DEPARTMENT: Medical Services Division		**POLICY NUMBER:** DPOTMH-MPP-IPCU-P018-(01)	
TITLE/DESCRIPTION: **RABIES EXPOSURE MANAGEMENT**			
EFFECTIVE DATE: December 31, 2024	**REVISION DUE:** December 30, 2027	**REPLACES NUMBER:** N/A	**NO. OF PAGES:** 1 of 24
APPLIES TO: All Medical Staff, IPCU, NSD		**POLICY TYPE:** Multi Disciplinary	

PURPOSE:

1. To ensure a safe and compassionate management of human rabies cases admitted in DPOTMH.
2. To provide guidelines on management of patients with exposure to possibly rabid animals.
3. To establish clear protocols for diagnosis, treatment, and vaccination, ensuring consistency in patient care.
4. To provide guidance on the selection and use of human rabies vaccine to help address the global shortage of WHO pre-qualified human rabies vaccine and immunoglobulin.
5. To equip healthcare professionals with the necessary knowledge and skills to manage rabies exposure effectively.
6. To minimize the risk of rabies transmission within the hospital setting.
7. To align with national and local public health guidelines to support community health initiatives.

DEFINITIONS:

Rabies - is a viral disease that cause brain inflammation in humans and mammals
Sterilization - is a process used to kill or deactivate all forms of organisms through heat, chemicals, irradiation, high pressure and filtration
Restraint - is a physical or chemical means that restrains a patient's freedom to and ability to move about and cannot be easily removed or eliminated by the patient
CSF - Cerebrospinal Fluid
RT-PCR - Real Time – Polymerase Chain Reaction
FAT - Florescence Antibody Test
SPL - Special Pathogens Laboratory

The likelihood of rabies infection varies with the nature and extent of exposure, which may fall into one of two categories: bite and non-bite. Human-to-human transmission is rare. The virus is introduced into bite wounds, open cuts in the skin, or onto mucous membranes. Once it enters the central nervous system of the human, it causes encephalomyelitis, which is 100% fatal.

Types of exposure include:

Bite - Any penetration of the skin by teeth constitutes a bite exposure. All bites, regardless of location, represent a potential risk for rabies transmission. Bites by some animals such as bats can inflict minor injury and thus be undetected.

- **Non-bite** - Exposures from terrestrial animals cause rabies and rarely require post-exposure prophylaxis.
  - The non-bite exposure of highest risk appears to be among persons exposed to large

DEPARTMENT: Medical Services Division		POLICY NUMBER: DPOTMH-MPP-IPCU-P018-(01)	
TITLE/DESCRIPTION: RABIES EXPOSURE MANAGEMENT			
EFFECTIVE DATE: December 31, 2024	REVISION DUE: December 30, 2027	REPLACES NUMBER: N/A	NO. OF PAGES: 2 of 24
APPLIES TO: All Medical Staff, IPCU, NSD		POLICY TYPE: Multi Disciplinary	

amounts of aerosolized rabies virus.

- The contamination of open wounds, abrasions, mucous membranes, or (theoretically) scratches with saliva or other potentially infectious material (such as neural tissue) from a rabid animal also constitutes a non-bite exposure.

Other contact, by itself, such as petting a rabid animal and contact with blood, urine, or feces (e.g., guano) of a rabid animal does not constitute an exposure and is NOT an indication for prophylaxis.

Human-to-human transmission

- Human-to-human transmission has occurred among eight recipients of transplanted corneas. Stringent guidelines for acceptance of donor corneas have been implemented to reduce the risk.

Active Immunization - refers to the administration of a vaccine to induce protective immune response.

Cell Culture & Embryonated Egg-based Vaccine (CCEEV) - Vaccines that we use mammalian cell lines (cell-culture) as well as embryonated eggs in the isolation, titration of animal viruses and cultivation to produce vaccines. CCEEV include Purified Vero Cell Rabies Vaccine (PVRV), Human Diploid Cell Vaccine (HDCV) and Purified Chick Embryo Vaccine (PCEC). CCEEV will replace everything that refers to Tissue Culture Vaccine (TCV).

Immunocompromised host - refers to patient receiving immunosuppressive drugs such as systemic steroid (not topical or inhaled) and chemotherapeutic drugs for cancer, AIDS and HIV infected patients and patients with immune deficiency. These patients are expected to have a lower immune response to immunization.

Incubation Period - refers to the period from the time if exposed up to the appearance of first clinical symptoms of rabies. It is extremely variable ranging from 4 days to 7 years; but generally 20-90 days.

- Observation Period - refers to animal observation of pre-formed antibodies 9immune globulins or passive immunization products) to provide immediate protection. These antibodies come from either human or animal source.
- Post-Exposure Prophylaxis (PEP); Formerly post exposure treatment (PET) - refers to anti-rabies treatment administered after an exposure (such as bite, scratch, lick, etc). to potentially rabid animals.

RESPONSIBILITY:

All healthcare workers at all levels shall adopt this treatment guidelines to ensure standard and rational management of rabies exposures, doctors, nurses, IPCU Staff, Employee Health Staff, Disease Surveillance Officer/PHU Team

DEPARTMENT: Medical Services Division		POLICY NUMBER: DPOTMH-MPP-IPCU-P018-(01)	
TITLE/DESCRIPTION: RABIES EXPOSURE MANAGEMENT			
EFFECTIVE DATE: December 31, 2024	REVISION DUE: December 30, 2027	REPLACES NUMBER: N/A	NO. OF PAGES: 3 of 24
APPLIES TO: All Medical Staff, IPCU, NSD		POLICY TYPE: Multi Disciplinary	

POLICY:

1. Rabies control program shall be integrated to the regular health services provided by the organization.
2. All patients ~~coming in should~~ will be admitted in an isolation room in the Isolation Facility (Station 14) ~~that is quiet and dark~~.
3. Patient should be treated with compassion and their privacy and dignity ~~preserved~~.
4. Palliative therapy is the default treatment choice to all patients admitted.
5. All patients shall be restrained ~~with the restrains~~ IF NEEDED suitable for age, body build and presentation.
6. ~~Restraints are never used for the staff convenience or as patient punishment.~~
7. ~~Sedation using diazepam or midazolam may be given following guidelines below.~~
8. Monitoring of the patient's vital signs shall be done ~~every shift.~~ if patient still has no signs of Rabies
9. Full personal protective equipment (PPE) will be used for direct contact with the patient.
10. Hand hygiene should immediately be done upon contact with the patient or any body fluids.
11. Family members and relatives accompanying the patient will be informed that, in the event of a cardiac arrest, resuscitation will not be performed.
12. Visitors ~~and~~ CARE TAKERS or watchers are highly discouraged except when:
    - 12.1 The patient is child
    - 12.2 The patient has paralytic rabies
    - 12.3 The patient is lucid or aware
13. Watchers may stay outside of the room as hospital circumstances allow.
14. All equipment used to the patient shall be cleaned and disinfected.

DEPARTMENT: Medical Services Division		**POLICY NUMBER:** DPOTMH-MPP-IPCU-P018-(01)	
TITLE/DESCRIPTION: **RABIES EXPOSURE MANAGEMENT**			
EFFECTIVE DATE: December 31, 2024	**REVISION DUE:** December 30, 2027	**REPLACES NUMBER:** N/A	**NO. OF PAGES:** 4 of 24
APPLIES TO: All Medical Staff, IPCU, NSD		**POLICY TYPE:** Multi Disciplinary	

15. Cleaning and disinfection/terminal cleaning of the patient room shall follow.

16. Hospital contacts of patients with rabies do not require post exposure prophylaxis unless they are bitten or there is exposure of their mucous membranes or open wounds to the patient's saliva, CSF or brain tissue.

17. Initiation of the post exposure prophylaxis (PEP) shall not be delayed for any reason regardless of interval between exposure and consultation as it increase the risk of rabies and it is associated with treatment failure.

18. Immediate washing of the bite wound/exposed area with soap and water and application of an antiseptic solution reduces the risk of rabies transmission.

19. There are no absolute contraindications to rabies PEP. Patients allergic to specific vaccine/RIG or its components shall be given the alternative vaccine/RIG.

20. Isolation of hospitalized patients standard precautions are recommended for the duration of illness.

21. Confirmed rabies in patients is a reportable disease. Notify Disease Surveillance Officer (DSO). Contact number **0063 923 287 6164**

DEPARTMENT: Medical Services Division		POLICY NUMBER: DPOTMH-MPP-IPCU-P018-(01)	
TITLE/DESCRIPTION: **RABIES EXPOSURE MANAGEMENT**			
EFFECTIVE DATE: December 31, 2024	**REVISION DUE:** December 30, 2027	**REPLACES NUMBER:** N/A	**NO. OF PAGES:** 5 of 24
APPLIES TO: All Medical Staff, IPCU, NSD		**POLICY TYPE:** Multi Disciplinary	

GUIDELINES

1. Clinically, human rabies present in two forms, furious and paralytic. About two thirds of the documented cases are furious. Furious rabies presents with alternating period of agitation and lucidity associated with autonomic dysfunction like lacrimation, pupillary, hypersalivation, and excessive sweating. Hydrophobia is the pathognomonic symptom and consists of inspiratory muscle spasm, painful laryngospasm and fear. It can be triggered by drinking water or even the mention of water. Aerophobia which is the fear of air is also seen.
   Paralytic rabies is characterized by paresthesia and weakness; and may not be clinically differentiable from GBS. Hydrophobia and aerophobia may be present in only 50% of the time and animal bite may be absent from the history. Clinical course is prolonged.

2. Infected patients go through 5 stages:
   2.1 Incubation Period - usually lasts between 20-90 days. More than 95% of infected patients will present with signs and symptoms within 6 months of exposure, while more than 98% will present within a year of exposure. The virus remains at the site of the bite where it goes amplification and later crosses the myoneural junction to reach the nerve ending. Patient has no symptoms except those related to local wound healing. There are no laboratory tests to diagnose rabies during this period. This is the only time that vaccination is effective.
   2.2 Prodrome - the period when the virus reached the spinal cord and the patient begins to exhibit nonspecific signs and symptoms such as fever, headache, body malaise. They may also exhibit pain, itching or paresthesia on the bite site secondary to ganglioneuritis of the dorsal root ganglion; which is the first rabies specific symptom.
   2.3 Acute Neurologic Phase - the virus reaches the brain, multiplies and spreads to other organs notably the salivary glands 2-7 days after the prodrome. The patient may present in one of two ways.
      2.3.1 Encephalitic or furious rabies - this is seen in 80% of the cases. The patient is hyperactive and may be combative and aggressive or agitated and apprehensive alternating with lucid moments. The patient has hydrophobia which is elicited by giving him/her/they glass of water and/or aerophobia which is observed when a draft of air hits the patient from the window or fanning the patient. Positive reaction occurs when there is agitation, cringing or muscle contraction caused by the painful contraction of laryngeal muscles to air.
      2.3.2 Paralytic or dumb rabies – is seen in 20% of cases. It starts as paralysis of the

DEPARTMENT: Medical Services Division		POLICY NUMBER: DPOTMH-MPP-IPCU-P018-(01)	
TITLE/DESCRIPTION: RABIES EXPOSURE MANAGEMENT			
EFFECTIVE DATE: December 31, 2024	REVISION DUE: December 30, 2027	REPLACES NUMBER: N/A	NO. OF PAGES: 6 of 24
APPLIES TO: All Medical Staff, IPCU, NSD		POLICY TYPE: Multi Disciplinary	

bitten limb which spreads to involve the rest of the limbs and eventually the respiratory muscles. It is often missed as hydrophobia and aerophobia may be absent. A High index of suspicion should be maintained in patients who come in with paralysis or encephalitis of undetermined etiology. A history of prior exposure should be elicited. Percussion myoedema is said to be a specific for paralytic rabies. Mounding of the muscle occurs following percussion on the chest, deltoid or thigh area and disappears after a few seconds.

2.4 Coma occurs within 4-10 days following the acute neurologic phase regardless of presentation.

2.5 Death is inevitable. It usually follows within 7 days for furious rabies and within 2 weeks for paralytic rabies.

3. Diagnosis of the patient is severely limited by the pathogenesis of the virus that has viremic phase and capably evades to the host immune system; and is largely clinical. The presence of pathognomonic hydrophobia and aerophobia In a patient with history of exposure is enough to be Pathognomonic. Testing is influenced by viral shedding, timing of sample collection relative to disease onset, specimen type and type of rabies. Paralytic rabies often have negative test results.

4. Test for the diagnosis of rabies.

4.1 Serologic test - Viral antibodies are seen in 20% of unvaccinated patients within 0-26 days after onset of disease. If no vaccine or rabies immune serum has been previously administered, high titer rabies antibody in the serum is diagnostic and CSF sampling may be omitted. Antibody in the CSF regardless of antibody in the serum is diagnostic and CSF sampling may be omitted. Antibody in the CSF regardless of immunization status indicated rabies infection. Viral antibodies appear after 7 days in the serum and longer in the CSF.

4.2 Skin biopsy- samples for biopsy are obtained from the nape of the neck, an area where hair follicles are abundant. Viral nucleocapsids may be seen on the nerve endings around the hair follicles. 20 sections of 5-6 mm full thickness skin biopsies are recommended. Timing of the biopsy affects the results with 82% sensitivity on the first 4 days of disease onset and drops to less than 60 five days after or more.

4.3 RTPCR – Saliva has the highest yield rate followed by the urine and CSF samples. Rate of positivity is also high within the first three days of symptoms onset. Virus detection in saliva is highest on the second to third day of symptom onset. Three collections in a day increases the yield to 100% due to intermittent shedding of the virus. There is no difference in yield between liquid saliva samples and swab.

DEPARTMENT: Medical Services Division		POLICY NUMBER: DPOTMH-MPP-IPCU-P018-(01)	
TITLE/DESCRIPTION: RABIES EXPOSURE MANAGEMENT			
EFFECTIVE DATE: December 31, 2024	REVISION DUE: December 30, 2027	REPLACES NUMBER: N/A	NO. OF PAGES: 7 of 24
APPLIES TO: All Medical Staff, IPCU, NSD		POLICY TYPE: Multi Disciplinary	

4.4 Brain biopsy - is the gold standard for diagnosis using fluorescence assays but not for antemortem diagnosis. Post mortem brain biopsy may obtain fragments of the orbitofrontal tissue thru the orbital or transnasal route using Trucut biopsy needles or the cerebellar and brain stem samples thru the occiput via the foramen magnum via lumbar puncture needles. Tissue samples should be refrigerated until FAT or molecular diagnostics can be performed. Some samples may be placed in 50% glycerol saline for virus isolation. Dried tissue smears on filter paper may be kept for transport or submitted in 10% formalin solution for antigen detection by immunohistochemistry. Brain biopsy should be submitted to the SPL for FAT.

4.5 Whenever feasible a combination of diagnostic examination shall be used.

4.6 Refer to laboratory guidelines for the submission and collection of samples.

5. Human rabies confer a high mortality rate. Aggressive therapy may be offered only if the following conditions are met:
   5.1 Administration of any rabies vaccine before the onset of clinical rabies.
   5.2 Presentation with a very early stage of disease, including paresthesias or pain at the site of a previous bite exposure, with minimal other neurological symptoms or signs.
   5.3 Good health and absence of chronic disease.
   5.4 Relatives who accept both the high probability of an unsuccessful outcome and possibility of disabling neurological deficits in a rabies survivor.
   5.5 Access to adequate resources and facilities.

6. As DPOTMH usually sees patients in the late stage of the disease, palliative therapy is the default choice of treatment. The aim of the therapy is to ensure patient comfort, easy family and prevent hospital transmission of the disease.

7. Patient privacy and dignity must be preserved.

8. Supportive management
   8.1 IV fluids may be given as 5% glucose solutions or isotonic, saline to compensate water and electrolyte loss as well as to alleviate thirst.
   8.2 Ensure immobilization of limb with IV access to prevent displacement.
   8.3 Sedation is preferred over physical restraints as the latter may aggravate agitation. Diazepam can be given intravenously, intramuscularly or intrarectally, mindful of possible respiratory depression. Dose is 0.1-0.3 mg/kg IV over 3-5 minute in children or 0.5 mg/kg

DEPARTMENT: Medical Services Division		POLICY NUMBER: DPOTMH-MPP-IPCU-P018-(01)	
TITLE/DESCRIPTION: RABIES EXPOSURE MANAGEMENT			
EFFECTIVE DATE: December 31, 2024	REVISION DUE: December 30, 2027	REPLACES NUMBER: N/A	NO. OF PAGES: 8 of 24
APPLIES TO: All Medical Staff, IPCU, NSD		POLICY TYPE: Multi Disciplinary	

intrarectally; 10my IV or intrarectally in adults and may be repeated every 1-4 hour via continuous infusion at a rate of 3-10 mg/kg. Midazolam can be given in bolus followed by a dose of I mg IV every 10 minutes reducing the dose for dehydrated patients.

8.4 Haloperidol lactate may be given for agitation at a dose of 2-5 mg. Intramuscularly every 4-8 hours not to exceed 20mg/day. Dosing and frequency should be dependent on patient symptoms and may be given as often as every hour.

9. Categories of exposure to a rabid animal or to an animal suspected to be rabid, with their corresponding management guidelines:

CATEGORY OF EXPOSURE

Category of exposure	Management
CATEGORY 1 a. Feeding/touching an animal b. Licking of intact skin (with reliable history and thorough physical examination) c. Exposure to patient with signs and symptoms of rabies by sharing of eating or drinking utensils. d. Casual contact (talking to, visiting and feeding suspected rabies cases) and routine delivery of health care to patient with signs and symptoms of rabies.	1. Wash exposed skin immediately with soap and water. 2. No vaccine or RIG needed. 3. Pre-exposure prophylaxis maybe considered for high risk persons.
CATEGORY II a. Nibbling of uncovered skin with or without bruising/hematoma b. Minor/superficial scratches/abrasions	MASTER COPY 1. Wash wound with soap and water. 2. Start vaccine immediately. 3. Complete vaccination regimen until Day 7

DEPARTMENT: Medical Services Division		POLICY NUMBER: DPOTMH-MPP-IPCU-P018-(01)	
TITLE/DESCRIPTION: **RABIES EXPOSURE MANAGEMENT**			
EFFECTIVE DATE: December 31, 2024	**REVISION DUE:** December 30, 2027	**REPLACES NUMBER:** N/A	**NO. OF PAGES:** 9 of 24
APPLIES TO: All Medical Staff, IPCU, NSD		**POLICY TYPE:** Multi Disciplinary	

without bleeding, including those induced to bleed c. All Category II exposures on the head and neck are considered Category III and shall be managed as such.	regardless of the status of the biting animal. 4. RIG is not indicated.
CATEGORY III a. Transdermal bites (punctured wounds, lacerations, avulsions) or scratches/abrasions with spontaneous bleeding b. Licks on broken skin or mucous membrane c. Exposure to rabies patient through bites, contamination of mucous membranes (eyes, oral. nasal mucosa, genital/anal mucous membrane) or open skin lesions with body fluids through splattering and mouth-to-mouth resuscitation. d. Unprotected handling of infected carcass e. Ingestion of raw infected meat f. Exposure to bats g. All Category II exposure on head and neck area.	1. Wash wound with soap and water. 2. Start vaccine and RIG immediately. 3. Complete vaccination regimen until Day 7 regardless of the status of the biting animal.

1.1 Dog owners have the responsibility to keep their dogs for observation under the Rabies Act of 2007, with penalties to violators provided by the law.

1.2 Only the Intradermal Regimen will be used for the administration of vaccines in all government facilities except for conditions that require IM administration as described in Section 3.

DEPARTMENT: Medical Services Division		POLICY NUMBER: DPOTMH-MPP-IPCU-P018-(01)	
TITLE/DESCRIPTION: RABIES EXPOSURE MANAGEMENT			
EFFECTIVE DATE: December 31, 2024	REVISION DUE: December 30, 2027	REPLACES NUMBER: N/A	NO. OF PAGES: 10 of 24
APPLIES TO: All Medical Staff, IPCU, NSD		POLICY TYPE: Multi Disciplinary	

2. **Immunization**

2.1 **Active Immunization**

2.1.1 Administration

2.1.1.1 Vaccine shall be administered to induce the antibody and T-cell production in order to neutralize the rabies virus in the body. It induces an active immune response in 7-10 days after vaccination, which may persist for years provided that primary immunization is completed.

2.1.2 Types of Rabies Vaccines and Dosage

2.1.2.1 The National rabies Prevention and Control Program (NRPCP) shall provide the following CCEEV.

a) Purified Vero Cell Rabies Vaccine (PVRV) -0.5 ml/vial and
b) Purified Chick Embryo Cell Vaccine 9PCECV)-1.0ml/vial (Table 2)

Table 2. List of CCEEV provided by the NRPCP to Animal Bite Treatment Centers with Corresponding Preparation and Dose

Generic Name	Preparation	Dose
Purified Verocell Rabies Vaccine (PVRV)	0.5 ml/vial	ID-0.1ml IM-0.5ml
Purified Chick Embryo Cell Vaccine (PCECV)	1 ml/vial	ID-0.1ml IM-1.0ml

1.1 **Passive Immunization**

Rabies immunoglobulin or RIG (also called passive immunization products) shall be given in combination with rabies vaccine to provide immediate availability of neutralizing antibodies at the site of the exposure before it is physiologically possible for the patient to begin producing his or her own antibodies after vaccination. This is especially important for patients with Category III exposures. RIGs have a half-life of approximately 21 days.

1.1.1 **Types of Rabies RIG**

1.1.1.1 Human Rabies Immune Globulin (HRIG) derived from plasma of human donors administered at a maximum of 20 IU per kilogram body weight. Available preparation is 2 ml/vial; 150 IU/ml.

1.1.1.2 Highly purified antibody antigen binding fragments produced from equine rabies immune globulin (ERIG) administered at a maximum of 40 IU per kilogram body weight. Available preparation is 5 ml/vial;200 IU/ml.

DEPARTMENT: Medical Services Division		POLICY NUMBER: DPOTMH-MPP-IPCU-P018-(01)	
TITLE/DESCRIPTION: RABIES EXPOSURE MANAGEMENT			
EFFECTIVE DATE: December 31, 2024	REVISION DUE: December 30, 2027	REPLACES NUMBER: N/A	NO. OF PAGES: 11 of 24
APPLIES TO: All Medical Staff, IPCU, NSD		POLICY TYPE: Multi Disciplinary	

1.1.1.3 Equine Rabies Immunoglubulin (ERIG) derived from purified horse serum administered at 40 IU per kilogram body weight. Available preparation is 5 ml/vial; 200 IU/ml.

Table 3. List of Rabies Immunoglobulins provided by the NRPCP to animal Bite Treatment Centers

Generic Name	Preparation	Dose
Human Rabies Immune Globulin (HRIG)	150 IU/ml at 2ml/vial	20 IU/kg
Equine Rabies Immune Globulin (ERIG, a.2 or a.3)	200 IU/ml at 5ml/vial	40 IU/kg

1.1.2 **Rabies Immunoglobulin Criteria:**

To ensure that only safe and efficacious RIG are provided by the National Rabies Prevention and Control Program to all Animal Bite Treatment Centers (ABTCs), the program shall be guided by the following criteria in procuring the RIG:

1.1.2.1 RIG must be registered and approved by FDA;

1.1.2.2 RIG must be proven to be safe and effective when used together with human rabies vaccine as evidenced by publication on peer reviewed journals. These include studies on:

1.1.2.2.1 Safety

1.1.2.2.2 Efficacy

1.1.2.2.3 Immunogenicity on interference when used together with anti- rabies vaccine;

1.1.2.2.4 Animal survivorship, if any; and

1.1.2.2.5 Post-marketing surveillance

1.1.2.3 Results of RFFIT showing antibody content as claimed by the manufacturer

1.1.3 **Prioritized to be given RIG**

1.1.3.1 Even if RIG is not available or affordable, prompt local treatment of all bite wounds or scratches, and for category II & III exposures a complete course of rabies vaccine is indicated.

1.1.3.2 For patients who can reliably document previous post exposure prophylaxis (PEP) of 6 doses (3 visits) or PrEP of 4 doses (2 visits) using WHO pre-qualified CCEEV or PEP of 8 doses (4 visits) or PrEP of 6 doses (3 visits) using non-WHO pre-qualified CCEEV, RIG is not indicated.

1.1.3.3 In cases of shortage or unaffordability, the following groups should be prioritized for RIG allocation:

DEPARTMENT: Medical Services Division		POLICY NUMBER: DPOTMH-MPP-IPCU-P018-(01)	
TITLE/DESCRIPTION: RABIES EXPOSURE MANAGEMENT			
EFFECTIVE DATE: December 31, 2024	REVISION DUE: December 30, 2027	REPLACES NUMBER: N/A	NO. OF PAGES: 12 of 24
APPLIES TO: All Medical Staff, IPCU, NSD		POLICY TYPE: Multi Disciplinary	

1.1.3.3.1 Multiple bites
1.1.3.3.2 Deep wounds
1.1.3.3.3 Highly innervated parts of the body, as head, neck, hands, genitals
1.1.3.3.4 immunocompromised patients
1.1.3.3.5 History of biting animal indicative of confirmed or probable rabies
1.1.3.3.6 A bite or scratch or exposure of a mucous membrane by a bat can be ascertained.

1.1.4 **Computation and Dosage of Rabies Immune Globulin**

1.1.4.1 HRIG at 20 IU/kg. body weight (150 IU/ml)
50kg. patient x 20 IU/kg. = 1000 IU
1000 IU/150 IU/ml
= 6.7 ml.

1.1.4.2 **ERIG/F(ab')2 at 40 IU/kg. body weight (200 IU/ml)**
50 kg. patient x 40 IU/ kg =2000 IU
2000IU/200 IU/ml
= 10 ml

1.1.5 **Administration**

1.1.5.1 The total computed RIG shall be infiltrated around and into the wound as much as anatomically feasible, even if the lesion has healed. In case some amount of the total computed dose of RIG is left after all wounds have been infiltrated, the remaining volume of RIG that is not infiltrated into the wound does not need to be injected IM. It may be reserved for the next patient who needs RIG, ensuring aseptic retention of the RIG i.e fractionated in smaller individual syringes.

1.1.5.2 A gauge 23 or 24 needle, I inch length shall be used for infiltration. Multiple needle injections into the same wound shall be avoided.

1.1.5.3 Equine immunoglobulins (ERIG) are clinically equivalent to human rabies Immunoglobulins (HRIG) and are considered safe and efficacious life - and - cost saving biologics. Skin testing for ERIG is highly recommended.

1.1.5.4 If a finger or toe needs to be infiltrated, care shall be take to ensure that blood circulation is not impaired. Injection of an excessive amount may lead to cyanosis, swelling and pain.

1.1.5.5 RIG shall not exceed the computed dose as it may reduce the efficacy of the vaccine. If the computed dose is insufficient to infiltrate all bite wounds, it may be diluted with sterile saline 2 or 3-fold for thorough

DEPARTMENT: Medical Services Division		POLICY NUMBER: DPOTMH-MPP-IPCU-P018-(01)	
TITLE/DESCRIPTION: RABIES EXPOSURE MANAGEMENT			
EFFECTIVE DATE: December 31, 2024	REVISION DUE: December 30, 2027	REPLACES NUMBER: N/A	NO. OF PAGES: 13 of 24
APPLIES TO: All Medical Staff, IPCU, NSD		POLICY TYPE: Multi Disciplinary	

infiltration of all wounds.

1.1.5.6 RIG shall always be given in combination with rabies vaccine. RIG shall be administered at the same time as the first dose of rabies vaccine (Day 0). In case RIG is unavailable on DAY 0, it may still be given until 7 days after the first dose of the vaccine. Beyond Day 7, regardless of whether day 3 and day 7 doses were received, RIG is not indicated because an active antibody response to the rabies CCEEV has already started and interference between active and passive immunization may occur.

1.1.5.7 In the event RIG and vaccine cannot be given on the same day, the vaccine shall be given before RIG because the latter inhibits the level of the neutralizing antibodies induced by immunization.

1.1.5.8 RIG shall be given only once during the same course of PEP.

1.1.5.9 Patient shall be observed for at least one hour after injection after injection of ERIG for immediate allergic reactions.

1.1.5.10 Severe adverse events or perceived lower efficacy of RIG (e.g batches of insufficient potency or lower purification degree) should be monitored, recorded and reported, so that biological producers receive immediate feedback and can respond accordingly. A classification of adverse events is available in Table 6 Post marketing surveillance is recommended.

1.1.6 **Management of Adverse Reactions**

Adverse reactions shall be managed as follows:

1.1.6.1 Anaphylaxis

1.1.6.1.1 Give 0.1% Adrenaline or Epinephrine (1:1,000 or 1mg/ml) underneath the skin or into the muscle.
Adults – 0.5 ml
Children -0.01 mg/kg, maximum of 0.5ml

1.1.6.1.2 Repeat Epinephrine dose every 10-20 minutes for 3 doses

1.1.6.1.3 Give steroids after Epinephrine

1.1.6.2 Hypersensitivity reactions

1.1.6.2.1 Give antihistamines, either as single drug or in combination

1.1.6.2.2 If status quo for 48 hours despite combination of antihistamines, may give short course (5-7days) of combined oral antihistamines plus steroids

1.1.6.2.3 If patient worsen and condition requires hospitalization or becomes life threatening, may give IV steroids in addition to antihistamines

DEPARTMENT: Medical Services Division		POLICY NUMBER: DPOTMH-MPP-IPCU-P018-(01)	
TITLE/DESCRIPTION: RABIES EXPOSURE MANAGEMENT			
EFFECTIVE DATE: December 31, 2024	REVISION DUE: December 30, 2027	REPLACES NUMBER: N/A	NO. OF PAGES: 14 of 24
APPLIES TO: All Medical Staff, IPCU, NSD		POLICY TYPE: Multi Disciplinary	

2. **Treatment**
   2.1 **Post-Exposure Prophylaxis**
      2.1.1 **Local Wound Treatment**
         2.1.1.1 Wound shall be immediately and vigorously washed and flushed with soap or detergent, and water preferably for 10 minutes. If soap is not available, the wound shall be thoroughly and extensively washed with water.
         2.1.1.2 Apply alcohol, povidone iodine or any antiseptic.
         2.1.1.3 Suturing of wounds shall be avoided at all times since it may it may inoculate virus deeper into the wounds. Wound maybe coaptated using sterile adhesive strips. If suturing is unavoidable, it should be delayed for at least 2 hours after administration of RIG to allow to diffusion of the antibody to occur through the tissues.
         2.1.1.4 Any ointment, cream or wound dressing shall not be applied to the bite site because it will favor the growth of bacteria and will occlude drainage of the wound, if any
         2.1.1.5 Anti-tetanus immunization may be given, if indicated. History of tetanus immunization (TT/DPT/Td) should be reviewed. Animal bites shall be considered tetanus prone wounds. Completion of the primary series of tetanus immunization is recommended.

Table 4. Guide to Tetanus Prophylaxis in routine Wound Management

      2.1.2 **Routine Wound Management**
         2.1.2.1 The most common organism isolated from the dog and cat bites is *Pasteurella multocida*. Other organisms include *S. areus, Bacteroides sp, Fusobacterium* and *Capnocytophaga*. Antimicrobials shall be recommended for the following conditions:
            2.1.2.1.1 All frankly infected wounds
            2.1.2.1.2 All category III cat bites
            2.1.2.1.3 All other category III bites that are either deep, penetrating, multiple or extensive or located on the hand/face/genital area

         2.1.2.2 Recommended antimicrobials for frankly infected wounds include:
            2.1.2.2.1 Amoxicillin/clavulanic
            Adults-500mg p.o. TID

DEPARTMENT: Medical Services Division		POLICY NUMBER: DPOTMH-MPP-IPCU-P018-(01)	
TITLE/DESCRIPTION: RABIES EXPOSURE MANAGEMENT			
EFFECTIVE DATE: December 31, 2024	REVISION DUE: December 30, 2027	REPLACES NUMBER: N/A	NO. OF PAGES: 15 of 24
APPLIES TO: All Medical Staff, IPCU, NSD		POLICY TYPE: Multi Disciplinary	

Children- 30-45 mg/kg/day in 3 divided doses

2.1.2.2.2 Cloxacillin
Adults – 500mg p.o.QID
Children – 10-150-100 mg/kg/day in 4 divided doses

2.1.2.2.3 Cefuroxime axetil
Adults -500 mg p.o. BID
Children-10-15mg/kg/day in 2 divided doses

2.1.2.2.4 For Penicillin allergic patients
Adults – Doxycycline
Children Erythromycin

2.1.2.2.5 For those instances where there are no obvious signs and infection, amoxicillin as prophylaxis may suffice
Adults -500 mg p.o. TID
Children- 30-45mg/kg/day in 3 divided doses

The public shall be educated in simple local wound treatment and warned not to use procedures that may further contaminate the wounds and other non-traditional practices

2.1.3 **Vaccination**

2.1.3.1 Storage

2.1.3.1.1 Vaccines shall be stored at +2 to +8 degrees Centigrade in a refrigerator, not freezer

2.1.3.1.2 Once reconstituted, vaccines shall be kept in the refrigerator and used within 8 hours.

2.1.3.2 Administration Area

2.1.3.2.1 Injections shall be given on the deltoid area of each arm in adults or at the anterolateral aspect of the thigh in infants.

2.1.3.2.2 Vaccine shall never be injected in the gluteal area as absorption is unpredictable

2.1.3.3 Treatment Regimen Schedule
Updated 2-Site Intradermal Schedule (2-2-2-0-2)

2.1.3.3.1 One dose for ID administration is equivalent to 0.1ml for PVRV and PCEV

2.1.3.3.2 One dose shall be given on each deltoid on Days 0,3,7 and 28

2.1.3.3.3 One intradermal dose should have at least 0.5 IU vaccine potency

DEPARTMENT: Medical Services Division		POLICY NUMBER: DPOTMH-MPP-IPCU-P018-(01)	
TITLE/DESCRIPTION: RABIES EXPOSURE MANAGEMENT			
EFFECTIVE DATE: December 31, 2024	REVISION DUE: December 30, 2027	REPLACES NUMBER: N/A	NO. OF PAGES: 16 of 24
APPLIES TO: All Medical Staff, IPCU, NSD		POLICY TYPE: Multi Disciplinary	

Table 7. Zagreb Regimen Schedule (2-0-1-0-1) Intramuscular Schedule

Day of immunization	PVRV	PCEV	Site of injection
Day 0	0.5ml	1.0 ml	Left and right deltoid or anterolateral thighs in infants
Day 7	0.5ml	1.0 ml	Left and right deltoid or anterolateral thighs in infants
Day 21	0.5ml	1.0 ml	Left and right deltoid or anterolateral thighs in infants

2.1.3.4 Shortened Intramuscular Schedule (CDC) (1-1-1-1-0)

Table 8. Shortened Intramuscular Schedule (CDC) (1-1-1-1-0)

Day of immunization	PVRV	PCEV	Site of injection
Day 0	0.5ml	1.0 ml	Left and right deltoid or anterolateral thighs in infants
Day 3	0.5ml	1.0 ml	Left and right deltoid or anterolateral thighs in infants
Day 7	0.5ml	1.0 ml	Left and right deltoid or anterolateral thighs in infants
Day 14	0.5ml	1.0 ml	Left and right deltoid or anterolateral thighs in infants

2.1.4 **Post-Exposure Prophylaxis under Special Conditions**

2.1.4.1 Pregnancy and infants shall NOT be contraindications to treatment with purified CCEEV (PVRV, PCECV) and RIG.

2.1.4.2 Babies who are born of rabid mothers shall be given rabies vaccination as well as RIG as early as possible at birth.

2.1.4.3 Patients with hematologic conditions where IM injection is contraindicated shall receive rabies vaccine by ID route.

2.1.4.4 Patients with chronic liver disease and those taking chloroquine, and systemic steroids shall be given standard IM regimen as the response to ID regimen is not optimum for these conditions. Vaccination shall not be delayed in these circumstances as it increases the risk of rabies.

2.1.4.5 Immunocompromised individuals(such as those with HIV infection, cancer/ transplant patients, patients on immunosuppressive therapy etc.) shall be given vaccine using standard IM regimen and RIG for both Category II and III exposures.

2.1.4.6 Exposed persons who present for evaluation or treatment weeks or

DEPARTMENT: Medical Services Division		POLICY NUMBER: DPOTMH-MPP-IPCU-P018-(01)	
TITLE/DESCRIPTION: RABIES EXPOSURE MANAGEMENT			
EFFECTIVE DATE: December 31, 2024	REVISION DUE: December 30, 2027	REPLACES NUMBER: N/A	NO. OF PAGES: 17 of 24
APPLIES TO: All Medical Staff, IPCU, NSD		POLICY TYPE: Multi Disciplinary	

months after the bite shall be treated as if exposure has occurred recently. However, if the biting animal has remained healthy and alive with no signs of rabies until 14 days after the bite, no treatment shall be needed.

2.1.4.7 Changes in the human rabies vaccine product and /or the route during the same PEP occurs acceptable, if unavoidable to ensure PEP course completion. Restarting PEP is not necessary.

2.1.4.8 Bites by rodents, guinea pigs and rabbits shall not require rabies post-exposure prophylaxis.

2.1.4.9 Bites by domestic animals (dog, cat) and livestock 9cows, pigs, horses, goats etc.) shall require PPE.

2.1.5 **Post-Exposure Prophylaxis of Previously Immunized Animal Bite Patients**

2.1.5.1 Local wound treatment shall always be carried out.

2.1.5.2 Persons with repeat exposure after having previously primary received complete primary IMMUNIZATIONS or Pre-Exposure Prophylaxis against rabies with CCEEV shall be given a booster dose of 0.1 ml ID dose at 1 site on D0 and D3 or 4 ID doses on Day 0. To maximize use of CCEEV, the use of an IM booster dose is discouraged.

Table 9a. Management of Previously Vaccinated Individuals

PEP/PrEP History	RIG	Management
Patient received complete PrEP (Day 0 and 7) OR Patient received at least days 0 and 3 doses of PEP ID/IM **AND**	No	Determine if high or low risk bite (see Table 9b)
Patient received complete PrEP (Day 0 and 7) **OR** Patient received at least days 0 and 3 doses of PEP ID/IM **AND** Patient is immunocompromised OR bitten by a bat	Yes, if indicated	Give full course PEP
Patient did not complete PrEP **OR** Patient received only 1 dose of PEP	Yes, if indicated	Give full course PEP

DEPARTMENT: Medical Services Division		POLICY NUMBER: DPOTMH-MPP-IPCU-P018-(01)	
TITLE/DESCRIPTION: **RABIES EXPOSURE MANAGEMENT**			
EFFECTIVE DATE: December 31, 2024	**REVISION DUE:** December 30, 2027	**REPLACES NUMBER:** N/A	**NO. OF PAGES:** 18 of 24
APPLIES TO: All Medical Staff, IPCU, NSD		**POLICY TYPE:** Multi Disciplinary	

Table 9b. Criteria for high and low risk exposures

Risk of Exposure	Criteria	Recommendations
High Risk	ANY ONE OF THE FOLLOWING: 1. Biting animal cannot be observed, dies or is sick 2. Site of bite is in highly innervated parts of the body-neck, head,, genital area, hands and toes 3. Multiple deep bites 4. Patient is coming from Geographically Isolated and Disadvantaged Areas (GIDA) like infrequent transportation to and from ABTC/ABC	Immediately provide the booster injections to the patient **Booster doses:** 0.1ml ID at 4 sites on day 0 OR 0.1 ml ID/IM at 1 site on days 0 and 3
Low Risk	Last dose of vaccine was within the previous 3 months **AND** Biting animal is healthy, owned, kept on a leash or can be confined and is available for observation **AND ANDY ONE OF THE FOLLOWING:** 1. Biting animal is the same animal that bit the patient previously **OR** 2. Biting animal is previously immunized **OR** 3. Bite is on the extremities/trunk	Observe biting animal for 14 days. If the animal remains healthy, withhold booster dose

1.1.1.1 Patients who have previously received complete primary immunization with rabies vaccine have the advantage that booster doses will rapidly induce a large increase in antibody production (a "secondary response"). Therefore, there is no need to give RIG.

1.1.1.2 Patients have not completed the primary immunization as described above shall receive full course including RIG if needed.

DEPARTMENT: Medical Services Division		**POLICY NUMBER:** DPOTMH-MPP-IPCU-P018-(01)	
TITLE/DESCRIPTION: **RABIES EXPOSURE MANAGEMENT**			
EFFECTIVE DATE: December 31, 2024	**REVISION DUE:** December 30, 2027	**REPLACES NUMBER:** N/A	**NO. OF PAGES:** 19 of 24
APPLIES TO: All Medical Staff, IPCU, NSD		**POLICY TYPE:** Multi Disciplinary	

1.1.2 **Management of Rabies Exposures from bites of animals vaccinated against rabies:**

1.1.2.1 <u>For Category I exposure, PEP is not needed.</u>

1.1.2.2 <u>For Category II exposures, the following are recommended:</u>

1.1.2.2.1 Immediate washing of the bite wound for ten minutes and application of antiseptic solution.

1.1.2.2.2 No human rabies vaccine shall be provided, provided that ALL of the following conditions are satisfied.

1.1.2.2.2.1 Dog/cat is healthy and available for observation for 14 days.

1.1.2.2.2.2 Dog/cat was vaccinated against rabies

1.1.2.2.2.2.1 Dog or cat shall be at least 1 year and 6 months old and has updated vaccination certificate from a duly license veterinarian for the last 2 years,

1.1.2.2.2.2.2 The last vaccination shall be within the past twelve (12) months, immunization status of the dog/cat shall not be considered updated if the animal is not vaccinated on the due date of the next vaccination.

1.1.2.2.3 If the biting animal starts to show signs of rabies, immediately give vaccine and RIG.

1.1.2.2.4 If the biting animal remains to be healthy within 14days, there is no need to administer CCEEV against rabies.

1.1.2.3 <u>Category III exposures, the following are recommended:</u>

1.1.2.3.1 Immediate washing of the bite wound for ten minutes and application of an antiseptic solution.

1.1.2.3.2 CCEEV and RIG are immediately administered regardless of the and other status of the biting animal.

1.1.2.4 PEP shall not be required for bite/s of the following biting animals: rats, mice, guinea, pigs, hamsters, rabbits, snakes, and other reptiles, birds and other avians, insects and fish.

DEPARTMENT: Medical Services Division		**POLICY NUMBER:** DPOTMH-MPP-IPCU-P018-(01)	
TITLE/DESCRIPTION: **RABIES EXPOSURE MANAGEMENT**			
EFFECTIVE DATE: December 31, 2024	**REVISION DUE:** December 30, 2027	**REPLACES NUMBER:** N/A	**NO. OF PAGES:** 20 of 24
APPLIES TO: All Medical Staff, IPCU, NSD		**POLICY TYPE:** Multi Disciplinary	

Table 10. Clinical Signs of Animal Rabies

Prodromal Stage (usually lasts 2-3 days; sometimes only a few hours)	
A) Changes in attitude/behavior/temperament such as unusual shyness or aggressiveness 1. Friendly animal becomes aggressive 2. Solitude 3. Restlessness 4. Snapping at imaginary objects 5. Apprehension 6. Nervousness 7. Anxiety 8. Barking/vocalization at the slightest provocation B) Dilated pupils; become myotic in advance state C) Mydriasis and/or sluggish alpebral or coroneal reflexes D) Slight rise in body temperature (slight fever)	
Clinical Rabies	
Furious Stage (usually lasts 1-7 days)	**Paralytic** (dumb) **Stage (**develops 2-10 days after clinical signs; usually last 2-4 days)
I. Increased response to auditory and visual stimulation such as: 1. Restlessness 2. Photophobia 3. Hyperaesthesia 4. Eating unusual objects 5. Aggression 6. Attacking any live or inanimate objects I. Erratic behavior: 1. Biting or snapping 2. Licking or chewing of wound bite/site 3. If caged, biting of their cage 4. Wandering and roaming 5. Excitability	Paralysis 1. May begin at the bite area and progress until entire CNS involvement 2. Following paralysis of the head and neck, the entire body becomes paralyzes 3. Change in tone of vocalization/barking (indicative of laryngeal/pharyngeal paralysis) 4. Hypersalivation or frothing; drooling/slobbering of saliva (indicative of laryngeal/ pharyngeal paralysis). 5. Dysphagia/difficulty/inability to swallow (indicative of laryngeal/pharyngeal paralysis). 6. "Jaw drop" Dropped jaw due to masseter muscle paralysis (suspects foreign body in mouth or esophagus). 7. Pupil dilation or pupil constriction.

DEPARTMENT: Medical Services Division		POLICY NUMBER: DPOTMH-MPP-IPCU-P018-(01)	
TITLE/DESCRIPTION: **RABIES EXPOSURE MANAGEMENT**			
EFFECTIVE DATE: December 31, 2024	**REVISION DUE:** December 30, 2027	**REPLACES NUMBER:** N/A	**NO. OF PAGES:** 21 of 24
APPLIES TO: All Medical Staff, IPCU, NSD		**POLICY TYPE:** Multi Disciplinary	

6. Irritability 7. Viciousness I. Self-mutilation II. Muscular in-coordination and seizures III. Disorientation • Roams and bites inanimate object and also other animals including man.	8. Protrusion of third eyelid. 9. Ataxia, progressive paralysis and cannibalism (terminal stage). 10. Coma and/or respiratory paralysis resulting in death within 2-4days.

1.1.1 **Management of the Biting Animal**

1.1.1.1 The biting animal shall be observed for 14 days. Adequate animal care shall be provided during the observation period.

1.1.1.2 It is advisable for patients to consult a veterinarian, whenever possible, regarding biting animal management especially when any of the following is observed:

1.1.1.2.1 sudden change of behavior (from wild to vicious temperament or vice versa).
1.1.1.2.2 Characteristic hoarse howl
1.1.1.2.3 Watchful, apprehensive expression of the eyes, staring, blank gaze
1.1.1.2.4 Drooling of saliva
1.1.1.2.5 paralysis of uncoordinated gait of hind legs
1.1.1.2.6 marked restlessness, pacing in cage
1.1.1.2.7 if at large runs aimlessly, biting anything in its way
1.1.1.2.8 depraved appetite, self mutilation
1.1.1.2.9 in some cases, lies quiescent, biting when provoked
1.1.1.2.10 snaps at imaginary objects
1.1.1.2.11 paralysis of lower jaw and tongue; inability to drink
1.1.1.2.12 sudden death without associated sign and symptoms

1.1.1.3 PEP utilizing non-WHO prequalified vaccine shall be discontinued if the biting animal remains healthy after 14-day observation period. If the animal died or get sick, the head shall be submitted to the nearest rabies diagnostic laboratory for testing.

DEPARTMENT: Medical Services Division		POLICY NUMBER: DPOTMH-MPP-IPCU-P018-(01)	
TITLE/DESCRIPTION: RABIES EXPOSURE MANAGEMENT			
EFFECTIVE DATE: December 31, 2024	REVISION DUE: December 30, 2027	REPLACES NUMBER: N/A	NO. OF PAGES: 22 of 24
APPLIES TO: All Medical Staff, IPCU, NSD		POLICY TYPE: Multi Disciplinary	

1.1.2 **Dispensing of Anti Rabies Immunizing Agent**

1.1.2.1 Patients needing PEP shall be referred to the nearest Animal Bite Treatment Center/Animal bite where rabies immunizing agents:

1.1.2.1.1 Assess the victim thoroughly and record in the Hospital Rabies Surveillance Form (Facility-based form).

1.1.2.1.2 If the situation warrants immunization (Category II and Category III), the patient shall be given the intradermal regimen.

1.1.2.1.3 If indicated, the patient shall be provided the required dose of passive immunization products/RIG, if available, preferably ERIG or F (ab) 2.

1.1.2.1.4 Explain decision to the patient with particular emphasis on adherence to treatment schedule, if immunization is indicated. Courtesy and tactfulness when dealing with patients particularly among individuals who need not be immunized.

1.1.2.1.5 Give advice on the practice of Responsible Pet Ownership.

1.1.2.1.6 Observe

1.1.3 Injection Equipment

The needle may either be fixed to the syringe when it is produced or attached by the healthcare worker just before use.

1.1.4 Management of Sharp Wastes

Used syringes and needles shall never be dumped in open areas where people might pick them up, step on them, or come in contact with them in any way. Adhere on the policy of safe management and disposal of sharps - DPOTMH-APP-IPCU-P009-01-PREVENTION & MANAGEMENT OF OCCUPATIONAL EXPOSURE NEEDLESTICK, SHARP INJURY AND BBF

1.1.5 Waste disposal

Disposal boxes when ¾ filled-with used syringe and needles shall be immediately closed, locked and brought to final disposal.

DEPARTMENT: Medical Services Division		**POLICY NUMBER:** DPOTMH-MPP-IPCU-P018-(01)	
TITLE/DESCRIPTION: **RABIES EXPOSURE MANAGEMENT**			
EFFECTIVE DATE: December 31, 2024	**REVISION DUE:** December 30, 2027	**REPLACES NUMBER:** N/A	**NO. OF PAGES:** 23 of 24
APPLIES TO: All Medical Staff, IPCU, NSD		**POLICY TYPE:** Multi Disciplinary	

PROCEDURE (SOP): N/A
WORK INSTRUCTION: N/A
WORK FLOW: N/A
FORMS: N/A
EQUIPMENT: N/A
REFERENCES: 1. Revised Guidelines on the Management of Rabies Exposures, Department of Health, Administrative Order No. 2018-0013, April 16, 2018. 2. Adapted from Research Institute of Tropical Medicine (RITM) CPG 2011, Management Protocol for Rabies

RIVERSIDE MEDICAL CENTER, INC.

DR. PABLO O. TORRE MEMORIAL HOSPITAL

METRO PACIFIC HEALTH
THE HEART OF FILIPINO HEALTHCARE

DEPARTMENT: Medical Services Division		**POLICY NUMBER:** DPOTMH-MPP-IPCU-P018-(01)	
TITLE/DESCRIPTION: **RABIES EXPOSURE MANAGEMENT**			
EFFECTIVE DATE: December 31, 2024	**REVISION DUE:** December 30, 2027	**REPLACES NUMBER:** N/A	**NO. OF PAGES:** 24 of 24
APPLIES TO: All Medical Staff, IPCU, NSD		**POLICY TYPE:** Multi Disciplinary	

APPROVAL:				
	Name/Title	**Signature**	**Date**	**TQM Stamp**
Prepared by:	**GERLYN J. DE LA CRUZ** Infection Prevention & Control Unit Supervisor		12/20/24	
Reviewed by:	**WENDY MAE D. GOMEZ** Accreditation and Documentation Manager		12/20/24	
Approved by:	**DOLORES ROMMELA T. RUIZ, MD** Infection Prevention & Control Unit Head		12/20/24	TQD
	ANNIVIE Y. GEROCHI, MD Company Physician		12/23/24	
	JOSE PEPITO B. MALAPITAN, MD Medical Director		12/27/2024	
	MA. ANTONIA S. GENSOLI, MD VP/Chief Medical Officer		12.26.24	
Final Approved by:	**GENESIS GOLDI D. GOLINGAN** President and Chief Executive Officer		01/02/25	

MASTER COPY