Women and STIs

Terri Foran

October 2022

Sexual History Taking and Screening for STIs

- Take nothing for granted
- Be flexible with language and questions
- Establish trust
- Consider the 5 'P's
    - Partners
    - Practices (Sexual)
    - Past History of STIs
    - Protection from STIs
    - Prevention Pregnancy
- Since most STIs are asymptomatic, those at higher risk should consider screening at least annually and additionally test should any symptoms occur in self or partner

This presentation takes a cis-gendered approach- Trans issues more complex

Introducing Casey

- Casey is 18 years old and in her last year of high school
- At a party last night she got wasted- and woke up while having unprotected sex with a boy from her class
- She sees her GP for the ECP because she stopped the Pill a couple of months ago when she broke up with her boyfriend
- She had seen her GP at the time because of BTB on the Pill- but testing diagnosed chlamydia and her boyfriend later admitted to other partners

Is Casey at higher risk of STIs?

Sexual Assault and STI Risk

- One in five Australian women (18% or 1.7 million) had experienced sexual violence, defined as the occurrence or threat of sexual assault[1]
- Women were most likely to experience sexual assault by a male they knew (87%)[1]
- The location of the most recent incident was most likely to be in the respondent's home (40%) or in the perpetrator's home (17%)[1]
- 9 out of 10 women (87%) did **not** contact the police[1]
- US study suggested that women who have been forced to have sex are at greater risk for STIs, but they are less likely to be treated[2]
- A 2010 US National Intimate Partner and Sexual Violence Survey[3] reported:
  - Lifetime prevalence of rape, physical violence, or stalking by an intimate partner was 35.0% for heterosexual women, 43.8% for lesbians and 61.1% for bisexual women

1. *Personal Safety Australia 2017:https://www.abs.gov.au/statistics/people/crime-and-justice/personal-safety-australia/latest-release*
2. *Data presented at the 2016 CDC STD Prevention Conference in Atlanta*
3. *Walters ML et al. 2010 findings on victimization by sexual orientation. Atlanta, Ga.: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention; 2013*

Young Women and STIs

- Young people experience higher rates of STIs than the general population in Australia[1,2]
  - Why?- more sexually active, more partners, more use of alcohol/drugs, often more risk-taking behaviour
  - In adolescent LGB research suggests higher rates of substance use, higher rates of multiple substance use and higher ongoing use with age[3]
  - Any young person with a previous STI is at higher risk of subsequent STIs[4,5]
- Young people have lower STI screening rates than the general population in Australia[1,2]
  - **Why?- Not generally seen by as a priority group by SHCs and will be directed to GP care**
  - But this group is also **less** likely to attend a GP for sexual healthcare because of concerns around confidentiality, judgement and costs[6]
  - Most STIs are asymptomatic

1.Department of Health and Ageing. Third national sexually transmissible infections strategy 2014–2017. Canberra: DHA 2014
2.Newman P et al. Family Planning NSW, 2011 https://www.fpnsw.org.au/sites/default/files/assets/rsh_in_nsw_and_australia.pdf
3.Goldbach JT et al. Prev Sci. 2014;15(3):350-363
4. Joffe GP et al. Sex Transm Dis 1992;19(5):272–78
5. den Heijer CDJ et al. Sex Transm Infect 2015;92(3):170
6. Coleman A et al. AJGP 2019;48(6):411-414

Back to Casey.....

- Casey has a GP she trusts and who previously managed her chlamydia
- They discuss the use of the EC, the pros and cons of various emergency contraceptive methods and Casey's ongoing contraceptive needs

- They discuss referral to a sexual assault service- but Casey says she's not interested
- They discuss Casey's alcohol and recreational drug use
- Casey has no current symptoms of STI but her GP arranges initial STI screening and further screening for chlamydia (and pregnancy testing) in 2-3 weeks
- Casey's GP provides her with some good web-links she may wish to explore for more information on STIs and safer sex

Why is STI Prevention in Young Women so Important?

- Historically, women have **not** been listed as a priority population in Australian STI health planning
- Effective treatment (including of contacts) is important to prevent ongoing community transmission
- Untreated chlamydia and gonorrhoea can lead to PID and/or chronic pelvic pain and more rarely to reactive arthritis
- Pregnancy related issues
  - Chlamydia and gonorrhoea are associated with infertility, higher rates of ectopic pregnancy and adverse birth outcomes
  - Herpes simplex, trichomonas and bacterial vaginosis are associated with adverse birth outcomes
  - Though Australian rates of congenital syphilis remain small, they are rising- in 2020, a total of 19 cases of congenital syphilis were reported[1]

1. https://www.clinicallabs.com.au/about-us/doctor-media-releases/syphilis-an-old-enemy-returns-nsw

Introducing Sigrun

- Sigrun is 30 years old
- Sigrun had a number of male sexual partners in her teens but has identified as lesbian for the past 10 years
- She lives in a committed but open relationship with her female partner of 6 years
- She says sex with her occasional casual and short-term partners is ‘usually protected’

Is Sigrun at higher risk of STIs?

STI Risk in WSW

- Disclosure to a health provider can be difficult for many WSW, as no certainty of practitioner attitudes before disclosure[1,2] and some GPs are less comfortable advising WSW[3]
- Other risk factors come into play- sex with men, smoking, drug use, safer sex practices, regular partner's STI risks [4,5]
- The **prevalence** of STIs among lesbian women is similar to that of heterosexual women, and possibly higher among bisexual women, though evidence limited[4,5]
- The **rates** of STIs tend to differ:
  - Bacterial vaginosis is more common, and treatment of symptomatic female partners is advised[6]
  - Chlamydia, gonorrhoea and blood borne viruses (except in IVDUs) appear less common[6]
  - However at least one more recent study indicates higher rates of chlamydia in younger WSW[7]
  - Rates of genital warts, genital herpes and trichomoniasis are similar[6]
- WSW have similar rates of cervical dysplasia(i.e. carriage of oncogenic HPV) to age-matched heterosexual women, indicating the need for cervical screening at the recommended intervals[8]

1. *Neville S et al. J Advance Nurs 2006;55:407–15*
2. *Goldbach JT et al. Prev Sci. 2014;15(3):350-363*
3. *Temple-Smith M et al. Sexually Transmitted Infections 1999;75:41–4*
4. *Mercer CH et al. Am J Public Health 2007;97:1126–33*
5. *Tao G. Am J Public Health 2008;98:1007–9*
6. *Bailey JV et al. Sex Transm Infect 2004;80:244–6*
7. *Marrazzo JM et al. Curr Infect Dis Rep. 2012;14(2):204-211*
8. *Marrazzo JM et al. Am J Public Health 2001;91:947–52*

Introducing Mandy

- Mandy is a 65-year-old women
- Divorced from her husband of 20 years 5 years ago
- Has had a number of short-term relationships with male partners of a similar age since
- Safer sex not practiced with most partners as they have been reluctant to use condoms and Mandy has not insisted

Is Mandy at higher risk of STIs?

STI Rates in Older Australian Women[1]

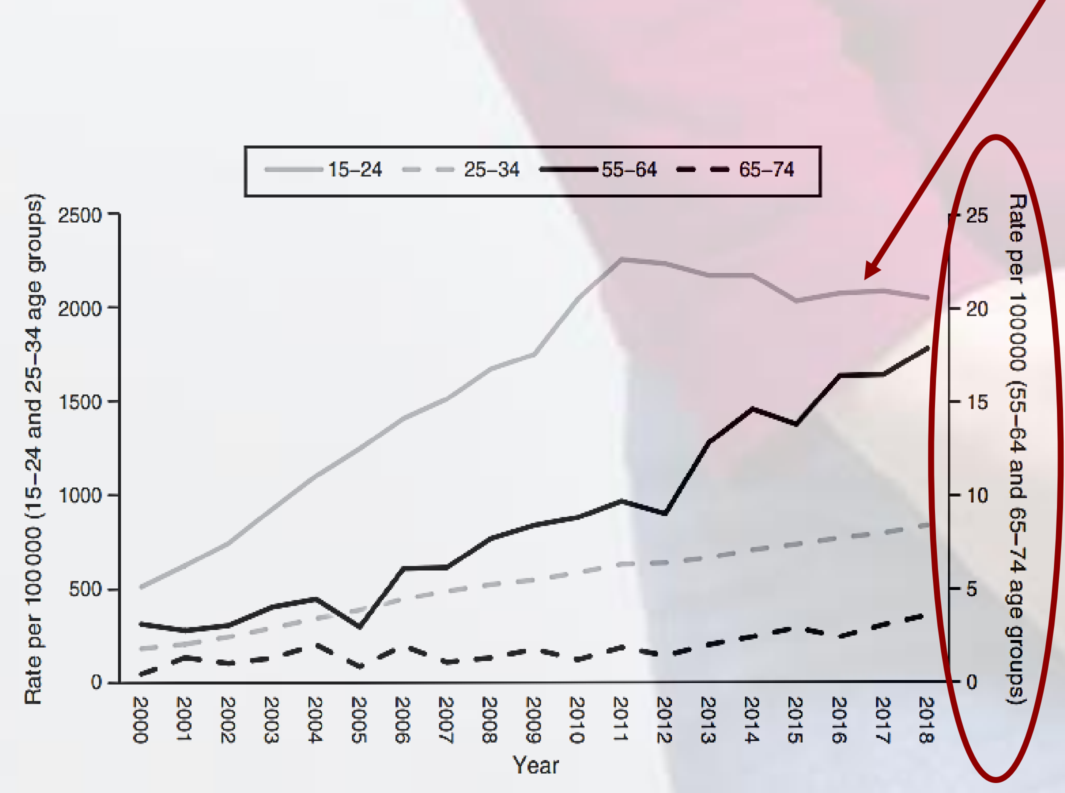
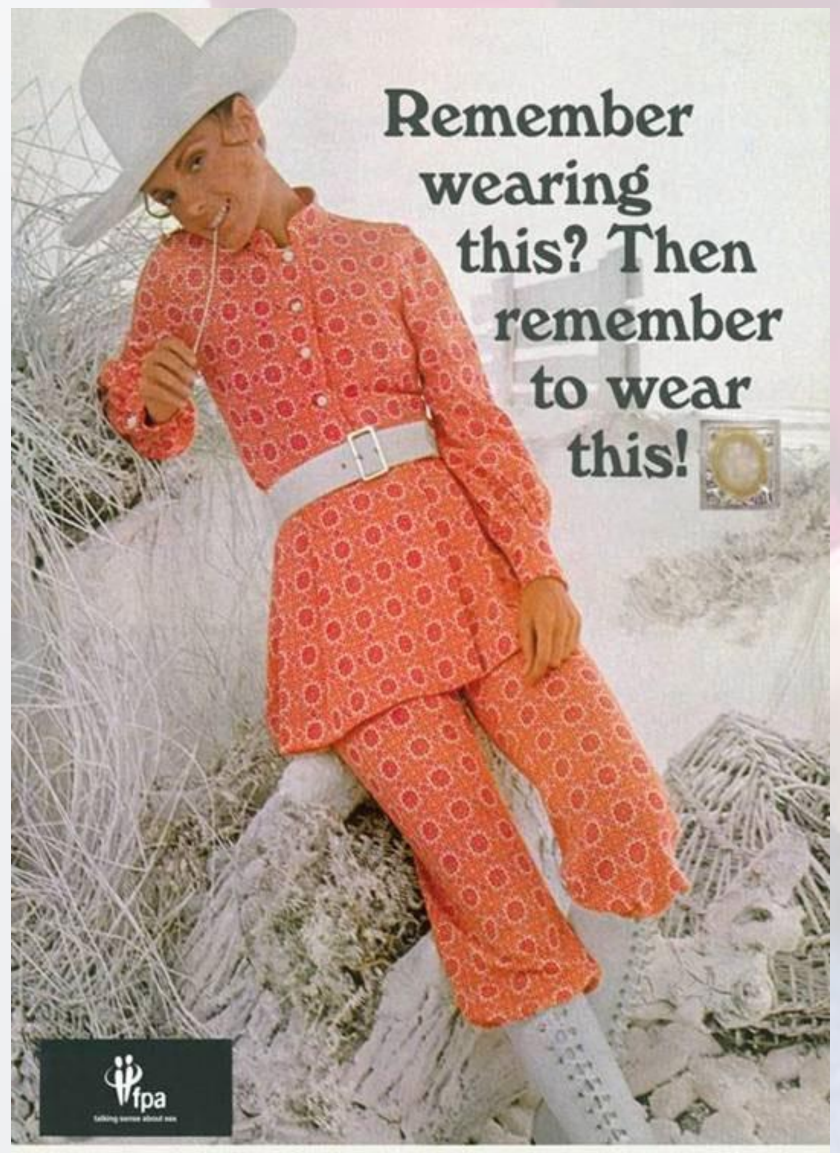
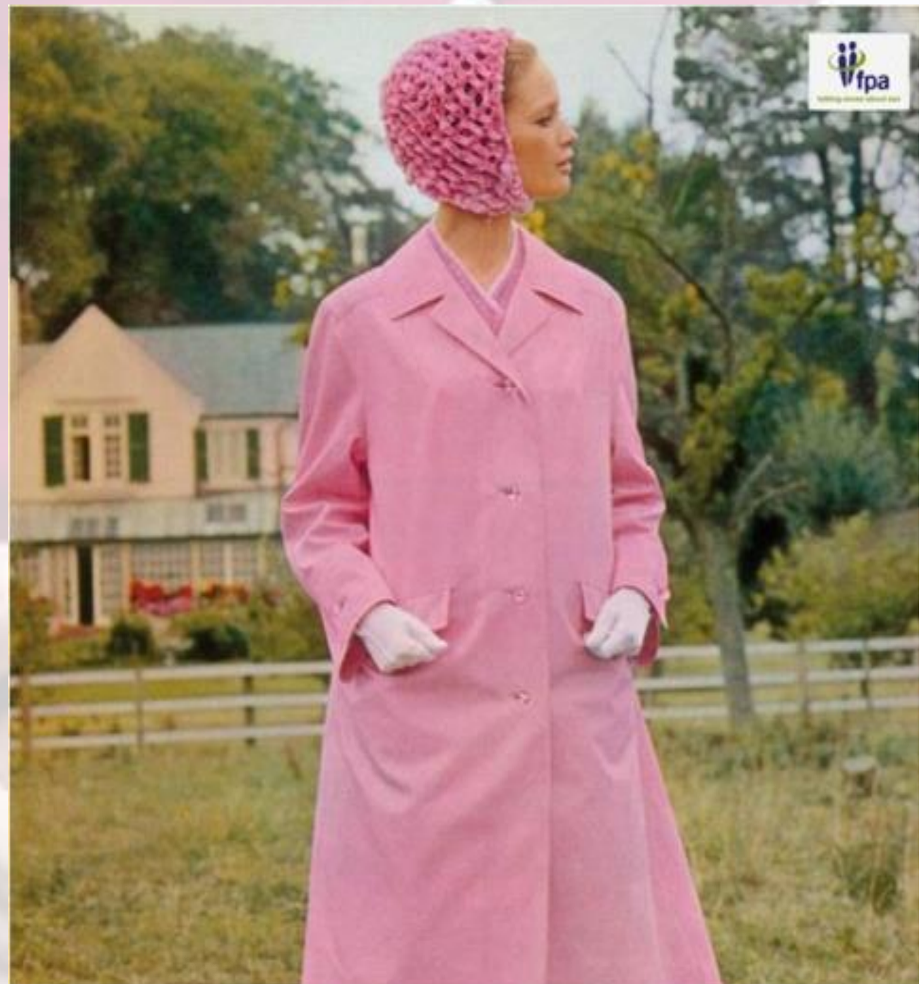


Fig. 1. Chlamydia trends among women in Australia, 2000–18.

- The highest burden of STIs is in Australian women aged 15-24 but:
  - Chlamydia incidence rates declined in this group from 2014 to 2018
  - Rates of gonorrhoea increased least in this age group
  - Rates of syphilis increased least in this age group
- **Absolute** rates of STIs are still low in older women in Australia but are increasing at a faster rate than in younger women
  - From 2014 to 2018, chlamydia rates increased the most among those aged 55–64 years
  - Gonorrhoea rates increased the most among those aged 65–74 years
  - Syphilis rates increased the most among those aged 55–64 years

1. Bourchier L et al. Sexual Health, 2020, 17, 517–524


Remember wearing this? Then remember to wear this!
fpa
Remember when you thought this looked fab and groovy? When everything was peace, love and tie-dye tee shirts? You're older and wiser now of course. An experienced lover. All the sexual anxieties of youth a thing of the past. But if that's true, how come it's older people who are getting more sexually transmitted infections (STIs) than ever before? Simple. Once we hit our 40s and 50s, we drop our guard. We think things like syphilis, gonorrhoea, genital warts and chlamydia are strictly for young people. Well, unfortunately, STIs don't ask how old you are before they infect you. And they don't care how few sexual partners you've had recently either. So, if you want to enjoy a few more perfect summers of love, remember - condoms rock. Use them!
For confidential advice phone the FPA helpline on 0845 122 8690 or Ask WES online at www.fpa.org.uk.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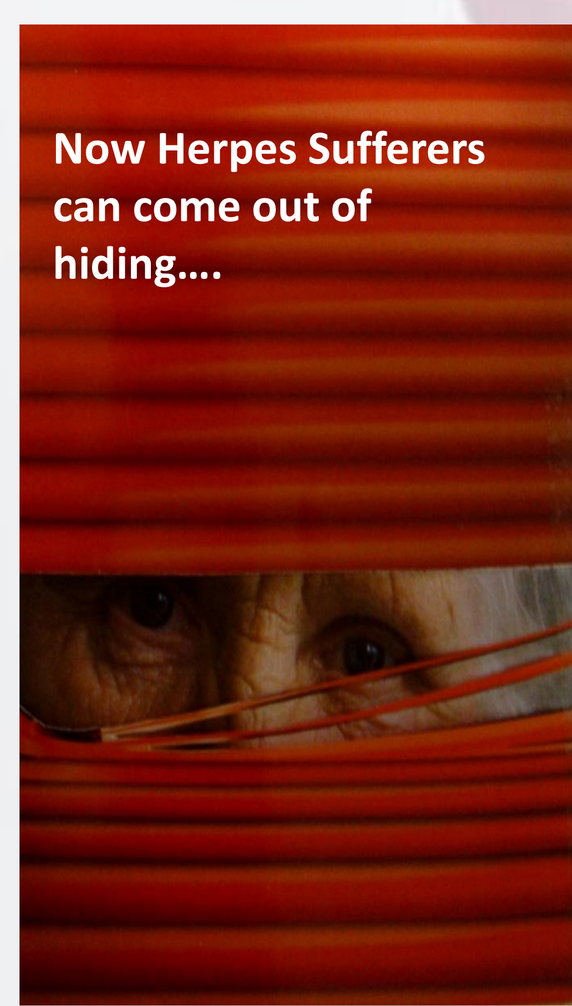
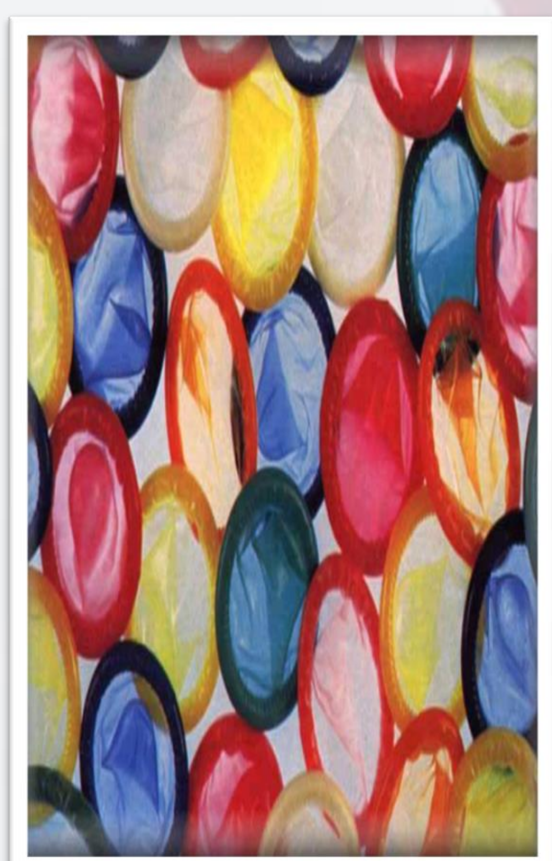
Why are STI rates increasing in Older Women?



- Risk of STIs in heterosexuals over 50 is perceived as low by most health professionals- don’t ask/don’t test/don’t find
- Knowledge of STIs may be less than in younger groups due to lack of public health messaging
- Unlike the UK-little of the Australian patient literature on the subject targets this sector
- Postmenopausal women may be more susceptible to infection due to thinning of the vaginal skin, reduced lubrication and vulnerability to microtrauma during intercourse[1]
- Rates of condom use lower in older Australians[2-5]

1. Brooks JT et al. Am J Public Health 2012; 102: 1516–26
2. Cheng Y et al. Sex Health 2018; 15: 223–31
3. Bourne C et al. Australas J Ageing 2009; 28: 32–6
4. Stewart M et al.Sex Health 2017; 14: 533–9
5. de Visser RO et al. Sex Health 2014; 11: 495–504

The Thing about Condoms......



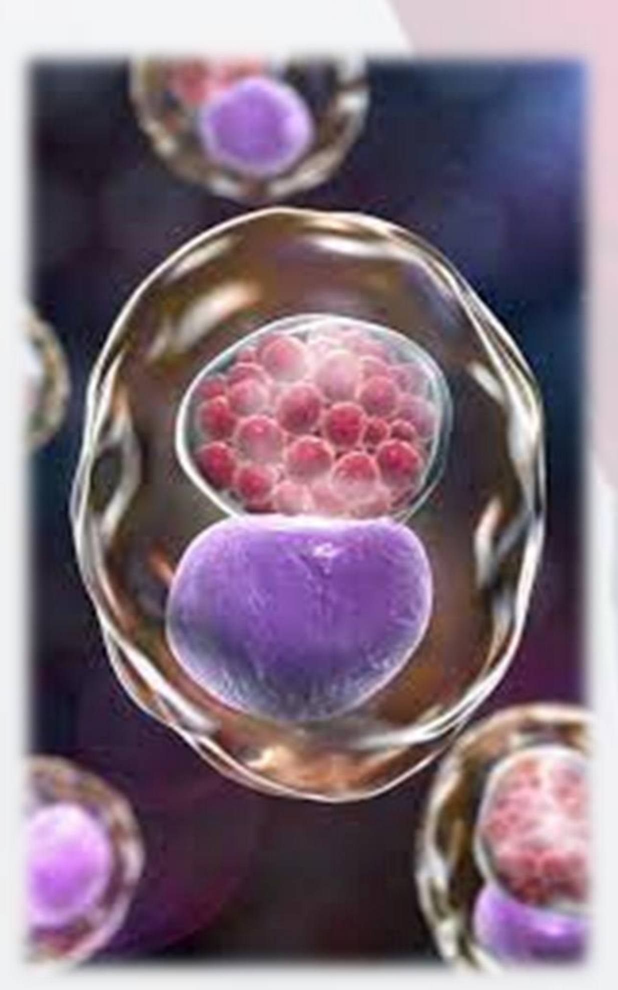
- FPA Survey[1] of 2339 heterosexual men who were using a dating App in 2014:
  - Men aged 50 or older were less likely to use condoms and more likely than younger men to think that condoms reduced sexual pleasure
  - 49 per cent of men over 60 did not know that chlamydia usually causes no symptoms
  - Older men with a higher number if sexual partners were **more** likely to take more risks when it came to safer sex
- Condoms may make erections more difficult to maintain in older men- PDE5 inhibitors may be useful
- Very few couples routinely use condoms/dams when engaging in oral sex
- 2012 FPA study indicated that women over 40 years of age were less likely to refuse sex without a condom than those under 40[2]

1.. *Cheng Y et al. Sexual Health 2017; 15: 223-231*
2. *Bateson DJ et al. Sex Health 2012; 9: 152–9*

Introducing Kirra

- Kirra is a 40-year-old indigenous woman who works as an admin assistant at a metropolitan Aboriginal Legal Centre
- Divorced, she is a single mother to 2 kids now in their late teens
- She has been in an on-and-off relationship with a male partner of similar age for the past 2 years
- Her partner has reassured her that this is a monogamous relationship but Kirra is not so sure, and has insisted on condom use whenever they have intercourse

Is Kirra at higher risk of STIs?



Chlamydia notification rates per 100,000 population

Notification rate per 100,000 popul...

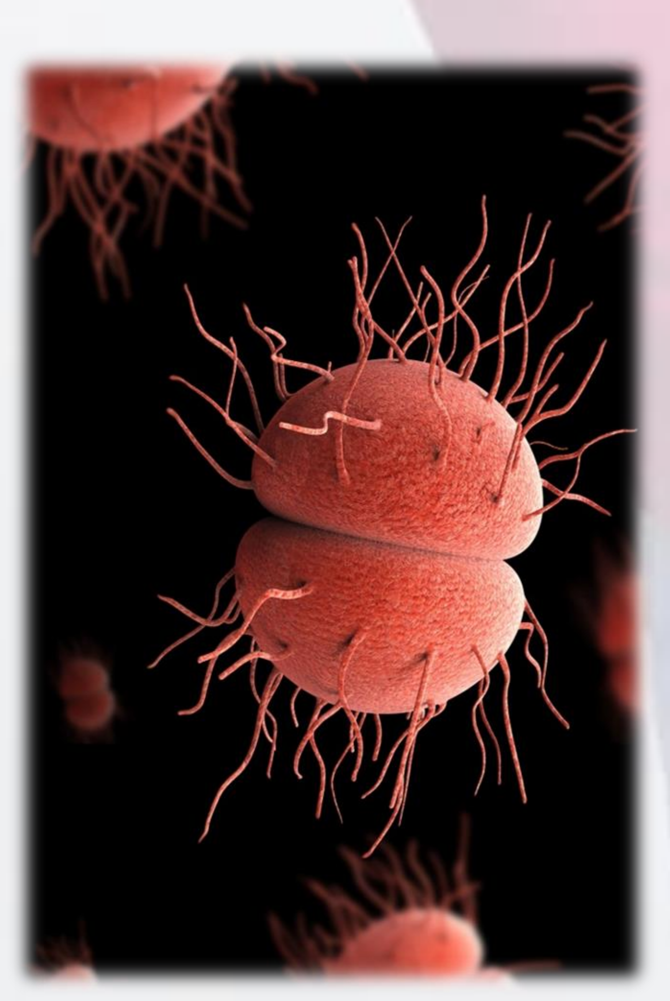
1,500.0
1,000.0
500.0
0.0

2016
2017
2018
2019
2020

Year

Population
Aboriginal and Torres ...
Aboriginal and Torres ...
Non-Indigenous female
Non-Indigenous male

Available at:https://kirby.unsw.edu.au/reports
Accessed September 2022



Gonorrohoea notification rates per 100,000 population

Notification rate per 100,000 popul...

500.0
400.0
300.0
200.0
100.0
0.0

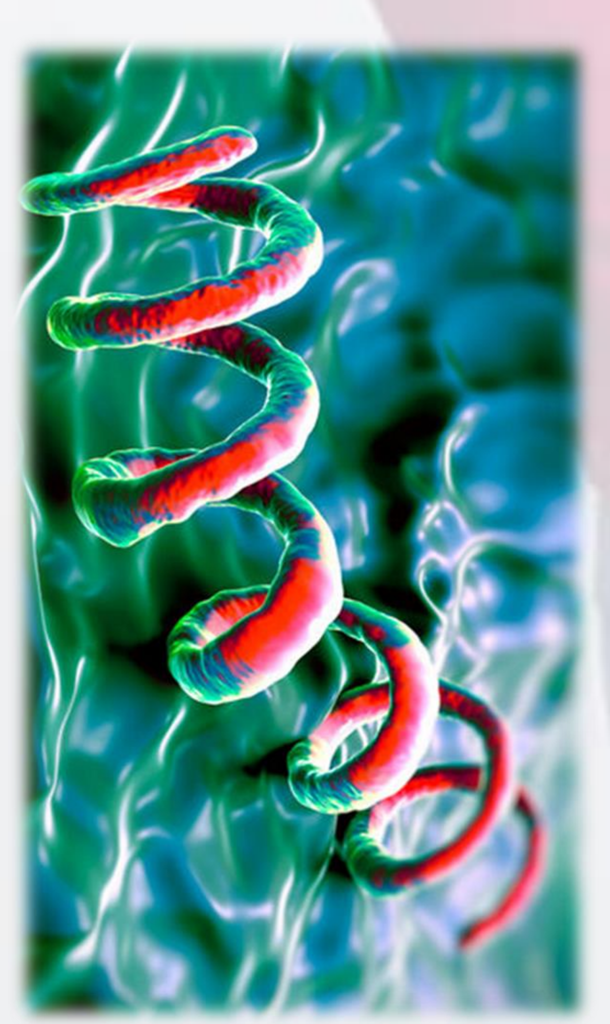
2016 2017 2018 2019 2020

Year

Population

- Aboriginal and Torres ...
- Aboriginal and Torres ...
- Non-Indigenous female
- Non-Indigenous male

Available at:https://kirby.unsw.edu.au/reports
Accessed September 2022



Infectious syphilis notification rates per 100,000 population

Notification rate per 100,000 popul...

120.0
100.0
80.0
60.0
40.0
20.0
0.0

2012 2013 2014 2015 2016 2017 2018 2019 2020

Year

Population
- Aboriginal and Torres ...
- Aboriginal and Torres ...
- Non-Indigenous female
- Non-Indigenous male

Available at:https://kirby.unsw.edu.au/reports
Accessed September 2022

STIs in Indigenous Australians

- Since stratified data has been reported, notification rates for chlamydia, gonorrhoea and infectious syphilis in **remote** communities have been recorded at between three and 50 times that of non-Indigenous Australians[1]
- 16–19 years old indigenous Australians carry the greatest burden of these infections, with almost half this age group living in remote communities having one or more of gonorrhoea, chlamydia and trichomonas infections[1,2]
- Rates of infectious syphilis notifications are up to 300 times higher in indigenous Australians, with up to 70% of infections among those aged between 15 and 29. Roughly equal numbers of males and females are affected[3]
- The disparity between remote Aboriginal people and their peers (both Aboriginal and non-indigenous) in urban and regional settings is far greater for gonorrhoea and infectious syphilis than it is for chlamydia[1]
- In a study of 67 remote communities the prevalence of chlamydia in those aged 16-24 years was 21%[4] compared with a rate of 5% in an urban GP/community heath setting[5]

1. *The Kirby Institute. HIV, viral hepatitis and sexually transmissible infections in Australia: annual surveillance report 2018. Sydney: Kirby Institute, 2018.* https://kirby.unsw.edu.au/report/hiv-viral-hepatitis-and-sexually-transmissible-infections-australia-annual-surveillance *accessed August 2022*
2. *2. Guy R et al. Sex Transm Infect 2015;91:201–6*
3. Australian Government Department of Health. Infectious syphilis outbreak, 2020. https://www1.health.gov.au/internet/main/publishing.nsf/Content/ohp-infectious-syphilis-outbreak.htm
4. *Silver BJ et al. Sex Transm Infect 2015; 91: 135–141*

5. Lewis D et al. BMC Infect Dis 2012; 12: 113.

But Putting this into Context…

- STI transmission is largely determined by community prevalence…..
- Those living in remote areas have poorer general determinants of health, such as education, health care access, income and employment, all of which are associated with higher rates of STIs[1]
- Age is a specific risk factor for STI transmission; only 1/3 of non-Indigenous Australians are aged under 25 years, compared with over 1/2 of Aboriginal people [2]
- Specific determinants of STI risk, such as poverty, age of sexual debut, number of sexual partners, mobility of population, substance abuse and lack of condom use may all contribute to the higher prevalence of STIs in Aboriginal people[3]
- Follow-up, contact tracing and access to appropriate treatment may be more difficult in more remote areas where temporary clinics and high staff turnover is common[4]

1. *MacPhail C et al. Health Soc Care Community 2018; 26: 131–146*
2. *ABS data 2016.Aboriginal population and housing http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/2071.0~2016~Main%20Features~Aboriginal%20and%20Torres%20Strait%20Islander%20Population%20Data%20Summary~10 accessed August 2022*
3. *Wand H et al. Sex Health 2018; 15: 68–75*
4. *Hengel B et al. Sexual health 2014; 12: 4–12.*

Introducing Ketifa

- 42-year-old Ketifa is a recently arrived refugee from Syria who is pregnant with her 5th child and attends the local hospital for antenatal care
- She is 20 weeks pregnant and speaks no English
- An interpreter has been arranged but Ketifa is very quiet and provides only a very limited medical history

Is Ketifa at higher risk of STIs?

STIs in Culturally Diverse Women

- One in four Australians was born OS and another 20% has a parent born OS[1]
- Research[2,3] has indicated that those from culturally diverse groups may have:
  - Less knowledge about STIs and different perceptions of risk
  - Limited access to culturally and linguistically appropriate information on SRH
  - A higher prevalence of some STIs than the general Australian population
  - Higher levels of shame/stigma/embarrassment
- Migration-related inequity and discrimination may intersect with family violence and reproductive coercion[2]
- Barriers exist to accessing appropriate health care- indicating need to improve sexual health literacy and access to appropriate and culturally secure health services for this population[2,3]

1. *Department of Social Services. The people of Australia - Australia's multicultural policy. Canberra: Department of Social Services;2013*

2. *Hach M. Common threads: the sexual and reproductive health of immigrant and refugee women in Australia [Internet]. Melbourne: Multicultural Centre for Women's Health; 2012* *https://www.mcwh.com.au/downloads/publications/MCWH_CommonThreads_Report_WEB.pdf*

3. *Mengesha Z et al . Sexual Health 2016. 13; 299-310*

Immigrant and Refugee Women

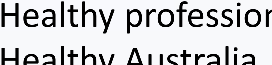
- Are at greater risk of suffering poorer maternal and child health outcomes[1]
- Are less likely than Australian-born women to have adequate information and familiarity with modern contraceptive methods[1]
- Are less likely to be using effective contraception-a 2012 general practice study found the use was half that reported in English-speaking households[2]
- Are at greater risk of contracting STIs/HIV, especially those from countries where the condition has a high prevalence and partners travel home[1]
- Are less likely to use health and social/support services[1]
- Are less likely to have access to evidence-based and culturally relevant information which will enable them to make decisions about their health[1]
- **BUT these women are uniquely placed to improve sexual and reproductive health for themselves and their communities through preventive health education and access to appropriate services**

1. Multicultural Centre for Women's Health- 2012 Report
https://www.mcwh.com.au/downloads/publications/MCWH_CommonThreads_Report_WEB.pdf
2. Mazza, D et al. MJA. Vol. 197 (2). p. 110-114

A Brief Word on Self-collected Testing

- **Cervical Screening**
  - Since July 2022 self-collected cervical screening testing available to **all** Australian women[1]
  - Clinicians should be proactive in offering self-collected testing as an option- currently only 52% are screening as per guidelines[1]
  - May be more acceptable to women who find conventional testing painful, embarrassing, culturally inappropriate etc, thus overcoming current barriers to screening
  - As effective in detecting HPV as a clinician-collected sample, but no cytology report[1]
  - Note different follow-up guidelines- for HPV (other) and for indigenous women
- **Self-collected Chlamydia/Gono (PCR vaginal swab)**
  - Only slightly less sensitive than cervical specimen[2]
  - Useful for screening and for follow-up
- **HSV PCR swabs**
  - Almost as effective as physician collected samples[3] and useful for confirming/typing long-standing or quickly-resolving HSV

1. *https://www.health.gov.au/initiatives-and-programs/ncsp-healthcare-provider-toolkit/cervical-screening-options/self-collection-for-cervical-screening*
2. *Lucashu A et al. Evidence-Based Practice: February 2018 - Volume 21 - Issue 2 - p E4-E5 doi: 10.1097/01.EBP.0000541982.39580.66*
3. *Rodrigues LS et al.Int J STD and AIDS; 30 (11):https://doi.org/10.1177/0956462419842007*



STIs In Australia

- Sexually transmitted infections comprise about 40% of all reported notifiable conditions in Australia- and some infection rates continue to increase[1]
- **But** some significant runs on the board-due to the work of clinicians like you:
  - Marked decrease in clinical genital warts in those < than 26 years old- following the launch of HPV vaccines in Australian female adolescents in 2007[2] (F down 60%, HM down 30%)
  - Concurrent decrease in HSIL in younger Australian women[3]
  - The virtual elimination of mother-to-child transmission of HIV[1]
  - Many successfully treated for Hep C treatment following the availability of direct acting antiviral treatment on the PBS[3]

1. *National notifiable diseases surveillance system [Internet]. Canberra: Australian Government, Department of Health; 2020.* https://www.health.gov.au/sites/default/files/documents/2021/09/australia-s-notifiable-disease-status-2016-annual-report-of-the-national-notifiable-diseases-surveillance-system-australia-s-notifiable-disease-status-2016-annual-report-of-the-national-interoperable-notifiable-diseases-su.pdf *Accessed August 2022*
2. *Donovan B et al. Lancet Infect Dis 2011; 11: 39-44*
3. *Brotherton JML et al. Med J Aust 2016; 204 (5): 184*
4. *Kirby Institute Data:* https://data.kirby.unsw.edu.au/hepatitis-c *Accessed August 2022*

Recommended Resources

- Australian Treatment Guidelines (also has section on WSW)

https://sti.guidelines.org.au/

- RACGP Red Book- STIs

https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/guidelines-for-preventive-activities-in-general-pr/communicable-diseases/sexually-transmissible-infections#ref-num-7

- Melbourne Sexual Health- information for Health Professionals

https://www.mshc.org.au/health-professionals

- Kirby Institute Data on STIs in Australia

https://data.kirby.unsw.edu.au/sexually-transmissible-infections

- Young Deadly Free. This site provides a range of useful information and resources for young people; elders, parents and other adults; and health workers- https://youngdeadlyfree.org.au/
- Girl2Girl- https://girl2girl.health/
- Anonymous Partner Notification for STIs-https://letthemknow.org.au/
- Full Stop Australia-https://fullstop.org.au/

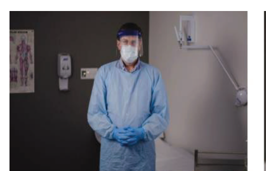
Thanks for Listening…
and Any Questions?

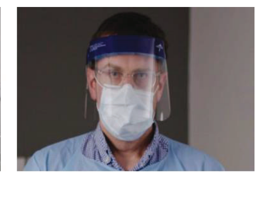
Women's Health Week

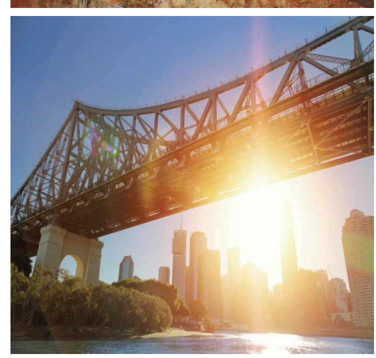
Jean Hailes
FOR WOMEN'S HEALTH

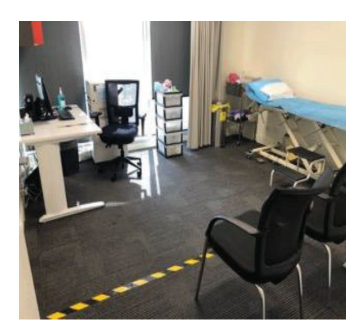
Combatting Australia's new syphilis epidemic: The crucial role of GPs

Dr Lara Roeske,
Chair – RACGP Specific Interests faculty









Healthy Profession.
Healthy Australia.

COVID has obscured an emerging and alarming Syphilis epidemic expanded across the whole of Australia

- On 22nd October 2021 Health Minister's advisory committee on BBV & STI met at a Syphilis Roundtable to discuss concerning data and information
- Australia not on track to meet WHO 2030 targets
- Syphilis continues to increase across Australia at an alarming rate
- Recently significant changes to the epidemiology and geography of Syphilis
- As Australia emerges from COVID more opportunities for travel, new partners & casual sex
- Undiagnosed and untreated Syphilis can be lethal and catastrophic

Chief Medical Officer

Increasing notifications of INFECTIOUS SYPHILIS IN WOMEN OF REPRODUCTIVE AGE

Essential information:

- Notifications of infectious syphilis among non-Indigenous and Aboriginal and Torres Strait Islander women of reproductive age have substantially increased, particularly in major cities of Australia, posing an increased risk of congenital syphilis and adverse pregnancy outcomes.
- Specific actions for clinicians include:
  - Repeat testing in pregnant women at high risk of infection or reinfection
  - Consider infectious syphilis as a possibility when conducting sexually transmissible infection screening
  - Test for infectious syphilis in any sexually active young person where they, or their partner, resides in an area of high prevalence

Dear Colleague,

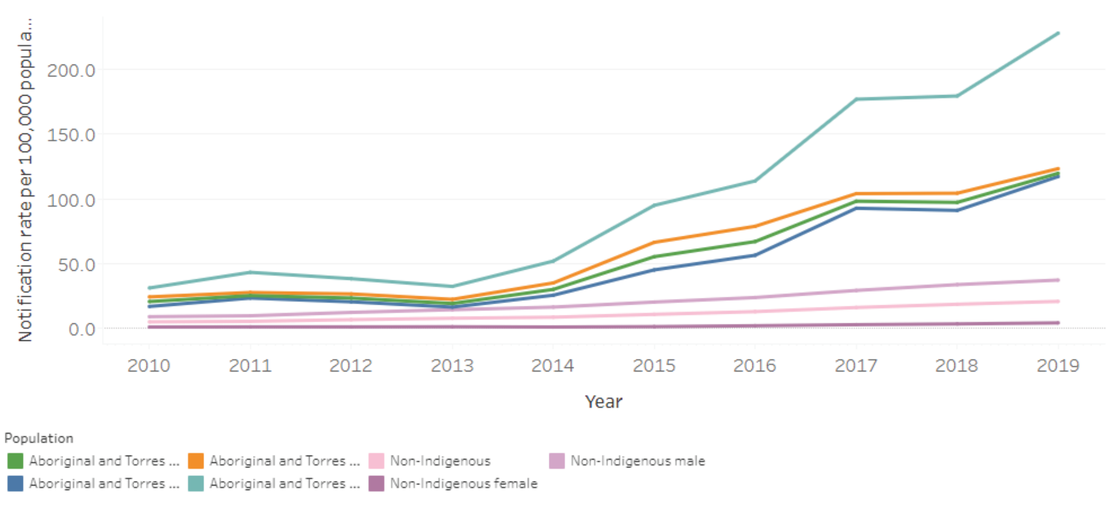
I am writing to provide you with an important update concerning the alarming rise of infectious syphilis in Australia, and to urge you to remain vigilant in testing, re-testing and treating at-risk patients.

Notifications of infectious syphilis among women in Australia have increased considerably since 2015. This is, in part, due to the ongoing outbreak in Aboriginal and Torres Strait Islander peoples residing in predominantly regional, remote and very remote areas of Queensland, the Northern Territory, Western Australia, and South Australia. Notifications among non-Indigenous and Aboriginal and Torres Strait Islander women outside of outbreak declared regions, including major cities, have also contributed to the marked increase in notifications overall. Particularly concerning is the high proportion of infections occurring in women of reproductive age (15-44 years) (approximately 90% of all female cases notified each year) which has considerable public health implications given the increased risk of congenital syphilis and adverse pregnancy outcomes.

Urgent need to alert GPs - GPs are key to Syphilis control

- GPs see ~ 2,000,000 Australians each week
- Most STIs >90% diagnosed and managed in primary care
- Greatest opportunity exists for Syphilis control through early detection and effective treatment in the community
- Many GPs are unaware of the epidemic and may lack current experience in managing Syphilis
- The GPs crucial role in early detection, testing and re-testing & timely appropriate antibiotic treatment of Syphilis – the focus of this webinar

Notification rates per 100,000 population



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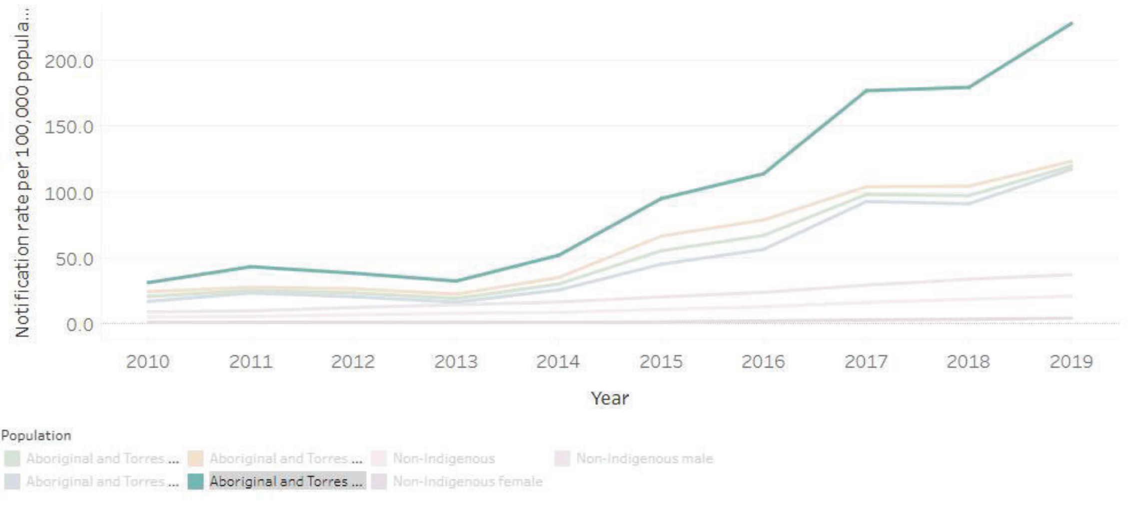
Notification rates per 100,000 population



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GP How to Guide: Penicillin Injection for the Treatment of Syphilis

Dr Lara Roeske
lara.roeske@racgp.org.au

GPs can treat & cure Syphilis

- ✓ Access to the right Penicillin formulation
- ✓ Use correct treatment dose
- ✓ Safest route for administration
- ✓ Recommended interval between doses
- ✓ # of doses is correct
- ✓ Allergies, pregnancy & complications
- ✓ Patient safety, education and comfort

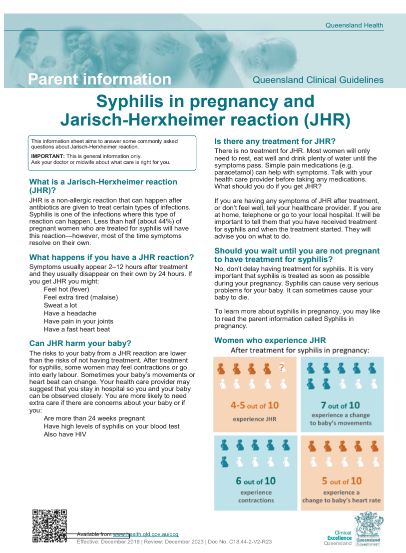
Preparing the patient

- Pre- and post treatment instructions
  - Health literacy
  - Culturally safe
- Verbal consent/document
- Offer a support person
- Allow sufficient time/ calm environment
- Check right patient & right medication
- Remain in clinic for observation after treatment
- Ice*

* The ICE trial A study protocol for a RCT of ice to reduce the pain of immunisation. AJGP Vol 51, No. 3, March 2022.

The Jarisch-Herxheimer (JHR) reaction

- is a transient non allergic reaction
- occurs in patients infected by spirochaetes who undergo antibiotic treatment
- not uncommon and usually resolves on its own.
- symptoms begin within 2 -12 hours after treatment
- include fever, malaise, sweats, headache, joint pains and elevated HR
- no definite treatment other than rest, plenty of fluids and paracetamol.



Queensland Health

Parent information

Queensland Clinical Guidelines

Syphilis in pregnancy and Jarisch-Herxheimer reaction (JHR)

This information sheet aims to answer some commonly asked questions about Jarisch-Herxheimer reaction.

IMPORTANT: This is general information only.
Ask your doctor or midwife about what care is right for you.

What is a Jarisch-Herxheimer reaction (JHR)?

JHR is a non-allergic reaction that can happen after antibiotics are given to treat certain types of infections. Syphilis is one of the infections where this type of reaction can happen. Less than half (about 44%) of pregnant women who are treated for syphilis will have this reaction—however, most of the time symptoms resolve on their own.

What happens if you have a JHR reaction?

Symptoms usually appear 2–12 hours after treatment and they usually disappear on their own by 24 hours. If you get JHR you might:

- Feel hot (fever)
- Feel extra tired (malaise)
- Sweat a lot
- Have a headache
- Have pain in your joints
- Have a fast heart beat

Can JHR harm your baby?

The risks to your baby from a JHR reaction are lower than the risks of not having treatment. After treatment for syphilis, some women may feel contractions or go into early labour. Sometimes your baby's movements or heart beat can change. Your health care provider may suggest that you stay in hospital so you and your baby can be observed closely. You are more likely to need extra care if there are concerns about your baby or if you:

- Are more than 24 weeks pregnant
- Have high levels of syphilis on your blood test
- Also have HIV

Is there any treatment for JHR?

There is no treatment for JHR. Most women will only need to rest, eat well and drink plenty of water until the symptoms pass. Simple pain medications (e.g. paracetamol) can help with symptoms. Talk with your health care provider before taking any medications.
What should you do if you get JHR?

If you are having any symptoms of JHR after treatment, or don't feel well, tell your healthcare provider. If you are at home, telephone or go to your local hospital. It will be important to tell them that you have received treatment for syphilis and when the treatment started. They will advise you on what to do.

Should you wait until you are not pregnant to have treatment for syphilis?

No, don't delay having treatment for syphilis. It is very important that syphilis is treated as soon as possible during your pregnancy. Syphilis can cause very serious problems for your baby. It can sometimes cause your baby to die.

To learn more about syphilis in pregnancy, you may like to read the parent information called Syphilis in pregnancy.

Women who experience JHR

After treatment for syphilis in pregnancy:

4-5 out of 10 experience JHR

7 out of 10 experience a change to baby's movements

6 out of 10 experience contractions

5 out of 10 experience a change to baby's heart rate

Available from www.health.qld.gov.au/qcg
Effective: December 2018 | Review: December 2023 | Doc No: C18.44-2-V2-R23

Clinical Excellence Queensland

Queensland Government

The correct treatment dose

Each syringe contains 1.2M I.U. of
Benzathine Penicillin G (BPG)

Do not mix, combine or reconstitute

For deep **IM** injection only

The correct treatment dose

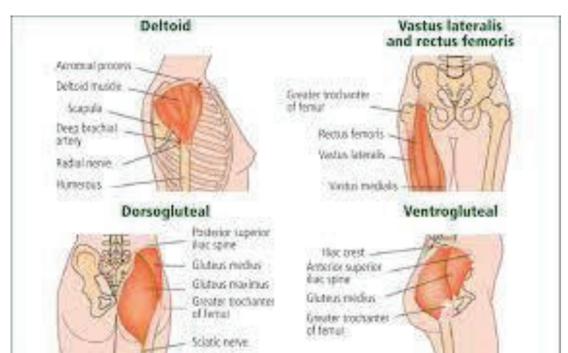
- **Treatment dose = 2.4 million I.U. of Benzathine Penicillin G (BPG)**
- Each syringe contains 1.2 million I.U of BPG
- 2 prefilled syringes = a treatment dose

- Primary, secondary or early latent Syphilis
  - x 1 treatment dose only
- Late latent or unknown duration
  - x 3 weekly treatment doses

IM BPG Injection site(s) & technique

- Choice of site –GP experience, patient weight & age, practice policy/protocol, patient preference

- More muscle, less subcutaneous fat, free of large nerves/blood vessels



- ✓ **Ventrogluteal (VG)- recommended**
- ✓ Dorsogluteal (DG) – recommended
- ✓ Vastas Lateralis – acceptable but not commonly used
- o Deltoid – NOT recommended

- Patient lying on side (VG) or prone (DG)

IM BPG Injection site(s) & technique

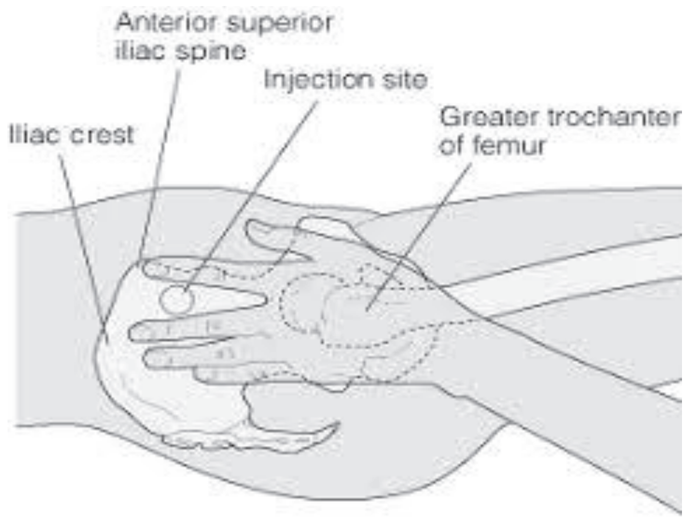
- Adequate time and calm environment
- Observe the patient throughout
- Distract the patient -wriggle toes/squeeze hand/whistle/hum/watch phone
- Use syringe cap to mark site on skin for injection
- Swab injection site site with alcohol
- Allow to dry before injecting
- Insert needle **90 degrees** to skin, aspirate before inject, come out same angle
- Injectable volume- reduce pain and increase absorption
- *Slowly* inject contents of **2** syringes at separate anatomical sites, via deep **IM** route
  - Simultaneous
  - Sequential

Table 1: **Injectable volumes per site in adults**

Site	Maximum volume
Ventrogluteal (recommended)	2.5ml
Vastus lateralis (recommended)	5ml
Deltoid	1ml
Rectus femoris	5ml
Dorsogluteal (not recommended)	4ml

Source: Adapted from Dougherty and Lister (2015)

The Ventrogluteal site (VG)



- Preferred site for IM injection
- Thicker muscle (gluteus medius)
- Thinner subcutaneous fat layer
- Fewer nerves and vessels
- Patient side lying
- Place your L hand on patients R hip (or vice versa)
- Use palm of you hand locate the greater trochanter of femur
- Index finger towards the ASIS
- Fan middle finger backwards along the iliac crest as far as possible
- Injection site is middle of triangle formed by your index and middle fingers

Access to Benzathine Penicillin G

Pre-order for Doctors bag

10 pre-filled syringes = 5 doses

Otherwise use a PBS script as expensive on private ~ $60 +

Pharmacy no readily available stock/call ahead

Keep refrigerated

Room temperature preferred for injecting

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Special treatment situations

Situation	Recommended action
Complicated	Refer acute neurological, ophthalmic or suspected tertiary disease to local sexual health or infectious diseases clinic
Pregnant women	Seek specialist advice. Only penicillin has been shown to be effective, so those allergic should be desensitised and treated with penicillin.
Allergy to penicillin	Non-penicillin regimens less evidence than penicillin but have shown to be effective. Infectious Syphilis: Doxycycline 100mg PO, BD for 14 days Non-infectious Syphilis: Doxycycline 100mg PO, BD for 28 days
HIV co-infection	Discuss with sexual health specialist

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Real-time clinical advice & support for GPs

Inadequate

Only one service nationally provides

- ✓ details for phone contact to a specialist clinician/ sexual health physician for GP clinical advice
- ✓ relevant details for operation - days/times
- ✓ within a minute of accessing the service website

VIC Melbourne Sexual Health Centre **1800 009 903 Monday to Friday 9am-1230, 1:30-5pm**

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Useful links per State or Territory

Victoria Melbourne Sexual Health Centre
New South Wales Sydney Sexual Health Centre
NSW Health Sexual Health clinics search https://www.health.nsw.gov.au/sexualhealth/Pages/sexual-health-clinics.aspx
Queensland Sexual Health Clinic Brisbane
QLD Sexual Health services search https://www.health.qld.gov.au/clinical-practice/guidelines-procedures/sex-health/services
Western Australia Royal Perth Hospital Sexual health service
Government of WA South Metropolitan Fremantle health service
Northern Territory Royal Darwin Hospital Clinic 34
NT Sexual Health services https://nt.gov.au/wellbeing/hospitals-health-services/sexual-health-services
South Australia - Adelaide Sexual Health Centre
Tasmania – Sexual Health Service Tasmania
ACT Canberra Sexual health Centre

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Resources

www.health.gov.au/syphilis

www.health.gov.au/resources/pregnancy-care-guidelines/ part-f-routine-maternal-health-tests/syphilis

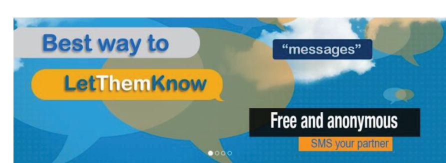
www.sti.guidelines.org.au/sexually-transmissible-infections/syphilis

Jurisdictional notification requirements

https://syphilisoutbreaktraining.com.au/notification/

Contact tracing
Better to know https://www.bettertoknow.org.au/
Let them know https://letthemknow.org.au/
The drama down under https://www.thedramadownunder.info/

Syphilis is on the rise in Australia among men who have sex with men, women of childbearing age and Aboriginal and Torres Strait Islander peoples living in outbreak areas. You may see patients presenting at your clinic who require testing and treatment.



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RACGP resources

[RACGP Red Book]

[RACGP Sexual Health Medicine Specific Interest Group]

GPSI@racgp.org.au

https://www.racgp.org.au/the-racgp/faculties/specific-interests

Overview –key messages

- Syphilis is back and is no longer a rare STI
- Consider Syphilis in all sexually active patients
- A routine STI check includes a test for Syphilis
- Take a sexual history for all patients at least annually
- Syphilis is easy to treat with antibiotics and cure if found early

  ✓ Penicillin saves lives

  ✓ Penicillin treats the unborn baby

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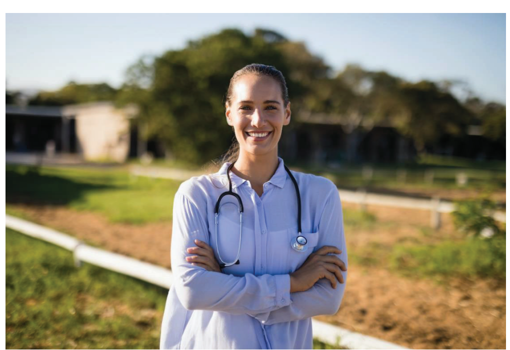
Overview – key messages

- For genital ulcers/lesions don't just think herpes test for Syphilis too
- Test all pregnant women at least once and more if at risk
- Pregnant + Syphilis = urgent referral/advice
- Congenital syphilis can be lethal and is preventable
- Include a sexual health check up as part of an annual women's/men's general check up
- culturally appropriate care, health literacy, destigmatise testing and treatment and address patient fear, anxiety, discomfort and pain



It has never been more important for GPs to detect and treat Syphilis

Thank you