Western Cape Government

Health

SEXUALLY TRANSMITTED INFECTIONS MANAGEMENT GUIDELINES 2015

ADAPTED FROM: STANDARD TREATMENT GUIDELINES AND ESSENTIAL DRUGS LIST PHC

health

Department: Health

REPUBLIC OF SOUTH AFRICA

Table of Contents

Sexually Transmitted Infections Diagnosis and Management 4

Commonest organisms causing sexually transmitted infection syndromes and commonest complications 6

RMR Data Elements 7

Vaginal Discharge Syndrome (VDS) 9

Lower Abdominal Pain (LAP) 10

Male Urethritis Syndrome (MUS) 11

Scrotal Swelling (SSW) 12

Genital Ulcer Syndrome (GUS) 13

Bubo 14

Balanitis/Balanoposthitis (BAL) 15

Syphilis Serology and Treatment 16

Syphilis 17

Syphilis in Pregnancy 18

Neonatal Conjunctivitis 20

Treatment of More than One STI Syndrome 22

Genital Molluscum Contagiosum (MC) 23

Genital Warts (GW): Condylomata Accuminata 23

Pubic Lice (PL) 21

Treatment Protocol for Asymptomatic Partner(s) 22

Sexually Transmitted Infections Diagnosis and Management

The syndromic approach to Sexually Transmitted Infection (STI) diagnosis and management is to treat the signs or symptoms (syndrome) of a group of diseases rather than treating a specific disease. This allows for the treatment of one or more conditions that often occur at the same time and has been accepted as the management of choice. This guide includes the current STI syndromic management algorithms.

STI screening should include the following three questions of all persons aged 15-49 years, regardless of clinical presentation:

- *Do you have any genital discharge?*
- *Do you have any genital ulcers?*
- *Has/have your partner(s) been treated for an STI in the last 8 weeks?*

STIs are preventable and many are treatable. Early access to care helps prevent further transmission to partners and from mother-to-child, acquisition of additional STIs, and decreases the risk of STI related complications. Screening for STIs at any and all health care visits, can promote STI prevention and management and provide an opportunity for additional health promotion and education. Where possible, STI screening and prevention should become routine and integrated into all health visits.

In order to perform a proper clinical assessment it is important to take a good sexual history and undertake a thorough ano-genital examination. The history should include questions concerning symptoms, recent sexual history, sexual orientation, type of sexual activity (oral, vaginal, anal sex), the possibility of pregnancy (females), use of

contraceptives including condoms, recent antibiotic history, any drug allergies, and recent overseas travel.

Promote HIV counselling and testing.

Suspected STIs in children should be referred to the hospital for further management.

General Measures

- Counselling and education, including HIV testing
- Condom promotion, provision and demonstration to reduce the risk of STIs
- Compliance/adherence with treatment
- Contact treatment/partner management
- Circumcision promotion with appropriate counselling concerning condoms
- Contraception and conception counselling

Common organisms causing STI syndromes and common complications and definitions of RMR data elements is a new addition to the guideline

Syndromes

Vaginal Discharge Syndrome (VDS)

Women over 35 years of age or those who **do NOT have a partner with MUS** – commonest causes are Candida albicans (thrush) and/or Gardnerella vaginalis (the predominant cause of bacterial vaginosis)

Women younger than 35 years or who **have a partner with MUS** – commonest causes are Neisseria gonorrhoea (Gonorrhoea), Chlamydia trachomatis (Chlamydia) and/or Trichomonas vaginalis (Trichomoniasis)

Complication of cervicitis due to a discharge caused by Gonorrhoea or Chlamydia if untreated: Pelvic inflammatory disease

Lower Abdominal Pain (LAP)

Commonest causes of STI syndrome "LAP" (not all LAP is of STI origin) are Neisseria gonorrhoea (Gonorrhoea), Chlamydia trachomatis (Chlamydia) and/or anaerobic organisms

Commonest complications are: Infertility, Ectopic pregnancies, Chronic lower abdominal pain

Male Urethritis Syndrome (MUS)

Commonest causes are Neisseria gonorrhea (Gonorrhoea) and/or Chlamydia trachomatis (Chlamydia)

Commonest complication if untreated is:
Scrotal swelling (orchitis)

Scrotal Swelling (SSW)

Commonest causes are Neisseria gonorrhea and/or Chlamydia trachomatis

Genital Ulcer Syndrome (GUS)

Commonest causes are:
Herpes simplex – 2 (Herpes)
Treponema pallidum (Syphylis)
Haemophylis ducreyi (Chancroid)

Complications are: Congenital syphilis in infant due to mother to child transmission during pregnancy
Tertiary syphilis – rare today (dementia and other neurological conditions)

Bubo (not common in the Western Cape)

Commonest cause is: Chlamydia trachomatis - Lymphogranuloma venereum (LGV)

Complication of STIs in general:

Enhanced transmission of HIV

*** based on classification in national guidelines**

RMR Data Elements

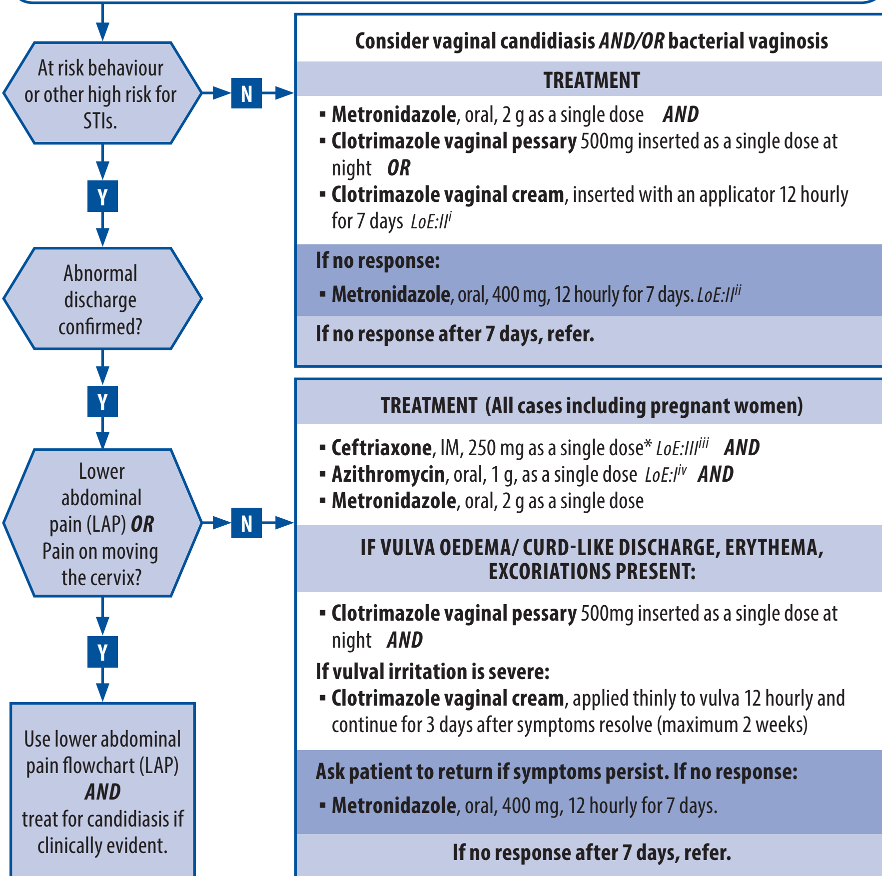
Data element name	Female condoms distributed
Bulleted definition	Female condoms from the stock of the facility which were given out at distribution points at the facility or elsewhere in the community (i.e. campaigns, non-traditional outlets etc.)
Components of the definition	Condoms should preferably be counted per box or per carton once they leave the store of the facility, i.e. by using the local stock register.
Important considerations	None.
Inclusions	None.
Exclusions	None.
Absolute Validation Rule	None.
Sites for data to be collected (data sources)	Health facility.
Purpose of indicator	Condoms are used for dual protection – to prevent the spread of STI's and pregnancies.
Indicator(s) the data element is used for	Female condom distribution rate.
Female condom distribution coverage (annualised)=(SUM([Female condoms distributed]))/(SUM([Female 15-44 years]) + SUM([Female 45 years and older]))	

Data element name	Male condoms distributed
Bulleted definition	Male condoms FROM THE STOCK OF THE FACILITY given out at a distribution points at the facility or in the community (e.g. campaigns, non-traditional outlets, etc.).
Components of the definition	Dedicated provincial primary distribution sites should only count male condoms distributed at the facility.
Important considerations	Count the condoms per box/carton ONCE THEY LEAVE THE STORE OF THE FACILITY (i.e. on the local stock register).
Inclusions	None.
Exclusions	EXCLUDE condoms distributed to other public sector health facilities for further distribution through these facilities.
Absolute Validation Rule	None.
Sites for data to be collected (data sources)	Health facility.
Purpose of indicator	Condoms are used for dual protection – to prevent the spread of STI's and pregnancies.
Indicator(s) the data element is used for	Couple year protection rate (annualised). Male condom distribution rate (annualised).
Male condom distribution coverage (annualised)=(SUM([Male condoms distributed]))/(SUM([Male 15-44 years]) + SUM([Male 45 years and older]))	

Data element name	STI treated new episode
Bulleted definition	A **new episode** of a **symptomatic** Sexually Transmitted Infection (STI) treated according to the Syndromic Approach.
Components of the definition	One client can have more than one new episode at the same time, e.g. vaginal discharge, wart and blister or MUS and wart, etc. Count each episode. Count ONLY NEW episodes of a SYMPTOMATIC STI.
Important considerations	This data element counts NEW episodes, AND not clients. Assume a new episode if the symptoms of a previous episode disappeared or substantially improved and now a new episode presents. Also assume a new episode if there is a history of recent, unprotected intercourse with a sexual partner whose infection status is unknown or who has not been treated.
Inclusions	None.
Exclusions	EXCLUDE a persistent episode.
Absolute Validation Rule	None.
Sites for data to be collected (data sources)	PHC facility.
Purpose of indicator	To monitor STI's.
Indicator(s) the data element is used for	STI treated new episode incidence (annualised).
STI treated new episode incidence (annualised)=(SUM([STI treated new episode]))/(SUM([Female 15-44 years]) + SUM([Male 15-44 years]) + SUM([Female 45 years and older]) + SUM([Male 45 years and older]))	

Data element name	Male urethritis syndrome treated – new episode (Prov.)
Bulleted definition	The number of men 15 years and older with newly diagnosed urethritis syndrome.
Components of the definition	None.
Important considerations	None.
Inclusions	INCLUDE only newly diagnosed cases.
Exclusions	EXCLUDE follow-up visits.
Absolute Validation Rule	None.
Sites for data to be collected (data sources)	PHC fixed clinics. CDC's & CHC's. Mobile units and satellite clinics.
Purpose of indicator	Monitor incidence of STIs overall.
Indicator(s) the data element is used for	Rate of male urethritis syndrome.
Male Urethritis Syndrome rate=(SUM([Male Urethritis Syndrome treated - new episode]))/(SUM([STI treated new episode]))	

Vaginal Discharge Syndrome (VDS)



1. Do TPHA/RPR
2. Issue Partner notification slip
3. Treat partner/s

***People who are allergic to penicillin may also react to ceftriaxone.**

If severe penicillin allergy, i.e. angioedema, anaphylactic shock or bronchospasm, omit ceftriaxone and increase azithromycin dose to:

- **Azithromycin**, oral, 2 g, as a single dose. *LoE:I[V]*

For ceftriaxone IM injection: Dissolve ceftriaxone **250 mg** in 0.9 mL lidocaine 1% without epinephrine (adrenaline) *LoE:III[vi]*

Note: This is only for IM dosing of Ceftriaxone, IV dosing should NOT be diluted with lidocaine

Take Pap smear after treatment, if indicated according to screening guidelines.

Note: Suspected STI in children should be referred to hospital for further management.

Lower Abdominal Pain (LAP)

Sexually active patient complains of lower abdominal pain with/ without vaginal discharge

Take history (including gynaecological) and examine (abdominal and vaginal). Emphasize HIV testing

Any of the following present:

- Pregnancy
- Missed period
- Recent delivery, TOP or miscarriage
- Abdominal guarding and/or rebound tenderness
- Abnormal vaginal bleeding
- Abdominal mass
- Fever > 38º C

Y →

Refer all patients for gynaecological or surgical assessment.

SEVERELY ILL PATIENTS

Set up an IV line and treat shock if present.

If referral is delayed > 6 hours:

- **Ceftriaxone**, IV, 1g **(Do not dilute with lidocaine 1%)** ***AND***
- **Metronidazole**, oral, 400 mg

For pain, add:* **Ibuprofen**, oral 400 mg 8 hourly with food *LoE:III*

N → Lower abdominal tenderness with/ without vaginal discharge

Urinalysis results or symptoms consistent with UTI ***AND*** absence of cervical motion tenderness

Y → Treat as UTI

N →

TREATMENT

- **Ceftriaxone, IM**, 250 mg single dose* *LoE:III*[iii] ***AND***
- **Azithromycin**, oral, 1 g as a single dose *LoE:II*[vii] ***AND***
- **Metronidazole**, oral, 400 mg 12 hourly for 7 days *LoE:III*[viii]

Pain not improving after 48–72 hours: refer urgently for gynaecological assessment

Improved after 7 days

- **Y** → Discharge patient
- **N** → Refer

1. Do TPHA/RPR
2. Issue Partner notification slip
3. Treat partner/s

***If severe penicillin allergy, i.e. angioedema, anaphylactic shock or bronchospasm, omit ceftriaxone and increase azithromycin dose to: Azithromycin**, oral, 2 g as a single dose. *LoE:I*[v]

For ceftriaxone IM injection: Dissolve **ceftriaxone** 250 mg in 0.9 mL lidocaine 1% without epinephrine (adrenaline). *LoE:III*[vi]

Note: The optimal timing of the PAP smear after an episode of STI is 6-8 weeks to allow time for inflammatory changes to resolve.

Male Urethritis Syndrome (MUS)

Patients who can show or report discharge.

Take history, including sexual orientation and examine. If no visible discharge; ask patient to milk urethra. Emphasise HIV testing and partner(s) tracing.

Discharge

Y

TREATMENT

- **Ceftriaxone**, IM, 250 mg single dose* *LoE:III[ii]* ***AND***
- **Azithromycin**, oral, 1 g as a single dose *LoE:I[iv]*

If sexual partner has VDS, add:

- **Metronidazole**, oral, 2 g as a single dose

Urethral discharge persists after 7 days

Suspected ceftriaxone 250 mg treatment failure:

- **Ceftriaxone**, IM, 1 g single dose ** *LoE:III[ix]* ***AND***
- **Azithromycin**, oral, 2 g as a single dose ***AND***
- **Metronidazole**, oral, 2 g as a single dose, if not already given

Refer all **ceftriaxone treatment failures** within 7 days for **gentamicin**, IM, 240 mg as a single dose. *LoE:III[ix, x]*

EMPHASISE PARTNER(S) TRACING

1. Do TPHA/RPR
2. Issue Partner notification slip
3. Treat partner/s

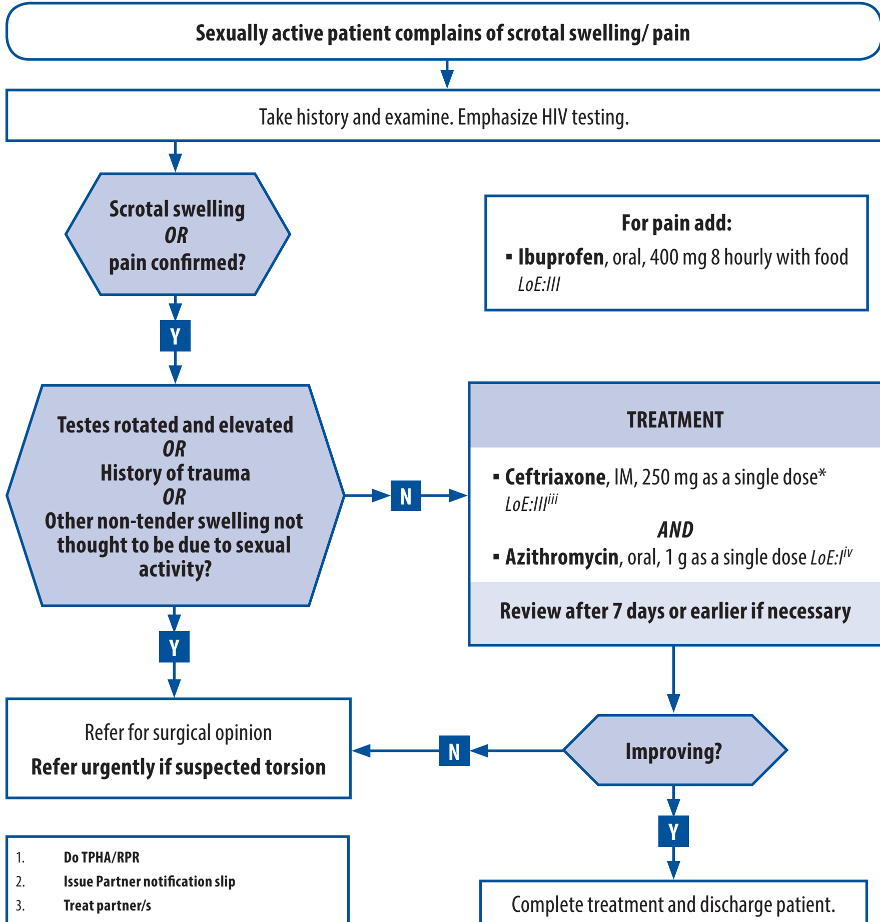
If severe penicillin allergy, i.e. angioedema, anaphylactic shock or bronchospasm:
*omit **ceftriaxone**, IM, 250 mg and increase azithromycin dose to azithromycin, oral, 2 g as a single dose *LoE:I[v]*
omit **ceftriaxone, IM, 1 g and refer to a centre for gentamicin, IM, 240 mg as a single dose plus azithromycin, oral, 2 g as a single dose. *LoE:III[ix, x]*

For ceftriaxone IM injection:

- Dissolve **ceftriaxone 250 mg** in 0.9 mL lidocaine 1% without epinephrine (adrenaline).
- Dissolve **ceftriaxone 1 g** in 3.6 mL lidocaine 1% without epinephrine (adrenaline). *LoE:III[vi]*

Please Note: Gentamicin may only be prescribed by a doctor and dispensed by a pharmacist (the provincial code list is set up for doctor prescribing). These patients therefore require referral to a CDC or CHC if unable to provide gentamicin.

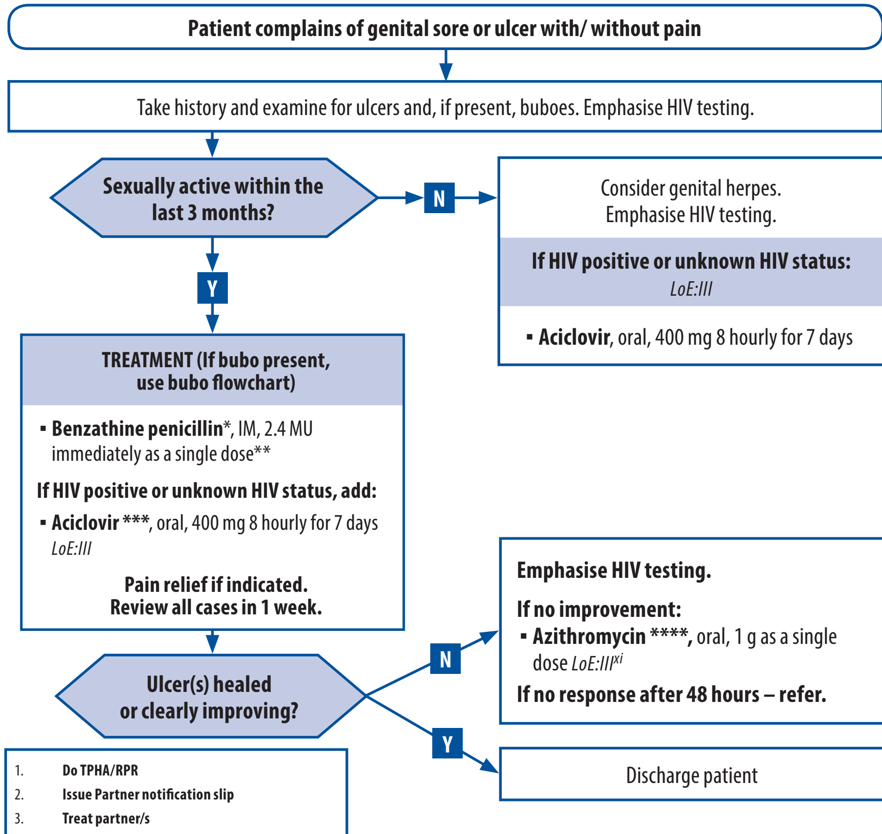
Scrotal Swelling (SSW)



***If severe penicillin allergy, i.e. angioedema, anaphylactic shock or bronchospasm, omit ceftriaxone and increase azithromycin dose to: Azithromycin**, oral, 2 g as a single dose *LoE:I, III*[v]

For ceftriaxone IM injection: dissolve ceftriaxone **250 mg** in 0.9 mL lidocaine 1% without epinephrine (adrenaline). *LoE:III*[vi]

Genital Ulcer Syndrome (GUS)



Penicillin allergic men and non-pregnant women:
Perform a baseline TPHA/RPR and replace benzathine penicillin with:
- **Doxycycline**, oral, 100 mg 12 hourly for 14 days.

Patient to return for a follow-up TPHA/RPR 6 months later. *LoE:III*

***Penicillin-allergic pregnant patients with a new syphilis infection should be referred to a tertiary hospital for further management. Blood tests (IgE penicillin and CAST) will be done. If these are negative penicillin skin testing will be done to determine further management. There they will do blood tests (IgE penicillin and CAST). If these are negative they will then do penicillin skin testing to determine further management..** *LoE:III[xii]*

****For Benzathine penicillin**, IM, 2.4 MU: Dissolve Benzathine penicillin **2.4 MU** in 6 mL lidocaine 1% without epinephrine (adrenaline). *LoE:III[xiii]*

****Acyclovir** *should be given to patients who are known HIV positive or unknown HIV status. Acyclovir is indicated in HIV-uninfected people with primary HSV infection only, which is characterised by fever, tender lymph nodes in the groin, and numerous lesions. Primary HSV should be diagnosed and managed by a doctor.*

Bubo

Patient complains of hot tender inguinal swelling with surrounding erythema and/or oedema

↓

Take history and examine.
Emphasise HIV testing.
Exclude hernia or femoral aneurysm.

↓

Bubo confirmed?

↓

Y

↓

TREATMENT

- **Azithromycin**, oral, 1 g immediately and 1 g a week later *LoE:III*[xiv]

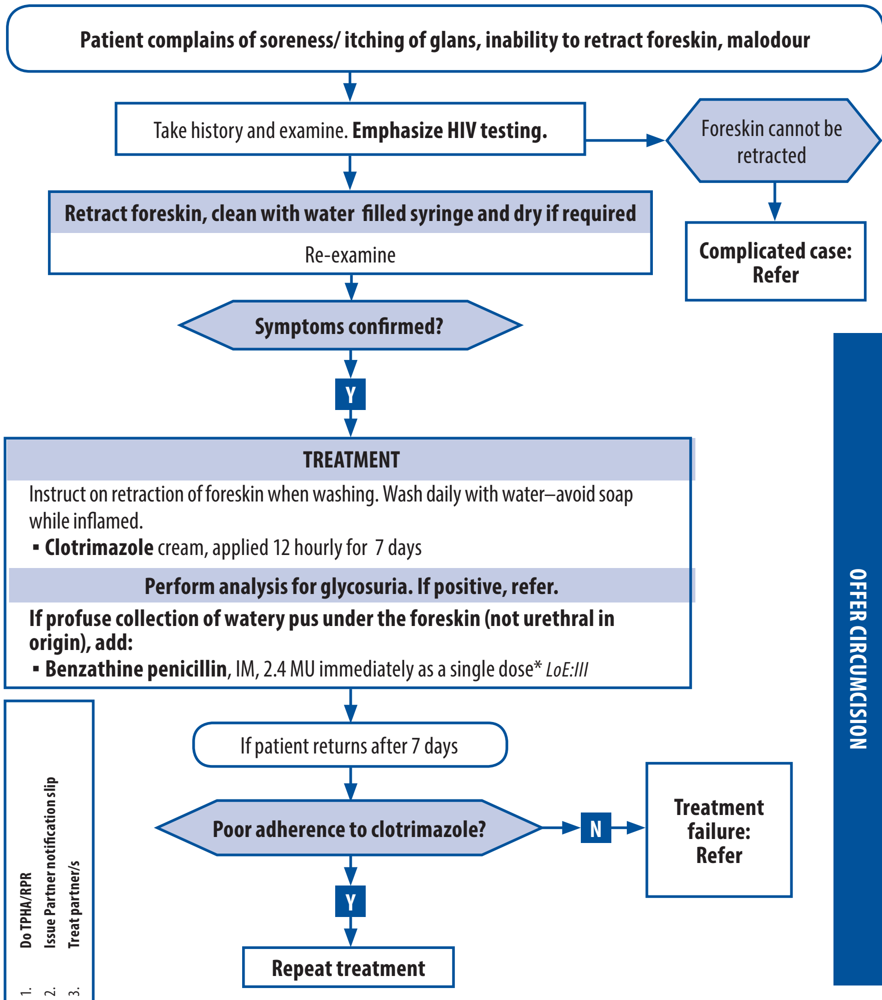
If bubo is fluctuant:

Aspirate pus in sterile manner.
Repeat every 72 hours, as necessary.

If no improvement after 14 days, refer.

1. **Do TPHA/RPR**
2. **Issue Partner notification slip**
3. **Treat partner/s**

Balanitis/Balanoposthitis (BAL)**



***Penicillin allergic men:**

- Replace Benzathine penicillin with: **Doxycycline**, oral, 100 mg 12 hourly for 14 days.

For Benzathine penicillin, IM, 2.4 MU: Dissolve Benzathine penicillin **2.4 MU** in 6 mL lidocaine 1% without epinephrine (adrenaline). *LoE:III*[xiii]

** **Algorithm** also pertains to partially circumcised men, but excludes the possibility of Balanitis in a fully circumcised man.

Syphilis Serology and Treatment

Syphilis Serology

The Rapid Plasmin Reagin (TPHA/RPR) measures disease activity, but is not specific for syphilis. False TPHA/RPR positive reactions may occur, notably in patients with connective tissue disorders (false positive reactions are usually low titre < 1:8). For this reason, positive TPHA/RPR results should be confirmed as due to syphilis by further testing of the serum with a specific treponemal test, e.g.:

- *Treponema pallidum* haemagglutination (TPHA) assay.
- *Treponema pallidum* particle agglutination (TPPA) assay.
- Fluorescent Treponemal Antibody (FTA) assay.
- *Treponema pallidum* ELISA.
- Rapid treponemal antibody test.

Screening can also be done the other way around starting with a specific treponemal test followed by a TPHA/RPR in patients who have a positive specific treponemal test. This is sometimes referred to as the "reverse algorithm".

Once positive, specific treponemal tests generally remain positive for life.

The TPHA/RPR can be used:

- To determine if the patient's syphilis disease is active or not,
- To measure a successful response to therapy (at least a fourfold reduction in titre, e.g. 1:256 improving to 1:64), or
- To determine a new re-infection.

Some patients, even with successful treatment for syphilis, may retain life-long positive TPHA/RPR results at low titres (≤1:8), which do not change by more than one dilution difference (up or down) over time (so-called serofast patients).

Note:

- Up to 30% of primary syphilis cases, i.e. those with genital ulcers may have a negative TPHA/RPR .
- The TPHA/RPR is always positive in the secondary syphilis stage and remains high during the first two (infectious) years of syphilis.

Medicine Treatment

Early Syphilis Treatment

Check if treated at initial visit.

- Benzathine penicillin, IM, 2.4 MU immediately as a single dose.
  - Dissolve Benzathine penicillin, IM, 2.4 MU in 6 mL lidocaine 1% without epinephrine (adrenaline).

In penicillin-allergic patients:

- Doxycycline, oral, 100 mg twice daily for 14 days.

If penicillin-allergic and pregnant: Refer for penicillin desensitisation.

Late Syphilis Treatment

Check if treatment was commenced at initial visit.

- Benzathine penicillin, IM, 2.4 MU once weekly for 3 weeks.
  - Dissolve Benzathine penicillin, IM, 2.4 MU in 6 mL lidocaine 1% without epinephrine (adrenaline).

If penicillin-allergic and pregnant: Refer for penicillin desensitisation.

Syphilis in Pregnancy

Mother-to-child transmission of syphilis occurs in up to 40% of cases in untreated mothers. Untreated maternal syphilis may lead to miscarriage, stillbirth, non-immune hydrops fetalis, or congenital syphilis in the newborn. Syphilis may be asymptomatic in pregnant women with diagnosis made by positive serology, preferably with on-site rapid testing.

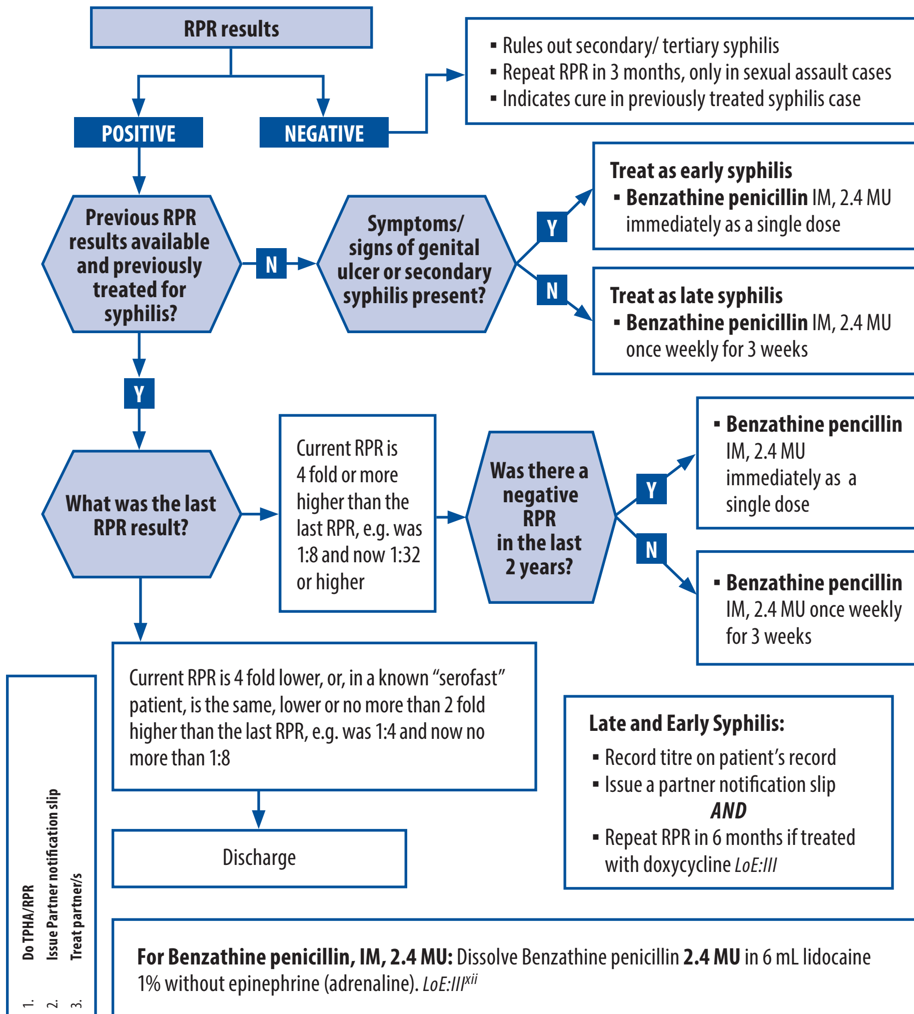
Referral

- Neurosyphilis.
- Clinical congenital syphilis.

Syphilis

Perform RPR if indicated:

- sexual assault case
- suspected secondary syphilis
- suspected tertiary syphilis
- 6 month follow-up of early syphilis cases treated with doxycycline



Syphilis in Pregnancy

All pregnant women at first antenatal visit and repeat testing at 32 weeks for women testing negative in the first trimester

↓

Take history and examine, explain need for syphilis screening, do pre-test counselling for HIV

↓

Take blood for RPR test (always), for HIV test (if consent), and for other ANC routines

Any STI syndrome or illness? → **Y** → Use appropriate flowchart, manage appropriately

Syphilis test positive? → **Y** →

Treat pregnant woman with:

- **Benzathine penicillin** 2.4 MU imi once weekly for 3 weeks. Reconstitute with 6mL of lidocaine 1% without epinephrine (adrenaline)

OR In case of penicillin allergy:

- Refer for penicillin desensitisation

HIV test positive?

- **Y** → Post test counselling, same day TB screen, HIV education, CD4 count, creatinine, clinical staging, support, and same day ART start
- **N** → Repeat HIV testing every 3 months throughout pregnancy, at labour/delivery, at 6 week EPI visit, every 3 months throughout breastfeeding

1. **Do TPHA/RPR**
2. **Issue Partner notification slip**
3. **Treat partner/s**

Symptomatic newborns of mothers with positive syphilis test during pregnancy:

- Refer all symptomatic babies

Notify: Notification of medical conditions, form GW17/5

Treat asymptomatic newborns of mothers with positive syphilis test if mother was not treated, ***OR*** if mother received < 3 doses of Benzathine penicillin, ***OR*** if mother delivers within 4 weeks of commencing treatment, with**:**

- **Benzathine penicillin** (depot formulation), IM, 50,000 units/kg as a single dose into lateral thigh*

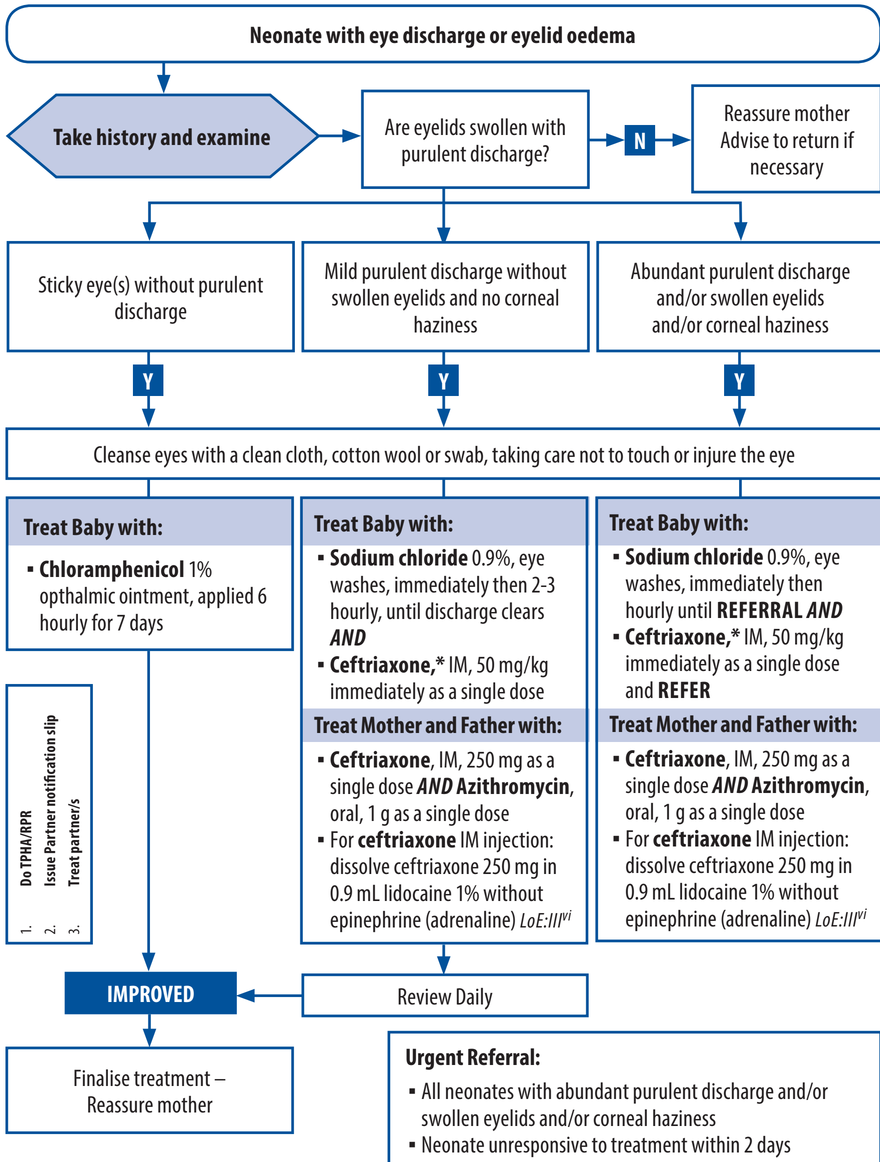
**Benzathine penicillin (depot formulation) must never be given IV*

Follow up at 3 months after the last injection to confirm a fourfold (i.e. 2 dilution) reduction in RPR titres, provided the initial titre was > 1:8. If the initial titre was < 1:8, further reduction may not occur.

All pregnant women: Educate, ensure compliance and counsel; promote couple-counselling if applicable

- Explain the risk of vertical transmission
- Promote consistent condom use particularly during pregnancy, demonstrate condom use, provide condoms
- Stress the importance of partner treatment, issue one notification slip for each sexual partner
- Promote HIV counselling and testing of partner

Neonatal Conjunctivitis



Parents of baby with confirmed neonatal conjunctivitis:

- Educate, ensure compliance, and counsel; promote couple-counselling if applicable.
- Promote abstinence from penetrative sex during the course of treatment.
- Promote and demonstrate condom use, retain condoms.
- Stress the importance of partner treatment and issue one notification slip for each sexual partner. Follow up partner treatment during review visit.
- Promote HIV counselling and testing. For negative results repeat test after 3 months.

*Infant Dosing of Ceftriaxone

Weight kg	**Dose** mg	**Use one of the following injections mixed with water for injection (WFI):**		**Age** months/years
		250 mg/2 mL (250 mg diluted in 2 mL WFI)	500 mg/2 mL (500 mg diluted in 2 mL WFI)	
>2–2.5 kg	100 mg	0.8 mL	0.4 mL	>34-36 weeks
>2.5-3.5 kg	150 mg	1.2 mL	0.6 mL	>36 weeks–1 month
>3.5-5.5 kg	200 mg	1.6 mL	0.8 mL	>1-3 months

LoE: III[V]

CAUTION: Use of ceftriaxone in severely ill neonates and children

Ceftriaxone should be used in neonates that are seriously ill only, and must be given even if they are jaundiced. In infants < 28 days of age, ceftriaxone should not be administered if a calcium containing intravenous infusion e.g. Ringer-Lactate, is given or is expected to be given. After 28 days of age, ceftriaxone and calcium containing fluids may be given but only sequentially with the giving set flushed well between the two products if given IV.

Annotate the dosage and route of administration in the referral letter.

Treatment of More than One STI Syndrome

STI Syndromes	Treatment (new episode)
MUS + SSW	Treat according to SSW flow chart.
MUS + BAL	Treat according to MUS flow chart ***AND*** ▪ **Clotrimazole** cream, 12 hourly for 7 days
MUS + GUS	▪ **Ceftriaxone**, IM, 250 mg immediately as a single dose** ***AND*** ▪ **Azithromycin**, oral, 1 g as a single dose ***AND*** ▪ **Aciclovir**, oral, 400 mg 8 hourly for 7 days*
VDS + LAP	Treat according to LAP flow chart ***AND*** Treat for candidiasis, if required (see VDS flow chart)
VDS + GUS	▪ **Ceftriaxone**, IM, 250 mg immediately as a single dose** ***AND*** ▪ **Metronidazole**, oral, 2 g immediately as a single dose ***AND*** ▪ **Azithromycin**, oral, 1 g as a single dose ***AND*** ▪ **Aciclovir**, oral, 400 mg 8 hourly for 7 days* ***AND*** Treat for candidiasis, if required (see VDS flow chart)
LAP+ GUS	▪ **Ceftriaxone**, IM, 250 mg immediately as a single dose** ***AND*** ▪ **Metronidazole**, oral, 400 mg 12 hourly for 7 days ***AND*** ▪ **Aciclovir**, oral, 400 mg 8 hourly for 7 days*.
SSW+ GUS	▪ **Ceftriaxone**, IM, 250 mg immediately as a single dose** ***AND*** ▪ **Aciclovir**, oral, 400 mg 8 hourly for 7 days*

***Treat with aciclovir only if HIV status is positive or unknown.**

****Penicillin allergic men and non-pregnant women avoid ceftriaxone and refer to relevant algorithms.**

Penicillin allergic pregnant or breastfeeding women, refer for penicillin desensitisation.

Genital Molluscum Contagiosum (MC)

Description

This is a viral infection which can be transmitted sexually and non-sexually. It is usually self-limiting but can be progressive in an advanced stage of immunodeficiency.

- Clinical signs include papules at the genitals or other parts of the body.
- The papules usually have a central dent (umbilicated papules).

Medicine Treatment

- Tincture of iodine BP.
  - Apply with an applicator to the core of the lesions.

Genital Warts (GW): Condylomata Accuminata

Description

The clinical signs include:

- Warts on the ano-genital areas, vagina, cervix, meatus or urethra.
- Warts can be soft or hard.

In most cases, warts resolve without treatment after 2 years in non-immunosuppressed patients.

General Measures

- If warts do not look typical or are fleshy or wet, perform an RPR/VDRL test to exclude secondary syphilis, which may present with similar lesions.
- Emphasise HIV testing.

Referral

All patients with:

- Warts > 10 mm
- Inaccessible warts, e.g. intra-vaginal or cervical warts
- Numerous warts

Pubic Lice (PL)

Description

Infestation of lice mostly confined to pubic and peri-anal areas, and occasionally involves eyelashes.

The bites cause intense itching, which often results in scratching with bacterial super-infection.

General Measures

Thoroughly wash clothing and bed linen that may have been contaminated by the patient in the 2 days prior to the start of treatment in hot water and then iron.

Medicine Treatment

- Benzyl benzoate 25%
  - Apply to affected area.
  - Leave on for 24 hours, then wash thoroughly.
  - Repeat in 7 days.

Pediculosis of the Eyelashes or Eyebrows

- Petroleum jelly.
  - Apply to the eyelid margins (cover the eyelashes) daily for 10 days to smother lice and nits.
  - Do not apply to eyes.

Referral

All children with lice on pubic, perianal area and eyelashes to exclude sexual abuse.

Treatment Protocol for Asymptomatic Partner(s)

Female Patient	Male Partner	Male Patient	Female Partner
VDS	MUS plus metronidazole 2 g stat	**MUS**	VDS
LAP	MUS plus metronidazole 2 g stat	**SSW**	VDS
GUS	GUS	**GUS**	GUS
GW	GW if signs	**GW**	GW if signs
PL	PL	**PL**	PL
MC	MC if signs	**MC**	MC if signs
RPR+	Benzathine penicillin 2.4mu im stat in addition RPR test	**RPR+**	Benzathine penicillin 2.4mu im stat in addition RPR test
		BAL	Cotrimazole vaginal pessary 500mgs inserted stat 2
In addition: treat any symptomatic STI		In addition: treat any symptomatic STI	

Footnotes

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