessee Tobacco Quit Line fax referral (may be faxed as a batch at the end of the day or on the following day)
- Tell **prenatal patients** that the Tennessee Tobacco Quit Line provides coaches specifically trained to help pregnant women

e) Refer to APN or MD/DO for treatment today, or RN may provide nicotine replacement therapy (NRT) products today, or schedule an appointment

f) **Pharmacotherapy** – If appropriate, pharmacotherapy provided by RN, APN or MD/DO after patient’s medical history and physical assessment

Note: Refer to Pharmacotherapies for Smoking Cessation (Appendix A) – for precaution/contraindications, adverse effects, dosage/ directions, and duration of available therapies. Dosing for nicotine gum and lozenge vary. Only nicotine gum, nicotine lozenge, and Chantix® to be stocked at this time.

Chantix® should **not** be routinely prescribed for the following patients**:

- ¾ pregnant females
- ¾ lactating females
- ¾ patients with current or significant past history of psychiatric disorders
- ¾ patients with **significant** changes in mood and behavior *including* erratic and/or aggressive behavior
- ¾ patients who refuse to discontinue alcohol/illicit drug use while taking Chantix®

****Careful review of the patient's medical history and clinical judgement by a physician (MD/DO) may warrant going off protocol. Justification for this decision must be thoroughly documented in the medical record.**

At a minimum, all patients being considered for pharmacotherapy must have an assessment documented in the medical record to include the following:

- i. Past Medical History/Review of Systems**
 - a. Psychosocial: Current or past history of psychiatric disorders; Current or past history of **significant** changes in mood or behavior including erratic or aggressive behavior; Current alcohol/illicit drug use
 - b. Oropharynx: TMJ disease; dentures
 - c. Resp: Asthma; COPD
 - d. CV: MI; MI within 2 weeks; Angina; Arrhythmias
 - e. GI: DM; insulin
 - f. Renal: Renal disease/renal impairment
 - g. GU: Last menstrual period; Pregnancy
 - h. Other: Breast feeding female
- ii. Medications**
 - a. All current medications including psychiatric medications, alternative medications, vitamins, herbal supplements, and OTCs
 - b. Screen for use of: Insulin; asthma medications; anticoagulants (*e.g.* warfarin)
- iii. Allergies**
- iv. Physical Assessment**

At a minimum, include the following and highlight the damage that can be done to each body system:

 - a. Vital signs: Heart rate, Respiratory rate, Blood pressure, Weight
 - b. Systems: Oropharynx, Lungs, Heart
- v. Patient Pharmacotherapy Counseling**
 - a. Patients receiving smoking cessation medication must be given the Health Department's 24-hour on-call number

- b. Patients who experience **significant** side effects, in particular **significant** mood and/or behavior changes including erratic and/or aggressive, should be instructed to:
 - i. Stop the medication immediately
 - ii. Immediately contact the health care provider
- c. **Patients should use caution when driving or operating machinery until they know how quitting smoking and the medications may affect them**
- d. If the patient is receiving Chantix[®], provide the patient with the teaching tool “How to Start Taking Chantix[®]”

5) ARRANGE – by RN, APN, MD/DO, or other trained staff

- a) For patients receiving pharmacotherapy, place patient in patient tracking system
- b) For patients receiving pharmacotherapy or other intensive smoking cessation counseling, schedule return visit by end of first month during initial visit
- c) Advise patient to call Health Department with any questions or problems with medications, or any other concerns
- d) **Follow-up visits for resupply:** At a minimum, assess and document the following:
 - i. Pharmacotherapy use and screen for side effects
 - a. Any **significant changes in mood or behavior** including erratic or aggressive behavior
 - b. **Significant drowsiness** due to quitting or medication
 - c. Any other side effects or general concerns
 - d. Alcohol/illicit drug use

If **negative** for “**any significant changes in mood or behavior including erratic or aggressive behavior,**” Æ then the RN may resupply the pharmacotherapy following written order of an APN or MD/DO.
RN may initiate an order for nicotine replacement therapy (NRT) products only

If **positive** for “**any significant changes in mood or behavior including erratic or aggressive behavior,**” Æ then the RN must consult with a physician immediately, either on-site or by phone, to determine current medical plan (including assessment for crisis intervention).

- e. For patients receiving pharmacotherapy who are making reasonable progress toward quitting and are felt to be committed by the provider, it will be acceptable with provider discretion to continue these patients on another three months of pharmacotherapy, provided the patient is enrolled for counseling with the QuitLine
- ii. Repeat “**Patient Pharmacotherapy Counseling**” from **Section 4.f.v**

- iii. Provide Practical Counseling
 - a. Congratulate success and review benefits derived from cessation
 - b. If relapse, obtain recommitment to abstinence (learning experience – Average 6-10 quit attempts before successful)
 - c. Identify problems encountered (barriers or triggers) and anticipate future challenges
 - d. Help patient identify additional sources of support – Tennessee Tobacco QuitLine
 - e. Consider providing or referring to more intensive counseling:
 - i. Appropriate for those willing to participate
 - ii. May be group, individual, or telephone
- iv. At the discretion of the provider, committed patients who are already in the Program may be restarted on treatment if they previously failed to complete a three month treatment regimen provided the patient is enrolled in the QuitLine

Patient Tobacco Survey (TSA), Clinical Documentation, and Data Management

- a) Review the patient section of the Patient Tobacco Survey (Appendix B). If necessary, assist patient in completing the patient section of the survey.
- b) Answer questions P1, P2, and P3.
- c) Question P4 should be answered with the best clinical judgment at the time of this visit. The answer to question P4 may change on subsequent visits.

Current smoker, not willing to quit

Current smoker, willing to quit

- Include in this category any patient who has quit for less than 30 days and will not be starting treatment

Current smoker, starting treatment or in treatment (any combination of the following: Smoking Cessation Program, QuitLine, tobacco cessation pharmacotherapy such as NRT or Chantix[®])

- Include in this category any patient who has received from the Health Department any counseling, QuitLine referral/recommendation, and/or pharmacotherapy for tobacco cessation and has subsequently quit for less than 90 days

Former Smoker -- Completed Health Department treatment

- A patient who has received from the Health Department any combination of counseling, QuitLine referral/recommendation, and or pharmacotherapy for tobacco cessation and has quit for 90 days or greater

Former smoker

- A patient identified at the first tobacco visit who has not smoked for 30 days or greater
- NOTE: A patient identified at the first tobacco visit who has quit for less than 30 days would be classified either as a “Current smoker, willing to quit” or a “Current smoker, starting treatment or in treatment”

Never smoked

- A patient identified at the first tobacco visit who has never smoked
- Include in this category any patient who has never smoked and only used smoke-less tobacco

Unable to determine

- A patient who has refused to answer questions pertaining to tobacco use and smoking

Not determined

- A patient who is not screened due to participation in mass vaccination clinics or in group classes (*e.g.* Quick WIC or WIC classes)

d) Perform medical history and physical exam. Document required findings pertinent to smoking cessation pharmacotherapy in SOAP note or on “**Tobacco Cessation Clinical Form: Initial Visit and Resupply Visit**” (Appendix C).

References:

Clinical Practice Guideline – “Treating Tobacco Use and Dependence”

US Department of Health and Human Services, Public Health Service, June 2000

Clinical Guidelines in Family Practice (Fourth Edition), Uphold and Graham 2003

Tennessee Tobacco QuitLine – <http://health.state.tn.us/tobaccoquitline.htm>

Facts and Comparisons 4.0, Wolters Kluwer Health, Inc., 2007

FDA: Early Communication about an Ongoing Safety Review – Varenicline (Marketed as Chantix®). November 20, 2007, updated February 1, 2008

FDA: Public Health Advisory – Important Information on Chantix® (varenicline). February 1, 2008, updated May 16, 2008

Pfizer: Medication Guide, Chantix® (varenicline) Tablets – May 2008

Pfizer: Package Insert, Chantix® (varenicline) Tablets – May 2008

Patient Not Willing to Make Quit Attempt Smoking Cessation Protocol

1) **ASK** – “Do you use any kind of tobacco now?” (Asked by office assistant)

If Yes – give self-assessment form to complete and discuss with nurse/provider

If No – second question by office assistant “Have you ever used any kind of tobacco?”

If Yes – give self-assessment form to complete and discuss with nurse/provider

If No – apply non-tobacco user identification to chart (blank sticker)

2) **ADVISE** – By RN, APN, MD/DO, or DDS/DMD

a) Tell patient importance of stopping tobacco use now and that you want to help

b) Emphasize that it is the most important health step that they can take

c) Give reasons of improved health for self and loved ones (second-hand smoke):

Parents – increased respiratory infections in children; poor role model

New smokers – easier to stop now

Adolescents – decreased athletic performance

Pregnant women – preterm birth, low birth weight, reduced oxygen levels, respiratory problems, and increased hospital stays for infants while mother goes home

Asymptomatic – 2x risk of stroke, 6x risk of oral cancer, 10x risk of larynx cancer and COPD, 12x risk of lung cancer and CAD, 5-8 year shorter life span

Symptomatic – URIs, gum disease, dyspnea, ulcers, angina, claudication, osteoporosis, esophagitis, shortened enjoyment of life, retirement and grandchildren

d) Negative social impact – costly, bad breath, stained teeth, facial wrinkles

3) **ASSESS** – by RN, APN, MD/DO, or DDS/DMD

Ask – “Are you thinking about quitting in the next six months?” - NO

4) **ASSIST** – by RN, APN, MD/DO, or DDS/DMD

a) Patient may be unwilling to quit for the following reasons

Patient Not Willing to Make Quit Attempt (Continued)

Misinformation

Concern about the effects of quitting

Demoralization from previous unsuccessful quit attempts

b) Assist with outside support system

Give patient Tennessee Tobacco Quit Line number (1-800-784-8669) and if patient willing, initiate Tennessee Tobacco Quit Line fax referral (may be faxed as a batch at the end of the day or on the following day)

Tell prenatal patients that the Tennessee Tobacco Quit Line provides coaches specifically trained to help pregnant women.

c) Use **5 Rs** motivational intervention:

Relevance – encourage patient to tell you why quitting would be personally relevant to him/her (ask them to be as specific as possible)

Risks – ask patient to identify potential negative consequences of tobacco use (acute and long-term disease risks and environmental risks)

Rewards – ask patient to identify potential benefits of stopping tobacco use (i.e. improved health, food tastes better, improved sense of smell, save money, better self-image, stop worrying about quitting, be good example to children, have healthier babies and children, perform better in physical activities, and reduce wrinkling/aging of skin)

Roadblocks – ask patient to identify barriers and note elements of treatment that could address barriers (i.e. withdrawal symptoms, fear of failure, weight gain, lack of support, depression, and enjoyment of tobacco)

Repetition – motivational intervention should be repeated every time an unmotivated patient presents to the Health Department (therefore, every tobacco user must be identified on every visit)

Patient Tobacco Survey (TSA) and Data Management

- a) Review the patient section of the Patient Tobacco Survey (Appendix B). If necessary, assist patient in completing the patient section of the survey.
- b) Answer questions P1, P2, and P3.
- c) Question P4 should be answered with the best clinical judgment at the time of this visit. The answer to question P4 may change on subsequent visits.

Patient Not Willing to Make Quit Attempt (Continued)

Current smoker, not willing to quit

Current smoker, willing to quit

- Include in this category any patient who has quit for less than 30 days and won't be starting treatment

Current smoker, starting treatment or in treatment (any combination of the following: smoking cessation program, quit line, tobacco cessation aid such as NRT or Chantix®)

- Include in this category any patient who has received from the Health Department any counseling, Quit Line referral/recommendation, and/or pharmacotherapy for tobacco cessation and has subsequently quit for less than 90 days

Former Smoker -- Completed Health Department treatment

- A patient who has received from the Health Department any combination of counseling, Quit Line referral/recommendation, and or pharmacotherapy for tobacco cessation and has quit for 90 days or greater

Former smoker

- A patient identified at the first tobacco visit who has not smoked for 30 days or greater
- NOTE: A patient identified at the first tobacco visit who has quit for less than 30 days would be classified either as a "Current smoker, willing to quit" or a "Current smoker, starting treatment or in treatment"

Never smoked

- A patient identified at the first tobacco visit who has never smoked
- Include in this category any patient who has never smoked and only used smoke-less tobacco

Unable to determine

- A patient who has refused to answer questions pertaining to tobacco use and smoking

Not determined

- A patient who is not screened due to participation in mass vaccination clinics or in group classes (*i.e.* Quick WIC or WIC classes)

Patient Not Willing to Make Quit Attempt (Continued)

References:

Clinical Practice Guideline – “Treating Tobacco Use and Dependence”
US Department of Health and Human Services, Public Health Service, June 2000

Clinical Guidelines in Family Practice (Fourth Edition), Uphold and Graham 2003

Tennessee Tobacco Quit Line – <http://health.state.tn.us/tobaccoquitline.htm>

Appendix A

Pharmacotherapies for Smoking Cessation^a

| Medication | Availability | Precautions / Contraindications | Adverse Effects | Dosage / Directions | Duration | Cost / Day ^b |
|---|---|---|---|---|---|--|
| Varenicline | Chantix [®] (prescription only) | Pregnancy (Category C), breast-feeding Not recommended in patients < 18 years of age. Caution in patients with renal impairment. See additional precautions below.^c | Nausea/Vomiting Constipation/Gas Insomnia Abnormal dreams Headache | Days 1-3 – 0.5 mg once daily; Days 4-7 – 0.5 mg twice daily; Days 8 through end of treatment – 1 mg twice daily | 12 weeks (if successful, additional 12 weeks recommended) | \$4.49 (based on dose-pack) |
| Nicotine Gum^d | Nicorette [®] , Nicorette [®] Mint (OTC only) | Pregnancy (Category C) ^e Recent (< 2 weeks) MI, unstable angina, serious underlying arrhythmias, TMJ disease, difficult to use with dentures | Increased heart rate Increased blood pressure Mouth soreness Dyspepsia Increased salivation | 1-24 cigs/day – 2 mg gum ^{fg} ; 25+ cigs/day – 4 mg gum ^{fg} Either dosage up to 24 pcs/day | Up to 12 weeks ^{fg} | \$5.03 – 2 mg or 4 mg (based on 10 pieces per day) |
| Nicotine Lozenge^d | Commit [®] (OTC only) | Pregnancy (Category C) ^e Recent (< 2 weeks) MI, unstable angina, serious underlying arrhythmias | Increased heart rate Increased blood pressure Hiccoughs Heartburn Nausea | 1 st cig ≤ 30 min. of waking – 4 mg loz. ^{gh} ; 1 st cig > 30 min. of waking – 2 mg loz. ^{gh} Either dosage at least 9 loz./day x first 6 wks | Up to 12 weeks ^{gh} | \$5.14 – 2 mg or 4 mg (based on 10 lozenges per day) |
| Nicotine Patch^d | Nicoderm CQ [®] (OTC only) | Pregnancy (Category D) ^e Recent (< 2 weeks) MI, unstable angina, serious underlying arrhythmias, acute and/chronic skin disorders. | Local skin reaction Insomnia | >10 cigs/day – 21 mg/24 hours; ≤10 cigs/day – 14 mg/24 hours start here x 6 weeks then 7mg x 2 weeks; 7 mg/24 hours | Weeks 1-6 Weeks 7-8 Weeks 9-10 | \$3.58 all strengths |
| Nicotine Inhaler^d | Nicotrol [®] Inhaler (prescription only) | Pregnancy (Category D) ^e Recent (< 2 weeks) MI, unstable angina, serious underlying arrhythmias, underlying reactive airway disease. | Local irritation of mouth and throat Insomnia | 6-16 cartridges/day | Up to 6 months | \$11.11 (based on 10 cartridges per day) |
| Nicotine Nasal Spray^d | Nicotrol NS [®] (prescription only) | Pregnancy (Category D) ^e Recent (< 2 weeks) MI, unstable angina, serious underlying arrhythmias, underlying chronic nasal disorders (rhinitis, nasal polyps, sinusitis), severe reactive airway disease. | Nasal irritation Insomnia | 8-40 doses/day | 3-6 months | \$5.62 (based on 12 doses per day) |
| Bupropion SR | Zyban [®] (prescription only) | Pregnancy (Category B), concomitant therapy with meds known to lower seizure threshold (e.g., antipsychotic/ depressants, theophylline, lithium, etc.) MAO inhibitor in previous 14 days, abrupt discontinuing of alcohol or sedatives, Hx of seizure, or eating disorder. | Insomnia Dry mouth | 150 mg every morning x 3 days, then 150 mg twice daily Begin treatment 1-2 weeks pre-quit. | 7-12 weeks maintenance up to 6 months | \$5.18 (based on twice a day dosing) |

^a Information contained within this table is not comprehensive. See package insert for additional information.

^b Prices are based on Average Wholesale Price (AWP) February 2008.

^c **Monitor** for behavior and mood changes, and have patients contact healthcare provider if they experience behavior or mood changes. Patients should use caution when driving or operating machinery until they know how quitting smoking with Chantix[®] may affect them. *FDA: Early Communication About an Ongoing Safety Review – Varenicline (Marketed as Chantix[®]), February 1, 2008.* Choose quit date and start treatment approximately 1 wk prior to quit date.

^d Age less than 18 years (unless ≥ 100 pounds and with parental/guardian consent only may use Nicotine Replacement Therapy (NRT)). RN or APN may request MD/DO consult as needed.

^e Unless after 20 weeks under special circumstances may use NRT. RN or APN may request MD/DO consult as needed.

^f Chew gum slowly until it tingles, then park it between the cheek and gum for 30 minutes. When tingling is gone instruct patient to repeat process.

^g One pc of gum or loz. every 1-2 hrs for wks 1-6; 1 pc of gum or loz. every 2-4 hrs for wks 7-9; 1 pc gum or loz. every 4-8 hrs for wks 10-12. No food or drink 15 min. before or while chewing gum or using lozenge. Do not smoke during treatment.

^h Do not use > 1 lozenge at one time or continuously. Do not use > 5 lozenges/day. Do not chew or swallow lozenge.

TINEA CORPORIS (Ringworm)

SUBJECTIVE

Round or oval patch(es) on body
Usually asymptomatic, but may itch

OBJECTIVE

Ring-shaped, erythematous, scaling patch(es) with central clearing and distinct border(s) which are often raised
Lesions may be located on face, trunk, or extremities

ASSESSMENT

Tinea Corporis (Ringworm)

PLAN

Instruct to bathe with soap and water
Apply wet dressing (water); allow to air dry 2 to 3 times daily to assist with debridement
Apply topical antifungals, such as clotrimazole 1% cream (Lotrimin), miconazole, or
tolnaftate (Tinactin) cream to affected area morning and evening until lesion clears
and for 2 weeks after clearing
Discontinue treatment if condition worsens
Simultaneous treatment of affected family members and pets
Avoid contact with infected animals
Do not share clothing or towels with others
Avoid community baths, showers, pools, sauna's, etc.

Referral Indicators:

Severe or extreme involvement (oral antifungal antibiotic therapy required)
Lesions on face or head (hair loss), eyes
No response to local treatment or worsening of condition
Secondary bacterial infection

Follow-Up:

Patient/parent will be asked to contact health provider if no improvement in one week

Reference

Mayo Clinic, Guide To Self-Care, Fifth Edition 2006
Ferri's Clinical Advisor 2008

TINEA CRURIS (Jock Itch, Gym Itch)

SUBJECTIVE

Marked itching of groin and upper thighs and under breast
Rash (varies in color from red to brown)
Oozing red rash
Scaly rash

Obesity

OBJECTIVE

Lesions consist of erythematous macules with sharp margins, cleared centers, and active, spreading peripheries in intertriginous areas; may be vesicle formation at the borders
Bilateral fan-shaped rash
May have associated tinea infection of feet

ASSESSMENT

Tinea Cruris (Jock Itch)

PLAN

Instruct to keep area clean and dry but avoid over bathing and excessive use of soap on skin while infected (blow dry with a hair dryer)
Advise to wear loose fitting, non-rough textured cotton clothing
Avoid conditions that cause sweating in affected areas
Instruct to change clothing frequently and launder in hot, soapy water
Instruct to apply topical over the counter antifungal preparation such as clotrimazole, miconazole, and tolnaftate (Tinactin) to the affected areas and surrounding skin twice daily for several weeks and at least 7 days after the rash has cleared; do not use steroids
Advise that the use of a bland, absorbent powder may be helpful adjuvant to therapy (apply evenly)
Recommend sitz baths to relieve itching of the anogenital area
Check for pubic lice

Health Teaching:

Mode of transmission - directly through contact with infected lesions or indirectly through contact with contaminated articles such as towels and shorts
Use separate towel to dry infected area
Dry feet last

Referral Indicators:

Patient will be asked to contact health provider if no response to treatment in 2- 3 days

Reference:

Mayo Clinic, Guide To Self-Care, Fifth Edition 2006
Ferri's Clinical Advisor 2008

TINEA VERSICOLOR

SUBJECTIVE

Patches on the skin that will not tan
Usually asymptomatic, but may burn or itch

OBJECTIVE

Hypo- or hyperpigmented round or oval macules or scaly patches on upper trunk (commonly chest, back, neck, and arms) which are unaffected by sunlight
Prevalent in older children and adolescents

ASSESSMENT

Tinea Versicolor

PLAN

Bathe and dry thoroughly prior to treatment

Appropriate therapy may include one of the following:

- A topical selenium sulfide suspension (Selsun or Exsel) applied daily x 7 consecutive days; rinse off after 10 minutes; if not cleared in one month, have patient repeat treatment
- Lotions, ointments, or creams containing 3-6% salicylic acid twice daily for 2-4 weeks
- Topical Miconazole, clotrimazole or ketoconazole cream twice daily for 2-4 Weeks

Use not indicated during pregnancy

Repigmentation may take months; reoccurrence is common

Treat other family members concurrently if symptomatic

Referral Indicators:

Extensive involvement with acute inflammation or exudation

No response to treatment after 3 weeks

Pregnancy

Follow-Up:

Patient will be asked to contact health provider if no improvement in 3 weeks

Reference

Ferri's Clinical Advisor 2008

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. TBEP 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.

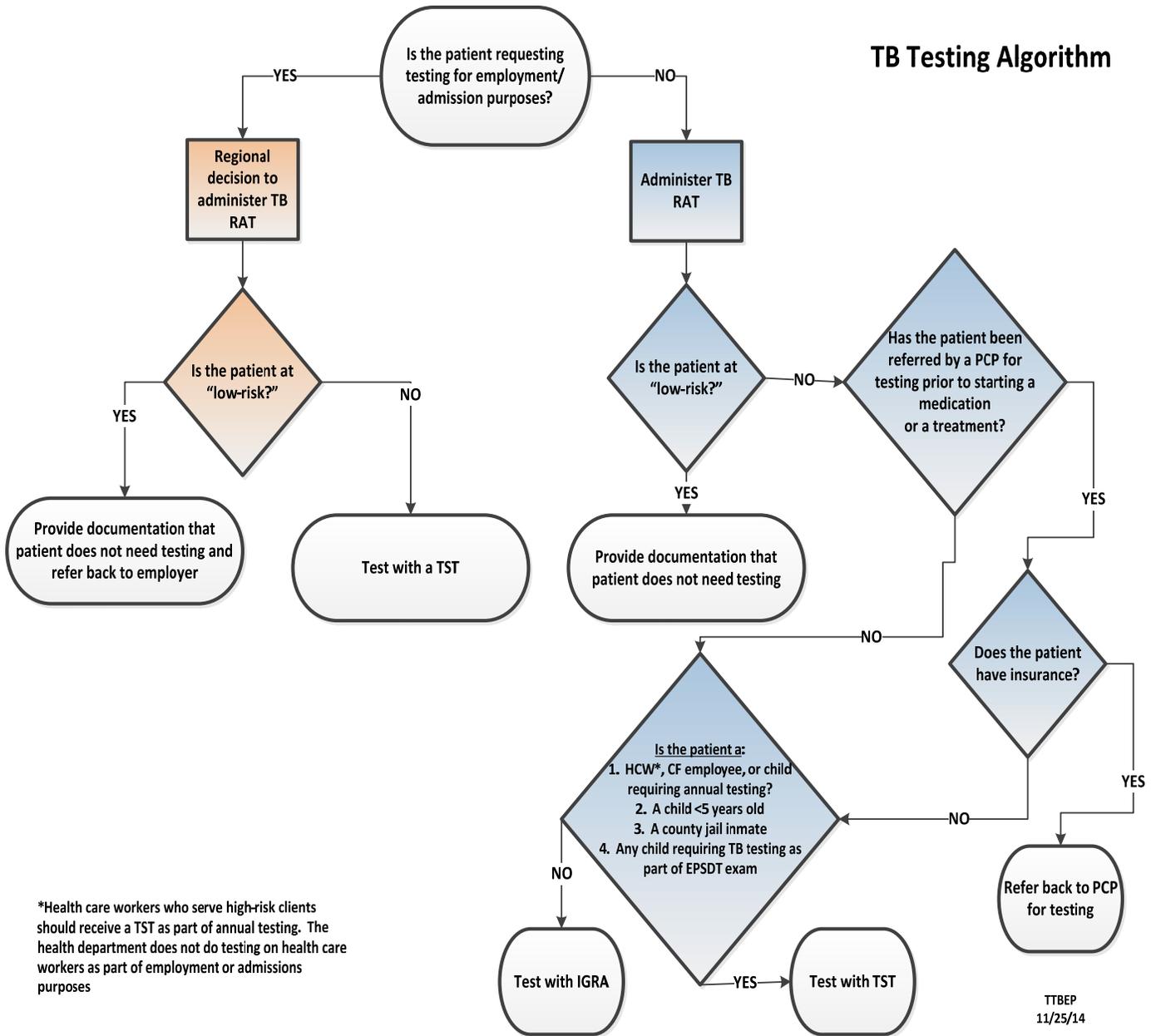
Refer to TB Elimination Program guidelines and Lab Manual for QuantiFERON[®]-TB Gold In-Tube assay collection and processing procedures.

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.

TB Testing Algorithm



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.

TABLE 4. Interpretation of TB Test Results, By Risk Group**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 $\geq 10\%$ 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 ≥ 15 mm 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.

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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 | |
|--|--|--------------------|-------------|-------------|
| C | Burundi | 031 | High | |
| | 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 | Low |
| | | 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-Saud 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 |
| | Zambia | 221 | High |
| | Zimbabwe (S. Rhodesia) | 222 | High |

TUBERCULIN SKIN TESTING, TWO STEP PROCEDURE

GENERAL INFORMATION

Two-step testing is done to detect waning sensitivity to infection with *Mycobacterium tuberculosis*

A person entering the health care field (with potential for direct patient contact) must be two stepped (i.e., first time employed in nursing home, hospital, health department, home health agency) regardless of age unless they can show documented proof within past 12 months of a PPD skin test

IGRAs are not recommended for those who require serial testing annually (health care workers, correctional facility employee, child requiring serial testing).

SUBJECTIVE:

Complete TB/LTBI Risk Assessment Tool at initial visit
(**Note: Not to be used for Health Department employees**)

OBJECTIVE:

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 TB skin test in the lower arm.

ASSESSMENT:

Read the tuberculin skin test in **48 to 72 hours**:

Palpate with the pads of your fingertips for the presence or absence of induration (a hard, dense, raised formation); **do not measure any soft swelling or redness** that may be present at the site. The diameter of the induration is measured across the forearm from the thumb side of the arm to the "little finger side" of the arm or vice versa by measuring the transverse diameter of induration.

Record TST results in millimeters only; do not record as positive or negative
A **non-reactive** 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; repeat TST placement is required.

Interpret TST results (i.e., "reactive" vs. "non-reactive") as outlined below:
"Interpretation of TST results by Risk Group."

1. TST Reaction ≥ 5 mm of induration

- HIV-infected persons
- Recent contacts of patients 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.*

2. TST Reaction ≥ 10 mm of induration

- 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., leukemia and lymphoma), other specific malignancies (e.g., carcinoma of the head or neck and lung), weight loss of $\geq 10\%$ of ideal body weight, history of gastrectomy or jejunioileal bypass surgery.
- Children younger than 4 years of age or infants, children, and adolescents exposed to adults at high-risk

3. TST Reaction ≥ 15 mm of induration

- Person with no risk factors for TB

If the initial reading is non-reactive, repeat the skin test one to three weeks after the first test.

If the initial reading is reactive, do not proceed to second test.

A **reactive** 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.

If second test has no significant induration, consider it non-reactive, depending on clinical situation, and record measurement in millimeters

For persons with TST results interpreted as “**non-reactive**” 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 infection with *M. tuberculosis*; such persons should be clinically evaluated for LTBI or active TB disease.

Note: TB/LTBI Risk Assessment Tool does not need to be completed twice unless a patient returns to the clinic at a later time and it is determined that they have a new exposure or risk factors, in which case another TB/LTBI Risk Assessment Tool should be completed

PLAN:

All reactive tuberculin skin test should be referred to a private physician or to a tuberculosis clinic for a chest radiograph and further evaluation

Document results in record in millimeters, even if negative, and give results in writing to patient

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. 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

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

TUBERCULOSIS, CASE OR SUSPECT (INITIAL VISIT)

SUBJECTIVE

Symptoms may include the following:

| | |
|-------------------------|--------------|
| Cough >2 weeks | Chills |
| Hemoptysis | Night sweats |
| Chest pain | Weight loss |
| Fever | Fatigue |
| Referral from physician | |

OBJECTIVE

| | |
|---|--------------------------------|
| Productive cough | Respirations normal or labored |
| Thin, pale | Documented weight loss |
| HIV status | Jaundice, yellow eyes |
| Positive or negative tuberculin skin test (TST) | |
| Positive, negative or indeterminate IGRA (Indeterminate should be repeated) | |
| Positive or negative smear, cultures, or culture pending | |
| Abnormal chest X-ray | |
| Other diagnostic tests/results | |

Baseline measurement from TB clinic to include CMP, CBC with platelets and differential, and HIV. (Routine laboratory monitoring for toxicity is generally not needed in individuals with normal baseline.)

Clinical information from other providers, hospital

ASSESSMENT

Tuberculosis suspect (culture report not available)

Tuberculosis case (culture report or nucleic acid amplification test result is positive, indicate site of infection)

Latent Tuberculosis Infection (LTBI)

PLAN

Have patient wear surgical mask if symptomatic; nurse must wear n-95 mask

Initial Nursing Assessment:

Face to face contact will be made within 24 hours of notification of new infectious (sputum smear positive or cavitory on chest x-ray) TB suspect/case; this contact may be in the home, office, hospital, or other facility

Explain contact investigation and begin identifying contacts

Face to face contact visit will be made within 3 working days of notification of a newly diagnosed case or suspect who is:

- sputum smear negative,
- culture pending or culture positive,
- abnormal chest x-ray non-cavitary

Records should be obtained within 24 hours of report of suspect

Conduct Home Assessment:

If the initial visit is not a home visit, nurse should make a home visit to assess the home environment within 3 working days from notification; preferably the home visit should be made prior to patient's discharge from hospital, but no later than 24 hours after discharge from a hospital (see TB Guidelines)

Nurse must ensure that no immunosuppressed persons or children <4 years of age are in the home if an infectious patient is being discharged home

Provide Screening Evaluation:

Consider psychosocial, cultural background, and language/literacy level

Provide interpreter services as needed

Complete TB/LTBI Risk Assessment Tool (if not done previously) and evaluate history, including onset and duration of symptoms and signs for TB (as listed above)

Evaluate for possible pregnancy

Screen for any contraindications to anti-tuberculosis drugs (using PH 2040, Screening and Monitoring Forms)

Observe patients and family's ability and availability of resources to cope, adherence to medications regimen, and compliance with follow-up

If being treated by private physician, obtain record of physical exam, chest X-ray report, significant lab tests (sputum cultures, liver functions, and WBC) and medication orders

Ascertain whether MD will follow or if Health Department to follow; if Health Department to follow, refer to TB Clinic

Assure that a focused physical exam and chest X-ray have been performed by TB clinic MD/NP; if not done, refer back to TB clinic

Begin contact investigation

If patient is hospitalized, notify hospital of isolation discharge requirements

If patient is discharged from hospital, obtain and send copy of all records (notes, lab, and radiology reports, physician orders, and medication sheets) to regional TB clinic

Obtain and Document the Following Information:

Physician referral of suspect, case, or orders for anti-TB drugs

Known contacts

HIV status/other TB risk factors

PPD skin test history (including measurement) or previous IGRA test (including dates and results)

Previous history of –

Tuberculosis disease

TB infection (LTBI)

Administration of anti-TB medications

Symptoms including –

Date of first symptom

Weakness, weight loss, anorexia

“Flu-like” episode, chills, fever

Productive cough, chest pain, blood in sputum

Night sweats

Other health problems including –

HIV or immunosuppression

Diabetes mellitus

Liver or kidney disease

History of alcohol or drug abuse

Current medications (including OTCs and herbal medicines)

LMP

Allergies

Other evaluation by private MD, other providers, or health care facility

Special patient needs

Treatment:

Instruct on home isolation precautions until no longer infectious, or place patient on isolation if indicated

Measure height, weight, and vital signs initially.

Obtain weight and vital signs monthly

Directly observed therapy (DOT) is the standard of care for all TB cases

Dispense anti-tuberculosis drugs as prescribed by TB clinic physician (only those medications approved by TB clinic MD may be dispensed)

If on ETHAMBUTOL perform visual acuity (Snellen chart) and Red/Green color discrimination monthly; if patient wears glasses, check vision with glasses and note this in record

If STREPTOMYCIN or an AMINOGLYCOSIDE (Capreomycin, Amikacin) is to be used, obtain BUN and creatinine; patient should be questioned at baseline and monthly about possible hearing loss or tinnitus, and monitor vestibular function using the Romberg at baseline and monthly

At treatment initiation, if not drawn in TB clinic, draw CMP, CBC with platelets and differential

and HIV (if not known); all labs to be reviewed by physician
 Issue 3 sputum containers, dated and numbered (if pulmonary TB or to rule out pulmonary TB)
 with instructions for collecting in AM
 Collect first sputum specimen in clinic in person by sputum induction using 3% sodium
 chloride.
 Issue patient 2 pre-labeled and dated cans for use the next 2 consecutive days for natural sputum
 collection
 Complete all required fields on lab requisition
 DOT worker should pick up sputums at home on the day of collection for mailing to the lab from
 the local health department

Perform Contact Investigation (see TB Guidelines)

All high-risk contacts should be tested within 7 working days
 Completion of initial medical assessments of high-risk contacts should be completed within 10
 working days of contact identification.
 Document all contact information on PH 1631, “TB Contact Record”

NOTE: IGRA test is preferred for baseline testing for contacts ≥ 5 years of age.
 All contacts should receive an IGRA or TST if they have a documented negative PPD or IGRA
 history.

All high-risk contacts (from all environments) that have a positive IGRA or Positive TST are to
 have a chest X-ray and evaluation by an MD or APN.
 Contacts that have an initial negative TST or IGRA but are at risk of progression to active TB
 (i.e., children < 4, immunosuppressed persons, pregnant women, dialysis patients, HIV+, etc.)
 are to have a chest X-ray and evaluation by an MD or APN as soon as possible.

All contacts with an initial negative IGRA or TST should have a repeat IGRA or TST at 8-10
 weeks after contact is broken (last exposure) with the suspect/case; only one IGRA or TST is
 needed if contact has been broken for more than 10 weeks when initially tested.

NOTE: Use consistent method of testing for evaluation of a contact

Example:

- if IGRA is drawn initially, then at 8-10 weeks, IGRA will be repeated
- if Tubersol PPD is placed initially, then at 8-10 weeks, a second PPD will be placed
 using Tubersol
- if Aplisol PPD is placed initially, then at 8-10 weeks, a second PPD will be placed
 using Aplisol

Any contact that has an **indeterminate** IGRA is to be retested within 1-2 weeks.

Consult with regional TB nurse/physician for preventative therapy on ALL children who are
 close contacts of infectious or potentially infectious cases of TB, regardless of skin test results.

Document on contact record (PH 1631).

When contact investigation is completed, send a copy of PH 1631 to Regional TB office.

Provide Follow-up

If patient is being followed by Health Department TB physician, schedule monthly return appointments to TB clinic.

If patient is being followed by a private provider, schedule monthly visit with PHN to dispense medication(s) and document any medication side effects.

Obtain monthly office visit medical record notes from private provider prior to monthly PHN visit at health department.

For patients with active TB:

- Ensure DOT as ordered by physician until regimen is completed
- Assess for side effects each time DOT is given
- Weigh at every TB clinic visit
- Ensure baseline labs and sputum culture results are in chart
- Report any symptoms suggesting toxicity promptly to the treating physician and obtain appropriate lab specimens as ordered
- If on ETHAMBUTOL, perform monthly vision checks including visual acuity and color red/green discrimination
- If on STREPTOMYCIN or an AMINOGLYCOSIDE (Capreomycin, Amikacin), perform monthly Romberg and hearing evaluation (see TB Guidelines)
- Repeat liver testing if indicated (underlying liver disease, alcohol use symptoms) or as ordered by physician
- Issue sputum containers (set of 3) at least monthly but should be more frequently if patient is infectious; three sputum cultures must be obtained at one month and two months as ordered by physician (document reason if unable to obtain and notify Regional TB clinic), remind physician to order at 2 months if not done
- Sputum cultures must be done every month until patient has 3 consecutive negative cultures for 2 consecutive months
- When culture sent to outside labs, contact private provider or lab to ensure culture and sensitivity are ordered and that culture isolate is sent to state lab
- Send a copy of completed drug monitoring sheet to the regional TB clinic monthly
- Ensure TB clinic is aware of all culture and sensitivity results

Provide Referral:

- Current medication intolerance and/or adverse reactions
- Abnormal laboratory findings
- Pregnancy
- Non-adherence

REFERENCES

- CDC. Core curriculum on TB: What the Clinician Should Know, 5th Ed., 2011.
- 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. [Guidelines for Using the QuantiFERON–TB Gold Test for Detecting *Mycobacterium tuberculosis* Infection, United States](#) *MMWR* 2005; 54 (No. RR–15, 1–37)
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<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
- Reichman LB, and Hershfield ES, eds. Tuberculosis: A Comprehensive International Approach, 2000; Vol. 144.
- Report of the Committee on Infectious Diseases*. Elk Grove Village, IL
- Tennessee Department of Health Tuberculosis Guidelines, 2004

TUBERCULOSIS, Treatment of Latent Tuberculosis Infection (LTBI)

Latent Tuberculosis Infection (LTBI) is an asymptomatic state in persons who are infected with Mycobacterium tuberculosis and have future risk of developing active TB, but is not currently infectious to others.

SUBJECTIVE:

History of positive Mantoux skin test or positive IGRA
Physician referral
History of positive HIV status
Previous treatment for LTBI
Contact to TB case or suspect
Risk factor(s) for TB on TB/LTBI Risk Assessment Tool (RAT)
Clinical information from other providers if applicable

OBJECTIVE:

Positive tuberculin skin test
Positive IGRA
Normal chest x-ray
No symptoms of TB

ASSESSMENT:

Positive tuberculin skin test
Positive IGRA
Immunosuppressed with known contact to TB case/suspect regardless of TST results
Child <4 years and contact to TB case/suspect regardless of TST results
Pregnant and contact to TB case/suspect regardless of TST results
Diabetic patients with a documented positive test or positive IGRA who cannot prove that they have completed adequate LTBI treatment should be assessed for new risk factors

PLAN:

Provide Screening Evaluation:

Complete TB/LTBI Risk Assessment Tool (TB RAT)
Provide TB testing, if appropriate
Make appointment for patient with the regional TB clinic for evaluation if not previously done and/or consult with TB clinic staff
Notify TB physician of any patient with TB symptoms
Patient will be evaluated by physician in TB clinic. Evaluation will include focused physical exam, chest x-ray (including PA and lateral for children), and appropriate lab tests, if indicated by physician
Obtain records from other providers
Obtain medical history
Record any allergies or previous adverse reactions to medications

Assess and document all current medications (prescription, OTCs, or home remedies)
 Assess and document history of substance abuse (alcohol or drugs)

Treatment:

Perform baseline laboratory tests CMP, CBC with platelets & without differential, (including HIV if not already drawn) for:

- Persons with chronic liver disease (see TB Guidelines)
- Those whose initial evaluation suggests a liver disorder
- Those with immunosuppression (HIV etc.)
- Pregnant women and those in the immediate post-partum period (i.e., those within 3 months after delivery)
- Those who use alcohol regularly

Testing can be considered on an individual basis for those taking other medications for chronic medical conditions

Obtain written medical order by physician for appropriate anti-tuberculosis medication
 Obtain copy of last office visit if seen by private provider

If patient is a child, notify regional clinic for recommendations and/or specific orders
 All children <4 years of age who are contacts to TB cases/suspects are to receive LTBI therapy until 10 week follow-up skin test is negative (window therapy)

Children (≤18 years of age) are to receive directly observed preventive therapy (DOPT) throughout LTBI

Dispense only one (1) month supply of drugs as ordered by physician

If patient is going out of town for an extended period, consult with TB clinic regarding dispensing more than one-month supply of medication

If patient buying medication, obtain name of drug store and monitor monthly pick-up

Monitor for possible contraindications prior to initiating drug therapy, especially liver disease or factors that may contribute to liver disease (i.e., liver toxic medications, and alcohol abuse) and document on drug monitoring form (notify TB clinic of any contraindications)

Consult with regional TB clinic regarding special circumstances (obtain approval from Regional TB physician to dispense medication orders from private providers; review chart to assure appropriateness)

If patient has stopped TB medication

less than 2 months ago, PHN may restart after consulting with TB Physician and carefully monitoring for signs and symptoms of active TB

greater than 2 months ago, TB physician must re-evaluate patient

Document treatment completion or reasons not completed

Provide Health Teaching:

Discuss specific drug dosage, the anticipated benefits and possible side effects (especially liver toxicity)

Educate patient on whom to contact (give name and number) if side effects develop, including contact for holidays and weekends (emergency room, etc.)

Provide “Patient Medication Instruction Sheet”

Advise patient to stop the drug if adverse reactions occur. Provide name and number of person to contact for instructions.

Educate patient about the importance of disclosing any other medications (prescription, over-the-counter, or home remedies) including use of alcohol or drugs

Educate patient about adverse effects of alcohol use with LTBI medications

Educate patient about the importance of keeping appointments and date of next clinic visit

Provide Documentation:

Send a copy of record, prescriptions and test results to regional TB clinic

Document patient’s verbalized understanding of risks/benefits and willingness to take LTBI treatment

Document TB/LTBI education materials given

Provide Follow up:

Set up tickler card system or utilize computerized tracking for follow-up

If patient does not pick up medication monthly,

 attempt to contact him/her by phone

 send letter requesting patient to contact the office

 make home visit,

 send non-compliance letter from TB physician outlining risks (send a copy to regional clinic along with copy of drug monitoring record)

Dispense only one (1) month supply of drugs as ordered by physician

Complete clinical evaluation monthly for contraindications and signs/symptoms of adverse reactions while on therapy and notify TB clinic of any signs/symptoms

Ask patient monthly about new medications (prescription, over-the-counter, home remedies)

Provide laboratory monitoring if indicated by clinical evaluation (or ordered by physician)

If any test exceeds the upper limit of normal (ULN), send results to TB clinic or private

 physician for review; if liver enzymes (SGOT/SGPT) exceed ULN by three (3) times

 with symptoms, or by five (5) times without symptoms, or bilirubin is over the ULN at

 any level, notify TB clinic immediately for special orders

Contact patient if appointment not kept

Provide Referral:

Refer patient to private physician or tuberculosis clinic:

 SGOT/SGPT > 3x ULN with symptoms, or > 5x ULN even without symptoms, or any abnormal bilirubin

 Symptoms of adverse reactions or drug toxicity (fill out the FDA 3500 voluntary form and send to the State TB Medical Director for review)

 Patient develops symptoms of active tuberculosis

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

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

Tennessee Department of Health, Tuberculosis Elimination Program Guidelines, 2005

URTICARIA (Hives)

SUBJECTIVE

Itchy, red welts present on skin either singly or in crops
Often exposure to aggravating substance reported, i.e., drug, food, insect bites, inhalant, or in association with an infection

OBJECTIVE

Erythematous, raised plaques of varying size, with distinct borders - may coalesce
May involve trunk and/or extremities
Often evidence of scratching

ASSESSMENT

Urticaria Reaction (Hives)

PLAN

Critical to **R/O ANAPHYLAXIS** with complete and immediate physical assessment - if evidence of hypotension, tachycardia, coughing, anxiety, dyspnea, wheezing, vomiting or cyanosis, refer to emergency treatment protocol; if symptoms began within last 2 hours, patient should be observed in clinic for a minimum of 30 minutes for development of further signs and symptoms

Mild Urticaria:

Assess etiology (diet history, drug history, insect bites), and counsel on avoidance of allergen
Use of oral antihistamine, i.e., Diphenhydramine HCL or Chlorpheniramine maleate syrup (as directed); Benadryl dosage according to packet-instructions.

WARN REGARDING DROWSINESS EFFECT OF ANTIHISTAMINE THERAPY

Treat pruritis with colloidal oatmeal (Aveeno bath)
Cut and clean nails to help prevent infection

Referral Indicators:

Anaphylaxis reaction after stabilization
Any evidence of respiratory involvement
Widespread urticaria, intense pruritis, or angioedema producing deeper, larger wheels, usually on hands, feet, lips, and eyelids
Evidence of secondary bacterial infection
Chronic or recurrent urticaria

Follow-Up:

Closely monitor response to treatment
Immediate assessment warranted if reaction reoccurs

Reference:

Mayo Clinic, Guide To Self-Care, Fifth Edition 2006
Ferri's Clinical Advisor 2008

VARICELLA (Chickenpox)

SUBJECTIVE

Fever, chills, headache, malaise
Itchy rash - first appears on trunk, later on face, neck, and extremities

OBJECTIVE

Discrete lesions; progress from macule to papule to vesicle to scab; appear in crops; various forms are present simultaneously; crusted vesicles
Rash generally follows active case exposure in about 14 days

ASSESSMENT

Varicella (chickenpox)

PLAN

Advise chickenpox is extremely contagious - keep away from others;
communicable from one to two days prior to onset of symptoms until all lesions
have crusted over (usually about six days after appearance of rash);
incubation period 14-21 days

Keep in house and out of school until all lesions are crusted or dry

Bathe with soap and water, lukewarm baking soda baths, or colloidal
oatmeal (Aveeno baths)
Cut fingernails short and encourage not to scratch; apply calamine or caladryl lotion
to lesions for itching
Recommend diphenhydramine (Benadryl) if needed; dosage according to package
instructions; warn regarding drowsiness
Use acetaminophen for elevated temperature,
CAUTION - DO NOT USE ASPIRIN (REYE'S SYNDROME)
Antibiotics not needed routinely

Referral Indicators:

Patients receiving steroid or immunosuppressive therapy or are immunocompromised
Patients with malignant disease
Newborns
Development of cough, shortness of breath, pneumonia, bleeding problems, or central nervous
system symptoms (i.e., Reye's Syndrome, encephalitis)
Secondary bacterial infections
Significant eye involvement
For those wishing to be treated with Acyclovir

Follow-Up:

In routine cases, no follow-up required
Varicella vaccine available for those 12 months and older

Reference:

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

SECTION IV: IMMUNIZATIONS

4.010 – 4.290

COMVAX (Haemophilus b Conjugate (Meningococcal Protein Conjugate) and Hepatitis B (Recombinant Vaccine))

GENERAL INFORMATION:

Hepatitis B vaccine is available in combination with *Haemophilus influenzae* type b (Hib) vaccine as Comvax® (by Merck). It is licensed for use when either or both antigens are indicated and the other antigen is not contraindicated. Because premature Hib vaccination can cause non-response to subsequent doses (“immunotolerance”) of Hib vaccine, instead of immunity, no Hib-containing vaccine should ever be administered before 6 weeks of age. Comvax may be used to complete the hepatitis B vaccine series in all infants, including those whose mothers are or may be infected with hepatitis B virus (HBsAg positive or HBsAg status unknown). (For additional information, see HIB and Hepatitis protocols)

Contraindications and precautions

Severe allergic reaction to vaccine component or following a prior dose
Moderate or severe acute illness
Age younger than 6 weeks

Adverse events may include:

Swelling, redness and/or pain
Systemic reactions infrequent, serious adverse reactions rare

PLAN

Have accompanying adult read “Vaccine Information Statement”/“Vaccine Information Materials”

Counsel regarding benefits, side effects, and management

Administration of Vaccine:

RECOMMENDED SCHEDULE

| Age | | Volume and Route | Minimum Age | Minimum interval |
|--------------|--------------|------------------|-------------|----------------------|
| 2 months | Primary dose | 0.5ml IM | 6 weeks | |
| 4 months | Primary dose | 0.5ml IM | | 4 weeks after dose 1 |
| 12-15 months | Booster dose | 0.5ml IM | 12 months | 8 weeks after dose 2 |

OFF SCHEDULE AND MIXING WITH OTHER HIB AND HEPATITIS B VACCINE

Children who have started the vaccine with Comvax or PedvaxHIB may complete the series with PedvaxHIB and/or Comvax following the 2 –dose primary series with a third dose as a booster after the first birthday (remember to administer Hepatitis B with PedvaxHIB)

If it is necessary to change vaccine type (by switching to a different type of Hib vaccine, such as ActHIB® or Pentacel® by Sanofi Pasteur), then three (3) doses of any combination constitute the primary series. In such cases, either vaccine may be used for the booster (4th dose), regardless of what was administered in the primary series (remember to administer a hepatitis B vaccine, if necessary, when using a Hib vaccine other than Comvax)

DELAYED VACCINE SCHEDULES

| VACCINE | AGE STARTING HIB AND HEP B SERIES | RECOMMENDED CATCH-UP FOR OLDER CHILDREN |
|--------------------|-----------------------------------|---|
| Hepatitis B | Birth (no Hib given) | Follow routine Comvax schedule above. Final valid Hep B dose is the booster dose (a 4-month dose is too early to be a valid 3 rd Hep B). |
| Comvax | Starting at 12-14 months | Give 2 doses of Comvax two (2) months apart and the third hepatitis B vaccine six (6) months after first Comvax |
| Comvax | Starting at 15-59 months | Give one dose of Comvax; give second hepatitis B at least 4 weeks later, and 3 rd (final) dose at least 8 weeks after the second dose and at least 16 weeks after the Comvax dose;* only one dose of Hib vaccine is required at this age |

*The accelerated catch up schedule is recommended whenever children are behind on their shots.

NOTE

If a child is **greater than 59 months of age**, Hib-containing vaccine is not normally indicated. Older children, if at **high risk** (e.g., sickle cell, post splenectomy, immunodeficient), may receive Hib-containing vaccine with a health department physician or nurse practitioner's order.

Comvax may be given **simultaneously with all other vaccines**

Comvax may be **interchangeable** with other Hib and Hepatitis B vaccine, but the total number of doses changes if switching brands of Hib vaccines (see schedule above)

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 VAERS form)

Referral Indicators:

Severe allergic (anaphylactic) hypersensitivity to any component of the vaccine

Follow-up:

Return for next Comvax at appropriate intervals

REFERENCES:

"Epidemiology and Prevention of Vaccine-Preventable Diseases, Department of Health and Human Services, Centers for Disease Control and Prevention, 10th Edition, February 2008

DIPHTHERIA, TETANUS TOXOID & ACELLULAR PERTUSSIS VACCINE (DTaP)

GENERAL INFORMATION

DTaP vaccine may be used for children **as early as 6 weeks through 6 years of age (up to 7th birthday)**

The **1st, 2nd, and 3rd doses** of DTaP should be **separated by a minimum of 4 weeks** (28 days)

For **4th dose** of DTaP, child must be **at least 12 months of age, and less than 7 years of age, and, at least 6 months (180 days) since 3rd dose** of DTaP

The **5th dose** of DTaP may be administered **any time after the fourth birthday and at least 6 months since the 4th dose** of DTaP vaccine (any brand of DTaP may be used for the 5th dose)

If a child has a **valid contraindication to Pertussis vaccine, DT should be used to complete the series:**

If a child is **12 months of age or older** when the first dose of DT vaccine is given (as DTaP or DT), then a total of **three doses** of DT (third dose 6-12 months after the second) are needed to complete the primary DT series

If the first dose is given **before 12 months, four primary doses** are required to complete the DT series

Contraindications to giving the vaccine include the following:

An immediate anaphylactic reaction to a vaccine or following a previous dose of vaccine containing any of the components of DTaP (diphtheria, tetanus, or pertussis)

Encephalopathy within 7 days of administration of previous dose of DTP or DTaP

The following precautions, although not considered contraindications, should be carefully evaluated concerning the risks and benefits of vaccination for individuals who experienced any one of the following adverse reactions:

Temperature of 105°F or higher within 48 hours (with no other identifiable cause) after vaccination with DTaP/DTP

Collapse or shock-like state (hypotonic-hyporesponsive episode) within 48 hours after vaccination with DTaP/DTP

Persistent, inconsolable crying lasting 3 hours or more, occurring within 48 hours after vaccination with DTaP/DTP

Convulsions, with or without fever, within 3 days after vaccination with DTaP/DTP

Defer vaccination of children with moderate to severe acute illness until they are well

NOTE: Stable/resolved neurologic condition (i.e., controlled epilepsy, cerebral palsy, or developmental delay), or a family history of convulsions in first-degree family members (parents or siblings) is **not** a contraindication for DTaP.

If a child has any of the following conditions, vaccination should be delayed until the child has been evaluated, treatment initiated, and the condition stabilized: (1) an evolving neurologic disorder (uncontrolled epilepsy, infantile spasms, progressive encephalopathy); (2) a history of seizures which has not been evaluated; or, (3) a neurologic event which occurs between doses of pertussis containing vaccine.

Adverse events include the following:

Local reactions (erythema, induration), increased risk of injection site swelling following 4th or

5th dose (not harmful, resolves spontaneously), nodule at injection site

Hypersensitivity reactions (Arthus-type)

Fever and systemic symptoms are uncommon

Severe systemic reactions are rare

PLAN

Ask parent or guardian about the medical history and recent health status of the child to determine the existence of any contraindications

Ask parent or guardian about adverse reaction after previous dose

Counsel regarding benefits, side effects, and management.

Recommend that parent may administer acetaminophen if a fever develops and the child is uncomfortable. If the child does not show signs of discomfort, medication is not necessary.

Have accompanying adult read “Vaccine Information Statement” (VIS)

Administer 0.5 cc DTaP vaccine INTRAMUSCULARLY according to recommended schedule:

| VACCINE | DOSE # | AGE | MINIMUM AGE | MINIMUM INTERVAL |
|---------|-------------|--------------|---|---|
| DTaP | Primary 1 | 2 months | 6 weeks | |
| | Primary 2 | 4 months | | at least 4 weeks since dose #1 |
| | Primary 3 | 6 months | | at least 4 weeks since dose #2 |
| | Primary 4 | 12-18 months | 12 months | at least 6 months since dose #3, but less than 7 years of age |
| | Booster (5) | 4-6 years | any time after 4 th birthday | at least 6 months since dose #4: not recommended if #4 given on or after 4 th birthday |

Advise to wait in clinic for 20 minutes after injection

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

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

Referral Indicators:

Unstable neurological conditions
Allergic hypersensitivity to any component of the vaccine
Severe reaction to previous DTaP/DTP
If severe reaction is reported as occurring within 30 days following vaccine administered by health department personnel, VAERS Report form must be completed
Undiagnosed seizure disorder
Refer for Tdap at 11-12 years

Follow-up:

Return for next DTaP, Tdap, or Td at appropriate interval
If child was **6 years and 6 months of age or older when DTaP #3** was given, **no additional DTaP or DT is indicated** because DTaP #4 must be given at least 6 months after DTaP #3, but before the 7th birthday
The **5th dose is omitted** if DTaP #4 was given on or after the 4th birthday
The **5th dose is given** if DTaP #4 was given prior to the 4th birthday, **AND it has been at least 6 months since DTaP was given, AND the child is at least 4 years old but less than 7 years old**
After completion of series, refer for Tdap at 11-12 years (if 5 years since last DTP or DtaP) and subsequently for Td every 10 years

REFERENCES:

Current PDR Packet Instructions
National Childhood Vaccine Injury Act
“Epidemiology and Prevention of Vaccine-Preventable Diseases”, Centers for Disease control and Prevention, DHHS, Current Addition
Current ACIP recommendations

DIPHTHERIA AND TETANUS TOXOID, PEDIATRIC DT (Pediatric)

GENERAL INFORMATION

DT is indicated in situations when there is documented history of severe reaction to previous DTaP/DTP:

- Fever of 105° F or greater ($\geq 40.5^{\circ}\text{C}$) (by any measurement route) not due to another identifiable cause within 48 hours of previous dose
- Collapse or shock-like state within 48 hours or more of previous dose
- Persistent, inconsolable crying or screaming for 3 or more hours within 48 hours of previous dose
- Convulsions (seizures) with or without fever within 3 days of a previous DTaP dose
- Encephalopathy

Contraindications to DT vaccine include the following:

- A history of neurologic reaction following previous dose of DT
- A history of severe allergic reaction (acute respiratory distress or collapse) to any vaccine containing diphtheria or tetanus antigen (e.g., DT or DTaP)
- Moderate to severe acute illness

PLAN

- Document medical contraindications to DTP/DTaP
- Have accompanying adult read "Vaccine Information Statement" (VIS) and "Vaccine Information Material"
- Counsel regarding benefits, side effects, and management
- Administer 0.5 cc DT (Pediatric) vaccine INTRAMUSCULARLY according to recommended schedule:

| VACCINE | DOSE # | AGE |
|------------|----------------------------|---|
| DT/DTaP | Primary 1 | 2 months |
| | Primary 2 | 4 months (or at least 4 weeks since dose #1) |
| | Primary 3 | 6 months (or at least 4 weeks since dose #2) |
| | Primary 4 ¹ | 12-18 months (must be at least 12 mos but less than 7 yrs of age, and at least 6 mos since dose #3) |
| | Booster (5) ^{1,2} | 4-6 years (any time after 4 th birthday, but at least 6 mos since dose #4 and before 7 th birthday) |
| TDAP or TD | Booster | 11-12 years |

¹ If Dose #1 is given at or after age 12 months, Dose #4 acts as a booster and should be given at age 4-6 years, Dose #5 is not recommended.

² If Dose #4 is given after the 4th birthday, Dose #5 is not recommended.

Provide statement regarding medical exemption in accordance with HIPAA guidelines (state that the child is exempt, but do not state the medical condition requiring exemption)

Advise parent that child is not protected from pertussis

Advise to wait in clinic 20 minutes after injection

Record manufacturer and lot-number of the vaccine administered, date vaccine and VIS were given, date of VIS version and name, address, and title of person administering vaccine

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

Referral Indicators:

Neurologic conditions associated with vaccine use Allergic hypersensitivity to any component of the vaccine History of severe reaction to previous dose of DT (Pediatric)

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

Vaccination of children with moderate to severe acute illness should be deferred until condition improves

Follow-up:

The child should return for the next scheduled dose according to the table above

When the series is completed, the child should return for a booster dose of Tdap or Td (per the Tdap protocol) at age 11-12 years.

REFERENCES

“Epidemiology and Prevention of Vaccine - Preventable Diseases” Centers for Disease Control and Prevention, DHHS, Jan. 2004

DIPHTHERIA, TETANUS TOXOID, ACELLULAR PERTUSSIS, INACTIVATED POLIO VACCINE (DTaP-IPV) (Kinrix®, by GSK)

GENERAL INFORMATION

Kinrix® (DTaP-IPV booster), by GSK, is licensed as a single dose by the FDA as the fifth dose in the diphtheria, tetanus, and acellular pertussis (DTaP) vaccine series and the fourth dose in the inactivated poliovirus vaccine (IPV) series in children 4 through 6 years of age. Kinrix® may be used only once as the DTaP-IPV booster dose routinely administered between ages 4 and 6 years

Contraindications to giving the vaccine include the following:

Kinrix® is not licensed for use before the 4th birthday or after the 7th birthday

An immediate anaphylactic reaction following a previous dose of vaccine containing any of the components of DTaP or IPV (diphtheria, tetanus, pertussis or poliomyelitis) or any vaccine components, including neomycin and polymixin B.

Encephalopathy within 7 days of administration of previous dose of DTP or DTaP Progressive neurologic disorder

Children with a severe (anaphylactic) allergy to latex should not receive Kinrix® in the pre-filled vaccine formulation. The single dose vial preparation is latex free.

The following precautions, although not considered contraindications, should be carefully evaluated concerning the risks and benefits of vaccination for individuals who experienced any one of the following adverse reactions:

Temperature of 105°F or higher within 48 hours (with no other identifiable cause) after vaccination with DTaP/DTP

Collapse or shock-like state (hypotonic-hyporesponsive episode) within 48 hours after vaccination with DTaP/DTP

Persistent, inconsolable crying lasting 3 hours or more, occurring within 48 hours after vaccination with DTaP/DTP

Convulsions, with or without fever, within 3 days after vaccination with DTaP/DTP

Guillain-Barre Syndrome occurring within 6 weeks of a previous dose of a tetanus toxoid- containing vaccine.

Defer vaccination of children with moderate to severe acute illness until they are well

NOTE: Stable/resolved neurologic condition (i.e., controlled epilepsy, cerebral palsy, or developmental delay), or a family history of convulsions in first-degree family members (parents or siblings) is **not** a contraindication for DTaP. If a child has any of the following conditions, vaccination should be delayed until the child has been evaluated, treatment initiated, and the condition stabilized: (1) an evolving neurologic disorder (uncontrolled epilepsy, infantile spasms, progressive encephalopathy); (2) a history of seizures which has not been evaluated; or, (3) a neurologic event which occurs between doses of pertussis containing vaccine.

Adverse events include the following:

Local reactions (injection site pain, swelling or redness)
Nodule at injection site
Hypersensitivity reactions (Arthus-type)
Fever
Drowsiness, loss of appetite
Severe systemic reactions are rare

PLAN

Ask parent or guardian about the medical history and recent health status of the child to determine the existence of any contraindications
Ask parent or guardian about adverse reaction after previous dose
Counsel regarding benefits, side effects, and management; recommend that parent may administer acetaminophen if a fever develops and the child is uncomfortable. If the child does not show signs of discomfort, medication is not necessary.
Have accompanying adult read “Vaccine Information Statement” (VIS)
Administer vaccine INTRAMUSCULARLY
Advise to wait in clinic for 20 minutes after injection
Record manufacturer and lot number of the vaccine administered, date that vaccine and VIS were given, name, address, and title of person administering vaccine
Instruct parent to contact Health Department if adverse reaction occurs (complete VAERS form)

Referral Indicators:

Unstable neurological conditions
Allergic hypersensitivity to any component of the vaccine
Severe reaction to previous DTaP/DTP or IPV
If severe reaction is reported as occurring within 30 days following vaccine administered by health department personnel, VAERS Report form must be completed
Refer for Tdap at 11-12 years

Follow-up:

After completion of series, refer for Tdap at 11-12 years

REFERENCES:

KINRIX™ (Diphtheria and Tetanus Toxoids and Acellular Pertussis Adsorbed and Inactivated Poliovirus Vaccine) by GSK. Package Insert June 2008.

“Epidemiology and Prevention of Vaccine-Preventable Diseases”, Centers for Disease Control and Prevention, DHHS, current edition. <http://www.cdc.gov/vaccines/pubs/pinkbook/pink-chapters.htm>. Last accessed August 12, 2008.

**DIPHTHERIA, TETANUS TOXOID & ACELLULAR
PERTUSSIS, INACTIVATED POLIO, HAEMOPHILUS
INFLUENZAE TYPE B COMBINATION VACCINE:
DTaP-IPV- Hib (PENTACEL[®] BY SANOFI PASTEUR)**

GENERAL INFORMATION

Pentacel® (DTaP-IPV-Hib) vaccine is licensed for use as doses 1 through 4 of DTaP, IPV and Hib vaccine series in children **42 days through 4 years** of age (**up to 5th birthday**)

DTaP-IPV-Hib is *not* licensed for use as the 5th dose in the DTaP series.

The vaccine consists of lyophilized ActHIB reconstituted with liquid DTaP-IPV.

The **1st, 2nd, and 3rd** doses of DTaP-IPV-Hib should be **separated by a minimum of 4 weeks**(28 days)

For **4th** dose of DTaP-IPV-Hib, the child must be **at least 12 months of age, and less than 5 years of age, and, at least 6 months (180 days) since 3rd dose** of DTaP

Contraindications to giving the vaccine include the following:

An immediate anaphylactic reaction following a previous dose of vaccine containing any of the components of DTaP-IPV-Hib

Encephalopathy within 7 days of administration of previous dose of any pertussis containing vaccine

No pertussis-containing vaccine should be given to a child with a progressive neurological disorder (see Note below)

The following precautions, although not considered contraindications, should be carefully evaluated concerning the risks and benefits of vaccination for individuals who experienced any one of the following adverse reactions:

Temperature of 105°F or higher within 48 hours (with no other identifiable cause) after vaccination with DTaP/DTP

Collapse or shock-like state (hypotonic-hyporesponsive episode) within 48 hours after vaccination with DTaP/DTP

Persistent, inconsolable crying lasting 3 hours or more, occurring within 48 hours after vaccination with DTaP/DTP

Seizures, with or without fever, within 3 days after vaccination with DTaP/DTP

Guillain-Barre syndrome within 6 weeks of a previous dose of a tetanus toxoid-containing vaccine

Defer vaccination of children with moderate to severe acute illness until they are well

NOTE: Stable/resolved neurologic condition (e.g., controlled epilepsy, cerebral palsy, or developmental delay), or a family history of convulsions is **not** a contraindication for DTaP.

If a child has any of the following conditions, vaccination should be delayed until the child has been evaluated, treatment initiated, and the condition stabilized: (1) an evolving neurologic disorder (uncontrolled epilepsy, infantile spasms or progressive encephalopathy); (2) a history of seizures which has not been evaluated; or, (3) a neurologic event which occurs between doses of pertussis containing vaccine.

Adverse events include the following:

Local reactions (pain, redness, swelling at injection site)

Increased chance of injection site swelling following 4th dose (not harmful, resolves spontaneously)

Nodule at injection site

Hypersensitivity reactions (Arthus-type)

Fever

Severe systemic reactions are rare

PLAN

Ask parent or guardian about the medical history and recent health status of the child to determine the existence of any contraindications

Ask parent or guardian about adverse reaction after previous dose

Counsel regarding benefits, side effects, and management; recommend that parent may administer acetaminophen if a fever develops and the child is uncomfortable. If the child does not show signs of discomfort, medication is not necessary.

Have accompanying adult read "Vaccine Information Statement" (VIS)

Reconstitute vaccine according to manufacturer's instructions

Administer vaccine INTRAMUSCULARLY according to recommended schedule:

| VACCINE | DOSE # | AGE |
|------------------|--------|---|
| DTaP-IPV- Hib | 1 | 2 months (minimum age 6 weeks) |
| | 2 | 4 months (or at least 4 weeks since dose #1) |
| | 3 | 6 months (or at least 4 weeks since dose #2) |
| | 4 | 12-18 months (must be at least 12 mos but less than 5 yrs of age, and at least 6 mos since dose #3) |

Advise to wait in clinic for 20 minutes after injection

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

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

Referral Indicators:

Unstable neurological conditions

Allergic hypersensitivity to any component of the vaccine

Severe reaction to previous DTaP, IPV, Hib or other vaccine component

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

If history of more than one seizure, consult with patient's private physician or public health physician

Refer for DTaP 5th dose and IPV final dose at age 4-6 years – The complete primary IPV series requires that the final dose be given on or after the 4th birthday. A 5th dose of IPV is necessary if the 4th dose was administered more than 4 days before the 4th birthday.

Follow-up:

Return for next DTaP appropriate interval

The 5th dose is omitted if DTaP #4 was given on or after the 4th birthday

The child will need a final dose of IPV after the 4th birthday (or up to 4 days before)

REFERENCES:

Diphtheria and Tetanus Toxoids and Acellular Pertussis Adsorbed, Inactivated Poliovirus and Haemophilus b Conjugate (Tetanus Toxoid Conjugate) Vaccine (Pentacel®) by Sanofi Pasteur. Package Insert. June 2008.

MMWR, Updated Recommendations for Use of Tetanus Toxoid, Reduced Diphtheria Toxoid and Acellular Pertussis (Tdap) Vaccine from the Advisory Committee on Immunization Practices (ACIP), January 14, 2011/60(01);13-15.

http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6001a4.htm?s_cid=mm6001a4_w

GENERIC INJECTIONS

GENERAL INFORMATION

Physician may request administration of specific injection

Patient may have received one injection, without side effects, from outside provider

A written physician's order, including dosage and duration (phone order followed by a written order within 72 hours), is required

Order must be current (within 6 months, unless otherwise specified by Health Officer)

PLAN

Health Officer will review all physicians' orders requesting injections for appropriateness

Approval will be granted for a maximum 6 months (time frame dependent on specific injection and/or individual circumstances)

Patient to provide own medication

Read medical insert regarding administration and side effects of the medication

Administer medication as ordered by physician

Counsel on side effects

Give return appointment

Rotate injection sites on return appointments

Re-certify physician orders as indicated

HAEMOPHILUS *INFLUENZAE* type b CONJUGATE VACCINE (Hib)

GENERAL INFORMATION

Contraindications and Precautions include the following:

- Anaphylactic reaction to a vaccine component or following a prior dose of that vaccine
- Moderate or severe acute illness
- Children younger than 6 weeks of age

Adverse events include the following:

- Swelling, redness and/or pain
- Systemic reactions infrequent, serious adverse reactions rare

ACIP Recommended Population

- All infants, including those born premature should receive a primary series conjugate Hib vaccine (separate or in combination), beginning at 2 months of age.
- The number of doses in the primary series depends on the type of vaccine used.
 - A primary series of PRP-OMP (PedvaxHIB) vaccine is two doses;
 - PRP-T (ActHIB) requires a three-dose primary series (see table).

A booster is recommended at 12-15 months regardless of which vaccine is used for the primary series.

One dose of Hib vaccine should be administered to persons who have functional or anatomic asplenia or sickle cell disease or are undergoing elective splenectomy if they have not previously received Hib vaccine. Hib vaccination 14 or more days before splenectomy is suggested. Recipients of a hematopoietic stem cell transplant should be vaccinated with a 3-dose regimen 6 to 12 months after a successful transplant, regardless of vaccination history; at least 4 weeks should separate doses. Administer with MD or APN order. (See **Table 2**)

Federally-purchased Hib vaccine is available only to children eligible for the Vaccines for Children (VFC) Program.

Administration of Vaccine:

Appropriate age for Hib: at least 2 months old, but less than 5 years (minimum age 6 weeks)

Appropriate time interval since last Hib

Children who have started the 3 dose primary series of vaccinations with ActHib vaccine may complete the primary series with Pedvax HIB but will still need a total of 3 doses in the primary series. The dose administered routinely after age 12 months is a booster dose.

PLAN

Ask patient/guardian about contraindications

Have patient/guardian read Vaccine Information Statement

Counsel regarding benefits, side effects, and management

NOTE: This vaccine is lyophilized and must be reconstituted with the diluent that is provided with the vaccine; **NO OTHER DILUENT CAN BE USED**; reconstitute with entire content of diluent vial and inject the entire amount of the reconstituted vial; this is a single unit dose and must be administered within 24 hours of reconstitution

Advise to wait in clinic for 20 minutes after injection

Document vaccine administration on the immunization clinic record

Instruct patient/guardian to contact Health Department if adverse reaction occurs

| Vaccine | Age beginning primary series | Primary series | Booster | Minimum interval |
|--------------------------------------|------------------------------|-------------------------|----------------|---|
| PRP-T (ActHib) 0.5cc IM | 2-6 months | 3 doses, 2 months apart | 12-15 months | 4 weeks between dose 1 and dose 2, 4 weeks between dose 2 and dose 3, 8 weeks between dose 3 and booster dose |
| | 7-11 months | 2 doses 2 months apart | 12-15 months | |
| | 12-14 months | 1 dose | 2 months later | |
| | 15-59 months | 1 dose | ---- | |
| PRP-OMP (Pedvax HIB) 0.5 cc IM | 2-6 months | 2 doses, 2 months apart | 12-15 months | 4 weeks between dose 1 and dose 2 8 weeks between dose 2 and booster dose |
| | 7-11 months | 2 doses, 2 months apart | 12-15 months | |
| | 12-14 months | 1 dose | 2 months later | |
| | 15-59 months | 1 dose | --- | |

NOTE:

- If child is greater than 59 months of age, Hib vaccine is not routinely indicated
- Ideally, the same brand of vaccine should be used throughout the entire vaccination series; however, where it is necessary to change the types of vaccine, a child 2-6 months of age seen for the primary series should receive three doses of Hib vaccine (i.e., child receives 1 dose ActHIB should then receive 2 doses of Pedvax HIB or if child receives 2 doses of ActHIB should then receive 1 dose of Pedvax HIB for primary series; child would then get booster at 12-15 months)
- Hib vaccines may be given simultaneously at different injection sites with all other vaccines.
- Hiberix brand PRP-T vaccine is approved only for the booster dose of the Hib series among children 12 months of age and older

Referral Indicators:

Allergic hypersensitivity to any component of the vaccine

Follow-up:

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

Return at appropriate interval according to schedule

TABLE 2. Guidance for *Haemophilus influenzae* type b (Hib) vaccination in high-risk groups

| High-risk group* | Hib vaccine guidance |
|--|---|
| Patients aged <12 mos | Follow routine Hib vaccination recommendations |
| Patients aged 12–59 mos | If unimmunized or received 0 or 1 dose before age 12 mos: 2 doses, 8 wks apart If received ≥2 doses before age 12 mos: 1 dose 8 wks after last dose If completed a primary series and received a booster dose at age ≥12 mos: no additional doses |
| Patients aged <60 months undergoing chemotherapy or radiation therapy† | If routine Hib doses administered ≥14 days before starting therapy: revaccination not required If dose administered within 14 days of starting therapy or given during therapy: repeat doses starting at least 3 mos following therapy completion |
| Patients aged ≥15 mos undergoing elective splenectomy | If unimmunized:‡ 1 dose prior to procedure§ |
| Asplenic patients aged >59 mos and adults | If unimmunized:§ 1 dose |
| HIV-infected children aged ≥60 mos | If unimmunized:§ 1 dose |
| HIV-infected adults | Hib vaccination is not recommended |
| Recipients of hematopoietic stem cell transplant, all ages | Regardless of Hib vaccination history: 3 doses (at least 4 wks apart) beginning 6–12 mos after transplant |

* Persons with functional or anatomic asplenia, HIV infection, immunoglobulin deficiency including immunoglobulin G2 subclass deficiency, or early component complement deficiency, recipients of a hematopoietic stem cell transplant, and those receiving chemotherapy or radiation therapy for malignant neoplasms.

† Some experts suggest conducting serologic testing for these patients (Source: Rubin LG, Levin MJ, Ljungman P, et al. 2013 IDSA clinical practice guideline for vaccination of the immunocompromised host. Clin Infect Dis 2013;[Epub ahead of print] doi: 10.1093/cid/cit684).

‡ Patients who have not received a primary series and booster dose or at least 1 dose of Hib vaccine after 14 months are considered unimmunized.

§ Some experts suggest vaccination at least 14 days before the procedure (Sources: CDC. General recommendations on immunization: recommendations of the Advisory Committee on Immunization Practices [ACIP]. MMWR 2011;60[No. RR-2]; CDC. Recommendations of the Advisory Committee on Immunization Practices

REFERENCES

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

ACIP Adult Immunization Schedule footnote, 2014

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

HEPATITIS A INACTIVATED, HEPATITIS B RECOMBINANT VACCINE (Twinrix®, GSK), Adult (age 18 years and up)

GENERAL INFORMATION

Twinrix® (inactivated hepatitis A and hepatitis B recombinant vaccine) is manufactured by GSK and licensed by the FDA for use in persons 18 years of age and up. It is typically given as a 3-dose series (although an alternative 4-dose schedule also is available).

Please consult current state or local health department policy concerning adults eligible to receive hepatitis A and B vaccines at the health department with or without a health department physician or nurse practitioner order.

In accordance with the general immunization guidelines of the CDC, Twinrix® may be used when protection against either disease is indicated and the other is not contraindicated. If the patient does not need vaccination against both hepatitis A and hepatitis B, then use Twinrix® only when the separate hepatitis A or B vaccine product is not available.

Twinrix® is not licensed for hepatitis A post-exposure prophylaxis (PEP).

Twinrix® may be used for anyone recommended for hepatitis A and B immunization, including, but not limited to:

Persons with chronic liver disease

Persons with an occupational risk of exposure to blood or body fluids and feces

Persons at risk because of sexual practices, including men who have sex with men

International travelers

Recreational injection drug users

Persons who are at increased risk for hepatitis A and are close contacts of persons with hepatitis B infection

Contraindications and precautions include the following:

Anaphylactic reaction to a previous dose of hepatitis A or B vaccine or vaccine component (including neomycin and yeast)

Moderate to severe febrile illness (defer until recovered)

Breast feeding are NOT contraindications if immunization is indicated

Give during pregnancy only if clearly indicated (Refer to a physician)

Persons with severe (anaphylactic) allergy to latex should not be given the vaccine in the pre-filled syringe preparation, which contains natural latex.

The single dose vial stopper is latex free and this preparation may be used for latex-allergic patients.

Administration of vaccine (see dosing schedule charts below):

Twinrix® may be administered simultaneously with any other vaccines; if not administered simultaneously, schedule next visit for deferred vaccine(s) at any time interval (does not have to be 30 days)

If any dose in the series is delayed, it should be administered when possible and the schedule resumed; DO NOT RE-START SERIES

PLAN

Read Vaccine Information Statement (VIS)

Draw up vaccine in accordance with package insert instructions

Administer vaccine IM using deltoid

Advise patient to wait 20 minutes for observation before leaving clinic

Counsel patient to return for next scheduled dose

Advise patient to report any suspected adverse events to the health department (health department to complete and submit VAERS form if necessary)

Recommended Schedule

| ROUTINE | ROUTINE SCHEDULE | ALTERNATE | ALTERNATE SCHEDULE |
|----------------|------------------------------------|------------------|--------------------------------------|
| Dose 1 | 1st visit | Dose 1 | 1st visit |
| Dose 2 | 1 month after 1 st dose | Dose 2 | 7 days after 1 st dose |
| Dose 3 | 6 months after 1st dose | Dose 3 | 21 days after 1 st dose |
| | | Dose 4 | 12 months after 1 st dose |

*doses administered more than 4 days earlier than any minimum interval are considered invalid

Referral Indicators:

Contraindications or precautions as noted

Return at appropriate interval

REFERENCES

GlaxoSmithKline. Prescribing Information. Twinrix (hepatitis A inactivated and hepatitis B recombinant vaccine). April 2007

CDC. A Comprehensive Immunization Strategy to Eliminate Transmission of Hepatitis B Virus Infection in the United States: Recommendations of the Advisory Committee on Immunization Practices (ACIP). Part II: Immunization of Adults. MMWR 2006;55(No. RR-16).

CDC. General Recommendations on Immunization: Recommendations of the Advisory Committee on Immunization Practices (ACIP). MMWR 2006;55(No. RR-15).

HEPATITIS B RECOMBINANT VACCINE, Birth through 18 Years, Pre-Exposure

GENERAL INFORMATION

Immunization is recommended for the following target groups:

ALL infants, beginning with birth dose prior to hospital discharge
ALL patients 18 years of age and under not previously vaccinated

Contraindications and precautions include the following:

Serious reaction to a previous dose of hepatitis B vaccine or vaccine component
Moderate to severe febrile illness (defer until resolved)

Administration of vaccine:

HBV may be administered simultaneously with other vaccines; if not administered simultaneously, schedule visit for deferred vaccine(s) at any time interval (does not have to be 30 days)

See table below for recommended infant and child schedules.

If the vaccination series is interrupted, it should be resumed as soon as possible;
DO NOT RE-START SERIES

PLAN

If patient being evaluated for potential sexual, perinatal or blood exposure to a person with hepatitis B infection, evaluate possible need for HBIG according to section on hepatitis.

Read Vaccine Information Statement (VIS)

Administer vaccine IM using anterolateral thigh of infants and deltoid in all others according to dosage schedule for age (review specific package insert for dosage)

Recommended Schedule/Dosage for Infants/Toddlers

| VACCINE Brand | DOSE | ROUTINE SCHEDULE | MINIMUM INTERVAL (accelerated schedule)* |
|--|--------|------------------------------|--|
| Recombivax HB (Merck) 0.5 ml (5mcg) of Pediatric Formula, or | Dose 1 | Birth | 4 weeks after 1 st dose |
| | Dose 2 | Age 1-2 months | |
| Engerix-B (GSK) 0.5ml (10 mcg) of Pediatric Formula | Dose 3 | Age 6-18 [†] months | 8 weeks after Dose 2 <i>and</i> 16 weeks after Dose 1 <i>and</i> minimum age of 24 weeks |

*doses administered more than 4 days earlier than any minimum interval are considered invalid and do not count toward completion of hepatitis B series

[†] Infants whose mother is hepatitis B positive or of unknown status should receive the last vaccine dose at 6 months of age (12-15 months if Comvax® series is used)

Use of Combination Vaccines in Infants/Toddlers (see separate protocols for details)

| VACCINE Brand | MAY BE USED FOR |
|---|--|
| Comvax (Merck) 0.5 ml (Hep B-Hib combination) | Doses administered after age 6 weeks |
| Pediarix (GSK) DTaP-Hep B- IPV combination | NOTE: The Comvax dose administered at age 4 months does not count toward hepatitis B series because it fails to meet minimum age/interval requirements |

Recommended Schedule/Dosage for older children up to 18 Years of Age

| VACCINE | OPTION | DOSE | RECOMMENDED SCHEDULE | MINIMUM INTERVAL |
|--|---|----------------------|--|--|
| Recombivax HB (Merck) 0.5 ml (5mcg) of Pediatric Formula or Engerix-B (GSK) 0.5ml (10 mcg) of Pediatric Formula | I | Dose 1 | First visit | 4 weeks 8 weeks after Dose 2 <i>and</i> 16 weeks after Dose 1 |
| | | Dose 2 | 1-2 months after 1 st Dose | |
| | | Dose 3 | 6 months after 1 st Dose | |
| Recombivax HB (Merck) 1 ml (10 mcg) ONLY | II If age 11 through 15 years for <u>both</u> doses | Dose 1 Dose 2 | First visit 4-6 months after 1 st dose | 4 months |

Referral Indicators:

Contraindications as noted under "General Information"

Return at appropriate interval to complete immunization series

REFERENCES

CDC. "Epidemiology and Prevention of Vaccine-Preventable Diseases, 10th Edition",
DHHS, January 2007

CDC. A Comprehensive Immunization Strategy to Eliminate Transmission of Hepatitis B Virus Infection in the United States: Recommendations of the Advisory Committee on Immunization Practices (ACIP). Part I: Immunization of Infants, Children and Adolescents. MMWR 2005;54(No. RR-16).

HEPATITIS B RECOMBINANT VACCINE, Adult (age 19 years and up) Pre-Exposure

GENERAL INFORMATION

Please consult current state or local health department policy concerning adults eligible to receive hepatitis B vaccine at the health department. Refer to the **current** Tennessee Immunization Program Policy on the use of Federal vaccine and any current guidance on the use of any special supplies of hepatitis B vaccine.

Immunization is recommended by CDC for the following unvaccinated persons:

ALL at risk adult patients (with ANY one of the following risk factors):

- All sexually-active persons not in long term, mutually-monogamous relationships
- History of more than one sex partner in the past 6 months
- Persons seeking evaluation or treatment of sexually transmitted infection
- History of injecting drug use or sexual partner(s) who use injecting drugs
- Men who have sex with men
- At risk (generally, household, sexual or needle-sharing) contacts of persons with Hepatitis B
- ALL persons served in HIV risk reduction, outreach activities
- Residents and staff of facilities for developmentally delayed persons
- Persons with end-stage renal disease, dialysis, HIV or chronic non-hepatitis B liver disease ALL adults with diabetes younger than age 60 years, generally as soon as possible after diagnosis
- Adults with diabetes aged 60 and over, with health department MD or APN order.
- ALL adults requesting vaccination against hepatitis B (no reported risk factor required)

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.](#)

Contraindications and precautions include the following:

- Anaphylactic reaction to a previous dose of hepatitis B vaccine or vaccine component
- Moderate to severe febrile illness (defer until recovered)
- Pregnancy or breast feeding are NOT contraindications if immunization is indicated

Administration of vaccine (see dosing schedule charts below):

- HBV may be administered simultaneously with any other vaccines; if not administered simultaneously, schedule next visit for deferred vaccine(s) at any time interval (does not have to be 30 days)
- If any dose in the series is delayed, it should be administered when possible and the schedule resumed; DO NOT RE-START SERIES

Immunocompetent persons are not recommended for booster doses. Immunocompetent persons who require serologic evidence of immunity with a documented remote history of hepatitis B immunization and a negative serology may receive a dose to stimulate an immune response and be retested for serologic evidence of immunity in 4 weeks.

PLAN

If patient being evaluated for potential sexual or blood exposure to a person with hepatitis B infection, evaluate possible need for HBIG according to section on hepatitis.

Read Vaccine Information Statement (VIS)

Educate about post-immunization serologic testing if in a group for whom testing is recommended (health care providers, sexual or neonatal contacts of persons with hepatitis B)

Draw up vaccine in accordance with package insert instructions

Administer vaccine IM using deltoid according to dosage schedule for age

Document vaccine administration on the immunization clinic record

Recommended Schedule/Dosage for Adults 19 Years of Age

| VACCINE Brand | DOSE | ROUTINE SCHEDULE | MINIMUM INTERVAL (accelerated schedule)* |
|--|--------|---------------------------------------|---|
| Recombivax HB (Merck) 0.5 ml (5mcg) Pediatric or Adult Formula, or | Dose 1 | 1st visit | 4 weeks after 1 st dose |
| | Dose 2 | 4 weeks after 1 st dose | |
| Engerix-B (GSK) 0.5ml (10 mcg) of Pediatric Formula, or | Dose 3 | 4-6 months after 2 nd dose | 8 weeks after Dose 2 <i>and</i> 16 weeks after Dose 1 |
| Engerix-B Adult formulation 1.0 ml (20 mcg) ³ | | | |

*doses administered more than 4 days earlier than any minimum interval are considered invalid

Recommended Schedule/Dosage for Adults 20 Years of Age and Older

| VACCINE | DOSE | SCHEDULE | MINIMUM INTERVAL (accelerated schedule)* |
|---|--------|---------------------------------------|---|
| Recombivax HB (Merck) 1.0ml (10 mcg) of Adult Formula, or | Dose 1 | 1st visit | 4 weeks after 1 st dose |
| | Dose 2 | 4 weeks after 1 st dose | |
| Engerix-B (GSK) 1.0 ml (20mcg) | Dose 3 | 4-6 months after 2 nd dose | 8 weeks after Dose 2 <i>and</i> 16 weeks after Dose 1 |

*doses administered more than 4 days earlier than any minimum interval are considered invalid

³ The adult formulation of Engerix-B may be used in adolescents, but the approved dose is 1.0 ml (20 mcg).

**Recommended Schedule/Dosage for Hemodialysis and Immunocompromised Patients
Aged 20 Years or Older (<20 years, recommendations same as general population)**

| VACCINE | DOSE | SCHEDULE | MINIMUM INTERVAL (accelerated schedule)* |
|--|---------|---|---|
| Recombivax HB (Merck): 1.0ml (40 mcg) of <u>Dialysis</u> Formulation, or | Dose 1 | 1st visit | None given |
| | Dose 2 | 4 weeks after 1 st dose | |
| | Dose 3 | 6 months after 1 st dose | |
| | Booster | If annual serologic testing <10 mIU/mL | |
| Engerix-B (GSK): each dose requires 40 mcg. Use two doses of the 1.0 ml (20 mcg) Adult Formulation | Dose 1 | 1st visit | None given |
| | Dose 2 | 1 month after 1 st dose | |
| | Dose 3 | 2 months after 1 st dose | |
| | Dose 4 | 6 months after 1 st dose | |
| | Booster | If annual serologic testing <10 mIU/mL | |

*doses administered more than 4 days earlier than any minimum interval are considered invalid

Referral Indicators:

Contraindications as noted under "General Information"

REFERENCES

- CDC. "Epidemiology and Prevention of Vaccine-Preventable Diseases, 10th Edition", DHHS
January 2007
- CDC. A Comprehensive Immunization Strategy to Eliminate Transmission of Hepatitis B Virus
Infection in the United States: Recommendations of the Advisory Committee on
Immunization Practices (ACIP). Part II: Immunization of Adults. MMWR 2006;55(No. RR-
16).
- "Federally Funded Vaccines for Adults" memo from Dr. Kelly Moore and Dr. Tom Jaselskis,
July 8, 2009

HERPES ZOSTER (SHINGLES) VACCINE LIVE VACCINE (Zostavax)

GENERAL INFORMATION

Herpes Zoster vaccine is recommended by the Advisory Committee on Immunization Practices of the CDC as a single dose for adults 60 years of age and older.¹ It is not licensed for use under age 50. Vaccination is recommended by CDC irrespective of a patient's history of shingles in order to reduce the risk of recurrence.

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.

Contraindications

History of severe allergic reaction (anaphylaxis) to any component of the vaccine, including neomycin or gelatin

Cancer: persons with leukemia, lymphoma or other malignancy affecting the bone marrow or lymphatic system. It may be given to persons with leukemia in remission who have not had chemotherapy or radiation in at least 3 months.

Persons with AIDS or other clinical manifestations of HIV infection

Persons on immunosuppressive therapy, including ≥ 20 mg/day of prednisone or equivalent for 2 or more weeks. Defer vaccination for at least 1 month after discontinuation.

Persons with cellular immunodeficiency

Persons undergoing stem cell transplants (may be considered at least 2 years after transplant)

Persons receiving recombinant human immune mediators and immune modulators (such as adalimumab, infliximab, etanercept). Defer vaccination for at least 1 month after discontinuation.

Precautions include the following:

Moderate to severe acute illness: postpone until recovery

Adverse events include the following:

Local reactions (erythema, pain or tenderness, and swelling)

Administration of Vaccine:

Give a single dose of Herpes Zoster vaccine for adults 60 years of age and older whether or not they report a prior episode of shingles.

This may be given simultaneously with any other vaccines indicated for the recipient. If not given simultaneously, live virus vaccines (e.g., MMR, yellow fever) must be administered at least 1 month apart.

PLAN

Have patient/guardian read Vaccine Information Statement/Vaccine Information Material
Counsel regarding benefits, side effects, and management
Administer unit dose of Herpes Zoster vaccine
subcutaneously Advise to wait in clinic 20 minutes after
injection
Document vaccine administration on the immunization clinic record
Instruct patient to contact Health Department if severe reaction occurs

Referral Indicators:

Person with contraindications as noted under “General Information”

Follow-Up:

All serious adverse events that occur after receipt of any vaccine should be reported to the Vaccine Adverse Event Reporting System (VAERS).

REFERENCE

CDC. Prevention of Herpes Zoster: Recommendations of the Advisory Committee on Immunization Practices. May 15, 2008
<http://www.cdc.gov/mmwr/preview/mmwrhtml/rr57e0515a1.htm>
Package insert 06/2011

QUADRIVALENT HUMAN PAPILLOMAVIRUS (HPV) VACCINE (GARDASIL® by Merck)

GENERAL INFORMATION

Human Papillomavirus (HPV) is the most common sexually-transmitted virus in the United States, with about 40 known strains. More than half of sexually-active men and women are infected with HPV at some point in their lives. Most HPV infections are asymptomatic and resolve on their own; however, certain HPV types can cause cervical cancer, oropharyngeal cancers, other rare genital cancers, and genital and respiratory tract warts. Approximately 22,000 HPV 16- or 18-related cancers occur in the United States each year; about 7,000 of them in males.

HPV vaccine is an inactivated vaccine, administered intramuscularly. Gardasil® is licensed by the Food and Drug Administration (FDA) for administration to males and females aged 9 years through 26 years. The vaccine is given in a three-dose series. It protects against HPV 16 and 18, which cause 70% of cervical cancer in the United States and HPV 6 and 11, which cause 90% of genital warts. The vaccine has no effect on pre-existing HPV infections; however, of the sexually active young women in the clinical trials, >90% were susceptible to at least 3 of the 4 vaccine strains.

GlaxoSmithKline produces the HPV vaccine Cervarix®, which targets the cancer-causing HPV strains 16 and 18, but does not prevent genital warts. It is FDA-licensed for females only, aged 9 through 25 years as a 3-dose series for use on a 0, 1 month, 6 month schedule. Because of its more limited indication, Cervarix® is not generally stocked by health departments; if a woman has already started the HPV vaccine series with an unknown brand or Cervarix® and she needs to be vaccinated at the health department, the HPV vaccine that is available may be used to complete the series.

The vaccine may be simultaneously administered with other vaccines, including live virus vaccines. It is stored in standard refrigerated conditions at 2-8°C (35-46°F).

ACIP Recommendations for Use:

Routine Recommendation: Give first dose to all pre-teens at age 11 or 12 years (may begin at 9 years); catch-up vaccination of all females age 13 through 26 years and all males 13 through 21 years is recommended. The vaccine *may* be given to older males 22-26 who have not completed the series. It is *recommended* for previously unvaccinated older males 22-26 who have sex with men or whose immune system is weakened by HIV infection, other illness or medication.

| | Recommended Interval | Minimum Interval |
|--------|-----------------------------|--|
| Dose 2 | 1 to 2 months after dose 1 | 4 weeks after dose 1 |
| Dose 3 | 6 months after dose 1 | 12 weeks after dose 2 and 24 weeks after dose 1 |

Contraindications to giving the vaccine include the following:

Severe allergic (anaphylactic) reaction to a previous dose of the vaccine or any component (including yeast). The vaccine contains no preservatives.

Precautions:

Moderate to severe acute illness (defer until recovery) [Note: Low grade fever <100.5°F or mild illnesses are not reasons for deferring immunization]

Pregnancy: the vaccine has not been associated with adverse events when given during pregnancy; however it is not recommended for use if recipient is known to be pregnant

Special Situations (per ACIP):

Breastfeeding is not a contraindication to immunization

A history of abnormal Pap smears, genital warts or other HPV infection is not a contraindication to vaccination. Persons with this history can benefit from protection against strains they have not yet acquired. Recipients should be advised that the vaccine does not protect against any strains they have already acquired.

Adverse Reactions:

Soreness, swelling or redness around the injection site

Syncope (especially common in adolescents)

PLAN

Counsel regarding HPV benefits, side effects, and management

Ask parent/guardian or recipient about contraindications, precautions

Have parent/guardian or recipient read Vaccine Information Statement

Administer the 0.5 mL dose of vaccine intramuscularly according to manufacturer instructions

Advise parent/guardian or recipient to return for the next dose at the appropriate interval

Advise to wait in clinic for 20 minutes after administration of vaccine

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

Instruct patient/guardian to contact Health Department if adverse reaction occurs

Referral Indicators

Please consult Department of Health policy (policy provided with protocol cover letter) concerning eligibility for federally-funded and state or locally-funded vaccine. Only children under 19 years eligible for the Vaccines for Children (VFC) Program may receive federally-funded vaccine.

REFERENCES

Centers for Disease Control and Prevention Advisory Committee on Immunization Practices (ACIP) Recommendations for the Use of Quadrivalent HPV Vaccine, MMWR March 12, 2007 / 56(Early Release);1-24

<http://www.cdc.gov/mmwr/preview/mmwrhtml/rr56e312a1.htm> Last accessed January 27, 2010.

GARDASIL® [Quadrivalent Human Papillomavirus (Types 6, 11, 16, 18) Recombinant Vaccine] Vaccine package insert, Merck, copyright 2006, Revised April 2011.

Cervarix [Bivalent Human Papillomavirus (Types 16, 18) Vaccine, Recombinant] Prescribing Information, GlaxoSmithKline, copyright 2009. Revised February 2012.

http://us.gsk.com/products/assets/us_cervarix.pdf

Centers for Disease Control and Prevention. Vaccine Information Statement – HPV (Human Papillomavirus) Vaccine 2/22/2012. <http://www.cdc.gov/vaccines/pubs/vis/downloads/vis-hpv-gardasil.pdf>. Last accessed March 20, 2012.

CDC. Recommendations on the Use of Quadrivalent Human Papillomavirus Vaccine in Males — Advisory Committee on Immunization Practices (ACIP), 2011. MMWR December 23, 2011.

<http://www.cdc.gov/mmwr/pdf/wk/mm6050.pdf>. Last accessed February 15, 2012.

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

GENERAL INFORMATION

General Recommendations for Seasonal Influenza Vaccination:

Beginning in 2013, CDC classifies influenza vaccine in 3 forms: inactivated influenza vaccine (IIV) and recombinant influenza vaccine (RIV, not in health departments), both administered by injection, and live-attenuated, intranasal vaccine (LAIV). See IIV protocol for persons who prefer it or who are ineligible for LAIV.

All LAIV is quadrivalent (contains 4 influenza virus strains). It is recommended that all persons aged 6 months and up be vaccinated each influenza season. Beginning in the fall 2014 influenza season, the ACIP now recommends that LAIV should be used, if available, for all eligible children aged 2 through 8 years. If LAIV is not readily available, use IIV: *do not* delay immunization because LAIV is unavailable. IIV and LAIV are considered equally good options for older children or adults through age 49 eligible to receive either.

All children aged 6 months through 8 years *who have not received 2 or more doses of influenza vaccine since July of 2010, or are not sure*, should receive 2 doses this season, regardless of previous influenza vaccination history, in order to assure adequate immunity to the 2009 H1N1 strain of influenza. This is unchanged from the last two seasons. New for 2014: because the 2014-15 vaccine is identical to the 2013-14 vaccine, *all children who received one dose last season require only one dose this season* (see schedule).

The 2014-2015 LAIV quadrivalent vaccine is unchanged from 2013-14. It has an A/California/7/2009 (H1N1) pdm09-like virus; an H3N2 virus antigenically like the cell-propagated prototype virus A/Victoria/361/2011; a B/Massachusetts/2/2012-like virus (Yamagata lineage); and a B/Brisbane/60/2008-like (Victoria lineage) virus. Trivalent vaccines do not contain the Victoria lineage B strain.

Begin vaccinating patients as soon as vaccine arrives; delaying vaccination **is not** recommended.

Seasonal LAIV indication:

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

Special situations:

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

LAIV may be given to breastfeeding women and to close contacts of pregnant women, infants and contacts of persons with mild to moderate immunocompromise. It should not be

administered to close contacts of severely immunocompromised persons who reside in a protective environment (such as a bone marrow transplant unit).

Because influenza antiviral medications (such as oseltamivir or zanamavir) reduce replication of influenza viruses, LAIV should not be given until 48 hours after stopping influenza antiviral therapy. Influenza antiviral medications should not be administered for 2 weeks after receipt of LAIV unless medically necessary.

Contraindications:

People under 2 years of age or age 50 years or older

Persons with a history of a severe allergic reaction (anaphylaxis) to a previous dose of influenza vaccine or to any component of LAIV, including egg protein.

Children or adolescents (*not* adults) on long term aspirin therapy

Precautions (use IIV or refer):

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

People of any age with asthma, children under 5 with recurrent wheezing, pregnant women and persons with a weakened immune system. Use IIV

For children under 5 years whose parent answers “yes” when asked “Does your child have a history of asthma or an episode of wheezing in past year?”, use IIV

People with a history of Guillain-Barré syndrome within 6 weeks following a previous dose of influenza vaccine (a precaution, refer)

Common Side Effects

Mild, transient symptoms, primarily nasal congestion (about 50%); 10% or fewer may have sore throat, headache, lethargy or transient low-grade fever.

PLAN

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

Counsel regarding benefits, side effects, and management

Administer vaccine intranasal spray (0.1 ml in each nostril) according to manufacturer's recommendation

Remind that seasonal influenza vaccine is recommended annually. Advise the parent or guardian of recipients less than 9 years of age to return for a second dose in 4 weeks if the child has not previously received either at least 2 doses of seasonal influenza vaccine since July 2010 or one dose in the 2013-14 season.

Advise that recipient should not use an antiviral medication within 2 weeks after LAIV administration unless medically necessary.

Advise to wait in clinic 20 minutes after intranasal administration

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

Instruct patient to contact Health Department if adverse reaction occurs (complete appropriate VAERS form: <http://vaers.hhs.gov>)

Recommended Schedule and Dosage of LAIV (FluMist®):

| Age Group | Influenza Vaccination Status | Dosage Schedule |
|---------------------------------------|--|---|
| Children 24 months through 8 years | Has not had at least 2 seasonal influenza vaccine doses since July 2010, or had no influenza vaccine last season, or not sure | 2 doses (each dose 0.1ml per nostril) given at least 4 weeks apart* |
| | Has had 2 or more seasonal influenza vaccine doses since July 2010 or had one dose last season (2013-14)** | 1 dose (0.1 ml per nostril) |
| Other persons aged 9 through 49 years | n/a | 1 dose (0.1 ml per nostril) |

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

**This is the simplest screening option. If a child is known to have had one dose last season (2013-14) or 2 doses of any seasonal influenza vaccine *and* at least 1 dose of any vaccine containing the 2009 H1N1 strain (the 2009 pandemic vaccine, or the 2010-11, 2011-12, or 2012-13 seasonal vaccines), such a child needs only one dose of seasonal vaccine this season.

Referral Indicators:

Persons with history of severe allergic reaction to components of vaccine (gelatin, gentamicin, arginine, egg protein) or a severe allergic reaction to a previous dose of influenza vaccine. Persons who report egg allergy. Evaluate them for administration of IIV using the assessment tool in the IIV protocol.

Persons with history of Guillain-Barré syndrome within 6 weeks of administration of a previous dose of influenza vaccine.

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

REFERENCES

CDC. Epidemiology and Prevention of Vaccine Preventable Diseases, 12th Ed. May 2012;151-171.

CDC. Summary Recommendations: Prevention and Control of Influenza with Vaccines: Recommendations of the Advisory Committee on Immunization Practices—(ACIP)—United States, 2013-14. <http://www.cdc.gov/flu/professionals/acip/2013-summary-recommendations.htm>. Last accessed August 12, 2013.

CDC Advisory Committee on Immunization Practices vote June 25, 2014 (<http://www.cdc.gov/vaccines/acip/meetings/meetings-info.html>)

FluMist® Quadrivalent, (Influenza Vaccine Live, Intranasal) Prescribing Information for 2014-2015 (MedImmune). <http://www.medimmune.com/docs/default-source/default-document-library/product-and-patient-information-for-flumist-quadrivalent.pdf>. Last accessed 7/23/14.

INACTIVATED SEASONAL INFLUENZA VACCINE (IIV)

GENERAL INFORMATION

General Recommendations for Seasonal Influenza Vaccination:

CDC now classifies influenza vaccine in 3 forms: inactivated influenza vaccine (IIV) and recombinant influenza vaccine (RIV, not in health departments in 2013-14 season), both administered by injection, and live-attenuated, intranasal vaccine (LAIV). LAIV is preferred and should be used if available for children ages 2 through 8 years without contraindications or precautions. See LAIV protocol for these children and others 9 through 49 years who prefer LAIV or who want a quadrivalent vaccine (if quadrivalent IIV is unavailable).

2014-15 U.S. trivalent influenza vaccines are identical to those used in 2013-14. They contain an A/California/7/2009 (H1N1)-like virus, an H3N2 virus antigenically like the cell-propagated prototype virus A/Victoria/361/2011, and a B/Massachusetts/2/2012-like virus (Yamagata lineage). Quadrivalent vaccines will include an additional vaccine virus, a B/Brisbane/60/2008-like virus (Victoria lineage). All LAIV is quadrivalent; some IIV is quadrivalent. The additional benefit of the extra strain cannot be predicted; CDC does not express a preference this season.

During the 2014-2015 season, the following children aged 6 months through 8 years should receive 2 doses this season for protection (see schedule): those who did *not* receive at least one flu vaccine last season (2013-14) **and** have not received 2 or more doses of influenza vaccine since July of 2010, **or** any child whose family is not sure of the child's history. All children who received one dose last season need only one dose this season because the vaccines are identical.

Begin vaccinating patients as soon as vaccine arrives for the season; delaying vaccination **is not** recommended.

Centers for Disease Control and Prevention (CDC) recommendations:

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

Contraindications (should not receive influenza vaccine):

History of severe allergic reaction to any component of the vaccine, including egg protein, or after previous dose of any influenza vaccine (*refer*).

Children less than 6 months of age.

Precautions:

Persons with history of Guillain-Barré syndrome within 6 weeks of administration of a previous dose of influenza vaccine (*refer* for further evaluation, this is not a contraindication)

Persons having moderate to severe acute febrile illness (until illness resolves)

PLAN

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

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

Administer vaccine injection according to manufacturer's recommendation

Remind that seasonal influenza vaccine is recommended annually. Advise the parent or guardian of recipients less than 9 years of age to return for a second dose in 1 month if the child has not previously received at least 2 doses of seasonal influenza vaccine since July 2010.

Advise to wait in clinic 20 minutes after injection

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

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

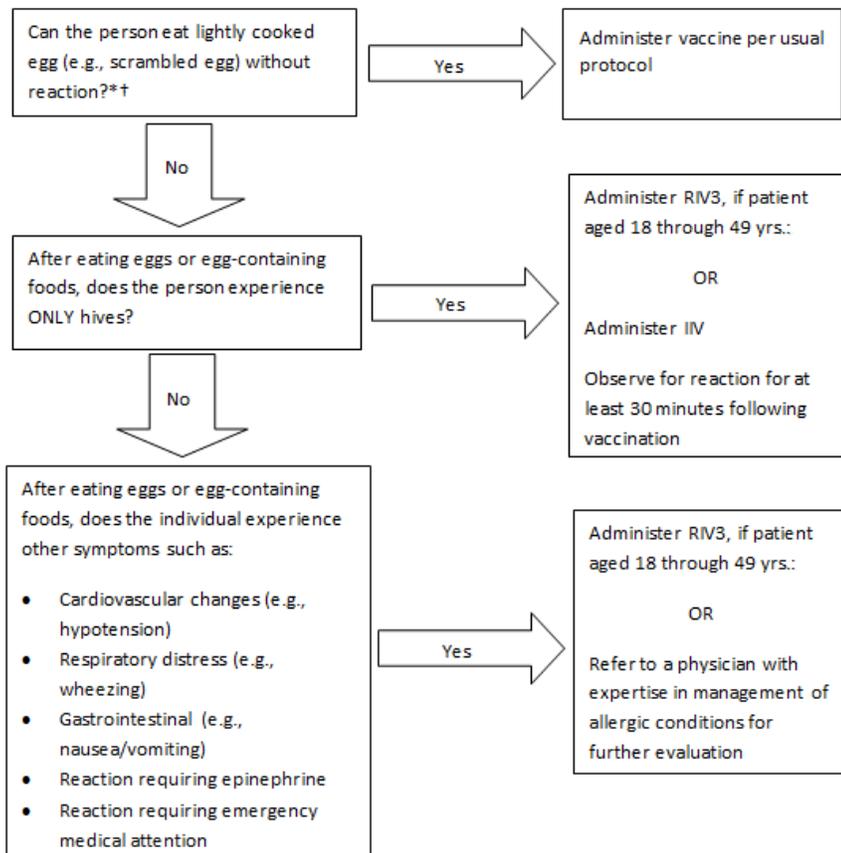
Recommended Schedule and Dosage of Seasonal Inactivated Influenza Vaccine (IIV):

| Age Group | Influenza Vaccination Status | Dosage Schedule |
|-------------------------------------|--|---|
| Children 6 months through 35 months | Has not had at least 2 seasonal influenza vaccine doses since July 2010, or had no influenza vaccine last season, or not sure | 2 doses (each dose 0.25 ml, IM) at least 4 weeks apart* |
| | Has had 2 or more seasonal influenza vaccine doses since July 2010 or one dose last season (2013-14) | 1 dose (0.25 ml, IM) |
| Children 36 months through 8 years | Has not had at least 2 seasonal influenza vaccine doses since July 2010, or had no influenza vaccine last season, or not sure | 2 doses (each dose 0.5 ml, IM) at least 4 weeks apart* |
| | Has had 2 or more seasonal influenza vaccine doses since July 2010 or one dose last season | 1 dose (0.5 ml, IM) |
| All others 9 years and up | Not relevant | 1 dose (0.5 ml, IM) |

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

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

FIGURE 2. Recommendations regarding influenza vaccination of persons who report allergy to eggs: Advisory Committee on Immunization Practices, United States, 2013-14 Influenza season.



IIV=Inactivated Influenza Vaccine; RIV3=Recombinant Influenza Vaccine, Trivalent

*Individuals with egg allergy may tolerate egg in baked products (e.g. bread, cake). Tolerance to egg-containing foods does not exclude the possibility of egg allergy (2).

† For individuals who have no known history of exposure to egg, but who are suspected of being egg-allergic on the basis of previously performed allergy testing, consultation with a physician with expertise in the management of allergic conditions should be obtained prior to vaccination. Alternatively, RIV3 may be administered if the recipient is aged 18 through 49 years.

REFERENCES

CDC. Epidemiology and Prevention of Vaccine Preventable Diseases, 12th Ed. May 2012;151-171.

CDC. Summary Recommendations: Prevention and Control of Influenza with Vaccines: Recommendations of the Advisory Committee on Immunization Practices—(ACIP)—United States, 2013-14.

<http://www.cdc.gov/flu/professionals/acip/2013-summary-recommendations.htm>. Last accessed August 12, 2013.

CDC Advisory Committee on Immunization Practices vote June 25, 2014 (<http://www.cdc.gov/vaccines/acip/meetings/meetings-info.html>)

MEASLES, MUMPS, RUBELLA VACCINE (MMR)

GENERAL INFORMATION – MMR is a live virus vaccine that is administered subcutaneously. MMR vaccine may be stored in the refrigerator or freezer and should be used within 8 hours of reconstitution.

Contraindications and Precautions, include the following:

Severe allergic (e.g., anaphylaxis) reaction to vaccine component, such as gelatin or Neomycin, or to a previous dose of MMR vaccine (Refer)

Moderate to severe acute illness (wait until resolving)

Pregnancy (if known, testing is not required before vaccinating)

Known severe immunodeficiency (e.g., from hematologic or solid tumors; receiving chemotherapy; congenital immunodeficiency; or, patients with HIV and severe immunocompromise) (Refer)

Patients currently on long term immune suppression therapy: has had ≥ 14 days of ≥ 2 mg/kg/day (or, ≥ 20 mg/day) of prednisone, or equivalent.

(Defer vaccination until high dose therapy has been stopped for 1 month).

Recent (within 11 months) antibody-containing blood product (specific interval depends upon the blood product – see CDC's General Recommendations on Immunization for details)

MMR vaccine may be given on the same day as other live virus vaccines (e.g. varicella) however, if not given on the same day, they must be separated by 4 weeks (28 days).

If not given on the same day, wait 4 weeks from date of MMR vaccine to administer TST.

History of thrombocytopenic purpura or thrombocytopenia (low platelet count) (Refer)

Note: The following are NOT contraindications or precautions to MMR vaccination: egg allergy; breast feeding or pregnant household contact; oral low dose, short course or inhaled steroid use.

Adverse events

Common: Susceptible recipients may develop the following mild symptoms caused by measles vaccine virus replication 5 to 12 days after immunization:

1-2 days of fever of 103°F or higher (5-15%)

rash (5%)

Joint symptoms (pain or inflammation) with onset 1-3 weeks after vaccination and lasting up to 3 weeks (up to 25% of adult females, uncommon in children and males)

Rare:

severe allergic reaction (e.g., anaphylaxis)

pain in arms and legs 1-3 weeks after vaccination

thrombocytopenia

parotitis

deafness

encephalopathy

ACIP Recommended Populations

NOTE: See current policy from the Tennessee Immunization Program for guidance concerning which recommended persons are eligible for federally funded vaccine

- All children (2 doses)
- Adults born in 1957 or later (at least 1 dose if no acceptable history of disease), with emphasis on certain groups at higher risk of infection or complication:
- Women of childbearing age (who have never had MMR or who lack serologic evidence of immunity)
- Unvaccinated HIV patients without evidence of severe immunocompromise
- College students (2 doses required by state law for full time students in TN)
- International travelers (total of 2 doses, §federal vaccine only for ages 6 months through 18 years)
- Healthcare workers (2 doses or evidence of immunity)
- Vaccinate susceptible persons age 6 months and up within ≤ 72 hours of exposure to measles

Administration of Vaccine:

Give first dose at 12-15 months of age

Give second dose at 4-6 years* (recommended if born after 1957)

MMR vaccine may be given simultaneously with all other vaccines; if MMR and varicella (or another live virus vaccine) are not administered at the same visit, they should be separated by at least 28 days

For children traveling outside the United States:

6-11 months: 1 MMR before travel (because it gives less than ideal protection, this extra dose does not count toward the 2 dose routine MMR series).

12 months or up: should get 2 doses of MMR before travel (28 days apart, minimum interval).

Two doses after 12 months of age completes the MMR series.*

Vaccine is not needed if patient has laboratory evidence of immunity to all three (measles, mumps and rubella). However, if any is negative, documentation of 2 MMR doses is needed.

PLAN

Have patient or accompanying adult read Vaccine Information Statement

Counsel regarding benefits, side effects, and management

Counsel females of childbearing age to avoid pregnancy for 28 days post vaccination (document LMP)

*The 2nd dose of MMR is recommended routinely at 4-6 yrs of age but may be administered during any visit, provided at least 1 month has elapsed since receipt of the 1st dose and that both doses are administered beginning at or after 12 months of age.

Administer unit dose of MMR subcutaneously
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 (National Childhood Vaccine Injury Act)
Instruct patient to contact Health Department if adverse reaction occurs

NOTE: Any dose of MMR vaccine given earlier than 4 days before the 1st birthday will not count as one of the routine two-dose series; persons who have not received 2 doses of measles mumps and rubella-containing vaccines, such as those who received only a monovalent measles vaccine or combined Measles/Rubella (MR) vaccine should complete a 2 dose series of MMR.

Referral indicators (in addition to contraindications or precautions listed above):

Uncontrolled neurological conditions, such as uncontrolled seizures
Active untreated tuberculosis

Follow-Up:

If severe reaction is reported as occurring within 30 days following vaccine administered by health department personnel, VAERS Report form must be completed.
Return at appropriate interval according to schedule

REFERENCES

Manufacturer Packet Inserts.
National Childhood Vaccine Injury Act, 1986.
Epidemiology and Prevention of Vaccine-Preventable Diseases. Department of Health and Human Services, Centers for Disease Control and Prevention, 12th Ed., May 2011.

MENINGOCOCCAL VACCINE MENINGOCOCCAL CONJUGATE VACCINE (MENACTRA™, MENVEO™)

GENERAL INFORMATION

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

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

Meningococcal Conjugate Vaccine (MCV4)

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

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

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

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

ACIP Recommended Populations include the following:

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

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

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

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

Military recruits (Health departments should refer)

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

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.

Contraindications to giving the vaccine include the following:

Persons under 2 years or over 55 years of age

If known to be pregnant, consult with health officer or refer to medical provider

Hypersensitivity to any component of the vaccine, including diphtheria toxoid

Menactra only: hypersensitivity to dry natural latex (contained in vaccine vial stopper)

Note: Menveo packaging does not contain latex.

Precautions include the following:

Immunization should be deferred during the course of any moderate to severe illness

Anyone who has ever had Guillain-Barre Syndrome

Adverse Reactions include the following:

COMMON

Mild injection site pain and redness (within 1 -2 days of vaccination)

Mild systemic reactions such as headache and malaise (within 7 days of vaccination)

RARE

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

PLAN

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

| Risk group | First dose (age in years) | Booster dose (age in years)§ |
|---|---|---|
| Persons aged 11 through 18 years | 11 through 12 | 16 (catch up dose through age 18)* |
| | 13 through 15 | 16 through 18* |
| | 16 or older | -none- |
| HIV-infected persons age 11 through 18 years | 11 through 12 (primary 2-dose series, at least 8 weeks apart*) | 16 (catch up dose through age 18)* ‡ |
| | 13 through 15 (primary 2-dose series, at least 8 weeks apart*) | 16 through 18*‡ |
| | ≥16 (primary 2-dose series, at least 8 weeks apart*) | -none- |
| Persons aged 2 through 55 years with persistent complement component deficiency (such as C5-C9, properdin or factor D) or asplenia (functional or anatomic) | At earliest opportunity (primary 2-dose series, at least 8 weeks apart) | Every 5 years following the second primary series dose. |

| | | |
|--|--------|--|
| Persons age 2-55 years with prolonged increased risk for exposure to N. meningitidis** | 1 dose | If aged 2 through 6 years, after 3 years, <i>if still at increased risk</i> If aged 7 years or older, after 5 years <i>if still at increased risk</i> |
| § <i>Minimum interval between primary and booster doses of vaccine is 8 weeks</i> | | |
| * <u>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.</u> | | |
| ¥ <i>Calculate need for booster dose based upon age at receipt of the second dose in the primary 2-dose series.</i> | | |
| ** <i>Microbiologists routinely working with Neisseria meningitidis and travelers or residents of countries where meningococcal disease is hyperendemic or epidemic.</i> | | |

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

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

Ask patient/guardian about contraindications

Have patient/guardian read Vaccine Information Statement

Document vaccine administration on the immunization clinic record

Advise to wait in clinic for 20 minutes after injection

Instruct patient/guardian to contact Health Department if adverse reaction occurs

Health Teaching:

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

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

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

Referral:

Pregnancy

Military recruits

Microbiologists occupationally exposed to isolates of N. meningitidis

Travelers (to a travel clinic)

REFERENCES

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

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

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

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

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

MENINGOCOCCAL VACCINE MENINGOCOCCAL POLYSACCHARIDE VACCINE (MENOMUNE)

GENERAL INFORMATION

Meningococcal disease is caused by bacteria (*Neisseria meningitidis*) that infect the bloodstream and the linings of the brain and spinal cord, causing serious illness. Every year in the United States, 1,400 to 2,800 people get meningococcal disease. Ten to 14 percent of people with meningococcal disease die, and 11-19 percent of survivors have permanent disabilities (such as mental retardation, hearing loss, and loss of limbs). Infection is spread by direct contact with infected individuals (e.g., sharing a glass or cigarette, or kissing), or through the air via droplets of respiratory secretions (e.g., coughing or sneezing). Symptoms include the sudden onset of fever, chills, severe headache, stiff neck, rash, nausea, vomiting and lethargy.

Meningococcal vaccine is inactivated and contains no live organisms. Different strains of the meningococcus are more likely to produce disease and the vaccine is designed to prevent infections from groups A, C, Y and W-135. Serogroup B is the most common cause of meningococcal disease in children < 1 year of age; no vaccine is yet available to offer protection against serogroup B. Protective antibody levels may be achieved within 7-10 days after vaccination. Meningococcal vaccine may be given at the same time as other immunizations, if needed.

Meningococcal Polysaccharide Vaccine (Menomune)

Licensed in 1981

It is manufactured by Sanofi Pasteur and is marketed as **MENOMUNE™**

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

It may be administered to persons 2 years of age and older

Menomune should only be administered to persons aged 11-55 years when Meningococcal Conjugate Vaccine (MCV4) is not available

Menomune is an acceptable alternative for college freshmen living in dormitories when Meningococcal Conjugate Vaccine (MCV4) is not available

Menomune is not recommended as a substitute for MCV4 in healthy adolescents ages 11-12 or for adolescents entering high school; healthy adolescents in these age groups, without medical or travel risk factors for disease, are recommended only to receive MCV4

ACIP Recommended Populations include the following:

College freshmen living in dormitories, including those enrolled in college who present for immunization before moving on campus who have not previously received MCV4

Persons who have anatomic or functional asplenia or terminal complement component deficiencies (with health department physician order)

Persons who travel to, or reside in, countries in which *N. meningitidis* is hyperendemic or epidemic, particularly if contact with the local population will be prolonged

Military recruits (Health departments should refer)

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

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.

Contraindications to giving the vaccine include the following:

- Children under 2 years of age (effectiveness questionable in this age group)
- Hypersensitivity to any component of the vaccine, including Thimerosal
- Anaphylactic hypersensitivity to dry natural rubber latex (contained in vial stopper)
- If pregnant, consult with health officer or refer to medical provider

Precautions include the following:

- Immunization should be deferred during the course of any moderate to severe illness
- If the vaccine is used in persons receiving immunosuppressive therapy, the expected immune response may not be obtained

Adverse Reactions include the following:

- MOST COMMON**
 - Mild injection site pain and redness
 - Transient fever
- RARE**
 - Headache, malaise, chills

PLAN

- Ask patient/guardian about contraindications
- Have patient/guardian read Vaccine Information Statement

Vaccine Administration:

- ¹Reconstitute the vaccine using only the diluent supplied for this purpose May be administered to persons 2 years of age and older as outlined in program policy
- May be given to any college student requesting vaccine
- Administer to individuals 2 years through 10 years of age that have medical or travel risk factors for meningococcal disease (see Recommended Population)
- Administer a single dose of vaccine, 0.5 ml, **SUBCUTANEOUSLY**
- Advise to wait in clinic for 20 minutes after injection
- Document vaccine administration on the immunization clinic record
- Instruct patient/guardian to contact Health Department if adverse reaction occurs

Health Teaching:

- Provide current Vaccine Information Sheet (VIS) about meningococcal disease and the benefits of vaccination
- Counsel regarding side effects of vaccine

¹ **Single dose vial - should be used within 30 minutes after reconstitution**
Multidose vial - discard remainder of vaccine within 35 days after reconstitution

Referrals:

Pregnancy

Military recruits

Microbiologists occupationally exposed to isolates of *N. meningitidis*

REFERENCES

Meningococcal Disease and Meningococcal Vaccines Fact Sheet, U.S. Department of Health and Human Services, Centers for Disease Control and Prevention (CDC), Atlanta, GA 30333, April 2005

Meningococcal Polysaccharide Vaccine Groups A, C, Y & W-135 Combined package insert, Sanofi Pasteur (Aventis Pasteur), February 2001

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

PEDIARIX **[Diphtheria, Tetanus Toxoid & Acellular Pertussis (DTaP), Hepatitis B Recombinant, and Inactivated Polio Vaccine (IPV) Combined]**

GENERAL INFORMATION (For additional information, see DTaP, Hep B pre-exposure, and IPV vaccine protocols)

Pediarix can be administered simultaneously with Hib, Hep A, Varicella, and MMR using separate injection sites

Pediarix is approved as a 3-dose primary series, and should be given at 2, 4, and 6 months

The vaccine is licensed for children 6 weeks through 6 years of age and should not be given to infants less than 6 weeks of age or to anyone 7 years of age or older

The vaccine should be refrigerated between 36° and 46° F (2° and 8°C); vaccine that has been subjected to freezing temperatures should be discarded

Immunosuppressive therapies may reduce the immune response to vaccine

Contraindications include:

Hypersensitivity to any component of the vaccine, including yeast, neomycin, and polymyxin B

A history of anaphylaxis to a previous dose of Pediarix, or any of its components

Moderate to severe febrile illness

A history of encephalopathy (e.g., coma, decreased level of consciousness, prolonged seizures) within 7 days of administration of previous dose of any pertussis-containing vaccine

Progressive neurologic disorder¹ (e.g., infantile spasms, uncontrolled epilepsy, progressive encephalopathy)

Pregnancy

The following precautions, although not considered contraindications, should be carefully evaluated concerning the risks and benefits of vaccination for individuals having experienced these circumstances following a previous dose of DTaP or DTP:

Temperature of 105°F or higher within 48 hours of prior dose (with no other identifiable cause)

Collapse or shock-like state (hypotonic-hyporesponsive episode) within 48 hours of prior dose

Persistent, inconsolable crying lasting 3 hours or more, occurring within 48 hours of receiving vaccine

Seizures, with or without fever, within 3 days of prior dose

Guillain-Barre syndrome within 6 weeks of prior dose

¹ Stable/resolved neurologic condition (i.e., controlled epilepsy, cerebral palsy, or developmental delay), or a family history of convulsions in first-degree family members (parents or siblings) is not a contraindication for Pediarix.

Adverse Reactions include:

- Local injection site reaction (pain, redness, swelling)
- Fever (higher rates relative to separately administered vaccines)
- Possibility of hypersensitivity reactions in individuals sensitive to streptomycin, polymixin B, or neomycin
- Arthus-type hypersensitivity reactions
- Severe systemic reactions are rare

Administration of vaccine:

- Pediarix should be given at 2, 4, and 6 months, with a 6 to 8 week interval between doses
- If an accelerated schedule is needed, there should be a minimum interval of 4 weeks between the first and second doses
- The third dose should be administered at least 16 weeks after the first dose and at least 8 weeks after the second dose but not before age 6 months
- Pediarix is NOT indicated for use as a booster dose following a 3-dose primary series
- A birth dose of single-antigen vaccine is preferred for all infants but **MUST** be administered to infants who are born to women who are HbsAg-positive or whose HbsAg status is unknown; the birth dose can then be followed by 3 doses of Pediarix at ages 2, 4, and 6 months

PLAN

Ask parent/guardian about personal/family history, adverse reaction following a previous vaccination, and recent health status of the child to determine existence of any contraindications

Counsel regarding vaccine benefits, side effects, and management.

Recommend that parent may administer acetaminophen if a fever develops and the child is uncomfortable. If the child does not show signs of discomfort, medication is not necessary.

Have accompanying adult read “Vaccine Information Materials” (VIMS) and “Vaccine Information Statement” (VIS)

Administer 0.5 mL Pediarix vaccine IM according to recommended schedule

Recommended Vaccine Schedule:

| Vaccine | Dose # | Age | Minimum Age | Minimum Dose Interval |
|-----------------|----------------|--------------|------------------------|-----------------------|
| PEDIARIX | 1 | 2 months | 6 weeks | N/A |
| | 2 | 4 months | 10 weeks | 4 weeks |
| | 3 | 6 months | 6 months | 8 weeks |
| DTaP | 4 | 15-18 months | 12 months ² | 6 months |
| | 5 ³ | 4-6 years | 4 years | 6 months |
| IPV | 4 | 4-6 years | 13 months | 1 month |

² May give #4 as early as 12 months of age if 6 months have elapsed since #3 and the child is unlikely to return at age 15-18 months

³ 5th dose may be omitted if dose 4 is given on or after fourth birthday

NOTE:

Pediarix may be used to **complete a hepatitis B vaccination series**

Pediarix may be used to **complete the first 3 doses of the IPV vaccination series if initiated with vaccine from a different manufacturer**

Pediarix is **NOT recommended for completion of the first 3 doses of the DTaP vaccination series when initiated with vaccine from a different manufacturer**

Children who have received a **3-dose primary series of Pediarix should receive a fourth dose of IPV at 4-6 years and a fourth dose of DTaP vaccine at 15 to 18 months of age²**

Advise to wait in clinic for 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 form)

Referral Indicators:

Allergic hypersensitivity to any component of the vaccine

History of severe reaction to previous dose

Follow-up:

Return at appropriate interval according to schedule

REFERENCES

MMWR, March 14, 2003/52(10); 203-204. FDA Licensure of Diphtheria and Tetanus Toxoids and Acellular Pertussis Adsorbed, Hepatitis B (Recombinant), and Poliovirus Vaccine Combined, (PEDIARIXtm) for Use in Infants

National Immunization Program, FAQs on Pediarixtm Vaccine

SmithKline Beecham Pharmaceuticals PEDIARIXtm Package insert

**PNEUMOCOCCAL VACCINE FOR CHILDREN
AGES 6 WEEKS THROUGH 18 YEARS
13-Valent Pneumococcal Conjugate Vaccine (PCV13) and 23-
Valent Pneumococcal Polysaccharide Vaccine (PPSV23)**

GENERAL INFORMATION

Pneumococcal vaccines help to prevent diseases caused by common strains of pneumococcus (also known as *Streptococcus pneumoniae*), including pneumonia, bloodstream infections, meningitis, and ear infections. There are two forms of pneumococcal vaccine.

Pneumococcal conjugate vaccine (PCV13, Prevnar-13®) is routinely recommended for all children and protects against 13 strains. It is approved by the Federal Food and Drug Administration (FDA) for use in children aged at least six (6) weeks of age through 17 years old and in adults aged 50 years and older. See the adult 19-64 or 65 and over pneumococcal vaccination protocols for indications in these age groups.

Pneumococcal polysaccharide vaccine (PPSV23) is licensed by the FDA for ages 2 years and up for the prevention of pneumococcal disease caused by 11 strains not included in PCV13. Pneumococcal vaccines may be administered simultaneously with other vaccines except each other. Because it can interfere with the immune response to PCV13, PPSV23 should be given after recommended doses of PCV13.

PCV13 is routinely recommended for pneumococcal disease prevention in all children younger than age 5 years. Children with specific conditions that put them at increased risk for pneumococcal diseases may be recommended to receive PCV13 at older ages or to receive PPSV23 in addition to PCV13.

PCV13 is recommended for:

All children who have not reached their 5th birthday. (See **Plan** for additional recommendations)

Children aged 60 months through 18 years with underlying medical conditions that increase their risk for invasive pneumococcal disease. See the table and plan for details.

PPSV23 is recommended for:

Children aged 2 years or older with specific conditions that put them at increased risk of invasive pneumococcal disease (see Plan for additional details)

Contraindications to giving PCV13 or PPSV23 include the following:

An immediate anaphylactic reaction to the vaccine or a constituent of the vaccine, such as diphtheria toxoid (PCV13) or phenol (in PPSV23)

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

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

Note: Safe for latex allergic patients. Products do not contain latex.

Adverse reactions:

Swelling, redness and/or pain at site of administration

Low-grade fever, headache

Systemic reactions infrequent, serious adverse reactions rare

PLAN

Have accompanying adult read “Vaccine Information Statement” (VIS)

Counsel regarding benefits, side effects, and management

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)

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. At the time of this protocol, federal pneumococcal vaccine is unavailable.**

Administration of pneumococcal vaccine:

The recommended immunization schedule consists of three (3) doses of PCV13 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 PCV13 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 healthy children, follow PCV13 **Table 1** (Routine Schedule)

For a list of high risk medical conditions and indications for PCV13 or PPSV23, see **Table 2**. Review the plan for details of administration based on age.

The dose is 0.5 ml to be given intramuscularly (PPSV23 may be given subcutaneously or intramuscularly)

OR

PCV13 must be shaken vigorously immediately prior to administration of vaccine in order to obtain a uniform suspension

PCV13 and PPSV23 should not be given at the same time

Table 1: Routine Schedule for PCV13, Ages 6 weeks to 6th birthday

Recommended routine vaccination schedule for PCV13 among infants and children who have not received previous doses of PCV7 or PCV13, by age at first dose

| Age at first dose (mos.) | Primary PCV13 series* | PCV13 booster dose† |
|--|------------------------------------|--------------------------|
| 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.

§ See Table 2 for details of vaccination of children with high-risk conditions

† For children younger than age 6 years with underlying medical conditions (see Table 2), a single supplemental PCV13 dose is recommended.

Vaccination of Children aged 2 through 5 years with high risk conditions with PCV13 and PPSV23

All recommended PCV13 doses should be administered prior to PPSV23 vaccination if possible.

- For children 2 through 5 years of age with any of the following conditions: chronic heart disease (particularly cyanotic congenital heart disease and cardiac failure); chronic lung disease (including asthma if treated with high-dose oral corticosteroid therapy); diabetes mellitus; cerebrospinal fluid leak; cochlear implant; sickle cell disease and other hemoglobinopathies; anatomic or functional asplenia; HIV infection; chronic renal failure; nephrotic syndrome; diseases associated with treatment with immunosuppressive drugs or radiation therapy, including malignant neoplasms, leukemias, lymphomas, and Hodgkin disease; solid organ transplantation; or congenital immunodeficiency:
 1. Administer 1 dose of PCV13 if 3 doses of PCV were received previously.
 2. Administer 2 doses of PCV13 at least 8 weeks apart if fewer than 3 doses of PCV were received previously.
 3. The minimum interval between doses of PCV is 8 weeks.
 4. For children with no history of PPSV23 vaccination, administer PPSV23 at least 8 weeks after the most recent dose of PCV13.

Vaccination of Children aged 6 through 18 years with high risk conditions with PCV13 and PPSV23 (see table 2 for reference list of conditions):

For children aged 6 through 18 years who have cerebrospinal fluid leak; cochlear implant; sickle cell disease and other hemoglobinopathies; anatomic or functional asplenia; congenital or acquired immunodeficiencies; HIV infection; chronic renal failure; nephrotic syndrome; diseases associated with treatment with immunosuppressive drugs or radiation therapy, including malignant neoplasms, leukemias, lymphomas, and Hodgkin disease; generalized malignancy; solid organ transplantation; or multiple myeloma:

1. If neither PCV13 nor PPSV23 has been received previously, administer 1 dose of PCV13 now and 1 dose of PPSV23 at least 8 weeks later.
 2. If PCV13 has been received previously but PPSV23 has not, administer 1 dose of PPSV23 at least 8 weeks after the most recent dose of PCV13.
 3. If PPSV23 has been received but PCV13 has not, administer 1 dose of PCV13 at least 8 weeks after the most recent dose of PPSV23.
- For children aged 6 through 18 years with chronic heart disease (particularly cyanotic congenital heart disease and cardiac failure), chronic lung disease (including asthma if treated with high-dose oral corticosteroid therapy), diabetes mellitus, alcoholism, or chronic liver disease, who have not received PPSV23, administer 1 dose of PPSV23. If PCV13 has been received previously, then PPSV23 should be administered at least 8 weeks after any prior PCV13 dose.
 - A single revaccination with PPSV23 should be administered 5 years after the first dose to children with sickle cell disease or other hemoglobinopathies; anatomic or functional asplenia; congenital or acquired immunodeficiencies; HIV infection; chronic renal failure; nephrotic syndrome; diseases associated with treatment with immunosuppressive drugs or radiation therapy, including malignant neoplasms, leukemias, lymphomas, and Hodgkin disease; generalized malignancy; solid organ transplantation; or multiple myeloma.

Table 2:

TABLE. Medical conditions or other indications for administration of PCV13,* and indications for PPSV23[†] administration and revaccination for children aged 6–18 years[‡]

| Risk group | Underlying medical condition | PCV13 | | PPSV23 | |
|--|---|-------------|-------------|-------------|--------------------------------------|
| | | Recommended | Recommended | Recommended | Revaccination 5 yrs after first dose |
| Immunocompetent persons | Chronic heart disease [§] | | | ✓ | |
| | Chronic lung disease ^{**} | | | ✓ | |
| | Diabetes mellitus | | | ✓ | |
| | Cerebrospinal fluid leaks | ✓ | | ✓ | |
| | Cochlear implants | ✓ | | ✓ | |
| | Alcoholism | | | ✓ | |
| | Chronic liver disease | | | ✓ | |
| | Cigarette smoking | | | ✓ | |
| Persons with functional or anatomic asplenia | Sickle cell disease/other hemoglobinopathies | ✓ | | ✓ | ✓ |
| | Congenital or acquired asplenia | ✓ | | ✓ | ✓ |
| Immunocompromised persons | Congenital or acquired immunodeficiencies ^{††} | ✓ | | ✓ | ✓ |
| | Human immunodeficiency virus infection | ✓ | | ✓ | ✓ |
| | Chronic renal failure | ✓ | | ✓ | ✓ |
| | Nephrotic syndrome | ✓ | | ✓ | ✓ |
| | Leukemia | ✓ | | ✓ | ✓ |
| | Lymphoma | ✓ | | ✓ | ✓ |
| | Hodgkin disease | ✓ | | ✓ | ✓ |
| | Generalized malignancy | ✓ | | ✓ | ✓ |
| | Iatrogenic immunosuppression ^{§§} | ✓ | | ✓ | ✓ |
| | Solid organ transplant | ✓ | | ✓ | ✓ |
| | Multiple myeloma | ✓ | | ✓ | ✓ |

* 13-valent pneumococcal conjugate vaccine.

[†] 23-valent pneumococcal polysaccharide vaccine.[‡] Children aged 2–5 years with chronic conditions (e.g., heart disease or diabetes), immunocompromising conditions (e.g., human immunodeficiency virus), functional or anatomic asplenia (including sickle cell disease), cerebrospinal fluid leaks, or cochlear implants, and who have not previously received PCV13, have been recommended to receive PCV13 since 2010.[§] Including congestive heart failure and cardiomyopathies.^{**} Including chronic obstructive pulmonary disease, emphysema, and asthma.^{††} Includes B-(humoral) or T-lymphocyte deficiency, complement deficiencies (particularly C1, C2, C3, and C4 deficiencies), and phagocytic disorders (excluding chronic granulomatous disease).^{§§} Diseases requiring treatment with immunosuppressive drugs, including long-term systemic corticosteroids and radiation therapy.

Note:

The use of PCV13 does not replace the use of 23-valent pneumococcal polysaccharide vaccine (PPSV23) in children ≥ 24 months of age with underlying medical conditions. If a child will need PPSV23 and PCV13, administer the PCV13 before the PPSV23 (at least 8 weeks apart).

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. Recommended Immunization Schedules for persons 0 through 18 years. United States 2014. <http://www.cdc.gov/vaccines/schedules/downloads/child/0-18yrs-child-combined-schedule.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), MMWR June 28, 2013. <http://www.cdc.gov/mmwr/pdf/wk/mm6225.pdf>

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>

PREVNAR 13® (Pneumococcal 13-valent Conjugate Vaccine [Diphtheria CRM197 Protein]) Prescribing Information: <http://labeling.pfizer.com/showlabeling.aspx?id=501>

Pneumovax 23® (pneumococcal vaccine polyvalent) Prescribing Information: http://www.merck.com/product/usa/pi_circulars/p/pneumovax_23/pneumovax_pi.pdf

PNEUMOCOCCAL VACCINE FOR ADULTS WITH HIGH RISK CONDITIONS AGED 19 THROUGH 64 YEARS: PNEUMOCOCCAL POLYSACCHARIDE VACCINE (PPSV23) AND PNEUMOCOCCAL CONJUGATE VACCINE (PCV13)

GENERAL INFORMATION

Pneumococcal vaccines help to prevent diseases caused by common strains of pneumococcus (also known as *Streptococcus pneumoniae*), including pneumonia, bloodstream infections, meningitis, and ear infections. There are two forms of pneumococcal vaccine.

Pneumococcal conjugate vaccine (PCV13, Prevnar-13®) is routinely recommended for all children and protects against 13 strains. It is licensed by the Federal Food and Drug Administration for adults 50 years and older, but is recommended by the federal Advisory Committee on Immunization Practices (ACIP) for certain adults with immunocompromising conditions aged 19 years and older. In cases where ACIP recommendations conflict with the label, ACIP recommendations are followed. See the adult 65 and over pneumococcal vaccination protocol for routine indications in that age group. PCV13 has been shown to be effective against invasive pneumococcal disease as well as non-invasive pneumococcal pneumonia.

Pneumococcal polysaccharide vaccine (PPSV23) is licensed by the FDA for ages 2 years and up for the prevention of pneumococcal disease caused by 11 strains not included in PCV13. Pneumococcal vaccines may be administered simultaneously with other vaccines except each other. Because it can interfere with the immune response to PCV13, in cases where both are recommended, PPSV23 should be given after PCV13. PPSV23 has been shown to be effective against invasive pneumococcal disease, but data are inconclusive concerning benefit against non-invasive pneumococcal pneumonia.

Immunization may be less effective in persons with immunocompromising conditions, but is recommended.

PPSV23 is recommended for:

Adults with conditions that put them at increased risk of invasive pneumococcal disease (see Plan for additional details). Vaccine should be given as soon as feasible following diagnosis.

PCV13 is recommended for:

Adults with immunocompromising conditions who have not previously received PCV13 (see Plan for details). Vaccine should be given as soon as feasible after diagnosis. If both PCV13 and PPSV23 are indicated, administer PCV13 first.

Adverse reactions:

Swelling, redness and/or pain at site of administration

Low-grade fever, headache

Systemic reactions infrequent, serious adverse reactions rare

Refer to the Pneumococcal Conjugate Vaccine (PCV13) protocol for information about vaccination of certain high risk adults with PCV13 in addition to PPSV23.

Contraindications and Precautions include the following:

An immediate anaphylactic reaction to the vaccine or a constituent of the vaccine, such as diphtheria toxoid (PCV13) or phenol (in PPSV23)

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

Pregnancy

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

Note: Safe for latex allergic patients. Products do not contain latex.

ACIP recommended persons aged 19 through 64 years: PPSV23 and/or PCV13

One dose PPSV23 only (no revaccination before age 65):

Chronic heart disease (excluding essential hypertension)

Chronic lung disease

Diabetes mellitus

Alcoholism

Chronic liver disease, cirrhosis

Current smokers

One dose PCV13 and 1 dose PPSV23 (no revaccination before age 65):

Cerebrospinal fluid leak

Cochlear implant

One dose of PCV13 and PPSV23 + revaccination with PPSV23 5 years after 1st dose:

Persons with functional or anatomic asplenia:

Sickle cell disease, other hemoglobinopathy

Congenital or acquired asplenia

Immunocompromised persons:

Congenital or acquired immunodeficiency, including B- or T-lymphocyte deficiencies, complement deficiencies and phagocytic disorders (excluding chronic granulomatous disease)

HIV infection

Chronic renal failure and nephrotic syndrome

Leukemia, lymphomas, Hodgkin disease, generalized malignancy

Iatrogenic immunosuppression (long term systemic steroids, radiation)

Solid organ transplant

Multiple myeloma

Dose intervals:

Recommend 8 weeks or longer after PCV13 to give PPSV23. For persons who need PCV13 but have been vaccinated previously with PPSV23, administer PCV13 one year or more after the most recent dose of PPSV23.

Additional notes: (1) Persons with unknown or uncertain immunization history may be vaccinated. (2) Give vaccine at least 2 weeks before planned splenectomy or initiation of immunocompromising treatments that will cause a person to become high risk.

PLAN

Have patient or accompanying adult read Vaccine Information Statement

PCV13 and PPSV23 should not be given at the same time

[PPSV23] Administer one dose of 0.5 cc PPSV23 vaccine intramuscularly or subcutaneously (preferably in the deltoid muscle or lateral mid thigh),

OR

[PCV13] Shake vigorously immediately before administering to achieve a uniform suspension, then administer 1 dose of 0.5cc PCV13 vaccine intramuscularly

Counsel regarding benefits, side effects, and management

Advise to wait in clinic for 20 minutes after injection

Document vaccine administration on the immunization clinic record

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

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. At the time of this protocol, federal pneumococcal vaccine is unavailable.**

NOTE: COUNSELING FOR DOSES AFTER TURNING AGE 65

Persons who received one *or two* doses of PPSV23 before age 65 and 5 or more years have passed since the most recent dose are recommended to receive a dose of PPSV23 after turning 65 years of age.

Adults who received PCV13 before turning 65 years of age are *not* recommended to receive a second dose of PCV13 after turning 65.

Referral Indicators:

Persons with contraindications as noted under “General Information”

REFERENCES

CDC. Updated Recommendations for Prevention of Invasive Pneumococcal Disease Among Adults Using the 23-Valent Pneumococcal Polysaccharide Vaccine (PPSV23). MMWR September 3, 2010. <http://www.cdc.gov/mmwr/pdf/wk/mm5934.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 12, 2012. <http://www.cdc.gov/mmwr/pdf/wk/mm6140.pdf>

PNEUMOCOCCAL VACCINE FOR ADULTS \geq 65 YEARS: PNEUMOCOCCAL CONJUGATE VACCINE (PCV13) AND PNEUMOCOCCAL POLYSACCHARIDE VACCINE (PPSV23)

GENERAL INFORMATION

Pneumococcal vaccines help to prevent diseases caused by common strains of pneumococcus (also known as *Streptococcus pneumoniae*), including pneumonia, bloodstream infections, meningitis, and ear infections. There are two types: a single dose of each is recommended for all persons 65 and older. See separate protocols for pneumococcal vaccine recommendations for ages 0-18 years and 19-64 years.

Pneumococcal conjugate vaccine (PCV13, Prevnar-13®) is licensed by the Food and Drug Administration (FDA) for adults \geq 50 years, and is recommended by the Advisory Committee on Immunization Practices (ACIP) for all adults aged 65 years and older. PCV13 reduces the risk of vaccine-type invasive pneumococcal disease by 75% and reduces the risk of vaccine-type non-bacteremic pneumonia by 45% in this age group.

Pneumococcal polysaccharide vaccine (PPSV23) is licensed by the FDA for ages 2 years and up for the prevention of pneumococcal disease caused by 11 strains not included in PCV13. PCV13 and PPSV23 may be administered with other vaccines *except* each other. Because it can interfere with the immune response to PCV13, when both are recommended, PPSV23 should be given *after* PCV13. PPSV23 has been shown to be effective against invasive pneumococcal disease; data are inconclusive concerning benefit against non-bacteremic pneumococcal pneumonia. In 2013, 38% of invasive pneumococcal disease in US adults \geq 65 was caused by strains only in PPSV23.

Immunization may be less effective in persons with immunocompromising conditions, including advanced age, but is recommended.

In adults aged 65 and up, one dose of PCV13 is recommended for:

All who have never received a dose of PCV13 or do not know.

In adults aged 65 and up, one dose of PPSV23 is recommended for:

All who have *already* received a dose of PCV13 since turning 65 but who have not received a dose of PPSV23 since turning 65 (and it has been \geq 5 years since the last PPSV23). Note: Persons who have had PPSV23 since turning 65 never need another.

Adverse reactions:

Swelling, redness and/or pain at site of administration

Low-grade fever, headache

Systemic reactions infrequent, serious adverse reactions rare

Contraindications and Precautions include the following:

An immediate anaphylactic reaction to the vaccine or a constituent of the vaccine, such as diphtheria toxoid (PCV13) or phenol (in PPSV23)

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

Pregnancy

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

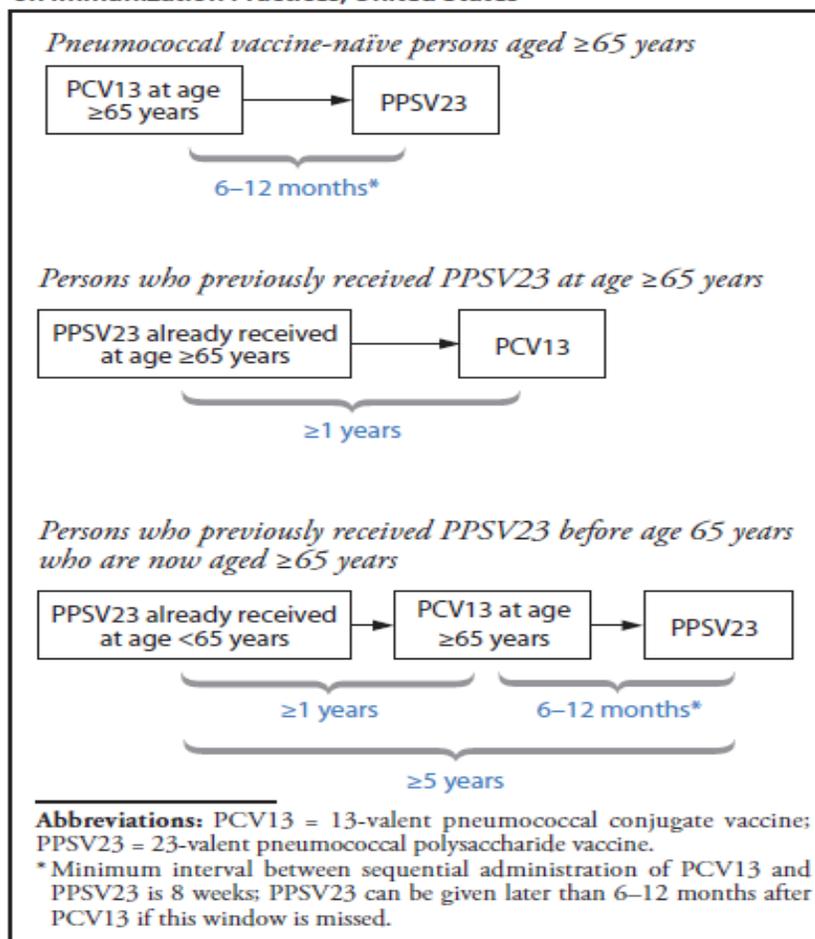
Note: Safe for latex allergic patients. Products do not contain latex.

Age 65 and over ACIP recommended schedule: PCV13 and PPSV23

Important note: Those with unknown or uncertain immunization history should receive PCV13. Medicare covers 1 dose of a pneumococcal vaccine under Part B. If the patient *can confirm* that they have had a dose since turning age 65, they will have to wait until Medicare regulations include both doses under Part B (anticipated early 2016) to have Medicare coverage for the second recommended dose. Patients immunized with PCV13 will have to wait until Medicare regulations include both doses under Part B to have Medicare pay for the recommended dose of PPSV23, regardless of the medically-recommended dosing interval. All vaccines for this age group must be non-federal.

Table to follow for recommendation and dose intervals:

BOX. Sequential administration and recommended intervals for PCV13 and PPSV23 for adults aged ≥ 65 years — Advisory Committee on Immunization Practices, United States



PLAN

Have patient or accompanying adult read Vaccine Information Statement

PCV13 and PPSV23 should not be given at the same time

[PCV13] Shake vigorously immediately before administering to achieve a uniform suspension, then administer 1 dose of 0.5cc PCV13 vaccine intramuscularly

OR

[PPSV23] Administer one dose of 0.5 cc PPSV23 vaccine intramuscularly or subcutaneously (preferably in the deltoid muscle or lateral mid thigh),

Counsel regarding benefits, side effects, and management

Advise to wait in clinic for 20 minutes after injection

Document vaccine administration on the immunization clinic record

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

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. At the time of this protocol, federal pneumococcal vaccine is unavailable.

Referral Indicators:

Persons with contraindications as noted under “General Information”

REFERENCES

CDC. Use of 13-Valent Pneumococcal Conjugate Vaccine and 23-Valent Pneumococcal Polysaccharide Vaccine Among Adults Aged ≥ 65 Years: Recommendations of the Advisory Committee on Immunization Practices (ACIP). MMWR September 19, 2014. <http://www.cdc.gov/mmwr/pdf/wk/mm6337.pdf>

POLIO VACCINE, INACTIVATED ALL-IPV SCHEDULE

GENERAL INFORMATION

IPV is the only poliovirus vaccine recommended for all persons

The all-IPV routine schedule requires 4 doses of vaccine to be given at ages 2 months, 4 months, 6-18 months, and 4-6 years

IPV can be administered simultaneously with all other vaccines recommended for the same visit

Contraindications and precautions to IPV include:

Anaphylactic hypersensitivity

Severe febrile illness (a precaution; delay until resolved)

Allergic to streptomycin, neomycin, or polymixin B

Pregnancy (a precaution; however, if required because immediate protection needed for traveling outside of country, obtain a physician order)

Adverse Reactions to IPV include:

Possibility of hypersensitivity reactions in individuals sensitive to streptomycin, polymixin B, or neomycin

PLAN

Have accompanying adult read Vaccine Information Statement/Vaccine Information Material

Counsel regarding benefits, side effects, and management

Administer appropriate vaccine, as specified by manufacturer, in accordance with Schedule

Recommended Vaccine Schedule:

2 months, 4 months, 6-18 months, and 4-6 years

The minimum age for dose 1 is 6 weeks.

A minimum interval of 4 weeks is required from dose 1 to dose 2 and from dose 2 to dose 3. A minimum interval of 6 months is required between doses 3 and 4.

Use of minimum intervals during the first 6 months of life is recommended only if the recipient is at risk for exposure (during an outbreak or for travel to a polioendemic area). History shots administered using minimum intervals do not need to be repeated.

The final dose of IPV is recommended routinely at 4-6 years of age, regardless of the number of previous doses.

Children immunized with the DTaP/IPV-Hib combination vaccine (Pentacel) will receive 4 doses of IPV by 18 months of age and are recommended to receive a 5th dose at 4-6 years. If a 5-dose schedule is used, a minimum interval of 6 months is recommended between doses 4 and 5.

The 4th dose is not needed if the 3rd dose is given on or after the 4th birthday and 6 months from the previous dose.

See table below for details of approved use for various IPV-containing vaccines.

TABLE. Currently licensed vaccines containing inactivated poliovirus vaccine (IPV) — United States, 2009*

| Vaccine composition | Trade name | Manufacturer | Approved use in ACIP [†] routine schedule | Comments |
|----------------------------|-------------------------------|-----------------|--|---|
| IPV | Ipol (Poliovax [§]) | Sanofi Pasteur | 2, 4, 6–18 mos, and 4–6 yrs | Approved for use in infants, children, and adults [¶] |
| DTaP-HepB-IPV** | Perdiarix | GlaxoSmithKline | 2, 4, and 6 mos | Approved for first 3 doses of IPV through age 6 yrs ^{††} |
| DTaP-IPV/Hib ^{§§} | Pentacel | Sanofi Pasteur | 2, 4, 6, and 15–18 mos | Approved for 4 doses of IPV through age 4 yrs ^{¶¶} |
| DTaP-IPV*** | Kinrix | GlaxoSmithKline | 4–6 yrs | Approved for booster dose at age 4–6 yrs ^{†††} |

* As of August 5, 2009.

† Advisory Committee on Immunization Practices. Full schedule available at <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5751a5.htm>.

§ Not currently distributed in the United States.

¶ Package insert available at <http://www.fda.gov/downloads/biologicsbloodvaccines/vaccines/approvedproducts/ucm133479.pdf>.

** Diphtheria and tetanus toxoids and acellular pertussis adsorbed, hepatitis B (recombinant), and inactivated poliovirus vaccine combined.

†† Package insert available at <http://www.fda.gov/downloads/biologicsbloodvaccines/vaccines/approvedproducts/ucm168055.pdf>.

§§ Diphtheria and tetanus toxoids and acellular pertussis adsorbed, inactivated poliovirus, and *Haemophilus b* conjugate (tetanus toxoid conjugate) vaccine.

¶¶ Package insert available at <http://www.fda.gov/downloads/biologicsbloodvaccines/vaccines/approvedproducts/ucm109810.pdf>.

*** Diphtheria and tetanus toxoids and acellular pertussis adsorbed, and inactivated poliovirus vaccine.

††† Package insert available at <http://www.fda.gov/downloads/biologicsbloodvaccines/vaccines/approvedproducts/ucm107220.pdf>.

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 (National Childhood Vaccine Injury Act)

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

Referral Indicators:

Allergic hypersensitivity to any component of the vaccine

History of severe reaction to previous dose

Follow-up:

Return at appropriate interval according to schedule

References

MMWR, August 7, 2009/58 (30): 829. Updated Recommendations of the Advisory Committee on Immunization Practices Regarding Routine Poliovirus Vaccination.

MMWR, July 16, 1999/48(27);590. Recommendations of the Advisory Committee on Immunization Practices; Revised Recommendations for Routine Poliomyelitis Vaccination

Epidemiology and Prevention of Vaccine-Preventable Diseases, Centers for Disease Control and Prevention, latest edition

RABIES VACCINE, POSTEXPOSURE - Information Only

In general, postexposure rabies vaccination is not provided by the Health Department. Referrals should be made to the emergency department or private physician. If these referral options are not available, the Regional Health Officer, Regional CEDS Director or on-call staff should be contacted.

GENERAL INFORMATION

Rabies postexposure prophylaxis is a medical urgency (not an emergency). However, when rabies prophylaxis is indicated, it should be started as soon as possible.

The following factors help determine whether rabies postexposure prophylaxis is indicated:

- History of possible rabies exposure:
 - Bite Exposure involves penetration of the skin by the animal's teeth, with injection of potentially infectious saliva with the wound
 - Nonbite Exposure involves contamination of scratches, abrasions, open wounds or mucous membranes with potentially infectious material (saliva or central nervous tissue); it should be noted that the probability of introduction of virus is much lower with nonbite than with bite exposures; casual contact, such as petting a rabid animal, or contact with its blood, urine, or feces, does not constitute an exposure
- Epidemiology of animal rabies in the area where the exposure occurred
- Vaccination status of animal (properly immunized pets are unlikely to be rabid)
- Circumstances of animal bite (while not the sole determinant of the need for post exposure prophylaxis, unprovoked attacks and bites constitute a higher risk than provoked ones)
- Species of animal involved (skunks, raccoons, and bats are most commonly infected and always suspect; foxes, coyotes, cattle, dogs, and cats [especially stray] are occasionally infected; and rodents, rabbits and hares are rarely infected)
- Rabies confirmed in animal
- Rabies suspected in animal - test results pending
- Animal unavailable for quarantine or testing (i.e., runaway animal, stray - unable to capture, killed-head destroyed, etc.)

RABIES POSTEXPOSURE TREATMENT PLAN:

Review patient history and provide local wound care:

- Meticulous deep cleaning and flushing of the wound site as soon as possible is an effective means of preventing attachment of the rabies virus if present
- Cleanse wound thoroughly and vigorously to the depth of the wound with soap and water and a virucidal agent such as povidone-iodine, flush wound thoroughly and deeply

Administer anti-rabies treatments: Reconstitute vaccine per manufacturer's directions

- **Previously vaccinated persons:** persons who have previously completed a preexposure or postexposure series should not receive Human Rabies Immune Globulin (HRIG); Administer 1 ml rabies vaccine (Human Diploid Cell Vaccine [HDCV / Imovax] **or** Purified Chick Embryo Cell Vaccine [PCEC / RabAvert]), IM on day 0 and day 3
- **Unvaccinated persons:** should always receive both HRIG and rabies vaccine
 - ✓ Administer HRIG (Imogam Rabies-HT or BayRab), 20 IU/kg or 1 ml/16 lb of body weight on day 0 (at the same time the first dose of vaccine is given) or as soon as possible after exposure
 - If possible, up to half the dose should be used to infiltrate the wound (except mucous membrane exposure), and the rest administered intramuscularly in the buttocks
 - If HRIG is not available, proceed with the vaccine series; HRIG can be given with the 2nd or 3rd rabies vaccine dose (until day 7), but should not be given any later in order to prevent immune response interference
 - ✓ Administer 1 ml of rabies vaccine (Human Diploid Cell Vaccine [HDCV /Imovax] **or** Purified Chick Embryo Cell Vaccine [PCEC / RabAvert]) on days 0, 3, 7, and 14 given IM per manufacturer's directions
- **Precautions–Immunosuppression:** for persons with broadly defined immunosuppression, post-exposure prophylaxis should be administered using 5 doses (on days 0, 3, 7, 14, and 28) of vaccine, with the awareness that the immune response may still be inadequate.

Instruct patient to remain in clinic for 20 minutes following treatment / vaccination (observe for possible reaction)

Health Education:

- Discuss adverse reactions such as mild to moderate inflammatory reactions, as well as mild systemic reactions such as headache, nausea, abdominal pain, muscle aches, dizziness
- Be sure that client understands the importance of keeping return appointment dates

Follow-Up:

- Post-vaccination serology is not recommended except in unusual circumstances, e.g., when the patient is known to be immunosuppressed
- Document and report any adverse reaction

References:

2006 Red Book, Report of the Committee on Infectious Diseases, American Academy of Pediatrics
Centers for Disease Control and Prevention, Human Rabies Prevention —United States, 2008, Recommendations of the Advisory Committee on Immunization Practices. MMWR 2008;57(No. RR-3).

Centers for Disease Control and Prevention, Use of a Reduced (4-Dose) Vaccine Schedule for Postexposure Prophylaxis to Prevent Human Rabies, Recommendations of the Advisory Committee on Immunization Practices. MMWR 2010;59(No. RR-2).

ROTAVIRUS VACCINE **(RotaTeq[®] “RV5” by Merck, Rotarix[®] “RV1” by GSK)**

GENERAL INFORMATION

Rotavirus causes severe diarrhea and is usually accompanied by fever and vomiting. It is the most common cause of severe gastroenteritis in infants and young children in the U.S. Rotavirus is seasonal, with peak numbers of cases occurring in the winter and early spring. Before the introduction of vaccine in 2006, rotavirus diarrhea resulted in about 200,000 emergency room visits and 55,000 hospitalizations in the US annually. Transmission occurs through the fecal-oral route.

Rotavirus vaccines are live vaccines administered by mouth, between the age of 6 weeks zero days and 8 months zero days of age. They may be administered simultaneously with other vaccines. Two rotavirus vaccines are licensed in the U.S.: Rotateq[®] by Merck (abbreviated “RV5” by CDC) and Rotarix[®] by GSK (abbreviated “RV1” by CDC). RV5(Rotateq) is a three-dose series and RV1 (Rotarix) is a two-dose series: the ACIP/CDC expresses no preference between the two vaccines. Please note: this protocol follows ACIP/CDC recommendations for a harmonized schedule of the two brands, which differs from product package inserts.

Special situations:

Infants in contact with pregnant women or persons with compromised immune systems **may** be vaccinated.

Infants who have received or will receive blood or antibody-containing products may receive the vaccine *at any time*. Previously, it was recommended that such infants wait 42 days before vaccination.

Re-administration of a dose to an infant who spits up or vomits during or after administration of the vaccine is not generally recommended. If this occurs, continue series at normal interval.

If *any* dose in the series is RV5, or if the brand of any dose is unknown, a total of 3 doses must be administered to complete the series. Although preferable to use one brand for the entire series, vaccination should not be deferred because the product previously used is unknown or unavailable.

3-Dose Immunization Schedule: If any dose is Rotateq® (RV5) or unknown brand

| Dose | Product | Recommended age | Minimum interval to next dose | Special Notes |
|------------------------------|--------------------------------|---|--------------------------------------|---|
| Dose 1 | RotaTeq (RV5) or Rotarix (RV1) | 2 months: Administer between age 6 weeks and 14 weeks 6 days (42-104 days) | 4 weeks | If dose 1 was given at ≥ 15 weeks, the series may be continued |
| Dose 2 | RotaTeq (RV5) or Rotarix (RV1) | 4 months | 4 weeks | |
| Dose 3 Final dose | RotaTeq (RV5) or Rotarix (RV1) | 6 months | | Do not administer after age 8 months 0 days |

2-Dose Immunization Schedule: If Using Rotarix® (RV1) Only

| Dose Number | Recommended age at administration | Minimum interval to next dose | Special Notes |
|------------------------------|---|--------------------------------------|--|
| Dose 1 | 2 months: Administer between age 6 weeks and 14 weeks 6 days (42-104 days) | 4 weeks | If dose 1 was given at ≥ 15 weeks, the series should be completed |
| Dose 2 Final dose | 4 months | | Do not administer after 8 months 0 days of age. |

Contraindications to giving the vaccine include the following:

- Infants <6 weeks (42 days) or >8 months 0 days (precise age in days not specified)
- Infants with a history of severe allergic reaction to a prior dose of rotavirus vaccine or to any rotavirus vaccine component
- Infants with a severe (anaphylactic) reaction to latex should not receive Rotarix (RV1). RotaTeq (RV5) should be used because it is latex free.
- Previous history of intussusception
- Infants diagnosed with Severe Combined Immunodeficiency (SCID)

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

- Moderate to severe acute illness (defer until illness resolves) [Note: Low grade fever <100.5°F or mild upper respiratory infections are not reasons for deferring]
- Preexisting chronic gastrointestinal disease (e.g., chronic diarrhea, congenital abdominal disorders)

Altered immunocompetence including:

- Blood disorders or cancers involving the bone marrow or lymph system
- Infants on high dose systemic corticosteroids
- Infants with an immunodeficiency other than SCID

Adverse Reactions:

- Severe allergic reaction to vaccine (rare)
- High fever

PLAN

- Ask parent/guardian about contraindications, precautions
- Have parent/guardian read Vaccine Information Statement
- If using Rotarix (RV1), reconstitute vaccine according to manufacturer's instructions
- Administer the vaccine by mouth according to the manufacturer instructions [if an incomplete dose is administered or the infant vomits, repeating the dose is not recommended]
- Counsel regarding side effects of vaccine
- Advise parent/guardian to return for the next dose in a minimum of 4 weeks
- Advise to wait in clinic for 20 minutes after administration of vaccine
- Record manufacturer and lot number of the vaccine administered, date vaccine and VIS given, address of facility, and name and title of person administering vaccine
- Instruct patient/guardian to contact Health Department if adverse reaction occurs (complete VAERS)

Referral Indicators:

- Infants with precautions to vaccination other than an acute moderate to severe illness should be referred for a physician order.

REFERENCES

- CDC. Cortese MM, Parashar UD. Prevention of rotavirus gastroenteritis among infants and children: recommendations of the Advisory Committee on Immunization Practices (ACIP). MMWR 2009;58(No. RR-2).
- RotaTeq (Rotavirus Vaccine, Live, Oral, Pentavalent) Vaccine package insert, Merck, Revised September 2011.
- Rotarix (Rotavirus Vaccine, Live Attenuated) Vaccine package insert, GSK, Revised February 2011.
- CDC. Prevention of Rotavirus Gastroenteritis among Infants and Children. Recommendations of the Advisory Committee on Immunization Practices, MMWR. August 11, 2006. <http://www.cdc.gov/mmwr/PDF/rr/rr5512.pdf>. Last accessed August 12, 2008.
- CDC. Addition of Severe Combined Immunodeficiency as a Contraindication for Administration of Rotavirus Vaccine, June 11, 2010. MMWR. <http://www.cdc.gov/mmwr/pdf/wk/mm5922.pdf>. Last accessed February 15, 2012.

**TETANUS, DIPHTHERIA, AND PERTUSSIS VACCINE
TETANUS, DIPHTHERIA, AND ACELLULAR PERTUSSIS
(Tdap) VACCINE FOR CHILDREN AND ADOLESCENTS
(7 through 18 years)
(ADACEL™ OR BOOSTRIX™)**

GENERAL INFORMATION

Tdap vaccine is inactivated and contains no live organisms. The vaccine protects against tetanus (“lockjaw”), diphtheria, and pertussis (“whooping cough”). Like tetanus and diphtheria, immunity to pertussis wanes following childhood immunization or disease. Two Tdap vaccines were licensed in 2005 by the U.S. Food and Drug Administration (FDA) as a **ONE-TIME DOSE**:

ADACEL™ (Sanofi Pasteur) is licensed **for ages 11 through 64 years**.

BOOSTRIX™ (GlaxoSmithKline) is licensed **for ages 10 years and older**.

Tdap is currently recommended by the Advisory Committee on Immunization Practices (ACIP) for routine use in adolescents aged 11 through 18 years. Subsequent routine Td BOOSTERS are recommended every 10 years (see Td protocol).

Tdap vaccine may be given at the same time as other immunizations, including meningococcal vaccine. It may be given before or after meningococcal vaccine if both vaccines cannot be given simultaneously.

With the exception of pregnant women, Tdap should be given only one time. It should be given if the patient is unable to verify or recall whether they have had Tdap.

Note: The CDC published ACIP recommendations in January 2011 that differ from the current manufacturers’ package inserts on age and dose intervals. ACIP guidelines for the use of vaccines take priority and should be followed as written below.

ACIP Recommendations for Use (updated May 2013):

Tdap may be used **ONE TIME** either as a routine **BOOSTER** dose, **OR** as one of a **PRIMARY** vaccine series, **OR** for tetanus **PROPHYLAXIS** in accordance with standard guidelines for wound management.

Tdap is recommended during EACH pregnancy and is preferred during the third trimester, regardless of Tdap vaccination history. Vaccination during pregnancy passes protective antibodies to the unborn child. A woman who has not had Tdap before and who does not receive it during pregnancy should be vaccinated immediately post-partum; however, a post-partum dose does not help the newborn and is not recommended if she has had Tdap previously.

Timing: Administer regardless of interval since last tetanus- or diphtheria- containing vaccine. Note: A “complete” primary series of pertussis vaccine in childhood is typically defined as 5 doses of DTaP. Four doses of DTaP is considered complete when the 4th dose is given after the 4th birthday.

Children (7 through 10 years) who have not had a complete primary series of pertussis

vaccine as defined above: give one dose of Tdap. Use Td for any additional doses necessary to complete the primary series of tetanus immunization.

Adolescents (11 through 18 years) who had a complete primary series of tetanus-containing vaccine in childhood - A single dose of Tdap is routinely recommended and should be given to **all children** between ages 11-12 years; administer at ages 13-18 years to any child that has not already received a Tdap.

Adolescents (11 through 18 years) who have not had a primary series of tetanus-containing vaccine - A single dose of Tdap should be **substituted for one Td** in the 3-dose primary series; it is preferred as the first dose.

Every pregnant adolescent who had a complete primary series of tetanus containing vaccine in childhood should be given Tdap during each pregnancy preferably during the third trimester, unless contraindicated. Previously unimmunized adolescents who fail to receive Tdap before or during pregnancy should receive a dose immediately post-partum.

REFERRAL INDICATORS (PER ACIP)

Contraindications to giving the vaccine include the following:

- History of an immediate severe allergic reaction (anaphylaxis) to any of the three components of Tdap (i.e., tetanus, diphtheria, or pertussis vaccines) or to any combination vaccine containing Tdap components
- History of encephalopathy (e.g., coma, prolonged seizures) within 7 days of administration of a pertussis-containing vaccine that is not attributable to another identifiable cause; tetanus/diphtheria vaccine (Td) should be used instead of Tdap in such patients.

Precautions which may require referral include the following:

- History of Arthus-type hypersensitivity reactions (extensive painful limb swelling within hours of injection) following prior tetanus vaccination; such patients should not be given any tetanus-containing vaccine more frequently than every 10 years
- A current progressive neurologic disorder, uncontrolled epilepsy, or progressive encephalopathy; defer vaccination with pertussis-containing vaccine until treatment regimen is established and condition is stabilized, Td may be used
- History of a severe allergic reaction (anaphylaxis) to latex¹
- Guillain-Barre syndrome (GBS) within 6 weeks after a previous dose of a tetanus toxoid-containing vaccine
- Patient has an acute moderate-to-severe illness, with or without fever; vaccination should be deferred until illness has resolved

PLAN

Provide current Vaccine Information Sheet (VIS) about Tdap and the benefits of vaccination
 Counsel regarding benefits, side effects, and management
 Shake the vial well, administer 0.5 ml of vaccine INTRAMUSCULARLY
 Remind that tetanus/diphtheria vaccine boosters are recommended every 10 years
 If pregnant, recommend Tdap for any unimmunized household members or infant caregivers.

¹ Boostrix™ pre-filled syringes contain latex. Adacel™ products and Boostrix™ single dose vials do not contain latex; there is no precaution against the use of these products in patients with latex allergy.

Advise to wait in clinic 20 minutes after injection
 Record manufacturer and lot number of the vaccine administered, date, name, address and title of the person administering vaccine
 Instruct patient to contact Health Department if adverse reaction occurs (complete appropriate form)

Referral Indicators:

History of an immediate severe allergic reaction (anaphylaxis) to prior tetanus, diphtheria, or pertussis vaccines
 History of encephalopathy (e.g., coma, prolonged seizures) within 7 days of administration of a pertussis-containing vaccine
 Refer for precautions as indicated

Follow-up:

Return for Td booster in 10 years, or for the next scheduled dose if administering a catch-up primary series.
 Return for wound management as required

REFERENCES

Advisory Committee on Immunization Practice (ACIP) Votes to Recommend Routine Use of Combined Tetanus, Diphtheria and Pertussis (Tdap) Vaccines for Adolescents, U.S. Department of Health and Human Services, Centers for Disease Control and Prevention (CDC), Atlanta, GA 30333, June 30, 2005

Tetanus Toxoid, Reduced Diphtheria Toxoid and Acellular Pertussis Vaccine Adsorbed (ADACEL™) Vaccine package insert, Sanofi Pasteur (Aventis Pasteur), June 2005

Tetanus Toxoid, Reduced Diphtheria Toxoid and Acellular Pertussis Vaccine, Adsorbed (BOOSTRIX™) Prescribing information, GlaxoSmithKline, May 2005, revised January 2009. http://us.gsk.com/products/assets/us_boostrix.pdf

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

Updated Recommendations for Use of Tetanus Toxoid, Reduced Diphtheria Toxoid, and Acellular Pertussis Vaccine (Tdap) in Pregnant Women — Advisory Committee on Immunization Practices (ACIP), 2012. <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6207a4.htm>. Last accessed June 3, 2013.

**TETANUS, DIPHTHERIA, AND PERTUSSIS VACCINE
TETANUS, DIPHTHERIA, AND ACELLULAR PERTUSSIS
(Tdap) VACCINE FOR ADULTS (19 and up)
(ADACEL™ OR BOOSTRIX™)**

GENERAL INFORMATION

Tdap vaccine is inactivated and contains no live organisms. The vaccine protects from tetanus (“lockjaw”), diphtheria, and pertussis (“whooping cough”). Immunity wanes following childhood immunization. With pertussis, adults may suffer prolonged coughing illness and may infect others, including infants at risk for severe complications.

ADACEL™ (Sanofi Pasteur) was licensed in 2005 by the U.S. Food and Drug Administration (FDA) for ages **11 through 64 years** as a **ONE-TIME DOSE**.

BOOSTRIX™ (GSK) is licensed **for ages 10 years or older** as a **ONE-TIME DOSE**.

The Advisory Committee on Immunization Practices (ACIP) recommends providers should not miss an opportunity to vaccinate persons aged 65 years and older with Tdap, and may administer the vaccine that they have available. When feasible, for adults aged 65 years and older, Boostrix should be used; however, either vaccine product administered to a person aged 65 years and older provides protection and is considered valid.

Tdap is routinely recommended by the ACIP for any person age 11 years or older who has not yet had Tdap, regardless of interval since last tetanus booster. (See the Tdap protocol for adolescents for recommendations ages 7 through 18 years). **Subsequent routine Td BOOSTERS are recommended every 10 years** (see Td protocol).

Tdap vaccine may be given at the same time as other immunizations, including meningococcal vaccine. It may be given before or after meningococcal vaccine if both vaccines cannot be given simultaneously.

Tdap is approved only as a ONE TIME dose; however, Tdap SHOULD be given if there is no documentation of a previous dose of Tdap and during each pregnancy.

Tdap is especially important for pregnant women, healthcare personnel and persons who care for or live with infants under age one, in order to help prevent exposing the infant to pertussis disease (“cocooning”)

Tdap is recommended during EACH pregnancy and is preferred during the third trimester, regardless of Tdap vaccination history. Vaccination during pregnancy passes protective antibodies to the unborn child. A woman who has not had Tdap before and who does not receive it during pregnancy should be vaccinated immediately post-partum; however, a post-partum dose does not help the newborn and is not recommended if she has had Tdap previously.

Note: The ACIP now recommends Tdap for all adults who have not previously had a dose of Tdap, regardless of the interval since the recipient's last Td. These ACIP recommendations differ from the manufacturer package insert and take priority over information contained in the package insert.

ACIP Recommendations for Use:

Tdap may be used **ONE TIME** either as a routine **BOOSTER** dose, OR as one of a **PRIMARY** vaccine series, OR for tetanus **PROPHYLAXIS** in accordance with standard guidelines for wound management:

Adults (19 and older): A single dose of Tdap is routinely recommended to any adult who has not had a dose of Tdap. Adults who have completed a primary series of tetanus containing vaccine in the past are routinely recommended to have a booster dose of tetanus containing vaccine every 10 years. The next tetanus booster would be due 10 years after the dose of Tdap.

Adults (19 and older) WITHOUT A COMPLETE PRIMARY SERIES of Td-containing vaccine - A single dose of Tdap should be substituted for one Td in the primary series; it is preferred as the first dose.

Adults (19 and older), REQUIRING TETANUS PROPHYLAXIS FOR WOUND MANAGEMENT - A single dose of Tdap should be given, if available, if the patient has not had Tdap before (See Protocol for Wound Management); otherwise, Td should be used.

PREGNANCY: Tdap may be given at any time during pregnancy. Unless contraindicated, **Tdap should be given to each pregnant woman, preferably during the third trimester, during EACH pregnancy, regardless of her history of Tdap vaccination.** Immunization during pregnancy passes protective antibodies from the mother to the unborn child and can help prevent illness in both mother and newborn. Women who have not previously had a dose of Tdap and fail to receive Tdap during pregnancy should receive a dose immediately post-partum. Post-partum immunization does not protect the newborn, so it is not recommended for every pregnancy, but only if the woman is previously unimmunized with Tdap.

DOSING INTERVALS since last tetanus vaccine dose: Tdap should be given regardless of the interval since the last tetanus-containing vaccine.

REFERRAL INDICATORS (PER ACIP)

Contraindications to giving the vaccine include the following:

History of an immediate severe allergic reaction (anaphylaxis) to any of the three components of Tdap (i.e., tetanus, diphtheria, or pertussis vaccines) or to any combination vaccine containing Tdap components

History of encephalopathy (e.g., coma, prolonged seizures) within 7 days of administration of a pertussis-containing vaccine that is not attributable to another identifiable cause; tetanus/diphtheria vaccine (Td) should be used instead of Tdap in such patients

Precautions which may require referral include the following:

History of Arthus-type hypersensitivity reactions (extensive painful limb swelling within hours of injection) following tetanus vaccination administered <10 years previously; such patients should not be given any tetanus-containing vaccine more frequently than every 10 years

A current unstable neurologic disorder, uncontrolled epilepsy, or progressive encephalopathy; defer vaccination with pertussis-containing vaccine until treatment regimen is established and condition is stabilized; Td may be used

Guillain-Barre syndrome (GBS) within 6 weeks after a previous dose of a tetanus toxoid-containing vaccine

Defer immunization if the patient has an acute moderate-to-severe illness, with or without fever, until illness has resolved

PLAN

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

Counsel regarding benefits, side effects, and management

Shake the vial well, administer 0.5 ml of vaccine INTRAMUSCULARLY

Remind that tetanus/diphtheria vaccine boosters are recommended every 10 years

If pregnant, recommend Tdap for any unimmunized household members or infant caregivers.

Advise to wait in clinic 20 minutes after injection

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

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

Referral Indicators:

History of an immediate severe allergic reaction (anaphylaxis) to prior tetanus, diphtheria, or pertussis vaccines

History of encephalopathy (e.g., coma, prolonged seizures) within 7 days of administration of a pertussis-containing vaccine

Refer or defer immunization for precautions as indicated

Follow-up:

Return for Td booster in 10 years (or for next dose, if completing a primary series)

Return for wound management as required

REFERENCES

Centers for Disease Control and Prevention. Preventing Tetanus, Diphtheria, and Pertussis Among Adults: Use of Tetanus Toxoid, Reduced Diphtheria Toxoid and Acellular Pertussis Vaccine Recommendations of the Advisory Committee on Immunization Practices (ACIP) and Recommendation of ACIP, supported by the Healthcare Infection Control Practices Advisory Committee (HICPAC), for Use of Tdap Among Health-Care Personnel. MMWR 2006;55(No. RR-17).

Tetanus Toxoid, Reduced Diphtheria Toxoid and Acellular Pertussis Vaccine Adsorbed (ADACEL™) Vaccine package insert, Sanofi Pasteur (Aventis Pasteur), June 2005. Revised 2/22/2012.

Tetanus Toxoid, Reduced Diphtheria Toxoid and Acellular Pertussis Vaccine, Adsorbed (BOOSTRIX™) Prescribing information, GlaxoSmithKline, July 2011, revised March 2012. http://us.gsk.com/products/assets/us_boostrix.pdf

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

Centers for Disease Control and Prevention. Updated Recommendations for Use of Tetanus Toxoid, Reduced Diphtheria Toxoid and Acellular Pertussis Vaccine (Tdap) in Pregnant Women and Persons Who Have or Anticipate Having Close Contact with an Infant Aged <12 Months — Advisory Committee on Immunization Practices (ACIP), 2011. MMWR 2011;60(No. 41): pp1424-1426.

ACIP provisional recommendations for adults aged 65 years and older on use of tetanus toxoid, reduced diphtheria toxoid and acellular pertussis vaccine (Tdap) and guidance on use of Tdap products for adults aged 65 years and older. <http://www.cdc.gov/vaccines/recs/provisional/Tdap-feb2012.htm>. Last accessed March 22, 2012.

Updated Recommendations for Use of Tetanus Toxoid, Reduced Diphtheria Toxoid, and Acellular Pertussis Vaccine (Tdap) in Pregnant Women — Advisory Committee on Immunization Practices (ACIP), 2012. <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6207a4.htm>. Last accessed May 23, 2013.

TETANUS AND DIPHTHERIA TOXOID, ADULT TYPE

Td (Adult Type)

GENERAL INFORMATION

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

SUBJECTIVE

Patient reports needs Tetanus booster

OBJECTIVE

Appropriate candidates for Td include the following:

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

ASSESSMENT

Contraindications include the following:

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

Precautions include the following:

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

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

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

PLAN

Have patient or accompanying adult read Vaccine Information Statement/Vaccine Information Material Counsel regarding benefits, side effects, and management

Administer 0.5 cc of Td INTRAMUSCULARLY

Advise to wait in clinic 20 minutes after injection

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

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

Referral Indicators:

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

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

Needs tetanus immune globulin (TIG) for wound management

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

Follow-Up:

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

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

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

REFERENCES

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

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

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

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

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

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

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

TETANUS PROPHYLAXIS IN WOUND MANAGEMENT

GENERAL INFORMATION

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

SUBJECTIVE

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

OBJECTIVE

Patient needs tetanus prophylaxis

ASSESSMENT

Review patient immunization history

PLAN

Teach wound care

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

Counsel regarding benefits, side effects, and management

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

Guide to tetanus prophylaxis in routine wound management.

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

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

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

Do not give DTaP if:

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

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

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

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

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

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

Pregnancy:

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

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

Referral Indicators:

Needs TIG

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

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

Follow-Up:

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

REFERENCES

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

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

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

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

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

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

VARICELLA VACCINE (VARIVAX® by Merck)

GENERAL INFORMATION

Varicella virus causes chickenpox and lies dormant in nerve roots following the primary infection. The virus can cause recurrent infection, resulting in herpes zoster (“shingles”). The virus is highly contagious and enters the body through the respiratory tract or mucus membranes. Up to 90% of susceptible household contacts of persons with chickenpox will become infected. In the U.S. each year, before routine vaccination, there were about 4 million cases of chickenpox, resulting in 11,000 hospitalizations and 100 deaths, with the highest risk of death among susceptible adults.

Varicella vaccine is a live attenuated (weakened) virus vaccine derived from the Oka strain of varicella and administered subcutaneously; it is licensed by the Food and Drug Administration (FDA) for administration to persons 12 months of age and older. Two doses of the vaccine are recommended for all recipients, including a second dose for those who may have had a single dose earlier in childhood. A single dose confers approximately 70-90% protection from disease; the seroconversion rate of 2-dose recipients is approximately 99%. The vaccine is not recommended for persons with evidence of immunity to varicella (see below).

The vaccine may be simultaneously administered with other vaccines, including other live virus vaccines. It is stored frozen at an average temperature of $\leq -15^{\circ}\text{C}$ (5°F), but not below -50°C . It must be discarded if not administered to the recipient within 30 minutes of reconstitution.

Evidence of immunity to varicella:

Persons with evidence of immunity to varicella should not be vaccinated. Acceptable evidence includes the following (Advisory Committee on Immunization Practices, ACIP, 2006):

1. Documentation of age-appropriate vaccination:
 - a. Children 12 months up to school entry: one dose
 - b. School-aged children: 2 doses
2. Laboratory evidence of immunity or laboratory confirmation of disease
3. Born in the US before 1980 (this is insufficient evidence for healthcare workers or pregnant women)
4. Healthcare provider diagnosis of varicella or provider verification of a patient’s credible reported history of varicella disease (for “atypical” or “mild” disease, this verification should include an epidemiologic link to a person with typical disease or laboratory confirmation, because other diseases may mimic atypical varicella)
5. Healthcare provider diagnosis of herpes zoster

ACIP Recommendations for Use:

- Routine immunization schedule: first dose at age 12-15 months, second dose at age 4-6 years (before starting school) (See below)
- A second, catch-up dose is recommended for all children and adults who previously had received only one dose (unless they have appropriate evidence of immunity due to breakthrough disease)
- Adults (2-dose series) for whom it is medically indicated (in other words, they do not meet criteria for immunity listed above)

NOTE: See current policy from the Tennessee Immunization Program for guidance concerning which recommended persons are eligible for federally-funded vaccine.

Routine Immunization Schedule

| Dose Number | Recommended age at administration | Minimum interval to next dose |
|--------------------|--|--|
| Dose 1 | 12-15 months | 3 months (age 1-12 years)** 4 weeks (28 days) (age >13 years) **At any age, a second dose administered at least 28 days after the first dose does not need to be repeated |
| Dose 2 | 4-6 years | |

Contraindications to giving the vaccine include the following:

Evidence of immunity (per above criteria)

Pregnancy

Moderate to severe acute illness (defer until recovery) [Note: Low grade fever <100.5°F or mild illnesses are not reasons for deferring immunization]

Anaphylactic reaction to a previous dose of the vaccine or any component (including neomycin and gelatin)

Blood dyscrasias, leukemia, lymphoma of any type, other malignant neoplasm affecting the bone marrow or lymphatic system

Primary or acquired cellular immunodeficiencies (e.g., AIDS or clinical manifestations of HIV)

Untreated, active tuberculosis (not latent tuberculosis infection)

Family history of congenital or hereditary immunodeficiency in a first-degree relative (e.g., parent or sibling), unless the immunocompetence of the recipient has been clinically confirmed by a physician or verified by a laboratory

Ongoing immunosuppressive therapy (does not apply to corticosteroid replacement therapy)

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

Persons on steroid therapy not otherwise immunocompromised (refer)

Impaired humoral immunity or asymptomatic HIV infection (refer)

Receipt of a blood or plasma transfusion or immune globulin within the past 5 months (defer vaccination until at least 5 months after receipt of blood products)

Varicella vaccine may be given on the same day as other live virus vaccines (e.g., MMR); however, if not given on the same day, they must be separated by 4 weeks (28 days).

If not given on the same day, wait 4 weeks (28 days) from date of varicella vaccine to administer TST.

Special Situations (per ACIP):

Breastfeeding is not a contraindication to immunization

Vaccinees who are healthcare workers or household contacts of susceptible, high risk persons in whom a vaccine-related vesicular rash develops should avoid contact with such persons while they have the rash

Women should be advised to avoid becoming pregnant for at least 1 month (per ACIP) following vaccination, though having a pregnant household contact is not a contraindication to vaccination

Aspirin use during natural varicella disease is associated with Reye's Syndrome and recipients should be advised to avoid salicylates for 6 weeks following vaccination

Adverse Reactions:

Soreness, swelling or redness around the injection site within 48 hours of immunization

An injection site or full body rash up to 1 month following vaccination in $\leq 5\%$ of Recipients

PLAN

Ask parent/guardian or recipient about contraindications, precautions

Have parent/guardian or recipient read Vaccine Information Statement

Reconstitute vaccine and administer the vaccine subcutaneously according to the manufacturer instructions

Counsel regarding side effects of vaccine, e.g., rash

Advise women of child-bearing age to avoid becoming pregnant for at least 1 month

Advise that recipients should avoid use of salicylates (e.g., aspirin) for 6 weeks

Advise parent/guardian or recipient to return for the next dose at the appropriate interval

Advise to wait in clinic for 20 minutes after administration of vaccine

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

Instruct patient/guardian to contact Health Department if adverse reaction occurs

Referral Indicators

Persons with impaired immune systems (acquired or primary)

Persons on steroid therapy (other than corticosteroid replacement)

REFERENCES

Advisory Committee on Immunization Practices (ACIP) Provisional Recommendations for Prevention of Varicella, posted August 2006.

http://www.cdc.gov/nip/vaccine/varicella/varicella_acip_recs_prov_june_2006.pdf Last accessed October 31, 2006.

VARIVAX® [Varicella Virus Vaccine Live (Oka/Merck)] Vaccine package insert, Merck, copyright 2001. Centers for Disease Control and Prevention. Prevention of varicella: recommendations of the Advisory Committee on Immunization Practices (ACIP). MMWR 1996; 45 (No. RR-11): pp1-36.

Centers for Disease Control and Prevention. Prevention of Varicella: updated recommendations of the Advisory Committee on Immunization Practices (ACIP). MMWR 1999; 48 (No. RR-6): pp1-5.

Centers for Disease Control and Prevention. Vaccine Information Statement – Varicella Vaccine 12/16/98. <http://www.cdc.gov/nip/publications/VIS/visvaricella.pdf> Last accessed October 31, 2006.

SECTION V:
SEXUALLY
TRANSMITTED
DISEASES

5.010 – 5.160

CHLAMYDIA TRACHOMATIS, Case or Contact

SUBJECTIVE

Symptoms may include:

FEMALES-

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

MALES -

Dysuria
Penile discharge
Commonly asymptomatic

“A friend told me to come in”

Sexual contact to confirmed or suspected case of chlamydia, gonorrhea, NGU, or non-specific cervicitis

Private physician or other health care provider referral

OBJECTIVE

Muco-purulent discharge from urethra or cervix

Laboratory positive for *Chlamydia trachomatis*

ASSESSMENT

Confirmed or suspected case of *Chlamydia trachomatis*

Contact to confirmed or suspected case of *Chlamydia trachomatis*

Last menstrual period

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

PLAN

Screen¹ for chlamydia and gonorrhea using currently available test; refer to “*Laboratory Policies and Procedures Manual for Local Health Departments*” for information on specimen storage and mailing.

Draw blood for syphilis serology.

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

Offer HIV counseling and literature for all clients; offer testing for high-risk individuals or those requesting service.

Interview patient for sexual contacts and encourage all contacts to obtain treatment:

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

Notify the public health representative of the original positive case name and contact information Counsel, examine, and test all persons exposed.

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

TREATMENT

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

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

AZITHROMYCIN is the drug of choice for chlamydia.

Treatment for Chlamydia Only²

Adult/Adolescent:

Azithromycin 1 gm orally as a single dose

OR

Doxycycline 100 mg orally BID x 7 days³

Pregnant Adult/Adolescent or Nursing Mothers:

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

Azithromycin 1 gm orally as a single dose

OR

Amoxicillin 500 mg orally TID x 7 days

Allergic Pregnant Individuals:

Consult with physician regarding choice of above antibiotics

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

Non-Allergic Adult/Adolescent:

Ceftriaxone 250 mg IM as a single dose

PLUS ONE OF THE FOLLOWING:

Azithromycin 1 gm orally as a single dose

OR

Doxycycline 100 mg orally BID x 7 days⁵

² Patients and/or sex partners presenting for treatment of laboratory confirmed chlamydia, and are **known to have a negative gonorrhea test**, are to be treated for chlamydia only.

³ Doxycycline is contraindicated in pregnancy and nursing mothers.

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

⁵ Doxycycline is contraindicated in pregnancy and nursing mothers.

Non-Allergic Pregnant Adult/ Adolescent/ Nursing Mothers:

Ceftriaxone 250 mg as a single dose

PLUS ONE OF THE FOLLOWING:

Azithromycin 1 gm orally as a single dose

OR

Amoxicillin 500 mg orally TID x 7 days

Allergic Adult/Adolescent:

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

Allergic Pregnant Adult/Adolescent/Nursing Mothers :

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

OR

Azithromycin 1 gm orally as a single dose for chlamydia and refer to physician for cephalosporin desensitization and treatment (an infectious disease physician experienced in the procedure should be selected)

DILUENT- Use 1% lidocaine solution, sterile water for injection, or 0.9% sodium chloride solution and document accordingly (if allergic to lidocaine, mix with sterile water or normal saline). Lidocaine allergy includes allergies to local anesthesia such as Nupercaine[®], Xylocaine[®], Carbocaine[®], Marcaine[®] or Atanert[®]. There has been no cross sensitivity shown to para-aminobenzoic derivatives such as procaine, tetracaine, and benzocaine.

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

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

⁷ Studies indicate that 10% of patients alleging an allergy to PCN are actually allergic when testing is done. Only 5-10% of patients allergic to PCN will have a cross reaction/sensitivity to cephalosporins. Therefore, only 0.5-1% of patients that allege an allergy to PCN would actually be allergic to a cephalosporin. With a thorough history taken on those patients alleging PCN allergy, a risk of an allergic reaction to ceftriaxone will be extremely rare.

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

Health Teaching

- Offer condoms and encourage use during any sexual activity.
- Encourage all sexual contacts to obtain care.
- Stress completion of all medicines and advise to avoid intercourse until patient and their sex partner(s) have completed treatment including 7 days after single-dose therapy or completion of 7 or 14-day treatment regimen.
- Warn patient that until medication is completed and all sex partners are treated, chlamydial infection may be transmitted and reinfection is likely.
- If using oral contraceptive, encourage use of barrier method until two weeks following completion of treatment. Offer condoms.
- Discuss HIV and STD prevention.
- Encourage voiding before and after intercourse.
- Increase water intake with medications.
- Avoid antacids and exposure to sun when taking doxycycline.
- Stress hygiene, including wearing cotton underwear, loose clothing, avoidance of underpants while sleeping, wiping front to back, and avoid feminine hygiene sprays and deodorants.
- Stress need for follow-up exam if symptoms persist, recur, or exacerbate.

Referral Indicators

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

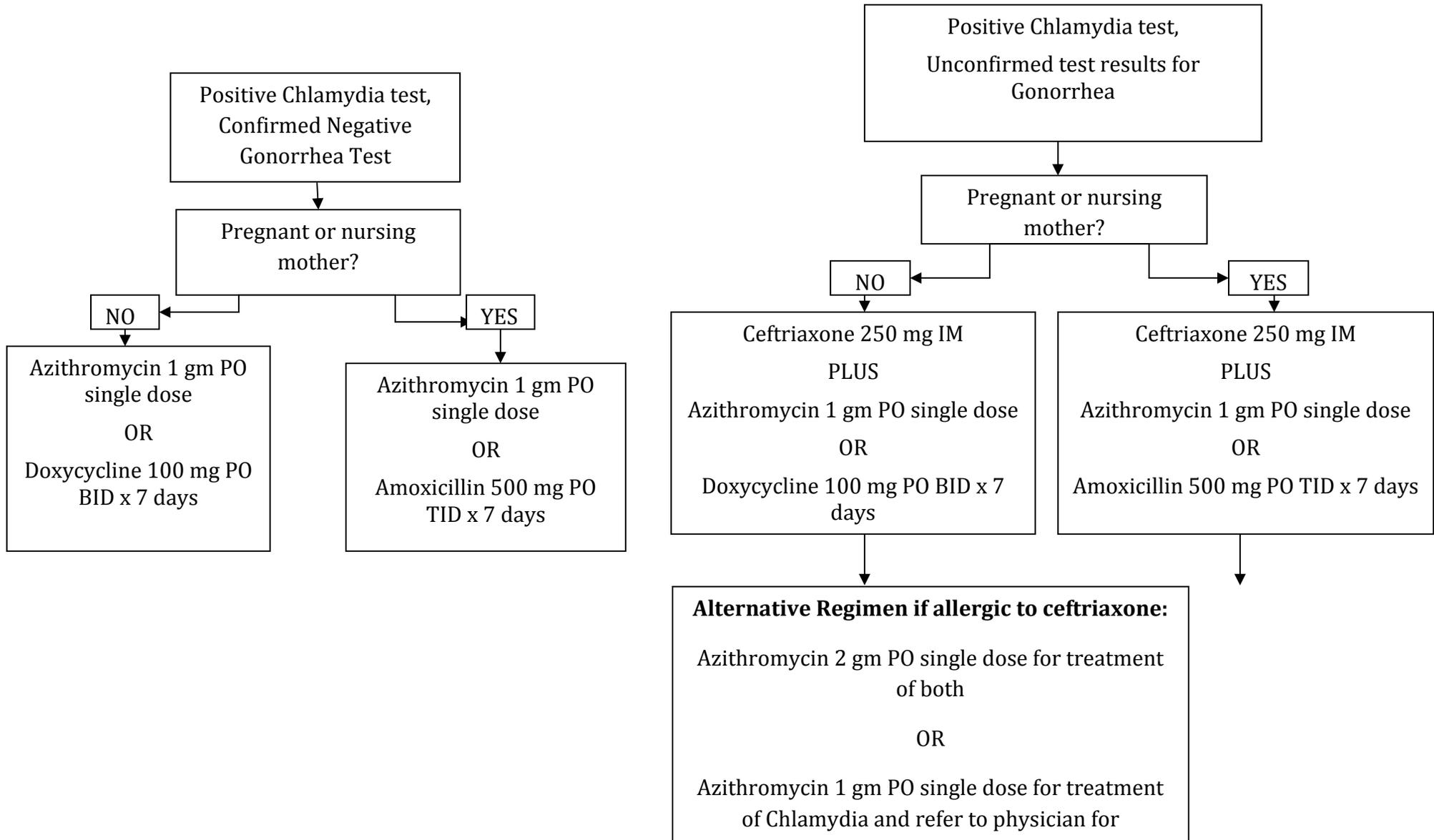
Follow-Up

- Return if no improvement after treatment.
- Counsel infected patient to return for retesting 3 months after completion of treatment. If this does not occur, retest all persons treated for chlamydia infection if they present for care within 12 months following treatment.
- In cases of treatment failure, consult with nurse practitioner or physician.
- Report all cases to Sexually Transmitted Disease Program representative.
- Test of cure is not appropriate except in pregnant women who should be tested 4-6 weeks after completing therapy.

REFERENCE

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

Chlamydia and Gonorrhea Treatment Decision Tree



CHLAMYDIA TRACHOMATIS, CONTACT PARTNER DELIVERED THERAPY

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

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

SUBJECTIVE

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

OBJECTIVE

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

Provision of treatment of the (index) patient for Chlamydia

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

PLAN

Document objective findings in index patient's record.

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

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

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

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

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

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

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

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

MALES -

Early Symptoms

Dysuria with increased frequency
Whitish discharge from penis
Pharyngitis

Later Symptoms

Yellowish/greenish discharge from penis
Epididymitis
Proctitis

OBJECTIVE

Purulent discharge from urethra or cervix noted on exam
Laboratory positive for *Neisseria gonorrhoeae*

ASSESSMENT

Confirmed or suspected case of *Neisseria gonorrhoeae*
Contact to confirmed or suspected case of *Neisseria gonorrhoeae*
Last menstrual period
Assess sites exposed (vaginal, oral, rectal, and urethra)

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.

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.

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.

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.

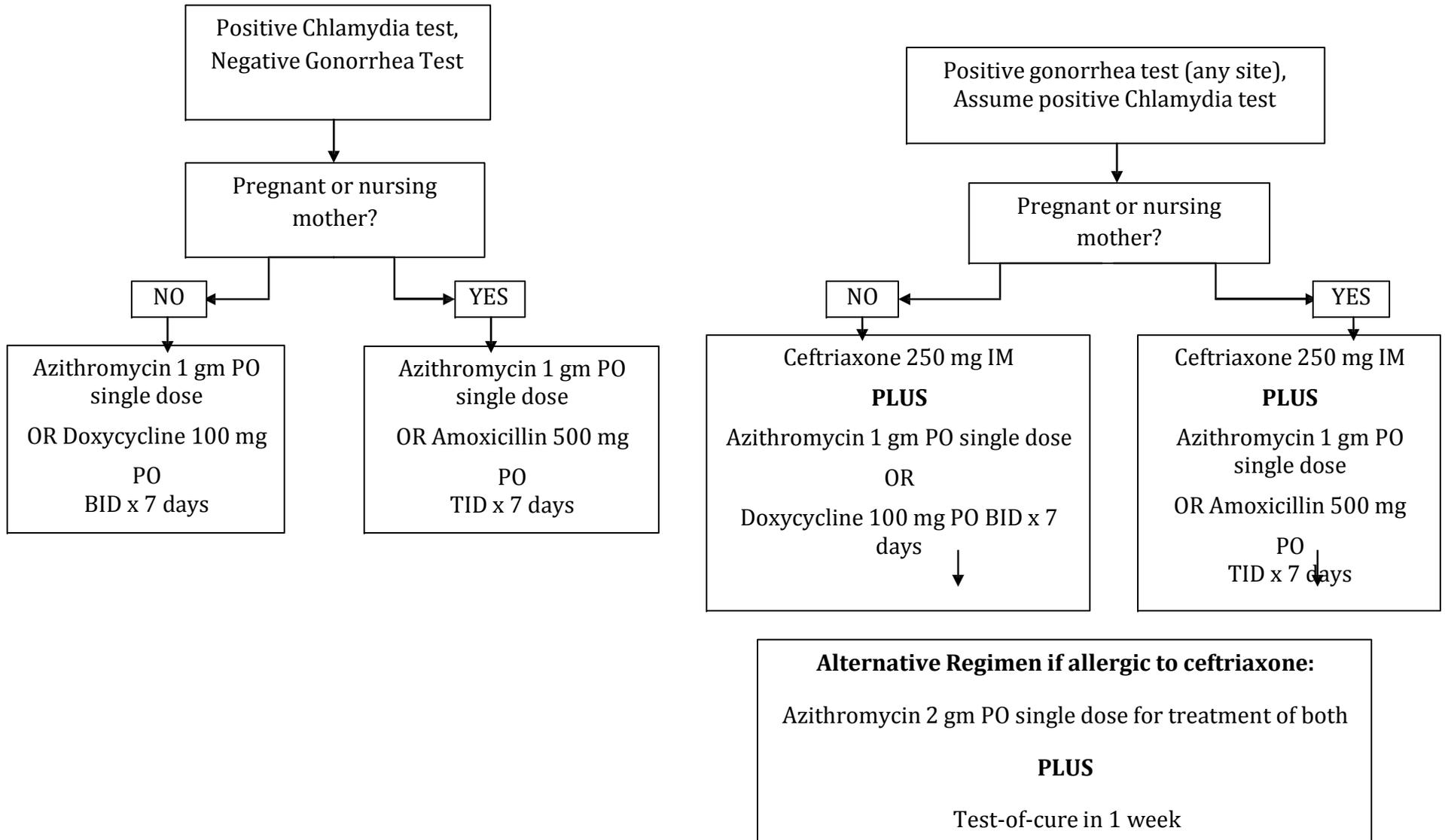
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Sathia L, Ellis B, Phillip S, et al. Pharyngeal gonorrhoea—is dual therapy the way forward? *Int J STD AIDS* 2007;18:647-8.

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 (ISSTD) Conference, London, UK, June 2009.

Gonorrhea and Chlamydia Treatment Decision Tree



HEPATITIS B, Case or Presumptive

BACKGROUND

Hepatitis B virus infection is an established cause of acute and chronic hepatitis and cirrhosis. Chronic hepatitis also increases the risk of developing liver cancer. The virus has an average incubation period of 90 days with a range of 60 to 150 days. In some instances, the virus has been shown to remain infectious on environmental surfaces for more than 7 days at room temperature. HBV is transmitted through the mixing of bodily fluids. Humans are the only known host. Acute hepatitis B infection and chronic or acute hepatitis B infection of a woman during each pregnancy is a reportable disease under Tennessee Reportable Disease regulations.

Risk factors for becoming infected include:

- Sexual contact with infected person
- Contaminated needles – this can be from sharing drug needles or syringes or from contaminated needles used for tattooing, acupuncture or piercings.
- Sharing toothbrushes, razors or other personal items with an infected person.
- Persons who live in the household of an infected person.
- Persons with diabetes

Hepatitis B can be passed from mother to infant, especially in the absence of proper prophylaxis of the infant at delivery. Perinatal transmission has the highest likelihood of chronic infection and subsequent liver disease in the infant.

SUBJECTIVE

May be asymptomatic

Non-specific symptoms characterized by insidious onset of malaise, anorexia, nausea, vomiting, right upper quadrant abdominal pain, fever, headache, muscle pain or tenderness, and dark urine beginning 1 to 2 days before the onset of jaundice.

OBJECTIVE

Confirmation is by serologic testing, the presence of HBsAg, IgM anti-HBc, or HBeAg. Some patients may present with a hepatitis B viral load or positive DNA test.

ASSESSMENT

Hepatitis B, confirmed or strongly suspected, requires reporting to the local health department by physician's office, laboratory or hospital treating the patient under state reportable disease rules.

PLAN

If pregnant, notify nursing supervisor, communicable disease director or medical director, and the region's designated Perinatal Hepatitis B Prevention Coordinator (if not one of the above) (see Tennessee Department of Health, Perinatal Hepatitis B Prevention Program guidelines for further information)

The suspected or confirmed acute case or chronic case (in the case of any pregnant woman) must be reported by appropriate staff in the National Electronic Disease Surveillance System.

Discuss blood and body fluid precautions until HBsAg disappears and anti-HBs appears.

Interview household and sexual contacts and others who may have contact with blood or secretions e.g., intravenous drug users (for contacts see PHN Protocol 5.080 Hepatitis B, All Other Contacts, Post Exposure)

Offer complete hepatitis B vaccine series at no cost to unvaccinated household or sexual contacts as well as any contacts that share drug paraphernalia. Advise that their contacts just need to notify the office staff that they are a contact of a hepatitis B case (whether chronic or acute).

Offer condoms and encourage use with each sexual contact

Offer testing/ counseling for other STD's, HIV and syphilis

If case is pregnant, inform that the regional Perinatal Hepatitis B Prevention Program Coordinator will follow up to provide additional education and postnatal case management assistance to ensure timely prophylaxis and vaccination for the baby to minimize the risk of transmission of infection to the baby.

REFERENCE

CDC . Hepatitis B Information for Health Professionals, Centers for Disease Control and Prevention, Division of Viral Hepatitis, January 2012
<http://www.cdc.gov/hepatitis/HBV/HBVfaq.htm>

Epidemiology and Prevention of Vaccine-Preventable Diseases, Department of Health and Human Services, Centers for Disease Control and Prevention, 12th Edition, May 2011

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Tennessee Department of Health, Perinatal Hepatitis B Prevention Program Guidelines, Revised 2012, available at <http://health.state.tn.us/ReportableDiseases/> under the "Public Health" tab of the reportable condition listed as "Hepatitis, viral, HBsAg+ Pregnant Female".

HEPATITIS B, Infant Contacts

GENERAL INFORMATION

Infant born to a woman infected with hepatitis B, either chronically or acutely, which includes all women who test positive for hepatitis B surface antigen (HBsAg) (see Tennessee Department of Health, Perinatal Hepatitis B Prevention Program Guidelines for further information)

PLAN

Notify CEDS Regional Director or designated Regional Perinatal Hepatitis B Coordinator of the infant that needs follow-up by the Perinatal Hepatitis B Prevention Program and care.

Assure that infant has received Hepatitis B Immune Globulin (HBIG) and the first dose of hepatitis B vaccine (HBV) (0.5 ml) I.M. within 12 hours of birth. If infant was not given HBIG and HBV at birth and more than 7 days have elapsed since birth - **do not give HBIG**. If infant was not given HBIG and **fewer than 7 days** have elapsed since birth, **give HBIG**, if available, or notify those listed above to arrange for HBIG to be given as soon as possible.

Administer the second and third dose of HBV according to Hepatitis B Vaccine protocol. Combination vaccines containing hepatitis B also may be used to complete the vaccine series using their recommended schedules.

Test infant for HBsAg and anti-HBs no earlier than one month after completion of HBV series at 9 to 18 months of age.

If infant is positive for HBsAg, refer for medical evaluation.

If infant is negative for anti-HBs and HBsAg, repeat the complete HBV series according to HBV single antigen vaccine protocol; retest for anti-HBs and HBsAg one month after last dose of HBV and follow Perinatal Hepatitis B Prevention Program guidelines.

Assure that the designated Regional Perinatal Hepatitis B Prevention Coordinator is aware of immunization visits and test results to facilitate case management.

Health Teaching:

Although many hepatitis B viral infections cause no symptoms, discuss the following symptoms of hepatitis which would need medical evaluation if present:

- serum sickness-like prodrome
- skin eruptions, urticaria
- arthralgias, arthritis
- lassitude
- anorexia
- nausea, vomiting
- headaches, fever
- dark urine, jaundice, moderate liver enlargement with tenderness

REFERENCES

“Epidemiology and Prevention of Vaccine-Preventable Diseases”, Centers for Disease Control and Prevention, DHHS, February 2008

Tennessee Department of Health, Perinatal Hepatitis B Prevention Program Guidelines, Revised 10/98
Red Book, Report of the Committee on Infectious Diseases, 27th Edition. 2006

HEPATITIS B

Other Non-Occupational Contacts POST-EXPOSURE

GENERAL INFORMATION

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

SUBJECTIVE

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

OBJECTIVE

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

ASSESSMENT

Perform serologic testing

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

PLAN

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

If patient is pregnant, notify Regional Perinatal Hepatitis B Coordinator

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

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

Use Table 2 below to evaluate need for Hepatitis B Immune Globulin (HBIG) and Hepatitis B Vaccine (HBV) (percutaneous or mucosal exposure) based on the HBsAg status of the source and the HBV immunization and vaccine-response status of the person exposed.

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

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

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

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

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

**Federally funded vaccine may be used for all HBV vaccine used as PEP and to complete immunization series of all at risk contacts, regardless of age.
Refer to most recent “Federally Funded Vaccines for Adults” guidance**

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

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

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

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

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

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

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

Health Teaching:

Encourage HBV vaccine and the importance of testing, where relevant.
Avoid sharing needles with others.

Diabetic patients should not share personal glucose monitors or lancets with others.
Abstain from sexual contact with infected partners.
Use condoms for each sexual encounter to prevent exchange of body fluids or skin contact.
Use only water based lubricants (such as K-Y) during sexual encounter. Do not use oil-based products.
Avoid donating blood or organs if test positive for hepatitis B.

REFERENCES

- “Epidemiology and Prevention of Vaccine-Preventable Diseases”, Centers for Disease Control and Prevention, DHHS, 12th Edition, May 2011
- Red Book, Report of the Committee on Infectious Diseases, 29th Edition. 2012
- MMWR, A Comprehensive Immunization Strategy to Eliminate Transmission of Hepatitis B Virus Infection in the United States. Recommendations of the Advisory Committee on Immunization Practices (ACIP) Part II: Immunization of Adults. December 8, 2006. Vol. 55 Number RR-16.
- MMWR, Recommendations for Identification and Public Health Management of Persons with Chronic Hepatitis B Virus Infection. September 19, 2008 / Vol. 57 / No. RR-8.

HEPATITIS C, (Non - A, Non - B), Case

NOTE: Only applicable for patients with physician diagnosed, active acute or chronic hepatitis C

General Information:

Hepatitis C may be chronic or acute.

If patient has positive hepatitis C antibody test, refer to physician for evaluation.

Client may have history of blood transfusion, IV drug use, tattooing, or percutaneous exposure to blood or be referred by physician, health care provider or blood donation agency because of hepatitis C or positive serology.

Acute disease tends to be mild and insidious, in onset, and most infections are asymptomatic; however symptoms may include jaundice, anorexia, nausea, vomiting, malaise, abdominal discomfort, flu-like syndrome and fever.

Hepatomegaly, splenomegaly, elevated ALT and AST enzyme levels may be seen in acute cases; positive anti- HCV (antibody to HCV) serology in chronic cases.

Hepatitis C virus infection becomes chronic in approximately 75-85% of cases.

PLAN:

Inform patient of false positives in early serologic testing, unclear risk of perinatal transmission, possible development of chronic active hepatitis, cirrhosis and need to refrain from donating blood.

Teach patient about transmission and prevention measures for percutaneous and sexual exposures (although not necessarily the method of transmission).

Immune Globulin is not recommended for contacts at this time.

Health Teaching:

Avoid IV drug use or sharing of needles with others.

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

Use of lubricant (such as KY) during sexual encounters can lower risk of tissue damage (do not use oil-based products).

Refrain from donating blood, organs, tissue or semen and from sharing toothbrushes and razors if test positive for hepatitis C.

Avoid alcohol/OTC medications that affect the liver.

Inform of need for immunization against hepatitis A and hepatitis B.

Reference:

Red Book, 2006 Report of the Committee on Infectious Diseases, 27th Edition

<http://www.cdc.gov/hepatitis/HCV/HCVfaq.htm#section1>

HERPES SIMPLEX (GENITAL HERPES)

BACKGROUND

Genital Herpes is a common sexually transmitted disease caused by the herpes simplex virus, usually type 2 (HSV-2). While HSV-2 causes mainly genital infections, HSV-1 is associated primarily with oral infection, however either type can infect any site. It is a life-long viral infection that can be transmitted through anal, vaginal, or oral sex.

The majority of genital herpes infections are transmitted by persons unaware that they have the infection or who are asymptomatic when transmission occurs. The average incubation period after exposure is 4 days with a range of 2 to 12 days.

Transmission from an infected male to his female partner is more likely than from an infected female to her male partner.

SUBJECTIVE

Primary infection:

Symptoms occur from 3 to 7 days after contact

Uniform shaped blisters that become painful ulcers. New lesions may develop for up to 5 – 7 days after the first group appears. Symptoms tend to resolve within 2-3 weeks.

Local pain, itching, and burning may be present at the affected site.

Dysuria (may lead to urinary retention)

May experience flu like symptoms including headache, low grade fever, muscle aches and swollen inguinal lymph nodes

Recurrent infection:

Common, particularly during the first year of infection.

May be brought on by alteration in the immune system, fatigue, stress, and local skin trauma.

Symptoms are typically shorter in duration and less severe than the first outbreak

OBJECTIVE

Multiple vesicular or ulcerative lesions that are uniform in size

Lesions may appear anywhere on genitalia, mouth, throat or anus

Tender enlarged nodes may be palpated in groin

Patient may have an elevated temperature and flu-like symptoms

ASSESSMENT

Possible genital herpes

PLAN

If available, culture for herpes

Refer to physician or clinician for prescription or order for acyclovir

Counsel regarding medication:

FIRST CLINICAL EPISODE of genital herpes, recommended regimen:

Acyclovir 400 mg orally three times a day for 7-10 days
OR
Acyclovir 200 mg orally five times a day for 7-10 days

EPISODIC RECURRENT INFECTION of genital herpes, recommended regimen:

Acyclovir 400 mg orally three times a day for 5 days
OR
Acyclovir 800 mg orally twice a day for 5 days
OR
Acyclovir 800 mg orally three times a day for 2 days

Suppressive therapy is a low dose antiviral treatment that is taken every day to prevent future outbreaks and to prevent spread to sex partner(s). Patients may discuss with the APN or MD to determine if suppressive therapy is an appropriate treatment option for their situation.

Provide STD counseling, screen for gonorrhea and chlamydia, offer testing for HIV and syphilis as indicated

Palliative measures:

Tepid water sitz bath 2-4 times daily while lesions are present (do not allow anyone else to use same towel). Urinating while sitting in a tub of tepid water may relieve the burning associated with voiding.

Keep genital area clean and dry. A hair dryer on cool setting may be used

May take Ibuprofen or Acetaminophen q 4 hrs/PRN for pain
Over the counter creams and ointments are generally not recommended

Increase consumption of water to keep urine dilute

Avoid tight or irritating underwear and clothing

Health Teaching:

Counsel patients regarding the natural history of the disease, with emphasis on the potential for recurrent episodes, asymptomatic viral shedding, and the risk for sexual transmission

Recurrent outbreaks are common but tend to become less frequent and severe after the first year. Recurrences may be triggered by emotional stress, illness, sunlight and fatigue. Many patients experience mild symptoms called prodromal symptoms before ulcers develop. These may

include itching, tingling or pain. Effective episodic treatment requires initiation of therapy within 1 day of lesion onset or during the prodromal period that precedes some outbreaks.

Encourage patient to inform their current sex partners that they have genital herpes and to inform future partners before initiating a sexual relationship

Advise to abstain from sexual activity when lesions or prodromal symptoms are present

Oral sex should be avoided if there are ulcers or blister around the mouth because a person with the oral form can give a partner genital herpes by performing oral sex.

Condoms used consistently and correctly may reduce the risk of herpes transmission

Do not touch the lesions or fluid from the lesions in order to avoid transfer of virus to other parts of the body, e.g., the eyes

Instruct patient in immediate and thorough hand washing after any genital contact or use disposable gloves

Assess and/or encourage Hepatitis B vaccination

Pregnant women should inform their doctor if they have ever experienced any symptoms of, been exposed to, or been diagnosed with genital herpes. HSV is of particular concern in pregnant women because the infection can be passed from mother to child during delivery resulting in a potentially fatal infection in the neonate.

REFERENCES

Albrecht, MA. Epidemiology, clinical manifestations and diagnosis of genital herpes simplex virus infection. In: UpToDate, Thorner AR(Ed), UpToDate, Waltham, MA, 2013

Albrecht, MA. Patient information: Genital herpes (Beyond the Basics). In: UpToDate, Thorner, AR (Ed), UpToDate, Waltham, MA, 2013

CDC. Diseases Characterized by Genital, Anal, or Perianal Ulcers, STD Treatment Guidelines, 2010.

<http://www.cdc.gov/std/treatment/2010/genital-ulcers.htm#hsv>

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HIV TESTING AND COUNSELING

GENERAL INFORMATION

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

SUBJECTIVE

Patient seeking evaluation and/or treatment for STDs

Patient request HIV testing or counseling

Patient identified as high risk

OBJECTIVE

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

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

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

ASSESSMENT

Assess client's individual risk status

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

PLAN

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

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

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

Health Teaching:

Counseling should focus on the following:

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

REFERENCES

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

CDC. HIV Basics. Prevention research, accessed September 6, 2013
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 Released by Centers for Disease Control and Prevention (CDC) December 17, 2010 /
 Vol. 59 / No. RR-12

PEDICULOSIS PUBIS (PUBIC LICE)

SUBJECTIVE

Severe itching in genital area
“Bugs down there”
“Crabs”

OBJECTIVE

Visible nits and/or lice on pubic hair
Excoriation of skin may be present (crusts or scales in pubic area)
Black dots (representing excreta) on surrounding skin and underclothing
Nits in eyebrows, eyelashes, scalp hair, axillary hair, and other body hair

ASSESSMENT

Pediculosis Pubis (Pubic Lice)

PLAN

Treatment:

Permethrin 1% creme rinse - Apply to affected area and wash off after 10 minutes.

OR

OTC pyrethrin with piperonyl butoxide – per package instructions.

In difficult cases, refer to nurse practitioner. In all cases, removal of nits is encouraged. Concurrently with treatment, machine launder all washable clothing and bed linens in hot water and detergent. Dry in high heat for at least 20 minutes.

Dry-clean clothing that is not washable.

Place items that cannot be washed or dry-cleaned in a large, heavy duty plastic bag, and securely seal for 10-14 days.

Both sexual and close personal or household contacts within the preceding month should be examined and treated.

Suspect other STDs and offer counseling and testing as appropriate.

Referral Indicators

Secondary bacterial infection

Pregnant or lactating women

Neurological disorders (in lindane only)

Known sensitivity to permethrin/pyrethrin products

Coexisting dermatological conditions

Lice found in eyelashes since shampoo cannot be used

Treatment failure

Follow-Up

Patient should be evaluated after one week if symptoms persist

Retreatment may be necessary if lice are found or if eggs are observed at the hair-skin junction.

Do not retreat with lindane without consulting a provider.

Patients who do not respond to one of the recommended regimens should be referred to a provider for treatment with an alternative regimen.

REFERENCES

CDC. Sexually Transmitted Diseases Treatment Guidelines, 2010. MMRW 2010; 59(No. RR-12).

SYPHILIS, CASE OR CONTACT

BACKGROUND

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

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

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

SUBJECTIVE

Previous history of syphilis infection

History of **symptoms suggestive of syphilis:**

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

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

Sore throat, fever, headaches, or general malaise

Sexual contact to serology proven or physician verified case

Referral from private physician

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

“My partner told me he/she has syphilis”

OBJECTIVE

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

Primary Syphilis:

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

Regional lymphadenopathy (unilateral or bilateral)

Secondary syphilis:

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

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

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

Regional lymphadenopathy (unilateral or bilateral)

Alopecia, hair may have "moth eaten look"

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

ASSESSMENT

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

PLAN**NOTE**

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

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

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

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

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

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

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

Refer all patients with syphilis for HIV counseling and testing.

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

Perform gonorrhea and chlamydia screening.

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

Report all prepubertal children to the Department of Human Services.

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

Consult physician as needed.

TREATMENT

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

Non-pregnant, Non-allergic Adult/Adolescent:

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

Non-pregnant, Penicillin Allergic Adult/Adolescent:

Doxycycline², 100 mg orally BID x 14 days

Non-tolerance to Doxycycline:

If follow-up or compliance cannot be assured, the patient should be referred for skin testing for penicillin allergy and undergo desensitization, if necessary.

With careful follow-up and permission obtained from regional health officer, may give ceftriaxone 1gm IM once a day for 10-14 days. Caution must be used as patients who are allergic to penicillin may also be allergic to cephalosporins.

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

Non-pregnant, Non-allergic Adult/Adolescent:

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

Non-pregnant, Penicillin Allergic Adult/Adolescent:

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

Doxycycline, 100 mg orally BID x 28 days

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

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

Syphilis in Pregnancy

All pregnant women should be screened early in pregnancy.

Seropositive pregnant women should be considered infected unless treatment history and sequential serologic antibody titers are showing an appropriate response.

In areas in which the prevalence of syphilis is high, or for patients at high risk, testing should be repeated at 28 weeks and at delivery.

² Doxycycline is contraindicated in pregnancy and nursing mothers

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

All Stages of Pregnancy, Non-allergic:

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

All Stages of Pregnancy, Penicillin Allergic:

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

Syphilis and HIV

All syphilis patients should be screened for HIV.

HIV, Non-allergic

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

Congenital Syphilis

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

Health Teaching

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

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

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

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

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

Counsel that RPR may stay reactive after treatment.

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

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

Referral Indicators

Pregnant and penicillin allergic

Continued elevated antibody titers after treatment

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

A primary lesion that is not healing one week after treatment

Follow-Up

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

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

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

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

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

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

Counsel that RPR may stay reactive after treatment.

Reference

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

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

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

TRICHOMONIASIS, Case or Contact

BACKGROUND

Trichomoniasis is considered the most common curable sexually transmitted disease. Infection is more common in women than in men. According to the CDC, about 70% of patients with trichomoniasis have no symptoms of the infection. This is true for most men and some women. The incubation period averages 1 week but ranges from 4-28 days.

SUBJECTIVE

In **women**, symptoms may include:

- Thin discharge with an unusual odor, may be clear, white, yellowish or greenish
- Itching, burning, redness or soreness of the genitals
- Discomfort with urination
- Painful sexual intercourse

In **men**, symptoms may include:

- Itching or irritation inside the penis
- Discharge from the penis
- Burning or pain during urination
- Burning after ejaculation
- Majority are asymptomatic

Referred by nurse practitioner, health department physician, or private physician
Contact to patient with positive wet mount or Pap smear indicating trichomoniasis
Self declaration of contact to trichomoniasis
Not pregnant

OBJECTIVE

Reported trichomoniasis on Pap smear not subsequently treated
Mobile trichomonads seen on normal saline slide preparation
LMP and pregnancy test, as indicated

ASSESSMENT

Trichomoniasis diagnosed on Pap smear or wet mount
Known or self reported contact to trichomoniasis case
Normal saline slide positive for mobile trichomonads

PLAN

All sexual partners should be treated at the same time. Instruct patient to abstain from sex until they and their sex partners have completed therapy and no longer have any symptoms
Determine any recent treatment with metronidazole

Treatment:

Non-Allergic, Non-Pregnant

Metronidazole (Flagyl) 2 Gm bolus dose in clinic or after next meal
(may cause nausea if taken without food)

OR

Metronidazole (Flagyl) 500 mg twice a day for 7 days

Pregnant

Consult with Health Department physician, APN or patient's OB/GYN provider.-Metronidazole is not contraindicated in pregnancy.

Allergic

Refer to physician or APN

If treatment failure occurs, patient should be re-treated with Metronidazole 500 mg twice a day for 7 days

For repeated treatment failure, the patient should be treated with a single 2 Gram dose of Metronidazole once a day for 3-5 days

Health Teaching:

Offer condoms and encourage use during all sexual activity

Counsel on other STDs; test as indicated

Stress importance of completing medication as ordered

Avoid consumption of alcoholic beverages (includes all products that contain alcohol such as cough syrups) during treatment with metronidazole and for 24 hours after completion on medication after treatment

Advise that Metronidazole can cause gastro-intestinal upset; also causes urine to darken

Comfort and personal hygiene measures include: cotton underwear, loose clothing, avoidance of underpants while sleeping, avoid feminine hygiene sprays and deodorants, sitz bath for several symptoms

Stress trichomoniasis has been associated with adverse pregnancy outcomes, particularly premature rupture of membranes pre-term delivery, and low birth weight babies.

Therefore, it is **very important that all pregnant females inform their OB/GYN** of any exposure, diagnosis or treatment of trichomoniasis during pregnancy.

Referral Indicators:

Known allergy to any component of drug

More than 2 infections within 6 months

Pap smear abnormalities

Sexual abuse indicators

REFERENCES

CDC. Sexually Transmitted Disease Treatment Guidelines, 2010: Diseases Characterize by Vaginal Discharge, <http://www.cdc.gov/std/treatment/2010/vaginal-discharge.htm>

CDC. Trichomoniasis – CDC Fact Sheet. National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention, Division of STD Prevention.
<http://www.cdc.gov/std/Trichomonas/STDFact-Trichomoniasis.htm>

Ferri, FF. (2010), Ferri's Clinical Advisor, Philadelphia, PA: Mosby Elsevier

Patient information: Trichomoniasis (The Basics) In: UpToDate, Waltham, MA 2013

Red Book, Report of the Committee on Infectious Diseases, 27th Edition. 2006

**SECTION VI:
DISASTER
PREPAREDNESS
AND
BIOTERRORISM**

6.010 – 6.030

ANTHRAX VACCINE

GENERAL INFORMATION

Anthrax Vaccine Adsorbed, (BioThrax™) is a sterile, milky-white suspension (when mixed) made from cultures of a benign strain of *Bacillus anthracis*

This vaccine contains no dead or live bacteria, but it does contain aluminum hydroxide, benzethonium chloride, and formaldehyde in 0.85% NaCl

Anthrax disease presents in three forms: cutaneous (skin), gastrointestinal and inhalational (pulmonary)

The fatality rate for inhalation anthrax is estimated to be 45% to 90%

Vaccine Supply, Handling, and Storage:

Anthrax Vaccine Adsorbed (BioThrax™) is supplied in 5 mL multidose vials

THIS PRODUCT IS TO BE STORED AT 2° C TO 8° C (36 TO 46° F); do not freeze

Do not use after the expiration date given on the package

Candidates for Vaccination:

Persons at high risk for exposure due to a bioterrorism event

Persons who work directly with *Bacillus Anthracis* in the laboratory

Persons who work with imported animal hides or furs from areas where exposure to anthrax spores may occur

Persons¹ who handle potentially infected animal products in high-incidence areas

Military personnel deployed to areas with high risk for exposure to the organism

Contraindications to Vaccination:

Persons with a history of anaphylactic or anaphylactic-like reaction following a previous dose of BioThrax™, or any of the vaccine components

Pregnant women, unless the potential benefits of vaccination clearly outweigh the potential risks to the fetus

Persons <18 or >65 years of age

Precautions:

Persons with a history of Guillain-Barré Syndrome (GBS)

Persons with a history of anthrax disease

Persons with impaired immune responsiveness due to congenital or acquired immunodeficiency, or immunosuppressive therapy (may not be adequately immunized following administration of BioThrax™); vaccination during chemotherapy, high dose corticosteroid therapy of greater than 2-week duration, or radiation therapy may result in a suboptimal response (deferral of vaccination for three months after completion of such therapy may be considered)

Persons with a concurrent moderate or severe illness

Persons with a latex allergy (the vial stopper contains dry natural rubber)

¹ While incidence is low in the United States, veterinarians who travel to work in other countries where incidence is higher should consider being vaccinated

Potential Adverse Reactions:

- Mild local reactions include tenderness, erythema, **subcutaneous nodule**, induration, warmth and local pruritis
- Severe local reactions are infrequent and consist of extensive swelling of the forearm in addition to the local reaction
- Systemic reactions include fever, chills, nausea, headache, malaise, anorexia and general body aches

PLAN

Evaluate individual receiving vaccine for the presence of any contraindications

Vaccine Administration:

Primary immunization requires six 0.5 mL subcutaneous injections; the first three injections are given 2 weeks apart, followed by injections at 6, 12, and 18 months

Booster injections of 0.5 mL of BioThrax are recommended annually after the primary series is completed

Immunization is best accomplished with a subcutaneous injection in the upper deltoid region of the arm away from the tricep muscle (to avoid the ulnar nerver), with a short needle (less than one inch, 5/8-inch, 25- to 27-gauge recommended) at a 45-degree angle with the skin surface

Use a different site for each injection

After injecting, withdraw the needle and briefly and gently massage the injection site to promote dispersal of the vaccine

Referral Indicators:

Patients who have conditions listed under precautions

Patients with respiratory difficulty or an allergic reaction (hives, swelling of hands, face and feet)

REFERENCES

<http://www.bt.cdc.gov/agent/anthrax/index.asp>

<http://www.anthrax.osd.mil/>

<http://www.bt.cdc.gov/agent/anthrax/vaccination/index.asp>

POTASSIUM IODIDE (KI) ADMINISTRATION

GENERAL INFORMATION:

Potassium Iodide is used to block the uptake of radioactive iodine by the thyroid gland in individuals exposed to radioactive iodine

Administration of Potassium Iodide has been shown to reduce the risk of developing thyroid cancer

Its use is indicated if Rad Health has determined that radioactive iodine was released and detected and the State Health Officer has issued an order for exposed people to take KI to block the uptake of radioactive iodine

EFFECTIVENESS IS INCREASED IF POTASSIUM IODIDE IS GIVEN BEFORE, OR SOON AFTER, EXPOSURE

Contraindications include:

Allergy to iodide

Dermatitis, herpetiformis, and hypocomplementemic vasculitis (extremely rare conditions associated with an increased risk of iodine hypersensitivity)

Caution should be used in:

Individuals with multinodular goiter, Graves' disease, and autoimmune thyroiditis, especially if dosing extends beyond a few days

People on lithium carbonate are more likely to have hypothyroidism if they take KI (less of an issue when only used for <10 days)

Pregnancy, if taking >10 days

PLAN

Assess the client for contraindications to KI

Educate the patient on adverse reactions:

Metallic taste

Rash

GI upset

Sialadenitis (rare inflammation of salivary gland)

Administer KI, if possible prior to exposure, in accordance with the following recommendations:

Dose recommendations:

| Recommended Doses of KI for Different Risk Groups | | | |
|--|--------------|---------------------|--------------------|
| Orally once a day (may be crushed if necessary) | | | |
| | KI dose (mg) | # of 130 mg tablets | # of 65 mg tablets |
| Adults over 40 yrs | 130 | 1 | 2 |
| Adults over 18 through 40 yrs | | | |
| Pregnant or lactating women | | | |
| Adoles. over 12 through 18 yrs* | 65 | 1/2 | 1 |
| Children over 3 through 12 yrs | | | |
| Over 1 month through 3 years | 32 | 1/4 | 1/2 |
| Birth through 1 month | 16 | 1/8 | 1/4 |

REFERENCES

Guidance, Potassium Iodide as a Thyroid Blocking Agent in Radiation Emergencies, U.S. Department of Health and Human Services, Food and Drug Administration Center for Drug Evaluation and Research (CDER), December 2001, Procedural

SMALLPOX VACCINE

GENERAL INFORMATION

Dr. Edward Jenner discovered a vaccine that would protect against smallpox in 1796; the vaccine was derived from the cowpox virus and a related strain is in use today

The last case of smallpox occurred in 1977, the United States discontinued vaccination in 1972, and smallpox was declared eradicated in 1980; since smallpox vaccination does not confer lifelong immunity, the vast majority of the population is not currently immune to smallpox

After exposure to smallpox, it takes between 7-17 days for symptoms of smallpox to appear (average incubation 12-14 days) during which time the infected person feels well and is not contagious

Immunity provided by the smallpox vaccine typically develops within 8 to 14 days, but vaccine can be given up to 3 days after exposure in order to prevent the development of disease

Smallpox is a potential threat as a biological weapon for the following reasons:

Smallpox is infectious when inhaled and has the potential to infect large groups of people because it can be disseminated as an aerosol

Smallpox is highly infectious, even in low doses, and is transmitted from person-to-person; however, it is less contagious than measles, influenza, or varicella

Smallpox infection can be fatal in up to 30% of cases

Vaccine Precaution:

Smallpox vaccine is made from live vaccinia virus

Unlike other current immunizations, smallpox vaccination is characterized by a virus that propagates in the skin and can potentially contaminate the vaccinee's hands or the skin and mucosa of others with whom the vaccinee comes into contact

Vaccinia virus is present at the vaccine site 3 to 4 days after vaccination

The vaccine site should be considered infectious until the scab falls off

General rules for vaccination with a live virus should be applied, i.e., vaccinations using live viruses should be separated by 4 weeks if not given simultaneously

Vaccinations may be given simultaneously except for varicella

Vaccinated persons should avoid taking steroids for 2 weeks after administration of smallpox vaccine

Vaccine Handling and Storage:

Keep at 2-8° C or 35-46°F when transferring; do not place ice directly on vial (use barrier between)

Mix vaccine according to package insert and mark date when opened

Do not shake following reconstitution but gently swirl the vaccine to insure adequate mixture (limit loss of doses through contact with stopper)

Vaccine can stay at room temperature for the duration of the smallpox clinic

When rubber stopper is removed prior to using vaccine, keep in a safe, clean space (e.g., screw top bottle, zip lock bag)
During clinic, place vaccine bottle in stabilizer to prevent spills, and place on plastic chux
Any vaccine spills should be cleaned in accordance with infectious control guidelines
Following smallpox clinic, any remaining vaccine should be returned to the refrigerator in bottle stabilizer and kept at 2-8° C or 35-46°F; empty vials should be placed in sharps container
Reconstituted vaccine must be used within 90 days

CANDIDATES FOR VACCINATION:

Routine Non-emergency Vaccination (No Outbreak, Pre-event Vaccination)

Public health, hospital, and other personnel, between 18 and 64 years of age, who may have to **respond to a smallpox case or outbreak**

Laboratory workers who handle cultures or animals contaminated or infected with vaccinia or other related viruses (e.g., monkeypox, cowpox, variola)

Emergency Vaccination (Smallpox Outbreak, Post-event Vaccination)

Anyone **directly exposed** to smallpox virus should get one dose of vaccine as soon as possible after exposure

Anyone **at risk of exposure** to smallpox virus should get one dose of vaccine when the risk occurs or becomes known

CONTRAINDICATIONS TO VACCINATION:

THERE ARE NO ABSOLUTE CONTRAINDICATIONS FOR PERSONS WHO ARE EXPOSED, OR AT RISK OF EXPOSURE, TO SMALLPOX; IN A POST-EVENT SITUATION, SPECIFIC GUIDANCE WILL BE PROVIDED BY THE CDC

Contraindications to vaccination for the INDIVIDUAL taking the vaccine (PRE-EVENT)

ALLERGY:

- Polymyxin B sulfate
- Streptomycin sulfate
- Chlortetracycline hydrochloride
- Neomycin sulfate
- Phenol
- Glycerin
- Serious allergic reaction to previous smallpox vaccination
- Extreme latex allergy (anaphylaxis)

ILLNESS:

- Acute to moderate illness (e.g., flu)

AGE:

Less than 18 years or over 64 years of age

BREAST FEEDING

HEART DISEASE²:

Do not give if diagnosed with a **heart condition, with or without symptoms**, including:

- Known coronary disease (previous myocardial infarction, angina)
- Congestive heart failure
- Cardiomyopathy
- Stroke or transient ischemic attack
- Chest pain or shortness of breath with activity
- Other conditions under the care of a doctor

Do not give if the individual has **3 or more of the following risk factors**:

- High blood pressure
- High cholesterol
- Diabetes
- First-degree relative with heart condition prior to the age of 50
- Smokes cigarettes

Contraindications to Vaccination in either the INDIVIDUAL taking the vaccine OR HOUSEHOLD MEMBERS (PRE-EVENT)

PREGNANCY

Query all females of childbearing age as to current, suspected, or planned pregnancy

IMMUNODEFICIENCY

Includes any disease with immunodeficiency, congenital or acquired, as a component:

- HIV Infection
- AIDS
- Many cancers
- Lupus

IMMUNO-SUPPRESSIVE THERAPY:

- Cancer treatments
- Organ/transplant maintenance
- Steroid therapy $\geq 2\text{mg/kg/day}$ or $\geq 20\text{mg/day}$ x 14 days (wait 3 months after steroid therapy to receive vaccine)

ECZEMA:

History or presence of eczema, (including "healed" eczema) or atopic dermatitis

²The presence of these conditions in a close contact is not a reason to defer vaccination

SKIN DISORDERS

Currently active, acute or chronic skin conditions that cause multiple areas of broken skin):

Severe Acne

Recent Burns

Wounds or current (non-healed) surgical incisional wounds

Acute contact dermatitis

Varicella

Allergic rash

Impetigo

Psoriasis

Darier's disease (a chronic, hereditary skin disease, placing individual at risk of developing eczema vaccinatum)

Anticipated Normal Vaccine Reaction:

| DAY | DESCRIPTION | AVERAGE SIZE |
|-------|---|--------------|
| 0 | Vaccination | |
| 3-4 | Papule (red and itchy) | 11-15 mm |
| 5-6 | Vesicle with surrounding erythema, Vesicle with depressed center | 16-24 mm |
| 8-9 | Well-formed pustule | 12 mm |
| 12+ | Pustule crusts over and forms a scab | |
| 17-21 | Scab detaches revealing scar | |

Normal Vaccine Side Effects:

Soreness at the vaccination site

Erythema surrounding the vaccination site (a normal reaction may be as large as 3 inches)

General malaise

Lymphadenopathy (local, usually in the vaccine site arm)

Myalgia, headache, chills, nausea, fatigue

Fever 7-12 days after vaccination

Rash around 10th day (resolves spontaneously in 2 to 4 days)

Normal Variants (not adverse events and require no specific treatment):

Satellite lesions around vaccination site (limited)

Lymphangitis from the site to regional nodes

Regional lymphadenopathy

Considerable local edema at the site

Intense erythema (viral cellulitis)

Adverse Events (true adverse events and referral required):

Allergic hypersensitivity to any component of the vaccine

Post-Vaccinial Encephalitis (10-14 days post-vaccination, headache, vomiting, drowsiness, fever)
 Ataxia, convulsions, paralysis, or confusion
 Accidental implantation (extensive satellite lesions, eye involvement)
 Bacterial infection (Staphylococcus aureus, Group A beta Hemolytic Streptococcus, anaerobic organisms)
 Generalized Vaccinia (multiple lesions within a week, rapid evolution to scarring)
 Eczema Vaccinatum (implantation of vaccinia virus into diseased skin)
 Erythema Multiforme (toxic and/or hypersensitivity rashes 1-2 weeks post-vaccination)
 Progressive Vaccinia (failure to heal, rapid local spread and by viremia to other parts of the body)
 Vaccinia Keratitis (viral replication with ulceration of cornea)

PLAN

Evaluate individual receiving vaccine for the presence of any contraindications, including contraindications for household members; **THERE ARE NO ABSOLUTE CONTRAINDICATIONS FOR PERSONS EXPOSED, OR AT RISK OF EXPOSURE, TO A CASE OF SMALLPOX**

Vaccine candidates must read pre-vaccination materials and sign consent form

Vaccine Administration:

Persons should be vaccinated in the deltoid area of the upper, non-dominant arm (avoiding previous smallpox scar)

Do not clean vaccine site prior to administration unless grossly contaminated; if vaccine site is grossly contaminated, clean with soap and water and completely dry with gauze prior to administration

With gloved hand, pull skin taut

Being careful not to contaminate the point, dip bifurcated needle into the vaccine, withdraw and hold for a few seconds to allow drainage of excess vaccine

Inspect needle tip after dipping in vaccine to assure that vaccine is present between the prongs of the bifurcated needle

For a **PRIMARY** vaccination (individual has not been previously immunized against smallpox as determined by history or lack of smallpox scar), prick the skin **3 times** within a 5 mm area, applying enough pressure during vaccine administration to produce trace amounts of blood that is visible in 10 to 20 seconds after giving the vaccine; if no blood is seen, prick the skin 3 more times (**DO NOT REDIP THE NEEDLE INTO THE VACCINE AFTER SKIN CONTACT HAS BEEN MADE**)

For **SECONDARY** vaccination (individual has been previously immunized against smallpox as determined by history or presence of smallpox scar), prick the skin **15 times** within a 5 mm area, applying enough pressure during vaccine administration to produce trace amounts of blood that is visible in 10 to 20 seconds after giving the vaccine; (do not prick again, even if no blood is seen)

For **REVACCINATION** (following a non-take), give the same number of sticks as was given at the initial vaccination

Wipe off excess vaccine at the immunization site with gauze

Dispose of needle in sharps container and gauze in a hazardous waste receptacle

Cover site with 2x2 gauze and semi permeable dressing³ (e.g., Tegaderm™, OpSite™, SureSite™)

Change gloves and wash hands with warm soapy water or hand rub containing $\geq 60\%$ alcohol between each vaccination

Successful vaccination will be indicated 6-8 days after vaccination by a clear-cut pustule OR an area of definite induration or congestion surrounding a central lesion that may be a scab or ulcer

An equivocal reaction, or non-take, includes any other reaction/response (e.g., “allergic” reaction) or no reaction; **REVACCINATION IS INDICATED IN ALL PERSONS WITH AN EQUIVOCAL REACTION**

It should be noted that appropriate vaccination techniques might sometimes result in no reaction

If no reaction occurs by 8th day, schedule an appointment for revaccination as soon as possible (if possible use a different vial and avoid previous vaccination site)

No further attempts should be made following a second unsuccessful immunization

Health Teaching:

Inform patient of the expected effects of the vaccine (see Anticipated Normal Reaction under General Information)

Educate patient on proper care of vaccine site because it is important to prevent dissemination of the vaccinia virus from the vaccination site to other parts of the vaccinee’s body or to others

Educate patient on good hand washing technique while handling vaccine site covering

Counsel patient to **avoid becoming pregnant for 4 weeks** after vaccination

Counsel patient to **avoid donating to blood banks until scab has fallen off**

Advise vaccinees and/or guardians with regards to the following:

Keep the vaccination site covered for 21 days or until scab separates and comes off; gauze (loosely taped) is recommended

Change the vaccination site covering every 3-5 days or when the bandage becomes wet, soiled, or is loose

Discard the vaccination site covering carefully (the covering contains viable virus and can spread the infection to others) by enclosing the gauze in a plastic bag that can be sealed prior to placing it in a trash receptacle

Always thoroughly wash hands with soap and running water after handling the vaccination site covering

³Semi permeable dressing required for health care workers having direct patient contact

Avoid touching, scratching, rubbing or otherwise performing any maneuvers that might transfer vaccinia virus to the eye or surrounding skin; encourage patient to wear long sleeves to avoid scratching site and as an extra barrier
Counsel regarding use of OTC ibuprofen and benadryl for pain and itching
Avoid placing any type of ointment or ice on the vaccination site
Cover the site with non-permeable material while bathing and for medical persons while in direct contact with patients
Avoid hot tubs and swimming pools for 2 weeks following vaccine administration
Wash linens and clothing that come in contact with vaccine site in hot water using detergent and/or bleach
Avoid taking steroids for 2 weeks following vaccination
Vaccination site must be evaluated (by medical personnel) for vaccine take on 6th, 7th or 8th day

Referral Indicators:

Allergic hypersensitivity to any component of the vaccine
Unusual side effects or adverse events as listed under “Adverse Events” in “General Information” section
Chest pain, shortness of breath, or other **symptoms of cardiac disease** following vaccination should be **referred immediately**
If side effects occur, notify Hospital Appointed Physician (HAP) and Tennessee Department of Health Adverse Events Coordinator (615-741-7247) immediately, and complete VAERs form

Follow-up:

Daily site-care checks (for all those having direct patient contact)
Evaluations on day 6, 7, or 8 for successful vaccination take
Appointment for revaccination as indicated (if no reaction occurs)
Follow-up at 21-28 days to assure absence of advent events

REFERENCES

Smallpox Vaccine Information Statement, U.S. Department of Health and Human Services Centers for Disease Control and Prevention National Immunization Program (1/16/03)
Smallpox Vaccination Pocket Guide, U.S. Department of Health and Human Services Centers for Disease Control and Prevention National Immunization Program
U.S. Department of Health and Human Services Centers for Disease Control and Prevention, Web site, <http://www.bt.cdc.gov/agent/smallpox/index.asp>

APPENDICES

A. ADDITIONAL IMMUNIZATION INFORMATION

7.010

B. LIST OF STANDARD ABBREVIATIONS

7.020

MEDICATION ADMINISTRATION
(How To Avoid Medication Errors)
Follow The Five Rights of Medication Administration

General Information

As nurses, we must do our part to observe basic rules we learned in nursing school to avoid medication errors. It is important that all nurses follow the **Five Rights of Medication Administration**: 1) Right Patient 2) Right Route 3) Right Dose 4) Right Time 5) Right Medication. Never take shortcuts with your license!

The Right Patient

Can you identify this patient? Don't assume you know who the patient is. Check the patient's identity and address the patient by name before administering the medication.

The Right Route

Be sure you know the prescribed route by which a medication is to be administered. Administering vaccines by the recommended route is imperative. Deviation from the recommended route of administration might reduce vaccine efficacy or increase the risk of local reactions.

The Right Dose

Does this dose make sense for your patient? Be sure you know the prescribed dose before administering a medication.

The Right Time

To achieve maximum therapeutic effectiveness, medications are scheduled to be administered at specific times. To ensure optimal results from each immunization, always follow the currently recommended immunization schedules for children, adolescents, and adults, including the catch-up schedule, when appropriate. Administering doses earlier than minimum intervals or minimum ages may interfere with the vaccine's antibody response and result in the need to repeat the dose at an appropriate time.

The Right Medication

Always check the medication order and check it against the medication label. **Check Expiration Date Before Use.**

VACCINES AND ROUTE OF ADMINISTRATION

| VACCINES | ROUTE |
|--|------------------|
| Diphtheria, Tetanus, Pertussis (DTap, DT, Tdap, Td) | IM |
| Haemophilus influenzae type b (HIB) | IM |
| Hepatitis A (HepA) | IM |
| Hepatitis B (HepB) | IM |
| Herpes Zoster (Shingles) | SC |
| Human papillomavirus (HPV) | IM |
| Influenza, live attenuated (LAIV) | Intranasal spray |
| Influenza, inactivated seasonal (IIV) | IM |
| Measles, mumps, rubella (MMR) | SC |
| Meningococcal, conjugated (MCV4) | IM |
| Meningococcal, polysaccharide (MPSV4) | SC |
| Pneumococcal conjugate (PCV13) | IM |
| Pneumococcal, polysaccharide (PPSV23) | IM or SC |
| Polio, inactivated (IPV) | IM or SC |
| Rotavirus | Oral |
| Varicella | SC |
| <i>COMBINATION VACCINES</i> | |
| DTaP+HepB+IPV (Pediarix) | IM |
| Hib+HepB (Comvax) | IM |
| DTaP + IPV (Kinrix) | IM |
| DTaP + IPV+ Hib (Pentacel) | IM |
| HepA + HepB (Twinrix) | IM |
| Rabies, Preexposure | IM |

Intramuscular (IM)

Subcutaneous (SC)

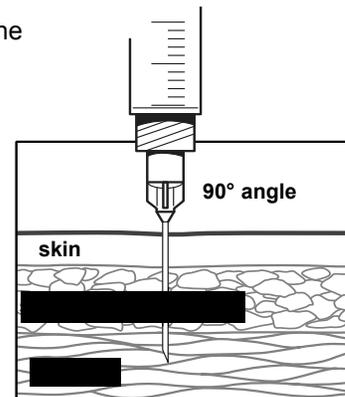
REFERENCE

Centers for Disease Control and Prevention, Epidemiology and Prevention of Vaccine-Preventable Diseases. Atkinson W, Wolfe S, Hamborsky J, eds. 12th ed. Washington DC: Public Health Foundation, 2011.

How to Administer Intramuscular (IM) Injections

Administer these vaccines via intramuscular (IM) route: Diphtheria-tetanus (DT, Td) with pertussis (DTaP, Tdap); Hib; hepatitis A; hepatitis B; human papillomavirus (HPV); inactivated influenza; meningococcal conjugate (MCV4); and pneumococcal conjugate (PCV). Administer inactivated polio (IPV) and pneumococcal polysaccharide (PPV) either IM or SC.

| Patient age | Site | Needle size | Needle insertion |
|---------------------------------------|--|--|--|
| Birth to 12 mos. | Anterolateral thigh muscle | 5/8" ^{**} needle (newborns only), 1" (older infants), 22–25 gauge | <p>Use a needle long enough to reach deep into the muscle.</p> <p>Insert needle at a 90° angle to the skin with a quick thrust.</p> <p>(Before administering an injection, it is not necessary to aspirate, i.e., to pull back on the syringe plunger after needle insertion.[†])</p> <p>Multiple injections given in the same extremity should be separated by a minimum of 1", if possible.</p> |
| 12 mos. to 10 yrs. | Thickest portion of deltoid muscle—above level of axilla and below acromion (if adequate muscle mass). The anterolateral thigh may also be used. | 5/8" ^{**†} to 1" needle, 22–25 gauge | |
| Children and adults 11 yrs. and older | Thickest portion of deltoid muscle—above level of axilla and below acromion | 1"–1½" ^{**†} needle, 22–25 gauge | |



*A 5/8" needle can be used if the skin is stretched tight and the subcutaneous tissue is not bunched.
[†]A 5/8" needle may be used in the deltoid muscle in children ages 12 mos. or older and in adults weighing less than 130 lbs.

[†]CDC. "ACIP General Recommendations on Immunization" at www.cdc.gov/nip/publications/ACIP-list.htm.

IM site for infants

IM injection site area (shaded area)

Insert needle at a 90° angle into the anterolateral thigh muscle.

IM site for children (after the 1st birthday) and adults

acromion

level of axilla

IM injection site (shaded area)

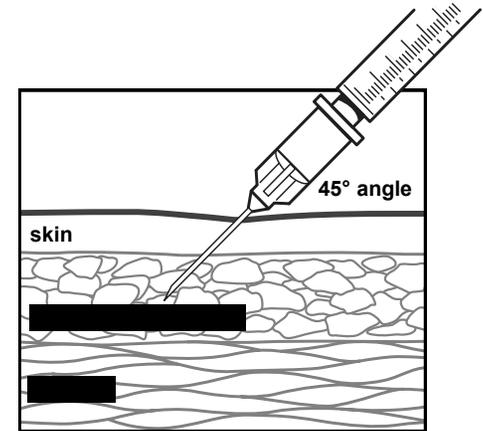
elbow

Insert needle at a 90° angle into thickest portion of deltoid muscle—above the level of the axilla and below the acromion.

How to Administer Subcutaneous (SC) Injections

Administer these vaccines via subcutaneous (SC) route: MMR, varicella, meningococcal polysaccharide (MPSV), and zoster (shingles). Administer inactivated polio (IPV) and pneumococcal polysaccharide (PPV) vaccines either SC or IM.

| Patient age | Site | Needle size | Needle insertion |
|-------------------|---|--------------------------|--|
| Birth to 12 mos. | Fatty tissue over the anterolateral thigh | 5/8" needle, 23–25 gauge | <p>Pinch up on SC tissue to prevent injection into muscle.</p> <p>Insert needle at 45° angle to the skin.</p> <p>(Before administering an injection, it is not necessary to aspirate, i.e., to pull back on the syringe plunger after needle insertion.*)</p> <p>Multiple injections given in the same extremity should be separated by a minimum of 1".</p> <p><small>*CDC. "ACIP General Recommendations on Immunization" at www.cdc.gov/nip/publications/ACIP-list.htm.</small></p> |
| 12 mos. and older | Fatty tissue over the triceps | 5/8" needle, 23–25 gauge | |



SC site for infants

SC injection site area (shaded area)

Insert needle at a 45° angle into fatty tissue of the anterolateral thigh. Make sure you pinch up on SC tissue to prevent injection into the muscle.

SC site for children (after the 1st birthday) and adults

acromion

SC injection site area (shaded area)

elbow

Insert needle at a 45° angle into the fatty tissue over the triceps muscle. Make sure you pinch up on the SC tissue to prevent injection into the muscle.

EMERGENCY SUPPLIES AND EQUIPMENT

Emergency supplies and equipment will be kept in an accessible, easily identifiable location in the clinical setting. Following PHN Protocol, the emergency kit will be used in events including, (but not limited to) the following: anaphylaxis, syncope, vasovagal reactions, cardiac arrest, shock, hemorrhage, respiratory distress and precipitous labor and delivery. Clinical staff should be aware of the location and use of this equipment.

- ✓ The emergency kit and oxygen equipment will be at the site of an emergency within one – two (1 - 2) minutes.
- ✓ A system must be in place for monthly inventory and maintenance (including removal/replacement of expiring supplies) of equipment and supplies.

Each clinical setting will have the appropriate equipment and supplies:

- ❖ Oxygen supplies and equipment:
 - Oxygen tank, with gauge and valve (Check monthly)
 - Face mask, ventilating, with oxygen inlet ports suitable for adult and pediatric use, with head strap
 - Oxygen tubing, tank to mask
- ❖ Pharmaceuticals:
 - Aspirin 325mg tab (at least 5 doses)
 - Diphenhydramine (Benadryl) injection 50/mg/ml(at least 2 doses)
 - Epinephrine HCl (Adrenaline) injection 1:1000 (at least 5 doses)
- ❖ Personal Protective equipment:
 - Goggles
 - Masks/shields
 - Gloves (no latex, powder free)
 - Mouth to mask disposable resuscitative mask
 - Gown
- ❖ Supplies:
 - Airways, oral; infant #3 (small), #4 (medium), #5 (large)
 - Alcohol packets
 - Bandage scissors
 - Blood pressure cuff, (pediatric, adult and extra large)
 - Bulbs, irrigation, sterile
 - Cotton swabs
 - Flashlight with extra batteries
 - Gauze pads, sterile and bandages
 - Stethoscope (pediatric and adult)
 - 50 cc irrigating bulb
 - Tape, adhesive, cloth and paper
 - Tongue blades
 - Syringes, (sterile)

- 3cc with 25g x 5/8 inch needle
 - 3cc with 23g or 21 g x 1 ½ inch needle
 - Tuberculin with needle
- ❖ Emergency childbirth kit¹ (minimum supplies):
- Cord clamp or tie, sterile
 - Scissors, sterile
 - Baby blanket, x1 each
 - Kelly clamp
 - Surgical gloves, (non-latex)

¹Emergency childbirth supplies may be purchased as one complete kit that includes the supplies listed or purchase the supplies separately

**Refer to current TN Department of
Health Immunization Program guidelines
for proper vaccine storage and handling.**

LIST OF STANDARD ABBREVIATIONS

Revised December 2014

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 -

| | |
|--------------|-------------------------------|
| E-cig/e-cig | electronic cigarettes |
| 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
 HSM Hepatosplenomegaly
 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 medius
 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, 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
 PAD Peripheral Arterial Disease
 palp palpable
 PAP Patient Assistant Program
 PC Primary Care
 phone conference/call
 pc after meals
 PCN penicillin
 PDPT Patient delivered partner treatment
 PE physical examination
 ped pediatric
 peri perineum
 PERRLA pupils equal, round, reactive to light and accommodation
 PGF paternal grandfather
 PGM paternal grandmother
 PHBC “Partners for Healthy Babies” curriculum
 PID pelvic inflammatory disease
 pk pack
 pkg package

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

- Q -

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

- R -

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

| | |
|--------|-------------------------------------|
| rec'd | received |
| rev'd | reviewed |
| recert | recertify, recertification |
| ref | referral, refer |
| reg | regulation, regular |
| rehab | rehabilitation |
| resp | respiratory |
| req | request |
| RF | refill |
| RFA | right forearm |
| RG | right gluteus |
| RGM | right gluteus medius |
| 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 |
| Rpt | repeat |
| RRR | regular rate rhythm |
| R/S | resupply |
| RSB | right sternal border |
| r/t | related to |
| RT | Right Thigh |
| RTC | return to clinic |
| RUA | right upper arm |
| RUE | right upper extremity |
| RUQ | right upper quadrant |
| RV | retroverted |
| Rx | prescribed, prescription, treatment |
| RxAP | prescription assistance program |

- S -

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

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

- T -

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

- U -

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

- V -

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

VACCINE MANUFACTURERS

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

- W -

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

- X -

(none)

- Y -

| | |
|-----|----------|
| y/o | year old |
| yd | yard |
| yr | year |

- Z -

(none)

CREDENTIALS/PERSONNEL

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

SYMBOLS

| | | | |
|-------------------|---------------------------------|---------------------------------|-----------------------|
| \bar{p} | after | \downarrow | low, decreased, below |
| \bar{a} | before | $\♂$ | male |
| $\&$ | and | \textcircled{M} | murmur |
| $@$ | at | \emptyset or O | no or normal |
| \sim | approximate | $\#$ | number |
| $b\checkmark$ | breast check | \ominus | negative |
| \checkmark | check, checked | $/$ | per |
| Δ | change | $\%$ | percent |
| $^\circ$ | degree | 1° | primary |
| $=$ | equal | $+ \text{ or } \textcircled{+}$ | positive |
| q | every | $?$ | question |
| $\♀$ | female | \textcircled{R} | right |
| $'$ | foot | 2° | 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 | | |

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