Australian STI Management Guidelines for Use in Primary Care

Anorectal syndromes

Overview

Anal discharge and pain are typical symptoms of proctitis. Many cis-gendered women are having condomless anal sex and should be tested for STI that cause proctitis if they are presented with symptoms.

Cause

Assess risk and investigate sexually transmitted infection (STI) and non-STI causes.

STI causes*

- *Neisseria gonorrhoeae*
- *Chlamydia trachomatis* (particularly *Lymphogranuloma venereum (LGV)* strains)
- *Treponema pallidum* (syphilis)
- Herpes simplex virus (HSV types 1 and 2)
- Mpox (previously known as monkeypox)

Patients with STI proctitis are frequently misdiagnosed with non-STI causes (e.g. ulcerative colitis, trauma, radiation proctitis). STIs should be excluded before further investigations are performed (e.g. flexible sigmoidoscopy or colonoscopy).

**Mycoplasma genitalium* can cause asymptomatic anorectal infection. Asymptomatic screening is not recommended. The role of testing in clinical proctitis is not clear.[1,2]

Clinical presentation

Symptoms	Considerations

Anal discharge	Mucopurulent or light blood staining. May be subtle.
Anal pain	Often accompanied by spasm. May preclude proctoscopy.
Perianal ulcers	May be painful or painless. Suggest herpes, mpox. or syphilis. NB: Absence of ulceration does not exclude these diagnoses.
Systemic features e.g. fever, malaise	Suggest herpes or syphilis.
Altered bowel habit	Constipation predominates in proctitis. Alternating constipation and diarrhoea occurs in proctocolitis.
Tenesmus	Sensation of needing to pass stool or incomplete passing of stool. Suggest *Lymphogranuloma venereum*, proctocolitis (e.g. shigella).

Diagnosis

All patients with proctitis should be assessed for risk of STIs and tested for human immunodeficiency virus (HIV) and other STIs.

Any patient with ano-rectal symptoms should ideally have a DARE with a proctoscope and swabs taken from the rectum under direct visualisation.

Specimen collection: **clinician collected during examination.**

Specimen	Test
Anorectal swab	Chlamydia[1] and gonorrhoea NAAT Test for LGV if chlamydia detected[1] HSV NAAT test[3] mpox NAAT test[3]
Anorectal swab	Gonorrhoea culture[2]
Swab of ulcer, if present	*Treponema pallidum* (syphilis) NAAT test[3]
Blood	Syphilis serology (NAAT test is not sufficient to exclude syphilis)[4]
Full STI screen including HIV testing[5]	

M. genitalium testing is not routinely recommended for proctitis, however testing may be considered in sexual contacts of *M. genitalium* or where no other infectious cause is identified.

NAAT – Nucleic acid amplification test

LGV – *Lymphogranuloma venereum*

HSV – herpes simplex virus

Special considerations

1. Anorectal chlamydia that presents with proctitis should raise the suspicion of LGV, which requires test-of-cure or a longer course of treatment.

2. Gonorrhoea culture for antibiotic sensitivity before giving empirical treatment. Waiting for these results should not delay treatment.

3. The absence of ulceration does not completely rule out HSV or mpox.

4. If syphilis is suspected, ideally both NAAT test and serology should be performed. Due to the window period, in some cases syphilis serology may be negative during early primary syphilis with proctitis.[3] A negative NAAT test is not sufficient to exclude syphilis.

5. Men who have sex with men should have three-site (pharyngeal, urethral, anal) and serological testing including HIV. Rectal infections are frequently accompanied by infections at other sites.

Management

Empirical treatment should be initiated without waiting for results
• doxycycline 100 mg PO bd for 21 days (chlamydia or LGV) • PLUS ceftriaxone 500mg in 2mL of 1% lignocaine, IMI stat (gonorrhoea) • PLUS Valaciclovir 500mg PO, bd for 5 – 10 days. (herpes).

Treatment advice

- If specific tests are negative, treatment for that STI can be discontinued.
- Testing for LGV may not be available in some locations, or turnaround time for results may be lengthy. Doxycycline can be stopped after 7 days if LGV is confirmed negative.

- Aciclovir, famciclovir and valaciclovir are therapeutically equivalent. Initial episodes of herpes may require a longer duration of treatment.
- If all tests are negative, all medications are ceased and if symptoms persist then seek specialist advice.

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.
- Advise no sex with partners from the last **6 months** until the partners have been tested and treated if necessary.
- Contact tracing.

Contact tracing

- Contact tracing for gonorrhoea, lymphogranuloma venereum (LGV)and chlamydia is a high priority and should be performed in all patients with confirmed infection.
- Contact tracing for herpes is not recommended.

See Australasian Contract Tracing Manual for more information.

Follow Up

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

- Confirm patient adherence to treatment and assess for symptom resolution.
- Confirm contact tracing procedures have been undertaken or offer more contact tracing support.
- Provide further sexual health education and prevention counselling.
- Discuss HIV pre-exposure prophylaxis (PrEP) as patients with anorectal STIs have a higher likelihood of acquiring HIV infection.

For **test of cure (TOC)** and **retesting** advice see:

- Lymphogranuloma venereum (LGV)
- Gonorrhoea
- Chlamydia

Auditable Outcomes

- 100% of patients diagnosed with proctitis are treated with an appropriate antibiotic regimen.
- 100% of patients with proctitis have been investigated with appropriate tests to exclude STIs.

Further reading

1. Read TR, Fairley CK, Tabrizi SN, Bissessor M, Vodstrcil L, Chow EP, et al. Azithromycin 1.5g over 5 days compared to 1g single dose in urethral Mycoplasma genitalium: impact on treatment outcome and resistance Clin Infect Dis 2017;64:250-6.
2. Latimer RL, Shilling HS, Vodstrcil LA, Machalek DA, Fairley CK, Chow EPF, et al. Prevalence of Mycoplasma genitalium by anatomical site in men who have sex with men: a systematic review and meta-analysis. Sex Transm Infect 2020;96:563-70.
3. Towns JM, Leslie DE, Denham I, Azzato F, Fairley CK, Chen M. Painful and multiple anogenital lesions are common in men with Treponema pallidum PCR-positive primary syphilis without herpes simplex virus coinfection: a cross-sectional clinic-based study. Sex Transm Infect 2016;92:110-5.

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

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Funded by: The Australian Government Department of Health