Republic of the Philippines
Department of Health
OFFICE OF THE SECRETARY

January 1, 2050

ADMINISTRATIVE ORDER
No. 17-B s, 1998

SUBJECT: Information and Guidelines for the management of Sexually Transmitted Diseases (STDs) in Children.

I. RATIONALE

The exact magnitude of Sexually Transmitted Diseases occurring in children is unknown. However, the United Nations Children's Fund (UNICEF) has observed that the prevalence of STDs among children, especially those who are in the prepubertal age, has been increasing in the past decade. UNICEF has attributed this to the problems of "child prostitution" and sexual abuse, which have been reported to be likewise increasing in frequency in recent years.

When STDs occur in children beyond the neonatal period, causes as sexual abuse must be considered. Because of the deleterious consequences of sexual abuse on the mental, psychological, and physical health of a child, health care providers should give special attention to the management of STDs as an important part of pediatric health care.

Many health care providers are not aware of the link between STDs and the sexual abuse and exploitation of children. In some cases, children who were sexually abused are not screened for STDs. Conversely, children found with STD are not routinely examined or investigated to determine the possible cause of the infection; sometimes, they are just presumed to have acquired the STD through non-sexual means.

This Administrative Order is therefore issued to guide and call the attention of health care providers on the need to include the diagnosis and treatment of sexually transmitted diseases in children, especially when transmission through sexual means cannot be ruled out. Guidelines covering the legal and psycho-social aspects of sexual abuse and exploitation are not included this Order.

II. PURPOSE

General:

To provide health care workers, with a standard protocol on the management of STDs in children which is consistent with the National STD Case Management Guidelines issues by the DOH.

Specific:

(a) To set the procedures in evaluating children with STD,
(b) To provide guidelines for the treatment of children with STD.

III. INFORMATION, GUIDELINES, AND PROCEDURES

A. Evaluating Children with Possible STD

1. General Considerations

1.1 Evaluation of children with STDs requires open-mindedness among health care providers. A careful investigation on the nature and mode of transmission of the STD pathogen should be done.

1.2 Pathogens related to STDs can be transmitted sexually or non-sexually. In determining the mode of transmission, health workers shall consider the following:
a) Sexually-abused children are often unable to report sexual abuse because of fear, embarrassment, guilt, and lack of verbal skills among others.

b) Some sexually transmitted diseases occurring in adults may occur through non-sexual means. Because some degree of intimacy which may be normal and non-abusive - often exists among household members, the possibility of sexual and non-sexual transmission should not be overlooked.

c) STDs can be acquired before birth, during birth, and through breast feeding.

1.3 Non-sexual transmission of pathogens commonly associated with STDs should be considered in the following instances:

a) Rectal or genital Chlamydia infection in children may be acquired perinatally and can persist up to three years;

b) Bacterial vaginosis and Genital Mycoplasma infections have been identified in both non-abused and abused children.

c) Genital warts, although suggestive of sexual abuse, are not specific for sexual abuse in the absence of other evidences. In the absence of sexual abuse, genital warts in the first year of life may

result from contact with the virus during delivery.

d) Molluscum contagious is frequent due to ease of casual transmission.

1.4 Sexual transmission: The diagnosis of STD in a child beyond the neonatal age suggests the possibility of sexual abuse.

2. Examination of the Child

2.1 Health care workers should minimise psychological and physical trauma to the child by carefully reviewing all available information on the child, such as social situation, clinical history, results of physical examinations, and other reports to avoid duplication of questions or investigators.

2.2 The safety, health, and well-being of the child should be the primary concerns of the health care provider. To ensure these, the health worker should always keep in mind the following general considerations:

a) Institutions, groups, or individuals with special skills and services in interviewing and examining children suspected of having been abused should be involved from the start of the work-up if possible.

b) As far as practicable, health workers doing examinations and collecting specimens should have special training in child abuse evaluation. They should be aware that the clinical manifestations of STDs in children differ from the manifestations in adults.

c) Physical examination and the available and appropriate laboratory tests should be completed before treatment is initiated for children who show signs and symptoms of STD.

d) A child with STD who has been medically documented to have been sexually abused must be placed in a safe and secure environment pending further investigation and social or legal disposition of the case.

e) Absence of abnormalities on physical examination does not exclude the possibility of sexual abuse. Many children who have been abused do not show specific physical findings to confirm the occurrence of sexual abuse. Oral sexual contact, fondling and external genital contact are common forms of abuse which do not result in visible physical changes in the child.

f) Presence of multiple STDs in a child may indicate sexual abuse by more than one person.

2.3 Scheduling the Initial and Follow-up Examination

a) Scheduling of examinations should depend on the history and circumstances surrounding the sexual abuse.

b) If the initial exposure is recent, infectious agents or organisms acquired during such exposure may be of inadequate number or may not have produce adequate concentrations of biological/chemical indicators to be detected by available laboratory tests.

c) Follow-up examinations should be done about 2 weeks and 12 weeks after the last sexual exposure and should include repeat physical examination and collection of necessary specimen.

d) A single examination may suffer if the child was abused for an extended period of time, or if the last suspected episode of abuse took place for sometime before the child received the medical evaluation.

e) The timing and nature follow-up examinations should always be considerate of the patient's psychological and social needs.

2.4 Laboratory Examinations:

Laboratory evidence of STD shall be done with tests that has high specificity to avoid legal and psychosocial consequences of false positive diagnosis. The following are recommended:

a. Initial examination and after 2 weeks as follow-up examination:

i. Gram staining of all genital and anal discharges

ii. Culture for N. gonorrhoea and Chlamydia trachomatis (where available) collected from specimens from the pharynx and anus in both sexes, the vagina in girls and the urethra in boys. Cervical specimens shall not be collected from the prepubertal girls. Because of the presence of columnar epithelium in the child's vagina, N. gonorrhoea and Chlamydia trachomatis that infect the cervix in adult will cause vaginitis in children. In boys, a meatal specimen of urethral discharge is an adequate substitute for an intraurethral swab specimen when the discharge is present. Only one standard culture system for the isolation of N. gonorrhoea shall be used.

iii. Wet mount microscope examination of a vaginal swab specimen for Trichomonas vaginalis infection. The presence of clue cells or other indicators of bacterial vaginoses as an indicator of sexual exposure in the presence or absence of vaginal discharge is unclear.

iv. Tissue cultures for herpes simplex virus and dark field microscopy or direct fluorescent antibody testing for T. pallidum (where available) from a specimen collected from vesicles or ulcers in children of all ages.

v. I, Collect1on of a serum sample to be preserved for subsequent analysis if follow-up serologtcal tests are posmve If the last sexual exposure-

v. Collection of a serum sample to be preserved for subsequent analysis if follow-up serological

tests are positive. If the last sexual exposure occurred more than 12 weeks before the initial examination, serum shall be tested immediately for antibody to STD agents. Agents for which suitable test are available include syphilis, HIV and Hepatitis B virus. The choice of agents for serological test shall be made on a case to case basis.

vi. Examine for the presence of venereal warts.

vii. Examine for pregnancy in females.

b. Examination at 12 weeks following assault:

i. An examination at this time is recommended to allow time for antibody to infectious agents to develop. Serological tests for the following agents shall be considered: Syphilis, HIV and Hepatitis B virus.

ii. Hepatitis B Virus test shall be interpreted carefully, since Hepatitis B virus may be transmitted by non sexual modes as well as sexually

c. In the absence of laboratory examinations, children who are in the post menarche stage shall be managed based on the National STD case management guide.

B. Treatment of STDs in Children:

1. Prophylactic or presumptive treatment are not generally indicated when sexual abuse of children is suspected. The infection rate in children is low such that prophylactic treatment will prevent few infections. In addition, the risk of complications from STD in children is low.

2. In the presence of congenital or neonatal infections, the following are recommended:

a. Gonococcal Infection: Gonococcal Ophthalmia
* Ceftriaxone 25-50 mg. / kg bw. Single does by IM to a maximum of 125 mg.

b. Chlamydial Infection: Conjunctivitis and Pneumonia
* Erythromycin 50 mg. / kg.bw. / day in 4 divided doses for 2 weeks

c. Syphilis

i. Early Congenital Syphilis: less than 2 years old with abnormal CSF
*Aqueous procaine penicillin, 50,000 IU / kg.bw. by IM for 10 days
ii. Early Congenital Syphilis: less than 2 years old with normal CSF
*Benzathine Penicillin, 50,000 IU/kg.bw., IM single dose
iii. Congenital Syphilis: greater than 2 years duration
*Aqueous procaine penicillin, 200,000 IU / kg.bw. by IM for 10 days, not to exceed 1.2. M units

daily
iv. For penicillin allergic children after the first month of life
*Erythromysin 50 mg. / kg.bw. orally, 4 times daily for 30 days.

3. In the presence of documented STD beyond the neonatal period, the following are recommended:

a. Gonococcal Infections: Uncomplicated ano-genital infections:
* Ceftriaxone 25-50 mg./kg.bw. single dose by IM to a maximum of 125 mg.
* Plus treatment for Chlamydia Trachomatis

b. Chlamydia Trachomatis Infections: Uncomplicated Ano-genital infections:
Children who weigh less than 45 kg.
* Erythromycin 50 mg./kg.bw./day in 4 divided doses for 10-14 days
Children who weigh greater than 45 kg. but are less than 8 years of age
* Erythromycin 500 mg. 4 x a day for 7 days
Children who weigh greater than 45 kg., more than 8 years of age
* Doxycycline 100 mg. 2 x a day for 7 days

c. Syphilis
(1) Primary, secondary and latent syphilis of less than 2 years duration
* Benzathine Penicillin 50,000 IU/kg.bw., IM, single dose
(2) Late latent syphilis more than 2 years duration
* Benzathine Penicillin, 50,000 IU/kg.bw., IM, single dose, weekly for 3 weeks

d. Genital Herpes
* Acyclovir 20 mg./kg.bw., 5 x a day for 7-10 days or until resolution is achieved

e. Genital Warts
* Podophyllin, 10-25% in compound tincture of benzoin

f. Trichomonas Vaginalis
* Metronidazole 15 mg./kg.bw., per day in 2-3 divided doses for 7 days

g. Bacterial Vaginoses
* Metronidazole 15 mg./kg.bw./ per day in 2-3 divided doses for 7 days or
* Clindamycin 20-30 mg./kg.bw./ day in 3-4 divided doses for 7 days

h. Genital Candidiasis
* Clotimazole cream, 1% apply 3 x day for 2 to 3 weeks.

IV EFFECTIVITY

This Order takes effect upon approval and signing by the Secretary of Health.

ALBERTO G. ROMUALDEZ, MD
Secretary of Health