

Referral to GP for Contact Management of Invasive Group A Streptococcal (iGAS) Disease

Dear

We have been notified that the below patient(s), registered with your practice, (is)are close contacts of a case of iGAS or a GAS associated clinical syndrome:

Name	DOB	Contact number	Address/ Email	Chemoprophylaxis required (Y/N)

A close contact is defined as any individual who has had prolonged close contact with a case in household type settings during the 7 days before the diagnosis of infection. This period could be as long as 30 days in residential institutions.

Your patient(s) above have been assessed by the public health unit and/or the case's treating clinician team as a close contact. Please provide relevant education and arrange for chemoprophylaxis if indicated in the above table.

Education

All contacts should be provided with education and information.

General practitioners should provide [information and advice](#) on the following:

- close contacts may be at higher risk of developing disease for up to a 30-day period following last contact with a case.
- symptoms of GAS and iGAS to monitor for.
- if symptoms of GAS develop (e.g. impetigo, pharyngitis), contacts should seek non-urgent medical review.
- if symptoms of iGAS develop, contacts should seek immediate medical attention.

Chemoprophylaxis

Chemoprophylaxis to all close contacts of a single case is generally not required. Contacts may require chemoprophylaxis if they fall into one of the relevant categories as outlined in **Table 1**. Your patient(s) eligibility will have been assessed by the public health unit and/or the case's treating clinician.

Antibiotics for chemoprophylaxis should be given to identified eligible close contacts as soon as possible after the contact is identified. This is preferably within 48 hours of exposure to the original case or, at least, within 48 hours of the case being diagnosed.

Recommended antibiotic regimens for contacts can be found in **Table 2**, however please refer to latest guidelines for the most up to date information.

Table 1: Contacts eligible for chemoprophylaxis

Eligible contacts for chemoprophylaxis (preferably given within 48 hours and no more than 10 days after case diagnosis)	Duration contacts should monitor for symptoms
Birthing person-neonate pairs	30 days
Household or household like contact or residential/institutional contacts* belonging to groups below: <ul style="list-style-type: none"> • sexual partners • elderly people, particularly those aged over 75 years • children aged less than 5 years • Aboriginal and Torres Strait Islander people • people with a chronic or immunocompromising disease or condition • people who inject drugs. 	30 days for single case 90 days in a cluster/outbreak
People experiencing homelessness	30 days

*Refers to residential aged care or disability facility, childcare, hospital, prison, or military barracks

Table 2: Therapeutic Guidelines: Antibiotic prophylaxis regimens for eligible close contacts

<p>1. Benzathine benzylpenicillin intramuscularly*, as a single dose#</p> <ul style="list-style-type: none"> • adult: 1.2 million units (2.3 mL) • child less than 10 kg: 0.45 million units (0.9 mL) • child 10 kg to less than 20 kg: 0.6 million units (1.2 mL) • child 20 kg or more: 1.2 million units (2.3 mL) <p>OR</p> <p>2. Cefalexin 1 g (neonate and child: 25 mg/kg up to 1 g) orally, 12-hourly for 10 days.</p> <p>* The ventrogluteal site is preferred for administration of intramuscular benzathine benzylpenicillin because of reduced pain and risk of nerve injury.</p> <p># It is unclear if eradication of pharyngeal group A <i>streptococcus</i> carriage is required to prevent secondary cases. Limited evidence suggests the addition of rifampicin to benzathine benzylpenicillin increases the rate of pharyngeal carriage eradication. However, the role of rifampicin in the prevention of secondary invasive group A streptococcal infection is uncertain, and routine combination prophylaxis is not recommended.</p> <p>For close contacts with delayed non-severe hypersensitivity to penicillins, cefalexin can be used in most cases^.</p> <p>For close contacts with immediate (non-severe or severe) or delayed severe hypersensitivity to penicillins, antibiotic choice depends on the susceptibility of the isolate from the index case (as rates of resistance to non-beta-lactam antibiotics are higher). If susceptibility results are not available, a reasonable regimen is:</p>

azithromycin 500 mg (child: 12 mg/kg up to 500 mg) orally, daily for 5 days.

^ It is safe to use cefalexin in patients who had a delayed non-severe reaction to a penicillin in the distant past. It is also safe to use cefalexin in patients who have had a delayed non-severe reaction recently, unless the reaction involved amoxicillin or ampicillin, because cross-reactivity between these drugs is possible. For patients who have had a recent delayed non-severe reaction to amoxicillin or ampicillin, use the drug recommended for patients with immediate (non-severe or severe) or delayed severe hypersensitivity.

Note: Recommendations regarding the provision of antibiotics for chemoprophylaxis to close contacts of a single case are not intended as a substitute for the expert knowledge of treating clinical teams, nor are they intended to override jurisdictional best-practice in accordance with their specific populations and contexts. Decisions about antibiotics for chemoprophylaxis must always consider the individual and population risks and benefits of this intervention.

As of August 2023, [Therapeutic Guidelines: Antibiotic prophylaxis regimens for invasive iGAS infection](#) indicates that the optimal antibiotic prophylaxis regimen for iGAS infection has not been determined but suitable regimens exist. Please refer to **Table 2**.

More information

See the [NSW Health iGAS fact sheet](#), or contact your local Public Health Unit on 1300 066 055.

[NSW invasive group A streptococcal \(iGAS\) disease control guideline for public health units](#)

Yours sincerely

[Staff Specialist/Director, Public Health Unit]