**Sample Sexually Transmitted Infection  
Standing Delegation Orders  
for Nurse Clinicians  
Created March 2020 (Revised April 2024)**





Contents

[Sample Authorization for STI SDOs for Nurse Clinicians 3](#_Toc87609213)

[Sample History, Counseling, Physical Exam and Laboratory Testing 8](#_Toc87609214)

[Sample Policy and Protocol for “Express” Clinic Services 10](#_Toc87609215)

[Sample Chlamydia SDO 11](#_Toc87609216)

[Sample Gonorrhea SDO 18](#_Toc87609217)

[Sample Syphilis SDO 26](#_Toc87609218)

[Appendix A — Sample Physical Exam Procedures 37](#_Toc87609219)

[Appendix B — Sample Specimen Collection Instructions 43](#_Toc87609220)

[Appendix C — Sample Self-Collection Posters 47](#_Toc87609221)

[Appendix D — Sample Expedited Partner Therapy Partner Instruction Sheets and Log 48](#_Toc87609222)

[Appendix E — Syphilis Serologic Screening Algorithms 58](#_Toc87609223)

*Click on the sections above or use [view] [navigation pane] [headings] in MS Word to navigate this publication.*

# Sample Authorization for STI SDOs for Nurse Clinicians

Name of Agency:

Name of Authorizing Physician:

## Introduction

Nurses provide many clinical nursing services in their communities. One important service is sexually transmitted infection (STI) care. The sample STI Nurse Clinician Standing Delegation Orders (SDOs) that follow are designed to assist nurse clinicians to provide high-quality STI care, including screening, assessing, treatment and client education. The SDOs are a generic example that clinicians can use in a variety of settings. They are not all-inclusive. Other testing and treatment options may be available. Authorizing physicians who supervise STI clinicians should edit and approve the SDOs. Base revisions on community needs and the capacity of clinics and staff.

## Definition and Purpose

A qualified physician writes standing delegation orders (SDOs). State rules and regulations authorize SDOs, which are a set of instructions, orders and procedures. They are not for individual clients. They are for a client population with specific diseases, disorders, health problems or sets of symptoms. The purpose of the SDOs is to provide authority and a plan for nurse clinicians to use with clients before being examined or evaluated by a physician. SDOs are distinct from specific orders written for an individual client.

## Authority

The Texas Administrative Code (TAC) authorizes STI clinical services using SDOs:

* [TAC Title 22, Part 9, Chapter 193, Rule §193.2, Definitions, Standing Delegation Orders](https://texreg.sos.state.tx.us/public/readtac$ext.TacPage?sl=T&app=9&p_dir=P&p_rloc=164182&p_tloc=&p_ploc=1&pg=3&p_tac=&ti=22&pt=9&ch=193&rl=4)
* [TAC Title 22, Part 9, Chapter 193, Rule §193.4, Scope of Standing Delegation Orders](https://texreg.sos.state.tx.us/public/readtac$ext.TacPage?sl=R&app=9&p_dir=&p_rloc=&p_tloc=&p_ploc=&pg=1&p_tac=&ti=22&pt=9&ch=193&rl=4)

These SDOs authorize licensed registered nurses (RNs)[[1]](#footnote-2) at **<<Name of Agency>>** to perform the acts described in these SDOs in consultation with the authorizing physician, **<<Name of Authorizing Physician>>**. All parties agree to follow procedures that conform to:

* Texas Administrative Code
* Texas Medical Practice Act
* Texas Nursing Practice Act
* 2021 CDC STI Treatment Guidelines

## Method for Development, Approval and Revision

* DSHS developed sample SDOs as evidenced-based practice using the 2021 CDC STI Treatment Guidelines.
* The authorizing physician, **<<Name of Authorizing Physician>>**, reviewed the sample SDOs, edited the content to be suitable for **<<Name of Agency>>**, signed the SDOs, and distributed the SDOs for authorized STI nurse clinicians they supervise to use.
* The authorizing physician, a physician licensed by the Texas Medical Board who executes these SDOs, will review and sign the SDOs yearly.
* RNs will review and sign the SDOs yearly. **<<Name of Agency>>** will retain the SDOs and signature sheets for **<<Number of Years>>** years.

## Required Experience, Training, Competence and Education

To carry out acts in these SDOs, the nurse clinician must:

* Be an employee of **<<Name of Agency>>**.
* Hold a current registered nursing license from the Texas Board of Nursing. **<<Name of Agency>>** will place verification of current licensure from the Texas Board of Nursing in the employee’s personnel file and review it yearly.
* Be currently certified in Basic Cardiac Life Support (BCLS).
* Complete authorizing physician approved training in accordance with appropriate STI clinical procedures and standards. The training should include the [Self-Study STD Modules for Clinicians](https://www.std.uw.edu/custom/self-study) from the University of Washington STD Prevention Training Center or similar course (specify).
* Complete the following initial or continuing evaluation of competence relevant to STI clinical services within 12 months before signing and providing services in these SDOs:
  + The nurse’s supervisor or licensed clinical designee must perform the initial evaluation of competence. This includes verification that the authorized licensed nurse possesses a valid nursing license, a post-test evaluation of initial training, as described above, and observation of the required clinical skills.
  + The nurse’s supervisor or licensed clinical designee must perform continuing evaluation of competence yearly. This includes verification that the authorized licensed registered nurse possesses a valid nursing license, a review with a post-test evaluation, and periodic observation of the required clinical skills.
  + If the nurse’s supervisor is not a licensed clinician, the authorizing physician (or their licensed clinical designee) must oversee the clinical practice of the authorized licensed nurse and observe the required clinical skills.
  + The nurse’s supervisor must document and maintain a record of the required training completed by and demonstrated competence of the authorized licensed nurse.
* Review these SDOs and sign the Attestation of Authorized Licensed Nurse (page 6 of this document) within 12 months before providing services in these SDOs.

## Required Procedures for Authorized Licensed Nurses

* Follow all infection control procedures when providing clinical services.
* Use interpreter services to communicate with limited English proficient (LEP) clients.
* Confirm that the client is who they claim to be, if possible.
* Create a health record and get client consent and signature in the preferred language of the client according to agency policy. Give the client copies of the **<<Name of Agency>>** HIPAA privacy notice and applicable signed consent forms.
* Document accurate and detailed information of each client visit in the client medical record, including:
  + Staff involved in treatment and evaluation
  + Nursing care delivered, including an appropriate physical exam, medical history, sexual history, risk assessment, and client teaching and counseling, including precautions and preventive measures
  + Actions carried out in these SDOs
  + Drugs administered, prescribed or provided
  + Other information routinely noted on client health records maintained by clinicians in their offices

## Limitations on Setting

Authorized licensed nurses can provide services in these SDOs in the clinic setting, the client home, or other field settings where the nurse can contact the authorizing physician by phone.

* Authorized licensed registered nurses (RNs) who provide services using these SDOs should contact the authorizing physician (or the authorized physician on call) when they need medical direction or consultation. They should do this when client assessment data deviates from normal limits or as specified in an individual SDO. In an emergency situation, call 911, provide first aid services, and contact the authorizing physician.
* RNs who treat clients off-site should bring a description of safety measures, including anaphylaxis response, verification of ambulance service availability, and phone accessibility (cell coverage or land line).
* Other clinic physicians may develop SDOs or standing medical orders which the **<<Name of Authorizing Physician>>** must review yearly and authorized licensed nurses must carry out. For more information on the authority of a physician to delegate, see [Texas Occupations Code, Chapter 157, Subchapter A, General Provisions, Section 157.001](https://statutes.capitol.texas.gov/Docs/OC/htm/OC.157.htm#157.001).

## Resources

**<<Name of Agency>>** must provide the latest versions of the following resources to the RN:

* Centers for Disease Control and Prevention (CDC). [CDC STI Treatment Guidelines](https://www.cdc.gov/std/treatment-guidelines/toc.htm).
* Centers for Disease Control and Prevention (CDC). [A Guide to Taking a Sexual History](https://www.cdc.gov/std/treatment/sexualhistory.pdf).
* Altarum Institute. [Sexual Health and Your Patients: A Provider’s Guide](https://nationalcoalitionforsexualhealth.org/tools/for-healthcare-providers/sexual-health-and-your-patients-a-providers-guide). Washington, DC: Altarum Institute; 2016. Updated 2020.
* Centers for Disease Control and Prevention (CDC). [CDC Expedited Partner Therapy](http://www.cdc.gov/std/ept/).
* Texas Department of State Health Services (DSHS). [Expedited STI Management Implementation Guide](https://dshs.texas.gov/hivstd/ept/ExSTDSvcsManual.doc).
* Texas Department of State Health Services. [Program Operating Procedures (POPS) Chapter 12: STI Clinical Standards](https://www.dshs.texas.gov/hivstd/pops/chap12.shtm), [POPs Chapter 23: Congenital Syphilis](https://www.dshs.state.tx.us/hivstd/pops/chap23.shtm), [POPs Chapter 9: DIS Performance Standards](https://www.dshs.texas.gov/hivstd/pops/chap09.shtm).
* Texas Department of State Health Services. [Child Abuse Reporting Requirements for Contractors and Providers](https://www.dshs.texas.gov/childabusereporting/default.shtm).
* Centers for Disease Control and Prevention (CDC). 2006. [CDC HIV Testing](http://www.cdc.gov/hiv/guidelines/testing.html).
* Texas Board of Nursing. [BNE Position Statement 15.5: Nurses with Responsibility for Initiating Physician Standing Orders](http://www.bne.state.tx.us/practice_bon_position_statements_content.asp#15.5) and [BNE Position Statement 15.17: Texas Board of Nursing and Board of Pharmacy Joint Position Statement on Medication Errors](http://www.bne.state.tx.us/practice_bon_position_statements_content.asp#15.17)
* Texas Department of State Health Services. [Management of Gonorrhea Treatment Failure](https://dshs.texas.gov/hivstd/info/edmat/gonorrheatreatmentfailure.pdf).
* NYC Prevention Training Center. [Syphilis Monograph: The Diagnosis, Management and Prevention of Syphilis](https://www.nycptc.org/x/Syphilis_Monograph_2019_NYC_PTC_NYC_DOHMH.pdf).
* Texas Department of State Health Services (DSHS). [DSHS Congenital Syphilis Call to Action](https://www.dshs.texas.gov/hivstd/info/edmat/CongenitalSyphilisCall.pdf), released on November 23, 2020.
* National Association of City and County Health Officials (NACCHO). [NACCHO Issue Brief — STI Express Services: Increasing Access and Testing While Maximizing Resources](https://www.naccho.org/uploads/downloadable-resources/issue-brief_STI-Express-Services.pdf). November 2019.

## Date and Signature of the Authorizing Physician

These SDOs are effective on the date the authorizing physician signs below. They will remain in effect until the authorizing physician rescinds them upon a change in the authorizing physician or at the end of business on **<<DD/MM/YY>>**.

Authorizing Physician Signature:

Authorizing Physician Title:

Printed Name:

Effective Date:

Emergency Contact Information:

## Attestation of Authorized Licensed Nurse

I read and understand these **<<Name of Agency>>** Sexually Transmitted Infection Standing Delegation Orders for Nurse Clinicians signed by the authorizing physician. I agree that I meet all qualifications for authorized licensed registered nurses (RNs) in these SDOs. I agree to follow all instructions in these SDOs.

Printed Name of Authorized Licensed RN:

Signature of Authorized Licensed RN:

Title of Authorized Licensed RN:

Date of Authorized Licensed RN Signature:

# Sample History, Counseling, Physical Exam and Laboratory Testing

## History

Cordially greet the client. Explain that providers ask all clients about their sexual history to provide the best possible care. Let the client know that information they share is confidential. Use the client’s preferred name and pronoun. Get the history in a non-judgmental manner. Use open-ended questions and plain language. The history should include:

1. Chief complaint
2. History of present Illness, including STI signs, symptoms and complications.
3. Current medications and medication allergies
4. Past medical history — You may defer for “Express” services.
5. Sexual history (and OB/GYN for people of child-bearing capacity) — The sexual history should include sex at birth, sexual orientation, gender identity and cover the “Five Ps”:
   * **P**artners — gender and number, new partners, most recent sexual contact
   * **P**ractices — types of sex (oral, anal, vaginal) and exposure (give, receive)
   * **P**ast history of STIs — previous STIs, HIV status
   * **P**rotection from STIs — condom use, risk reduction, Pre-Exposure Prophylaxis (PrEP)
   * **P**regnancy intention — family planning, contraceptive use
   * **P**lus-Pleasure, Problems, Pride — optional sixth “P”
6. **P**sychosocial history — behavioral and other risk factors for HIV and other STIs, e.g. substance use, history of criminal justice involvement, transactional sex, screening for intimate partner and domestic violence, and human trafficking

## Counseling

After obtaining a sexual history, encourage risk reduction by offering prevention counseling. Prevention counseling is most effective if provided in a nonjudgmental and empathetic manner appropriate to the client’s culture, language, sex and gender identity, sexual orientation, age, and developmental level.

## Physical Exam

A physical exam for STIs includes inspection of the skin, oropharynx, lymph nodes, anogenital area, and neurologic system (as indicated for syphilis). Base the exam on the client’s current anatomy. See Appendix A — Sample Physical Exam Procedures.

### Female Anatomy

For female anatomy, the pelvic exam should include:

1. Inspection of the external genitalia, urethral meatus, vaginal introitus, and perianal region;
2. Speculum exam of the vagina and cervix; and
3. Bimanual exam of the uterus, cervix, and adnexa.

### Male Anatomy

For male anatomy, the exam should include:

1. Inspection of the penis, urethral meatus, scrotum, and perianal region, and
2. Palpation of the scrotum and testicles.

## Laboratory Testing

Collect and interpret all specimens in accordance with manufacturer instructions, approved laboratory protocols, and CLIA regulations. See Appendix B — Sample Specimen Collection Instructions. All lab technology, including gonorrhea (GC) and chlamydia (CT) extragenital Nucleic Acid Amplification Test (NAAT), must be FDA-approved or internally validated by a laboratory. Collect specimens as indicated in the SDOs:

* GC/CT NAAT
* Gram stain
* Syphilis serological tests (specify algorithm)
* Pregnancy test — as indicated for people at risk for pregnancy with last menstrual period (LMP) > 30 days
* HIV test (4th generation, specify algorithm)

# Sample Policy and Protocol for “Express” Clinic Services

**Policy:** It is the policy of **<<Name of Agency>>** to provide the appropriate level of sexually transmitted infection (STI) care to each client depending on symptoms, risk factors and personal concerns.

**Purpose:** To provide a procedure for triaging appropriate clients into “Express” STI laboratory testing, treatment or both

Approved staff functioning under an authorizing physician’s standing delegation orders provide “Express” STI services. “Express” services should include a sexual history and risk assessment, laboratory testing for STIs (gonorrhea [GC], chlamydia [CT], syphilis) and HIV, GC/CT treatment and instructions (except men who have sex with men [MSM] contacts to GC/CT), and risk reduction counseling.

**Protocol:** Triage staff will determine if the client is pregnant, symptomatic for an STI, a contact to HIV, syphilis or GC/CT, or is otherwise at increased risk for STIs, as defined by STI trends in the jurisdiction. Staff will triage clients as follows:

* + - Clients who are pregnant, symptomatic for an STI, a contact to syphilis or HIV, and MSM contacts to GC/CT should get a comprehensive STI evaluation (including exam) from a licensed clinician.
    - Clients at increased risk for STIs as identified by the jurisdiction should get a comprehensive STI evaluation, if available. They may receive “Express” services.
    - All other clients may get the option of “Express” services. **Clients may opt for comprehensive services.**

# Sample Chlamydia SDO

## Introduction

DSHS developed sample SDOs as evidenced-based practice using the 2021 CDC STI Treatment Guidelines. This information is not all-inclusive. Other testing and treatment options may be available.

## Background

* Asymptomatic infection is common among men and women.
* CDC recommends yearly screening of all sexually active women aged 24 years and younger, and screening of women aged 25 years and older with risk factors such as:
  + New sex partner or multiple sex partners
  + People who report that their sex partner may have a sex partner or an STI
* Men who have sex with men (MSM) are at increased risk and should receive yearly screening.
* CDC recommends that sexually active men who have sex with women (MSW) only should not receive routine C. trachomatis (CT) screening due to certain factors (i.e., feasibility, efficacy, and cost-effectiveness). However, providers should consider routine CT screening for sexually active young men in clinical settings (i.e. adolescent clinics, correctional facilities, STI/sexual health clinics) with a high prevalence of CT.
* Adapt screening for transgender and gender diverse people based on anatomy, sexual behavior and sites of exposure.
* Nucleic Acid Amplification Tests (NAATs) are the most sensitive tests for CT specimens and are the recommended tests. Screening using NAAT tests include:
  + First catch urine from males and females
  + Vaginal or endocervical swabs from females
  + Rectal and oropharyngeal swabs from males and females
* NAATs must be FDA-cleared or internally validated by a lab for use with rectal or oropharyngeal swab specimens.
* Most people with CT detected at oropharyngeal sites do not have oropharyngeal symptoms.
* Available evidence suggests oropharyngeal CT can be sexually transmitted to genital sites.
* CT may cause a variety of syndromes (NGU, MPC, or proctitis). These syndromes may also have other etiologies.

## Diagnosis

Nucleic Acid Amplification Test (NAAT) is considered diagnostic of CT.

### History

* Often asymptomatic
* Symptomatic males may report:
  + Penile discharge
  + Dysuria
  + Burning and itching around the meatus
  + Infection spreading to the epididymis is uncommon but may cause testicular pain and swelling.
* Symptomatic females may report:
  + Abnormal vaginal discharge
  + Dysuria
  + If infection spreads from cervix to fallopian tubes, the client may complain of:
    - Lower abdominal pain
    - Low back pain
    - Nausea
    - Fever
    - Pain with intercourse
    - Bleeding between menstrual periods
* People who have receptive anal intercourse may get CT infection in the rectum, which can cause rectal pain, discharge or bleeding.
* Concomitant rectal CT infection is common in females. Reported sexual activity will not predict such an infection. Inadequately treated rectal CT infection in females with urogenital CT can increase the risk for transmission and repeat urogenital CT infection through autoinoculation from the anorectal site.
* Pharyngeal infection is often asymptomatic. If detected, treat it while screening for N. gonorrhea (GC).
* CT may cause complications, such as pelvic inflammatory disease (PID) and epididymitis. **Consult clinic physician if you suspect complications**.

### Exam

* Oropharyngeal: often asymptomatic, often normal exam
* Males:
  + Inspect the penis:
    - Retract foreskin.
    - Inspect meatus.
    - “Milk” urethra for discharge. Discharge is often whitish or clear.
  + Palpation of scrotal contents:
    - Possible unilateral scrotal pain
    - Swelling or tenderness
* Females:
  + Palpate lower abdomen if symptomatic.
  + Speculum exam of the vagina and cervix — you may often observe:
    - Mucopurulent cervical discharge
    - Cervical hypertrophic ectopy and friability (edematous and bleeds easily)
  + Bimanual pelvic exam
* Anal exam:
  + Often asymptomatic
  + Possible bleeding, mucopurulent discharge or both

### Laboratory — NAAT

* Collect urine specimens (first void) on **ALL** males:
  + If client is unable to produce urine, urethral NAAT tests are available upon request.
* Collect vaginal specimens on **ALL** females:
  + Self-collected vaginal swab if client is asymptomatic or declines exam
  + Urine NAAT testing is available if client declines exam, self-collects, or has had a hysterectomy.
* Collect rectal specimens on males who report receptive anal intercourse.
* Consider rectal NAAT for females. Individualize testing based on reported sexual behaviors and exposure and through shared clinical decision-making between the client and clinician.
* Clinicians may instruct clients to self-collect specimens according to manufacturer’s recommendations. See Appendix C — Sample Self-Collection Posters.

## Treatment

* **Recommended**: Doxycycline 100 mg orally twice a day for 7 days (if not pregnant or lactating)
  + **Alternatives**: Azithromycin 1 gram orally once (if nonadherence with doxycycline multiday dosing is a concern, but has lower efficacy, particularly for rectal CT), OR Levofloxacin 500 mg orally once daily for 7 days. **Consult clinic physician before dispensing or prescribing.**
* **Pregnancy or Lactation:**
  + **Recommended**: Azithromycin 1 gram orally once
  + **Alternative**: Amoxicillin 500 mg orally three times a day for 7 days (if unable to take azithromycin, but less effective)
  + **Contraindications**: Do not use Doxycycline and levofloxacin if client is pregnant or lactating.

## Other Considerations

* CDC does not advise routine **test-of-cure** (i.e., repeat testing 4 weeks after completing therapy) for non-pregnant people treated with the recommended or alternative regimens unless therapeutic adherence is in question, symptoms persist, or if the clinician suspects reinfection.
  + When nonadherence to doxycycline regimen is a substantial concern, azithromycin 1-gram regimen is an alternative treatment option but might require post-treatment evaluation and testing because it has demonstrated lower treatment efficacy among people with rectal infection.
  + Do not use chlamydial NAAT testing < 4 weeks after completed therapy because false-positive results might occur due to the continued presence of nonviable organisms.
  + Pregnant people **should complete** test-of-cure (preferably by NAAT) 4 weeks after they complete therapy due to risk of adverse reproductive health complications with persistent infection.
* Clinicians should retest all people who have been treated for CT 3 months after treatment, regardless of whether they believe that their sex partners where treated. Reinfection is common.
* People who have CT and are living with HIV should receive the same treatment regimens as people who do not have HIV.
* Test people diagnosed with CT for GC, syphilis and HIV.
* Use a status-neutral approach for HIV testing. Refer people with preliminary positive HIV results for care and rapid initiation of antiretroviral therapy. Evaluate or refer people with risk factors for HIV and negative HIV results for Pre-Exposure Prophylaxis (PrEP) for HIV prevention.
* Promptly notify your [local or regional health department](https://www.dshs.texas.gov/hivstd/reporting/regions/) of any positive CT lab results or diagnoses and include treatment in the report.

## Medication Issues

### Doxycycline

* Adverse Reactions:
  + Nausea:
    - This drug may cause nausea or vomiting.
    - Client instructions: usually eating with the dose makes it tolerable.
  + Photosensitivity:
    - The drug is a photosensitizer, meaning that skin is more susceptible to the effects of UV rays, including sunburn. This occurs in all skin types but is likely worse with lighter skin types.
    - Client instructions: avoid the sun while taking medication to avoid sunburn or wear protective outer covering or sunscreen.
  + Calcium Binding:
    - Doxycycline may be bound by minerals including calcium, which prevents absorption of the drug into the body from the intestine.
    - Client instructions: avoid taking medication 2 hours before or after calcium containing foods or supplements.
  + Esophagitis:
    - Doxycycline can cause irritation of the esophagus.
    - Client instructions: take each pill with a glass of water. Maintain upright position at least 30 minutes after each dose.
* Contraindications:
  + Pregnancy — All tetracyclines are Pregnancy Category D because of effects on developing fetal bone and tooth structures.
  + Lactation — Do not use in lactating women due to adverse effects on teeth and bone in infants.
  + Hypersensitivity to any tetracycline

### Azithromycin

* Adverse Reactions:
  + Nausea or vomiting:
    - Client instructions: usually eating with the dose makes it tolerable
    - If client vomits at least 45 minutes after they took a dose, the drug has likely already passed into the duodenum — do not give another dose. Re-treat the client if intact pills appear in the vomitus.
  + QT interval prolongation has been reported, including cases of torsade de pointes, especially in clients with known or congenital QT prolongation, history of torsade de pointes, bradyarrhythmias, uncompensated heart failure, proarrhythmic conditions, or clients on concomitant drugs known to prolong the QT interval.
* Contraindications:
  + Hepatic dysfunction or jaundice with prior azithromycin therapy
  + Hypersensitivity to azithromycin or to any product component, erythromycin, or any macrolide or ketolide antibiotic

### Levofloxacin

* Adverse Reactions: **See Full Prescribing Information**
  + **Boxed Warnings, Precautions and Serious Adverse Reactions:** 
    - Fluoroquinolones are associated with disabling and potentially irreversible serious adverse reaction that may occur together, including tendinopathy and tendon rupture, peripheral neuropathy, and CNS effects.
    - Discontinue levofloxacin immediately and avoid using fluoroquinolones in patients who experience any of these serious adverse reactions.
    - Clients of any age, or without preexisting risk factors, have experienced these reactions; may occur within hours to weeks after initiation.
  + Cardiovascular:
    - Aortic aneurysm and dissection
    - Altered cardiac conduction — may prolong QTc interval
    - Avoid use in patients with a history of QTc prolongation, uncorrected hypokalemia, hypomagnesemia, or concurrent administration of other medications known to prolong the QT interval
  + Photosensitivity:
    - May cause moderate to severe phototoxicity reactions
    - Client instructions: Avoid excessive sunlight and take precautions to limit exposure (e.g., loose-fitting clothing, sunscreen). Discontinue use if photosensitivity occurs.
  + Other Conditions — See full prescribing information for considerations around myasthenia gravis, hepatotoxicity, glucose regulation, rheumatoid arthritis, G6PD deficiency, renal function impairment.
  + Hypersensitivity — severe hypersensitivity reactions, including anaphylaxis
* Contraindications:
  + Hypersensitivity to levofloxacin, other quinolones, or components
  + Pregnancy and lactation

## Counseling

* **Infertility Risk:**
  + Untreated CT can lead to PID and its sequelae of infertility or ectopic pregnancy.
  + Repeated infection with CT appears to increase the risk of tubal damage and infertility.
* **Abstain from sexual contact** for 7 days regardless of treatment regimen. To minimize the risk for reinfection, instruct client to abstain from sexual intercourse until all their sex partners get treatment.
* **Prevention** — Consistent condom use lowers the risk of acquiring an infection.
* **Early Detection of Re-Infection** — Due to high rate of reinfection, clinicians should advise all people with CT infections, especially people age 24 years and younger, to be re-evaluated for STIs three months after treatment, regardless of whether the client believes that their sex partner(s) got treated.

## Follow-Up

For persistent or recurrent symptoms, consult clinic physician.

## Management of Contacts

* Clinicians should perform **evaluation, testing and presumptive treatment** for all contacts in the past 60 days regardless of symptoms.
* **If the most recent contact occurred more than 60 days ago**, clinicians should still evaluate and presumptively treat that contact.
* **Give clients contact cards** for all recent sexual contacts. This will increase the likelihood that partners will get treatment.
* **Treatment of CT Contacts:** 
  + Contacts presenting to the clinic: Follow the treatment recommendations.
  + Offer expedited partner therapy (EPT) to clients with a lab-confirmed diagnosis of CT whose partners are unable to promptly access evaluation and treatment services. Individualize EPT for MSM partners through shared clinical decision-making. Consider possible increased risk of STI co-infections and HIV.
    - Doxycycline 100 mg orally twice a day for 7 days (recommended if not pregnant or lactating), OR azithromycin 1 gm orally once (alternative if adherence with multi-day dosing is a concern or pregnant or lactating).
    - Document in the health record if the client accepted or declined EPT, partner allergies and pregnancy status (if known), the medication dispensed, number of doses, and instruction sheets provided. Document the required information in the EPT log. See Appendix D — Sample EPT Partner Instruction Sheets and Log.

Printed Name and Credentials of Authorizing Physician:

Signature of Authorizing Physician:

Job Title of Authorizing Physician:

Date of Authorizing Physician’s Signature:

# Sample Gonorrhea SDO

## Introduction

DSHS developed sample SDOs as evidenced-based practice using the 2021 CDC STI Treatment Guidelines. This information is not all-inclusive. Other testing and treatment options may be available.

## Background

* Urethral infections caused by N. gonorrhea (GC) among men produce symptoms that cause them to seek curative treatment soon enough to prevent sequelae, but often not soon enough to prevent transmission to others.
* Among women, GC infections are commonly asymptomatic or might not produce recognizable symptoms until complications happen.
* Complications of GC infections include PID which can result in tubal scarring that can lead to infertility or ectopic pregnancy.
* CDC recommends **yearly** GC screening for all sexually active women aged 24 years and younger, and screening for women aged 25 years and older with risk factors such as:
  + New sex partner or multiple sex partners
  + Sex partner may have a concurrent sex partner or an STI
  + Previous GC infection, other STIs
  + Engaging in transactional sex or substance use
  + Living in communities with a high prevalence of disease
* CDC recommends **yearly** screening at minimum for men who have sex with men (MSM) based on reported sexual behaviors and sites of exposure. Clinicians may consider more frequent screening, i.e. every 3–6 months, if at increased risk.
* CDC does not routinely recommend screening for GC among men who have sex with women (MSW) only and women aged 25 years and older who are at low risk for infection.
* Adapt screening for transgender and gender diverse people based on anatomy, sexual behavior and sites of exposure.
* For all people diagnosed with GC, test for other STIs, including chlamydia, syphilis, and HIV.

## Diagnosis

Diagnose GC with a positive Gram stain, culture or NAAT result.

### History

* Often asymptomatic
* Symptomatic may include the following signs and symptoms:
  + Males:
    - Penile discharge
    - Dysuria
    - May also have edema and erythema of the meatus
    - Infection spreading to the epididymis may cause testicular pain and swelling
* Females:
  + Abnormal vaginal discharge
  + Dysuria
  + Intermenstrual uterine bleeding
  + Menorrhagia that may range in intensity from minimal to severe
  + If the infection spreads from the cervix to the fallopian tubes, she may complain of various combinations of:
    - Lower abdominal pain
    - Lower back pain
    - Fever
    - Nausea
    - Pain with intercourse
    - Abnormal menses
* People who have receptive anal intercourse may get GC in the rectum, which can cause:
* Rectal pain
* Discharge
* Bleeding
* People can also have pharyngeal infection if having oral sex with an infected partner and may complain of sore throat; however, they are often asymptomatic.
* GC may cause complications such as PID and epididymitis. **Consult the clinic physician if you suspect complications.**

### Exam for Symptomatic People

* Oropharyngeal: often asymptomatic
* Males:
  + Inspect the penis:
    - Retract the foreskin.
    - Inspect meatus.
    - “Milk” urethra for discharge; discharge is often mucoid or mucopurulent (yellow or green).
  + Palpate scrotal contents and evaluate for unilateral scrotal pain, swelling or tenderness.
* Females:
  + Palpate the lower abdomen.
  + Perform a speculum exam of the vagina and cervix; evaluate for mucopurulent cervical discharge and cervical hypertrophic ectopy (edematous and bleeds easily).
  + Perform a bimanual pelvic exam.
* Anal:
  + Evaluate for bleeding, mucopurulent discharge or both; often asymptomatic.

### Laboratory

Perform Nucleic Acid Amplified Test (NAAT) testing on all clients requesting testing. Gram stain and cultures as outlined below.

* Gram stain — smear showing polymorphonuclear leukocytes (PMNs) with Gram negative intracellular diplococci (GNID) of typical morphology is diagnostic of GC. A negative Gram stain does not rule out infection in asymptomatic males.
  + Urethra: Obtain on all symptomatic males
  + Pharynx, Rectum, Endocervix: Gram stain is unreliable and should not be performed
* NAAT
  + Collect urine specimens (first void) on **ALL** males.
    - If client cannot produce urine, urethral NAAT tests are available upon request.
  + Collect vaginal specimens on **ALL** females.
    - Self-collected vaginal swab if client declines exam
    - Urine NAAT testing is an option for females who decline exam or self-collection or have had a hysterectomy.
  + Collect or allow client to self-collect rectal specimens on males who report receptive anal intercourse. Collect pharyngeal specimens on males who report receptive oral intercourse.
  + Consider pharyngeal and rectal testing for females. Individualize testing based on reported sexual behaviors and exposure at these sites, through shared clinical decision-making between the client and clinician.
  + Instruct clients on self-collection of specimens according to manufacturer recommendations. See Appendix C — Sample Self-Collection Posters.

## Treatment

* **Recommended** (use if no history of cephalosporin or severe [hives, anaphylaxis, respiratory compromise] PCN allergy):
  + Ceftriaxone 500 mg IM once for persons weighing < 150 kg (330 lbs.) **OR**
  + Ceftriaxone 1 gm IM once for persons weighing > 150 kg (330 lbs.)
* **Alternative:** 
  + Gentamicin 240 mg IM once AND azithromycin 2 grams orally once (If severe allergy to cephalosporin/PCN; not recommended in pregnancy) **OR**
  + Cefixime 800 mg in a single oral dose (Non-allergic, but if client refuses IM treatment; **for urogenital and rectal GC only**)
* **Pregnancy or Lactation:**
  + **Recommended:**
    - Ceftriaxone 500 mg IM once for people weighing < 150 kg (330 lbs.) **OR**
    - Ceftriaxone 1 gm IM once for people weighing > 150 kg (330 lbs.)
  + **Alternative**: Cefixime 800 mg in a single oral dose (Non-allergic, but client refuses IM treatment; **for urogenital and rectal GC only**)
  + **Other Alternative** (if severe allergy to cephalosporin/PCN):
    - **Consult with clinic physician.**
    - **Gentamicin is Category D and not recommended in pregnancy.**
* **If concurrent CT infection in the client is not excluded, treat for CT** with:
  + **Recommended**: Doxycycline 100 mg orally twice daily for 7 days (if not pregnant or lactating) **OR**
  + **Alternative**: Azithromycin 1 gm orally once (if pregnant or lactating or concern for nonadherence with doxycycline multi-day regimen) **OR** Levofloxacin 500 mg orally once daily for 7 days (if not pregnant or lactating)
* People with GC and living with HIV should receive the same treatment regimen as people without HIV.

## Other Considerations

* **Pharyngeal** **Test-of-Cure (TOC)**: Because gonorrhea infection is more difficult to eradicate from the pharynx than other sites, a test-of-cure should be done after treatment for pharyngeal infection but is not recommended after treatment of uncomplicated urogenital/rectal infections.
* Any person with pharyngeal gonorrhea should return 7-14 days after initial treatment for a test-of-cure by using either culture or nucleic acid amplification test (NAAT); however testing at 7 days might result in an increased likelihood of false positive tests. NAATs are very sensitive and can detect non-viable *N. gonorrhoeae* genetic material. **Urogenital/Rectal Reinfection**: If urogenital/rectal symptoms do not resolve after treatment, it is important to remember that reinfections are much more common than true ceftriaxone treatment failures. If reinfection is suspected, the client should be retreated with ceftriaxone. If an alternative treatment was used initially, then the client should be retreated with ceftriaxone (unless allergic).
* **Possible Treatment Failure**: Ceftriaxone treatment failure is the persistence of laboratory-confirmed *N. gonorrhoeae* infection despite appropriate ceftriaxone treatment when the client has not been re-infected. Consider possible ceftriaxone treatment failure when:
  + Symptoms do not resolve in 3-5 days after appropriate ceftriaxone treatment and no reported sexual contact after treatment, or
  + Pharyngeal test-of-cure (in asymptomatic client) is positive after appropriate ceftriaxone treatment and no reported sexual contact after treatment.

Follow these steps to ensure adequate evaluation and management of possible ceftriaxone treatment failure when a client was appropriately treated for lab-confirmed *N. gonorrhoeae* infection with ceftriaxone and reinfection is unlikely**. Consult with clinic physician and obtain medication order prior to retreatment.**

1. Obtain a detailed sexual history including signs and symptoms of STIs, dates and types of recent gonorrhea testing across exposed anatomic sites (including types of gonorrhea NAATs performed), treatment, possible re-exposure, and recent travel of client and partners.

2. Test for other STIs which can cause persistent symptoms.

3. Order test-of-cure with culture for antibiotic sensitivity testing (AST) and NAAT of relevant clinical sites of exposure/infection prior to retreatment. If the site of possible persistent gonorrhea infection is the penile urethra, also obtain a urethral Gram stain, if available.

4. Await test results prior to retreatment unless the client is symptomatic.

5. Report cases with positive test-of-cure result(s) to the [local or regional health department](https://www.dshs.texas.gov/hivstd/reporting/regions/) within 24 hours.

6. Consult with the [STD Clinician Consultation Network](https://www.stdccn.org/render/Public) at Denver Prevention Training Center or CDC Gonorrhea Treatment Failure team ([gcfailure@cdc.gov](mailto:gcfailure@cdc.gov) or 404-718-5447) for guidance on clinical management and retreat as indicated.

* NAATs can produce false positive results due to cross-reactivity with commensal *Neisseria* in extragenital sites. Additional testing with a NAAT that detects a different *N. gonorrhoeae* target can help exclude these false positive results.
* Criteria for resistance to cefixime and ceftriaxone have not been defined by the Clinical and Laboratory Standards Institute. However, isolates with cefixime mean inhibitory concentration (MIC) of ≥0.25 ug/ml or ceftriaxone MICs ≥0.125 μg/mL are considered to have decreased susceptibility by the CDC.
* If there is any possibility of reinfection, retreatment with standard therapy of ceftriaxone dosed based on weight is preferred. If reinfection is deemed unlikely, for treatment failure at urogenital sites, dual treatment with single doses of IM gentamicin 240 mg plus oral azithromycin 2 gm PO can be considered, particularly when isolates are identified as having elevated cephalosporin MICs. For pharyngeal sites initially treated with ceftriaxone 500mg IM once and deemed unlikely to be reinfection, retreatment with ceftriaxone 1g IM once can be considered.

7. Counsel the client to refrain from deep kissing, oral, vaginal, and rectal sex after retreatment and return for another test-of-cure (NAAT and culture/AST).

8. Encourage the client to cooperate with health department partner services.

9. Test all partners (NAAT and culture/AST) in the last 60 days at all sites of exposure and empirically treat with the same treatment as the client. If result(s) are positive, the partner returns for a test-of-cure (NAAT and culture/AST). If the effective treatment regimen for the index case has not yet been determined, empirically treat the partners with the recommended ceftriaxone regimen. If test results are positive, the partner returns for a test-of-cure (NAAT and culture for AST). Retreatment may be indicated based on test results or new information from the index case in consultation with experts at the CDC or Denver PTC.

* **Disseminated Gonococcal Infection (DGI)** occurs rarely. Suspect DGI in sexually active people with:
  + Petechial or pustular acral (i.e. at wrists and ankles) skin lesions
  + Asymmetrical arthralgias
  + Tenosynovitis or septic arthritis

**If you suspect DGI, consult the clinic physician. If you think DGI is present, you must refer the client for hospitalization.**

* **Gonococcal Conjunctivitis** is uncommon and data regarding treatment of gonococcal conjunctivitis among adults are limited. The recommended treatment is ceftriaxone 1-gram IM in a single dose with one-time lavage of affected eye with saline solution. **Consider consultation with an infectious disease specialist.**
* Test people diagnosed with GC for CT, syphilis and HIV.
* Use a status-neutral approach for HIV testing. Refer people with preliminary positive HIV results for care and rapid initiation of antiretroviral therapy. Evaluate or refer people with risk factors for HIV and negative HIV results for Pre-Exposure Prophylaxis (PrEP) for HIV prevention.
* Promptly notify your [local or regional health department](https://www.dshs.texas.gov/hivstd/reporting/regions/) of positive GC lab results or diagnoses, suspected antibiotic resistance, or DGI. Include treatment in the report.

## Medication Issues

* **Ceftriaxone and Cefixime:**
  + Contraindications:
    - Possible PCN allergy: Do not use ceftriaxone or cefixime if the client reports hives, anaphylaxis, tongue swelling or difficulty breathing as a reaction to PCN in the past.
    - Simple, non-hives-type rashes to PCN are not a contraindication to use of a cephalosporin antibiotic.
    - Hypersensitivity to cephalosporins
* **Gentamicin:**
  + Adverse Reactions:
    - Dermatologic: Rash (3.5%)
    - Gastrointestinal: Abdominal pain (2.2%), Diarrhea (5%), Nausea (3.7%), Vomiting (1.6%)
    - Neurologic: Dizziness (1.7%), Headache (4.2%)
    - Cardiovascular: Prolonged QT interval
    - Musculoskeletal: Myasthenia gravis, Exacerbation, Rupture of tendon, Tendinitis
    - Neurologic: Peripheral neuropathy
  + Contraindications:
    - Allergy to aminoglycosides
    - Gentamicin is Category D and not recommended in pregnancy.

## Counseling

* **Abstaining from Sexual Contact:** Advise client to abstain from all sexual contact until:
  + 7 days after client completes treatment;
  + client symptoms are resolved, if present;
  + all partners complete treatment;
  + all partners abstain from sexual contact for 7 days post-treatment; and
  + all partners are without symptoms.
* **Early Detection of Reinfection:** Because of the high rate of reinfection, refer people with GC infections, especially people age 24 and younger, for retesting for STIs three months after treatment, regardless of whether the client believes their sex partner(s) got treated.
* **Prevention:** Consistent, correct condom use lowers the risk of an infection.
* **HIV Risk:** Because of the association of GC and HIV infection, counsel MSM with GC on risk reduction and refer them for a follow-up HIV test in three months. Evaluate or refer people with risk factors for HIV and negative HIV results for Pre-Exposure Prophylaxis (PrEP) for HIV prevention.

## Follow-Up

For persistent or recurrent symptoms, consult the clinic physician.

## Management of Contacts

* Evaluate and presumptively treat contacts in the past 60 days regardless of symptoms.
* If the most recent contact occurred more than 60 days ago, evaluate and presumptively treat that contact.
* Give clients contact cards for all recent sexual contacts. This will increase the likelihood that partners will get treated.
* **Treatment of Contacts to GC:**
  + Contacts presenting to the clinic: Follow the treatment recommendations in **Sample Gonorrhea SDO — Treatment**.
  + Offer expedited partner therapy (EPT) to clients with a lab-confirmed diagnosis of GC whose partners cannot promptly access evaluation and treatment. Individualize EPT for MSM partners through shared clinical decision-making. Consider possible increased risk of STI co-infections and HIV.
    - Treat the partner(s) with cefixime 800 mg orally once **AND**
    - If concurrent CT infection in the client is present or not excluded, treat partner(s) for CT with doxycycline 100 mg orally twice daily for 7 days (recommended if not pregnant or lactating) **OR** alternative azithromycin 1 gm orally once (if adherence with multi-day dosing is a concern or pregnant or lactating).
    - Document in the health record if the client accepted or declined EPT, partner allergies and pregnancy status (if known), medication dispensed, number of doses, and instruction sheets provided. Document the required information in the EPT log. See Appendix D — Sample EPT Partner Instruction Sheets and Log.

Printed Name and Credentials of Authorizing Physician:

Signature of Authorizing Physician:

Job Title of Authorizing Physician:

Date of Authorizing Physician’s Signature:

# Sample Syphilis SDO

## Introduction

DSHS developed sample SDOs as evidenced-based practice using the 2021 CDC STI Treatment Guidelines. This information is not all-inclusive. Other testing and treatment options may be available.

## Background

Syphilis is a systemic infection caused by the bacterium Treponema pallidum. It is divided into a series of overlapping stages based on clinical findings and serologic testing. Use this information to guide treatment and follow-up.

## Diagnosis

### History

* **Primary**: chancre or ulcer at site of infection
* **Secondary**: can produce a wide variety of symptoms, but may include a rash (most characteristic), mucocutaneous lesions, lymphadenopathy, condylomata lata, alopecia, loss of eyelashes and lateral eyebrows, fever, headache, malaise, anorexia, sore throat, myalgias, and weight loss.
* **Latent**: asymptomatic
  + **Early Latent**: within one year of infection
  + **Late Latent**: more than one year since infection or unknown duration
* **Tertiary**: refers to gummas, cardiovascular syphilis, psychiatric manifestations (e.g., memory loss or personality changes), or late neurosyphilis.
* **Neurosyphilis**: can occur at any stage of syphilis. Symptoms include headache, neck stiffness, stroke, photophobia, dizziness, memory loss, weakness or numbness of arms or legs, seizures, difficulty concentrating, problems with vision or hearing.
* **Ocular Syphilis and Otosyphilis**: can occur at any stage of syphilis but are commonly identified during the early stages and can present with or without additional central nervous system (CNS) involvement.
  + Ocular syphilis often presents as panuveitis but can involve structures in both the anterior and posterior segment of the eye, including conjunctivitis, anterior uveitis, posterior interstitial keratitis, optic neuropathy, and retinal vasculitis. Ocular syphilis can result in permanent vision loss.
  + Otosyphilis typically presents with cochleo-vestibular symptoms, including tinnitus, vertigo, and sensorineural hearing loss. Hearing loss can be unilateral or bilateral, have a sudden onset, and progress rapidly. Otosyphilis can result in permanent hearing loss.

### Exam

* Inspect skin of the oral cavity, trunk, extremities, genitals (including vaginal speculum exam for females), perianal area, perineum, hands and feet. Thoroughly note the following:
  + Chancre (ulcer) — typically singular lesion, at site of inoculation, painless, one to two-centimeter diameter, raised indurated margin, and non-exudative base; heals spontaneously in 3 – 6 weeks
  + Rash — classically a diffuse, symmetric macular or papular, involving the entire trunk and extremities, including the palms and soles; individual lesions may be discrete red or reddish-brown and measure 0.5 to 2 cm in diameter, often scaly but may be smooth and rarely pustular.
  + Condylomata lata – large, raised, gray to white lesions, involving warm, moist areas such as mucous membranes. Extremely infectious.
* Inspect lymph nodes of the posterior cervical, axillary, inguinal and femoral regions; often bilateral, palpable, minimally tender, firm and rubbery
* If you suspect syphilis, evaluate for signs and symptoms of neurological, ocular and otic involvement using screen tool below. **The clinic physician must evaluate the client if any of these signs or symptoms are present.** 
  + Screening questions for neurological (including ocular/otic involvement):

**Neurosyphilis Screening Tool**

| Symptom present? | Yes | No |
| --- | --- | --- |
| Change in or blurring of vision? |  |  |
| Recent eye pain or redness? |  |  |
| Spots or distortion in vision? |  |  |
| Double vision? |  |  |
| Light hurts eyes? |  |  |
| New weakness in arms, legs, or face? |  |  |
| New headache unlike usual headaches? |  |  |
| Stiff neck? |  |  |
| New or recent hearing loss? |  |  |
| New or recent ringing of ears? |  |  |
| Sign present? | Yes | No |
| Ocular injection |  |  |
| Photophobia |  |  |
| Nuchal rigidity |  |  |
| Facial palsy |  |  |

Clinical consultation is available through the [Denver PTC Warmline](https://www.denverptc.org/Consultation.html). Administer benzathine penicillin G 2.4 million units IM to any client thought to have ocular, otic or neurosyphilis before leaving the clinic.

### Laboratory

Screening can begin with **EITHER** an RPR (nontreponemal test; traditional sequence screening) **OR** an EIA (treponemal test; reverse sequence screening). See Appendix E — Syphilis Serologic Screening Algorithms. **<<Insert agency’s screening algorithm>>**

**Traditional Sequence Screening with RPR:**

* RPR:
  + Pregnancy: at first prenatal visit, **AND** during third trimester (no earlier than 28 weeks’ gestation), **AND** at delivery
  + MSM: at least yearly and every 3 to 6 months with risk behaviors
  + People living with HIV (PLWH): at least yearly and every 3 to 6 months with risk behaviors
  + Presenting for treatment and more than one week since last RPR
  + Previous history of syphilis with potential new exposure or risk
* STAT RPR is indicated when the following occurs:
  + Contact to syphilis or potential exposure to syphilis
  + Genital or perianal ulcerations not typical of genital herpes, warts not typical for condylomata acuminata, any undiagnosed general skin rash, or oral ulceration suspicious of syphilis
  + Draw TPPA for every client that has a reactive stat RPR.
* Confirmation of a positive RPR: If screened with an RPR and is positive, perform a treponemal-specific test such as a TPPA, EIA, or FTA.
  + If the treponemal test is positive, syphilis is confirmed.
  + If the treponemal test is negative, the RPR was a false positive.

**Reverse Sequence Screening with an EIA:**

* EIA — Do not use for a client with a known history of a positive syphilis test. EIA can remain positive for an extended time. Use an RPR in all cases with known history of syphilis or prior positive treponemal test. Screen as follows:
  + Pregnancy: at first prenatal visit, AND during third trimester (no earlier than 28 weeks’ gestation), AND at delivery
  + MSM: at least yearly and every 3 to 6 months with risk behaviors
  + People living with HIV (PLWH): at least yearly and every 3 to 6 months with risk behaviors
  + Contact to syphilis or potential exposure to syphilis
  + Genital or perianal ulcerations not typical of genital herpes, warts not typical for condylomata acuminata, any undiagnosed general skin rash, or oral ulceration suspicious of syphilis
* Confirmation of a positive EIA: If screened with an EIA, perform an RPR for confirmation and for assessment of baseline titers.
  + If RPR positive, syphilis is confirmed.
  + If RPR negative, perform another treponemal-specific test such as a TPPA or FTA.
    - If second treponemal test is positive:
      * People with previous treatment require no further management unless re-exposed.
      * If history suggests they may have been re-exposed, repeat RPR in 2–4 weeks to evaluate for early infection.
      * Offer treatment for syphilis to people without prior treatment.
    - If second treponemal test is negative, provide no further evaluation or treatment.

**Additional Testing:**

* Perform an HIV test for anyone testing positive for syphilis. If initial HIV test is negative, recommend repeat HIV test in three months. Use a status-neutral approach for HIV testing. Refer people with preliminary positive HIV results for care and rapid initiation of antiretroviral therapy. Evaluate people with risk factors for HIV and negative HIV results for Pre-Exposure Prophylaxis (PrEP) for HIV prevention.
* CSF evaluation is warranted for people with clinical signs of neurosyphilis (e.g., cranial nerve dysfunction, meningitis, stroke, acute or chronic altered mental status, or loss of vibration sense).
* Clients with ocular symptoms and reactive syphilis serology need a full ocular exam, including cranial nerve evaluation. Conduct a CSF evaluation if cranial nerve dysfunction is present. A CSF evaluation is unnecessary before treatment among people with isolated ocular symptoms (i.e., no cranial nerve dysfunction or other neurologic abnormalities), confirmed ocular abnormalities on exam, and reactive syphilis serology. CSF analysis is helpful in evaluating people with ocular symptoms and reactive syphilis serology who do not have ocular findings or cranial nerve dysfunction on exam.
* Among clients with isolated auditory abnormalities and reactive syphilis serology, CSF evaluation is likely to be normal and is unnecessary before treatment.
* Perform a thorough neurologic, ocular, and otic exam for all people living with HIV and with syphilis. Reserve CSF evaluation for people with an abnormal neurologic exam. Evaluate people with ocular or otic signs or symptoms for ocular syphilis and otosyphilis according to clinical presentations.

### Making the Diagnosis

* **Primary**:
  + Exam findings consistent with primary syphilis at the time of treatment:
    - Presence of a classic, syphilitic chancre (i.e., single, painless, rubbery or indurated anogenital or oral ulcer)
    - Presence of multiple or atypical anogenital primary lesions
    - Primary lesions can sometimes be confirmed with dark field or T pallidum PCR testing
  + Serologic evidence of infection (or reinfection); Reactive syphilis serologic results support the diagnosis but may be absent in early primary syphilis.
* **Secondary**:
  + Laboratory evidence of syphilis infections (or reinfection), e.g. serologic (both treponemal and non-treponemal tests reactive) or lesion-based testing **AND**
  + Exam findings consistent with secondary syphilis at the time of treatment, for example:
    - Mucocutaneous eruptions (localized or generalized), including palmar or plantar rashes
    - Condylomata lata (moist, flat, whitish-gray, wart-like papules or plaques)
    - Mucous patches (membranous lesions of tongue, buccal mucosa, lips)
    - Generalized lymphadenopathy, malaise, fever, other nonspecific constitutional symptoms
    - Patchy alopecia
* **Early Latent:** 
  + Serologic evidence (both treponemal and non-treponemal tests reactive) of syphilis infection (or reinfection) **AND**
  + No exam findings of primary, secondary or tertiary syphilis at the time of treatment **AND ANY OF THE FOLLOWING:**
    - Documented seroconversion within the past 12 months (i.e., a currently reactive syphilis serology with nonreactive results documented within the past 12 months)
    - A sustained (>2 weeks) in nontreponemal test titer of 2 or more dilutions (i.e., > or equal to 4-fold rise) within the past 12 months (in a previously treated person)
    - Unequivocal symptoms of primary or secondary syphilis within the past 12 months
    - Sexual or needle-sharing contact with a person diagnosed with an infectious stage of syphilis (i.e., primary, secondary or early latent) during the past 12 months
    - Only possible exposure has been within the previous 12 months, e.g., a client who reports that their first sexual contact occurred within the last 12 months
* **Late Latent:**
  + Serologic evidence (treponemal typically stays reactive for life and nontreponemal may be reactive or non-reactive) of infection (or reinfection) **AND** No exam findings of primary, secondary, or tertiary syphilis at the time of treatment **AND** None of the criteria for early latent syphilis are met **AND** Evidence suggests that the infection was acquired greater than 12 months prior to diagnosis
* **Latent of Unknown Duration:**
  + Serologic evidence (treponemal typically stays reactive for life and nontreponemal may be reactive or non-reactive) of infection (or reinfection) **AND** No exam findings or primary, secondary, or tertiary syphilis at the time of treatment **AND** None of the criteria for early latent are met **AND** Available information is insufficient to determine the duration of infection.
* **Tertiary**:
  + **Consult clinic physician if suspected**.
  + Clinical manifestations of late syphilis including:
    - Cardiovascular disease (e.g., aortitis, coronary vessel disease)
    - Gummatous disease of skin or other organs
    - Late neurologic complications (e.g., tabes dorsalis, or general paresis) **AND**
    - Laboratory evidence of infection by serologic; CSF, or direct pathology testing
* **Neurosyphilis:**
  + **A diagnosis of neurosyphilis is made in an inpatient setting and usually relies on the following:**
  + Serum serologic evidence of syphilis, e.g., reactive treponeme-specific result alone or in combination with reactive nontreponemal result, **AND**
  + Abnormal CSF Testing – Reactive CSF-VDRL, or – Elevated CSF WBCs or Increased CSF Protein
* Establishing a diagnosis of syphilis in a client with a prior history of appropriately treated syphilis requires ≥ 4-fold rise in RPR titer over post-treatment baseline.
* Persistent infection or reinfection is suggested by the following:
  + Persistent/recurrent signs or symptoms of syphilis
  + ≥ 4-fold increase in RPR titer persisting for > 2 weeks
* Failure of an RPR to decrease ≥ 4-fold within 12 (for early syphilis) or 24 months (for latent or unknown duration syphilis) months. (This may not occur if the initial RPR was less than or equal to 1:8).

## Treatment

### Early Syphilis (Primary, Secondary, and Early Latent Syphilis)

* **Recommended**: benzathine penicillin G 2.4 million units IM
  + Administer benzathine penicillin G as two doses of 1.2 million units IM into the upper, outer quadrant of each buttock.
  + Ask the client to wait 20 to 30 minutes before leaving the clinic in case of allergic response to the penicillin injection.
* **Alternative**: (use only if client is allergic to penicillin and you cannot refer the client for desensitization): Doxycycline 100 mg BID PO #28 for 14 days

### Late Latent Syphilis and Latent Syphilis of Unknown Duration

* **Recommended**: benzathine penicillin G 2.4 million units IM every 7-9 days x 3 (total 7.2 million units). **If client misses a dose (i.e., >9 days), consult with clinic physician to determine if client should restart the series.**
  + Administer benzathine penicillin G 1.2 million units IM into the upper, outer quadrant of each buttock.
  + Ask the client to wait 20 to 30 minutes before leaving the clinic in case of allergic response to the penicillin injection.
* **Alternative** (use only if client is allergic to penicillin): Doxycycline 100 mg PO BID #56 for 28 days

### Pregnancy

* **Consult with clinic physician before treatment.**
* Penicillin G is the only known effective antimicrobial for treating fetal infection and preventing congenital syphilis. Treat pregnant people only with the penicillin G regimen appropriate for their stage of infection. In case of penicillin allergy, refer for penicillin desensitization and treatment.
* Certain evidence indicates additional therapy may be beneficial for pregnant people. For primary, secondary or early latent syphilis, administer a second dose of benzathine penicillin G 2.4 million units IM 7 days after the initial dose.
* Treat pregnant people with late latent or syphilis of unknown duration with benzathine penicillin G 2.4 million units IM **optimally every 7 days x 3** (total 7.2 million units). **Missed doses (i.e., >9 days) are not acceptable for pregnant people. Restart the series if a pregnant client misses a dose.**

### People Living with HIV (PLWH)

* If no neurologic symptoms are present, follow stage-specific treatment recommendations for people without HIV infection.
* The efficacy of alternative non-penicillin regimens for PLWH is not well studied. Refer PLWH with penicillin allergy (whose compliance with therapy or follow-up you cannot ensure) for penicillin desensitization and treatment.

### Neurosyphilis

* **Always evaluate and treat suspected neurosyphilis in an inpatient hospital setting.**
* **Recommended**: Aqueous crystalline penicillin G 18-24 million units per day, administered as 3-4 million units IV every 4 hours or continuous infusion for 10-14 days
* Consider the following **alternative** regimen if you can ensure compliance with therapy: Procaine penicillin G 2.4 million units IM daily PLUS Probenecid 500 mg PO QID, both for 10-14 days.
* Skin-test and, if necessary, desensitize people with a history of penicillin allergy.
* The durations of the recommended and alternative regimens for neurosyphilis are shorter than the duration of the regimen used for latent syphilis. Therefore, consider benzathine penicillin, 2.4 million units IM once per week for 1–3 weeks after completion of these neurosyphilis treatment regimens to provide a comparable total duration of therapy.

## Other Considerations

* If client reports a prior syphilis diagnosis, contact the [local or regional health department](https://www.dshs.texas.gov/hivstd/reporting/regions/) to confirm reported syphilis history and treatment history (from anywhere in the US).
* Syphilis screening during pregnancy is mandated by the Texas Health and Safety Code §81.090 at first prenatal visit **AND** during third trimester (no earlier than 28 weeks’ gestation) **AND** at delivery.
* Promptly notify your [local or regional health department](https://www.dshs.texas.gov/hivstd/reporting/regions/) of positive syphilis lab results or diagnoses. Include treatment and pregnancy status in the report.

## Medication Issues

### Benzathine Penicillin G

* Adverse Reactions:
  + Jarisch-Herxheimer Reaction:
    - An acute febrile reaction frequently accompanied by headache, myalgia and other symptoms that usually occur in the first 24 hours following treatment for early syphilis.
    - Client instructions: Advise to take Tylenol every 4–6 hours during the first 24 hours to reduce symptoms whether or not feeling sick
  + People treated for syphilis during the second half of pregnancy are at risk for premature labor, fetal distress or both if the treatment precipitates the Jarisch-Herxheimer Reaction. **Consult clinic physician before treatment.**

### Doxycycline

* Adverse Reactions:
  + Nausea:
    - May cause nausea or vomiting
    - Client instructions: eating with the dose usually makes it tolerable.
  + Photosensitivity:
    - The drug is a photosensitizer, meaning that skin is more susceptible to the effects of UV rays, including sunburn. This occurs in all skin types, with the degree of effect likely to be worse with lighter skin types.
    - Client instructions: avoid the sun while taking medication in order to avoid sunburn or wear protective outer covering or sunscreen.
  + Esophagitis:
    - The drug can cause severe esophagitis, especially if taken when lying down.
    - Client instructions: take each pill with a full glass of water and maintain an upright position for 30 minutes after each dose.
  + Calcium binding:
    - Doxycycline may be bound by minerals including calcium, which prevents absorption of the drug into the body from the intestine.
    - Client instructions: avoid taking medication 2 hours before or after calcium-containing foods or supplements.
* Contraindications:
  + Pregnancy — All tetracyclines are Pregnancy Category D because of effects on developing fetal bone and tooth structures.
  + Lactation — Adverse effects on teeth and bone in an infant; do not use during breastfeeding.
  + Hypersensitivity to any tetracycline

## Counseling

* **Firm adherence to the regimen is important, since missing only a few doses will significantly increase the failure rate.**
* **Advise sexual abstinence:**
  + For one week after one-time penicillin for early syphilis therapy
  + Until completion of treatment with other regimens

## Follow-Up

* Treatment failure is common in all stages of syphilis, even with recommended treatment regimens. In addition to resolution of signs and symptoms, the serological response is used to define cure. **Consult clinic physician if you suspect treatment failure.**
* **Advise clients with active syphilis for a follow-up HIV test in three months.**

### Early Syphilis (Primary, Secondary)

* Clinic exam after 1 week
* Repeat serology (RPR) at 6 and 12 months after treatment.
* Evaluate for reinfection or treatment failure (with CSF evaluation if neurological findings are present or if no neurological findings and no sexual contact in previous 3–6 months), and treat accordingly if:
  + The RPR titer increases 4-fold persisting for > 2 weeks
  + The RPR titer fails to fall 4-fold in 12 months (this may not occur if the initial RPR was less than or equal to 1:8)
  + Signs or symptoms of syphilis persist or recur

### Latent Syphilis (Early, Late and Unknown Duration)

* Repeat serology (RPR) at 6, 12 and 24 months after treatment.
* Evaluate for reinfection or treatment failure (with CSF evaluation if neurological findings are present or if no neurological findings and no sexual contact in previous year), and treat accordingly if:
  + The RPR titer increases 4-fold persisting for > 2 weeks
  + The RPR titer fails to fall 4-fold in 12 to 24 months (this may not occur if the initial RPR was less than or equal to 1:8)
  + Signs or symptoms of syphilis persist or recur

### Neurosyphilis

* Repeat serology (RPR) at 6, 12 and 24 months after treatment.
* Evaluate for reinfection or treatment failure (including CSF evaluation for persistent or recurrent neurosyphilis), and treat accordingly if:
  + The RPR titer increases 4-fold persisting for > 2 weeks
  + The RPR titer fails to fall 4-fold in 12 to 24 months (this may not occur if the initial RPR was less than or equal to 1:8)
  + Signs or symptoms of syphilis (including neurosyphilis) persist or recur

### People Living with HIV (PLWH)

* Early syphilis (primary, secondary) — repeat serology (RPR) at 3, 6, 9, 12, and 24 months after treatment.
* Early or late latent syphilis — repeat serology (RPR) at 6, 12, 18, and 24 months after treatment.
* Evaluate for reinfection or treatment failure (with CSF if neurological signs/symptoms are present) and manage PLWH in the same manner as people without HIV infection.
* Consider CSF evaluation and retreatment for PLWH whose RPR titers do not decrease fourfold within 24 months of therapy (this may not occur if the initial RPR was less than or equal to 1:8).

### Pregnancy

* Many pregnant people will not achieve a fourfold decrease in titers before delivery, although this does not indicate treatment failure.
* However, a fourfold increase in titer after treatment (e.g., from 1:8 to 1:32) that is sustained for >2 weeks is concerning for reinfection or treatment failure. Nontreponemal titers can increase immediately after treatment, presumably related to the treatment response. Therefore, unless symptoms and signs exist of primary or secondary syphilis, do not repeat follow-up titer until approximately eight weeks after treatment.
* Inadequate maternal treatment is likely if delivery occurs within 30 days of therapy, clinical signs of infection are present at delivery, or the maternal antibody titer at delivery is fourfold higher than the pretreatment titer

## Management of Contacts

* **Treatment:**
  + Assume sexual partners of infected clients are at risk and provide treatment if they had sexual contact with the client:
    - People exposed 90 days before diagnosis of primary, secondary, or early latent syphilis in a sex partner might be infected even if seronegative; therefore, presumptively treat such persons for early syphilis.
    - Presumptively treat people exposed more than 90 days before the diagnosis of primary, secondary, or early latent syphilis in a sex partner if serologic test results are not available immediately and the opportunity for follow-up is uncertain. If serologic tests are negative, the person needs no treatment. If serologic tests are positive, base treatment on clinical and serologic evaluation as described above.
  + Conduct clinical and serological syphilis evaluation of contacts of clients with late latent syphilis. Treat based on the evaluation findings.
* **Complete and document this information for contacts to syphilis in the health record:** 
  + A full physical exam including the inside of the mouth, skin (palms of hands, arms, chest, back), palpation of lymph nodes, genital exam including a speculum exam for females. Anyone reporting rectal intercourse must receive a visual inspection of their anus. If they get tested for GC/CT, the nurse can collect sample.
  + Laboratory results, as indicated, including HIV if status unknown
  + Partner Notification
  + Refer all clients with syphilis to DIS staff for partner notification interview.
  + If a DIS is not available, recommend evaluation of client sexual partners. Evaluate partners based on client’s stage of syphilis:
    - Client has primary syphilis: evaluate sexual partners in last three months plus the duration of symptoms
    - Client has secondary syphilis: evaluate sexual partners in last six months plus duration of symptoms
    - Client has early latent syphilis: evaluate sexual partners in the past 12 months

Printed Name and Credentials of Authorizing Physician:

Signature of Authorizing Physician:

Job Title of Authorizing Physician:

Date of Authorizing Physician’s Signature:

# Appendix A — Sample Physical Exam Procedures

## The Female Physical Exam

### Preparation for the Exam

1. Ask the client to empty their bladder before the physical exam. If you collect a urine GC/CT NAAT test, supply the appropriate container at this time. After transferring the urine specimen to the transport tube, you may use the remainder for pregnancy testing, UTI testing or both.
2. Instruct client to remove clothing from the waist down, sit on the end of the exam table, and arrange drape to cover genitalia. Provide privacy for the patient to undress.

### Physical Exam

1. Inquire about and inspect scalp for hair loss (alopecia).
2. Inspect face for lesion, rash or both.
3. **Abbreviated cranial nerve exam** — Assess extraocular movements and pupil reactivity to light and accommodation. If indicated by history, assess visual and hearing acuity. While speaking to client, assess facial muscle symmetry.
4. **Inspect oral cavity** — Use a tongue blade and light to perform oropharynx exam which consists of checking the posterior pharynx, under the tongue, and buccal and labial mucosa. Note pharyngitis, ulcers, mucous patches, and/or condyloma acuminata. Collect a pharyngeal GC/CT NAAT, if indicated by sexual history.
5. **Palpate cervical, supraclavicular, axillary and epitrochlear lymph nodes**— Remove or adjust client’s shirt or blouse to palpate axillary, supraclavicular, and epitrochlear lymph nodes. Clothing can interfere with the ability to adequately palpate lymph nodes and may result in the failure to diagnose the presence of lymphadenopathy.
6. **Inspect chest and back** — Instruct the client to remove or adjust clothing for complete visual inspection of the chest and back for lesions, rashes or both (clothing may remain on if held by client in a manner which allows for complete visual inspection by the clinician).
7. Inspect the **palms of the hands and soles of the feet** for signs of a palmar rash, plantar rash or both (secondary syphilis).

### Female Genital Exam

Each clinic should determine if a chaperone is necessary when client and clinician are not the same gender.

1. **Abdominal palpation**: Place client in a supine position on the exam table.
2. Evaluate for signs of pelvic inflammatory disease (PID) by gently pressing on the abdomen in the right and left lower quadrants and midline just below the umbilicus.
3. Using palmar surface of fingers, gently press into the abdomen and quickly release the pressure. A female with acute PID will often have rebound tenderness when you use this technique. Rebound tenderness is also associated with acute appendicitis. Ask client about abdominal pain, usually severe and throughout the abdomen, followed by nausea and vomiting.
4. Palpate the inguinal lymph nodes. (Option #2: Palpate the inguinal and femoral lymph nodes when client is in position for pelvic exam.)
5. Place the client in position for pelvic exam by gently guiding each foot into the stirrup and sliding the client’s buttocks toward the end of the table until the external genitalia is easily accessible for a speculum exam. If the client’s buttocks are not at the end of the table or slightly over the edge, inserting the speculum can be difficult for the clinician and painful for the client.
6. Arrange the drape to cover the pelvic region, leaving open the external genitalia for the exam.
7. Palpate the femoral lymph nodes. (Option #2: Palpate the inguinal and femoral lymph nodes while client is in position for pelvic exam.)

### External Genital Exam

1. Inspect the mons pubis for lesions, rashes, nits and live lice.
2. Visually inspect the labia for discharge, rashes, lesions, masses, and growths by separating the labia minora from the labia majora. Note presence of discharge from the vaginal introitus (vaginal opening).
3. Palpate the external area of the Bartholin’s glands for enlargement and tenderness.
4. Visually inspect the Skene’s (periurethral) glands for inflammation or cysts.

### Internal Exam of the Bartholin’s Glands

1. Gently place a gloved finger inside the introitus (vaginal opening) and rotate the finger to a 7 o’clock position (base of the left labia majora).
2. Place a thumb in the same position on the outside of the perineum.
3. Gently palpate the Bartholin’s gland between the internal finger and the external thumb.
4. Note any swelling, discharge or tenderness.
5. Rotate the internal finger to the 5 o’clock position (base of the right labia majora) and repeat the procedure.

### Internal Procedure for “Milking” Urethra for Discharge

1. Gently place a gloved finger inside the introitus (vaginal opening) and rotate to a 12 o’clock position.
2. Place the finger against the anterior wall of the vagina approximately 6–7 cm. into the vaginal vault.
3. Move the finger in a forward motion, gently stroking the tissue of the anterior wall of the vagina toward the introitus.
4. Discharge in the urethra will be visible at the urethral meatus if present.

### Speculum Insertion

1. Gently place two fingers into the vaginal introitus. Press in a downward direction to relax muscles of the pelvic floor.
2. When the client relaxes these muscles, turn speculum sideways and slowly insert the narrow bills of speculum over the two fingers that are creating an opening when pressing on the pelvic floor. Remove the fingers and slowly turn speculum into the proper position at the same time.
3. Locate the cervix and click speculum into the locked position. If you cannot easily locate the cervix, slowly back the speculum out a few inches and reposition it to view a different area of the vagina.
4. If after several tries the cervix is still not visible, remove the speculum and insert two gloved fingers into the vagina to locate the cervix. This will help mentally guide the speculum to the correct location on the next attempt. The client can experience extreme discomfort during numerous attempts to locate the cervix.

### Internal Exam

1. Inspect the mucosa of the vaginal vault — note discharge, lesions, and masses.
2. Inspect the cervix — note presence of discharge, lesions, masses, ectopy, and induced bleeding on the ectocervix (outer portion of the cervix), in the cervical os (opening of the cervix), and in the endocervix (canal of the cervix).

### Laboratory

1. Collect a vaginal or endocervical GC/CT NAAT and a wet mount if indicated (and a STAT laboratory or trained clinician is available to perform a wet mount). Proper specimen collection and handling of vaginal samples is crucial for accurate results.

### Concluding the Vaginal Inspection

1. Gently unlock the speculum and slowly remove from vagina, observing the vaginal walls as you remove the instrument.
2. Inspect the anus and perianal area. The clinician may collect a rectal GC/CT NAAT, as indicated based on exposure.
3. Instruct client to remain on exam table for bimanual exam.

### Performing the Bimanual Exam

1. Apply a small amount of lubricant to index and middle fingers of dominant hand.
2. Uncover vulva and lower abdomen by moving center of drape toward client.
3. Place foot that corresponds to dominant hand on exam table step.
4. Inform client about procedure, then touch client on thigh with back of hand before proceeding.
5. Spread labia and insert fingers into vagina. Avoid contact with anterior structures.
6. Place other hand on client’s lower abdomen midway between the umbilicus and symphysis pubis.
7. Examine the cervix:
   * Palpate cervix with index finger noting size, shape and consistency.
   * Gently move cervix side-to-side between fingers and note mobility and tenderness (cervical motion tenderness).
   * Gently lift cervix forward and note mobility and tenderness.
   * Examine anterior uterine fundus.
   * Continue to gently lift cervix with vaginal hand.
8. Using palmar surface of fingers, press downward with abdominal hand, “trapping” the uterus between internal and external hands. Palpate uterus noting size, position, consistency, mobility, and tenderness.
9. Examine adnexal structures.
10. Pull back vaginal hand to clear cervix.
11. Gently slide vaginal fingers into right fornix, palm up.
12. Sweep right ovary downward with abdominal hand positioned 3 or 4 cm. medial to the iliac crest.
13. Gently “trap” the ovary between fingers of both hands (if possible). Note size and shape, along with any other palpable adnexal structures.
14. Pull back and repeat on the left side.
15. Replace drape and help client remove feet from stirrups and sit up. Provide tissue for client to remove lubricant. Allow client to dress in privacy.

## The Male Physical Exam

**The client should not empty their bladder a minimum of one hour before the physical exam.**

### Physical Exam

1. Inquire about and inspect **scalp** for hair loss (alopecia).
2. Inspect **face** for lesion, rash or both.
3. **Abbreviated cranial nerve exam** — Assess extraocular movements and pupil reactivity to light and accommodation. If indicated by history, assess visual and hearing acuity. While speaking to client, assess facial muscle symmetry.
4. **Inspect oral cavity** — Use a tongue blade and light to perform oropharynx exam which consists of checking the posterior pharynx, under the tongue, and buccal and labial mucosa. Note pharyngitis, ulcers, mucous patches, and condyloma acuminata. Collect a pharyngeal GC/CT NAAT, if indicated by sexual history.
5. **Palpate cervical, supraclavicular, axillary, and epitrochlear lymph nodes** — Remove or adjust client shirt to palpate axillary, supraclavicular, and epitrochlear lymph nodes. Clothing can interfere with the ability to adequately palpate lymph nodes and may result in the failure to diagnose the presence of lymphadenopathy.
6. **Inspect the chest and back** — Instruct the client to remove or adjust clothing for complete visual inspection of the chest and back for lesions, rashes or both (clothing may remain on if held by client in a manner which allows for complete visual inspection by the clinician).
7. Inspect the **palms of the hands and soles of the feet** for signs of a palmar rash, plantar rash or both (secondary syphilis).

### Preparation for Genital Exam

1. Explain procedure to the client.
2. Ask client to stand at end of exam table with feet shoulder width apart.
3. Reassure client that exam should not cause discomfort. If client feels discomfort, ask them to immediately inform you.
4. Sit on low rolling stool in front of client.
5. Inform client of contact by stating the area you plan to examine first. Example: “First, I am going to check your lymph nodes.”
6. Discuss each step of the exam process. Keeping a client involved will lessen the possibility of an erection. If the client has an erection, continue the exam. Acknowledge that this is a natural response if the client appears to be distressed or concerned.

### General Inspection of Genitals

1. Assess sexual maturity by visual inspection. Note hair pattern, size and shape of penis and testes, and color and texture of scrotal sac.
2. Inspect for pubic lice or excoriations suggestive of lice or scabies throughout exam.

### Palpation and Inspection of the Penis

1. Gently grasp shaft of penis and inspect all sides, including the inferior side and base.
2. Retract foreskin. Ask client to assist if painful or difficult to retract. “Teaching moment” — briefly stress the importance of retracting the foreskin and keeping the area around the glans penis clean.
3. You should be able to easily retract the foreskin from glans. Phimosis is when the foreskin is not retractable. Paraphimosis — once the foreskin is retracted, it cannot return, which can cause edema.
4. Inspect glans for ulcers, scars, nodules, inflammation, and hygiene.
5. Examine urethral meatus — note size and position of opening. Hypospadias is a congenital, ventral displacement of the meatus.
6. Open the distal end of the urethra by compressing the glans between the index finger and thumb. Inspect for discoloration, inflammation, discharge, and lesions.
7. If performing urogenital swabs, collect a specimen for NAAT GC/CT testing. Collect a specimen for a gram stain if indicated.

### Inspection and Palpation of Scrotum and Contents

1. Examine all sides of scrotum by having client flex leg on side being examined to increase access to area.
2. Examine the scrotal sac by rolling the skin between the fingers of one or both hands.
3. Lift scrotum to visually inspect posterior side.
4. Evaluate any swelling or masses within the scrotum.
5. **Testicles** — Individually examine each testicle between the fingers of one hand for nodules, masses, and tenderness. A grainy texture could indicate an irregularity (e.g., testicular cancer). Avoid excessive pressure during palpation which could cause a deep aching sensation for the client.
6. **Epididymis** — on the postero-lateral surface of each testis is the softer, comma-shaped epididymis. Gently palpate the epididymis between the thumb and index finger. It moves with the testes yet can also move independently. The texture feels like a “cluster of soft noodles.”
7. **Spermatic cord and vas deferens** — locate spermatic cord and vas deferens by gently grasping scrotal sac between thumb and index finger close to base of penis. Move thumb and finger outward laterally until you make contact. Spermatic cord feels like soft, pliable tubing. You can usually feel the vas deferens as a separate, movable cord in the tubing.

### Inspection of the Anus

1. Inspect the anus and perianal area, if indicated by sexual history. The clinician may collect a rectal GC/CT NAAT, as indicated based on exposure.

# Appendix B — Sample Specimen Collection Instructions

## NAAT Urine Test (preferred method for males****)****

* **Collect after male physical exam and before female exam.**

1. Ensure that the client has not voided in the last hour before collection.
2. Instruct client to collect the first part of the urine stream, obtaining 15-20 cc. of urine in a paper or disposable cup. Allow the remainder of stream to go into the toilet.
3. Obtain urine specimen from client and use kit pipette to transfer 2 cc. to the urine tube provided in the kit. (This is different than urine collection for culture which requires clean-catch midstream in a sterile container.)
4. Close the tube securely and label with client name, clinic name, and date of collection. Place in biohazard bag with requisition form (when required) and refrigerate immediately if transport is delayed.

**-OR-**

## NAAT Urogenital Swab (males)

* **NAAT urine tests are more sensitive, comfortable and preferred over this collection method.**

1. Remove excess mucous from the urethral meatus using the white cleaning swab provided. Discard this swab.
2. Insert the blue shaft specimen collection swab into the urethra approximately 2-4 cm.
3. Gently rotate the swab clockwise for 3-5 seconds.
4. Remove cap from swab transport tube and immediately place the specimen swab into the transport tube. Carefully break the swab at the score line, using care not to splash contents.
5. Recap the swab specimen tube tightly. Label with client’s name, date and clinic name.
6. Place in biohazard bag with requisition form (when required).

## NAAT Vaginal Swab (preferred method)

1. Peel open the swab package and remove the swab. Be extremely careful not to touch the soft tip or to lay the swab down. If the soft tip becomes contaminated, you must open and use a new vaginal swab collection kit.
2. Hold the swab, placing your thumb and forefinger in the middle of the swab shaft covering the score line. Do not hold the swab shaft below the score line.
3. Carefully insert the swab into the vagina about 2 inches (5 cm.) past the introitus and gently rotate swab for 10 to 30 seconds. Make sure the swab touches the walls of the vagina so that moisture is absorbed by the swab. Withdraw swab without touching the skin.
4. While holding the swab in the same hand, unscrew the cap from the tube. Do not spill the contents of the tube. If you spill the contents of the tube, use a new vaginal swab specimen collection kit.
5. Immediately place the swab into the transport tube so the score line is at the top of the tube.
6. Carefully break the swab shaft at the score line against the side of the tube.
7. Immediately discard the top portion of the swab shaft.
8. Tightly screw the cap onto the tube.
9. Place in biohazard bag with requisition form when required.

**-OR-**

## NAAT Endocervical Swab

1. Remove excess mucous from the cervical os using the white cleaning swab provided. Discard this swab.
2. Insert the blue shaft specimen collection swab into the endocervical canal.
3. Gently rotate the swab clockwise for 10-30 seconds.
4. Remove cap from swab transport tube and immediately place the specimen swab into the transport tube. Carefully break the swab at the score line, using care not to splash contents.
5. Recap the swab specimen tube tightly. Label with client’s name, date, and clinic name.
6. Place in biohazard bag with requisition form when required.

## Rectal NAAT

1. Ask client to stand at the end of the exam table facing the length of table. Ask client to bend forward until their elbows rest on the exam table.
2. Insert the blue shaft swab 3–5 cm into the rectum and rotate against the rectal wall several times. Move swab from side to side in the anal canal to sample crypts. If it is difficult to adequately visualize the anus, ask the client to grasp a buttock in each hand and gently spread the opening for specimen collection.
3. Allow swab to remain 10–30 seconds for absorption of organisms onto the swab.
4. Repeat the process if the swab is grossly contaminated with feces.
5. Immediately place the blue swab into the specimen transport tube.
6. Break the swab at the score line. Recap the tube tightly.

## Pharyngeal NAAT

1. Swab back of throat and tonsillar area with a sterile applicator in the test kit.
2. Carefully remove the swab, not touching any area of the mouth. Immediately place the swab into the specimen transport tube and break swab at the score line.
3. Recap the tube tightly.
4. Recap the swab specimen tube tightly. Label with client name, date and clinic name.
5. Place in biohazard bag with requisition form when required.

## Rectal Gonorrhea Culture

* **Rectal gonorrhea culture is indicated only when you suspect antibiotic resistance.**

1. Ask client to stand at the end of the exam table facing the length of table. Ask client to bend forward until their elbows rest on the exam table.
2. Insert sterile swab approximately 1–1.5 inches in the anal canal. Move swab from side to side in the anal canal to sample crypts.
3. If it is difficult to adequately visualize the anus, ask the client to grasp a buttock in each hand and gently spread the opening for specimen collection.
4. Allow swab to remain 10–30 seconds for absorption of organisms onto the swab.
5. Repeat the process if the swab is grossly contaminated with feces.
6. Swab appropriate culture media supplied by laboratory.

## Pharyngeal Gonorrhea Culture

* **Pharyngeal gonorrhea culture is indicated only for test of cure or when you suspect antibiotic resistance.**

1. Explain the procedure to the client and reassure them that they should feel no pain or discomfort. They should feel only a mild tickling sensation as you take the sample.
2. Ask the client to keep their mouth wide open and tongue at rest. Pass a sterile swab around the tonsils and posterior pharyngeal wall. As the mouth is kept wide open and the tongue is at rest, pass a sterile swab around the tonsils and posterior pharyngeal wall. Remove the applicator carefully to avoid contamination by touching other areas within the mouth. Remove the applicator carefully to avoid contamination with other areas in the mouth.
3. Swab appropriate culture media provided by laboratory.
4. For clients with a bulky tongue, use a tongue depressor to provide better exposure of the pharynx.

## Wet Mount

### Test Tube Collection Technique

1. Insert a cotton-tipped applicator (swab) into the vagina and collect discharge on the vaginal walls and in the vaginal pool (area located posterior to the cervix).
2. Test pH of vaginal secretions. A pH greater than 4.5 may indicate bacterial vaginosis (BV) or trichomoniasis.
3. Place swab in a test tube containing 0.5 ml. saline.
4. Vigorously mix the swab in and out of the saline making sure to collect all the material adhering to the side of the tube.
5. Remove the swab from the saline and depress onto a clean, dry microscope slide expressing a small amount of fluid. Repeat this procedure on a second microscope slide.
6. Cover slip the first sample.
7. Add potassium hydroxide (KOH) to the second sample and perform an amine (“whiff”) test before applying a cover slip.
8. Examine the saline slide first for trichomoniasis and BV to allow the KOH to properly digest other cellular elements such as epithelial and blood cells on the second slide.
9. Examine KOH slide for yeast.

### Microscope Slide Collection Technique

1. Insert a cotton-tipped applicator (swab) into the vagina and collect discharge on the vaginal walls and in the vaginal pool (area located posterior to the cervix).
2. Test pH of vaginal secretions. A pH greater than 4.5 may indicate BV or trichomoniasis.
3. Depress swab onto a clean, dry microscope slide expressing a small amount of vaginal secretions. Repeat this procedure on a second microscopic slide.
4. Using a pipette or eye dropper, apply 1–2 drops of saline solution on the first slide.
5. Cover slip the first sample.
6. Add KOH to the second sample and perform an amine (“whiff”) test before applying a cover slip.
7. Examine the saline slide first for trichomoniasis and BV to allow the KOH to properly digest other cellular elements such as epithelial and blood cells on the second slide.
8. Examine KOH slide for yeast.

### Gram Stain

1. Using a cotton-tipped applicator (swab) collect visible discharge from the urethral meatus.
2. Roll three, short thin-layered lines on a microscopic slide allowing all sides of the swab to be exposed to the slide.

# Appendix C — Sample Self-Collection Posters

Sample GC/CT NAAT pharyngeal, rectal, and vaginal self-collection visual aids in English and Spanish are available for download from the [Denver STD Prevention Training Center (PTC)](https://www.denverptc.org/resource_search.html?pub_type_id=7).





# Appendix D — Sample Expedited Partner Therapy Partner Instruction Sheets and Log

## 

## Sample Partner Fact Sheet for Chlamydia Trachomatis (English)

**<<Name of Agency>>**

**<<Address and Phone>>**

**<<Name of Authorizing Physician>>**

**Expedited Partner Therapy (EPT) for Chlamydia**

**You were exposed to chlamydia. You may have chlamydia even if you feel fine and have no symptoms.**

**What is Chlamydia?**

Chlamydia is a sexually transmitted infection (STI) that can cause a bad infection in the female organs. The infection can cause fever, discharge and pain. It can also cause future tubal pregnancy or sterility in women. Men can develop pain, discharge, or more severe infections in the testes or scrotum.

**We recommend that you have a test to find out if you have chlamydia and other possible STIs.**

Please call the STI clinic for an appointment at **<<appointment phone number>>.** Tell them a partner asked you to call. There is a **$<<amount>>** fee for the exam and treatment. If you cannot pay, we will examine and treat you for free.

* You may also take the medicine your partner gave you if you cannot come to the clinic.
* It is possible that you have this infection and do not have symptoms. It is important that you get treated to prevent complications. The medicine will also stop the infection from spreading to others.
* Do not have sex for 7 days after treatment. It takes that long for the medicine to work.
* Tell all sex partners you have been with in the last 2 months to get checked for chlamydia.

**MEDICINE: Azithromycin 1 gram. Take all 4 pills by mouth at one time. OR**

**Doxycycline 100 mg capsules. Take one capsule by mouth every 12 hours for 7 days.**

* **Do not share this medicine. You need to take all the pills to cure your chlamydia.**
* **Do not** take this medicine if you have been allergic to any antibiotic in the past. **Do not take doxycycline if you are pregnant or breastfeeding.** Call the clinic if you have questions.
* **Do not take this medicine if you have pain in your abdomen, pelvic area, groin area, or testes — it may not work. Come to the STI clinic for a check-up to be sure you get the right medicine.**

**Possible Side Effects:** We carefully chose the medicine for your treatment. It is safe and effective. But any medicine can have side effects. The most common side effect is an upset stomach. Sometimes, the medicine causes stomach cramping or diarrhea. Very rarely, the medicine causes rash, fever or breathing problems. If you get any of these symptoms, please call the clinic at <<agency phone number>>. If your symptoms are severe — especially if it is hard to breathe — call 911.

**DO NOT HAVE ANY KIND OF SEX (ORAL, ANAL, or VAGINAL) WITH OR WITHOUT CONDOMS FOR 7 DAYS after you take this medicine. After 7 days, use condoms. Condoms help protect against gonorrhea and other STIs.**

Reinfection is common. People with chlamydia should get another test three (3) months after taking the medicine to be sure they are not reinfected.

**Date Given:**

## Ejemplo de hoja informativa para la pareja. *Chlamydia Trachomatis* (clamidia)

**<<Name of Agency>>**

**<<Address and Phone>>**

**<<Name of Authorizing Physician>>**

**Terapia acelerada de pareja (EPT) para la clamidia**

**Usted ha estado expuesto a la clamidia. Es posible que tenga clamidia, aunque se sienta bien y no tenga síntomas.**

**¿Qué es la clamidia?**

La clamidia es una infección de transmisión sexual (ITS) que puede infectar de gravedad los órganos reproductores femeninos. La infección de clamidia puede causar fiebre, secreción y dolor. En las mujeres, también puede causar un embarazo ectópico en el futuro o esterilidad. Los hombres pueden experimentar dolor, secreción o infecciones más graves en los testículos o el escroto.

**Le recomendamos que se haga una prueba para saber si tiene clamidia y otras posibles ITS.**

Llame a la clínica de ITS y pida una cita al **<<appointment phone number>>.** Explíqueles que un compañero le ha pedido que llame. El examen y el tratamiento tienen un costo de **$<<amount>>**. Pero, si no puede pagar, le examinaremos y trataremos en forma gratuita.

* Si no puede venir a la clínica, también puede tomar el medicamento que le dio su pareja.
* Es posible que tenga esta infección y no presente síntomas. Es importante que se trate con el fin de evitar complicaciones. El medicamento también evitará que la infección se transmita a otras personas.
* No tenga relaciones sexuales durante los 7 días posteriores al tratamiento. Ese es el tiempo necesario para que el medicamento funcione.
* Dígales a todas sus parejas sexuales con las que ha estado en los últimos 2 meses que se hagan una prueba para detectar la clamidia.

**MEDICAMENTOS:** **Azithromycin 1 gramo. Tome por vía oral las 4 pastillas a la vez. O BIEN Doxycycline 100 mg cápsulas. Tome por vía oral una cápsula cada 12 horas durante 7 días.**

* **No comparta esta medicación. Para curarse de la clamidia, necesita tomarse todas las pastillas.**
* **No tome** este medicamento si ha tenido una reacción alérgica a algún antibiótico en el pasado. **No tome doxycycline si está embarazada o amamantando.** Llame a la clínica si tiene alguna pregunta al respecto.
* **No tome este medicamento si tiene dolor en el abdomen, la zona de la pelvis, la zona de la ingle o en los testículos, ya que podría no funcionar.** **Acuda a la clínica de ITS para que le hagan un chequeo y así asegurarse de que recibe el medicamento correcto.**

**Posibles efectos secundarios:** Para tratarle, hemos elegido cuidadosamente el medicamento. Este es seguro y eficaz. Pero cualquier medicamento puede tener efectos secundarios. El más común en este caso es el malestar estomacal. A veces, provoca calambres estomacales o diarrea. En muy raras ocasiones, el medicamento provoca sarpullido, fiebre o problemas respiratorios. Si experimenta alguno de estos síntomas, llame a la clínica al <<agency phone number>>. Si tiene síntomas graves, especialmente si tiene dificultad para respirar, llame al 911.

**NO TENGA NINGÚN TIPO DE RELACIONES SEXUALES (ORALES, ANALES O VAGINALES) CON O SIN CONDONES, DURANTE LOS 7 DÍAS SIGUIENTES a la toma de este medicamento.** **Después de 7 días, use condón. Los condones ayudan a protegerse contra la gonorrea y otras ITS.**

La reinfección es frecuente. Las personas con clamidia deben hacerse otra prueba tres (3) meses después de tomar el medicamento para asegurarse de que no se han vuelto a infectar.

**Fecha de administración:**

## Sample Partner Fact Sheet for Gonorrhea (English)

**<<Name of Agency>>**

**<<Address and Phone>>**

**<<Name of Authorizing Physician>>**

**Expedited Partner Therapy for Gonorrhea**

**You were exposed to gonorrhea. You can have gonorrhea even if you feel fine and have no symptoms.**

**What is gonorrhea?**

Gonorrhea is a sexually transmitted infection (STI) that can cause a bad infection. The infection can cause fever, discharge and pain. It can also cause future tubal pregnancy or sterility in women. Men can develop pain, discharge, or more severe infections in the testes or scrotum.

**We recommend that you have a test to find out if you have gonorrhea and other STIs.**

Please call the STI clinic for an appointment at **<<appointment phone number>>.** Tell them a partner asked you to call. There is a **$<<amount>>** fee for the exam and treatment. If you cannot pay, we will examine and treat you for free.

* You may also take the medicine your partner gave you if you cannot come to the clinic.
* It is possible that you have this infection and do not have symptoms. It is important that you get treated to prevent complications. The medicine will also stop the infection from spreading to others. If you do not feel better in 3 days, it is VERY important that you go to the clinic for an exam and testing.
* Do not have sex for 7 days after treatment. It takes that long for the medicine to work.
* Tell all sex partners you have been with in the last 2 months to get checked for gonorrhea.

**MEDICINE: Cefixime 800mg (two 400 mg pills). Take both pills (2) by mouth at one time.**

**Possible Side Effects:** We carefully chose the medicine for your treatment. It is safe and effective. But any medicine can have side effects. The most common side effect is an upset stomach. Sometimes, the medicine causes stomach cramping or diarrhea. Very rarely, this medicine causes rash, fever or breathing problems. If you get any of these symptoms, please call the clinic at <<agency phone number>>. If your symptoms are severe — especially if it is hard to breathe — call 911.

* **Do not take this medicine if you were allergic to any antibiotic in the past.** Call the clinic if you have questions.
* **Do not take this medicine if you have pain in your abdomen, pelvic area, groin area, or testes – it may not work. Come to the STI clinic for a check-up to be sure you get the right medicine.**
* **DO NOT HAVE ANY KIND OF SEX (ORAL, ANAL, or VAGINAL) WITH OR WITHOUT CONDOMS FOR 7 DAYS after you take this medicine**. After 7 days, use condoms. Condoms help protect against gonorrhea and other STIs.

Reinfection is common. People with gonorrhea should get another test three (3) months after taking the medicine to be sure they are not reinfected.

**Date Given:**

## Ejemplo de hoja informativa para la pareja. Gonorrea

**<<Name of Agency>>**

**<<Address and Phone>>**

**<<Name of Authorizing Physician>>**

**Terapia acelerada de pareja (EPT) para la gonorrea**

**Usted ha estado expuesto a la gonorrea.** **Es posible que tenga gonorrea, aunque se sienta bien y no tenga síntomas.**

**¿Qué es la gonorrea?**

La gonorrea es una infección de transmisión sexual (ITS) que puede causar otras infecciones graves. La infección de gonorrea puede causar fiebre, secreción y dolor. En las mujeres, también puede ser causa de un embarazo ectópico en el futuro o de esterilidad. Los hombres pueden experimentar dolor, secreción o infecciones más graves en los testículos o el escroto.

**Le recomendamos que se haga una prueba para saber si tiene gonorrea y otras ITS.**

Llame a la clínica de ITS y pida una cita al **<<appointment phone number>>.** Explíqueles que un compañero le pidió que llamara. El examen y el tratamiento tienen un costo de **$<<amount>>**. Pero, si no puede pagar, le examinaremos y trataremos en forma gratuita.

* Si no puede venir a la clínica, también puede tomar el medicamento que le dio su pareja.
* Es posible que tenga esta infección sin que presente ningún síntoma. Es importante que se trate para evitar complicaciones. El medicamento también evitará que la infección se transmita a otras personas. Si no se siente mejor en 3 días, es MUY importante que vaya a la clínica para que lo examinen y le hagan pruebas.
* No tenga relaciones sexuales en los 7 días posteriores al tratamiento. Ese es el tiempo necesario para que el medicamento funcione.
* Dígales a todas sus parejas sexuales con las que ha estado en los últimos 2 meses que se hagan la prueba para detectar la gonorrea.

**MEDICAMENTO:** **Cefixime 800 mg (dos pastillas de 400 mg). Tome por vía oral las dos (2) pastillas a la vez.**

**Posibles efectos secundarios:** Para tratarle, hemos elegido cuidadosamente el medicamento. Este es seguro y eficaz. Pero cualquier medicamento puede tener efectos secundarios. El más común en este caso es el malestar estomacal. A veces, el medicamento provoca calambres estomacales o diarrea. En muy raras ocasiones, este medicamento provoca sarpullido, fiebre o problemas respiratorios. Si tiene alguno de estos síntomas, llame a la clínica al **<<agency phone number>>**. Si tiene síntomas graves, especialmente si tiene dificultad para respirar, llame al 911.

* **No tome este medicamento si en el pasado ha tenido una reacción alérgica a algún antibiótico.** Llame a la clínica si tiene preguntas al respecto.
* **No tome este medicamento si tiene dolor en el abdomen, la zona de la pelvis, la zona de la ingle o en los testículos, ya que podría no funcionar.** **Acuda a la clínica de ITS para que le hagan un chequeo y así asegurarse de que recibe el medicamento correcto.**
* **NO TENGA NINGÚN TIPO DE RELACIONES SEXUALES (ORALES, ANALES o VAGINALES) CON O SIN CONDONES, DURANTE LOS 7 DÍAS SIGUIENTES a la toma de este medicamento.** Después de 7 días, utilice condón. Los condones protegen contra la gonorrea y otras ITS.

La reinfección es frecuente. Las personas con gonorrea deben hacerse otra prueba tres (3) meses después de tomar el medicamento para asegurarse de que no han vuelto a infectarse.

**Fecha de administración:**

## Sample Expedited Partner Therapy Log

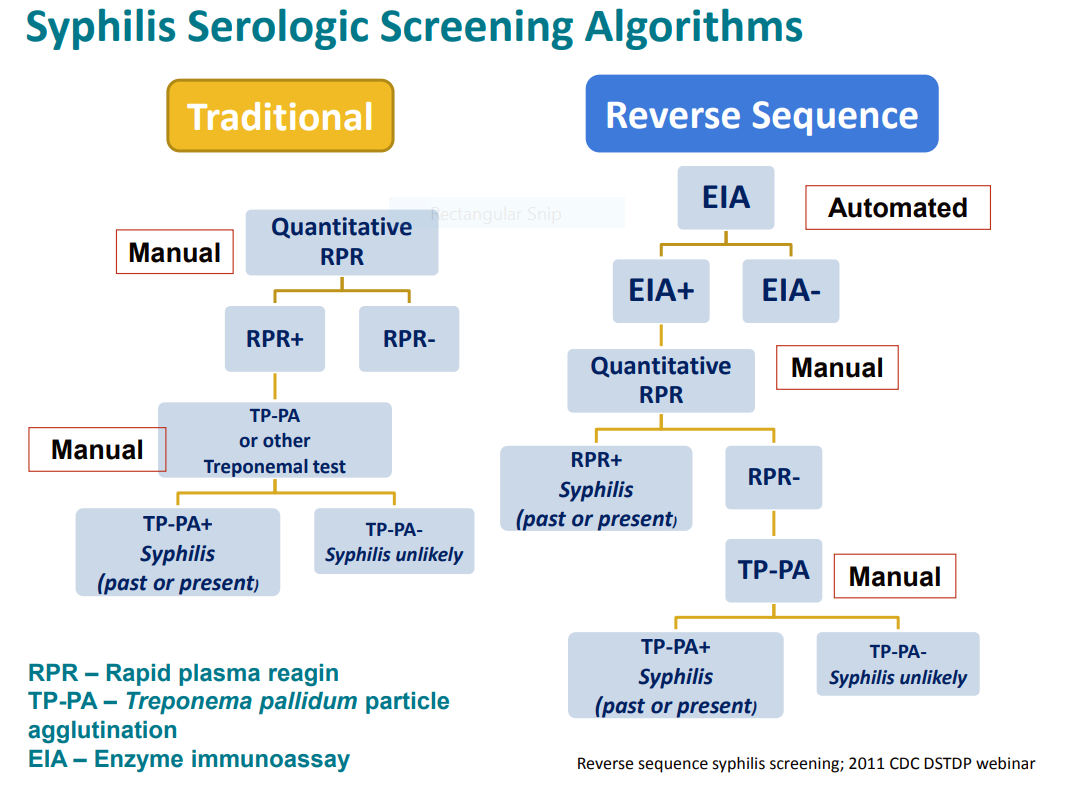
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| --- | --- | --- | --- | --- | --- | --- |
| **Date** | **Index Client Name** | **Date of Birth** | **Medication and Strength:**  **Azithromycin 250 mg (4 tabs)**  **Cefixime 400 mg (2 tabs)**  **Doxycycline 100 mg (14 caps)** | **NDC / Lot / Expiration Date** | **# of Rx** | **Nurse Initials** |
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Nurse Signature:

Nurse Signature:

Nurse Signature:

# Appendix E — Syphilis Serologic Screening Algorithms





DSHS TB/HIV/STD Program  
***dshs.texas.gov/hivstd***

1. These SDOs are not for licensed vocational nurses (LVNs) or unlicensed staff. However, agencies can revise these SDOs to use with LVNs or unlicensed staff. [↑](#footnote-ref-2)