Australian STI Management Guidelines for Use in Primary Care

Pregnant people

Overview

- Sexually transmitted infections (STIs) and blood borne viruses (BBVs) in pregnancy are associated with significant morbidity and mortality, including spontaneous abortion, fetal demise, premature labour, low birth weight and neonatal infection.
- Many STIs and BBVs are asymptomatic and people may be unaware of their risk of infection or may be unwilling to disclose risk.
- Antenatal STI and BBV testing offers the opportunity for early detection; prompt and appropriate management; prevention or reduction of adverse outcomes for the fetus or neonate; prevention of long-term sequelae in the parent; informed antenatal care; patient education and contact tracing.
- RANZCOG recommends a risk-based assessment for some STIs but it is important to be aware of local epidemiology and guidelines.
- Pelvic inflammatory disease (PID) can occur in pregnancy and may be misdiagnosed. Do STI tests in pregnant person with new or abnormal genital discharge, bleeding, or pelvic pain.

Testing advice

Infection	Consideration

Hepatitis B	Routinely offer and recommend hepatitis B virus testing at the first antenatal visit. If not high-risk, the testing guidelines recommend Hepatitis B surface antigen (HBsAg) testing only, with further testing with Hepatitis B e antigen (HBeAg) and Hepatitis B DNA if HBsAg positive. Consider vaccination post partum if not immune. Any person diagnosed with hepatitis B infection in pregnancy should be assessed by an experienced clinician who will determine the phase and stage of their hepatitis B, including consideration of treatment in the third trimester. Discuss need for the infant to receive hepatitis B immunoglobulin (HBIG) and vaccination at birth to prevent transmission, and need for follow-up testing for the infant.
HIV	Routinely offer and recommend human immunodeficiency virus (HIV) testing at the first antenatal visit. Repeat test if patient exposed within previous 45 days (window period) or have ongoing risk of HIV acquisition. Pregnant people who test positive for HIV should be referred to a clinician experienced in treating HIV and HIV community organisations for peer support.
HCV	Pregnant people should be made aware of the benefits of routine screening for hepatitis C virus (HCV) infection. Anti-HCV testing should be offered at first antenatal visit and people who are HCV antibody positive need to be tested for HCV RNA because the small risk of perinatal transmission is conditional on the presence of parental HCV RNA. Pregnant people who test positive for HCV RNA should be referred to a clinician experienced in treating HCV.
Syphilis	Routinely offer and recommend syphilis testing at the first antenatal visit. Untreated syphilis in pregnancy is associated with significant complications including pre term birth, neonatal death and congenital syphilis. Early treatment in pregnancy improves neonatal outcomes. Recommend repeat testing early in the third trimester (28–32 weeks) according to local guidelines. For a person at high risk of syphilis a further test at 6 weeks post partum is recommended. See local guidelines for further information, particularly in an outbreak declared area, as recommendations for repeat testing vary. If there is a clinical suspicion of syphilis or exposure to syphilis, refer to syphilis guideline and seek urgent specialist advice.

Chlamydia	Routinely offer chlamydia testing at first antenatal visit to all pregnant people under the age of 30. Testing for chlamydia and other STIs regardless of age should be considered for people who live in areas where STI prevalence is high. Consider testing for people presenting with adverse outcomes such as preterm rupture of membranes and miscarriage. Consider the use of self-collected vaginal or urine samples for testing in asymptomatic people. Treatment during pregnancy is recommended.
Gonorrhoea	Routinely offer gonorrhoea testing at first antenatal visit to all pregnant people under the age of 30. Testing for gonorrhoea and other STIs regardless of age should be considered for people who live in areas where STI prevalence is high. Consider testing for people presenting with adverse pregnancy outcomes such as preterm rupture of membranes and miscarriage. Consider the use of self-collected vaginal or urine samples for testing asymptomatic people. Treatment during pregnancy is recommended.
HSV	Screening for herpes simplex virus (HSV) is not recommended in pregnancy with either serology or swabs. For advice on pregnant people with past or current HSV infection, see the Herpes guideline.

HBsAg – Hepatitis B surface antigen

HBeAg – Hepatitis B e antigen

NAAT – Nucleic acid amplification test

FPU – First pass urine

Specimen collection guidance

Clinician collected | Self-collection

Clinical indicators for testing

- Many tests are conducted as routine antenatal screening, and HIV, syphilis, hepatitis B and chlamydia testing should be seen as part of the routine antenatal screen.
- Bearing in mind sensitive risk indicators may not be disclosed in an antenatal setting, testing should be guided by risk assessment where possible; consider also particular at risk groups such as people < 30 years, people who use drugs, Aboriginal and Torres Strait Islander people, past

history of an STI, contact of someone with an STI or BBV, late, limited or no antenatal care, homeless people, those with a recent partner change, and local epidemiology.

- Pregnant people undergoing pre-abortion assessment should be tested for HIV, hepatitis B, syphilis, chlamydia and gonorrhoea on an opt-out basis. People undergoing surgical abortion should be offered antibiotic prophylaxis. Antibiotic prophylaxis is not recommended for medical abortion.
- Routine screening is not recommended for herpes, human papillomavirus (HPV) , bacterial vaginosis or trichomoniasis, however management should be considered if clinical suspicion exists, as recommended.

Follow-up

If test results are positive, refer to STI management section for advice on:

- Chlamydia
- Hepatitis B
- HIV
- Syphilis
- Hepatitis C
- Gonorrhoea

For pregnant people who test positive for hepatitis B, HIV, hepatitis C or syphilis seek urgent specialist advice.

Test of cure

In the event of a positive test result for syphilis, chlamydia or gonorrhoea, test of cure should be considered following treatment. Contact tracing for all sexual partners is essential to prevent re-infection of the pregnant person.

Retesting

Retesting for syphilis in second and third trimester is recommended in some jurisdictions. See local guidelines for further information, particularly in an outbreak declared area.

Where continued risk (see clinical indicators for testing) is identified during pregnancy, consider retesting before delivery (about 36 weeks) and post partum.

Even if all test results are negative, use the opportunity to:

- Educate about condom use, contraception, HIV PrEP/PEP, safe injecting practices, consent, CST and vaccinations for HAV, HBV and HPV as indicated.
- Vaccinate for hepatitis B postnatally.
- Discuss and activate reminders for regular testing according to risk, especially if their behaviours indicate the need for more frequent testing.

Auditable Outcomes

- 100% of pregnant people are tested for HIV, syphilis and hepatitis B.

Resources

- Bloodborne Viruses and Sexually Transmissible Infections in Antenatal Care

Endorsement: These guidelines have been endorsed by the Blood Borne Viruses and Sexually Transmitted Infections Standing Committee (BBVSS).

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