Infection	First line treatment	
Bacterial Vaginosis	Metronidazole 400 mg orally, 12-hourly with food for five days OR metronidazole 2 g orally, as a single dose (less effective) OR metronidazole gel 0.75% gel 5 g, nocte for five nights (not on PBS) OR tinidazole 2 g orally, as a single dose with food OR clindamycin 2% vaginal cream 5 g, daily for seven days (not on PBS) OR clindamycin 300 mg orally, 12-hourly for seven days (not on PBS).	**Incubation period** Unknown **Requires notification** No **Usual testing method** Microscopy of a vaginal smear.
Candidiasis	Any of the available imidazole preparations are effective, either as cream or pessaries. Various preparations are available for either single dose therapy, or three to seven days of therapy.	**Incubation period** Indefinite. *C. albicans* is usually normal flora **How far back to contact trace** Only current regular partner/s if recurrent symptoms **Requires notification** No **Usual testing method** Microscopy or culture of vaginal swab.
Chancroid	Single dose directly observed therapy is preferred. Azithromycin 1 g orally, as a single dose OR ceftriaxone 500 mg in 2 mL 1% lignocaine intramuscularly OR ciprofloxacin 500 mg orally, 12-hourly for three days.	**Incubation period** 6 days to 2 weeks **How far back to contact trace** 2 weeks before ulcer appeared or since arrival from endemic area **Requires notification** Yes **Usual testing method** Usually clinical in resource poor settings. NAAT is ideal.
Genital Herpes	**First episode** Valaciclovir 500 mg orally, 12-hourly for five to ten days OR aciclovir 200 mg orally five times daily for five to ten days. **Episodic** Episodic treatment is indicated for infrequent recurrences (i.e. intervals of more than six to eight weeks). Short courses of three to five days duration of valaciclovir, famciclovir or aciclovir should be initiated early on by the patient at the first sign of prodrome or very early lesions. **Suppressive** Suppressive therapy is indicated in significant, frequent disease. Valaciclovir, famciclovir, aciclovir on a daily basis can reduce severity and frequency of outbreaks.	**Incubation period** Often unknown **How far back to contact trace** Not necessary but current/ future partners may benefit from education on transmission **Requires notification** No **Usual testing method** Swab lesion for HSV/syphilis NAAT and donovanosis in high prevalence regions.
Genital Warts	**Not pregnant** Podophyllotoxin paint (0.5%) (not on PBS) or cream (0.15%) topically twice daily for three days, do not treat for four days. Repeat for up to four weeks OR imiquimod 5% cream topically, three times a week for up to 16 weeks (not on PBS). **Pregnant** Cryotherapy: apply liquid nitrogen to visible warts weekly until resolution occurs OR surgical ablative therapy for large or extensive lesions.	**Incubation period** Commonly 3–6 months but often much longer **How far back to contact trace** Consider current partner(s) **Requires notification** No **Usual testing method** Clinical diagnosis. Always screen for other STIs.

Infection	First line treatment	
HIV	**Treatment** Initial HIV assessment and staging should be done by an HIV/ Sexual Health specialist and ideally followed by shared care with a general practitioner. Contact Clinical Immunology at Royal Perth Hospital on 08 9224 2899, or the Infectious Diseases Department at Fiona Stanley Hospital on 08 6152 6744 or 6152 6745. **Pre-exposure prophylaxis** Pre-exposure prophylaxis (PrEP) is an important new prevention option and can provide highly effective biomedical prevention of HIV in HIV-negative individuals. See the National PrEP Guidelines at www.arv.ashm.org.au/arv-guidelines/prep-resources-for-clinicians and WA's Interim PrEP Gudelines at www.health.wa.gov.au/circularsnew/circular.cfm?Circ_ID=13251 for more information. **Post-exposure prophylaxis** Non-occupational post-exposure prophylaxis (NPEP) is a course of antiretroviral drugs (e.g. Truvada® [300 mg Tenofovir and 200 mg Emtricitabine] once daily for four weeks) that should be commenced as soon as possible (and definitely within 72 hours), following exposure to HIV. NPEP may help reduce the risk of HIV transmission after unsafe sex, sharing of injecting equipment or a needle-stick injury when it is known or likely that there has been a high risk of exposure. For more information, see the Department of Health's operational directive *Protocol for non-occupational post-exposure prophylaxis (NPEP) to prevent HIV in Western Australia at* www.health.wa.gov.au/circularsnew/circular.cfm?Circ_ID=12318. Patients who identify themselves as having had a high risk exposure to HIV may also call the NPEP telephone line or 'PEP line' on 1300 767 161.	**Incubation period** 1-12 weeks **How far back to contact trace** At least 12 weeks before a confirmed primary HIV illness. If the date of primary infection cannot be confirmed, the trace-back period may be years, depending on the patient's history of risk behaviour and clinical presentation. **Requires notification** Yes **Usual testing method** Serology, initial enzyme immunoassay (EIA), positive results are confirmed by a Western Blot assay

Help with contact tracing

Health care providers can obtain further information about contact tracing from:
http://ww2.health.wa.gov.au/Silver-book/Contact-tracing-managing-sex-partners

Regional public health units:

Goldfields (Kalgoorlie-Boulder) 9080 8200

Great Southern (Albany) 9842 7500

Kimberley (Broome) 9194 1630

Midwest/Gascoyne (Carnarvon) 9941 0500

Midwest (Geraldton) 9956 1985

Pilbara (South Hedland) 9174 1660

Southwest (Bunbury) 9781 2350

Wheatbelt (Northam) 9622 4320

Perth:

Metropolitan Communicable Disease Control 9222 8588

For more information go to: www.silverbook.health.wa.gov.au OR phone: South Terrace Clinic – 9431 2149
Royal Perth Hospital Sexual Health Clinic – 9224 2178

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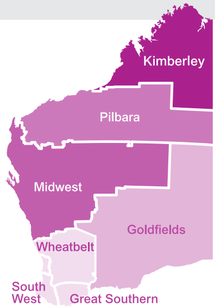
Government of **Western Australia**
Department of **Health**

Quick guide to **STI management**

2017

health.wa.gov.au

Infection	First line treatment	
Chlamydia	**Adults** Azithromycin 1 g orally, as a single dose (preferred treatment) OR doxycycline 100 mg orally, 12-hourly for seven days (LGV see Silver Book, section 2.6.4). **Children 0-8 years** Azithromycin 10 mg/kg (to a maximum of 1 g) orally, daily for five days (restricted PBS availability) OR erythromycin 10 mg/kg per day orally, in four doses for 10-14 days. **Children > 8 years** Azithromycin 20 mg/kg (to a maximum of 1 g) orally, as a single dose OR doxycycline 100 mg orally, 12-hourly for seven days. **Pregnant women** Azithromycin 1 g orally, as a single dose (category B1) (preferred option) OR erythromycin ethyl succinate 800 mg orally, 12-hourly for 10 days (category A) OR erythromycin base 250 mg orally, six-hourly for 14 days (category A). Use ZAP pack for empirical treatment of uncomplicated infections contracted in the Goldfields, Kimberley or Pilbara regions of WA***	**Incubation period** > 2 days–2 months for male urethral infection, though many remain asymptomatic. Most cervical infections in women and anal infections in men and women remain asymptomatic **How far back to contact trace** According to symptoms or sexual history; usually up to 6 months **Requires notification** Yes **Usual testing method** NAAT* of vaginal, cervical, anal, throat swab, or first void urine.**
Gonorrhoea	**Treating:** **a. uncomplicated gonorrhoea contracted in the Perth metropolitan area; Great Southern, South West and Wheatbelt regions of WA; interstate; overseas; or where place of acquisition is not known.** **OR** **b. anorectal or pharyngeal gonorrhoea** **Adults** • ceftriaxone 500 mg in 2 mL 1% lignocaine intramuscularly AND • azithromycin 1 g (oral), given together as a single treatment. **Children** • ceftriaxone 50 mg/kg (maximum 500 mg) intramuscularly (using the adult dilution) AND • azithromycin 20 mg/kg (oral tablet or syrup) to a maximum of 1 g (oral), given together as a single treatment. **Treating uncomplicated gonorrhoea contracted in the Goldfields, Kimberley or Pilbara regions of WA.***** **Adults** • amoxycillin 3 g orally AND • probenecid 1 g orally, given together as a single treatment **Children, weighing <45kg** • amoxycillin 50 mg/kg orally AND • probenecid 25 mg/kg orally, given together as a single treatment. Use ZAP pack for empirical treatment of uncomplicated infections contracted in the Goldfields, Kimberley or Pilbara regions of WA***.	**Incubation period** 2–10 days for male urethral infection; occasionally weeks to months. Most cervical, anal and throat infections are asymptomatic **How far back to contact trace** Minimum 2 months - consider up to 6 months **Requires notification** Yes **Usual testing method** Culture (any site) or NAAT (genital, anal, or throat swabs or urine). When delays of greater than 24 hours occur in getting the specimen to a laboratory (eg in rural and remote areas) NAAT is the preferred test. However, where there is pus, a swab for culture and antibiotic resistance testing should still be sent.



Infection	First line treatment	
Urethritis/ Cervicitis	Manage as for chlamydia and also gonorrhoea in areas where this is common.	
Syphilis	**Penicillin** remains the drug of choice. If there is any doubt about the clinical stage of the patient's infection, treat as for late latent syphilis. **Primary, secondary and early latent syphilis (up to 24 months)** Benzathine penicillin 1.8 g intramuscularly, as a single dose OR procaine penicillin 1 g for patients less than 60 kg bodyweight and 1.5 g for patients over 60 kg bodyweight intramuscularly, daily for 10 consecutive days. *If allergic to penicillin* - doxycycline 100 mg orally, 12-hourly for 14 days. **Late latent syphilis (more than 24 months)** Benzathine penicillin 1.8 g intramuscularly, once weekly for three doses. If treatment is missed for more than two weeks, must restart OR procaine penicillin 1 g for patients less than 60 kg bodyweight and 1.5 g for patients over 60 kg bodyweight, intramuscularly, daily for 15 days. *If allergic to penicillin* - doxycycline 100 mg orally, 12-hourly for 28 days.	**Incubation period** 9 days–3 months (mean 1 month) to primary syphilis; 1–5 months to secondary syphilis; usually 5–35 years to tertiary syphilis **How far back to contact trace** Primary syphilis - 3 months plus duration of symptoms Secondary syphilis - 6 months plus duration of symptoms Early latent syphilis - 12 months **Requires notification** Yes **Usual testing method** Serology. Ulcer swab can be tested by NAAT.
Pelvic Inflammatory Disease	Begin treatment early. Delayed treatment is associated with a significantly increased risk of tubal infertility or ectopic pregnancy. Rest. Use non-steroidal anti-inflammatory for pain relief Prevent any *Candida* infection with pessaries during the treatment period. Sexually acquired PID - Immediate treatment. Azithromycin 1 g orally, as a single dose PLUS ceftriaxone 500 mg in 2 mL 1% lignocaine intramuscularly, as a single dose. For mild to moderate infection (outpatient treatment) After the immediate treatment above, **continue with:** doxycycline 100 mg orally, 12-hourly for two weeks OR a second dose of azithromycin 1 g seven days later (where compliance is thought to be an issue) PLUS either metronidazole 400 mg orally, 12-hourly for two weeks OR tinidazole 500 mg orally, daily for two weeks. Consider admission if: • diagnosis uncertain • surgical emergency - appendicitis or ectopic pregnancy • pelvic abscess • severe illness or no response to outpatient medicine • no clinical follow-up • cannot take therapy. Patient to avoid sexual intercourse until they are non-infectious and symptomatically better. For pregnant/breastfeeding women or inpatient management see ww2.health.wa.gov.au/Silver-book/Notifiable-infections/Syphilis.	**Incubation period** Often several months **How far back to contact trace** According to sexual history, up to 6 months **Requires notification** No **Usual testing method** Clinical diagnosis, may be reinforced by detection of chlamydia or gonorrhoea in the patient or her contact **RULE OUT Pregnancy.**

Infection	First line treatment	
Viral Hepatitis A	No antiviral therapy available. **Post-exposure prophylaxis:** Within two weeks of sexual exposure, recommend monovalent hepatitis A vaccine contacts >=1 year old who are not immunosuppressed, who do not have chronic liver disease, and for whom vaccine is not contraindicated. Normal human immunoglobulin (NHIG) 160 mg/mL, within two weeks of sexual exposure, is recommended for contacts who are <1 year old, or are immunosuppressed, or have chronic liver disease, or for whom vaccine is contraindicated. **Weight NHIG Dose** **Under 25 kg** - 0.5 mL **25–50 kg** - 1 mL **Over 50 kg** - 2 mL	**Incubation period** 3 weeks (range 2–7 weeks) **How far back to contact trace** Up to 7 weeks from onset of symptoms **Requires notification** Yes **Usual testing method** Serology (HAV IgM positive).
Viral Hepatitis B	Acute infection does not usually require treatment. **Post-exposure prophylaxis** Percutaneous contacts should be given hepatitis B immunoglobulin (HBIG) 400 IU intramuscularly, as a single dose within 72 hours of exposure. Individuals sexually exposed should be given HBIG 400 IU intramuscularly and vaccine within two weeks of sexual contact for maximum protection. If more than two weeks vaccination should still be commenced. Hepatitis B vaccination and immunoglobulin can be given at the same time, but at different sites.	**Incubation period** 10 weeks (range 1–6 months) **How far back to contact trace** Up to 6 months prior to index case developing symptoms; if asymptomatic according to risk history **Requires notification** Yes **Usual testing method** Serology (HBsAg positive).
Viral Hepatitis C	Directly-acting antiviral drugs are highly effective in curing hepatitis C (>95% cure rate) and are available on the PBS. GPs and other medical practitioners experienced in the treatment of chronic hepatitis C infection are eligible to independently prescribe hepatitis C treatment under the PBS without consulting an infectious diseases physician, hepatologist or gastroenterologist. Medical practitioners NOT experienced in the treatment of chronic hepatitis C infection may initiate hepatitis C treatment in consultation with an infectious diseases physician, hepatologist or gastroenterologist by submitting a remote consultation request for initiation of Hepatitis C treatment form (see ww2.health.wa.gov.au/Silver-book/Notifiable-infections/Hepatitis-C). All patients with evidence of cirrhosis should be referred to an infectious diseases physician, hepatologist or gastroenterologist for hepatitis C treatment.	**Incubation period** 7 weeks (range 2 weeks–5 months) **How far back to contact trace** Contact tracing not generally carried out for all HCV cases **Requires notification** Yes **Usual testing method** Serology (HCV antibody positive). HCV-PCR test to confirm active infection.
Trichomoniasis	Metronidazole 2 g orally, as a single dose OR tinidazole 2 g orally, as a single dose with food OR metronidazole 400 mg orally, 12-hourly for five days.	**Incubation period** Days to weeks. May remain asymptomatic indefinitely **How far back to contact trace** Recent months: easily contactable partners only **Requires notification** No **Usual testing method** Microscopy or specific culture of vaginal swab (if available). NAAT becoming available.

*** NAAT = Nucleic Acid Amplification Test (e.g. PCR)**
****First void urine to detect STIs is first 20 mL of urine passed, collected at any time of the day**
*****The standard treatment for uncomplicated chlamydia and gonorrhoea contracted in the Goldfields, Kimberley or Pilbara regions of WA is a ZAP pack, which contains azithromycin 1 g, amoxicillin 3 g, probenecid 1 g and a patient advice sheet. Please see the WA HIV/STI control supplement for endemic regions www.silverbook.health.wa.gov.au. For more information on contact tracing recommendations view the *Australasian Contact Tracing Guidelines* at www.contacttracing.ashm.org.au**