TREATMENT OF STI CONTACTS

This decision support tool (DST) provides RN(C)s1 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 DST.

Refer to the corresponding infection-specific certified 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 STI DST 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-/chest-feeding clients depending upon the recommended treatment. Refer to the specific STI DST for further information.

BCCNP STI DSTs are not indicated for clients who are less than 12 years old and RN(C)s must follow the PHSA Pelvic Exam DST (indicated for clients aged 14 years and up) when providing STI care (see the STI Assessment DST 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.

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1 Note: RN(C) is an authorized title recommended by BCCNP that refers to BCCNP-certified RNs, and is used throughout this Decision Support Tool (DST).

The DSTs are not intended to replace the RN(C)'s professional responsibility to exercise independent clinical judgment and use evidence to support competent, ethical care. The RN(C) must consult with or refer to a physician or nurse practitioner as appropriate, or whenever a course of action deviates from the DST.
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

STI CONTACT ASSESSMENT

Offer full comprehensive STI assessment and screening. If declined, provide treatment appropriate to the type of contact and/or symptoms. See the *STI Assessment DST* for further information.

**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 the corresponding STI DST, and consult with or refer to physician or NP as needed

SCREENING DIAGNOSTIC TESTS

- provide screening and diagnostic testing for STI contact based on the type of exposure and presenting symptoms

MANAGEMENT AND INTERVENTIONS

Goals of Treatment

- treat potential infection
- prevent potential complications due to untreated or undiagnosed infection
- 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 STI DST for information regarding treatment options including pharmaceutical and therapeutic suitability.

<table>
<thead>
<tr>
<th>STI or Syndrome</th>
<th>Contact Management and Trace Back Period</th>
<th>Treatment of Contact</th>
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</table>
| Bacterial Vaginosis (BV) | • offer assessment to all applicable contacts  
• treatment of male contacts is not indicated and does not prevent recurrence | See Bacterial Vaginosis 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 BV DST.  
3. Refer to the BV DST for client education, screening recommendations, alternate treatments and further medication information. |
| 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 Chlamydia DST. | 1. Advise to abstain from sexual activity during the 7-day course of treatment or for 7 days post-single-dose therapy.  
2. Refer to the CT DST for client education, screening recommendations, alternate treatments and further medication information. |
<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>Lymphogranuloma venereum (LGV)</td>
<td>60 days</td>
<td>First Choice: doxycycline 100 mg PO BID for 21 days</td>
<td>1. Empiric LGV treatment is recommended for all partners of confirmed or probable cases. Completion of treatment is recommended regardless of results.</td>
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<td>Alternate Choice: Consult with or refer to physician or NP.</td>
<td>2. Contacts should abstain from sexual activity for 7 days after initiation of treatment.</td>
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<td>First Choice: doxycycline 100 mg PO BID for 21 days</td>
<td>3. Testing of all exposed sites (e.g., throat, suspicious lesions, urine, vagina, cervix, rectum) is recommended. Indicate “contact to LGV” on requisition.</td>
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<tr>
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<td>Alternate Choice: Consult with or refer to physician or NP.</td>
<td>4. Consult with or refer to physician or NP if client is symptomatic, and all confirmed cases.</td>
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<tr>
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<td>First Choice: doxycycline 100 mg PO BID for 21 days</td>
<td>5. For confirmed LGV cases, please contact the Provincial STI Clinic’s syphilis/LGV nursing desk (604.707.5607) for further management.</td>
</tr>
<tr>
<td>Gonorrhea (GC)</td>
<td>60 days</td>
<td>First Choice: cefixime 800 mg PO in a single dose and azithromycin 1 gm PO in a single dose OR ceftriaxone 250 mg IM in a single dose and azithromycin 1 gm PO in a single dose</td>
<td>General:</td>
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<tr>
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<td>First Choice: cefixime 800 mg PO in a single dose and azithromycin 1 gm PO in a single dose OR ceftriaxone 250 mg IM in a single dose and azithromycin 1 gm PO in a single dose</td>
<td>1. Treatment covers both gonorrhea and chlamydia.</td>
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<tr>
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<td>First Choice: cefixime 800 mg PO in a single dose and azithromycin 1 gm PO in a single dose OR ceftriaxone 250 mg IM in a single dose and azithromycin 1 gm PO in a single dose</td>
<td>2. Canadian Guidelines for 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.</td>
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<td></td>
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<td>First Choice: cefixime 800 mg PO in a single dose and azithromycin 1 gm PO in a single dose OR ceftriaxone 250 mg IM in a single dose and azithromycin 1 gm PO in a single dose</td>
<td>3. Future GC Treatment regimens will continue to reflect national recommendations in association with local GC antimicrobial resistance trends (AMR) trends.</td>
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<tr>
<td></td>
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<td>First Choice: cefixime 800 mg PO in a single dose and azithromycin 1 gm PO in a single dose OR ceftriaxone 250 mg IM in a single dose and azithromycin 1 gm PO in a single dose</td>
<td>4. Retreatment is indicated if the client has missed 2 consecutive doses of doxycycline or has not completed a full 5 days of treatment.</td>
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<tr>
<td></td>
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<td>First Choice: cefixime 800 mg PO in a single dose and azithromycin 1 gm PO in a single dose OR ceftriaxone 250 mg IM in a single dose and azithromycin 1 gm PO in a single dose</td>
<td>5. Consult a physician or NP if client is unable to use cefixime, ceftriaxone, or azithromycin.</td>
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<tr>
<td></td>
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<td>First Choice: cefixime 800 mg PO in a single dose and azithromycin 1 gm PO in a single dose OR ceftriaxone 250 mg IM in a single dose and azithromycin 1 gm PO in a single dose</td>
<td>6. See BCCDC STI Medication Handouts for further</td>
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First Choice: doxycycline 100 mg PO BID for 21 days
Alternate Choice: Consult with or refer to physician or NP.

General:
1. Treatment covers both gonorrhea and chlamydia.
2. Canadian Guidelines for 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 Handouts for further
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<td>Second Choice:</td>
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<td>cefixime 800 mg PO in a single dose and doxycycline 100 mg PO BID for 7 days</td>
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<td>OR</td>
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<tr>
<td>ceftriaxone 250 mg IM in a single dose and doxycycline 100 mg PO BID for 7 days</td>
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<td>Third Choice:</td>
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<td>azithromycin 2 gm PO in a single dose</td>
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7. See Monitoring and Follow-up section for test-of-cure (TOC) requirements.

**Allergy and Administration:**

8. DO NOT USE ceftriaxone or cefixime if history of allergy or anaphylaxis to cephalosporins. Consult with or refer to a physician or NP if history of anaphylaxis or immediate reaction to penicillins.

9. DO NOT USE azithromycin if history of allergy to macrolides.

10. DO NOT USE doxycycline if pregnant and/or allergic to doxycycline or other tetracyclines.

11. If an azithromycin or doxycycline allergy or contraindication exists, consult with or refer to a physician or NP for alternate treatment.

12. Azithromycin and doxycycline are sometimes associated with gastrointestinal adverse effects. Taking medication with food and plenty of water may minimize adverse effects.

13. The preferred diluent for ceftriaxone IM is 0.9 mls lidocaine 1% (without epinephrine) to minimize discomfort.

14. DO NOT USE lidocaine if history of allergy to lidocaine or other local anaesthetics. Use cefixime PO as alternate treatment.

15. For IM injections of ceftriaxone the ventrogluteal site is preferred. (See [http://www.bccdc.ca/health-professionals/clinical-resources/immunization/vaccine-administration](http://www.bccdc.ca/health-professionals/clinical-resources/immunization/vaccine-administration)).

16. Advise client to remain in the clinic for at least 15
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17. 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.

18. 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.

19. 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.
- has clinically relevant bradycardia, cardiac
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</table>
| Epididymitis                    | 60 days                                  | 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 relevant DST (e.g., *Epididymitis DST*, *MPC DST*, *PID DST*, *Proctitis DST*) for client education, screening recommendations, alternate treatments and further medication information. |
| Mucopurulent Cervicitis (MPC)   |                                          |                      |       |
| Pelvic Inflammatory Disease (PID)|                                          |                      |       |
| Proctitis                       |                                          |                      |       |
| Early Syphilis:                 |                                          |                      |       |
| • Primary Syphilis:             |                                          |                      |       |
| For contacts to Primary Syphilis: |                                          | First Choice: benzathine penicillin G (Bicillin LA®) 2.4 MU prepared as 2 separate intramuscular injections (IM) 1.2 MU each | 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 |
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| **Secondary Syphilis**<br> **Early Latent Syphilis**<br> asymptomatic infection of < one year's duration) | 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 | 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).*  
doxycycline 100 mg PO BID for 14 days | 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:**  
6. DO NOT USE Bicillin LA® if history of allergy, anaphylaxis or immediate reaction to penicillins.  
7. Administer Bicillin LA® into the ventral (preferred) or dorsal gluteal sites on the same visit, at 2 separate sites. (See [http://www.bccdc.ca/health-professionals/clinical-resources/immunization/vaccine-administration](http://www.bccdc.ca/health-professionals/clinical-resources/immunization/vaccine-administration)).  
8. 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 a drug allergy.  
9. If syphilis serology is 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.  
10. Refer to the *Syphilis DST* for client education, screening recommendations, alternate treatments and further medication information. |
| Late Latent Syphilis<br> 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. |
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<tbody>
<tr>
<td>Trichomoniasis</td>
<td>60 days</td>
<td>See <em>Trichomoniasis DST</em>.</td>
<td>1. Advise to abstain from sexual contact until completion of multi-dose treatment or for 7 days after single-dose therapy.</td>
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<td>2. Refer to the <em>Trichomoniasis DST</em> for client education, screening recommendations, alternate treatments and further medication information.</td>
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<td>3. Refer to the <em>Trichomoniasis DST</em> for client education, screening recommendations, alternate treatments and further medication information.</td>
</tr>
<tr>
<td>Urethritis – presumptive Gonorrhea</td>
<td>60 days</td>
<td>See <em>Treatment for Contacts to Gonorrhea section within this DST</em>.</td>
<td>1. Treatment covers potential gonorrhea and chlamydia infection.</td>
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<td>2. See <em>Notes</em> section under <em>Contacts to Gonorrhea</em> section within this DST.</td>
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<td>3. Refer to the <em>GC DST</em> for client education, screening recommendations, alternate treatments and further medication information.</td>
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</table>
| 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 | Treatment of Contact: See *Treatment for Contacts to Chlamydia* section within this DST. | Notes: 1. Treatment covers potential chlamydia infection.  
2. See *Notes* section under *Contacts to Chlamydia* section within this DST.  
3. Refer to the *CT DST* for client education, screening recommendations, alternate treatments and further medication information. |
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
REFERENCES

More recent editions of any of the items in the reference list may have been published since this DST was published. If you have a newer version, please use it.


