

# Australian STI Management Guidelines for Use in Primary Care

## Urethritis - penile

### Overview

Urethral discharge and dysuria are typical symptoms of penile urethritis.

Make a clinical diagnosis of gonorrhoea or non-gonococcal urethritis (NGU) and treat accordingly (see clinical presentation).

### Possible causes

- Chlamydia trachomatis, Mycoplasma genitalium and Neisseria gonorrhoeae are the most common causes of penile urethritis.
- Other organisms include: herpes simplex virus (HSV), adenoviruses and Trichomonas vaginalis. Ureaplasma urealyticum is considered normal urethral flora.
- M. genitalium is often resistant to azithromycin or doxycycline. Azithromycin fails to eradicate about 10% of susceptible infections, leading to the selection of resistance, whereas doxycycline does not select resistance and is therefore preferred for the treatment of NGU.
- Up to 50% of cases may have no microbiological cause identified.

### Clinical presentation

Symptoms	Considerations
Urethral discharge	<u>Gonorrhoea</u> - usually copious and purulent. More common in <u>men who have sex with men</u> and <u>Aboriginal and Torres Strait Islander people</u> NGU - usually less discharge
Dysuria	In a penis, indicates a sexually transmitted infection ( <u>STI</u> ) rather than a urinary tract infection (UTI) until proven otherwise

Urinary frequency	Suggestive of bladder infection
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## Diagnosis

Test for the following infections

Site/specimen	Test	Consideration
First pass urine (FPU)	NAAT: <i>Chlamydia trachomatis</i> , <i>Mycoplasma genitalium</i> and <i>Neisseria gonorrhoeae</i>	All patients who have suspected or confirmed NGU should be tested for <i>chlamydia</i> , <i>gonorrhoea</i> and <i>M. genitalium</i> by using NAATs. A specific diagnosis can potentially reduce complications, re-infection and transmission. If omitted initially, test for <i>M. genitalium</i> in patients with persistent or recurrent symptoms after initial empirical treatment
Urethral swab	<i>Gonorrhoea</i> culture and antibiotic sensitivity	In patients with urethral discharge

NAAT – Nucleic acid amplification test

\*If test results are negative and symptoms persist, consider testing of FPU for *herpes simplex virus* (HSV), adenovirus and *trichomoniasis* (NAAT).

## Specimen collection guidance

Clinician collected | Self-collection

A urethral swab can be collected for NAAT if urine cannot be obtained.

## Special considerations

For *men who have sex with men* (MSM), undertake the following additional tests:

- Anorectal swabs and pharyngeal swabs for *chlamydia*(NAAT) and *gonorrhoea* (NAAT)
- Blood test for *syphilis*, human immunodeficiency virus (HIV), *hepatitis A* and *hepatitis B*. Consider testing for *hepatitis C*, if there is a history of *injecting drug use* or patient is *HIV positive*.

## Management

Principal treatment options		
Infection	Recommended	Alternative regimens
NGU likely	Doxycycline 100 mg PO, BD for 7 days	
<b><u>Gonorrhoea</u></b> likely	Ceftriaxone 500 mg in 2 mL of 1% lignocaine IMI, stat PLUS Azithromycin 1 g PO, stat	Ceftriaxone 500 mg in 2 mL of 1% lignocaine IMI, stat PLUS Doxycycline 100 mg PO, BD for 7 days
<b><u>Mycoplasma genitalium</u></b>	See <u>Mycoplasma genitalium</u>	Seek specialist advice

NGU – Non-gonococcal urethritis

### Treatment advice

- Ceftriaxone is the most effective treatment for gonorrhoea but azithromycin is added to reduce the chance of resistance emerging.
- Doxycycline is preferred for NGU and chlamydia and also initiates treatment for M. genitalium.
- When NGU is considered likely but you would also prefer to treat a potential case of gonorrhoea, it is reasonable to add doxycycline instead of azithromycin to ceftriaxone.
- If symptoms do not resolve, seek specialist advice for management of persistent NGU, including M. genitalium (often resistant), herpes simplex virus (HSV) and adenovirus.

### 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 according to identified pathogen.
- Provide patient with factsheet.

### Contact Tracing

- Contact tracing for gonorrhoea, chlamydia and Mycoplasma genitalium is a high priority and should be performed in all patients with confirmed

infection

- For urethritis not caused by these specific infections, all partners should be traced back for a minimum of **4 weeks** and offered asymptomatic screening tests.

See [Australasian Contact Tracing website](#) for more information.

### **Follow Up**

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

- Confirm patient adherence to treatment and assess for symptom resolution
- Confirm contact tracing has 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.

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

- [Gonorrhoea](#)
- [Chlamydia](#)
- [M. genitalium](#).

### **Auditable Outcomes**

- 100% of patients diagnosed with urethritis are treated with an appropriate antibiotic regimen.

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

**Developed by:** the Australasian Society for HIV, Viral Hepatitis and Sexual Health Medicine (ASHM) ABN 48 264 545 457 | CFN 17788

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