BC Centre for Disease Control
Provincial Health Services Authority

Certified Practice

DST 901 Care and Treatment Plan:
STI Contacts

This Care and Treatment Plan provides RN(C)s with clinical guidance for treatment of clients who are contacts to an STI and require treatment with schedule 1 medications. STIs described in both the certified practice and non-certified practice DSTs are included in this Care and Treatment Plan.

Refer to the corresponding infection-specific Care and Treatment Plan and/or non-certified practice STI DST to ensure the client has received the recommended sexual health history/risk assessments, education and, if appropriate, screening. For symptomatic clients who are contacts to an STI, refer to the appropriate Care and Treatment Plans to determine if consultation with or referral to a physician or nurse practitioner (NP) is required based on DST recommendations, assessment, and diagnostic findings.

Consultation with or referral to a physician or NP is required for all pregnant clients and may be required for breast/chestfeeding clients depending upon the recommended treatment. Refer to the specific Care and Treatment Plan for further information.

The *Care and Treatment Plans* are not indicated for clients who are less than 12 years old. RN(C)s must follow the PHSA Pelvic Exam DST (indicated for clients aged 14 years and up) when providing STI care (see the Assessment and Diagnostic DST: STI for further screening and treatment recommendations). Clients 12-13 years of age who are symptomatic require consultation with or referral to a physician or NP.

Definition

The process of offering testing and treatment to the sexual contacts of a person diagnosed with an STI or STI syndrome.

Potential Causes

Bacterial:

- Neisseria gonorrhoeae (GC)
- Chlamydia trachomatis (CT)
- Bacterial Vaginosis (BV)
- Treponema pallidum (syphilis)

Protozoan:

- Trichomonas vaginalis (TV)

Syndromes:

- Urethritis
- Mucopurulent cervicitis (MPC)
- Pelvic inflammatory disease (PID)
- Epididymitis
- Proctitis

Predisposing Risk Factors

- Sexual contact with someone with an STI
- Vaginal, anal, or oral sexual contact

Assessment

Offer full comprehensive STI assessment and screening. If declined, provide treatment appropriate to the type of contact and/or symptoms.

Sexual Health History

- Complete a sexual health history and risk assessment – typical findings include:
    - Sexual contact with at least one partner
    - Identified as a sexual contact to someone with confirmed positive laboratory test for STI
    - Identified as a sexual contact to STI syndrome (e.g., urethritis NYD)

Physical Assessment

- Offer focused physical assessment
- If symptoms present, refer to *DST 900: Assessment and Diagnostic Guideline: STI* and the corresponding *Care and Treatment Plan* for more information, and consult with or refer to physician or NP as needed

Diagnostic Tests

- Provide screening and diagnostic testing for STI contact based on the type of exposure and presenting symptoms (*see DST 900: Assessment and Diagnostic Guideline: STI*)

Management and Interventions

Goals of Treatment

- Treat potential infection
- Prevent potential complications due to untreated or undiagnosed infections
- Prevent the spread of infection

Treatment of Choice for STI Contacts

The treatment required for an STI contact may differ from treatment provided for the index case. When recommended treatment for the contact is the same as the index, refer to the specific Care and Treatment Plan for information regarding treatment options including pharmaceutical and therapeutic suitability.

STI or Syndrome	Contact Management and Trace Back Period	Treatment or Contact	Notes
Bacterial Vaginosis (BV)	• Offer assessment to all applicable contacts • Treatment of male contacts is not indicated and does not prevent recurrence	See *DST 904: Care and Treatment Plan: Bacterial Vaginosis (BV DST).*	1. There may be an increased incidence of concordant BV infection in sexual partnering and/or sexual behaviours where BV could flourish. 2. Where relevant, sexual partners of people diagnosed with BV may benefit from assessment and testing for BV. If clinical assessment and/or lab testing results are positive for BV, then treat as per *the DST 904: Care and Treatment Plan: Bacterial Vaginosis* 3. Refer to the *DST 904: Care and Treatment Plan: Bacterial Vaginosis* for client education, screening recommendations, alternate treatments, and further medication information.

STI or Syndrome	Contact Management and Trace Back Period	Treatment or Contact	Notes
Chlamydia (CT)	60 days • Test and treat all contacts in the last 60 days • If there are no sexual contacts in the last 60 days, then recommend testing and treatment for the last sexual contact	See *DST 908: Care and Treatment Plan: Chlamydia Trachomatis (CT DST).*	1. Advise to abstain from sexual activity during the 7-day course of treatment or for 7 days 2. *Refer to the DST 908: Care and Treatment Plan: Chlamydia Trachomatis* for client education, screening recommendations, alternate treatments, and further medication information.
Lympho-granuloma venereum (LGV)	60 days • Test and treat all contacts in the last 60 days • If there are no sexual contacts in the last 60 days, then recommend testing and treatment for the last sexual contact	**First Choice:** Doxycycline 100mg PO BID for 21 days **Alternate Choice:** Consult with or refer to physician or NP.	1. Empiric LGV treatment is recommended for all partners of confirmed or probable cases. Completion of treatment is recommended regardless of results 2. Contacts should abstain from sexual activity for 7 days after initiation of treatment. 3. Testing of all exposed sites (e.g., throat, suspicious lesions, urine, vagina, cervix, rectum) is recommended. Indicate "contact to LGV" on requisition. 4. Consult with or refer to physician or NP if client is symptomatic, and all confirmed cases 5. For confirmed LGV cases, please contact the Provincial STI Clinic's syphilis/LGV nursing desk (604.707.5607) for further management

Gonorrhea (GC)	60 days • Test and treat all contacts in the last 60 days • If there are no sexual contacts in the last 60 days, then recommend testing and treatment for the last sexual contact	**First Choice:** Cefixime 800mg PO in a single dose, and Azithromycin 1gm PO in a single dose OR Ceftriaxone 250mg IM in a single dose, and Azithromycin 1gm PO in a single dose **Second Choice:** Cefixime 800mg PO in a single dose, and Doxycycline 100mg PO BID for 7 days OR Ceftriaxone 250mg IM in a single dose, and	**General:** 1. Treatment covers both gonorrhea and chlamydia 2. *Canadian Guidelines on STI* (CGSTI, PHAC, 2013) recommend ceftriaxone IM and azithromycin PO for the treatment of uncomplicated anogenital and pharyngeal infection; however, BC surveillance patterns of GC resistance suggest that both cefixime and ceftriaxone are appropriate choices for the treatment of GC 3. Future GC Treatment regimens will continue to reflect national recommendations in association with local GC antimicrobial resistance trends (AMR) trends. 4. Retreatment is indicated if the client has missed 2 consecutive doses of doxycycline or has not completed a full 5 days of treatment. 5. Consult a physician or NP if client is unable to use cefixime, ceftriaxone, or azithromycin *6.* See *BCCDC STI Medication Handout* for further medication reconciliation and client information 7. See *Monitoring and Follow-up* section for test-of-cure (TOC) requirements. **Allergy and Administration:** 1. DO NOT USE ceftriaxone or cefixime if history of allergy or anaphylaxis to cephalosporins. Consult with or refer

		Doxycycline 100mg PO BID for 7 days **Third Choice** Azithromycin 2gm PO in a single dose	to a physician or NP if history of anaphylaxis or immediate reaction to penicillin. 2. DO NOT USE azithromycin if history of allergy to macrolides. 3. DO NOT USE doxycycline if pregnant and/or allergic to doxycycline or other tetracyclines. 4. If an azithromycin or doxycycline allergy or contraindication exists, consult with/refer to a physician or NP for alternate treatment. 5. Azithromycin and doxycycline are sometimes associated with gastrointestinal adverse effects. Taking medication with food and plenty of water may minimize adverse effects 6. The preferred diluent for ceftriaxone IM is 0.9ml lidocaine 1% (without epinephrine) to minimize discomfort 7. DO NOT USE lidocaine if history of allergy to lidocaine or other local anaesthetics. Use cefixime PO as alternate treatment 8. For IM injections of ceftriaxone the ventrogluteal site is preferred 9. Advise client to remain in the clinic for at least 15 minutes post-IM injection in case of anaphylactic reaction to treatment. Provide anaphylaxis treatment as required, using BCCDC Immunization Manual-

			Section V: Management of Anaphylaxis in a Non-Hospital Setting (April 2023) 10. If serious allergic reaction develops including difficulty breathing and/or severe itchiness, have the client inform clinic staff immediately. If symptoms develop after leaving the clinic, advise the client to seek immediate emergency care 11. Advise client they may experience pain redness and swelling at the injection site. If any of these effects persist or worsen advise to contact health care provider 12. Recent data has emerged regarding azithromycin and QT prolongation. Although rare, it is more significant in older populations, those with pre-existing heart conditions, arrhythmias, or electrolyte disturbances. It is unclear how significant these findings are in young to mid-age healthy adults consuming a one-time dose of azithromycin; however, please use the following precautions: • Consult with or refer to an NP or physician if the client: ○ Has a history of congenital or documented QT prolongation ○ Has a history of electrolyte disturbance in particular hypokalemia, hypomagnesaemia

STI or Syndrome	Contact Management and Trace Back Period	Treatment or Contact	Notes
			○ Has clinically relevant bradycardia, cardiac arrhythmia, or cardiac insufficiency ○ Is on any of the following medications: ▪ Antipsychotics: pimozide (Orap®), ziprasidone (Zeldox®) ▪ Cardiac: dronedarone (Multaq®) ▪ Migraine: dihydroergotamine (Migranal®), ergotamine (Cafergot®) 13. Refer to *DST 906: Care and Treatment Plan: Gonorrhea* for client education screening recommendations, alternate treatments and further medication information
Epididymitis Mucopurulent Cervicitis (MPC) Inflammatory Disease (PID) Proctitis	60 days • Test and treat all contacts in the last 60 days • If no sexual contacts in the last 60 days then testing and treatment of the last sexual contact is recommended	See the *Treatment for Contacts to Gonorrhea* section within this DST.	1. Treatment covers potential gonorrhea and chlamydia infection 2. See *Notes* section under *Contacts to Gonorrhea* section within this *Care and Treatment Plan*. 3. Refer to the relevant DST (e.g., *Epididymitis DST, MPC DST, PID DST, Proctitis DST*) for client education, screening recommendations, alternate treatments, and further medication information.

<table>
<tr>
<td>Early Syphilis:
Primary Syphilis
Secondary Syphilis
Early Latent Syphilis (asymptomatic infection of < one year's duration)</td>
<td>For contacts to Primary Syphilis:
• Test and treat all contacts within last 90 days
For contacts to Secondary Syphilis
• Test all contacts within last 6 months
• Test and treat all contacts within last 90 days
For contacts to Early Latent Syphilis:
• Test all contacts within last 12 months or as directed by BCCDC physician
• Test and treat all contacts within 90 days</td>
<td>First Choice:
Benzathine penicillin G (Bicillin LA®) 2.4 MU prepared as 2 separate intramuscular injections (IM) 1.2 MU each

Second Choice:
*Consider for clients with penicillin allergy or who require alternate treatment (e.g., Bicillin L.A.® is unavailable and client follow-up is not assured).</td>
<td>General:
1. Contact the BCCDC CPS STI nurse responsible for contact follow-up strategy. Syphilis case management is centralized through the BCCDC.
2. Advise clients to abstain from sexual contact for the duration of oral therapy or for 14 days post-treatment for single-dose therapy.
3. If syphilis serology confirms infection, refer to Syphilis DST and contact the BCCDC CPS STI nurse responsible for syphilis contact follow-up strategy.
4. If the client declines treatment and initial testing is negative, repeat syphilis screening in 3 months.
5. Refer to the Syphilis DST for client education, screening recommendations, alternate treatments and further medication information.
Allergy and Administration:
1. DO NOT USE Bicillin LA® if history of allergy, anaphylaxis or immediate reaction to penicillin
2. Administer Bicillin LA® into the ventral (preferred) or dorsal gluteal sites on the same visit, at 2 separate sites. (See here)</td>
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STI or Syndrome	Contact Management and Trace Back Period	Treatment or Contact	Notes
		Doxycycline 100mg PO BID for 14 days	3. Provide client education about the potential for a Jarisch Herxheimer reaction which may occur soon after treatment and is expected to resolve within 24 hours. This is not a sign of drug allergy. 4. If syphilis serology confirms infection, refer to Syphilis DST and contact the BCCDC CPS STI nurse responsible for syphilis contact follow-up strategy. Syphilis case management is centralized in BC through the BCCDC 5. Refer to the *Syphilis DST* for client education, screening recommendations, alternate treatments, and further medication information.
Late Latent Syphilis (asymptomatic infection > one year's duration)	Test (do not treat) contacts to latent syphilis • All long-term sexual contacts, and • Children whose mother has a late latent syphilis diagnosis	Treat only if serology is reactive.	
Trichomoniasis	60 days • Treat all contacts in the last 60 days • Testing is also offered to certain contacts within the past 60 days as per the *Trichomoniasis DST* • If no sexual contacts in the last 60 days then recommend treatment of the last sexual contact	See *DST 909: Care and Treatment Plan: Trichomoniasis*	1. Advise to abstain from sexual contact until completion of multi-dose treatment or for 7 days after single-dose therapy 2. Refer to the *DST 909: Care and Treatment Plan: Trichomoniasis* for client education, screening recommendations, alternate treatments and further medication information.

STI or Syndrome	Contact Management and Trace Back Period	Treatment or Contact	Notes
Urethritis-Presumptive Gonorrhea	60 days • Test and treat all contacts case in the last 60 days • If no sexual contacts, then testing and treatment of the last sexual contact is recommended	See *Treatment for Contacts to Gonorrhea* section within this DST.	1. Treatment covers potential gonorrhea and chlamydia infection. 2. See Notes section under Contacts to Gonorrhea section within this DST. 3. Refer to the *DST 906: Care and Treatment Plan: Gonorrhea* for client education, screening recommendations, alternate treatments, and further medication information
Non-gonococcal Urethritis (NGU)	60 days • Test and treat all contacts in the last 60 days • If no sexual contacts then testing and treatment of the last sexual contact is recommended	See *Treatment for Contacts to Chlamydia* section within this DST.	1. Treatment covers potential chlamydia infection 2. See Notes section under Contacts to Chlamydia section within this DST. 3. Refer to the *DST 908: Care and Treatment Plan: Chlamydia Trachomatis* for client education, screening recommendations, alternate treatments, and further medication information

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Client Education

Counsel client regarding:

- Returning for follow-up assessment if symptoms occur
- The appropriate use of medications (dosage, side effects, and need for re-treatment if dosage not completed, or symptoms do not resolve)
- Avoiding sexual contact until treatment is completed as indicated in the treatment table
- Harm reduction (condom use significantly reduces the risk of transmission)
- Cleaning sex toys between use and using condoms if sharing sex toys
- The benefits of routine STI screening
- The potential complications of untreated STI
- Co-infection risk for HIV when another STI is present
- The asymptomatic nature of STI

Documentation

As per agency policy

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