Australian STI Management Guidelines for Use in Primary Care

Anogenital lumps

Overview

Anogenital lumps (papules, nodules, vesicles)

Possible causes

- Sexually transmitted infections (STIs): human papillomavirus (HPV), *Molluscum contagiosum* virus, herpes simplex virus (HSV), syphilis.
- Other conditions: haemorrhoids, folliculitis, impetigo, intra-epithelial neoplasia or carcinoma.
- Normal anatomical variations (e.g. skin tag, sebaceous glands, penile or vulval papillae, Fordyce spots).

Clinical presentation

Symptoms	Considerations
Vesicles	Herpes simplex viruses (HSV) types 1 and 2 are the most common causes, generally evident by clusters of small painful vesicles. Other causes include varicella zoster, bullous impetigo (*Staphylococcus aureus*), immunobullous diseases such as pemphigus.

Papules and nodules	Anogenital warts caused by human papillomavirus (HPV) can vary greatly in size, number and appearance. *M. contagiosum* causes regular pale dome shaped lesions with a central punctum. Bacterial folliculitis is common in hair bearing areas, which can sometimes be difficult to distinguish from *M. contagiosum*. Hydradenitis suppurativa can present with anogenital lesions and lesions in the groin, inner thighs, suprapubic area and buttocks. Syphilis can cause painless irregular nodules with a wart-like appearance in moist anatomical sites. Scabies can present as itchy, erythematous nodules. Lesions may be isolated and just present in the anogenital areas. On the genitals, care must be taken to avoid misdiagnosis of normal anatomic variants such as vestibular papillae, sebaceous glands, angiokeratomata, pearly penile papules, Tyson glands and Fordyce spots as warts. These conditions are usually notable for the regularity and consistency in their appearance and distribution of lesions.

Diagnosis

Infection	Site/Specimen	Test
Genital warts (human papillomavirus (HPV)	Diagnosis is usually based on visual appearance. If there are atypical lesions (e.g. variable pigmentation, raised plaque-like lesions, ulceration, bleeding) or failure to respond to standard treatments consider biopsy to exclude high-grade squamous intraepithelial lesions and cancer. Cervical warts should be referred for specialist assessment. HPV DNA testing is not used to diagnose genital warts.	
Molluscum contagiosum	Clinical diagnosis	
Herpes	Swab of base of ulcer or deroofed vesicle	NAAT
Syphilis	Swab of base of ulcer Blood	NAAT Serology. If clinical suspicion of syphilis, refer to the syphilis guidelines

Donovanosis	Dry swab or punch biopsy of lesions	Histology has low-to-moderate sensitivity but highly specific; requires experienced histopathologist as classic Donovan bodies may be sparse NAAT is highly sensitive and specific but NAAT only available in research laboratories
Chancroid	If chancroid suspected, seek specialist advice	

NAAT – Nucleic acid amplification test

Specimen collection guidance

Clinician collected | Self-collection

Management

Please see relevant treatment sections

Genital warts (human papilloma virus (HPV))
Herpes
Syphilis
Donovanosis

M. contagiosum: Deroof lesions with needle and express contents. Cryotherapy.

Other immediate management

- If a specific STI is considered likely, refer to the specific guideline for information on advice to patient of any requirement to abstain from sexual contact.
- When diagnosis is in doubt consider recommending abstinence until results of diagnostic tests are available, especially where significant behavioural risk factors are present.
- Contact tracing.

Contact Tracing

- Contact tracing is a high priority for syphilis, and should be performed in all patients with confirmed infection.

- If the contact of syphilis is confirmed (i.e. the named contact names the index case) then treatment should be offered even if the serology is negative.
- Contact tracing for herpes and genital warts is not recommended.

See Australasian Contract Tracing Manual for more information.

Follow Up

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.
- Educate about condom use, contraception, HIV PrEP/PEP, safe injecting practices, consent, CST and vaccinations for HAV, HBV and HPV as indicated.

Consider alternative diagnoses, biopsy or referral for any lesions not responding as expected to treatment.

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

- Syphilis
- Donovanosis

Auditable Outcomes

- 100% of patients complaining of a genital lump have a genital examination.

Further reading

1. Rane V, Read T. Penile appearance, lumps and bumps. Aust Fam Phys 2013;42:270-4.
2. Syed TA, Lundin S, Ahmad M. Topical 0.3% and 0.5% podophyllotoxin cream for self-treatment of molluscum contagiosum in males. A placebo-

controlled, double-blind study. Dermatology 1994;189:65-8.

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

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