Symptom-based integrated approach to the adult in primary care

- TB
- HIV
- Asthma/COPD
- Cardiovascular disease
- Diabetes
- Mental health conditions
- Epilepsy
- Musculoskeletal disorders
- Women's health
What is Primary Care 101?
Primary Care 101 is a symptom-based integrated clinical management guideline using an algorithmic approach for the management of common symptoms and chronic conditions in adults. The guidelines are intended for use by all health care practitioners working at primary care level in South Africa.

Rationale and ethos of Primary Care 101
The aim is to standardise the approach to adults presenting to primary care with symptoms, or attending for review of their chronic condition or conditions. Primary Care 101 is aimed at assisting primary healthcare practitioners in providing the best evidence-based clinical care for patients whilst being fully cognisant that this is only one element of good quality care. The other key values that must be practised during all interactions with patients are:
• To accept that each person is unique and must be approached with due regard for their multiple roles as individuals, within families and as a member of their community
• To respect your patient’s concerns and choices
• To develop a relationship of mutual trust with your patient
• To communicate effectively, courteously and with empathy
• To actively arrange follow-up care especially for patients with chronic conditions
• To link the patient to community-based resources and support
• To ensure continuity of care, if possible.

Development of Primary Care 101
The Primary Care 101 Guideline is an expansion of the Practical Approach to Lung Health and HIV/AIDS in South Africa (PALSA PLUS), which originally drew on the World Health Organisation’s Practical Approach to Lung Health. The role of the Knowledge Translation Unit of the University of Cape Town Lung Institute is acknowledged in leading the development of these guidelines under contract from the National Department of Health. Primary Care 101 was finalised through a rigorous process of consultation with health managers in the public sector, clinicians, academics, patient advocacy groups and inputs from the Colleges of Medicine of South Africa, the South African Nursing Council, the South African Pharmacy Council and Medicines Control Council. More details regarding the development and the role of contributors can be found at www.knowledgetranslation.co.za.

The Primary Care 101 Guideline is aligned with the following Department of Health policies and clinical protocols:
• Standard Treatment Guidelines and Essential Medicines List for Primary Health Care
• Standard Treatment Guidelines and Essential Medicines List for Hospital Level (Adult) 2012
• Standard Treatment Guidelines and Essential Medicines List for Hospital Level (Paediatric) 2013 - Draft
• South African Antiretroviral Treatment Guidelines 2013
• South African Prevention of Mother to Child Transmission of HIV Guidelines 2013 (Draft)
• Draft National Tuberculosis Management Guidelines 2013
• National Guideline: Comprehensive Management and Control of Sexually Transmitted Infections 2009
• National Infection Prevention and Control Policy and Strategy 2007
• South African Guidelines for Maternity Care in South Africa 3rd edition 2007
• National Contraception Clinical Guidelines 2012
• National Guideline: Updated Management of Type 2 Diabetes in Adults at Primary Care Level 2012 (Draft).

Implementing Primary Care 101
The Primary Care 101 and PALSA PLUS training programmes recognise that guidelines alone are insufficient to improve practice. Active implementation is recommended, and guidelines are combined with short on-site training sessions, repeated over several months to allow primary healthcare practitioners to integrate recommendations into their clinical practice, and feedback experiences. Primary Care 101 is being implemented as part of the ICDM (Integrated Chronic Disease Management), a new model to improve the quality of care and outcomes for patients with chronic diseases. The ICDM integrates chronic disease care at primary care clinics for patients with both communicable and non-communicable conditions, and is aligned with the PHC Re-engineering Framework. The ICDM engages stakeholders at multiple levels to strengthen the quality of care provided at clinics, to assist individuals to assume responsibility for their health, and for communities to participate in screening and health promotion activities.

Using Primary Care 101
Primary Care 101 is divided into two main sections: symptoms and chronic conditions. In patients presenting with symptoms, start by identifying your patient’s main symptom. Use the symptoms contents page to find the relevant symptom page in the guideline. Then follow the algorithms to either a management plan for that symptom or to the relevant chronic condition in the second section of the guideline.

In patients presenting with a known chronic condition, use the chronic conditions contents page to find that condition in the guideline. Now go to the routine care pages for that condition to manage your patient using the assess, advise and treat framework. Chronic patients may also have other symptoms – these can be managed using the relevant symptom pages, and will prompt an assessment of the degree of control of the chronic condition, if appropriate.

All drug names are highlighted in either orange or blue.
• Orange-highlighted drugs may be prescribed by a doctor or a nurse according to his/her scope of practice.
• Blue-highlighted drugs may only be prescribed by a doctor.
## Communicating Effectively

Communicating effectively with your patient during a consultation need not take much time or specialised skills. Try to use straightforward language and take into account your patient’s culture and belief system.

Integrate these four communication principles into every consultation:

### Listen

**Listen** effectively helps to build an open and trusting relationship with the patient.

<table>
<thead>
<tr>
<th>DO</th>
<th>The patient might feel:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- give all your attention</td>
<td>- ‘I can trust this person’</td>
</tr>
<tr>
<td>- recognise non-verbal behaviour</td>
<td>- ‘I feel respected and valued’</td>
</tr>
<tr>
<td>- be honest, open and warm</td>
<td>- ‘I feel hopeful’</td>
</tr>
<tr>
<td>- avoid distractions e.g. phones</td>
<td>- ‘I feel heard’</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>DON’T</th>
<th>The patient might feel:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- talk too much</td>
<td>- ‘I am not being listened to’</td>
</tr>
<tr>
<td>- rush the consultation</td>
<td>- ‘I feel disempowered’</td>
</tr>
<tr>
<td>- give advice</td>
<td>- ‘I am not valued’</td>
</tr>
<tr>
<td>- interrupt</td>
<td>- ‘I cannot trust this person’</td>
</tr>
</tbody>
</table>

**The patient might feel:**
- ‘I can trust this person’
- ‘I feel respected and valued’
- ‘I feel hopeful’
- ‘I feel heard’

**The patient might feel:**
- ‘I am not being listened to’
- ‘I feel disempowered’
- ‘I am not valued’
- ‘I cannot trust this person’

### Discuss

Discussing a problem and its solution can help the overwhelmed patient to develop a manageable plan.

<table>
<thead>
<tr>
<th>DO</th>
<th>The patient might feel:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- use open ended questions</td>
<td>- ‘I choose what I want to deal with’</td>
</tr>
<tr>
<td>- offer information</td>
<td>- ‘I can help myself’</td>
</tr>
<tr>
<td>- encourage patient to find solutions</td>
<td>- ‘I feel supported in my choice’</td>
</tr>
<tr>
<td>- respect the patient’s right to choose</td>
<td>- ‘I can cope with my problems’</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>DON’T</th>
<th>The patient might feel:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- force your ideas onto the patient</td>
<td>- ‘I am not respected’</td>
</tr>
<tr>
<td>- be a ‘fix-it’ specialist</td>
<td>- ‘I am unable to make my own decisions’</td>
</tr>
<tr>
<td>- let the patient take on too many problems at once</td>
<td>- ‘I am expected to change too fast’</td>
</tr>
</tbody>
</table>

**The patient might feel:**
- ‘I am not respected’
- ‘I am unable to make my own decisions’
- ‘I am expected to change too fast’

### Empathise

Empathy is the ability to imagine and share the patient’s situation and feelings.

<table>
<thead>
<tr>
<th>DO</th>
<th>The patient might feel:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- listen for, and identify his/her feelings e.g. ‘you sound very upset’</td>
<td>- ‘I can get through this’</td>
</tr>
<tr>
<td>- allow the patient to express emotion</td>
<td>- ‘I can deal with my situation’</td>
</tr>
<tr>
<td>- be supportive</td>
<td>- ‘My health worker understands me’</td>
</tr>
<tr>
<td>- ‘I feel supported’</td>
<td>- ‘I feel supported’</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>DON’T</th>
<th>The patient might feel:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- judge, criticise or blame the patient</td>
<td>- ‘I am being judged’</td>
</tr>
<tr>
<td>- disagree or argue</td>
<td>- ‘I am too much to deal with’</td>
</tr>
<tr>
<td>- be uncomfortable with high levels of emotions and burden of the problems</td>
<td>- ‘I can’t cope’</td>
</tr>
<tr>
<td>- ‘My health worker is unfeeling’</td>
<td></td>
</tr>
</tbody>
</table>

**The patient might feel:**
- ‘I am being judged’
- ‘I am too much to deal with’
- ‘I can’t cope’
- ‘My health worker is unfeeling’

### Summarise

Summarising what has been discussed helps to check the patient’s understanding and to agree on a plan for a solution.

<table>
<thead>
<tr>
<th>DO</th>
<th>The patient might feel:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- get the patient to summarise</td>
<td>- ‘I can make changes in my life’</td>
</tr>
<tr>
<td>- agree on a plan</td>
<td>- ‘I have something to work on’</td>
</tr>
<tr>
<td>- offer to write a list of his/her options</td>
<td>- ‘I feel supported’</td>
</tr>
<tr>
<td>- offer a follow-up appointment</td>
<td>- ‘I can come back when I need to’</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>DON’T</th>
<th>The patient might feel:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- direct the decisions</td>
<td>- ‘My health worker disapproves of my decisions’</td>
</tr>
<tr>
<td>- be abrupt</td>
<td>- ‘I feel resentful’</td>
</tr>
<tr>
<td>- force a decision</td>
<td>- ‘I feel misunderstood’</td>
</tr>
</tbody>
</table>

**The patient might feel:**
- ‘My health worker disapproves of my decisions’
- ‘I feel resentful’
- ‘I feel misunderstood’

**The patient might feel:**
- ‘I can make changes in my life’
- ‘I have something to work on’
- ‘I feel supported’
- ‘I can come back when I need to’
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Assess and manage the patient using his/her symptoms as a starting point

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<td>Abdominal pain</td>
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<td>Abnormal vaginal bleeding</td>
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<td>Aggressive patient</td>
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<td>Anal symptoms</td>
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<td>Arm symptoms</td>
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<td>Heartburn</td>
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<td>Injured patient</td>
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<td>Jaundice</td>
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<td>Joint symptoms</td>
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<td>Leg symptoms</td>
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<td>Lymphadenopathy</td>
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<td>Mouth symptoms</td>
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<td>Nail symptoms</td>
<td>48</td>
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<td>Neck pain</td>
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<tr>
<td>Overweight patient</td>
<td>68</td>
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<td>P</td>
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<td>Pain</td>
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<td>Pap smear</td>
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<tr>
<td>Rape</td>
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<tr>
<td>Seizures</td>
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<td>Sexually transmitted infections</td>
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<td>Skin symptoms</td>
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<td>Difficulty sleeping</td>
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<td>Stressed patient</td>
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<td>Suicidal patient</td>
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<td>Syphilis</td>
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<td>Throat symptoms</td>
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<td>Tiredness</td>
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<td>Traumatised patient</td>
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<tr>
<td>Unconscious patient</td>
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<td>Urinary symptoms</td>
<td>31</td>
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<td>V</td>
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<tr>
<td>Abnormal vaginal bleeding</td>
<td>29</td>
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<tr>
<td>Violent patient</td>
<td>50</td>
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<tr>
<td>Vision symptoms</td>
<td>10</td>
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<tr>
<td>Vomiting</td>
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<td>Weakness</td>
<td>6</td>
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<td>Weight loss</td>
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THE UNCONSCIOUS PATIENT

Clear airway
• Clear mouth and throat and insert oropharyngeal airway if available.

Give 40% oxygen via face-mask. Intubate if:
• Patient centrally cyanosed (blue tongue/lips) and/or
• Respiratory rate < 10 breaths/minute and/or
• Coma score < 9 (to assess coma score see chart to the right)
If equipment or skills unavailable give mask-bag ventilation.

Establish IV access
• Use as large bore venous access as possible.
• If patient bleeding, give Ringer's lactate; if no bleeding, give sodium chloride 0.9% solution.

Check BP
• If systolic BP < 90, give 500mℓ IV fluids rapidly. Repeat until systolic BP > 90. Stop if patient becomes breathless.

Check glucose
• If glucose < 3.5 or unable to measure, give 50mℓ of dextrose 50% IV.
• If glucose ≥ 15, give sodium chloride 0.9% 1V/ℓ in first hour and then 1ℓ over the next 2 hours and 10U short-acting insulin IM.

Manage according to likely cause:

<table>
<thead>
<tr>
<th>Temperature ≥ 38°C</th>
<th>Soft tissue swelling of eyes/lips/wheeze</th>
<th>Pneumonia or meningitis likely</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Give ceftriaxone 2g IV/IM.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Anaphylaxis likely</th>
<th>Small pupils and/or history of drug overdose</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Give adrenaline 1mℓ (1:1000) IM every 5 minutes until better</td>
<td></td>
</tr>
<tr>
<td>Give hydrocortisone 100mg slow IV</td>
<td></td>
</tr>
<tr>
<td>Give promethazine 50 mg IM/slow IV</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Opiate poisoning likely</th>
<th>Signs of trauma</th>
</tr>
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<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Give naloxone 0.4–1.2mg IV</td>
<td></td>
</tr>
<tr>
<td>Stop bleeding</td>
<td></td>
</tr>
<tr>
<td>Stabilise cervical spine</td>
<td></td>
</tr>
<tr>
<td>Stabilise fractures</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Recent seizure/fit</th>
</tr>
</thead>
<tbody>
<tr>
<td>→2.</td>
</tr>
</tbody>
</table>

Assess coma score
Eye opening
• 4 Spontaneous
• 3 To speech
• 2 To pain
• 1 None

Best motor response
• 6 Obeying commands
• 5 Localises purposefully to pain
• 4 Withdraws to pain
• 3 Flexing
• 2 Extending
• 1 None

Best verbal response
• 5 Orientated
• 4 Confused
• 3 Inappropriate words
• 2 Incomprehensible
• 1 None

Add scores to give a single score

Pneumonia or meningitis likely
• Give ceftriaxone 2g IV/IM.

Anaphylaxis likely
• Give adrenaline 1mℓ (1:1000) IM every 5 minutes until better
• Give hydrocortisone 100mg slow IV
• Give promethazine 50 mg IM/slow IV

Opiate poisoning likely
• Give naloxone 0.4–1.2mg IV

Recent seizure/fit
→2.

Write a clear referral letter and refer urgently to hospital

Record history from relatives and emergency staff:
• Onset of coma and details of how found.
• Known chronic disease/s and medication. Ask about diabetes, hypertension, asthma, HIV, cancer, epilepsy. Send medication with patient to hospital.
• Known substance abuse or depression. Was a suicide note found?
• Any recent trauma.
• Recent travel to a malaria area and any prophylaxis taken.

Document level of consciousness, blood pressure and pulse and any treatment given.

1 Do not mix Ringer's lactate and IV ceftriaxone. Flush IV line with sodium chloride 0.9% before and after IV ceftriaxone. If giving ceftriaxone IM, divide dose: 1g into 2 different injection sites. 2 Adrenaline is also known as epinephrine.
## SEIZURES/FITS

**Manage urgently the patient who is unconscious and fitting:**

- Ensure the patient is safe. Place in a lateral lying (recovery) position. Do not place anything in the mouth.
- Give 40% facemask oxygen.
- Check glucose. If < 3.5 or unable to measure, give 50mL of dextrose 50% IV. Continue IV dextrose 5% in sodium chloride 0.9% slowly (30 drops per minute).
- If ≥ 20 weeks pregnant up to 1 week postpartum, give diazepam 10mg IV slow infusion over at least 5 minutes or lorazepam 4mg IM/IV stat.
- Repeat after 10 minutes if fit continues.
- Treat for status epilepticus if:
  - Fits do not respond to 2 doses of diazepam/orlorazepam or
  - Fits last longer than 30 minutes or
  - Patient does not recover consciousness between fits.

**Patient has status epilepticus:**

- Give phenytoin 20mg/kg IV in sodium chloride 0.9% over 60 minutes. If dysrhythmia develops, stop infusion.
- If fits continue repeat phenytoin 10mg/kg IV in sodium chloride 0.9% over 30 minutes.
- If IV phenytoin unavailable, give phenytoin 20mg/kg crushed tablet via nasogastric tube.
- Refer urgently to hospital.

**Patient does not have status epilepticus and fit stops:**

- Temperature ≥ 38°C: give ceftriaxone 2g IM/IV
- Neck stiffness/meningism
- HIV patient
- Reduced level of consciousness more than 1 hour after fit
- Glucose still < 3.5 after one hour or patient on glibenclamide or insulin

**Refer patient same day if:**

- New weakness, numbness, visual disturbance, facial asymmetry, unable to name 3 out of 3 objects (like hand, nose, pen) or recent headaches
- BP ≥ 180/110 one hour after fit has stopped
- Substance abuse: overdose or withdrawal
- Head injury within past 6 weeks
- Pregnant or up to 1 week postpartum

**Approach to patient who is not fitting now and does not need same day referral**

Confirm that patient indeed had a fit: jerking movements of part of or the whole body, with/without tongue biting, incontinence, post-fit drowsiness and confusion.

### Yes

Is patient known with epilepsy?

- Yes
  - New weakness, numbness, visual disturbance, facial asymmetry, unable to name 3 out of 3 objects (like hand, nose, pen) or recent headaches
  - BP ≥ 180/110 one hour after fit has stopped
  - Substance abuse: overdose or withdrawal
  - Head injury within past 6 weeks
  - Pregnant or up to 1 week postpartum

- No
  - Stroke or transient ischaemic attack likely →76.

### No

Episode/s of weakness or disturbance of speech for < 24 hours?

- Yes
  - Stroke or transient ischaemic attack likely →76.

- No
  - Episodes of acute anxiety?
    - Yes
      - Panic attack likely →81.
    - No
      - Collapse following hot feeling, nausea, prolonged standing or intense pain with rapid recovery?
        - Yes
          - Blackout likely →7.
        - No
          - Refer for specialist assessment if diagnosis uncertain.

---

1. Do not mix Ringer’s lactate and IV ceftriaxone. Flush IV line with sodium chloride 0.9% before and after IV ceftriaxone. If giving ceftriaxone IM, divide dose: 1g into 2 different injection sites.
If food intake inadequate, look for a cause:

- Nausea and/or vomiting
  - Eat small frequent meals.
  - Drink high energy drinks (milk, maas, mageu, soup, sweetened fruit juice).
  - Increase energy value of food by adding sugar, milk powder, peanut butter or oil.

- Loss of appetite

- Ask, ‘Are you stressed?’
  - If yes, \(\rightarrow\) 52.

- No money for food
  - If available, refer to nutrition scheme.

- Sore mouth or difficulty swallowing
  - Oral/oesophageal thrush likely \(\rightarrow\) 14

Check thyroid function (TSH) if none of the above and patient has any of pulse > 80, tremor, irritability, dislike of hot weather or thyroid enlargement.

Refer within 1 month for further investigation the patient with persistent documented weight loss and no obvious cause.
FEVER

A patient with a fever has an axillary temperature ≥ 38°C or had a fever in the past 4 days.

Recognise the patient with fever needing urgent attention:

- Confusion or agitation
- Respiratory rate ≥ 30 breaths/minute
- Unable to walk unaided
- Unable to drink
- Jaundice
- Renal angle tenderness
- Seizures
- BP < 90/60
- Easy bleeding/bruising/blood in urine

Management:
- Establish IV access and give 5% dextrose in ½ strength Darrow’s or Ringer’s lactate. If unavailable give oral rehydration solution.
- Give ceftriaxone² 2g IM/IV stat.
- Refer same day to hospital.

Approach to the patient with fever not needing urgent attention

Ask about associated symptoms
If cough → 16; sore throat → 14; blocked/ runny nose → 13; vaginal discharge → 23; burning urine → 31, painful skin → 40, headache → 9, diarrhoea → 21.

If above symptoms are not present, has patient visited in the past 12 weeks a malaria endemic area?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>
| • Refer for malaria test and treatment.  
   • Consider other cause especially TB → 55. | • Exclude TB in the patient with fever ≥ 2 weeks → 55.  
   • If status unknown, test for HIV → 60.  
   • The HIV patient with fever > 1 month and weight loss ≥ 10% has AIDS and needs ART → 61. |

Refer the patient with persistent fever and no obvious cause.

¹ Do not mix Ringer’s lactate and IV ceftriaxone. Flush IV line with sodium chloride 0.9% before and after ceftriaxone. If giving ceftriaxone IM, divide dose: 1g into 2 different injection sites.
# LYMPHADENOPATHY (enlarged lymph node/s)

## Approach to patient with enlarged lymph nodes

- Lymphadenopathy is common in HIV. If status unknown, test for HIV and manage on relevant page.
- Ask about associated symptoms, especially TB symptoms (weight loss, cough ≥ 2 weeks, chest pain, night sweats)

### Are nodes equally enlarged < 2cm or 1 or more ≥ 2cm?

#### All lymph nodes enlarged equally but < 2cm in size

- Check for secondary syphilis with RPR or if unavailable, look for signs: rash especially palms and soles, mouth ulcers, genital wart-like lesions.
- RPR positive or signs of secondary syphilis
  - Treat syphilis → 28.
  - Give routine HIV care → 61.
  - Advise repeat test after 3 month window period.
  - If asymptomatic, reassure and advise to return if symptoms occur.

- HIV positive
  - Refer for further investigation if after 2 weeks patient is unwell with lymphadenopathy and no obvious cause.

- HIV and/or RPR negative
  - Undergo routine care → 61.

#### 1 or more lymph node/s ≥ 2cm in size

- Is there a nearby infection (skin, throat) or Kaposi’s sarcoma lesion?
  - No
  - Inguinal/groin swelling
    - No
      - Swelling hot, painful and/or red?
        - No
        - Refer to exclude hernia, aneurysm.
        - Yes
          - Confirmed this is a lymph node: discrete, movable and rubbery.
          - Patient needs lymph node aspirate for TB and cytology.
          - If patient is coughing, also exclude TB with sputa → 55.
          - Treat patient and partner for bubo
            - First assess and advise the patient and partner → 23.
            - Doxycycline 100mg 12 hourly for 14 days and Ciprofloxacin 500mg 12 hourly for 3 days
            - Pregnant/breastfeeding: erythromycin 500mg 6 hourly for 14 days instead of doxycycline and ciprofloxacin
            - Paracetamol 1g 6 hourly for pain
            - Look for genital ulcer. If present → 23.
            - Aspirate fluctuant lymph node through intact skin.

  - Yes
    - Sore throat → 14
    - Skin infection → 40
    - Kaposi’s sarcoma lesion → 44
## WEAKNESS and/or TIREDNESS

### Recognise the patient with weakness and/or tiredness needing urgent attention:
- Possible stroke or TIA: sudden onset of weakness on 1 or both sides perhaps with vision problems, dizziness, difficulty speaking or swallowing →76.
- Difficulty breathing →16.
- Chest pain →15.
- Patient on ART with other signs of lactic acidosis: nausea, abdominal pain or swelling, weight loss, fatigue, shortness of breath →63.
- Diarrhoea and/or vomiting with reliable signs of dehydration:
  - Postural hypotension (systolic BP drop > 20mmHg between lying and standing)
  - Poor urine output
  - Confusion

**Management:**
- If dehydrated give oral or IV rehydration. Reassess after 2 hours and refer if no improvement.

### Approach to patient with weakness and/or tiredness not needing urgent attention:
- Tiredness is a problem when it persists so that the patient is unable to complete routine tasks and it disrupts work, social and family life.
- Look for a cause of the patient’s weakness/tiredness:

<table>
<thead>
<tr>
<th><strong>First check patient’s temperature.</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>If ≥ 38°C →4.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Then exclude TB, HIV, pregnancy and stress.</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Ask about TB symptoms. Exclude TB →55.</td>
</tr>
<tr>
<td>If status unknown, test for HIV →60. The HIV patient needs routine HIV care →61.</td>
</tr>
<tr>
<td>Exclude pregnancy. If pregnant →93.</td>
</tr>
<tr>
<td>Ask ‘Are you stressed?’ If yes →52.</td>
</tr>
<tr>
<td>If patient has difficulty sleeping →54.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>If none of the above, test for anaemia, diabetes, kidney and thyroid disease.</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Check Hb for anaemia: if &lt; 11 (woman) or &lt; 12 (man), refer to doctor same week.</td>
</tr>
<tr>
<td>Exclude diabetes with random finger prick blood glucose. To interpret result →70.</td>
</tr>
<tr>
<td>Look for kidney disease on urine dipstick: check eGFR if patient has proteinuria, diabetes, hypertension, or is &gt; 60 years.</td>
</tr>
<tr>
<td>Check TSH if any of weight gain, dry skin, constipation, cold intolerance. If TSH abnormal refer to doctor.</td>
</tr>
</tbody>
</table>

**Refer the patient with persistent weakness/tiredness and no obvious cause.**
### COLLAPSE

**Recognise the patient who has collapsed needing urgent attention:**

- Unconscious → 1
- Fit → 2
- Sudden onset of weakness which may not have resolved on 1 or both sides → 76
- Difficulty breathing → 16
- Chest pain → 15
- Loss of consciousness for > 2 minutes

**Management:**
- Check blood glucose: if < 3.5mmol/ℓ, give oral **glucose** if conscious, or if unconscious, 40–50mℓ **dextrose 50%** IV. If known with diabetes → 71.
- Refer same day to hospital.

**Approach to the patient who has collapsed but not needing urgent attention**

- Ensure patient has had an ECG. Refer same day if abnormal.
- Screen for substance abuse if > 21 drinks/week (man) or > 14 drinks/week (woman) and/or > 5 drinks/session or misuse of illicit or prescription drugs → 83.
- Check for postural hypotension: Measure BP lying and repeat after standing for 3 minutes.

<table>
<thead>
<tr>
<th>Systolic BP drops by ≥ 20mmHg.</th>
<th>No change in systolic BP or change &lt; 20mmHg Ask patient to breathe rapidly for 2–3 minutes. Are symptoms reproduced?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Simple faint likely**

- There may be twitching of limbs, face, eyes that last < 12 seconds (not a fit).
- Advise to avoid overheating and prolonged standing.

**Hyperventilation likely**

- Advise re-breathing into a brown paper bag.
- Assess and manage patient’s stress → 52.

Refer the patient > 70 years with possible heart disease, or who collapses repeatedly, or where no cause for collapse is obvious.
### Dizziness

#### Recognise the Patient with Dizziness Needing Urgent Attention:
- Dehydration due to vomiting/diarrhoea (systolic BP drop ≥ 20mmHg between lying and standing) with poor response to IV or oral rehydration
- Consider stroke if sudden onset of dizziness is associated with vision problems, weakness on 1 or both sides, difficulty speaking or swallowing →76.
- BP < 90/60
- Pulse < 40 and/or irregular

#### Management:
- Refer same day to hospital.

#### Approach to the Patient with Dizziness Not Needing Urgent Attention

- Ask about ear symptoms. If present →12.
- Screen for substance abuse: if > 21 drinks/week (man) or > 14 drinks/week (woman) and/or > 5 drinks/session or misuse of illicit or prescription drugs →83.
- Screen for substance abuse: if > 21 drinks/week (man) or > 14 drinks/week (woman) and/or > 5 drinks/session or misuse of illicit or prescription drugs →83.
- Review patient’s medication. Anti-hypertensives, sedatives, efavirenz, oral hypoglycaemics, anti-convulsants can all cause dizziness. Refer to doctor.
- If diabetic, check finger prick blood glucose for hypoglycaemia →71.
- Check for anaemia with Hb. If < 11 (woman) or < 12 (man), refer doctor same week.
- Check BP. If > 130/80 →73 to interpret result. Assess for postural hypotension: Measure BP lying and repeat after standing for 3 minutes.

#### Postural Hypotension Likely
- This is common in elderly or pregnant →93.
- Advise patient to stand up slowly.
- Doctor must review if patient on any medication.

#### Hyperventilation Likely
- Advise re-breathing into a brown paper bag.
- Assess and manage patient’s stress →52.

#### No Drop or Drop in Systolic BP < 20mmHg
- Ask patient to breathe rapidly for 2–3 minutes. Are symptoms reproduced?
- No
- Ask about associated features
  - Recent flu-like illness
  - Vestibular neuronitis likely
    - Mobilize as soon as possible.
    - Refer to ENT if:
      - Symptoms > 2 weeks
      - Tinnitus
      - New deafness
- Patient needs Epley manoeuvre. Refer to doctor.

#### If None of the Above
- Check TSH. If abnormal, refer to doctor.
- Refer if no cause is found or dizziness persists.
HEADACHE

The patient with headache and one or more of the following needs urgent attention:

- Sudden onset of severe headache
- New onset, persistent, different to usual headache
- Headache that wakes or is worse in the morning
- Vomiting
- Temperature ≥ 38°C
- Neck stiffness/meningism
- BP ≥ 180/110, or if pregnant, diastolic BP ≥ 90.

Management:

- If temp ≥ 38°C and neck stiffness, treat for meningitis. Give ceftriaxone1 2g IM/IV.
- If BP ≥ 180/110 and not pregnant, give amlodipine 10mg orally stat. If unavailable, give enalapril 10mg orally stat2. If pregnant refer same day to hospital.

Approach to the patient with headache not needing urgent attention

Is headache recurrent with nausea and/or vomiting and/or visual disturbance that resolves completely?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No: Pain or pressure over forehead or cheek/s worse on bending forwards, recent common cold, runny nose?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Migraine likely</td>
<td>Sinus infection likely</td>
</tr>
<tr>
<td>• Give immediately and then as needed paracetamol 1g 6 hourly or ibuprofen 400mg 8 hourly with food up to 5 days and metoclopramide 10mg 8 hourly up to 3 doses and refer if no better.</td>
<td>• Give paracetamol 1g 6 hourly.</td>
</tr>
<tr>
<td>• Advise patient to recognise and treat migraine early, rest in a dark, quiet room, avoid precipitants like loud noise, stress, flashing lights, missing meals, alcohol, chocolate, cheese.</td>
<td>• If nasal discharge for &gt; 6 days, give amoxicillin 500mg 8 hourly for 5 days. If penicillin allergic, give erythromycin 500mg 6 hourly for 5 days.</td>
</tr>
<tr>
<td>• Avoid oestrogen-containing contraceptives.</td>
<td>• Refer if poor response to treatment, meningism, tooth infection, swelling over sinus or around eye.</td>
</tr>
<tr>
<td>• If ≥ 2 attacks/month, refer/discuss for medication to prevent migraines.</td>
<td>• If patient has recurrent sinusitis, test for HIV.</td>
</tr>
<tr>
<td>• Refer if poor response to treatment.</td>
<td>• Check patient’s medication</td>
</tr>
<tr>
<td></td>
<td>- ART: Look for meningitis. Refer if headache persists for more than 6 weeks after starting ART.</td>
</tr>
<tr>
<td></td>
<td>- Overuse of analgesics can cause headaches. Advise to avoid regular use and to cut down on amount used.</td>
</tr>
<tr>
<td></td>
<td>• If patient not on above medication consider tension headache, temporal arteritis or neck pain:</td>
</tr>
<tr>
<td></td>
<td>Tightness of scalp</td>
</tr>
<tr>
<td></td>
<td>Tension headache likely</td>
</tr>
<tr>
<td></td>
<td>• Give paracetamol 1g 6 hourly.</td>
</tr>
<tr>
<td></td>
<td>• Discuss stress.</td>
</tr>
<tr>
<td></td>
<td>Pain mainly in neck with muscle stiffness.</td>
</tr>
<tr>
<td></td>
<td>• Go to neck pain page.</td>
</tr>
<tr>
<td></td>
<td>&gt; 50 years, pain over temples</td>
</tr>
<tr>
<td></td>
<td>Temporal arteritis likely</td>
</tr>
<tr>
<td></td>
<td>• Check CRP</td>
</tr>
<tr>
<td></td>
<td>• Give paracetamol 1g 6 hourly.</td>
</tr>
<tr>
<td></td>
<td>• Review next day: if CRP &gt; 5, give prednisone 40mg &amp; refer same day.</td>
</tr>
</tbody>
</table>

- Decreased level of consciousness
- Confusion
- Vision problems (e.g. double vision, photophobia)
- Following a first seizure
- Sudden weakness on one or both sides
- Speech disturbance
- Pupils different in size

1 Do not mix Ringer’s lactate and IV ceftriaxone. Flush IV line with sodium chloride 0.9% before and after IV ceftriaxone. If giving ceftriaxone IM, divide dose: 1g into 2 different injection sites. 2 Do not give short-acting nifedipine unless pregnant, as it may drop the blood pressure too quickly, causing a stroke. 3 Avoid ibuprofen if peptic ulcer, asthma, hypertension, heart failure, kidney disease.
### EYE/VISION SYMPTOMS

#### Recognise the patient with eye or vision symptoms needing urgent attention:
- Single painful red eye
- Shingles involving the eye (or if eyelid swollen closed, the tip of the nose)
- Sudden loss or change in vision, including blurred or reduced vision
- Consider stroke if sudden onset of vision problems is associated with dizziness, weakness on 1 or both sides, difficulty speaking or swallowing →76.
- Metallic foreign body or foreign body associated with welding or grinding
- Chemical burn to one or both eyes: wash the eye continuously for at least 20 minutes with clean water or saline.
- Whole eyelid swollen, red and painful: possible orbital cellulitis. Give ceftriaxone 1 2g IV/IM stat

**Management:**
- If painful red eye associated with coloured haloes around light, dilated oval pupil, headache, nausea and vomiting, acute glaucoma likely. Give acetazolamide oral 500mg immediately and then 250mg 6 hourly and pilocarpine 1% eye drops every 15 minutes for 4 doses.
- Refer same day to hospital.

#### Approach to patient with eye/vision symptoms not needing urgent attention

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Both eyes are discharging/watery</td>
<td>± Wash out eye with clean water. Remove the cause. Treat with oxymetazoline eye drops 1–2 drops 6 hourly for 7 days.</td>
</tr>
<tr>
<td>Red or swollen eyelids</td>
<td>± Give chloramphenicol 1% ointment 6 hourly for 7 days. Complete course. Refer for next available eye OPD appointment.</td>
</tr>
<tr>
<td>Foreign body</td>
<td>± Wash the eye with clean water or saline. Remove foreign body with cotton-tipped stick or bud.</td>
</tr>
<tr>
<td>Gradual change in vision</td>
<td>± Exclude diabetes &gt; 70. Exclude hypertension &gt; 73. If status unknown, test for HIV &gt; 60. Give chloramphenicol 1% ointment 6 hourly for 7 days.</td>
</tr>
<tr>
<td>Localised cause (makeup) likely</td>
<td>± Treat with oxymetazoline eye drops 1–2 drops 6 hourly for 7 days. The localised cause is likely to be makeup.</td>
</tr>
<tr>
<td>Allergic conjunctivitis likely</td>
<td>± Give chloramphenicol 1% ointment 6 hourly for 7 days. Advise patient to avoid rubbing eyes and to wash hands regularly.</td>
</tr>
<tr>
<td>Bacterial conjunctivitis likely</td>
<td>± Give 0.9% saline eye washes. Give oxymetazoline eye drops 1–2 drops 6 hourly for 7 days. Avoid using &gt; 7 days as this may result in rebound conjunctivitis.</td>
</tr>
<tr>
<td>Viral conjunctivitis likely</td>
<td>± Refer to eye OPD if symptoms do not improve within 2 days.</td>
</tr>
<tr>
<td>Is there prominent itch?</td>
<td>± Refer to eye OPD if symptoms do not improve within 2 days.</td>
</tr>
<tr>
<td>Is the discharge clear or pus?</td>
<td>± Refer to eye OPD if symptoms do not improve within 2 days.</td>
</tr>
<tr>
<td>Pus</td>
<td>± Refer to eye OPD if symptoms do not improve within 2 days.</td>
</tr>
<tr>
<td>Clear</td>
<td>± Refer to eye OPD if symptoms do not improve within 2 days.</td>
</tr>
</tbody>
</table>

1. Do not mix Ringer’s lactate and IV ceftriaxone. Flush IV line with sodium chloride 0.9% before and after IV ceftriaxone. If giving ceftriaxone IM, divide dose: 1g into 2 different injection sites.
### Approach to patient with facial symptoms not needing urgent attention

#### Face pain
- Pain of cheek or jaw with/without swelling and on tapping involved tooth
  - **Gum/tooth infection** likely
  - Give paracetamol 1g 6 hourly
  - Give amoxicillin 500mg 8 hourly for 5 days. If penicillin allergic, give erythromycin 500mg 6 hourly for 5 days and metronidazole 400mg 8 hourly for 5 days.
  - Refer to dentist same week.

#### Sinus infection likely
- Give paracetamol 1g 6 hourly
- If symptoms for > 6 days, give amoxicillin 500mg 8 hourly for 5 days. If penicillin allergic, give erythromycin 500mg 6 hourly for 5 days.
- Salt water washes or steam inhalation may relieve symptoms.
- Refer if:
  - Associated tooth infection
  - Poor response to treatment
  - Swelling over sinuses or around eye
  - Meningism
  - If sinusitis is recurrent and status unknown test for HIV > 60.
  - Recurrent sinusitis is a stage 2 HIV diagnosis. Patient needs routine HIV care > 61.

#### Sudden weakness of 1 side of face
- Unable to wrinkle forehead; cannot close eye fully
  - **Idiopathic (Bell’s) palsy** likely
  - Rarely may be painful.
  - Sagging mouth, dribbling, taste impairment, watering or dry eyes
  - Patient cannot wrinkle forehead, blow forcefully, whistle or pout out cheek.
  - Protect eye by closing eyelid with surgical tape if cornea is exposed.
  - Reassure patient that most people recover completely within 10 days.
  - Refer if:
    - No improvement after 10 days
    - Patient has otitis media
    - Any change in hearing
    - Recent head trauma
    - Damage to cornea
    - Unsure of diagnosis

#### Swelling of face
- Ensure patient has no difficult breathing, RR < 30, otherwise manage urgently as above.

- Is patient on enalapril?
  - Yes
    - Patient has angioedema and must stop enalapril and never start it again.
    - Give chlorpheniramine 4mg 8 hourly for 1–2 days until swelling resolved.
    - Refer to doctor for review of medication.
    - Advise patient to return urgently should difficult breathing occur.
  - No
    - Refer to doctor for review.
# Ear Symptoms

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Likely Diagnosis</th>
<th>Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Itchy ear</td>
<td>Otitis externa likely</td>
<td>- Give pain relief.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Clean ear if discharge is present.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Amoxicillin 500mg 8 hourly for 5 days. If penicillin allergic give erythromycin 500mg 6 hourly for 5 days instead.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Refer if infected and no response to treatment within 48 hours.</td>
</tr>
<tr>
<td>Painful ear</td>
<td>Referred pain likely</td>
<td>- Give pain relief.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Clean ear if discharge is present.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Refer if:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- No response to antibiotics after 5 days.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Recurrent otitis media</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Painful swelling behind ear</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Neck stiffness/meningism</td>
</tr>
<tr>
<td>Discharge from ear</td>
<td>Acute otitis media likely</td>
<td>- Clean ear.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>The ear can heal only if dry.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Refer if:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- No improvement after 4 weeks.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Foul-smelling discharge</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- A large hole in eardrum</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Hearing loss</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Pain in or behind ear</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Consider TB and HIV in chronic otitis media that responds poorly to treatment.</td>
</tr>
<tr>
<td>Difficulty hearing</td>
<td>Chronic otitis media likely</td>
<td>- Clean ear.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>The ear can heal only if dry.</td>
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<tr>
<td></td>
<td></td>
<td>Refer if:</td>
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<td>- Pain in or behind ear</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Consider TB and HIV in chronic otitis media that responds poorly to treatment.</td>
</tr>
</tbody>
</table>

1 Cleaning the ear: Make a wick by twisting a tuft of cotton wool, paper towel or absorbent cloth onto a thin wooden stick. If using cotton wool, it should adhere tightly onto the stick but be fluffy and absorbent on the other end. Insert into ear and remove once wet, continue until wick is dry. Never leave wick or other object inside the ear.
## NOSE SYMPTOMS

<table>
<thead>
<tr>
<th>Common cold likely</th>
<th>Influenza (flu) likely</th>
<th>Sinusitis likely</th>
<th>Allergic rhinitis likely</th>
<th>Recurrent episodes of sneezing and itchy nose most days for &gt; 4 weeks</th>
<th>Bleeding nose</th>
</tr>
</thead>
</table>
| Runny or blocked nose | Ask about duration and associated symptoms. | • Advise the patient with influenza:  
  - bed rest  
  - avoid contact with others to prevent spread  
  - use tissues when sneezing/coughing and dispose of these carefully.  
  • Pain and fever relief (paracetamol 1g 6 hourly)  
  • Regular oral fluids  
  • Reassure patient that antibiotics are not necessary. Use antibiotics only if pus on examination.  
  • Colds and flu should improve within 3–7 days. | • Give paracetamol 1g 6 hourly  
• If pus from nose or symptoms > 6 days: give amoxicillin 500mg 8 hourly for 5 days. If penicillin allergic, erythromycin 500mg 6 hourly for 5 days instead.  
• Salt water washes or steam inhalation may relieve symptoms.  
• Refer if:  
  - Associated tooth infection  
  - Poor response to treatment  
  - Swelling over a sinus or around eye  
  - Meningism  
• If sinusitis is recurrent and status unknown, test for HIV ≥ 60.  
• Recurrent sinusitis is a stage 2 HIV diagnosis. Patient needs routine HIV care ≥ 61. | • Chlorpheniramine 4mg 6–8 hourly for up to 5 days only when symptoms worsen (side effect is sedation).  
• Refer if no improvement with above treatment and symptoms debilitating.  
• If persistant (≥ 4 days per week), give beclomethasone nasal spray long term 2 sprays in each nostril daily and cetirizine 10mg at night. | • Pinch nose wings together for 10 minutes.  
• Check BP.  
  - If < 90/60, elevate legs and give IV sodium chloride 0.9%.  
  - If ≥ 130/80 ≥ 73.  
• If still bleeding:  
  - Insert nasal tampons or BIPP stripping into bleeding nostril/s.  
  - Refer for further management if bleeding persists.  
• If patient has recurrent episodes:  
  - Advise patient to avoid nose-picking, contact sport and trauma to nose.  
  - Educate patient to pinch the soft nose wings when bleeding. |

| Sore throat and/or fever | Body aches/muscle pains and/or fever and/or cold chills | Purulent nasal and/or post nasal discharge and/or headache worse on bending forward and/or pressure over sinuses | | |
# MOUTH AND THROAT SYMPTOMS

**Examine the mouth and throat for redness, white patches, blisters or ulcers.**

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Action</th>
</tr>
</thead>
</table>
| **Red throat** | - **Are there pus or white patches on tonsils?**  
  - **No**: **Viral pharyngitis** likely  
    - Give paracetamol 1g 6 hourly  
    - Salt water mouthwash  
    - Reassure patient that antibiotics are not necessary.  
  - **Yes**: **Bacterial tonsillitis** likely  
    - Give paracetamol 1g 6 hourly  
    - Salt water mouthwash  
    - Give benzathine penicillin 1.2MU IM single dose or phenoxymethylpenicillin 500mg 12 hourly for 10 days. If penicillin allergic give erythromycin 500mg 6 hourly for 10 days instead.  
    - Refer for ENT assessment if > 4 episodes per year. |
| **White patches on cheeks, gums, tongue, palate, may have angular cheilitis (cracks in corners of mouth).** | - **Oral thrush/candida** likely  
  - Nystatin suspension 1ml orally after eating for 7 days. Keep in mouth as long as possible.  
  - If patient uses inhaled corticosteroids, ensure she uses spacer and rinses mouth after use.  
  - If status unknown, test for HIV.  
  - Herpes simplex likely  
    - Apply tetracaine 0.5% on blisters 6 hourly.  
    - If HIV give aciclovir 400mg 8 hourly for 7 days if:  
      - Ulcers are extensive or recurrent  
      - Severe pain  
      - Ulcers present for > 1 month  
  - Aphthous ulcer/s likely  
    - Apply tetracaine 0.5% on ulcers 6 hourly until healed.  
    - Refer if:  
      - Not healed within 2 weeks  
      - Larger than 1 cm in diameter |
| **Painful blisters on lips/mouth** | - If status unknown, test for HIV.  
  - Herpes > 1 month is a stage 4 HIV disease.  
  - Patient needs ART. |
| **White patches on cheeks, gums, tongue, palate, may have angular cheilitis (cracks in corners of mouth).** | - Advise the patient with a sore mouth/throat to avoid spicy, hot, sticky, dry or acidic food and to eat soft, moist food or to soften food with margarine or gravy, or dip in tea/coffee or soup.  
  - Advise to keep mouth and teeth clean by brushing and rinsing regularly. |
| **Painful ulcer/s in mouth/throat** |  |

**Recognise the patient needing urgent attention:**
- Unable to open mouth
- Unable to swallow at all

**Management:**
- Refer same day
CHEST PAIN

Recognise the patient with chest pain needing urgent attention:
- Respiratory rate ≥ 30 breaths/minute
- BP ≥ 180/110 or < 90/60
- Pulse irregular, > 100 or < 60
- Severe pain
- New onset of central chest pain

Management:
- If unconscious → 1. If conscious, sit patient up.
- Give 40% face mask oxygen.
- If BP < 90/60, give 200mℓ sodium chloride 0.9% IV.
- Manage according to temperature:
  - ≥ 38°C
    - Chest infection likely
      - Give ceftriaxone1 1g IV/IM stat.
      - If BP still < 90/60, give 500mℓ sodium chloride 0.9% IV over 30 minutes.
      - Repeat if BP persists < 90/60. Stop fluids if respiratory rate increases.
      - Refer patient same day.
  - < 38°C
    - Do an ECG
      - ECG normal or unavailable or uncertain
        - Is chest pain worse on lying down, palpation or breathing deeply?
        - Yes: Heart attack unlikely: refer urgently.
        - No: ECG abnormal
          - Heart attack likely → 77

Approach to the patient with chest pain not needing urgent attention

First exclude pain related to heart and lungs.

Recurrent episodes of central chest pain, brought on by exertion and relieved by rest: angina likely → 77.

Pain on coughing and breathing deeply: → 16.

Once heart and lung conditions excluded, consider heartburn, musculoskeletal problem or shingles.

Retrosternal or epigastric pain with eating, hunger or lying down: heartburn or indigestion likely
- Avoid spicy/acidic food, fizzy drinks, eat small frequent meals and prop up head of bed.
- If waist circumference > 88cm (woman), 102cm (man), assess patient’s CVD risk → 68.
- Give omeprazole 20mg daily for 14 days.
- Refer same week if any of: no better after 7 days of omeprazole, new onset and > 45 years, pain on swallowing, vomiting, weight loss, loss of appetite, feeling of early fullness, occult blood positive, abdominal mass.

Tender at costochondral junction, no fever or cough: Musculoskeletal problem likely
- Give ibuprofen 400mg 8 hourly with food for up to 5 days.
- Refer if pain persists > 4 weeks.

Burning pain on 1 side with or without rash for 1–2 days: Shingles likely → 41.

Refer same week if uncertain of diagnosis.

1 Do not mix Ringer’s lactate and IV ceftriaxone. Flush IV line with sodium chloride 0.9% before and after IV ceftriaxone.
Cough and/or Difficult Breathing

Assess the patient with cough and/or difficult breathing not needing urgent attention

Cough and/or difficult breathing < 2 weeks

Sputum, chest pain and fever
- Treat for chest infection:
  - Bed rest and regular fluid intake.
  - Give antibiotic if sputum is new, increased or changed in colour: Is patient at risk of severe infection (HIV, > 65 years, known severe lung, heart, liver disease, diabetes or alcohol abuse)?
  - Yes
    - Give amoxicillin/clavulanic acid 875/125mg 12 hourly for 5 days. Advise to return immediately if worse or if no better after 3 days.
  - No
    - Give benzylpenicillin 2MU IM stat and amoxicillin 1g 8 hourly for 5 days.
    - If no better after 2 days add erythromycin 500mg 6 hourly for 5 days if not already on it or refer same day.

Leg swelling or 1st episode of wheeze in patient ≥ 50 years
- Heart failure likely →75.

Wheeze, no leg swelling, if 1st episode of wheeze, patient < 50 years
- Treat wheeze →17.

Cough and/or difficult breathing ≥ 2 weeks

Exclude TB → 55.
- While looking for TB, consider other cause for cough and/or difficult breathing.

HIV patient with dry cough, worsening breathlessness on exertion, CD4 < 200
- PCP likely
- Consider lung cancer.
- Productive cough most days of at least 3 months for ≥ 2 years, no difficult breathing or weight loss
- Chronic bronchitis
- Advise patient to stop smoking.
- If TB, lung cancer and chronic bronchitis are excluded
- If above conditions excluded, consider asthma or COPD →65.

Temperature ≥ 38°C
- Give single dose of ceftriaxone 1g IM/IV.
- Refer urgently with continuous oxygen.

Wheeze and difficult breathing, no leg swelling, if 1st episode of wheeze, patient < 50 years
- Treat wheeze →17.

Difficult breathing worse on lying flat especially with leg swelling or 1st episode of wheeze in patient ≥ 50 years
- Heart failure likely →75.

- Doctor to diagnose on history and X-Ray: give co-trimoxazole 320/1600mg 6 hourly for 21 days.
- Start workup for ART →61.
- Refer if X-Ray not typical, patient was adherent to co-trimoxazole prophylaxis and/or ART, or if no improvement on treatment.

- If no better after 2 days add erythromycin 500mg 6 hourly for 5 days if not already on it or refer same day.

- If heart failure and TB excluded
- If heart failure likely
- Post-infectious cough likely. Advise patient that the cough should resolve within 8 weeks.
- Leg swelling or 1st episode of wheeze in patient ≥ 50 years
- Weight loss
- Productive cough most days of at least 3 months for ≥ 2 years, no difficult breathing or weight loss
- Chronic bronchitis
- Advise patient to stop smoking.
- If TB, lung cancer and chronic bronchitis are excluded
- If above conditions excluded, consider asthma or COPD →65.

1 Do not mix Ringer’s lactate and IV ceftriaxone. Flush IV line with sodium chloride 0.9% before and after IV ceftriaxone. 2 If penicillin allergic, give erythromycin 500mg 6 hourly for 5 days.
WHEEZE/TIGHT CHEST

Initial Management

• Give salbutamol (beta-agonist) via:
  - Large-volume spacer: 4–8 puffs every 20 minutes for 1 hour then reassess, or
  - Nebuliser (oxygen-driven nebuliser is preferable): 1 or 2mL of 0.5% salbutamol solution in 3mL of sodium chloride 0.9% solution every 20 minutes for 1 hour.
• Give first dose of oral prednisone if no immediate response, or is currently taking oral prednisone. If prednisone unavailable or patient unable to take it, give hydrocortisone 100mg IV.

After 1 hour assess if patient has respiratory distress.

Worse
Refer immediately. While waiting for transport:
• Add 2mL ipratropium bromide to salbutamol nebuliser solution.
• Continue nebulisation every 20 minutes with oxygen in between.

No change
• Add 2mL ipratropium bromide to salbutamol solution.
• Continue nebulisation or large volume spacer every 20 minutes with oxygen in between.
• Refer immediately if no response within 3 hours of arrival.
• If improved, follow discharge plan below.

Better or no symptoms
• If stable after 1 hour, follow discharge plan below.

Discharge plan for the patient who has responded to treatment

• Start, or increase dose and frequency of inhaled salbutamol to a maximum of 2 puffs 4 times a day until condition improves. Check inhaler technique.
• If patient received oral prednisone or IV hydrocortisone above, give oral prednisone 40mg daily for 6 more days.
• If patient has fever, increased sputum production or a change in sputum colour give amoxicillin 1g 8 hourly for 5 days. If penicillin allergic, give erythromycin 500mg 6 hourly for 5 days instead.
• Ask about allergic rhinitis/hayfever (sneezing, itchy or runny nose): treating hayfever effectively improves asthma symptoms.
• People are more likely to stop smoking if advised to do so by a health professional. Urge your patient to stop smoking. For tips on communicating effectively see Preface.
• Book follow-up visits before medicines are expected to run out.
• Treat according to known diagnosis (see below). If the cause of wheezing is not known.

Known asthma
• Start inhaled corticosteroid if 2nd emergency visit for asthma in 6 months or previously using inhaled corticosteroid.
• If already on inhaled corticosteroid, adjust dose.
• Give oral prednisone 40mg daily for 7 days if:
  - Recent/frequent emergency visits or previous hospital admission for asthma.
  - Worsening of symptoms in the months or weeks leading up to the exacerbation.
• Refer same week to doctor if: no response to 7 days of oral prednisone in past 4 weeks, more than 2 courses of oral prednisone in the last 6 months, or exacerbation occurs in spite of maximum level of chronic treatment.
• Follow up the asthma patient.

Known COPD
• Give oral prednisone 40mg daily for 7 days if:
  - Breathlessness has improved but remains worse than usual.
  - Patient has been on long-term daily oral prednisone.
• Refer same month to doctor if 2 or more exacerbations in 6 months.
• Follow up the COPD patient.

Tell patient to return before follow-up appointment if no improvement after completing a short course of oral prednisone.

1 If an oxygen-driven nebuliser is not available, use an air-driven nebuliser instead and give facemask oxygen between nebulisation.
2 Oral prednisone is an important component in the management in all but the mildest exacerbations.
3 Continuous nebulisation is better if there is an inadequate response to initial treatment.
# BREAST SYMPTOMS

## Approach to the patient with a breast symptom who is not breast feeding

### Breast lump/s
- **One or both breasts?**
  - **Both breasts**
  - **One breast**
    - **Patient > 35 years or a family history of breast cancer?**
      - **Yes**
        - Re-examine breast on day 7 of menstrual cycle. Refer same week if lump persists.
      - **No**
        - Refer same week to breast clinic.

### Breast Pain
- Reassure patient that breast cancer rarely causes pain.
- Advise a well-fitting bra.
- If pregnant, reassure and give antenatal care →94.
- Give paracetamol 1g 6 hourly as needed.
- May be a side effect of hormonal contraceptive. If no better after 3 months on contraception, change method →91.

### Nipple Discharge
- Is the discharge blood stained, on 1 side, in patient > 50 years, or in a man?
  - **Yes**
    - Refer same week to breast clinic.
  - **No**
    - If pregnant, reassure and give antenatal care →94.
    - If on hormonal contraceptive, reassure. Change to non-hormonal method if distressing →91.

## Approach to the patient with a breast symptom who is breast feeding

### Painful/cracked nipples
- Usually in first few days of breastfeeding due to poor latching.
  - **Avoid soap on washing nipples.**
  - **Help patient to latch properly.**
  - **Advise patient to apply breastmilk onto nipples and areola after feeding and expose to the air.**
  - **Advise HIV patient to stop feeding from the breast, express and heat-treat¹ the milk, and cup-feed baby until cracks have healed.**

### Painful breast/s
- Is temperature ≥ 38°C?
  - **No**
  - **Yes**
    - **Engorgement likely**
      - Advise frequent breastfeeding and cold compresses.
    - **Mastitis likely**
      - Give *flucloxacillin* 500mg 6 hourly for 5 days.
      - Paracetamol 1g 6 hourly
      - Advise HIV patient to stop feeding from the breast, express and heat-treat¹ the milk, and cup-feed baby until mastitis resolves.
      - Refer if no better after 2 days

### Breast lump
- Is temperature ≥ 38°C?
  - **No**
  - **Yes**
    - **Breast abscess likely**
      - Refer same day for incision and drainage.
      - Advise HIV patient to stop feeding from the breast, express and heat-treat¹ the milk, and cup-feed baby until abscess resolves.
    - **Blocked duct likely**
      - Advise frequent breastfeeding, warm compresses and to massage lump.

¹ Heat-treat milk to rid it of HIV and bacteria: place breastmilk in sterilized peanut butter jar. Close lid and place in pot. Fill pot with water 2cm above level of milk and heat water. Remove jar when water is rapidly boiling.
**ABDOMINAL PAIN WITH OR WITHOUT SWELLING (NO DIARRHOEA)**

Recognise the patient with abdominal pain needing urgent attention:

- Peritonitis (guarding, rebound tenderness or rigidity of abdomen)
- Jaundice
- Temperature ≥ 38°C
- No stool or flatus for last 24 hours and vomiting
- Nausea, vomiting, fatigue, sore muscles or difficulty breathing, consider acidosis. Check blood glucose > 70. If on ART, check lactate > 63.
- No urine passed for last 12 hours and swelling of abdomen ≥ 31.
- Pregnant woman with lower abdominal pain
- Chest pain → 15
  Refer same day.

**Approach to the patient with abdominal pain not needing urgent attention**

- If women with lower abdominal pain and/or vaginal discharge, treat for likely pelvic infection → 23.
- If the patient has urinary symptoms → 31.
- If the patient is constipated → 22.
  If patient has none of the above, try to identify cause of pain: is the pain in the upper abdomen and related to eating?

Refer same week if any warning signs:

- Weight loss
- Loss of appetite
- Early fullness
- Blood in stool or occult blood positive
- Abdominal mass
- Persistent vomiting or vomiting blood
- New episode in patient ≥ 55 years

**Approach to the patient with no warning signs**

- If associated with chest pain on exertion → 15.
- Assess patient’s CVD risk ≥ 68.
- Advise patient who smokes and drinks alcohol to stop ≥ 83.
- Avoid spicy, hot or acidic foods, carbonated drinks.
- Stop non-steroidal anti-inflammatory drugs, aspirin.
- If pregnant, give antenatal care → 93.
- Give omeprazole 20mg daily for 14 days.
- Refer if no response after 7 days of omeprazole.

---

Yes - dyspepsia likely

Yes

Has patient lost weight?

No

Does patient have difficulty breathing, abdominal or leg swelling?

No

Does the patient report worms?

Yes

Tapeworm: give albendazole 400mg daily for 3 days.
- Other worm or unsure: give single dose mebendazole 500mg.
- Educate on personal hygiene.

Heart failure likely → 75.

No

No

Yes

Exclude TB → 55.

No Consider cancer. Refer same week.

---

No

Is there fever, night sweats, cough and/or HIV?

Yes

Refer same week.

---

Yes

Give paracetamol 1g 6 hourly.
- Review regularly until pain resolves or a cause is found.

No

If the pain is recurrent with constipation and/or diarrhoea and bloating, irritable bowel syndrome likely. Refer to doctor.
VOMITING

Recognise the patient needing urgent attention:

- Reliable signs of dehydration:
  - Postural hypotension (systolic BP drop > 20mmHg between lying and standing)
  - Poor urine output
  - Confused or drowsy
- Peritonitis (guarding, distension or rigidity of abdomen)
- Vomiting blood
- Jaundice
- Abdominal pain and no stools or flatus/wind
- Headache
- Patient on ART with other signs of lactic acidosis: nausea, abdominal pain or swelling, weight loss, fatigue, shortness of breath

Management:
- Oral or IV rehydration
- Check blood glucose ≥ 70.
- If on ART with signs of lactic acidosis, stop ART → 63.
- Refer same day to hospital.

Approach to the patient with vomiting not needing urgent attention:

Exclude pregnancy. If pregnant → 93.

What is duration of vomiting?

< 24 hours

- Most vomiting is due to a viral infection and resolves within 24 hours.
- If ≥ 21 drinks/week (man), 14 drinks/week (woman) and/or > 5 drinks/session → 83.
- If patient is dizzy → 8.
- Give oral rehydration.
- Advise the patient to eat small frequent meals, avoid lying down after meals, avoid hot greasy food and to eat lightly salted dry food before getting out of bed.
- Review in 24 hours if still vomiting.

Vomiting continuously for ≥ 24 hours

Is patient on TB medication or ART?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Assess for dehydration as above.</td>
<td>• Give oral rehydration solution.</td>
</tr>
<tr>
<td>• Stop all medication and refer same day.</td>
<td>• Review in 2 days if still vomiting.</td>
</tr>
</tbody>
</table>

If still vomiting, refer same day.
## DIARRHOEA

**Recognise the ill patient with diarrhoea needing urgent attention:**

Diarrhoea and 1 or more of the following:
- Reliable signs of dehydration
  - Postural hypotension (systolic BP drop > 20mm Hg between lying and standing)
  - Poor urine output
  - Altered mental state (confused or drowsy)

**Management:**
- **Oral rehydration** (IV if unable to keep fluids down)
- If patient has had diarrhoea for ≥ 2 weeks send stool sample for ‘ova, cysts and parasites’. Indicate on the request form if the patient has HIV.
- Refer same day.

### Approach to the patient with diarrhoea not needing urgent attention:

- Confirm that this is in fact diarrhoea: 3 or more watery stools per day.
- Routine antibiotics are unnecessary and increase the likelihood of antibiotic resistance and side effects.
- Knowing the patient’s HIV status helps in the management. If status unknown, test for HIV ≥ 60.
- Advise patient to increase fluid intake, eat small frequent meals and avoid milk products, caffeinated drinks and high-fat, high-fibre foods.
- Ask about duration of diarrhoea.

#### Diarrhoea for < 2 weeks
- Give oral rehydration.
- Record current weight in patient notes.
- Is the temperature ≥ 38°C and/or is there blood and/or mucus in the stool?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

**Treat with ciprofloxacin**
- 500mg 12 hourly for 3 days.

**Give loperamide**
- 4mg initially, then 2mg after each loose stool, maximum 12mg/day.

Review in 2 weeks if diarrhoea still present.

#### Diarrhoea for ≥ 2 weeks
- Give oral rehydration solution to prevent dehydration.
- Send stool for ‘ova, cysts and parasites’. Indicate on request form if patient has HIV.
- Knowing the patient’s HIV status helps in the management. If status unknown, test for HIV ≥ 60.

**HIV positive**
- Give routine HIV care ≥ 61.
- ddI and lopinavir/ritonavir can cause ongoing loose stools.
- Review symptoms and stool result in 1 week.

**Isospora belli**
- Give co-trimoxazole
  - 320/1600mg (4 tablets) 12 hourly for 10 days.
  - Patient needs ART ≥ 61.

**Cryptosporidium**
- Patient needs ART ≥ 61.
  - Give loperamide 2mg as needed up to 12mg/day.

**Review stool result.**

**HIV negative**
- Give metronidazole 2g daily for 3 days to treat empirically for giardiasis. Advise patient to avoid alcohol for 48 hours after last dose.

**Review stool result.**

If diarrhoea persists despite treatment, refer for specialist review.
## CONSTIPATION

**Recognise the patient with constipation needing urgent attention:**
- No stools or wind in the last 24 hours plus abdominal pain and vomiting
- Refer same day to hospital.

**Approach to the patient who is constipated and not needing urgent attention:**
- Review diet, fluid intake and medication (amitriptyline, codeine/morphine and antacids can cause constipation). Ask about chronic use of enemas or laxatives.
- Exclude pregnancy. If pregnant refer to a doctor.
- Try non drug approaches before prescribing laxatives:
  - Advise a high fibre diet (vegetables, fruit, coarse mielie meal, bran and cooked dried prunes) and adequate fluid intake.
  - Advise moderate regular exercise (20 minutes walk daily).
  - Stop chronic use of laxatives or enemas.

<table>
<thead>
<tr>
<th>No response</th>
<th>Resolved</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Give sennosides A and B 7.5mg 2 tablets at night for 3 days.</td>
<td>Advise to continue with diet and exercise and avoid chronic use of laxatives and enemas.</td>
</tr>
<tr>
<td>• If no improvement increase to 4 tablets.</td>
<td></td>
</tr>
<tr>
<td>• Refer if no response after 1 week, recent change in bowel habits or uncertain cause for constipation.</td>
<td></td>
</tr>
</tbody>
</table>

## ANAL SYMPTOMS

**Recognise the patient with an anal symptom needing urgent attention:**
- Unable to sit because of anal symptoms
- Unable to pass stool because of anal symptoms
- Refer same day

<table>
<thead>
<tr>
<th>Anal pain and/or bleeding</th>
<th>Ulcer/s</th>
<th>Perianal warts</th>
<th>Anal Itch</th>
<th>Dermatitis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Crack/s or lump/pile</td>
<td>Redraw skin in patient with chronic diarrhoea</td>
<td>Ulcer/s</td>
<td>Perianal warts</td>
<td>Worms</td>
</tr>
<tr>
<td>• Treat constipation as above.</td>
<td>• Apply zinc and castor oil ointment.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• To manage diarrhoea →21.</td>
<td>• Treat as for genital ulcer →26.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Refer if no improvement.</td>
<td></td>
<td></td>
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<tr>
<td></td>
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</tbody>
</table>

## Worms
- Give mebendazole 500mg stat.
- Treat as for genital warts →27.
- Refer if no improvement.

## Perianal warts
- Give mebendazole 500mg stat.
- Apply 1% hydrocortisone cream twice a day for 5 days.

## Anal Itch
- Advise good hygiene
- Wash with aqueous cream.
# GENITAL SYMPTOMS

## Assess the patient with genital symptoms and his/her partner/s

<table>
<thead>
<tr>
<th>Assess</th>
<th>Note</th>
</tr>
</thead>
<tbody>
<tr>
<td>Symptoms</td>
<td>Ask about genital discharge, rash, itch, lumps, ulcers and manage as below. Manage other symptoms as on symptom pages.</td>
</tr>
<tr>
<td>Abuse</td>
<td>Ask about rape/sexual assault or if patient unhappy in relationship. If yes → 53. Manage and refer the recently raped/sexually assaulted patient urgently → 53.</td>
</tr>
<tr>
<td>Safe sex</td>
<td>Ask if patient or regular partner has new or multiple partners, uses condoms unreliably or has substance abuse → 83.</td>
</tr>
<tr>
<td>Family planning</td>
<td>Assess patient’s family planning needs → 91. Exclude pregnancy. If pregnant → 93.</td>
</tr>
<tr>
<td>Examination</td>
<td>Woman: look for abdominal masses, discharge, rash or lumps, cervical tenderness or pelvic masses. Man: look for discharge, inguinal lymph nodes, ulcers, scrotal swelling and/or masses.</td>
</tr>
<tr>
<td>HIV</td>
<td>If status unknown test for HIV → 60. The HIV patient needs routine HIV care → 61.</td>
</tr>
<tr>
<td>RPR</td>
<td>Check RPR/VDRL if patient has an STI, is pregnant or was raped or whose partner has an STI or is RPR positive. If positive → 28.</td>
</tr>
<tr>
<td>Pap smear</td>
<td>Do a Pap smear if indicated → 27 once an abnormal discharge has been treated → 25. If cervix looks abnormal/suspicious of cancer, refer same week.</td>
</tr>
</tbody>
</table>

## Advise the patient with genital symptoms and his/her partner/s

- Educate patient about the cause of symptoms and if a sexually transmitted infection (STI), that this increases the risk of HIV transmission.
- Urge the patient to adhere to treatment and to abstain from penetrative sex for the duration of treatment.
- Stress the importance of partner treatment and issue 1 notification slip with the patient’s diagnosis in code (as below) for each partner.
- Discuss safe sex: provide male and female condoms, advise patient to stick to one partner at a time and offer referral for medical male circumcision if available.

## Treat the patient with genital symptoms

<table>
<thead>
<tr>
<th>Discharge</th>
<th>Dysuria</th>
<th>Scrotal swelling</th>
<th>Itch</th>
<th>Ulcer/s</th>
<th>Lump/s</th>
</tr>
</thead>
<tbody>
<tr>
<td>Man → 24 Woman → 25 Man → 24 Woman → 31</td>
<td>→ 24</td>
<td>Discharge in woman → 25</td>
<td>Glans penis → 24 Pubic area → 27</td>
<td>→ 26 Groin → 5 Skin → 27</td>
<td></td>
</tr>
</tbody>
</table>

## Treat the patient’s partner/s according to the patient’s diagnosis as well as the partners’ symptoms (if any)

<table>
<thead>
<tr>
<th>Patient’s diagnosis (code)</th>
<th>Partner treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vaginal discharge (VDS)</td>
<td>Cefixime 400mg orally stat and doxycycline 100mg 12 hourly for 7 days and metronidazole 2g stat¹</td>
</tr>
<tr>
<td>Lower abdominal pain in woman (LAP)</td>
<td>Cefixime 400mg orally stat and doxycycline 100mg 12 hourly for 7 days and metronidazole 2g stat¹</td>
</tr>
<tr>
<td>Male urethritis (MUS)</td>
<td>Cefixime 400mg orally stat and doxycycline 100mg 12 hourly for 7 days and metronidazole 2g stat¹</td>
</tr>
<tr>
<td>Scrotal swelling (SSW)</td>
<td>Cefixime 400mg orally stat and doxycycline 100mg 12 hourly for 7 days and metronidazole 2g stat¹</td>
</tr>
<tr>
<td>Genital ulcer (GUS)</td>
<td>Benzathine penicillin 2.4MU IM stat and erythromycin 500mg 6 hourly for 7 days and aciclovir 400mg 8 hourly for 7 days</td>
</tr>
<tr>
<td>RPR positive</td>
<td>Benzathine penicillin 2.4MU IM stat</td>
</tr>
<tr>
<td>Balanitis (BAL)</td>
<td>Clotrimazole vaginal pessary 500mg inserted stat or clotrimazole vaginal cream inserted 12 hourly for 6 days</td>
</tr>
<tr>
<td>Pubic lice (PL)</td>
<td>Benzyl benzoate 25%</td>
</tr>
<tr>
<td>Bubo</td>
<td>Doxycycline 100mg 12 hourly for 14 days and ciprofloxacin 500mg 12 hourly for 3 days²</td>
</tr>
</tbody>
</table>

¹ If pregnant or breastfeeding, give amoxicillin 500mg 8 hourly for 7 days instead of doxycycline and avoid metronidazole in the 1st trimester. ² If pregnant or breastfeeding, give erythromycin 500mg 6 hourly for 14 days instead of doxycycline and ciprofloxacin.
**GENITAL SYMPTOMS IN A MAN**

First assess and advise the man with genital symptoms 23 and his partner/s.

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urethral discharge or dysuria/burning urine</td>
<td><strong>Yes</strong> Torsion of testicle likely. Refer to doctor same day.</td>
</tr>
</tbody>
</table>
|                                              | **No** Repeat treatment:  
|                                              | - Cefixime 400mg orally stat and  
|                                              | - Doxycycline 100mg 12 hourly for 7 days  
|                                              | Advise patient to return in 7 days if symptoms persist.                   |
|                                              | Refer if not resolved                                                     |
|                                              | **Yes** Phimosis or paraphimosis likely.  
|                                              | Refer same week to doctor.                                                |
|                                              | **No**                                                              |

**Treat for male urethritis syndrome (MUS):**
- Cefixime 400mg orally stat and  
- Doxycycline 100mg 12 hourly for 7 days  
- Treat patient’s partner/s 23.

If ongoing urethral discharge or dysuria, ask if possible reinfection or poor adherence.

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Treatment</th>
</tr>
</thead>
</table>
| Scrotal swelling or pain                     | Does patient have any of:  
|                                              | - Sudden onset of severe pain  
|                                              | - Affected testicle is higher  
|                                              | - A history of trauma  
|                                              | **Yes** Torsion of testicle likely. Refer to doctor same day.             |
|                                              | **No** Repeat treatment:  
|                                              | - Cefixime 400mg orally stat and  
|                                              | - Doxycycline 100mg 12 hourly for 7 days  
|                                              | (Avoid alcohol for 24 hours)                                               |
|                                              | Refer if not resolved                                                     |

**Treat for scrotal swelling (SSW):**
- Ceftriaxone 250mg IM stat.  
- If penicillin allergic give ciprofloxacin 500mg 12 hourly for 3 days and  
- Doxycycline 100mg 12 hourly for 14 days.  
- Treat patient’s partner/s 23.  
- Treat patient if no improvement after 7 days.

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Treatment</th>
</tr>
</thead>
</table>
| Pain or itchiness of glans or inability to retract or reduce foreskin | Yes  
|                                              | Phimosis or paraphimosis likely.  
|                                              | Refer same week to doctor.                                                |
|                                              | **No**                                                              |

**Treat for balanitis (BAL):**
- Wash with weak salt solution, avoid soap.  
- Retract foreskin while washing.  
- Prescribe clotrimazole cream twice daily.  
- If no response after 7 days:  
  - Repeat treatment.  
  - Test for diabetes 70 and HIV 60.  
  - Treat female partner 23.  
  - If still no better, refer to doctor.

- Gonococcal resistance to ciprofloxacin is common. If severe penicillin allergic (angioedema, anaphylactic shock or bronchospasm) replace cefixime with ciprofloxacin 500 mg oral stat. Refer if no improvement within 48 hours.

24
**VAGINAL DISCHARGE**

- It is normal for women to have a vaginal discharge. Abnormal discharges are itchy or different in colour or smell. Not all women with a discharge have an STI.
- First assess and advise the patient with vaginal discharge and her partner/s.

<table>
<thead>
<tr>
<th>Is there lower abdominal pain or cervical tenderness?</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
</tr>
<tr>
<td>Yes</td>
</tr>
</tbody>
</table>

If the vulva is red, scratched and inflamed, also treat for thrush:
- Clotrimazole vaginal tablet 500mg inserted stat and
- Clotrimazole vaginal cream applied twice a day for 6 days after symptoms resolve.
- Avoid washing with soap.

Persistently thrush:
- Repeat clotrimazole.
- Test for diabetes and HIV.

Ongoing discharge, no thrush:
- Ask if possible re-infection or poor adherence to treatment.

Yes
- Repeat treatment. If still no improvement, refer to doctor same week.

No
- Refer to doctor same week.

If the patient is sexually active in the last 3 months?

<table>
<thead>
<tr>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
</tr>
</tbody>
</table>

**Recognise the patient needing urgent attention**
- Refer same day if any of the following are present:
  - Recent miscarriage/delivery/abortion
  - Pregnant or missed or overdue period
  - Peritonitis (guarding or rigidity on examination)
  - Abnormal vaginal bleeding
  - Temperature ≥ 38°C
  - Abdominal mass

Management:
- If dehydrated or shocked: give IV fluids
- If temp ≥ 38°C, give ceftriaxone 1g IV/IM stat and metronidazole 400mg orally stat.
- Refer same day.

**Treat for lower abdominal pain (LAP):**
- Ceftriaxone 250mg IM stat. If penicillin allergic give ciprofloxacin 500mg 12 hourly for 3 days and
- Doxycycline 100mg 12 hourly for 14 days (if breastfeeding, use amoxicillin 500mg 8 hourly for 7 days instead) and
- Metronidazole 400mg orally stat. Avoid in 1st trimester of pregnancy. No alcohol for 24 hours after metronidazole.
- Treat the patient’s partner/s.
- Treat the baby with pus in eyes born to mother with VDS.

**Treat for bacterial vaginosis:**
- Metronidazole 2g orally stat. Avoid in 1st trimester of pregnancy. No alcohol for 24 hours after metronidazole.

**Treat for vaginal discharge syndrome (VDS):**
- Cefixime 400mg orally stat and
- Doxycycline 100mg 12 hourly for 7 days (if pregnant or breastfeeding, use amoxicillin 500mg 8 hourly for 7 days instead) and
- Metronidazole 2g orally stat. Avoid in 1st trimester of pregnancy. No alcohol for 24 hours after metronidazole.
- Treat the patient’s partner/s.
- Treat the baby with pus in eyes born to mother with VDS.

**Treat the patient’s partner/s:**
- Treat the baby with pus in eyes born to mother with VDS.

Persistent thrush:
- Repeat clotrimazole.
- Test for diabetes and HIV.

Advise patient to return in 7 days if symptoms persist.

1 If severe penicillin allergic (angioedema, anaphylactic shock or bronchospasm) replace cefixime with ciprofloxacin 500mg oral stat. If severe penicillin allergic and pregnant or breastfeeding, replace cefixime and amoxicillin with erythromycin 500mg 6 hourly for 7 days. Refer if no improvement within 48 hours.

2 Do not mix Ringer’s lactate and IV ceftriaxone. Flush IV line with sodium chloride 0.9% before and after IV ceftriaxone.
### GENITAL ULCER SYNDROME

First assess and advise the patient with genital ulcer and his/her partner/s 23.

The patient may have a blister, sore, ulcer, and/or swollen inguinal (groin) lymph nodes that might be tender or fluctuant and/or vaginal/urethral discharge.

If patient sexually active in the past 3 months also treat for genital ulcer syndrome (GUS):
- **Benzathine penicillin** 2.4MU IM stat and
- **Erythromycin** 500mg 6 hourly for 7 days
If penicillin-allergic replace benzathine penicillin with **doxycycline** 100mg 12 hourly for 14 days and replace erythromycin with **ciprofloxacin** 500mg 12 hourly for 3 days.
If pregnant and penicillin allergic, give **erythromycin** 500mg 6 hourly for a total of 14 days.

Check if patient also has swollen nodes and/or a discharge.

Treat patient and partner/s for **bubo**:
- Omit erythromycin above and give:
  - **Doxycycline** 100mg 12 hourly for 14 days and
  - **Ciprofloxacin** 500mg 12 hourly for 3 days
If pregnant or breastfeeding, replace both with **erythromycin** 500mg 6 hourly for 14 days.
If nodes painful and swollen:
  - Aspirate through healthy skin any fluctuant lymph node every 3 days as needed.
  - Give pain relief if needed.
  - Review after 14 days. If no better, refer to doctor same week.

Treat patient and partner/s for **gonorrhoea and chlamydia**:
- Omit erythromycin above and give:
  - **Doxycycline** 100mg 12 hourly for 7 days (if pregnant or breastfeeding use **amoxicillin** 500mg 8 hourly for 7 days instead)
  - **Cefixime** 400mg orally stat and
  - **Erythromycin** 500mg 8 hourly for 7 days instead)
  - Also give to woman patient **metronidazole** 2g orally stat (avoid alcohol for 24 hours).
  - Review after 7 days. If no better, refer to doctor same week.

First treat for **herpes**
- Give pain relief if necessary.
- Keep lesions clean and dry.
- Give **aciclovir** 400mg 8 hourly for 7 days.
- Explain that herpes infection is lifelong and that herpes transmission can occur even when asymptomatic. The likelihood of HIV transmission is increased when there are ulcers.
- HIV patients with genital herpes > 1 month have stage 4 HIV and need co-trimoxazole and ART 61.

1Gonococcal resistance to ciprofloxacin is common. If severe penicillin allergic (angioedema, anaphylactic shock or bronchospasm) replace cefixime with **ciprofloxacin** 500mg orally stat. Refer if no improvement within 48 hours.
2If severe penicillin allergic and pregnant or breastfeeding, replace cefixime and amoxicillin with **erythromycin** 500mg 6 hourly for 7 days. Refer if no improvement within 48 hours.
OTHER GENITAL SYMPTOMS

CERVICAL SCREENING

- Papanicolaou (Pap)/cervical smears detect cervical abnormalities which occur before cancer develops. Cervical cancer is caused by certain types of human papilloma virus (HPV). HPV is usually transmitted sexually.
- Women who smoke are more likely to have cervical abnormalities. Advise smokers to stop.
- An asymptomatic HIV-negative woman should receive 3 smears in her lifetime from age 30, with a 10-year interval between each smear.
- An HIV-positive woman should receive a Pap smear on diagnosis, regardless of her age. If the result is normal, she needs a Pap smear every year.
- In pregnancy, Pap smears can be performed safely up to 30 weeks’ gestation.
- If the patient has an abnormal vaginal discharge, treat the discharge first and then take a Pap smear at a follow-up visit.

Manage according to the Pap result

- Unsatisfactory smear: repeat within 3 months.
- ASC-US: repeat within one year.
- 3 consecutive ASC-US and HIV negative: refer colposcopy.
- ASC-H (ASC-US ? HSIL) or AGUS – refer colposcopy.

Inform patient of symptoms of cervical cancer (abnormal bleeding, vaginal discharge) and instruct her to return should they occur.

ASC-US: Atypical squamous cells of undetermined significance; LSIL: Low-grade squamous intraepithelial lesions; HSIL: High-grade squamous intraepithelial lesions; ASC-H: Atypical cells - cannot exclude HSIL; AGUS: Atypical glandular cells of undetermined significance

Genital warts
If warts are soft, involve the skin, and < 10mm:
- Protect surrounding skin with petroleum jelly and apply 20% tincture of podophyllin solution. Do not apply internally.
- Wash solution off after 4 hours.
- Repeat weekly for 4 weeks.
- Do a Pap smear.
- Check RPR → 28. Refer if:
  - No response or
  - If warts are > 10mm, hard, on mucosal surfaces or
  - Pregnant or
  - Podophyllin not available

Molluscum contagiosum
- Papules with central dent
- Paint with tincture of iodine.
- If HIV, should resolve with ART.

Pubic lice
Treat patient and partner/s:
- Apply benzyl benzoate 25% from the neck down for 24 hours. Advise patient to avoid mucous membranes, urethral opening and raw areas as it may sting. Repeat after 7 days if lice or nits are seen.
- Wash clothes and linen.

Scabies
Treat patient:
- Apply benzyl benzoate 25% from the neck down for 24 hours. Advise patient to avoid mucous membranes, urethral opening and raw areas as it may sting.
- Repeat after 1 week if necessary.
- Wash clothes and linen.
- Treat partner/s even if asymptomatic.

Inform patient of symptoms of scabies (itchy rash in pubic area) and instruct her to return should they occur.
### POSITIVE SYPHILIS RESULT

- First assess and advise the patient with a positive syphilis result and his/her partner/s → 23.
- Do a RPR/VDRL test in those who are pregnant, sexually assaulted, with a sexually transmitted infection (STI), genital warts, signs of secondary or tertiary syphilis¹ or recently treated for early syphilis, as well as those whose partners have an STI or positive RPR result.
- If RPR checked before 20 weeks’ gestation, recheck at 34 weeks. Do a rapid VDRL if patient is unbooked in labour or after delivery before discharge.
- RPR and VDRL tests reflect disease activity but do not necessarily indicate syphilis infection. They are useful to measure successful response to treatment.
- TPHA or FTA tests are specific for syphilis and confirm its diagnosis. They usually remain positive for life.

#### RPR/VDRL positive

<table>
<thead>
<tr>
<th>Not pregnant</th>
<th>Pregnant</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Is RPR titre from last 2 years available?</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Does patient have a genital ulcer or signs of secondary syphilis¹?</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td></td>
</tr>
<tr>
<td>• Treat for late syphilis.</td>
<td></td>
</tr>
<tr>
<td>• Treat partner/s → 23.</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>• New titre is either:</td>
<td></td>
</tr>
<tr>
<td>• ≤ 1:8 and unchanged or</td>
<td></td>
</tr>
<tr>
<td>• at least 4 times lower (eg was 1:32, now 1:8)</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td></td>
</tr>
<tr>
<td>• New syphilis infection likely.</td>
<td></td>
</tr>
<tr>
<td>• Treat for early syphilis.</td>
<td></td>
</tr>
<tr>
<td>• Treat partner/s → 23.</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>• No further treatment needed.</td>
<td></td>
</tr>
<tr>
<td>• Discharge.</td>
<td></td>
</tr>
<tr>
<td>• If not already treated, treat partner/s → 23.</td>
<td></td>
</tr>
</tbody>
</table>

**Early syphilis:**
- Benzathine penicillin 2.4MU IM stat
- If penicillin allergic give doxycycline 100mg 12 hourly for 14 days.

**Late syphilis:**
- Benzathine penicillin 2.4MU IM weekly for 3 weeks
- If penicillin allergic and not pregnant give doxycycline 100mg 12 hourly for 28 days.

**Treat the newborn of the RPR positive mother:**
- Examine the baby.
  - Well baby: benzathine penicillin 50 000u/kg IM stat.
  - Signs of congenital syphilis²: procaine penicillin 50 000u/kg IM daily for 10 days.

---

¹The signs of secondary syphilis occur 6–8 weeks after the primary ulcer and include a generalized rash (including palms and soles), flu-like symptoms, flat wart-like genital lesions, mouth ulcers and patchy hair loss. Tertiary syphilis occurs many years later and affects skin, bone, heart and nervous system. ²Signs of congenital syphilis are rash (red/blue spots or bruising especially on soles and palms), jaundice, pallor; distended abdomen due to enlarged liver or spleen, low birthweight, respiratory distress, large, pale placenta, hypoglycaemia. Erythromycin does not reliably cure syphilis in either the mother or the baby.
ABNORMAL VAGINAL BLEEDING

**Recognise the patient with vaginal bleeding needing urgent attention:**
- BP < 90/60
- Exclude pregnancy. If pregnant → 93.
- Following abortion or miscarriage
  Management:
  - Give IV sodium chloride 0.9% and refer same day.

**Approach to the patient with abnormal vaginal bleeding not needing urgent attention**
- Refer within 2 weeks the patient with vaginal bleeding who is menopausal (no periods for at least one year).
- In patient who is not menopausal determine the type of bleeding problem.

<table>
<thead>
<tr>
<th>Heavy regular bleeding with/without pain (bleeding &gt; 7 days, passing clots)</th>
<th>Periods have irregular pattern (&lt; 24 days or &gt; 35 days between periods)</th>
<th>Spotting between periods</th>
<th>Bleeding after sex</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Any bleeding elsewhere (gums, easy bruising, rash)?</strong></td>
<td><strong>Does patient have hot flushes, mood swings and/or difficulty sleeping?</strong></td>
<td><strong>If on hormonal contraception: manage according to method</strong></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>Yes</td>
<td><strong>Oral contraceptive</strong></td>
<td></td>
</tr>
</tbody>
</table>
| No | No | - Ensure correct use.
| | | - If diarrhoea and vomiting, advise condom use until diarrhoea, vomiting and spotting resolve.
| | | - If on phenytoin, carbamazepine, rifampicin or lopinavir/ritonavir, change to IUCD or injectable.
| | | **Injectable contraceptive** |
| | | - Common in first 3–6 months.
| | | - Give levonorgestrel/ethinyl oestradiol 0.15/0.03mg for 7 days.
| | | - Give ibuprofen 400mg 8 hourly for 3 days instead if breast feeding, smoker > 35 years, BP ≥ 140/90, migraine with focal symptoms, DVT or pulmonary embolus.

Refer the patient within 2 weeks if:
- Unsure of diagnosis
- Menopausal (no periods for at least 1 year)
- Bleeding persists: > 1 week after STI treatment, after diarrhoea and vomiting stop or for > 3 months
- Abnormal cervix on speculum examination (susicious of cancer)
## SEXUAL PROBLEMS

<table>
<thead>
<tr>
<th>Problem with erections</th>
<th>Woman who has pain with sex</th>
<th>Loss of libido</th>
</tr>
</thead>
<tbody>
<tr>
<td>Was the onset of the problem gradual or sudden?</td>
<td>Is the pain superficial or deep?</td>
<td>• Ask: ‘Are you stressed?’ If yes [52].</td>
</tr>
<tr>
<td>Gradual onset Partial or poorly sustained erections</td>
<td>Superficial pain</td>
<td>• Ask about sexual assault or abuse [53].</td>
</tr>
<tr>
<td>Sudden onset Has erections in morning, but not during sex</td>
<td>Deep pain</td>
<td>• If low mood or sadness, loss of interest or pleasure, feeling tense or worrying a lot or not coping as well as before, consider depression/anxiety [81].</td>
</tr>
</tbody>
</table>

- Assess cardiovascular disease risk [68].
- Screen for substance abuse: if > 21 drinks/week or > 5 drinks per session or misusing prescription or illicit drugs [83].
- Atenolol, furosemide, HCTZ, fluoxetine, amitriptyline, phenytoin, carbamazepine, cimetidine may cause erection problems. Doctor can consider changing medication but needs to balance disease control with possible improvement in erections.
- Advise the patient who smokes to stop.
- Ask: ‘Are you stressed?’ If yes [52].
- Ask about sexual assault or abuse [53].
- Ask about sexual dryness. If there is vaginal atrophy or has other menopausal symptoms like flushes, problems sleeping, mood changes, headaches [98].
- Advise use of lubricant with sex, but to avoid using Vaseline® with condoms.
- Look for STI: if vaginal discharge or ulcers [23].
- Ask about irritative bowel syndrome: recurrent abdominal pain with constipation and/or diarrhoea and bloating [19].
- Severe spasm of vagina during sex: ask about sexual assault or abuse [53].
- Refer to gynaecologist if mass in abdomen or periods have become heavy and painful.
- Look for STI: if vaginal discharge or lower abdominal pain [23].
- Ask about anxiety/fear about sex and fertility. Refer to available counselor.
- Assess patient’s family planning needs [91].
- Screen for substance abuse: if > 21 drinks/week (man) or > 14 drinks/week (woman) or > 5 drinks/session or misusing prescription or illicit drugs [83].
- Ask the woman patient about pain with sex.
- Ask about sexual assault or abuse [53].
- If low mood or sadness, loss of interest or pleasure, feeling tense or worrying a lot or not coping as well as before, consider depression/anxiety [81].
- Screen for substance abuse: if > 21 drinks/week (man) or > 14 drinks/week (woman) or > 5 drinks/session or misusing prescription or illicit drugs [83].
- Ask the woman patient about pain with sex.
- Ask about sexual assault or abuse [53].
- If low mood or sadness, loss of interest or pleasure, feeling tense or worrying a lot or not coping as well as before, consider depression/anxiety [81].
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- Ask the woman patient about pain with sex.
- Ask about anxiety/fear about sex and fertility. Refer to available counselor.
- Assess patient’s family planning needs [91].

Refer if sexual problems do not resolve.
### URINARY SYMPTOMS

#### Recognise patient with urinary symptoms needing urgent attention:
- **Unable to pass urine with lower abdominal discomfort**
- **Management:**
  - Insert urethral catheter.
  - Refer same day.

#### Approach to patient with urinary symptoms not needing urgent attention

<table>
<thead>
<tr>
<th>Blood in urine</th>
<th>Has patient been in bilharzia area?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>Give single dose praziquantel 40mg/kg. To prevent re-infection advise patient to boil water before use and avoid swimming in contaminated water.</td>
</tr>
<tr>
<td>No</td>
<td>Does patient have burning urine?</td>
</tr>
<tr>
<td>Yes</td>
<td>Leucocytes and nitrites on urine dipstick?</td>
</tr>
<tr>
<td>No</td>
<td>Refer for investigation of cause of blood in urine.</td>
</tr>
</tbody>
</table>

**Burning urine**

- **Woman**
  - **Yes:** Give ciprofloxacin 500mg 12 hourly for 3 days.
  - **No:** Encourage patient to drink plenty of fluids and to empty bladder after sex.

- **Man**
  - **Look for discharge**
  - **No discharge:** Are there leucocytes and nitrites on midstream urine?
  - **Yes:** Patient has an STI → 23.
  - **No:** Patient has a simple urinary tract infection.

**Flow Problem**

- **Leakage of urine**
  - **Doctor to review use of amitriptyline.**
  - **Refer for assessment, same week if patient has weight loss or hard and nodular prostate on rectal examination.**

- **Poor stream or difficulty passing urine**
  - **Check dipstick to exclude urinary tract infection.**
  - **Doctor to review use of furosemide.**
  - **Look for vaginal atrophy ¥ 98.**
  - **Ask about constipation ¥ 22.**
  - **Advise patient to cut down alcohol and caffeine and to do Kegal exercises.**
  - **Refer to physiotherapist if available.**
  - **Refer if patient has vaginal prolapse or no response to above measures.**

---

1. Bilharzia areas include Limpopo, North West, Mpumalanga, KwaZulu-natal and isolated areas in Eastern Cape (Transkei).
2. If penicillin allergic, give erythromycin 500mg 6 hourly for 7 days.
**BODY/GENERAL PAIN**

### Approach to the patient who aches all over

- Check patient's temperature and weight.
- Ask about a sore throat or runny/blocked nose.

**Normal**

Do a musculoskeletal screen to check if problem is in the joint. Ask the patient to:
- Place hands behind head; then behind back.
- Make a fist and open hand.
- Press palms together with elbows lifted.
- Walk. Sit and stand up with arms folded.

**Unable to do all actions comfortably.**

Examine the joints.

- Joints are warm, tender, swollen or have limited movement.
  - **→ 33**

**Able to do all actions comfortably**

Examine the joints.

- Joints are normal.

  - If status is unknown, test for HIV → 60.
  - Ask patient: 'Are you stressed?' If yes → 52.
  - If patient has experienced recent trauma or abuse → 53.
  - Ask about duration of generalised pain.

**< 4 weeks**

- Give paracetamol 1g 6 hourly.
- Patient to return if no better in 2 weeks.

**≥ 4 weeks**

- Give paracetamol 1g 6 hourly.
- Take blood for CRP, creatinine, random blood glucose and finger-prick Hb.
- If patient has weight gain, low mood, dry skin or constipation, check TSH.
- Review in 2 weeks.

**Blood results all normal**

- Consider fibromyalgia → 90.

**Blood results abnormal**

- Refer to doctor for further assessment.

- If temperature ≥ 38°C → 4
- If weight loss ≥ 5% of body weight in past 4 weeks → 3.
- If sore throat → 14.
- If runny/blocked nose → 13.
**JOINT SYMPTOMS**

**Recognise the patient with a joint symptom needing urgent attention:**

Short history of single, warm swollen, extremely painful joint and:
- Temperature ≥ 38°C. If known with gout →89, otherwise refer same day.
- Known haemophiliac – possible bleed into the joint
- Trauma in the past 48 hours

Refer same day.

**Approach to the patient with a joint symptom not needing urgent attention**

Do a musculoskeletal screen to check if problem is in the joint. Ask the patient to:
- Place hands behind head; then behind back. Make a fist and open hand. Press palms together with elbows lifted.
- Walk. Sit and stand up with arms folded.

**Able to do all actions comfortably.**

**Joint problem unlikely**
- If general body pain ≥ 32.
- If localised pain see relevant page.

**Unable to do all actions comfortably.**

**Recent trauma?**
- Yes
  - Rest and elevate joint.
  - Apply ice.
  - Apply pressure bandage.
  - Give ibuprofen 200mg 3 a day with food for 5 days. Avoid if peptic ulcer, asthma, hypertension, heart failure, kidney disease.
  - X-Ray to exclude fracture if no better after 5 days.
- No
  - Ask about duration of joint pain.

**< 8 weeks**

**Does patient have a genital discharge?**
- Yes
  - Painful big toe, knee or ankle with warm red overlying skin?
    - Yes →23
    - No

**≥ 8 weeks**

**Chronic arthritis**
- Yes
- No

**Acute gout likely**
- Might have had similar episode previously.
- For treatment of acute gout attack and routine gout care →89.

**If no better, refer to specialist.**
### BACK PAIN

**Recognise the patient with back pain needing urgent attention**

- Bladder or bowel disturbance
- Sudden onset of leg weakness
- Recent trauma with severe pain and X-ray unavailable or abnormal
- Temperature $\geq 38^\circ$C and vomiting, pulse rate $>80$, respiratory rate $>17$, BP $<90/60$, diabetes, pregnancy, menopause or male patient: *pyelonephritis* likely.
- Severe stabbing flank pain (one sided) with cramp-like radiation to groin and blood in urine: *kidney stone* likely.

**Management:**
- Pyelonephritis: give IV *sodium chloride 0.9%* and *ceftriaxone* $1g$ IM/IV.
- Kidney stone: give IV *sodium chloride 0.9%* and *morphine* $10–15mg$ IM single dose.
- Refer urgently to hospital.

**Approach to patient with back pain not needing urgent attention**

- If patient is a non-pregnant woman of reproductive age with temperature $\geq 38^\circ$C and:
  - Vaginal discharge with/without lower abdominal pain: *pelvic inflammatory disease* is likely $\rightarrow$ [23].
  - Flank pain: *uncomplicated pyelonephritis* is likely. Give *ciprofloxacin* oral 500mg 12 hourly for 7 days and *paracetamol* 1g 6 hourly as needed.
- Next, ask about *TB* symptoms: cough, weight loss, night sweats, feeling unwell.

<table>
<thead>
<tr>
<th>TB symptoms</th>
<th>Pain nature</th>
<th>Management</th>
</tr>
</thead>
</table>
| Yes         | Mechanical back pain likely | *Measure waist circumference: if $>80cm$ (woman) or $94cm$ (man) assess CVD risk $\rightarrow$ [68].
*Assess and manage patient’s stress $\rightarrow$ [52].
*Advise patient to be as active as possible, continue to work and avoid resting in bed.
*Give *paracetamol* 1g 6 hourly.
*If poor response after 1 week add *ibuprofen* 400mg 8 hourly for up to 5 days. Avoid if peptic ulcer, asthma, hypertension, heart failure, kidney disease.
*If still a poor response add *tramadol* 50mg 4–6 hourly.
*Refer to physiotherapy if pain persists > 2 weeks, or unable to cope with daily activities/work.
*Refer to specialist if pain persists > 6 weeks, urgently if bladder disturbance or leg weakness. |
| No          | Inflammatory back pain likely | *Check CRP.*
*Do back X-Ray.*
*Refer to specialist.* |
| Yes         | Sleep not usually disturbed by pain and No stiffness or stiffness on waking lasts < 30 minutes and Pain is worse with activity and improves with rest. | |
| No          | Is there any of: < 20 years, > 55 years, pain progressive or for > 6 weeks, previous cancer or oral steroid use, HIV or deformity? | |
| Yes         | Refer to doctor. | |

---

1 Do not mix Ringer’s lactate and IV ceftriaxone. Flush IV line with *sodium chloride 0.9%* before and after IV ceftriaxone.
NECK PAIN

Recognise the patient with neck pain needing urgent attention:

- Neck stiffness with temperature ≥ 38°C: give ceftriaxone1 2g IV/IM stat.
- New onset of hand or arm symptoms (weakness or numbness) or gait disturbance (leg weakness, stiffness or loss of balance)
- Trauma with neurological symptoms or abnormal X-Ray: immobilise neck with hard collar or sandbags on either side of the neck.
Refer same day.

Approach to the patient with neck pain not needing urgent attention

Is there any of < 20 years, > 55 years, pain progressive or for > 6 weeks, previous TB, cancer or oral steroid use, feeling unwell or weight loss?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do X-Ray and refer.</td>
<td>Neck pain with arm pain</td>
</tr>
<tr>
<td>Give paracetamol 1g 6 hourly. Avoid NSAIDs like ibuprofen.</td>
<td>Give paracetamol 1g 6 hourly. Avoid NSAIDs like ibuprofen.</td>
</tr>
<tr>
<td>Refer if no response after 1 month or hand weakness develops.</td>
<td>Refer if no response after 3 months.</td>
</tr>
</tbody>
</table>

ARM SYMPTOMS

Recognise the patient with arm symptoms needing urgent attention:

- Pain and limitation of movement following injury: refer
- Arm, elbow or hand pain with swelling and temperature ≥ 38°C: refer
- Left arm pain with chest pain: exclude ischaemic heart disease →15.
- Sudden onset of weakness of arm perhaps with vision problems, dizziness, difficulty speaking or swallowing: consider stroke/TIA →76.

Approach to the patient with arm symptoms not needing urgent attention

Screen if problem is in the joint: Place hands behind head; then behind back. Make a fist and open hand. Press palms together with elbows lifted. Walk. Sit and stand up with arms folded.

<table>
<thead>
<tr>
<th>Cannot do screen comfortably.</th>
<th>Painful shoulder Referred pain likely</th>
</tr>
</thead>
<tbody>
<tr>
<td>Joint problem likely</td>
<td>Pain at base of thumb relieved by rest De Quervains tenosinovitis likely</td>
</tr>
<tr>
<td>→33.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Can do screen comfortably. Check for associated symptoms.</th>
<th>Wrist pain worse at night and if arm hangs down. May be pins and needles in 1st, 2nd and 3rd fingers. Carpal tunnel syndrome likely</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pain at base of thumb relieved by rest De Quervains tenosinovitis likely</td>
<td></td>
</tr>
</tbody>
</table>

1Do not mix Ringer’s lactate and IV ceftriaxone. Flush IV line with sodium chloride 0.9% before and after IV ceftriaxone. If giving ceftriaxone IM, divide dose: 1g into 2 different injection sites.
## LEG SYMPTOMS

**Recognise the patient with leg symptoms needing urgent attention:**
- Unable to bear weight following injury
- Swelling and localised pain in calf: DVT likely especially if > 35 years, BMI > 25, smoker, immobile, pregnant, on oestrogen, recent surgery, TB or cancer
- Muscle pain in legs or buttocks on exercise associated with pain at rest, gangrene or ulceration: critical limb ischemia
- Sudden onset of weakness of leg perhaps with vision problems, dizziness, difficulty speaking or swallowing: consider stroke/TIA →76.

Refer same day.

### Approach to the patient with leg symptoms not needing urgent attention

<table>
<thead>
<tr>
<th>Is there leg swelling?</th>
<th>One leg swollen</th>
<th>Has there been a recent injury?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>No</strong></td>
<td></td>
<td><strong>No</strong></td>
</tr>
<tr>
<td>Pain in buttoc radiating down back of leg</td>
<td></td>
<td>Examine skin for discolouration, ulcers or lumps.</td>
</tr>
<tr>
<td>Muscle pain in legs or buttocks on exercise</td>
<td></td>
<td><strong>Yes</strong></td>
</tr>
<tr>
<td>Irritation of sciatic nerve likely</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Refer same week.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Yes</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Both legs swollen</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is there cough/wheeze/difficult breathing?</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Yes</strong></td>
<td></td>
<td><strong>Yes</strong></td>
</tr>
<tr>
<td>• Exclude pregnancy. If pregnant →93.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Check for kidney disease on urine dipstick: if blood or protein, check BP ≥73 and refer to doctor.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>→16.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- Pain in buttock radiating down back of leg
- Muscle pain in legs or buttocks on exercise
- Irritation of sciatic nerve likely
- Refer same week.

**Soft tissue injury likely**
- Ensure patient can bear weight on leg, otherwise refer same day.
- Apply firm supportive bandage.
- Advise patient to use leg within limits of pain.
- Give ibuprofen 400mg 3 times a day with food up to 5 days, or if peptic ulcer, hypertension or asthma, paracetamol 1g 4 times a day.
- Review if no better after 2 weeks or if symptoms worsen.

- Discoulouration, ulcers or breaks in skin
- Venous stasis likely
- Kaposis sarcoma likely
  - If status unknown test for HIV ≥60.
  - Patient needs ART within 2 weeks →61.
  - Refer to KS clinic.

**If none of the above or unsure of diagnosis, refer same week.**
FOOT SYMPTOMS

Give urgent attention to the patient with foot symptoms:

- Unable to bear weight following injury
- On ART with signs of lactic acidosis: nausea, abdominal pain or swelling, weight loss, fatigue, shortness of breath. Check lactate → 63.
- On ART and symptoms rapidly worsening over a few weeks, sensation decreased, and/or arms involved: stop ART.
- Muscle pain in legs or buttocks on exercise associated with foot pain at rest, gangrene or ulceration: critical limb ischemia
  Refer same day.

Approach to the patient with foot symptoms not needing urgent attention

<table>
<thead>
<tr>
<th>Generalised foot pain</th>
<th>Localised pain</th>
</tr>
</thead>
<tbody>
<tr>
<td>Constant burning pain, pins/needles and/or numbness of feet worse at night</td>
<td>Ensure that shoes fit properly.</td>
</tr>
<tr>
<td><strong>Peripheral neuropathy</strong> likely</td>
<td></td>
</tr>
<tr>
<td>If status unknown, test for HIV 60. HIV patient needs routine care 61.</td>
<td></td>
</tr>
<tr>
<td>Exclude diabetes 70.</td>
<td></td>
</tr>
<tr>
<td>Give <strong>amitriptyline</strong> 25–75mg at night and <strong>paracetamol</strong> 1g 6 hourly.</td>
<td></td>
</tr>
<tr>
<td>If no response, add <strong>ibuprofen</strong> 400mg 8 hourly with food up to 5 days.</td>
<td></td>
</tr>
<tr>
<td>Refer same week if one-sided, other neurological signs, or loss of function.</td>
<td></td>
</tr>
</tbody>
</table>

On IPT or TB treatment: give **pyridoxine** 75mg daily for 3 weeks, then 25mg daily for duration of treatment. Refer if no response within 1 week of treatment.

Foot pain on exercise with muscle pain in legs and buttocks

<table>
<thead>
<tr>
<th><strong>Peripheral vascular disease</strong> likely</th>
</tr>
</thead>
<tbody>
<tr>
<td>If on d4T switch to TDF 300mg daily. Check eGFR: if &lt; 50 refer 63.</td>
</tr>
<tr>
<td>If on AZT or ddI refer.</td>
</tr>
</tbody>
</table>

If no response to treatment, refer.

In the patient with diabetes and/or PVD identify the foot at risk to prevent ulcers and amputation

- Skin: callus, corns, cracks, wet soft skin between toes, ulcers. Refer the patient with ulcers for specialist care.
- Foot deformity: most commonly bunions (see above). Refer the patient with foot deformity for specialist care.
- Sensation: light prick sensation abnormal after 2 attempts
- Circulation: claudication (muscle pain in legs or buttocks on exercise with/without rest pain), absent foot pulses. Refer the patient with claudication for specialist care.

Advise patient with diabetes and/or PVD to care for feet daily to prevent ulcers and amputation

- Inspect and wash feet daily and carefully dry between the toes. Do not soak your feet.
- Moisten dry cracked feet daily with aqueous cream. Do not moisturise between toes.
- Tell your health worker at once if you have any cuts, blisters or sores on the feet.
- Avoid walking barefoot or wearing shoes without socks. Inspect inside shoes daily.
- Clip nails straight across. Do not cut corns/calluses yourself or use chemicals/plasters to remove them.
- Avoid testing water temperature with feet or using hot water bottles or heaters near feet.
**INJURED PATIENT**

**Recognise the injured patient needing urgent attention:**

- Unconscious → 1
- BP < 90/60: give IV Ringer's lactate. Check Hb.
- Difficulty breathing – may need a chest drain. Doctor to assess.
- Blood in urine
- Enlarging or pulsating swelling
- Fracture: see below
- Head injury: see below
  Refer patient urgently.

### Fracture/s

- Immobilise the limb.
- Patient should be assessed same day by a doctor.
- Refer urgently if:
  - Poor perfusion below a limb fracture: poor capillary refill, limb colder or pale below injury
  - Loss of function or weakness
  - Loss of sensation
  - Overlying open wound
  - Fractures of femur or pelvis
  - Suspected spinal fracture
  - Deformity

### Laceration/s

- Clean with saline and suture if needed.
- Avoid suturing stab wounds > 12 hours on body, > 24 hours on face/head; bullet wounds, crush injuries, chest stabs
- Give paracetamol 1g 6 hourly as needed.
- Remove sutures after 7 days except:
  - Face and neck: 4–5 days
  - Leg: 10 days
  - Below knee: 2 weeks
  - Wound under tension like amputation: 2 weeks

### Bruising

- Elevate and apply ice.
- Apply supportive bandage if severe.
- If bruising extensive check for blood in urine.
- Give paracetamol 1g 6 hourly.
- If blood in urine give IV sodium chloride 0.9% and refer same day.

### Head injury

**Approach to patient with head injury not needing urgent referral**

- Clean any wound and suture if needed.
- Give paracetamol 1g 6 hourly for pain relief. Advise patient to avoid sleeping tablets and tranquilizers.
- On discharge home ensure a responsible person is available to keep an eye on the patient for 24 hours.
- Advise patient to avoid drinking alcohol for 24 hours.
- Patient to go to hospital if any of the following occur: vomiting, visual disturbances, headache not relieved by paracetamol, balance problem, difficult to wake.

**Recognise the patient with a head injury needing urgent referral:**

- Skull fracture
- Amnesia
- Loss of consciousness or fit after injury
- Increasing restlessness, confusion, aggression
- Nausea and/or vomiting
- Double vision
- Blood or serous fluid from nose or ear
- Haematoma around eye or behind eardrum
- Limb weakness
- Drunk patient
- Pupils respond slowly to light or are different size.

- If patient has been assaulted → 53.
- Ask about substance abuse → 83.
- Give the patient with a wound tetanus toxoid 0.5mℓ IM if not had in last 5 years.
- Advise patient to return if no improvement.
**BURNS**

**Attend urgently to the patient with a burn**

- Remove smouldering, hot and/or constrictive clothing and rings and immerse burnt area in cold water for 30 minutes.
- Clean burn gently with clean water or sodium chloride 0.9%.
- Assess the percentage of body surface burnt (see adjacent guide) and depth of the burn:
  - Full thickness burns: complete skin loss, dry, charred, whitish/brown/black, painless
  - Partial thickness burns: moist white/yellow slough, red, mottled, only slightly painful
- Cover full thickness and extensive burns with an occlusive dressing, other burns with paraffin gauze and dry gauze on top. If infected apply povidone iodine 5% cream daily.
- If inhalation burn with black sputum, difficulty breathing, hoarse voice or stridor apply face mask oxygen.
- Ensure hydration: if < 10% burns give oral fluids; if ≥ 10% burns, give sodium chloride 0.9% IV [burn x weight (kg) x 4mℓ]: give half volume in first 8 hours.
- Give tetanus toxoid 0.5mℓ IM if not had in last 5 years.
- Give paracetamol 1g 6 hourly as needed.
- Ask about abuse ☞ 53 and substance abuse ☞ 83.

Refer same day the patient with:
- Full thickness burns
- Partial thickness burns > 10% of total body surface
- Burns of hands/face/feet/genitalia/perineum/major joints
- Circumferential burns of limbs/chest
- Electrical or chemical burns
- Inhalation injury

**Calculate % of body surface burnt:**
- Head 9%
- Neck 1%
- Front torso 18%
- Arm 9%
- Leg 18%
- Back 18%

**Approach to the patient with a burn**

- Remove smouldering, hot and/or constrictive clothing and rings and immerse burnt area in cold water for 30 minutes.
- Clean burn gently with clean water or sodium chloride 0.9%.
- Assess the percentage of body surface burnt (see adjacent guide) and depth of the burn:
  - Full thickness burns: complete skin loss, dry, charred, whitish/brown/black, painless
  - Partial thickness burns: moist white/yellow slough, red, mottled, only slightly painful
- Cover full thickness and extensive burns with an occlusive dressing, other burns with paraffin gauze and dry gauze on top. If infected apply povidone iodine 5% cream daily.
- If inhalation burn with black sputum, difficulty breathing, hoarse voice or stridor apply face mask oxygen.
- Ensure hydration: if < 10% burns give oral fluids; if ≥ 10% burns, give sodium chloride 0.9% IV [burn x weight (kg) x 4mℓ]: give half volume in first 8 hours.
- Give tetanus toxoid 0.5mℓ IM if not had in last 5 years.
- Give paracetamol 1g 6 hourly as needed.
- Ask about abuse ☞ 53 and substance abuse ☞ 83.

Refer same day the patient with:
- Full thickness burns
- Partial thickness burns > 10% of total body surface
- Burns of hands/face/feet/genitalia/perineum/major joints
- Circumferential burns of limbs/chest
- Electrical or chemical burns
- Inhalation injury

**Bites**

**Recognise the patient with a bite needing urgent attention:**

- Snake bite even if bite marks not seen
- Insect bite/s and weakness, drooping eyelids, difficulty swallowing & speaking, double vision
- Suspected rabid animal (animal with strange behaviour)
- Deep and large wound needing surgery

**Management:**
- Give tetanus toxoid 0.5mℓ IM if not had in last 5 years
- Snake bite: do not apply a tourniquet or attempt to squeeze or suck out the venom. Discuss with poison help line ☞ back page.
- If rabies suspected give rabies immunoglobulin 10IU/kg injected in and around wound and 10IU/kg IM.
- Refer same day.

**Approach to the patient with a bite not needing urgent attention**

**Human or animal bite/s**

- Remove any foreign bodies and encourage bleeding.
- Irrigate with warm water and chlorhexidine 0.05% solution or povidone iodine 10% solution.
- Do not close the wound.
- Give tetanus toxoid 0.5mℓ IM if not had in last 5 years.
- Give paracetamol 1g 6 hourly as needed.
- Give antibiotic if human bite/s or animal bite/s to hand or extensive bite: amoxicillin/clavulanic acid 875/125mg 12 hourly or if penicillin allergy, erythromycin 500mg 6 hourly plus metronidazole 400mg 8 hourly all for 5 days, or for 10 days if infected.

**Insect bites**

- If very painful scorpion sting, inject lignocaine 2% 2mℓ around site.
- Give chlorpheniramine 4mg 8 hourly up to 5 days.
- Apply calamine lotion.
- Give paracetamol 1g 6 hourly as needed.
SKIN SYMPTOMS

This is the starting page for the patient with skin symptom/s.

Recognise the patient with skin symptom/s needing urgent attention:

Refer urgently:
- Purple rash with headache, vomiting: give ceftriaxone\(^1\) 2g IM/IV.
- Rash with BP < 90/60: give Ringer’s lactate IV.
- Diffuse itchy rash with respiratory rate ≥ 30 breaths/minute: treat for anaphylaxis.

Refer same day:
- Extensive blistering
- Shingles involving the eye
- If on any medication like ART, TB drugs, co-trimoxazole or anticonvulsants, with 1 or more of the following, stop all drugs:
  - Temperature ≥ 38°C
  - Systemically unwell (vomiting/headache)
  - Any mucosal involvement (look in the mouth)
  - Blistering or raw areas
  - Diffuse purple discolouration of the skin
  - Jaundice

Approach to the patient with skin symptom/s not needing urgent attention

If status unknown, test for HIV, especially if rash is extensive, recurrent and/or difficult to treat.

---

\(^1\) Do not mix Ringer’s lactate and IV ceftriaxone. Flush IV line with sodium chloride 0.9% before and after IV ceftriaxone. If giving ceftriaxone IM, divide dose: 1g into 2 different injection sites.
PAINFUL SKIN

**Boil/abscess likely**
Skin is swollen, red, hot and tender to the touch.

- Advise patient to wash with soap and water, keep nails short, and avoid sharing clothing or towels.
- Give paracetamol 1g 6 hourly for pain relief as needed.
- Incise and drain if larger or fluctuant. Refer if on face or perianal region.
- If enlarged lymph nodes or temperature ≥ 38°C, give flucloxacillin 500mg 6 hourly for 5 days. If penicillin allergic, give erythromycin 500mg 6 hourly for 5 days.
- If recurrent boils: test for HIV ≥ 60 and diabetes ≥ 70. Wash body daily for 1 week with antiseptic wash.

**Cellulitis likely**
There may be blistering.

- Give paracetamol 1g 6 hourly for pain relief.
- Give flucloxacillin 500mg 6 hourly for 5 days. If penicillin allergic, give erythromycin 500mg 6 hourly for 5 days.
- Refer if symptoms worsen or no better after 4 days.

**Shingles likely**
If status is unknown test for HIV → 60

- Treat rash topically with povidone iodine cream.
- If blisters are fresh, give aciclovir 800mg 4 hourly (miss the middle of the night dose) for 7 days.
- Shingles is very painful. Give regular analgesia:
  - Paracetamol 1g 6 hourly.
  - If no response, add tramadol 50mg 4 times a day.
  - If poor response or pain persists after rash has healed, give amitriptyline 25mg at night, increase by 25mg every 2 weeks if needed to 75mg.
- If infected, add flucloxacillin 500mg 6 hourly for 5 days. If penicillin allergic, give erythromycin 500mg 6 hourly for 5 days.
- A stage 2 HIV diagnosis. HIV patient needs routine HIV care → 61.
- Refer same day if:
  - Eye involvement
  - Features of meningitis
  - Blisters elsewhere on the body

**Blisters with crusting in a band along one side of the body or face for 3 days or less.**

- Treat rash topically with povidone iodine cream.
- If status is unknown test for HIV → 60

**Firm, red lump which softens in the centre to discharge pus.**

- Advise patient to wash with soap and water, keep nails short, and avoid sharing clothing or towels.
- Give paracetamol 1g 6 hourly for pain relief as needed.
- Incise and drain if larger or fluctuant. Refer if on face or perianal region.
- If enlarged lymph nodes or temperature ≥ 38°C, give flucloxacillin 500mg 6 hourly for 5 days. If penicillin allergic, give erythromycin 500mg 6 hourly for 5 days.
- If recurrent boils: test for HIV ≥ 60 and diabetes ≥ 70. Wash body daily for 1 week with antiseptic wash.
**ITCH WITH LOCALISED RASH**

- **Ringworm** likely
  - A clearly-demarcated active, scaly or blistering edge is characteristic. If multiple or large lesions, test for HIV.  
  - Give clotrimazole cream twice a day for 2 weeks after lesion has cleared.  
  - Advise patient to avoid sharing towels/clothes.  
  - Give routine HIV care to the HIV patient.  
  - Refer if rash is extensive, recurrent or responds poorly to clotrimazole cream.

- **Athlete’s foot** likely
  - Give clotrimazole cream twice a day for 2 weeks after lesion has cleared.  
  - Advise patient to wash and dry feet well.  
  - Encourage open shoes/sandals.

- **Lice** likely
  - Look for nits/eggs on hair.  
  - Dip comb in vinegar and fine comb the hair.  
  - Give permethrin 1% cream rinse: apply after washing and rinse after 10 minutes or benzyl benzoate: apply to scalp overnight and wash off in morning.  
  - Repeat after 1 week if necessary.

- **Psoriasis** likely
  - Confirm diagnosis with doctor  
  - Apply emulsifying ointment.  
  - Expose skin to sunlight.  
  - Apply LPC cream daily.  
  - Refer if extensive or not responding or LPC cream unavailable.

- **Well demarcated pink raised plaques covered with a silvery scale.**

**ITCH WITH NO RASH**

- **Confirm there is no rash, especially scabies or insect bites.**  
  - Is the skin very dry?

  - **No**  
    - Review patient's medication.
  
  - **Yes**  
    - **Dry skin/ichthyosis** likely  
      - Use emulsifying ointment, petroleum jelly or aqueous cream as moisturiser.  
      - Use aqueous cream instead of soap to wash.

- **All TB drugs can cause itch with no rash.**  
  - Continue TB treatment.  
  - Chlorpheniramine 4mg at night, or up to 8 hourly, for up to 5 days (may cause sedation).  
  - Advise patient to return if rash develops or if no better after 5 days.
### GENERALISED ITCHY RASH

If status unknown, test for HIV, especially if rash is extensive, recurrent and difficult to treat 60.

<table>
<thead>
<tr>
<th>Condition</th>
<th>Likely Cause</th>
<th>Symptoms</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Scabies</strong></td>
<td>Commonly involves web-spaces of hands and feet, axillae and genitalia.</td>
<td>A widespread very itchy rash with burrows</td>
</tr>
<tr>
<td><strong>Papular-pruritic eruption</strong></td>
<td>Likely to co-exist with scabies.</td>
<td>Very itchy bumps. Skin often hyper-pigmented</td>
</tr>
<tr>
<td><strong>Eczema</strong></td>
<td>Likely to co-exist with scabies.</td>
<td>Patches of dry, scaly skin with/without itch that may be localised</td>
</tr>
<tr>
<td><strong>Urticaria</strong></td>
<td>Likely due to allergy.</td>
<td>Very itchy red raised wheals that appear suddenly, disappear and then reappear elsewhere</td>
</tr>
</tbody>
</table>

#### Treatment Options

- **Scabies**
  - Prescribe 25% benzyl benzoate lotion.
  - Apply, leave to dry, wash off after 24 hrs, repeat after 1 week (repeat once only).
  - Treat all household members and clean linens/clothes.
- **Scabies**
  - For itching: chlorpheniramine 4mg at night up to 10 days.
- **Papular-pruritic eruption**
  - Often co-exists with scabies.
  - Usually seen in HIV patients 60.
  - May temporarily worsen on starting ART.
  - A stage 2 HIV condition. HIV patient needs routine HIV care 61.
- **Eczema**
  - Use emulsifying ointment instead of soap.
  - Prescribe 1% hydrocortisone cream.
  - Use aqueous cream as a moisturiser.
- **Urticaria**
  - Try to identify and remove allergen.

#### Additional Instructions

- **Scabies**
  - First treat as for scabies in adjacent column.
  - If no response, give emulsifying ointment and 1% hydrocortisone cream.
  - For itching: chlorpheniramine 4mg 8 hourly up to 5 days.
  - If poor response doctor to give betamethasone 0.1% ointment twice a day for 7 days (do not apply to face).
- **Urticaria**
  - Refer if no better with above treatment.

If no response to treatment, refer for specialist review.
LUMPS

Refer same week the patient with a lump that:
- Bleeds easily
- Is a new or changed mole
- If the diagnosis is uncertain to exclude skin cancer

Raised nodules or papules
Small, skin-coloured bumps with pearly central dimples
Purple lumps on skin or in mouth
Small, firm lump beneath the skin, may discharge white material
Red papules, pustules and blackheads on face and perhaps on upper back, arms, buttocks and chest

Warts likely
- Common on hands in young adults.
- Plantar warts on the soles of the feet are thick and hard with a black central point.
- Reassure patient that warts often disappear spontaneously.
- Apply podophyllin resin 20% and salicylic acid 25% ointment under a plaster at night.
- Protect surrounding skin with petroleum jelly.
- Refer if warts are extensive.

Molluscum contagiosum likely
- May be extensive in HIV.
- If status is unknown test for HIV \( \rightarrow 60 \).
- May be extensive in HIV.
- If status is unknown test for HIV \( \rightarrow 60 \).
- Reassurance (may disappear quickly with ART).
- If distressing to patient, try local destructive treatment (open molluscum with sterile blade/needle and paint with tincture of iodine).
- Refer if no response to ART or local destructive treatment.

Kaposi’s sarcoma likely
- These can vary from isolated lumps to florid tumours.
- If status is unknown test for HIV \( \rightarrow 60 \).
- May be extensive in HIV.
- If status is unknown test for HIV \( \rightarrow 60 \).
- This is an AIDS-defining illness.
- Patient needs routine HIV care and ART \( \rightarrow 61 \).
- May be extensive in HIV.
- If status is unknown test for HIV \( \rightarrow 60 \).

Epidermal cyst likely
- If not infected no treatment needed.
- If warm, tender and red, the cyst is infected:
  - Incise and drain if large or fluctuant. Refer if on face or perianal region.
  - If enlarged lymph nodes or temperature \( \geq 38^\circ C \) give flucloxacillin 500mg 6 hourly for 5 days. If penicillin allergic give erythromycin 500mg 6 hourly for 5 days.
- Refer if large, symptomatic, recurrent infection or diagnosis uncertain.

Acne likely
- Steroids, anticonvulsants, isoniazid can all worsen acne.
- Advise to avoid squeezing lesions and greasy cosmetics. Diet will not affect acne.
- Apply benzoyl peroxide 5% gel at night to inflamed pustules and discuss with doctor to give doxycycline 100mg daily for at least 3 months. Doxycycline interferes with oral contraceptive. Advise to use condoms as well.
- If woman needs contraception, advise oestrogen-containing oral contraceptive \( \rightarrow 91 \).
- Response to treatment is usually slow.
- Refer if severe or not responding to treatment.
**GENERALISED NON ITCHY RED RASH**

<table>
<thead>
<tr>
<th>Is patient taking any medication?</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drug reaction likely</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Presentation is variable, from mild, patchy spots on the trunk to widespread skin damage (like burns).</td>
<td></td>
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</tr>
<tr>
<td>Hand involvement is characteristic.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>May occur within 6 weeks of starting or restarting antiretrovirals especially nevirapine, TB drugs, anticonvulsants, penicillin or co-trimoxazole.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Does the patient have any of the following markers of severity:</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Temperature ( \geq 38^\circ C )</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vomiting or nausea</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Headache</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Jaundice</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Painful mouth, eyes or genitals</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blistering or ‘raw’ areas</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diffuse purple discoulouration of skin</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Abdominal pain</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| Patient is severely ill.                                      |     |    |
| Stop all drugs.                                               |     |    |
| Refer to hospital same day.                                   |     |    |
| Patient must continue with medication. Do not increase nevirapine if still on once daily dose until rash has resolved and ALT is normal. |     |    |
| Check ALT.                                                    |     |    |
| - if \( \geq 200 \) refer same day.                          |     |    |
| - if 50–199 and patient is well, repeat ALT after 1 week.    |     |    |
| Apply emulsifying ointment.                                   |     |    |
| Chlorpheniramine 4mg at night if itchy up to 5 days.         |     |    |
| Review daily until rash resolves.                            |     |    |
| Advise patient to return urgently if markers of severity develop. |     |    |

| Patient is not severely ill.                                  |     |    |
| Most likely due to infection.                                 |     |    |
| Patient may have fever, headache, lymphadenopathy, muscle pain. |     |    |
| Ensure patient is not severely ill \( \geq 40. \)             |     |    |

| Treatment of patient who is not severely ill                  |     |    |
| Give pain relief if needed. \( \text{Paracetamol} 1g \) 6 hourly. |     |    |
| Check for syphilis.                                           |     |    |
| If status unknown, test for HIV \( \geq 60. \)                |     |    |

**Syphilis test positive or unavailable**
About one third of patients with untreated primary syphilis develop secondary syphilis.
Rash is often on soles and palms. There may also be condylomata lata and patchy hairloss.

| Syphilis test positive or unavailable                          |     |    |
| HIV negative                                                  |     |    |
| Rash may be an HIV seroconversion illness.                    |     |    |
| Advise patient to repeat HIV test after 3 months.             |     |    |

| HIV positive                                                  |     |    |
| Patient needs routine HIV care \( \geq 61. \)                  |     |    |

**Drug reaction likely**

**Does the patient have any of the following markers of severity:**
- Temperature \( \geq 38^\circ C \)
- Vomiting or nausea
- Headache
- Jaundice
- Painful mouth, eyes or genitals
- Blistering or ‘raw’ areas
- Diffuse purple discoulouration of skin
- Abdominal pain

**HIV negative**
Rash may be an HIV seroconversion illness.

**HIV positive**
Patient needs routine HIV care \( \geq 61. \)
## Ulcers and Crusts

### Ulcer/s

**Is ulcer/s on the leg?**

<table>
<thead>
<tr>
<th>No</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>• If genital ulcer → 23.</td>
<td></td>
</tr>
<tr>
<td>• If elsewhere on body and no obvious cause like trauma, refer to exclude skin cancer.</td>
<td></td>
</tr>
</tbody>
</table>

**Check if foot pulses are present and if patient has muscle pain in legs or buttocks on exercise.**

**Foot pulses are present and no muscle pain in legs or buttocks on exercise.**

**Is there darkening of skin around the ulcer, varicose veins and/or chronic swelling of the leg?**

<table>
<thead>
<tr>
<th>No</th>
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<tbody>
<tr>
<td>• If patient has weight loss, cough or sweats, exclude TB → 55.</td>
<td></td>
</tr>
<tr>
<td>• Refer for further assessment.</td>
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**Venous stasis ulcer** likely

- • Apply dressing under compression (ideally hydrocolloid dressing or silver sulfadiazine cream).
- • Assess CVD risk → 68.
- • Refer if patient has diabetes or ulcer no better after 1 month of treatment.

**Peripheral vascular disease** likely

- • Patient needs specialist assessment.
- • Do not apply compression bandage to ulcer/s.
- → 79.

**Foot pulses not present and/or muscle pain in legs or buttocks on exercise**

**Blisters which dry to form honey coloured crusts.**

- Impetigo likely
  - • Usually starts on face, spreads to neck, hands, arms and legs. May complicate bites or grazes.
  - • May be extensive in HIV. If status is unknown test for HIV → 60.
  
- • Use aqueous cream to remove crusts.
- • Apply povidone iodine 5% cream 3 times a day.
- • Give amoxicillin 500mg 8 hourly for 5 days if extensive infection. If no response give flucloxacillin 500mg 6 hourly for 5 days. If penicillin allergic give erythromycin 500mg 6 hourly for 5 days. If rash does not resolve completely, give antibiotics for 5 days more.
- • Refer if no better after 10 days.

**Ulcer/s on the leg?**

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### CHANGES IN SKIN COLOUR

#### Yellow skin
- Jaundice likely

**Approach to jaundiced patient who does not need same-day referral:**
- If patient takes > 21 drinks/week (man), > 14 drinks/week (woman) and/or > 5 drinks/session, assess for alcohol abuse.
- Check ALT and ALP/GGT.
- Review with blood results.

- Darkening of skin
  - Is skin smooth or scaly?
  - Smooth
    - Dark brown patches on cheeks and upper lip
  - Scaly
    - Scaly dark or light patches usually occur on the trunk – they may coalesce.

- Absence of colour
  - Is skin smooth or scaly?
  - Smooth
    - Is absence of colour generalised or patchy?
      - Patchy
      - Generalised
      - Present from birth, hair and eyes are involved.

- Albinism likely
  - Encourage sun avoidance and use of sunscreen.
  - Monitor for the development of skin cancers.

- Melasma likely
  - Avoid use of skin-lightening agents.
  - Encourage sun avoidance and use of sunscreen.
  - Change oral contraceptive to alternative contraception.
  - Ask about symptoms of menopause.
  - Stop all topical preparations like cosmetics, perfumes, perfumed soap and moisturisers.
  - This is often difficult to treat.

- Tinea versicolor likely
  - Apply selenium sulphide shampoo to affected areas overnight once a week.
  - Advise that colour may take months to return to normal, but that absence of scale indicates adequate treatment.
  - Recurrence is common.

- Vitiligo likely
  - Advise use of camouflage cosmetics.
  - Skin colour may return but seldom does on hands, feet, lips and genitalia.
  - Refer to dermatologist if extensive.

- Refer if diagnosis is uncertain.

#### Approach to jaundiced patient who does not need same-day referral:
- If patient takes > 21 drinks/week (man), > 14 drinks/week (woman) and/or > 5 drinks/session, assess for alcohol abuse.
- Check ALT and ALP/GGT.
- Review with blood results.

- ALT ≥ 120
- ALP/GGT ≥ 3 times upper limit
- Do hepatitis B screen.
- Refer for ultrasound liver and further management.

- Review weekly.
- Repeat fingerprick Hb.
- Refer if Hb falls < 10, patient develops markers of severity above or jaundice persists > 6 weeks.

- Refer if diagnosis is uncertain.
NAIL SYMPTOMS

Disfigured nail with swollen nail bed

Chronic Paronychia likely

- Often associated with working with water. Advise patient to wear gloves and keep hands dry.
- Apply betamethasone 0.1% ointment to nailfold at night.
- If no better after 2 weeks, add clotrimazole cream 8 hourly.

Painful, red, swollen area around the nail.

Acute Paronychia likely

- Often associated with trauma like nail biting or pushing the cuticle. Advise patient to stop.
- Give flucloxacinil 500mg 6 hourly for 10 days.
- Refer for incision and drainage if no response after 5 days.

White/yellow disfigured nails

Fungal infection

Refer for management if very troublesome.

Diffuse blue/black discolouration of nails.

HIV or drug side effect

If status is unknown test for HIV →60.

Painful, red, swollen area around the nail.

White/yellow disfigured nails

Diffuse blue/black discolouration of nails.

Painful, red, swollen area around the nail.

White/yellow disfigured nails

Diffuse blue/black discolouration of nails.
SUICIDAL PATIENT

Recognise the patient who has attempted or had thoughts of suicide/self harm needing urgent attention:

- Unconscious → 1.
- If aggressive or violent → 50.
- Intent to attempt suicide: suicidal thoughts; ongoing wish to commit suicide; plans have been made for suicide
- Suicide attempt was serious: planned, took care against discovery; violent or potentially lethal; perhaps preceded by ‘final acts’ like leaving a note or new will.
- Overdose of medication like paracetamol or ferrous sulphate or other potentially harmful substance
- Exposure to carbon monoxide

Management:
- If patient took an oral overdose of medication within past 2 hours and is fully conscious give 500mℓ water added to 100g activated charcoal via nasogastric tube.
- Avoid activated charcoal if patient ingested paraffin, petrol, corrosive poisons, iron, lithium or alcohol.
- If patient took opioid like codeine or morphine: give naloxone 0.4–2mg IV. If no immediate effect, repeat every 5 minutes until pupils dilate (maximum 10mg).
- If exposed to carbon monoxide: give 100% face mask oxygen.
- Contact local poison centre for advice → backpage.
- If the patient has signs of mental illness (see below) and refuses treatment or admission, consider admitting under the Mental Health Care Act → 80.
- Refer same day.

Assess the patient who has no suicidal intent and has not had a serious suicide attempt not needing urgent attention

Screen for mental illness
- If low mood or sadness, loss of interest or pleasure, feeling anxious or worrying a lot or not coping as well as before, consider depression/anxiety → 81.
- If hallucinations, delusions and abnormal behaviour, consider psychosis → 84.
- If memory problems, screen for dementia → 86.
- If patient takes > 21 drinks/week (man) or > 14 drinks/week (woman) and/or > 5 drinks per session or misuses illicit or prescription drugs → 83.

Explore possible stressors
- Ask ‘Are you stressed?’ If yes → 52.
- Ask ‘Are you unhappy in your relationship? Has anything happened to you which changed your life?’ If yes to either → 53.

Make discharge and follow-up plans according to the following factors:

If any 1 of the following are present:
- Male and/or
- ≥ 45 years and/or
- Socially isolated and/or
- Adolescent and/or
- Family history of suicide and/or
- Previous attempts at suicide and/or
- Known mental illness and/or
- Substance abuse and/or
- Functioning impaired and/or
- Chronic medical illness like HIV, cancer

Refer same week to community psychiatric nurse or social worker.

If all of the following are present:
- Female and
- < 45 years and
- Adequate social support and
- First suicide attempt and
- Suicide attempt was an impulsive act in context of a crisis now resolved and
- No evidence of mental illness or substance abuse and
- Functioning not impaired and
- Otherwise well

- Discharge to family/carers.
- Review within 1 week:
  - Reassess for suicidal intent, mental illness, stressors.
  - Consider referral to community psychiatric nurse.
## Approach to the aggressive or violent patient

*Ensure the safety of yourself, the patient and those around you:*
- Ensure enough security personnel are present, call the police if necessary. They should disarm patient if s/he has a weapon.
- Assess patient in a safe room in the presence of other staff. Handle the patient in a calm authoritative manner. Try to talk the patient down.
- Restrain only if absolutely necessary.

**Check for confusion:** try to avoid sedation before assessing confusion

- Varying levels of drowsiness and alertness
- Unaware of surroundings/disorientated
- Talking incoherently

**Look for mental illness and substance abuse:**
- Take a history from the escort for known mental illness or substance abuse.
- Consider psychosis if hallucinations, delusions, incoherent speech.
- Consider substance withdrawal or intoxication if alcohol on breath or history of alcohol or illicit drug use.

If the patient fulfills all 3 of the following, consider admitting under the Mental Health Care Act before sedation:
- Has signs of mental illness and
- Refuses treatment or admission and
- Is a danger of harm to self, others, own reputation or financial interest/property

<table>
<thead>
<tr>
<th>Is sedation needed?</th>
<th>No</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Give lorazepam 2mg and haloperidol 2–5mg IM or orally if patient accepts oral medication.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Monitor and record BP, pulse and level of consciousness every 15 minutes.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Reassess for mental illness.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Is patient’s behaviour still aggressive after 60 minutes?</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>Repeat haloperidol 2–5mg IM or orally if patient accepts oral medication.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Monitor and record BP, pulse and level of consciousness every 15 minutes.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• If necessary, repeat haloperidol to a maximum of 10mg in 24 hours.</td>
<td></td>
</tr>
</tbody>
</table>

*Refer the mentally ill aggressive patient same day to hospital.*
*Document history, details of Mental Health Care Act, and time and dose of medication given.*
CONFUSED PATIENT

- The confused patient may be disoriented for place and time, unsure of his/her own name, and may have a poor attention span and altered sleep pattern.
- If the confused patient is also aggressive, try to assess and manage confusion before sedating the patient → 50.

**Recognise the confused patient needing urgent attention:**
- **Sudden onset** of confusion or disturbed speech or behaviour, perhaps with weakness, visual disturbance that may have resolved: **stroke** likely → 76
- **Had a fit** → 2
- **Sudden onset** over hours or days of confusion with impaired awareness, varying levels of alertness and drowsiness and change in sleep pattern: **delirium** likely
- **Temperature ≥ 38°C**
- **Head injury within past 6 weeks**
- **Finger prick blood glucose ≤ 3.5**

**Management:**
- Give face mask oxygen.
- If glucose ≤ 3.5, give oral glucose or 40–50mℓ dextrose 50% IV. If confusion resolves, refer only if on glibenclamide, gliclazide or insulin. If diabetic → 71.
- If temperature ≥ 38°C: give ceftriaxone¹ 2g IM/IV immediately.
- Alcohol withdrawal (known alcohol user who has taken less alcohol for 12 hours): give thiamine 100mg IM and diazepam 10mg orally and oral rehydration.
- Drunk (smells of alcohol, recent drinking): give 1 ℓ sodium chloride 0.9% with thiamine 100mg IV over 4 hours. Refer only if still confused when drip complete → 83.
- Refer same day to hospital unless confusion resolves when sober or with glucose not on glibenclamide, gliclazide or insulin.

**Approach to the confused patient not needing urgent attention**

Is the patient psychotic?
Lack of insight with 1 or more of hallucinations (hearing voices), delusions (fixed false beliefs) and disorganized speech and behaviour.

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Psychosis or mania → 84</strong></td>
<td></td>
</tr>
</tbody>
</table>

Has patient had memory problems and been disoriented for at least 6 months?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Dementia likely → 86</strong></td>
<td>Refer same day for assessment.</td>
</tr>
</tbody>
</table>

¹Do not mix Ringer’s lactate and IV ceftriaxone. Flush IV line with sodium chloride 0.9% before and after IV ceftriaxone. If giving ceftriaxone IM, divide dose: 1g into 2 different injection sites.
Recognise the stressed/miserable patient needing urgent attention

Assess the stressed/miserable patient
- The patient may have headache, dizziness, fatigue, abdominal pain. S/he may have poor eye contact, cry easily, be agitated or communicate poorly.

Screen for mental problem
- If low mood or sadness, loss of interest or pleasure, feeling tense, worrying a lot or not coping as well as before, consider depression/anxiety \( \rightarrow \) 81.
- If > 21 drinks/week (man) or > 14 drinks/week (woman) and/or > 5 drinks/session or misuses illicit or prescription drugs consider substance abuse \( \rightarrow \) 83.
- If hallucinations, delusions and abnormal behaviour, consider psychosis \( \rightarrow \) 84.
- If memory problems, screen for dementia \( \rightarrow \) 86.

Identify the traumatised/abused patient
- Ask ‘Are you unhappy in your relationship? Has anything happened to you which changed your life?’ If yes to either \( \rightarrow \) 53.

Try to identify a cause to focus on a solution
- Ask about financial difficulty, bereavement, post-natal \( \rightarrow \) 97, menopause \( \rightarrow \) 98 or chronic ill-health (is HIV status known? \( \rightarrow \) 60).
- Review medication: oral corticosteroids, oestrogen-containing oral contraceptives \( \rightarrow \) 91, theophylline, efavirenz can cause mental side effects. Reassure patient on efavirenz that low mood is usually self-limiting and resolves within 6 weeks on ART. If > 6 weeks doctor to change to NVP 200mg 12 hourly.

Advise the stressed/miserable patient
- Encourage patient to take time to relax:
  - Do a relaxing breathing exercise each day.
  - Find a creative or fun activity to do.
  - Spend time with supportive friends or family.
- Regular exercise might help.
- Advise patient to get adequate sleep. If patient has difficulty sleeping \( \rightarrow \) 54.
- Link patient to available psychosocial services: counsellor, psychologist, support group, social worker, helpline \( \rightarrow \) back page.
- Deal with negative thinking
  - The patient may often predict the worst, generalise, exaggerate the problem, inappropriately take the blame, or take things personally.
  - Encourage the patient to question his/her way of thinking (like changing ‘I am a failure’ to ‘I am not a failure, I have achieved many good things in the past’), examine the facts realistically and look for strategies to get help and cope.
- See communicating effectively see Preface.

Offer to review the patient in 1 month.
TRAUMATISED/ABUSED PATIENT

Recognize the traumatised/abused patient needing urgent attention

- Injuries need attention
- Immediate risk of being harmed and in need of shelter
- At risk of harm to self
- Recent rape/sexual assault:
  - Arrange doctor assessment ideally at a designated facility for management of rape and sexual assault (same day if patient wishes to lay a charge).
  - All documentation and patient’s notes must be correctly completed and labelled. Record in a register and keep locked away all forensic specimens.
  - Aim to prevent HIV, STIs and pregnancy as soon as possible after the abuse:

Prevent HIV
- If status unknown, test for HIV.
- If HIV negative or unknown, start post-exposure prophylaxis for 1 month within 72 hours of rape: AZT 300mg 12 hourly and STIC 150mg 12 hourly. Add nevirapine 400/100mg 12 hourly if high risk rape: anal penetration, multiple perpetrators, perpetrator known with HIV, or obvious genital trauma.

Prevent STIs
- If asymptomatic give cefixime 400mg orally single dose and doxycycline 100mg 12 hourly for 7 days and metronidazole 2g orally single dose.
- If symptomatic, treat symptoms.
- Advise patient to use condoms with regular partner for 3 months.

Prevent syphilis
- Offer RPR:
  - If RPR negative, repeat after 1 month.
  - If RPR positive.
  - Advise patient to use condoms with regular partner for 3 months.

Prevent pregnancy (if not on contraceptive and of child-bearing age):
- Within 5 days of rape: give as soon as possible ideally within 24 hours levonorgestrel 0.75mg 2 tablets once or norgestrel/ethinyl estradiol 0.5/0.05mg 2 tablets and repeat 12 hours later.
- Within 5 days: intrauterine device can be inserted.
- After 5 days: check pregnancy test 6–8 weeks after last period. If pregnant.

Also assess and support the patient needing urgent attention as below.

Approach to the traumatized/abused patient

Listen and support see preface
- Interview the patient in a private room, supported by a trusted friend/relative if the patient wishes.
- Clearly record the patient’s story in his/her own words. Include the nature of the assault and the identity of the perpetrator.
- Help the patient to identify strengths and support structures. Do not give up if the patient fails to follow your advice.
- Offer to see the patient again. A supportive relationship with the same health practitioner helps to contain frequent visits for multiple problems.

Screen for mental problem
- If low mood or sadness, loss of interest or pleasure, feeling tense, worrying a lot or not coping as well as before, consider depression/anxiety.
- Ask ‘Are you stressed?’ If yes.
- If > 21 drinks/week (man) or > 14 drinks/week (woman) and/or > 5 drinks/session or misuses illicit or prescription drugs consider substance abuse.

Exclude pregnancy and STIs
- Check for pregnancy. If pregnant.
- If status unknown, test for HIV. The HIV patient needs routine HIV care.
- Ask about symptoms of sexually transmitted infections. If present.

Refer to available supportive resource
- Refer to available trauma counselor, psychiatric nurse, psychologist, social worker, helpline.
- Encourage patient to file a J88 form and to report case to the police. Respect the patient’s wishes if s/he declines to do so.
- Encourage patient to apply for protection order at local magistrate’s court. Refer to police Victim Empowerment office, family violence NGOs for assistance.
DIFFICULTY SLEEPING

Assess the patient with difficulty sleeping
- Check that the patient really is getting insufficient sleep. Adults need on average 6–8 hours sleep per night. This decreases with age.
- Determine the type of sleep difficulty: waking too early or frequently, difficulty falling asleep, insufficient sleep.

Exclude medical problems
- Ask about pain, difficulty breathing, urinary problems. See relevant symptom pages.
- Over-the-counter decongestants, oral steroids, theophylline, fluoxetine, efavirenz may cause sleep problems. Discuss with doctor.
- Reassure patient that sleep disturbance from efavirenz is usually self-limiting and resolves within 6 weeks on ART. If > 6 weeks change to NVP 200mg 12 hourly.

Screen for substance abuse
- If patient takes > 21 drinks/week (man) or > 14 drinks/week (woman) and/or > 5 drinks/session or misuses illicit or prescription drugs 83.

Screen for mental problem
- If low mood or sadness, loss of interest or pleasure, feeling tense, worrying a lot or not coping as well as before, consider depression/anxiety 81.
- Consider psychosis if hallucinations, delusions, incoherent speech 84.
- Consider dementia if memory problems 86.
- Ask ‘Are you stressed?’ If yes 52.

Ask about associated loud snoring
- Refer the patient with difficulty sleeping who snores for further assessment.

Advise the patient with difficulty sleeping
- Encourage patient to adopt sensible sleep habits. These often help to resolve a sleep problem without the use of sedatives.
  - Get regular exercise (but not before bedtime).
  - Avoid caffeine (coffee, tea) and smoking before bedtime.
  - Avoid day-time napping.
  - Encourage routine: try to get up at the same time each day (even if tired) and go to bed the same time every evening.
  - Wind down/relax before bed.
  - Use bed only for sleeping and sex. Spend only 6–8 hours a night in bed.
  - Once in bed do not clock-watch. If not asleep after 20 minutes, do a low energy activity out of bed, like a short walk around the house.
  - Keep a sleep diary. Review this at each visit.
- Review the patient regularly. A good relationship between practitioner and patient can help.

If problems with daytime functioning, daytime sleepiness, irritability, anxiety or headaches that do not improve with 1 month of sensible sleep habits, refer patient for further assessment.
**TB: DIAGNOSIS**

Exclude TB in the patient with cough ≥ 2 weeks, weight loss, drenching night sweats, fever ≥ 2 weeks, chest pain on breathing, blood-stained sputum.

**Give urgent attention to the TB suspect with one or more of the following:**
- Respiratory rate of ≥ 30 breaths/minute
- Breathlessness at rest or while talking
  - Give 1 dose of **ceftiraxone** 1g IM/IV.
  - Give oxygen (40% face-mask oxygen or at 4ℓ/minute via nasal prongs).
  - Refer same day to hospital.
- Prominent use of breathing muscles
- Confusion or agitation

**Start the workup to diagnose TB**
- If status unknown test for HIV ⦁ 60.
- Check sputum for TB: send 1 spot sputum specimen for Xpert. Xpert detects Mycobacterium tuberculosis and only rifampicin sensitivity.
- If patient has chest pain on breathing or is coughing frank blood, also arrange chest X-Ray and doctor review (see below).
- Ask patient to return for results after 2 days.

**Review results**

<table>
<thead>
<tr>
<th>MTB detected</th>
<th>MTB not detected</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rifampicin resistant</td>
<td>Rifampicin susceptible</td>
</tr>
</tbody>
</table>

**Diagnose drug resistant TB**
- Refer to DR-TB unit.

**Diagnose TB**
- Give routine TB care and start TB treatment same day → 57.
- Send spot sputum specimen for smear microscopy.
- Register as smear negative or positive depending on microscopy result.

**MTB not detected**
- Manage further according to HIV status.
- Encourage patient who has not tested to do so ⦁ 60.

**MTB detected**
- If status unknown test for HIV ⦁ 60.
- Check sputum for TB: send 1 spot sputum specimen for Xpert. Xpert detects Mycobacterium tuberculosis and only rifampicin sensitivity.
- If patient has chest pain on breathing or is coughing frank blood, also arrange chest X-Ray and doctor review (see below).
- Ask patient to return for results after 2 days.

**Diagnose TB**
- Give routine TB care and start TB treatment same day → 57.
- Send spot sputum specimen for smear microscopy.
- Register as smear negative or positive depending on microscopy result.

**HIV positive**
- Send spot sputum specimen for LPA² (or culture and DST³ if LPA unavailable).
- Give **amoxicillin** 1g 8 hourly for 5 days.
- Review in 1 week.

**HIV negative**
- Give **amoxicillin** 1g 8 hourly for 5 days.
- Review in 1 week.

**No or partial response**
- Advise to return if symptoms recur.

**Resolved**
- Arrange chest X-Ray and doctor review.

---

¹ Do not mix Ringer's lactate and IV ceftriaxone. Flush IV line with sodium chloride 0.9% before and after IV ceftriaxone. ² Line Probe Assay detects TB drug resistance and is quicker than culture and DST. ³ Drug susceptibility testing. ⁴ If penicillin-allergic: **erythromycin** 500mg 6 hourly for 5 days.
Doctor to review chest X-Ray

<table>
<thead>
<tr>
<th>Intrathoracic lymphadenopathy</th>
<th>Miliary TB</th>
<th>Pleural effusion</th>
<th>Any lung opacification/s can be TB in HIV patient</th>
<th>Upper lobe cavitation</th>
<th>Pericardial effusion</th>
</tr>
</thead>
</table>

Doctor decision about chest X-Ray

<table>
<thead>
<tr>
<th>Chest X-Ray similar to X-Ray above</th>
<th>Chest X-Ray normal</th>
<th>Chest X-Ray different to above or unsure</th>
</tr>
</thead>
</table>

- **Diagnose TB** on basis of chest X-Ray:  
  - Give routine TB care and start TB treatment same day →57.  
  - Send one spot sputum specimen for smear microscopy.  
  - Register as smear negative or positive depending on microscopy result.

- **Drug sensitive**  
  - Diagnose TB  
    - Give routine TB care and start TB treatment same day →57.  
    - Send one spot sputum specimen for smear microscopy.  
    - Register as smear negative or positive depending on microscopy result.

- **Drug resistant (DR)**  
  - Diagnose DR-TB  
    - Refer to DR-TB unit.

- **Culture negative or still pending**  
  - If symptoms persist: Refer for experienced TB clinician review.  
  - If culture negative and symptoms resolve: advise to return if symptoms recur.

- **Do not discharge from workup until TB excluded.**

1 Line Probe Assay detects TB drug resistance and is quicker than culture and DST.  
2 Drug susceptibility testing.

3 If penicillin-allergic: erythromycin 500mg 6 hourly for 5 days.
**TB: ROUTINE CARE**

Assess the patient with TB at diagnosis, at 2 weeks and then once a month throughout TB treatment.

<table>
<thead>
<tr>
<th>Assess</th>
<th>When to assess</th>
<th>Note</th>
</tr>
</thead>
</table>
| Symptoms                | Each visit     | • If respiratory rate ≥ 30 breaths/minute, prominent use of breathing muscles, breathless at rest or while talking or confused or agitated, give urgent attention \(55\).   
  • Expect gradual improvement on TB treatment. Refer for doctor review if symptoms worsen or do not improve. |
| Contacts                | At diagnosis and if symptomatic | Screen household contacts who are symptomatic, < 5 years or have HIV.                                                                 |
| Family planning         | At diagnosis and each visit | Assess contraceptive needs \(91\). No need to change interval between injectable doses. Avoid oral contraceptives, use instead injectable or IUCD plus condoms.     |
| Adherence               | At diagnosis and each visit | • Request patient brings all medication to each visit. Check adherence with the community care worker, on the TB card and/or with a pill count.  
  • Manage the patient who interrupts TB treatment \(58\).                                           |
| Side effects            | At diagnosis and each visit | On starting TB treatment, advise patient about possible side effects \(58\) and to report these promptly.                              |
| Substance abuse         | At diagnosis; if adherence poor | If > 21 drinks/week (man), > 14 drinks/week (woman) and/or > 5 drinks/session or misuses illicit or prescription drugs \(83\).            |
| Weight                  | At diagnosis and each visit | • Expect gradual weight gain on treatment. Adjust TB dose with weight gain \(58\). Refer same week for doctor review if losing weight on treatment. |
| Chest X-Ray             | Not routinely, but only if needed | Do chest X-Ray at 2 months if patient diagnosed with pleural effusion. Do chest X-Ray same day if patient deteriorates or coughs ≥ 1 tablespoon of blood. |
| Smear microscopy result | At diagnosis | Register as smear negative or smear positive depending on result.                                                                  |
| LPA\(^1\) or DST\(^2\) result | If sent during diagnostic workup | If LPA\(^1\) or DST\(^2\) sent during diagnostic workup show drug sensitivity, continue treatment. If any drug resistance, refer to doctor. |
| 1 spot sputum specimen for smear microscopy\(^3\) | If sent during diagnostic workup | Check smear microscopy regardless of smear result at diagnosis and interpret result:  
  • If smear negative at 7 weeks change to continuation phase at end of week 8.  
  • If smear positive at 7 weeks manage as per 7 week algorithm \(59\).  
  • Use 23 week sputum result to determine treatment outcome below. |
| Treatment outcome       | 6 months       | • If smear negative at 23 weeks, stop treatment at the end of week 24 and register treatment outcome:  
  - If smear positive at diagnosis and smear negative at 7 weeks (or if taken, 11 weeks) and smear negative at 23 weeks, register as cured.  
  - If smear negative at diagnosis, register as treatment completed.  
  - If smear positive at 11 weeks and smear negative at 23 weeks register as treatment completed. 
  • If smear positive at 23 weeks manage as per 23 week algorithm \(59\). |
| HIV                     | If status unknown | Test for HIV \(60\). Give the HIV patient routine HIV care and ART irrespective of CD4 or stage \(61\).                                    |
| CD4 to decide timing of ART in HIV | HIV patient not on ART: at diagnosis | If not already on ART, start ART once tolerating TB treatment:  
  • If CD4 ≤ 50 start ART within 7 days.  
  • If CD4 > 50 and stage 3, start ART within 2–8 weeks of starting TB treatment.  
  • If patient has TB meningitis, start ART within 4–6 weeks of TB treatment. |

**Advise the patient with TB**

- Refer for TB/HIV education and adherence support. Arrange clinic DOT for the first 2 weeks of treatment and then arrange for community care worker or workplace support.  
- Educate patient about TB treatment side effects \(58\) and to report these promptly should they occur.  
- Advise patient on when to return to work: if on drug-sensitive TB treatment, after 2 weeks; if on drug-resistant TB treatment when culture is negative.  
- Advise the patient abusing alcohol and/or illicit or prescription drugs to stop. Substance abuse can interfere with recovery and adherence to treatment. Urge the patient who smokes to quit.  

**Treat the patient with TB \(→58\).**

\(^{1}\)Line Probe Assay detects TB drug resistance.  \(^{2}\)Drug susceptibility testing.  \(^{3}\)Make every effort to obtain sputum, even if early morning or by nebulisation.
Discuss TB treatment side effects

- Jaundice and vomiting: Most TB drugs. Stop all drugs and refer to hospital same day.
- Skin rash/itch: Most TB drugs. Assess and manage.
- Loss of colour vision: Ethambutol. Refer.
- Ringing in ears/deafness: Streptomycin. Stop streptomycin immediately.
- Nausea/poor appetite: Rifampicin. Take treatment at night.
- Joint pain: Pyrazinamide. Ibuprofen 400mg 8 hourly up to 5 days.
- Orange urine: Rifampicin. Reassure.

Review the TB patient at 2 weeks and then monthly until discharge.

Manage the patient who interrupts TB treatment

- Trace the patient and look for explanation for treatment interruption. Ask about substance abuse, stress, side effects.
- Give increased adherence support and educate the patient about the risks of poor adherence.
- Manage treatment interruption according to duration of interruption:

  **Interrupts for < 1 month**
  - Continue TB treatment.
  - Extend treatment phase by the number of missed doses.

  **Interrupts for 1–2 months**
  - Send 1 spot sputum specimen for LPA1 or Xpert.
  - Continue TB treatment and review results.

  **Drug sensitive**
  - Continue TB treatment.
  - Extend treatment phase by the number of missed doses.

  **Drug resistant (DR)**
  - Stop TB treatment.
  - Register as treatment failure.
  - Refer to DR-TB unit.

  **Interrupts for ≥ 2 months**
  - Send 1 spot sputum specimen for LPA1 or Xpert.
  - Do not continue with TB treatment until results available.

  **Drug sensitive**
  - Stop TB treatment and register as treatment default.
  - Re-register as re-treatment after default and restart full course of TB treatment.

*Treat the patient with TB

- Treat the patient with TB (whether a new or retreatment case) 7 days a week for 6 months:
  - Give intensive phase RHZE for 2 months. (Prolong for 1 month if 7 week smear positive)
  - Change to continuation phase RH to complete 6 months of TB treatment.
  - If TB meningitis, TB spine or a TB pus collection, treat for at least 9 months, guided by a specialist.

- If HIV give co-trimoxazole and ART.
- If HIV on lopinavir/ritonavir, doctor to increase LPV/r dose:
  - After 1 week of TB treatment, increase to 3 tablets LPV/r (600/150mg) 12 hourly for 1 week.
  - Then increase to 4 tablets LPV/r (800/200mg) 12 hourly until 2 weeks after TB treatment has finished.
  - Monitor for liver problem (jaundice, abdominal pain, vomiting) and check ALT monthly.

- Give rifampicin and isoniazid.

- If HIV give ART.

Treat according to weight. Adjust dose as weight increases.

<table>
<thead>
<tr>
<th>Weight (kg)</th>
<th>Intensive phase: 2 months RHZE (150/75/400/275)</th>
<th>Continuation Phase: 4 months RH</th>
</tr>
</thead>
<tbody>
<tr>
<td>30–37</td>
<td>2 tablets</td>
<td>2 tablets (150,75)</td>
</tr>
<tr>
<td>38–54</td>
<td>3 tablets</td>
<td>3 tablets (150,75)</td>
</tr>
<tr>
<td>55–70</td>
<td>4 tablets</td>
<td>2 tablets (300,150)</td>
</tr>
<tr>
<td>≥ 71</td>
<td>5 tablets</td>
<td>2 tablets (300,150)</td>
</tr>
</tbody>
</table>

*R – rifampicin  H – isoniazid  Z – pyrazinamide  E – ethambutol

1Line Probe Assay detects TB drug resistance
Manage the patient with a positive 7 week sputum smear
- Check patient's TB symptoms and weight gain.

<table>
<thead>
<tr>
<th>TB symptoms improving and patient has gained weight.</th>
<th>TB symptoms not improving or worse and/or patient has lost weight.</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Was patient taking treatment regularly?</td>
<td>• Send 1 spot sputum specimen for LPA, or if unavailable culture and DST.</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Continue intensive phase for 1 month more.</td>
<td>Send 1 spot sputum specimen for Xpert.</td>
</tr>
<tr>
<td></td>
<td>Continue intensive phase and review results.</td>
</tr>
</tbody>
</table>

Drug susceptible TB
- • At 11 weeks send 1 spot sputum specimen for smear microscopy.
- • If drug susceptible and/or smear negative, change to continuation phase at end of week 12.
- • If sputum positive, send sputum for LPA if not already sent. If drug resistant, refer to DR-TB unit.

Drug resistant TB
- • Stop TB treatment.
- • Register as treatment failure.
- • Refer to DR-TB unit.

Manage the patient with a positive 23 week sputum smear
- Collect sputum specimen for LPA or if unavailable, culture and DST.
- Continue treatment.
- Review LPA results after 1 week.

<table>
<thead>
<tr>
<th>Drug sensitive TB</th>
<th>Drug resistant TB</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>Stop TB treatment.</td>
</tr>
<tr>
<td>• Has the patient missed any doses of TB treatment?</td>
<td>• If registered smear positive at diagnosis, register patient as treatment failure.</td>
</tr>
<tr>
<td>Yes</td>
<td>• Refer patient for DR-TB treatment.</td>
</tr>
<tr>
<td>&lt; 2 months TB treatment missed</td>
<td>• Stop TB treatment.</td>
</tr>
<tr>
<td>• Extend continuation phase by number of missed doses.</td>
<td>• Register as treatment default.</td>
</tr>
<tr>
<td>• At the end of extension period, send 1 spot sputum specimen for microscopy.</td>
<td>• Re-register as re-treatment after default.</td>
</tr>
<tr>
<td>≥ 2 months TB treatment missed</td>
<td>• Restart full course of TB treatment.</td>
</tr>
</tbody>
</table>

Smear negative
- • Stop treatment.
- • Register as treatment completed.

Smear positive
- • Stop TB treatment.
- • Register as treatment failure.
- • Re-register as re-treatment after failure.
- • Restart full course of TB treatment.
Encourage your patient and partner and children to test for HIV.

**Obtain informed consent**
- Educate patient about HIV and AIDS, methods of HIV transmission, risk factors and benefits of knowing one’s HIV status.
- Explain test procedure and that it is completely voluntary.
- Children < 12 years need parental/guardian consent. If consent is granted, proceed to testing immediately.

**Test**
Do first rapid HIV test on finger-prick blood.

- Positive
- Negative

Do a second rapid HIV test on finger-prick blood.

- Positive
- Negative

Discordant results: do an ELISA test.

- Positive
- Negative

Patient has HIV.

- Give routine HIV care at this visit → 61.

HIV test result negative

- A rapid test detects HIV antibodies which may take up to 3 months to be formed.
- Was patient at risk of HIV infection in the past 3 months?

- Yes
- No

Support
Ensure patient understands test result and knows where and when to access further care.

- Repeat HIV test after the 3 month window period.
- Patient does not have HIV.
- Encourage patient to remain negative.
- Offer to refer for male circumcision to diminish risk of HIV infection.
HIV: ROUTINE CARE

Assess the patient with HIV

### Assess

<table>
<thead>
<tr>
<th>Symptom</th>
<th>When to assess</th>
<th>Note</th>
</tr>
</thead>
<tbody>
<tr>
<td>Symptoms</td>
<td>Every visit</td>
<td>Manage patient’s symptoms according to symptom pages. Ask especially about TB symptoms</td>
</tr>
<tr>
<td>TB</td>
<td>Look for TB at every visit</td>
<td>• Check for TB if cough ≥ 2 weeks, weight loss, night sweats, chest pain or blood-stained sputum →55. Do not start ART until TB excluded.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• If TB and not on ART, start ART once tolerating TB treatment: within 7 days if CD4 ≤ 50 or stage 4; 4–6 weeks if TB meningitis, otherwise within 2–8 weeks.</td>
</tr>
<tr>
<td>Adherence</td>
<td>Every visit</td>
<td>• Check patient’s adherence with pill counts and record of attendance. Remember to give patient a follow-up date. Delay starting ART if adherence to other medications or attendance is poor.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• More than 95% of ART doses must be taken to avoid resistance to ART. If adherence poor, give adherence support 63.</td>
</tr>
<tr>
<td>ART side effects</td>
<td>Every visit after starting ART</td>
<td>• Ask about ART side effects 64. Manage side effects as on symptom page. Refer if “self-limiting” side-effects persist after 6 weeks 64.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Consider lactic acidosis in adherent woman who gains &gt; 10kg 6–24 months after starting d4T, AZT, 3TC or TDF 62.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Switch d4T to TDF if woman with weight gain &gt; 10kg or BMI &gt; 28, peripheral neuropathy 37, pregnancy or change in body shape.</td>
</tr>
<tr>
<td>Mental health</td>
<td>At diagnosis and if adherence poor</td>
<td>• Screen for depression if patient has low mood or not coping as well as in the past 81.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• If patient takes &gt; 21 drinks/week (man), &gt; 14 drinks/week (woman) and/or &gt; 5 drinks/session or misuses drugs, assess for substance abuse 83.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• If patient has problems with memory and perhaps coordination for &gt; 6 months, consider dementia 86.</td>
</tr>
<tr>
<td>Safe sex</td>
<td>Every visit</td>
<td>Ask if patient or regular partner has new or multiple partners, uses condoms unreliably or has substance abuse 83.</td>
</tr>
<tr>
<td>Pregnancy status</td>
<td>Every visit</td>
<td>• If needed, advise reliable contraception (IUCD, subdermal implant, injectable or sterilisation plus condoms) 91.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• If pregnant, give antenatal care 93 and if not on ART, start ART same day. If on ART, check viral load 62.</td>
</tr>
<tr>
<td>Weight</td>
<td>Every visit</td>
<td>• Record weight. Investigate weight loss ≥ 5% of body weight in 4 weeks 3.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• BMI is weight (kg)/[height (m) x height (m)]. If &lt; 18.5, refer for nutritional support.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• If weight gain on ART &gt; 10kg or to BMI &gt; 28, switch woman on d4T to TDF to avoid lactic acidosis.</td>
</tr>
<tr>
<td>Stage</td>
<td>Every visit</td>
<td>Check weight, mouth, skin, previous and current problems. Apply the most advanced stage even after recovery from the illness that determined the stage.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Stage 2, 3 and 4: give co-trimoxazole 63.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Stage 3 or 4: patient needs ART 63.</td>
</tr>
</tbody>
</table>

### Stage 1
- No symptoms
- Painless swollen glands

### Stage 2
- Recurrent sinusitis, tonsillitis, otitis media
- Pruritic papular eruption
- Fungal nail infections
- Shingles
- Recurrent mouth ulcers
- Angular cheilitis
- Unexplained weight loss < 10% body weight

### Stage 3
- Current pulmonary TB or within past year
- Oral thrush
- Oral hairy leukoplakia
- Unexplained weight loss ≥ 10% body weight and/or BMI < 18.5
- Diarrhoea > 1 month
- Fever > 1 month
- Severe recurrent bacterial infections (pneumonia, meningitis)
- Unexplained anaemia < 8, neutropaenia < 0.5 or chronic thrombocytopenia < 50

### Stage 4: AIDS
- Current extrapulmonary TB
- Oesophageal thrush (pain on swallowing)
- Weight loss ≥ 10% and diarrhoea or fever > 1 month
- Cryptococcal meningitis
- Herpes simplex of mouth or genital area > 1 month
- Kaposi's sarcoma
- HIV associated dementia
- Recurrent severe pneumonia, PCP
- Invasive cervical cancer
- Cryptosporidium or isospora belli diarrhoea

Continue to assess the patient with HIV →62.
Continue to assess the patient with HIV

<table>
<thead>
<tr>
<th>Assess</th>
<th>When to assess</th>
<th>Note</th>
</tr>
</thead>
<tbody>
<tr>
<td>IPT screen</td>
<td>If no TB symptoms and never had IPT</td>
<td>• Do TST: clean arm with alcohol swab, pull skin taut and inject 2 units PPD-RT23 or 5 units PPD-S into skin to see weal develop. • Measure swelling after 48–72 hours. ≥ 5mm is a positive TST. Give IPT according to result and whether on ART or not → 63.</td>
</tr>
<tr>
<td>Pap smear</td>
<td>At diagnosis and if normal yearly</td>
<td>→ 27</td>
</tr>
<tr>
<td>CD4</td>
<td>• Pre-ART: at diagnosis, then 6 monthly • On ART: at 12 months on ART</td>
<td>• If CD4 ≤ 200, give co-trimoxazole → 63. Stop after 1 year if CD4 &gt; 200 and patient is well on ART. • If CD4 ≤ 350 give ART → 63.</td>
</tr>
<tr>
<td>ART bloods</td>
<td>At baseline and on ART</td>
<td>Check blood according to ART regimen and review result as below.</td>
</tr>
</tbody>
</table>

### Baseline 1st regimen
- TDF: eGFR
- NVP: ALT

<table>
<thead>
<tr>
<th>Baseline 2nd regimen</th>
<th>3 months on ART</th>
<th>6 months on ART</th>
<th>1 year on ART</th>
<th>Yearly</th>
</tr>
</thead>
<tbody>
<tr>
<td>AZT: Hb + diff</td>
<td>Viral load</td>
<td>TDF: eGFR²</td>
<td>TDF: eGFR²</td>
<td>TDF: eGFR²</td>
</tr>
<tr>
<td>LPV/r: fasting cholesterol &amp; triglycerides</td>
<td>Viral load</td>
<td>AZT: Hb + diff</td>
<td>Viral load</td>
<td>Viral load</td>
</tr>
</tbody>
</table>

### ALT
- If baseline ALT ≥ 100, refer to doctor: refer if signs of liver failure. If well, doctor to start ART (avoid NVP) and repeat ALT after 1 week.
- Check ALT if non-severe rash develops on NVP. (Refer same day the patient with a severe rash → 40).
- If ALT 50–199 and patient well: continue NVP once a day, repeat ALT in 1 week.
- If ≥ 200 or unwell: stop ART and refer same day.
- If ALT < 50 and rash resolved increase NVP to 12 hourly.

### eGFR (creatinine clearance)
- Estimated glomerular filtration rate reflects kidney function. Request eGFR on request form and give age, weight and sex.
- If baseline eGFR < 60, doctor to review: avoid TDF and adjust doses of ART and co-trimoxazole → 64.
- On ART, if eGFR < 60 and patient unwell, refer same day. If well and eGFR < 60, doctor to switch TDF to AZT/d4T, stop NSAIDs/streptomycin, check BP and for proteinuria and discuss with specialist.

### Creatinine if pregnant
- If creatinine at baseline or on ART is > 85, discuss/refer.

### Hb and diff
- If baseline Hb < 8, doctor to investigate anaemia and avoid AZT.
- Once on ART, if Hb < 8 or neutrophils < 0.75, switch to TDF or d4T.

### HepBsAg
- If hepBsAg positive, do not stop TDF or start regimen 2, and refer to doctor.

### Fasting cholesterol, triglycerides
- Refer urgently same day if triglycerides > 15 (risk of pancreatitis). If cholesterol > 8 or triglycerides > 8.5, refer to specialist.

### Viral load
- Viral load on ART should be < 400
- Viral load 400–1000: Give increased adherence support → 63 and repeat viral load in 6 months.
- Viral load > 1000 for the 1st time: Give increased adherence support → 63 and repeat viral load after 2 months.
- Viral load > 1000 for the 2nd time: If getting increased adherence support → 63 and adherence > 80%, doctor to switch to regimen 2 ART → 63. If failing regimen 2, refer.

### CD4
- Decide when to stop co-trimoxazole and fluconazole prophylaxis → 64.

### Lactate
- Check rapid/on-site venous blood lactate (uncuffed).
- If lactate < 2.5: if > 1 of weight loss, nausea, vomiting, abdominal pain, shortness of breath and fatigue, refer for laboratory lactate. Look for other cause. Repeat after 1 week.
- If lactate ≥ 5: refer same day to hospital.
- If lactate 2.5–4.9 and respiratory rate ≥ 20 breaths/minute: refer same day to hospital.
- If lactate 2.5–4.9 and respiratory rate < 20 breaths/minute: switch d4T to TDF and recheck lactate after 3 days. If lactate falls and symptoms improve, recheck weekly until normal. If symptoms worse and/or lactate is increasing, stop ART and discuss with specialist.

**Advise and treat the patient with HIV → 63 and 64.**

1 Tuberculin Skin Test (Mantoux®) 2 If patient is pregnant, use creatinine instead of eGFR.
### Advise the patient with HIV

- Support by encouraging disclosure and referring to counselor/support group. Advise patient's partners and children be tested for HIV.
- Encourage patient to have 1 partner at a time. Advise safe sex even if partner has HIV or patient on ART. Demonstrate and give male/female condoms.
- Educate patient that treatment for HIV requires lifelong adherence.
- Ensure the patient about to start ART attends drug-readiness training.
- Give increased adherence support to the patient with < 80% adherence, poor attendance or viral load > 400:
  - Educate on the importance of adherence and dangers of resistance.
  - Plan with patient how to take treatment. Consider adherence aids (pillboxes, diaries).
- Refer for support: adherence counselor, support group, treatment buddy, CCW.
- See the patient more frequently (weekly instead of monthly).

### Treat the patient with HIV

- Give co-trimoxazole 960mg daily (2 single strength tablets) if stage 2, 3 or 4 or CD4 ≤ 200. Adjust dose if eGFR 10–50: 480mg daily; if eGFR < 10: 480mg 3 times a week.
- Give IPT: isoniazid 5mg/kg (up to 300mg) daily. Do not give if TB symptoms, on TB treatment, previous IPT, liver disease or alcohol abuse. If needing ART, start ART before IPT. Decide when to stop IPT.
- Give pyridoxine 25mg daily while on TB treatment or IPT.
- If on ART, continue ART lifelong unless on maternal ART prophylaxis – decide when to stop maternal ART prophylaxis using step 6.
- If not on ART, start ART if CD4 ≤ 350 or stage 3 or 4 or if pregnant or breastfeeding (regardless of CD4 or stage) using steps 1–4:

#### 1. Decide which ART regimen the patient needs

<table>
<thead>
<tr>
<th>Has patient had 2 or 3 ARVs for longer than 1 month in the past?</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

#### Choose regimen 1 ART

- **TDF and 3TC and EFV** or fixed dose combination (FDC) TDF/FTC/EFV if available unless:
  - Depression or psychosis: use NVP instead of EFV. If CD4 > 250 (woman) or > 400 (man), refer/discuss.
  - If pregnant with depression, psychosis, known kidney disease, diabetes, hypertension or ≥ 2+ proteinuria, start AZT 300mg 12 hourly instead of regimen 1 ART and refer to doctor.

#### Choose regimen 2 ART

- **LPV/r and 3TC and:**
  - AZT if currently using TDF or
  - TDF if currently using AZT or d4T
  - Do not stop TDF if hepBsAg positive.

#### 2. Check baseline bloods according to regimen 62:

- If patient not pregnant, review patient with results within 2 weeks.
- If patient pregnant, start ART same day and review baseline blood results within 1 week.

#### 3. Decide when to start ART:

- If patient pregnant, start ART same day. If pregnant and starting TB treatment, give AZT 300mg 12 hourly and switch to ART after 2 weeks.
- If patient has TB and CD4 ≤ 50, start ART within 7 days. If CD4 50–350 start ART within 2–8 weeks of starting TB treatment once tolerating TB treatment. If CD4 > 350 start ART at 8 weeks of TB treatment.
- If TB meningitis or cryptococcal meningitis, start ART after 4–6 weeks of treatment.
- If patient does not have TB, start ART within 7 days if CD4 < 200 or stage 4, otherwise within 2 weeks.
4. Start ART:

- Give 3 ARVs from table below according to chosen ART regimen \( \Rightarrow 63 \). If starting regimen 1, give fixed dose combination (FDC) TDF/FTC/EFV 1 tablet daily if available.
- Delay ART and refer to doctor if blood results abnormal \( \Rightarrow 63 \), poor adherence, TB symptoms or depression or psychosis.

<table>
<thead>
<tr>
<th>Antiretroviral</th>
<th>Dose</th>
<th>Frequency</th>
<th>if eGFR &lt; 50</th>
<th>Side effects (refer if &quot;self-limiting&quot; side-effects persist after 6 weeks)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lamivudine (3TC)</td>
<td>150mg</td>
<td>12 hourly</td>
<td>eGFR 10–50: 150mg daily</td>
<td>Uncommon</td>
</tr>
<tr>
<td></td>
<td>300mg</td>
<td>Once daily</td>
<td>eGFR &lt; 10: 50mg daily</td>
<td></td>
</tr>
<tr>
<td>Tenofovir (TDF)</td>
<td>300mg</td>
<td>Once daily</td>
<td></td>
<td>Nausea, vomiting, diarrhoea, kidney failure</td>
</tr>
<tr>
<td>Stavudine (d4T)</td>
<td>30mg</td>
<td>12 hourly</td>
<td>eGFR 10–50: 15mg 12 hourly</td>
<td>Lactic acidosis ( \Rightarrow 62 ), burning toes, body shape change (switch to TDF)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>eGFR &lt; 10: 15mg daily</td>
<td></td>
</tr>
<tr>
<td>Zidovudine (AZT)</td>
<td>300mg</td>
<td>12 hourly</td>
<td></td>
<td>Lactic acidosis, vomiting, nausea (self limiting, take with food), headache, fatigue (self limiting, if Hb &lt; 7 ( \Rightarrow 62 ), body shape change (switch to TDF)</td>
</tr>
<tr>
<td>Emtricitabine (FTC)</td>
<td>200mg</td>
<td>Once daily</td>
<td></td>
<td>Uncommon</td>
</tr>
<tr>
<td>Efavirenz (EFV)</td>
<td>600mg</td>
<td>24 hourly - the same time every night</td>
<td>Same dose</td>
<td>Dizziness, sleep problems, depression (all self limiting), gynaecomastia</td>
</tr>
<tr>
<td>Nevirapine (NVP)</td>
<td>200mg</td>
<td>Once daily for 2 weeks, then 12 hourly to reduce risk of skin rash and hepatitis.</td>
<td>Same dose</td>
<td>Skin rash, nausea (self limiting, take with food), abdominal pain, jaundice or vomiting may be hepatitis – advise patient to return urgently and refer same day.</td>
</tr>
<tr>
<td>Lopinavir/ritonavir (LPV/r)</td>
<td>400/100mg 2 tablets 12 hourly. On TB treatment, doctor to double dose gradually.</td>
<td>Same dose</td>
<td>Diarrhoea, change in body shape (switch to TDF). If also on TB treatment, abdominal pain, jaundice or vomiting may be hepatitis – refer same day.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>eGFR &lt; 10</th>
<th>Lamivudine (3TC) 150mg daily</th>
<th>Uncommon</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Tenofovir (TDF) 300mg daily</td>
<td>Nausea, vomiting, diarrhoea, kidney failure</td>
</tr>
<tr>
<td></td>
<td>Stavudine (d4T) 30mg 12 hourly</td>
<td>Lactic acidosis ( \Rightarrow 62 ), burning toes, body shape change (switch to TDF)</td>
</tr>
<tr>
<td></td>
<td>Zidovudine (AZT) 300mg 12 hourly</td>
<td>Lactic acidosis, vomiting, nausea (self limiting, take with food), headache, fatigue (self limiting, if Hb &lt; 7 ( \Rightarrow 62 ), body shape change (switch to TDF)</td>
</tr>
<tr>
<td></td>
<td>Emtricitabine (FTC) 200mg Once daily</td>
<td>Uncommon</td>
</tr>
<tr>
<td></td>
<td>Efavirenz (EFV) 600mg 24 hourly - the same time every night</td>
<td>Same dose</td>
</tr>
<tr>
<td></td>
<td>Nevirapine (NVP) 200mg Once daily for 2 weeks, then 12 hourly to reduce risk of skin rash and hepatitis.</td>
<td>Same dose</td>
</tr>
<tr>
<td></td>
<td>Lopinavir/ritonavir (LPV/r) 400/100mg 2 tablets 12 hourly. On TB treatment, doctor to double dose gradually.</td>
<td>Same dose</td>
</tr>
</tbody>
</table>

5. Decide when to review the HIV patient on ART:

- If pregnant: review patient and baseline blood results 1 week after starting ART, and then monthly.
- If not pregnant: review 2 weeks after starting ART, then monthly until stable.
- If stable (patient has CD4 > 350, VL < 400, normal routine ART blood results, is adherent and well on ART): review 3 monthly.

6. Decide when to stop the following treatments in the HIV patient:

- Co-trimoxazole: stop after 1 year if CD4 > 200 and patient well on ART.
- Fluconazole for cryptococcal meningitis: stop after 1 year if CD4 > 200 and patient well on ART.
- Pyridoxine: Stop when patient finishes TB treatment or isoniazid preventive therapy.
- Maternal ART prophylaxis in the mother with baseline CD4 >350 and stage 1 or 2:
  - Check stage, hepBsAg, and CD4 result from past 12 months.
  - Stop ART 1 week after last breastfeed if still stage 1 or 2, hepBsAg negative and CD4 > 350.
- Nevirapine in the baby exposed to HIV:
- IPT: stop isoniazid depending on baseline TST result and if on ART:

<table>
<thead>
<tr>
<th>TST(^1) not done</th>
<th>TST(^1) negative &lt; 5mm</th>
<th>TST(^1) positive ≥ 5mm</th>
</tr>
</thead>
<tbody>
<tr>
<td>CD4 &gt; 350, not on ART</td>
<td>On ART</td>
<td></td>
</tr>
<tr>
<td>Stop IPT after 6 months.</td>
<td>Stop IPT after 12 months.</td>
<td>Stop IPT after 36 months.</td>
</tr>
</tbody>
</table>

\(^1\) Tuberculin Skin Test (Mantoux®)
ASTHMA AND COPD: DIAGNOSIS

• The patient with chronic cough may have more than one disease.
• In the patient with chronic cough, first exclude TB, PCP, lung cancer, chronic bronchitis, heart failure and post infectious cough.
• Then consider asthma or chronic obstructive pulmonary disease (COPD) which both present with cough, difficult breathing, tight chest or wheezing.
• If the cause of wheezing is not known, distinguish COPD and asthma as follows:

<table>
<thead>
<tr>
<th>Asthma likely.</th>
<th>COPD likely.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Onset before 20 years of age</td>
<td>Onset after 40 years of age</td>
</tr>
<tr>
<td>Associated hayfever, eczema, allergic conjunctivitis, allergies</td>
<td>Symptoms are persistent and worsen slowly over time</td>
</tr>
<tr>
<td>Intermittent symptoms with normal breathing in between</td>
<td>Cough with sputum starts long before difficult breathing</td>
</tr>
<tr>
<td>Symptoms worse at night, early morning, with cold or stress</td>
<td>Patient is or was a heavy smoker (tobacco/cannabis)</td>
</tr>
<tr>
<td>Patient or family have a history of asthma</td>
<td>Previous doctor diagnosis of COPD</td>
</tr>
</tbody>
</table>

If unsure of diagnosis, treat as asthma and refer to doctor within 1 month.

USING INHALERS AND SPACERS

• Incorrectly using an inhaler leads to poor delivery of medication into the lungs and poor control of symptoms.
• Add a spacer if the patient is unable to use an inhaler correctly to increase drug delivery to the lungs and/or if using inhaled corticosteroids to prevent oral thrush.

Check that patient can use inhaler and spacer correctly

- Shake inhaler.
- Remove inhaler cap.
- Fit inhaler into spacer. Check the seal is tight.
- Exhale first and then form a seal with lips around mouthpiece.
- Press pump once and take a deep breath from spacer. Do not pump inhaler more than once for each breath.
- Hold that breath and count up to 10.
- Breathe out.

- Rinse mouth after using inhaled corticosteroid.
- Wash the spacer with soapy water once a week. Allow it to drip dry. Do not rinse with water after each use.
- Prime the spacer with two puffs after washing before use.
ASTHMA: ROUTINE CARE

Ensure that a doctor confirms the diagnosis of asthma within 1 month of diagnosis.

Assess the patient with asthma

<table>
<thead>
<tr>
<th>Assess</th>
<th>When to assess</th>
<th>Note</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asthma symptoms to determine if asthma is</td>
<td>Every visit</td>
<td>Any of the following in the past month indicate uncontrolled asthma:</td>
</tr>
<tr>
<td>controlled</td>
<td></td>
<td>- Daytime cough, difficulty breathing, tight chest or wheezing &gt; twice a week</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Nighttime or early morning waking due to asthma symptoms</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Limitation of daily activities due to asthma symptoms</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Peak flow measurement can be unreliable and need not be used routinely to assess asthma control. Asthma symptoms are more useful.</td>
</tr>
<tr>
<td>Other symptoms</td>
<td>Every visit</td>
<td>Manage symptoms as on symptom pages.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Ask about hayfever: sneezing, itchy or runny nose. Treating hayfever may improve asthma control</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Ask the patient using inhaled corticosteroids about a sore mouth. See advice below.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Ask about heartburn or upper abdominal pain after eating. Treating gastro-oesophageal reflux may improve asthma control.</td>
</tr>
<tr>
<td>Medication use</td>
<td>Every visit</td>
<td>Ensure patient is adherent to treatment before adjusting or adding treatment.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Check that patient can use inhaler and spacer correctly.</td>
</tr>
</tbody>
</table>

Advise the patient with asthma

- Ask about smoking. If yes, urge patient to stop.
- Ensure the patient understands the need for medication received:
  - Beta-agonist (eg salbutamol) inhaler only relieves symptoms and does not control asthma.
  - Inhaled corticosteroid (eg budesonide) prevents symptoms and controls asthma, but does not give instant relief. It is the mainstay of treatment.
- Check that patient can use inhaler and spacer correctly.
- Inhaled corticosteroids can cause oral thrush: advise patient to rinse and gargle after each dose of inhaled corticosteroid.

Treat the patient with asthma

- Give inhaled salbutamol 2 puffs as needed up to 4 times a day.
- Before adjusting treatment ensure patient is adherent and can use inhaler and spacer correctly.
- If asthma is uncontrolled:
  - Start inhaled corticosteroid budesonide 200μg 12 hourly if patient not already on it.
  - If patient already on inhaled corticosteroid, doctor to double the dose of inhaled corticosteroid budesonide to maximum 400μg 2 puffs 12 hourly.
  - If still uncontrolled, add slow release theophylline 200mg 12 hourly. Increase to 300mg if still uncontrolled. Stop theophylline if no better after 1 month.
- If asthma is controlled:
  - Continue inhaled corticosteroid at the same dose.
  - If controlled for at least 6 months, decrease inhaled corticosteroid dose by 200μg.
  - Stop inhaled corticosteroid if controlled for at least 6 months on 200μg daily.
  - Inhaled corticosteroids are not needed for the patient with controlled exercise-induced asthma who has had no emergency visits for asthma in the past 6 months.
- Oral prednisone is only used for emergency visits for asthma. Refer to doctor if needing more than 2 courses of prednisone in 6 months.

Review the controlled patient 3 monthly, the patient whose asthma is uncontrolled after 1 month.

Advise patient to return before next appointment if no improvement or worsening of symptoms.
CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD): ROUTINE CARE

- Ensure that a doctor confirms the diagnosis of COPD within 1 month of diagnosis.

### Assess the patient with COPD

<table>
<thead>
<tr>
<th>Assess</th>
<th>When to assess</th>
<th>Note</th>
</tr>
</thead>
</table>
| COPD symptoms: persistent cough and difficult breathing | Every visit | • Assess disease severity: difficulty breathing occurs with strenuous activity like climbing stairs (mild COPD), at normal pace like walking (moderate COPD) or with activities of daily living like dressing (severe COPD).  
  - Treat for chest infection as below if sputum increases or changes in colour to yellow/green.  
  - Investigate for TB only if patient has other TB symptoms like weight loss, sweats.
| Other symptoms | Every visit | • Manage symptoms as on symptom pages.  
  - Ask the patient using inhaled corticosteroids about a sore mouth. See advice below.  
  - If patient has leg swelling, refer to doctor for assessment.
| Medication use | Every visit | • Ensure patient is adherent to treatment before adjusting or adding treatment.  
  - Check that patient can use inhaler and spacer correctly.
| CVD risk assessment | At diagnosis | • The patient with COPD is at increased risk of cardiovascular disease.  
  - Assess the patient’s CVD risk.

### Advise the patient with COPD

- Ask about smoking. If yes, urge patient to stop. This is the mainstay of COPD care.
- Exercise: encourage the patient to take a walk daily and to increase activities of daily living like gardening, housework and using stairs instead of lifts.
- Help the patient to manage his/her CVD risk.
- Check that patient can use inhaler and spacer correctly.
- Inhaled corticosteroids can cause oral thrush: advise patient to rinse and gargle after each dose of inhaled corticosteroid.

### Treat the patient with COPD

- Ensure patient can use inhaler and spacer correctly before adjusting treatment.
- Give bronchodilator inhaled salbutamol 2 puffs when needed (up to 4 times a day).
- Give influenza vaccination yearly and pneumococcal vaccination every 5 years.
- Add bronchodilator inhaled ipratropium bromide 2 puffs when needed (up to 4 times a day) if moderate or severe COPD.
- Add slow release theophylline 200–300mg twice a day long-term if severe COPD.
- Treat for chest infection if sputum increases or changes in colour to yellow/green:  
  - Give amoxicillin 500mg 8 hourly for 10 days or doxycycline 100mg 12 hourly for 10 days.  
  - If increased breathlessness, give oral prednisone 40mg daily for 7 days if severe COPD.  
  - Doctor to give inhaled corticosteroid budesonide 400µg 12 hourly if severe COPD and > 2 chest infections per year.

### Review every 3–6 months if stable.
Cardiovascular disease (ischaemic heart disease, peripheral vascular disease, stroke) is preventable and treatable.

Identify the patient with established cardiovascular disease:
• If patient has or has had chest pain, screen for ischaemic heart disease → 15.
• If patient has or has had leg pain, screen for peripheral vascular disease → 36.
• If patient has had sudden weakness of limbs or face, visual disturbance, difficulty speaking or understanding, dizziness, or severe new headache, screen for stroke → 76.

Look for risk factors for cardiovascular disease:
• Ask about smoking.
• Look for hypertension. Hypertension is diagnosed at different BP levels depending on risk factors. Check BP → 73.
• Check random finger prick glucose for diabetes and interpret result → 70.
• Calculate BMI (weight (kg)/[height (m) x height (m)]). More than 25 is a risk factor.
• Measure waist circumference on breathing out, midway between lowest rib and top of iliac crest. More than 80cm (woman) or 94cm (man) is a risk factor.

Calculate the patient’s risk of a heart attack or stroke over the next 10 years:
• Plot the patient’s risk on the charts below using age, BMI and systolic BP in the columns for sex and smoking status.
• Do not use these charts if the patient is known to have diabetes and/or CVD as s/he is already at high risk.

Manage the CVD risk in the patient with CVD or a CVD risk ≥ 10% and/or CVD risk factors → 69.
## CARDIOVASCULAR DISEASE (CVD) RISK: ROUTINE CARE

### Assess the patient with CVD risk

<table>
<thead>
<tr>
<th>Assess</th>
<th>When to assess</th>
<th>Note</th>
</tr>
</thead>
<tbody>
<tr>
<td>Symptoms</td>
<td>Every visit</td>
<td>Manage symptoms on symptom page. Ask about chest pain, difficulty breathing, leg pain and symptoms of stroke/TIA.</td>
</tr>
<tr>
<td>Risk factors</td>
<td>Every visit</td>
<td>Ask about smoking, diet, exercise and activities of daily living.</td>
</tr>
<tr>
<td>BMI</td>
<td>Every visit</td>
<td>BMI is weight (kg)/(height (m) x height (m)). Aim for &lt; 25.</td>
</tr>
<tr>
<td>Waist circumference</td>
<td>At diagnosis, yearly or 3 monthly if trying to lose weight</td>
<td>Measure waist circumference on breathing out midway between lowest rib and top of iliac crest. Aim for &lt; 80cm (woman), 94cm (man).</td>
</tr>
<tr>
<td>BP</td>
<td>Every visit</td>
<td>Diagnose and treat hypertension depending on CVD risk.</td>
</tr>
<tr>
<td>CVD risk</td>
<td>At diagnosis, then 5 yearly</td>
<td>If CVD risk ≤ 20%, show the patient what his/her risk might be in 10 years using current BP, BMI and smoking status.</td>
</tr>
<tr>
<td>Glucose</td>
<td>At diagnosis, then depending on risk</td>
<td>Timing of repeat diabetes screen depends on risk factors.</td>
</tr>
<tr>
<td>Total cholesterol</td>
<td>At diagnosis if CVD risk &gt; 20%</td>
<td>Check random total cholesterol. If ≥ 7.5, refer to specialist. No need to repeat.</td>
</tr>
</tbody>
</table>

### Advise the patient with CVD risk

- **Physical activity**
  - Aim for at least 30 minutes brisk exercise at least 5 days/week.
  - Increase activities of daily living like gardening, housework, walking instead of taking transport, using stairs instead of lifts.
  - Exercise with arms if unable to use legs.

- **Diet**
  - Eat a variety of foods in moderation.
  - Reduce portion sizes.
  - Increase fruit, vegetables and low fat dairy.
  - Reduce fatty foods: eat low fat food, cut off animal fat, replace brick margarine/butter with soft tub margarine.
  - Reduce salty processed foods like gravies, stock cubes, packet soup. Avoid adding salt to food.
  - Use less sugar.

- **Smoking**
  - Urge patient who smokes to stop.

- **Weight**
  - Aim for BMI < 25, and waist circumference < 80cm (woman) and < 94cm (man). Any weight reduction is beneficial, even if targets not met.

- **Screen for alcohol/substance misuse**
  - Limit alcohol intake to 2 drinks/day (man) and 1 drink/day (woman). 1 drink is 1 tot of spirits, a small glass of wine or 1 can of beer.
  - If patient exceeds these limits or abuses illicit or prescription drugs.

- **Manage stress**
  - Perform a relaxing breathing exercise each day.
  - Find a creative or fun activity to do.
  - Spend time with supportive friends or family.
  - If patient is stressed.

- **Advocate for support**
  - Identify support to maintain lifestyle change: health education officer or dietitian/nutritionist, friend, partner or relative to attend clinic visits, a healthy lifestyle group, helpline.
  - Be encouraging and congratulate any achievement. Avoid judging, criticising or blaming. It is the patient's right to make decisions about his/her own health. For tips on communicating effectively, see back page.

### Treat the patient with CVD risk

Give the patient with CVD risk > 20% simvastatin 10mg for life.
CHRONIC DISEASES OF LIFESTYLE

DIABETES: DIAGNOSIS

Recognise the patient with glucose ≥ 15 needing urgent attention:

- Nausea and/or vomiting
- Abdominal pain
- Deep sighing breathing
- Temperature ≥ 38°C
- Drowsiness
- Confusion
- Unconsciousness → 1
- Dehydration: systolic BP drop > 20mmHg between lying and standing and poor urine output

Management:
- Rehydrate urgently: give sodium chloride 0.9% IV 1ℓ in first hour then 1ℓ over next 2 hours.
- Give 10IU short-acting insulin IM¹ (not IV).
- Refer urgently to hospital.

If the patient does not need urgent attention, interpret random glucose result as follows:

Random glucose normal: 4–7.7

Look for risk factors:
- family history of diabetes
- history of diabetes in pregnancy
- BMI > 25
- a diagnosis of hypertension
- waist circumference > 80cm (woman), > 94cm (man)

No risk factors
Risk factors are present

Recheck glucose in 5 years.

Random glucose 7.8–11

Is patient pregnant?

No
Yes

Does patient have urinary frequency, thirst, or weight loss?

No
Yes

Patient needs antenatal care and fasting glucose → 94.

Random glucose 11.1–25

Is patient pregnant?

No
Yes

Repeat finger prick blood glucose after 8-hour fast.

< 7
≥ 7

Diagnose diabetes

< 15
≥ 15:

- Ensure patient does not need urgent attention above.
- Check urine ketones.

1+ or more ketones:
- Give sodium chloride 0.9% IV 1ℓ 4 hourly and
- If referral delay > 2 hours give 10IU short-acting insulin IM¹ (not IV).
- Refer same day.

No/trace ketones:
- Start routine diabetes care → 71.
- Refer if patient < 30 years

Random glucose > 25

Is patient pregnant?

No
Yes

Ensure patient does not need urgent attention above.

Check urine for ketones.

Refer patient same day.

May be at risk for diabetes.
- Do cardiovascular disease risk assessment → 68.
- Repeat finger-prick blood glucose in 1 year.

¹ Do not give IV insulin without checking electrolytes, as it may cause low potassium and heart dysrhythmia.
## DIABETES: ROUTINE CARE

### Assess the patient with diabetes

<table>
<thead>
<tr>
<th>Assess</th>
<th>When to assess</th>
<th>Note</th>
</tr>
</thead>
<tbody>
<tr>
<td>Symptoms</td>
<td>Every visit</td>
<td>Manage symptom as on symptom page. Ask about chest pain [\uparrow] 15 and leg pain [\downarrow] 36.</td>
</tr>
<tr>
<td>BP</td>
<td>Every visit</td>
<td>Diagnose hypertension if [&gt;140/80] on 2 days. Treat to target: 120/70–140/80 [\downarrow] 74.</td>
</tr>
<tr>
<td>BMI</td>
<td>At diagnosis, yearly or 3 monthly if trying to lose weight</td>
<td>BMI is weight (kg)/[height (m) x height (m)]. Aim for BMI [&lt;25].</td>
</tr>
<tr>
<td>Waist circumference</td>
<td>At diagnosis, yearly or 3 monthly if trying to lose weight</td>
<td>Aim for (&lt;80\text{cm}) in woman and (&lt;94\text{cm}) in man.</td>
</tr>
<tr>
<td>Pregnancy status</td>
<td>Every visit</td>
<td>Discuss family planning needs [\uparrow] 91. Refer for specialist care if pregnant.</td>
</tr>
<tr>
<td>Eyes for retinopathy</td>
<td>At diagnosis, yearly and if visual problems develop</td>
<td>Refer if new diabetes diagnosis, visual problems, cataracts or retinopathy.</td>
</tr>
<tr>
<td>Feet</td>
<td>At diagnosis, 3 months, then yearly, more often if high risk</td>
<td>Check for pain, pulses, sensation, deformity, skin problems. For foot screen and foot care education [\uparrow] 37.</td>
</tr>
<tr>
<td>Random glucose</td>
<td>Every visit</td>
<td>Finger prick sample is adequate. See below: aim for (&lt;8).</td>
</tr>
</tbody>
</table>
| Protein on urine dipstick | At diagnosis and yearly | • If no protein on dipstick, send urine to lab for microalbuminuria.  
• If albuminuria or proteinuria: start enalapril 10mg daily regardless of BP. Doctor to increase to 20mg after 1 month. |
| Ketones on urine dipstick | If glucose \[\geq 15\] | If glucose \[\geq 15\] and \[\geq 1+\] ketones, see below. |
| HbA1c | 6 monthly if HbA1c \(<7\%) but 3 months after treatment change | Aim for HbA1c \(<7\%). HbA1c reflects glucose control over past 3 months. See below. |
| eGFR | At diagnosis and yearly | Give patient's age and sex on form. If eGFR \(<60\), refer to doctor. |
| Fasting total cholesterol, triglycerides | At diagnosis if not already done. | Refer to specialist if total cholesterol \[\geq 7.5\] or triglycerides \[\geq 15\]. |

### Check random finger prick glucose at every visit and HbA1c 6 monthly if HbA1c \(<7\%) \text{ but 3 months after change in glucose-lowering treatment.}

- **Glucose < 4**
  - With/without hunger, palpitations, sweating, tremors, fatigue, headache, mood changes, fits, confusion, drowsiness, coma.
  - **Give sugar water** orally or if coma give 50mℓ dextrose 50% IV. Repeat if glucose \(<4\).  
  - Identify cause and educate about meals and doses \[\rightarrow 72\].  
  - Refer same day if incomplete recovery or on glibenclamide or long-acting insulin.  
  - Continue 5% dextrose water 1ℓ 6 hourly IV.

- **Glucose 4–14.9**
  - Review HbA1c result from within past 3 months.
  - **HbA1c \(<7\%) \text{ or not done in past 3 months}**
    - Glucose < 8
      - Review in 6 months.  
      - Check HbA1c yearly.
    - Glucose 8–14.9
      - Check HbA1c.
      - Review in 1 month.
  - **HbA1c \(\geq 7\%)**
    - No ketones
      - No - check urine for ketones
    - \(>1+\) ketones:
      - Give sodium chloride 0.9% IV (1ℓ in first hour, 1ℓ over next 2 hours and continue 1ℓ every 2 hours).
      - Give 10IU short-acting insulin IM\(^1\) (not IV).
      - Refer urgently to hospital: avoid delay.

1. Do not give IV insulin without checking electrolytes, as it may cause low potassium and heart dysrhythmia.
## Advise the patient with diabetes

- Help the patient to manage his/her CVD risk \(\Rightarrow\) 69.
- Encourage the patient to adhere to medication and to eat regular meals.
- Ensure patient can recognise and manage hypoglycaemia:
  - If palpitations, sweats, headache or tremors, drink milk with sugar or eat a sweet or sandwich. Always carry something sweet. If fits, confusion or coma, rub sugar inside mouth.
- Identify and manage the cause: increased exercise, missed meals, inappropriate dosing of glucose-lowering drugs, alcohol, intercurrent illness like diarrhoea.
- Educate the patient to care for his/her feet to prevent ulcers and amputation \(\Rightarrow\) 37.

## Treat the patient with diabetes

- Give aspirin 150mg daily if CVD or a family history thereof, hypertension, smoking, dyslipidaemia, albuminuria or > 40 years. Avoid if < 30 years, previous peptic ulcer or dyspepsia or BP ≥ 180/110.
- Give simvastatin 10mg regardless of cholesterol if patient has CVD, hypertension, smoking, obesity, and/or > 40 years.
- Give enalapril 10mg up to 20mg daily if albuminuria/proteinuria, and first line for hypertension. Avoid in pregnancy, angioedema or renal artery stenosis.
- Give glucose-lowering drugs in a stepwise fashion. Ensure patient is adherent before increasing treatment:

<table>
<thead>
<tr>
<th>Step</th>
<th>Drug/s</th>
<th>Breakfast</th>
<th>Lunch</th>
<th>Supper</th>
<th>Bed</th>
<th>Note</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Start metformin</td>
<td>500mg 500mg 850mg</td>
<td>500mg 850mg</td>
<td>850mg</td>
<td></td>
<td>• Avoid in pregnancy, kidney or liver disease, recent heart attack, heart failure, alcoholism. • Take with meals. • Increase every 2 weeks if random glucose &gt; 8 and patient is adherent. • If after 3 months on maximum dose, HbA1c &gt; 7%, move to step 2.</td>
</tr>
</tbody>
</table>
| 2    | Add sulphonyurea:  
  - glibenclamide if < 65 years or  
  - gliclazide if ≥ 65 years | 2.5mg 5mg 5mg 7.5mg 7.5mg 40mg 80mg 80mg 120mg 120mg 160mg 160mg | 2.5mg 5mg 5mg 7.5mg 40mg 80mg 80mg 120mg 120mg 160mg 160mg | | | • Continue metformin. • Take with meals. • Avoid in pregnancy, severe kidney and liver disease, co-trimoxazole allergy. • Increase every 2 weeks if random glucose > 8 and patient is adherent. • If after 3 months on maximum dose, HbA1c > 7%, move to step 3. |
| 3 | Add basal insulin (intermediate or long acting) | | | Start dose: 8IU. Increase by 2IU. Max dose: 20IU. | | | • Continue metformin and sulphonyurea. • Patient to check fasting glucose on waking once a week. If ≥ 7 and patient is adherent, increase dose by 2 units. • Educate about insulin: injection technique and sites (abdomen, thighs, arms recommended), store insulin in fridge or a cool dark place, meal frequency, recognition of hypoglycaemia and hyperglycaemia, sharps disposal at clinic. • If after 3 months on maximum dose, HbA1c > 7%, move to step 4. |
| 4 | Substitute with biphasic insulin | 10IU 14IU 14IU 18IU | 10IU 10IU 14IU 14IU | | | • Continue with metformin. • Stop sulphonyurea and bedtime basal insulin. • Patient to check fasting glucose on waking once a week. If ≥ 7 and patient is adherent, increase dose by 4 units. • Educate about insulin as in step 3 above. • Refer if HbA1c > 7% and > 30 units per day are needed. |
# HYPERTENSION: DIAGNOSIS

## Check blood pressure (BP)

- Seat patient with arm supported at heart level for 5 minutes.
- Use a standard cuff or larger cuff if mid-upper arm circumference is > 33cm.
- Record systolic BP (SBP) and diastolic BP (DBP). SBP is the first appearance of sound. DBP is the disappearance of sound.
- If raised, recheck until a reading is repeated. Use this reading to determine the patient’s BP.
- Do not diagnose hypertension on the basis of one reading alone.

<table>
<thead>
<tr>
<th>SBP/DBP</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 140/90</td>
<td>140/90–179/109</td>
</tr>
<tr>
<td>Review in 5 years if all readings normal.</td>
<td>Review in 1 year if any raised readings.</td>
</tr>
<tr>
<td>Assess CVD risk ≥ 68. Is CVD risk &gt; 20%?</td>
<td>No</td>
</tr>
<tr>
<td>Patient is at risk for hypertension.</td>
<td>Manage patient’s CVD risk →69.</td>
</tr>
<tr>
<td>140/90</td>
<td>≥ 140/90</td>
</tr>
<tr>
<td>&lt; 140/90</td>
<td>≥ 140/90</td>
</tr>
</tbody>
</table>

### ≥ 180/110

Does patient have any of the following: headache, difficult breathing, visual disturbances, chest pain, confusion, leg swelling?

<table>
<thead>
<tr>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnose hypertension. Only treat BP if no sign of stroke: sudden onset of weakness on 1 or both sides, vision problems, dizziness, difficulty speaking or swallowing. Give amlopidine 10mg orally stat. If unavailable, give enalapril 10mg orally stat. Avoid short-acting nifedipine as it may drop the BP too quickly, causing a stroke. If dizzy or faint after treatment, check BP: if more than 25% drop or &lt; 160/100, lie patient down with legs raised. Refer same day to hospital.</td>
</tr>
</tbody>
</table>

### < 180/110

- If patient has diabetes diagnose hypertension if BP > 140/80 on 2 days →71.
- Is there ischaemic heart disease, peripheral vascular disease, stroke, heart failure or kidney disease?

<table>
<thead>
<tr>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient needs urgent care</td>
</tr>
</tbody>
</table>

### 140/90–179/109

Assess CVD risk ≥ 68. Is CVD risk > 20%?

<table>
<thead>
<tr>
<th>Action</th>
</tr>
</thead>
</table>

### 130/80–179/109

<table>
<thead>
<tr>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do not diagnose hypertension on the basis of one reading alone.</td>
</tr>
</tbody>
</table>

### < 140/90

<table>
<thead>
<tr>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Continue CVD risk management →69.</td>
</tr>
</tbody>
</table>
**HYPERTENSION: ROUTINE CARE**

<table>
<thead>
<tr>
<th>Assess</th>
<th>When to assess</th>
<th>Note</th>
</tr>
</thead>
<tbody>
<tr>
<td>Symptoms</td>
<td>Every visit</td>
<td>Manage symptoms on symptom page. Ask about symptoms of stroke or transient ischaemic attack (TIA).</td>
</tr>
<tr>
<td>BP</td>
<td>Every visit</td>
<td>BP is controlled if &lt; 140/90 (or 120/70–140/80 if diabetes, or &lt;130/80 if CVD, heart failure or kidney disease).</td>
</tr>
<tr>
<td>BMI</td>
<td>At diagnosis, yearly or 3 monthly if trying to lose weight</td>
<td>BMI is weight (kg) / [height (m) x height (m)]. If BMI &gt; 25, calculate target weight: 25 x height (m) x height (m).</td>
</tr>
<tr>
<td>Waist circumference</td>
<td>At diagnosis, yearly or 3 monthly if trying to lose weight</td>
<td>Aim for &lt; 80cm (woman), &lt; 94cm (man).</td>
</tr>
<tr>
<td>CVD risk</td>
<td>At diagnosis and every 5 years</td>
<td>If CVD or diabetes no need to check. It reflects the risk of a heart attack or stroke over the next 10 years [68].</td>
</tr>
<tr>
<td>Glucose</td>
<td>Yearly and if glucose on urine dipstick</td>
<td>Check random finger-prick glucose [70] to interpret result. Check every visit if patient diabetic.</td>
</tr>
<tr>
<td>eGFR</td>
<td>Yearly</td>
<td>Estimated glomerular filtration rate reflects kidney function. Give age and sex on form. If &lt; 60 refer to doctor.</td>
</tr>
<tr>
<td>Urine dipstick</td>
<td>Yearly</td>
<td>Refer to doctor if blood or protein on repeat dipstick. If glucose on dipstick, screen for diabetes [70].</td>
</tr>
<tr>
<td>Cholesterol</td>
<td>At diagnosis</td>
<td>Refer to specialist if total cholesterol ≥ 7.5.</td>
</tr>
</tbody>
</table>

If patient on treatment, check if BP is controlled: < 140/90 (or 120/70–140/80 if diabetes, or <130/80 if CVD, heart failure or kidney disease).

**BP controlled on treatment**

- Continue current treatment.
- Review 6 monthly.

**BP not controlled on treatment**

- If ≥ 180/110: check for symptoms needing urgent attention [73].
- Adherent: Step up treatment (to at least step 3 if ≥ 180/110) and review in 1 month.
- Not adherent: Advise patient to take current treatment reliably. Review in 1 month.

**Advising the patient with hypertension**

- Help the patient to manage his/her CVD risk [69].
- Advise patient to avoid non-steroidal anti-inflammatory drugs (like ibuprofen), oestrogen-containing oral contraceptives [91].
- Educate the patient on enalapril to stop it immediately should angioedema (swelling of tongue, lips, face, difficulty breathing) develop.
- Explain that patient will need lifelong hypertension care to prevent stroke (brain attack) and kidney disease.

**Treat the patient with hypertension**

- Give simvastatin 10mg daily if patient has CVD or a CVD risk > 20%. Avoid in pregnancy, liver disease.
- Give aspirin 150mg daily if patient has CVD and/or diabetes. Avoid if < 30 years, previous peptic ulcers or dyspepsia or if BP ≥ 180/110.
- Treat hypertension stepwise as in table below along with CVD risk management [69]. If BP is not controlled after 1 month on treatment and patient is adherent, proceed to the following step:

<table>
<thead>
<tr>
<th>Step</th>
<th>Drugs all once a day</th>
<th>Note</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Start hydrochlorothiazide (HCTZ) 12.5mg</td>
<td>Avoid in pregnancy (refer), liver or kidney disease, gout. Use enalapril first instead in diabetes, kidney disease, heart failure.</td>
</tr>
<tr>
<td>2</td>
<td>Add enalapril 10mg</td>
<td>Avoid/stop in pregnancy, angioedema or renal artery stenosis: use amlodipine 5mg daily instead. If eGFR &lt; 60 and/or peripheral vascular disease, check eGFR and potassium within 4 weeks of starting/changing dose.</td>
</tr>
<tr>
<td>3</td>
<td>Add amlodipine 5mg and increase enalapril to 20mg.</td>
<td>Avoid amlodipine in heart failure if possible.</td>
</tr>
<tr>
<td>4</td>
<td>Add atenolol 50mg; increase HCTZ to 25mg and amlodipine to 10mg.</td>
<td>Avoid atenolol in pregnancy, asthma, COPD, heart failure. Refer for specialist assessment if BP not controlled on step 4 treatment.</td>
</tr>
</tbody>
</table>
HEART FAILURE: ROUTINE CARE

• The patient with heart failure has difficulty breathing especially on lying down/with effort as well as leg swelling. **A doctor must confirm the diagnosis.**

Recognise the patient with heart failure needing urgent attention:

• Respiratory rate > 30 breaths/minute
• Fainting/blackouts
• Irregular pulse
• Temperature ≥ 38°C

• Sit patient up and give 100% oxygen via face mask to deliver 40% oxygen.
• Give **furosemide** slowly IV. 1st dose 40mg. If respiratory rate does not improve after 30 minutes, add 80mg; if still no better after 20 minutes give another 40mg.
• Give **morphine** IV: dilute 15mg with 14mℓ of water for injection or sodium chloride 0.9%. Give 1mℓ/min to a maximum of 5mg even if there is no pain.
• Give sublingual **isosorbide dinitrite** 5mg. Repeat 4 hourly even if there is no pain.
• Refer urgently

Assess the patient with heart failure

<table>
<thead>
<tr>
<th>Assess</th>
<th>When to assess</th>
<th>Note</th>
</tr>
</thead>
<tbody>
<tr>
<td>Symptoms</td>
<td>Every visit</td>
<td>Manage symptom as on symptom page. If cough and difficult breathing ‡ 16 and refer to doctor.</td>
</tr>
<tr>
<td>Pregnancy status</td>
<td>Every visit</td>
<td>Discuss family planning needs ‡ 91. If pregnant, refer for specialist care.</td>
</tr>
<tr>
<td>Substance abuse</td>
<td>At diagnosis</td>
<td>&gt; 21 drinks/week (man) or &gt;14 drinks/week (woman) and/or &gt; 5 drinks/session or misuse of illicit or prescription drugs ‡ 83.</td>
</tr>
<tr>
<td>Weight</td>
<td>Every visit</td>
<td>Assess changes in fluid balance by comparing with weight when patient is asymptomatic as possible.</td>
</tr>
<tr>
<td>BP</td>
<td>Every visit</td>
<td>If BP ≥ 130/80 ‡ 73. Aim to treat hypertension to &lt; 130/80. Avoid atenolol.</td>
</tr>
<tr>
<td>Blood tests</td>
<td>At diagnosis</td>
<td>Check Hb, glucose, eGFR, TSH, HIV if status unknown ‡ 60.</td>
</tr>
</tbody>
</table>

Advise the patient with heart failure

• Advise patient to adhere to treatment even if asymptomatic.
• Help the patient to manage his/her CVD risk ‡ 69. Advise regular exercise within limits of symptoms.
• Restrict fluid intake to less than 1 litre/day if marked leg or abdominal swelling.

Treat the patient with heart failure

• Give drugs as in table below. If symptoms not resolved after 1 month on treatment and patient is adherent, proceed to the following step:

<table>
<thead>
<tr>
<th>Step</th>
<th>Drug</th>
<th>Dose</th>
<th>Note</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td><strong>Enalapril and either HCTZ or furosemide</strong></td>
<td>Up to 10mg twice a day 25–50mg daily 40–80mg daily</td>
<td>• Avoid enalapril in pregnancy, previous angioedema or renal artery stenosis. If eGFR &lt; 60 and/or PVD, check eGFR and potassium within 4 weeks of starting/changing dose. • Use HCTZ if mild heart failure symptoms and eGFR ≥ 60. Avoid in gout, liver, kidney disease. • Use furosemide if significant heart failure symptoms or eGFR &lt; 60. Monitor eGFR and electrolytes.</td>
</tr>
<tr>
<td>2</td>
<td><strong>Add spironolactone</strong></td>
<td>25mg daily</td>
<td>Monitor serum potassium. Avoid with potassium supplements and in kidney failure.</td>
</tr>
<tr>
<td>3</td>
<td><strong>Add carvedilol</strong></td>
<td>3.125mg twice daily. Double dose 2 weekly up to 25mg twice daily.</td>
<td>Avoid in cardiogenic shock, severe fluid overload, BP &lt; 90/60, asthma. Avoid or decrease dose if pulse &lt; 60.</td>
</tr>
<tr>
<td>4</td>
<td><strong>Add digoxin</strong></td>
<td>0.125mg daily</td>
<td>Also refer patient for further assessment.</td>
</tr>
</tbody>
</table>
**STROKE: ROUTINE CARE**

**Sudden onset** of any of the following suggests a stroke (or a transient ischaemic attack (TIA) if symptoms lasted < 24 hours and resolved completely):

- Weakness, numbness or paralysis of the face, arm or leg on one or both sides of the body
- Blurred or decreased vision in one or both eyes or double vision
- Difficulty speaking or understanding
- Dizziness, loss of balance, any unexplained fall or unsteady gait
- Severe new headache

**A doctor must confirm the diagnosis of stroke.**

**Recognise the patient with stroke needing urgent attention:**

Stroke/TIA is a brain attack. Quick treatment within 48 hours of onset of symptoms of a minor stroke or TIA reduces the risk of a major stroke.

- Give face mask oxygen.
- Nil by mouth until swallowing is formally assessed.
- Check blood glucose: if ≤ 3.5 give up to 50mL dextrose 50% IV.
- Do not treat raised BP as this may worsen stroke and can be managed at referral hospital.
- Give aspirin 150mg stat if patient unable to reach hospital within 24 hours of onset of symptoms.
- Refer urgently for thrombolysis (to a specialist stroke unit if available) if the patient can reach the unit/hospital within 4 hours of onset of symptoms.
- Otherwise refer same day to nearest hospital if symptoms of stroke/TIA > 4 hours but < 48 hours.

### Assess the patient with stroke/TIA

<table>
<thead>
<tr>
<th>Assess</th>
<th>When to assess</th>
<th>Note</th>
</tr>
</thead>
<tbody>
<tr>
<td>Symptoms</td>
<td>Every visit</td>
<td>Ask about symptoms of another stroke/TIA. Also ask about chest pain 📊 77 or leg pain 📊 79.</td>
</tr>
<tr>
<td>Depression</td>
<td>Every visit</td>
<td>Screen for depression if patient has low mood or not coping as well as in the past 📊 81.</td>
</tr>
<tr>
<td>Rehabilitation needs</td>
<td>Every visit</td>
<td>Refer to appropriate therapist: physiotherapy for mobility, physiotherapy/occupational therapy for self care, speech therapist for swallowing, coughing after eating, speaking and drooling.</td>
</tr>
<tr>
<td>BP</td>
<td>Every visit</td>
<td>Aim for BP &lt; 130/80. Start treatment only 48 hours after a stroke 📊 73.</td>
</tr>
<tr>
<td>Glucose</td>
<td>At diagnosis and yearly</td>
<td>Check random finger-prick glucose 📊 70 to interpret result.</td>
</tr>
<tr>
<td>Fasting cholesterol and triglycerides</td>
<td>At diagnosis if not already done</td>
<td>Refer to specialist if total cholesterol ≥ 7.5 or triglycerides ≥ 5.</td>
</tr>
<tr>
<td>HIV</td>
<td>At diagnosis if status unknown especially if patient &lt; 50 years</td>
<td>Test for HIV 📊 60. The HIV patient needs routine HIV care 📊 61.</td>
</tr>
</tbody>
</table>

**Advise the patient with stroke/TIA**

- Help patient to manage cardiovascular disease risk 📊 69. Refer patient to available helpline/s 📊 backpage.
- If patient is < 55 years (man) or < 65 years (woman), advise the first degree relatives to have CVD risk assessment 📊 68.
- Avoid oral contraceptives containing oestrogen. Advise other method such as IUCD, injectable, progesterone-only pill 📊 91.

**Treat the patient with stroke/TIA**

- Give aspirin 150mg daily for life. Avoid if < 30 years, haemorrhagic stroke, previous peptic ulcers or dyspepsia.
- Refer for warfarin instead of aspirin if patient has prosthetic heart valve, valvular heart disease or atrial fibrillation.
- Give simvastatin 10mg daily for life if patient had an ischaemic stroke.
ISCHAEMIC HEART DISEASE (IHD): DIAGNOSIS

• Angina due to IHD is typically central burning or crushing chest pain that may spread to jaw, left shoulder, down left arm and is suggested by:
  - Pain lasting for 5 minutes or less, usually brought on by exercise, effort or anxiety and relieved by rest and
  - Pain occurring consistently at same distance or level of effort and
  - 9 out of 10 times occurring with effort and 1 out of 10 times at rest.

• A doctor must make or confirm the diagnosis of ischaemic heart disease.

Recognise the patient with possible unstable angina or heart attack needing urgent attention:

• Chest pain at rest or minimal effort.
• Chest pain lasting more than 10 minutes.
• If known IHD: pain worsening, lasting longer than usual, not relieved by sublingual nitrates.
• Patient may be sweating, nauseous, vomiting, breathless.
• ECG may show ST segment depression or elevation, but a normal ECG does not exclude diagnosis of angina or heart attack.
• BP < 90/60

Arrange urgent ambulance transfer to hospital and manage as follows:

• Give 40% face mask oxygen.
• If BP < 90/60 give 200mℓ sodium chloride 0.9% IV.
• Give aspirin 150mg single dose.
• Isosorbide dinitrate sublingual 5mg every 5-10 minutes until pain relieved to a maximum of 5 tablets.
• Morphine 15mg diluted with 14mℓ of water for injection or sodium chloride 0.9%. Give 1mℓ/min IV until pain relieved.
• Doctor to confirm unstable angina or heart attack and assess patient for streptokinase:
  - Give if within 6 hours of onset of pain and ST segment elevation above baseline or new LBBB on ECG.
  - Avoid if active bleeding or known bleeding disorder, stroke within the last 6 months or any previous haemorrhagic stroke, gastrointestinal bleeding within the last 3 months or peptic ulcer, streptokinase given within the past year or known allergy to it, or recent major trauma, surgery or head injury.
• Doctor to give streptokinase 1.5 million IU diluted in 100mℓ dextrose 5% or sodium chloride 0.9% IV over 30–60 minutes.
• Refer urgently to hospital.

For routine care of the patient with IHD →78.
ISCHAEMIC HEART DISEASE: ROUTINE CARE

Assess the patient with ischaemic heart disease

<table>
<thead>
<tr>
<th>Assess</th>
<th>When to assess</th>
<th>Note</th>
</tr>
</thead>
</table>
| Symptoms              | At diagnosis and every visit | • Ask about angina and treat as below. Refer if angina persists on full treatment or interferes with daily activities.  
• Screen for depression if patient has low mood or not coping as well as in the past \[81\]. |
| BP                    | At diagnosis and every visit | If BP ≥ 130/80 \[73\]. Aim to treat hypertension to < 130/80 \[74\].     |
| Glucose               | At diagnosis and yearly   | Check random finger-prick glucose \[70\] to interpret result.          |
| Fasting cholesterol and triglycerides | At diagnosis if not already done | Refer to specialist if total cholesterol ≥ 7.5 or triglycerides ≥ 5. |

Advise the patient with ischaemic heart disease

• Help the patient to manage his/her CVD risk \[69\].
• Patient can resume sexual activity 1 month after heart attack and when symptom free.
• Emphasize the importance of lifelong adherence to medication. Ensure patient knows how to use isosorbide dinitrate as below.
• Patient should avoid non steroidal anti-inflammatory drugs like ibuprofen and diclofenac, as they may precipitate angina.
• If patient is < 55 years (man) or < 65 years (woman), advise the first degree relatives to have CVD risk assessment \[68\].

Assess When to assess Note

Symptoms At diagnosis and every visit • Ask about angina and treat as below. Refer if angina persists on full treatment or interferes with daily activities.

BP At diagnosis and every visit If BP ≥ 130/80 \[73\]. Aim to treat hypertension to < 130/80 \[74\].

Glucose At diagnosis and yearly Check random finger-prick glucose \[70\] to interpret result.

Fasting cholesterol and triglycerides At diagnosis if not already done Refer to specialist if total cholesterol ≥ 7.5 or triglycerides ≥ 5.

Treast the patient with ischaemic heart disease

• Give aspirin 150mg daily for life. Avoid if < 30 years, a history of peptic ulcers or dyspepsia.
• Give atenolol 50mg daily, even if no angina. Avoid in pregnancy, asthma, COPD, heart failure, peripheral vascular disease.
• Give simvastatin 10mg daily for life. No need to monitor cholesterol.
• If patient has had a heart attack, give enalapril 2.5mg twice a day and increase slowly to 10mg twice a day. Avoid if pregnancy, angioedema or renal artery stenosis.\[DT\]
• If patient has angina, treat in a step-wise fashion as in table below:
  - If angina persists, increase dose to maximum, then add next step.

<table>
<thead>
<tr>
<th>Step</th>
<th>Drug</th>
<th>Start dose</th>
<th>Maximum dose</th>
<th>Note</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>isosorbide dinitrate with angina and</td>
<td>5mg sublingual with angina</td>
<td>3 doses of 5mg with 1 episode of angina</td>
<td>If angina starts, do not walk through the pain, stop and take 1st dose. If angina persists, take a further 2 doses 5 minutes apart. If no improvement 5 minutes after 3rd dose, contact emergency services. Avoid atenolol in pregnancy, asthma, COPD, heart failure, peripheral vascular disease and use amlodipine instead or if side effects (impotence, fatigue, depression) occur.</td>
</tr>
<tr>
<td></td>
<td>before exertion and</td>
<td>50mg daily</td>
<td>100mg daily</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Atenolol</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Amlodipine</td>
<td>5mg in the morning</td>
<td>10mg daily</td>
<td>Avoid in heart failure.</td>
</tr>
<tr>
<td>3</td>
<td>isosorbide mononitrate or isosorbide</td>
<td>10mg at 8am and 2pm</td>
<td>20mg at 8am and 2pm</td>
<td>Refer if angina persists on full treatment or interferes with daily activities.</td>
</tr>
<tr>
<td></td>
<td>dinitrate</td>
<td>20mg at 8am and 2pm</td>
<td>40mg at 8am and 2pm</td>
<td></td>
</tr>
</tbody>
</table>

Refer if angina persists on full treatment or interferes with daily activities.
PERIPHERAL VASCULAR DISEASE (PVD)

• Peripheral vascular disease is characterised by claudication: muscle pain in legs or buttocks on exercise.
• Refer the patient newly diagnosed with peripheral vascular disease for specialist assessment.

 Recognise the patient with peripheral vascular disease needing urgent attention:

Claudication with any one of:
• Pain at rest
• Gangrene
• Ulceration
• Suspected abdominal aortic aneurysm: pulsatile mass in abdomen
Refer same day to hospital.

PERIPHERAL VASCULAR DISEASE: ROUTINE CARE

Assess the patient with peripheral vascular disease

<table>
<thead>
<tr>
<th>Assess</th>
<th>When to assess</th>
<th>Note</th>
</tr>
</thead>
</table>
| Symptoms                      | At diagnosis and every visit    | •Document the walking distance before onset of claudication.  
                              |                                | •Ask about chest pain \(77\) and symptoms of stroke/TIA \(76\).  
                              |                                | •Manage symptoms as per symptom pages. |
| BP                            | At diagnosis and every visit    | If BP \(≥ 130/80\) \(73\). Aim to treat hypertension to < 130/80 \(74\). |
| Femoral pulses                | At diagnosis and every visit    | Refer if weak or absent.                      |
| Abdomen                       | At diagnosis and every visit    | If a pulsatile mass felt, refer for assessment for possible aortic aneurysm. |
| Random glucose                | At diagnosis and yearly         | Check random finger-prick glucose \(70\) to interpret result. Check every visit if patient diabetic. |
| Fasting cholesterol and triglycerides | At diagnosis if not already done | Refer to specialist if total cholesterol \(≥ 7.5\) or triglycerides \(≥ 5\). |

Advise the patient with peripheral vascular disease

• Help the patient to manage his/her CVD risk \(69\).
• Walking an hour a day for at least 6 months can increase by 50% the walking distance. Advise patient to pause and rest whenever claudication develops.
• If patient is < 55 years (man) or < 65 years (woman), advise the first degree relatives to have CVD risk assessment \(68\).

Treat the patient with peripheral vascular disease

• Give simvastatin 10mg daily for life regardless of cholesterol level.
• Give aspirin 150mg daily for life if no history of peptic ulcers or dyspepsia. Avoid if under 30 years.

Refer if unacceptable symptoms occur despite adherence to advice and drug treatment.
MENTAL HEALTH CARE ACT (MHCA)

Approach to the mentally ill patient in need of hospital admission

- Before sedating the patient (if needed) fully inform patient in his/her own language about reasons for admission and treatment.
- Can patient give informed consent: the patient understands that s/he is ill, is needing treatment and can communicate his/her choice to receive treatment?

No: Does patient oppose admission?

No

- Admit as an assisted patient under the Mental Health Care Act.
  - A staff member must accompany the patient to hospital.
  - Request police assistance only if the patient is too dangerous to be transferred in a staff vehicle or is likely to abscond.
  - All police transport of mentally ill patients must be accompanied by form 22.

Yes

- Does patient meet all of the following?
  - Mental illness or severe or profound mental disability
  - Refusing treatment and
  - Danger of harm to self, others, own reputation, financial interest or property

No

- Manage as an outpatient.

Yes

- Admit the patient voluntarily
  - Record everything clearly in patient notes and referral letter.

Yes

- Admit as an assisted patient under the Mental Health Care Act.
  - A staff member must accompany the patient to hospital.
  - Request police assistance only if the patient is too dangerous to be transferred in a staff vehicle or is likely to abscond.
  - All police transport of mentally ill patients must be accompanied by form 22.

No

- Manage as an outpatient.

Yes

- Applican1 must complete MHCA 04 form.
  - Mental health practitioner must complete MHCA 05 form and doctor must complete another MHCA 05 form (at same or other facility).
  - Completion of the 2 MHCA 05 forms should be done independently of one another.

The 2 MHCA 05 forms disagree.

- Third mental health practitioner must complete a third MHCA 05 form independently.

The 2 MHCA 05 forms agree to admit the patient under the Mental Health Care Act.

- Head of facility must complete MHCA 07 form.
  - Admit patient under Mental Health Care Act.

Third MHCA 05 form agrees to admit the patient under the Mental Health Care Act.

Manage as outpatient.

Third MHCA 05 form does not agree to admit the patient under the Mental Health Care Act.

Third MHCA 05 form

1The applicant is the patient’s spouse, next-of-kin, associate, partner, parent or guardian or health care provider. For a patient < 18 years, the applicant must be a parent or guardian.
**DEPRESSION AND ANXIETY: DIAGNOSIS**

**Ask the following 2 questions to assess for depression:**

**Question 1:** For at least 2 weeks, has the patient had at least 2 of the core features of depression?
- Depressed mood most of the day, almost every day
- Loss of interest or pleasure in activities that are normally pleasurable
- Decreased energy or increased fatigue

**Question 2:** For at least 2 weeks, has the patient had any 3 other features of depression?
- Reduced concentration and attention
- Reduced self-esteem and self-confidence
- Ideas of guilt and unworthiness
- Bleak and negative view of future
- Ideas or acts of self-harm or suicide
- Disturbed sleep
- Decreased appetite

---

**Yes to both Question 1 and Question 2**

- Does the patient have difficulties carrying out ordinary work, domestic or social activities?
  - Yes
    - Diagnose **moderate-severe depression.**
    - Give routine depression and/or anxiety care ➞82.
  - No
    - No
    - The patient is not depressed.
    - Is the patient feeling tense/nervous and/or worrying a lot?
      - Yes
        - The patient has **anxiety.**
        - Does the anxiety have one or more of the following features?
          - Induced by a situation
          - Sudden fear, no obvious cause
          - Follows a traumatic event
          - Yes
            - The patient may have phobia, panic or post-traumatic stress disorder.
            - Refer same week for specialist assessment.
          - No
            - If the patient has depression and anxiety, treat for depression as treating the depression usually improves the anxiety.
            - If there is no depression, treat anxiety as for mild depression.
      - No
        - Yes
          - Assess the patient on stressed patient page ➞52.
        - No
          - No
  - Diagnose **mild depression.**
  - Give routine depression and/or anxiety care ➞82.

---

**Yes to only Question 1 or Question 2**

- No to both Question 1 and Question 2
  - Yes
    - The patient is not depressed.
    - Is the patient feeling tense/nervous and/or worrying a lot?
      - Yes
        - Assess the patient on stressed patient page ➞52.
      - No
        - No

---

**No to both Question 1 and Question 2**

- Yes
  - The patient is not depressed.
  - Is the patient feeling tense/nervous and/or worrying a lot?
    - Yes
      - Assess the patient on stressed patient page ➞52.
    - No
      - No
## DEPRESSION AND/OR ANXIETY: ROUTINE CARE

**Assess the patient with depression and/or anxiety**

<table>
<thead>
<tr>
<th>Assess</th>
<th>When to assess</th>
<th>Note</th>
</tr>
</thead>
</table>
| Symptoms                | Every visit    | • Assess for symptoms of depression and/or anxiety \[81.\] Refer if no improvement after 8 weeks of treatment or if patient deteriorates. \[81.\]  
|                         |                | • If patient has hallucinations, delusions and abnormal behaviour, consider psychosis \[84.\]. If memory problems, screen for dementia \[86.\]. \[84.\]  
|                         |                | • Assess and treat other symptoms on symptom pages. \[84.\]  
|                         |                | • Ask about side effects of antidepressant medication (see below). \[84.\]  
| Suicide                 | Every visit    | If patient has suicidal thoughts or plans, refer same day \[81.\]. \[81.\]  
| Mania                   | Every visit    | Refer if mania (being abnormally happy, energetic, talkative, irritable or reckless) at diagnosis or develops on antidepressant medication. \[81.\]  
| Stressors               | Every visit    | Help identify the domestic, social and work factors contributing to depression and/or anxiety. If patient is being abused \[81.\]. \[81.\]  
| Substance abuse         | Every visit    | > 21 drinks/week (man) or > 14 drinks/week (woman) and/or > 5 drinks per session or misuse of illicit or prescription drugs \[83.\]. \[83.\]  
| Family planning         | Every visit    | Discuss patient’s contraceptive needs \[91.\]. If patient is pregnant refer for specialist care. \[91.\]  
| Chronic disease         | Every visit    | • Ensure other chronic diseases are adequately treated. \[83.\]  
|                         |                | • Discuss with specialist if patient is on medication that might cause depression like oral steroids, efavirenz and atenolol. \[83.\]  
| Thyroid function        | At diagnosis   | Check TSH if weight change, dry skin, constipation, intolerance to cold or heat, pulse > 80, tremor, or thyroid enlargement. Refer to doctor if result abnormal. \[83.\]  

### Advise the patient with depression and/or anxiety

- Devise with patient a strategy to cope when thoughts of self harm, suicide or substance misuse occur. \[81.\]  
- Deal with negative thinking: encourage patient to question his/her way of thinking, examine the facts realistically and look for strategies to get help and cope. \[81.\]  
- Encourage patient to do activities that used to give pleasure, to engage in regular social activity and to exercise for at least 30 minutes 5 days a week. \[81.\]  
- Discuss sleep hygiene \[54\] and relaxation techniques. \[54\]  
- Refer patient to available helpline and/or support group \[back page\]. \[81.\]  
- The best treatment for mild depression and/or anxiety is cognitive behavioural therapy. Antidepressants work best for those with moderate-severe depression. \[81.\]  

### Treat the patient with depression and/or anxiety

- Refer patient for counselling, ideally cognitive behavioural therapy, with counsellor, social worker or psychologist. \[81.\]  
- Treat the patient with moderate-severe depression with an antidepressant. Refer the patient who is pregnant, breastfeeding or bipolar for specialist care. \[81.\]  
- Emphasise the importance of adherence even if feeling well and to stop antidepressants only with the guidance of a clinician. \[81.\]  
- Antidepressants can take 4–6 weeks to start working. Review 2 weekly until stable, then monthly. Refer if no response after 8 weeks. \[81.\]  

<table>
<thead>
<tr>
<th>Drug</th>
<th>Dose</th>
<th>Note</th>
</tr>
</thead>
</table>
| Fluoxetine   | Start 20mg daily (or 10mg if > 65 years or if very anxious). If partial or no response after 4 weeks increase to 40mg daily. | Avoid in kidney or liver disease. Monitor glucose in diabetes and for fits in epilepsy. Side effects: headache, nausea, diarrhoea, sexual dysfunction. \[81.\]  
| Amitriptyline| Start 50mg at night (or 25mg if > 65 years). Increase by 25mg/day every 3-5 days (or 7–10 days if > 65 years). Maximum dose: 150mg/day (or 75mg if > 65 years). | Use if fluoxetine contraindicated. Avoid if suicidal thoughts (can be fatal in overdose), heart disease, urinary retention, glaucoma, epilepsy. Side effects: dry mouth, sedation. \[81.\]  

- Doctor to consider stopping antidepressant when patient has had no or minimal depressive symptoms and has been able to carry out routine activities for 9–12 months: reduce dose gradually over at least 4 weeks (more gradually if withdrawal symptoms develop: irritability, dizziness, sleep problems, headache, nausea, fatigue).
# Substance Abuse

## Identify the patient with substance abuse if 1 or more of:

- The misuse of drugs or alcohol causes serious problems for patient, the family and perhaps even the community and/or
- > 21 drinks/week (man); > 14 drinks/week (woman); or > 5 drinks/session. 1 drink is 1 tot of spirits, or 1 small glass of wine or 1 can of beer and/or
- Yes to 2 or more¹: Ever felt you should Cut down on drinking? Annoyed if criticized about drinking? Ever felt Guilty about drinking? Ever drink first thing to steady your nerves or treat a hangover? (Eye-opener) and/or
- Any use of illicit drugs or misuse of prescription drugs.

## Substance Abuse: Routine Care

### Assess the patient with substance abuse

<table>
<thead>
<tr>
<th>Assess</th>
<th>Note</th>
</tr>
</thead>
<tbody>
<tr>
<td>Symptoms</td>
<td>Restlessness, confusion, sweating, sleeplessness, hallucinations, agitation, weakness, tremor, headache, nausea - may be withdrawal: refer same day.</td>
</tr>
<tr>
<td>Harmful use</td>
<td>Alcohol: &gt; 35 drinks/week (man); &gt; 20 drinks/week (woman); &gt; 5 drinks/session and/or any use of illicit or prescription drugs can become harmful.</td>
</tr>
<tr>
<td>Dependence</td>
<td>Much time and energy spent on getting and using substance and withdrawal symptoms above occur on stopping or cutting down.</td>
</tr>
<tr>
<td>Trauma/abuse</td>
<td>If patient reports recent trauma or emotional or sexual abuse ▶️ 53.</td>
</tr>
<tr>
<td>Chronic disease</td>
<td>Chronic use of alcohol and/or drugs can have a long term impact on physical health. Assess and manage according to symptoms and chronic disease.</td>
</tr>
<tr>
<td>Mental illness</td>
<td>If low mood or sadness, loss of interest or pleasure, feeling tense or anxious or worrying a lot about things, consider depression/anxiety ▶️ 81.</td>
</tr>
</tbody>
</table>

### Advise the patient with substance abuse

- Educate patient about effects of substance abuse. Explore patient’s willingness to cut down or stop. Encourage patient to use helpline ▶️ back page. For communicating effectively see Preface.
- Alcohol: Advise abstinence or moderate use (≤ 21 drinks/week (man); ≤ 14 drinks/week (woman) and avoid binges). Advise the pregnant woman to abstain.
- Advise patient to stop using illicit or prescription drugs.

### Doctor to treat the dependant patient with substance abuse

- Enrol the dependant patient in a rehabilitation programme starting with detoxification. Ensure patient is motivated to adhere and has the support of a relative/friend.
- Admit the patient who refuses help under the Mental Health Care Act only if there is an accompanying mental disorder and patient is causing harm to self or others ▶️ 80.
- For inpatient detoxification if previous withdrawal delirium, fits, psychosis, suicidal, liver disease, failed prior detoxification, no home support, opioid abuse, or if legally committed or detained.
- Doctor to provide outpatient detoxification if none of the above inpatient criteria and patient is abusing alcohol, cannabis, mandrax, cocaine, tik or benzodiazepines:

<table>
<thead>
<tr>
<th>Substance</th>
<th>Detoxification programme</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol</td>
<td>Thiamine 100mg twice a day for 14 days and&lt;br&gt; Diazepam orally 10mg immediately, then 5mg 6 hourly for 3 days; then 5mg 12 hourly for 2 days; then 5mg daily for 2 days, and then stop. If withdrawal symptoms occur, refer or discuss.</td>
</tr>
<tr>
<td>Cannabis/Mandrax/Cocaine/Tik</td>
<td>Treatment not always needed. Review after 1 day of abstinence.&lt;br&gt; Treat anxiety or sleep problems with diazepam 5mg 1–3 times a day tapering over 3–7 days or promethazine 25–50mg orally 8 hourly.</td>
</tr>
<tr>
<td>Benzodiazepines</td>
<td>Avoid suddenly stopping benzodiazepines after long-term use.&lt;br&gt; Replace patient's benzodiazepine with diazepam. If on lorazepam 0.5mg–1mg give diazepam 5mg (for other benzodiazepines, refer to SAMF or MIC hotline ▶️ back page).&lt;br&gt; Adjust diazepam according to symptoms, then decrease diazepam by 2.5mg every 2 weeks. On reaching 20% of initial dose taper by 0.5–2mg/week.</td>
</tr>
</tbody>
</table>

¹ CAGE questions
MENTAL HEALTH

MENTAL HEALTH

PSYCHOSIS AND/OR MANIA

• Psychosis is likely in the patient who has difficulty carrying out ordinary work, domestic or social activities and any of:
  - Hallucinations: hearing voices or seeing things that are not there
  - Delusions: unusual/bizarre beliefs, not shared by society; beliefs that thoughts are being inserted or broadcast
  - Abnormal behaviour: incoherent or irrelevant speech, unusual appearance, self neglect, withdrawal, disturbance of emotions
  - Manic symptoms: several days of being abnormally happy, energetic, talkative, irritable or reckless.
• Consider bipolar disorder if patient has manic symptoms on some occasions, and depressed mood and energy on others.
  • The patient with psychosis and/or mania must be assessed initially by a doctor.

Recognise the patient with psychosis and/or mania needing same-day referral:

- Suicidal thoughts or attempt → 49
- If aggressive or violent → 50
- First episode psychosis or mania
- Pregnant or breastfeeding
- Muscle spasms (may be painful) within 48 hours of initiating antipsychotic medication
Management:
  • Consider admitting under the Mental Health Care Act if refusing treatment or admission and a danger of harm to self, others, own reputation or financial interest/property → 80.
  • For acute dystonic reactions (painful muscle spasms in patient on anti-psychotics), give *biperiden* 2mg IM. Repeat every 30 minutes to a maximum of 4 doses in 24 hours.
  • Refer patient same day.

PSYCHOSIS AND/OR MANIA: ROUTINE CARE

Assess the patient with psychosis and/or mania

<table>
<thead>
<tr>
<th>Assess</th>
<th>When to assess</th>
<th>Note</th>
</tr>
</thead>
<tbody>
<tr>
<td>Symptoms</td>
<td>Every visit</td>
<td>• Ask about symptoms of psychosis and mania above. If symptomatic despite treatment refer.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Assess for symptoms of depression and/or anxiety → 81. If memory problems, screen for dementia → 86. If present refer.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Assess and treat other symptoms on symptom pages.</td>
</tr>
<tr>
<td>Suicide</td>
<td>Every visit</td>
<td>If patient has suicidal thoughts or plans, refer same day → 49.</td>
</tr>
<tr>
<td>Stressors</td>
<td>Every visit</td>
<td>Help identify the psychosocial stressors that may exacerbate symptoms. If patient is being abused → 53.</td>
</tr>
<tr>
<td>Substance abuse</td>
<td>Every visit</td>
<td>&gt; 21 drinks/week (man) or &gt; 14 drinks/week (woman) and/or &gt; 5 drinks/session or misuse of illicit or prescription drugs → 83.</td>
</tr>
<tr>
<td>Family planning</td>
<td>Every visit</td>
<td>Discuss patient’s contraceptive needs → 91. If patient is pregnant or breastfeeding refer for specialist care.</td>
</tr>
<tr>
<td>Chronic disease</td>
<td>Every visit</td>
<td>• Refer the patient with other chronic diseases. Give routine chronic disease care as per chronic diseases pages.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Discuss with specialist if patient is on medication that might cause psychosis like oral steroids, efavirenz and antidepressants.</td>
</tr>
<tr>
<td>Medication</td>
<td>Every visit</td>
<td>• Ask about side effects of antipsychotic medication → 85. Refer if these are present.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• If non adherent re-commence medication. Consider changing from oral to depot medication.</td>
</tr>
<tr>
<td>HIV, RPR</td>
<td>First visit</td>
<td>• If status unknown, test for HIV → 60. Give routine HIV care to HIV patient → 61.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• If RPR positive, refer.</td>
</tr>
</tbody>
</table>

PSYCHOSIS AND/OR MANIA: DIAGNOSIS

Dr
**Advise the patient with psychosis**

- Educate the patient and carer/family about the condition: the patient with psychosis often lacks insight into the illness and may be hostile towards carers and health care workers. S/he may have difficulty functioning, especially in high stress environments.
- Emphasize the importance of adherence with medication.
- Encourage patient to resume social, educational and work activities as appropriate. Work with local agencies to find educational or employment opportunities.
- Explore housing/assisted living support if needed and available.
- Refer for support group and cognitive behavioural therapy if available.
- People with psychosis are often discriminated against. Always consider protection of the patient’s human rights and the need to avoid institutional care.

**Treat the patient with psychosis**

- Refer the patient with bipolar disorder to a psychiatrist for care.
- Initiation, titration and withdrawal is best done by a psychiatrist.
- Use intramuscular antipsychotic medication if patient is not adherent to oral medication and needs long term treatment.

<table>
<thead>
<tr>
<th>Drug</th>
<th>Starting dose</th>
<th>Maintenance dose</th>
<th>Note</th>
</tr>
</thead>
<tbody>
<tr>
<td>Haloperidol</td>
<td>1.5–10mg oral as a single dose or in 2 divided doses. If &gt; 60 years start at lower dose and increase more gradually.</td>
<td>Usually 2–10mg per day.</td>
<td>Minimal anticholinergic side effects.</td>
</tr>
<tr>
<td>Chlorpromazine</td>
<td>25mg oral twice daily</td>
<td>Usually 75–300mg daily but 1000mg may be needed. Once symptoms are controlled, give as a single bedtime dose.</td>
<td>One of the most sedating antipsychotics.</td>
</tr>
<tr>
<td>Fluphenazine decanoate</td>
<td>12.5mg deep intramuscular injection</td>
<td>Usually 25–50mg every 4 weeks.</td>
<td>Full response can take 2 months.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Fewer anticholinergic side effects than chlorpromazine.</td>
</tr>
<tr>
<td>Flupenthixol decanoate</td>
<td>20mg deep intramuscular injection</td>
<td>Usually 60mg every 4 weeks.</td>
<td>Full response can take 2 months.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Fewer anticholinergic side effects than chlorpromazine.</td>
</tr>
<tr>
<td>Zuclopenthixol decanoate</td>
<td>100mg deep intramuscular injection</td>
<td>Usually 200–400mg every 4 weeks.</td>
<td>Full response can take 2 months.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Fewer anticholinergic side effects than chlorpromazine.</td>
</tr>
</tbody>
</table>

**Refer if any side effects develop on antipsychotic medication**

- Anticholinergic side effects: dry mouth, blurred vision, constipation, urinary retention, worsening of closed angle glaucoma
- Extrapyramidal side effects:
  - Acute dystonic reactions (often painful muscle spasms) may appear within 24-48 hours of starting medication. Give biperiden 2mg IM, repeat every 30 minutes to maximum 4 doses in 24 hours. Refer patient same day for further management.
  - Parkinsonian signs (bradykinesia, tremor, rigidity) may occur after weeks or months on treatment, more commonly in elderly patients. Give orphenadrine 50mg up to 3 times a day.
  - Akathisia (motor restlessness) may occur after days or weeks of treatment.
  - Tardive dyskinesia (persistent involuntary movements) may occur after months (usually more than 6 months) of treatment.
DEMENTIA

DEMENTIA: DIAGNOSIS

Ensure a doctor confirms the diagnosis of dementia. Consider dementia in the patient who for at least 6 months:
- Has problems with memory. Test by asking patient to repeat 3 common words immediately and then again after 5 minutes.
- Is disoriented for time (unsure what day/season it is) and place (unsure of shop closest to home or where the consultation is taking place).
- Experiences difficulty with speech and language – unable to name parts of the body.
- Struggles with simple tasks, decision making and carrying out daily activities.
- Is less able to cope with social and work function.
- If patient has HIV, has difficulty with coordination.

DEMENTIA: ROUTINE CARE

Assess the patient with dementia

<table>
<thead>
<tr>
<th>Assess</th>
<th>When to assess</th>
<th>Note</th>
</tr>
</thead>
<tbody>
<tr>
<td>Symptoms</td>
<td>At diagnosis, every visit</td>
<td>• Check for new symptoms and manage as per symptom pages.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• If recent change in mood, energy/interest levels, sleep or appetite, consider depression and refer. Assess risk for self-harm D 49.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• If patient has hallucinations, delusions, agitation, aggression or wandering refer to psychiatrist.</td>
</tr>
<tr>
<td>Vision/hearing problems</td>
<td>At diagnosis, every visit</td>
<td>Manage poor vision or hearing with proper devices.</td>
</tr>
<tr>
<td>Nutritional status</td>
<td>At diagnosis, every visit</td>
<td>Ask about food and fluid intake. Arrange nutritional support if BMI &lt; 18.5.</td>
</tr>
<tr>
<td>Cardiovascular disease</td>
<td>At diagnosis</td>
<td>Assess CVD risk D 68. Ask about previous stroke/TIA, chest or leg pain.</td>
</tr>
<tr>
<td>HIV</td>
<td>At diagnosis</td>
<td>• HIV-associated dementia may improve on ART. If status unknown, test for HIV D 60.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• If HIV give routine care D 61 and test for coordination problems: with non-dominant hand as quickly as possible (allow patient to practice twice):</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Open and close the first 2 fingers widely.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- On a flat surface, clench a fist, then place palm down, then on the side of the 5th digit.</td>
</tr>
<tr>
<td>Syphilis</td>
<td>At diagnosis</td>
<td>Refer the RPR positive patient with dementia.</td>
</tr>
<tr>
<td>Thyroid</td>
<td>At diagnosis</td>
<td>Refer if result is abnormal.</td>
</tr>
</tbody>
</table>

Advise the patient with dementia and his/her carer

• Discuss what can be done to support the patient, carer/s and family. Identify local resources, social worker, counsellor, NGO, helpline D back page.
• Discuss with carer if respite or institutional care is needed. Advise the carer/s to:
  - Give regular orientation information (day, date, weather, time, names)
  - Try to stimulate memories with newspaper, radio, TV, photos.
  - Use simple short sentences.
  - Avoid changes in routine.
  - Plan daily activities that assist the person to be independent.
  - Remove clutter in the environment.
  - Regulate fluid intake to deal with incontinence.
  - Maintain physical activity.

Treat the patient with dementia

• HIV-associated dementia often responds well to ART D 61.
• Treat aggressive or violent behaviour towards self or others D 50.
• Treat agitation, distressing behaviour, psychotic symptoms with haloperidol 0.5–1mg up to twice daily.
• If the patient is fitting ≥ 2 to control the fit. If the patient is not known with epilepsy and has had a fit ≥ 2 to assess and manage further.

• Epilepsy is a doctor diagnosis in the patient who has had at least 2 definite fits with no identifiable cause or 1 fit following TB meningitis, stroke or head trauma.

### EPILEPSY: ROUTINE CARE

#### Assess the patient with epilepsy

<table>
<thead>
<tr>
<th>Assess</th>
<th>When to assess</th>
<th>Note</th>
</tr>
</thead>
<tbody>
<tr>
<td>Symptoms</td>
<td>Every visit</td>
<td>Manage symptoms as on symptom page.</td>
</tr>
<tr>
<td>Fit frequency</td>
<td>Every visit</td>
<td>Review fit diary. Assess if fits prevent patient from leading a normal lifestyle.</td>
</tr>
<tr>
<td>Adherence</td>
<td>Every visit, if fits occur</td>
<td>Assess attendance, pill counts and if still fitting on treatment, drug level (doctor decision).</td>
</tr>
<tr>
<td>Side effects</td>
<td>Discuss at diagnosis, every visit</td>
<td>Side effects often explain poor adherence. Patient may need to weigh side effects with fit control.</td>
</tr>
<tr>
<td>Other medication</td>
<td>If fits occur</td>
<td>Check if patient has started other medication like TB treatment, ART or oral contraceptive. See below.</td>
</tr>
<tr>
<td>Substance abuse</td>
<td>At diagnosis, if fits occurs or adherence poor</td>
<td>&gt; 21 drinks/week (man) or &gt; 14 drinks/week (woman) and/or &gt; 5 drinks/session or misuse of illicit or prescription drugs 83.</td>
</tr>
</tbody>
</table>
| Family planning | Every visit | • Refer if patient is pregnant or planning to be, for epilepsy and antenatal care.  
• Assess family planning needs: avoid oral contraceptives on carbamazepine or phenytoin 91. |
| Drug level | Only if needed | Doctor to check drug level if unsure about adherence or on higher than maximum dose of phenytoin. |

#### Advise the patient with epilepsy

- Educate about epilepsy and stress the importance of adherence to treatment. Advise patient to keep a fits diary to record frequency dates and times of fits.
- Refer for social support if necessary (Epilepsy South Africa) and help patient to get a Medic Alert bracelet back page.
- Advise avoiding sleep deprivation, alcohol and drug use, dehydration, flashing lights and video games. These may trigger a fit.
- Avoid dangers like heights, fires, swimming alone, cycling on busy roads, operating machinery. Avoid driving until fit free for 1 year.
- Advise patient there are many drugs that interfere with anti-convulsant treatment (see below) and to discuss with doctor when starting any new medication.

#### Treat the patient with epilepsy

- A single drug is best. Giving 2 anti-convulsant drugs together is a specialist decision.
- If still fitting on treatment increase dose only if patient is adherent and there is no substance abuse.
- If still fitting after 4 weeks on maximum dose or side effects intolerable, add new drug and increase 2 weekly until fit free. Then taper off old drug over 1 month.

<table>
<thead>
<tr>
<th>Drug</th>
<th>Dose</th>
<th>Note</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phenytoin</td>
<td>Starting dose and usual dose: 300mg daily. If not controlled, increase by 50mg 2 weekly and check drug level.</td>
<td>Avoid in women as it can cause facial hair/coarse facial features. Side effects: skin rash, slurred speech, drowsiness. Drug interactions: isoniazid, warfarin, furosemide, oral contraceptive, ART.</td>
</tr>
<tr>
<td>Carbamazepine</td>
<td>Start 100mg 12 hourly. Increase daily dose by 100mg every week until controlled. Usual dose: 300–600mg 12 hourly.</td>
<td>Side effects: skin rash, blurred or double vision, ataxia, nausea. Drug interactions: isoniazid, warfarin, fluoxetine, theophylline, amitriptyline, oral contraceptives, ART.</td>
</tr>
<tr>
<td>Lamotrigine</td>
<td>25mg daily for 2 weeks, then 50mg daily for 2 weeks. Then increase by 50mg 2 weekly until controlled. Usual dose: 100–200mg/day as single dose.</td>
<td>Use in HIV. Increase dose if fits on TB treatment or lopinavir/ritonavir. Side effects: skin rash, blurred or double vision. Drug interactions: paracetamol, rifampicin, ART.</td>
</tr>
</tbody>
</table>

- If fit free review 6 monthly. Doctor should review monthly the patient who is fitting until fit frequency improves. Refer if still fitting after maximum doses of 2 drugs for 4 weeks each.
- Doctor can consider with patient stopping treatment if no fits for 2 years: gradually withdraw 1 drug at a time over 2–3 months.
### CHRONIC ARTHRITIS: DIAGNOSIS

- If patient has discrete episodes of joint pain and swelling that completely resolve in between, consider gout → 89.
- The most common chronic arthritis (lasting > 8 weeks) is osteoarthritis. Rheumatoid arthritis is the most common form of chronic inflammatory arthritis:

**Osteoarthritis**
- Affects joints only.
- Weight-bearing joints and maybe hands and feet.
- Joints may be swollen but not warm.
- Stiffness on waking lasts less than 30 minutes.
- Pain is worse with activity and improves with rest.

**Inflammatory arthritis**
- Can be systemic: weight loss, fatigue, poor appetite, muscle wasting.
- Hands and feet are mainly involved.
- Joints are swollen and warm.
- Stiffness on waking lasts more than 30 minutes.
- Pain and stiffness improve with activity.

Refer the patient with probable inflammatory arthritis or an unclear diagnosis for specialist assessment.

### CHRONIC ARTHRITIS: ROUTINE CARE

#### Assess the patient with chronic arthritis

<table>
<thead>
<tr>
<th>Assess</th>
<th>When to assess</th>
<th>Note</th>
</tr>
</thead>
<tbody>
<tr>
<td>Symptoms</td>
<td>Every visit</td>
<td>Manage symptoms as on symptom pages.</td>
</tr>
<tr>
<td>Activities of daily living</td>
<td>Every visit</td>
<td>Ask if patient can walk as well as before, can cope with buttons and use knife and fork properly.</td>
</tr>
<tr>
<td>Sleep</td>
<td>Every visit</td>
<td>If patient has problems sleeping → 54.</td>
</tr>
<tr>
<td>Depression</td>
<td>Every visit</td>
<td>If low mood or sadness, loss of interest or pleasure, feeling tense, worrying a lot or not coping as well as before, consider depression/anxiety → 81.</td>
</tr>
<tr>
<td>Joints</td>
<td>Every visit</td>
<td>Look for warmth and tenderness of joints.</td>
</tr>
<tr>
<td>BMI</td>
<td>At diagnosis</td>
<td>Calculate BMI: weight (kg)/[height (m) x height (m)] &gt; 25 is overweight and puts stress on weight-bearing joints. Assess patient’s CVD risk → 68.</td>
</tr>
<tr>
<td>Blood monitoring</td>
<td>If on disease modifying anti-rheumatic drugs</td>
<td>Ensure the patient using disease modifying drugs knows to have regular blood monitoring depending on the prescribed drugs from the specialist clinic.</td>
</tr>
</tbody>
</table>

#### Advise the patient with chronic arthritis

- If BMI > 25 advise to reduce weight to decrease stress on weight-bearing joints like knees and feet. Help patient to manage CVD risk → 69.
- Encourage the patient to be as active as possible, but to rest with acute flare-ups.
- Refer patient and carer for education about chronic arthritis, to available support group and helpline → back page.

#### Treat the patient with chronic arthritis

- Refer to physiotherapist or occupational therapist if rheumatoid arthritis and/or difficulty with activities of daily living.
- Give **paracetamol** 1g 6 hourly. If no response and inflammation is present in the patient with osteoarthritis, give **ibuprofen** 200–400mg 8 hourly after meals only as needed up to 1 month.
- Give **amitriptyline** 25mg night, 10mg if patient > 65 years.
- Rheumatoid arthritis must be treated early with disease modifying anti-rheumatic drugs to control symptoms, preserve function, and minimise further damage.
- If inflammatory arthritis likely, start **prednisone** 7.5mg daily and refer for hospital outpatient appointment.

Review monthly till symptoms controlled, then 3–6 monthly. Refer patient to a specialist if poor response to treatment.
GOUT

- Gout is a metabolic disease where uric acid crystals are deposited in the joints. It occurs most commonly in men over 40 years and post-menopausal women.
- Acute gout tends to affect 1 joint (often big toe, knee or ankle) and to recover completely.
- In chronic gout, many joints may be affected and they may not be very painful, but there is incomplete recovery in between.

GOUT: ROUTINE CARE

Assess the patient with gout

<table>
<thead>
<tr>
<th>Assess</th>
<th>When to assess</th>
<th>Note</th>
</tr>
</thead>
<tbody>
<tr>
<td>Symptoms</td>
<td>Every visit</td>
<td>Manage symptoms as per symptom pages.</td>
</tr>
<tr>
<td>Substance abuse</td>
<td>At diagnosis</td>
<td>&gt; 21 drinks/week (man) or &gt;14 drinks/week (woman) and/or &gt; 5 drinks/session or misuse of illicit or prescription drugs →83.</td>
</tr>
<tr>
<td>Medication</td>
<td>Acute attacks</td>
<td>Hydrochlorothiazide, ethambutol, pyrazinamide and aspirin can all induce acute gout attacks. Discuss with doctor.</td>
</tr>
</tbody>
</table>
| Joints          | Every visit    | • Recognise the acute gout attack: Sudden onset of 1–3 hot, extremely painful, swollen joints with red, shiny overlying skin (often big toe, knee or ankle).
|                 |                | • Tophaceous gout appears as painless yellow hard irregular lumps around the joints (picture). |
| CVD risk        | At diagnosis   | Assess cardiovascular disease risk → 68. If BMI < 25 or < 40 years, refer within 1 month to exclude possible cancer cause for gout. |
| eGFR            | At diagnosis   | If eGFR < 50, refer.                                                 |
| Urate           | At diagnosis and with allopurinol | Normal is ≤ 0.3. The patient needs allopurinol if urate > 0.5. Adjust allopurinol dose until urate < 0.3. |

Advise the patient with gout

- Help the patient to manage his/her cardiovascular disease risk → 69.
- Give dietary advice:
  - Avoid fizzy drinks, alcohol, red meat, liver, kidneys, turkey, crayfish, sardines and anchovy.
  - Avoid fasting.
  - Drink at least 2ℓ of fluids a day.
- Advise bed rest until the pain subsides.
- Advise patient there are drugs that may induce a gout attack, like aspirin and to discuss with doctor when starting any new medication.

Treat the patient with an acute gout attack

- Give ibuprofen 800mg after food 8 hourly for 1–2 days. Then ibuprofen 400mg 8 hourly until pain and swelling are improved.
- If patient has peptic ulcer, asthma, hypertension, heart failure or kidney disease, give prednisone 40mg daily for 3–5 days instead of ibuprofen.
- If patient is already using allopurinol, do not stop it during the acute attack.

Treat the patient with chronic gout

- Patient needs allopurinol if: > 2 attacks per year, chronic tophaceous gout (picture), kidney stones, kidney disease, serum urate > 0.5.
- Give allopurinol 100mg once daily. Do not start allopurinol during or for 3 weeks after an acute attack.
- Increase by 100mg monthly until serum urate < 0.3 or the maximum dose of 400mg.

Refer patient to specialist if no response to treatment or unsure about diagnosis.
Consider fibromyalgia if the patient has had general body pain that waxes and wanes for more than 3 months associated with the following:
- Multiple tender points (see picture)
- The pain is often worsened by lack of sleep, stress, cold, fatigue, physical exertion.
- There may be stiffness, fatigue, poor sleep (sleeping lightly and waking frequently), depression, tender skin, irritable bowel, poor memory, headaches, Raynaud's phenomenon, dizziness, restless legs, easy bruising, urinary frequency, numbness, tingling or swelling of hands.
- The patient may be sensitive to food and medication.

A doctor must confirm the diagnosis of fibromyalgia
- Press the tender points in the picture with the pressure that would blanch a fingernail. Compare with a control site on forehead.
- Check temperature and weight. If temperature ≥ 38°C →4 or weight loss →3 and consider another diagnosis.
- Screen for a joint problem: patient to place hands behind head; then behind back. Bury nails in palm and open hand. Press palms together with elbows lifted. Walk. Sit and stand up with arms folded. If unable to do screen comfortably →33.
- Check CRP, glucose →70, TSH, Hb, eGFR, and HIV if status unknown →60.
- Refer to consider another diagnosis if joint problem, HIV positive, blood results abnormal or unsure of diagnosis.

Assess the patient with fibromyalgia

<table>
<thead>
<tr>
<th>Assess</th>
<th>When to assess</th>
<th>Note</th>
</tr>
</thead>
</table>
| Symptoms | Every visit    | • Manage symptoms as on symptom pages. Ask patient to identify the 3 symptoms that bother her/him most and focus on these.  
• Do not dismiss all symptoms as fibromyalgia: exclude treatable and serious illness. If unsure, refer. |
| Sleep    | Every visit    | If patient has problems sleeping →54.                              |
| Depression| Every visit    | If low mood or sadness, loss of interest or pleasure, feeling tense or anxious or worrying a lot about things, consider depression/anxiety →81. |
| Stressors| Every visit    | Help identify the psychosocial stressors that may exacerbate symptoms. If patient is being abused →53. |

Advise the patient with fibromyalgia
- Educate patient about fibromyalgia as above. Fibromyalgia tends to wax and wane over years.
- Advise patient to keep as active as possible.
- Encourage patient to involve the family and refer to available support group and helpline →back page.
- Encourage the patient to adopt sensible sleep habits →54.

Treat the patient with fibromyalgia
- Give paracetamol 1g 6 hourly as needed.
- Give amitriptyline 25mg taken at 6pm every night for 3 months. If still symptomatic, increase dose to 50mg.
- If still symptomatic after 3 months, add fluoxetine 20mg in the morning. If still symptomatic after 3 months, add ibuprofen 200mg 3 times a day with food.

A supportive relationship with the same health practitioner can contain frequent visits for multiple problems. Review patient 6 monthly once stable.
CONTRACEPTION

**Give emergency contraception if patient had unprotected sex in past 5 days and does not want pregnancy:**
- First exclude pregnancy. If pregnant do not give emergency contraception →93.
- Give ideally within 24 hours of unprotected sex: levonorgestrel 0.75mg 2 tablets once or norgestrel/ethinyl oestradiol 0.5/0.05mg 2 tablets and repeat after 12 hours. Offer to start injectable/oral contraceptive at same visit.
- If patient chooses, insert emergency CuT 380A intrauterine device instead.

**Help patient to choose contraception method**
- Recommend dual contraception: one method below plus condoms to protect from STIs and HIV.
- In the menopausal patient: if < 50 years, give contraception for 2 years after last period; if ≥ 50 years, for 1 year after last period →98.

<table>
<thead>
<tr>
<th>Method</th>
<th>Help patient to choose method</th>
<th>Instructions for use</th>
<th>Side effects</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Intrauterine device (IUCD)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• CuT 380A</td>
<td>• Effective for 10 years</td>
<td>• Insert within first 12 days of cycle. If later, exclude pregnancy first.</td>
<td>• Periods may be heavier, longer or more painful. Refer if excessive bleeding occurs after insertion, or if tired and Hb &lt; 10.</td>
</tr>
<tr>
<td>• Levonorgestrel (two-rod: 5 years)</td>
<td>• Fertility returns on removal. Avoid if patient has multiple partners, had an STI in past 3 months or heavy periods</td>
<td>• Avoid if abnormal cervix/uterus.</td>
<td></td>
</tr>
<tr>
<td><strong>Subdermal implant</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Levonorgestrel (one-rod: 3 years)</td>
<td>• lasts for 3–5 years depending on implant type.</td>
<td>• Small plastic rod placed just under skin of upper arm. Must be inserted/removed by trained staff.</td>
<td>• Wound pain, bleeding, swelling or discharge. refer.</td>
</tr>
<tr>
<td>• Levonorgestrel (two-rod: 5 years)</td>
<td>• Fertility returns without delay after removal. Avoid if current or past breast cancer or if on certain medications.</td>
<td>• Use condoms for 7 days after insertion.</td>
<td>• Irregular bleeding or amenorrhoea: reassure this is common.</td>
</tr>
<tr>
<td><strong>Injectable contraceptive</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Progestosterone injection</td>
<td>• 8 or 12 weekly injection</td>
<td>• Can start any time in menstrual cycle: if after day 5 of cycle, need to use condoms for 7 days.</td>
<td>• Amenorrhoea: reassure that this is common.</td>
</tr>
<tr>
<td>• Triphasic: levonorgestrel/ethinyl oestradiol (0.15/0.03mg)</td>
<td>• Fertility returns 4–6 months after last injection. Avoid if current or past breast cancer.</td>
<td>• No need to adjust dosing interval for HIV, TB or epilepsy treatment. Remind patient to use condoms to prevent HIV and STIs.</td>
<td>• Mild headaches, nausea, dizziness, breast tenderness: reassure that these should resolve.</td>
</tr>
<tr>
<td>• Combined progestone/oestrogen pill</td>
<td>• If motivated to take pill daily at the same time. Fertility returns once pill is stopped. Avoid if unlikely to take pill reliably, on certain medications, current or previous breast cancer, heart or liver disease.</td>
<td>• Must be taken every day at the same time. Use condoms for 7 days if started after day 5 of cycle. Advise patient with diarrhoea/vomiting or on antibiotics to use condoms during illness and for 7 days thereafter.</td>
<td>• Moodiness: reassure that this should resolve.</td>
</tr>
<tr>
<td>• Progestone only pill</td>
<td>• Levonorgestrel 0.03mg</td>
<td>• Take same time every day (no more than 3 hours late). Start any time in cycle, use condoms for next 7 days. If breastfeeding, start 6 weeks postpartum.</td>
<td>• Abdominal pain – refer if pain severe or persists.</td>
</tr>
<tr>
<td><strong>Sterilisation</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Woman: tubal ligation</td>
<td>• Permanent contraception</td>
<td>• Refer for assessment</td>
<td>• Wound pain, swelling or bleeding: refer.</td>
</tr>
<tr>
<td>• Man: vasectomy</td>
<td>• Surgical procedure</td>
<td>• Written informed consent required</td>
<td></td>
</tr>
</tbody>
</table>

1Phenytoin, carbamazepine, rifampicin, lopinavir/ritonavir may reduce the efficiency of contraceptive.
CONTRACEPTION: ROUTINE CARE

**Assess the patient starting and using contraception**

- Follow up the patient on pill after 3 months, thereafter 6 monthly. Follow up patient with IUCD, 6 weeks after insertion to check strings, thereafter yearly.

<table>
<thead>
<tr>
<th>Assess</th>
<th>When to assess</th>
<th>Note</th>
</tr>
</thead>
</table>
| Symptoms        | First and every visit | • Ask about side effects of contraceptive method \[91.2\].  
• Check for symptoms of STIs: vaginal discharge, ulcers, lower abdominal pain. If present \[23.2\]. If sexual problems \[30.2\].  
• If > 45 years ask about menopausal symptoms: flushing, irregular periods, irritability, tiredness, mood changes \[98.2\].  
• Manage other symptoms as on symptom pages. |
| Adherence       | Every visit     | • Ask about concerns and satisfaction with method.  
• If patient has missed injections or pills, see below to manage. |
| Safe sex        | First and every visit | Ask about concerns and satisfaction with method.  
• If patient has missed injections or pills, see below to manage. |
| Medication changes | First and every visit | If started TB treatment or anticonvulsants switch to IUCD or injectable contraceptive plus condoms. |
| Vaginal bleeding | First and every visit | • Before starting contraception: exclude pregnancy if missed period. If abnormal vaginal bleeding \[29.2\].  
• If on contraception exclude pregnancy if missed period if using IUCD or combined pill.  
• IUCD and hormonal methods may cause abnormal bleeding. See method to manage \[29.2\]. |
| Breast check    | First visit and yearly on pill | If any lumps found in breasts or axillae, refer same week to breast clinic. |
| Weight          | First and every visit | If BMI > 25 assess CVD risk \[68.2\]. If using two-rod implant and weight ≥ 80kg, replace implant after 4 years instead of 5 years. |
| BP              | First and every visit on pill | If BP ≥ 130/80 \[73.2\] to interpret result. If BP ≥ 140/90 avoid/change from combined pill. |
| HIV             | First and every visit | If status unknown test for HIV \[60.2\]. The HIV patient needs routine HIV care \[61.2\]. |
| Pap smear       | When needed     | If HIV negative, 3 smears 10 years apart from age 30. The HIV patient needs smear at diagnosis then yearly if normal \[27.2\]. |

**Advertise the patient starting and using contraception**

- Advise patient to discuss concerns, problems with contraceptive method and find an alternative, rather than just stopping it and risking an unwanted pregnancy.
- Demonstrate and give male/female condoms. Recommend dual contraception: one method of contraception plus condoms to protect from STIs and HIV.
- Educate about the availability of emergency contraception \[91.2\] and termination of pregnancy \[94.2\] to prevent unwanted pregnancy.
- Encourage patient to have 1 partner at a time and if HIV negative to test for HIV between partners. Advise partner/s to be tested for HIV.
- Advise patient on pill to tell clinician if starting TB or epilepsy treatment: may interfere with pill effectiveness. If diarrhoea/vomiting or on antibiotics use condoms during illness and for 7 days thereafter.
- Educate patient to use contraception reliably. If patient has missed pills or injections:

**Late injection**

- < 2 weeks late: give injection, there is no loss of protection.
- ≥ 2 weeks late: exclude pregnancy. If pregnant \[93.2\]. If not pregnant, give injection and use condoms for 7 days.
- If unable to exclude pregnancy give progestrone-only pill and condoms for 2 weeks, then give injection if pregnancy test negative.

**Missed/late progestrone only pill**

- Pill missed or > than 3 hours late: take pill as soon as possible and continue pack and use condoms for 48 hours.
- If ≤ 5 days since unprotected sex, give emergency contraception \[91.2\].

**Missed combined oral contraceptive pill**

- 1 active pill missed: take pill as soon as remembered and take next 1 at usual time.
- 2 active pills missed: take last missed pill as soon as remembered and next 1 at usual time. Use condoms or abstain for next 7 days.
- 2 or more pills missed in last 7 active pills of pack: omit the inactive tablets and immediately start first active pill of next pack.
- 2 or more pills missed in first 7 active pills of pack and patient has had sex: give emergency contraception \[91.2\], restart active pills 12 hours later and use condoms for next 7 days.
THE PREGNANT PATIENT

Provide routine antenatal care to the pregnant patient not needing urgent attention →94.

Recognise the pregnant patient needing urgent attention:

- Fitting
- Diastolic BP ≥ 110 and proteinuria: treat as pre-eclampsia
- Diastolic BP ≥ 90 and headache, blurred vision or abdominal pain: treat as imminent eclampsia
- Temperature ≥ 38°C and headache, weakness or back pain
- Difficulty breathing

Management:
- If fitting or having difficulty breathing give 40% face mask oxygen. See below.
- If BP < 90/60 give IV sodium chloride 0.9% rapidly until BP > 90/60.
- If temperature ≥ 38°C give ceftriaxone1 1g IM/IV, if unavailable amoxicillin 1g orally. If also a vaginal discharge in 2nd or 3rd trimester, give metronidazole 400mg orally as well.
- Manage further according to problem and refer same day:
  - Swollen red calf
  - Vaginal bleeding
  - Decreased/no fetal movements
  - Preterm labour: painful contractions, 3 per 10 minutes < 37 weeks
  - Preterm prelabour rupture of membranes < 34 weeks

Fitting
- Place patient in a lateral lying position.
- Avoid placing anything in the mouth.
- Give 40% facemask oxygen.
- Check glucose. If < 3.5 or unable to measure, give 50mℓ of 50% dextrose IV.
- Give dextrose 5% in sodium chloride 0.9% IV slowly (30 drops per minute).
- Manage further according to gestation:
  - < 20 weeks - up to 1 week post partum: Patient has eclampsia.
  - ≥ 20 weeks - up to 1 week post partum: Patient has eclampsia.

Preterm labour
- Determine duration of pregnancy.
- Refer into MOU.

Preterm labour
- < 26 weeks
- 26–33+ weeks
- ≥ 34 weeks
- Give betamethasone 12mg IM, record time given in referral letter.
- Give sodium chloride 0.9% 300mℓ IV.
- Then give nifedipine 20mg oral, then 10mg after 30 minutes, then 10mg 4-hourly until transferred.
- Refer same day.
- Allow labour to continue.

Preterm prelabour rupture of membranes
- ≥ 34 weeks
- Confirm amniotic fluid leak with sterile speculum, liquor is alkaline.
- Avoid digital vaginal examination.
- Give betamethasone 12mg IM, record time given in referral letter.
- Refer same day.

Severe pre-eclampsia/ imminent eclampsia
- Give sodium chloride 0.9% 200mℓ slowly IV.
- If diastolic BP still ≥ 110, give nifedipine 10mg to swallow (not chew).
- Repeat BP after 30 minutes. If diastolic BP still ≥ 110, repeat nifedipine 10mg.
- If imminent eclampsia: give magnesium sulphate loading dose and infusion before referral.

- Give magnesium sulphate 4g in 200mℓ sodium chloride 0.9% IV over 20 minutes and 5g IM in each buttock. Repeat 5g IM 4 hourly in alternate buttocks till transferred to hospital.
- Insert urethral catheter.
- Stop magnesium sulphate if urine output < 100mℓ in 4 hours or respiratory rate < 16 breaths/minute.
- Refer urgently.

1 Do not mix Ringer’s lactate and IV ceftriaxone. Flush IV line with sodium chloride 0.9% before and after IV ceftriaxone.
# THE PREGNANT PATIENT

## Does the patient want the pregnancy?

<table>
<thead>
<tr>
<th>No or unsure</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Discuss the options around continuing with pregnancy, choosing adoption or termination of pregnancy (TOP). Refer to social worker.</td>
<td></td>
</tr>
<tr>
<td>- Discuss future contraception 91.</td>
<td></td>
</tr>
<tr>
<td>- Determine gestational age by dates and on examination.</td>
<td></td>
</tr>
</tbody>
</table>

### Patient requests a TOP:

<table>
<thead>
<tr>
<th>&lt; 20 weeks</th>
<th>≥ 20 weeks</th>
</tr>
</thead>
<tbody>
<tr>
<td>- &lt; 13 weeks: book for an on-demand TOP &lt; 13 weeks.</td>
<td></td>
</tr>
<tr>
<td>- ≥ 13 weeks: book for assessment for TOP as soon as possible &lt; 20 weeks.</td>
<td></td>
</tr>
<tr>
<td>- TOP not an option.</td>
<td></td>
</tr>
<tr>
<td>- Discuss possibility of adoption.</td>
<td></td>
</tr>
<tr>
<td>- Give routine antenatal care.</td>
<td></td>
</tr>
</tbody>
</table>

### Identify the pregnant patient who needs secondary level antenatal care:

- Current medical problems: diabetes, heart/kidney disease, asthma, epilepsy, on TB treatment, substance abuse, diastolic BP > 90
- Current pregnancy problems: rhesus negative, multiple pregnancy, currently < 16 or > 36 years, vaginal bleeding or pelvic mass
- Previous pregnancy problems: stillbirth or neonatal loss, > 3 consecutive spontaneous abortions, birth weight < 2500g or > 4500g, admission for pre-eclampsia
- Previous admission for hypertension or reproductive tract surgery

---

If not needing secondary level antenatal care, plan patient's routine antenatal care in primary care facility 95.
# ROUTINE ANTENATAL CARE

Assess the pregnant patient at booking visit and 4 follow-up visits at 20, 26–28, 32–34, 38 weeks.

<table>
<thead>
<tr>
<th>Assess</th>
<th>When to assess</th>
<th>Note</th>
</tr>
</thead>
<tbody>
<tr>
<td>Symptoms</td>
<td>Every visit</td>
<td>Manage symptoms as per symptom page.</td>
</tr>
<tr>
<td>Estimated delivery date</td>
<td>Booking visit</td>
<td>• Plot on antenatal card.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• If patient ≥ 42 weeks, confirm EDD and symphysis-fundal measurement and refer for fetal evaluation and possible induction of labour.</td>
</tr>
<tr>
<td></td>
<td>Every visit</td>
<td>• If cough ≥ 2 weeks, weight loss, poor weight gain or anaemia, check for TB [55].</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• If patient has TB refer for secondary hospital antenatal care.</td>
</tr>
<tr>
<td>Mental health</td>
<td>Every visit</td>
<td>• If 2 or more of: a difficult major life event in last year, unhappy about pregnancy, absent or unsupportive partner, previous depression or anxiety, or experiencing violence at home, screen for depression/anxiety [53]. See also traumatised/abused patient [53].</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• &gt; 14 drinks/week, &gt; 5 drinks/session or misusing illicit or prescription drugs, screen for substance abuse [83]. Refer for secondary hospital antenatal care.</td>
</tr>
<tr>
<td>Mid upper arm circumference</td>
<td>Booking visit</td>
<td>• MUAC &lt; 23cm: exclude TB and HIV, check weight at every visit, refer for nutritional support.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• MUAC &gt; 33cm: continue routine antenatal care but deliver at secondary hospital. Assess and manage CVD risk [68].</td>
</tr>
<tr>
<td>Abdominal examination</td>
<td>Every visit</td>
<td>• If mass other than uterus in abdomen or pelvis, refer for assessment.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Measure symphysis-fundal distance and plot on antenatal card. Refer for assessment if discrepancy with EDD, &lt;10th or &gt; 90th centiles, or multiple pregnancy likely.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Look for breech presentation. If present at 32/34 and 38 weeks, refer to high risk clinic.</td>
</tr>
<tr>
<td>Vaginal discharge</td>
<td>Every visit</td>
<td>• If abnormal discharge, treat for STI [23]. If discharge is runny, suspect premature rupture of membranes [93].</td>
</tr>
<tr>
<td>BP</td>
<td>Every visit</td>
<td>BP is normal if &lt; 140/90. If raised, repeat after 1 hour rest. If 2nd BP normal, repeat BP after 2 days. If 2nd BP still raised: check urine dipstick for protein:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• No proteinuria: start methyldopa 250mg 8 hourly and refer same week to high risk clinic.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• ≥ 1+ proteinuria: refer patient same day. If abdominal pain, blurred vision, headache, treat for pre-eclampsia [93].</td>
</tr>
<tr>
<td>Urine dipstick: test</td>
<td>Every visit</td>
<td></td>
</tr>
<tr>
<td>clean, midstream urine</td>
<td></td>
<td>• If leucocytes and nitrates in urine treat for complicated urinary tract infection [31].</td>
</tr>
<tr>
<td>Random blood glucose</td>
<td>If glucose in urine</td>
<td>• If random blood glucose ≥ 11: refer to high risk clinic same day. If glucose &gt; 15 and ketones in urine, give sodium chloride 0.9% IV 1ℓ 4 hourly and short-acting insulin 10IU IM.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• If random blood glucose 8–11, repeat blood glucose after an 8 hour fast.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Fasting blood glucose 6–8: assess and manage CVD risk [68]. Refer to high risk clinic for next antenatal visit.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Fasting blood glucose ≥ 8: refer to high risk clinic same day.</td>
</tr>
<tr>
<td>Haemoglobin</td>
<td>Booking visit and if patient pale</td>
<td>Refer to high risk clinic if &lt; 34 weeks and Hb &lt; 8, or ≥ 34 weeks and Hb &lt; 10.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Treat if Hb &lt; 10 [96]. Repeat Hb monthly.</td>
</tr>
<tr>
<td>Rapid rhesus</td>
<td>Booking visit</td>
<td>If rhesus negative refer to high risk clinic.</td>
</tr>
<tr>
<td>Rapid syphilis</td>
<td>Booking visit</td>
<td>If positive do RPR and give benzathine penicillin 2.4MU IM single dose and see in 1 week for result [28].</td>
</tr>
<tr>
<td>HIV</td>
<td>Booking visit, 3 monthly and at 32 weeks if negative</td>
<td>• If status unknown test for HIV [60]. If patient refuses, offer at each visit, even in early labour.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• If HIV give routine HIV care [61]. If not on ART, do baseline bloods (CD4 and creatinine) and start ART same day [63]. Review within 1 week.</td>
</tr>
<tr>
<td>CD4, stage</td>
<td>Booking visit if HIV not on ART</td>
<td>• If CD4 &gt; 350 and stage 1 or 2: continue ART as prophylaxis through antenatal, delivery and postnatal care until 1 week after last breastfeed.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• If CD4 ≤ 350 or stage 3 or 4: continue ART as lifelong treatment.</td>
</tr>
<tr>
<td>Viral load</td>
<td>If on ART at booking visit</td>
<td>• If patient already on ART, check viral load at booking visit. If patient starting ART, check viral load at 6 months and then yearly.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• If viral load ≥ 400, discuss with specialist same day to consider switching ART regimen.</td>
</tr>
</tbody>
</table>
**Treat the pregnant patient**

- Give **folic acid** 5mg daily.
- Give iron according to Hb. Avoid tea within 2 hours of taking iron tablets.
  - If Hb ≥ 10 give **ferrous sulphate compound BPC** 170mg daily with food.
  - If Hb < 10 give **ferrous sulphate compound BPC** 170mg 8 hourly with food, continue for 3 months after Hb > 11, then continue once daily for duration of pregnancy.
- Give **elemental calcium** 500mg twice a day to reduce the risk of pre-eclampsia.
- Give the HIV patient:
  - *Influenza vaccine.*
  - If on ART, do not stop it.
  - If not on ART: start ART **same day** 63 and review in 1 week. Give **TDF/FTC/EFV** (FDC) 1 tablet daily if available. Avoid if depression, psychosis, known kidney disease, diabetes, hypertension or ≥ 2+ proteinuria: start **AZT** 300mg 12 hourly instead and refer to doctor.
  - If CD4 >350 and stage 1 or 2: continue ART as prophylaxis through antenatal, delivery and postnatal care until 1 week after last breastfeed.
  - If CD4 ≤ 350 or stage 3 or 4: continue ART as lifelong treatment.

**Advise the pregnant patient**

- Advise to stop smoking and to stop drinking alcohol.
- Discuss safe sex. Advise patient to use condoms throughout pregnancy and have only 1 partner at a time.
- Complete antenatal card and give to patient, remind patient to bring it to every visit and when in labour.
- Ensure patient knows the signs of a pregnancy emergency 93 and of early labour.
- Discuss contraception following delivery 91.
- Regardless of HIV status, encourage exclusive breastfeeding for 6 months: baby gets only breast milk (no formula, water, cereal) and if HIV-exposed, NVP and co-trimoxazole prophylaxis.
- If mother has HIV consider exclusive formula feeding only if affordable, feasible, acceptable, safe and sustainable. Check correct mixing. Discourage mixed feeding.
- From 6 months, introduce food while continuing with feeding choice. If HIV, continue breastfeeding until 1 year if mother on ART or baby on NVP and until 2 years if baby diagnosed HIV positive.

**Treat the HIV patient in labour**

- Give together during early labour: one tablet of **nevirapine** 200mg and one tablet of combined **TDF/FTC** 300mg/200mg.
- Continue **AZT** 300mg 3 hourly until delivery and then stop.

- **Give baby born to HIV positive mother** or to the mother whose HIV status is unknown **nevirapine** syrup (10mg/ml) as soon as possible after birth according to weight 1. If baby vomits within 1 hour, repeat once only at least 1 hour before discharge. Give nevirapine daily for 6 weeks.
- If baby born to mother whose HIV status is unknown, check rapid HIV test and if positive continue nevirapine for 6 weeks.

Give postnatal care to patient and baby 97.

---

1 **Nevirapine** (10mg/ml) syrup daily dose: 2–2.4kg: 0.5ml, 2.5–2.9kg: 0.6ml, 3–3.9kg: 0.7ml; 4–5.9kg: 1ml
POSTNATAL CARE

Assess the mother and her baby 6 hours, 6 days, and 6 weeks after delivery. If HIV, baby needs PMTCT follow-up within 2 weeks.

<table>
<thead>
<tr>
<th>Assess</th>
<th>When to assess</th>
<th>Note</th>
</tr>
</thead>
</table>
| Symptoms                | Every visit    | • Manage mother’s symptoms as on symptom page. Manage baby’s symptoms with IMCI guide.  
• If baby born with swollen eyelids and pus in eyes, give ceftriaxone 50mg/kg IM stat, saline washes hourly and refer urgently. Treat mother and partner for vaginal discharge 23. |
| Mental health           | Every visit    | • If patient not interacting with baby and/or 2 or more of: a difficult major life event in last year, unhappy about pregnancy, absent or unsupportive partner, previous depression or anxiety, or experiencing violence at home, screen for depression/anxiety 81. See also traumatised/abused patient 53.  
• If > 14 drinks/week or > 5 drinks/session or misusing illicit or prescription drugs, screen for substance abuse 83. |
| Family planning         | Every visit    | Assess patient’s family planning needs 91.                          |
| Infant feeding          | Every visit    | • Monitor baby’s weight as per IMCI guideline.  
• If breastfeeding, check for problems 18. If formula feeding ensure correct mixing and that it is affordable, feasible, acceptable, safe and sustainable. |
| Uterus                  | Every visit    | If painful abdomen, smelly vaginal discharge, temperature ≥ 38°C, give ceftriaxone 1g IM/M plus metronidazole 400mg orally and refer same day. |
| BP                      | Every visit    | If diastolic ≥ 90, recheck after 1 hour rest, if still raised or any of headache, abdominal pain, blurred vision, refer urgently. |
| BMI                     | Every visit    | Mother’s BMI is weight (kg)(height (m) x height (m)). If < 18.5, arrange nutritional support. |
| HIV in mother           | If not done    | If positive, give routine HIV care 61. If not on ART and breastfeeding, start ART same day 63. |
| HIV PCR in baby         | 4-6 weeks      | • If PCR positive, explain baby has HIV and needs ART urgently.  
• If PCR negative, repeat PCR 6 weeks after last breastfeeding (no need to repeat if not breastfed) and confirm HIV negative with rapid HIV test at 18 months. |
| Syphilis                | If not done    | If mother positive and not already treated, assess, advise and treat 28. Treat baby as on page 28. |
| Pap smear               | 6 weeks        | Check pap smear if > 30 years and not done in past 10 years. If HIV, check pap smear at diagnosis and yearly if normal 27. |

Advertise the mother

• Encourage mother to become active soon after delivery, rest frequently and eat well. Advise on perineal and wound care. Arrange support for the mother who has little support at home.  
• Advise to return urgently if excessive vaginal bleeding, sepsis, dizziness, severe headache, blurred vision, severe abdominal pain occur or baby is unwell.  
• Encourage exclusive breastfeeding for 6 months: baby gets only breast milk (no formula, water, cereal). Refer to an infant feeding support group.  
• Suggest exclusive formula feeding if mother has HIV and formula is affordable, feasible, acceptable, safe and sustainable. Check correct mixing. Discourage mixed feeding.  
• From 6 months, introduce food while continuing with feeding choice. If HIV, continue breastfeeding until 1 year if mother on ART or baby on NVP and until 2 years if baby diagnosed HIV positive.  

Treat the mother

• Continue ferrous sulphate compound BPC 170mg daily with food for 6 weeks after delivery. If HB < 10 continue until HB > 11 for 3 months.  
• If not on ART and breastfeeding, start ART same day 63. If mother has HIV and is on lifelong ART continue with it, if on maternal ART prophylaxis decide when to stop 64.  

Treat the baby of the mother with HIV

• Give nevirapine syrup daily from birth for 6 weeks, irrespective of feeding choice: dose according to age and weight. 2 Decide when to stop NVP:  
  • If breastfeeding and mother was on ART for < 4 weeks before delivery, stop NVP at 12 weeks.  
  • If breastfeeding and mother was on ART for ≥ 4 weeks before delivery, stop NVP at 6 weeks. If mother’s 6 month viral load ≥ 400, discuss with specialist.  
  • If formula feeding, stop NVP at 6 weeks.  
  • If baby diagnosed HIV positive at any time, stop NVP and refer urgently for ART  
• Give co-trimoxazole prophylaxis daily from 6 weeks: < 5kg: 2.5ml, 5–13.9kg: 5ml. Stop when confirmed PCR negative.  

1 Do not mix Ringer’s lactate and IV ceftriaxone. Flush IV line with sodium chloride 0.9% before and after IV ceftriaxone.  
2 Nevirapine (10mg/ml) syrup daily dose from age birth–2 weeks: 2–2.4kg: 0.5mℓ, 2.5–2.9kg: 0.6mℓ, 3–3.9kg: 0.7mℓ; 4–5.9kg: 1mℓ. Nevirapine (10mg/ml) syrup daily dose from age 2–12 weeks: 2–2.4kg: 0.8mℓ, 2.5–2.9kg: 1mℓ, 3–3.9kg: 1.5mℓ, 4–4.9kg: 2mℓ, 5–5.9kg: 2.5mℓ.
# MENOPAUSE

Menopause is the cessation of menstruation for at least 1 year. Most women have menopausal symptoms and irregular periods during the perimenopause.

## MENOPAUSE: ROUTINE CARE

### Assess the menopausal patient

<table>
<thead>
<tr>
<th>Assess</th>
<th>When to assess</th>
<th>Note</th>
</tr>
</thead>
</table>
| Symptoms   | Every visit    | • Ask about menopausal symptoms: flushes, sexual problems 30, sleeping problems 54, headache 9, mood changes.  
• If other TB symptoms like weight loss and cough ≥ 2 weeks, exclude TB 55.  
• If low mood or sadness, loss of interest or pleasure, feeling tense, worrying a lot or not coping as well as before, consider depression/anxiety 81.  
• Manage other symptoms as on symptom pages. |
| Vaginal bleeding | Every visit | Refer within 2 weeks if bleeding between periods, after sex or after being period-free for 1 year. |
| CVD risk   | First visit, BP 3 monthly on HRT | • Assess CVD risk 68.  
• Interpret BP result 73. |
| Osteoporosis risk | First visit | If < 60 years with loss of > 3cm in height and fractures of hip, wrist or spine; previous non-traumatic fractures; oral steroid treatment for > 6 months; onset of menopause < 45 years; BMI < 19; heavy alcohol user; heavy smoker |
| Family planning | First visit | If < 50 years, give contraception for 2 years after last period; if ≥ 50 years switch to progesterone only pill, subdermal implant, IUCD and/or condoms until 1 year after last period 91. If amenorrhea on implant or progesterone pill, continue until 55 years. If ≥ 55 years and still menstruating, refer for investigation. |
| Breast check | First visit, yearly on HRT | If any lumps found in breasts or axillae, refer same week to breast clinic. |
| Pap smear  | When needed | If HIV negative, 3 smears 10 years apart from age 30. The HIV patient needs smear at diagnosis then yearly if normal 27. |

### Advise the menopausal patient

- To cope with the flushes, advise patient to dress in layers and to decrease alcohol and caffeine intake.
- Help patient to manage CVD risk if present 69.
- If patient is having mood changes and/or not coping as well as in the past, refer to counselor, support group or helpline  back page.
- Educate the patient about the risks, contraindications and benefits of HRT and that it can be used to treat menopausal symptoms for up to 5 years. Risk of breast cancer, DVT and cardiovascular disease increase with increasing age. 6–12 months after discontinuation risk is equivalent to rest of population.

### Treat the menopausal patient

- Treat with hormone replacement therapy (HRT) to relieve menopausal symptoms and to prevent osteoporosis in the patient at risk. Avoid if abnormal vaginal bleeding, cancer of uterus or breast, previous deep vein thrombosis or pulmonary embolism, recent myocardial infarction, uncontrolled hypertension, liver disease or porphyria: give oestradiol 0.5–1mg daily or conjugated oestrogens 0.3mg–0.625mg. If patient has a uterus also give medroxyprogesterone oral 5mg daily. Adjust dose to control menopausal symptoms with minimal side effects.
- Treat vaginal dryness and pain with sex with lubricants (avoid Vaseline® with condoms). Refer if no better with HRT or HRT contraindicated.
- Review the menopausal patient 3 monthly once settled on HRT. Decrease and stop HRT for menopausal women within 5 years, or before 60 years of age.
Assess the patient not needing urgent attention in the prep room

Has the patient been coughing ≥ 2 weeks?
- Assign the patient with cough to the fast track/coughing queue.
- Collect first sputum for TB.  

Does the patient know his/her HIV status?
- If no, urge patient to test for HIV.
- If yes and patient negative, encourage patient to test once a year. Record year last tested in patient notes.

If the patient is a woman:
- Exclude pregnancy. If late menstrual period do a pregnancy test.
- Check if patient needs a Pap smear: if HIV negative, 3 Pap smears in a lifetime, 1 every 10 years from age 30; if HIV positive Pap smear at diagnosis and then if normal yearly. If abnormal smear → 27 for next date.

Patient has hypertension, stroke, ischaemic heart disease and/or peripheral vascular disease.

Check at every visit:
- BP
- Weight
- Finger prick glucose
- Urine dipstick only if glucose ≥ 15

Check once a year:
- Urine dipstick
- Waist circumference

Patient has diabetes.

Check at every visit:
- BP
- Finger prick glucose
- Weight
- Urine dipstick

Check once a year:
- Urine dipstick
- Waist circumference

Patient is pregnant.

Check at every visit:
- BP
- Finger prick glucose
- Weight
- Urine dipstick

Also check at booking visit:
- MUAC
- Hb if pale
- Rapid rhesus
- Rapid syphilis

Check once a year:
- Urine dipstick
- Waist circumference

The patient over 40 years needs a cardiovascular disease risk calculated every 5 years → 68:
- Weight
- Height
- BP
- Finger prick glucose
- Waist circumference
PROTECT YOURSELF FROM OCCUPATIONAL INFECTION

### Adopt measures to diminish your risk of occupational infection

#### Protect yourself

**Adopt hygienic practices**
- Wash hands regularly with soap and water. Use alcohol-based hand-cleaner regularly.
- Adopt universal precautions in your approach to all patients.
- Wear gloves when handling specimens.
- Dispose of sharps in the correct manner.

**Get vaccinated**
- Get vaccinated against hepatitis B.
- All frontline health workers must be vaccinated against influenza.

**Know your HIV status**
- If status unknown, test for HIV ≥ 60. ART and INH prophylaxis can decrease the risk of TB.
- If HIV positive, you are entitled to work in an area of the facility where exposure to TB is limited.

**Wear a face mask**
- Wear an N95 respirator when in contact with TB suspects.
- Wear a surgical facemask when in contact with influenza suspects.

#### Protect your facility

**Clean the facility**
- Wash all surfaces (including door handles, telephones, keyboards) daily with chlorine disinfectant.

**Ensure adequate ventilation**
- Regularly clean extractor fans.
- Open windows and use fans to increase air exchange.

**Organise waiting areas**
- Prevent overcrowding in waiting areas.
- Fast track influenza and TB suspects.

**Manage sharps safely**
- Ensure sharps containers are easily accessible and regularly replaced.

**Manage infection control in the facility**
- Appoint an infection control officer for the facility to coordinate and monitor infection control policies.

### Approach to possible occupational exposure

#### TB

- **Identify TB suspects promptly**
  - The patient with cough ≥ 2 weeks is a TB suspect.
  - Separate TB suspects from others in the facility.
  - Educate TB suspect about cough hygiene.
  - Provide a surgical face mask or tissues to cover mouth and nose to protect others from infection.

- **Diagnose TB rapidly**
  - Aim to complete TB workup within 3 to 4 visits.
  - Protect yourself from TB
  - Wear an N95 respirator (not a surgical mask) when in contact with an infectious TB patient.

#### HIV

- **If status unknown, test for HIV ≥ 60.**
- **If HIV negative or unknown, start PEP for 1 month as soon as possible (ideally within 1–2 hours):**
  - **Give AZT 300mg and 3TC 150mg 12 hourly.**
  - Check Hb prior to starting AZT and after 4 weeks.
  - Refer to doctor if Hb < 8.
  - **Add LPV/r 400/100mg 12 hourly if high risk: deep injury, large bore or biopsy needle, obvious blood on device, source with AIDS or VL > 100 000.**
  - Repeat HIV test at 6 weeks, 3 and then 6 months.
  - **Advise condom use for 6 months with regular partner.**

#### H1N1 influenza

- **Wash hands with soap and water.**
- **Wearing a surgical face mask over the mouth and nose may be protective when performing procedures on patient suspected of influenza.**
- **Encourage patient who coughs and sneezes to cover mouth/nose with a tissue, to ensure used tissues are disposed of correctly and to wash hands regularly with soap and water.**
- **Advise patient with symptoms of influenza to stay indoors and avoid close contact with others.**
ROUTINE CARE SUMMARY

CVD RISK
- Assess: Assess at least every 5 years
- Advise: Urge patient to stop smoking
- Treat: Control BP to prevent stroke/heart attack

DIABETES
- Assess: Screen for complications
- Advise: Control glucose to save eyes, kidneys, feet
- Treat: Screen for complications

HYPERTENSION
- Assess: Screen for TB
- Advise: Control BP to prevent stroke/heart attack
- Treat: Give statin

STROKE
- Assess: Test for HIV
- Advise: Urge patient to stop smoking
- Treat: Give statin

TB
- Assess: Urge adherence to prevent resistance
- Advise: Test for HIV
- Treat: Urge patient with COPD to stop smoking

HIV
- Assess: Start ART as soon as needed
- Advise: Identify depression
- Treat: Control asthma with inhaled steroids

PREGNANCY
- Assess: Start routine antenatal care early
- Advise: Identify depression
- Treat: Control asthma with inhaled steroids

CHRONIC RESPIRATORY DISEASE

DEPRESSION
<table>
<thead>
<tr>
<th>Helpline</th>
<th>Services provided</th>
<th>Contact number/s</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>General counselling</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lifeline National Counselling Line</td>
<td>Counselling for any life crisis and referral to relevant services</td>
<td>0861 322 322 (24 hour national helpline)</td>
</tr>
<tr>
<td>Child line SA (ages 0 – 16 years)</td>
<td>For children and young adolescents who are in crises, abuse or at risk of abuse and violence</td>
<td>0800 055 555 (24 hour toll free)</td>
</tr>
<tr>
<td><strong>Abuse</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stop Gender Violence</td>
<td>Support for children, women and men experiencing domestic violence</td>
<td>0800 150 150 (24 hour toll free)</td>
</tr>
<tr>
<td>Safeline</td>
<td>Abuse counselling, court preparation, anti-abuse awareness campaigns and group therapy</td>
<td>0800 035 553 (24 hour crisis line 0723674588)</td>
</tr>
<tr>
<td>Rape Crisis</td>
<td>Counselling and court support for rape survivors &gt; 13 years</td>
<td>021 447 97 62 (24 hour service)</td>
</tr>
<tr>
<td><strong>Chronic condition</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Arthritis Foundation</td>
<td>Education and monthly support groups for patient with arthritis and/or fibromyalgia</td>
<td>0861 30 30 30 (National helpline)</td>
</tr>
<tr>
<td>Epilepsy South Africa</td>
<td>Education, counselling and support groups for patient with epilepsy and his/her family</td>
<td>0860 37 45 37 (National helpline)</td>
</tr>
<tr>
<td>Diabetes South Africa</td>
<td>Education, dietary plans, support groups and workshops for patient with diabetes</td>
<td>086 111 3913 (National helpline)</td>
</tr>
<tr>
<td>Heart &amp; Stroke Foundation</td>
<td>Education and support groups for patient with stroke, any heart condition or CVD risk.</td>
<td>0860 143 278 (National helpline) · <a href="http://www.heartfoundation.co.za">www.heartfoundation.co.za</a></td>
</tr>
<tr>
<td>National AIDS helpline</td>
<td>Counselling and information for patient who has HIV or thinking of testing</td>
<td>0800 012 322 (24 hour national helpline)</td>
</tr>
<tr>
<td><strong>Mental health</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>S A Depression and Anxiety group</td>
<td>Counselling and support for patient with mental illness and/or family with suicide crisis line</td>
<td>0800 567 567 (Toll free service 8am–8pm)</td>
</tr>
<tr>
<td>Substance abuse</td>
<td>Counselling for patient and family with substance abuse, referral to rehabilitation centre</td>
<td>0800 12 13 14 (24 hour toll free)</td>
</tr>
<tr>
<td>Alzheimer’s South Africa</td>
<td>Information, training and support groups for carers</td>
<td>0860 102 681 (National helpline) · <a href="http://www.alzheimers.org.za">www.alzheimers.org.za</a></td>
</tr>
<tr>
<td>Alcoholics Anonymous</td>
<td>Counselling, education and support groups for patient with alcohol abuse</td>
<td>0861 435 722</td>
</tr>
<tr>
<td><strong>Health worker</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Drug and Poisoning</td>
<td>Advice on the management of exposure to or ingestion of poisonous substances</td>
<td>021 689 5227 and 021 931 6129 both 24 hours a day, 7 days a week</td>
</tr>
<tr>
<td>National HIV &amp; TB Health Care Worker Hotline</td>
<td>For HIV and TB related clinical queries</td>
<td>0800 212 506 (08:30–16:30 Monday to Friday)</td>
</tr>
<tr>
<td>Medicines Information Centre</td>
<td>Advice on medicine related query like drug interactions, side effects, dosage, treatment failure</td>
<td>021 4066829 (08:30–16:30 Monday to Friday)</td>
</tr>
<tr>
<td>Nutrition Information Centre (NICUS)</td>
<td>For all nutrition related queries for health workers and the public.</td>
<td>021 9331408 (08:30–16:30 Monday to Friday) · <a href="http://www.sun.ac.za/nicus">www.sun.ac.za/nicus</a></td>
</tr>
<tr>
<td><strong>Administration</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Legal Aid Advice line</td>
<td>Information and guidance on any legal matter. They will return messages left after hours.</td>
<td>0800 110 110 (07:00–19:00 Monday to Friday) (National helpline)</td>
</tr>
<tr>
<td>Medic Alert</td>
<td>Assistance with application for Medic Alert disc or bracelet</td>
<td>086 111 2979 (09:00–16:00 Monday to Friday) (24 hour emergencies 021 4610000)</td>
</tr>
</tbody>
</table>

**Your helplines**

- [Lifeline](https://www.lifeline.org.za)
- [Childline SA](https://www.childline.org.za)
- [Stop Gender Violence](https://www.stopgenderviolence.co.za)
- [Safeline](https://www.safeline.org.za)
- [Rape Crisis](https://www.rapecrisis.org.za)
- [Arthritis Foundation](https://www.arthritisfoundation.org.za)
- [Epilepsy South Africa](https://www.epilepsy.org.za)
- [Diabetes South Africa](https://www.diabetes.org.za)
- [Heart & Stroke Foundation](https://www.heartfoundation.co.za)
- [National AIDS helpline](https://www.aids.org.za)
- [S A Depression and Anxiety group](https://www.sadep.org.za)
- [Substance abuse](https://www.substanceabuse.org.za)
- [Alzheimer’s South Africa](https://www.alzheimers.org.za)
- [Alcoholics Anonymous](https://www.alcoholics.org.za)
- [Drug and Poisoning](https://www.drugpoisoning.org.za)
- [National HIV & TB Health Care Worker Hotline](https://www.nationalhiv.org.za)
- [Medicines Information Centre](https://www.medicines.org.za)
- [Nutrition Information Centre (NICUS)](https://www.nicus.org.za)
- [Legal Aid Advice line](https://www.legaidsouthafrica.org.za)
- [Medic Alert](https://www.medicalert.co.za)