

SCOPE OF PRACTICE

TARGET POPULATION

- Clients who present with genital symptoms consistent with a sexually transmitted infection (STI's) who require assessment, testing and treatment
- Clients who are asymptomatic and who request screening for STI's
- Clients who present as a contact of an STI

EXCLUSION CRITERIA

Clients presenting with conditions outside the scope of the Nurse Practitioner (NP) Role including:

- Clients with established pregnancy
- Clients with persistent symptoms post treatment
- Clients with chronic gynaecological or urological issues
- Clients with immunosuppression illness including Human Immunodeficiency Virus (HIV) who are on highly active anti-retroviral therapy (HAART)

GUIDELINE OBJECTIVES AND ANTICIPATED OUTCOMES

- Determine cause of symptoms and identify probable aetiology, diagnosis and differential diagnoses
- Provide treatment for clients with a confirmed diagnosed infection or presumptive treatment for symptomatic clients
- Identification of individual STI risk and provision of appropriate screening
- Identify public health risks to control infections by:
 - Provision of STI education and information
 - Identification and exploration of sexual risk taking behaviours
 - Partner notification as required

BACKGROUND

An accurate medical and sexual history is the key component for providing a comprehensive assessment of a clients sexual health. Sexual history taking and genital examination are used to aid in the diagnosis and testing and screening requirement for each client. Testing includes microscopy and other investigations for symptomatic clients. Screening includes STI's and other genital tract infections, HIV and other blood borne viruses (BBV) in clients who may present asymptotically, symptomatically, or as a contact of infection.^{1,2}

CLINICAL ASSESSMENT

The sexual health assessment consists of;

- General medical history
- Sexual history and risk assessment
- Symptom history
- Genital examination

GENERAL MEDICAL HISTORY ²

- Past medical history including depression and anxiety
- Past history of STI's
- Current medication, recent antibiotic use (within 1 month) and or complementary medicines
- Drug allergies
- Last STI screen (last HIV test)
- Vaccination status for Hepatitis B, A (MSM) and Gardasil (Women <27 yrs)
- Past sexual assault

SPECIFIC SEXUAL HISTORY	BBV HISTORY
<ul style="list-style-type: none"> • Last sexual contact; type of sexual contact • Last (un)protected vaginal /anal intercourse (UPAI/VI) • Condom usage • Regular partner or partners (RSP); duration of relationship • Casual partner or partners (CSP) in past 3 months and 12 months. • Gender of partner(s) • Type of sexual contact with partners • Explore other sexual practices • Overseas contacts in past 12 months 	<ul style="list-style-type: none"> • Intra venous drug use (IDU) /history of sharing needles • Tattoo history (safe/unsafe) • Blood transfusions • Body piercing • Scarification • Overseas medical procedures

Table G1.2: Risk Assessment for STI's and BBV's ^{1,2,3,4}

SEXUAL HISTORY AND RISK ASSESSMENT^{2,4}

- Assessment of potential risk for STI's and BBV include the following;
- Sexual Contacts
 - Partners HIV / STI status and symptoms
 - Partners from high prevalent countries
- If anal or vaginal intercourse – condom use with RSP; CSP past 3 months / 12 months
- Lifetime partners; age of first sexual intercourse
- Context of sexual activity: beats, Sex On Premise Venues (SOPV), swingers clubs and the influence of alcohol and other substances on risk taking
- Casual partners: anonymous or contactable
- Sexual function and dysfunction assessment

ADDITIONAL SEXUAL HISTORY FOR WOMEN	CURRENT METHOD OF CONTRACEPTION
<ul style="list-style-type: none"> • Last menstrual period • Pattern of menstrual cycle • Any recent changes in menstrual cycle • Intermenstrual bleed or post-coital bleed • Live births, premature births • Miscarriages • Terminations 	<ul style="list-style-type: none"> • Oral • Intradermal • Injectable • Coils, rings • Condoms

Table G1.3: Additional sexual history taking for women ²

ADDITIONAL SEXUAL HISTORY FOR MEN WHO HAVE SEX WITH MEN (MSM)

- Distinguish type of sexual activity for MSM clients
- Determine whether anal sex was as a receptive or insertive partner
- Explore anal sex practices and para- anal activities
- Determine condom use with anal sex
- Sero-status of partner(s)
- Drug and alcohol use
- History of depression and or anxiety

Table G1.4: Additional MSM Sexual history taking

SYMPTOM HISTORY

- Nature and duration of symptoms
- More than one STI may be present
- Duration of symptoms
- Urethral and vaginal discharge
 - Amount
 - Colour
 - Odour
 - Character
- Abnormal vaginal or rectal bleeding
- Genital rashes, lumps and sores
- Itching and or discomfort in genital area
- Lower abdominal pain and dyspareunia
- Difficulties or pain with micturition or defecation

FEMALE	MALE
<ul style="list-style-type: none"> • Vaginal discharge • Genital and pelvic pain • Pruritus • Dysuria and other urinary symptoms • Dysmenorrhoea • Post coital bleeding • Intermenstrual bleeding • Ano-genital ulcers • Genital Lumps • Genital skin conditions • Anal symptoms • Genital rash 	<ul style="list-style-type: none"> • Urethral discharge • Dysuria and other urinary symptoms • Ano-genital or urethral irritation • Epididymal tenderness • Meatitis • Genital lumps • Ano-genital ulcers • Genital skin conditions <p style="text-align: center;">MSM</p> <ul style="list-style-type: none"> • Genital or oral ulcers • Anal symptoms • Generalised rash • HIV Seroconversion illness

Table G1.1: Common genital symptoms^{2,3,4}

GENITAL EXAMINATION

MALE GENITAL EXAMINATION	
CONSENT, PERMISSION, EXPLANATION	<ul style="list-style-type: none"> • Ask client for permission to examine genital region • Explain procedure and rationale for genital examination • Ensure privacy and patient comfort • Offer chaperone
ORO-PHARYNGEAL EXAMINATION	<ul style="list-style-type: none"> • For MSM/bisexual clients • Assess for presences of ulcers, chancre, discharge, tonsillitis
EXTERNAL GENITAL	<ul style="list-style-type: none"> • Visual inspection of genitals for any obvious lumps, growths, ulcers, redness or other skin conditions • Visual inspection of pubic area, pubic hair • Palpate groin and/or inguinal region for presence of enlarged

	lymph nodes (adenopathy) and/or herniation
GENITAL EXAMINATION	<ul style="list-style-type: none"> • Examine foreskin if present • Shaft – visually inspect for lumps (warts or molluscum contagiosum (MC), ulceration (trauma, herpes) and anatomical variations • Glans – visual inspection • Meatus – check for discharge, redness, presence of warts • Note any normal anatomical variant that may concern client, pearly papules, Tyson’s glands, sebaceous glands
SCROTAL / TESTICULAR EXAMINATION	<ul style="list-style-type: none"> • Testicular examination – palpate for lumps , growths, abnormalities • Assess for pain or discomfort • Teach testicular self examination
ANOGENITAL EXAMINATION	<ul style="list-style-type: none"> • Examine perianal area and external anal • Assess presence of fissures, external anal warts, ulcers and normal anatomical variants

Table G1.5 Male physical examination^{1,2,3,4,5}

FEMALE GENITAL EXAMINATION	
CONSENT, PERMISSION, EXPLANATION	<ul style="list-style-type: none"> • Ask client for permission to examine genital region • Explain procedure and rationale for genital examination • Ensure privacy and patient comfort • Offer chaperone
EXTERNAL GENITAL EXAMINATION	<ul style="list-style-type: none"> • Visual inspection of genitals for any obvious lumps, growth, ulcers, redness or other skin conditions • Visual inspection of pubic hair • Palpate groin or inguinal region for presence of enlarged lymph nodes (adenopathy) and/or herniation
SPECULUM EXAMINATION VAGINAL	<ul style="list-style-type: none"> • Place client in position and ensure privacy • Place speculum on thigh to gain temperature comfort to client • Place on introitus and insert gently • Examine vaginal walls for any lumps, ulcers and abnormalities
CERVIX	<ul style="list-style-type: none"> • Visualise cervix; observe for any unusual discharge or bleeding, lumps or abnormalities • Remove excess mucus from the os • Collect specimens where indicated • If microscopy is indicated, collect swabs from cervix, vaginal and vulval areas • Wet preparation if indicated • Vaginal pH
ANOGENITAL EXAMINATION (IF INDICATED)	<ul style="list-style-type: none"> • Examine perianal area and external rectum • Assess presence of fissures, anal warts, ulcers and normal anatomical variants
EXAMINATION OF WOMEN WITH ABSENT CERVIX (POST HYSTERECTOMY)*	<ul style="list-style-type: none"> • Where there is no cervix due to a hysterectomy, a first pass urine (FPU) is sufficient for Chlamydia and where indicated, gonorrhoea, and a high vaginal swab for Trichomonas. • A urethral swab for Chlamydia and gonorrhoea may be performed. • For women with history of malignancy and a hysterectomy vault smears should be taken at recommended intervals

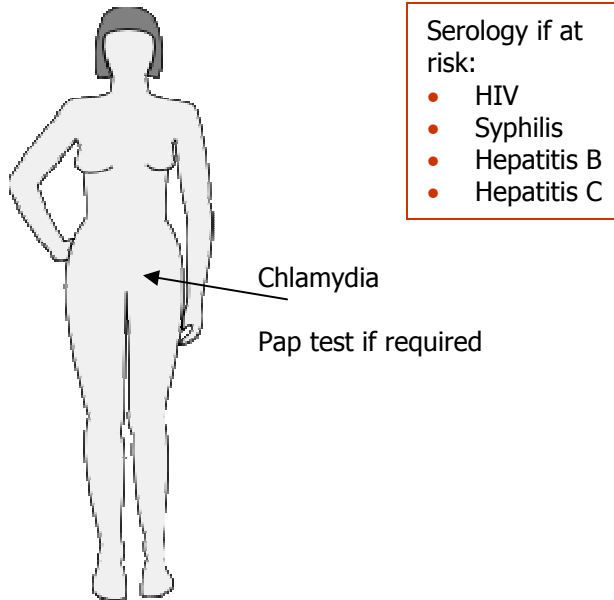
Table G1.6 Female physical examination^{1,2,3,4,5}

*Post operative transgender clients will require FPU for Chlamydia and gonorrhoea

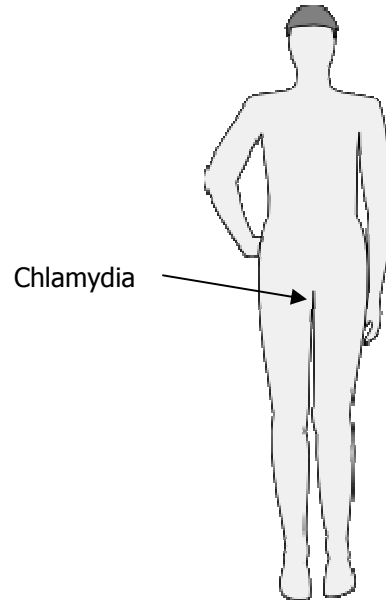
RECOMMENDED TESTS & INVESTIGATIONS

- Screening is dependant on the risk profile of the client and presenting symptoms
- Refer to MSHC Policy and procedures for screening guidelines
- Refer to Diagnostic formulary for full description of testing requirements

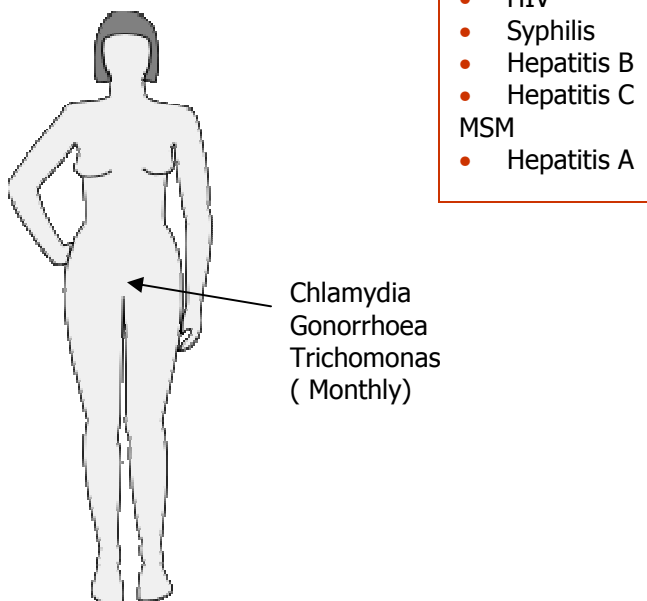
Screening recommendations: Asymptomatic heterosexual women



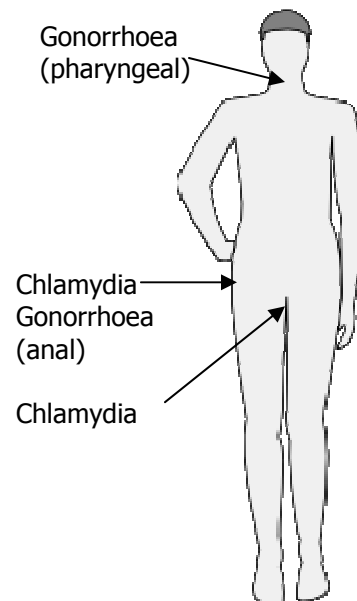
Screening recommendations: Asymptomatic heterosexual males



Screening recommendations: Asymptomatic sex workers



Screening recommendations: Asymptomatic homosexual males



pictures courtesy of <http://www.clker.com>

MANAGEMENT

After diagnosis and clinical assessment, the appropriate Melbourne Sexual Health Centre (MSHC) management and treatment guidelines and the Clinical Practice Guidelines (CPG's) should be used. The guidelines identify clinical indicators, recommended diagnostic investigations, recommended treatment, management and follow up for particular conditions.

- The clinical scope of practice for Nurse Practitioners is clearly defined for each condition
- Times when referral to a Medical Officer (MO) is warranted are clearly indicated for each specific condition
- HIV and Hepatitis C pre and post test counselling are essential parts of the sexual health history

EDUCATION

- Use of MSHC client information sheets, consumer information and written instructions are part of good client management
- Reinforce safe sex practices and provide a range of pamphlets relevant for clients needs
- Refer to appropriate counseling and support services as required

PUBLIC HEALTH CONSIDERATIONS - FOLLOW UP AND REVIEW

- Clients attend or phone for results as per MSHC policy
- Refer to appropriate CPG for management of positive results
- Referral to counseling services, GP and medical review as appropriate
- Clients are advised to contact trace all sexual contacts for past 6 months.
- Protected sex is recommended for a minimum of seven days following treatment and until all sexual contacts are treated.
- All clients with positive results will undergo follow up according to MSHC follow up procedures including recall for treatment and results, serological monitoring, test of reinfection, test of cure, Department of Human Services (DHS) notification and surveillance forms, partner notification and assistance in contact tracing.

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