

Australian STI Management Guidelines for Use in Primary Care

Trichomoniasis

Overview

- In Australia, trichomonas is more common in older people, people from regional and remote areas, especially Aboriginal and Torres Strait Islander people and street-based sex workers.
- Uncommon cause of vaginal discharge or penile urethritis in urban settings.
- Long natural history (years) if not treated.
- Without treatment, the infection is cleared more quickly in a penis than in a vagina.

Cause

- Trichomonas vaginalis, a protozoan which infects the vagina, urethra and paraurethral glands.

Clinical presentation

Symptoms
• <u>Urethritis</u> – usually asymptomatic. See <u>chlamydia</u> for more information. • <u>Urethral discharge</u> (uncommon) • <u>Dysuria</u> (uncommon) • Malodourous <u>vaginal discharge</u> – typically profuse and frothy • Vulval itch/soreness • <u>Cervicitis</u>
Complications
• Associated with prostatitis • Associated with premature rupture of membranes, pre-term delivery and low birth weight. • Post-partum sepsis

Special considerations

- Up to 50% of vaginal infections are asymptomatic; urethral infections are usually asymptomatic.
- May enhance human immunodeficiency virus (HIV) transmission.

Diagnosis

- Testing is not routinely recommended for people with urethritis.
- Screening is not recommended except in high prevalence populations; refer to local guidelines.
- Treat contacts presumptively.

Site/Specimen	Test	Consideration
High vaginal swab	NAAT	• Preferred option in people with a vagina. • Should ideally be clinician collected if the patient is symptomatic but can be self-collected if client declines examination.
<u>First pass urine (FPU)</u>	NAAT	• Available in major laboratories in each state.

NAAT – Nucleic Acid Amplification Test

Specimen collection guidance

Clinician collected | Self-collection

Management

Principal treatment options		
Situation	Recommended	Alternative
Uncomplicated infection	Metronidazole 400 mg PO with food, BD for 7 days	Metronidazole 2 g PO with food, stat

Treatment advice

- Re-infection and poor adherence should be ruled out in persistent or recurrent infection.
- Seek specialist advice if suspected metronidazole resistance or

contraindication.

- Avoid alcohol with metronidazole treatment and for 24 hours thereafter.

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.
- Recommend that their current sexual partner is treated.
- Contact tracing.
- Provide patient with [factsheet](#).
- Trichomoniasis is only a notifiable condition in the Northern Territory.

Special Treatment Situations

Special considerations

- Consider seeking specialist advice before treating any complicated presentation.

Situation	Recommended
Pregnancy	Category B2 in pregnancy
Breastfeeding	Metronidazole may affect taste of breast milk; avoid high doses in breastfeeding.
Allergy to principal treatment choice	There is no effective alternative to 5-nitroimidazole compounds. Metronidazole desensitisation has been described.
People living with HIV	Reports indicate single-dose metronidazole is less effective than extended metronidazole.

Contact Tracing

- There is currently insufficient data to provide a definitive period for contact tracing, focus on current and recent partners.
- Test from genital sites.
- Consider presumptive treatment if there has been sexual contact within the past 2 weeks or when the person's individual circumstances mean later treatment may not occur.
- Partners with a penis may test negative for trichomonas as it is more likely

to resolve spontaneously in these people.

See [Australasian Contact Tracing Manual – Trichomoniasis](#) for more information

Follow Up

Review in **1 week** 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.

Test of cure

Not recommended unless symptoms persist.

Retesting

- For patients who remain symptomatic or where partner treatment remains uncertain, retesting should be performed after 4 weeks.
- This also provides the opportunity to retest, post the window period, for other STIs.

Auditable Outcomes

100% of vaginal infections diagnosed are treated with recommended principal treatment option

Further reading

1. Dize L, Agreda P, Quinn N, Barnes MR, Hsieh YH, Gaydos CA. Comparison of self-obtained penile-meatal swabs to urine for the detection of *C. trachomatis*, *N. gonorrhoeae* and *T. vaginalis*. *Sex Transm Infect* 2013;89:305-7.
2. Lusk MJ, Naing Z, Rayner B, Rismanto N, McIver CJ, Cumming RG, et al.

Trichomonas vaginalis: underdiagnosis in urban Australia could facilitate re-emergence. Sex Transm Infect 2010;86:227-30.

3. British Association for Sexual Health and HIV (BASHH). Trichomonas vaginalis . Available at: <https://www.bashh.org/guidelines> (last accessed 24 October 2021).

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

Funded by: The Australian Government Department of Health

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