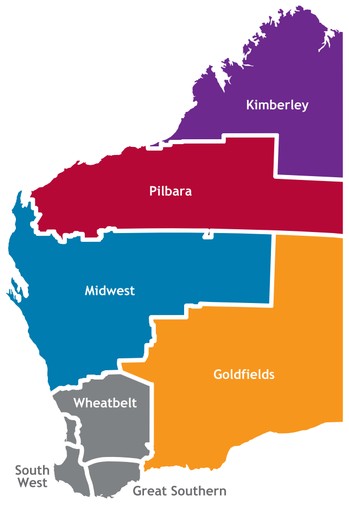
Infection	First line treatment	
Bacterial Vaginosis	Metronidazole 400 mg orally, 12-hourly with food for five days OR metronidazole 2 g orally, as a single dose (less effective) OR metronidazole gel 0.75% gel 5 g, nocte for five nights (not on PBS) OR tinidazole 2 g orally, as a single dose with food 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.
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.	**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 Herpes (recurrent) (see Silver Book, section 3.6.4. for details of suggested episodic and suppressive therapy regimens)	**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.	
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	
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, Pilbara or Midwest 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 Endemic Regions STI/HIV Control Supplement – http://silverbook.health.wa.gov.au**

For more information on contact tracing recommendations order the *Australasian Contact Tracing Guidelines 4th Edition* (2010) at http://www.ashm.org.au/publications

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Australasian Society for HIV Medicine

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

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

Quick reference to STI management

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, Pilbara or Midwest 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 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, Pilbara or Midwest 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, Pilbara or Midwest regions of WA***.	**Incubation period** 2–10 days for male urethral infection; occasionally weeks to months. Most cervical, anal and throat infections remain 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 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.

● **HIV - Initial assessment and staging should be done by an HIV / Sexual Health specialist ideally involving shared care with the General Practitioner.**
Contact Clinical Immunology (HIV only), Royal Perth Hospital 9224 2899 Or Infectious Diseases Department, Fremantle Hospital 9431 2149 in the first instance
How far back to contact trace: can be years, seek expert advice.

Infection	First line treatment	
Urethritis/ Cervicitis	Manage as for chlamydia and also gonorrhoea in areas where this is common.	
Donovanosis	Azithromycin 1 g orally directly observed therapy, weekly for four weeks or until healing occurs (whichever is longer) (preferred treatment because of much greater compliance) OR azithromycin 500 mg orally directly observed therapy, daily for seven days only.	**Incubation period** Weeks to months **How far back to contact trace** Weeks to months according to sexual history **Requires notification** Yes **Usual testing method** Clinical, histology of a shave biopsy, or (if available) NAAT of a lesion swab.
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.
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.
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).

Infection	First line treatment	
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	Treatable using pegylated interferon and ribavirin. No specific prophylaxis or vaccine is available for HCV.	**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.
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 Silver Book, section 3.10.5.	**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.**