Approved by Quality & Patient Safety Committee
17 April 2014

SEXUAL TRANSMITTED INFECTIONS (STI) / BLOOD BORN VIRUSES (BBV) ANTENATAL SCREENING AND TREATMENT

1. OPTIMAL OUTCOMES

- To provide appropriate screening and any treatment required to the woman during her pregnancy.
- Reduce morbidity to the fetus or neonate.

2. PATIENT

- Antenatal woman
- High risk antenatal woman includes:
    - Aboriginal/Torres Strait Islanders
    - Under 25 years of age
    - Having sex with multiple partners
    - Sex workers
    - Intravenous drug users (IDU)
    - Woman who is symptomatic of STI
    - Women with sexual or IDU partners with BBV infection
    - Women from countries with high prevalence for specific BBV infections

3. STAFF

- Registered midwives
- Student midwives
- Medical staff

4. EQUIPMENT

- Sterile urine container
- Vacutainer

5. CLINICAL PRACTICE

- Ensure woman's confidentiality is maintained
- Define whether routine antenatal screening or high-risk antenatal screening is recommended

Routine antenatal screening

- Review or organise the following serology at booking after discussing with the woman and obtaining verbal consent:
    - Syphilis serology (blood)
    - Hepatitis BsAg (blood)
    - HIV antibody (blood)
    - Hepatitis C antibody (blood)

Chlamydia

- Recommend Chlamydia PCR in first pass (that is not midstream) urine for all women < 25 years, from areas with high Chlamydia prevalence or who have other risk factors for STIs. Collect urine at initial booking 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 gonorrhea if symptoms.

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High risk screening

- Consider repeating antenatal screening at 28/40 gestation for HIV, Syphilis, Hepatitis B and C if high risk behaviours such as unprotected vaginal or anal intercourse with an infected partner or a partner:
    - known to have high risk factors
    - sharing of injecting drug use equipment
    - tattooing and other body piercing where unsterile practices are used or equipment is reused

Screen positive women

Syphilis

- Consult with Infectious Diseases regarding treatment if positive
- Notify the Public Health Unit (PHU) and commence Syphilis Case Management form (Appendix 1) by treating doctor
- Notify PHU by treating doctor if seroconversion, or increase in RPR, identified at repeat test
- Give a letter stating treatment given to the woman for her future reference once treatment completed
- Refer to associated LOPs if positive for Hepatitis B, Hepatitis C or HIV
- Arrange contact tracing if positive for Syphilis, Hepatitis B, Hepatitis C, HIV, Genital chlamydial infection, or Gonorrhoea

Chlamydia

- Treat with stat dose of oral Azithromycin 1 G if positive
- Treat partner at the same time as above
- Retest at 28 weeks or more than 2 months from treatment. If positive, retreat woman and partner

Unbooked women presenting in labour

- Collect bloods for full screen
- Ring Laboratory as results for HIV, syphilis and hepatitis B to be reported ASAP (STAT) on request form. ***You must ring laboratory Ext -29152 and after hours Ext – 29092 and advise this is urgent***
- Follow up results and any actions required must be done by Birthing Services

6. DOCUMENTATION

- Antenatal yellow card
- Integrated clinical notes
- Case management for positive syphilis (Appendix 1)

7. EDUCATIONAL NOTES

- Antenatal screening and detection for STI and BBV provides an opportunity for
    - 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, an increase in vaginal discharge or spotting.

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ROYAL HOSPITAL FOR WOMEN

LOCAL OPERATING PROCEDURE

CLINICAL POLICIES, PROCEDURES & GUIDELINES

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

Hepatitis C

- There is limited evidence on screening of pregnant women for hepatitis C and routine testing is advised against in the United Kingdom, the United States, and Canada.(6) The Australian Department of Health and Ageing advises that routine screening of pregnant women is not a clinically justifiable or cost effective approach. The RANZCOG however does recommend screening all women for hepatitis C.(5) If a woman is known to be hepatitis C positive, steps can be undertaken to reduce possible fetal transmission (avoid fetal blood sampling etc). If universal screening is not performed, recommend targeted screening for Hepatitis C antibody in blood for the following women, and for all women prior to a chorionic villus sampling:
    - Women with a history of intravenous drug use or needle sharing
    - Women with tattoos or body piercings where unsterile practices are used or equipment is reused
    - Women who have even been in prison
    - Women who received blood products in Australia prior to 1990
    - Women who have received blood products or had invasive procedures overseas
    - Women from a country with high prevalence of hepatitis C
    - Women who screen positive for any other STI

8. RELATED POLICIES/ PROCEDURES/CLINICAL PRACTICE GUIDELINES

- SESIAHS Notifiable Diseases HOSPITALS PHU January 2006
- Adult urine testing and collection
- Human immunodeficiency Infection in Pregnancy management
- Hepatitis B
- Hepatitis C
- Antimicrobial guideline (obstetrics)

9. REFERENCES

- 1. HIV Confidentiality: A Guide to Legal Requirements – PD2005_048
- 2. HIV Confidentially: A Guide to Legal Requirements – PD 2005_134
- 3. Privacy Manual (Version 2) - NSW Health– PD 2005_593
- 4. Royal Australian and New Zealand College of Obstetricians and Gynaecologists policy: Screening in Pregnancy, RANZCOG, College Statement, C-Obs 3:March 2013
- 5. Royal Australian and New Zealand College of Obstetricians and Gynaecologists statement C-Obs 3. Management of Hepatitis C in Pregnancy. March 2013
- 6. Clinical Practice Guidelines: Antenatal Care - Module I, Commonwealth of Australia 2012

REVISION & APPROVAL HISTORY

Reviewed and endorsed Obstetrics LOPs group 8/4/14
Approved Quality & Patient Safety Committee 16/7/09
Endorsed Obstetrics Clinical Guidelines Group June 2009

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) date taken: ( )
Placenta sent to histology if positive syphilis serology**:** Date sent: ( )
Baby referral: Paediatrician _____ Date referred ( )

0r Infectious Disease Specialist _____Date referred ( )

Baby management_____

_____

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