Infection	First line treatment	
Bacterial Vaginosis	Metronidazole 400 mg orally, 12-hourly with food for 7 days OR metronidazole 2 g orally, as a single dose (less effective) OR metronidazole gel 0.75% gel 5 g, nocte for 5 nights (not on PBS) OR tinidazole 2 g orally, as a single dose with food OR clindamycin 2% vaginal cream 5 g, daily for 7 days (not on PBS) OR clindamycin 300 mg orally, 12-hourly for 7 days (not on PBS).	**Incubation period** Unknown **Requires notification** No **Usual testing method** Microscopy of a vaginal smear.
Candidiasis	Any of the available imidazole preparations are effective, either as cream or pessaries. Various preparations are available for either single dose therapy, or three to seven days of therapy.	**Incubation period** Indefinite. *C. albicans* is usually normal flora **How far back to contact trace** Only current regular partner/s if recurrent symptoms **Requires notification** No **Usual testing method** Microscopy or culture of vaginal swab.
Chancroid	Single dose directly observed therapy is preferred. Azithromycin 1 g orally, as a single dose OR ceftriaxone 500 mg in 2 mL 1% lignocaine intramuscularly OR ciprofloxacin 500 mg orally, 12-hourly for 3 days.	**Incubation period** 6 days to 2 weeks **How far back to contact trace** 2 weeks before ulcer appeared or since arrival from endemic area **Requires notification** Yes **Usual testing method** Usually clinical in resource poor settings. NAAT is ideal.
Genital Herpes	**First episode** Valaciclovir 500 mg orally, 12-hourly for 5 to10 days OR aciclovir 400 mg orally three times daily for 5 to 10 days. **Episodic** Episodic treatment is indicated for infrequent recurrences (i.e. intervals of more than six to eight weeks). Episodic therapy should be initiated early on by the patient at the first sign of prodrome or very early lesions. Valaciclovir 500mg orally, 12 hourly for 3 days OR famciclovir 1g orally stat OR aciclovir 800mg orally, 3 times daily for 2 days. **Suppressive** Suppressive therapy is indicated in significant, frequent disease. Valaciclovir, famciclovir, aciclovir on a daily basis can reduce severity and frequency of outbreaks.	**Incubation period** Often unknown **How far back to contact trace** Not necessary but current/ future partners may benefit from education on transmission **Requires notification** No **Usual testing method** Swab lesion for HSV/syphilis NAAT and donovanosis in high prevalence regions.
Genital Warts	**Not pregnant** Podophyllotoxin paint (0.5%) (not on PBS) or cream (0.15%) topically twice daily for three days, then do not treat for four days. Repeat for up to four weeks OR imiquimod 5% cream topically, three times a week for up to 16 weeks (not on PBS). **Pregnant** Cryotherapy: apply liquid nitrogen to visible warts weekly until resolution occurs OR surgical ablative therapy for large or extensive lesions.	**Incubation period** Commonly 3–6 months but often much longer **How far back to contact trace** Consider current partner(s) **Requires notification** No **Usual testing method** Clinical diagnosis. Always screen for other STIs.

Infection	First line treatment	
HIV	**Treatment** Initial HIV assessment and staging should be done by an HIV/ Sexual Health specialist and ideally followed by shared care with a general practitioner. Contact Clinical Immunology at Royal Perth Hospital on 08 9224 2899, or the Infectious Diseases Department at Fiona Stanley Hospital on 08 6152 6744 or 6152 6745. **Pre-exposure prophylaxis** Pre-exposure prophylaxis (PrEP) is an important prevention option and can provide highly effective biomedical prevention of HIV in HIV-negative individuals. See the National PrEP Guidelines at Communicable Disease Control Directorate's *Guideline for Non-Occupational Post-Exposure Prophylaxis (NPEP) to Prevent HIV in Western Australia* available at https://ww2.health.wa.gov.au/Articles/A_E/Communicable-disease-control-guidelines for more information. **Post-exposure prophylaxis** Post-exposure prophylaxis (PEP) is a course of antiretroviral drugs that should be commenced as soon as possible (and definitely within 72 hours) following exposure to HIV. The Department of Health recommends 300mg tenofovir/200mg emtricitabine as first line for two drug regimen. PEP will reduce the risk of HIV transmission after unsafe sex, sharing of injecting equipment, occupational exposure or when it is known or likely that there has been a high risk of exposure. For more information, see the Department of Health's Communicable Disease Control Directorate's *Guideline for Non-Occupational Post-Exposure Prophylaxis (NPEP) to Prevent HIV in Western Australia* and *Guideline for Occupational Exposure to Blood and Body Fluids in Healthcare Settings* available at https://ww2.health.wa.gov.au/Articles/A_E/Communicable-disease-control-guidelines	**Incubation period** 1-12 weeks **How far back to contact trace** At least 12 weeks before a confirmed primary HIV illness. If the date of primary infection cannot be confirmed, the trace-back period may be years, depending on the patient's history of risk behaviour and clinical presentation. **Requires notification** Yes **Usual testing method** Serology, initial enzyme immunoassay (EIA), positive results are confirmed by a Western Blot assay.

***NAAT = Nucleic Acid Amplification Test (e.g. PCR)**
****First void urine to detect STIs is first 20 mL of urine passed, collected at any time of the day**
*****The standard treatment for uncomplicated chlamydia and gonorrhoea contracted in the Goldfields, Kimberley or Pilbara regions of WA is a ZAP pack, which contains azithromycin 1 g, amoxycillin 3 g, probenecid 1 g or a LAC pack, which contains azithromycin 1g and ceftriaxone 500mg with lignocaine 1% 2ml and a patient advice sheet.**
Please see the WA HIV/STI control supplement for endemic regions www.silverbook.health.wa.gov.au
For more information on contact tracing recommendations view the *Australasian Contact Tracing Guidelines* at www.contacttracing.ashm.org.au

Help with contact tracing

Health care providers can obtain further information about contact tracing from: www.silverbook.health.wa.gov.au

Regional public health units

Goldfields (Kalgoorlie-Boulder)..... 9080 8200
Great Southern (Albany)..... 9842 7500
Kimberley (Broome)..... 9194 1630
Midwest/Gascoyne (Carnarvon)..... 9941 0500
Midwest (Geraldton)..... 9956 1985
Pilbara (South Hedland)..... 9174 1660
Southwest (Bunbury)..... 9781 2359
Wheatbelt (Northam)..... 9690 1720

Perth

Metropolitan Communicable Disease Control..... 9222 8588

For more information go to: www.silverbook.health.wa.gov.au OR phone: South Terrace Clinic – 9431 2149
Royal Perth Hospital Sexual Health Clinic – 9224 2178

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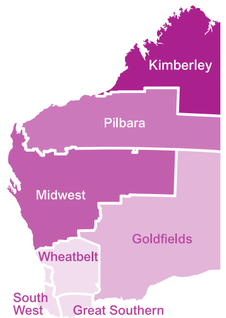
Government of **Western Australia**
Department of **Health**

Quick guide to **STI and BBV management**

2023

health.wa.gov.au

Infection	First line treatment	
Chlamydia	**Adults uncomplicated genital or pharyngeal infection** Doxycycline 100mg orally, 12 hourly for 7 days (preferred treatment) OR Azithromycin 1g orally, as a single dose (For LGV see Silver Book). **Adults anorectal infection** Doxycycline 100 mg orally, 12 hourly for 7 days if asymptomatic, but 21 days if symptomatic OR Azithromycin 1 g PO, stat. and repeat in 12-24 hours **Children 0–8 years** Azithromycin 10 mg/kg (to a maximum of 1 g) orally, daily for 5 days (restricted PBS availability) OR erythromycin 10 mg/kg per day orally, in 4 doses for 10 to 14 days. **Children > 8 years** Azithromycin 20 mg/kg (to a maximum of 1 g) orally, as a single dose OR doxycycline 100 mg orally, 12-hourly for 7 days. **Pregnant women** Azithromycin 1 g orally, as a single dose Use ZAP pack for empirical treatment of uncomplicated infections contracted in the Goldfields, Kimberley or Pilbara regions of WA***	**Incubation period** > 2 days – 2 months for male urethral infection, though many remain asymptomatic. Most cervical infections in women and anal infections in men and women remain asymptomatic **How far back to contact trace** According to symptoms or sexual history; usually up to 6 months **Requires notification** Yes **Usual testing method** NAAT* of vaginal, cervical, anal, throat swab, or first void urine.**
Gonorrhoea	**Treating:** **a. uncomplicated gonorrhoea OR anorectal gonorrhoea** **Adults** Ceftriaxone 500 mg in 2 mL 1% lignocaine intramuscularly AND Azithromycin 1 g (oral), given together as a single treatment. **b. pharyngeal gonorrhoea** **Adults** Ceftriaxone 500 mg in 2 mL 1% lignocaine intramuscularly AND Azithromycin 2 g (oral), given together as a single treatment. **Children** Ceftriaxone 50 mg/kg (maximum 500 mg) intramuscularly (using the adult dilution) AND Azithromycin 20 mg/kg (oral tablet or syrup) to a maximum of 1 g (oral), given together as a single treatment. **Use ZAP pack for empirical treatment of uncomplicated infections contracted in the Goldfields, Kimberley or Pilbara regions of WA.***** **Adults** Amoxycillin 3 g orally AND Probenecid 1 g orally AND Azithromycin 1 g orally, given together as a single treatment. **Children, weighing <45 kg** Amoxycillin 50 mg/kg orally AND Probenecid 25 mg/kg orally AND Azithromycin 20 mg/kg oral tablet or syrup to a maximum of 1 g orally, given together as a single treatment.	 **Incubation period** 2–10 days for male urethral infection; occasionally weeks to months. Most cervical, anal and throat infections are asymptomatic **How far back to contact trace** Minimum 2 months – consider up to 6 months **Requires notification** Yes **Usual testing method** Culture (any site) or NAAT (genital, anal, or throat swabs or urine). When delays of greater than 24 hours occur in getting the specimen to a laboratory (eg in rural and remote areas) NAAT is the preferred test. However, where there is pus, a swab for culture and antibiotic resistance testing should still be sent.
Urethritis/ Cervicitis	Manage as for chlamydia and also gonorrhoea in areas where this is common.	

Infection	First line treatment	
Syphilis	**Penicillin** remains the drug of choice. If there is any doubt about the clinical stage of the patient's infection, treat as for late latent syphilis. Benzathine benzylpenicillin (Bicillin L-A) is now on the Emergency Drug Supply Schedule (Prescriber's Bag) **Primary, secondary and early latent syphilis (up to 24 months)** Benzathine penicillin 1.8 g (=2, 400, 000 units) intramuscularly, as a single dose OR procaine penicillin 1 g for patients less than 60 kg bodyweight and 1.5 g for patients over 60 kg bodyweight intramuscularly, daily for 10 consecutive days. *If allergic to penicillin* – doxycycline 100 mg orally, 12-hourly for 14 days. **Late latent syphilis (more than 24 months)** Benzathine penicillin 1.8 g (=2, 400, 000 units) intramuscularly, once weekly for three doses. If 2nd or 3rd dose is delayed by >3 days, restart the 3 week course OR procaine penicillin 1 g for patients less than 60 kg bodyweight and 1.5 g for patients over 60 kg bodyweight, intramuscularly, daily for 15 days. *If allergic to penicillin* – doxycycline 100 mg orally, 12-hourly for 28 days.	**Incubation period** 9 days – 3 months (mean 1 month) to primary syphilis; 1–5 months to secondary syphilis; usually 5–35 years to tertiary syphilis **How far back to contact trace** Primary syphilis – 3 months plus duration of symptoms Secondary syphilis – 6 months plus duration of symptoms Early latent syphilis – 12 months **Requires notification** Yes **Usual testing method** Serology. Ulcer swab can be tested by NAAT.
Pelvic Inflammatory Disease	Begin treatment early. Delayed treatment is associated with a significantly increased risk of tubal infertility or ectopic pregnancy. Rest. Use non-steroidal anti-inflammatory for pain relief Prevent any *Candida* infection with pessaries during the treatment period. Sexually acquired PID – Immediate treatment. Ceftriaxone 500mg in 2ml of 1% lignocaine intramuscularly, as a single dose PLUS Doxycycline 100mg orally, twice daily for 14 days PLUS Metronidazole 400mg orally, twice daily for 14 days. For patients who may be non-adherent to Doxycycline, consider replacing with Azithromycin 1g orally, as a further single dose 1 week later. Consider admission if: • diagnosis uncertain • surgical emergency – appendicitis or ectopic pregnancy • pelvic abscess • severe illness or no response to outpatient medicine • no clinical follow-up • cannot take therapy. Patient to avoid sexual intercourse until they are non-infectious and symptomatically better. For pregnant/breastfeeding women, inpatient management, and *M. genitalium*-confirmed PID refer to the PID section of www.silverbook.health.wa.gov.au	**Incubation period** Often several months **How far back to contact trace** According to sexual history, up to 6 months **Requires notification** No **Usual testing method** Clinical diagnosis, may be reinforced by detection of chlamydia or gonorrhoea in the patient or her contact **RULE OUT Pregnancy.**
Trichomoniasis	Metronidazole 2 g orally, as a single dose OR tinidazole 2 g orally, as a single dose with food OR metronidazole 400 mg orally, 12-hourly for 5 days.	**Incubation period** Days to weeks. May remain asymptomatic indefinitely **How far back to contact trace** Recent months: easily contactable partners only **Requires notification** No **Usual testing method** Microscopy or specific culture of vaginal swab (if available). NAAT becoming available.

Infection	First line treatment	
Mycoplasma Genitalium	Doxycycline is used to lower the bacterial load, increasing the chance of cure with subsequent antibiotic. Doxycyline 100mg (orally), 12-hourly for 7 days, **followed by** azithromycin 1g (orally) as a single dose, then 500mg daily for 3 days (total 2.5g). **If infection known or suspected to be macrolide-resistant:** Doxycycline 100mg orally, 12-hourly for 7 days **followed by** Moxifloxacin 400mg daily for 7 days **For Pelvic inflammatory disease (PID) caused by *M.genitalium* only** Moxifloxacin 400mg daily for 14 days If moxifloxacin fails or cannot be used, seek specialist advice. Macrolide resistance has been an increasing issue in Australia. Therefore a test of cure should always be performed at 3 weeks.	**Incubation period** Unknown but symptoms commonly develop within 1–3 weeks **How far back to contact trace** All sexual contacts over the last 6 months **Requires notification** No **Usual testing method** NAAT of vaginal, cervical or anal swab, or first void urine. Standard microscopy and culture will not detect this infection.
Viral Hepatitis A	No antiviral therapy available. **Post-exposure prophylaxis:** Contacts >=1 year old, not immunosuppressed, no chronic liver disease and no contraindication to the vaccine: Monovalent hepatitis A vaccine within 2 weeks of sexual exposure. Contacts <1 year old, or immunosuppressed, or have chronic liver disease, or with contraindication to the vaccine: Normal human immunoglobulin (NHIG) 160 mg/mL within 2 weeks of sexual exposure. **Weight NHIG Dose** **Under 25 kg** – 0.5 mL **25–50 kg** – 1 mL **Over 50 kg** – 2 mL	**Incubation period** 3 weeks (range 2–7 weeks) **How far back to contact trace** Up to 7 weeks from onset of symptoms **Requires notification** Yes **Usual testing method** Serology (HAV IgM positive).
Viral Hepatitis B	Acute infection does not usually require treatment. **Post-exposure prophylaxis** Percutaneous contacts should be given hepatitis B immunoglobulin (HBIG) 400 IU intramuscularly, as a single dose within 72 hours of exposure. Individuals sexually exposed should be given HBIG 400 IU intramuscularly and vaccine within 2 weeks of sexual contact for maximum protection. If more than 2 weeks vaccination should still be commenced. Hepatitis B vaccination and immunoglobulin can be given at the same time, but at different sites.	**Incubation period** 10 weeks (range 1–6 months) **How far back to contact trace** Up to 6 months prior to index case developing symptoms; if asymptomatic according to risk history **Requires notification** Yes **Usual testing method** Serology (HBsAg positive).
Viral Hepatitis C	Highly effective direct-acting antiviral (DAA) medicines are available on the PBS to treat hepatitis C (>95% cure rate). GPs/medical practitioners experienced in treating chronic hepatitis C can independently prescribe DAAs for hepatitis C without consulting a specialist (i.e. infectious diseases physician, hepatologist or gastroenterologist.) Those NOT experienced in treating chronic hepatitis C may initiate treatment in consultation with a specialist by submitting a remote consultation request form (available from https://ww2.health.wa.gov.au/Silver-book/Notifiable-infections/Hepatitis-C). Patients with evidence of cirrhosis should be referred to a specialist for treatment.	**Incubation period** 7 weeks (range 2 weeks – 5 months) **How far back to contact trace** Contact tracing not generally carried out for all HCV cases **Requires notification** Yes **Usual testing method** Serology (HCV antibody positive) with reactive HCV-PCR test if positive to confirm active infection.