PHC Chapter 12: Sexually transmitted infections

12.1 Vaginal discharge syndrome (VDS)
   12.1.1 Sexually non-active women
   12.1.2 Sexually active women
12.2 Lower abdominal pain (LAP)
12.3 Male urethritis syndrome (MUS)
12.4 Scrotal swelling (SSW)
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12.8 Syphilis serology and treatment
12.9 Treatment of more than one STI syndrome
12.10 Treatment of partners
12.11 Genital molluscum contagiosum (MC)
12.12 Genital warts (GW) Condylomata Accuminata
12.13 Pubic lice (PL)
The syndromic approach to Sexually Transmitted Infections (STIs) diagnosis and management is to treat the signs or symptoms (syndrome) of a group of diseases rather than treating a specific disease. This allows for the treatment of one or more conditions that often occur at the same time and has been accepted as the management of choice.

Causative organisms and medicine management for STI syndromes:

<table>
<thead>
<tr>
<th>ORGANISM</th>
<th>SYNDROME/S</th>
<th>MEDICINE MANAGEMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neisseria gonorrhoeae</td>
<td>VDS, MUS, LAP</td>
<td>ceftriaxone + azithromycin</td>
</tr>
<tr>
<td>Chlamydia trachomatis</td>
<td>VDS, MUS, LAP, GUS, Bubo</td>
<td>azithromycin</td>
</tr>
<tr>
<td>Trichomonas vaginalis</td>
<td>VDS, LAP</td>
<td>metronidazole</td>
</tr>
<tr>
<td>Bacterial vaginosis</td>
<td>VDS</td>
<td>metronidazole</td>
</tr>
<tr>
<td>(overgrowth of Gardnerella vaginalis, lactobacillus, anaerobes etc.)</td>
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<tr>
<td>Candida albicans</td>
<td>VDS</td>
<td>clotrimazole</td>
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<tr>
<td>Treponema pallidum</td>
<td>GUS</td>
<td>doxycycline/ benzathine benzylpenicillin</td>
</tr>
<tr>
<td>Herpes simplex</td>
<td>GUS</td>
<td>aciclovir</td>
</tr>
<tr>
<td>Haemophilus ducreyi</td>
<td>GUS, Bubo</td>
<td>azithromycin</td>
</tr>
</tbody>
</table>

It is important to take a good sexual history and undertake a thorough ano-genital examination in order to perform a proper clinical assessment. The history should include questions concerning symptoms, recent sexual history, sexual orientation, type of sexual activity (oral, vaginal, anal sex), the possibility of pregnancy (females), use of contraceptives including condoms, recent antibiotic history, antibiotic allergy, recent overseas travel and domestic violence. Refer to a social worker, as required.

Note: Standard referral letter for treatment failure must include the following:
» reason for referral: presumptive diagnosis (e.g. persistent cervicitis with suspected resistant gonorrhoea)
» clinical findings including speculum examination for vaginal discharge
» treatment history (including all medicines with dose and duration)
» details of notification and treatment history of partner(s)

Suspected STI in children should be referred to hospital for further investigation and management.

GENERAL MEASURES
» Counselling and education, including HIV testing.
» Condom promotion, provision and demonstration to reduce the risk of STIs.
» Compliance/ adherence with treatment.
» Contact treatment/ partner management.
» Circumcision promotion (counselling to continue condom use).
» Cervical cancer screening.
Benzathine benzylpenicillin
Benzathine benzylpenicillin remains the recommended treatment for syphilis. However, due to global shortage of benzathine benzylpenicillin (limited global supply of the active pharmaceutical ingredient) the algorithms now recommend doxycycline, oral except in pregnant women and children. Azithromycin is not recommended for the treatment of syphilis in pregnancy as azithromycin does not effectively treat syphilis in the fetus, and resistance develops rapidly to macrolides. Therefore, the limited stock of benzathine benzylpenicillin must be reserved for use in pregnant women and children.
12.1 VAGINAL DISCHARGE SYNDROME (VDS)
B37.3/N76.0/N89.8

12.1.1 SEXUALLY NON-ACTIVE WOMEN

Patient complains of abnormal vaginal discharge AND NOT sexually active within last 3 months

**Treat for vaginal candidiasis**
- Clotrimazole vaginal pessary 500mg inserted as a single dose at night OR
- Clotrimazole vaginal cream, insert applicator 12 hourly x 7 days
If prominent vulval symptoms present:
- Clotrimazole topical cream, apply 12 hourly for 7 days.
If no response after 7 days, refer for further investigation and management

**Treat for bacterial vaginosis**
- Metronidazole, oral, 2 g as a single dose.
If no response after 7 days:
Do a PV and speculum examination of cervix

Use lower abdominal pain flowchart (LAP)

Y

Pain on moving the cervix?

N

**Treat cervicitis**
- Ceftriaxone, IM, 250 mg as a single dose* AND
- Azithromycin, oral, 1 g, as a single dose

Y

Cervicitis?
(Cervical inflammation, mucopurulent discharge, red granular cervical erosion, cervical friability, oedema)

N

Continue treatment for bacterial vaginosis
- Metronidazole, oral, 400 mg 12 hourly for 7 days.

If no response after 7 days, refer for further investigation and management

*People who are severely allergic to penicillin may also react to ceftriaxone.
If severe penicillin allergy, i.e. angioedema, anaphylactic shock or bronchospasm, omit ceftriaxone and increase azithromycin dose to:
- Azithromycin, oral, 2g, as a single dose.

For ceftriaxone IM injection: Dissolve 250mg in 0.9mL lidocaine 1% without epinephrine (adrenaline).

**Note:**
- Do a speculum examination in all patients presenting with VDS.
- Pap smear should be taken after treatment, according to screening guidelines.
- Suspected STI in children should be referred to hospital for further management.
CHAPTER 12 SEXUALLY TRANSMITTED INFECTIONS

12.1.2 SEXUALLY ACTIVE WOMEN

Patient complains of abnormal vaginal discharge
AND
Sexually active within last 3 months

Lower abdominal pain (LAP) or
Pain on moving the cervix?

N

TREATMENT (all cases including pregnant women)

- Ceftriaxone, IM, 250 mg as a single dose*
  and
- Azithromycin, oral, 1 g, as a single dose
  and
- Metronidazole, oral, 2 g as a single dose

If vulva red/scratched/inflamed and/or curd-like discharge: treat for vaginal candidiasis

- Clotrimazole vaginal pessary 500mg inserted as a single dose at night
  OR
- Clotrimazole vaginal cream, insert applicator 12 hourly for 7 days

Ask patient to return if symptoms persist.
- Metronidazole, oral, 400 mg, 12 hourly for 7 days
If no response after 7 days, refer for further investigation and management.

Y

Use lower abdominal pain flowchart (LAP)

*People who are severely allergic to penicillin may also react to ceftriaxone.
If severe penicillin allergy, i.e. angioedema, anaphylactic shock or bronchospasm, omit ceftriaxone and increase azithromycin dose to:
- Azithromycin, oral, 2 g, as a single dose.

For ceftriaxone IM injection: Dissolve 250 mg in 0.9 mL lidocaine 1% without epinephrine (adrenaline).

Note:
- Do a speculum examination in all patients presenting with VDS.
- Pap smear should be taken after treatment, according to screening guidelines.
- Suspected STI in children should be referred to hospital for further management.
12.2 LOWER ABDOMINAL PAIN (LAP) N73.9

Sexually active patient complains of lower abdominal pain with/without vaginal discharge

Take history (including gynaecological) and examine (abdominal and vaginal)
Emphasise HIV testing

Any of the following present:
» Pregnancy
» Missed period
» Recent delivery, TOP or miscarriage
» Abdominal guarding and/or rebound tenderness
» Abdominal vaginal bleeding
» Abdominal mass
» Fever > 38°C

Y

Lower abdominal tenderness with/without vaginal discharge

N

Urinalysis results or symptoms consistent with UTI and absence of cervical motion tenderness

N

TREATMENT
• Ceftriaxone, IM, 250 mg single dose* AND
• Azithromycin, oral, 1 g as a single dose AND
• Metronidazole, oral, 400 mg 12 hourly for 7 days

Pain not improving after 48 – 72 hours, refer urgently for gynaecological assessment

Y

Improved after 7 days

N

Refer

Discharge patient

Y

SEVERELY ILL PATIENTS
Set up an IV line and treat shock if present.
• Ceftriaxone, IV, 1 g (Do not dilute with lidocaine 1%).
AND
• Metronidazole, oral, 400 mg

For pain, add: Ibuprofen, oral 400 mg 8 hourly with food

*If severe penicillin allergy, i.e. angioedema, anaphylactic shock or bronchospasm, omit ceftriaxone and increase azithromycin dose to:
• Azithromycin, oral, 2 g as a single dose.

For ceftriaxone IM injection: Dissolve 250 mg in 0.9 mL lidocaine 1% without epinephrine (adrenaline).
12.3 MALE URETHRITIS SYNDROME (MUS)

A64 + N34.1

Patient complains of urethral discharge or dysuria

Take history, including sexual orientation and examine. If no visible discharge; ask patient to milk urethra. Emphasise HIV testing and partner(s) tracing

Discharge

Y

TREATMENT

- Ceftriaxone, IM, 250 mg single dose*
- Azithromycin, oral, 1 g as a single dose

If sexual partner has VDS, add:
- Metronidazole, oral, 2 g as a single dose

Urethral discharge persist after 7 days

Suspected ceftriaxone 250 mg treatment failure:
Refer all ceftriaxone treatment failures within 7 days for further investigation and management.

*If severe penicillin allergy, i.e. angioedema, anaphylactic shock or bronchospasm, omit ceftriaxone and increase azithromycin dose to:
  - Azithromycin, oral, 2 g as a single dose.

For ceftriaxone IM injection:
- Dissolve ceftriaxone 250 mg in 0.9 mL lidocaine 1% without epinephrine (adrenaline).
12.4 SCROTAL SWELLING (SSW)

Sexually active patient complains of scrotal swelling/ pain

Take history and examine. Emphasise HIV testing.

Scrotal swelling or pain confirmed?

Y

Testes rotated and elevated or History of trauma or Other non-tender swelling not thought to be due to sexual activity?

N

Refer for surgical opinion

Refer urgently if suspected torsion

For pain add:
- Ibuprofen, oral, 400 mg 8 hourly with food

TREATMENT
- Ceftriaxone, IM, 250 mg as a single dose*
- Azithromycin, oral, 1 g as a single dose

Review after 7 days or earlier if necessary

Improving?

Y

Complete treatment and discharge patient.

N

*If severe penicillin allergy, i.e. angioedema, anaphylactic shock or bronchospasm, omit ceftriaxone and increase azithromycin dose to:
- Azithromycin, oral, 2 g as a single dose.

For ceftriaxone IM injection: dissolve 250 mg in 0.9 mL lidocaine 1% without epinephrine (adrenaline).
12.5 GENITAL ULCER SYNDROME (GUS)

A60.9/A51.0

LoE:III*  

**Penicillin allergic pregnant women: refer for confirmation of new syphilis infection and possible penicillin desensitisation.**

**For benzathine benzylpenicillin, IM, 2.4 MU: Dissolve benzathine benzylpenicillin 2.4 MU in 5 mL lidocaine 1% without epinephrine (adrenaline).**

*** 6-month follow-up RPR required of early syphilis cases treated with doxycycline OR amoxicillin + probenecid.

Note: Pregnant women presenting with genital ulcer(s) in the third trimester should be referred (risk of neonatal herpes).
12.6 BUBO

Patient complains of hot tender inguinal swelling with surrounding erythema and/or oedema.

Take history and examine. **Emphasise HIV testing.** Exclude hernia or femoral aneurysm.

Bubo confirmed?

**Y**

**TREATMENT**

- **Azithromycin**, oral, 1 g immediately, followed by 1 g, weekly for 2 weeks.

**If bubo is fluctuant**

Aspirate pus in sterile manner. Repeat every 72 hours, as necessary.

**If no improvement after 14 days, refer.**

LoE:III**

2018 12.10
12.7 BALANITIS/BALANOPOSTHITIS (BAL) N48.1

Sexually active patient complains of scrotal swelling/pain

Take history and examine. Emphasise HIV testing.

Scrotal swelling or pain confirmed?

N

Testes rotated and elevated or History of trauma or Other non-tender swelling not thought to be due to sexual activity?

N

TREATMENT

- Ceftriaxone, IM, 250 mg as a single dose∗ and
- Azithromycin, oral, 1 g as a single dose

Review after 7 days or earlier if necessary

Y

Improving?

Y

Complete treatment and discharge patient.

N

For pain add:
- Ibuprofen, oral, 400 mg 8 hourly with food

Refer urgently if suspected torsion

Y

∗If severe penicillin allergy, i.e. angioedema, anaphylactic shock or bronchospasm, omit ceftriaxone and increase azithromycin dose to:
- Azithromycin, oral, 2 g as a single dose.

For ceftriaxone IM injection: dissolve 250 mg in 0.9 mL lidocaine 1% without epinephrine (adrenaline).
12.8 SYPHILIS SEROLOGY AND TREATMENT
A53.9

Syphilis serology
The Rapid Plasmin Reagin (RPR) measures disease activity, but is not specific for syphilis. False RPR-positive reactions may occur, notably in patients with connective tissue disorders (false positive reactions are usually low titre <1:8). For this reason, positive RPR results should be confirmed due to syphilis by further testing of the serum with a specific treponemal test, e.g.:
- Treponema pallidum haemagglutination (TPHA) assay.
- Treponema pallidum particle agglutination (TPPA) assay.
- Fluorescent Treponemal Antibody (FTA) assay.
- Treponema pallidum ELISA.
- Rapid treponemal antibody test (TPAb)

Screening can also be done the other way around starting with a specific treponemal test followed by a RPR in patients who have a positive specific treponemal test. This is sometimes referred to as the “reverse algorithm”.

- Once positive, specific treponemal tests generally remain positive for life and therefore the presence of specific treponemal antibodies cannot differentiate between current and past infections
- A person with previously successfully treated syphilis will retain lifelong positive specific treponemal test results.

The RPR can be used:
- To determine if the patient’s syphilis disease is active or not,
- To measure a successful response to therapy (at least a fourfold reduction in titre, e.g. 1:256 improving to 1:64), or
- To determine a new re-infection.

Some patients, even with successful treatment for syphilis, may retain life-long positive RPR results at low titres (≤1:8), which do not change by more than one dilution difference (up or down) over time (so-called serofast patients).

Note:
- Up to 30% of early primary syphilis cases, i.e. those with genital ulcers may have a negative RPR.
- The RPR is always positive in the secondary syphilis stage and remains high during the first two (infectious) years of syphilis.

For syphilis treatment in pregnancy, see Section 6.4.4: Syphilis in pregnancy.
CHAPTER 12 SEXUALLY TRANSMITTED INFECTIONS

Perform RPR if indicated:
- sexual assault case
- suspected secondary syphilis
- suspected tertiary syphilis
- 6-month follow-up of syphilis cases treated with doxycycline OR amoxicillin + probenecid

RPR results

- positive
- negative

Previous RPR results available and previously treated for syphilis?

- Y

What was the last RPR result?

- Current RPR \( \geq 4 \) fold than the last RPR, e.g., was 1:8 and now \( \geq 1:32 \)
- Negative RPR in the last 2 years?

Symptoms/ signs of genital ulcer or secondary syphilis present?

- Y

- N

Treat as early syphilis:
- Benzathine benzylpenicillin IM, 2.4 MU immediately as a single dose*

Treat as latent syphilis:
- Benzathine benzylpenicillin IM, 2.4 MU once weekly for 3 weeks**

Penicillin-allergic pregnant women:
Refer for penicillin desensitisation.

- N

Current RPR is 4 fold lower, or, in a known "serofast patient," is the same, lower or no more than 2 fold higher than the last RPR e.g., was 1:4 and now no more than 1:8 (Refer to text).

Discharge

*Early syphilis treatment:
Severe penicillin allergy or benzathine benzylpenicillin is unavailable:
- Doxycycline, oral, 100 mg 12 hourly for 14 days.

Pregnant or benzathine benzylpenicillin is unavailable:
- Amoxicillin, oral, 1 g 8 hourly for 14 days
  AND
- Probenecid, oral 250 mg 8 hourly for 14 days.

**Latent/late latent syphilis treatment:
Severe penicillin allergy or benzathine benzylpenicillin is unavailable:
- Doxycycline, oral, 100 mg 12 hourly for 30 days.

Pregnant or benzathine benzylpenicillin is unavailable:
- Amoxicillin, oral, 1 g 8 hourly for 28 days
  AND
- Probenecid, oral 250 mg 8 hourly for 28 days.

For benzathine benzylpenicillin, IM, 2.4 MU: Dissolve 2.4 MU in 6 mL lidocaine 1% without epinephrine (adrenaline).
MEDICINE TREATMENT

Early syphilis treatment
Check if treated at initial visit.
- Benzathine benzylpenicillin, IM, 2.4 MU immediately as a single dose.
  - Dissolve benzathine benzylpenicillin, IM, 2.4 MU in 6 mL lidocaine 1% without adrenaline (epinephrine).

In penicillin-allergic patients or if benzathine benzylpenicillin is unavailable: (Z88.0)
- Doxycycline, oral, 100 mg 12 hourly for 14 days.

If pregnant and benzathine benzylpenicillin is unavailable:
- Amoxicillin, oral 1 g 8 hourly for 14 days (Doctor initiated).

AND
- Probenecid, oral 250 mg, 8 hourly for 14 days (Doctor initiated).

If penicillin-allergic and pregnant: Refer for penicillin desensitisation.

Late/late latent syphilis treatment
Check if treatment was commenced at initial visit.
- Benzathine benzylpenicillin, IM, 2.4 MU once weekly for 3 weeks.
  - Dissolve benzathine benzylpenicillin, IM, 2.4 MU in 6 mL lidocaine 1% without adrenaline (epinephrine).

In penicillin-allergic patients or if benzathine benzylpenicillin is unavailable: (Z88.0)
- Doxycycline, oral, 100 mg 12 hourly for 30 days.

If pregnant and benzathine benzylpenicillin is unavailable:
- Amoxicillin, oral 1 g 8 hourly for 28 days (Doctor initiated).

AND
- Probenecid, oral 250 mg, 8 hourly for 28 days (Doctor initiated).

If penicillin-allergic and pregnant: Refer for penicillin desensitisation.

REFERRAL
» Tertiary syphilis: neurosyphilis, cardiovascular syphilis; gummatous syphilis.
» Clinical congenital syphilis.

12.9 TREATMENT OF MORE THAN ONE STI SYNDROME

<table>
<thead>
<tr>
<th>STI SYNDROMES</th>
<th>TREATMENT (NEW EPISODE)</th>
</tr>
</thead>
<tbody>
<tr>
<td>MUS + SSW</td>
<td>Treat according to SSW flow chart.</td>
</tr>
</tbody>
</table>
| MUS + BAL     | Treat according to MUS flow chart.  
  AND
  - Clotrimazole cream, 12 hourly for 7 days. |
| MUS + GUS     | - Ceftriaxone, IM, 250 mg immediately as a single dose.  
  AND
  - Azithromycin, oral, 1 g as a single dose.  
  AND
  - Aciclovir, oral, 400 mg 8 hourly for 7 days*. |
<table>
<thead>
<tr>
<th>Syndrome</th>
<th>Asymptomatic partner</th>
<th>Symptomatic partner</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>VDS</strong></td>
<td>• Ceftriaxone, IM, 250 mg immediately as a single dose.</td>
<td>• Ceftriaxone, IM, 250 mg immediately as a single dose.</td>
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<tr>
<td></td>
<td>AND</td>
<td><strong>AND</strong></td>
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<tr>
<td></td>
<td>• Metronidazole, oral, 2 g immediately as a single dose.</td>
<td>• Metronidazole, oral, 2 g immediately as a single dose.</td>
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<tr>
<td></td>
<td>AND</td>
<td><strong>AND</strong></td>
</tr>
<tr>
<td></td>
<td>• Azithromycin, oral, 1 g as a single dose.</td>
<td>• Azithromycin, oral, 1 g as a single dose.</td>
</tr>
<tr>
<td></td>
<td>PLUS treatment for syndrome present if not included in the above.</td>
<td>PLUS treatment for syndrome present if not included in the above.</td>
</tr>
<tr>
<td><strong>LAP</strong></td>
<td>• Ceftriaxone, IM, 250 mg immediately as a single dose.</td>
<td>• Ceftriaxone, IM, 250 mg immediately as a single dose.</td>
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<tr>
<td></td>
<td><strong>AND</strong></td>
<td><strong>AND</strong></td>
</tr>
<tr>
<td></td>
<td>• Azithromycin, oral, 1 g as a single dose.</td>
<td>• Azithromycin, oral, 1 g as a single dose.</td>
</tr>
</tbody>
</table>

**Treat with aciclovir only if HIV status is positive or unknown.**

**Penicillin allergic men and non-pregnant women avoid ceftriaxone and refer to relevant algorithms.**

Penicillin allergic pregnant/breastfeeding women, refer for penicillin desensitisation.
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<tr>
<th>Chapter 12: Sexually Transmitted Infections</th>
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</thead>
<tbody>
<tr>
<td><strong>MUS</strong></td>
</tr>
<tr>
<td>• Metronidazole, oral, 2 g immediately as a single dose.</td>
</tr>
<tr>
<td>AND</td>
</tr>
<tr>
<td>• Azithromycin, oral, 1 g as a single dose.</td>
</tr>
<tr>
<td>AND</td>
</tr>
<tr>
<td>• Azithromycin, oral, 1 g as a single dose.</td>
</tr>
<tr>
<td>PLUS treatment for syndrome present if not included in the above.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Scrotal swelling</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Ceftriaxone, IM, 250 mg immediately as a single dose.</td>
</tr>
<tr>
<td>AND</td>
</tr>
<tr>
<td>• Azithromycin, oral, 1 g as a single dose.</td>
</tr>
<tr>
<td>AND</td>
</tr>
<tr>
<td>• Azithromycin, oral, 1 g as a single dose.</td>
</tr>
<tr>
<td>PLUS treatment for syndrome present if not included in the above. (see VDS flow chart).</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>GUS</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Doxycycline, oral, 100 mg 12 hourly for 14 days.</td>
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<tr>
<td>Except pregnant women:</td>
</tr>
<tr>
<td>• Benzathine benzylpenicillin, IM, 2.4 MU immediately as a single dose.</td>
</tr>
<tr>
<td>o Dissolve benzathine benzylpenicillin, IM, 2.4 MU in 6 mL lidocaine 1% without epinephrine (adrenaline). (If pregnant and benzathine benzylpenicillin is unavailable, see syphilis flow chart).</td>
</tr>
<tr>
<td>AND</td>
</tr>
<tr>
<td>• Azithromycin, oral, 1 g as a single dose.</td>
</tr>
<tr>
<td>AND</td>
</tr>
<tr>
<td>• Azithromycin, oral, 1 g as a single dose.</td>
</tr>
<tr>
<td>PLUS treatment for syndrome present if not included in the above. (If pregnant and benzathine benzylpenicillin is unavailable, see syphilis flow chart).</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Bubo</th>
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</thead>
<tbody>
<tr>
<td>• Azithromycin, oral, 1 g as a single dose.</td>
</tr>
</tbody>
</table>

| LoE:II**                                  |

2018 12.16
12.11 GENITAL MOLLUSCUM CONTAGIOSUM (MC)  
B08.1

DESCRIPTION
This is a viral infection which can be transmitted sexually and non-sexually. It is usually self-limiting but can be progressive in an advanced stage of immunodeficiency. Clinical signs include papules at the genitals or other parts of the body. The papules usually have a central dent (umbilicated papules).

MEDICINE TREATMENT
- Tincture of iodine BP, topical.
  - Apply with an applicator to the core of the lesions.

12.12 GENITAL WARTS (GW): CONDYLOMATA ACCUMINATA  
A63.0

DESCRIPTION
The clinical signs include:
» Warts on the ano-genital areas, vagina, cervix, meatus or urethra.
» Warts can be soft or hard.
In most cases, warts resolve without treatment after 2 years in non-immunosuppressed patients.

GENERAL MEASURES
» If warts do not look typical or are fleshy or wet, perform a RPR test to exclude secondary syphilis, which may present with similar lesions.
» Emphasise HIV testing.

REFERRAL
» All patients with:
  - warts > 10 mm
  - inaccessible warts, e.g. intra-vaginal or cervical warts
  - numerous warts

12.13 PUBIC LICE (PL)  
B85.3

DESCRIPTION
Infestation of lice mostly confined to pubic and peri-anal areas, and occasionally involves eyelashes. The bites cause intense itching, which often results in scratching with bacterial super-infection.
CHAPTER 12 SEXUALLY TRANSMITTED INFECTIONS

GENERAL MEASURES
Thoroughly wash clothing and bed linen that may have been contaminated by the patient in the 2 days prior to the start of treatment in hot water and then iron.

MEDICINE TREATMENT
- Benzyl benzoate 25%
  - Apply to affected area.
  - Leave on for 24 hours, then wash thoroughly.
  - Repeat in 7 days.

Pediculosis of the eyelashes or eyebrows
- Yellow petroleum jelly (Note: Do not use white petroleum jelly near the eyes).
  - Apply to the eyelid margins (cover the eyelashes) daily for 10 days to smother lice and nits.
  - Do not apply to eyes.

REFERRAL
All children with lice on pubic, perianal area and eyelashes to exclude sexual abuse.

References:


CHAPTER 12 SEXUALLY TRANSMITTED INFECTIONS


