Australian STI Management Guidelines for Use in Primary Care

Cervicitis

Overview

- Cervicitis is an inflamed cervix characterised by friability of the cervix with easily induced bleeding and/or mucopurulent discharge at the cervical os.
- Gonorrhoea as the causative organism of cervicitis is increasing in Australia.

Possible causes

Chlamydia trachomatis and Neisseria gonorrhoeae are the most common causes of cervicitis.

Other less common causes include:

- Mycoplasma genitalium, herpes simplex virus (HSV) and Trichomonas vaginalis.
- Radiation treatment, malignancy, trauma (e.g. recent surgery), chemical irritants in the vagina (douching), allergic reactions to latex in condoms.
- Bacterial overgrowth of some of the normal flora of the vagina (bacterial vaginosis).

In a person with a low risk of sexually transmitted infections (STIs), cervicitis is often not associated with an identifiable pathogen.

Clinical presentation

Signs and symptoms	Considerations

Vaginal discharge	Speculum examination to view the cervix, +/- bimanual if pelvic pain or dyspareunia is reported. Cervicitis may be a sign of an upper genital-tract infection therefore it is important to assess for pelvic inflammatory disease (PID).
Intermenstrual or post-coital bleeding	As above. May also require pregnancy test if at risk and cervical screening test (CST) if indicated.
If cervicitis found incidentally on speculum examination e.g. with CST, consider testing for STIs	Especially if patient is < 30 years old; has had a previous STI, is an Aboriginal or Torres Strait Islander person; has had change in sexual partner or more than 1 partner in last 12 months.
Vulval or vaginal pain and irritation	May be associated with profuse vaginal and cervical discharge.
Abdominal and pelvic pain	May occur if associated with endometritis or PID.
Friable cervix	Bleeds with gentle touch from a swab or opening the speculum.

Diagnosis

A speculum examination and endocervical swab, as a minimum, are required to diagnose cervicitis.

Assess for symptoms of PID.

Site/specimen	Test	Consideration
Endocervical swab	Chlamydia and gonorrhoea NAAT	Positive – confirmed Chlamydia trachomatis and Neisseria gonorrhoeae Negative – cervicitis of another cause
	MC&S – request Neisseria gonorrhoeae culture	Neisseria gonorrhoeae sensitivity and possible resistance
	Mycoplasma genitalium NAAT	Positive – requires further testing for antibiotic sensitivity (seek advice)
	HSV NAAT (only if cervicitis doesn't settle or reoccurs in the absence of other causes)	Positive – see HSV for management
High vaginal swab	Trichomonas vaginalis NAAT	Positive – see Trichomonas vaginalis guidelines

Vaginal pH	Normal 3.5-4.5	> 4.5 indicates disturbance to vaginal flora
Anal / rectal swab[1]	Chlamydia trachomatis and Neisseria gonorrhoeae NAAT	Positive – confirmed Chlamydia trachomatis and Neisseria gonorrhoeae Negative – with receptive anal intercourse may be the cause of recurrent bacterial vaginosis
	MC&S Neisseria gonorrhoeae	Neisseria gonorrhoeae sensitivity and possible resistance profile

NAAT – Nucleic acid amplification test

MC&S – microscopy culture and sensitivity

Specimen collection guidance

Clinician collected | Self-collection

If the client declines an examination, the NAAT specimens can be self-collected. Ideally samples for microscopy and culture should be clinician collected.

Management

It is important to know which organism is causing the cervicitis.

If possible, wait for the test results before considering treatment as targeted treatment is more successful.

If same day treatment is given, treat for Chlamydia trachomatis and Neisseria gonorrhoeae at a minimum.

Principal treatment options		
Situation	**Recommended**	**Alternative**
Chlamydia	Doxycycline 100 mg PO, BD for 7 days Use before the 18th week of pregnanacy[2]	Azithromycin 500 mg x 2 PO, stat Safe in pregnancy

Gonorrhoea	Ceftriaxone 500 mg, in 2 mL lignocaine 1% IMI, stat Plus azithromycin 500 mg x 2 PO, stat	Safe in pregnancy Alternative treatments are not recommended because of high levels of resistance, EXCEPT for some remote Australian locations and severe allergic reactions. Seek local specialist advice

If organism is known or PID is suspected, see relevant STI guidelines for treatment recommendations:

- Herpes simplex virus
- M. genitalium
- Trichomoniasis
- PID

Treatment advice

- Patients with a clinical diagnosis of cervicitis who are at increased of being lost to follow-up should be treated at initial assessment whether a pathogen is identified or not.
- Testing and treatment of regular sexual partner/s should also occur.
- Refer to a specialist for review if persistent cervicitis in the absence STI re-infection or bacterial vaginosis and after treatment of partners.
- Use azithromycin 1g stat as first-line Chlamydia trachomatis treatment in pregnancy; Neisseria gonorrhoeae treatment is the same as in non-pregnant people.

Other immediate management

- Advise no sexual contact for **7 days** after treatment is commenced, or until the course is completed and symptoms resolved, whichever is later.
- Contact tracing if a STI is confirmed.
- Do a blood borne virus (BBV) screen if a STI is diagnosed.

Contact Tracing

- Treat sexual partner(s) as appropriate for the identified infection/s.
- Contact tracing is a high priority for chlamydia, gonorrhoea, trichomoniasis and M. genitalium and should be performed in all patients with confirmed

infection.
- Contact tracing for HSV 1 and 2 is not recommended.

See Australasian Contact Tracing Manual for more information.

Follow Up

- Routine follow-up is not required unless an STI has been identified or symptoms of pelvic inflammatory disease (PID).
- If indicated, review on day 7 with speculum, and/or bimanual, examination as required.

If PID diagnosed, assess response to antibiotics after **48-72 hours.**

If STI confirmed, follow-up provides an opportunity to:

- Confirm patient adherence with treatment and assess for symptom resolution
- Confirm contact tracing procedures have been undertaken or offer more contact tracing support
- Provide further sexual health education and prevention counselling
- Mucopurulent cervicitis will often persist despite treatment if due to an ectropion, however no further treatment is required.[3]

For **test of cure** and **retesting** advice see:

- Chlamydia
- Gonorrhoea
- Herpes
- M. genitalium
- Trichomoniasis

Auditable Outcomes

- 100% of patients with cervicitis are tested for an STI.

References

1. Dukers-Muijrers NH, Schachter J, van Liere GA, Wolffs PF, Hoebe CJ. What is needed to guide testing for anorectal and pharyngeal Chlamydia trachomatis and Neisseria gonorrhoeae in women and men? Evidence and opinion. BMC Infect Dis 2015;15:533.
2. Australian Product Information. Doxycycline monohydrate. Available at: https://www.nps.org.au/medicine-finder/apo-doxycycline-tablets#full-pi (last accessed 22 October 2021).
3. Centers for Disease Control and Prevention (CDC). Sexually Transmitted Infections Treatment Guidelines: Diseases characterised by urethritis and cervicitis. July 2021. Available at: https://www.cdc.gov/std/treatment-guidelines/urethritis-and-cervicitis.htm (last accessed 22 October 2021).

Endorsement: These guidelines have been endorsed by the Blood Borne Viruses and Sexually Transmitted Infections Standing Committee (BBVSS).

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