BC Centre for Disease Control
Provincial Health Services Authority

Clinical Prevention Services
Provincial STI Services
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Date: **September 23, 2020** **Administrative Circular: 2020:19**

ATTN: Medical Health Officers and Branch Offices
Public Health Nursing Administrators and Assistant Administrators
Holders of Communicable Disease Control Manuals

Re: **Revisions to the Communicable Disease Control Manual – Chapter 5: Sexually Transmitted Infections: Section 1: STIs**

Please note the following changes to the BCCDC Communicable Disease Control Manual – Chapter 5: Sexually Transmitted Infections: Section 1: STIs

1. **Please remove the following sections from the Communicable Disease Control Chapter 5: Sexually Transmitted Infections: Non-certified Practice Decision Support Tools for STI**

   - Candidal Balanitis (Yeast Balanitis) (pp. 1-4)
   - Epididymitis (pp. 1-8)
   - Genital herpes Simplex Virus, HSV (pp. 1-10)
   - Molluscum Contagiosum (pp. 1-4)
   - Pediculosis Pubis, Pubic Lice (pp. 1-4)
   - Pelvic Inflammatory Disease, PID (pp. 1-10)
   - Proctitis (pp. 1-8)
   - Scabies (pp. 1-4)
   - Syphilis (pp. 1-11)
   - Vulvovaginal Candidiasis, VVC (pp. 1-8)

   Please insert the following updated section into the Communicable Disease Control Chapter 5: Sexually Transmitted Infections: Non-certified Practice Decision Support Tools for STI

   - Candidal Balanitis (Yeast Balanitis) (pp. 1-4)
   - Epididymitis (pp. 1-9)
   - Genital herpes Simplex Virus, HSV (pp. 1-11)
   - **NEW**: Lymphogranuloma venereum, LGV (pp. 1-7)
   - Molluscum Contagiosum (pp. 1-5)
   - Pediculosis Pubis, Pubic Lice (pp. 1-5)
   - Pelvic Inflammatory Disease, PID (pp. 1-8)
   - Proctitis (pp. 1-9)
   - Scabies (pp. 1-6)
   - Syphilis (pp. 1-15)
   - Vulvovaginal Candidiasis, VVC (pp.1-8)

Please insert the following new sections into the Communicable Disease Control Chapter 5: Sexually Transmitted Infections: Supporting Documents for STI Clinical Practice

- Differences between Certified and Non-certified STI practice (pp. 1)
- STI Screening and Testing Guide for RN(C)s (pp. 1)

2. **Please note the following updates**:
   - **New format, sections include:**
     - Scope
     - Etiology
     - Epidemiology (where appropriate)
       - Risk Factors
     - Clinical Presentation
     - Physical Assessment
     - Diagnostic and Screening Tests
     - Management
       - Diagnosis/Clinical Evaluation
       - Consultation or Referral
       - Treatment
       - Monitoring and Follow-up
       - Partner Counselling and Referral
       - Potential Complications
       - Client Education
     - References
   - **Candidal Balanitis (Yeast Balanitis) DST**
     - Information about Phimosis and Paraphimosis added throughout
   - **Epididymitis DST**
     - Scope:
       - New alert: “Testicular torsion is a surgical emergency and requires immediate consultation. As it can mimic epididymitis, testicular torsion must be considered in all people presenting with sudden onset, severe testicular pain. Viability of the testis can be compromised as soon as 6-12 hours after the onset of sudden and severe testicular pain.”

- Epidemiology/Risk Factors:
  - Expanded. Numerous other considerations beyond STI risk factors that could present similarly.
- Clinical Presentation
  - Emphasized quick onset of pain
  - Added UTI and urethritis symptoms
- Physical Assessment
  - Alert box added regarding testicular torsion
- Diagnostic and Screening Tests
  - If enteric infection(s) or genitourinary bacteriuria suspected:
    - Urine specimen for dipstick
    - Order urine culture if:
      - If dipstick positive for leukocytes, nitrites and/or blood
      - If dipstick negative, but symptomatic with urethral symptoms
- Diagnosis/Clinical Evaluation
  - **NEW** flowchart with < 35 yrs and ≥ 35 yrs age split and +/- condomless insertive anal intercourse, based upon likelihood of CT/GC infection vs. infections caused by enteric organisms
- Treatment
  - Ofloxacin no longer recommended
  - Revised treatment table with < 35 yrs and ≥ 35 yrs age split, likelihood of CT/GC infection vs. one caused by enteric organisms
- Monitoring and Follow-up
  - Clarified, pain and erythema should resolve within 3 to 7 days

- **Genital Herpes Simplex Virus (HSV) DST**
  - Diagnostic and Screening Tests
    - HSV IgG serology removed, as no longer offered
    - **Recommendations removed**:
      - Clients who have HIV infection (no longer relevant in era of highly effective ARV's)
      - Clients who have a partner who is HIV positive (see above)
      - Clients who have undergone at least 2 attempts to swab lesions suggestive of HSV where results have been HSV none found (not necessary as a general rule, unless concerns about poor quality of sample – HSV PCR is a highly sensitive test)

    - **NEW RECOMMENDATIONS for HSV type specific serology (TSS):**
        - Perinatal screening, aligned with Society of Obstetricians and Gynecology recommendations (SOGC)
        - Based upon clinical judgement:
            - Atypical or recurrent genital disease, where prior testing (including HSV PCR swab) has not provided a definitive clinical diagnosis
            - Serodiscordant couples, where one partner has had HSV diagnosed and typed
- Treatment
    - Revised to include more information to assist in counseling clients about decision to take treatment
- Monitoring and Follow-up
    - Recommendation to review initial treatment response after 1 week, as sometimes treatment duration may need to be extended

- **Molluscum Contagiosum DST**
    - Treatment
        - Removed from 'Treatment of Choice':
            - Advise clients that they can self-treat by un-roofing the lesions (may use sterile pin or needle tip), and expelling the contents.
        - LN2 and Histofreezer moved up to First Choice
        - Moved/Added to Alternate Treatment:
            - No treatment
    - Client Education
        - Removed recommendation to self-treat by unroofing lesions

- **Pediculosis Pubis, Pubic Lice DST**
    - Monitoring and Follow-up
        - Follow-up after 9 to 10 days recommended, as nits can hatch after 6 to 8 days if they have not all been physically removed at time of treatment
    - Partner Counselling and Referral
        - Clarified follow-up period as 1 month

- **Pelvic Inflammatory Disease, PID DST**
    - Physical Assessment
        - Added abdominal assessment
        - Added note to rule-out other potential causes of abdominal pain, and which cardinal signs require immediate consultation with and/or referral to a MD/NP

- Treatment
  - Co-treatment with 14-day course of metronidazole recommended
  - Duration of doxycycline co-treatment has been increased to 14 days
- Monitoring and Follow-up
  - Reassess by MD/NP if symptoms have not diminished within 3 days, or if symptoms worsen after 3 days
- Potential Complications
  - Added note about risk of potential complications can increase with the number of and severity of PID episodes despite treatment

- **Proctitis DST**
  - Diagnosis and Clinical Evaluation
    - **REMOVED**: Smear for TID, Darkfield (DF) and Direct Fluorescent Antibody (DFA) removed
    - New table, organized according to whether external lesion is present or not
    - Clarified can perform blind swabs for all recommended diagnostic testing
    - Clarified no routine indication for blind rectal syphilis PCR swabs
  - Treatment
    - **REMOVED**: Third line treatment option of Azithromycin 2g

- **Scabies DST**
  - Physical Assessment
    - Separated into ‘Classic Scabies’ and ‘Crusted Scabies’ sections
  - Consultation or Referral
    - Added: Extensive scabies or crusted scabies
    - Added: Extensive dermatitis, pruritus or pre-existing skin condition(s)
  - Partner Counselling and Referral
    - Clarified 1 month trace back period recommended

- **Syphilis DST**
  - Clinical Presentation
    - New table summarizing syphilis staging, incubation periods, symptoms and diagnosis terminology
  - Diagnostic and Screening Tests
    - Direct Fluorescent Antibody *T. pallidum* (DFA-TP) test information removed, as it is only done @ BCCDC

- Diagnosis and Clinical Evaluation
  - Note added, re: "RN(C)'s do **not** require a client-specific order to provide treatment for individuals identified as **contacts** to a case of syphilis (see the certified practice Treatment of Contacts DST)."
- Consultation or Referral: Pregnant or Breast-/Chest-feeding
  - Clarification: "Consult with a BCCDC Provincial STI/HIV Clinic physician and the MD/NP managing the case in the community. After consultation and receipt of a client specific order, RN's can administer treatment to pregnant people and/or breast-/chest feeding people."
  - Practitioner Alert added to emphasize the importance of prenatal screening. Link to Perinatal Services BC added for up to date guidelines and information.
- Treatment
  - Practitioner Alert added to address concern about medication errors. Highlights concerns about:
    - Incorrect dose given (only 1 Bicillin injection, not 2)
    - Incorrect formulation of pen G given (short acting vs. long acting)
    - Reminder to rule out pregnancy
- Monitoring and Follow-up – new table
- Partner Counselling and Referral – new table
- Appendix A
  - New table outlining tests used at the BCCDC PHL for initial screening and confirmatory serologic testing for syphilis
- Appendix B
  - Revised Bicillin treatment form

- **Vulvovaginal Candidiasis DST**
  - Clinical Presentation
    - Added note to consider differential diagnosis (e.g., vaginal atrophy and/or dryness), and alternative treatment options for those who are peri-menopausal or menopausal
  - Diagnostic and Screening Tests
    - Removed wet-mount microscopy

- **New "**Differences between Certified and Non-certified STI practice" to help support understanding of the distinction between RN(C)/RN limits in clinical practice as laid out in the different sections of the DSTs
- **New "**STI Screening and Testing Guide for RN(C)s". A quick reference guide to help support RN(C)s in their STI clinical practice.

If you have any questions regarding these changes, please contact:

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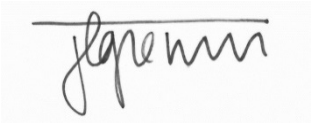
Sincerely,



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