SEXUALLY TRANSMITTED INFECTIONS (STI) / BLOOD BORNE VIRUSES (BBV) ANTENATAL SCREENING AND TREATMENT

1. AIM

- Provide appropriate screening and treatment for STI and BBV to woman during pregnancy.
- Reduce morbidity to the mother and fetus/neonate

2. PATIENT

- Antenatal woman
    - High risk antenatal woman includes:
        - Aboriginal/Torres Strait Islanders (ATSI)
        - Under 25 years of age
        - Having sex with multiple partners
        - Sex workers
        - Intravenous drug users (IDU)
        - Woman who is symptomatic of STI
        - Woman with sexual or IDU partners with BBV infection
        - Woman from countries with high prevalence for specific BBV infections
        - Women or her partner[s]) resides in a declared syphilis outbreak area (see Syphilis outbreak below) or an area of known high prevalence

- Fetus and neonate

3. STAFF

- Medical and midwifery staff

4. EQUIPMENT

- Sterile urine container
- Venepuncture equipment
- Pathology swabs
- Cervical screening equipment

5. CLINICAL PRACTICE

- Ensure woman's confidentiality is maintained
- Define whether routine or high-risk antenatal screening is recommended
- Counsel woman on **ALL** screening tests performed and their implications on maternal and fetal/neonatal morbidity
- Treat women according to national and/or local recommendations

Routine antenatal screening

- Review or organise serology for STIs for **ALL** women at booking after a discussion, obtain verbal consent for following:
    - Syphilis serology (blood)
    - Hepatitis BsAg (blood)
    - HIV antibody (blood)
    - Hepatitis C serology (blood)
    - Human Papilloma Virus (HPV)/Cervical screening should be recommended at first visit if this was due during pregnancy, in conjunction with the new Cancer Council Australia Cervical Cancer Screening Guidelines [8]

SEXUALLY TRANSMITTED INFECTIONS (STI) / BLOOD BORNE VIRUSES (BBV) ANTENATAL SCREENING AND TREATMENT contd'd

- Routine screening for herpes, gonorrhoea, and bacterial vaginosis is not recommended unless clinical suspicion exists.
- Recommend Chlamydia Polymerase Chain Reaction (PCR) in first pass urine (not midstream) for all women < 25 years, from areas with high Chlamydia prevalence or who have other risk factors for STIs or other STIs
- Collect urine at initial booking visit at least 1 hour post void. Alternatively, a PCR can also be performed on an endocervical swab.
- Consider endocervical swab or first pass urine for gonorrhoea if symptomatic, previous infection, sex worker or migration from endemic area (ATSI, Africa and Western Pacific).

High risk screening

- Consider a repeat antenatal screening at 28/40 gestation for HIV, Hepatitis B and/or C if high risk behaviours such as unprotected vaginal, oral or anal intercourse with an infected partner or a partner:
    - known to have high risk factors
    - sharing injecting drug use equipment
    - tattooing and other body piercing where unsterile practices are used or equipment is reused
- Recommend repeat syphilis testing early in the third trimester (28–32 weeks) and at the time of birth for women at high risk of infection or reinfection. Pregnant woman is at high risk if she:
    - (or her partner[s]) resides in a declared outbreak area (remote and rural areas of Northern Australia) or an area of known high prevalence
    - is aged 15 to 29 years and resides in an area of high prevalence
    - has a sexually transmitted infection in the current pregnancy or within the previous 12 months
    - has previously had infectious syphilis in pregnancy
    - engages in intravenous substance use during pregnancy.

Unbooked women presenting in labour

- Collect bloods for full screen
- Request urgent results for HIV, syphilis and hepatitis B and C ***You must also ring laboratory Ext -29152 and after hours Ext – 29092 and advise this is urgent***
- Follow up of results and any actions required must be done by requesting practitioner

Management of a positive woman

- Arrange contact tracing if positive for Syphilis, Hepatitis B, Hepatitis C, HIV, Genital chlamydial infection, or Gonorrhoea

Syphilis

- Consult with Infectious Diseases regarding treatment if positive. For women with newly confirmed infectious syphilis, recommend an intramuscular dose of 1.8 g (given as two 900 mg injections) benzathine penicillin as soon as possible, ensuring that women receive treatment at least 30 days before the estimated date of birth to ensure adequate treatment before the birth.

SEXUALLY TRANSMITTED INFECTIONS (STI) / BLOOD BORNE VIRUSES (BBV) ANTENATAL SCREENING AND TREATMENT cont'd

- Refer woman to the infection in pregnancy clinic for review.
- Notify the Public Health Unit (PHU) and commence Syphilis Case Management form (Appendix 1)
- Notify PHU and treating doctor if seroconversion, or, increase in Rapid Plasma Reagin (RPR) identified at repeat test (performed monthly after first treatment until delivery)
- Give a letter stating treatment to the woman for future reference once treatment is complete

Hepatitis B, Hepatitis C, HIV

- Refer to the individual LOPs

Chlamydia

- Treat with stat dose of oral Azithromycin One gram if positive
- Treat partner at the same time as above
- Perform contact tracing and notify PHU
- Retest at 28 weeks or more than 2 months from treatment. If positive, retreat woman and partner

Management of a neonate of a positive woman

- Refer to the Australia Society for Infectious disease document on perinatal infections
    - https://www.asid.net.au/documents/item/368

6. DOCUMENTATION

- Medical records
- Case management for positive syphilis (Appendix 1)

7. EDUCATIONAL NOTES

- Antenatal screening and detection for STIs and BBVs provides an opportunity for [4]:
    - Early detection
    - Prompt and appropriate management
    - Prevention or reduction of adverse outcomes for the fetus or neonate
    - Prevention of long term sequelae in the mother
    - Informed antenatal care
    - Patient education
    - Contact tracing

  Chlamydia Trachomatis is the most commonly notifiable sexually transmitted infection in Australia. Chlamydia usually has no symptoms but the woman may experience the following:
  cramps or pain in the lower abdomen
    - Dysuria,
    - Bleeding or pain during or after intercourse,
    - Increase in vaginal discharge or spotting [4].

Hepatitis C

- In line with the RANZCOG and NHMRC maternity care guidelines RHW recommends screening for all pregnant women. If a woman is known to be hepatitis C positive, steps can be undertaken to reduce possible fetal transmission for example avoid fetal blood sampling in labour [5,9]. In addition, this diagnosis will facilitate provision of information and follow up and treatment after birth, if desired.

SEXUALLY TRANSMITTED INFECTIONS (STI) / BLOOD BORNE VIRUSES (BBV) ANTENATAL SCREENING AND TREATMENT cont'd

Syphilis

- Syphilis testing should be performed by screening with a specific treponema pallidum assay, for example, Treponema pallidum haemaglutination assay (TPHA) or the Treponema pallidum particle agglutination assay (TPPA)[1]. The non-specific Treponema pallidum assays, such as the rapid plasma reagin (RPR) or Veneral Diseases Reference Laboratory (VDRL) tests, although cheaper, are less likely to pick up latent infection therefore not advised[1].
- Factors that increase the risk of syphilis infection or reinfection about which women may not be aware include when:
    - she is a sexual contact of a person with infectious syphilis
    - she has unprotected vaginal, oral or anal sex with a male partner at high risk of having syphilis
    - she has a male sexual partner who has sex with men
    - she and/or her partner(s) have sexual partners from high prevalence countries (e.g. countries in Africa and Asia, especially among refugees from these countries)
    - An existing syphilis infection may be undetected among women who have had no or limited antenatal care.
- Untreated syphilis during pregnancy is associated with stillbirth and fetal loss, preterm birth, neonatal death, low birthweight and congenital syphilis. Early treatment of maternal syphilis improves outcomes for the baby.
- A baby with congenital syphilis may be severely affected at birth (with hepatomegaly, ascites, hydrops, fetal anaemia) or more frequently, may appear unaffected (CDNA 2015). If the diagnosis is not made then, the baby will present later with non-specific complaints (rhinitis, failure to thrive, pneumonia), nearly always within 3 months of birth. Neonates with severe disease have a poorer prognosis

8. RELATED POLICIES/ PROCEDURES/CLINICAL PRACTICE GUIDELINES

- Public Health Act 2010 No 127 schedule 2 notifiable disease https://www.health.nsw.gov.au/infectious/pages/notification.aspx
- Human Immunodeficiency Virus (HIV) in Pregnancy, Birth and Postpartum period
- Human Immunodeficiency Virus (HIV) in Pregnancy: Prevention of Mother-to-child transmission (RHW/SCH)
- Hepatitis B Positive Mothers and their Babies
- Hepatitis C Positive Mothers and their Babies
- Antimicrobial Guideline (obstetrics)

9. RISK RATING

- Medium (3 years)

10. NATIONAL STANDARD

- Standard 5 – Comprehensive Care

SEXUALLY TRANSMITTED INFECTIONS (STI) / BLOOD BORNE VIRUSES (BBV) ANTENATAL SCREENING AND TREATMENT cont'd

11. REFERENCES

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3. Australian Society for Infectious Diseases: Management of Perinatal infections. 2014 Available from: https://www.asid.net.au/documents/item/368
4. Australasian Sexual Health Alliance: STI management guidelines for use in Primary Care. 2018: Available from: http://www.sti.guidelines.org.au/populations-and-situations/pregnant-women
5. Royal Australian and New Zealand College of Obstetricians and Gynaecologists statement: Management of Hepatitis C in Pregnancy, C-Obs 51. July 2019
6. NSW Health Guide to managing HIC Information 2019, IB2019_004
7. Privacy Manual for Health Information - NSW Health – March 2015, ISBN 978-1-76000-002-8
8. Cancer Council Australia Cervical Cancer Screening Guidelines Working Party. National Cervical Screening Program: Guidelines for the management of screen-detected abnormalities, screening in specific populations and investigation of abnormal vaginal bleeding. Sydney: Cancer Council Australia. https://wiki.cancer.org.au/australiawiki/index.php?oldid=209973, cited 2020 Mar 23 Available from https://wiki.cancer.org.au/australia/Guidelines:Cervical_cancer/Screening
9. Infectious Syphilis outbreak. Australian Government Department of Health. https://www1.health.gov.au/internet/main/publishing.nsf/Content/ohp-infectious-syphilis-outbreak.htm

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Approved Quality & Patient Safety Committee 16/7/09
Endorsed Obstetrics Clinical Guidelines Group June 2009

FOR REVIEW : MAY 2023

…./Appendix 1

Appendix 1

CASE MANAGEMENT FOR POSITIVE SYPHILLIS

(Please tick and fill in box as appropriate)

INSERT PATIENT LABEL

Name: _____ DOB: _____

Address: _____

MRN: _____EDD: _____

Initial Blood test: RPR: Date VDRL: Date Result:
Notify P.H.U: Date:
Referral: Specialist: Sexual Health: Date Infectious Disease: Date
Classification: ( ) Adequate treatment: Date
( ) Untreated Early (primary, secondary and early latent)
( ) Untreated Late (latent > 2 years or unknown duration or tertiary)
( ) Biological false positives
( ) Other _____

Treatment needed: Yes ( ) No ( ) **_____Name/signature**

If yes, state: Drug _____Dose_____ Frequency_____ Duration_____

By Whom: GP _____Sexual health clinic_____ Hospital_____

Date treatment completed_____

Retest post treatment: date performed: ( ) Result: ( )

Further treatment required?

AT BIRTH:

Blood from mother: (gold top test tube, 10mls.) date taken: ( )
Blood from baby: (red top tube, 1 ml order Syphilis IgM, RPR) date taken: ( )
Placenta sent to histology if positive syphilis serology**:** Date sent: ( )
Baby referral: Paediatrician _____ Date referred ( )

Or Infectious Disease Specialist _____Date referred ( )

Baby management

_____

_____

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