Australian STI Management Guidelines for Use in Primary Care

Anogenital ulcers

Overview

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

Possible Causes

- Sexually transmitted infections (<u>STIs</u>): most common: Herpes simplex viruses (<u>HSV</u>) or <u>syphilis</u>; uncommonly mpox, *lymphogranuloma venereum* (<u>LGV</u>); rarely <u>donovanosis</u> 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
----------	----------------

11	مما	rc
U	ıce	ıs

Herpes simplex virus (<u>HSV</u>) types 1 and 2 are the most common causes.

Ulcers are generally painful and may commence as vesicles. Inguinal nodes are often tender.

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.

Rarer infectious causes include *lymphogranuloma venereum* (<u>LGV</u>), <u>donovanosis</u> and chancroid. <u>LGV</u> 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 <u>HSV</u> and <u>syphilis</u>.

Consider varicella zoster (especially if older or immunocompromised).

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.

Consider biopsy if ulcer persists and other investigations are negative.

Diagnosis

Infection	Site/Specimen	Test
<u>Herpes simplex</u>	Swab of base of ulcer or deroofed vesicle	NAAT
<u>Syphilis</u>	Swab of base of ulcer Blood	NAAT Serology. If clinical suspicion of syphilis, refer to the syphilis guideline
<u>Mpox</u>	Dry sterile swab in either dry transport (preferred) or viral transport media	NAAT
Herpes zoster	Swab of base of ulcer or deroofed vesicle	NAAT
<u>Donovanosis</u>	Dry swab or punch biopsy of lesions	NAAT is highly sensitive and specific but only available in research laboratories Histology has low-to-moderate sensitivity but highly specific; requires experienced histopathologist as classic Donovan bodies may be sparse

<u>Lymphogranuloma</u> <u>venereum (LGV)</u>	Swab from ulcer	NAAT (<u>chlamydia</u>) – refer to <u>LGV</u> 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#

Mpox

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 <u>herpes</u>. The ability for the patient to adhere to the recommended dosing frequency should be considered when selecting the appropriate treatment. Initial episodes of <u>herpes</u> may require a longer duration of treatment.

Other immediate management

- If a specific <u>STI</u> 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.

^{*} Seek specialist advice for all patients who are <u>pregnant</u>, or hypersensitive to penicillin.

Contact tracing.

Contact Tracing

- Contact tracing is a high priority for <u>syphilis</u>, <u>mpox</u>, <u>donovanosis</u>, <u>lymphogranuloma venereum (LGV)</u> and should be performed in all patients with confirmed infection.
- If the contact of <u>syphilis</u> 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 <u>Australasian Contract Tracing Manual</u> 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).

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

Disclaimer: Whilst the Australian Department of Health provides financial assistance to ASHM, the material contained in this resource produced by ASHM should not be taken to represent the views of the Australian Department of Health. The content of this resource is the sole responsibility of ASHM. www.ashm.org.au