# Australian STI Management Guidelines for Use in Primary Care

## Anogenital ulcers

### Overview

- Anogenital ulcers can be caused by a wide variety of infectious and non-infectious conditions.

### Possible Causes

- Sexually transmitted infections (STIs): most common: Herpes simplex viruses (HSV) or syphilis; uncommonly *lymphogranuloma venereum (LGV)*; rarely donovanosis or chancroid
- Other conditions: fixed drug eruptions, aphthous ulcers, trauma, squamous intra-epithelial lesions, carcinoma, Behçet disease, and Crohn's disease.

### Clinical presentation

| Symptoms | Considerations |
| --- | --- |

| | |
|---|---|
| Ulcers | Herpes simplex virus (HSV) types 1 and 2 are the most common causes. Ulcers are generally painful and may commence as vesicles. Inguinal nodes are often tender.<br>Syphilis is more likely if sexual exposure to men who have sex with men (MSM), Aboriginal and Torres Strait Island populations in remote Australia and outside Australia. However, syphilis incidence is rising among heterosexuals. Lesions may be indurated and have non-tender lymphadenopathy.<br>Rarer infectious causes include *lymphogranuloma venereum (LGV),* donovanosis and chancroid. LGV should be suspected in people at high risk of STIs where a concurrent bubo is found and the testing from the ulcer returns negative for HSV and syphilis.<br>Consider varicella zoster (especially if older or immunocompromised).<br>Non-infectious causes include irritant and allergic contact dermatitis, fixed-drug eruptions, aphthous ulcers, trauma, autoimmune and vasculitis (such as Behçet disease), squamous intra-epithelial lesions, carcinoma, lichen sclerosus, erosive lichen planus and Crohn disease.<br>Consider biopsy if ulcer persists and other investigations are negative. |

## Diagnosis

| Infection | Site/Specimen | Test |
|---|---|---|
| Herpes simplex | Swab of base of ulcer or deroofed vesicle | NAAT |
| Syphilis | Swab of base of ulcer<br>Blood | NAAT<br>Serology. If clinical suspicion of syphilis, refer to the syphilis guideline |
| Herpes zoster | Swab of base of ulcer or deroofed vesicle | NAAT |
| Donovanosis | Dry swab or punch biopsy of lesions | NAAT is highly sensitive and specific but only available in research laboratories<br>Histology has low-to-moderate sensitivity but highly specific; requires experienced histopathologist as classic Donovan bodies may be sparse |
| Lymphogranuloma venereum (LGV) | Swab from ulcer | NAAT (chlamydia) – refer to LGV section |
| 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**

Herpes*

Syphilis#

Donovanosis

Lymphogranuloma venereum (LGV)

* Limited evidence comparing other antiviral agents (aciclovir and famciclovir) with valaciclovir indicates that all these agents are therapeutically equivalent for treating herpes. The ability for the patient to adhere to the recommended dosing frequency should be considered when selecting the appropriate treatment. Initial episodes of herpes may require a longer duration of treatment.

# Seek specialist advice for all patients who are pregnant, or hypersensitive to penicillin.

**Other immediate management**

- If a specific STI is considered likely, refer to the disease 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, donovanosis, lymphogranuloma venereum (LGV) 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 (if contact is within 3 months).
- Contact tracing for herpes 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
- Lymphogranuloma venereum (LGV)

**Auditable Outcomes**

100% of patients complaining of an anogenital ulcer have an anogenital examination.

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

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