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**REGULATIONS CONCERNING ISOLATION OF PERSONS  
ILL OR INFECTED WITH A COMMUNICABLE DISEASE  
AND RESTRICTION OF CONTACTS OF SUCH  
COMMUNICABLE DISEASE**

The State Department of Health of the State of New Jersey, pursuant to authority vested in it by statute, hereby establishes the following Regulations concerning isolation of persons ill or infected with a communicable disease and restriction of contacts of such communicable disease. Any Regulations in these matters which may have been adopted heretofore by this Department are hereby rescinded.

These Regulations relate to and are to be used in conjunction with Chapter 2, Regulation 7 of the State Sanitary Code.

**NEW JERSEY (STATE) DEPARTMENT OF HEALTH**

iii

By:

s/ Roscoe P. Kandle

ROSCOE P. KANDLE, M. D.

State Commissioner of Health

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# ADMINISTRATIVE REGULATIONS

November 15, 1966

## DIPHTHERIA

### REPORT REQUIRED

#### **Minimum Period of Isolation of Patient**

Until clinical recovery and until two successive cultures from nose and throat taken at least 24 hours apart are negative for virulent diphtheria organisms, such cultures being taken at least 7 days after the discontinuance of any antibiotic therapy.

All isolates of diphtheria should be submitted to the State Laboratory for virulence testing.

If a history of immunization exists, it is useful to perform a Shick test about one-half hour before administration of antitoxin, thus documenting the presence or absence of measurable circulating immunity to the toxin.

#### **Minimum Period of Restriction of Contacts**

##### **ADULTS—**

Household contacts who are food handlers or whose occupation involves close contact with children, e.g., nurses or teachers, shall be excluded from their occupation until at least two successive cultures from nose and throat taken at least 24 hours apart are negative for virulent diphtheria organisms, such cultures being taken at least 7 days after the discontinuance of antibiotic therapy. Such contacts and all other adult household contacts shall be kept under surveillance for at least 7 days from last exposure, then released from observation if nose and throat cultures taken as above are negative.

##### **CHILDREN—**

Household contacts shall be excluded from school or other public gatherings until at least two successive nose and throat cultures taken at least 24 hours apart are negative for virulent diphtheria organisms, such cultures being taken at least 7 days after the discontinuance of antibiotic therapy.

Household and classroom contacts shall be kept under surveillance for at least 7 days from last exposure.

All previously immunized adult and childhood household and classroom contacts should receive toxoid boosters. Non-immune household contacts with positive nose or throat cultures should receive 10,000 U of antitoxin i.m. phophylactically, and should at the same time be started on a course of active immunization with toxoid, injected at a different site. In those with positive cultures, the recommended therapy is 2,000,000 U Procaine Penicillin G i.m. daily for at least 7 days. In the absence of local facilities for performing cultures, swabs of nose and throat may be mailed in a sterile tube (*not* containing nutrient medium) to the State Laboratory.

## HEPATITIS, INFECTIOUS (Type A)

### REPORT REQUIRED

#### **Minimum Period of Isolation of Patient**

Until end of febrile period.

#### **Minimum Period of Restriction of Contacts**

*Adults*—No restrictions.

*Children*—No restrictions.

Due to the persistence of virus in feces for at least 1 to 2 weeks after the appearance of jaundice, appropriate care should be taken to prevent household spread by fecal-oral route.

It is recommended that all household contacts, particularly adults, receive within 14 days of the onset of illness in the index case a dose of gamma globulin equal to 0.01 cc./lb.

Household contacts are defined as individuals who have spent over 24 hours in the household or who have eaten food prepared by the index case. Even individuals who have a history of prior hepatitis should receive this prophylaxis (which modifies, though not necessarily prevents, disease if given early enough), as strain differences between various viruses may exist. Food handlers who are household contacts must be excluded from food handling for

21 days following onset of symptoms in the first household case. At the end of this period food handlers may return to work if: (a) they are in good health; (b) they have received gamma globulin; (c) they have been instructed by local health personnel in the scrupulous practice of personal hygiene.

Recent evidence indicates gamma globulin may decrease infectivity of persons carrying the infectious hepatitis virus. Food handlers who for any reason do not receive gamma globulin must be excluded from work for 45 days. Any food handlers who is a household contact of a hepatitis case may, of course, continue to be employed in other capacities where his duties do not include handling of food.

## HEPATITIS, SERUM (Type B)

### REPORT REQUIRED

#### **Minimum Period of Isolation of Patient**

As for Infectious Hepatitis.

#### **Minimum Period of Restriction of Contacts**

*Adults*—No restrictions.

*Children*—No restrictions.

Although classical serum hepatitis with Type B virus is not communicable except parenterally, there is no way of absolutely determining whether or not a given case of hepatitis is serum-transmitted Type A (Infectious-incubation period under 60 days, usually less than 42 days) or Type B (Serum-incubation period of 60 days or more), even if there is a history of prior transfusion, etc. Therefore all cases of hepatitis should be managed as if they were Infectious-Type A.

It is not generally recommended that hospital personnel caring for a case of hepatitis receive gamma globulin prophylactically. It is not generally recommended that any person receiving blood products at any age routinely receive gamma globulin prophylaxis against serum-transmitted hepatitis, the efficacy of which and dosage for which remains under investigation.

## MEASLES (Rubeola)

### REPORT REQUIRED

#### Minimum Period of Isolation of Patient

None.

#### Minimum Period of Restriction of Contacts

No restrictions.

#### Recommendations and Comments

This patient should be excluded from school until seven days from appearance of rash.

It is recommended that parents of school children be notified upon the appearance of the first case of measles in the school, with the recommendation that non-immunes immediately consult their physicians regarding the receipt of measles vaccine of the live virus type in one of the proven schedules. Such prompt action may be expected to abort a major measles epidemic. In addition to the administration of live vaccine, classroom contacts, siblings, and playmates, who are non-immune should also receive gamma globulin. Such globulin is available for indigent patients from biological distributing stations of the State Department of Health, being supplied by the American Red Cross. The preventive dose of 0.10 cc./lb. is recommended for chronically ill children, children with disturbed immunologic mechanisms (in whom live vaccine is contraindicated, and who should electively receive killed vaccine), and in children below the age of three years. All others should receive the modifying dose of 0.02 cc./lb. if given within the first 6 days after onset of rash in the first household case, or 0.04 cc./lb. if given thereafter.

All susceptible children one year of age or older should receive measles vaccine. Attenuated live-virus vaccines provide lasting active immunity. Killed vaccine is available for children with special immunologic problems. In view of the significant incidence of pneumonia, otitis, encephalitis, and death occurring as sequellae to measles, eradication of this disease by use of presently available vaccines is urgent.

## MENINGITIS, MENINGOCOCCAL

### REPORT REQUIRED

#### **Minimum Period of Isolation of Patient**

Until end of febrile period, or until 24 hours after the administration of sulfadiazine or penicillin has begun. Other forms of meningitis require no restrictions as covered elsewhere in this code.

#### **Minimum Period of Restriction of Contacts**

No restrictions.

Family members and other close personal contacts of the index case should receive prophylaxis with sulfadiazine (0.5 gm. orally twice daily for 2 days in children, or 1.0 gm. orally twice daily for 2 days in adults).

Mass sulfadiazine prophylactic treatment of asymptomatic institutional contacts will only contribute to the increasing problem of sulfa-resistant meningococci. While penicillin has become the treatment of choice for individual cases, it is ineffective in long-term eradication of the carrier state when used in programs of mass prophylaxis. In addition, penicillin resistant organisms exist in the laboratory and could at any time become a serious clinical problem.

## POLIOMYELITIS

### REPORT REQUIRED

#### **Minimum Period of Isolation of Patient**

No restrictions, except for hospitalized patients, when patient should be treated as any other enteric infection.

#### **Minimum Period of Restriction of Contacts**

*Adults*—No restrictions.

*Children*—No restrictions.

Adequate prevention of further cases of poliomyelitis depends today purely on the induction and maintenance of immunity

through the use of killed or live attenuated vaccines, the latter being preferred, except in unusual instances. It is imperative that early stool specimens and acute (within 3 days of the onset of paralysis) and convalescent blood specimens be obtained in cases suspected of being due to poliomyelitis virus so that isolation and identification of the virus may be made and knowledge gained as to its type for use in preventing an outbreak, if such seems imminent.

Hospitals with poliomyelitis patients on their wards may, if the type is known, find it more useful to immunize exposed staff and even fellow patients with oral vaccine than to depend upon relatively ineffective precaution techniques.

Administration of oral vaccine should generally be reserved for the non-poliomyelitis season, to obviate erroneous implication of the vaccine in cases caused by naturally circulated wild virus. The exception to this dictum is in the presence of an outbreak of poliomyelitis, at which time mass administration of type-specific vaccine is in order to abort the epidemic. If the virus type is unknown, triple vaccine may be used, although less effective. Killed (Salk) vaccine is of little use in an epidemic among unvaccinated individuals, though it may be of use in well-vaccinated persons.

## **SALMONELLOSIS (Except Typhoid Fever)**

### **REPORT REQUIRED**

#### **Minimum Period of Isolation of Patient**

Until clinical recovery. Food handlers and adults whose occupations involve intimate care of children shall be excluded from their occupations until three successive, authentic, stool cultures taken at least 7 days after specific antimicrobial therapy has been discontinued, and at least 24 hours apart, are negative. Food handlers, etc., whose infection was diagnosed as having invaded the blood stream must also submit evidence that three successive, authentic urine specimens taken at least 7 days after specific antimicrobial therapy has been discontinued, and at least 24 hours apart, are negative before they may return to their occupations.

### **Minimum Period of Restriction of Contacts**

*Adults*—No restrictions, except for food handlers and adults whose occupation involves intimate care of children. Such individuals shall be governed as are cases. They may not begin to submit the requisite stool specimens until termination of their contact with a stool-positive case.

*Children*—No restrictions.

Salmonellosis (including Salmonella Food Poisoning and Paratyphoid) appears to be increasing in terms of the number of reported cases, if not also in true incidence. Search for source of illness among contaminated foods, asymptomatic human carriers, and symptomatic or asymptomatic household pets, may be useful if investigation is undertaken early. Suspected foods should be placed in sterile containers (or left in their own containers) and refrigerated until samples may be submitted for laboratory examination. Investigation is most useful where multiple cases occur and when started early.

It should be noted that antibiotic therapy of the gastrointestinal illness and the carrier stage is often unrewarding, despite apparent in vitro antibiotic sensitivity, and repeated, prolonged courses of antibiotic therapy do not usually resolve that which does not respond in previous courses. If local facilities are not available, stools may be mailed to the State Laboratory in kits provided by the Division of Laboratories.

Routine stool cultures at the time of employment of food handlers, and at the time of admission of inmates to institutions, are of little use in the prevention of Salmonellosis and are not recommended.

## **SMALLPOX (Variola)**

### **REPORT REQUIRED**

#### **Minimum Period of Isolation of Patient**

Two weeks from onset of disease and until all crusts or scabs have fallen off. It is recommended that patients who are only mildly ill *not* be hospitalized but be cared for in their homes if possible.

### Minimum Period of Restriction of Contacts

*Adults*—For 16 days from last exposure unless immunized by previous disease or by previous successful vaccination, in which case the contact may be released from quarantine but maintained under surveillance following successful revaccination. (See below).

*Children*—As for adults.

Special instructions on the nursing and precaution technique to be applied to cases of smallpox are available from the Division of Preventable Diseases, State Department of Health, Trenton, 609-292-5590. Notify at once by phone.

It is recommended that, because of increasing foreign travel by air and increasing likelihood of the importation of cases of smallpox into this country, individuals with a high risk of exposure maintain a regular program of revaccination every 3 years. These individuals include physicians and all hospital personnel, airport and overseas airline employees, longshoremen, taxi drivers, policemen, ambulance drivers.

If a patient with suspected smallpox is hospitalized, all hospital personnel *and patients* should be immediately revaccinated irrespective of the time of their most recent vaccination. No patient should be admitted to the hospital who presents serious contraindication to vaccination. If hospitalization of such an individual cannot be deferred or done elsewhere, immunization may be performed followed in 12 hours by the administration of 0.3 ml./kg. of vaccinia immune globulin available from Red Cross Regional Blood Center only upon release by a designated consultant, who for this New Jersey area is:

Horace Hodes, M.D.  
Pediatrician-in-Chief  
Mt. Sinai Hospital  
New York, New York 10029  
212 TR 6-1158 or  
212 TR6-1000 Ext. 732  
Home: Long Island, New York  
516 MA 7-3691

Alternate:  
Eugene Ainbender, M.D.  
Department of Pediatrics  
Mt. Sinai Hospital  
New York, New York 10029  
Phone: Same as for Dr. Hodes  
Home: Ossining, New York  
914 RO 2-1148

Instructions for follow-up of Smallpox Surveillance Orders of the Foreign Quarantine Division of the U.S. Public Health Service or the National Health Service of the Dominion of Canada:

## **INADEQUATE VACCINATION**

In the case of a person entering this country who is designated a surveillance *subject* (for a multiplicity of reasons) and who has *not* been exposed to a known or suspect active smallpox case within the fourteen (14) day period prior to his arrival:

1. The health officer is to instruct the person to report to him any illness no matter how trivial.
2. The health officer is to determine from the person who may be ill the name of his physician.
3. The health officer is to instruct the person to visit the physician.
4. The health officer is to obtain from the physician the diagnosis of the current illness.

Where any possibility of the diagnosis being smallpox exists in the physician's mind, the State Health Department must be consulted immediately at 609 292-5590. After hours, a department representative may be contacted by calling 609 396-6067.

5. A person subject to surveillance in this category need not be restricted or quarantined. His family contacts need not be re-immunized.
6. The health officer does not need to maintain daily contact with the person if he is believed to be a responsible individual.
7. Quarantine Division forms are to be completed and returned at the end of the period of surveillance.
8. The Division of Preventable Diseases is to be notified by telephone that the person under surveillance is well.

## **KNOWN OR SUSPECT EXPOSURE TO SMALLPOX**

In the case of a person entering this country who has been reported as having had contact with a known or suspect case of smallpox within the fourteen day period prior to his entry, information will be telephoned to the health officer by this Department.

1. The health officer shall assure that the person under surveillance is immediately vaccinated, with the following exceptions:
  - a. The person presents evidence of a fresh vaccination crust.

- b. The surveillance request states that the person was vaccinated on arrival in the United States.
  - c. If a family member has eczema, then either that individual or the surveillance subject must be excluded from the remainder of the household, but the surveillance subject *must* be vaccinated.
2. The health officer shall assure that the immediate family and intimate contacts of a person under surveillance are immediately vaccinated. The only exception to this rule is the presence of eczema in the family member or contact: In this case, vaccinia immune globulin is to be administered to the family member or contact.
  3. The health officer is to obtain the name of the subject's physician, contact the physician and inform him concerning the necessary surveillance procedures.
  4. The health officer is to instruct the person under surveillance and the physician to report immediately to him any illness, no matter how trivial.
  5. The health officer is to see or call the patient daily until the end of the surveillance period. The subject should be instructed to check his temperature each evening and report any elevation to the health officer.
  6. The person under surveillance should restrict his activity. If his work brings him into contact with large numbers of people he should stay home from work, and he should avoid attendance at public functions, parties and family gatherings, movies, etc.
  7. Restriction is not necessary for his contacts or family.
  8. The health officer is to assume that any surveillance order he received is of the type requiring the measures outlined in "Inadequate Vaccination" above, unless he is specifically notified by the State Health Department to the contrary.
  9. Questions regarding these measures should be directed to the Division of Preventable Diseases, 609 292-5590.

## TYPHOID FEVER

### REPORT REQUIRED

#### **Minimum Period of Isolation of Patient**

Until clinical recovery. Food handlers and adults whose occupations involve intimate care of children shall be excluded from their occupations until three successive, authentic stool *and* urine cultures taken at least 7 days after specific antimicrobial therapy has been discontinued, and at least one week part, are negative. All other patients must be kept under surveillance until the above cultures have been submitted, but may return to their occupations.

#### **Minimum Period of Restriction of Contacts**

*Adults*—No restrictions, except for food handlers and adults whose occupation involves intimate care of children. Such individuals shall be governed as are cases. They may not begin to submit the requisite stool specimens until termination of their contact with a stool-positive case.

*Children*—No restrictions.

Commencing at least 90 days after the cessation of antimicrobial therapy, four additional, authentic samples of both stool and urine must be submitted at least 3 months apart. If any of the cultures in this period are found positive, the patient shall be declared a carrier.

Carriers may not handle food or food products to be consumed by persons other than the members of their immediate household, may not reside in the same household as a dairy worker or other food handlers, may not send soiled undergarments to a public laundry unless they have been previously boiled or otherwise disinfected, and must notify their local board of health or the State Department of Health of change of permanent residence.

It is recommended that household contacts of a carrier be immunized with Typhoid Vaccine (0.5 cc s.c. at each of 3 injections at least one week apart, followed by boosters at yearly intervals) while high risk of exposure remains.

A person who has been determined to be a chronic fecal or urinary carrier and who has undergone such therapeutic procedures

as are, in the opinion of the State Department of Health, likely to result in the elimination of his carrier status, may be released if eight successive, authentic stool and/or urine specimens taken at intervals of not less than one month are determined to be negative in a laboratory approved by the State Department of Health. An authentic specimen will usually be a direct specimen obtained under supervision of a health officer, or his agent, or following the patient's ingestion of a vegetable dye marker in the presence of a health officer, his agent, or a member of the staff of the State Department of Health, which is then noted to be present in the specimen submitted. Such dye markers may be obtained from the Division of Preventable Diseases, State Department of Health.

Refusal of a case or suspected case or carrier of typhoid fever to submit specimens requires the issuance of an order to submit to such examination by the local board of health under *RS26:4-50*. Failure to respect this order leads to an appeal to the courts under *RS26:4-51 to 57* for an order which may be enforced under the State's police powers.

Reliance should not be placed upon the Widal Agglutination test in the diagnosis of Typhoid Fever, as the results of these tests are very often misleading. A four-fold or greater rise in titer in two serum specimens taken several days apart, but run simultaneously in the same laboratory, may be considered highly suggestive of the diagnosis, but cultures of blood, urine and stool will give a more definitive diagnosis and often give it earlier.

Routine stool cultures at time of employment of food handlers and at time of admission of inmates to institutions are of little use in the prevention of Typhoid Fever and are not recommended.

## MUMPS

### REPORT REQUIRED

**Minimum Period of Isolation of Patient**

None.

**Minimum Period of Restriction of Contacts**

No restrictions.

### **Recommendations and Comments**

The patient should be excluded from school for the period of acute illness, but no longer than six days.

Hyperimmune anti-mumps globulin is commercially available only. 5 to 7.5 cc. may be given to adults with a negative skin test up to 24 hours after onset of parotitis in the recipient to prevent complications of orchitis, although its efficacy is not proven. Presumably the earlier it is given after exposure, the more effective immune globulin might be. A commercial skin test is 75 per cent reliable in differentiating those who have had inapparent infection in the past (40 per cent), on the basis of erythema at the site of the intradermal injection within 18-24 hours.

As with many of the viral diseases of childhood, isolation of the patient is not a major importance in the prevention of outbreaks, as the virus is spread for at least one week prior to the onset of diagnostic symptoms. Children should, except in unusual circumstances, be permitted to obtain active immunity to the infection, and should not receive prophylactic mumps-immune globulin.

## **PERTUSSIS (Whooping Cough)**

### **REPORT REQUIRED**

#### **Minimum Period of Isolation of Patient**

None.

#### **Minimum Period of Restriction of Contacts**

No restrictions.

### **Recommendations and Comments**

The patient should be excluded from school until clinical recovery and for three weeks after the onset of typical paroxysms. Contact with unvaccinated infants should be avoided.

Unless culturing on Bordet-Gengou medium is done, many atypical cases will be missed, while many cases will be erroneously diagnosed as whooping cough in the non-specific catarrhal stage. Antibiotic therapy cannot be depended upon to reduce the communicability of this illness. Non-immune, childhood contacts, especially those under age 3, should receive 2.5 cc. of hyperimmune

antipertussis globulin as soon after exposure as possible, this material being commercially available, although not supplied by the State to indigent patients.

Contacts should be seen daily at school by a nurse or physician for a period of 14 days from last exposure to a known case, but may attend school if no symptoms of respiratory infection are detected. Previously immunized childhood contacts should receive a booster dose of 4 National Institute of Health units of unabsorbed pertussis vaccine.

## **RUBELLA (German Measles, 3-Day Measles)**

### **REPORT NOT REQUIRED**

#### **Minimum Period of Isolation of Patient**

None.

#### **Minimum Period of Restriction of Contacts**

No restrictions.

#### **Recommendations and Comments**

Children should be excluded from school until three days from appearance of rash.

Exposure of pregnant females (e.g., schoolteachers) is especially to be avoided. Exposed non-immune pregnant females in the first trimester should receive 20 cc. of gamma globulin i.m. within one week of exposure, the earlier the better. The medication will be supplied to indigent patients upon request by their physician to the Division of Preventable Diseases, from whence it is mailed by Special Delivery the same day the request is received. The therapy is of dubious effectiveness even if given at the optimal time, in reducing the incidence of congenital malformations or fetal loss.

It is highly recommended that non-immune, non-pregnant females be exposed to cases of this disease as prophylaxis against subsequent infection while pregnant, the illness being uniformly mild and the immunity permanent.

## **STREPTOCOCCAL INFECTIONS**

**(Includes Scarlet Fever, Sore Throat, Erysipelas)**

### **REPORT NOT REQUIRED**

#### **Minimum Period of Isolation of Patient**

None.

#### **Minimum Period of Restriction of Contacts**

No restrictions.

#### **Recommendations and Comments**

Children should be excluded from school until clinical recovery and the disappearance of purulent discharges, or until 24 hours after the commencement of specific antimicrobial therapy, provided such therapy is continued for at least 10 days.

It is strongly recommended that all children who are close personal contacts, especially household contacts, of cases of streptococcal disease receive throat culture with treatment of positives with specific chemoprophylaxis which is continued for 10 days. The recommended therapy is penicillin (or erythromycin if penicillin allergy exists), 250,000 units p.o. four times daily or 1 million units aqueous procaine penicillin i.m. daily or a single dose of 1.2 million units of benzathine penicillin i.m. In the absence of local facilities for culturing, dry swabs may be mailed in sterile empty tubes to the State Laboratory.

## **CHICKENPOX (Varicella)**

### **REPORT NOT REQUIRED**

#### **Minimum Period of Isolation of Patient**

None.

#### **Minimum Period of Restriction of Contacts**

No restrictions.

### **Recommendations and Comments**

Patients should be excluded from school until six days after onset of rash. All crusts and scabs need not have fallen off.

Gamma globulin is not supplied to indigents by the State for this illness, nor is this therapy recommended for routine use. It may be useful in modifying (but not preventing) illness if given early after exposure at 0.2 cc./kg., and such treatment may be considered in individuals with no past history of varicella who are taking high doses of steroids or are suffering from diseases with altered immunologic responsiveness (e.g., leukemia, Hodgkin's disease, myeloma).

## VENEREAL DISEASE TREATMENT — QUICK REFERENCE SUMMARY

|  |  |  |
|--|--|--|
| <p><b>SYPHILIS</b><br/>(Primary, secondary and latent with nonreactive spinal fluid)</p>   | <p>Benzathine<br/>Penicillin G</p>       | <p>2,400,000 units intramuscularly at a single session</p>   |
| <p><b>SYPHILIS</b><br/>(Early latent and late latent if no examination of spinal fluid is made)</p>  | <p>Benzathine<br/>Penicillin G</p>       | <p>6,000,000 units total, divided evenly in two sessions seven days apart.</p>   |
| <p><b>LATE SYPHILIS</b><br/>(Cardiovascular, late benign, and neurosyphilis)</p>   | <p>Benzathine<br/>Penicillin G</p>       | <p>6,000,000 to 9,000,000 units given<br/>3,000,000 units per session at seven-day intervals</p>   |
| <p><b>CONGENITAL SYPHILIS</b><br/>(under 2 years' duration)</p>  | <p>Aqueous Procaine<br/>Penicillin G</p> | <p>50,000 units per lb. body weight<br/>10 equally divided daily injections</p>  |
| <p><b>CONGENITAL SYPHILIS</b><br/>(Over 2 years' duration nonreactive spinal fluid) (if spinal fluid reactive, treat as neurosyphilis)</p> | <p>Benzathine<br/>Penicillin G</p>       | <p>2,400,000 units intramuscularly at a single session. Should be adjusted for age and body weight.</p>                                    |
| <p><b>GONORRHEA</b></p>  | <p>Aqueous Procaine<br/>Penicillin G</p> | <p>Men: 2,400,000 units in one intramuscular injection.<br/>Women: 4,800,000 units intramuscularly in two injection sites at one visit</p> |
| <p><b>CHANCROID</b></p>  | <p>Sulfadiazine</p>                      | <p>One gram orally four times a day for seven days, to a total of 28 grams</p>   |
| <p><b>GRANULOMA INGUINALE</b></p>  | <p>Tetracycline or<br/>Erythromycin</p>  | <p>500 mg. orally 4 times a day for 15 days<br/>500 mg. orally 4 times a day for 15 days</p>   |
| <p><b>LYMPHOGRANULOMA VENEREUM</b></p>   | <p>Sulfadiazine or<br/>Tetracycline</p>  | <p>One gram orally 4 times a day for 15 days<br/>500 mg. orally 4 times a day for 15 days</p>  |

## VENEREAL DISEASES

Syphilis  
Gonorrhea  
Chancroid  
Granuloma Inguinale  
Lymphogranuloma Venereum  
Ophthalmia Neonatorum

### REPORT REQUIRED

#### Minimum Period of Isolation

Isolation is not required while patient is under treatment.

In *Ophthalmia Neonatorum* isolation is required until cure is achieved.

#### Minimum Period of Restriction of Contacts

None.

Sexual contacts should be considered infected and infectious until examination (physical and laboratory) rules out infection, or until epidemiologic treatment is given.

Because of persistent increases in infectious syphilis, routine reporting, diagnosis, treatment, and epidemiology are no longer sufficient. Emergency action is needed in every case.

All physicians, hospitals and clinics are urged to consider every primary, secondary or recently infectious case of syphilis as a medical and public health emergency, and to report every early syphilis case by telephone to the State Department of Health in order that the patient may be interviewed for contacts immediately.

Physicians are invited to telephone requests for assistance in darkfield examination of suspicious lesions *prior to treatment*. *EPIDEMIOLOGICAL, CONSULTATIVE*, and *DARKFIELD* services are available by calling Area Code 609-392-2020 immediately. This service is rendered on a 24 hour, 7 day-a-week basis.

Departmental representatives, Field Epidemiologists, trained to give this assistance are located strategically throughout the State.

Within an hour they will make detailed arrangements for rendering the darkfield service, and performing the necessary contact interview of the patient, or both. In most instances the epidemiologist can be in the doctor's office in less than two hours after the initial call.