1.0 Purpose:
1.1 To ensure an evidence-informed and consistent approach in the public health management of gonococcal infections.

2.0 Scope and Goal:
2.1 This guideline is intended for Public Health Nurses (PHNs) working with the Healthy Sexuality and Harm Reduction team in order to follow-up sexually transmitted gonococcal infections as per the Manitoba Health Communicable Diseases Management Protocols.

3.0 Definition:
3.1 Gonorrhea: caused by Neisseria gonorrhoeae (N. gonorrhoeae), a gram-negative diplococcal bacterium. Confirmed Case: Isolation of N. gonorrhoeae from any site by culture OR detection of N. gonorrhoeae by nucleic acid amplification test (NAAT). Males having intracellular diplococci present on stain of urethral exudates are also considered laboratory-confirmed cases. Clinical Case: Urethral or cervical/vaginal discharge without laboratory confirmation, in a person with a history of sexual contact with a laboratory-confirmed case in the preceding six to eight weeks. Cases include both genital and extra-genital infections. Perinatally-acquired cases are cases occurring in neonates (up to four weeks of age), leading to the diagnosis of gonococcal conjunctivitis, scalp abscess, vaginitis, bacteremia, arthritis, meningitis or endocarditis.

4.0 Background:
4.1 All positive laboratory tests are reportable by laboratory to the Communicable Disease Control Branch, Manitoba Health for surveillance and Public Health follow-up.
4.2 All clinical and laboratory-confirmed cases are reportable by attending health care professional to the Communicable Disease Control Branch, Manitoba Health for surveillance and Public Health follow-up.
4.3 Operators of Manitoba clinical laboratories are required to submit clinical isolate sub-cultures of N. gonorrhoeae to Cadham Provincial Laboratory (CPL) within seven days of report for surveillance purposes.
4.4 Gonorrhea infections are prioritized by PHNs over chlamydia infections.
5.0 Procedure:

5.1 Upon assignment of the case to the PHN, the PHN will initially assess the case/chart so the chart can be submitted to the Clinic Liaison Nurse to contact the testing practitioner within the appropriate timeframe (also referred to as ‘diarizing’):

5.1.1 Submit on the same day when the case was tested at a location where it is likely the case will stay for only a short time, and more immediate notification will increase likelihood of appropriate follow-up.

5.1.2 For Cases identified as “neonatal conjunctivitis risk” or “ocular swab result”, the PHN pr Clinic Liaison nurse will attempt to make contact with health care provider on the same business day that the result was received. If unable to contact the health care provider, the PHN should attempt to contact the client.

5.1.3 Diarize for all other cases. Refer to Gonorrhea Case Algorithm or Appendix 1 of the Clinical Liaison Nurse operational guideline.

5.2 The PHN will make reasonable efforts to contact the case for the purpose of education and to interview for contacts if the testing practitioner did not do so. This may occur via telephone, home-visit, in-person at a health services site or an alternative venue.

5.3 Cases identified as “high risk” for poor outcomes will be prioritized (ie, no treatment, <18 years old, pregnant, repeaters - >3 cases of STI or >3 contacts with STI in one year, test result indicates antibiotic-resistant *N gonorrhoeae*, neonatal conjunctivitis risk, ocular swab result).

5.3.1 For Cases identified as “high risk”, the PHN will attempt to make up to three phone calls and send one letter. The ‘PNT’ (positive no treatment) letter will be sent to cases without treatment, the ‘Health Matter’ letter is sent to those who require an interview only. Leave between 1-3 phone messages; send 1 letter. Two or less home visits may also be attempted.

5.3.2 For other cases, make one phone call and leave a message if that is an option. If no message can be left, send a ‘Health Matter’ letter. If no response, close the case if only the interview was left to be done.

5.4 The interview will consist of the following components:

5.4.1 Introduction
- Privacy ensured and confidentiality discussed
- Case identity confirmed with 2 identifiers (name, date of birth or Personal Health Information Number (PHIN))
• Introduction of self & PHN role

5.4.2 Clinical history
• Symptoms and onset

5.4.3 Treatment
• Assess treatment completion and tolerance;
  • If case vomited pills within 1-hr of administration, or is PNT (untreated), PHN encourages attendance for treatment with a treating practitioner. If client meets Antibiotic Treatment for Uncomplicated Chlamydia and Gonorrhea guideline criteria, PHN may offer to provide antibiotic (See Antibiotic Treatment for Uncomplicated Chlamydia and Gonorrhea guideline)

5.4.4 Counseling/Education
• Discuss other testing
• Assess case’s level of understanding
• Risk assessment
• Disease transmission and prevention (include discussion of asymptomatic transmission and incubation period)
• Timeframe for sexual abstinence (for 5 days after their contacts’ treatment is complete) in order to decrease risk of reinfection.
  • If case does not adhere to timeframe for sexual abstinence with a contact who has been treated, the case should be encouraged to attend for retesting with health care practitioner (not sooner than 6-weeks post treatment unless case is symptomatic)
  • If index case has sexual contact with another case who has not been treated, the index case should be assessed and managed as a contact (see Investigation of Contacts of Chlamydia and Gonococcal Infections guideline)
• Potential consequences of untreated N. gonorrhoeae
• Potential medication side effects and what to do if unable to complete treatment
• When test of cure is recommended (see 5.4.5. below)
• Harm reduction counseling and referral to appropriate resources
• Retesting of individuals with gonorrhea after six months is recommended as re-infection is common

5.4.5 Test-of-cure (TOC)
• Routine TOC is not recommended
• Criteria for when TOC/follow up testing would be recommended:
  ✓ patient remains symptomatic after treatment
  ✓ infection occurs during pregnancy
  ✓ patient was not treated with a recommended regimen
  ✓ patient was treated with a quinolone (ciprofloxacin 500mg or ofloxacin 400 mg) and antimicrobial susceptibility has not been demonstrated by culture and sensitivity testing
  ✓ treatment failure has previously occurred
  ✓ antimicrobial resistance to therapy is documented
  ✓ compliance is uncertain
  ✓ pharyngeal or rectal gonorrhea is diagnosed
  ✓ patient is a child
  ✓ PID or disseminated gonococcal infection was diagnosed
  ✓ there is concern over accuracy of nonculture test result (i.e. false positive)
• TOC is recommended to be done with a culture with sampling on all positive sites approximately four to five days after completion of therapy
• NAAT is not recommended as TOC, however, when it is the only choice, testing should be done six-weeks post-treatment to avoid false-positive results due to the presence of non-viable organisms

5.4.6 Contact/Partner notification
• To be done as soon as possible (preferably in 5 working days)
• Discuss partner notification process
• Obtain names and locating information of all sex partners exposed 2 months before onset of symptoms. If the case is asymptomatic or has had repeated infections the interview may extend to 3 months prior to diagnosis
• See Procedure for Investigation of Contacts of Chlamydia and Gonococcal Infections.

5.5 PHNs will make reasonable efforts to ensure that highest priority cases have been notified, counseled, and treated. If PHN is satisfied that health care provider has adequately managed the case, no further intervention is required.

5.6 Case is closed when the PHN is reasonably assured that the case has been adequately treated and contacts have been notified. The case will also be closed if all available means of contacting the case and/or contacts have failed (see Gonococcal Case Follow-Up Algorithm).
5.7 If case resides outside of the WRHA jurisdiction, referral must be sent to Manitoba Health to ensure it is forwarded to appropriate jurisdiction.

6.0 Validation:

7.0 Recommended Reading: