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APPENDIX A

Reporting of Sexually Transmissible Infections in Children Under 14 Years of Age, and in Children Aged 14 Years or Above, and Less than 16 Years

Protocol for On-referral of Notifications to Child Protection Agencies, by Staff in the Communicable Disease Control Directorate and Population Health Units of the Department of Health

1. Introduction

In response to the recommendations of the Gordon Inquiry (Gordon, Hallahan & Henry 2002) into sexual abuse in Aboriginal communities, the Government has committed to inter-departmental reporting of sexually transmissible infections (STIs) diagnosed in children. Most particularly, it has been agreed by the Government that all notifications (under the Infectious and Venereal Disease provisions of the *Health Act 1911*) of STIs in children **under 14 years of age**, and which are verified by public health disease control staff to be valid and resulting from, or likely to be a result of, a sexual means of transmission, will be reported by the Director of the Communicable Disease Control Directorate (CDCD) to nominated officers in the Department of Community Development (DCD) and the WA Police.

In addition, where public health disease control staff become aware that a notified STI in a child aged **14 years or above, but below 16 years of age**, may be a result of sexual abuse, then those cases should be similarly reported. It is unlikely that disease control staff will become aware of many cases in this category.



Features have been programmed into the Western Australian Notifiable Infectious Disease Database (WANIDD), such that any instance of an STI in a child <14 years will be flagged to staff performing data entry at the time details of the case are entered into the database (in the case of notifications by medical or nurse practitioners) or through a special alert screen (for both laboratory and practitioner notifications). These features facilitate the verification of information on these cases, and the eventual reporting of verified cases to the appropriate agencies.

CDCD will monitor WANIDD as a back-up to Population Health Units (PHUs) to ensure that cases are not missed, but PHUs hold primary responsibility for detecting and validating cases.

By agreement, this new obligation commenced as of July 1st, 2004. This protocol provides direction to disease control staff of the CDCD and PHUs across the state for ensuring the appropriate reporting of STIs in children to CDCD and WA Police.

2. Receipt and processing of notifications

Currently, STI notifications are received by two mechanisms:

2.1. Directly from doctors; usually on standard notification forms by mail, but occasionally by fax or telephone. These notifications are received and processed at regional PHUs – Kimberley, Pilbara, Midwest, Midwest/Gascoyne, Goldfields, Wheatbelt, Great Southern and Southwest – and by CDCD in Perth. Doctor notifications are entered into WANIDD by clerical or nursing staff at each of these sites. (Note that nurse practitioners are also legally required to notify cases following the passage of amendments to the *Health Act 1911*).*

* See *Health Amendment Act 2006*.



2.2. From laboratories; either as electronic line-listings or paper laboratory reports for individual cases. Laboratory notifications are almost exclusively received centrally by CDCD, and entered into WANIDD by clerical staff.

An alert system within WANIDD highlights newly entered or modified notifications for each region, such that designated staff in those regions see the new or modified notifications for their area only, and can initiate appropriate follow-up. The alert system is particularly important for the laboratory notifications that are entered centrally by CDCD.

The protocol for ensuring that notified STIs in children under 14 years are on-reported appropriately to child protection agencies places responsibility on staff in regional PHUs and CDCD to verify information on these cases, before advising the Director of CDCD. The latter will formally advise the nominated officers in DCD and WA Police.

3. Notification database enhancements

Two enhancements to WANIDD facilitate identification of STI cases under 14 years of age, and help to ensure that such cases are verified and referred appropriately and in a timely fashion.

3.1. Data entry flag: A screen box with the message: ***“Sexually transmissible infection in child under 14 years. Please verify details immediately and ensure follow-up action as per protocol”*** appears whenever a manually entered STI notification (or any modification of details to a notification) indicates a person with an “age at onset” of infection less than 14 years of age (see Figure 1). Age at onset is auto-calculated, using the entered date-of-birth and the “date of onset” field. If date of onset is not available, then it uses the first available date from: notification date; specimen date; or optimal date of onset (which itself is a derived field).



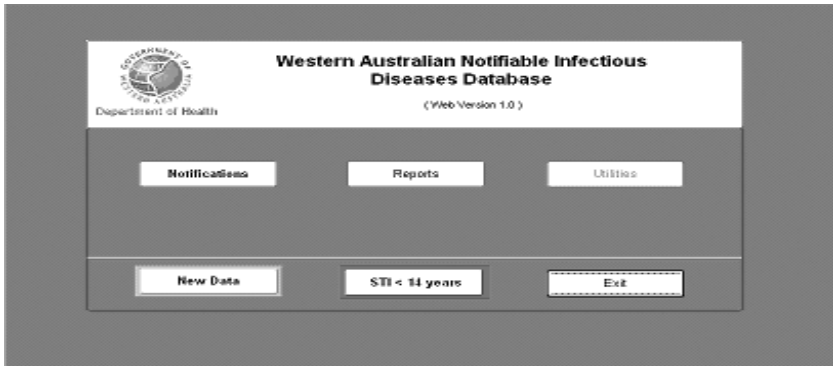
Figure 1: WANIDD data entry flag for STI notification in a child under 14 years of age



3.2. “STI <14 years” alert button and screen: This button is found on the first screen as one enters WANIDD, adjacent to the “Exit” button, and is only visible to those PHUs which at that time have one or more STI notifications in children <14 years of age that require verification and on-reporting (see Figure 2). The button will flash with a red border in those regions with alerted cases, until such time that the alert for that or those cases has been de-activated by CDCD. The latter will occur when CDCD have received appropriate verification of information from the PHU, and have entered either a date or the words “non-sexual” in the “date DCD notified” column (see next paragraph). Once all the cases in any one PHU region have a valid entry in the “date DCD notified” column, that region will no longer see the “STI <14 years” button.



Figure 2: WANIDD “STI <14 years” alert button on main screen



Clicking on the “STI <14 years” button leads to a specific screen that lists new and historical (received since 1st July 2004) cases of STIs in children <14 years of age. Regions are only able to see records for cases with residential addresses (known or unknown) within their own region, or with an unknown address anywhere in the state. The screen lists the following fields for each case: name, sex, age, notification (ID) number, PHU, disease, date verified, date DCD notified and date (notification) received (see Figure 3). Clicking on “view” in the “view record” column allows one to view the full notification record for that individual. Upon exiting the notification, one is taken back to the “STI under 14 years” screen.

In the metropolitan area, cases for verification will be referred by the Data Entry Officer at CDCD to appropriate staff at the relevant metropolitan PHU.

In addition to the data entry flag, the “STI <14 years” button will also flash and details of the case will appear in the alert screen, providing a back-up mechanism to alert the case to disease control staff.

4.2. Paper laboratory notifications: The CDCD Data Entry Officer will be alerted to a case in a child <14 years of age by the data entry flag. The procedure will then be as specified in section 4.1, except that the details of the case should be telephoned to the appropriate Public Health Nurse or Public Health Physician **for the region of origin of the case** (e.g. South Metropolitan or Goldfields PHU) for follow-up with the notifying practitioner. Paper laboratory notifications are occasionally also received and entered by country PHUs – in these instances the procedure will be as specified in section 4.1.

The “STI <14 years” button will also flash and details of the case will appear in the alert screen, providing a back-up mechanism to identify the case to disease control staff.

4.3. Electronic laboratory notifications: The data entry flag will not appear for cases imported to WANIDD from electronic laboratory data. PHU staff will, however, be alerted to imported STI cases in children <14 years of age by the red-bordered “STI <14 years” alert button and associated screen. Hence the importance of nominated disease control staff in each PHU checking on a daily basis to see if they have cases that need verification.



5. Verification of information with diagnosing practitioner

The Public Health Nurse or Public Health Physician should attempt to contact the notifying practitioner within 24 hours of receipt of the notification and verify the following:

- ◆ the name and address of the patient
- ◆ the date of birth
- ◆ the date of onset of infection
- ◆ the diagnosis
- ◆ the site of infection (e.g. genital, anal, eye, throat)
- ◆ whether there is likely to be a non-sexual explanation for the infection (e.g. congenital syphilis, perinatal chlamydial and gonococcal eye infections, epidemic gonococcal conjunctivitis)
- ◆ whether to the practitioner's knowledge the case has been reported by them, or anyone else, to child protection agencies or WA Police. If known, record the name of the agency and officer involved, and the date the agency was notified.

Discussion with the notifying practitioner should include some background explanation to the effect that:

“The DoH is required by Government to report all sexually acquired STIs in children under 14 years of age (irrespective of whether sex is thought to have been consensual), or any STIs thought to be the result of sexual abuse in children aged 14 or 15 years, to DCD and WA Police. This may mean, particularly if the case has not already been reported to DCD and WA Police, that either of these agencies may contact the practitioner to seek further information. Younger children, in whom consensual sex is most unlikely, will be the highest priority for investigation.”

Where the notifying practitioner is not available, discretion should be used in clarifying the nature of the infection (e.g. waiting until the following day when the practitioner



will be present, or asking for another doctor in the practice to check the information). This verification should ideally be completed **within two working days** of receipt of the notification.

6. Reporting to the Director of the Communicable Disease Control Directorate

6.1. STI in a child <14 years: Once the case has been verified with the diagnosing practitioner to be an STI in a child under 14 years of age, the date of verification should be entered by the PHU into the “Date verified” column in the alert screen (see Figure 3). The “STI <14 years” alert button and screen will remain visible to the PHU until CDCD has completed the “Date DCD notified” column. Once the latter information is entered, the alert button will no longer be visible to the PHU, unless there are other unverified cases relevant to that PHU.

6.2. STI in an adolescent aged 14 or 15 years, and in whom sexual abuse is suspected: Where the CDCD or a PHU are advised by a treating practitioner that they believe an STI in a teenager aged 14 or 15 years is most likely be a result of some form of sexual abuse, then the details of that case should be verified as described in section 5, above. The information should then be reported to the Director of CDCD, as described in section 6.3, below. A comment to this effect should be entered in the “General Comments” box on the first screen of the case’s WANIDD notification record (e.g. “Notifying doctor advises that STI may be due to sexual abuse. Disease and age details verified on [date]. Director CDCD advised on [date].”).



6.3. Communication to CDCD: The verified information, as detailed in section 5, and additional case details should preferably be recorded in the “Report of a sexually transmissible infection....” form (see page 194). The form should be completed both for cases where the practitioner believes the infection is sexually acquired and for cases where the infection is non-sexual (e.g. epidemic gonococcal conjunctivitis, perinatal infections).

The completed form should then be emailed as an attachment (marked “confidential”) or faxed (fax no. 9388 4848, marked “confidential”) directly to the **Director of CDCD**. If neither email nor fax is possible, the information should be communicated by telephone (08 9388 4801).

If email or fax communication is used, unless a confirmation of receipt and action is received from CDCD within one day, then the Director of CDCD should be telephoned. If s/he is unavailable, please provide the information to his/her delegate (telephone 08 9388 4801 to find out who to contact)

CDCD should normally be advised within one day of verification of the details, and within three working days of receipt of the notification. Depending on internal protocols and structures within individual PHUs, the person making the report to CDCD may also need to advise their line manager or PHU Director that a report is being made.

NOTE: PHUs should not report these cases directly to DCD or WA Police, unless the PHU clinical staff are themselves directly involved in the diagnosis and care of these children, and where they believe that the child or adolescent has been sexually abused. That is, the normal clinical duty of care to report directly to child protection agencies is applicable in such circumstances.



7. Reporting to the Department of Community Development and WA Police

Having received verifying details as per section 5, the Director of CDCD will endorse the “Report of a sexually transmissible infection....” form and for those cases where the infection is thought to have been acquired sexually, will forward it, within a working day of verification by the PHU, directly to nominated officers within DCD and WA Police for their action. It is anticipated that these agencies will use discretion in deciding whether older cases (especially those aged between 13 and 14 years), in whom sex is more likely to have been consensual, will be investigated.

Once the case has been reported to DCD, the date of report will be entered by CDCD into the “Date DCD notified” column of the alert screen. Once all cases in the screen have been reported to DCD, the flashing red border on the “STI <14 years” alert button will disappear. However, the button and associated screen will remain visible to nominated staff at CDCD for monitoring purposes. PHU staff will not see the button and screen unless there are cases for their region that have not yet been verified and reported.



APPENDIX B

SAMPLE LETTER re: CONTACT TRACING

The newly diagnosed patient should be given a letter for their partner to pass on to their own GP explaining:

- ◆ that they have been in contact with a person diagnosed with an STI
- ◆ that they might have also contracted an STI
- ◆ the importance and need for examination and testing and contact tracing.

..... Sender's surgery address and telephone number

Dear Doctor

The bearer of this letter has been in contact with someone diagnosed with the following sexually transmitted infection(s):

- | | | | |
|--------------------------------------|--------------------------------------|---|--|
| <input type="checkbox"/> Candidiasis | <input type="checkbox"/> Donovanosis | <input type="checkbox"/> Genital herpes | <input type="checkbox"/> Genital warts |
| <input type="checkbox"/> Hepatitis B | <input type="checkbox"/> HIV | <input type="checkbox"/> Molluscum | <input type="checkbox"/> Pubic lice |
| <input type="checkbox"/> Scabies | <input type="checkbox"/> Syphilis | <input type="checkbox"/> Other (please specify) _____ | |

Guidelines recommend that contacts of confirmed cases should be **examined** and **investigated** for sexually transmitted infections and receive **treatment** if required for the infection(s) indicated above.

If the test results come back positive, please notify the infection (if required) and ensure that contact tracing is undertaken.

Yours sincerely

Doctor

PLEASE TEAR OFF THE RETURN SLIP AND SEND IT TO THE ADDRESS AT THE TOP OF THIS LETTER

..... Responder's surgery address and telephone number

Dear Doctor

I have examined and tested the contact of your patient for
They have received the following treatment

Yours sincerely

Doctor



SAMPLE LETTER re: EMPIRICAL TREATMENT

The newly diagnosed patient should be given a letter for their partner to pass on to their own GP explaining:

- ◆ that they have been in contact with a person diagnosed with an STI
- ◆ that they might have also contracted an STI
- ◆ the importance and need for examination and testing, and that empirical treatment should be given for readily treatable bacterial STIs.

.....
Sender's surgery address and telephone number

Dear Doctor

The bearer of this letter has been in contact with someone diagnosed with the following readily treatable bacterial sexually transmitted infection(s):

- | | |
|--|---|
| <input type="checkbox"/> Gonorrhoea | <input type="checkbox"/> Chlamydia |
| <input type="checkbox"/> Non-specific Urethritis | <input type="checkbox"/> Trichomoniasis |

Guidelines recommend that contacts of confirmed cases should be **investigated** for sexually transmitted infections and receive **immediate treatment** for the infection(s) listed above (i.e. without waiting until the results of tests are available).

If the test results come back positive, please notify the infection (if required) and ensure that contact tracing is undertaken.

Yours sincerely

Doctor

PLEASE TEAR OFF THE RETURN SLIP AND SEND IT TO THE ADDRESS AT THE TOP OF THIS LETTER

.....
Responder's surgery address and telephone number

Dear Doctor

I have examined and tested the contact of your patient for
They have received the following treatment

Yours sincerely

Doctor



APPENDIX C

Table 1: Risk of transmission following a single unprotected exposure to an HIV-infected person

TYPE OF EXPOSURE	ESTIMATED RISK OF HIV TRANSMISSION (PER EPISODE)
Receptive anal intercourse	0.1% – 3%
Insertive anal intercourse	No published per contact estimates of risk, but estimated to be at least as high as for insertive vaginal intercourse (0.03 - 0.09%)
Receptive vaginal intercourse	0.1% – 0.2%
Insertive vaginal intercourse	0.03% – 0.09%
Receptive oral sex	<< 0.1% (estimate)
Use of contaminated injecting equipment	0.1% – 1.0%
Percutaneous exposure of health care worker	0.3%
Mucous membrane exposure	0.09%
Associated STIs	Increased risk



Table 2: Health Advice and Follow-up

Disease	Incubation Period	Period of Communicability (untreated)	Per contact Infectivity	Follow-up (time after completion of medication)	Further follow-up ¹
Chlamydia	7 – 14 days or longer*	Unknown, relapses are probably common*	High – 68% of male partners of infected women are positive by NAT (PCR) [^]	1 week for clinical assessment	Test of cure at 4 weeks with NAT; HIV, HBV and syphilis serology and retest for chlamydia at 3 months
Gonorrhoea	2-7 days or longer*	May extend for months*	Approximately 20% to insertive partner; approximately 50% to receptive partner [^]	Test of cure at 7 days with culture or 4 weeks with NAT at sites where previously positive	HIV, HBV and syphilis serology at 3 months. Consider retesting for gonorrhoea, those at high risk of reinfection.
Donovanosis	Unknown, probably 1 – 16 weeks*	Unknown, probably for the duration of open lesions on the skin or mucous membrane*	Low [^]	Review each week if possible. Essential at 4 weeks after commencement of treatment.	3 and 6 months after lesion has healed to ensure relapse does not occur. HIV, HBV and syphilis serology
HIV infection	1-3 months to detect antibodies*	Lifelong*	Depends on type of contact – see Table 1	Immune assessment#	3-6 monthly immune assessment#. Review at 3 months for HBV, HCV and syphilis serology.
Early syphilis	10 days – 3 months, usually 3 weeks*	Generally 2 years, transmission can occur with relapse up to 4 years	Primary, secondary, early latent syphilis: >20% Late latent and tertiary: not infectious [^]	4 weeks clinical assessment#	Clinical assessment and syphilis serology at 3, 6, 12 months # after completing treatment.



Disease	Incubation Period	Period of Communicability (untreated)	Per contact Infectivity	Follow-up (time after completion of medication)	Further follow-up ¹
Hepatitis B (Surface antigen positive)	45-180 days, average 60-90 days. Can be as short as 2 weeks to appearance of HBsAg and rarely as long as 6-9 months.*	As long as HBsAg persists. HBeAg positive patients are highly infectious.	25% OR unknown. High if injecting equipment is shared. [^]	Liver function tests (LFTs), α-fetoprotein, HBe antigen/antibody and repeat serology in 6 months#	Referral if abnormal LFTs. Regular sex partner(s), injecting partners and household contacts should be offered hepatitis B vaccination and prophylaxis.# Vaccinate for hepatitis A.
Hepatitis C infection	2 weeks-6 months, commonly 6-9 weeks*	May persist indefinitely. Peaks in virus concentration appear to correlate with peaks in ALT levels.*	Low rate of penile-vaginal transmission; increased by blood or trauma (anal sex, menstruating women)	LFTs, α-fetoprotein, hepatitis C PCR if not previously positive	Refer to specialist if LFTs remain elevated for 6 months. Vaccinate for hepatitis A and B.
Bacterial vaginosis	Unknown*	N/A	N/A	Return for results. Review if symptoms persist.	
Candidiasis	Variable, 2-5 days for thrush in infants	While lesions are present*	Unknown	Return for results#	Consider systemic predisposing factors for recurrent infections
Genital herpes	2 – 12 days. Can be years*	2 – 7 weeks after primary infection; 5 days after recurrences. Intermittent shedding may be lifelong in presence or absence of clinical lesions.*	High if lesions present, low if no lesions [^]	As required. Check for other STIs.	As required



Disease	Incubation Period	Period of Communicability (untreated)	Per contact Infectivity	Follow-up (time after completion of medication)	Further follow-up ¹
Genital warts	2 – 3 months, range 1 – 20 months*	Probably lasts as long as visible lesions persist*	High if lesions present, lower if no lesions	Clinical assessment at 1 week#	Re-treat as required# Regular cervical screening for women
Molluscum contagiosum	Experimental inoculation, 19 – 50 days; Clinical reports, 7 days – 6 months	Probably as long as lesions persist*	High	Clinical assessment at 5 – 10 days after completion of treatment#	Return for further treatment if any lesions remain after first treatment:#
Non-specific urethritis			Unknown	Review 1 – 2 weeks after cessation of treatment OR 5-10 days for clinical assessment if symptoms persist#	Partners tested and treated
Pediculosis pubis	Life cycle of crab louse is 15 days*	As long as lice or eggs remain alive*	High	Return for results and re-examination after 2 weeks	Partners examined and treated
Scabies	2-6 weeks before onset of itching in people without previous exposure, 1 – 4 days after re-exposure*	Until mites and eggs are destroyed by treatment. May need 2 doses of treatment 1 week apart.*	High	No follow-up usually required. Repeat treatment if new burrows appear.	
Trichomoniasis	4 – 20 days, average 7 days; many are symptom free carriers for years*	Duration of persistent infection, which may be for years*	Low-moderate ^A	Repeat test at one week for test of cure. Consider re-testing for gonorrhoea.	Partners tested and treated

¹Ensure that partners are tested and treated

Sources (see Bibliography on page 181): *Heymann DL (ed.) 2004; #Royal Adelaide Hospital 2005; Office of Aboriginal and Torres Strait Islander Health 1999; ^AAustralasian Society for HIV Medicine Inc 2002.



APPENDIX D

RESOURCES FOR PATIENTS

Contacts for specialist advice on STIs and HIV are listed on page viii.

Where to go

Confidential testing and treatment are available from:

(Most of these services are free. Please telephone first to see if you need an appointment)

A doctor of your choice or:

Fremantle Hospital

Infectious Diseases Dept
Sexual Health Service (B2 Clinic)
Level 2, B Block
Alma Street,
FREMANTLE 6160
Tel: (08) 9431 2149

Rockingham Clinic

(Thursdays 3-6pm)
City of Rockingham Youth
Health Services
9 Baralda Court
ROCKINGHAM
Tel: (08) 9527 7464

Royal Perth Hospital

Sexual Health Clinic
Level 4, Ainslie House
48 Murray Street
PERTH 6000
Tel: (08) 9224 2178

FPWA (Sexual Health Services)

Clinical Services, 70 Roe Street
NORTHBRIDGE 6003
Tel: (08) 9227 6177

Sexual Health Helpline

Tel: (08) 9227 6178, 1800 198 205

Quarry Health Centre

(for under 25 years of age)
Rear, 7 Quarry Street
FREMANTLE 6160
Tel: (08) 9430 4544

Women's Health Care House

100 Aberdeen Street,
NORTHBRIDGE
Tel: (08) 9227 8122

Derbarl Yerrigan Health Service

156 Wittenoom Street, PERTH
Tel: (08) 9421 3888



Appendix D

Carnarvon

Communicable Disease Control
Cnr Johnson & Cleaver Streets
CARNARVON 6701
Tel: (08) 9941 0570

South Hedland

Roberts Street
SOUTH HEDLAND 6722
Tel: (08) 9172 8333

Kalgoorlie

Population Health STI Clinic
36 Ware Street
Boulder
KALGOORLIE 6432
Tel: (08) 9080 8200

**And some regional
Aboriginal
Community
Controlled Health
Services.**

FOR MORE INFORMATION

**Communicable Disease Control Directorate
Department of Health**

PO Box 8172
Perth Business Centre
Tel: 9388 4999

HealthInfo 1300 135 030 (resources and publications)

HealthDirect 1800 022 222 (telephone advice)



REGIONAL POPULATION HEALTH UNITS

Goldfields	(Kalgoorlie)	(08) 9080 8200
Great Southern	(Albany)	(08) 9842 7500
Kimberley	(Broome)	(08) 9194 1630
Midwest/Gascoyne	(Carnarvon)	(08) 9941 0560
Midwest	(Geraldton)	(08) 9956 1985
Pilbara	(South Hedland)	(08) 9172 8333
Southwest	(Bunbury)	(08) 9781 2350
Wheatbelt	(Northam)	(08) 9622 4320

FOR ASSISTANCE WITH LANGUAGES

Translating and Interpreting Service (TIS)

Tel: 13 14 50 (24 hour service)

Cultural Diversity Policy Officer

Cultural Diversity Unit, Population Health Policy Branch,
Department of Health

Tel: (08) 9222 4222

Aboriginal Languages (see Derbarl Yerrigan)

Tel: (08) 9421 3888



APPENDIX E

AUSTRALIAN NATIONAL NOTIFIABLE DISEASES CASE DEFINITIONS⁺

ACQUIRED IMMUNODEFICIENCY SYNDROME (AIDS)

Reporting

Only **confirmed cases** should be notified.

Confirmed case

A confirmed case requires **laboratory definitive evidence AND clinical evidence.**

Laboratory definitive evidence

Definitive diagnosis of HIV infection (see case definitions for human immunodeficiency virus).

Clinical evidence

A diagnosis of at least one of the following clinical conditions:*

- ◆ Candidiasis of the bronchi, trachea or lungs – definitive diagnosis only
- ◆ Oesophageal candidiasis – definitive or presumptive diagnosis
- ◆ Invasive cervical cancer – definitive diagnosis
- ◆ Coccidioidomycosis, disseminated or extrapulmonary - definitive diagnosis only
- ◆ Cryptococcosis, extrapulmonary – definitive diagnosis only
- ◆ Cryptosporidiosis of more than one month's duration - definitive diagnosis only

* Communicable Diseases Network Australia 2004, *Interim Surveillance Case Definitions for the Australian National Notifiable Diseases Surveillance System*, Department of Health and Ageing, Canberra, available at <www.health.gov.au/internet/wcms/publishing.nsf/Content/cda_surveil-nndss-dislist.htm>.

* Australian National Council on AIDS 1994. 'Definition of HIV infection and AIDS-defining illnesses' *ANCA Bulletin*, vol. 18, Canberra.



- ◆ Cytomegalovirus retinitis, with loss of vision – definitive or presumptive diagnosis
- ◆ Encephalopathy, HIV related – definitive diagnosis only
- ◆ Herpes simplex: chronic ulcer(s) of more than one month's duration, bronchitis, pneumonitis or oesophagitis – definitive diagnosis only
- ◆ Histoplasmosis, disseminated or extrapulmonary – definitive diagnosis only
- ◆ Isosporiasis, chronic intestinal, of more than one month's duration – definitive diagnosis only
- ◆ Kaposi's sarcoma – definitive or presumptive diagnosis
- ◆ Lymphoma, Burkitt's – definitive diagnosis only
- ◆ Lymphoma, immunoblastic – definitive diagnosis only
- ◆ Lymphoma, primary, of brain – definitive diagnosis only
- ◆ Mycobacterium tuberculosis complex, any site, pulmonary or extrapulmonary – definitive or presumptive diagnosis
- ◆ Non-tuberculous mycobacterial disease, disseminated or extrapulmonary – definitive or presumptive diagnosis
- ◆ Pneumocystis carinii pneumonia – definitive or presumptive diagnosis
- ◆ Pneumonia, recurrent bacterial – definitive or presumptive
- ◆ Progressive multi-focal leukoencephalopathy – definitive diagnosis only
- ◆ Salmonella septicaemia, recurrent – definitive diagnosis only
- ◆ Toxoplasmosis - definitive or presumptive diagnosis
- ◆ Wasting syndrome due to HIV infection – definitive diagnosis only
- ◆ Bacterial infection affecting a child less than 13 years of age - definitive diagnosis only
- ◆ Lymphoid interstitial pneumonia and/or pulmonary lymphoid hyperplasia affecting a child less than 13 years of age – definitive or presumptive diagnosis.



HEPATITIS B (newly acquired)

Reporting

Only **confirmed cases** should be notified.

Confirmed case

A confirmed case requires **laboratory definitive evidence** only.

Laboratory definitive evidence

1. Detection of hepatitis B surface antigen (HBsAg) in a patient shown to be negative within the last 24 months
OR
2. Detection of HBsAg and IgM to hepatitis B core antigen, in the absence of prior evidence of hepatitis B virus infection
OR
3. Detection of hepatitis B virus by nucleic acid testing, and IgM to hepatitis B core antigen, in the absence of prior evidence of hepatitis B virus infection.

HEPATITIS B (Unspecified)

Reporting

Only **confirmed cases** should be notified.

Confirmed case

A confirmed case requires **laboratory definitive evidence** AND that the case does not meet any of the criteria for a newly acquired case.

Laboratory definitive evidence

Detection of hepatitis B surface antigen (HBsAg), or hepatitis B virus by nucleic acid testing, in a patient with no prior evidence of hepatitis B virus infection.



HEPATITIS C (newly acquired)

Reporting

Only **confirmed cases** should be notified.

Confirmed case

A confirmed case requires either:

1. **Laboratory definitive evidence**
OR
2. **Laboratory suggestive evidence AND clinical evidence.**

Laboratory definitive evidence

1. Detection of anti-hepatitis C antibody from a person who has had a negative anti-hepatitis C antibody test recorded within the past 24 months
OR
2. Detection of hepatitis C virus by nucleic acid testing from a person who has had a negative anti-hepatitis C antibody test result within the past 24 months
OR
3. Detection of anti-hepatitis C antibody from a child aged 18 to 24 months
OR
4. Detection of hepatitis C virus by nucleic acid testing in a child aged one to 24 months.

Laboratory suggestive evidence

Detection of anti-hepatitis C antibody, or hepatitis C virus by nucleic acid testing.

Clinical evidence

Clinical hepatitis within the past 24 months (where other causes of acute hepatitis have been excluded) defined as:

1. Jaundice
OR
2. Bilirubin in urine
OR
3. Alanine transaminase (ALT) seven times the upper limit of normal.



HEPATITIS C (UNSPECIFIED)

Reporting

Only **confirmed cases** should be notified.

Confirmed case

A confirmed case requires **laboratory definitive evidence** AND that the case does not meet any of the criteria for a newly acquired case AND is aged more than 24 months.

Laboratory definitive evidence

In a person with no prior evidence of hepatitis C virus infection:

1. Detection of anti-hepatitis C antibody
OR
2. Detection of hepatitis C virus by nucleic acid testing.

HUMAN IMMUNODEFICIENCY VIRUS (HIV) – child aged less than 18 months at the time of blood sample collection

Reporting

Both **confirmed cases** and **probable cases** should be notified.

Confirmed case

A confirmed case requires **laboratory definitive evidence** only.

Laboratory definitive evidence

Detection of HIV by at least two virologic assays (nucleic acid testing for proviral DNA; HIV p24 antigen, with neutralisation; virus isolation) on at least two separate blood samples (excluding cord blood).



Probable case

A probable case requires **laboratory suggestive evidence** only.

Laboratory suggestive evidence

Detection of HIV by one of the following virologic assays (nucleic acid testing for proviral DNA; HIV p24 antigen, with neutralisation; virus isolation) in one blood sample (excluding cord blood) and no subsequent negative HIV virologic or antibody tests.

HUMAN IMMUNODEFICIENCY VIRUS (HIV) – Newly acquired

Newly acquired HIV infection may be diagnosed in individuals aged 18 months or older at the time of blood sample collection. A diagnosis of newly acquired HIV infection excludes a diagnosis of HIV infection (unspecified).

Reporting

Both **confirmed cases** and **probable cases** should be notified.

Confirmed case

A confirmed case requires **laboratory definitive evidence** only.

Laboratory definitive evidence

1. Repeatedly reactive result on a screening test for HIV antibody followed by a positive result on a Western Blot AND laboratory evidence of a negative or indeterminate HIV antibody result in the 12 months prior to blood sample collection

OR



Appendix E

2. A group IV indeterminate Western Blot AND detection of HIV by at least one of the following virologic assays (nucleic acid testing for proviral DNA; HIV p24 antigen, with neutralisation; virus isolation). A group IV indeterminate Western Blot is defined by the presence of a glycoprotein band (gp41, gp120 or gp160) and one or two other HIV specific bands.

Probable case

A probable case requires **laboratory suggestive evidence** and **clinical evidence**.

Laboratory suggestive evidence

1. Detection of HIV by at least one of the following virologic assays (nucleic acid testing for proviral DNA; HIV p24 antigen, with neutralisation; virus isolation)
OR
2. Repeatedly reactive result on a screening test for HIV antibody followed by a positive result on a Western Blot.

Clinical evidence

HIV seroconversion illness within the 12 months prior to blood sample collection.

HUMAN IMMUNODEFICIENCY VIRUS (HIV) – unspecified

HIV infection (unspecified) is diagnosed in individuals aged 18 months or older at the time of blood sample collection, who do not have evidence of HIV acquisition in the previous 12 months. A diagnosis of HIV infection (unspecified) excludes a diagnosis of newly acquired HIV infection.

Reporting

Both **confirmed cases** and **probable cases** should be notified.



Confirmed case

A confirmed case requires **laboratory definitive evidence** only AND that the case does not meet any of the criteria for a newly acquired case.

Laboratory definitive evidence

1. Repeatedly reactive result on a screening test for HIV antibody followed by a positive result on a Western Blot. A positive result on a Western Blot is defined by the presence of a glycoprotein band (gp41, gp120 or gp160) and at least three other HIV-specific bands
OR
2. Detection of HIV by at least two virologic assays (nucleic acid testing for proviral DNA; HIV p24 antigen, with neutralisation; virus isolation) performed on at least two separate blood samples.

Probable case

A probable case requires **laboratory suggestive evidence** only.

Laboratory suggestive evidence

Detection of HIV by at least one of the following virologic assays (nucleic acid testing for proviral DNA; HIV p24 antigen, with neutralisation; virus isolation) in one blood sample.

CHANCROID (SOFT SORE) not covered in National case definitions

1. Isolation of *Haemophilus ducreyi* from a clinical specimen
OR
2. A clinically compatible illness in a patient who is epidemiologically related to a laboratory confirmed case, where syphilis, granuloma inguinale and *Herpes simplex* have been excluded as the only cause of the ulcers.



CHLAMYDIAL INFECTION

Reporting

Only **confirmed cases** should be notified.

Confirmed case

A confirmed case requires **laboratory definitive evidence** only.

Laboratory definitive evidence

1. Isolation of *Chlamydia trachomatis*
OR
2. Detection of *Chlamydia trachomatis* by nucleic acid testing
OR
3. Detection of *Chlamydia trachomatis* antigen.

DONOVANOSIS

Reporting

Both **confirmed cases** and **probable cases** should be notified.

Confirmed case

A confirmed case requires **laboratory definitive evidence** AND **clinical evidence**.

Laboratory definitive evidence

1. Demonstration of intracellular Donovan bodies on smears or biopsy specimens taken from a lesion
OR
2. Detection of *Calymmatobacterium granulomatis** by nucleic acid testing of a specimen taken from a lesion.

* Referred to as *Klebsiella granulomatis* on page 93.



Clinical evidence

Clinically compatible illness involving genital ulceration.

Probable case

A probable case requires **clinical evidence** AND **epidemiological evidence**.

Clinical evidence

As with confirmed case.

Epidemiological evidence

1. A compatible sexual risk history in a person from an endemic area
OR
2. A compatible sexual risk history involving sexual contact with someone from an endemic area.

GONOCOCCAL INFECTION***Reporting***

Only **confirmed cases** should be notified.

Confirmed case

A confirmed case requires **laboratory definitive evidence** only.

Laboratory definitive evidence

1. Isolation of *Neisseria gonorrhoeae*
OR
2. Detection of *Neisseria gonorrhoeae* by nucleic acid testing
OR
3. Detection of typical Gram-negative intracellular diplococci in a smear from a genital tract specimen.



SYPHILIS – infectious (primary, secondary and early latent), less than 2 years duration

Reporting

Only **confirmed cases** should be notified.

Confirmed case

A confirmed case requires either:

1. **Laboratory definitive evidence**
OR
2. **Laboratory suggestive evidence AND clinical evidence.**

Laboratory definitive evidence

1. Seroconversion in past two years: specific treponemal test (e.g. IgG enzyme immunoassay, *Treponema pallidum* haemagglutination assay, *Treponema pallidum* particle agglutination, *Treponema pallidum* immobilisation assay, or fluorescent treponemal antibody absorption) reactive when previous treponemal test non-reactive within past two years
OR
2. A four-fold or greater rise in non-specific treponemal antibody titre (e.g. Venereal Diseases Research Laboratory, Rapid Plasma Reagin) in the past two years, and a reactive specific treponemal test (e.g. IgG enzyme immunoassay, *Treponema pallidum* haemagglutination assay, *Treponema pallidum* particle agglutination, *Treponema pallidum* immobilisation assay, or fluorescent treponemal antibody absorption).

Laboratory suggestive evidence

1. Demonstration of *Treponema pallidum* by dark field microscopy (not oral lesions), direct fluorescent antibody



tests, equivalent microscopic methods (e.g. silver stains), or nucleic acid testing

OR

2. Non-specific treponemal test (e.g. Venereal Diseases Research Laboratory, Rapid Plasma Reagin) reagin titre of greater than or equal to 1:8.

Clinical evidence

1. Presence of a primary chancre (or ulcer)
OR
2. Clinical signs of secondary syphilis.

SYPHILIS – more than 2 years or unknown duration

Reporting

Only **confirmed cases** should be notified.

Confirmed case

A confirmed case requires that the case does not meet the criteria for a case of less than 2 years duration AND either:

1. **Laboratory definitive evidence**
OR
2. **Laboratory suggestive evidence AND clinical evidence.**

Laboratory definitive evidence

1. A reactive specific treponemal test (e.g. IgG enzyme immunoassay, *Treponema pallidum* haemagglutination assay, *Treponema pallidum* particle agglutination, *Treponema pallidum* immobilisation assay, or fluorescent treponemal antibody absorption) which is confirmed either by a reactive non-specific treponemal test (e.g. Venereal Diseases Research Laboratory, Rapid Plasma Reagin) OR a different specific treponemal test if the non-specific treponemal test is non-reactive



AND

2. The absence of a history of documented previous adequate treatment of syphilis, or endemic treponemal disease (e.g. Yaws).

Note:

In a high prevalence area, only one reactive specific treponemal test result is necessary.

Laboratory suggestive evidence

Demonstration of *Treponema pallidum* by dark field microscopy (not oral lesions), direct fluorescent antibody tests, equivalent microscopic methods (e.g. silver stains), or DNA methods (e.g. nucleic acid testing).

Clinical evidence

Clinical signs of tertiary syphilis.

CONGENITAL SYPHILIS

Reporting

Both **confirmed cases** and **probable cases** should be notified.

Confirmed case

A confirmed case requires either:

1. **Laboratory definitive evidence**
OR
2. **Laboratory suggestive evidence AND clinical evidence.**



Laboratory definitive evidence

1. Treponemal-specific antibody titres (e.g. *Treponema pallidum* haemagglutination assay, *Treponema pallidum* particle agglutination, fluorescent treponemal antibody absorption) in infant serum greater than four-fold higher than in maternal serum
OR
2. Treponemal specific antibody titres in infant serum comparable with those in maternal serum and specific treponemal IgM enzyme-linked immunosorbent assay or immunofluorescence assay positive
OR
3. Detection of *T. pallidum*
DNA in normally sterile specimen from infant (CSF, tissue) by nucleic acid testing.

Laboratory suggestive evidence

1. Dark field microscopy of infant lesion exudate or node aspirate smears (not oral lesions) to demonstrate characteristic morphology and motility of *T. pallidum*
OR
2. Demonstration of *T. pallidum* in infant tissues by special stains (e.g. silver)
OR
3. Detection of *T. pallidum* DNA from an infant non-sterile site by nucleic acid testing
OR
4. Reactive fluorescent treponemal absorbed-19S-IgM antibody test or IgM enzyme-linked immunosorbent assay AND treponemal non-specific antibody titre (e.g. RPR) in infant serum greater than four-fold higher than in maternal serum.

Clinical evidence

1. Asymptomatic infection (in the infant of an infected mother)
OR
2. Foetal death *in utero*
OR
3. Stillbirth, which is a foetal death that occurs after a 20-week gestation or in which the foetus weighs greater than 500 g and the mother is untreated or inadequately treated for syphilis at delivery. Inadequate treatment is a non-penicillin regimen or penicillin treatment given less than 30 days prior to delivery.
OR
4. Clinical evidence of congenital syphilis on examination
 - a. Age <2 years
Hepatosplenomegaly, rash, condyloma lata, snuffles, jaundice (non-viral hepatitis), pseudoparalysis, anaemia, oedema
 - b. Age >2 years
Interstitial keratitis, nerve deafness, anterior bowing of shins, frontal bossing, mulberry molar, Hutchinson teeth, saddle nose, rhagades or Clutton joints
 - c. Evidence of congenital syphilis on long bone X-ray (changes in the metaphysis and epiphysis are considered classic for congenitally acquired syphilis)
 - d. Evidence of congenital syphilis on cerebrospinal fluid (CSF) examination (even if the mother has been adequately treated). This could include an elevated CSF cell count or protein (without other cause) as well as a reactive cerebrospinal fluid (CSF) Venereal Diseases Research Laboratory (VDRL) titre. This diagnosis should be made with paediatrician input because the white cell count of neonates is normally elevated.



Probable case

A probable case requires either:

1. An infant (regardless of clinical signs) whose mother has been inadequately treated for syphilis during pregnancy. Inadequate treatment is a non-penicillin regimen or penicillin treatment given less than 30 days prior to delivery.

OR

2. An infant or child who has a reactive treponemal antibody test for syphilis and any one of the following:
 - ◆ Any evidence of congenital syphilis on physical examination
 - ◆ Any evidence of congenital syphilis on radiographs of long bones
 - ◆ A reactive cerebrospinal fluid (CSF) Venereal Diseases Research Laboratory (VDRL) titre
 - ◆ An elevated CSF cell count or protein (without other cause)
 - ◆ A reactive fluorescent treponemal antibody absorbed assay -19S-IgM antibody test or IgM enzyme-linked immunosorbent assay.



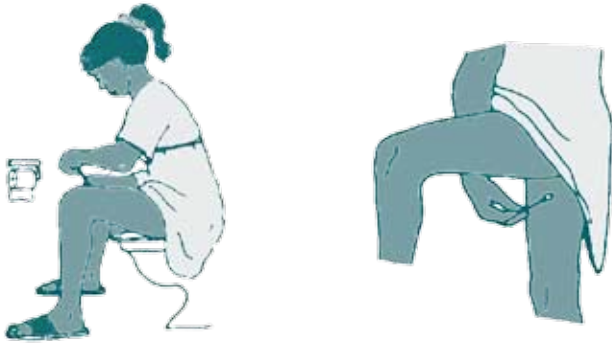
APPENDIX F

SELF-OBTAINED LOW VAGINAL SWAB: PATIENT INSTRUCTIONS

Self-obtained low vaginal swabs (SOLVS) for the diagnosis by NAT of organisms such as *Chlamydia trachomatis* and *Neisseria gonorrhoeae*.*

Patient Instructions

This is how to take your own swab for a SOLVS PCR test



Put the tip of the cotton swab stick about 2 cm (length of one finger joint) inside your vagina.



Turn the swab around once. Count to 10 while leaving the cotton swab stick in the vagina.

* Diagrams courtesy of Kimberley PHU



GLOSSARY

A

Aboriginal health worker

An Aboriginal person who has undertaken a training program at a recognised training institution to act as a health worker for Aboriginal people. The precise role of Aboriginal health workers is still evolving and varies considerably both within WA and between the States.

Acquired immunodeficiency syndrome (AIDS)

The stage in HIV infection when the immune system is severely depleted and opportunistic infections and cancers develop.

Anaphylaxis

A potentially fatal allergic reaction to foreign protein or other substances.

B

Behcet's syndrome

A chronic inflammatory disorder of unknown aetiology with recurrent ulceration of the oral and pharyngeal mucous membranes and the genital skin.

Bimanual pelvic examination

An examination technique that uses both hands, one for feeling the cervix through the vagina, and the other for feeling the body of the uterus through the lower abdominal wall. This provides considerable information about the state of the uterus, adnexa and the pelvic cavity.

C

Chancere

The ulcer of primary syphilis.

Clue cells

Vaginal epithelial cells covered in bacteria and seen on a Gram stain of a high vaginal swab.

Communicable Disease Control Directorate (CDCD)

That section of the Department of Health (Western Australia) with responsibility for communicable diseases including STI/HIV.

Condom

A thin latex rubber sheath worn over the penis for disease prevention or contraception.

Condylomata lata

Wart-like lesions seen in second stage syphilis, often in the perianal region and other warm moist areas.

Conjunctivitis

An inflammation of the conjunctiva or lining of the eye usually accompanied by purulent discharge.



Glossary

Contact

A person who has had sex with, shared injecting equipment with or has had some other high-risk exposure to the index case.

Contact tracing

The process of identifying contacts of the index case so that they can also be given appropriate testing, counselling and treatment.

Counselling

Interviewing a patient to give advice and support. For patients with STIs, counselling involves education about risk behaviour, disease and treatment, and helping patients to cope with the psychosocial implications of their infection.

Cytobrush

A wire brush on a short stick for taking specimens from the cervix.

D

Diplococcus

Diplococcus is the form of the organism causing gonorrhoea. It is a spherical bacterium that occurs in pairs. This organism stains red with the Gram stain and hence is referred to as Gram-negative.

Dysuria

Pain on passing urine.

E

Ectopic pregnancy

A pregnancy occurring outside the uterus, i.e. in the fallopian tube.

Ectopy

Extension of columnar epithelium onto the vaginal surface of the cervix.

Enzyme immunoassay (EIA)

A test for an antigen or antibody that uses a colour reaction produced by an enzyme to give a positive result.

Epididymitis

Inflammation of the epididymis of the testicle.

F

First void urine

First amount of urine passed (not a midstream sample).

Fluorescent treponemal antibody absorption (FTA-Abs) test

A specific test for antibodies to syphilis. This test remains positive for life after syphilis has been contracted, whether treated or not.



G**Gram stain**

A common dye stain used in microbiology for classifying bacteria.

Guarding

A rigidity of the muscles of the abdominal wall on physical examination; a sign of underlying peritonitis.

Gummata

Granulomatous lumps that can occur in almost any organ; a manifestation of tertiary syphilis.

H**Hepatosplenomegaly**

Enlargement of the liver and spleen.

Human immunodeficiency virus (HIV)

A virus which attacks specific cells of the immune system giving rise to immune deficiency.

Hysterectomy

The removal of the uterus by surgical operation.

I**IgG**

Immunoglobulin of class G antibodies produced in response to an antigen. This immunoglobulin is longer lasting than IgM.

IgM

Immunoglobulin of class M antibodies. This antibody is produced on first exposure and the levels fall more rapidly than do those of IgG.

Immunosuppressed

The state of an immune system that has been suppressed and as a result does not produce antibodies. Such suppression may be medication-induced (e.g. corticosteroids), or by disease (e.g. HIV).

Index case

The original person identified with an infection. The index case may or may not have infected other persons but represents a starting point for the process of contact tracing (sometimes referred to as "index patient").

Informed consent

A patient's agreement to a medical procedure (including physical examination), obtained after telling the patient what will be done and why. Patients are entitled to know what risks, if any, are involved in medical procedures offered to them. No medical procedures can proceed without the patient's informed consent.



Glossary

J

Jarisch-Herxheimer reaction

A common reaction to treatment in patients with primary and secondary syphilis. It is a mild reaction with fever, headache, malaise, rigors and joint pains and lasts for several hours.

L

Ligase chain reaction (LCR)

See Nucleic Acid Test

M

Meningitis

Inflammation of the meninges or the lining of the brain.

N

Needlestick injury

Inadvertent piercing of the skin with a hyperdermic needle or other sharp instrument.

Neonate

An infant from birth to the age of 4 weeks (28 days).

Neutrophils

One of the variety of white cells circulating in the blood stream, mostly in response to bacteria.

Nucleic Acid Test (NAT)

A generic name for tests, which include ligase chain reaction (LCR) and polymerase chain reaction (PCR), that detect the DNA of an organism (e.g. *Neisseria gonorrhoeae*, *Chlamydia trachomatis*). The test can be performed on urine or discharge containing the organism.

O

Orchitis

Inflammation of the testicle.

P

PathWest Laboratory Medicine WA

The Western Australian Centre for Pathology and Medical Research.

Pelvic inflammatory disease (PID)

A condition characterised by lower abdominal pain that mimics a range of abdominal emergencies such as acute appendicitis or ectopic pregnancy and which can have serious outcomes, including peritonitis and infertility.



Penicillinase

An enzyme produced by some bacteria, that is capable of antagonizing the antibacterial action of penicillin and certain other antibiotics.

Perihepatitis

Inflammation around the liver, usually in the region of the portal vein and bile ducts.

Polymerase chain reaction (PCR)

See Nucleic Acid Test.

Pre-term delivery

The delivery of an infant before the normal term of pregnancy.

Procaine reaction

A rare reaction to penicillin, characterised by a sensation of impending doom with hallucinations.

Proctitis

Inflammation of the rectum.

Proctoscope

A short tubular instrument used for examining the rectum.

Proctoscopy

The direct examination of the anorectal mucosa with the aid of a proctoscope.

Prostatitis

Inflammation of the prostate gland.

R**Rapid plasma reagin (RPR) test**

A test for syphilis that measures antibodies to a protein called cardiolipin. These antibodies are formed during infection by *Treponema pallidum*. This test is quantified and hence can be used to monitor progress of infection or treatment.

Rebound tenderness

Tenderness on releasing pressure of the hand on the muscles of the abdominal wall. A sign of underlying peritonitis.

Reiter's syndrome

A condition characterised by inflammation of the urethra, conjunctivitis and arthritis.

Glossary

S

Safe sex

Sexual activity that minimises the risk of transmitting infection: no exchange of bodily fluids; no penetrative sex without the use of a condom.

Safer sex practices*

Mutual monogamy with a non-infected partner, avoiding multiple sexual partners or anonymous and other casual sex, and consistent and correct use of condoms with all partners not known to be free of infection.

Salpingitis

Inflammation of the fallopian tubes.

Screening

The process of testing individuals or individuals within communities who are not known to have an infection for the purpose of identifying otherwise unknown cases.

Serology

Tests on the patient's serum (blood tests) to detect antibodies to infectious agents.

Sexual contact

Oral, vaginal, anal or some other form of sexual contact with the index case during the period when there was risk of transmission of infection.

Speculum

A metal instrument used to enable a visual examination of the vagina.

Syndrome

A group of symptoms that patients describe, combined with the signs that providers observe during examination.

T

Titre

The extent to which an antibody-containing substance can be diluted before losing its power of reacting with the appropriate antigen. Expressed as titres of 1:2, 1:4, 1:8, 1:16, and so on.

***Treponema pallidum* haemagglutination test (TPHA)**

A specific blood test for syphilis. This test remains positive for life after syphilis has been contracted, whether treated or not.

***Treponema pallidum* particle agglutination test (TPPA)**

A specific blood test for syphilis.

Trichomonas

A flagellated protozoan that causes inflammation of the vagina.

*Chin J (ed.) 2000, *Control of Communicable Diseases Manual*, 17th edn, American Public Health Association, Washington.



U**Urethritis**

Inflammation of the urethra that may or may not be accompanied by a discharge.

Urticaria

A skin rash of varying type due to allergy. The rash is usually itchy.

V**Venereal Diseases Research Laboratory (VDRL) test**

A test that measures antibodies to a protein called cardiolipin, which are formed during infection by *Treponema pallidum*. It can be quantified and hence can be used to monitor progress of infection or treatment.

W**Western Blot**

A test for antibodies to various antigens. Particularly used to confirm a positive EIA test for HIV.

Window period

The period after infection, before sufficient antibodies have developed to be detected by tests. Test results will be negative, although the person is infected and infectious.



INDEX

Page numbers in bold type indicate the major section dealing with that entry.

Page numbers in italics refer to illustrations.

The letter 'n' following a page number denotes a footnote.

A number in (parenthesis) after a page number indicates the number of times the item appears on that page.

A

- abdominal pain syndrome (lower)**, 43, **52-54**
- Aboriginal health worker, 1, 221
- abstinence, 8
- aciclovir, 56
 - genital herpes, for, 153(4), 154
- acute proctitis**, 43, **55-56**
- acute salpingitis, *see* PID
- acquired immunodeficiency syndrome, *see* AIDS
- adnexitis, *see* PID
- AIDS, *see* HIV and AIDS**
- amoxicillin
 - chlamydia, for, 78
 - epididymo-orchitis, for, 149
 - gonorrhoea, for, 85(2), 87, 89
- anal swabs, 34, 35, 42, 46, 48, 69, 72, 83(2)
- anaphylaxis, 89, 221
- antibiotic treatment, 56, *see also* individual diseases
 - chlamydia, for, 77, 78
 - donovanosis, for, 95-96
 - gonorrhoea, for, 85, 86-89
 - syphilis, for, 121-123, 129, 131
- aortic incompetence, tertiary syphilis, and, 115
- arthritis, gonorrhoea and, treatment of, 86, 89, 90
- azithromycin, 56,
 - chancroid, for, 134
 - chlamydia, for, 56(2), 77(2), 78(2)
 - donovanosis, for, 51, 89(2), 96 (2)
 - gonorrhoea for, 56
 - PID, for, 168
 - syphilis, 51

B

- bacterial vaginosis**, 139-141
 - clinical presentation of**, 139
 - investigation of**, 140
 - management of partners**, 141
 - organism**, 139
 - PID, and, 53, 166
 - tests for, 39, 140
 - treatment of**, **46(2)**, 140
 - vaginal discharge, and, 43(2), 139, 146
- Behcet's syndrome, 50, 221
- best practice**, 2
- bimanual pelvic examination, 23, 221
- breast feeding, tetracyclines, and, 78, 96

C

- candidiasis 142-144
 - associated conditions, and, 139, 178
 - clinical presentation of**, 50, **142**
 - investigation of**, 142
 - management of partners**, 144
 - organism**, 142
 - tests for, 142
 - treatment of**, 46, **142-144**
 - vaginal discharge, and, 43(3), 139, 146
- cefotaxime, PID, for, 169
- ceftriaxone, 56
 - chancroid, for, 134
 - donovanosis, for, 96(2)
 - epididymo-orchitis, for, 149
 - gonorrhoea, for, 85(2), 86, 87(3), 88(2), 89
 - PID, for, 168, 170
 - syphilis, for, 122
- cephalosporins, penicillin and, 86(2)n



- cerebrospinal fluid, *see* CSF
- cervical discharge, 44, 53
gonorrhoea, and, 82
- cervical intra-epithelial neoplasm, 148
- cervicitis, 44-47, 75, 145-147**
clinical presentation of, 44-45, 145
investigation of, 45-46, 146
management of partners, 147
STI syndromes and, 44-47
treatment of, 47, 146
- chancro, 113, 114, 215, 221
- chancroid, 133-134**
case definition, 211
clinical presentation of, 49, 133
investigation of, 29, 133
management of partners, 134
notification of, 12, 14
organism, 133
treatment of, 51, 134
- check, STI, for, 5
- child sexual abuse and STIs, 10-11**
management of child with an STI, 10
- chlamydia, 75-81**
case definition of, 212
child sexual abuse and, 10
children with, treatment of, 77, 78
clinical presentation of, 75
contact tracing, 80-81, *see also*,
contact tracing, principles of
epididymitis, and, 79, 81
gonorrhoea, and, 78(3), 79, 86
investigation of, 32-33, 76-77
LGV, and, 42, 79(2), 159
management of partners, 80
notification of, 12, 14
organism, 75
PID, and, 79(2), 166
pregnant women with, treatment of, 78
prostatitis and, 171
self-obtained low vaginal swabs, for,
22, 29, 36-37, 76, 220
specimen collection, for, 29-38,
76, 77
tests for, 6, 29-38, 76-77
treatment for, 56, 77-79
- ciprofloxacin
chancroid, for, 134
gonorrhoea, for, 86, 87(4)
- clindamycin, bacterial vaginosis, for,
140(2), 141(2)
- clinic environment, the, 3, 4**
- clinical management, general principles**
of, 3-18
- clotrimazole
candidiasis, and, 143(2)
trichomoniasis, for, 179
- clue cells, 140(2)n, 221
- community screening, see screening**
- condoms, use of, 6, 9, 19, 24(4), 47, 49,**
51, 56, 69(3), 70, 71, 72, 158, 221, 226(2)
- condom breakage, sex workers, and, 69
- condylomata lata, 93, 114, 130, 157, 218,
221
- confidentiality, 3, 28
- conjunctivitis, 75, 80, 82, 221, 225
gonococcal, 88-89, 91
- consultative process, list of contributors
for, xvii
- consumer advice, contacts for, viii
- contact interview forms, 25, 67-68
- contact tracing, 2, 16, 17, 20, 25, 28,**
57-68, 222
advising contacts, methods for, 60-
62, see also individual diseases
chlamydia, for, 80, 81
consent for, 59
contacts for, viii
definitions, used in, 57
donovanosis, for, 99
follow-up, and, 64
gonorrhoea, for, 91, 92
HIV, for, 109-111
identifying, 59
information for, 58-59
principles of, 57-58
sample forms, 25, 66-68
sample letter, 195
syphilis, for, 124
uncooperative patients, and, 65-66
urgency of, 64-65, see also clinical
management, general principles of
viral hepatitis, for, 136-138
- counselling, 16-17, 27-29, 222, see also**
individual diseases
chlamydia, for, 79
contact tracing, and, 28-29
donovanosis, for, 97
examination, with, 28
gonorrhoea, for, 90-91
HIV, for, 107-109
negative diagnosis, for, 16
positive diagnosis, for, 16-17, 28
presentation, on, 28
post-test counselling, 16, 108



pre-test discussion, 16, 109
 rationale for, 16
 syphilis, for, 123
 test results, interpreting, 28
 CSF, syphilis and, 113(3), 115, 117,
 119(3), 122, 131(2), 132(3)
cytology, abnormalities detected on,
148

D

dementia, tertiary syphilis, and, 115
diagnostic testing, 29-39, see also
 individual diseases
collection and handling, checklist
for, 36-38
essential communication, 27-29
essential tests, 27
nucleic acid tests, 29
specimen collecting, men, for, 34
specimen collecting, women, for,
35
test pack for, 30-31
vaginal pH testing, 38-39
 diagnostic tests, *see* laboratory
 investigations, *see also* individual
 diseases
 diplococci, identification of, 82, 83, 222,
see also Gram stains
 doctors, primary care, 1
 Donovan bodies, 94, 95, 212
donovanosis, 49, 93-99
case definition of, 212
clinical presentation of, 93
contact tracing, 98, see also,
 contact tracing, principles of
 crush smear for, 95
 impression smear for, 51, 95
investigation of, 93-95
management of partners, 98
notification of, 12, 14
organism, 93
 pregnant women, and, *see* pregnant
 women
 punch biopsy for, 95
 testing indicated, for, 27
tests for, 29, 50-51, 93-95
treatment for, 51(3), 95-96
 vaginal examination for, 23
 doxycycline, 56
 breastfeeding, and, 56, 78, 96, 122,

169(2)
 cervicitis, for, 146
 children, for, 78(2), 96, 122
 chlamydia, for, 56, 77, 78(2)
 donovanosis, for, 96(2)
 epididymo-orchitis, for, 149
 lymphogranuloma venereum, for,
 159, 160
 non-specific urethritis, for, 164
 PID, for, 168, 169(2)
 pregnancy, for, 56, 78, 96, 122, 160,
 169(2)
 syphilis, for, 121(2), 122
dysuria, 19, 24, 43, 44, 47-49, 52, 75,
149, 167, 222

E

econazole, candidiasis, for, 143
 ectopic pregnancy, 52(2), 53, 75, 90, 167,
 168(2), 169(2), 222
 ectopy, 44, 222
education and prevention, 3, 8-9, see
also clinical management, general
 principles of, counselling, *see also*
 individual diseases
 EIA, 222
 HIV, for, 103(3)
 syphilis, for, 117, 118(2), 120(2)
empirical treatment, 62-63
 gonorrhoea, for, 84, 85
 sample letter, 196
 enzyme immunoassay, *see* EIA
 epididymitis, 222, *see also* epididymo-
 orchitis
 chlamydia and, 79, 81
 gonorrhoea and, 82, 86, 89, 90
epididymo-orchitis, 149-150, see also
 epididymitis
 chlamydia and, 75, 79
clinical presentation of, 75, 149
investigation of, 149
treatment for, 79, 149
 equipment, 30-31
 erythromycin
 chlamydia, for, 77, 78(3)
 lymphogranuloma venereum, for,
 160(2)
 pregnancy, in, 78(3), 160
 examination, *see* physical examination



F

- famciclovir
 - genital herpes, for, 153(3)
- fluconazole, candidiasis, for, 143, 144
- fluorescent treponemal antibody absorption, *see* FTA-Abs
- follow-up, 17-18, 29** *see also* individual diseases
 - chancroid, for, 134
 - chlamydia, for, 17, 80-81
 - contact tracing, and, 64**
 - donovanosis, for, 98-99
 - gonorrhoea, for, 17, 92
 - hepatitis B, for, 17
 - hepatitis C, for, 18
 - HIV, for, 17, 111
 - injecting drug use, for, 18
 - men who have sex with men, for, 73
 - screening, 17-18**
 - sex workers, for, 69
 - syphilis, for, 17, 125-126, 129, 132
- forms**
 - HIV Case Investigation Report, 68
 - HIV/AIDS notification, 12, 15
 - sexual contact interview and tracing, 23, 25.
 - standard notification, 12, 14
 - STI Case Investigation Report, 67
 - STI clinical management, 23, 24
- FTA-Abs, 117, 118(2), 120(2), 131, 222

G

- gender requirements in clinics, 4(2), 20**
- genital chlamydia, *see* chlamydia
- genital herpes, 151-155, *see also***
 - genital ulceration, 49-51**
 - child sexual abuse, and, 10
 - clinical presentation of, 44, 49, 151**
 - investigation of, 152**
 - management of partners, 154**
 - organism, 151**
 - tests for, 6, 27(2), 45, 152**
 - treatment of, 56, 153-154**
- genital warts, 156-158**
 - child sexual abuse, and, 10(2)
 - clinical presentation of, 156, 161**
 - investigation of, 156**
 - management of partners, 158**
 - organism, 156**
 - tests for, 156**
 - treatment of, 157-158**

gonorrhoea, 82-92

- case definition of, 213**
- child sexual abuse and, 10
- clinical presentation of, 82**
- contact tracing, 91, 92, *see also*,**
 - contact tracing, principles of culture, for, 82, 83, 84
- investigation of, 32-33, 82-84**
- management of partners, 91**
- NAT, for, 29(3), 36, 38, 41, 82, 83(7) 84(2), *see also* NAT
- notification of, 12, 14**
- organism, 82**
- penicillin-resistant, 64, 65, 92
- specimen collection protocol 32-35**
- specimen collection and handling, for, 29, 30-31, 32-38, 41, 84
- tests for, 6, 27-39, 82-84**
- gonorrhoea, treatment of, 56, 84-90**
 - anorectal, 87
 - children, with, 85(2), 87(2), 88, 89(2)
 - chlamydia co-infection, and, 86
 - complicated by associated infections, 89-90
 - conjunctivitis, 88-89
 - neonatal, 87, 89
 - pharyngeal, 87
 - penicillin, allergy to, and, treatment of, 86-87
 - self-obtained low vaginal swabs, for, 22, 29, 36-37, 76, 83, 220
 - uncomplicated, 85-86, *see also* PID:
 - epididymitis: prostatitis: arthritis: disseminated infections
- Gram stains, interpretation of, 55, 82, 133, 223
- granuloma inguinale, *see* donovanosis
- guarding, 53(2), 167, 223
- gummata, tertiary syphilis, and, 114, 116, 130, 223

H

- hepatitis, *see* **viral hepatitis**
- hepatitis A, 135-136**
 - post-exposure prophylaxis, 136
 - testing for, 6, 27, 34-35, 42, 46, 48, 71, 72-73, 116
 - vaccination, 106, 135
- hepatitis B, 135, 136-138**
 - case definition of, 206-207**
 - follow-up screening for, 17, 111



post-exposure prophylaxis, 137
 testing for, 6, 27, 34-35, 42, 46, 48, 70, 71, 72-73, 116
 vaccination, 106, 136-137

hepatitis C, 135, 138
case definition of, 207-208
 follow-up screening for, 18, 111
 injecting drug use and testing for, 6, 27, 34-35, 42, 46, 48, 71, 116

hepatitis D, 135
 hepatosplenomegaly, 130, 218, 223
 hepatotoxicity, 78
 herpes simplex, *see* genital herpes
 high risk behaviour, 6, 8-9

history, clinical, 6, 19-21, 24-25
drug history, and, 6, 21
 interpreter, use of, 20
sexual, 6, 19-20, 24, *see also* clinical management, general principles of

HIV and AIDS, 100-112, 221, 223
AIDS, case definition of, 204-206
 assessing risk factors, for, 104-105
clinical presentation of, 100-102
contact tracing, 109-111, 112, *see also* contact tracing, principles of
HIV, case definition of, 208-211
 indications for testing for, 19, 104-105
investigation of, 102-105
management of partners, 109-111
 neurological manifestations, and, 101
notification of, 12, 15
 offering tests for, 6
organism, 100
 other STIs, and, 105
post-exposure prophylaxis, non occupational, and, 112
 post-test counselling, 108-109
 pre-test discussion, 107
 seroconversion illness, and, 101
 symptoms following acute illness, and, 102
 syphilis in, 127
tests, for, 6, 27, 34-36, 102-105
treatment, for, 106, *see also* patient care, essentials of
 vaccination of patients with, 106
 viraemic manifestations, and, 102

HSV, *see* genital herpes
 human immunodeficiency virus, *see* HIV
 human papilloma virus, *see* genital warts
 Hutchinson's Triad, 130
 hysterectomy, 83, 223

I
 IgG, 118(3), 120(2), 223
 IgM, 131, 206(2), 223
 imidazole, candidiasis, for, 144
index case/patient, 57-68, 223
 infection control, guidelines for, 4n, 181
 informed consent, 22, 223
 informing the patient, 3, *see also* patient care, essentials of
 investigations, other possible STI infections for, 3, *see also* patient care, essentials of

J
 Jarisch-Herxheimer reaction, 122, 128, 224

K
 Kaposi's sarcoma, 100
 Kempe & Kempe, 10n, 182
 ketoconazole
 candidiasis, for, 143(2), 144
 hepatotoxicity, and, 143
 Kimberley Public Health Reference Group, 7n
Kimberley Population Health Unit, 23, 203

L
 laboratory investigations, 27-39, 41-42, *see also* individual diseases
 chlamydia, for, 76-77
 chancroid for, 133
 donovanosis, for, 93-95
 gonorrhoea, for, 82-84
 HIV/AIDS, for, 102-104
 range of tests for STI/HIV assessment, 6
 syphilis, for, 116-120, 125-126, 130
 latent syphilis, *see* syphilis
 LCR, 29, 41, 76, 94, 224, *see also* NAT
 LGV, *see* lymphogranuloma venereum
 ligase chain reaction, *see* LCR
 local community representatives, inclusion of, 7
 lower abdominal pain syndrome, 52-54
 lumbar puncture, indications for, in syphilis, 119, 125, 132



lymphogranuloma venereum, 50, 159-160, *see also* genital ulceration
clinical presentation of, 50, 159
investigation of, 159
management of partners, 160
organism, 75, 159
treatment of, 159-160
 lymphoma, HIV and, 100

M

management of partners, *see* individual diseases
 meningitis, 82, 130, 224
 metronidazole
 bacteria vaginosis, for, 140(3), 141(2)
 non-specific urethritis, for, 164(2)
 PID, for, 168, 169(2)
 trichomoniasis, for, 179(7)
 miconazole, candidiasis and, 143
 minors, need to advise authorities about, 3, *see also* patient care, essentials of, *see also* child sexual abuse and STIs
molluscum contagiosum, 161-162
clinical presentation of, 161
investigation of, 161
management of partners, 162
organism, 161
treatment of, 161-162

N

NAT, 29, 30-38, 41-42, 224
 chancroid, for, 133
 chlamydia, for, 76-77, 81
 donovanosis for, 94-95
 genital herpes, for, 152 (3)
 gonorrhoea, for, 29, 82-84, 92(2)n
 syphilis, for, 116, 117
 needlestick injury, 113, 224, *see also* percutaneous exposure
 neonates, vi, 224
 gonorrhoea and, 87, 89(2)
 syphilis and, 130, 132, 219
 nerve deafness, tertiary syphilis, and, 115
 neurological disorders, tertiary syphilis, and, 114, 115
 neutrophils, 182, 224
non-notifiable infections, 2, 139-180, *see also* individual diseases
non-specific urethritis, 163-165
 cervicitis, and, 145, 165

clinical presentation of, 139, 163-164
 female equivalent of, and, 145, 165, *see also* urethral discharge,
investigation of, 164
management of partners, 165
treatment of, 164

notifiable diseases case definitions, 204-219

notifiable infections, 12-15, 75-138
 notification, requirements for, 12-13, 14-15
 HIV/AIDS, and, 12-13, 15
 NSU, *see* non-specific urethritis
 nucleic acid test, *see* NAT
 nurses in remote areas, 1

O

organisation of manual, 2
 outcomes in health care, 1

P

Pap smear, 21, 24, 33(3), 35(3), 148(2), 156, 158, 179
 PathWest, viii, 115, 224
 patient care, essentials of, 3
 patient support, contacts for, viii
patients' special needs, respect for, 4
 PCR, 24(7), 29, 37, 41, 76, 94(2), 224, 225, *see also* NAT
pelvic inflammatory disease, *see* PID
 pelvic peritonitis, *see* PID
 penicillin, benzathine, syphilis, treatment of, 121(2), 122, 131
 penicillin, benzyl, syphilis, treatment of, 122, 131
 penicillin, cephalosporins and, 86(2)n
 penicillin, procaine
 gonorrhoea, 88(2)
 reaction, 123, 225
 syphilis, treatment of, 121(2), 122(2), 123
 penicillin-resistance, 85, 121
 penicillin-resistant gonorrhoea, 64, 65, 92
 penicillinase, 92, 225
 percutaneous exposure, 197
 personality change, tertiary syphilis, and, 115
physical environment, 3,4, *see also* clinical management, general principles of
physical examination, 22-23, 24, 223
consent to, 22
 eye protection, during, 23



gloves, use of, and, 23
 interpreter, use of, and, 22
 posters, use of, and, 22
 self-obtained low vaginal swab and, 22
 vaginal examination, and, 22-23
 women, and, 22-23

PID, 166-170, 224
 cervicitis, and, 47
 chlamydia, and, 75(2), 79(2), 80, 81, 166
clinical presentation of, 52(2), 75(2), 82, 139, 167
definition of, 166
 gonorrhoea and, 82, 86, 89-90, 166(2)
investigation of, 53-54, 167
lower abdominal pain, and, 52-54
management of partners, 170
organisms, 166
treatment of, 54, 79(2), 86, 89, 90(2), 168-169

polymerase chain reaction *see* PCR
 practice policies, *see* clinical guidelines
 pregnancy, medicines in, vi-vii
 pregnant women, treatment of,
 bacterial vaginosis and, 141(3)
 candidiasis and, 144(3)
 cervicitis and, 146
 chlamydia and, 78
 ciprofloxacin, 56, 86, 87(4)
 donovanosis and, 96
 doxycycline and, 56, 78, 96, 122, 160, 169,
 genital herpes and, 154
 genital warts and, 158
 gonorrhoea and, 87
 lymphogranuloma venereum and, 160
 PID and, 169
 pubic lice and, 174(3)
 scabies and, 177(2)
syphilis and, 122, 128-129, 131
 tetracyclines contraindicated, in, 78, 96
 trichomoniasis and, 179(2)

prevention, *see* education and prevention:
see also counselling, *see also* individual
 diseases

primary syphilis, *see* syphilis
 privacy, 28
 probenecid
 gonorrhoea, for, 85(2)
 syphilis, for, 122

procaine reaction, 88, 123, 225
proctitis, acute, 43, 55-56, 225
prostatitis, 171, 225
clinical presentation of, 82, 163, 171
 gonorrhoea and, 82, 86, 89, 90
 investigation of, 165(2)
 NSU and, 163, 165(2)
treatment of, 86, 89, 90, 165, 171

pubic lice, 172-174
clinical presentation of, 172
investigation of, 173
management of partners, 174
organism, 172
treatment of, 173-174

pupillary abnormalities, tertiary syphilis,
 and, 115

R

rapid plasma reagin, *see* RPR
 rebound tenderness, 53(2), 225
 Reiter's syndrome, 75, 225
 relationships, long-term, monogamous,
 advantages of, 8

resources
contacts for specialist advice on STIs and HIV, viii
for patients, 201-203, 220

retesting, *see* follow-up
 retinal disease, tertiary syphilis, and, 115
 risk behaviour, *see* high-risk behaviour
 roxithromycin, 56
 lymphogranuloma venereum, for, 160
 non-specific urethritis, for, 164
 PID, for, 169(2)

RPR, 225,
 syphilis and, 116, 117(2), 118, 119,
 120, 123, 125-126, 129(4), 131(3)

S

safer sexual practices, education for, 8-9, 226 *see also* patient care, essentials
 of

salpingitis, 166, 226

scabies, 175-177, *see also* genital
 ulceration
clinical presentation of, 50, 175
organism, 175
investigation of, 176



- management of partners, 177
- treatment of, 176-177
- screening, community, 7-8
 - definition of, 7, 226
 - ownership of information, and, 8
 - principles for, 7-8
- screening, asymptomatic patients, of, 41-42
- screening, follow-up, 17
- screening, high-risk populations, for, 69-73
 - asymptomatic sexually active people who injected drugs, 71
 - asymptomatic young people, 70
 - current sex workers, 69
 - men who have sex with men, 72-73
- screening, opportunistic, 5-6
- secondary syphilis, *see* syphilis
- self-obtained low vaginal swabs, 5, 22, 36-37, 220
 - chlamydia and, 76
 - gonorrhoea and, 83
 - patient instruction for taking, 36-37, 220
- sex worker screening, STI testing recommendations, 69
- sexual history, 19-20
- sexual partners,
 - managing (contact tracing), 57-68, *see also* individual diseases
 - negotiating involvement of, 3
 - reducing numbers of, 9
- soft sore, *see* chancroid
- specialist advice, contacts for, viii
- specimen collection and examination, 27-39, *see also* clinical management, general principles of: laboratory investigations
- spectinomycin, gonorrhoea, for, 86
- swabs, (*key references only*), 29-38, 41-42, 44-46, 48
 - anal swabs, 34, 35, 42, 46, 48, 69, 72, 83(2)
 - self-obtained low vaginal, 5, 22, 36-37, 76, 83, 220
 - storage of, 36, 38, 77, 83
- syndromes, 43-56, 226
 - acute proctitis, 43, 55-56
 - genital ulceration, 43, 49-51
 - lower abdominal pain, 43, 52-54
 - urethral discharge/dysuria, 43, 47-49
- vaginal discharge, 43-47
- syphilis, 113-132
 - case definition of, 214-219
 - clinical presentation of, 113-116
 - congenital, 130-132, 216-219
 - contact tracing, 57-68, 124, *see also* contact tracing, principles of
 - genital ulceration and, 49, 50, 51
 - HIV, and, 127
 - immunosuppressed patients, and, 127
 - incubation period, of, 113
 - investigation of, 116-120
 - latent, presentation of, 114
 - management of partners, 124
 - notification of, 12, 14
 - organism, 113
 - pregnancy, during, 128-129
 - staging of, 114
 - tertiary, presentation of, 115-116
- syphilis, tests, for, 6, 116-120, 125-126, 128
 - congenital, 130
 - EIA, *see* EIA
 - follow-up and management, 125-126, 129, 132
 - FTA-Abs, *see* FTA-Abs
 - non-treponemal, 117, 119-120
 - PCR, *see* PCR
 - pregnancy, during, 128
 - RPR, *see* RPR
 - tests, choice of, 117-118,
 - tests, interpretation of, 118-119
 - TPHA, *see* TPHA
 - TPPA, *see* TPPA
 - treponemal, 117-118, 120
 - VDRL, *see* VDRL
- syphilis, treatment of, 121-123
 - congenital, 130-132
 - deliver, at, 129, 131
 - follow-up for, 125-126, 129, 132
 - genital ulcers, and 51(3)
 - Jarisch-Herxheimer reaction, in, 122, 128, 224
 - late latent, 114
 - penicillin, for, 121-123, 129(3), 131(3)
 - penicillin allergy, and, 122, 129
 - pregnancy, during, 129
 - primary, secondary and early latent, 114
 - procaine reaction, in, 123, 225
 - tertiary, 114



T

- tertiary syphilis, *see* syphilis
- test pack for diagnostic testing, 30-31
- tests, essential, 6, 27**
- tetracycline
 - in pregnancy, 78, 96
- tinidazole
 - bacterial vaginosis, for, 140(2)
 - non-specific urethritis, for, 164(2)
 - PID for, 168, 169
 - trichomoniasis, for, 179(2)
- titre, 125, 129, 131, 226
- TPHA, 117-120, 131, 226
- TPPA, 117-120, 131, 226
- treatment, *see* treatment of individual diseases, *see also* clinical management, general principles of
 - Treponema pallidum*, 113, *see also* syphilis
 - Treponema pallidum* haemagglutination test, *see* TPHA
 - Treponema pallidum* particle agglutination test, *see* TPPA
 - Trichomonas*, 45, 47, 164, 178, 226
- trichomoniasis, 178-180**
 - child sexual abuse and, 10
 - clinical presentation of, 178**
 - investigation of, 148, 178**
 - management of partners, 179**
 - organism, 178**
 - NSU, and, 164
 - PAP smear, and, 148
 - tests for, 6, 27, 39, 148, 178-179
 - treatment for, 46(2), 63, 179**
- vaginal discharge and, 43(3), 178

U

- urethral discharge (acute), 30(2), 43, 45, 47-49, *see also* individual diseases**
 - chlamydia, and, 75
 - epididymo-orchitis, and, 149
 - gonorrhoea, and, 29, 82
 - non-specific urethritis, 163
- urethral infection in women, 44
- urethritis, **47-49**, 227, *see also* individual diseases
- urine samples for diagnostic testing, 29, 34-35, **36**
- urticaria, 89, 227
- uveitis, tertiary syphilis, and 115

V

- vaginal discharge 43-47, 53(3), *see also* individual diseases**
 - cervicitis, and, 145
 - chlamydia, and, 75
- vaginal pH testing, 38-39**
- vaginitis, 39, 43-46, 178**
- valaciclovir, 56
 - genital herpes, for, 153(4)
- VDRL, 117(3), 214, 215, 216, 219(2), 227
- Veneral Diseases Research Laboratory, *see* VDRL
- viral hepatitis, 135-138, *see also* under hepatitis A, B or C**
 - case definitions, 206-208**
 - notification of, 12, 14**
- vulvitis, 143, 144, 178

W

- Western Blot, 103(3), 227
- window period, 18, 103(2), 227

