

# 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
-------------------	---------------------------------

## 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

**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](http://www.ashm.org.au)