Lakeridge Health	Domestic Violence/Sexual Assault – Medical Directive	
	Manual: Medical Directives & Delegated Controlled Acts	Original Date: 16MAR2021
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	Cross Reference to:	

Authorizing Prescribers

LHO – Domestic Violence/Sexual Assault Care Centre (DV/SACC) Physicians
LHO – Emergency Department Physicians

Authorized to Whom

Nurses working at the DV/SACC who have been certified as a Sexual Assault Nurse Examiner (SANE) or nurses that have the knowledge, skill and judgment to work within the DV/SACC Program.

Co-implementers:

- Medical Laboratory Assistants/Technologists (MLA/T) employed at Lakeridge Health (LH)
- Pharmacists and Pharmacy Technicians employed at LH
- Phlebotomists employed at LH

Patient Description/Population

Any patient 12 years of age or older presenting with signs or reports of sexual assault and/or domestic violence within 12 days of a sexual assault and meets the procedure specific indications as per the Order Table.

Patients 12 years of age or older presenting for follow-up care at DV/SACC.

Order and/or Procedure

The order and/or procedures are not presented in sequential order. Any one of or combination may be performed by a DV/SACC/ SANE nurse. All acute medical need(s) (e.g., loss of consciousness) will take precedence over any discussion of Post-Exposure Prophylaxis (PEP). Refer to the Order Table Form. The DV/SACC/ SANE nurse will:

- Obtain DV/SACC standard sexual assault and health history, including allergies, in consultation with the patient.

- Explain each intervention to the patient and/or family, and/or Substitute Decision Maker (SDM), and/or legal guardian.
- Explain options regarding sexually transmitted infections, treatment(s) and testing.
- Collect urine β HCG for all patients with a uterus and ovaries of childbearing years.
- Complete a HIV transmission risk assessment using the Risk Assessment for HIV Prophylaxis (Appendix A), as required.
- Complete the HIV PEP checklist with the patient if the patient is deemed at risk and is to receive HIV PEP (Appendix B).
- Obtain written consent for prophylactic treatment, if applicable, and explain to the patient that HIV PEP is prophylactic in the absence of laboratory results.
- Advise patient of possible medication side effects related to the treatment(s) regimen(s).
- Obtain Best Possible Medication History (BPMH) and assess the HIV PEP medications using available resources (e.g., Lexicomp) to identify any potential drug interactions and/or reactions. Consult a pharmacist (LH or via Telehealth) to assess any identified interactions to determine if adjustments in therapy are required. This includes any history related to medications (including alternative therapies and vitamins), recreational drug use, and kidney, liver, pancreatic and blood diseases.
- Refer the patient to the Positive Care Clinic (PCC) or alternative care center (e.g., patient does not live in the area) as appropriate if a patient is put on HIV PEP for follow up care. The nurse will enter the PCC consult request in EPIC, or refer to the appropriate alternative care center and instruct the patient to book a follow-up appointment within 7 days. Relevant written instruction will be provided to the patient as well.

Indications to the Implementation of the Directive

Any patient consulted to DV/SACC/SANE with indications as listed in the order tables for:

- Analgesic for Mild to Moderate Pain,
- HIV Post Exposure Prophylaxis,
- Baseline Testing for Individuals At Risk for HIV and STI (regardless of administration of prophylaxis),
- Sexually Transmitted Infection Prophylaxis for Chlamydia,
- Sexually Transmitted Infection Prophylaxis for Gonorrhea,
- Hepatitis B Prophylaxis,
- DimenhyDRINATE for Prevention of Nausea Induced by Prophylactic Medication,
- Emergency Contraceptive Pill (ECP) for Pregnancy Drug Prophylaxis,
- Sexually Transmitted Infection Treatment for Gonorrhea in Follow Up,
- Sexually Transmitted Infection Treatment for Chlamydia in Follow Up,
- Treatment of Bacterial Vaginosis in Follow Up

Contraindications to the Implementation of the Directive

The directive must not be implemented in any of the following circumstances:

- The patient or SDM or guardian refuses to consent to the treatment.
- Existence of treatment specific contraindications as noted in the order table form
- Patient has known allergies to any of the medications and the alternatives listed within this directive.
- Patient has decreased level of consciousness and/or head injury.

- Patient is having/has difficulty swallowing PO medications.
- Nurse does not possess the knowledge, skill and judgment to enact these directive(s).

Notify DV/SACC/ Physician/ED physician to determine alternative treatment plan and follow up.

Consent

The DV/SACC/SANE nurse implementing the medical directive must obtain consent and document that consent has been obtained. If the patient, SDM or guardian refuses treatment, contact the Most Responsible Practitioner (MRP) or delegate immediately to determine the appropriate plan of care.

Documentation Requirements

In addition to standard documentation practices, the DV/SACC/SANE nurse implementing this directive must document the following in the order section of the person's health record:

- The name of this medical directive (in comment form)
- The procedure(s)/treatment(s) implemented
- Order mode: Per medical directive
- Ordering Provider: Nurse
- Authorizing Provider: Physician
- The date and time
- Nurse dispensing record, as applicable

Co-implementers will document in the patient's health record and as per standard documentation practices.

Review/Evaluation Process

This directive will be reviewed by the Emergency Department Program every 2 years.

References

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Appendix A: Post Exposure Prophylaxis After Sexual Assault Risk Assessment

POST EXPOSURE PROPHYLAXIS (PEP) AFTER SEXUAL ASSAULT RISK ASSESSMENT

RISK WARRANTING PEP USAGE: PEP may be indicated by what is known about the **source (assailant)** or what is known about the setting in which the sexual assault took place

SOURCE		TYPE OF EXPOSURE	RECOMMENDATIONS
Known HIV positive source OR **Known** high risk source (i.e., Person who Injects Drugs (PWID) or man who has sexual contact with men (MSM)) OR **Known** to be multiple assailants	**PLUS**	No or unknown barrier used Vaginal Penetration OR Anal Penetration OR Unknown exposure	Recommend HIV PEP started kit started **as soon as possible and within 72 hours of** sexual assault If source known to be HIV + may recommend PEP after 72 hours, call ID on call.
Unknown HIV status	**PLUS**	No or unknown barrier used Vaginal penetration OR Anal Penetration OR Unknown exposure	Discuss risks and benefits of HIV PEP medications. Patient decides if they want starter kit initiated **as soon as possible and within 72 hours of** sexual assault

NEGLIGIBLE RISK:	
Vaginal/anal penetration may have occurred, but the **source** is known to be HIV negative Oral/digital exposure alone is considered to be negligible risk regardless of HIV status of source. Consideration for PEP with an oral exposure would be relevant if exposed person has an oral piercing or infected oral mucosa Kissing, fisting. Sex toy	RECOMMENDATION **Do not offer PEP to patients in this category.** Provide counselling and information to reduce anxiety.

NOTE: If the exposure is no risk and the assailant is HIV positive, HIV PEP is not offered.
Penetration= attempted, partial or completed penetration or ejaculation in vagina or anus.

Appendix B: Post-Exposure Prophylaxis (PEP) Checklist

Post - Exposure Prophylaxis (PEP) Checklist:
Read This Through with the Patient

- ❑ The patient has no medical history that would contraindicate PEP, such as significant renal impairment and allergy to the medications.
- ❑ The patient is not knowingly allergic to any of the PEP medications.
- ❑ The patient is not taking medications which are not recommended to be combined with PEP or that require adjustment when taken with PEP (as per references and/or pharmacist).
- ❑ Patient is advised to avoid unnecessary medications, vitamins, alternative medicines or recreational drugs while taking HIV PEP. If a new medication is prescribed, ensure that the prescriber is aware that PEP is being taken.
- ❑ Provide education to the patient regarding remaining on birth control during PEP regime (i.e. risk with pregnancy). Condoms should be worn for additional birth control and to provide barrier protection for HIV until patient has been cleared of HIV infection.
- ❑ Educate female patients **NOT** to breastfeed during PEP regime.
- ❑ Discuss the risks of HIV infection and the risks of taking PEP
- ❑ Instruct the patient to take these medications concurrently:
  - Tivicay (Dolutegravir 50 mg) 1 tab **daily** for 7 days
  - Truvada (Emtricitabine 200 mg and Tenofovir 300 mg) 1 tab **daily** for 7 days
- ❑ Educate the patient on the importance of contacting the Positive Care Clinic for further risk assessment and review of recommendations for serial testing.
- ❑ Educate the patient that adherence to HIV PEP regime and attending follow up visits at the Positive Care Clinic will PEP work effectively.
- ❑ Provide the patient a list of side effects (i.e. Lexicomp) that may be experienced with the treatment regime.
- ❑ Advise the patient to call the Positive Care Clinic, their Family Physician, or the Emergency Department if they are experiencing any side effects.
- ❑ Discuss support systems the patient may have in place and/or how to access them
- ❑ Educate the patient to not to donate blood, plasma, tissue, organs or sperm until consult with Positive Care Clinic.
- ❑ Educate the patient to not share toothbrushes, razors, needles etc. that could be contaminated with blood or body fluids.

This table must **not** be used independently apart from the Medical Directive

Order Table Form

Analgesia for (Mild to Moderate) Pain			
Order	**Indication**	**Contraindication**	**Notes (Optional)**
Patient weighs less than or equal to 65 kg: Acetaminophen 650 mg PO one dose **OR** **Patient weighs more than 65 kg**: Acetaminophen 975 mg PO one dose	• Mild to moderate pain (less than 8 on the pain scale)	• Acetaminophen administration in the last 4 hours **OR** more than 3 doses in the past 24 hours • The patient is not experiencing pain • The patient has a known/documented allergy to Acetaminophen	• If patient is under the age of 18, notify MRP or Paediatrician on call to determine plan of care regarding weight based dosing
OR Ibuprofen 400 mg PO one dose	• Mild to moderate pain (less than 8 on the pain scale) • Patient has an intolerance/allergy to acetaminophen • Patient has received acetaminophen within the last 3 hours OR more than 3 doses of acetaminophen within the past 24 hours	• Ibuprofen administration in the past 6 hours **OR** more than 3 doses in the past 24 hours • History of cirrhosis, chronic liver disease, alcohol abuse, active peptic ulcer disease, gastrointestinal bleeding or impaired renal function • Patient is pregnant • Known/documented allergic manifestations precipitated by ASA or other non-steroidal anti-inflammatory agents (NSAIDS)	• If patient is under the age of 18, notify MRP or Paediatrician on call to determine plan of care regarding weight based dosing

HIV Post Exposure Prophylaxis			
Order	**Indication**	**Contraindication**	**Notes (Optional)**
Laboratory Investigations Prior to PEP administration: creatinine, VDRL, HIV serology, serum HCG (if female of childbearing years), Hepatitis B profile and Hepatitis C serology If the patient is deemed "at risk" but HIV PEP is not administered, collect: VDRL, HIV serology, Hepatitis B profile, and Hepatitis C serology	• Oral (if exposed person has oral piercing or infected/injured oral mucosa), vaginal, or anal penetration with a penis and/or is uncertain/does not remember, regardless of condom use or ejaculation. • As indicated on the risk assessment tool and/or as desired by the patient (Appendix B).	• If the patient is deemed as "no risk" using the risk assessment (Appendix A)	• The nurse must complete the HIV PEP checklist with patient • The nurse must show results of creatinine and serum βHCG (if applicable) to the Emergency Physician before patient leaves DV/SACC. If the patient refuses to stay the nurse should have the patient sign an against medical advice form and note it in the patient's chart • If at risk, review with the patient that they should have follow-up HIV testing at 3-6 weeks, and 3-6 months after the assault

HIV Post Exposure Prophylaxis			
Order	**Indication**	**Contraindication**	**Notes (Optional)**
Medications Truvada (Emtricitabine 200mg and Tenofivir 300mg) PO once **AND** Tivicay (Dolutegravir 50 mg) PO once **Plus** From the HIV PEP Kit Dispense remaining 6 tablets of Truvada (Emtricitabine 200 mg and Tenofivir 300 mg) to be taken PO daily for 6 days **AND** Dispense remaining 6 tablets of Tivicay (Dolutegravir 50mg) to be taken PO daily for 6 days	• Patient is deemed at risk using the risk assessment (Appendix A)	• Patient is pregnant and/or breast feeding • Patient has an intolerance/allergy to Emtricitabine and/or Tenofivir and/or Dolutegravir • If the patient is deemed as no risk using the risk assessment • History of renal impairment (CrCl less than 50ml/min for Truvada only), decompensated liver disease, Hepatitis B. • Medications that interact with Truvada or Tivicay that is either not recommended (i.e. avoid combination) or that requires dosage adjustments. Notify MRP to determine plan of care • If the exposure did not occur within 72 hours. Consult ID to determine plan of care **if client is deemed *at risk*** using the risk assessment (Appendix A)	• If contraindications are present consult MRP/ID to determine plan of care • Administer first dose as soon as patient deemed at risk and consents to treatment. It can be given without lab results. If abnormal lab results are returned, consult MRP/ID for a plan for the remaining 6 doses. • Advise patient of their need to attend follow up with positive care clinic to receive remaining 21 days of medication • Both drugs may be taken together at the same time and can be taken with or without food • Tivicay (Dolutegravir) should be administered 2 hours prior or 6 hours after cation-containing antacids or laxatives, sucralfate, oral supplements containing iron, calcium or magnesium. If taken with food, dolutegravir may be taken at the same time as calcium or iron supplements.

Baseline Testing for Individuals At Risk for HIV and STI (regardless of administration of prophylaxis)			
Order	**Indication**	**Contraindication**	**Notes (Optional)**
<u>Bloodwork for Baseline STI Testing:</u> Syphilis serology, HIV serology, Hepatitis B screen, and Hepatitis C (PHL) **<u>Swabs/Urine for Asymptomatic Baseline STI testing:</u>** **Patients with a penis:** C. trachomatis/N. gonorrhoea, NAAT **URINE** **Patients with a vagina:** C. trachomatis/N. gonorrhoea NAAT • Cervical swab **OR;** • Vaginal swab (if cervix not visualized) **OR;** • Urine (if swabs cannot be collected) **AND** Vaginal Screen **VAGINAL SWAB** for Gardnerella (BV) and trichomonas **<u>Rectal and Pharyngeal testing (Asymptomatic)</u>** C. trachomatis/N. gonorrhoea, NAAT site specific swab	• Oral (if exposed person has oral piercing or infected/injured oral mucosa), vaginal, or anal penetration with a penis and/or is uncertain/does not remember, regardless of condom use or ejaculation • Oral, vaginal, or anal contact with the patient's penis and/or the patient is uncertain/does not remember, regardless of condom use or ejaculation • Oral, or penile contact with the patient's vagina or vulva and/or the patient is uncertain/does not remember, regardless of condom use or ejaculation	• If the patient is deemed as "no risk" using the risk assessment (Appendix A).	• Review with the patient that they should have follow-up HIV testing at 3-6 weeks, and 3-6 months after the assault • Specimens should be collected on all points of contact as reported in the sexual assault • NAAT testing may become positive sooner than cultures for gonorrhea and chlamydia, but do not include antibiotic sensitivity testing, if symptomatic consult MRP to consider ordering culture swabs • Vaginal swabs can be collected by the clinician or by self-swab

Baseline Testing for Individuals At Risk for HIV and STI (regardless of administration of prophylaxis)			
Order	**Indication**	**Contraindication**	**Notes (Optional)**
<u>Swabs/Urine for Symptomatic Baseline STI testing:</u> Chlamydia Trachomatis Culture • Urethral swab (patients with a penis) • Cervical swab **OR;** • Vaginal swab (if cervix not visualized) **OR;** • Urine (if swabs cannot be collected) **AND** Gonococcus Culture • Urethral swab (patients with a penis) • Cervical swab **OR;** • Vaginal swab (if cervix not visualized) **OR;** • Urine (if swabs cannot be collected) **<u>Rectal and Pharyngeal testing (Symptomatic)</u>** C. trachomatis/N. gonorrhoea, NAAT site specific swab	• Oral (if exposed person has oral piercing or infected/injured oral mucosa), vaginal, or anal penetration with a penis and/or is uncertain/does not remember, regardless of condom use or ejaculation • Oral, vaginal, or anal contact with the patient's penis and/or the patient is uncertain/does not remember, regardless of condom use or ejaculation • Oral, or penile contact with the patient's vagina or vulva and/or the patient is uncertain/does not remember, regardless of condom use or ejaculation • Patient is symptomatic	• If the patient is deemed as "no risk" using the risk assessment (Appendix A).	• Specimens should be collected on all points of contact as reported in the sexual assault • NAAT testing may become positive sooner than cultures for gonorrhea and chlamydia, but do not include antibiotic sensitivity testing, if symptomatic consult MRP to consider ordering culture swabs • Vaginal swabs can be collected by the clinician or by self-swab

Sexually Transmitted Infection Prophylaxis for Chlamydia			
Order	**Indication**	**Contraindication**	**Notes (Optional)**
<u>Chlamydia Prophylaxis</u> Azithromycin 1 Gram PO once	• Oral, vaginal, or anal penetration with a penis and/or is uncertain/does not remember, regardless of condom use or ejaculation • Patient is at risk of exposure, or patient may not be reliable/able to return for follow up	• Patient has an intolerance/allergy to Azithromycin, Erythromycin, and Clarithromycin, Doxycycline and/or any of the Tetracycline's. • Patient is pregnant and/or breastfeeding	• If contraindications are present, consult MRP/ID to determine plan of care • Explain options regarding sexually transmitted infections treatment and testing (Option 1. If medication is given, patient is to be retested in 3 weeks. Option 2. If the medication is not given, patient is to be retested in 1 week) • Assess for any intolerances/allergies to medication • Advise patient of possible side effects (i.e. gastrointestinal disturbances, cardiac arrhythmia). • Azithromycin and/or Doxycycline can be taken with food • As there is concern for increasing antibiotic drug resistance to treat infections, a consideration is to test for STIs and treat based on a positive result in follow up
OR If allergy to Azithromycin, Erythromycin or Clarithromycin, Doxycycline 100 mg PO BID for 7 days	Same as above and: • Patient has allergy to Azithromycin, Erythromycin, or Clarithromycin		

Sexually Transmitted Infection Prophylaxis for Gonorrhea			
Order	**Indication**	**Contraindication**	**Notes (Optional)**
<u>Gonorrhea Prophylaxis</u> cefTRIAXone 250 mg IM (with 0.9 mL 1% Lidocaine) once **OR** Cefixime 800 mg PO once **<u>PLUS</u>** Azithromycin 1 gram PO once (omit if already being taken as per Chlamydia directive)	• Oral, vaginal, or anal penetration with a penis and/or uncertain/does not remember, regardless of condom use or ejaculation • Patient is at high risk of exposure (assailant known positive), or patient may not be reliable/able to return for follow up	• Patient has known/documented allergies to Azithromycin, Cefixime, Cephalosporin's, Erythromycin, and/or Penicillin • Breastfeeding: It is unknown if Cefixime is excreted in breast milk • Already taking Azithromycin 1 gram for Chlamydia prophylaxis	• If contraindications are present consult MRP/ID to determine plan of care • Advise patient of possible side effects (e.g. gastrointestinal; cardiac arrhythmia with Azithromycin) • Advise patient Cefixime/Azithromycin can be taken with food • Inform patient they should be retested for STIs in 3 weeks following completion of Azithromycin and/or Cefixime administration • If difficulty swallowing, notify MRP to determine plan of care • cefTRIAXone is considered first line, though it is likely that our population may choose the better tolerated cefixime orally, to avoid injection • As there is concern for increasing antibiotic drug resistance to treat infections, a consideration is to test for STIs and treat based on a positive result in follow up

Hepatitis B Prophylaxis			
Order	**Indication**	**Contraindication**	**Notes (Optional)**

Patients 20 years of age and older Hepatitis B Vaccine (Engerix-B) 20mcg (1ml) IM (deltoid) x 1, then repeat at 1 & 6 months **OR** Hepatitis B Vaccine (Recombivax HB) 10 mcg (1ml) IM (deltoid) x 1 dose then, repeat at 1 & 6 months **Patients 11 to 19 years of age (inclusive)** Hepatitis B Vaccine (Engerix –B) 10mcg (0.5 ml) IM (deltoid) x 1, then repeat at 1 & 6 months **OR** Hepatitis B Vaccine (Recombivax HB) 5mcg (0.5ml) IM (deltoid) x 1, repeat at 1 & 6 month**s** **AND**	• Patient has not been completely immunized for Hepatitis B (3 doses of the vaccine) or unsure of status • HBsAb (Anti-HBs) is negative (if available)	• Allergy to aluminum hydroxide or a previous adverse reaction is known • Patient history of allergic reaction/sensitivity to immune globulin or blood product/blood transfusion reaction (fever, hives, joint pain, anaphylaxis). • If patient has a fever greater than or equal to 38ºC	• If contraindications, consult the MRP/ID to determine plan of care • Explain to patient why it is important to receive Hepatitis B vaccine in conjunction with Hepatitis B Immune globulin (if necessary) • Explain options regarding Hepatitis B virus base line testing, immunity testing and prophylactic treatment for Hepatitis B virus • Obtain patient's written consent for testing and treatment and explain to patient that Hepatitis B Immune Globulin (HBIG) is prophylactic in the absence of laboratory results. • Dispense type of vaccine (Engergix or Recombivax) based on availability

All ages Hepatitis B Immune Globulin 0.06 ml/kg IM gluteal (see dosage chart and product insert dosage information) x 1 dose			

DimenhyDRINATE for Prevention of Nausea			
Order	**Indication**	**Contraindication**	**Notes (Optional)**
DimenhyDRINATE 50 mg PO once	• Patient is experiencing nausea due to the administration of prophylactic medication(s)	• Patient has a known allergy to dimenhyDRINATE • Loss of consciousness • Head injury	• If contraindications, notify MRP to determine plan of care • Ensure patient is aware of sedative effects of dimenhyDRINATE

Emergency Contraceptive Pill (ECP) for Pregnancy Drug Prophylaxis			
Order	**Indication**	**Contraindication**	**Notes (Optional)**
Measure patient height and weight Ulipristal acetate 30 mg PO regardless of weight **OR** If allergy to Ulipristal acetate, levonorgestrel 1.5 mg PO one dose	• Patient is 12 years of age or older, has a uterus and ovaries, presenting within 120 hours (5 days) of a suspected or known sexual assault regardless of condom use. • Urine β HCG result is negative	• Suspected or known sexual assault occurred more than 120 hours (5 days) regardless of condom use. • Positive urine β HCG, or is known to be pregnant • Patient is allergic to levonorgestrel or ulipristal • Patient has had tubal ligation/other highly effective methods of contraception without interruption (IUD, patch, ring, BCP) • Patient is premenarche • Patient is post menopausal without a period for greater than 1 year	• If contraindications, notify MRP to determine plan of care • Advise patient that levonorgestrel has a low incidence of side effects (i.e. gastrointestinal disturbance, dizziness, headache, breast tenderness, vaginal bleeding and fatigue) • Advise patient to have pregnancy test if period is more than one week late starting and that spotting is not considered a period. • Advise patient that there is considerable reduction in effectiveness with delay between the sexual assault and the initiation of treatment • Levonorgestrel can be used up to 5 days with a 50% efficacy rate, Ulipristal Acetate is more effective up to 5 days after vaginal penetration with a penis

Sexually Transmitted Infection Treatment for Gonorrhea in Follow Up			
Order	**Indication**	**Contraindication**	**Notes (Optional)**
Positive Gonorrhea Follow Up Treatment: cefTRIAXone 250 mg IM (with 0.9 mL 1% Lidocaine) once **OR** Cefixime 800 mg PO once **PLUS** Azithromycin 1 gram PO once **Follow up Testing:** **Prior to administration of treatment:** Gonorrhea site specific **culture** swab (if not already completed) **Test of cure (TOC):** Gonorrhea site specific culture swab (first line) **OR** C. trachomatis/N. gonorrhoeae, NAAT site specific swab/urine specimen	• Patient has been found to be positive for gonorrhea on testing completed during the acute visit • A culture swab was not collected on initial visit • Patient is 3-7 days post completion of treatment • Patient is 3 weeks post completion of treatment and/or patient declines swab collection	• Patient has known/documented allergies to Azithromycin, Cefixime, Cephalosporin's, Erythromycin, and/or Penicillin (consult ER MD or ID on alternative treatment regimen) • Breastfeeding: It is unknown if Cefixime is excreted in breast milk, consult the Emergency Physician to discuss alternative treatment • A culture swab has already been collected at initial visit	• If contraindications, notify MRP to determine plan of care • Advise patient of possible side effects (e.g. gastrointestinal; cardiac arrhythmia with Azithromycin) • Advise patient Cefixime/Azithromycin can be taken with food • Inform patient they should be retested for STIs in 3 weeks following completion of Azithromycin and/or Cefixime administration • cefTRIAXone is considered first line, it is likely that our population may choose the better tolerated cefixime orally, to avoid injection • As there is concern for increasing antibiotic drug resistance to treat infections, a consideration is to test for STIs and treat based on a positive result in follow up • When TOC is indicated, specimens should be collected from all positive sites • TOC using NAAT should only be performed post-treatment interval to avoid detection of residual genetic material • Advise the patient that repeat screening is recommended 3-6 months post-treatment due to risk of reinfection

Sexually Transmitted Infection Treatment for Chlamydia in Follow Up			
Order	**Indication**	**Contraindication**	**Notes (Optional)**
<u>Positive Chlamydia Follow Up Treatment</u> Azithromycin 1 Gram PO once	• Patient has tested positive for chlamydia trachomatis • Patient is expected to have poor compliance to 7 day regimen	• Patient has an intolerance/allergy to Azithromycin, Erythromycin, and Clarithromycin, Doxycycline and/or any of the Tetracycline's. • Patient is pregnant and/or breastfeeding	• If contraindications, notify MRP to determine plan of care • Advise patient of possible side effects (i.e. gastrointestinal disturbances, cardiac arrhythmia). • Azithromycin and/or Doxycycline can be taken with food • Inform patient they should be retested for sexually transmitted infections in 3 weeks following completion of Azithromycin administration • Doxycycline is the first line treatment for chlamydia, however, if the patient is expected to have poor compliance to the 7 day medication regimen consider using Azithromycin
OR If allergy to Azithromycin, Erythromycin or Clarithromycin, and/or patient is expected to be compliant with a 7 day regimen Doxycycline 100 mg PO BID for 7 days	• Patient has allergy to azithromycin, erythromycin, or clarithromycin • Patient is expected to be compliant with 7 day regimen		

Treatment of Bacterial Vaginosis in Follow Up			
Order	**Indication**	**Contraindication**	**Notes (Optional)**
<u>Bacterial Vaginosis (BV) Treatment</u> metroNIDAZOLE 500 mg po BID for 7 days **<u>OR</u>** (if allergy to metronidazole) Clindamycin 300 mg po BID for 7 days	• Patient has positive test for BV • Patient is symptomatic with vaginal discharge and/or odour • Patient has positive test for BV and has allergy/intolerance to metronidazole	• Patient has intolerance/allergy to Metronidazole • Patient has allergy/intolerance to Clindamycin, Erythromycin, Azithromycin	• If contraindications, notify MRP to determine plan of care • BV treatment is recommended for all symptomatic pregnant women as it has been associated with adverse pregnancy outcomes • Advise patient to refrain from sexual activity or use condoms consistently and correctly during the BV treatment regimen. • If oral route is not appropriate for patient, consult Infectious Disease specialist for further direction