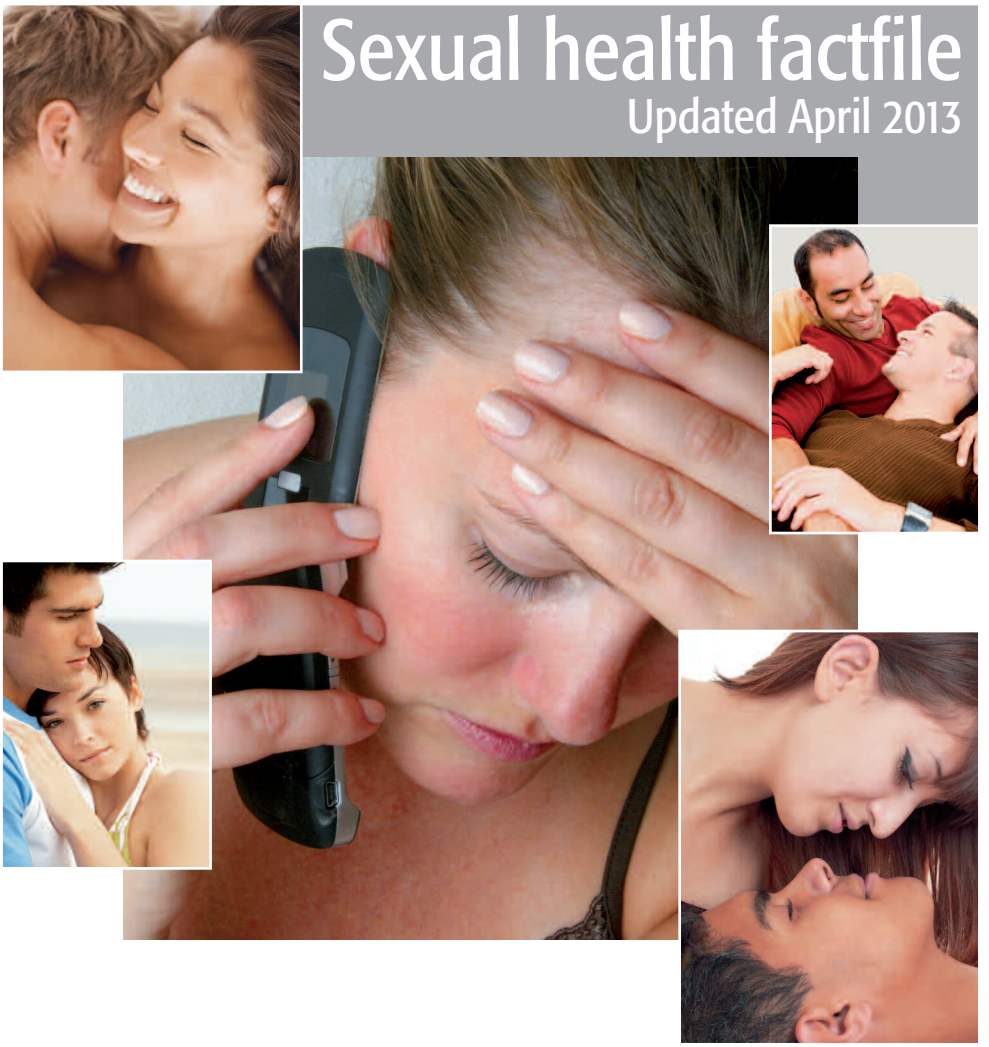
CPPE 1

An open learning programme for pharmacists and pharmacy technicians

Sexual health in pharmacies:

developing your service



CPPE

CENTRE FOR PHARMACY POSTGRADUATE EDUCATION

MANCHESTER 1824
The University of Manchester

Educational solutions for the NHS pharmacy workforce

DLP 159

Sexual health in pharmacies:
developing your service

Sexual health factfile

Updated April 2013

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Introduction

This interactive resource forms part of the open learning programme: *Sexual health in pharmacies: developing your service.*

The learning element of this programme is provided in two parts:

- an open learning pack which looks at the background to providing a sexual health service, and includes information to guide you through the preparation of a standard operating procedure for handling a sexual health service consultation in the pharmacy
- this factfile which looks at each of the sexually-transmitted infections (STIs), providing advice on prevention, testing and treatment, and useful links to which you can signpost customers and clients for further advice and information.

These two elements are supported by a workbook which you can use to record your own ideas in response to the team activities set out in both parts of the programme, as well as any useful points that are raised by your colleagues.

This factfile has been produced as an interactive PDF so that you can add to it as you expand your knowledge, providing a useful resource for the future. We have included information about the management and treatment of many of the sexually-transmitted infections, but we would always recommend that before giving advice or making prescribing decisions you ensure you refer to the most up-to-date treatment guidelines and prescribing resources.

You can download the factfile and complete it on your computer, or print it off to work on if you prefer. If you are working on the document on your computer, then once you have entered text into any of the boxes you can save the document (perhaps add today's date to your file name).Then, at a later date you can reopen the saved document and continue entering text, and then resave it with the added information.

You will find it helpful to have a copy of the latest edition of the *British National Formulary (BNF)* to hand as you work through this factfile, or alternatively you can use the online version: **http://www.bnf.org/bnf/** NB. You need to register and log in to view information, but this is free of charge.

Note: *Sexual health in pharmacies* replaces the open learning programme *Sexual health: testing and treating* (2007). If you have already completed the old programme and passed the assessment, commissioners may accept that for a period of time; however, if you want to offer a new sexual health service or be re-accredited for an existing service, then we expect this programme and its accompanying assessment to form part of that requirement.

Aim

The aim of this programme is to give you a framework to support you in the promotion and provision of sexual health services and to help you to gain the background knowledge necessary to undertake accredited training for operating sexual health services. The accredited training includes the CPPE *local solutions* programme: *Sexual health in pharmacies, offering your service*, the British Association of Sexual Health and HIV Sexually-transmitted infection foundation (STIF) training and assessment courses, as well as other accredited courses.

Target audience

This programme is aimed primarily at community pharmacists and pharmacy technicians who are thinking about providing an NHS-funded sexual health service. It is also relevant to primary care pharmacists who might be involved in implementing such a service.

Hospital and prison-based pharmacists may find the programme of interest even though it does not relate directly to their area of practice.

Brand names and trademarks

CPPE acknowledges the following brand names and registered trademarks which are mentioned within this factfile:

Cervarix®, Clamelle®, Gardasil®, K-Y Jelly®, Vaseline®

All web links in this update were checked on 25 January 2013.

The infections

In this factfile we present some introductory information and then a summary of key facts about each sexually-transmitted infection in turn. As you work through each of these you will be encouraged to carry out activities and read through some basic background information. We also provide links within the text to other learning, online resources and other useful information.

The sexually-transmitted infections covered in this factfile are:

- Chlamydia
- Genital herpes
- Genital warts
- Gonorrhoea
- Syphilis
- Hepatitis B
- Hepatitis C
- HIV
- Trichomoniasis
- Pubic lice
- Balanitis
- Non-gonococcal urethritis
- Scabies
- Thrush
- Bacterial vaginosis

Note: Thrush is often wrongly classed as a sexually-transmitted infection. However, candida is part of the natural flora of the vagina, and thrush is a result of overgrowth which can occur irrespective of sexual activity. We include thrush (and balanitis, often caused by thrush) within this factfile because clients and pharmacists may assume that certain symptoms are due to thrush when this is not the case.

Bacterial vaginosis is not a sexually-transmitted infection, but women who are sexually active and have had a change of partner are more likely to have it, including women in same-sex relationships.

Facts and figures

Much of the information that is presented in the sections on the individual sexually-transmitted infections comes from the NHS Choices website and the FPA factsheet on sexually-transmitted infections. All figures on incidence and prevalence of sexually-transmitted infections come from the Health Protection Agency (HPA) data on sexually-transmitted infections, from the sexually-transmitted infections section of the NHS Choices website or from the British Association of Sexual Health and HIV (BASHH) guidance.

Note: The most recent HPA data is only available for England and not the UK as a whole and so does not compare directly to the previous 2011 update or the original factfile, where the figures were provided for the UK as a whole. For data for other UK regions go the HPA website: **http://www.hpa.org.uk** and search for 'STI annual data tables' and the region. Furthermore, there has been a change in the method of recording by the HPA. Data collected by genito-urinary medicine (GUM) clinics now includes a unique patient identifier; as a result, duplicated coding for initial diagnoses can be detected and corrected, whereas this was not previously the case. In addition to correction of current STI data, historic figures have been revised since April 2008. Therefore data given in the January 2012 update for this time period has since been revised.

Before thinking about the best ways of preventing individual sexually-transmitted infections, let's start by thinking about the sort of sexual activities that put people at risk of contracting a sexually-transmitted infection.

Factfile team exercise A

Risky behaviours

Get your staff together and talk about risky sexual behaviours. Write your answers here and ask your staff members to complete the relevant space in their personal workbook.

Reflective question

List all the activities you can think of that could result in transmission of a sexually-transmitted infection.

For an introduction to the topic of sexual activities and risk, look at the NHS Choices webpage available at:
http://www.nhs.uk/Livewell/STIs/Pages/Sexualactivitiesandrisk.aspx

Did you miss any of the activities listed? Add any that you missed to your list above.

So far you have thought of sexual activities that can lead to the transmission of sexually-transmitted infections, but there are certain complicating factors to take into account which can make the risk of passing on sexually-transmitted infections much greater. Engaging in sexual activity while under the influence of alcohol is one example. Think of any others and note your answers here, asking your staff members to complete the relevant space in their personal workbook.

Reflective question

List the complicating factors which can make a sexually-transmitted infection more likely.

You might have thought of some or all of the following:

- unprotected sex with anyone
- sex with an infected partner
- sex with a casual partner
- sex with multiple partners
- sex under the influence of drugs
- rape or sexual assault
- sex with a drug user
- sex with a person with serious mental illness[1]
- paying for sex.

Factfile team exercise B

Talking about risky behaviours

As well as testing for and treating sexually-transmitted infections and carrying out a sexual health consultation *(see Section 2 in the associated open learning programme for more details)* you and your staff will need to talk to customers about the prevention of sexually-transmitted infections, possibly when they haven't even asked for your advice!

Get your staff together during a coffee or lunch break. Ask them the following questions and note down here any ideas that are raised. Ask your staff members to complete the relevant space in their personal workbook.

When could you raise the topic of risky sexual behaviours?

How could you start the conversation?

What points would you make when trying to persuade people to practise safer sex?

When should your staff refer clients to you?

Add the ideas to your standard operating procedure for handling sexual health consultations in the pharmacy.

Preventing sexually-transmitted infections

We include specific advice about the prevention of each sexually-transmitted infection below, but the key points to make to any client that will help them to have a safer sex life and help prevent any sexually-transmitted infection are:

- keep the number of sexual partners to a minimum
- use a condom (male or female) every time they have vaginal or anal sex (advice about how to use condoms correctly is provided online via the NHS Choices website at: **http://www.nhs.uk/livewell/sexandyoungpeople/pages/howtouseacondom.aspx** or call the FPA for advice)
- if they have oral sex, as well as covering the penis with a condom they can use a latex or polyurethane (plastic) square to cover the anal area or female genitals (dental dams are usually only available at genitourinary medicine (GUM) clinics, although the local pharmacist may be able to order these)
- avoid sharing sex toys; if they are shared, then wash them or cover them with a new condom before anyone else uses them.

Apart from abstinence from all forms of sexual activity, condoms are the single most effective method of reducing the risk of all sexually-transmitted infections, including HIV.

Take a look at the following information on the NHS Choices website:

- Condom tips
  http://www.nhs.uk/Livewell/Contraception/Pages/Condomtips.aspx
- Condoms don't fit me and other excuses
  http://www.nhs.uk/Livewell/Contraception/Pages/condomexcuses.aspx
- How to use a condom
  http://www.nhs.uk/livewell/sexandyoungpeople/pages/howtousea condom.aspx

Other forms of prevention, as well as condoms, are discussed here:

- Sexually-transmitted infections (STIs) – preventing STIs
  http://www.nhs.uk/Livewell/STIs/Pages/Sexualactivitiesandrisk.aspx

Sources of help and advice for people worried about sexually-transmitted infections are listed here:

- Sexually-transmitted infections (STIs) – help and advice
  http://www.nhs.uk/livewell/stis/pages/stis-hub.aspx

BASHH have produced a printable patient leaflet on *Safer sex*, this is an additional resource that could be given to patients. It can be accessed at:
http://www.bashh.org/guidelines

Factfile team exercise C

Talking about preventing sexually-transmitted infections

If you have internet access in your workplace, show your staff some of the above sites and discuss how to talk to clients about using a condom properly and other methods of preventing sexually-transmitted infections.

Refer back to the open learning programme *(page 21)* for advice on how to talk to young people and other vulnerable groups.

While you have your staff together, ask them the following questions and note down their ideas here. Ask your staff members to complete the relevant space in their personal workbook.

What words could you use when trying to persuade someone to practise safer sex?

What words could you use when showing someone how to use a condom?

When should your staff refer clients to you?

Add the ideas to your standard operating procedure for handling sexual health consultations in the pharmacy.

Free condoms

Condoms are available free of charge in all settings providing NHS-funded management of sexually-transmitted infections – regardless of the age of the client. It is important that you can demonstrate how to use them properly, for example, look at the *How to use a condom* page on the NHS Choices website at: **http://www.nhs.uk/livewell/sexandyoungpeople/pages/howtouseacondom.aspx**

The C-Card (condom card) is a small card, which will fit into the pocket, wallet or purse, that entitles young men and women to free condoms from various outlets which are part of the scheme. Some local schemes determine an age limit; see, for example, the C-Card scheme for the Nottingham City area explained here: **http://www.ccardnottingham.co.uk/**

and the Brighton and Hove scheme, which is explained here: **http://www.swish.org.uk/?q=node/321**

Do you have a C-Card scheme in your area? Find out by entering the name of your town/city and C-Card into an internet search engine.

If there is a local scheme then why not offer to participate? Who will you contact?

People of any age (even under 16) are entitled to free condoms from community contraceptive clinics, sexual health and GUM clinics, some young people's services and some GP surgeries.

For further advice and information

As you work through each of the sexually-transmitted infections in detail you will see that we have provided useful links for you to signpost clients to. However, it is worth making a note of the following two helplines as they will be able to give advice and support on all of the sexually-transmitted infections, as well as guidance on practising safe sex.

Terrence Higgins Trust Helpline (HIV) THT Direct
Telephone: 0845 122 1200

FPA helpline – Sexual health direct (for England)
Telephone: 0845 122 8690

Reflective question
What do you already know about chlamydia?

How common is it? How do you prevent it? What are the signs and symptoms? How do you test for it? How do you treat it?

Reflective question
What don't you know?

What would you like to learn?

To start with…

Chlamydia usually infects the genitals, but can also infect the throat, rectum and eyes. It is particularly common in young people but can affect anyone who is sexually active.

Chlamydia is easily transmitted. It is passed from one person to another through:

- vaginal or anal sex with an infected partner
- oral sex (though this is less common)
- sharing sex toys.

It can also be passed from a mother to her baby at birth.

If it is not treated the infection can spread to other parts of the body, causing damage and serious long-term health problems. In 10-40 percent of untreated women, chlamydia can cause pelvic inflammatory disease. This can lead to:

- ectopic pregnancy
- blocked fallopian tubes (which can result in reduced fertility or infertility)
- long-term pelvic pain
- early miscarriage or premature birth
- Reiter's syndrome (inflammation of the joints, urethra and eyes).

In men, chlamydia can lead to:

- painful inflammation of the testicles (which may result in fertility problems)
- Reiter's syndrome (inflammation of the joints, urethra and eyes).

Because of its asymptomatic nature, prevalence and potential long-term consequences, chlamydia is the target of two campaigns.

- the national chlamydia screening programme (with details available online at: **http://www.chlamydiascreening.nhs.uk/ps/index.asp**) which targets young men and women aged 15-25 and is free
- the Clamelle chlamydia service (see: **http://www.clamelle.co.uk/**) which is a private service, run in association with the National Pharmacy Association and paid for by the client. It consists of the Clamelle chlamydia test kit and Clamelle azithromycin 500 mg tablets.

How common is chlamydia?

Chlamydia is the most commonly diagnosed sexually-transmitted infection in England, with 186,196 new diagnoses made in any clinical setting in 2011, a decrease of two percent since 2010, when a total of 189,314 cases were diagnosed in England. The rate of new diagnoses in England in 2011 was 356.5 per 100,000, compared with 362.4 in 2010.[2] However it is also worth noting that the HPA attributes this decline largely due to a reduction in testing during this period.[3] These figures are higher than those published in previous years as, for the first time in 2009, the data included diagnoses made in all settings, rather than GUM clinics only.

Advice on prevention

Advise your clients that – as well as the advice given above *(page 8)* – it is also important to get tested for sexually-transmitted infections, and to ask their new partners to get tested before having sexual intercourse.

What are the signs and symptoms?

Around 70 percent of women and 50 percent of men who have chlamydia show no symptoms at all; the rest may have mild symptoms that are not noticed.

Symptoms in women:

- an unusual vaginal discharge
- pain when urinating
- bleeding between periods and breakthrough bleeding on contraception
- pain during sex or bleeding after sex
- lower abdominal pain.

Symptoms in men:

- a white/cloudy watery discharge from the tip of the penis
- pain or a burning sensation when urinating
- testicular pain or swelling, or both.

How do you test for chlamydia?

Women can provide a vaginal swab that they have taken themselves, or a urine sample (although this is a much less sensitive test in women compared to men and not really recommended). The sample is then placed into the container provided and sent to a laboratory. These tests avoid the need for an intimate examination and make testing much easier for women than the cervical tests that were needed a few years ago.

Men provide a urine sample. This avoids the discomfort of a swab from inside the tip of the penis (urethra), which is the alternative. The sample is sent to a laboratory for testing.

How do you treat chlamydia?

Treat chlamydia with azithromycin 1 g as a single dose or with doxycycline 100 mg twice daily for seven days; alternatively, treat with erythromycin 500 mg twice daily for 14 days. Partners should be traced and notified *(see page 37 of the open learning programme for further information about partner notification)*.

Practice point

So, what are you going to do about chlamydia?	Tick box
Nothing, my learning needs are met	☐
Learn more about it	☐
Where from?	
Provide better advice on self care	☐
Provide better advice post-prescription	☐
Provide better advice on safe sex	☐
Refer patients more appropriately	☐
Where to?	
Signpost patients more appropriately	☐
Where to?	
Look out for an opportunity to start a service	☐
Doing what?	

For further advice and information

British National Formulary online
http://bnf.org/bnf/

NHS Choices: *Chlamydia*
http://www.nhs.uk/Conditions/Chlamydia/Pages/Introduction.aspx

British Association of Sexual Health and HIV (BASHH) *UK guidance for the management of genital tract infection with chlamydia trachomatis*
http://www.bashh.org/documents/61/61.pdf

For clients

Netdoctor website: *Chlamydia*
http://www.netdoctor.co.uk/diseases/facts/chlamydia.htm

Reflective question
What do you already know about genital herpes?

How common is it? How do you prevent it? What are the signs and symptoms? How do you test for it? How do you treat it?

Reflective question
What don't you know?

What would you like to learn?

To start with…

Genital herpes is caused by the herpes simplex virus (HSV), which has two subtypes (HSV1 and HSV2). Both can affect the genital and anal areas; they can also affect the mouth and nose as cold sores. Some people only have one outbreak of herpes, others have repeated outbreaks.

Genital herpes is passed on through:

- direct skin contact, mainly during vaginal, anal or oral sex with an infected partner
- sharing sex toys.

It is possible to get herpes simplex by having sex with an infected person who has never had any signs or symptoms.

How common is genital herpes?

There were 31,154 new cases of genital herpes diagnosed in England in 2011. This was 5 percent more than in 2010, when there were 28,794 new diagnoses. The overall rate of new diagnoses in England in 2011 was 59.6 per 100,000 population.[2] The highest rates were in women aged 20-24. There were 3,231 diagnoses in men and women in the 45-64 age group, this is a rate of 24.4 per 100,000 population, compared with 23.2 per 100,000 in 2010.[4]

Advice on prevention

Advise your clients that – as well as the advice given above *(page 8)* – to prevent the herpes simplex virus (HSV) spreading to others, they should:

- Avoid all sexual intercourse
  Anyone with genital herpes should avoid having sex, including vaginal, anal and oral sex, until after any blisters, or ulcers, around their genital area have cleared up. It is best not to have sex if they have symptoms of genital herpes because at this point the condition is very contagious (even from when they are aware of the first tingle, or itch).
- Always use a condom
  Even after their symptoms have gone they should always use a condom while they are having any kind of sexual intercourse (vaginal, anal and oral). This is particularly important when having sex with new partners.

  However, while using a condom may help to prevent spreading genital herpes, the condom only covers the penis. If the virus is present on other parts of the ano-genital area including the anus, it can still be passed on through sexual contact.

  As HSV survives within the nerves of the skin, there is a chance that the virus can be present on the skin even after the symptoms have gone. Therefore, there is still a chance that the genital herpes virus could be passed on.
- Advise their partner to be screened for genital herpes
  If someone has genital herpes, they should encourage their partner to visit a GUM clinic to be tested for the condition, even if the partner does not have any

symptoms of genital herpes. As the first symptoms of genital herpes often develop some time after exposure to the virus, their partner may be unaware that they are infected.

- **Avoid sharing towels or flannels with others**
  Although it is very unlikely that HSV would survive on an object long enough to be passed on, it is sensible to take steps to prevent this. Therefore, if someone has herpes they should avoid sharing towels or flannels, to ensure that they do not spread HSV on to others.

Valaciclovir 500 mg once daily taken by the infected partner can reduce the chance of herpes transmission, but this needs to be initiated by a GUM specialist.

What are the signs and symptoms?

Many people show no signs of the virus, while others have mild symptoms which they may not notice. Symptoms can develop at any time after contact with the virus, most usually after three to four days.

Symptoms include:

- fluid-filled blisters that burst leaving painful sores
- flu-like symptoms (eg, headache, backache, swollen glands in the groin, fever)
- a tingling or itching sensation in the genitals or anal area
- pain when urinating.

If left untreated the symptoms of a first attack last approximately two to three weeks. Recurrent infections are milder and the symptoms clear up more quickly, usually within a week.

People often experience early warning signs of an outbreak, such as a tingling sensation in the affected area. Self-help measures that can prove useful in preventing an outbreak (or reducing symptoms) include:

- avoiding stress
- eating a balanced diet
- cutting down on smoking and drinking
- avoiding direct sunlight (or using a sun bed) on the affected area
- avoiding Lycra or nylon underwear.

Note: Genital herpes in pregnancy requires emergency referral to a GUM specialist as neonatal herpes can be devastating.

Genital herpes does not affect fertility and is not linked to cancer of the cervix.

How do you test for genital herpes?

Genital herpes should be confirmed by direct detection of the herpes simplex virus (HSV) in genital lesions. This is achieved by taking a swab from the genital lesion. Alternatively a blood test can be taken and analysed for the presence of HSV type-specific antibodies to confirm infection. Such testing is essential for diagnosis, counselling and management of genital herpes.

How do you treat genital herpes?

Treat using aciclovir 200 mg, five times daily, or 400 mg, three times daily, usually for five days (longer if new lesions appear during treatment or if healing is incomplete). See current *BNF* for doses of other antivirals.

The antiviral dosage must be increased in immunocompromised or HIV-positive patients.

Practice point

So, what are you going to do about genital herpes?

	Tick box
Nothing, my learning needs are met	☐
Learn more about it	☐
Where from?	
Provide better advice on self care	☐
Provide better advice post-prescription	☐
Provide better advice on safe sex	☐
Refer patients more appropriately	☐
Where to?	
Signpost patients more appropriately	☐
Where to?	
Look out for an opportunity to start a service	☐
Doing what?	

For further advice and information

British Association for Sexual Health and HIV. *National guideline for the management of genital herpes* (2007).
http://www.bashh.org/documents/115/115.pdf

British National Formulary online
http://bnf.org/bnf/

NHS Choices: *Genital herpes*
http://www.nhs.uk/conditions/genital-herpes/Pages/Introduction.aspx

For clients

Herpes Viruses Association
Telephone: 0845 123 2305
http://www.herpes.org.uk

Netdoctor website: *Genital herpes*
http://www.netdoctor.co.uk/diseases/facts/herpesgenitalis.htm

Reflective question
What do you already know about genital warts?

How common are they? How do you prevent them? What are the signs and symptoms? How do you test for them? How do you treat them?

Reflective question
What don't you know?

What would you like to learn?

To start with…

Genital warts *(condylomata acuminata)* are caused by the human papilloma virus (HPV) and can appear anywhere on the genital or anal area. They are passed on by direct skin-to-skin contact with an infected partner. This includes:

- vaginal or anal sex
- close body contact
- sharing sex toys.

How common are genital warts?

Genital warts are now the most common viral STI in England. The number of new diagnoses in England in 2011 was 76,071, a 1 percent increase from 75,415 in 2010. However, this was a decline from a peak of 78,156 in 2008. The overall rate of new diagnoses in 2011 in England was 145.6 per 100,000 population, with the highest rates among men and women aged 20-24, which was 755.0 per 100,000.[2, 4]

Advice on prevention

Advise your clients that – as well as the advice given above *(page 8)* – genital warts can be prevented either by being celibate (not having sex) or by vaccination *(see below)*. The transmission of warts can be reduced but not eliminated by condom use.[5]

HPV vaccine

There are currently two types of HPV vaccine: Gardasil and Cervarix. Gardasil protects against the main strains of the human papillomavirus (HPV) that are known to cause cervical cancer and genital warts. It is estimated to be 99 percent effective against the two strains of HPV responsible for 90 percent of genital warts in young men and women. Cervarix, however, is only effective against cervical cancer, not genital warts. From September 2012 Gardasil was given to girls from 12 to 13 years as part of the UK Immunisation Programme; prior to this Cervarix was given.[6]

While vaccination with Gardasil provides a very good level of protection against genital warts, it does not protect against other sexually-transmitted infections. Therefore, the procedure should not be seen as a substitute for using a condom.

What are the signs and symptoms?

Only about one percent of people with HPV have any visible warts. These may appear as small white lumps or larger, cauliflower-shaped growths. They are painless but can irritate the skin.

There may be just one wart or many, and it can take from two weeks to several months before they are noticeable.

Warts can appear anywhere on the genitals: around the vulva, penis, scrotum or anus (even without anal sex), and they can develop inside the vagina or anus or on the cervix.

How do you test for genital warts?

In healthcare settings where a clinical examination is possible, the warts are often visible. To detect 'invisible' genital warts the doctor or nurse will swab the skin with acetic acid. The genital warts will then show as white patches on the skin. It may be necessary to do an internal examination of the vagina or anus to check for hidden warts.

How do you treat genital warts?

Treat using podophyllotoxin cream or solution, twice daily for three days, repeated at weekly intervals for a total of four (cream) or five (solution) courses.

Practice point

So, what are you going to do about genital warts?

	Tick box
Nothing, my learning needs are met	☐
Learn more about it	☐
Where from?	
Provide better advice on self care	☐
Provide better advice post-prescription	☐
Provide better advice on safe sex	☐
Refer patients more appropriately	☐
Where to?	
Signpost patients more appropriately	☐
Where to?	
Look out for an opportunity to start a service	☐
Doing what?	

For further advice and information

British Association for Sexual Health and HIV. *United Kingdom national guideline on the management of anogenital warts* (2007).
http://www.bashh.org/documents/86/86.pdf

British National Formulary online
http://bnf.org/bnf/

NHS Choices: *Genital warts*
http://www.nhs.uk/conditions/genital_warts/Pages/Introduction.aspx

For clients

Netdoctor website: *Genital warts*
http://www.netdoctor.co.uk/diseases/facts/genitalwarts.htm

Reflective question
What do you already know about gonorrhoea?

How common is it? How do you prevent it? What are the signs and symptoms? How do you test for it? How do you treat it?

Reflective question
What don't you know?

What would you like to learn?

To start with…

Sometimes referred to as 'the clap', gonorrhoea is a bacterial infection that can infect the genitals, urethra, rectum and throat. More rarely, it can affect the blood, skin, joints and eyes.

Gonorrhoea is easily passed on through:

- vaginal, anal or oral sex with an infected partner
- close physical contact
- sharing sex toys.

It can also be passed from a mother to her baby at birth, and from the genitals to the eyes (it is carried on the skin, so can be passed on by scratching the genitals then rubbing the eyes, without washing the fingers first).

How common is gonorrhoea?

There were 20,965 new cases diagnoses in England in 2011, a 25 percent increase on 2010, when there were 16,835 new cases. The overall rate of new diagnoses was 40.1 per 100,000 population in England, with the highest number of treatments given to men aged 20-24 years, at 201.6 per 100,000 population.[2, 7]

Advice on prevention

Advise your clients that gonorrhoea can be successfully prevented by following the advice provided above *(see page 8)*.

What are the signs and symptoms?

About 50 percent of women and 10 percent of men who have gonorrhoea show no symptoms at all. Any symptoms that do occur may be noticed between one to 14 days after infection. Gonorrhoea in the throat rarely shows symptoms.

Symptoms in women:

- a strong smelling vaginal discharge that may be thin and watery or yellow/green
- pain when urinating
- irritation or discharge from the anus
- possibly some lower abdominal or pelvic pain.

Symptoms in men:

- a white, yellow or green discharge from the tip of the penis
- inflammation of the testicles and prostate gland
- pain when urinating
- irritation or discharge from the anus.

How do you test for gonorrhoea?

Women can provide a urine sample or a self-taken vaginal swab. The sample is then placed into the container provided and sent to a laboratory. Men provide a urine sample which is sent to a laboratory for testing. These samples can be tested but there is a possibility of false positive results. Anyone with a positive result using this method should be referred to a GUM clinic for further assessment including a cervical (women) or urethral (men), and possibly anal or throat swabs, as appropriate, to confirm the diagnosis and determine antibiotic sensitivity.

How do you treat gonorrhoea?

Due to increased antibiotic resistance, first-line treatment is now ceftriaxone 500 mg as a single dose, by deep intramuscular injection, plus a single oral dose of azithromycin 1 g.

Furthermore, a test of cure is recommended for all cases. Partners should be traced and notified.

Practice point

So, what are you going to do about gonorrhoea?

	Tick box
Nothing, my learning needs are met	☐
Learn more about it	☐
Where from?	
Provide better advice on self care	☐
Provide better advice post-prescription	☐
Provide better advice on safe sex	☐
Refer patients more appropriately	☐
Where to?	
Signpost patients more appropriately	☐
Where to?	

Look out for an opportunity to start a service	Tick box ☐
Doing what?	

For further advice and information

British Association for Sexual Health and HIV. *UK national guideline for the management of gonorrhoea in adults* (2011).
http://www.bashh.org/guidelines

British National Formulary online
http://bnf.org/bnf/

NHS Choices: *Gonorrhoea*
http://www.nhs.uk/Conditions/Gonorrhoea/Pages/Introduction.aspx

For clients

Netdoctor website: *Gonorrhoea*
http://www.netdoctor.co.uk/diseases/facts/gonorrhoea.htm

Reflective question
What do you already know about syphilis?

How common is it? How do you prevent it? What are the signs and symptoms? How do you test for it? How do you treat it?

Reflective question
What don't you know?

What would you like to learn?

To start with…

Syphilis is a bacterial infection, sometimes called 'the pox'. It has three stages: primary and secondary stages are very infectious; a latent stage occurs if the infection is left untreated, which can then develop into tertiary syphilis.

Syphilis is easily passed on in the primary and secondary stages through:

- vaginal, anal or oral sex with an infected partner
- sharing sex toys
- close intimate body contact with syphilis sores or rashes.

It can also be passed from a mother to her unborn baby.

How common is syphilis?

There were 2,915 new cases of syphilis diagnosed in England in 2011, a 10 percent increase on 2010, when there were 2,650 new diagnoses. Men accounted for nearly 90 percent of the diagnoses. Nearly 70 percent of new diagnoses were in men who have sex with men. The overall rate of new diagnoses in England was 5.6 per 100,000 population. The highest rates were in men aged 25-34 years, at 24.7 per 100,000 population.[2, 8, 9]

Advice on prevention

Advise your clients that, as well as the advice given above *(see page 8)*:

- the only guaranteed way to prevent a syphilis infection is to avoid sexual contact, or to only have sexual contact with a faithful partner who has been tested and is clear from the infection
- condoms can reduce their risk of catching syphilis, but cannot prevent it altogether; they can still catch syphilis if their mouth makes contact with a sore on an infected person's anus or vagina, for example.
- sexual penetration or ejaculation does not need to take place for syphilis to spread.

What are the signs and symptoms?

The symptoms of syphilis can take up to three months to show after sex with an infected person and can be difficult to recognise. Some people have no symptoms at all. When present, the symptoms are:

- **Primary stage:** on average two to three weeks after infection one or more painless sores may appear;[10, 11] in women these may be on the vulva, urethra or cervix; in men they may be on the penis or foreskin. They are very infectious and may take up to six weeks to heal. Sores can also appear around the anus and mouth in both sexes.

- **Secondary stage:** if the primary infection is not treated the following symptoms may appear between three to six weeks after the sores have gone:
  - a non-itchy rash that covers the whole body
  - wart-like growths on the vulva or around the anus
  - a flu-like illness, including swollen glands, sore throat and headache
  - white patches in the mouth and patchy hair loss.

  These symptoms can last several weeks or months. Second-stage syphilis is very infectious.
- **Latent stage:** if syphilis is not treated there may be no symptoms for many years after the primary and secondary sores and rash have cleared up.
- **Tertiary syphilis** may develop about ten years after first infection. It can cause very serious damage to the heart, brain, eyes, other internal organs and nervous system, which can be fatal.

How do you test for syphilis?

After a visual examination of the ano-genital area, the clinic will take blood to test for syphilis antibodies. If sores are present, a swab will be used to take a small sample of fluid from the sore. This is then either looked at under a microscope in the clinic, or sent to a laboratory for examination.

How do you treat syphilis?

Treat early syphilis (infection of less than two years) with benzathine benzylpenicillin, 2.4 million units, intramuscularly as a single dose (repeat dose after seven days for women in the third trimester of pregnancy), or with doxycycline 100 mg twice daily for 14 days, azithromycin 2g in a single oral dose, or erythromycin 500 mg, four times daily for 14 days.[10]

Treat late latent syphilis (asymptomatic infection of more than two years) with doxycycline 100 mg, twice daily for 28 days, or with benzathine benzylpenicillin, 2.4 million units, intramuscularly weekly for three doses.

Partners should be traced, notified and screened. Treat asymptomatic contacts of patients with infectious syphilis with regimens including benzathine penicillin 2.4MU intramuscularly as a single dose, or doxycycline 100 mg twice daily for 14 days.[10]

Practice point

So, what are you going to do about syphilis?

	Tick box
Nothing, my learning needs are met	☐
Learn more about it	☐
Where from?	
Provide better advice on self care	☐
Provide better advice post-prescription	☐
Provide better advice on safe sex	☐
Refer patients more appropriately	☐
Where to?	
Signpost patients more appropriately	☐
Where to?	
Look out for an opportunity to start a service	☐
Doing what?	

For further advice and information

British National Formulary online
http://bnf.org/bnf/

Family Planning Association:
Syphilis: Looking after your sexual health (2009)
http://www.fpa.org.uk/media/uploads/helpandadvice/syphilisapril09.pdf

British Association for Sexual Health and HIV, *United Kingdom national guideline on management of syphilis, 2008*. **http://www.bashh.org/guidelines**

NHS Choices: *Syphilis*
http://www.nhs.uk/Conditions/Syphilis/Pages/Introduction.aspx

For clients

Netdoctor website: *Syphilis*
http://www.netdoctor.co.uk/diseases/facts/syphilis.htm

Reflective question
What do you already know about hepatitis B?

How common is it? How do you prevent it? What are the signs and symptoms? How do you test for it? How do you treat it?

Reflective question
What don't you know?

What would you like to learn?

To start with…

Hepatitis B is caused by infection with hepatitis B virus which can be transmitted in a number of ways:

- contact with blood from an infected person – transfusion with infected blood and blood products, or by contaminated needles and other paraphernalia used by intravenous drug users, tattooists or acupuncturists
- sexual contact with an infected person
- from a pregnant woman to her child during delivery
- in rare cases, among family members without sexual contact, or contact with infected blood, possibly via toothbrushes or kissing
- accidental needlestick injuries among healthcare workers.

How common is hepatitis B?

Hepatitis B is commonly seen in drug users, homosexual men, immigrants from countries in Africa and Asia (where hepatitis is very common) – and their sexual partners.

Advice on prevention

Advise your clients that, as well as the advice given above *(see page 8)*, they should:

- be careful to protect their family and sexual partners from the virus
- abstain from all alcohol intake if blood samples show that the disease is active
- refrain from drinking alcohol daily if they have chronic type B hepatitis
- be examined regularly by their doctor if they have chronic hepatitis
- eat a healthy, well-balanced diet.

Hepatitis B infection transmission can be prevented by vaccination of high risk groups, such as healthcare and laboratory staff, drug users and men who have sex with men (MSM).

Note: If you are undertaking examinations or handling body fluids, you should be vaccinated yourself. Talk to your own GP, or your service commissioner to find out what arrangements are in place for you and your staff to be vaccinated.

What are the signs and symptoms?

The incubation period, from the time of exposure to the virus until the onset of the disease, is two to six months. Early symptoms include poor appetite, lack of interest in food, nausea, aching muscles and joints, and mild fever, although there are often no symptoms.

Later symptoms include yellowing of the skin, mucous membranes and white portions of the eyes (jaundice, icterus); light-coloured stools; and dark urine.

When the late symptoms have developed, the patient usually begins to get better. In approximately five percent of patients, the infection becomes chronic. Patients with chronic hepatitis B may have only mild symptoms, such as tiredness, aching muscles and joints and periodical pressure below the right ribs from the enlarged liver.

Approximately one-fifth of people with chronic hepatitis B develop cirrhosis over a number of years which may result in liver failure and other serious complications.

On average, cirrhosis develops 15 years after the virus has been contracted. Newborn babies show no symptoms of acute hepatitis. However, in around 90 percent of the cases, the infection becomes chronic.

How do you test for hepatitis B?

The diagnosis is made on the basis of a blood sample which will demonstrate antibodies against hepatitis B, or hepatitis B components in the patient's blood.

The blood sample can demonstrate the presence of several different viral components. All patients with chronic infections have the surface antigen (HBeAg).[12] When HBeAg is present, the infectiousness of the disease is at its highest and those patients are at increased risk of developing complications later in life.

A blood test for liver function can determine the severity of the disease – the extent to which the liver is affected by the virus. In cases of chronic hepatitis B, the severity of the disease can be determined by a tissue sample from the liver

How do you treat hepatitis B?

There is no specific medical treatment for acute hepatitis B. Chronic hepatitis B can by treated with injections of interferon alfa, when disease activity has been confirmed by a blood sample or a tissue sample from the liver. Approximately one-third of the patients will benefit from the treatment. Longer courses of specific antiviral medicines are currently being given with hopeful results. Lamivudine is helpful for some patients.

Most patients with acute hepatitis B fully recover in about four to six weeks. Very few patients (about one in 300) develop liver failure as a result of acute hepatitis, and consequently risk dying.

The infection becomes chronic in one in 20 adult patients. However, the number is much higher in cases of newborn babies who have contracted the virus from their mothers. The most serious complications of chronic type B hepatitis are cirrhosis, and, in rare cases, liver cancer.

Practice point

So, what are you going to do about hepatitis B?

	Tick box
Nothing, my learning needs are met	☐
Learn more about it	☐
Where from?	
Provide better advice on self care	☐
Provide better advice post-prescription	☐
Provide better advice on safe sex	☐
Refer patients more appropriately	☐
Where to?	
Signpost patients more appropriately	☐
Where to?	
Look out for an opportunity to start a service	☐
Doing what?	

For further advice and information

British National Formulary online
http://bnf.org/bnf/

Department of Health. *Immunisation against infectious disease. The green book.* (2007). Hepatitis B chapter. **http://immunisation.dh.gov.uk/category/the-green-book/**

British Liver Trust. *A professional's guide to Hepatitis B* (2009).
http://79.170.44.126/britishlivertrust.org.uk/home-2/health-professionals/627-2/a-professionals-guide-to-hepatitis-b/

For clients

Netdoctor website: *Hepatitis B*
http://www.netdoctor.co.uk/diseases/facts/hepatitisb.htm

Reflective question
What do you already know about hepatitis C?

How common is it? How do you prevent it? What are the signs and symptoms? How do you test for it? How do you treat it?

Reflective question
What don't you know?

What would you like to learn?

To start with…

Hepatitis C is caused by infection with hepatitis C virus which can be transmitted in a number of ways:

- contact with blood from an infected person – transfusion with infected blood and blood products or by contaminated needles and other paraphernalia used by intravenous drug users, tattooists or acupuncturists
- in specific situations by sexual contact with an infected person (most cases of transmission by sexual contact have been found in men who are HIV positive who have sex with men)
- from a pregnant woman to her child during delivery (this is rare)
- in rare cases, among family members without sexual contact, or contact with infected blood, possibly via toothbrushes or kissing
- accidental needlestick injuries among healthcare workers.

How common is hepatitis C?

Hepatitis C is common in intravenous drug users due to their sharing of contaminated needles. It is also seen in haemophiliacs and people who have had blood transfusions or treatment with blood products. Since 1991 all blood has been tested for hepatitis C and the risk of transmission through blood in the UK is now insignificant.

About one-third of all cases of hepatitis C come from an unidentifiable source.

Advice on prevention

Advise your clients that, as well as the advice given above *(see page 8)*, they should:

- avoid sharing needles and syringes
- avoid sharing razors and toothbrushes with an infected person
- abstain from all alcohol intake if blood tests have shown that the disease is active
- refrain from drinking alcohol daily if they have chronic hepatitis C.

Unfortunately, there is no vaccine to prevent hepatitis C virus infection so other preventive measures have to be implemented. Anyone with chronic hepatitis should be examined regularly by their doctor and should aim to eat a healthy, well-balanced diet.

What are the signs and symptoms?

The incubation period, from the time of exposure to the virus until the onset of the disease, is one to six months. Early symptoms include poor appetite, lack of interest in food, nausea, aching muscles and joints, and light fever.

Later symptoms include yellowing of skin, mucous membranes and white portions of the eyes (jaundice, icterus); light-coloured stools; and dark urine. Once the late

symptoms have developed, in most cases the patient quickly begins to get better. The disease typically lasts two to eight weeks.

Only one in 10 patients with acute hepatitis has symptoms. The remaining nine are symptom-free. In eight out of 10 patients, the infection becomes chronic.

Patients with chronic type C hepatitis may not have any symptoms at all, or experience only mild symptoms such as tiredness, periodical pressure below the right ribs caused by the enlarging liver, and aching muscles and joints.

Approximately one-third of the patients develop cirrhosis over a number of years, which can lead to liver failure and other serious complications. On average, cirrhosis develops about 20 years after the virus has been contracted.

How do you test for hepatitis C?

The diagnosis is made on the basis of a blood sample which will demonstrate the presence of genetic segments from the hepatitis C virus, or antibodies against the hepatitis C virus in the patient's blood.

A blood test for liver function can determine the severity of the disease, ie, to what extent the liver is affected by the virus. In the case of chronic hepatitis, the severity of the illness can be assessed through a tissue sample from the liver.

How do you treat hepatitis C?

Chronic hepatitis C can be treated by a combination of interferon alfa injections and ribavirin capsules, with half of the patients benefiting from this treatment.

Most patients with acute hepatitis C have fully recovered after four to eight weeks.

Very few patients (one in 300) develop liver failure in connection with acute hepatitis and subsequently risk dying from the disease. The infection becomes chronic in four out of five patients. The most serious complications of chronic type C hepatitis are cirrhosis and in rare cases, liver cancer.

Practice point

So, what are you going to do about hepatitis C?

	Tick box
Nothing, my learning needs are met	☐
Learn more about it	☐
Where from?	
Provide better advice on self care	☐
Provide better advice post-prescription	☐
Provide better advice on safe sex	☐
Refer patients more appropriately	☐
Where to?	
Signpost patients more appropriately	☐
Where to?	
Look out for an opportunity to start a service	☐
Doing what?	

For further advice and information

British National Formulary online
http://bnf.org/bnf/

The British Liver Trust has a healthcare professional's guide to hepatitis C, available via the following weblink:
http://79.170.44.126/britishlivertrust.org.uk/home-2/health-professionals/627-2/a-professionals-guide-to-hepatitis-c/

For clients

Netdoctor website: *Hepatitis C*
http://www.netdoctor.co.uk/diseases/facts/hepatitisc.htm

Reflective question
What do you already know about HIV?

How common is it? How do you prevent it? What are the signs and symptoms? How do you test for it? How do you treat it?

Reflective question
What don't you know?

What would you like to learn?

To start with…

Human immunodeficiency virus (HIV) is a virus that damages the immune system, the body's defence against disease. A person infected with HIV is infected for life – there is no cure.

Over time, as the immune system weakens, a person with HIV may develop rare infections or cancers. When these are particularly serious the person is said to have developed AIDS (acquired immune deficiency syndrome).

HIV can only be passed on through the transfer of blood, semen, vaginal fluids and breast milk. The two main ways in which a person can become infected are:

- vaginal or anal sex without a condom with an infected partner
- using a needle or syringe that has already been used by someone who is infected.

An infected pregnant woman can pass the virus to her unborn baby, before or during birth. However, improvements in the treatment and care of HIV-positive women means far fewer children are now born HIV-positive in the UK.

Other potential routes of transmission include:

- giving and receiving first aid (though transmission will only occur if significant amounts of HIV-infected blood pass from one person to the other)
- contact with used needles and syringes
- giving and receiving oral sex (though there are very few proven instances of this; generally, transmission will only occur if a person has cuts or sores in their mouth).

Other extremely rare methods of transmission include:

- contact with a dentist, doctor or nurse (it is extremely rare for HIV to be passed from a healthcare professional to a patient as in the UK all medical instruments are sterilised or used only once)
- fighting and biting (though there have been few reported cases of infection)
- playing sport (the risk is from HIV-infected blood getting into a wound or a cut).

Even though the risk of contracting HIV through any of these routes is small, it is still possible and care should always be taken.

Blood transfusions and the use of blood products are other potential routes of transmission, but since 1985 all donated blood in the UK has been screened for HIV. However, this remains a possibility if someone receives healthcare in the developing world.

How common is HIV?

An estimated 96,000 (90,800-102,500) people were living with HIV in the UK by the end of 2011, an increase from 91,500 (85,400-99,000) in 2010. The overall prevalence in 2011 was 1.5 per 1,000 population with 24 percent (19 percent to 28 percent) of people living with HIV were unaware of their infection in 2011, the same proportion as seen in 2010.[13]

In 2011, 6,280 people were newly diagnosed with HIV in the UK, a 21 percent decline from the peak in new diagnoses in 2005. The decrease is largely due to a reduction in the number of diagnoses reported among those born outside of the UK. New diagnoses among MSM have been increasing since 2007 with 3,010 reports in 2011, representing an all-time high. Direct and indirect measures of incidence show that the rate of HIV transmission in this population remains high. Over half of the 2,990 heterosexual men and women diagnosed in 2011 probably acquired their HIV infection in the UK, compared to 27 percent in 2002.[13]

Advice on prevention

Advise your clients that – as well as the advice given above *(see page 8)* – the transmission of HIV can be prevented by using a clean needle every time drugs are injected. The steps an HIV-positive woman can take to reduce the chance of passing on HIV to her child during pregnancy include:

- taking an anti-HIV drug towards the end of pregnancy and at the time of birth
- considering a delivery by Caesarean section
- giving the baby formula milk instead of breast-feeding.

What are the signs and symptoms?

Some people experience signs and symptoms of HIV as soon as they become infected; others do not. These are often mistaken for flu or a mild viral infection. The person appears to recover, usually between one and four weeks later. Signs and symptoms include:

- fever
- headache
- tiredness
- nausea
- diarrhoea
- enlarged lymph nodes (neck, armpits and groin).

These signs and symptoms are similar to many different viral infections and diseases. The only way to confirm HIV infection is to be tested. Many people infected with HIV do not have any signs and symptoms for many years.

How do you test for HIV?

There are two methods in routine practice for testing for HIV, involving either taking a blood sample for a screening assay where blood is sent to a laboratory for testing, or a rapid point-of-care test (POCT).

A POCT gives a result within minutes from either a fingerprick or mouth swab sample. It is ideal for use in settings where taking a blood sample is not possible, and where a delay in obtaining a result is a disadvantage.

Unfortunately a POCT has reduced specificity and reduced sensitivity compared with current laboratory tests. Therefore, all positive results must be confirmed by serological tests as there will be false positives, particularly in lower prevalence environments.

UK national guidelines for HIV testing state that HIV testing can be carried out by any healthcare worker who is trained to gain consent and conduct a test.

See the HIV testing guidelines from the British HIV Association (BHIVA) **http://www.bhiva.org/documents/Guidelines/Testing/GlinesHIVTest08.pdf**

How do you treat HIV?

There is no cure for HIV but there are a number of drugs that can help to prevent someone who is HIV-positive from developing AIDS. The treatment, which is known as combination therapy, requires taking several drugs every day, although monotherapy is emerging and may be a consideration in pregnancy. If taken correctly, the drugs can significantly increase the life expectancy of someone with HIV (refer to your current *BNF*, section 5.3.1 or look online at: **http://www.bnf.org/bnf/**). NB. You need to register, and log in to view information, but this is free of charge.

Research to develop a HIV vaccine is continuing. Progress is being made, but it is likely to be a number of years before such a vaccine is widely available.

Practice point

So, what are you going to do about HIV?

	Tick box
Nothing, my learning needs are met	☐
Learn more about it	☐
Where from?	
Provide better advice on self care	☐
Provide better advice post-prescription	☐
Provide better advice on safe sex	☐
Refer patients more appropriately	☐
Where to?	

	Tick box
Signpost patients more appropriately	☐
Where to?	
Look out for an opportunity to start a service	☐
Doing what?	

For further advice and information

AVERT (a UK-based international HIV and AIDS charity)
Telephone: 01403 210202
http://www.avert.org

Women, HIV and AIDS
http://www.avert.org/women-hiv-aids.htm

British HIV Association, *UK national guidelines for HIV testing* (2008).
http://www.bhiva.org/documents/Guidelines/Testing/GlinesHIVTest08.pdf

For clients

Terrence Higgins Trust (THT)
Telephone: 0845 1221200
http://www.tht.org.uk/

Trichomoniasis (Trich or TV)

Reflective question
What do you already know about trichomoniasis?

How common is it? How do you prevent it? What are the signs and symptoms? How do you test for it? How do you treat it?

Reflective question
What don't you know?

What would you like to learn?

To start with…

Trichomoniasis (also called Trich or TV) is a common sexually-transmitted infection caused by a tiny parasite called *Trichomonas vaginalis* found in the vagina and urethra. It is passed on through:

- vaginal sex with an infected partner
- sharing sex toys.

It can also be passed from a mother to her baby at birth.

Trichomoniasis **cannot** be passed on through oral or anal sex; kissing; hugging; sharing cups, plates or cutlery; toilet seats or towels; but, as a protozoa, can live for up to 45 minutes outside the host.

How common is trichomoniasis?

There is little data on the prevalence of trichomoniasis in the UK, but it is estimated to be present in three to five percent of women in the United States, and is more common in people who frequently change sexual partners.

Advice on prevention

Advise your clients that if they have had trichomoniasis and it has been treated, they will not be immune to the infection and they could get it again. Like any sexually-transmitted infection, the best preventive measures are given above *(see page 8)*; and these measures will also help prevent them passing it on to their partner.

Also, for female clients, if they rub their vulva against their female partner's vulva, one of them should cover their genitals with a dam.

What are the signs and symptoms?

Up to 50 percent of infected people show no symptoms; in others, symptoms can appear between five and 28 days after infection.

Symptoms in women:

- an increased discharge from the vagina, which may be thin or frothy, change colour, and have a musty or fishy smell
- itching, soreness and inflammation in and around the vagina
- pain when urinating or having sex
- tenderness in the lower abdomen.

Symptoms in men:

- a thin, whitish discharge from the tip of the penis, which can stain underwear
- pain or a burning sensation when urinating.

Men may be carriers of the infection without having any symptoms.

How do you test for trichomoniasis?

Testing for trichomoniasis may involve:

- a genital examination by a doctor or nurse
- a swab taken from the vagina or urethra and examined under a microscope
- an internal examination.

It is sometimes discovered during a routine cervical smear test.

How do you treat trichomoniasis?

Treatment is simple and involves taking metronidazole in a single dose (2 g). Once it is successfully treated trichomoniasis does not return unless a new infection is acquired, so to avoid reinfection all sexual partners should be treated too. A check-up is advised after treatment to make sure the infection has gone.

Unprotected vaginal sex should be avoided until the treatment has been completed and the infection has cleared up.

While trichomoniasis does not cause any serious long-term health problems, it can increase the risk of HIV transmission during sexual contact with an infected individual.

Practice point

So, what are you going to do about trichomoniasis?

	Tick box
Nothing, my learning needs are met	☐
Learn more about it	☐
Where from?	
Provide better advice on self care	☐
Provide better advice post-prescription	☐
Provide better advice on safe sex	☐
Refer patients more appropriately	☐
Where to?	

	Tick box
Signpost patients more appropriately	☐
Where to?	
Look out for an opportunity to start a service	☐
Doing what?	

For further advice and information

British Association for Sexual Health and HIV. *United Kingdom national guideline on the management of trichomonas vaginalis* (2007).
http://www.bashh.org/documents/87/87.pdf

NHS Choices: *Trichomoniasis*
http://www.nhs.uk/conditions/trichomonas_vaginalis/Pages/Introduction.aspx

Reflective question
What do you already know about pubic lice?

How common are they? How do you prevent them? What are the signs and symptoms? How do you test for them? How do you treat them?

Reflective question
What don't you know?

What would you like to learn?

To start with…

Pubic lice are sometimes called 'crabs' or 'crab lice' *(pthirus pubis)*. They live in coarse body hair, such as pubic hair, but they can also live in underarm hair, on hairy legs and chests and, occasionally, in beards, eyebrows and eyelashes. The lice are yellow-grey in colour, measure about 2 mm long, and have large, crab-like claws with which they fasten themselves to the hair.

Pubic lice are easily passed on through sexual or close physical contact as they crawl from hair to hair.

The eggs of the lice can survive away from the body for up to 24 hours, which means they can be passed on by sharing clothes, bedding or towels.

How common is it?

There is very little data available on the incidence or prevalence of pubic lice infection, but extrapolations from international data put the incidence at 1.1 percent annually.

Advice on prevention

Advise your clients that they can reduce their risk of getting pubic lice by keeping the number of sexual partners they have to a minimum and by having regular check-ups for sexually-transmitted infections and encouraging their partner to have regular check-ups.

Although condoms cannot prevent pubic lice infection, they will provide protection from most other sexually-transmitted infections. Anyone who does not know their partner's sexual history should use a condom.

What are the signs and symptoms?

Symptoms are noticed between five days to several weeks after infection. They include:

- itchy skin or inflammation of the affected area
- black powder (lice droppings) in underwear
- brown eggs on the hair
- visible lice and eggs (occasionally).

Spots of blood are sometimes seen as the lice feed from blood vessels close to the surface of the skin.

How do you test for pubic lice?

Testing for pubic lice may involve:

- a physical examination by a doctor or nurse
- a medical history
- examination of the lice under a microscope.

How do you treat pubic lice?

People can easily treat pubic lice using shampoos, creams or lotions. These are used to kill the lice and their eggs without the pubic hair having to be shaved. The itching or rash may continue after treatment and may take a few weeks to clear up.

Pubic lice do not cause any serious long-term health problems. However, people must wash their clothes and bedding, and to avoid reinfection, all sexual partners must treat themselves too.

People should avoid all sexual contact and other close contact until the treatment has been completed and the lice and their eggs have gone.

Practice point

So, what are you going to do about pubic lice?

	Tick box
Nothing, my learning needs are met	☐
Learn more about it	☐
Where from?	
Provide better advice on self care	☐
Provide better advice post-prescription	☐
Provide better advice on safe sex	☐
Refer patients more appropriately	☐
Where to?	
Signpost patients more appropriately	☐
Where to?	
Look out for an opportunity to start a service	☐
Doing what?	

For further advice and information

British Association for Sexual Health and HIV, *United Kingdom national guideline on management of Phthirus pubis infestation*, 2007
http://www.bashh.org/documents/28/28.pdf

NHS Choices: *Pubic lice*
http://www.nhs.uk/Conditions/pubic-lice/Pages/Introduction.aspx

Reflective question
What do you already know about balanitis?

How common is it? How do you prevent it? What are the signs and symptoms? How do you test for it? How do you treat it?

Reflective question
What don't you know?

What would you like to learn?

To start with…

Balanitis is an inflammation of the glans penis that occurs secondary to a variety of different conditions. Patients are often concerned that balanitis is due to a sexually-transmitted infection, but this is rarely the case. The differential diagnoses are broadly categorised into infections (bacterial and fungal), those related to a sexually-transmitted infection, and non-infective causes (including various dermatoses).

Bacterial non-sexually-transmitted infection	Streptococci (Group A and B), Staphylococci aureus, Anaerobes
Fungal non-sexually-transmitted infection	Candida species
Sexually-transmitted infection-related	Syphilis, *Trichomonas vaginalis*, Herpes simplex virus, Human papilloma virus
Non-infective	Trauma, irritant, poor hygiene, allergy, fixed drug eruption; various dermatoses, including lichen sclerosus, psoriasis, Stevens Johnson syndrome, Zoon's balanitis

How common is it?

Balanitis is a common condition and occurs in three percent of uncircumcised males and accounts for 11 percent of GUM clinic attendees.

Advice on prevention

Preventing balanitis often just means avoiding irritating substances and employing good hygiene. Advise your clients about the key points presented below.

Good hygiene

- Wash the glans carefully every day, making sure they gently clean under the foreskin.
- Do not use perfumed shower gels. Using water alone, or water and a mild soap, is sufficient to clean the penis.
- Alternatively, use aqueous cream as a soap substitute, to avoid irritation.
- Make sure the penis is completely dry before getting dressed.

Avoiding irritants

- Condoms/lubricants: sometimes the chemicals used in condoms or lubricants can irritate the penis. If someone thinks their symptoms may be related to this, they could try using a condom for sensitive skin.
- Detergents: wash underwear with non-biological washing powder and make sure all the detergent is rinsed out before wearing.
- Chemicals: anyone who works with chemicals or has traces of other products on their hands should make sure they wash their hands before using the toilet, as the chemicals or products could irritate the delicate skin of the penis.

What are the signs and symptoms?

Symptoms

- Pain and soreness during sexual intercourse
- Thick, lumpy discharge from the glans/behind the foreskin
- Local rash or ulceration
- Itch
- Unpleasant odour
- A tight foreskin that will not retract (phimosis)
- Pain when passing urine

Signs

- Erythema/purpura of glans penis
- Scaling, ulceration, fissuring, crusting, exudate, oedema, odour and presence of a phimosis

Some of these clinical features can be a sign of another condition; it is therefore important to get an exact diagnosis and the correct treatment.

How do you test for balanitis?

In a healthcare setting where examination is possible, the doctor should be able to diagnose the cause of balanitis based on the history, clinical findings and investigation. Potential investigations may include:

- screening for sexually-transmitted infections
- sub-preputial swab for bacterial culture
- gram-stain microscopy of exudate if present
- urinalysis for glucose
- biopsy if diagnosis remains unclear.

How do you treat balanitis?

If balanitis is due to an irritant:

- avoid the allergen or irritant
- one percent hydrocortisone cream can be prescribed to reduce inflammation; note a steroid cream should not be used alone if an infection is suspected. NB: This medication should not be supplied over-the-counter for use on the anogenital area.

If balanitis is caused by a yeast infection, treat with an antifungal cream, such as clotrimazole or miconazole. If the yeast infection was picked up by having sex, both partners need treatment and should avoid sex or use a condom while being treated.

If balanitis is caused by a bacterial infection, treat with antibiotics, such as metronidazole.

Some aerobic bacterial infections are found as commensals, so only treat if symptomatic.

If the balanitis is dermatological in origin, the patient should be referred to a dermatologist or GUM clinic for further investigation and management.

Practice point

So, what are you going to do about balanitis?

	Tick box
Nothing, my learning needs are met	☐
Learn more about it	☐
Where from?	
Provide better advice on self care	☐
Provide better advice post-prescription	☐
Provide better advice on safe sex	☐
Refer patients more appropriately	☐
Where to?	
Signpost patients more appropriately	☐
Where to?	
Look out for an opportunity to start a service	☐
Doing what?	

For further advice and information

British Association for Sexual Health and HIV. *2008 UK national guideline on the management of balanoposthitis*.

http://www.bashh.org/guidelines

NHS Choices: *Balanitis*
http://www.nhs.uk/Conditions/Balanitis/Pages/Introduction.aspx

UpToDate website. *Balanitis and balanoposthitis in adults*.
http://www.uptodate.com/contents/balanitis-and-balanoposthitis-in-adults?source=search_result&search=balanitis&selectedTitle=1~27

Reflective question
What do you already know about non-gonococcal urethritis?

How common is it? How do you prevent it? What are the signs and symptoms? How do you test for it? How do you treat it?

Reflective question
What don't you know?

What would you like to learn?

To start with…

Non-gonococcal urethritis (also referred to as NSU or non-specific urethritis) is an inflammation of the urethra that only affects men. A variety of infections, as well as other factors, can cause this. These include:

- vaginal, anal or oral sex with a partner who already has a sexually-transmitted infection (particularly chlamydia)
- other genital or urinary tract infections
- damage to the urethra resulting from vigorous sex or masturbation
- excess alcohol intake
- a urine or bladder infection (though this is rare in young men).

How common is it?

Non-gonococcal urethritis is one of the most common reasons men visit their local GUM or sexual health clinic. In 2004, in the UK, there were 46,000 reported cases of non-gonococcal urethritis as a result of chlamydia.

Advice on prevention

Advise your clients that – as well as following the advice given above *(see page 8)* – they should avoid using oil-based lubricants, such as Vaseline, or baby oil during sex, as they can weaken the condom and increase the chances of it splitting. Water-based lubricants, such as K-Y Jelly are preferred, and can be bought at pharmacies.

What are the signs and symptoms?

Non-gonococcal urethritis has three main symptoms:

- a white/cloudy discharge from the tip of the penis, which is often more obvious first thing in the morning
- pain, irritation or a burning sensation when urinating
- wanting to urinate often.

How do you test for non-gonococcal urethritis?

It is diagnosed using a microscope to look at the number of pus cells seen on a smear made by collecting a sample from just inside the tip of the male urethra and rubbing it on a microscope slide. This facility is generally only available in GUM clinics. The number of cells resulting in a diagnosis depends on the clinic standards, but on average if on looking down the microscope, there are over five pus cells per high power field a man may be diagnosed with NSU. At this point it is often not possible to tell whether a specific infection is causing it, but usually men are treated as if it is caused by chlamydia because this is the most common and also most significant cause.

Clients should be advised that it is important not to urinate for two to four hours before such a swab is taken.

To confirm the cause of the non-gonococcal urethritis the following may need to be done:

- a urine test
- a genital examination by a doctor or nurse.

How do you treat non-gonococcal urethritis?

Non-gonococcal urethritis is easily treated with antibiotics, though damage to the urethra can take time to heal. To avoid reinfection all sexual partners should be treated too.

After treatment the client may need a check-up to ensure that the infection has cleared up; if it has not, a second course of antibiotics may be needed.

Clients should drink less alcohol during treatment as it can irritate the urethra, and vaginal, anal and oral sex should be avoided until the treatment has been completed and the infection has cleared up.

If left untreated, and depending on the underlying cause, non-gonococcal urethritis can cause serious health problems, including:

- inflammation of the testicles (which may result in fertility problems)
- (occasionally) Reiter's syndrome (inflammation of the joints, urethra and eyes).

Practice point

So, what are you going to do about non-gonococcal urethritis?

	Tick box
Nothing, my learning needs are met	☐
Learn more about it	☐
Where from?	
Provide better advice on self care	☐
Provide better advice post-prescription	☐
Provide better advice on safe sex	☐
Refer patients more appropriately	☐
Where to?	
Signpost patients more appropriately	☐
Where to?	
Look out for an opportunity to start a service	☐
Doing what?	

For further advice and information

NHS Choices: *Non-specific urethritis.*
http://www.nhs.uk/conditions/non_specific_urethritis/pages/introduction.aspx

British Association for Sexual Health and HIV. *Management of non-gonococcal urethritis* (2007) – December 2008 update.
http://www.bashh.org/guidelines

Reflective question
What do you already know about scabies?

How common is it? How do you prevent it? What are the signs and symptoms? How do you test for it? How do you treat it?

Reflective question
What don't you know?

What would you like to learn?

To start with…

Scabies is a contagious skin condition where the main symptom is intense itching. It is caused by tiny mites called *Sarcoptes scabiei*, which burrow into the skin. It can be spread by:

- skin-to-skin contact for long periods of time with someone who is infected
- sexual contact with someone who is infected.

Scabies can also be passed on through sharing clothing, towels and bedding with someone who is infected. However, this is less likely than getting the infection through skin-to-skin contact.

The incubation period for scabies is up to eight weeks.

How common is it?

Scabies is particularly widespread in countries that have a high population density and limited access to medical care. The condition is endemic in the following tropical and subtropical areas:

- Africa
- Egypt
- Central and South America
- northern and central Australia
- Caribbean Islands
- India
- southeast Asia.

In developed countries, outbreaks of scabies can sometimes occur in places where there are lots of people in close contact, such as schools, nurseries and nursing homes. There can also be individual cases of scabies that are not isolated to one specific place.

It is difficult to estimate the exact number of scabies cases in England and Wales because many people treat the condition themselves.

Advice on prevention

Advise your clients that:

- scabies like warm places on the skin, such as skin folds, between the fingers, under fingernails or around the buttock or breast creases; they can also hide under watch straps or bracelets, and in the skin on the finger under rings
- a condom will not prevent sexual transmission as the disease is passed through skin-to-skin contact during any sexual activity with an infected person.

What are the signs and symptoms?

The main symptoms of scabies are:

- intense itching that is worse at night
- skin rash in the areas of the body where mites have burrowed.

The scabies mites will also leave small red blotches and silver lines on the skin, caused by the mites burrowing into the skin.

How do you test for scabies?

Experienced healthcare professionals can diagnose scabies from the appearance of the skin, and by looking for the burrow marks that are made by the *Sarcoptes scabiei* mite. However, as the scabies infection is spread very easily, it is often possible to make a confident diagnosis if more than one family member has the same symptoms.

The burrows of scabies mites can be highlighted by using an ink test. The ink is rubbed around an area of itchy skin before being wiped off with an alcohol pad. If scabies burrows are present, some of the ink will remain and will have tracked into the burrows, showing up as a dark line.

In order to confirm the diagnosis, a skin sample may be gently scraped from the affected area so that it can be examined under a microscope for evidence of scabies mites and their eggs and faeces.

How do you treat scabies?

The two most widely used treatments for scabies are:

- permethrin cream
- malathion lotion.

It is important that all members of the household and any close contacts (including recent sexual partners) are treated at the same time, even if they do not have symptoms.

Permethrin cream or malathion lotion should be applied to cool, dry skin and not after a hot bath. If the cream or lotion is applied when the body is hot, it will be absorbed quickly into the skin and will not remain on the area where the burrows are present.

People must be advised to wash bedding and clothes and avoid having sex and other forms of close bodily contact until they and their partner(s) have completed the treatment.

Practice point

So, what are you going to do about scabies?

	Tick box
Nothing, my learning needs are met	☐
Learn more about it	☐
Where from?	
Provide better advice on self care	☐
Provide better advice post-prescription	☐
Provide better advice on safe sex	☐
Refer patients more appropriately	☐
Where to?	
Signpost patients more appropriately	☐
Where to?	
Look out for an opportunity to start a service	☐
Doing what?	

For further advice and information

British Association for Sexual Health and HIV. *United Kingdom national guideline on the management of scabies infestation* (2007).
http://www.bashh.org/documents/27/27.pdf

NHS Choices: *Scabies*
http://www.nhs.uk/conditions/Scabies/Pages/Introduction.aspx

Reflective question
What do you already know about thrush?

How common is it? How do you prevent it? What are the signs and symptoms? How do you test for it? How do you treat it?

Reflective question
What don't you know?

What would you like to learn?

To start with…

Thrush is a common infection caused by overgrowth of candida albicans, a yeast that lives on the skin and in the mouth, gut and vagina. It is usually harmless but changes in the body can cause the yeast to grow rapidly. This can lead to an outbreak of thrush.

Thrush can develop following sex with an infected partner but it is often unrelated to sex. It is more likely to occur as a result of:

- taking broad spectrum antibiotics
- pregnancy
- poorly controlled diabetes
- using products, such as vaginal deodorants, that may cause irritation
- a seriously damaged immune system, for example, people on chemotherapy, taking high dose steroids or who are HIV positive
- wearing tight trousers or nylon underwear.

How common is thrush?

Men and women can get thrush. Up to 75 percent of women will have thrush at some point in their lives. Up to half of these will have thrush more than once. Thrush most commonly affects women in their 20s and 30s, and those who are pregnant.

Thrush is less common in girls who have not yet started their periods, and women who have started the menopause. Hyperestrogenaemia (including that caused by taking hormone replacement therapy or the combined oral contraceptive pill) can be a host factor in candida infection. Some women experience bouts of thrush around their period, which may be because of a change in pH in the vagina which makes conditions for growth favourable. It is not known what makes some women more prone to thrush than others, but women with poorly controlled diabetes or a seriously damaged immune system have an increased risk of developing the condition.

In men, thrush is a relatively common condition, particularly candida balanitis. It is estimated that one in 10 men who visit a sexual health clinic have balanitis. Skin infections are less common in the general population, but are relatively widespread among certain groups of people, such as:

- those with a weakened immune system
- those who are obese, as they often have large rolls of skin (an environment where fungi can often thrive)
- people who have type 1 or type 2 diabetes – this is because the high levels of glucose that are associated with diabetes can encourage the fungus to breed, and also people with diabetes tend to sweat more which also encourages the fungus.

Advice on prevention

Advise your **female** clients that:

- some women who have vaginal thrush use probiotics, such as live yogurts, to help treat and prevent the condition – there is no medical evidence that probiotics are effective, but there is no reason to think that they would be unsafe
- other techniques they may wish to try include:
  - wearing loose fitting underwear
  - avoiding tight or synthetic (man-made) clothing, such as leggings or tight jeans
  - avoiding perfumed soap, bubble bath and vaginal deodorant
  - making sure the vagina is well lubricated before sexual intercourse, for example, by using a lubricating gel to prevent any damage to the vagina
  - when going to the toilet, making sure that they wipe the genital area from front to back.
- if they are prescribed antibiotics for another condition and this has given them thrush in the past, they should speak to their GP about it.

Advise your **male** clients that:

- they can help to prevent thrush by having good standards of hygiene, such as cleaning the penis regularly and using a condom while having sex with their partner (if they have thrush)
- they should avoid the use of perfumed shower gels or soaps on the genitals, as they can cause irritation, and make sure the penis is dried properly after washing
- wearing loose-fitting cotton underwear can help to prevent moisture building up under the foreskin, which lowers the chances of the candida fungus multiplying.

What are the signs and symptoms?

Symptoms in **women**:

- soreness, redness and itching around the vulva, vagina and anus
- a thick, white vaginal discharge that looks like cottage cheese and smells of yeast
- pain during sex
- pain when urinating.

Symptoms in **men**:

- burning, itching, redness and red patches under the foreskin or on the tip of the penis
- a thick, cheesy discharge under the foreskin
- problems pulling back the foreskin.

How do you test for thrush?

Testing for thrush may involve:

- a genital examination by a doctor or nurse
- a swab taken from the infected area and examined under a microscope or sent to the lab for culture
- an internal examination.

How do you treat thrush?

Thrush is easily treated using imidazole pessaries, cream or oral medication. Men are usually treated with creams.

All sexual contact should be avoided until the treatment has been completed and the infection has cleared up.

Thrush does not cause serious long-term health problems and will clear up without treatment, but this will prolong the discomfort. Furthermore, econazole, fenticonazole and isoconazole preparations damage latex condoms and diaphragms. It is not known if clotrimazole preparations damage latex contraceptives.

Practice point

So, what are you going to do about thrush?

	Tick box
Nothing, my learning needs are met	☐
Learn more about it	☐
Where from?	
Provide better advice on self care	☐
Provide better advice post-prescription	☐
Provide better advice on safe sex	☐
Refer patients more appropriately	☐
Where to?	

Signpost patients more appropriately ☐

Where to?

Look out for an opportunity to start a service ☐

Doing what?

For further advice and information

NHS Choices: *Thrush, men*
http://www.nhs.uk/conditions/thrush-men/pages/introduction.aspx

NHS Choices: *Thrush, vaginal*
http://www.nhs.uk/conditions/Thrush/Pages/Introduction.aspx

British Association for Sexual Health and HIV, 2007 *United Kingdom national guidelines on management of vulvovaginal candidiasis* (2007).
http://www.bashh.org/guidelines

Also of use in differential diagnosis is:

British Association for Sexual Health and HIV and Faculty of Sexual and Reproductive Healthcare *Management of vaginal discharge in non-genitourianry medicine settings*, 2012.

Reflective question
What do you already know about bacterial vaginosis?

How common is it? How do you prevent it? What are the signs and symptoms? How do you test for it? How do you treat it?

Reflective question
What don't you know?

What would you like to learn?

To start with…

The cause of bacterial vaginosis is not well understood. Women who have bacterial vaginosis show:

- less of the normal vaginal bacteria (*lactobacilli*)
- an overgrowth of other types of bacteria in the vagina
- a change in pH (acid/alkaline balance) of the vagina, with the vagina becoming more alkaline.

Bacterial vaginosis can occur in women who:

- use scented soaps or perfumed bubble bath
- put antiseptic liquids in the bath
- douche or use vaginal deodorant
- use strong detergents to wash their underwear
- smoke.

Hormonal changes during the menstrual cycle, semen in the vagina after sex without a condom, use of an intrauterine contraceptive device and genetic factors may also play a part.

Bacterial vaginosis is not a sexually-transmitted infection, but women who are sexually active and have had a change of partner are more likely to have it, including women in same-sex relationships.

How common is bacterial vaginosis?

The reported prevalence has varied from five percent in a group of asymptomatic college students, to as high as 50 percent of women in rural Uganda. A prevalence of 12 percent was found in pregnant women attending an antenatal clinic in the United Kingdom, and of 30 percent in women undergoing termination of pregnancy.[14]

Advice on prevention

Advise your clients that the causes of bacterial vaginosis are not fully understood, so it is not possible to completely prevent it. However, they may be able to lower their risk of developing bacterial vaginosis by avoiding:

- scented soaps and perfumed bubble bath
- vaginal deodorant
- douching (washing or cleaning out the vagina)
- putting antiseptic liquids in the bath
- using strong detergents to wash their underwear.

All these products can upset the natural bacterial balance in the vagina, making it more likely that they will develop bacterial vaginosis.

Although bacterial vaginosis is not sexually transmitted, many infections are. If someone is sexually active, having safe sex offers them and their partner the best

protection against sexually-transmitted infections – so refer again to the general advice provided *(see page 8)*.

What are the signs and symptoms?

Around half of women with bacterial vaginosis will not have any signs or symptoms at all, or may not be aware of them. There may be a change in the usual vaginal discharge. This may increase, become thin and watery, change to a white/grey colour and develop a strong, unpleasant, fishy smell, especially after sexual intercourse. Bacterial vaginosis is not usually associated with itching or irritation.

How do you test for bacterial vaginosis?

In a healthcare setting that allows for physical examination, the doctor may diagnose bacterial vaginosis from a description of symptoms and a vaginal examination. In particular, the doctor will look for:

- a thin, greyish discharge
- an unpleasant smell.

In some cases, this may be enough to confirm the diagnosis. However, if the woman is sexually active and it is possible that she may have a sexually-transmitted infection instead of bacterial vaginosis, she may need to have some further tests, such as a vaginal swab to check vaginal pH and/or to check for bacterial vaginosis.

How do you treat bacterial vaginosis?

Treatment is simple and involves taking metronidazole: either a single dose (2 g) or short course (400-500 mg every 12 hours for five to seven days). Alternatively, clindamycin cream 2 percent inserted vaginally for seven nights. If used correctly, treatment is effective in 85-90 percent of cases. It is quite common for bacterial vaginosis to return, and some women get repeated episodes. Be aware that clindamycin cream may damage latex contraceptives.

Non-antibiotic based treatment with probiotic lactobacilli or lactic acid preparations have not yielded consistently reproducible evidence of efficacy as treatments for bacterial vaginosis and no recommendation on their use can be made at present.[14]

If bacterial vaginosis is left untreated, there is some evidence that women may be at a higher risk of having pelvic inflammatory disease (PID) or getting HIV. Bacterial vaginosis may cause problems with a pregnancy. The infection has been found in some women who have had a miscarriage, a premature birth or a low birth weight baby. Pregnant women who have had a previous premature birth will usually be offered a test for bacterial vaginosis.

Sometimes women confuse the symptoms of thrush and bacterial vaginosis and the appearance and odour of discharge which distinguishes them.

Practice point

So, what are you going to do about bacterial vaginosis?

	Tick box
Nothing, my learning needs are met	☐
Learn more about it	☐
Where from?	
Provide better advice on self care	☐
Provide better advice post-prescription	☐
Provide better advice on safe sex	☐
Refer patients more appropriately	☐
Where to?	
Signpost patients more appropriately	☐
Where to?	
Look out for an opportunity to start a service	☐
Doing what?	

For further advice and information

British Association for Sexual Health and HIV. *National guideline for the management of bacterial vaginosis* (2012).
http://www.bashh.org/guidelines

NHS Choices: *Bacterial vaginosis.*
http://www.nhs.uk/conditions/bacterialvaginosis/Pages/Introduction.aspx

Summary

This factfile has described the signs and symptoms, prevalence, diagnosis and management of sexually-transmitted infections and shown you how to give advice to promote safer sex and prevent sexually-transmitted infections.

Intended outcomes	
By the end of this section you should be able to:	Can you?
▶ describe the presentation, diagnosis and treatment of the most common sexually-transmitted infections (STIs) and access reliable sources for keeping that knowledge up to date	
▶ advise clients on how to reduce the risk of contracting sexually-transmitted infections.	

1. Meade CS, Sikkema KJ. HIV risk behavior among adults with severe mental illness: a systematic review. *Clinical Psychology Review*, 2005; 25(4): 433-57. Epub 2005 Apr 12. **http://www.ncbi.nlm.nih.gov/pubmed/15914265**

2. Health Protection Agency. *Table 1: Number and rates of new STI diagnoses in England 2002-2011.* Published in 2012. **http://www.hpa.org.uk/webc/HPAwebFile/HPAweb_C/1215589015024**

3. Health Protection Agency. *Genital chlamydia trachomatis diagnoses in young adults in England 2011.* Health Protection Report, June 2012 (6) 22.

4. Health Protection Agency. *Table 9: Number and rates of anogenital herpes diagnoses in England 2002-2011.* Published in 2012.

5 British Association for Sexual Health and HIV. *United Kingdom national guideline on management of genital warts, 2007.* **http://www.bashh.org/guidelines**

6. Department of Health. *Vaccine update*, Issue 187, March 2012.

7. Health Protection Agency. *Table 8: Number and rates of gonorrhoea diagnoses in England, 2002-2011.* Published in 2012. **http://www.hpa.org.uk/webc/HPAwebFile/HPAweb_C/1281953082152**

8. Health Protection Agency. *Table 3: Number of selected STI diagnoses in England, 2009-2011.* Published in 2012. **http://www.hpa.org.uk/webc/HPAwebFile/HPAweb_C/1215589014186**

9. Health Protection Agency. *Table 10 (ii): Rates of syphilis diagnoses in England, 2002-2011.* Published in 2012. **http://www.hpa.org.uk/webc/HPAwebFile/HPAweb_C/1281953088000**

10. British Association for Sexual Health and HIV. *United Kingdom national guideline on management of syphilis, 2008.* **http://www.bashh.org/guidelines**

11. Family Planning Association. *Syphilis: looking after your sexual health.* London: FPA, 2009. **http://www.fpa.org.uk/media/uploads/helpandadvice/syphilisapril09.pdf**

12. British Liver Trust. *A professional's guide to hepatitis B.* Ringwood: British Liver Trust, 2009. Available to download from: **http://79.170.44.126/britishlivertrust.org.uk/home-2/health-professionals/627-2/a-professionals-guide-to-hepatitis-b/**

13. Health Protection Agency. *HIV in the United Kingdom: 2012 report.* London: HPA, 2012. **http://www.hpa.org.uk/webc/HPAwebFile/HPAweb_C/1317137200016**

14. British Association for Sexual Health and HIV. *UK national guideline for the management of bacterial vaginosis*; London: BASHH, 2012.

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