

Acute Care

INTEGRATED MANAGEMENT OF ADOLESCENT AND ADULT ILLNESS

***INTERIM GUIDELINES FOR
FIRST-LEVEL FACILITY HEALTH WORKERS AT
HEALTH CENTRE AND DISTRICT OUTPATIENT CLINIC***



This is one of 4 IMAI modules relevant for HIV care:

- ❖ **Acute Care**—this module is for adolescents and adults.
For children use the IMCI-HIV adaptation.
- ❖ **Chronic HIV Care with ARV Therapy**
- ❖ **General Principles of Good Chronic Care**
- ❖ **Palliative Care: Symptom Management and End-of-Life Care**

These are interim guidelines released for country adaptation and use to help with the emergency scale-up of antiretroviral therapy (ART) in resource-limited settings. These interim guidelines will be revised soon based on early implementation experience. Please send comments and suggestions to: 3by5help@who.int.

The IMAI guidelines are aimed at first-level facility health workers and lay providers in low-resource settings. These health workers and lay providers may be working in a health centre or as part of a clinical team at the district clinic. The clinical guidelines have been simplified and systematized so that they can be used by nurses, clinical aids and other multi-purpose health workers, working in good communication with a supervising MD/MO at the district clinic. Acute Care presents a syndromic approach to the most common adult illnesses including most opportunistic infections. Instructions are provided so the health worker knows which patients can be managed at the first-level facility, and which require referral to the district hospital or further assessment by a more senior clinician. Preparing first-level facility health workers to treat the common, less-severe opportunistic infections will allow them to stabilize many clinical stage 3 and 4 patients prior to ARV therapy without referral to the district.

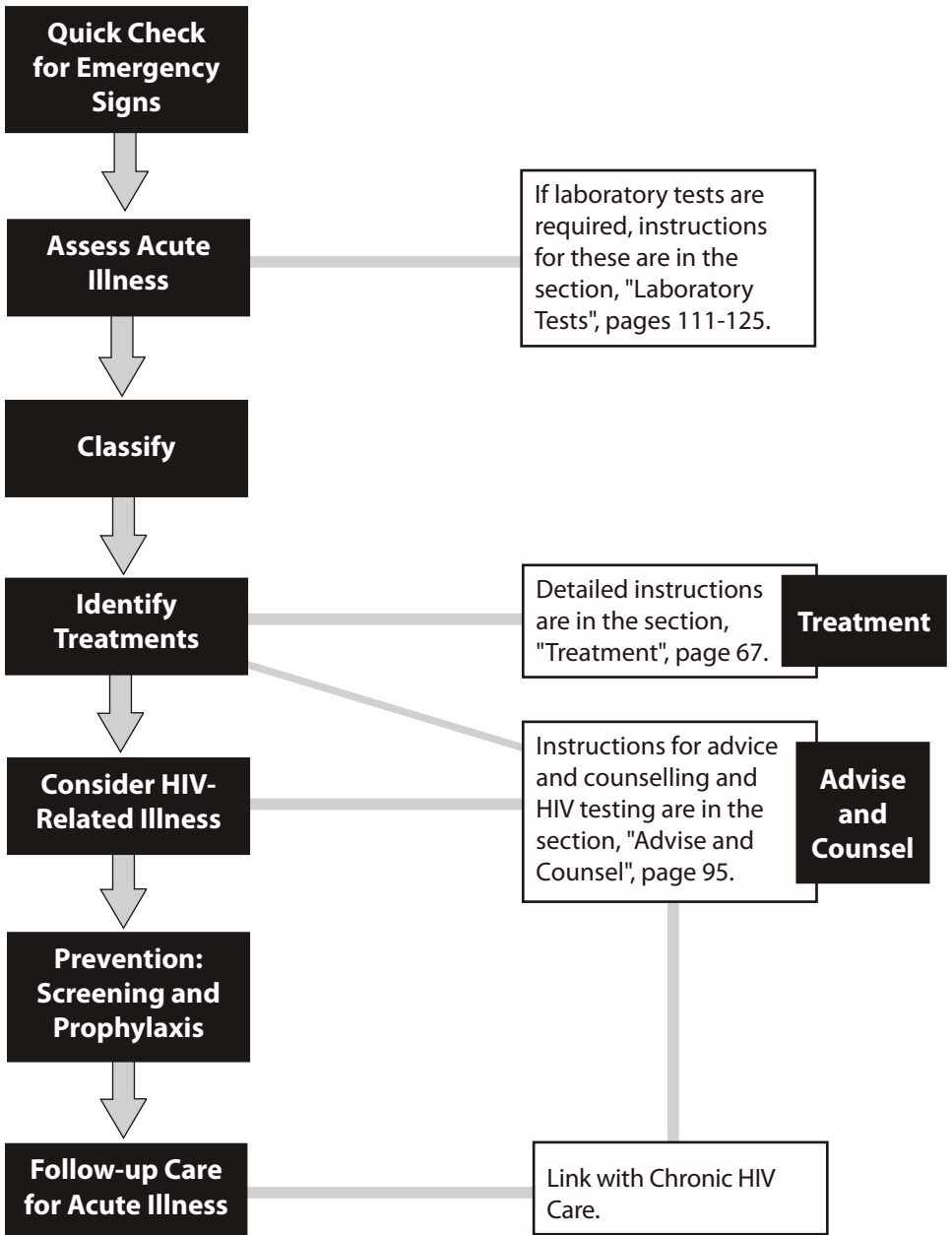
This module cross-references the IMAI **Chronic HIV Care with ART** guidelines and **Palliative Care: Symptom Management and End-of-Life Care**. If these are not available, national guidelines for HIV care, ART and palliative care can be substituted.

Integrated Management of Adolescent and Adult Illness (IMAI) is a multi-departmental project in WHO producing guidelines and training materials for first-level facility health workers in low-resource settings.

For more information about IMAI, please visit <http://www.who.int/hiv/toolkit/arv/> or contact 3by5help@who.int.

WHO HIV Department—IMAI Project

Integrated Management: Acute Care



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(for both Acute and Chronic Care patients)

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- Exercises, lifting skills to prevent low-back pain
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- Also for women and girls of childbearing age:
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Steps to Use the IMAI Acute Care Module

Quick Check for Emergency Signs

Do the Quick Check for Emergency Signs—if any positive sign, call for help and begin providing the emergency treatment.

Assess Acute Illness

Ask: What is your problem? Why did you come for this consultation? Prompt: "Any other problems?"

- Determine if patient has acute illness or is here for follow-up. Circle this on the recording form (126).
- How old are you?
- If woman of childbearing age, are you pregnant? (She will also need to be managed using the antenatal guidelines—circle this on the recording form.)

In all patients:

- Ask: cough or difficult breathing? (16-17)
- Check for undernutrition and anaemia. (18-19)
- Ask: genital or anal sore, ulcer or warts? (20-21)
- Ask men: do you have a discharge from your penis? (22-23)
- Look in the mouth (and respond to volunteered mouth/dental/throat problems). (24-26)
- Ask about pain. (27)

If patient is in pain, grade the pain, determine location and consider cause. Manage pain using the *Palliative Care* module.

- Ask: Are you taking any medications?

Respond to volunteered problems or observed signs.

Mark with an X on the recording form all the main symptoms the patient has.

You will need to do the assessment for any of these symptoms if volunteered or observed:

- Fever (28-30)
- Diarrhoea (32-34)
- Genito-urinary symptoms or lower abdominal pain in women (36-39)
- Skin problem or lump (40-45)
- Headache or neurological problem or painful feet (46-48)
- Mental problem (50-52)—use this page if patient complains of or appears depressed, anxious, sad or fatigued, or has an alcohol problem, recurrent multiple complaints or pain. Remember to use this page. If you have a doubt, use it.

For special considerations in assessing adolescents, see *Adolescent Job Aid*.

Assess and treat other problems. Use national and other existing guidelines for other problems that are not included in the *Acute Care* module.

If laboratory tests are required, instructions for these are in the section "**Laboratory Tests**" at the end of the module (111).

Classify

Classify using the IMAI acute care algorithm, following the 3 rules:

- 1. Use all classification tables where the patient fits the description in the arrow.**
- 2. Start at the top** of the classification table. Decide if the patient's signs fit the signs in the first column. If not, go down to next row.
- 3. Once you find a row/classification—STOP!** Use only **one row** in each classification table. (Once you find the row where the signs match, do not go down any further, even if the patient has signs that also fit into other, lower rows/classifications.)

Then record **all** classifications on the recording form. Remember that there is often more than one.

**Identify
Treatments**

Read the treatments for each classification you have chosen. List these.

The detailed treatment instructions are in the section called Treatment.

Treatment

Instructions for patient education, support and counselling are in Advise and Counsel, including how to suggest HIV testing and counselling.

**Advise
and
Counsel**

**Consider HIV-
Related Illness**

If it advises you to "Consider HIV-related illness", circle this on the recording form and use this section.

If the patient is HIV+, also use the *Chronic HIV Care* module, for chronic care, ART, prevention and support.

If the treatment list advises sputums for TB, note this on the recording form and send sputums.

**Prevention:
Screening and
Prophylaxis**

Remember that for all patients you need to also consider what Prevention and Prophylaxis are required. (Circle on the recording form.)

**Follow-up Care
for Acute Illness**

Reassess the patient and treat or refer as necessary. This is initial follow-up care after acute illness, not ongoing chronic care.

Quick Check for
Emergency Care

then

Assess Acute Illness/
Classify/Identify
Treatments

Quick Check for Emergency Signs

Use this chart for **rapid triage assessment for all patients**. Then use the **Acute Care** guidelines.

If **trauma or violent or aggressive patient, or other psychiatric emergency**, also see the **Quick Check** module.

► **Quick check for emergency signs (medical)** (Consider all signs)

FIRST ASSESS: AIRWAY AND BREATHING

- Appears obstructed or
- Central cyanosis (blue mucosa) or
- Severe respiratory distress

Check for obstruction, wheezing and pulmonary oedema.

THEN ASSESS: CIRCULATION (SHOCK)

- Cold skin or
- Weak and fast pulse or
- Capillary refill longer than 2 seconds

Check BP and pulse. Look for bleeding. Ask: Have you had diarrhoea?

TREATMENT

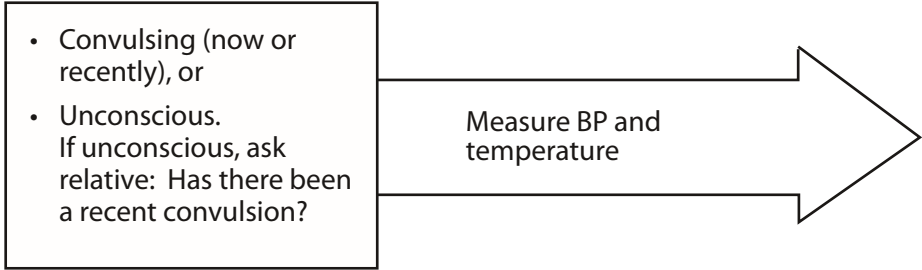
- **If obstructed breathing, manage the airway.**
- Prop patient up or help to assume position for best breathing.
- If wheezing, treat urgently (p. 74).
- If pulmonary oedema, consider furosemide if known heart disease.
- Give appropriate IV/IM antibiotics pre-referral.
- **Refer urgently to hospital.**

This patient may be in shock:

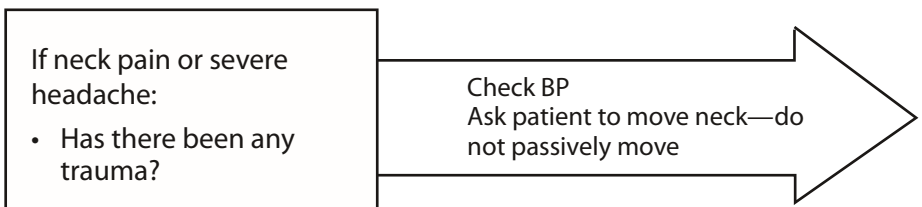
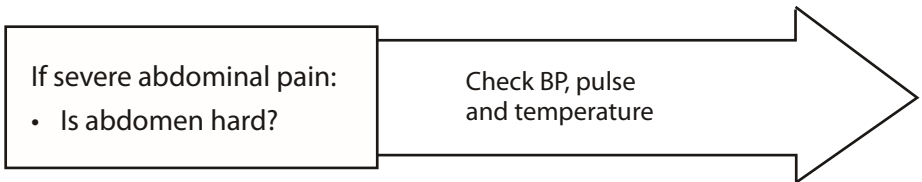
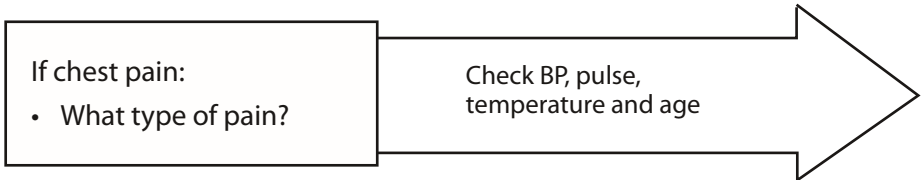
- If systolic BP < 90 mmHg or pulse >110 per minute:
 - Insert IV and give fluids rapidly.
If not able to insert peripheral IV, use alternative.
 - Position with legs higher than chest.
 - Keep warm (cover).
 - Consider sepsis—give appropriate IV/IM antibiotics.
 - Refer urgently to hospital.
- If diarrhoea: assess for dehydration and follow plan C. (This patient may not need referral after rehydration.) If severe undernutrition, see p. 18.
- If melena or vomiting blood, manage as in **Quick Check** module and refer to hospital.
- If haemoptysis > 50 ml, insert IV and refer to hospital.

If trauma—see **Quick Check** module.

UNCONSCIOUS/CONVULSING



PAIN



For all:

- Protect from fall or injury. Get help.
- Assist into recovery position. (Wait until convulsion ends.)
- Insert IV and give fluids slowly.
- Give appropriate IM/IV antibiotics.
- Give IM antimalarial.
- Give glucose*.
- Refer urgently to hospital after giving pre-referral care. Do not leave alone.

If convulsing, also:

- Give diazepam IV or rectally.
- Continue diazepam en route as needed.

If unconscious:

- Manage the airway.
- Assess possibility of poisoning, alcohol or substance abuse.

If trauma, use the **Quick Check** guidelines.

If age > 50, no history of trauma and history suggests cardiac ischaemia:

- Give aspirin (160 or 325 mg, chewed).
- **Refer urgently to hospital.**

If pleuritic pain with cough or difficult breathing, assess for pneumonia. Consider pneumothorax.

For other pain, use the **Acute Care** module to determine cause.

- Insert IV. If hard abdomen or shock, give fluids rapidly. If not, give fluids slowly (30 drops/minute).
- **Refer urgently to hospital** *.

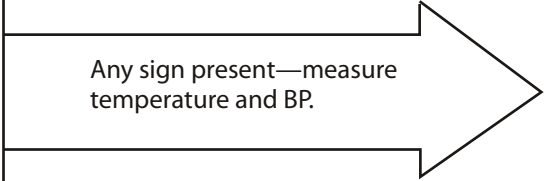
See the **Palliative Care** module for management of pain.

- Consider meningitis and other causes of acute headache. (See p. 46-48.)
- If BP > systolic 180, refer urgently to hospital.
- If pain on neck movement by patient after trauma by history or exam, immobilize the neck and refer.

* If high glucose, see *diabetes management guidelines*.

FEVER from LIFE-THREATENING CAUSE

- Any fever with:
 - stiff neck
 - very weak/not able to stand
 - lethargy
 - unconscious
 - convulsions
 - severe abdominal pain
 - respiratory distress



Any sign present—measure temperature and BP.

- Insert IV. Give fluids rapidly if shock or suspected sepsis. If not, give fluids slowly (30 drops/minute).
- Give appropriate IV/IM antibiotics.
- Give appropriate IM antimalarial.
- Give glucose.
- **Refer urgently to hospital.**

Also consider neglected trauma with infection—see **Quick Check** guidelines.

If no emergency signs, proceed immediately to

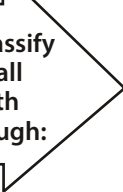
Assess Acute Illness/ Classify/Identify Treatments

Ask: what is your problem? Why did you come for this consultation?

Prompt: "Any other problems?"

- Determine if patient has acute illness or is here for follow-up. Circle this on recording form (p. 126).
- How old are you?
- If woman of childbearing age, are you pregnant? (She will also need to be managed using the antenatal guidelines—circle this on the recording form.)

► In all patients: Do you have cough or difficult breathing?

IF YES, ASK:		LOOK AND LISTEN	 <p>Classify in all with cough:</p>
<ul style="list-style-type: none"> • For how long? • Are you having chest pain? <ul style="list-style-type: none"> — If yes, is it new? Severe? Describe it. • Have you had night sweats? • Do you smoke? • Are you on treatment for a chronic lung or heart problem, or TB? Determine if patient diagnosed as asthma, emphysema or chronic bronchitis (COPD), heart failure or TB. (Also look in Chronic Disease Register.) • If not, have you had previous episodes of cough or difficult breathing? <ul style="list-style-type: none"> — If recurrent: <ul style="list-style-type: none"> -- Do these episodes of cough or difficult breathing wake you up at night or in the early morning? -- Do these episodes occur with exercise? 		<ul style="list-style-type: none"> • Is the patient lethargic? • Count the breaths in one minute—repeat if elevated. • Look and listen for wheezing. • Determine if the patient is uncomfortable lying down. • Measure temperature. <p>If not able to walk unaided or appears ill, also:</p> <ul style="list-style-type: none"> • Count the pulse. • Measure BP. 	
AGE	FAST BREATHING IS:	VERY FAST BREATHING IS:	
5-12 years	30 breaths per minute or more	40 breaths per minute	
13 years or more	20 breaths per minute or more	30 breaths per minute or more	

Use this classification table in all with **cough or difficult breathing**:

SIGNS:	CLASSIFY AS:	TREATMENTS:
<p>One or more of the following signs:</p> <ul style="list-style-type: none"> • Very fast breathing or • High fever (39°C or above) or • Pulse 120 or more or • Lethargy or • Not able to walk unaided or • Uncomfortable lying down or • Severe chest pain. 	<p>SEVERE PNEUMONIA OR VERY SEVERE DISEASE</p>	<ul style="list-style-type: none"> • Position. • Give oxygen. • Give first dose IM antibiotics. • If wheezing present, treat (p. 74). • If severe chest pain in patient 50 years or older, use <i>Quick Check</i>. • If known heart disease and uncomfortable lying down, give furosemide. • Refer urgently to hospital. • Consider HIV-related illness (p. 54). • If on ARV therapy, this could be a serious drug reaction. See <i>Chronic HIV Care</i> module.
<p>Two of the following signs:</p> <ul style="list-style-type: none"> • Fast breathing • Night sweats • Chest pain 	<p>PNEUMONIA</p>	<p>Give appropriate oral antibiotic Exception: if second/third trimester pregnancy, HIV clinical stage 4, or low CD4 count, give first dose IM antibiotics and refer urgently to hospital.</p> <ul style="list-style-type: none"> • If wheezing present, treat (p. 74). • If smoking, counsel to stop smoking. • Consider HIV-related illness (p. 54). • If on ARV therapy, this could be a serious drug reaction; consult/refer. • If cough > 2 weeks, send sputums for TB (p. 63). • Advise when to return immediately. • Follow up in 2 days (p. 62).
<ul style="list-style-type: none"> • Cough or difficult breathing for more than 2 weeks or • Recurrent episodes of cough or difficult breathing which: <ul style="list-style-type: none"> - Wake patient at night or in the early morning or - Occur with exercise. 	<p>POSSIBLE CHRONIC LUNG OR HEART PROBLEM</p>	<ul style="list-style-type: none"> • If cough > 2 weeks, send 3 sputums for TB or send the patient to district hospital for sputum testing. (Record in register.) • If sputums sent recently, check register for result. If negative, refer to district hospital for assessment if a chronic lung problem has not been diagnosed (p. 63). • If smoking, counsel to stop. • If wheezing, treat (p. 74). • Advise when to return immediately.
<ul style="list-style-type: none"> • Insufficient signs for the above classifications 	<p>NO PNEUMONIA COUGH/COLD, OR BRONCHITIS</p>	<ul style="list-style-type: none"> • Advise on symptom control. • If smoking, counsel to stop. • If wheezing, treat (p. 74). • Advise when to return immediately.

► **Check all patients for undernutrition and anaemia:**

IF YES, ASK:	LOOK AND FEEL
<ul style="list-style-type: none"> • Have you lost weight? • What medications are you taking? <p>If wasted or reported weight loss, how much has your weight changed?</p> <ul style="list-style-type: none"> • Ask about diet. • Ask about alcohol use. <div style="border: 1px solid black; padding: 10px; margin: 10px 0;"> $\% \text{ weight loss} = \frac{\text{old} - \text{new}}{\text{old weight}}$ </div> <p>If pallor:</p> <ul style="list-style-type: none"> • Black stools? • Blood in stools? • Blood in urine? • In menstruating adolescents and women: heavy menstrual periods? 	<ul style="list-style-type: none"> • Look for visible wasting. • Look for loose clothing. <p>If present, did it fit before?</p> <p>If wasted or reported weight loss:</p> <ul style="list-style-type: none"> • Weigh and calculate % weight loss. • Measure mid-upper arm circumference (MUAC). • Look for sunken eyes. • Look for oedema of the legs. <p>If present:</p> <ul style="list-style-type: none"> • Does it go up to the knees? • Is it pitting? • Assess for infection using the full <i>Acute Care</i> algorithm. • Look at the palms and conjunctiva for pallor. Severe? Some? <p>If pallor: *</p> <ul style="list-style-type: none"> • Count breaths in one minute. • Breathless? • Bleeding gums? • Petechiae?

If visible wasting or weight loss:

If pallor:

* If haemoglobin result available, classify as SEVERE ANAEMIA if haemoglobin < 7 gm; SOME ANAEMIA if < than 10 gm.

Use this table if visible wasting or weight loss:

SIGNS:	CLASSIFY AS:	TREATMENTS:
<ul style="list-style-type: none"> • MUAC < 160 mm or • MUAC 161-185 mm plus one of the following: <ul style="list-style-type: none"> - Pitting edema to knees on both sides - Cannot stand - Sunken eyes 	SEVERE UNDER-NUTRITION	<ul style="list-style-type: none"> • Refer for therapeutic feeding if nearby or begin community-based feeding. • Consider TB (send sputums if possible). • Consider HIV-related illness (p. 54). • Counsel on HIV testing.
<ul style="list-style-type: none"> • Weight loss > 5 % or • Reported weight loss or • Loose clothing which used to fit. 	SIGNIFICANT WEIGHT LOSS	<ul style="list-style-type: none"> • Treat any apparent infection. • If diarrhoea, manage as p. 32-34. • Increase intake of energy and nutrient-rich food—counsel on nutrition. • Consider TB (send sputums if possible); diabetes mellitus (dipstick urine for glucose); excess alcohol; and substance abuse. • Consider diabetes mellitus if weight loss accompanied by polyuria or increased thirst (dipstick urine for glucose). • Consider HIV-related illness (p. 54). • Counsel on HIV testing. • Follow up in two weeks.
* Weight loss < 5 %.	NO SIGNIFICANT WEIGHT LOSS	<ul style="list-style-type: none"> • Advise on nutrition.

Use this table if pallor

<ul style="list-style-type: none"> • Severe palmar and conjunctival pallor; • Any pallor with: <ul style="list-style-type: none"> - 30 or more breaths per minute or - Breathless at rest; • Bleeding gums or petechiae; or • Black stools or blood in stools. 	SEVERE ANAEMIA OR OTHER SEVERE PROBLEM	<ul style="list-style-type: none"> • Refer to hospital. • If not able to refer, treat as below and follow up in one week. • Consider HIV-related illness (p. 54). • Consider ARV side effect (especially ZDV) or cotrimoxazole side effects. (See <i>Chronic HIV Care</i>.) • Consider malaria if low immunity or increased exposure (p. 28).
<ul style="list-style-type: none"> • Palmar or conjunctival pallor. 	SOME ANAEMIA	<ul style="list-style-type: none"> • Consider HIV-related illness (p. 54). • ARV drugs, especially ZDV and cotrimoxazole, can cause anaemia. (See <i>Chronic HIV Care</i>.) • Consider malaria if low immunity or increased exposure (p. 28). • Give twice daily iron/folate. • Counsel on adherence. • Advise to eat locally available foods rich in iron. • Give albendazole if none in last 6 months. • If heavy menstrual periods—see p. 39. • Follow up in 1 month.

► In all patients, ask: Do you have a **genital or anal sore, ulcer or wart?**

IF YES, ASK:	LOOK AND FEEL
<ul style="list-style-type: none"> • Are these new? If not, how often have you had them? 	<ul style="list-style-type: none"> • Look for anogenital sores or ulcers. • Look for vesicles. • Look for warts. • Look/feel for enlarged lymph node in inguinal area. <p>If present: Is it painful?</p>

** For haemorrhoids/anal fissure management, see **Palliative Care**.*

If anogenital ulcer:

If painful inguinal node:

If warts:

SIGNS:**CLASSIFY AS:****TREATMENTS:**

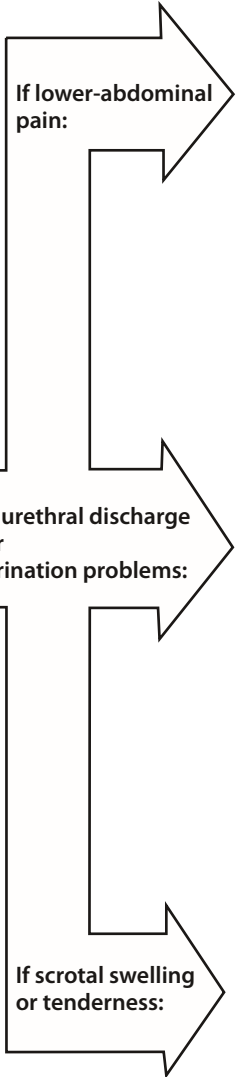
<ul style="list-style-type: none"> • Only vesicles present 	GENITAL HERPES	<ul style="list-style-type: none"> • Keep clean and dry. • Give aciclovir, if available. • Promote/provide condoms. • Educate on STIs, HIV and risk reduction. Offer HIV testing, counselling and syphilis testing.
<ul style="list-style-type: none"> • Sore or ulcer 	GENITAL ULCER	<ul style="list-style-type: none"> • Give benzathine penicillin for syphilis. • Give ciprofloxacin for chancroid. • If vesicles also give aciclovir if available. • Promote/provide condoms. • Consider HIV infection. Offer HIV testing and counselling. • Consider HIV-related illness if ulcerations present > one month (p. 54). • Educate on STIs, HIV and risk reduction. • Treat all partners within last 3 months. • Follow up in 7 days if sores not fully healed, and earlier if worse (p. 64).

<ul style="list-style-type: none"> • Enlarged and painful inguinal node 	INGUINAL BUBO	<ul style="list-style-type: none"> • If ulcer also present give ciprofloxacin for 3 days. • If no ulcer give doxycycline for 21 days; also treat partner. • If fluctuant, aspirate through healthy skin; do not incise. • Promote/provide condoms. • Partner management. • Consider HIV infection. Offer HIV testing and counselling and syphilis testing. • Educate on STIs, HIV and risk reduction. • Follow up in 7 days (p. 64).
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<ul style="list-style-type: none"> • Warts 	GENITAL WARTS	<ul style="list-style-type: none"> • Apply podophyllin. • Consider HIV-related illness. • Offer HIV testing and counselling. • Educate on STIs, HIV and risk reduction.
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► **Ask men: Do you have a discharge from your penis?
If male patient complains of genito-urinary
symptoms or lower-abdominal pain:**
(Use this page for men.)

IF YES, ASK:	LOOK AND FEEL
<ul style="list-style-type: none"> • What is your problem? • Do you have discharge from your urethra? — If yes, for how long? If this is a persistent or recurrent problem, see follow-up box. • Do you have burning or pain on urination? • Do you have pain in your scrotum? — If yes, have you had any trauma there? • Do you have sore(s)? 	<p>Perform genital exam:</p> <ul style="list-style-type: none"> • Look for scrotal swelling. • Feel for tenderness. • Look for ulcer: — If present, also use p. 20. • Look for urethral discharge. • Look and feel for rotated or elevated testis. — If abdominal pain, feel for tenderness. — If tenderness: — Is there rebound? — Is there guarding? — Can you feel a mass? — Are bowel sounds present? — Measure temperature. — Measure pulse.



** If fever with right lower abdominal pain and referral is delayed, give ampicillin and metronidazole for possible appendicitis.*

Use this table in men with lower abdominal pain:

SIGNS:	CLASSIFY AS:	TREATMENTS:
Abdominal tenderness with: <ul style="list-style-type: none"> • Fever > 38°C or • Rebound or • Guarding or • Mass or • Absent bowel sounds or • Not able to drink or • Pulse > 110 	SEVERE OR SURGICAL ABDOMINAL PROBLEM	<ul style="list-style-type: none"> • Give patient nothing by mouth (NPO). • Insert IV. • Give appropriate IV/IM antibiotics. • Refer URGENTLY to hospital.*
<ul style="list-style-type: none"> • Abdomen soft and none of the above signs 	GASTROENTERITIS OR OTHER GI PROBLEM	<ul style="list-style-type: none"> • If diarrhoea, see p. 32. • If constipation, advise remedies. • Return if not improved.

Use this table in men with urethral discharge or urination problem

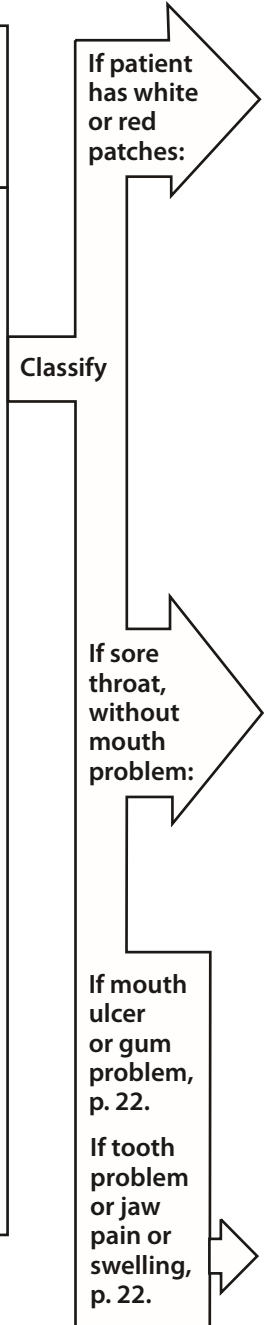
<ul style="list-style-type: none"> • Not able to urinate and • Bladder distended 	PROSTATIC OBSTRUCTION	<ul style="list-style-type: none"> • Pass urinary catheter if trained. • Refer to hospital.
<ul style="list-style-type: none"> • Urethral discharge or • Burning on urination 	POSSIBLE GONORRHOEA/ CHLAMYDIA INFECTION	<ul style="list-style-type: none"> • Treat patient and partner with antibiotics for possible GC/chlamydia infection. • Promote/provide condoms. • Return if worse or not improved within 1 week (p. 65). • Offer HIV/STI counselling and HIV and syphilis testing. • Consider HIV infection (p. 54). • Partner management.

Use this table in all men with scrotal swelling or tenderness

<ul style="list-style-type: none"> • Testis rotated or elevated or • History of trauma 	POSSIBLE TORSION	<ul style="list-style-type: none"> • Refer URGENTLY to hospital for surgical evaluation.
<ul style="list-style-type: none"> • Swelling or tenderness (without the above signs) 	POSSIBLE GONORRHOEA/ CHLAMYDIA INFECTION	<ul style="list-style-type: none"> • Treat patient and partner with antibiotics for possible GC/chlamydia infection. • Promote/provide condoms. • Follow up in 7 days; return earlier if worse (p. 65). • Offer HIV counselling and HIV and syphilis testing. • Consider HIV infection (p. 54).

► **Look in the mouth of all patients and respond to any complaint of mouth or throat problem:**

If you see any abnormality or patient complains of a mouth or throat problem, ASK:	LOOK
<ul style="list-style-type: none"> • Do you have pain? <ul style="list-style-type: none"> — If yes, where? When does this occur? (When swallowing? When hot or cold food?) • Do you have problems swallowing? • Do you have problems chewing? • Are you able to eat? • What medications are you taking? 	<p>Look in mouth for:</p> <ul style="list-style-type: none"> • White patches <ul style="list-style-type: none"> — If yes, can they be removed? • Ulcer <ul style="list-style-type: none"> - If yes, are they deep or extensive? • Tooth cavities • Loss of tooth substance • Bleeding from gums • Swelling of gums • Gum bubble • Pus • Dark lumps <p>Look at throat for:</p> <ul style="list-style-type: none"> • White exudate • Abscess <p>Look for swelling over jaw.</p> <p>Feel for enlarged lymph nodes in neck.</p> <p>If patient complains of tooth pain, does tapping or moving the tooth cause pain?</p>

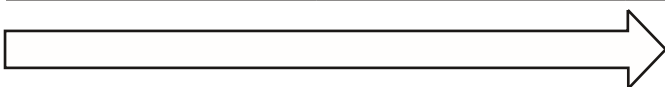



If patient has white or red patches:

SIGNS:	CLASSIFY AS:	TREATMENTS:
<ul style="list-style-type: none"> • Not able to swallow 	SEVERE OESOPHAGEAL THRUSH	<ul style="list-style-type: none"> • Refer to hospital. • If not able to refer, give fluconazole.
<ul style="list-style-type: none"> • Pain or difficulty swallowing 	OESOPHAGEAL THRUSH	<ul style="list-style-type: none"> • Give fluconazole. • Give oral care. • Follow up in 2 days (p. 64). • Consider HIV-related illness (p. 54).
<ul style="list-style-type: none"> • White patches in mouth and • Can be scraped off 	ORAL THRUSH	<ul style="list-style-type: none"> • Give nystatin or miconazole gum patch or clotrimazole. • If extensive, give fluconazole or ketoconazole. • Give oral care. • Consider HIV-related illness (p. 54).
<ul style="list-style-type: none"> • White patches/vertical ridges on side of tongue and • Cannot be scraped off and • Painless. 	ORAL (HAIRY) LEUKOPLAKIA	<ul style="list-style-type: none"> • No treatment needed. • Consider HIV-related illness (p. 54). • Instruct in oral care.

Use this table if sore throat without mouth problem:

<ul style="list-style-type: none"> • Not able to swallow or • Abscess. 	TONSILLITIS	<ul style="list-style-type: none"> • Refer urgently to hospital. • Give benzathine penicillin.
<ul style="list-style-type: none"> • Enlarged lymph node on neck and • White exudate on throat. 	STREPTOCOCCAL SORE THROAT	<ul style="list-style-type: none"> • Give benzathine penicillin. • Soothe throat with a safe remedy. • Give paracetamol for pain. • Return if not better.
<ul style="list-style-type: none"> • Only 1 or no signs in the above row present. 	NON-STREP SORE THROAT	<ul style="list-style-type: none"> • Soothe throat with a safe remedy. • Give paracetamol for pain.


 go to next page 

Use this table if mouth ulcer or gum problem:

SIGNS:	CLASSIFY AS:	TREATMENTS:
<ul style="list-style-type: none"> • Deep or extensive ulcers of mouth or gums or • Not able to eat 	SEVERE GUM/ MOUTH INFECTION	<ul style="list-style-type: none"> • Refer urgently to hospital unless only palliative care planned. • Trial aciclovir. • Start metronidazole if referral not possible or distant. • Consider HIV-related illness (p. 54). • If on ARV therapy, this may be drug reaction. (See <i>Chronic HIV Care</i>.)
<ul style="list-style-type: none"> • Ulcers of mouth or gums. 	GUM/MOUTH ULCERS	<ul style="list-style-type: none"> • Show patient/family how to clean with saline, peroxide or sodium bicarbonate. • If lips or anterior gums, give aciclovir. • Instruct in oral care. • Consider HIV-related illness (p. 54). • If on ARV, started cotrimoxazole or INH prophylaxis within last month, this may be drug reaction, especially if patient also has new skin rash. (See <i>Chronic HIV Care</i>—refer, stop drugs.) • See <i>Palliative Care</i> for pain relief. • Follow up in 7 days.
<ul style="list-style-type: none"> • Bleeding from gums (in absence of other bleeding or other symptoms) • Swollen gums 	GUM DISEASE	<ul style="list-style-type: none"> • Instruct in oral care.

Use this table if tooth problem, jaw pain or swelling:

<ul style="list-style-type: none"> • Constant pain with: <ul style="list-style-type: none"> - Swollen face or gum near tooth or - Gum bubble or • Tooth pain when tapped or moved. 	DENTAL ABSCESS	<ul style="list-style-type: none"> • If fever, give antibiotics. • Lance abscess or pull tooth. • Refer urgently to dental assistant if not able to do so. • Consider sinusitis. (Do not pull teeth if this is cause.)
<ul style="list-style-type: none"> • Pain when eating hot or cold food or • Visible tooth cavities or • Loss of tooth substance. 	TOOTH DECAY	<ul style="list-style-type: none"> • Place gauze with oil of clove. • Refer to dentist for care or pull tooth.

In all patients, ask: Are you in pain?

- If patient is in pain, grade the pain, determine location and consider cause.
- Manage pain using the *Palliative Care* guidelines.

In all patients, ask: Are you taking any medications?

It is particularly important to consider toxicity from ARV drugs and immune reconstruction syndrome in the first 2-3 months of antiretroviral therapy (ART), when evaluating new signs and symptoms.

Now respond to:

Volunteered Problems
or Observed Signs

► **Does the patient have fever**—by history of recent fever (within 48 hours) or feels hot or temperature 37.5°C or above?

IF YES, ASK:	LOOK AND FEEL
<ul style="list-style-type: none"> • How long have you had a fever? • Any other problem? • What medications have you taken? <p>Determine if antimalarial and for how long.</p> <div style="border: 1px dashed black; padding: 5px;"> <p>Decide malaria risk: High Low No</p> <ul style="list-style-type: none"> • <i>Where do you usually live?</i> • <i>Have you recently travelled to a malaria area?</i> • <i>If woman of childbearing age:</i> <ul style="list-style-type: none"> - <i>Are you pregnant?</i> • <i>Is an epidemic of malaria occurring?</i> • <i>HIV clinical stage 3 or 4.</i> </div>	<ul style="list-style-type: none"> • Look at the patient's neurological condition. Is the patient: <ul style="list-style-type: none"> — Lethargic? Confused? Agitated? • Count the breaths in one minute. Use table on p.16 to determine if fast breathing. <ul style="list-style-type: none"> — If fast breathing, is it deep? • Check if able to drink. • Feel for stiff neck. • Check if able to walk unaided. • Skin rash? • Headache? For how long? • Look for apparent cause of fever. (Assess all symptoms in this <i>Acute Care</i> algorithm and consider whether this could be related to ARV treatment—see <i>Chronic HIV Care</i>.) • Do malaria dipstick or smear if available.

Classify the individual patient's malaria risk:



HIGH
MALARIA
RISK

If low immunity (with malaria transmission):

- Pregnant.
- Child < 10 years, if there is intense or moderate malaria.
- Stage 3 or 4 HIV infection. (See *Chronic HIV Care* module.)

Or increased exposure:

- Epidemic of malaria is occurring.
- Moved to or visited area with intense or moderate malaria.

LOW
MALARIA
RISK

If high immunity:

- Adolescent or adult who has lived since childhood in area with intense or moderate malaria.

Or low exposure:

- Low malaria transmission and no travel to higher transmission area.

NO
MALARIA
RISK

- If no malaria transmission and
- No travel to area with malaria transmission.

Patient has high malaria risk

Patient has low malaria risk

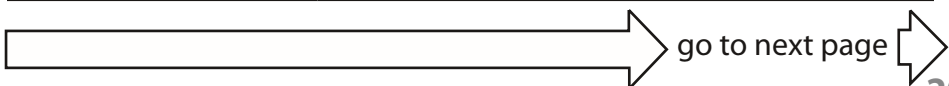
Patient has no malaria risk, p. 30

Use this table if patient has fever with high malaria risk:

SIGNS:	CLASSIFY:	TREATMENTS:
<p>One or more of the following signs:</p> <ul style="list-style-type: none"> • Confusion, agitation, lethargy or • Fast and deep breathing or • Not able to walk unaided or • Not able to drink or • Stiff neck 	VERY SEVERE FEBRILE DISEASE	<ul style="list-style-type: none"> • Give IM quinine or artemether. • Give first dose IM antibiotics. • Give glucose. • Refer urgently to hospital.
<ul style="list-style-type: none"> • Fever or history of fever 	MALARIA	<ul style="list-style-type: none"> • Give appropriate oral antimalarial. • Determine whether adequate treatment already given with the first-line antimalarial within 1 week—if yes, an effective second-line antimalarial is required. • Look for other apparent cause. • Consider HIV-related illness (p. 54). • If fever for 7 days or more, consider TB. (Send sputums/refer.) • Follow up in 3 days if still febrile (p. 63).

Use this table if patient has fever with low malaria risk:

<ul style="list-style-type: none"> • Confusion, agitation, lethargy or • Not able to drink or • Not able to walk unaided or • Stiff neck or • Severe respiratory distress 	VERY SEVERE FEBRILE DISEASE	<ul style="list-style-type: none"> • Give IM quinine or artemether. • Give first dose IM antibiotics. • Give glucose. • Refer urgently to hospital.
<ul style="list-style-type: none"> • Fever or history of fever and • No new rash and • No other apparent cause of fever or • Dipstick or smear positive for malaria 	MALARIA	<ul style="list-style-type: none"> • Give appropriate oral antimalarial. • Determine whether adequate treatment already given with the first-line antimalarial within 1 week—if yes, an effective second-line antimalarial is required. • Consider fever related to ARV use. (See <i>Chronic HIV Care</i>.) • Follow up in 3 days if still febrile (p. 63).
<ul style="list-style-type: none"> • Other apparent cause of fever or • New rash or • Dipstick or smear negative for malaria 	FEVER MALARIA UNLIKELY	<ul style="list-style-type: none"> • Treat according to the apparent cause. (Exception: Also give IM antimalarial if patient is classified as SEVERE PNEUMONIA.) • Consider HIV related illness if unexplained fever for > 30 days (p. 54). • Consider fever related to ARV use. (See <i>Chronic HIV Care</i>.) • If no apparent cause and fever for 7 days or more, send sputums for TB and refer to hospital for assessment (p. 63).



Use this table if patient has fever with no malaria risk:

SIGNS:	CLASSIFY AS:	TREATMENTS:
<ul style="list-style-type: none"> • Confusion, agitation, lethargy or • Not able to drink or • Not able to walk unaided or • Stiff neck 	<p>VERY SEVERE FEBRILE DISEASE</p>	<ul style="list-style-type: none"> • Give first dose IM antibiotics. • Give glucose. • Refer urgently to hospital.
<ul style="list-style-type: none"> • Fever for 7 days or more 	<p>PERSISTENT FEVER</p>	<ul style="list-style-type: none"> • Treat according to apparent cause. • Consider TB. (Send sputums/refer.) • If no apparent cause, refer to hospital for assessment. • Consider HIV related illness if unexplained fever for > 7 days (p. 54). • Consider fever related to ARV use. (See <i>Chronic HIV Care.</i>)
<ul style="list-style-type: none"> • None of the above 	<p>SIMPLE FEVER</p>	<ul style="list-style-type: none"> • Follow up in 2-3 days if fever persists (p. 63). • Treat according to apparent cause.

NOTES:

► **If the patient has diarrhoea:**

IF YES, ASK:	LOOK AND FEEL
<ul style="list-style-type: none"> • For how long? <ul style="list-style-type: none"> – If more than 14 days, have you been treated before for persistent diarrhoea? – If yes, with what? When? • Is there blood in the stool? 	<ul style="list-style-type: none"> • Is the patient lethargic or unconscious? • Look for sunken eyes. • Is the patient: <ul style="list-style-type: none"> – Not able to drink or drinking poorly? – Drinking eagerly, thirsty? • Pinch the skin of the inside of the forearm. Does it go back: <ul style="list-style-type: none"> – Very slowly (longer than 2 seconds)? – Slowly?

Classify all patients with diarrhoea for DEHYDRATION:

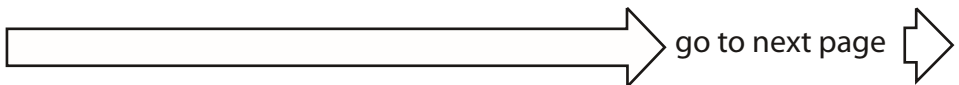
Classify DIARRHOEA

If diarrhoea for 14 days or more and no blood, p. 34.

And if blood in stool, p. 34.

Use this table in all patients with diarrhoea:

SIGNS:	CLASSIFY AS:	TREATMENTS:
<p>Two of the following signs:</p> <ul style="list-style-type: none"> • Lethargic or unconscious • Sunken eyes • Not able to drink or drinking poorly • Skin pinch goes back very slowly 	<p>SEVERE DEHYDRATION</p>	<ul style="list-style-type: none"> • If no other severe classification, give fluid for severe dehydration, (Plan C on p. 90) then reassess. (This patient may not require referral.) <p>Or, if another severe classification:</p> <ul style="list-style-type: none"> • Refer URGENTLY to hospital after initial IV hydration or, if not possible, with frequent sips of ORS on the way. <p>If there is cholera in your area, give appropriate antibiotic for cholera (according to sensitivity data).</p>
<p>Two of the following signs:</p> <ul style="list-style-type: none"> • Sunken eyes • Drinks eagerly, thirsty • Skin pinch goes back slowly 	<p>SOME DEHYDRATION</p>	<ul style="list-style-type: none"> • Give fluid and food for some dehydration. (See Plan B on p. 89.) • Advise when to return immediately. • Follow up in 5 days if not improving.
<p>Not enough signs to classify as some or severe dehydration</p>	<p>NO DEHYDRATION</p>	<ul style="list-style-type: none"> • Give fluid and food to treat diarrhoea at home. (See Plan A on p. 88.) • Advise when to return immediately. • Follow up in 5 days if not improving.



Also use this table if diarrhoea for 14 days or more and no blood:

SIGNS:	CLASSIFY AS:	TREATMENTS:
<ul style="list-style-type: none"> Some or severe dehydration present 	<p>SEVERE PERSISTENT DIARRHOEA</p>	<ul style="list-style-type: none"> Give fluids for dehydration (Plan B or C on pp. 89-90) before referral, then reassess. (This patient may not require referral.) If signs of dehydration persist, or another severe classification, refer urgently to hospital.
<ul style="list-style-type: none"> No dehydration 	<p>PERSISTENT DIARRHOEA</p>	<ul style="list-style-type: none"> Give appropriate empirical treatment, depending on recent treatment and HIV status. Consider HIV-related illness (p. 54). If on ARV treatment, this could be drug side effect. (See <i>Chronic HIV Care</i>.) Give supportive care for persistent diarrhoea. (See <i>Palliative Care</i>.) Give nutritional advice and support. Follow up in 5 days. (Explain when to refer.)

Also use this table if blood in stool:

<ul style="list-style-type: none"> Blood in the stool 	<p>DYSENTERY</p>	<ul style="list-style-type: none"> Treat for 5 days with an oral antibiotic recommended for <i>Shigella</i> in your area. Advise when to return immediately. Follow up in 2 days.
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NOTES:

► If female patient complains of genito-urinary symptoms or lower abdominal pain:

- ❖ For an adult non-pregnant woman or an adolescent, use this page.
- ❖ For a pregnant woman, use antenatal guidelines.
- ❖ For a man, use page 22.

IF YES, ASK:	LOOK AND FEEL
<ul style="list-style-type: none"> • What is the problem? • What medications are you taking? <p>Do you have:</p> <ul style="list-style-type: none"> • Burning or pain on urination? • Increased frequency of urination? • Ulcers or sore in your genital area? • An abnormal vaginal discharge <ul style="list-style-type: none"> — If yes, does it itch? • Any bleeding on sexual contact? • Has your partner had any genital problem? <ul style="list-style-type: none"> — If partner is present, ask him about urethral discharge or sores. • When was your last menstrual period? <ul style="list-style-type: none"> — If missed period: Do you think you might be pregnant? <p>Have you had very heavy or irregular periods?</p> <ul style="list-style-type: none"> — If yes: <ul style="list-style-type: none"> — Is the problem new? — How many days does your bleeding last? — How often do you change pads or tampons? <ul style="list-style-type: none"> • Do you have very painful menstrual cramps? • Are you using contraception? If yes, which one? • Are you interested in contraception? If yes, use <i>Family Planning</i> guidelines**. 	<ul style="list-style-type: none"> • Feel for abdominal tenderness. <ul style="list-style-type: none"> If tenderness: <ul style="list-style-type: none"> — Is there rebound? — Is there guarding? — Can you feel a mass? — Are bowel sounds present? — Measure temperature. — Measure pulse. • Perform external exam, look for large amount of vaginal discharge. (If only small amount white discharge in adolescent, this is usually normal.) • Look for anal or genital ulcer. <ul style="list-style-type: none"> If present, also use p. 20. • Feel for enlarged inguinal lymph node. <ul style="list-style-type: none"> If present, also use p. 20. • If you are able to do bimanual exam, feel for cervical motion tenderness. • If burning or pain on urination or complaining for back or flank pain: <ul style="list-style-type: none"> — Percuss flank for tenderness.

If lower abdominal pain (other than menstrual cramps):

Classify:

If abnormal vaginal discharge, p. 38.

Burning or pain on urination or flank pain, p. 38.

If menstrual pain or missed period or bleeding irregular or very heavy periods, p. 39.

If suspect gonorrhoea/chlamydia infection based on any of these factors:

* If fever with right lower abdominal pain and referral is delayed, give ampicillin and metronidazole for possible appendicitis.

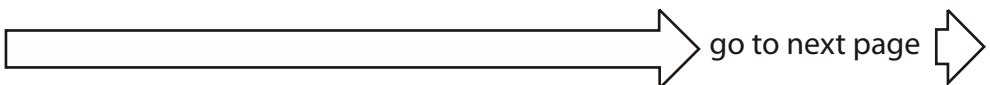
** Such as *Decision-Making Tool for Family Planning Clients and Providers*.

Use this table in all women with lower abdominal pain (other than menstrual cramps):

SIGNS:	CLASSIFY AS	TREATMENTS:
Abdominal tenderness with: <ul style="list-style-type: none"> • Fever > 38° C or • Rebound or • Guarding or • Mass or • Absent bowel sounds or • Not able to drink or • Pulse > 110 or • Recent missed period or abnormal bleeding 	SEVERE OR SURGICAL ABDOMINAL PROBLEM	<ul style="list-style-type: none"> • Give appropriate IV/IM antibiotics. • Give patient nothing by mouth (NPO). • Insert IV. • Refer URGENTLY to hospital *. • If bleeding, follow other guidelines for bleeding in early pregnancy; consider ectopic pregnancy.
<ul style="list-style-type: none"> • Lower abdominal tenderness or • Cervical motion tenderness 	PID (pelvic inflammatory disease)	<ul style="list-style-type: none"> • Give ciprofloxacin plus doxycycline plus metronidazole. • Follow up in 2 days if not improved; follow up all at 7 days (p. 66). • Promote/provide condoms. • Offer HIV/STI counselling and HIV and syphilis testing • Treat partner for GC/chlamydia. • Abstain from sex during treatment.
<ul style="list-style-type: none"> • Abdomen soft and none of the above signs 	GASTRO-ENTERITIS OR OTHER GI OR GYN PROBLEM	<ul style="list-style-type: none"> • If diarrhoea, see p. 32. • If constipation, advise remedies. (See <i>Palliative Care</i>.) • Return if not improved.

Use this table if suspect gonorrhoea/chlamydia based on any of these factors

<ul style="list-style-type: none"> • Sex worker or • Bleeding on sexual contact or • Partner with urethral discharge or burning on urination or • Any woman who thinks she may have a STI 	POSSIBLE GONORRHOEA/CHLAMYDIA INFECTION	<ul style="list-style-type: none"> • Treat woman and partner with antibiotics for possible GC/chlamydia infection. • Promote/provide condoms. • Offer HIV/STI counselling and HIV and syphilis testing. • Follow up in 7 days if symptoms persist (p. 65).
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Use this table in all women with **abnormal vaginal discharge**:

SIGNS:	CLASSIFY AS:	TREATMENTS:
<ul style="list-style-type: none"> • Itching or • Curd-like vaginal discharge 	CANDIDA VAGINITIS	<ul style="list-style-type: none"> • Treat with nystatin. • Return if not resolved. • Consider HIV-related illness if recurrent (p. 54).
<ul style="list-style-type: none"> • None of the above 	BACTERIAL VAGINOSIS (BV) OR TRICHOMONIASIS	<ul style="list-style-type: none"> • Give metronidazole 2 gm at once • Follow up in 7 days if not resolved. (p. 66)

Use this table in all women with **burning or pain on urination or flank pain**:

<ul style="list-style-type: none"> • Flank pain or • Fever. 	KIDNEY INFECTION	<p>If systemically ill:</p> <ul style="list-style-type: none"> • Give appropriate IM antibiotics. • Refer URGENTLY to hospital. Also refer if on indinavir (an ARV drug). <p>If not:</p> <ul style="list-style-type: none"> • Give appropriate oral antibiotics. • Follow up next day. (p. 66)
<ul style="list-style-type: none"> • Burning or pain on urination and • Frequency and • No abnormal vaginal discharge 	BLADDER INFECTION	<ul style="list-style-type: none"> • Give appropriate oral antibiotics. • Increase fluids. • Follow up in 2 days if not improved. (p. 66)
<ul style="list-style-type: none"> • None of the above 	BLADDER INFECTION UNLIKELY	<ul style="list-style-type: none"> • Treat for vaginitis if abnormal discharge. • Dipstick urine if possible.

Use this table in all women with menstrual pain or missed period or bleeding irregular or very heavy period:

SIGNS:

CLASSIFY AS:


TREATMENTS:

<ul style="list-style-type: none"> • Irregular bleeding and • Sexually active or • Any bleeding in known pregnancy 	<p>PREGNANCY-RELATED BLEEDING OR ABORTION</p>	<ul style="list-style-type: none"> • Follow guidelines for vaginal bleeding in pregnancy (e.g. IMPAC *) or • Refer
<ul style="list-style-type: none"> • Missed period and • Sexually active and • Not using a very reliable method of contraception*. 	<p>POSSIBLE PREGNANCY</p>	<ul style="list-style-type: none"> • Confirm pregnancy. • Discuss plans for pregnancy. • If she wishes to continue pregnancy, use guidelines for antenatal care (e.g. IMPAC**). • Refer or provide PMTCT interventions if pregnant.
<p>Not pregnant with:</p> <ul style="list-style-type: none"> • New, irregular menstrual bleeding or • Soaks more than 6 pads each of 3 days (with or without pain) 	<p>IRREGULAR MENSES OR VERY HEAVY PERIODS (MENORRHAGIA)</p>	<ul style="list-style-type: none"> • Consider contraceptive use and need (see <i>Family Planning</i> guidelines): <ul style="list-style-type: none"> - If contraception desired, suggest oral contraceptive pill. - IUD in the first 6 months and long-acting injectable contraceptive can cause heavy bleeding; combined contraceptive pills or the mini-pill can cause spotting or bleeding between periods. • If on ART, consider withdrawal bleeding from drug interaction. (See <i>Chronic HIV Care</i> module.) • Refer for gynaecological assessment if unusual or suspicious bleeding in women > 35 years. • If painful menstrual cramps or to reduce bleeding, give ibuprofen (not aspirin). • Follow up in 2 weeks.
<ul style="list-style-type: none"> • Only painful menstrual cramps 	<p>DYSMENORRHOEA</p>	<ul style="list-style-type: none"> • If she also wants contraception, suggest oral contraceptive pill. • Give ibuprofen. (Aspirin or paracetamol may be substituted but are less effective.)

* Very reliable methods include injectable, implant, IUD, pills, sterilization.

** WHO Integrated Management of Pregnancy and Childbirth (IMPAC)

► If patient has a **skin problem or lump**:

IF YES, ASK:	LOOK AND FEEL
<ul style="list-style-type: none"> • Do you have a sore, a skin problem or a lump? If yes, where is it? If yes, for how long? • Does it itch? • Does it hurt? • Duration? • Discharge? • Do other members of the family have the same problem? • Are you taking any medication? <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> <p>If on ARV therapy, skin rash could be a serious side effect. See <i>Chronic HIV Care</i>.</p> </div>	<ul style="list-style-type: none"> • Are there lesions? Where? How many? Are they infected (red, tender, warm, pus or crusts)? • Are they tender? • Is there sensation to light touch? • Feel for fluctuance. • Feel for lymph nodes. Are they tender? <div style="text-align: center; margin: 10px 0;">  </div> <ul style="list-style-type: none"> • Look/feel for lumps. <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> <p>If painful inguinal node or ano-genital ulcer or vesicles, see p. 20.</p> </div> <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> <p>If dark lumps, consider HIV-related illness, see p. 54.</p> </div>

If enlarged lymph nodes or mass:

Is it infected? Consider this in all skin lesions.

If red, tender, warm, pus or crusts (infected skin lesion):

If itching-skin problem, use p. 42.

If skin sores, blisters or pustules, use p. 43.

If skin patch with no symptoms or loss of feeling, use p. 44.

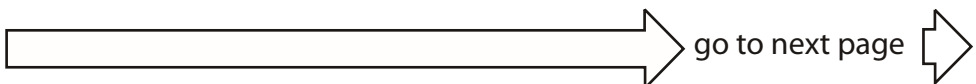
Use this table if enlarged lymph nodes or mass:

SIGNS:	CLASSIFY AS:	TREATMENTS:
<ul style="list-style-type: none"> • Size > 4 cm or • Fluctuant or • Hard or • Fever 	SUSPICIOUS LYMPH NODE OR MASS	<ul style="list-style-type: none"> • Refer for diagnostic work at district hospital. • Consider TB.
<ul style="list-style-type: none"> • Nearby infection, which could explain lymph node or • Red streaks 	REACTIVE LYMPHADENOPATHY	<ul style="list-style-type: none"> • Give oral antibiotic. • Follow up in 1 week.
<ul style="list-style-type: none"> • > 3 lymph node groups with: <ul style="list-style-type: none"> — > 1 node — > 1 cm — 1 month duration — No local infection to explain 	PERSISTENT GENERALIZED LYMPHADENOPATHY	<ul style="list-style-type: none"> • Do RPR test for syphilis if none recently. • Consider HIV-related illness (p. 54).



Is it infected? Ask this in all skin lesions. If yes, also use the infection classification table below.

Use this table if lesion red, tender, warm, pus or crusts (infected skin lesion):

<ul style="list-style-type: none"> • Fever or • Systemically unwell or • Infection extends to muscle 	SEVERE SOFT TISSUE OR MUSCLE INFECTION	<ul style="list-style-type: none"> • Refer to hospital. • Start IV/IM antibiotics. (If not available, give oral cloxacillin.) • Consider HIV-related illness.
<ul style="list-style-type: none"> • Size > 4 cm or • Red streaks or • Tender nodes or • Multiple abscesses 	SOFT TISSUE INFECTION OR FOLLICULITIS	<ul style="list-style-type: none"> • Start cloxacillin. • Drain pus if fluctuance. • Elevate the limb. • Follow up the next day.
<ul style="list-style-type: none"> • Only red, tender, warm, pus or crusts—none of the signs in the pink or yellow row 	IMPETIGO OR MINOR ABSCESS	<ul style="list-style-type: none"> • Clean sores with antiseptic. • Drain pus if fluctuance. • Follow up in 2 days.






Use this table if itching skin problems:*

Scabies	Papular itching rash (prurigo)	Eczema	Ringworm (tinea)	Dry itchy skin (xerosis)
<p>Rash and excoriations on torso; burrows in webspace and wrist; face spared.</p> 	<p>Itching rash with small papules and scratch marks. Dark spots with pale centers.</p>	<p>Wet, oozing sores or excoriated, thick patches.</p> 	<p>Pale, round, bald scaling patches on scalp or round patches with thick edge on body or web of feet.</p>	<p>Dry and rough skin, sometimes with fine cracks.</p>
<ul style="list-style-type: none"> • Manage with benzyl benzoate (p.86). • Treat itching. • If persistent, consider HIV-related illness (p. 54). 	<ul style="list-style-type: none"> • Treat itching. • Locally effective remedies. • Give chlorpheniramine 4 mg every 8 hours or promethazine hydrochloride 25 mg at night. • Consider HIV-related illness (p. 54). 	<ul style="list-style-type: none"> • Soak sores with clean water to remove crusts (no soap). • Dry the skin gently. • Short term: use topical steroid cream (not on face). • Treat itching. 	<ul style="list-style-type: none"> • Whitfield's ointment (or other antifungal cream) if few patches. • If extensive, give ketoconazole or griseofulvin. • If in hairline, shave hair. • Treat itching. • Consider HIV-related illness (p. 54). 	<ul style="list-style-type: none"> • Emollient lotion or calamine lotion; continue if effective. • Locally effective remedies. • Give chlorpheniramine or promethazine. • Consider HIV-related illness (p. 54).

* Seborrhoea may itch – see p. 44.



Is it infected? Ask this in all skin lesions. If yes, also use the infection classification table on page 41.

Use this table if blister, sore or pustules:

Contact dermatitis	Herpes zoster	Herpes simplex	Drug reaction	Impetigo or folliculitis
<p>Limited to area in contact with problem substance.</p> <p>Early: blistering, red. Later: thick, dry, scaly.</p> 	<p>Vesicles in 1 area on 1 side of body plus intense pain; or scars plus shooting pain.</p> 	<p>Vesicular lesion or sores, also involving lips and/or mouth—see p. 24.</p> <p>In children, primary herpes simplex presents with many small sores or ulcers in mouth, with or without fever and lymphadenopathy; usually resolves within 2 weeks.</p>	<p>Generalized red, widespread with small bumps or blisters; or 1 or more dark skin areas (fixed drug reaction).</p>	<p>Red, tender, warm crusts or small lesions.</p> 
<ul style="list-style-type: none"> Hydrocortisone 1 % ointment or cream. If severe reaction with blisters, exudate or oedema, give prednisone. Find and remove cause. 	<ul style="list-style-type: none"> Keep clean and dry; use local antiseptic. If eye involved or any suspicion encephalitis, give aciclovir 800 mg 5 times daily x 7 days. Pain relief—analgesics and low dose amitriptiline. Offer HIV counselling and testing. Consider HIV-related illness. Discuss the possible HIV illness. (p. 54). Follow up in 7 days if sores not fully healed, earlier if worse. 	<ul style="list-style-type: none"> If ulceration for > 30 days, consider HIV related illness. If first or severe ulceration, give aciclovir. Maintain fluid intake. Give liquid food and pain relief as required. 	<ul style="list-style-type: none"> Stop medications. Give chlorpheniramine or promethazine HCl. If peeling rash with involvement of eyes and/or mouth—refer urgently to hospital. Give prednisone if severe reaction or any difficulty breathing – refer urgently to hospital. 	<p>See infection table on p. 41.</p>

Is it infected? Ask this in all skin lesions. If yes, also use the infection classification table on page 41.

Use this table if skin rash with no or few symptoms:

No or few symptoms				
<p>Leprosy</p> <p>Skin patch(es) with:</p> <ul style="list-style-type: none"> • No sensation to light touch, heat or pain. • Any location. • Pale or reddish or copper-colored. • Flat or raised or nodular. • Chronic (> 6 months). • Not red or itchy or scaling. 	<p>Seborrhoea</p> <p>Greasy scales and redness, on central face, scalp, body folds, and chest.</p> 	<p>Psoriasis</p> <p>Red, thickened and scaling patches (may itch in some). Often on knees and elbows, scalp and hairline, lower back.</p> 	<p>Molluscum contagiosum</p> <p>Raised dome-shaped lumps which may have a dimple in the center. Usually on face, neck, armpits, hands. In adults, on the genitals.</p>	<p>Warts</p> <p>Small lumps or bumps with rough surface. May appear anywhere (see p. 20 for genital warts).</p>
<ul style="list-style-type: none"> • Treat with leprosy MDT (multidrug therapy) if no MDT in past (see Chronic Care module or other leprosy guidelines). 	<ul style="list-style-type: none"> • Ketoconazole shampoo (alternative: keratolytic shampoo with salicylic acid or selenium sulfide or coal tar). Repeated treatment may be needed. • If severe, topical steroids or trial ketoconazole. • Consider HIV-related illness (p. 54). 	<ul style="list-style-type: none"> • Coal tar ointment 5% in salicylic acid 2%. • Expose to sunlight 30-60 minutes/day. 	<ul style="list-style-type: none"> • Freeze with silver nitrate or scrape. Do not treat fascial molluscum as may get scarring. • Consider HIV-related illness (p. 54), especially if giant or extensive. 	<ul style="list-style-type: none"> • Freeze with liquid nitrogen, salicylic acid or silver nitrate. Do not treat facial warts as may get scarring. • If severe, consider HIV-related illness (p. 54).

Is it infected? Ask this in all skin lesions. If yes, also use the infection classification table on page 41.

See *Adolescent Job Aid* for acne.

If on ARV therapy, see *Chronic HIV Care* module and consult. Skin reactions are potentially serious.

See other guidelines for:

- Tropical ulcer.
- Other skin problems not included here.

List it as, "other skin problem", if you don't know what it is. Consult.

► If patient has a headache or neurological problem:

IF YES, ASK:	LOOK AND FEEL
<ul style="list-style-type: none"> • Do you have weakness in any part of your body? • Have you had an accident or injury involving your head recently? • Have you had a convulsion? • Assess alcohol/drug use. • Are you taking any medications? • Do you feel like your brain/mind is working more slowly? • Do you have trouble keeping your attention on any activity for long? • Do you forget things that happened recently? • Ask family: <ul style="list-style-type: none"> — Has the patient's behaviour changed? — Is there a memory problem? — Is patient confused? <p>If memory problem by patient or family report, tell patient you want to check his/her memory:</p> <ul style="list-style-type: none"> — Name 3 unrelated objects, clearly and slowly. Ask patient to repeat them: — Can he/she repeat them? (registration problem?) <p><i>If yes</i>, wait 5 minutes and again ask, "Can you recall the 3 objects?" (recall problem?)</p> <p>If confused:</p> <ul style="list-style-type: none"> — When did it start? — Determine if patient is oriented to place and time. <ul style="list-style-type: none"> • If headache: <ul style="list-style-type: none"> — For how long? — Visual defects? — Vomiting? — On one side? — Prior diagnosis of migraine? — In HIV patient, new or unusual headache? 	<p>Assess for focal neurological problems:</p> <ul style="list-style-type: none"> • Test strength. • Look at face: flaccid on one side? • Problem walking? • Problem talking? • Problem moving eyes? • Flaccid arms or legs? <ul style="list-style-type: none"> - If yes, loss of strength? • Feel for stiff neck. • Measure BP. • Is patient confused? <p>If patient reports weakness, test strength.</p> <p>If headache, feel for sinus tenderness.</p> <p>If confused or disoriented, look for physical cause, alcohol or drug or medication toxicity, or withdrawal.</p>

If acute headache or loss of body function:

If delusions or bizarre thoughts, see p. 50.

If painful feet or legs:

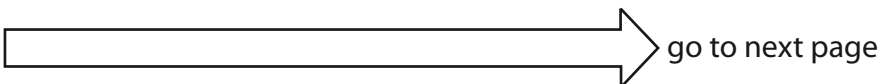
If cognitive problems, see p. 48.

Use this table if headache or neurological problem:

SIGNS:	CLASSIFY AS:	TREATMENTS:
<ul style="list-style-type: none"> • Loss of body functions or • Focal neurological signs or • Stiff neck or • Acute confusion or • Recent head trauma or • Recent convulsion or • Behavioural changes or • Diastolic BP > 120 or • Prolonged headache (> 2 weeks) or • In known HIV patient: <ul style="list-style-type: none"> — Any new unusual headache or — Persistent headache more than 1 week 	SERIOUS NEURO- LOGICAL PROBLEM	<ul style="list-style-type: none"> • Refer urgently to hospital. • If stiff neck or fever, give IM antibiotics and IM antimalarial. • If flaccid paralysis in adolescent < 15 years, report urgently to EPI programme. • If recent convulsion, have diazepam available during referral. • Consider HIV-related illness (p. 54).
<ul style="list-style-type: none"> • Tenderness over sinuses 	SINUSITIS	<ul style="list-style-type: none"> • Give appropriate oral antibiotics. • Give ibuprofen. • If recurrent, consider HIV-related illness (p. 54).
<ul style="list-style-type: none"> • Repeated headaches with <ul style="list-style-type: none"> - Visual defects or - Vomiting or - One-sided or - Migraine diagnosis 	MIGRAINE	<ul style="list-style-type: none"> • Give ibuprofen and observe response. • If more pain control is needed, see <i>Palliative Care</i> guidelines on acute pain.
<ul style="list-style-type: none"> • None of the above 	TENSION HEADACHE	<ul style="list-style-type: none"> • Give paracetamol. • Check vision—consider trial of glasses. • Suggest neck massage. • Reduce: stress, alcohol and drug use. • Refer if headache more than 2 weeks. • If on ARV drugs, this may be a side effect. (See <i>Chronic HIV Care</i>.)

Use this table if painful leg neuropathy

<ul style="list-style-type: none"> • Painful burning or numb or cold feeling in feet or lower legs 	PAINFUL LEG NEUROPATHY	<ul style="list-style-type: none"> • If on INH, give pyridoxine. If chronic diarrhoea, try ORS. • Consider HIV-related illness (p. 54), syphilis (do RPR, p.118); diabetes (check blood or urine for glucose); ART side effect—see <i>Chronic HIV Care</i>. • Refer for further assessment if cause unclear. • Treat with low-dose amitriptyline (p. 82). • Follow up in 3 weeks.
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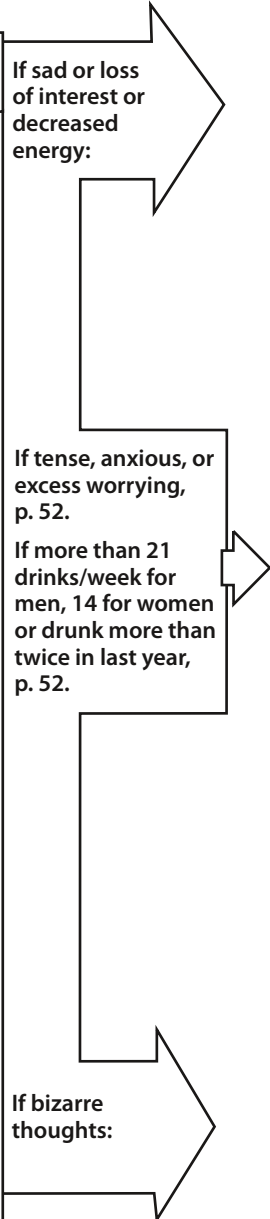
Use if cognitive problems—problems thinking or remembering or disorientation:

SIGNS:	CLASSIFY AS:	TREATMENTS:
<ul style="list-style-type: none"> Recent onset of confusion or Difficulty speaking or Loss of orientation or Restless and agitated or Reduced level of consciousness 	DELIRIUM	<ul style="list-style-type: none"> Refer to hospital. Give antimalarial pre-referral if malaria risk (p. 70). Give glucose and thiamine. (Check blood glucose.) Treat physical cause (systemic illness) or alcohol (p. 52) or drug/medication toxicity or withdrawal. Consider HIV-related illness (p. 54). If HIV-related, may improve on ARV therapy. If not able to refer, also give fluids. If very agitated and not alcohol or drug intoxicated, give low dose sedation with haloperidol (p. 83).
<p>No reduced level of consciousness with:</p> <ul style="list-style-type: none"> Serious memory problems or Slowed thinking with trouble keeping attention or Misplaces important objects or Loss of orientation or Slowed thinking with trouble keeping attention 	DEMENTIA	<ul style="list-style-type: none"> Consult or refer for assessment if cause uncertain. Every patient with dementia needs a full assessment once to exclude a reversible cause. Consider HIV-related illness (p. 54) If HIV-related, may improve on ARV therapy. Advise family. In elderly, make sure adequately hydrated. If known diagnosis, arrange for home care support to provide a safe, protective environment. Supportive contact with familiar people can reduce confusion.
<ul style="list-style-type: none"> Occasional decreased concentration or Minor short term memory loss 	NORMAL AGING	<ul style="list-style-type: none"> Reassure patient and relatives.

NOTES:

► **If patient has a mental problem, looks depressed or anxious, sad, fatigued, alcohol problem or recurrent multiple problems:**

IF YES, ASK:	LOOK AND FEEL
<p>How are you feeling? (Listen without interrupting.) Ask:</p> <ul style="list-style-type: none"> — Do you feel sad or depressed? — Have lost interest/pleasure in things you usually enjoy? — Do you have less energy than usual? <p>If yes to any of the above three questions, ask for these depression symptoms:</p> <ul style="list-style-type: none"> — disturbed sleep — appetite loss (or increase) — poor concentration — moves slowly — decreased sex drive — loss of self-confidence or esteem — guilty feelings — thoughts of suicide or death <p>Have you had bad news for yourself or your family?</p> <p>If suicidal thoughts, assess the risk:</p> <ul style="list-style-type: none"> — Do you have a plan? — Determine if patient has the means. — Find out if there is a fixed time-frame. — Is the family aware? — Has there been an attempt? How? Potentially lethal? <p>Do you drink alcohol? If yes:</p> <ul style="list-style-type: none"> — Calculate drinks per week over last 3 months. — Have you been drunk more than 2 times in past year? 	<ul style="list-style-type: none"> • Does patient appear: <ul style="list-style-type: none"> — Agitated? — Restless? — Depressed? • Is patient disoriented to time and place? • Is patient confused? • Does the patient express bizarre thoughts? If yes, <ul style="list-style-type: none"> — Does the patient express incredible beliefs (delusions) or see or hear things others cannot (hallucinations)? — Is the patient intoxicated with alcohol or on drugs which might cause these problems? • Does patient have a tremor? <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> <p>If fatigue or loss of energy, consider medical causes of fatigue such as anaemia (p. 18), infection, medications, lack of exercise, sleep problems, fear of illness, HIV disease progression.</p> </div> <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> <p>If confusion or cognitive problems, see p. 48.</p> </div> <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> <p>If HIV patient, consider underlying medical problem or drug toxicity for any new change in mental status.</p> </div>



Use this table if sad or loss of interest or decreased energy:

SIGNS:	CLASSIFY AS:	TREATMENTS:
<ul style="list-style-type: none"> • Suicidal thoughts If patient also has a plan and the means, or attempts it with lethal means, consider high risk 	SUICIDE RISK	<ul style="list-style-type: none"> • If high risk, refer for hospitalization (if available) or arrange to stay with family or friends (do not leave alone). • Manage the suicidal person. • Remove any harmful objects. • Mobilize family support. • Follow up.
<ul style="list-style-type: none"> • Five or more depression symptoms and • Duration more than 2 weeks 	MAJOR DEPRESSION	<ul style="list-style-type: none"> • If suspect bipolar disorder (manic at other times), refer for lithium. • If patient is taking efavirenz (EFV), see <i>Chronic HIV Care</i>. • Otherwise, start amitryptiline (p. 82). • Educate patient and family about medication. • Refer for counselling if available or provide basic counselling to counter depression (see p. 107-108). • Follow up.
<ul style="list-style-type: none"> • Less than 5 depression symptoms or • More than 2 months of bereavement with functional impairment 	MINOR DEPRESSION/ COMPLICATED BEREAVEMENT	<ul style="list-style-type: none"> • Counsel to counter depression. • Give amitryptiline if serious problem with functioning. • If problems with sleep, suggest solutions. • Follow up in 1 week.
<ul style="list-style-type: none"> • Bereaved, but functioning 	DIFFICULT LIFE EVENTS/LOSS	<ul style="list-style-type: none"> • Counsel, assure psychosocial support. • If acute, uncomplicated bereavement with high distress and not able to sleep, give diazepam 5 mg or amitryptiline 25 mg at night for one week only.

Use this table in all with bizarre thoughts:

<ul style="list-style-type: none"> • Delusions • Hallucinations 	POSSIBLE PSYCHOSIS	<ul style="list-style-type: none"> • Exclude alcohol intoxication or drug toxicity or ARV side effect (especially EFV). • Consider infection and other causes—see Delirium, p. 48. • Refer for psychiatric care. • If acutely agitated or dangerous to self or others, give haloperidol (p. 83).
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Use this if tense, anxious or excess worrying:

SIGNS:	CLASSIFY AS:	TREATMENTS:
<ul style="list-style-type: none"> • Sudden episodes of extreme anxiety or • Anxiety in specific situations or • Exaggerated worry or • Inability to relax or • Restlessness 	<p>ANXIETY DISORDER</p>	<ul style="list-style-type: none"> • Counsel on managing anxiety according to specific situation. • Teach patients slow breathing and progressive relaxation. • If severe anxiety, consider short-term use of diazepam (up to 2 weeks only). Refer if severe anxiety > 1 month. • Follow up in 2 weeks.

Use this if more than 21 drinks/week for men, 14 for women or drunk more than twice in last year:

<p>Two or more of:</p> <ul style="list-style-type: none"> • Severe tremors • Anxiety • Hallucinations 	<p>SEVERE WITHDRAWAL SIGNS</p>	<ul style="list-style-type: none"> • Refer to a treatment center or hospital. • Give diazepam for withdrawal if not able to refer; monitor daily. • Give thiamine to all, and glucose if poor nutrition.
<ul style="list-style-type: none"> • Possible excessive alcohol use 	<p>HAZARDOUS ALCOHOL USE</p>	<ul style="list-style-type: none"> • Assess further using WHO AUDIT and counsel. (Use brief intervention guidelines for hazardous alcohol use.)

Assess and treat other problems

If:

- pain from chronic illness,
- constipation,
- hiccups, and/or
- trouble sleeping,
see *Palliative Care* module.

If chronic illness, see *Chronic Care* modules.

Consider HIV-related Illness

Clinical Signs of Possible HIV Infection

- Repeated infections
- Herpes zoster
- Skin conditions including prurigo, seborrhoea
- Lymphadenopathy (PGL)—painless swelling in neck and armpit
- **Kaposi lesions (painless dark or purple lumps on skin or palate)**
- **Severe bacterial infection—pneumonia or muscle infection**
- **Tuberculosis—pulmonary or extrapulmonary**
- **Oral thrush or oral hairy leukoplakia**
- **Gum/mouth ulcers**
- **Oesophageal thrush**
- **Weight loss more than 10 % without other explanation**
- **More than 1 month:**
 - **Diarrhoea (unexplained)**
 - **Vaginal candidiasis**
 - **Unexplained fever**
 - **Herpes simplex ulceration (genital or oral)**

Other indications suggesting possible infection:

- Other sexually transmitted infections
- A spouse or partner or child:
 - known to be HIV positive
 - has HIV or HIV-related illness
- Unexplained death of young partner
- Injecting drug use
- High risk occupation
- Sexually active person with multiple partners living in high HIV-burden area

► **Consider TB and send sputums for examination of TB (p. 112) if any of these signs:**

- Cough for more than 2 weeks
- Father, mother, partner, or sibling diagnosed as TB
- Weight loss
- Hemoptysis
- Painless swelling in neck or armpit
- Sweats
- Weight loss

- ❖ **If HIV status is unknown, advise to be tested for HIV infection. (See p. 97)**
- ❖ **If patient has signs in bold in the gray box on the previous page:**
 - These signs indicate HIV clinical stage 3 or 4. Patient is likely eligible for ARV therapy. HIV testing is urgent (see ***Chronic HIV Care*** module).
- ❖ **For patients with a positive HIV test:**
 - Obtain a CD4 count if available.
 - **Provide ongoing HIV Care—use the *Chronic HIV Care* module.**

Prevention:
Check Status of
Routine Screening,
Prophylaxis and
Treatment

Do this in all acute and chronic patients!

**Prevention:
Screening and Prophylaxis**

ASSESS	TREAT AND ADVISE
<ul style="list-style-type: none"> • Ask whether patient and family are sleeping under a bednet. <ul style="list-style-type: none"> - If yes, has it been dipped in insecticide? 	<ul style="list-style-type: none"> • Encourage use of insecticide-treated bednets.
<ul style="list-style-type: none"> • Is patient sexually active? (For adolescent: Have you started having sex yet? See next page.) • Determine if patient is at risk for HIV infection. • Is patient's HIV status known? 	<ul style="list-style-type: none"> • Counsel on safer sex. See next page for adolescents. • Offer family planning. • If unknown status: <ul style="list-style-type: none"> - offer HIV testing and explain its advantages (p. 97), and - counsel after HIV testing.
<ul style="list-style-type: none"> • Does patient smoke? • If adolescent, do you feel pressure to do so? 	<p>If yes, counsel to stop smoking. (See <i>Brief Interventions: Smoking Cessation.</i>)</p> <ul style="list-style-type: none"> • If adolescent is smoking: educate on hazards, help to say no. If not, provide positive reinforcement.
<ul style="list-style-type: none"> • Does patient drink alcohol? If yes, calculate drinks per week over last 3 months. • Have you had 5 or more drinks on 1 occasion in last year? 	<ul style="list-style-type: none"> • If more than 21 drinks/week for men, 14 for women or 5 drinks at once, assess further and counsel to reduce or quit. (See <i>Brief Interventions: Hazardous Alcohol.</i>) • If adolescent is drinking: educate on hazards, help to say no. If not, provide positive reinforcement.
<ul style="list-style-type: none"> • Has patient over 15 years been screened for hypertension within last 2 years? 	<ul style="list-style-type: none"> • Measure blood pressure. Repeat measurement if systolic >120 mmHg. • If still elevated, see hypertension guidelines.
<ul style="list-style-type: none"> • Occupation with back strain or history of back pain. 	<ul style="list-style-type: none"> • Exercises to stretch and strengthen abdomen and back. • Correct lifting and other preventive interventions.

ASSESS	TREAT AND ADVISE
<p>In adolescent girls and women of childbearing age:</p> <p>Check Tetanus Toxoid (TT) immunization status:</p> <ul style="list-style-type: none"> - When was TT last given? - Which doses of TT was this? - Check when last dose mebendazole. 	<p>Give mebendazole if due.</p> <p>If Tetanus Toxoid (TT) is due:</p> <ul style="list-style-type: none"> • give 0.5 ml IM, upper arm. • advise her when next dose is due. • record on her card. <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> <p>TETANUS TOXOID (TT or Td) SCHEDULE:</p> <ul style="list-style-type: none"> • At first contact with woman of childbearing age or at first antenatal care visit, as early as possible during pregnancy. • At least four weeks after TT1 →TT2. • At least six months after TT2 →TT3. • At least one year after TT3 →TT4. • At least one year after TT4 →TT5. </div>
<p>In women of childbearing age:</p> <ul style="list-style-type: none"> - Is she pregnant? 	<ul style="list-style-type: none"> • If pregnant, discuss her plans, follow antenatal care guidelines. • If not pregnant, offer family planning.

Special Prevention for Adolescents See *Adolescent Job Aid*.

ASSESS	TREAT AND ADVISE
<ul style="list-style-type: none"> ❖ Is patient sexually active? ❖ <i>If yes—sexually active</i>, also ask: <ul style="list-style-type: none"> — does the patient use condoms? — was the patient forced to have sex? — does the patient consider him/herself to be at risk of HIV, other STIs or pregnancy? — does patient know his/her HIV status? <p>Young people may know very little about HIV and how it is transmitted. Be sure to check their understanding, especially about how to protect themselves.</p>	<p><i>If no</i>, encourage the patient to delay initiation of penetrative vaginal, anal or oral sexual intercourse, and to avoid anything that brings him/her into contact with his/her partner’s semen or vaginal secretions.</p> <ul style="list-style-type: none"> ❖ Advise to explore sexual pleasure in other forms of intimacy. Find non-sexual activities that you and your partner enjoy. <p><i>If yes—sexually active</i>, provide information and counselling about the prevention of HIV, STIs and pregnancy, <i>emphasizing that condoms are dual protection for pregnancy and STIs/HIV.</i></p> <ul style="list-style-type: none"> ❖ Advise the patient to reduce the number of partners or, better yet, be faithful to one. ❖ Advise to use condoms correctly and consistently every time that s/he has sexual intercourse. <p>Demonstrate how to use a condom.</p> <ul style="list-style-type: none"> ❖ Discuss appropriate ways of saying no to unwanted sex and negotiating condom use. Reinforce skills to say no. (Refer to an appropriate organization or group if s/he does not have the skills.) Make sure girls understand that they cannot tell by looking at someone if the person is infected with HIV and that HIV risk increases with the age of the man. ❖ Offer HIV testing and counselling. (See p. 98-99.) ❖ If unprotected sexual intercourse, advise on emergency contraception within 120 hours and prevention and treatment of STIs. ❖ If patient has been forced to have sex or raped, see <i>Quick Check</i> module.

Always use condoms

How you should use condoms:



1 Open condoms and check expiry date.



2 Squeeze air from the teet of the condom.



3 Roll rim of condom on erect penis.



5 Knot condom to avoid spilling sperm. Throw used condom in pit latrine or burn it.



4 Hold condom and remove penis from vagina

Condoms should be put on at the beginning of intercourse, not just before ejaculation.

Follow-up Care for Acute Illness

► **Follow-up pneumonia**

❖ **After 2 days, assess the patient:**

- Check the patient with pneumonia using the Look and Listen part of the assessment on page 16.
- Also ask, and use the patient's record, to determine:
 - Is the breathing slower?
 - Is there less fever?
 - Is the pleuritic chest pain less?
 - How long has the patient been coughing?

❖ **Treatment:**

- **If signs of SEVERE PNEUMONIA OR VERY SEVERE DISEASE or no improvement in pleuritic chest pain**, give IM antibiotics and refer urgently to hospital.
- **If breathing rate and fever** are the same, change to the second-line oral antibiotic and advise to return in 2 days.

Exception: refer to hospital if the patient:

- has a chronic disease or
 - is over 60 years of age or
 - has suspected or known HIV infection
- **If breathing slower or less fever**, complete the 5 days of antibiotic. Return only if symptoms persist.

❖ **Also:**

- If still coughing and cough present for more than 2 weeks, send 3 sputums for TB or send the patient to district hospital for sputum testing.
- Consider HIV-related illness (p. 54).
- If recurrent episodes of cough or difficult breathing and a chronic lung problem has not been diagnosed, refer patient to district hospital for assessment.

► **Follow-up TB: diagnosis based on sputum smear microscopy** (three sputum samples)

If:	Then:
Two (or three) samples are positive	Patient is sputum smear-positive (has infectious pulmonary TB). Patients need TB treatment—see <i>TB Care</i> .
Only one sample is positive	Diagnosis is uncertain . Refer patient to clinician for further assessment.
All samples are negative	Patient is sputum smear-negative for infectious pulmonary TB: <ul style="list-style-type: none"> - If no longer coughing, no treatment is needed. - If still coughing, refer to a clinician if available, or treat with a non-specific antibiotic such as cotrimoxazole or ampicillin. If cough persists, repeat examination of three sputum smears.

► **Follow-up fever**

If high or low malaria risk—examine malaria smear

If persistent fever—consider:

- TB
- HIV-related illness (See p. 54).

Refer if unexplained fever 7 days or more.

► **Follow-up persistent diarrhoea in HIV negative patient** (for HIV positive, see *Chronic HIV Care* module)

- Advise to drink increased fluids (see Plan A, p. 88).
- Continue eating.
- Consider giardia infection—give metronidazole and follow up in 1 week.
- Stop milk products (milk, cheese).
- If elderly or confined to bed, do rectal exam to exclude impaction (diarrhoea can occur around impaction).
- If blood in stool, follow guidelines for dysentery.
- If fever, refer.
- If no response, refer. District clinician should evaluate.

► **Follow-up oral or oesophageal candida**

- For suspected oesophagitis—if no response and not able to refer, give aciclovir if mouth lesions suggest herpes simplex.
- If not already tested for HIV, encourage testing and counselling.
- If HIV positive, see *Chronic HIV Care* module.

► **Follow-up anogenital ulcer**

If ulcer is healed: no further treatment

If ulcer is improving:

- Continue treatment for 7 more days
- Follow up in 7 days

If no improvement: refer

► Follow-up urethritis in men

Rapid improvement usually seen in a few days with no symptoms after 7 days.

If not resolved, consider the following:

- Has patient been reinfected? Were partners treated? If not, treat partners and patient again.
- Make sure treatment for both GC and chlamydia was given and that patient adhered to treatment. If not, treat again.
- If trichomonas is an important cause of urethritis locally, treat patient and partner with metronidazole.
- If patient was adherent and no reinfection likely and resistant GC is common, give second-line treatment or refer.

For all patients

- Promote and provide condoms.
- Offer HIV testing and counselling, p. 98.
- Educate on STIs, HIV and risk reduction.

► Follow-up gonorrhoea/chlamydia infection in women

- Make sure treatment for both GC and chlamydia was given and that patient adhered to treatment. If not, treat again.
- If abnormal discharge or bleeding on sexual contact continues after re-treatment, refer for gynaecological assessment. Persistence of these symptoms after repeated treatment can be an early sign of cervical cancer, especially in women > 35 years.

► Follow-up candida vaginitis

Some improvement usually seen in a few days with no symptoms after 7 days of treatment.

If symptoms persist:

- Re-treat patient.
- Ask about oral contraceptive or antibiotic use—these can contribute to repeated candida infections.
- Consider HIV infection or diabetes, particularly if symptoms of polyuria or increased thirst or weight loss. Check urine glucose—if present, refer for fasting blood sugar, repeat candida infections are common. Consider prophylaxis (H16).
- Consider treating for possible GC/chlamydia infection if not treated on the first visit.

► Follow-up bladder infection or menstrual problem

Consider STIs if symptoms persist—treat patient and partner for GC/chlamydia. Consider use of second-line antibiotic.

If polyuria continues or is associated with increased thirst or weight loss, check for diabetes mellitus by dipstick of urine. If positive for sugar, refer for fasting blood sugar and further assessment.

Check adherence to treatment.

► Follow-up PID

Some improvement usually seen in 1-2 days but it may take weeks to feel better. (Chronic PID can cause pain for years.)

If no improvement:

- Consider referral for hospitalization.
- If IUD in place, consider removal.

If some improvement but symptoms persist:

- Extend treatment. Make sure partner has been treated for GC/chlamydia. Follow up regularly and consider referral if still not resolved.

For all patients

- Promote and provide condoms.
- Offer HIV testing and counselling, p. 98.
- Educate on STIs, HIV and risk reduction.

► Follow-up BV or trichomonas vaginitis

Some improvement usually seen in a few days with no symptoms after 7 days.

If symptoms persist:

- Treat patient and partner with 7 days course of metronidazole at same time.
- Consider treating candida infection and cervicitis if these were not treated on the first visit.
- For bacterial vaginosis (BV), make sure she avoids douching or using agents to dry vagina.
- If discharge persists after re-treatment, refer for gynaecological assessment.

Treatments

Special advice for prescribing medications for symptomatic HIV or elderly patients

- ❖ For some medications, start low, go slow. (Give full dose of antimicrobials and ARV drugs.)
- ❖ Expect the unexpected—unusual side effects and drug interactions.
- ❖ Need for dynamic monitoring—you may need to adjust medications with change in weight and illness.
- ❖ If on ARV therapy, be sure to check for drug interactions before starting any new medication—see *Chronic HIV Care* module.

Instructions for Giving IM/IV Drugs:

- ❖ Explain to the patient why the drug is given.
- ❖ Determine the dose appropriate for the patient's weight. For some drugs, it is preferable to calculate exact dose for weight.
- ❖ Use a sterile needle and sterile syringe for each patient.
- ❖ Measure the dose accurately.

► Give benzathine penicillin

For syphilis:

- ❖ Do not treat again for positive RPR if patient and partner both treated within last 6 months.
- ❖ Treat woman and her partner with 2.4 million units benzathine penicillin. If pregnant, plan to treat newborn.
- ❖ If allergic to penicillin: give doxycycline 100 mg twice daily for 14 days or tetracycline 500 mg orally 4 times daily for 14 days.

For rheumatic fever/heart disease (RF/RHD) prophylaxis:

- ❖ Give 1.2 million units every 4 weeks—see RF/RHD *Chronic Care* module.

Adolescent or adult	BENZATHINE PENICILLIN IM Add 5 ml sterile water to vial containing 1.2 million units = 1.2 million units/6 ml total volume
Primary syphilis	12 ml (6 ml in each buttock)
Prophylaxis: RF/RHD	6 ml every 4 weeks
Suspect streptococcal pharyngitis	6 ml once

► Give glucose

- ❖ Give by IV. Make sure IV is running well. Give by slow IV push.

	50% GLUCOSE SOLUTION *	25% GLUCOSE SOLUTION	10% GLUCOSE SOLUTION (5 ml/kg)
Adolescent or Adult	25 - 50 ml	50 - 100 ml	125 - 250 ml

- * 50% glucose solution is the same as 50% dextrose solution or D50. This solution is irritating to veins. Dilute it with sterile water or saline to produce 25% glucose solution.

- ❖ If no IV glucose is available, give sugar water by mouth or nasogastric tube.
- ❖ To make sugar water, dissolve 4 level teaspoons of sugar (20 grams) in a 200 ml cup of clean water.

► Give IM antimalarial

❖ Give initial IM loading dose before referral.

- **Artesunate:** Give one IM injection.
- Or **artemether:** Give one IM injection.
- Or **quinine:** give 20 mg/kg divided equally into two injections— one in each anterior thigh.

always give glucose with quinine

WEIGHT	QUININE IM 20 mg/kg* (loading dose)		ARTEMETHER 3.2 mg/kg (loading dose)	ARTESUNATE 2.4 mg/kg (loading dose)
	150 mg/ml (in 2 ml ampoules)	300 mg/ml (in 2 ml ampoules)	80 mg/ml (in 1 ml ampoules)	60 mg/3 ml (after reconstitution with 1 ml of 5% sodium bicarbonate and dilution with 2 ml normal saline)
30-39 kg	4 ml	2 ml	1.2 ml	3.6 ml
40-49 kg	5.3 ml	2.7 ml	1.6 ml	4.8 ml
50-59 kg	6.7 ml	3.3 ml	2.0 ml	6 ml
60-69 kg	8 ml	4 ml	2.4 ml	7.2 ml

* Dosages are appropriate for quinine hydrochloride, quinine dihydrochloride or quinine sulfate. If quinine base, give 8.2 mg/kg every 8 hours.

❖ If not able to refer, continue treatment as follows:

- **After loading dose of artesunate,** give 1.2 mg/kg (half of above dose) IM at 12h and 24h, then once a day until able to take orally, to complete 6 days of treatment.
- **After loading dose of artemether,** give 1.6 mg/kg (half of above dose) IM each day until able to take orally, to complete 6 days of treatment.
- **After loading dose of quinine,** give quinine 10 mg/kg (half of above dose) every 8 hours until able to take oral medication: give a full course of an effective antimalarial treatment, preferably of combination therapy, ACT or quinine plus clindamycin or doxycycline. Regimens containing mefloquine should be avoided if the patient presented initially with impaired consciousness.

► Give diazepam IV or rectally

- ❖ Call for help to turn and hold patient.
- ❖ Draw up 4 ml dose from an ampoule of diazepam into a 5 ml syringe. Then remove the needle.
- ❖ Insert small syringe 4 to 5 centimeters into the rectum and inject the diazepam solution.

DIAZEPAM RECTALLY 10 mg/2 ml solution 0.5 mg/kg		IV 0.2-0.3 mg/kg
Initial dose	4 ml (20 mg)	2 ml (10 mg)
Second dose	2 ml (10 mg)	1 ml (5 mg)

- ❖ Hold buttocks together for a few minutes.

If convulsion continues after 10 minutes, give a second, smaller dose of 1 ml diazepam IV or 2 ml rectally.

Maintenance dose during transportation if needed and health worker accompanies:

- 2 ml rectal dose can be repeated every hour during emergency transport **or**
- Give slow IV infusion of 10 mg diazepam in 150 ml over 6 hours.

Stop the maintenance dose if breathing less than 16 breaths per minute. If respiratory arrest, ventilate with bag and mask.

Maximum total dose diazepam: 50 mg.

► **Give appropriate IV/IM antibiotic pre-referral**

Classification	Antibiotic
Severe Pneumonia, Very Severe Disease	<p>First-line antibiotic: _____</p> <p>(Common choice: benzylpenicillin plus gentamicin)</p> <p>Second-line antibiotic: _____</p> <p>(Common choice: chloramphenicol)</p>
Very Severe Febrile Disease or suspect sepsis	<p>First-line antibiotic: _____</p> <p>(Common choice: chloramphenicol)</p> <p>Second-line antibiotic: _____</p> <p>(Common choice: benzylpenicillin plus gentamicin; or ceftriaxone)</p>
Severe soft tissue, muscle, or bone infection or suspected Staphylococcal infection	<p>First-line antibiotic: _____</p> <p>(Common choice: cloxacillin)</p> <p>Second-line antibiotic: _____</p> <p>(Common choice: _____)</p>
Severe or surgical abdomen	<p>First-line antibiotic: _____</p> <p>(Common choice: ampicillin plus gentamicin plus metronidazole)</p> <p>Second-line antibiotic: _____</p> <p>(Common choice: ciprofloxacin plus metronidazole)</p>
Kidney infection	<p>First-line antibiotic: _____</p> <p>(Common choice: ampicillin plus gentamicin)</p> <p>Second-line antibiotic: _____</p> <p>(Common choice: ciprofloxacin)</p>

► IV/IM antibiotic dosing

WEIGHT	BENZYL PENICILLIN Dose: 50 000 units per kg.	GENTAMICIN Dose: 5 mg/kg/day. Calculate EXACT dose based on body weight. Only use these doses if this is not possible.	
	To a vial of 600 mg (1 000 000 units): Add 2.1 ml sterile water = 2.5 ml at 400 000 units/ml	Vial containing 20 mg = 2 ml at 10 mg/ml undiluted	Vial containing 80 mg = 2 ml at 40 mg/ml undiluted
30-39 kg	4 ml	15-19 ml	4-5 ml
40-49 kg	6 ml	20-24 ml	5-6 ml
50-59 kg	7 ml	25-29 ml	6-7 ml
60-69 kg	8 ml	30-34 ml	7.5-8.6 ml
	If not able to refer: Give above dose IV/IM every 6 hours	If not able to refer: Give above dose once daily	

	CHLORAMPHENICOL Dose: 40 mg per kg	CLOXACILLIN Dose: 25-50mg/kg	AMPICILLIN Dose: 50mg/kg
WEIGHT	Add 5.0 ml sterile water to vial containing 1000 mg = 5.6 ml at 180 mg/ml	IV: To a vial of 500 mg add 8 ml of sterile water to give 500 mg/10 mls IM: Add 1.3 ml of sterile water to a vial of 250 mg to give 250 mg/1.5 ml	To a vial of 500 mg add 2.1 ml sterile water = 2.5 ml for 500 mg
30-39 kg	8 ml	6-12 ml IM (20-40 ml IV)	10 ml
40-49 kg	10 ml	7.5-15 ml IM (25-50 ml IV)	12 ml
50-59 kg	12 ml	9-18 ml IM (30-60 ml IV)	15 ml
60-69 kg	14 ml	10-20 ml IM (35-70 ml IV)	18 ml
	If not able to refer: Give above dose IV/IM every 12 hours	If not able to refer: Give above dose IV/IM every 4-6 hours	If not able to refer: Give above dose IV/IM every 6 hours

► Give salbutamol by metered-dose inhaler

100 mcg/puff; 200 doses/inhaler

Use spacer and/or mask depending on patient.

- ❖ If SEVERE WHEEZING with severe respiratory distress: give 20 puffs of salbutamol in a row. If possible, give continuously by nebulizer.
If no response in 10 minutes, give epinephrine. *
- ❖ If MODERATE WHEEZING or SEVERE WHEEZING without severe respiratory distress:
 - 2 puffs every 10 minutes x 5 times, then
 - 2 puffs every 20 minutes x 3 times, then
 - 2 puffs every 30 minutes x 6 times, then
 - 2 puffs every 3, 4 or 6 hours
- ❖ If MILD WHEEZING: 2 puffs every 20 minutes x 3 times, then 2 puffs every 3 to 6 hours.

* For further management of wheezing, see **Quick Check** module or asthma guidelines.

Instructions for Giving Oral Drugs

TEACH THE PATIENT HOW TO TAKE ORAL DRUGS AT HOME

- ❖ Determine the appropriate drugs and dosage for the patient's age and weight.
- ❖ Tell the patient the reason for taking the drug.
- ❖ Demonstrate how to measure a dose.
- ❖ Watch the patient practice measuring a dose by himself.
- ❖ Ask the patient to take the first dose.
- ❖ Explain carefully how to take the drug, then label and package the drug.
- ❖ If more than 1 drug will be given, collect, count and package each drug separately.
- ❖ Explain that all the oral drug tablets must be used to finish the course of treatment, even if the patient gets better.
- ❖ Support adherence.
- ❖ Check the patient's understanding before s/he leaves the clinic.

► Give appropriate oral antibiotic

For pneumonia if age 5 years up to 60 years

First-line antibiotic: _____
(Common choice: penicillin VK (oral) or cotrimoxazole)
Second-line antibiotic: _____
(Common choice: amoxicillin or erythromycin)

For pneumonia if age greater than 60 years

First-line antibiotic: _____
(Common choice: amoxicillin or cotrimoxazole)
Second-line antibiotic: _____
(Common choice: amoxicillin-clavulanate)

For dysentery

First-line antibiotic: _____
(Common choice: nalidixic acid or ciprofloxacin)
Second-line antibiotic: _____

For cholera - single dose treatment

First-line antibiotic: _____
(Common choice: tetracycline or doxycycline)
Second-line antibiotic: _____
(Common choice: ciprofloxacin or erythromycin)

For abscess, soft tissue infection, folliculitis, dental abscess

First-line antibiotic: _____
(Common choice: cloxacillin)
Second-line antibiotic: _____

For chancroid (treat for 7 days)

First-line antibiotic: _____
(Common choice: ciprofloxacin or erythromycin)
Second-line antibiotic: _____

For lymphogranuloma venereum, treat for 14 days

First-line antibiotic: _____
(Common choice: doxycycline)
Second-line antibiotic: _____

For reactive lymphadenopathy

First-line antibiotic: _____
Second-line antibiotic: _____

For outpatient treatment PID

First-line antibiotic: _____
(Common choice: ciprofloxacin and doxycycline and metronidazole)
Second-line antibiotic: _____

For bladder infection

First-line antibiotic: _____
(Common choice: cotrimoxazole)
Second-line antibiotic: _____

	COTRIMOXAZOLE (trimethoprim + sulfamethoxazole) Give 2 times daily for 5 days	AMOXICILLIN Give 3 daily for 5 days		CLOXACILLIN Give 4 times daily for 5 days
AGE or WEIGHT	ADULT TABLET 80 mg trimethoprim + 400 mg sulfamethoxazole	TABLET 500 mg	TABLET 250 mg	TABLET 500 mg
5 years to 13 years (19-50 kg)	1	1/2	1	1
14 years or more (> 50 kg)	2	1	2	1

	DOXYCYCLINE* Give 2 times daily for 5 days (avoid doxycycline in young adolescents)	ERYTHROMYCIN Give 4 times daily for 5 days	PEN VK Give 3 times daily for 5 days	CIPRO-FLOXACIN Give 2 times daily for 7 to 14 days
AGE or WEIGHT	TABLET 100 mg	TABLET 500 mg	TABLET 250 mg	TABLET 500 mg
5 years to 13 years (19-50 kg)	1	1/2	1	1/2
14 years or more (> 50 kg)	1	1	2	1

* Avoid doxycycline under 12 years.

► **Give antibiotics for possible GC/chlamydia infection**

IN NON-PREGNANT WOMAN, OR MAN:

First-line antibiotic combination for GC/chlamydia: _____

(Common choice: ciprofloxacin plus doxycycline)

Second-line antibiotic combination if high prevalence resistant GC or recent treatment: _____

IN PREGNANT WOMAN:

First-line antibiotic combination for GC/chlamydia: _____

(Common choice: cefixime plus amoxicillin)

Second-line antibiotic combination if high prevalence resistant GC or recent treatment: _____

► **Antibiotics for gonorrhoea (GC)**

SAFE FOR USE IN PREGNANCY:	125 mg IM
Ceftriaxone	
Cefixime 400 mg	1 tablet in clinic
Spectinomycin	2 grams IM
Kanamycin	2 grams IM
NOT SAFE FOR USE IN PREGNANCY:	
Ciprofloxacin 250 mg	2 tablets in clinic
500 mg	1 tablet in clinic

► Antibiotics for chlamydia

SAFE FOR USE IN PREGNANCY: Amoxicillin 500 mg 250 mg	1 tablet 3 times daily for 7 days 2 tablets 3 times daily for 7 days
Azithromycin 250 mg	4 capsules in clinic
Erythromycin base 250 mg base 500 mg	2 tablets 4 times daily for 7 days 1 tablet 4 times daily for 7 days
NOT SAFE FOR USE IN PREGNANCY OR DURING LACTATION: Doxycycline 100 mg	1 tablet 2 times daily for 10 days
Tetracycline 500 mg	1 tablet daily for 10 days

► Give metronidazole

Advise to avoid alcohol when taking metronidazole

❖ For bacterial vaginosis or trichomoniasis

	METRONIDAZOLE 250 mg tablet
Adolescent or adult	2 grams (8 tablets) at once in clinic or 2 tablets twice daily for 7 days

❖ For persistent diarrhoea, bloody diarrhoea, PID or severe gum/mouth infection:

Weight	METRONIDAZOLE 250 mg tablet twice daily for seven days	METRONIDAZOLE 500 mg tablet twice daily for 7 days
Adolescent or adult	2	1

► Give appropriate oral antimalarial

First-line antimalarial: _____

Second-line antimalarial: _____

AGE or WEIGHT	ARTESUNATE + AMODIAQUINE daily dose, once daily for 3 days	ARTEMETHER/ LUMEFANTRINE twice daily for 3 days*	SULFADOXINE/ PYRIMETHAMINE (SP) Single dose in clinic + ARTESUNATE daily for 3 days**	ARTESUNATE daily for 3 days + MEFLOQUINE split over the 2nd and 3rd days						
	Separate tablets: artesunate tablet 50 mg; amodiaquine tablet 153 mg base	Coformulated tablet: artemether 20 mg + lumefantrine 120 mg	Separate tablets: SP tablet (sulfadoxine 500 mg + pyrimethamine 25 mg); artesunate tablet (Art) 50 mg	Separate tablets: artesunate tablet (Art) 50 mg; mefloquine tablet (Mef) 250 mg base						
			Day	1	2	3	Day	1	2	3
5-7 yr (19-24 kg)	1+1	2	SP Art	1 1	1 1	1 1	Art Mef	1 1	1 1	1 1
8-13 yr or small or wasted adult (25-50 kg)	2+2	3	SP Art	2 2	2 2	2 2	Art Mef	2 2	2 2	2 1
14 yr + (>50 kg)	4+4	4	SP Art	3 4	4 4	4 4	Art Mef	4 4	4 4	4 2

* The second dose on the first day should be given any time between 8h and 12h after the first dose. Dosage on the second and third days is twice a day (morning and evening)

** Do not use sulfadoxine/pyrimethamine for treatment if patient is on cotrimoxazole prophylaxis. For children under 5 years, see IMCI guidelines.

► Give paracetamol for pain

- ❖ Give every 6 hours (or every 4 hours if severe pain).
- ❖ Do not exceed 8 tablets (4 gms) in 24 hours. If pain not controlled with paracetamol, alternate aspirin with paracetamol. If pain is chronic, see *Palliative Care* module P8. If severe acute pain, see *Quick Check* module.

Adolescent or Adult	paracetamol 500 mg tablet
40-50 kg or more	1 tablet
50 kg or more	1-2 tablets

Do not use for > 1 week if on nevirapine.

► **Give albendazole or mebendazole**

albendazole 400 mg single dose OR
mebendazole 500 mg single dose

► **Give prednisolone**

❖ **For acute moderate or severe wheezing, before referral:**

Give prednisolone or prednisone 60 mg orally.

Or, if not able to take oral medication, give either:

- hydrocortisone 300 mg IV or IM, or
- methylprednisolone 60 mg IV/IM.

❖ **For asthma or COPD not under control, where prednisone is in the treatment plan, give prednisolone or prednisone.**

Give high dose for several days, then taper, and then stop.

COPD may require longer treatment at low level. (See Practical Approach to Lung Health—PAL Guidelines.)

	prednisolone or prednisone 5 mg tablets						
	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
ADULT	7	7	7	6	5	4	3

► Give amitriptyline

Useful for depression, insomnia and for some neuropathic pain. Helps relieve pain when used with opioids and for sleep, in a low dose.

❖ For depression:

Educate about the drug (the patient and family):

- Not addictive.
- Do not use with alcohol.
- Takes 3 weeks to get a response in depression—don't be discouraged; often see effect on sleep or pain within 2-3 days.
- May feel worse initially. Side effects (dry mouth, constipation, difficulty urinating and dizziness) usually fade in 7-10 days.
- Will need to continue for 6 months. Do not stop abruptly.
- If suicide risk, give only one week supply at time or have caregiver dispense drug.
- May impair ability to perform skilled tasks such as driving—take precautions until used to drug.
- For elderly or HIV patients, warn to stand up slowly (risk of orthostatic hypotension).
- HIV clinical stage 3 or 4 patients are very sensitive to side effects of amitriptyline.

Weight	Starting dose	After 1 week, increase to:	After 2 weeks, increase to:	2 weeks later if inadequate response
< 40 kg	0.5-1 mg/kg			
40 kg or more	50 mg pm	75 mg pm	25 mg am 75 mg pm	50 mg am 100 mg pm
Elderly or HIV stage 3 or 4 patient	25 mg pm	25 mg am 50 mg pm	25 mg am 50 mg pm	

❖ For painful foot/leg neuropathy:

Low-dose amitriptyline—25 mg at night or 12.5 mg twice daily. (Some experts advise starting as low as 12.5 mg daily.) Wait 2 weeks for response, then increase gradually to 50 mg.

❖ For problems with sleep:

Use low dose at night—12.5 to 25 mg.

► Give haloperidol

Indications:

psychosis, acute severe agitation, or danger to self or others.

Make sure any underlying medical condition is also treated.

❖ If medically healthy:

haloperidol 5 mg once or twice daily.

❖ If medically ill, elderly or HIV clinical stage 3 or 4:

haloperidol 0.5 to 1 mg once or twice daily (orally or IM).

❖ In uncontrollable HIV clinical stage 3 or 4 patient:

haloperidol 2 mg and, if no response in one hour, add haloperidol 2 mg.

Then, if still not adequately sedated, add diazepam 2 to 5 mg orally.

Side effect of haloperidol: stiffness, tremor, muscle spasm and motor restlessness. (HIV positive patients are especially sensitive to the side-effects of haloperidol.)

If acute severe muscle spasm, especially of the mouth, neck or eyes:

- Maintain airway.
- Stop haloperidol.
- Give diazepam 5 mg rectally.
- Refer.
- If available, give biperiden 5 mg IM.

► **Treat with nystatin**

❖ **Treat oral thrush with nystatin:**

- Suck on nystatin uncoated lozenges twice daily or apply nystatin suspension five times daily (after each meal and between meals) for seven days (or until 48 hours after lesions resolve).

❖ **Treat candida vaginitis with nystatin pessaries:**

- Dosage: 100 000 IU daily by vaginal pessaries.
- Dispense 14 nystatin suppositories.

If relapse—treat first week of every month or when needed (consider HIV-related illness and diabetes).

► **Treat with antiseptic**

❖ **Wash hands before and after each treatment.**

To treat impetigo or herpes zoster with local bacterial infection:

- Gently wash with soap and water.
- Paint with topical antiseptic. Choices include:
 - chlorhexidine
 - polyvidone iodine
 - full-strength gentian violet (0.5%)
 - brilliant green
- Keep skin clean by washing frequently and drying after washing.

▶ Give aciclovir

❖ Primary infection:

200 mg five times daily for seven days or
400 mg three times daily for seven days.

❖ Recurrent infection:

As above except for five days only.

▶ Give fluconazole

❖ For suspected oesophageal candidiasis:

400 mg in clinic, then 200 mg per day for 14 days. If no response in
3-5 days, increase to 400 mg per day.

▶ Give ketoconazole

❖ For resistant oral thrush or vaginal candidiasis, give ketoconazole
200 mg daily.

▶ Apply podophyllin (do not use in pregnancy or children)

❖ **By health worker**—10-20% in compound tincture of benzoin.

Apply weekly.

Apply only to warts—avoid and protect normal tissue. Let dry.

Wash thoroughly 1-4 hours after application.

❖ **By patient**—only if Podofilox or Imiquimod are available.

► Treat scabies

Treat with one of the following:	Treatment period	Warnings
		For all treatments—will initially itch more (as mites die and lead to inflammatory response) then itch goes away.
1% Lindane (gamma benzene hexachloride) cream or lotion	once—wash off after 24 hours (after 12 hours in children)	potentially toxic if overused; avoid in pregnancy and small children
25% benzyl benzoate emulsion—dilute 1:1 for children; 1:3 for infants	at night, wash off in morning—repeat if necessary	tendency to irritate the skin
5% permethrin cream		expensive, very low systemic absorption and toxicity

- ❖ Patient and all close contacts must be treated simultaneously—whole household and sexual partners, even if asymptomatic.
- ❖ Clothing or bed linen that have possibly been contaminated by the patient in the two days prior to the start of treatment should be washed and dried well (or dry-cleaned).
- ❖ Do not bathe before applying the treatment (increases systemic absorption and does not help).
- ❖ Apply the cream to the whole skin surface giving particular attention to the flexures, genitalia, natal cleft, between the fingers and under the fingernails. Include the face, neck and scalp but avoid near the eyes and mouth.
- ❖ The cream may irritate the skin a little, especially if there are excoriations.
- ❖ Keep on for the treatment period.
- ❖ If any cream is washed off during the treatment period (e.g., hands) reapply immediately.
- ❖ Wash the cream off at the end of the treatment period.
- ❖ Itching should start to diminish within a few days, but may persist for a number of weeks. This does not mean that the treatment has failed. Another cream may help with the itching (crotamiton or topical steroid).

► Advise on symptom control for cough/cold/bronchitis

❖ Advise to use a safe, soothing remedy for cough

- Safe remedies to recommend:

- Harmful remedies to discourage (health worker should add local harmful remedies):

❖ If running nose interferes with work: suggest decongestant

❖ For fever, give paracetamol (p. 80)

► Give iron/folate

❖ For anaemia: 1 tablet twice daily

iron/folate tablets:
iron 60 mg, folic acid
400 microgram

Dehydration

► **Plan A for adolescents/adults: treat diarrhoea at home.**

❖ **Counsel the patient on the *3 Rules of Home Treatment*: Drink extra fluid, continue eating, when to return.**

1. Drink extra fluid (as much as the patient will take)—any fluid (except fluids with high sugar or alcohol) or ORS.

- Drink at least 200-300 ml in addition to usual fluid intake after each loose stool.
- If vomiting, continue to take small sips. Antiemetics are usually not necessary.
- Continue drinking extra fluid until the diarrhoea stops.
 - It is especially important to provide ORS for use at home when:
 - the patient has been treated with Plan B or Plan C during this visit;
 - the patient cannot return to a clinic if the diarrhoea gets worse; or
 - the patient has persistent diarrhoea or large volume stools.

**IF ORS is provided: TEACH THE PATIENT HOW TO MIX AND DRINK ORS.
GIVE 2 PACKETS OF ORS TO USE AT HOME.**

2. Continue eating.

3. When to return.

► Plan B for adolescents/adults: treat some dehydration with ORS

❖ Give in clinic recommended amount of ORS over 4 hour period.

- Determine amount of ORS to give during first 4 hours.

* Use the patient's age only when you do not know the weight. The approximate amount of ORS required (in ml) can also be calculated by multiplying the patient's weight (in kg) times 75.

- If the patient wants more ORS than shown, give more.

AGE *	5-14 years	≤15 years
WEIGHT	20 < 30 kg	30 kg or more
In ml	1000-2200	2200-4000

- If the patient is weak, help him/her take the ORS:

- Give frequent small sips from a cup.
- If the patient vomits, wait 10 minutes. Then continue, but more slowly.
- If patient wants more ORS than shown, give more.

- After four hours:

- Reassess the patient and classify for dehydration.
- Select the appropriate plan to continue treatment.
- Begin feeding the patient in clinic.

- If the patient must leave before completing treatment:

- Show how to prepare ORS solution at home.
- Show how much ORS to give to finish four-hour treatment at home.
- Give enough ORS packets to complete rehydration. Also give two packets as recommended in Plan A.
- Explain the **3 Rules of Home Treatment:**

1. Drink extra fluid

2. Continue eating

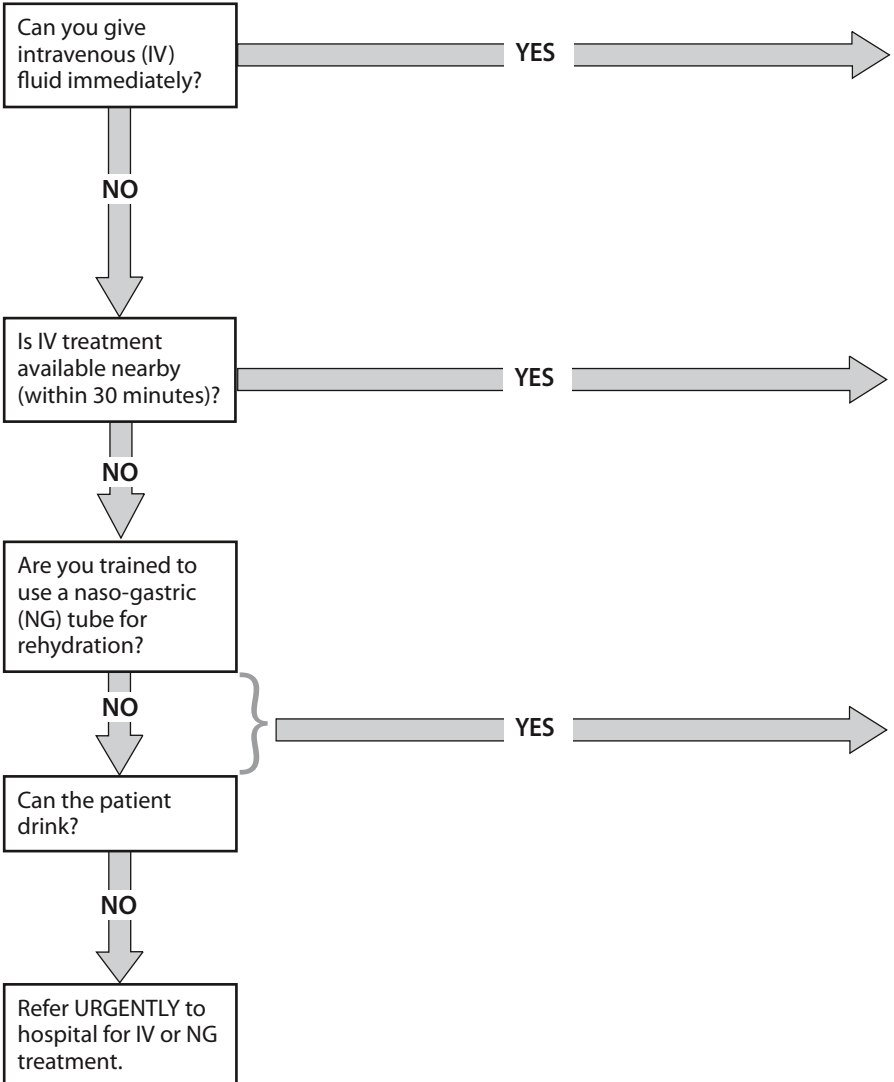
3. When to return

See Plan A for recommended fluids

► Plan C: Treat severe dehydration quickly—at any age

- ❖ FOLLOW THE ARROWS. IF ANSWER IS “YES”, GO ACROSS. IF “NO”, GO DOWN.

START HERE



- Start IV fluid immediately. If the patient can drink, give ORS by mouth while the drip is set up. Give 100 ml/kg Ringer's Lactate Solution (or, if not available, normal saline), divided as follows:

Age	First give 30 ml/kg in:	Then give 70 ml/kg:
Infants (under 12 months)	1 hour *	5 hours
Older (12 months or older, including adults)	30 minutes *	2 ½ hours

* Repeat once if radial pulse is very weak or not detectable.

- Reassess the patient every 1-2 hours. If hydration status is not improving, give the IV drip more rapidly.
- Also give ORS (about 5 ml/kg/hour) as soon as the patient can drink: usually after 3-4 hours (infants) or 1-2 hours for children, adolescents and adults.
- Reassess an infant after 6 hours and older patient after 3 hours. Classify dehydration. Then choose the appropriate plan (A, B, or C) to continue treatment.

- Refer URGENTLY to hospital for IV treatment.
- If the patient can drink, provide the mother or family/friend with ORS solution and show how to give frequent sips during the trip.

- Start rehydration by tube (or mouth) with ORS solution: give 20 ml/kg/hour for six hours (total of 120 ml/kg).
- Reassess the patient every 1-2 hours:
 - If there is repeated vomiting or increasing abdominal distension, give the fluid more slowly.
 - If hydration status is not improving after 3 hours, send the patient for IV therapy.
- After six hours, reassess the patient. Classify dehydration. Then choose the appropriate plan (A, B, or C) to continue treatment.

NOTE: If possible, observe the child at least 6 hours after rehydration to be sure the mother can maintain hydration giving the child ORS solution by mouth.

► Refer urgently to hospital *

- ❖ Discuss decision with patient and relatives.
- ❖ Quickly organize transport.
- ❖ Send with patient:
 - Health worker, if airway problem or shock.
 - Relatives who can donate blood.
 - Referral note.
 - Essential emergency supplies (below).
- ❖ Warn the referral centre by radio or phone, if possible.
- ❖ During transport:
 - Watch IV infusion.
 - Keep record of all IV fluids, medications given and time of administration.
 - If transport takes more than four hours, insert Foley catheter to empty bladder; monitor urine output.

* If referral is difficult and is refused:

Adapt locally

* If chronic illness, determine if palliative care is preferred.

Does patient have known terminal disease in a late stage (AIDS without ART, COPD, lung cancer, etc)?

Discuss needs with family and patient—can these be better met at home, with support? Comfort of the patient is prime responsibility.

Essential Emergency Supplies To Have During Transport

<u>Emergency Drugs</u>	<u>Quantity for Transport</u>
• Diazepam (parenteral)	30 mg
• Artemether or	160 mg (2 ml)
• Quinine	300 mg
• Ampicillin	2 grams
• Gentamicin	240 mg
• IV glucose—50% solution	50 ml
• Ringer's lactate (take extra if distant referral)	4 litres

<u>Emergency Supplies</u>	<u>Quantity for Transport</u>
IV catheters and tubing	2 sets
Clean dressings	
Gloves, one of which is sterile	at least 2 pairs
Clean towels	3
Sterile syringes and needles	
Urinary catheter	

Advise and Counsel

❖ Preamble

These guidelines are in accordance with the June 2004 WHO/UNAIDS Policy Statement on HIV Testing which calls for the standard pre-test counseling used in VCT services to be adapted in provider-initiated testing and counselling to simply provide pre-test education and ensure informed consent, without a counselling session. The minimum amount of information that patients require in order to be able to provide informed consent is outlined below. This is for country adaptation.

► Provide key information on HIV (Human Immune Deficiency Virus)

❖ Counsel on how HIV is transmitted and not transmitted

HIV is a virus that destroys parts of the body's immune system. A person infected with HIV may not feel sick at first, but slowly the body's immune system is destroyed. S/he becomes ill and is unable to fight infection. Once a person is infected with HIV, s/he can transmit the virus to others.

HIV can be transmitted through:

- Exchange of HIV-infected body fluids such as semen, vaginal fluid or blood during unprotected sexual intercourse.
- HIV-infected blood transfusions.
- Injecting drug use.
- Sharing of instruments for tattoo or skin piercing.
- From an infected mother to her child during:
 - pregnancy;
 - labour and delivery; and
 - postpartum through breastfeeding

HIV cannot be transmitted through hugging or kissing, or mosquito bites.

A special blood test is done to find out if the person is infected with HIV.

► HIV Testing and Counselling

❖ A provider-initiated HIV test and counselling session is composed of three steps:

- 1 Pre-test information and education (*see p. 100*)
- 2 HIV testing. (*see p. 120*)
- 3 Post-test counselling. (*see p. 103*)

► When and how to offer

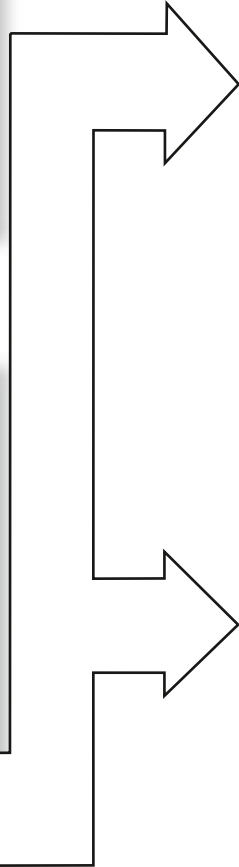
❖ An HIV test and counselling session should be offered:

- whenever a patient presents with signs or symptoms consistent with HIV infection, or
- whenever a sexually active individual of unknown serostatus can benefit from an HIV test and counselling.

❖ In a clinical context, there are two situations in which an HIV test will be offered:

- **Diagnostic testing** as part of a health worker's workup for a diagnosis of a sick patient
- **Routine offer** for a patient accessing the clinic for other, non-HIV related services (antenatal care, other illnesses, family planning, STI, etc.)

❖ In both situations, the patient should be offered the opportunity to refuse or "opt-out" of the test.



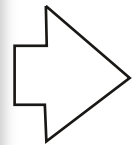
► Diagnostic testing

- ❖ Diagnostic testing is part of the clinical process of determining the diagnosis of a sick patient. If the patient presents with symptoms consistent with HIV infection, explain that you will be testing for the HIV virus as part of your clinical workup.
- ❖ Diagnostic HIV testing should be offered in this way for all the conditions in **Acute Care** where the treatment column indicates “Consider HIV-related illness.” These are summarized on p. 54.
- ❖ For example: *“You are sick; I want to find out why. In order for us to diagnose and then treat your illness, you need tests for typhoid, TB and HIV infection. Unless you object, I will conduct these tests.”*

► Routine offer

- ❖ Routine offer of testing and counselling means offering an HIV test to all sexually active patients who present for medical care regardless of their initial reason for seeking medical attention.
- ❖ For example: *“One of our hospital policies is to provide everyone with the opportunity to have an HIV test so that we can provide you with care and treatment while you are here and refer you for follow-up after discharge. Unless you object, I will conduct this test and provide you with counselling and the results.”*

- ❖ In both **diagnostic testing** and **routine offer** the patient should be provided with the following pre-test information.
- ❖ This information can be delivered either individually by a health care worker, including a social worker, or through group pre-test information sessions.



► Pre-test information and education to an adult*

- ❖ **Pre-test information may be given by a physician, nurse or ART Aid or other counsellor.** Pre-test information can be given to an individual or to a group of patients.
- ❖ **Pre-test information should focus on three main components**
 1. Provide key information on HIV/AIDS
 2. Explain procedures to safeguard confidentiality
 3. Confirm willingness of patient to proceed with test and seek informed consent. Additional information should be provided as necessary with referral for additional counselling, as needed.

1. Provide key information on HIV

Say: *“HIV is a virus or a germ that destroys the part of your body needed to defend a person from illness. The HIV test will determine whether you have been infected with the HIV virus. It is a simple blood test that will allow us to make a clearer diagnosis.*

Following the test, we will be providing counselling services to talk more in-depth about HIV AIDS.

If your test result is positive, we will provide you with information and services to manage your disease. This may include antiretroviral drugs and other medicines to manage the disease. In addition, we will help you with support for prevention and for disclosure.

If it is negative, we will focus on ensuring you have access to services and commodities to help you remain negative.”

* For adolescent, see *Adolescent Job Aid*

2. Explain procedures to safeguard confidentiality

Say: *“The results of your HIV test will only be known to you and the medical team that will be treating you. This means the test results are confidential and it is against our facility’s policy to share the results with anyone else, without your permission. It is your decision to tell other people the results of this test.”*

3. Confirm willingness of patient to proceed with test and seek informed consent

Informed consent means that the individual has been provided essential information about HIV/AIDS and HIV testing, has fully understood it and based on this has agreed to undergo an HIV test.

- Unless you object, I will get a sample for HIV testing. I think it will be important for you to know this information.

OR

- I want to perform an HIV test today. If that isn’t all right, you need to let me know.

OR

- I think this test will help me take care of your health and, unless you object, I’m going to obtain a sample. Can you agree with me?

If the patient has additional questions, provide additional information (next page). If the patient is unsure about or uncomfortable with proceeding with the HIV test or declines the test, refer him/her to the facility-based counsellor for a full pre-test counselling session. This session should address barriers to testing and re-offer the test.

If the patient is ready, then seek oral consent: *“In order to carry out this test, we need your consent.”*

Remember: It is the patient’s right to refuse an HIV test. HIV testing is **never mandatory**.

❖ **If patient requires additional information, discuss advantages and importance of knowing HIV status.**

Things to say:

- The testing will allow health care providers to make a proper diagnosis and ensure effective follow-up treatment.
- If you test negative, we can eliminate HIV infection from our diagnosis and provide counselling to help you remain negative.
- If you test positive, you will be supported to protect yourself from reinfection and your partner from infection.
- You will be provided with treatment and care for managing your disease, including:
 - cotrimoxazole prophylaxis;
 - regular follow-up and support;
 - treatment for infections; and
 - ARV therapy. (Explain availability and when it is used. See ***Chronic HIV Care*** module.)
- You will be supported to access interventions to prevent transmission from mothers to their infants, and make informed decisions about future pregnancies.
- We will also discuss the psychological and emotional implications of HIV infection with you and support you to disclose your infection to those you decide need to know.
- An early diagnosis will help you cope better with the disease and plan better for the future.

► Post-test counselling

❖ If test result is positive and has been confirmed:

- Explain that a positive test result means that s/he has the infection.
- Give post-test counselling and provide support (p. H50).
- Offer ongoing care (see *Chronic HIV Care* module) and **arrange for a follow-up visit**.
- Advise that it is especially important to practice safer sex—to avoid infecting others, to avoid other sexually transmitted infections and to avoid getting a second strain of HIV. Create a risk reduction plan with patient
- Advise adult men to avoid sex with teenagers outside marriage, to avoid spreading the infection to the next generation.
- Refer, as needed, patient for additional prevention and/or care services, including peer support, and special services for vulnerable populations.

❖ If test result is negative:

- Share relief or other reactions with the patient.
- Counsel on the importance of staying negative by correct and consistent use of condoms, and other practices to make sex safer. Create a risk reduction plan with patient.
- If recent exposure or high risk, explain that a negative result can mean either that s/he is not infected with HIV, or is infected with HIV but has not yet made antibodies against the virus. (This is sometimes called the "window" period—3 to 6 months.) Repeat HIV testing can be offered after 8 weeks.
- Refer, as needed, patient for additional prevention and/or care services, including peer support, and special services for vulnerable populations.

❖ If the patient has not been tested, has been tested but does not want to know results or does not disclose the result:

- Explain the procedures to keep the results confidential.
- Reinforce the importance of testing and the benefits of knowing the result.
- Explore barriers to testing, to knowing, and to disclosure (fears, misperceptions, etc.).

► Support disclosure

- Discuss advantages of disclosure.
- Ask the patient if they have disclosed their result or are willing to disclose the result to anyone.
- Discuss concerns about disclosure to partner, children and other family, friends.
- Assess readiness to disclose HIV status and to whom. (Start with least risky.) Assess social network.
- Assess social support and needs. (Refer to support groups.) See **Chronic HIV Care** Annex A.4.
- Provide skills for disclosure. (Role play and rehearsal can help.)
- Help the patient make a plan for disclosure.
- Encourage attendance of the partner to consider testing; explore barriers to this.
- Reassure that you will keep the result confidential.
- If domestic violence is a risk, create a plan for a safe environment.

❖ If the patient does not want to disclose the result:

- Reassure that the results will remain confidential.
- Explore the difficulties and barriers to disclosure. Address fears and lack of skills. (Help provide skills.)
- Continue to motivate. Address the possibility of harm to others.
- Offer another appointment and more help as needed (such as peer counsellors).

❖ Especially for women, discuss benefits and possible disadvantages of disclosure of a positive result, and involving and testing partners.

Men are generally the decision makers in the family and communities. Involving them will:

- Have greater impact on increasing acceptance of condom use and practicing safer sex to avoid infection.
- Help avoid unwanted pregnancy.
- Help to decrease the risk of suspicion and violence.
- Help to increase support to their partners.
- Motivate them to get tested.

Disadvantages of involving and testing the partner: danger of blame, violence and abandonment.

Health worker should try to counsel couples together, when possible.

► Counsel on safer sex and condom use

- ❖ **Safer sex is any sexual practice that reduces the risk of transmitting HIV and other sexually transmitted infections (STIs) from one person to another.**
 - Protection can be obtained by:
 - Correct and consistent use of condoms; condoms must be used before any penetrative sex, not just before ejaculation.
 - Abstaining from sexual activity.
 - Choosing sexual activities that do not allow semen, fluid from the vagina or blood to enter the mouth, anus or vagina of the partner, and not touching the skin of the partner where there is an open cut or sore.

- ❖ **If HIV positive:**
 - Explain to the patient that s/he is infected and can transmit infection to the partner. A condom should be used, as above.
 - If partner's status is unknown, counsel on benefits of involving and testing the partner (p. 101).
 - For women: explain the extra importance of avoiding infection during pregnancy and breastfeeding. The risk of infecting the baby is higher if the mother is newly infected.

- ❖ **If HIV negative OR result is unknown:**
 - Discuss the risk of HIV infection and how to avoid it.
 - If partner's status is unknown, counsel on benefits of testing the partner.
 - For women: explain the extra importance of remaining negative during pregnancy and breastfeeding. The risk of infecting the baby is higher if the mother is newly infected during this time.

Make sure the patient knows how to use condoms and where to get them. **Provide easy access to condoms in clinic in a discrete manner.**

Ask: Will you be able to use condoms? Check for barriers.

► Educate and counsel on STIs

❖ **Speak in private, with enough time, and assure confidentiality.**

❖ **Explain:**

- The disease.
- How it is acquired.
- How it can be prevented.
- The treatment.
- That most STIs can be cured, except HIV, herpes and genital warts.
- The need also to treat the partners (except for vaginitis):
 - Recent sex partner(s) are likely to be infected but may be unaware.
 - If partners are untreated, they may develop complications.
 - Sex with untreated partners can lead to re-infection.
 - Treatment of the partner, even if no symptoms, is important to the health of the partner and to you.

*Special counselling for adolescents:
See Adolescent Job Aid.*

❖ **Listen to the patient: is there stress or anxiety related to STIs?**

❖ **Promote safer sexual behaviour to prevent HIV and STIs.**

- Counsel on limiting partners (or abstinence) and careful selection of partners.
- Instruct in condom use (p. 102).

❖ **Educate on HIV.**

❖ **Advise HIV testing and counselling (p. 98).**

❖ **Inform the partner(s) or spouse.**

- Ask the patient, can you do this? Ask, is it possible for you to:
 - Talk with your partner about the infection?
 - Convince your partner to get treatment?
 - Bring/send your partner to the health centre?
- Determine your role as the health worker.
- Strategies to discuss and introduce condom use.
- Risk of violence or stigmatizing reactions from partners and family.

Refer for counselling on:

- Concerns about herpes infection (no cure).
- Possible infertility related to PID.
- Behavioural-risk assessment.
- Patient with multiple partners.
- Difficult circumstances or risk.

► Basic counselling

All providers can apply counselling skills in a range of clinical situations. These include:

- ❖ Educating patients
- ❖ Providing emotional support
- ❖ Supporting patients with mental illness such as depression or anxiety disorders
- ❖ Addressing multiple aspects of HIV care (HIV testing, disclosure of HIV status, safer sex and condom use, adherence to care and treatment)
- ❖ Intervening in a crisis situation

Elements of basic counselling

- ❖ Establish a good relationship.
- ❖ Find out (what) the patient's current situation (is).
- ❖ Respond with empathy.
- ❖ Provide feedback that enables the patient to make sense of the situation.
- ❖ Offer information.
- ❖ Help the patient recognize his/her strengths.
- ❖ Help the patient identify and find ways to connect with family or friends who can provide support.
- ❖ Teach specific skills that help patients deal with their situation:
 - Relaxation techniques such as deep breathing or progressive muscular relaxation or positive imagery.
 - Problem solving.
- ❖ Provide encouragement.
- ❖ Convey hope.

Useful tools for counselling:

- ❖ Use more open-ended than closed questions.
 - Open-ended question: What problems have you had recently in taking your medicines?
 - Closed question: Did you take your medicine today?
- ❖ Listen carefully, paying attention to verbal and non-verbal communication.
- ❖ Clarify responses that you do not understand.
- ❖ Use role-playing to help the patient develop skills and confidence to carry out a plan.
- ❖ Allow time for questions from the patient.
- ❖ Ask about suicidal thoughts (in the case of crises and mental illness).

The counsellor's role:

- ❖ Provide confidentiality.
- ❖ Provide support.
- ❖ Help the patient prioritize problems and find own solutions.
- ❖ Be aware of the patient's treatment.
- ❖ Be aware of other referral resources.
- ❖ Be aware of the patient's social-support resources.
- ❖ Advocate for the patient.
- ❖ Refer to treatment, care and prevention services, as appropriate.

When working with patients:

- ❖ Ensure privacy.
- ❖ Minimize interruptions.
- ❖ Ensure patient's comfort.
- ❖ Agree on the length of time you have.
- ❖ Make arrangements for follow-up when necessary.

► Counsel the depressed patient and family

❖ Review the symptoms of depression that the patient is experiencing. (See p. 50-51).

❖ Give essential information.

- Explain that the symptoms are part of the illness called depression.
- Depression is common and effective treatment is available.
- Depression is not a sign of weakness or laziness.
- The patient is trying hard to manage.

❖ Recognize the distress of the patient by saying that you understand how badly s/he feels and that you want to be of some assistance to him/her.

❖ Inquire of the patient how depressed s/he feels at the moment compared to how s/he has been feeling, in order to inform your treatment plan.

❖ Ask if s/he has thought about hurting themselves or if s/he is thinking much about death.

If risk of suicide and harm to others, see **Quick Check** guidelines.

❖ Plan short-term activities which give the patient enjoyment or build confidence.

❖ Identify current life problems or social stresses. Focus on small, specific steps the patient might take towards managing these problems.

- If bereavement after a death, see **Palliative Care** module, p. 48.
- If HIV+, give support. See **Chronic HIV Care** module, Annex A.
- If new TB diagnosis and worried about HIV, give support.
- Teach new problem-solving techniques.

- ❖ Encourage patient to resist pessimism and self-criticism:
 - Not to act on pessimistic ideas (end marriage, leave job).
 - Not to concentrate on negative or guilty thoughts.
- ❖ If counselling is not sufficiently helpful, consider these additional interventions:
 - Give amitriptyline, especially if sleep and appetite are significantly disturbed (p. 82).
 - If already on anti-depressant, check on adherence and dose. The dose may need to be raised.
 - Remind patient that it takes 2-3 weeks for the medication to work.
 - After improvement, discuss action to be taken if signs of depression return.
 - Refer to support group.
 - Refer to skilled counsellor.
 - If suicide risk or major depression not responding to treatment, consult or refer.

Laboratory Tests

Collect sputum for examination for TB

- ❖ **Explain** that the TB suspect needs a sputum examination to determine whether there are TB bacilli in the lungs.
- ❖ **List** the TB suspect's name and address in the Register of TB Suspects.
- ❖ **Label** sputum containers (not the lids).
 - Three samples are needed for diagnosis of TB.
 - Two samples are needed for follow-up examination.

TB SPECIMEN	
Name:	_____
Health facility:	_____
Date:	_____
Specimen no.	_____

- ❖ **Fill out *Request for Sputum Examination form.***
- ❖ **Explain and demonstrate, fully and slowly, the steps to collect sputum.**
 - Show the TB suspect how to open and close the container.
 - Breathe deeply and demonstrate a deep cough.
 - The TB suspect must produce sputum, not only saliva.
 - Explain that the TB suspect should cough deeply to produce sputum and spit it carefully into the container.
- ❖ **Collect**
 - Give the TB suspect the container and lid.
 - Send the TB suspect outside to collect the sample in the open air, if possible, or to a well-ventilated place with sufficient privacy.
 - When the TB suspect returns with the sputum sample, look at it. Is there a sufficient quantity of sputum (not just saliva)? If not, ask the TB suspect to add some more.
 - Explain when the TB suspect should collect the next sample, if needed.

Schedule for collecting three sputum samples

Day One:

- Collect "on-the-spot" sample as instructed above (**Sample 1**).
- Instruct the TB suspect how to collect an early-morning sample tomorrow (first sputum after waking). Give the TB suspect a labelled container to take home. Ask the TB suspect to bring the sample to the health facility tomorrow.

Day Two:

- Receive early-morning sample from the TB suspect (**Sample Two**).
- Collect another "on-the-spot" sample (**Sample Three**).

❖ **When you collect the third sample, tell the TB suspect when to return for the results.**

❖ **Store**

- Check that the lid is tight.
- Isolate each sputum container in its own plastic bag, if possible, or wrap in newspaper.
- Store in a cool place.
- Wash your hands.

❖ **Send**

- Send the samples from health facility to the laboratory.
(See page 113.)

Send sputum samples to laboratory

- ❖ Keep the samples in a refrigerator, or in a place as cool as possible until transport.
- ❖ When you have all 3 samples, pack the sputum containers in a transport box. Enclose the *Request for Sputum Examination*. (See next page.) If there are samples for more than 1 patient, enclose a *Request for Sputum Examination* for each patient's samples.
- ❖ If a patient does not return to the health facility with the second sample within 48 hours, send the first sample to the laboratory anyway.
- ❖ Send the samples to the laboratory as soon as possible. Do not hold for longer than 3–4 days. The total time from collection until reaching the laboratory should be no more than 5 days. Sputum samples should be examined by microscopy no later than 1 week after they have been collected.
- ❖ Prepare a dispatch list to accompany each transport box. (See example below.) The dispatch list should identify the sputum samples in the box. Before sending the box to the laboratory:
 - Check that the dispatch list states:
 - the correct total number of sputum containers in the box;
 - the identification numbers on the containers; and
 - the name of each patient.
 - Check that a *Request for Sputum Examination* is enclosed for each patient.
 - Close the box carefully.
 - Write the date on the dispatch list.

Put the dispatch list in an envelope and attach envelope to the outside of the transport box.

TB LABORATORY FORM REQUEST FOR SPUTUM EXAMINATION

Name of health facility _____ Date _____
 Name of patient _____ Age _____ Sex: M F
 Complete address _____
 _____ District _____

Reason for examination:

Diagnosis TB Suspect No. _____
 OR Follow-up Patient's District TB No.* _____

Disease site: Pulmonary Extrapulmonary (specify) _____

Number of sputum samples sent with this form _____

Date of collection of first sample _____ Signature of specimen collector _____

* Be sure to enter the patient's District TB No. for follow-up of patients on TB treatment.

RESULTS (to be completed by Laboratory)

Lab. Serial No. _____

(a) Visual appearance of sputum:

Mucopurulent Blood-stained Saliva

(b) Microscopy:

DATE	SPECIMEN	RESULTS	POSITIVE (GRADING)			
			+++	++	+	scanty (1-9)
	1		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	2		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	3		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Date _____ Examined by (Signature) _____

The completed form (with results) should be sent to the health facility and to the District Tuberculosis Unit.

Instructions for some lab tests which can be performed in clinic:

❖ Haemoglobin

Insert local method.

❖ Urine dipstick for sugar or protein:

- Follow instructions from test package.

❖ Blood sugar by dipstick

❖ Malaria dipstick

- Insert instructions from test package.

❖ Malaria smear (thick film):

- *Prepare a thick film (so that printed letters can't be read through it).*
- Air dry.
- Cover with diluted Leishman stain (1:3) for 7 mins
OR cover with diluted Giemsa (1:10) for 15 mins
OR dip for two seconds in Field stain A and wash with water, and then two seconds in Field stain B and wash in water.
- Allow to dry.
- Examine a minimum of 100 fields under X100.

Result: look for red chromatin dot, blue cytoplasm.

Note:

If the film is positive, do a thin film to identify the species.

When dealing with *Plasmodium falciparum* do an exact parasite count.

Grading:

Parasite count:

- 1 to 10 malaria parasites per 100 fields
- 10 to 100 malaria parasites per field
- 1 to 10 parasites per field
- 10 to 100 parasites per field

Grade:

- +
- ++
- +++
- ++++

Perform RPR (Rapid Plasma Reagin) test for syphilis and respond to result

- ❖ Have patient sit comfortably on chair. Explain procedure and obtain consent. Put on gloves.
- ❖ Use a sterile needle and syringe. Draw up 5 ml blood from a vein. Put in a plain test tube.
- ❖ Let test tube sit 20 minutes to allow serum to separate. (Or centrifuge 3-5 minutes at 2000-3000 rpm.) In the separated sample, serum will be on top.
- ❖ Use sampling pipette to withdraw some of the serum. Take care not to include any red blood cells from the lower part of the separated sample.
- ❖ Hold the pipette vertically over a test-card circle. Squeeze teat to allow one drop (50 ml) of serum to fall onto a circle. Spread the drop to fill the circle using a toothpick or other clean spreader.

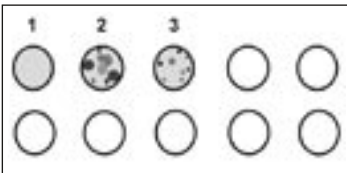
Important: Several samples may be done on 1 test card. Be careful not to contaminate the remaining test circles. Use a clean spreader for each sample. Carefully label each sample with a patient name or number.

- ❖ Attach dispensing needle to a syringe. Shake antigen.* Draw up enough antigen for the number of tests done (one drop per test).
- ❖ Holding the syringe vertically, allow exactly one drop of antigen to fall onto each test sample. **Do not stir.**
- ❖ Rotate the test card smoothly on the palm of the hand for 8 minutes. ** (Or rotate on a mechanical rotator.)

INTERPRETING RESULTS

- ❖ After 8 minutes rotation, inspect the card in good light. Turn or tilt the card to see whether there is clumping (reactive result). Most test cards include negative and positive control circles for comparison.

Example Test Card



1. **Non-reactive** (no clumping or only slight roughness)—negative for syphilis
2. **Reactive** (highly visible clumping)—positive for syphilis
3. **Weakly reactive** (minimal clumping)—positive for syphilis

NOTE: Weakly reactive can also be more finely granulated and difficult to see than in this illustration.

* Make sure antigen was refrigerated (not frozen) and has not expired.

** Room temperature should be 73° - 85°F (22.8° - 29.3°C).

Assure confidentiality in performing the RPR test

If RPR positive:

- ❖ Determine if the patient and partner have received adequate treatment.
- ❖ If not, treat patient and partner for syphilis with benzathine penicillin (p. 69).
 - If patient has just delivered, treat newborn with benzathine penicillin.
 - Follow up on newborn in 2 weeks.
- ❖ Counsel on safer sex. Advise to use condoms.

Note: Do not test for cure with a repeat RPR.

The RPR remains positive for some time although the titer goes down.

Perform rapid HIV test, interpret results, then counsel

The following strategy is proposed for countries with HIV prevalence of greater than 5%. If HIV prevalence is less than 5%, refer to the IMAI Country Adaptation Guide.

All countries should adapt the strategy to reflect national HIV testing and counselling guidelines (including HIV test kits and their validation).

❖ Collection of blood from a finger tip

- Always use gloves to take or transfer blood.
- Rub the finger tip warm to get the blood circulating (index, middle or ring finger).
- Clean the finger with alcohol and allow to air dry.
- Hold finger lower than elbow.
- Prick the finger with a clean and sterile unused lancet.
- Collect sample of blood as per test instructions (e.g. use pipette for *Uni-Gold HIV™* and sample loop for *Stat-Pak™*).
- Dispose the used lancet in a biohazardous safe container.
- Complete the specific test procedure.
- Disinfect finger and cover with a plaster.
- Follow universal safety precautions for waste disposal. The preferred methods are autoclaving at 120°C for 60 minutes or by incineration.



How to prick a finger tip.

❖ Test kits

- You should have at least two different test kits available.
- Only use test kits and testing algorithms as recommended by the national and/or international bodies.
- Respect expiry dates—kits that have expired should not be used.
- Strictly follow storage procedures.
- If kits have been stored at 2–8°C, allow kits to reach room temperature by removing them from the refrigerator approximately 20 minutes before using them.

- Validate your test kit using the manufacturer's directions and the positive and negative controls provided. If possible run the controls for each new operator, new test batch or if you are concerned with storage conditions.
- Strictly follow testing procedures.
- Very strictly respect the recommended reading time.
- Always label specimens and/or test devices clearly.
- Prepare worksheet in which specimen numbers are clearly written and results are immediately recorded.

❖ **Test kit preparation (applicable to all test kits)**


- If refrigerated, remove test kit from refrigerator and allow to stand for at least 20 minutes to reach room temperature (20–25°C).
- Prepare your worksheet, indicating test batch number and expiry date; indicate operator name and date.
- Check that expiry time has not lapsed.
- After appropriate time, validate that test is working properly by using positive and negative controls; you are now ready to start testing clinical specimens.
- Write specimen number on worksheet.
- Remove test device from protective wrapping.
- Write specimen number on test device.
- Proceed to test-specific instructions.


This is an example of a testing plan based on Uni-Gold HIV™, Determine HIV™1/2 and HIV 1/2 Stat-Pak™. Adapt to your country's chosen kits.

❖ **Uni-Gold HIV™**

- Prepare test kit (see above).
- Collect whole blood finger prick using included disposable pipette.
- Add two drops of blood from the pipette to the sample port.
- Add two drops of wash reagent to the sample port.
- Allow ten minutes for reaction to occur.
- Read result immediately at the end of ten minutes. Do not read after 20 minutes as result is no longer stable.
- Interpret result.

One line in the control region:  Negative result

One line in the control region and
one in the test region:  Positive result


No line in the control region
(with or without line in test region):  Invalid result


- Record test result on worksheet.
- Post-test counselling.


Interpretation of

❖ Determine HIV™ 1/2

- Prepare test kit (see p. 121).
- Collect whole blood finger prick using EDTA capillary tube.
- With the capillary tube apply 50 µl of sample to the sample pad (marked by arrow symbol).
- Wait until blood is absorbed and then apply one drop of chase buffer to the sample pad.
- Allow 15 minutes for reaction to occur.
- Read the result. Result should be read between 15–60 minutes after sample addition.
- Interpret result.

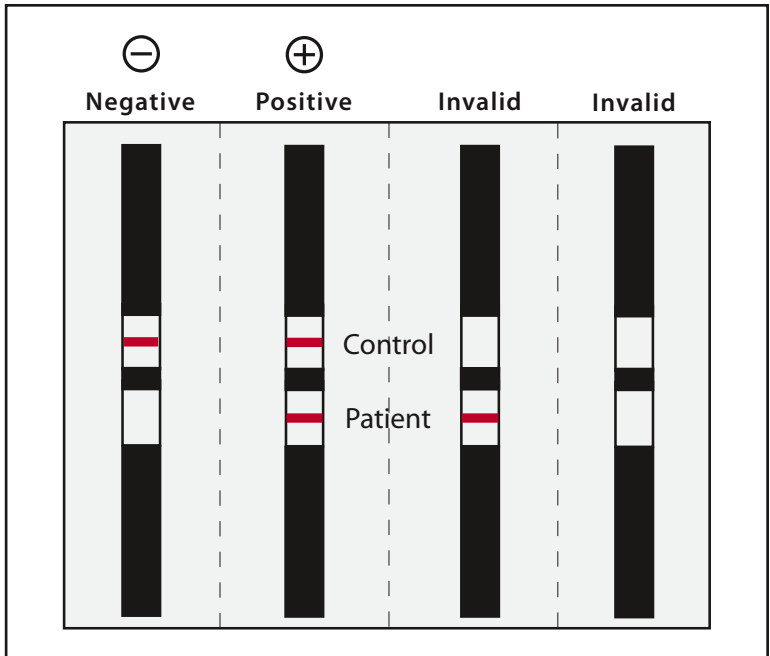
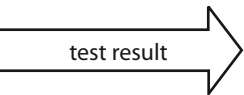
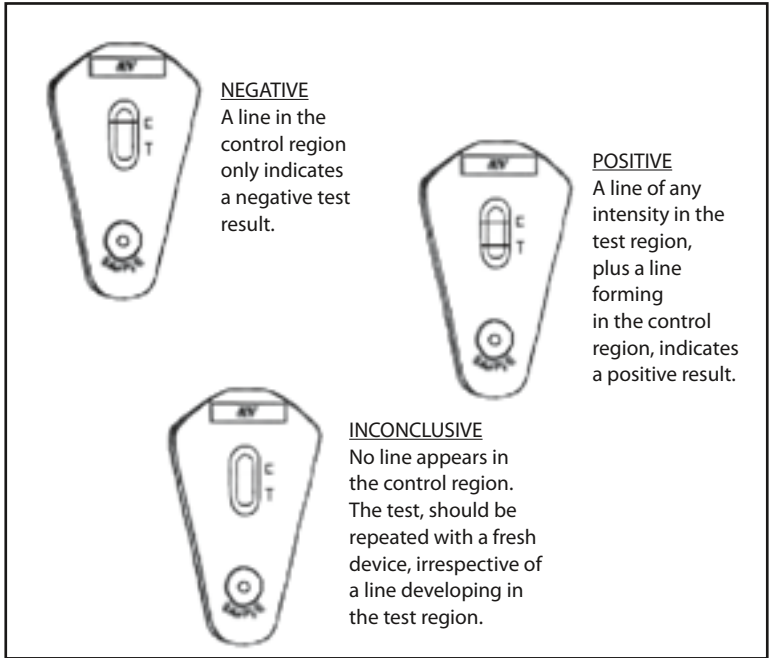
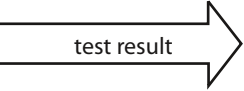
Red bar in the control region:  Negative result

Red bar in the control region and
red bar in the patient region:  Positive result

No bar in the control region
(with or without bar in patient region):  Invalid result

- Record test result on worksheet.
- Post-test counselling.


Interpretation of




❖ HIV 1/2 Stat-Pak™

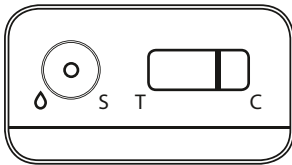
- Prepare test kit (see p. 121).
- Collect whole blood finger prick using sample loop provided.
- Touch loop to center of sample well, holding loop vertically.
- Add 3 drops of buffer, holding vial vertically.
- Allow 10 minutes for reaction to occur.
- Read the result. Result should be read between 15–60 minutes after sample addition.
- Interpret result.

One line in the control region:  Negative result

One line in the control region and one in the test region:  Positive result

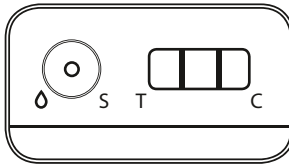
No line in the control region (with or without line in test region):  Invalid result

- Record test result on worksheet.
- Post-test counselling.



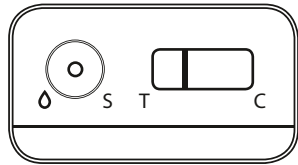
NEGATIVE

A line in the control region only indicates a negative test result.



POSITIVE

A line of any intensity in the test region, plus a line forming in the control region, indicates a positive result.

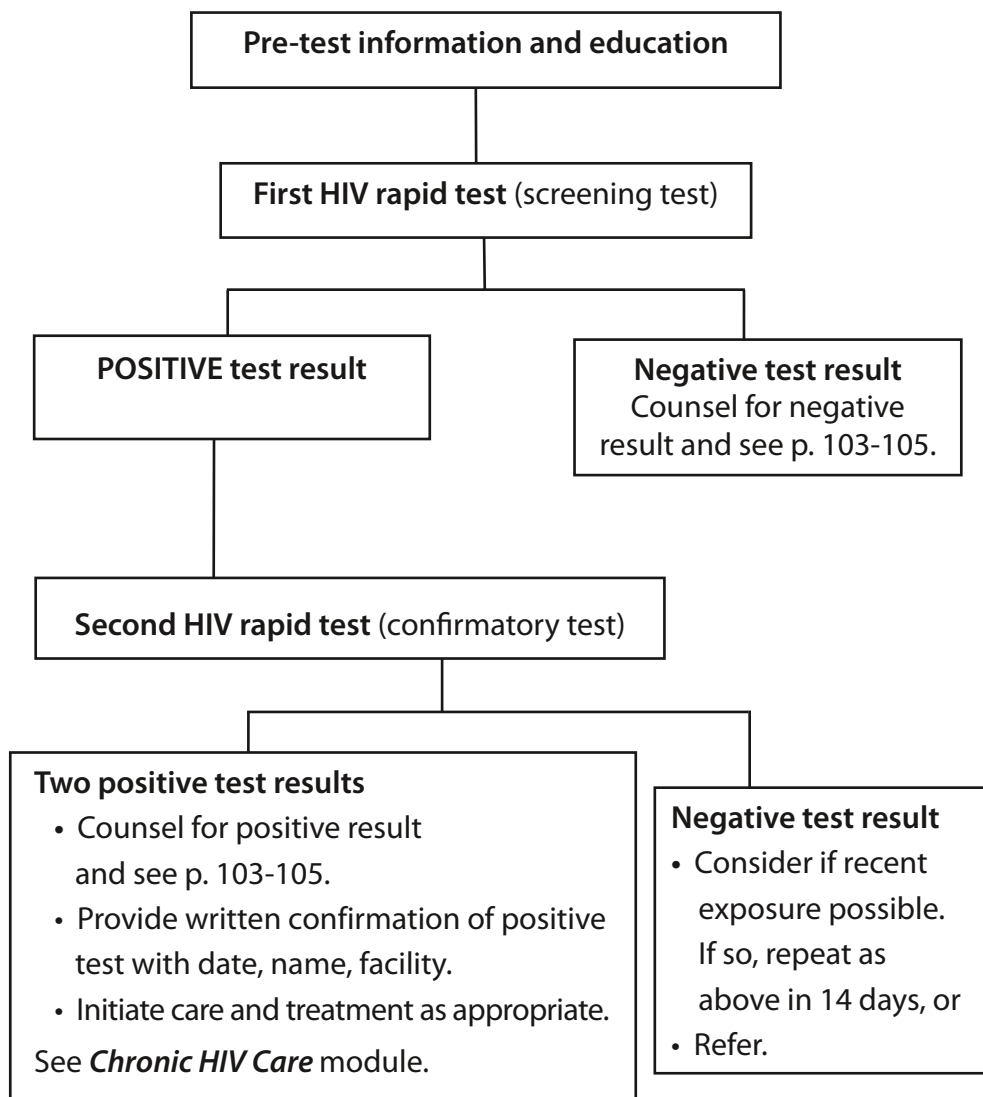


INCONCLUSIVE

No line appears in the control region. The test should be repeated with a fresh device, irrespective of a line developing in the test region.

- ❖ **At the end of the working day, store materials as appropriate. Clean the testing area with disinfectant.**

Strategy for Use of Rapid HIV Tests in Testing and Counselling Services*



* Strategy is applicable for countries with HIV prevalence greater than 5%. For countries with HIV prevalence less than 5%, adapt according to the IMAI Country Adaptation Guide.

**INTEGRATED MANAGEMENT OF ADOLESCENT/ADULT ILLNESS
ACUTE CARE RECORDING FORM**

Name: _____ Sex: _____ Age: _____ Weight: _____ BP: _____ (if not measured within year or if hypertension)

What are the patient's problems? _____

Acute illness / Follow-up acute / Follow-up chronic **Quick check—emergency signs? Yes No** *If yes, _____*

All patients	All patients	All patients	nts
<p>ASSESS (circle all signs present)</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No DOES THE PATIENT HAVE COUGH OR DIFFICULT BREATHING?</p>			
<p>If yes, ASK:</p> <ul style="list-style-type: none"> • For how long? _____ • Are you having chest pain? <i>If yes, new? Severe?</i> • Describe it: _____ <i>Pleuritic</i> • Night sweats? • Do you smoke? • On treatment for: _____ • Asthma? • Emphysema or chronic bronchitis (COPD)? • Heart failure? • TB? <p><i>If no:</i> Have you had previous episodes of cough or difficult breathing? <i>Recurrent episodes</i></p> <p><i>If yes:</i></p> <ul style="list-style-type: none"> - Do these episodes wake you up at night or in the early morning? <i>Yes No</i> - Do they occur with exercise? <i>Yes No</i> 			
<p>LOOK, LISTEN:</p> <ul style="list-style-type: none"> • Is the patient: Lethargic? Confused? Agitated? • Count the breaths in one minute: _____ <i>Fast Very fast breathing? breathing?</i> • Look/listen for wheezing. • Measure temperature _____ <i>< 35°C 37.5°C or above >40°C</i> • <i>If not able to walk unaided or appears ill, also:</i> <ul style="list-style-type: none"> - Count pulse: _____ - Measure BP: _____ - Uncomfortable lying down? 			
<p>X CHECK ALL PATIENTS FOR UNDERNUTRITION AND ANAEMIA</p> <ul style="list-style-type: none"> • Have you lost weight? • Taking medications? • Which ones? _____ • <u>If wasted or weight loss:</u> <ul style="list-style-type: none"> - Diet: Problem: _____ - Alcohol use? • Pallor? <u>If pallor:</u> Black stools? _____ - Blood in stools? - Blood in urine? _____ • <u>If menstruating:</u> Heavy periods? _____ 			
<p>CLASSIFY</p>			

All patie

Yes ___ **No** **DOES THE PATIENT HAVE ANOGENITAL ULCER OR SORE?**

- Are these new? Recurrent?
- Look for anogenital sores. If present, are there vesicles?
- Look for warts.
- Look/feel for enlarged lymph node in inguinal area. If present, is it painful?

Yes ___ **No** **DOES MALE PATIENT HAVE DISCHARGE FROM PENIS? ANY OTHER GENITO-URINARY SX OR LOWER ABDOMINAL PAIN?**

• What is your problem? _____

• Discharge from urethra?
- If yes, for how long?

• Burning or pain when you urinate?

• Pain in your scrotum?
- If yes, have you had any trauma there?
- If yes, have you had any sores?

Genital exam:

- Look for scrotal swelling
- Look for ulcer
- Feel for rotated or elevated testis.
- Feel for abdominal pain. If tenderness:
- Rebound? - Guarding? - Mass?
- Absent bowel sounds? - Temperature: _____
- Pulse: _____

All patients

Yes ___ **No** **DOES THE PATIENT HAVE MOUTH OR THROAT PROBLEM?**

- Do you have pain? If yes, Tooth, mouth or throat?
- When swallowing? - When hot or cold food?
- Problems swallowing?
- Problems chewing?
- Not able to eat?
- Taking medications?
Which ones? _____
- Look in mouth for:
• White patches
- If yes, can they be removed? Yes No
• Ulcer
- If yes, deep or extensive?
- Tooth cavities - Loss of tooth substance
- Bleeding from gums - Swelling of gums
- Gum bubbles - Pus
- Dark lumps
• Look at throat for:
- White exudate - Abscess
- Swelling over jaw - Enlarged lymph nodes
• If tooth pain, does tapping/moving tooth cause pain?

All patients

All patients

Prevention, prophylaxis—all patients

- Encourage insecticide-treated bednet
- Counsel on safer sex • Offer HIV testing and counselling
- Offer family planning • Counsel to stop smoking
- Counsel to reduce or quit alcohol
- If back pain history or risk, teach exercise & correct lifting
- Measure BP

Women of childbearing age:

- Update tetanus toxoid
- Give mebendazole if due
- If pregnant, give antenatal care
- If not pregnant, offer family planning

Adolescent girls:

- Update tetanus toxoid
- Encourage delay interventions if sexually active

	CLASSIFY
<p>IF FEVER (by history or feels hot or temperature 37.5°C or above)</p> <ul style="list-style-type: none"> • How long have you had a fever? _____ • Any other problem? Medications? _____ • Have you taken an antimalarial in the previous week? _____ • If <u>yes</u>, what and for how long? _____ <div style="border: 1px solid black; padding: 5px; margin: 10px 0;"> <p>Decide malaria risk: <i>High Low No</i></p> <ul style="list-style-type: none"> - Where do you usually live? _____ - Recent travel to a malaria area? _____ - If woman of childbearing age: Pregnant? _____ - Epidemic of malaria occurring? _____ - HIV clinical stage 3 or 4? _____ </div>	<p>CLASSIFY</p> <ul style="list-style-type: none"> • Is the patient: Lethargic? Confused? Agitated? _____ • Count the breaths in one minute: _____ <i>Fast breathing?</i> • - <u>If fast breaths</u>, is it deep? _____ • Check if able to drink <i>Not able to drink</i> • Feel for stiff neck _____ • Check if able to walk unaided <i>Not able to walk unaided</i> • Skin rash? _____ • Headache? If <u>yes</u>, for how long? _____ <i>Prolonged</i> • Look for apparent cause of fever _____
<p>IF DIARRHOEA</p> <ul style="list-style-type: none"> • For how long? _____ days - If <u>more than 14 days</u>, have you been treated before for persistent diarrhoea? <i>Yes No</i> - If <u>yes</u>, with what? _____ When? _____ • Is there blood in the stool? _____ 	<ul style="list-style-type: none"> • Look at the patient's general condition: <ul style="list-style-type: none"> - Lethargic? _____ - Unconscious? _____ • Look for sunken eyes. • Is the patient: <ul style="list-style-type: none"> - Not able to drink or drinking poorly? _____ - Drinking eagerly, thirsty? _____ • Pinch the skin of the inside forearm. Does it go back: <i>Very slowly (longer than 2 seconds)? Slowly?</i>
<p>IF FEMALE PATIENT HAS GENITO-URINARY SX OR LOWER ABDOMINAL PAIN</p> <ul style="list-style-type: none"> • What is the problem? _____ Meds? _____ • Burning or pain on urination? _____ • Increased frequency of urination? _____ • Ulcer or sore in your genital area? _____ • Abnormal vaginal discharge? If <u>yes</u>, does it itch? _____ • Bleeding on sexual contact? _____ • Partner have problem? _____ • If <u>present</u>, Ask: <i>Urethral discharge or sore?</i> • Missed a period? If <u>yes</u>, possibly pregnant? _____ • When was last period? _____ • Periods: heavy or irregular periods? If <u>yes</u>, new? _____ - Days of bleeding: _____ Number pads used: _____ • Very painful menstrual cramps? _____ • Using contraception? Which? _____ • If <u>no</u>, interested? If <u>interested</u>, use FP guidelines. 	<ul style="list-style-type: none"> • Feel for abdominal tenderness. If <u>pain</u>: <ul style="list-style-type: none"> - Rebound? _____ - Guarding? _____ - Mass? _____ • Absent bowel sounds? _____ • Temperature _____ - Pulse _____ • External exam: <ul style="list-style-type: none"> - Large amount vaginal discharge? _____ - Anal/genital ulcer? _____ - Enlarged inguinal lymph node? _____ • If <u>able to do bimanual exam</u>, cervical motion tenderness? _____ • If <u>burning or pain on urination</u>, percuss back: Flank pain? _____
<p>IF SKIN PROBLEM OR LUMP</p> <ul style="list-style-type: none"> • Do you have a sore or skin problem or lump? _____ - If <u>yes</u>, where is it? _____ 	<ul style="list-style-type: none"> • Where are the lesions? _____ • How many are there? _____ • Are they infected (red, tender, warm, pus or crusts)? _____

<ul style="list-style-type: none"> - <u>If yes</u>, for how long? <ul style="list-style-type: none"> - Does it hurt? <ul style="list-style-type: none"> - Duration _____ Discharge? - Do other family members have same problem? 	<ul style="list-style-type: none"> - Are they tender? <ul style="list-style-type: none"> - Is there sensation to light touch? • Feel for fluctuance. • Look/feel for lumps.
<h3>IF HEADACHE OR NEUROLOGICAL PROBLEM</h3>	
<ul style="list-style-type: none"> • Weakness in any part of body? • Recent accident or injury involving head? • Convulsion? • Alcohol use? _____ Drug use? _____ • Medications? _____ • Brain/mind working more slowly? • Trouble keeping attention? • Forget things that happened recently? • Ask family: - Patient's behaviour changed? <ul style="list-style-type: none"> - Memory problem? - Patient confused? - If confused, when did it start? _____ - Disoriented to place or time? _____ • If memory problem, test registration/recall _____ • If headache: <ul style="list-style-type: none"> - For how long? _____ Vomiting? - One-sided? _____ Prior diagnosis of migraine? 	<ul style="list-style-type: none"> • Assess for focal neurological problems: <ul style="list-style-type: none"> - Test strength - Look at face: flaccid on one side? - Problem walking? - Problem talking? - Flaccid arms or legs? <u>If yes</u>, loss of strength? - Feel for stiff neck. - Measure BP. _____ - Is patient confused? - <u>If patient reports weakness</u>, test strength. - <u>If headache</u>, feel for sinus tenderness. - <u>If confused or disoriented</u>: <ul style="list-style-type: none"> - Physical cause? - Alcohol or drug medication or toxicity? - Withdrawal? <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> <ul style="list-style-type: none"> • Name 3 unrelated objects, clearly and slowly. Ask patient to repeat them. • Can he/she repeat them? (registration problem?) </div>
<h3>IF MENTAL PROBLEM, LOOKS DEPRESSED OR ANXIOUS, SAD, FATIGUED, ALCOHOL PROBLEM OR RECURRENT MULTIPLE PROBLEMS</h3>	
<ul style="list-style-type: none"> • How are you feeling? (listen without interrupting) • Do you feel sad, depressed? • Loss of interest/pleasure? • Loss of energy? <u>If yes to any of the above 3 questions</u>, ask for depression symptoms: <ul style="list-style-type: none"> - Disturbed sleep - Poor concentration - Decreased libido - Guilty feelings - Appetite loss (or increase) - Moves slowly - Loss of self-confidence or esteem - Thoughts of suicide or death • Have you had bad news? _____ • Do you drink alcohol? <u>If yes</u>: <ul style="list-style-type: none"> - Drinks/week over last 3 months: _____ - Have you been drunk more than 2 times in past year? 	<ul style="list-style-type: none"> • Does patient appear: Agitated? Restless? Depressed? • Patient disoriented to time and place? Is patient confused? • Does the patient express bizarre thoughts? <u>If yes</u>: <ul style="list-style-type: none"> - Does the patient express incredible beliefs (delusions) or sees or hears things others cannot (hallucinations)? - Is the patient intoxicated with alcohol or on drugs which might cause these problems? • Does patient have a tremor? _____ <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> <p><u>If suicidal thoughts</u>, assess the risk:</p> <ul style="list-style-type: none"> - Do you have a plan? - Determine if patient has the means. - Find out if there is a fixed timeframe. - Is the family aware? - Has there been an attempt? How? Potentially lethal? </div>

Acute Care Acronyms

AIDS	Acquired Immunodeficiency Syndrome
ARV	Antiretroviral
ART	Antiretroviral Therapy
BP	Blood Pressure
BV	Bacterial Vaginosis
CD4	Count of the lymphocytes with a CD4 surface marker per cubic millimetre of blood
cm	Centimetre
COPD	Chronic Obstructive Pulmonary Disease
EPI	Expanded Programme on Immunization
GC	Gonorrhoea
GI	Gastrointestinal
GYN	Gynaecological
Hg	Mercury
HIV	Human Immunodeficiency Virus
IM	Intramuscular
IMAI	Integrated Management of Adolescent and Adult Illness
IMCI	Integrated Management of Childhood Illness
IMPAC	Integrated Management of Pregnancy and Childbirth
INH	Isoniazid
IU	International Units
IUD	Intrauterine Device
IV	Intravenous
kg	Kilogram
mcg	Microgram
MD	Medical Doctor
MDT	Multi-Drug Therapy (for leprosy)
mg	Milligram
ml	Millilitre
mm	Millimetre
MO	Medical Officer
MUAC	Middle Upper Arm Circumference
NG	Naso-gastric
NPO	Nothing per os = nothing by mouth
ORS	Oral Rehydration Solution
PCN	Penicillin
PGL	Persistent Generalised Lymphadenopathy
PID	Pelvic Inflammatory Disease
PMTCT	Prevention of Mother to Child Transmission (of HIV)
RF	Rheumatic Fever
RHD	Rheumatic Heart Disease
RPR	Rapid Plasma Reagent test for syphilis
RPM	Rotations per Minute
STIs	Sexually Transmitted Infection
Td	Tetanus Diphtheria
TB	Tuberculosis
TT	Tetanus Toxoid
ZDV	Zidovudine