Australian STI Management Guidelines for Use in Primary Care

Anorectal syndromes

Overview

Anal discharge and pain are typical symptoms of proctitis.

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)

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 or syphilis.
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.

Specimen collection: clinician collected during examination.

Specimen	Test
Anorectal swab	Chlamydia[1] and gonorrhoea NAAT Test for LGV if chlamydia detected[1]
Anorectal swab	Gonorrhoea culture[2]
Swab of ulcer, if present	HSV NAAT test[3] *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 a longer course of treatment.

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

[3.] HSV and *Treponema pallidum* NAAT test from swab of ulcer, if ulceration is present. Many labs process these from the same specimen. Some guidelines recommend an anorectal swab if ulcers are not visualised.

[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.
- Although ceftriaxone is given with azithromycin for the treatment of gonorrhoea alone, this is not considered necessary if the patient is being prescribed doxycycline.
- Testing for LGV may not be available in some locations, or turnaround time for results may be lengthy. Single doses of azithromycin and shorter duration of doxycycline are not recommended for treating LGV.
- 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).

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