BCCDC Certified Practice Decision Support Tool Updates

Reproductive Health – STI

STI/HIV Services Education Team

June 10, 2025

BC Centre for Disease Control
Provincial Health Services Authority

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We gratefully acknowledge that we are gathered on the unceded, traditional, and ancestral lands of First Nations in this place currently known as British Columbia where we work, play and live.

First Nations have been responsible for stewarding this land for all time and we give thanks as uninvited guests on these lands.

We recognize the historic and ongoing colonial impacts on all First Nations, Métis Peoples and Inuit that call this land home.

Certified Practice DST Update

- All certified practice documents have been revised
- Process included literature scan, and recommendations discussed with BCCDC Scientific Committee and External Working Group
- Format aligns with non-certified documents

- Statements to address our duty as nurses to provide culturally safe care and address indigenous specific racism are reflected.
- Change to anatomy-based language and body site-based testing across documents, removal of gender-based language

Assessment & Diagnostic Guideline

BC Centre for Disease Control
Provincial Health Services Authority

Assessment & Diagnostic Guideline

Scope

Referral/consultation is required for:

- All individuals 11 years and under
- Symptomatic individuals aged 12-13 years
- All pregnant individuals*

*Asymptomatic STI screening can be completed without consultation, but treatment and follow-up require consultation and/or referral. Pregnant individuals can have vaginal swabs or self-swabs completed; if cervical swabs are required consult and/or refer.

- Breast/chest feeding individuals for treatment.

Assessment & Diagnostic Guideline

Pelvic Exam

Indications for a pelvic exam include abnormal bleeding, pelvic pain, change in usual discharge and collection of specimens (e.g. cervical cancer screening).

- A pelvic exam can consist of 3 main components:
    - External exam
    - Speculum exam
    - Bimanual exam
        - Routine bimanual exams are no longer recommended; however, bimanual examinations are performed as part of an STI assessment when symptoms are present.

Refer to PHSA's *Pelvic Exam DST* when offering or performing a speculum or bimanual exam.* Referral to the PHSA Pelvic Exam DST is not required for external exams or for provider or individual collected vaginal swabs without a speculum

For exams post penile inversion vaginoplasty / individuals with a neovagina:

- The anatomy of a neovagina created as part of gender-affirming care differs from a natal vagina in that it is a blind cuff without a cervix and may have a more posterior orientation. Referral/consultation with an experienced provider is recommended.

Assessment & Diagnostic Guideline

Site-Based STI Testing Table

- Penile urethra:

  If ‘female’ or ‘X’ gender marker, indicate ‘Trans patient’ to reduce likelihood of sample rejection

  If urethral symptoms occur after gender affirming surgery, consult with an experienced clinician, as swabs may be contraindicated.

- Vagina (with cervix)

  If not on testosterone: Nugent score/gram stain or clue cells (Amsel’s Criteria).

  If on testosterone: Consult/Refer for comprehensive yeast and bacterial culture. For community lab testing consider C&S superficial wound panel.

- Vagina after vaginoplasty

  The role of vaginal GC /CT specimens, as opposed to urine testing only, is unknown in individuals who have undergone penile inversion vaginoplasty. Providers may consider vaginal specimens if individual finds pelvic exam affirming, however urine testing should be considered essential.

  If ‘male’ or ‘X’ gender marker, indicate ‘Trans patient’ to reduce likelihood of sample rejection

- Skin, Genital, Rectal and or oral ulcers or lesions

  All one section now, addition of mpox PCR
  The highest yield is from skin and mucosal lesions. If lesions are present on different areas of the body, use a different swab for different anatomic areas.
  Where appropriate consult with MD/NP to ensure that the best sample types are collected to maximize test sensitivity, and the wide differential of agents is considered.

- Bacterial Vaginosis
- Chlamydia
- Genital Warts
- Gonorrhea
- Mucopurulent Cervicitis
- Trichomoniasis
- Uncomplicated Lower UTI
- Urethritis /Recurrent Urethritis
- Treatment of STI Contacts

All contain new opening statement:

The BCCDC decision support tools (DST) aim to provide more equitable, inclusive, and affirming care for all people, particularly for sexually diverse, transgender, Two-Spirit and non-binary people. While anatomy and site-specific testing language are used throughout this document, nurses should always strive to foster safer conversations and gender-affirming care by using an individual's chosen terminology when providing STI assessment and management.

Bacterial Vaginosis

- Scope

Addition of considerations for those on gender affirming care, and link to Trans Care BC Primary Toolkit, note these clients require consultation/referral as testing and assessment out of scope.

- Diagnosis and Clinical Evaluation

Removal of Amsel's criteria, focus on Modified Amsel's as diagnostic criteria for BV as this is more commonly used in practice, single algorithm

Addition of language for considerations re: screening prior to IUD insertion

  - Evidence suggests that IUD insertion is low risk for PID even in the presence of BV. Routine screening at time of IUD insertion is not recommended, and BV treatment at the time of or following IUD insertion is only indicated in the presence of symptoms

- Treatment

Updated recommendations around metronidazole & alcohol: newer research indicates this is not an absolute contraindication, but may wish to avoid

  - Ingestion of alcohol is not contraindicated during metronidazole therapy. Individuals may, however, wish to avoid alcohol and alcohol-containing medications (e.g., Nyquil®) for 12 hours prior to initiating treatment, during treatment, and for 24-48 hours after treatment completion as a means to limit the risk of possible adverse side effects.

Was a surprise to us as well!

Mini review: [Fact vs Fiction: Review of Evidence behind Alcohol and Antibiotic Interactions]

Bacterial Vaginosis

- Partner Notification

Addition of a consideration for treatment for partners with penile anatomy due to newer BV research recently was released

Male-Partner Treatment to Prevent Recurrence of Bacterial Vaginosis | New England Journal of Medicine

- For circumstances where treatment of partners with penile anatomy is being considered (e.g. monogamous couples where partner is agreeable to treatment to prevent BV recurrence) consult with NP or MD.

Chlamydia

- Epidemiology

Addition of a link to the STIBBI and TB Surveillance Dashboard

- Treatment

Preference for doxycycline as first choice treatment

Azithromycin now listed as alternate choice

- Monitoring and Follow-Up

Addition of management of indeterminate results. This section will be getting an update once lab memo is released on the aligning of reporting terminology, as well as recommendations for treatment of contacts

- Management of Indeterminate results:
  - Repeat NAAT testing is not recommended as results often remain indeterminate
  - Offer treatment as per the Treatment section
  - Discuss and recommend partner notification be completed for partner(s) in previous 60 days by the individual
  - For those declining treatment, provide education and follow up recommendations

Genital Warts

- Physical Assessment

Addition of wording around visualizing warts and what a physical assessment includes

- Consultation/ Referral

Addition of referral for potential cancer screening for individuals who are post-menopausal and first presentation of warts
Removed specific timeline for consultation if not responding to treatment, now based on treatment duration

- are postmenopausal and present with a 1st episode of wart-like lesions. Such lesions may require biopsy before any initiation of therapy to rule out underlying vulvar intraepithelial neoplasia or vulvar cancer
- have reached maximum treatment duration, administered as recommended per treatment modality, without resolution of symptoms (see treatment guidance below)

- Treatment

Updated format for information in a table. Treatment options by provider applied/individual applied

- Podophyllin has stopped being sold by Paladin in Canada, kept on as a provider only treatment in the event clinics still had in stock.
- Health Canada lists the product as ‘Cancelled Post Market’ can still be bought through wholesale/retailers if not past expiry date.

Gonorrhea

• Epidemiology	Addition of a link to the STIBBI and TB Surveillance Dashboard
• Etiology	Details included on uncomplicated vs complicated infections. Reminder urogenital, anogenital and pharyngeal infections are in scope, ocular and disseminated need to be consulted or referred.
• Indeterminate results	Indeterminate section added, scenarios included based on NAAT and culture results Will include update with lab definitions and partner follow-up recommendations once this is available, coming soon!

Gonorrhea

- Treatment

Treatment updates to align with BC GC guidelines

- The move toward monotherapy is driven by antibiotic stewardship and increasing rates of azithromycin resistance. If chlamydia test is negative at time of diagnosis, concurrent treatment for chlamydia is not recommended.

- First choice: 500 mg Ceftriaxone IM in a single dose

- Alternate: Cefixime 800mg orally in a single dose

  AND

  Doxycycline 100mg orally twice a day for 7 days; or

  Azithromycin 1g PO in a single dose

  AND

  Test of Cure

Test of Cure is considered part of the alternate treatment!

Gonorrhea

- Treatment

Update to Ceftriaxone and penicillin reactions, was previously worded as do not use, has been updated:

- If history of penicillin reaction, refer to Beta-Lactam Cross Reactivity Chart, consult physician or NP if needed

[Guest Post: Beta-Lactam Allergy: Benefits of De-Labeling Can Be Achieved Safely | College of Pharmacists of British Columbia]

Beta-lactam Antibiotic Cross-Allergy Chart

Beta-lactams	AMOXICILLIN*	AMPICILLIN	CLOXACILLIN	PENICILLIN	PIPERACILLIN*	CEFADROXIL	CEFAZOLIN	CEPHALEXIN	CEFOXITIN	CEFPROZIL	CEFUROXIME	CEFIXIME	CEFOTAXIME	CEFTAZIDIME	CEFTRIAXONE	CEFEPIME	ERTAPENEM	IMIPENEM	MEROPENEM
AMOXICILLIN*		X[1]	X[5]	X[4]	X[3]	X[1]	✓	X[1]	✓	X[2]	✓	✓	✓	✓	✓	✓	✓	✓	✓
AMPICILLIN	X[1]		X[5]	X[4]	X[3]	X[2]	✓	X[2]	✓	X[2]	✓	✓	✓	✓	✓	✓	✓	✓	✓
CLOXACILLIN	X[5]	X[5]		X[5]	X[5]	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
PENICILLIN	X[4]	X[4]	X[5]		X[5]	✓	✓	✓	X[3]	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
PIPERACILLIN*	X[3]	X[3]	X[5]	X[5]		X[3]	✓	X[3]	✓	X[3]	✓	✓	✓	✓	✓	✓	✓	✓	✓

Mucopurulent Cervicitis

- Physical Assessment

Clarification around language that DST applies to mucopurulent presentations and not all cervicitis

- Mucopurulent discharge seen from the cervical os (i.e. thick yellow or green pus) and/or friability of the cervix (sustained bleeding after swabbing gently)
- Cervicitis associated with HSV infection is to be referred to a physician or nurse practitioner (NP) for further assessment
- If cervicitis is noted that is not mucopurulent, refer to physician or NP for consult/further assessment as other etiology which may cause cervicitis are out of scope for RN(C).

- Diagnostic & Screening Tests

Addition of HSV polymerase chain reaction (PCR), and syphilis PCR if lesions are present on the cervix

- Treatment

Revised treatment recommendations to reflect chlamydia and gonorrhea treatment changes. Note MPC recommendation are still to treat for BOTH GC & CT as etiology is unknown

- Treatment covers both gonorrhea and chlamydia as etiology is unknown. Preference is to use Doxycycline over Azithromycin when the choice is available.

Trichomoniasis

- Treatment

First Choice now 7-day treatment as evidence showed highest efficacy, also in line with other guidance documents. 2g of metronidazole in a single dose remains as an alternate

Updated recommendations around metronidazole & alcohol: newer research indicates this is not an absolute contraindication, but may wish to avoid

- Ingestion of alcohol is not contraindicated during metronidazole therapy. Individuals may, however, wish to avoid alcohol and alcohol-containing medications (e.g., Nyquil®) for 12 hours prior to initiating treatment, during treatment, and for 24-48 hours after treatment completion as a means to limit the risk of possible adverse side effects.

Mini review: Fact vs Fiction: Review of Evidence behind Alcohol and Antibiotic Interactions

- Partner Notification

Clarification around partner testing and treatment for partners with penile or vaginal anatomy
Note, not a change in practice, wording has been clarified:

- Notification of all sexual partners within the last 60 days
- Sexual contacts within the last 60 days require treatment
- Sexual contacts within the last 60 days with vaginal/vulvar anatomy also require testing
- If no sexual partners within the last 60 days, the last sexual partner should be offered treatment

Uncomplicated Lower UTI

- Diagnostic and Screening Tests

Updated language around diagnostics/assessment with addition of urine analyzers

Reported symptoms that align with those outlined in the Clinical Presentation section above are the most predictive indicator of lower UTI, particularly in the absence of vaginal symptoms (e.g., pruritus or discharge).

†Point of care testing includes dipstick urine test strips and point-of-care urine analyzers.

*A RN(C) can order a urine C&S and/or complete urinalysis to support clinical assessment and diagnosis. It must be accompanied by a consultation/referral to a physician or nurse practitioner. These scenarios may include:

- The second presentation of an uncomplicated UTI within a one-year time frame
- Evidence of an upper UTI is present (i.e., presentation with fever, chills, rigor, or flank plain)
- Atypical urinary symptoms are present such as severe urgency, new or worsening incontinence and/or absence of nitrates and leukocytes which may indicate another diagnosis other than UTI

- Treatment

Clarification on wording of nitrofurantoin to ensure correct dosing formula

Addition of fosfomycin as a treatment option for those where multidose treatment course is difficult.

- New Fosfomycin medication sheet available!

Urethritis/Recurrent Urethritis

Now one DST!

- Management

Update in approach to urethritis, this is aligned with other foundational guidelines

- Due to trends with antimicrobial resistance, it is recommended to wait for test results before treating urethritis to ensure appropriate action.
- By prioritizing appropriate testing and diagnosis we aim to improve treatment outcomes while reducing unnecessary antibiotic use. For individuals who returning to clinic for follow-up is of concern and an infectious cause is suspected, empiric treatment can be considered without presence of discharge

New algorithm to assist decision making, and recommendation to consult once recurrent urethritis definition is reached. This is due to other investigations that may be appropriate, e.g. m.gen, e.coli, or potential for referral to urology.

- Treatment

Treatments updated in line with GC and CT changes

New treatment factsheet made in collaboration with Community Antimicrobial Stewardship Team given the large change in practice:
Urethritis Treatment

Treatment of STI Contacts

Simplified!

• Consultation / Referral	Removed information that was duplicated in other DSTs Note ALL pregnant individuals still included in consult/refer as this DST is for treatment
• Table: Treatment of Contacts	Removed syndromes as repetitive wording to see appropriate DST Aligned with syphilis DST to ensure contact recommendations weren't conflicting Clarification around partner testing for trichomoniasis in line with trichomoniasis DST

Non-Certified DSTs

- PID, Proctitis and Epididymitis
  - All updated with new treatment d/t GC changes
  - PID updated with information around metronidazole and alcohol
- No other changes at this time, will be going through review process for non-certified DSTs as some updates to recommendations within PHAC guidance, and were released

Q&A

- **What if someone is on Doxy PEP, given the preference for doxycycline now?**
  - Consult for those on Doxy PEP
- **Will the Post-Sexual Assault DST follow the same updated treatment recommendations?**
  - Yes
  - Updates to this DST coming shortly
- **What are the recommendations for treatment of contacts to indeterminate CT/GC results before further details are available in the DSTs?**
  - directions will be coming out in an upcoming release, in line with lab memo on indeterminate results
  - For now, advise individuals to inform their contacts and if contacts present to clinic, test and treat these individuals
- **Can I give ceftriaxone & bicillin on the same day?**
  - Yes; there are no drug interactions/contraindications
  - Best practice to administer different products in different sites, and product monograph for ceftriaxone lists only deep intragluteal (not deltoid)
  - Prioritize bicillin injection in ventrogluteal L&R sites; then administer ceftriaxone in dorsogluteal site. If individual expressing concern about pain tolerance consider oral treatment for GC and TOC as alternate treatment

Q&A

- **What is the definition for post-menopausal in individuals with first presentation of warts to refer for cancer follow-up? Where does this recommendation come from?**
  - Recommendations from UptoDate: Carusi. Condylomata acuminata:
    - Postmenopausal individuals should be biopsied before initiating therapy as they have a greater chance of underlying vulvar intraepithelial neoplasia or vulvar cancer than younger individuals.
  - This recommendation was supported by BCCDC scientific committee for inclusion in the DSTs and as a point to initiate referral.
  - For purpose of the DST, post-menopausal individuals are defined as those who have experienced 12 months of amenorrhea without any other obvious pathologic or physiologic cause.
- **What is the rationale behind HSV not being a part of certified scope, can this be added?**
  - There is a possibility that this could be added to certified scope through a proposal to the BCCNM and advocacy around how this best supports STI care in BC.
  - Unknown what the rationale was when certified practice began around 15 years ago. This topic and advocacy work to develop a proposal can be explored at further STBBI PHN meetings

Q&A

- **Why are pelvic exams recommended with a change to normal vaginal discharge?**
  - Recommendation is to **offer** a pelvic exam but not a requirement
  - Allows for further assessment to rule out PID or other concerns if symptoms are present
- **How should we communicate indeterminate results to clients?**
  - Definitions will be coming out from the lab that make distinction between indeterminate results and those that are invalid such as if damaged in transport. Will share these once available
  - Indeterminate results are usually due to low bacterial or viral target in the specimen which is near the detection limit or threshold of the test.
    The test is picking up some pathogen, but not enough to say with confidence it is positive.
- **When is Test of Cure (TOC) recommended?**
  - TOC is recommended with GC NAAT 4 weeks after treatment for those who are:
    - Pregnant
    - Had pharyngeal infection
    - If alternate treatment was used
    - If person has persistent symptoms or treatment failure is suspected
- **With changes in antimicrobial resistance, is the recommendation to wait for test results before treating contacts of syndromes such as urethritis and MPC?**
  - Yes, it is recommended to wait for test results and confirm etiology to recommend appropriate follow-up for contacts

Q&A

- **Why is the recommendation to only offer treatment to sexual contacts of trichomoniasis who have penile anatomy as opposed to offering testing as well? Is this a cost-related measure?**

  - Testing for those with penile anatomy is not routinely recommended, there has not been a change in practice but language clarification in the document. As per all previous versions of the Trichomoniasis DST, “diagnostic testing is not available” for people with penile anatomy.
  - It is not directly a cost-related measure but reflects low prevalence rates and self-limiting nature of T. Vaginalis infection in people with penile anatomy.
  - It is unknown the frequency at which T. Vaginalis spontaneously resolves in these individuals and that untreated infection can lead to symptoms of proctitis and epididymitis, the testing technology available is “highly complex”, requiring multiple specimens.
  - For example, in the US, The Aptima T. vaginalis assay (Hologic) is FDA cleared for detection of T. vaginalis from symptomatic or asymptomatic women. This assay has not been FDA cleared for use among men.

Thank you

For questions on the updates please contact our team at sticourse@bccdc.ca

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