

# SECTION 1: HISTORY AND ASSESSMENT

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<b>Legal obligations.....</b>	<b>3</b>
Privacy and confidentiality.....	3
<i>More information.....</i>	3
Informed consent .....	4
<i>Table 1 – Example of informed consent criteria .....</i>	4
<i>More information .....</i>	4
Documentation .....	5
Create a safe environment .....	5
<b>Comprehensive sexual health assessment .....</b>	<b>6</b>
History taking .....	6
<i>Young people .....</i>	7
<i>Principles.....</i>	7
<i>Tool to assist history taking .....</i>	8
<i>Obtaining history.....</i>	8
<i>Reason for attendance.....</i>	8
<i>Review of systems .....</i>	15
Risk assessment .....	16
Examination.....	16
<i>Objectives.....</i>	16
<i>Preparation.....</i>	16
<i>Client .....</i>	16
<i>Staff.....</i>	17
A general examination should include .....	17
<i>General Health.....</i>	17
<i>Physical Appearance .....</i>	17
<i>Behaviour and psychological presence.....</i>	17
<i>Physical examination.....</i>	18
Examination of female clients .....	18
<i>Oro-pharynx .....</i>	18
<i>Abdomen.....</i>	18
<i>Genital.....</i>	18
<i>Vulva .....</i>	18
<i>Peri-anal .....</i>	18
<i>Vagina .....</i>	18
<i>Cervix .....</i>	19

<i>Uterus</i> .....	19
<i>Rectum</i> .....	19
Examination of male clients .....	19
<i>Oro-pharynx</i> .....	19
<i>Genital</i> .....	19
<i>Testicles</i> .....	20
<i>Urethra</i> .....	20
<i>Peri-anal</i> .....	20
<i>Rectum</i> .....	20
Examination of transgender clients.....	20
<i>Female-to-male</i> .....	20
<i>Male-to-female</i> .....	20
Investigation.....	21
Follow-up.....	25
Client education.....	26
Contact tracing.....	26
<i>Aims</i> .....	26
<i>Principles</i> .....	26
<i>Contact tracing process</i> .....	26
<i>Contact tracing conducted by the index case ( preferred method)</i> .....	27
<i>Contact tracing conducted by the service provider</i> .....	27
<i>Contact tracing by a referral agency</i> .....	27
<i>Empirical treatment</i> .....	28
<i>More information</i> .....	28
<b>Asymptomatic screen .....</b>	<b>29</b>
History taking .....	29
Clinical indicators .....	29
Examination.....	29
Investigation.....	29
Management and treatment .....	29
References.....	30

# LEGAL OBLIGATIONS

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## PRIVACY AND CONFIDENTIALITY

Queensland Health sexual health clinics maintain confidentiality and privacy of records according to conditions set out in the *Queensland Health Sexual Health Clinical Services and Privacy Policy (SHCSPP) – September 2008*<sup>1</sup>. You should familiarise yourself with this policy and understand the circumstances under which full confidentiality cannot be promised to clients.

The *SHCSPP* operates under the *Health Services Act 1991* (part 7)<sup>3</sup> which requires all current and former Queensland Health staff to abide by a legal duty of confidentiality. This duty prohibits disclosure of confidential information directly or indirectly to another person, if the information would enable a person who has received (or is receiving) a public sector health service to be identified.

Exceptions apply where the client has given their consent to the disclosure or where information is disclosed for the care and treatment of a client.

Queensland Health is also subject to the *Queensland Government Information Standard 42A (IS42A)*<sup>2</sup>. While the duty of confidentiality in the *Health Services Act 1991* takes precedence over the privacy principles in *IS42A*, all staff need to be mindful of their information handling obligations under the privacy principles, including how they collect and store personal information.

### More information

*Queensland Health Sexual Health Clinical Services and Privacy Policy (2008)*<sup>1</sup>  
[www.health.qld.gov.au/sexhealth/documents/31753.pdf](http://www.health.qld.gov.au/sexhealth/documents/31753.pdf)

*Queensland Government Information Standard 42A: Information Privacy for the Queensland Department of Health (2002)*<sup>2</sup>  
[www.qgcio.qld.gov.au/SiteCollectionDocuments/Architecture%20and%20Standards/Information%20Standards/Current/is42a.pdf](http://www.qgcio.qld.gov.au/SiteCollectionDocuments/Architecture%20and%20Standards/Information%20Standards/Current/is42a.pdf)

*Health Services Act (1991)*<sup>3</sup> [www.legislation.qld.gov.au/LEGISLTN/CURRENT/H/HealthServA91.pdf](http://www.legislation.qld.gov.au/LEGISLTN/CURRENT/H/HealthServA91.pdf)

# INFORMED CONSENT

Informed consent is when a client gives their consent based on an understanding of the facts and implications of an action, enabling them to control what is done to their person.

The table below outlines the principles and criteria of informed consent

**Table 1 – Example of informed consent criteria<sup>4</sup>**

Criteria		Explanation
1	Consent must be informed	<p>The client must be given an explanation in a language and format they understand. It should include:</p> <ul style="list-style-type: none"> <li>• nature and purpose of the intervention</li> <li>• reasonable alternatives to the intervention, including the option of no intervention</li> <li>• potential short and long term benefits/risks of each option</li> <li>• detail about who is carrying out the intervention, their level of competency and experience.</li> </ul>
2	The client should have appropriate decision-making capacity	<p>The client should have the ability to:</p> <ul style="list-style-type: none"> <li>• comprehend the explanation</li> <li>• understand the nature and effect of decisions (including consequences of refusing treatment)</li> <li>• communicate their decision.</li> </ul>
3	Consent must be freely given	<ul style="list-style-type: none"> <li>• consent must be voluntarily given</li> <li>• information should be presented in a way that is easily understood by the client</li> <li>• the client should not be manipulated, coerced or unduly influenced and be given reasonable time to consider the information.</li> </ul>
4	Consent should be specific	<ul style="list-style-type: none"> <li>• the client should not be asked to consent to broad, vaguely expressed actions.</li> </ul>
5	Consent must be current	<ul style="list-style-type: none"> <li>• consent should apply to the client’s circumstances at the time and be able to be revoked if circumstances or expectations change within the time frame</li> <li>• the option to revoke consent should always be available.</li> </ul>

Source: Queensland Nursing Council Framework – Informed consent criteria

## More information

[www.health.qld.gov.au/consent](http://www.health.qld.gov.au/consent)

## DOCUMENTATION

- document consultation clearly and concisely, using standard medical abbreviations. For a list of acronyms/abbreviations refer to Appendix (section nine)
- comply with district policies and government and legal requirements relevant to your position/qualifications/skills i.e. the supply and/or administer of approved drugs should comply with requirements of the *DTP-SRH and Health (Drugs and Poisons) Regulation (1996)*<sup>5</sup>.

## CREATE A SAFE ENVIRONMENT<sup>4</sup>

Take active steps to promote health care access for lesbian, gay, bisexual, transgender and intersex (LGBTI) clients. Example your practices, office, policies and staff training and consider provision of training for health concerns of transgender and intersex people.

LGBTI clients often 'scan' an office to determine whether they feel comfortable sharing information with their health care provider. You could consider the following:

- display poster showing racially and ethnically diverse same-sex couples or posters from non-profit HIV/AIDS or LGBTI organisations E.g. rainbow window sticker
- have LGBTI specific magazines onsite
- MSM may be at increased risk of hepatitis A and hepatitis B, breast cancer and STIs
- display a non-discrimination statement which states that care will be provided to all clients regardless of age, race, ethnicity, physical ability or attributes, religion, sexual and gender identity.

# COMPREHENSIVE SEXUAL HEALTH ASSESSMENT

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- *History taking*
- *Risk assessment*
- *Examination*
- *Investigation*
- *Management*
- *Follow-up*
- *Client education*
- *Contact tracing*

## HISTORY TAKING

Accurate medical and sexual history is essential in providing a comprehensive consultation for clients. It identifies risk and determines examinations and investigations necessary for detection of sexually transmitted infections (STIs), blood borne viruses (BBVs) and other sexual health issues, while guiding formulation of a management plan.

There is no strict format for obtaining information, however we have provided guidelines on minimum information required to complete a comprehensive history.

Create a comfortable atmosphere with a relaxed and friendly approach. You should explain to the client that history taking is not designed to create embarrassment or discomfort and that it should aid the best client outcome. This may encourage them to feel safe talking about sexual behaviour and sexuality because it is then seen as a normal part of any professional consultation and important in their overall management.

Maintaining confidentiality is the basis of a sexual history. The client should feel assured that details given to you are kept in strict confidence, will only be used within the service and not released without permission.

Sexual history taking may need to be delegated to someone of the same sex or cultural background. The expression of an individual's sexuality and ability to discuss sexual health with other people is influenced by many factors, including the cultural environment where a person is raised and lives, social norms and environmental factors. Recognition of these influences on an individual's sexual development and behaviour is essential to understanding the client's condition and ability to talk openly about these issues during history taking.

Clients of all ages may not be familiar with medical terms such as ‘fellatio’ and ‘urethra’ therefore use non-technical language to adapt to the client’s level of understanding. This is also important to remember when talking with clients from Indigenous communities, culturally and linguistically diverse origins or clients with a disability, literacy or learning difficulty.

## Young people

If a person under 18 years of age is engaging in sexual activity, further assessment is necessary to determine whether they have been harmed or are at risk of harm. Comprehensively document the assessment to meet legal, policy and ethical requirements.

The *Queensland Health Protecting Queensland Children: Policy Statement and Guidelines on the Management of Abuse and Neglect in Children and Young People (0-18 years)*<sup>6</sup>, outline the roles and responsibilities of Queensland Health employees in relation to recognising, reporting and responding to children and young people at harm or at risk of harm, including notification in relation to sexual acts involving young people.

Several assessment tools are available to assess a young person’s ability to comprehend what is happening. More information can be found in this Manual in Screening and Priority Groups (section two).

## Principles

- Establish rapport with the client.
- Provide a simple explanation of the consultation and explain that the reasons for the questions is to assess their risk for STIs and that an examination may be necessary
- The client has the right to withhold information (including contact information) or request that you do not contact them with results or follow-up. Document the client’s request and ensure the client understands the consequences of their actions.
- Explain the *Queensland Health Sexual Health Clinical Services and Privacy Policy (2008)* at time of registration.
- Explain the coding system applied to pathology tests and client charts.
- When discussing sexual history consider using the same language as the client, reflecting their terminology about partners and behaviours. Many people do not identify themselves with a sexual identity label, yet may have sex with persons of their same gender or with more than one gender.
- Do not use complex medical terms.
- Know your attitudes to sexuality and sexual expression. If you are uncomfortable, then the client will be, so consider referring them to someone else.
- Ask ‘easy’ questions first, such as presenting history, social history, past illnesses and allergies.
- Be straight forward when questioning about sexual behaviour and drug use (avoid vague terms like ‘having sex’ or ‘using drugs’ - be exact about the behaviour).
- Use non-threatening language (verbal and body language).

- Be able to answer questions on common infections.
- Be careful with questions. Not every sexual experience is wanted or pleasurable, therefore some clients may be shocked or ill prepared for questions.
- Ask about the quality of sex the client is having. Knowledge of male and female arousal and dysfunction issues is important.
- Refer the client to a practitioner/specialist service if you feel unable to manage the situation.
- Document all details of the visit.

### Tool to assist history taking

OLD CART is a tool that guides you to prompt clients in a logical order to gather accurate and thorough history. It is useful in structuring history taking to evaluate symptoms and obtain important details regarding the client’s condition.

		Example Questions
O	Onset of symptoms	When did the pain/lesion/discharge commence?
L	Location of symptoms	Where is the pain/lesion/discharge located?
D	Duration of symptoms	How long have you had this pain/lesion? Does it come and go or is it consistent?
C	Characteristics of symptoms	Size, appearance, distribution, level of pain, description of discharge, odour etc.
A	Associated/aggravating factors	Any other signs and symptoms or things that make it worse?
R	Relieving factors	Does anything help or reduce the symptoms?
T	Treatment	Have you had any treatment? Are you on any treatment/medications?

### Obtaining history

Ensure the client understands their rights under State and Commonwealth privacy legislation. Explain how the information collected will be used, how it will be stored and who will have access to it. Also explain why you are asking personal questions E.g. “So I can work out the right tests for you I need to know some details about your sex life”.

### Reason for attendance

Allow the client to verbalise their reason for attendance. Do keep in mind that sometimes the stated reason may not be the actual reason for attendance. Consider the following issues:

- They may be attending for sexual information or support.
- Do not presume that a presenting genital symptom is the only problem.

- More than one STI may be present.
- Remember that many STIs may not have symptoms.

History taking – suggested questions	
<b>Sexual history</b>	<p>After enquiring about genital symptoms ask the client when they last had sex. This question is relatively inoffensive and opens up further discussion such as “Who was it with?” and “Was it a regular partner, someone you know well, or someone you just met?” Consider the following questions:</p> <p><b>Regular partners</b></p> <ul style="list-style-type: none"> <li>• Ask if the client has a regular sexual partner, and if so how long have they been together? When was the last time they had sexual contact? Was this protected or unprotected?</li> <li>• Are sexual partners local or from overseas?</li> </ul> <p><b>Nature of sexual contact</b></p> <ul style="list-style-type: none"> <li>• Ask about the type of sexual contact the client has engaged in i.e. vaginal, anal (receptive/insertive), oral (gave/received).</li> <li>• Was the contact protected or unprotected?</li> <li>• Was it consensual?</li> </ul> <p>Determining sexual practice allows for adequate pre-test counselling concerning risk factors and correct site-specific tests to be performed.</p> <p><b>Other partners</b></p> <ul style="list-style-type: none"> <li>• When was the last sexual contact with any partner other than their regular partner? Was this contact protected or unprotected?</li> <li>• It is important to ask about any other partners the client may have had sexual contact with during the past three months. For infections with long asymptomatic periods (e.g. HIV, syphilis), a period of twelve months or longer may be relevant, but client memories may be vague beyond three months.</li> <li>• Do not assume that their sexual partners are all male or all female. It is important to ask about current same-sex sexual experiences. Avoid terms like ‘homosexual’, ‘bisexual’ or ‘heterosexual’. Avoid closed questions that require a yes/no answer. A better approach is to say, “In the last 12 months you said you had nine partners. Could you tell me whether they were male or female?”</li> </ul> <p><b>Partners at risk</b></p> <ul style="list-style-type: none"> <li>• Remember that a client may be at risk of STIs through the activities of a regular partner, not because of his/her own sexual behaviour. Some clients may find this difficult to articulate, so gentle questioning about their partner’s sexual activities is necessary.</li> </ul>

<p><b>Sexual history cont.</b></p>	<p><b>Multiple partners</b></p> <ul style="list-style-type: none"> <li>Does the client have more than one sexual partner at the same time? Approach this question with care, so the client feels safe and comfortable disclosing information. For example, “How many people have you had sex with in the past three months?”</li> </ul> <p><b>Condom use</b></p> <ul style="list-style-type: none"> <li>Ask client about their knowledge and use of condoms or other prophylactic measures. Use this as an opportunity to provide some preventative education.</li> </ul> <p><b>Past history of STI</b></p> <ul style="list-style-type: none"> <li>STIs may be overlooked or not disclosed by the client. It is important not to miss this clue to the client’s present condition. Asking about past STIs is a relatively easy way to lead into sexual history.</li> <li>Has the client ever had an HIV test? If so, when was the date of the last test and where were they tested? Was the result negative or positive?</li> </ul> <p><b>Overseas contact</b></p> <ul style="list-style-type: none"> <li>Ask whether the client has had sexual contact with a partner(s) from overseas either inside or outside Australia? If so, when was the contact, was it protected or unprotected and what country/ countries were partners from?</li> </ul> <p><b>Sexual function difficulties</b></p> <ul style="list-style-type: none"> <li>Has the client ever experienced sexual difficulties/dysfunction? E.g. erectile dysfunction, premature ejaculation, low sexual desire, dyspareunia, vaginismus, issues with sexual arousal or any other sexuality issue.</li> </ul> <p><b>Coitarche</b></p> <ul style="list-style-type: none"> <li>At what age did the client first experience sexual contact?</li> </ul>
<p><b>Social history</b></p>	<p><b>Alcohol consumption</b></p> <ul style="list-style-type: none"> <li>Ask the client how many drinks they have per day/week? Ask them to describe their pattern of drinking i.e. binge drinking. (Clinician to calculate: grams per day/week. Note - 1 standard drink = 10g).</li> </ul> <p><b>Cigarettes</b></p> <ul style="list-style-type: none"> <li>Does the client smoke cigarettes? If so, how many per day?</li> <li>Are they an ex-smoker? If so, when did they stop smoking?</li> <li>Does the client smoke any other substances? If so, what and how much?</li> </ul>

**Social history  
cont.**

**Injecting drug use**

- Has the client ever injected drugs? If so, have they shared any injecting equipment?
- When did the client first inject? When was the last time they injected? What substances do they inject and how often? Did they ever become addicted and how was it managed?
- Any client who identifies a risk through injecting should be offered hepatitis B vaccination. Testing for hepatitis C should be considered with appropriate pre/post test information.
- Use of other social drugs i.e. tablets or sniffing.

**Blood risks**

- Injecting Drug User (IDU) - past or present use, history of sharing or re-using of needles/syringes/equipment, partner IDU history.
- Recipient of blood transfusion pre 1990 or conducted overseas.
- Prison inmate in a detention centre or correctional facility.
- Tattoos or body piercing where there is doubt regarding sterility of the procedure.
- People born in Mediterranean countries, Middle East, South-East Asia, Africa, South America and the Pacific Islands.
- Occupational exposure - percutaneous injury such as needle stick injury (NSI) and/or other non-percutaneous accidental exposure to infected blood or products.
- Non occupational exposure - percutaneous injury and/or other non-percutaneous exposure.
- Recipient of immunisation, injection and/or surgical, medical or dental procedures overseas, particularly in countries of high prevalence.
- Babies born to mothers infected with BBV: HIV/AIDS, hepatitis B virus (HBV) or hepatitis C virus (HCV).
- Client and/or partner from high prevalence area for BBV.

**Sexual abuse/assault**

- Asking clients about sexual abuse/assault is important. It should be approached with care and sensitivity. They may never have been asked before or may be attending because of a recent/past sexual assault and do not know how to disclose their reason for attendance.

<p><b>Social history cont.</b></p>	<ul style="list-style-type: none"> <li>• Clients may not recognise unwanted sexual experiences as ‘assault’. Use prompts such as “Have you ever been forced to have sex against your will?” or “Have you had any unpleasant experiences with sex?” If the client identifies a history of sexual assault or abuse, offer appropriate follow-up and counselling.</li> <li>• Identify and develop links with local support and counselling services to assist referrals.</li> </ul> <p><b>Domestic violence</b></p> <ul style="list-style-type: none"> <li>• Has the client ever experienced any form of domestic violence, and if so, are they wishing to seek support at this time? E.g. refer to a domestic violence organisation for support and counselling.</li> </ul> <p>Identify and develop links with local support and counselling services to assist referrals.</p> <p><b>Sex work</b></p> <ul style="list-style-type: none"> <li>• Ask the client if they have ever accepted money, drugs or favours for sex? A sex worker may present requesting a sexual health check without identifying themselves as a sex worker, because of fear of discrimination or loss of confidentiality. Approach the question with sensitivity so the client feels safe to discuss any issues relating to their sexual health or concerns.</li> <li>• Recommend hepatitis A and hepatitis B vaccination to any client identifying as a sex worker.</li> <li>• Ask about any past or present sexual contact with sex workers in Australia or overseas.</li> </ul>
<p><b>Medical/surgical history</b></p>	<p><b>Family history</b></p> <ul style="list-style-type: none"> <li>• Relevant conditions such as diabetes, epilepsy, asthma, clotting disorders, hypertension and reproductive cancer.</li> </ul> <p><b>Major childhood and adult illnesses</b></p> <ul style="list-style-type: none"> <li>• Including chronic illness and medical conditions such as diabetes, epilepsy and asthma.</li> </ul> <p><b>Medication</b></p> <ul style="list-style-type: none"> <li>• Current, past month and past treatment including complementary therapies and over-the-counter medication.</li> <li>• HPV (Gardasil) vaccinations.</li> </ul> <p>Every medical history includes these items, but in STI management they are particularly relevant. Antibiotic therapy will have to be tailored to take account of past allergic reactions and symptoms/signs may be modified or suppressed by self-medication with previously prescribed antibiotic, antiviral or antifungal therapy.</p>

<p><b>Medical/surgical history cont.</b></p>	<p><b>Hepatitis</b></p> <ul style="list-style-type: none"> <li>• Hepatitis A virus (HAV), hepatitis B virus (HBV), hepatitis C virus (HCV) <ul style="list-style-type: none"> <li>- Unknown/not tested</li> <li>- Acute/chronic</li> <li>- Immune from previous exposure or vaccination</li> <li>- Year immunised (if previously immunised has client received full course?).</li> </ul> </li> </ul> <p><b>Immunisations and dates</b></p> <ul style="list-style-type: none"> <li>• Reaction to immunisations.</li> </ul> <p><b>Surgery</b></p> <ul style="list-style-type: none"> <li>• Dates, hospital, diagnosis, complications.</li> </ul> <p><b>Allergies</b></p> <ul style="list-style-type: none"> <li>• Medications, environmental, food (include description of reaction).</li> </ul> <p><b>Transfusions</b></p> <ul style="list-style-type: none"> <li>• Has the client ever had a transfusion? If so, when was the date and how many units (if known)?</li> </ul> <p><b>Emotional status</b></p> <ul style="list-style-type: none"> <li>• Mood disorders, depression, history of mental illness, psychiatric attention.</li> </ul>
<p><b>Genitourinary history</b></p>	<ul style="list-style-type: none"> <li>• Duration of symptoms</li> <li>• Discharge (urethral, vaginal or anal): amount, colour, odour, character</li> <li>• Lower abdominal pain and /or dyspareunia</li> <li>• Dysuria or pain/difficulties with defecation</li> <li>• Abnormal vaginal or rectal bleeding</li> <li>• Itch and/or discomfort in perineum, peri-anal and pubic region</li> <li>• Genital rashes, lumps and sores</li> <li>• Sexual difficulties.</li> </ul> <p><b>Male reproductive history</b></p> <ul style="list-style-type: none"> <li>• Puberty onset, history of undescended testes, circumcision, quality of erections, testicular pain or masses, hernias, lesions/ discharge, infertility, prostate.</li> </ul>

**Genitourinary history cont.**

**Female reproductive history**

**Menstrual pattern**

- Menarche
- Regular/irregular periods, length of cycle, duration of bleeding, date of last normal period
- Dysmenorrhoea.

**Abnormal bleeding**

- Post-coital bleeding
- Menorrhagia
- Intermenstrual bleeding
- Post-menopausal bleeding.

**Dyspareunia**

- Pain with intercourse (deep or superficial)
- Chronic/acute
- Transient/all the time.

**Pap smears**

- Has never had a pap smear
- Date of last pap smear
- Result - normal/abnormal
- Previous abnormal pap smear result
- Treatment and/or follow-up of abnormal smear e.g. colposcopies, biopsies
- HPV vaccination.

**Contraception**

- Method of contraception used
- Past/present problems with contraceptives
- Any missed pills in the last two cycles

**Parity**

- Pregnancy (Total;live births, miscarriages, terminations, still births)
- Complications of pregnancy e.g. gestational diabetes, pre-eclampsia, toxæmia cholestasis.

<b>Genitourinary history cont.</b>	<p><b>Breast</b></p> <ul style="list-style-type: none"> <li>• Pain, tenderness, discharge, lumps, breast awareness, mammogram and results.</li> </ul> <p><b>Gynaecological surgery</b></p> <ul style="list-style-type: none"> <li>• Colposcopy, Large Loop Excision of the Transformation Zone (LLETZ) or other procedures, Dilatation and Curettage (D&amp;C), hysterectomy, hysteroscopy, laparoscopy.</li> </ul> <p><b>Continence status</b></p> <ul style="list-style-type: none"> <li>• Any problems with leaking or passing of urine and/or faeces? (for referral purposes).</li> </ul>
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## Review of systems

Additional questions regarding other body systems may be indicated based on presenting condition, history or examination as some STIs and HIV affect multiple systems. Assessment may include:

- General: fever, chills, sweats, weight changes, weakness, fatigue, heat/cold intolerance, bleeding, radiation
- Skin/hair/nails; rashes, lumps, sores, itching, colour or texture changes, bruising, abnormal growths
- Head; headaches, injury, dizziness, syncope, LOC, stroke
- Eyes; vision/correction, blurring, diplopia, eye meds, trauma, redness, pain, glaucoma, cataracts
- Ears; hearing/loss, pain, discharge, infection, tinnitus, vertigo/dizziness
- Nose; smell, obstruction, injury, epistaxis, discharge, colds, allergies, sinus pain
- Mouth and throat; hoarseness, sore throats, gum problems, tooth abscess, dental care, sore tongue, taste
- Neck; lumps, swollen glands, goitre, pain/stiffness
- Lymph nodes; enlargement, tenderness
- Respiratory; pain, dyspnea, shortness of breath, cyanosis, wheezing, cough, sputum (colour and quantity), asthma, bronchitis, emphysema, pneumonia, TB/BCG, last chest x-ray and results, smoking
- Cardiovascular; chest pain/distress, palpitations, shortness of breathe, dyspnea, orthopnea (pillows needed), paroxysmal nocturnal dyspnea, myocardial infarction, rheumatic fever, murmur, exercise tolerance, electrocardiograph or other cardiac tests, hypertension, oedema, leg pains/oedema/coolness/hair loss, varicose veins, thrombosis, ulcers
- Gastrointestinal; appetite, digestion intolerance, heartburn, nausea, vomiting, haematemesis, bowel irregularity, stool appearance, flatulence, haemorrhoids, jaundice, ulcers, gallstones, abdominal enlargement, previous x-ray

- Endocrine; thyroid enlargement/tenderness, heat/cold intolerance, unexplained weight change, diabetes signs and symptoms
- Musculoskeletal; joint stiffness, pain, motion restriction, weakness paresthesia, cramps, deformities, back problems
- Hematologic; anaemia, lymph swelling, bruising/petechiae, fatigue, blood transfusion, radiation
- Neurologic; central nervous system disease, syncope, blackouts, dizziness, numbness, tingling, seizures, weakness/paralysis, tremors, loss of coordination, memory, cognition, headache, head injury.

## RISK ASSESSMENT

The risk assessment enables you to determine required investigations and examinations, based on history gathered. The level of risk determined will direct you toward further history you may need, to assist in your decision making.

You should also determine the risk of sexual assault or violence that you may need to report in the case of child protection issues. Consider the risk of unplanned pregnancy.

Some clients may withhold information, so it's important to reiterate that the risk assessment is based on the information they supply.

## EXAMINATION

You should perform a thorough physical examination of clients, not just a routine examination of their genitals. Symptoms of sexually transmissible infections aren't always limited to the genital area.

### Objectives

It is good practice to explain these to the client:

- screen the client's well-being and provide information for assessment
- validate complaints and reason for attendance
- use information to form a provisional diagnosis, identify necessary investigations and develop a management plan.

### Preparation

- ensure privacy, confidentiality and no interruptions
- ensure a comfortable and warm environment with a good light source
- prepare all necessary equipment.

### Client

- reassure the client to help make them as relaxed as possible before the examination
- inform the client of recommended procedure/s and obtain their verbal consent

- maintain client privacy and ensure client understands the privacy policy
- refer to your local chaperone policy
- offer the client an opportunity to look at their genitals (a mirror may be useful for cervical and vaginal visualisation)
- stop the examination if the client is becoming unsettled by the experience. Explain that they can ask for the examination to be stopped at any time.

## Staff

- some clients may use a sexual health examination for sexual gratification. It is important you feel comfortable and safe when examining a client
- sexual harassment should not be tolerated. You have the right to refuse a client examination, ask for a chaperone to be present or refer examination to another clinician. Terminate the consultation if you feel uncomfortable or unsafe.

## A GENERAL EXAMINATION SHOULD INCLUDE

### General Health

- existing illness, medical conditions,
- general appearance and body fat
- motor activity, stature and mobility
- vital signs (if appropriate)

### Physical Appearance

- age
- sex
- general Appearance: posture, pain
- skin colour: pigmentation, lesions
- body structure: height, weight, nutritional state

### Behaviour and psychological presence

- personal hygiene. dress and grooming
- facial expression and eye contact,
- speech, appropriate responses
- mood and manner: depression, anger, anxiety

## Physical examination

- a systemic physical examination is an essential part of the assessment of patients concerned about STIs and other conditions and should include examination of the:
  - skin
  - mouth
  - neck
  - abdomen
  - inguinal lymph nodes
  - skin of the genital area
  - additional systemic examinations may be required according to history and clinical findings

## EXAMINATION OF FEMALE CLIENTS

### Oro-pharynx

- examine the posterior pharynx, tonsillar crypts and mouth for signs of erythema, masses, ulcers and other abnormalities
- palpate regional lymph nodes for enlargement and tenderness

### Abdomen

- palpate the abdomen to identify guarding or tenderness

### Genital

- palpate the inguinal lymph nodes

### Vulva

- examine the vulva for evidence of erythema, masses, ulcers, rashes or abnormalities

### Peri-anal

- examine the peri-anal area for discharge, erythema, masses, fissures or other abnormalities

### Vagina

Inspect the vaginal walls for:

- erythema
- discharge – note colour, consistency, amount, odour, etc
- masses or other abnormalities

## Cervix

Assess the cervix for:

- appearance – masses, punctation, ulcers, patulous, erythema, oedema
- cervical os – open or closed
- squamo-columnar junction (scj) ectropion - visible or not
- discharge – note colour, consistency, amount, odour, etc
- contact bleeding
- other abnormalities

## Uterus

Perform a pelvic/bimanual examination (if indicated) noting:

- size, position of uterus
- tenderness of uterus or adnexae
- cervical motion tenderness (CMT)
- adnexal masses.

### Note:

- be alert for non-verbal and verbal expressions of pain both prior to and during the examination.
- if pregnant with abdominal pain do not undertake a bimanual examination. Refer to MO

## Rectum

- perform a rectal examination/proctoscopy if indicated noting discharge, lesions or other abnormalities.

## EXAMINATION OF MALE CLIENTS

### Oro-pharynx

- examine the posterior pharynx, tonsillar crypts and mouth for signs of erythema, masses, ulcers and other abnormalities
- palpate regional lymph nodes for enlargement and tenderness

### Genital

- palpate the inguinal lymph nodes
- examine the genital area including shaft of penis noting any rashes, masses or other abnormalities

## Testicles

- perform testicular examination (both standing and lying) noting pain or abnormalities
- instruct client on self-examination if indicated

## Urethra

- examine the urethral meatus and glans penis for evidence of urethral discharge, erythema, lesions or other abnormalities

## Peri-anal

- examine the peri-anal area for discharge, lesions or other abnormalities

## Rectum

- perform a rectal examination/proctoscopy if indicated noting discharge, erythema, masses, fissures or other abnormalities.

## EXAMINATION OF TRANSGENDER CLIENTS

You should be sensitive to a transgender client's identity and needs and have knowledge of specific health care concerns. If your experience with the issue is limited, you should establish an appropriate pathway of care. Acceptance of disclosure can have a crucial impact on the client's confidence.

Before deciding which examinations to perform, sensitively ask the client about their genital anatomy and/or history of sex reassignment surgery.

The history and risk assessment should enable you to determine required examinations and investigations.

Performing a transgender examination will depend on the sexual behaviour of the client, risks identified and the anatomical sex of the client in consideration of anatomical changes that may have occurred.

### Female-to-male

- follow guidelines for 'Examination of males'
- if a cervix is present, a pap smear is required in accordance with the *National Health and Medical Research Council (NHMRC) Guidelines* at [www.nhmrc.gov.au/guidelines/index.htm](http://www.nhmrc.gov.au/guidelines/index.htm). Topical oestrogen therapy is always required for two weeks prior to the specimen collection if the client is on testosterone.

### Male-to-female

- follow guidelines for 'Examination of Females'. Speculum examination is necessary
- as penile skin is sometimes used to form the vagina, transgender clients are not at risk of cervical chlamydia or gonorrhoea therefore pap smears are not required, but they do require a first catch urine (FCU) for chlamydia or gonorrhoea PCR
- if the colon is used to form the vagina, rectal mucosal infections are possible.

## INVESTIGATION

- investigations listed are recommended tests only
- you are not required to perform all tests for all clients or individual conditions. Deciding which investigations are necessary, requires clinical judgement and depends on identified risks and/or symptoms, client history and clinical findings, in conjunction with disease prevalence in the target population
- use local policy and availability of investigations at your local pathology services to guide which investigations you perform
- inform client regarding recommended investigations based on their risk assessment and obtain informed client consent before collecting investigations
- inform client regarding turnaround time of test results
- document process for results collection in the client chart, especially if their results are to be obtained via phone, email or another indirect method
- be aware of the registers which certain results must be reported
- inform the client about the process of notification that is required for some infections
- offer pre-test and post-test information and discussion as required.

The following is a guide only, as available investigations will vary between clinical practices.

Site specific investigations <sup>7</sup>	
Skin	<ul style="list-style-type: none"> <li>• skin scrapings for suspected fungal conditions</li> <li>• swab for culture for staph/strep infections or folliculitis.</li> </ul>
Mouth	<ul style="list-style-type: none"> <li>• PCR for herpes simplex virus type 1 or 2 (if lesions present)</li> <li>• swab for oral candidiasis culture (if indicated)</li> </ul> <p>Note: oral candida is rare unless underlying immunosuppression is present (e.g. HIV). If the client has candida (thrush) or oral hairy leukoplakia (OHL) an HIV test is warranted, with client consent.</p>
Pharyngeal	<ul style="list-style-type: none"> <li>• swab for gonorrhoea culture and sensitivity (if indicated)</li> <li>• swab for chlamydia and gonorrhoea PCR</li> </ul> <p>Note: Although PCR is not validated at this site, this is still the recommended test. Positive results are checked with a supplementary test in the laboratory which is only available for gonorrhoea.</p>

Site specific investigations continued...

- Vagina
- high vaginal swab for microscopy (gram stain and wet preparation), culture and sensitivity to look for trichomonas, candidiasis and bacterial vaginosis
  - high vaginal swab for trichomonas PCR
  - if vulval or vaginal ulceration is present or herpes is suspected due to history, take PCR test for herpes simplex virus
  - self-collected low vaginal swab for gonorrhoea, trichomonas and chlamydia PCR.

- Cervix
- endocervical swab for chlamydia and gonorrhoea PCR
  - endocervical swab for gonorrhoea culture and sensitivity
  - offer pap smear, additional thin prep and HPV DNA (if indicated)
  - if unable to do a speculum examination:
    - take first catch urine for gonorrhoea, trichomonas and chlamydia PCR
    - or
    - self-collected lower vaginal swab for gonorrhoea, trichomonas and chlamydia PCR.
- Note: Although PCR is not validated at this site, this is the recommended test. Positive results for gonorrhoea are checked with a supplementary test in the laboratory.

- Urethra
- nucleic acid amplification testing (PCR)
  - first catch urine for gonorrhoea, trichomonas and chlamydia PCR
  - if discharge is present or history indicates high risk of gonorrhoea add
  - external urethral swab for gonorrhoea culture and sensitivity.
- Note: Urethral swabs should be done prior to urine collection. Conduct urine HCG in women, if pregnancy suspected.

Site specific investigations continued...	
Lesion	<ul style="list-style-type: none"> <li>• swab for HSV PCR from any ulcers or suspicious lesions or chronic skin tears</li> <li>• swab for M/C/S</li> <li>• press slide and GUMP for Donovanosis</li> <li>• dark ground microscopy (if available)</li> <li>• swab for syphilis treponemal PCR</li> <li>• add serology</li> <li>• syphilis</li> <li>• HIV.</li> </ul> <p>Note: Queensland Health Pathology Services request syphilis serology to accompany specimens when syphilis treponemal PCR is taken.</p>
Anorectal	<p>Via proctoscope or blind swab (as indicated by history)</p> <ul style="list-style-type: none"> <li>• swab for gonorrhoea culture and sensitivity (not smears)</li> <li>• swab for chlamydia and gonorrhoea PCR</li> </ul> <p>Note: Although nucleic acid amplification testing (PCR) is not validated at this site, this is the recommended test. Positive results for gonorrhoea are checked with a supplementary test in the laboratory.</p> <ul style="list-style-type: none"> <li>• take faeces culture for enteric pathogens. This should be done if history suggests infective enteritis.</li> </ul>

Site specific investigations continued...

Serology

Syphilis (clotted blood)

- EIA or TPPA or FTA-Abs (specific treponemal tests)
- RPR titre (non-specific test).

Note: Contact local pathology lab for confirmation of which syphilis test is available locally for routine screening.

Hepatitis A (clotted blood)

- Anti-HAV IgG screening
- IgM if acute hepatitis suspected.

Hepatitis B (clotted blood)

- HBV surface antigen (HBsAg)
- HBV surface antibody (AntiHBs) HBsAb
- HBV core antibody (Anti HBc IgG or IgM) HBcAb. (*AntiHBc IgM detects recent HBV infection*)
- other HBV markers (if indicated).

Hepatitis C (clotted blood)

- Hepatitis C Ab (if indicated).

HIV 1- 2 (clotted blood)

- HIV antibody/antigen detection via ELISA.

Note

Availability of investigations may be influenced by location, internal clinic policy and laboratory resources.

The following are guidelines to assist in determining investigations:

- If client asymptomatic and from population subset with low prevalence of gonorrhoea, minimum recommended testing may include only chlamydia PCR screening.
- If client symptomatic then gonorrhoea PCR testing may be omitted and chlamydia PCR and gonorrhoea M/C/S requested.

Swab for gonorrhoea M/C/S indicated if:

- symptomatic
- in areas of high prevalence eg. North Queensland
- where history or clinical finding indicates risk e.g. MSM.

Note cont.	<p>Swab for trichomonas indicated if:</p> <ul style="list-style-type: none"> <li>• client from or contact with partner from areas of high prevalence e.g. North Queensland, Papua New Guinea or South Pacific Islands</li> <li>– high vaginal swab for trichomonas M/C/S available for remote communities</li> <li>– high vaginal swab and first catch urine for trichomonas PCR are validated.</li> </ul> <p>Syphilis serology indicated for:</p> <ul style="list-style-type: none"> <li>• all sexually active population</li> <li>• pregnant women</li> <li>• areas of high prevalence or where risk history suggests e.g. North Queensland, sex in an endemic country or MSM.</li> </ul> <p>Hepatitis B serology</p> <ul style="list-style-type: none"> <li>• immunise if HBsAb negative</li> <li>• once a client is immunised against HBV, further serology is unnecessary unless HIV positive or immunosuppressed<sup>13</sup>.</li> </ul> <p>HIV serology</p> <ul style="list-style-type: none"> <li>• If HIV negative. UPSI (unprotected sexual intercourse).</li> </ul> <p>Note: Polymerase Chain Reaction (PCR)/Nucleic acid amplification tests (NAAT) for gonorrhoea and chlamydia have only been validated and registered for use in vaginal, urethral, cervical and urine samples. According to Queensland Health CaSS Pathology database<sup>8</sup> PCR is not validated for use at other sites (rectum and throat). Positive results should be interpreted carefully when used on other sites. Positive results are checked with a supplementary test in the laboratory.</p>
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## FOLLOW-UP

- when a STI is diagnosed, advise re-screening in 3 months to minimise risk of re-infection
- discuss additional STI screening (if required)
- promote safe sex and safe injecting practices to minimise harm
- partner notification, testing and treatment
- refer to support services where necessary.

## CLIENT EDUCATION

- provide written information as well as verbal information. Have a variety of pamphlets available, relevant to identified risk populations i.e. MSM, sex workers, people who inject drugs, people living with HIV/AIDS (PLWHA) and people from culturally and linguistically diverse (CALD) backgrounds
- reinforce safe sex message and provide condoms/lube/dams. Ensure you understand correct condom usage so you can educate the client. Perform demonstration if necessary
- refer clients to reliable websites for further information resources and fact-sheets available at [www.health.qld.gov.au/sexhealth](http://www.health.qld.gov.au/sexhealth)
- contact Family Planning on (07) 3250 0240 to obtain the Sexual and Reproductive Health and Blood Borne Virus resource CD or visit [www.fpq.com.au](http://www.fpq.com.au)

## CONTACT TRACING

Contact tracing (or partner notification) is the process of identifying people who have been in contact with a person who has an infectious disease and ensuring these contacts are aware of their exposure and options for follow-up<sup>9</sup>.

### Aims

- interrupt ongoing transmission of infection
- identify people who may benefit from treatment and minimise likelihood of complications
- provide individual counselling to effect sustained behaviour change
- identify and reach 'at risk' populations in order to influence community norms<sup>9</sup>.

### Principles

Consider medical, social, legal and ethical consequences when contact tracing. Respect human rights of the index case and contact(s) maintain confidentiality of all parties and remember that providing information on contacts and contact tracing is voluntary. Contact tracing is of particular value for STIs such as chlamydia and gonorrhoea, however it is less so for others such as HPV and HSV.

### Contact tracing process

Cooperation of the index case is essential to successful contact tracing. Enhance cooperation of the index case by obtaining trust and providing an explanation of the reasons for contact tracing. Balancing duty to warn, duty of care, and duty of confidentiality enables effective contact tracing<sup>10</sup>. Contact tracing should not be undertaken unless an STI or BBV has been diagnosed through an examination or lab test<sup>10</sup>. If there is an uncertain diagnosis or findings of significance consult a medical officer.

Contact tracing can be conducted by the index case, the service provider, a referral agency or a combination of these.

Contact tracing is particularly desirable where:

- contact has occurred during the period of infectivity
- there is reasonable chance of serious consequences
- contacts will benefit from prophylaxis, treatment and counselling on preventive measures.

When deciding which contact tracing method to recommend, consider:

- risk of exposure
- disease/infection diagnosed
- motivation level of index case to notify contact(s).

Discuss and document the agreed method of identifying and notifying partner(s).

### Contact tracing conducted by the index case ( preferred method)

Ideally partner notification is best done by the index case.<sup>14</sup> You should provide adequate education to the index case about:

- which contacts need to be advised (consider timeframe)
- what information to provide to contacts
- how to convey the information.

You can facilitate this process by providing the client a contact tracing card, website information or a 'contact letter' stating diagnosis and management or written information i.e. bilingual pamphlets.

There are a number of useful websites enabling the index case to anonymously or personally advise contacts that the contact may have acquired an STI. Two are listed below:

- **www.thedramadownunder.info** provides information for MSM about the most common STIs. Visitors to the site can advise their sexual partner/s (previous or current) that they may be at risk of STI by sending an e-card or SMS either personally or anonymously. They can also register to receive a regular reminder to attend a sexual health check-up.
- **www.letthemknow.com.au** was developed by Melbourne Sexual Health Centre to enable people diagnosed with chlamydia to inform sexual partners that they might be at risk. This site includes frequently asked questions, examples of conversations, emails, SMS or letters that can be used to inform partners. SMS or email can be sent to a partner directly from the site either personally or anonymously.

### Contact tracing conducted by the service provider

With client consent, clinicians may wish to take responsibility for notification of contacts.

### Contact tracing by a referral agency

Sexual health clinics may be able to assist with contact tracing. Useful information to provide is name, address, age, hair colour, ethnicity, STI, workplace and telephone number.

Irrespective of who takes responsibility for contact tracing, ideally the referring clinician follows –up to confirm that contacts have been advised and assessed adequately. This provides an opportunity to renegotiate who will conduct the notification of a particular contact.

## **Empirical treatment**

Contacts of proven cases of most STIs should be offered sexual health screening, information and empirical same day treatment of the relevant condition, regardless of whether they are symptomatic or not.

Empirical treatment rationale

- STIs are highly infectious so there is increased probability the contact has acquired infection
- initial presentation of the contact may be the only opportunity for treatment due to population mobility and loss to follow-up<sup>11</sup>
- early diagnosis and treatment of STIs reduces risk of ongoing transmission and decreases risk of negative sequelae.
- reduce the risk of reinfection in index case.

## **More information**

Australasian Society for HIV Medicine, 2006

*Australasian Contact Tracing Manual (3<sup>rd</sup> edition)*

[www.ashm.org.au](http://www.ashm.org.au)

National Health and Medical Research Council (NHMRC), 2008

*The Australian Immunisation Handbook (9<sup>th</sup> edition, p161 VI)*

# ASYMPTOMATIC SCREEN

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## HISTORY TAKING

An accurate sexual history which includes medical, surgical and gynaecological history is essential in providing a comprehensive consultation for all clients including those presenting for an asymptomatic screen. It helps identify risk and determine subsequent examination/investigation necessary for detection of STIs and sexual health issues.

## CLINICAL INDICATORS

Risk or contact of STI.

## EXAMINATION

Perform examination based on history and risk assessment.

## INVESTIGATION

Perform examination based on history, risk assessment and clinical findings of examination.

### *Asymptomatic heterosexual male*

- chlamydia and gonorrhoea
- trichomonas (if indicated).

### *Asymptomatic female*

- chlamydia and gonorrhoea
- trichomonas (if indicated).

### *All asymptomatic clients*

Discuss additional STI screening as indicated. Serology may include the following:

- syphilis
- HIV
- hepatitis A Ab (if indicated)
- hepatitis B HbsAg, HBsAb, HBcAb (if unvaccinated or unclear vaccination history)
- hepatitis C Ab (if indicated).

Note: Investigations are recommendations only and may vary according to local disease prevalence and laboratory resources.

## MANAGEMENT AND TREATMENT

- findings outside of NOs scope of practice require medical consultation and referral
- refer to section four for management and treatment of specific pathogens and conditions

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