



Sexually Transmitted Infections
SUMMARY OF GUIDELINES

2017
July 2017 Edition



NEW ZEALAND
HERPES FOUNDATION



JUST THE FACTS.CO.NZ
about Sexual Health and STIs

Sexually Transmitted Infections Education Foundation resources

Helpline

HERPES

Tollfree 0508 11 12 13

Website

www.herp.org.nz

Resources

Health professionals' resources

1. Guidelines for the Management of Genital Herpes in New Zealand – 12th Edition 2017
Only available online at www.herp.org.nz
2. Sexually Transmitted Infections – Summary of Guidelines 2017

Patient information pamphlets

1. The Facts: A guide for people with Herpes Simplex
Includes –
Genital Herpes – The Facts
Herpes and Relationships
Herpes and Pregnancy
Facial Herpes
2. Herpes: Myth vs Facts

HPV

Tollfree 0508 11 12 13

www.hpv.org.nz

Health professionals' resources

1. Guidelines for the Management of Genital, Anal and Throat HPV Infection in New Zealand – 9th Edition 2017
Only available online at www.hpv.org.nz
2. Sexually Transmitted Infections – Summary of Guidelines 2017

Patient information pamphlets

1. Some Questions and Answers about HPV and Genital Warts
2. Cervical Smears and Human Papillomavirus Infection (HPV)
3. Preventing HPV Cancers by Vaccination: What Everyone Should Know
4. HPV and Men
5. HPV and Throat Cancer: Common Questions and Answers

Website for youth with information about sexual health and sexually transmitted infections: www.justthefacts.co.nz

JUSTTHEFACTS.co.nz posters are available in A2, A3 and A4 sizes for display, in addition to wallet cards for consumers.

All the above resources are available free of charge from the Sexually Transmitted Infections Education Foundation

Phone: 09 433 6526

Email: info@stief.org.nz

New Zealand Sexual Health Society (NZSHS) resources

Comprehensive STI Management Guidelines and Patient Information handouts are available on www.nzshs.org/guidelines

Contents

3 **GENITAL HERPES – SUMMARY OF GUIDELINES**

8 Genital Herpes: Key Information to provide patients on diagnosis

9 **GENITAL, ANAL AND THROAT HPV INFECTION – KEY INFORMATION SUMMARY**

11 HPV: Key Information for Patients

12 **NZSHS STI MANAGEMENT GUIDELINES – SUMMARIES 2017**

Principles of Sexual Health Care

13 Sexual Health Check

14 Partner Notification/Contact Tracing – Management Summary

15 Partner Notification/Contact Tracing – Patient Information

Management of Sexual Health Conditions

16 Chlamydia – Management Summary

17 Chlamydia – Patient Information

18 Gonorrhoea – Management Summary

19 Gonorrhoea – Patient Information

20 Epididymo-orchitis – Management Summary

21 Epididymo-orchitis – Patient Information

22 Genital Skin Lesions (Non-Ulcerative) – Management Summary

23 Genital Ulcer Disease (GUD) – Management Summary

24 Pelvic Inflammatory Disease (PID) – Management Summary

25 Pelvic Inflammatory Disease (PID) – Patient Information

26 Syphilis – Management Summary

27 Syphilis – Patient Information

28 Trichomoniasis – Management Summary

29 Trichomoniasis – Patient Information

30 Urethritis in Males – Management Summary

31 Urethritis in Males – Patient Information

32 Vaginal Discharge – Management Summary

Taken from: **Guidelines for the Management of Genital Herpes in New Zealand** 12th Edition - 2017

www.herpess.org.nz

The Ministry of Health supports the use of these clinical guidelines, developed by clinical experts and professional associations to guide clinical care.

Genital Herpes – Key Management Points

- Genital herpes is under-recognised and under-treated. Minor lesions are common; any recurring localised anogenital symptoms or lesions should be investigated as possible genital herpes.
- Oral antiviral treatment of the first clinical episode (**without waiting for results**) should always be offered, regardless of the time of symptom onset. **The '72 hour' herpes zoster rule does NOT apply to first episode genital herpes infection.**
- Antiviral therapy of recurrent genital herpes may be suppressive or episodic.
- Some patients prefer suppressive antiviral therapy. It is often considered for those with frequent and/or severe recurrences or associated psychosocial morbidity. Adherence to suppressive treatment reduces but does not eliminate transmission.
- For those on episodic antiviral therapy, it is more effective when patients start therapy themselves at the first signs of a recurrence; this requires anticipatory prescribing ("pill-in-the-pocket" antibiotic prescription).
- Neonatal HSV infection needs specialist advice on management for women with a history of genital herpes and active lesions at term and especially in the high-risk situation of a first episode up to 6 weeks prior to delivery.
- Neonatal HSV infection is a rare, but potentially fatal, disease of babies, occurring within the first 4-6 weeks of life. Symptoms are non-specific and a high index of suspicion is required. Most neonatal HSV infections are acquired at birth, generally from mothers with an unrecognised first genital herpes infection acquired during pregnancy.

What's new since 2015

Valaciclovir

The special authority and Hospital Medicines List restriction was removed from 1 March 2016 (Pharmac).

This is recommended first line treatment.

Treatment of first episode genital herpes

- Oral valaciclovir 500mg bd for 7/7 or longer if new lesions appear during treatment or healing is incomplete.
- Immunocompromised patients consider valaciclovir 1g bd for 7 to 10 days.
- Alternative: oral aciclovir 400mg 3 times daily (8 hourly) for 7 days.

Treatment of recurrent genital herpes

Episodic Treatment

- Oral valaciclovir 500mg bd for 3/7.
- Alternative: oral aciclovir 800mg 3 times daily for 2 days.

Prescribe enough tablets for patients to be able to self-initiate treatment at onset of symptoms.

Suppressive therapy

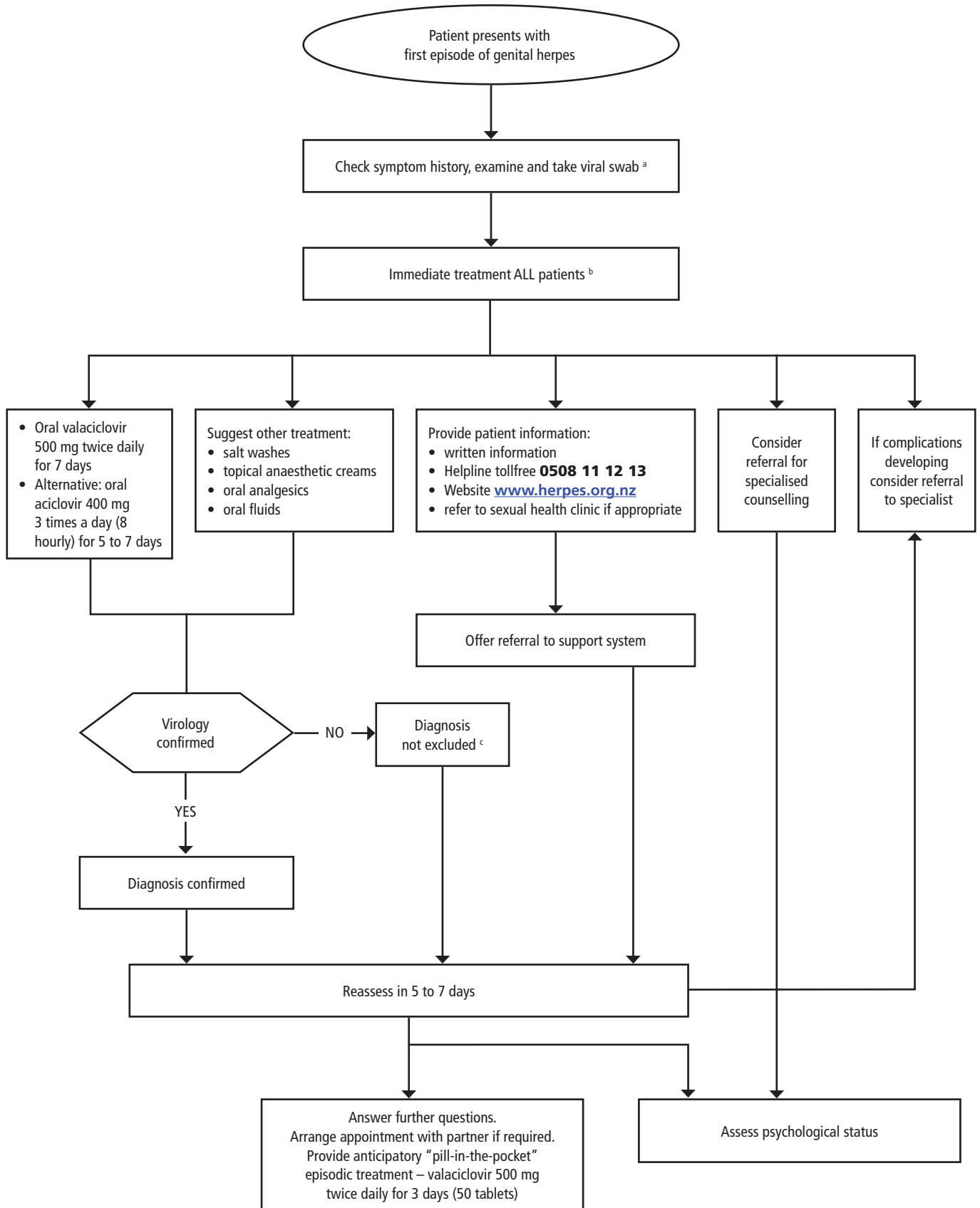
Only recommended for people with HSV confirmed on testing. Given daily to prevent recurrences and reduce asymptomatic shedding. Suggest prescribing for 12 months, followed by a break of 3 months to see if recurrences are still frequent and/or bothersome.

- Oral valaciclovir 500mg daily (increase to 500mg bd on individual basis of clinical presentation and/or having breakthrough recurrences on 500mg daily).
- Alternative: oral aciclovir 400mg twice daily.

Epidemiology

- As many as one in five adults in New Zealand have genital herpes due to HSV-2, most will have asymptomatic or unrecognised disease.
- Genital herpes due to HSV-1 (through oral to genital transmission) has also become common; HSV-1 is a frequent cause of primary genital herpes.
- The natural history of genital HSV-1 infection involves significantly fewer clinically apparent recurrences and less subclinical shedding than HSV-2.

Management of First Episode of Genital Herpes

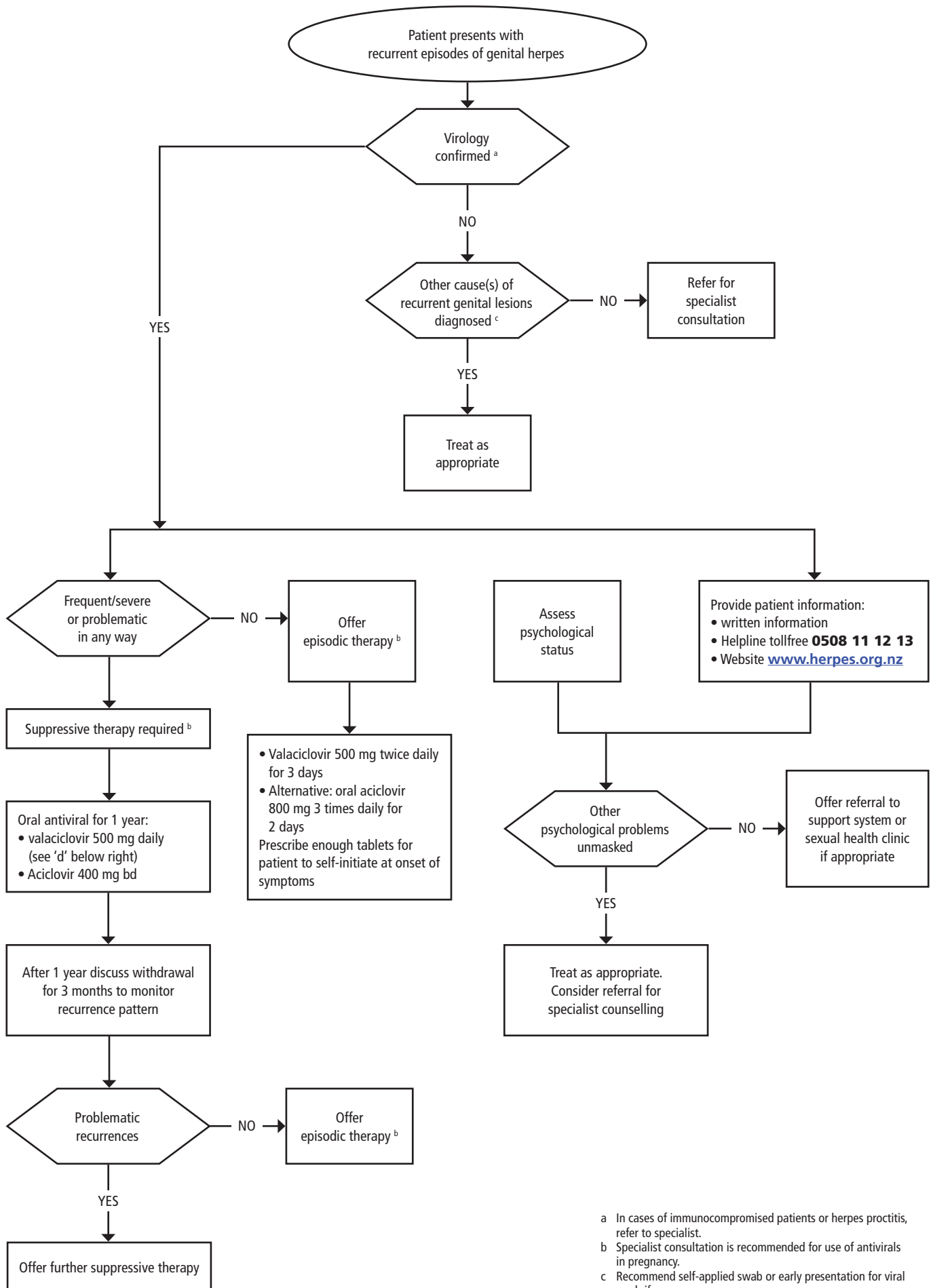


a In cases of immunocompromised patients or herpes proctitis, refer to specialist.

b Specialist consultation is recommended for use of antivirals in pregnancy.

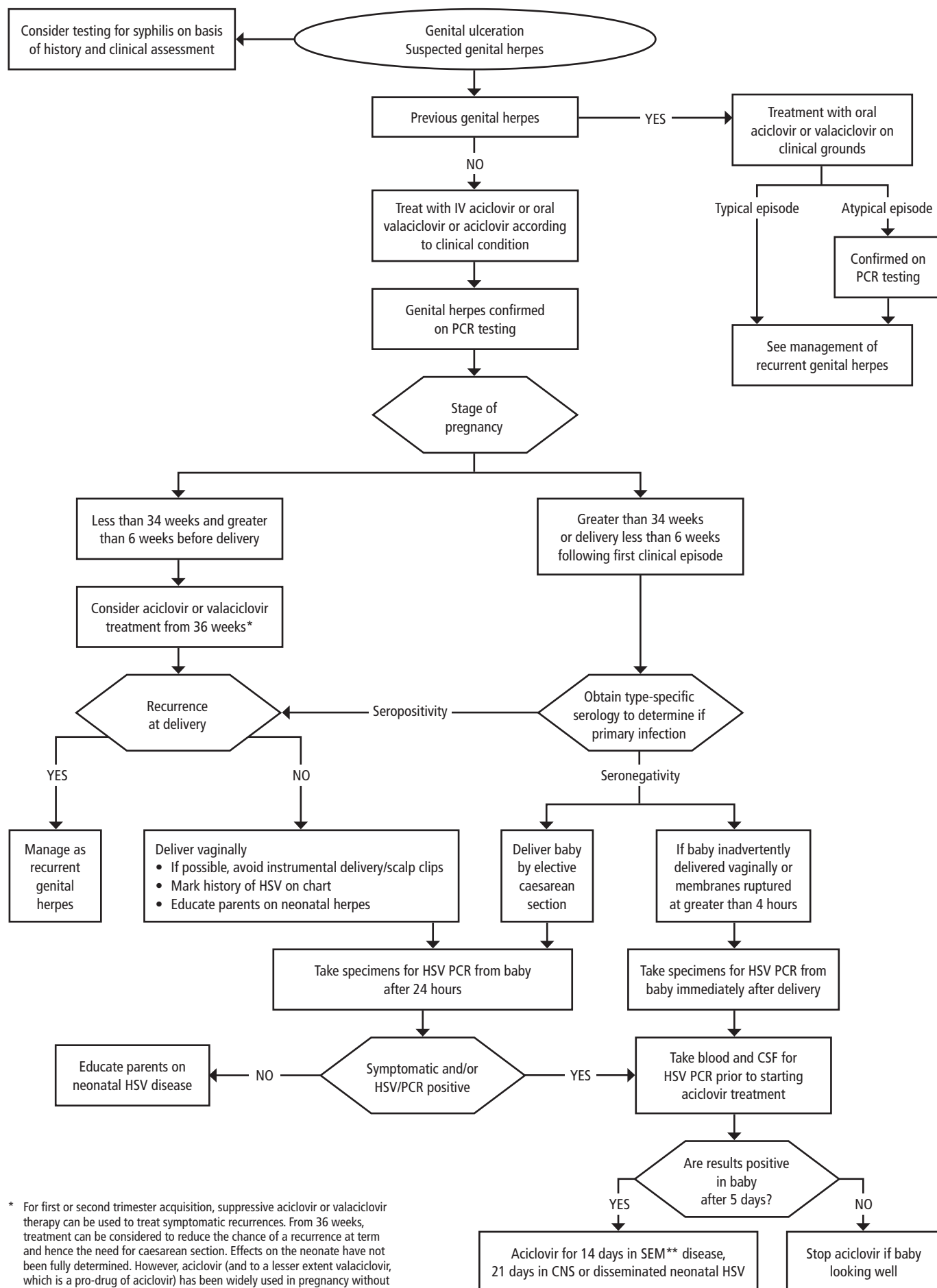
c Recommend early presentation for viral swab if recurrence.

Management of Recurrent Episodes of Genital Herpes



- a In cases of immunocompromised patients or herpes proctitis, refer to specialist.
 b Specialist consultation is recommended for use of antivirals in pregnancy.
 c Recommend self-applied swab or early presentation for viral swab if recurrence.
 d Increase to 500 mg BD on individual basis of clinical presentation and/or having breakthrough recurrences on 500mg daily.

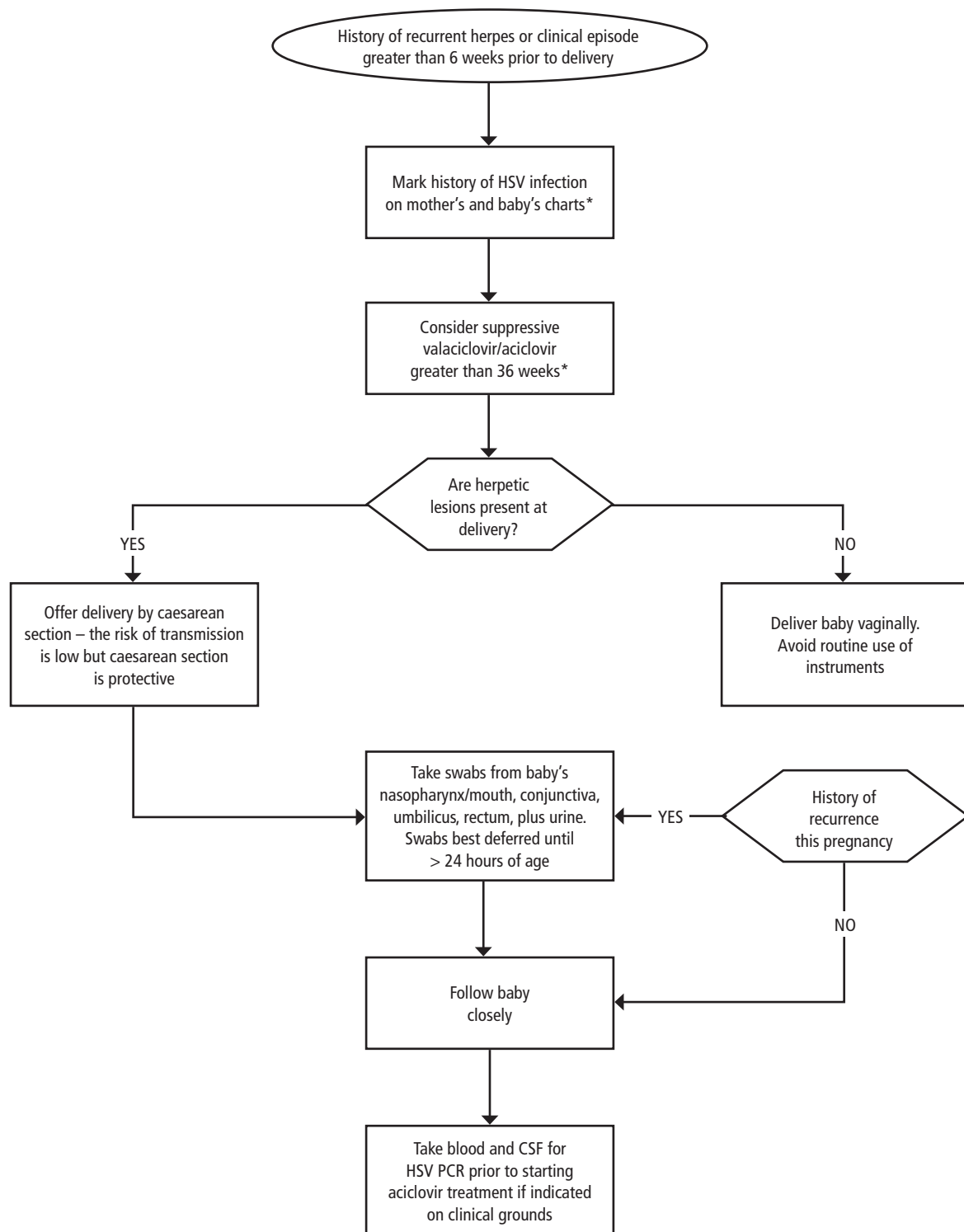
Management of women with suspected genital herpes in pregnancy (in consultation with a specialist)



* For first or second trimester acquisition, suppressive aciclovir or valaciclovir therapy can be used to treat symptomatic recurrences. From 36 weeks, treatment can be considered to reduce the chance of a recurrence at term and hence the need for caesarean section. Effects on the neonate have not been fully determined. However, aciclovir (and to a lesser extent valaciclovir, which is a pro-drug of aciclovir) has been widely used in pregnancy without reported adverse consequences. See full text for further information.

** SEM – skin, eye and/or mouth lesions only.

Management of women with history of genital herpes prior to pregnancy and women with first clinical episode greater than 6 weeks prior to delivery (in consultation with a specialist)



* For women with recurrences during pregnancy, suppressive aciclovir or valaciclovir therapy can be used to treat symptomatic recurrences. From 36 weeks treatment can be considered to reduce the chance of a recurrence at term and hence the need for caesarean section. Effects on the neonate have not been fully determined. However, aciclovir (and to a lesser extent valaciclovir, which is a pro-drug of aciclovir) has been widely used in pregnancy without reported adverse consequences. See full text for further information.

Key Information to provide patients on diagnosis – available on www.herples.org.nz – 3 minute Patient (PowerPoint) Tool (under Health Professionals tab)

- Up to one in three people have genital herpes, but only 20% of them experience symptoms. (This includes genital herpes caused by both HSV-1 and HSV-2.)
- Most people (80%) who become infected with genital herpes will not have any symptoms, or have such mild symptoms that they will not be recognised or diagnosed as genital herpes. 75% of herpes is acquired from partners unaware they have it.
- For most people who experience symptoms, genital herpes is a sometimes-recurring 'cold sore' on the genitals. It does not affect your overall health or longevity of life.
- A small percentage of people who get genital herpes may experience problematic recurrences.
- There is effective oral anti-viral treatment available.
- People who experience a first episode of genital herpes will get better, lesions will heal and there will be no evidence of the initial lesions left.
- Most people who experience a first episode of HSV-2 will have recurrences, but they are generally milder than the first episode. HSV-1 tends to cause fewer recurrences than HSV-2.
- Getting genital herpes in a long-term relationship does not mean that the other partner has been unfaithful. However, a full sexual health screen may be reassuring.
- Where both partners in a long-term relationship have the virus, use of condoms is not necessary as they cannot reinfect each other.
- It is advisable to avoid sexual contact when lesions are present, as friction may delay healing.
- Oral to genital transmission of HSV-1 is very common through oral sex. This can happen when 'cold sores' are not causing symptoms.
- Genital herpes does not affect your fertility or stop you having children. Vaginal delivery is usual for most women with a history of genital herpes.
- Genital herpes does not stop you having sex.
- Anybody with genital herpes, whether they get symptoms or have never had symptoms, may shed the virus from time to time with no symptoms present.
- There is no evidence that genital herpes causes cancer of the cervix.
- Condoms reduce the risk of transmission. The use of condoms in a long-term relationship should be a matter of discussion between the individuals. It is advisable to avoid genital-to-genital contact, even with a condom, until any lesions are completely healed.
- Even if the virus is passed on, the most likely outcome is that the person will never experience symptoms.
- Ensure patients have access to the NZHF patient pamphlets and/or the **HELPLINE TOLLFREE 0508 11 12 13** or visit www.herples.org.nz

Genital, Anal and Throat HPV Infection

Taken from: **Guidelines for the Management of Genital, Anal and Throat HPV Infection in New Zealand** 9th Edition - 2017
www.hpv.org.nz

The Ministry of Health supports the use of these clinical guidelines, developed by clinical experts and professional associations to guide clinical care.

What's new – Changes since the 2015 Guidelines

9-valent vaccine (HPV9)

9-valent vaccine (Gardasil 9 Seqirus/MSD) is registered for use in females 9-45 years and in males 9-26 years.

HPV9 is funded for both males and females aged 9-26 years (inclusive).

Those aged 9-14 years will get a two dose schedule and those aged 15-26 years will receive a three dose schedule.

Individuals who have received one or more prior doses of HPV4 may complete the vaccine course with HPV9.

HPV9 is available (but not funded) up to (and including) age 45 for females.

New patient information pamphlet

One new patient information pamphlet is available from the HPV website – Preventing HPV Cancers by Vaccination: What Everyone Should Know (www.hpv.org.nz)

The NZ HPV Project produces excellent patient information resources which are available free of charge.

1. Some Questions and Answers about HPV and Genital Warts
2. Cervical Smears and Human Papillomavirus Infection (HPV)
3. Preventing HPV Cancers by Vaccination: What Everyone Should Know
4. HPV and Men
5. HPV and Throat Cancer: Common Questions and Answers

HPV FAQs

What are the consequences of HPV infection?

- Most HPV infections are asymptomatic and of no consequence.
- HPV causes all anogenital warts – 90% of which are caused by non-oncogenic HPV 6 or 11.
- Persistent infection with oncogenic HPV types such as HPV 16 and 18 is responsible for a portion of intraepithelial neoplasia and cancers of the anogenital tract and oropharynx (cervical 100%, vaginal 90%, anal 80%, penile 50%, vulval 40%, oropharynx 26%).
- Although genital warts and genital tract cancers are declining, HPV-associated head and neck cancers and anal cancers are increasing – especially in men.

Does natural infection induce protective immunity?

- Not always. Current evidence suggests that overall naturally acquired immunity is unlikely to be effective because of the ability of the virus to evade the immune system. Previous infection does not necessarily create long term immune memory so does not prevent future re-infection with the same HPV type.

Does reactivation of latent HPV occur?

- For most people HPV infection is transient and becomes undetectable by DNA testing within 6-12 months. HPV infection can remain latent and may reactivate years later. It is not possible to detect HPV in its latent state so it is not possible to know whether in some cases the immune system has completely cleared the virus or whether the virus remains latent in an undetectable level.

Can asymptomatic people be tested for HPV?

- There is no available test to determine the HPV status of a person.
- Current laboratory assays for HPV DNA detect only particular high risk types (in order to guide clinical management in cervical screening) so cannot be used as a screening test for 'all HPV types'.

What are the important points to know about HPV associated anal cancer?

- The incidence of anal cancer is increasing and the burden of disease is highest in men who have sex with men and HIV positive MSM. There is no effective method (including anal cytology/smear) for screening for anal cancer. Annual digital anorectal examination (DARE) is recommended for HIV positive MSM who are aged 50 years or over (see www.ashm.org.au/hiv/management-hiv/anal-cancer). HPV vaccination is the most effective method of prevention.

What are the important points to know about HPV-associated oropharyngeal cancer?

- Although oral cavity cancers associated with smoking and alcohol are decreasing, HPV-associated oropharyngeal cancer is increasingly common – especially in men.
- In common with anogenital HPV-related disease, a viral aetiology for oropharyngeal cancer raises questions for the patient, their partner and health practitioners. There is no clinically apparent premalignant condition and no reliable laboratory screening test. Common concerns are how the virus is acquired, whether there have been sexual partners outside of the couple and how to manage an ongoing sexual relationship. It is important to emphasise that a diagnosis of HPV-related cancer does not necessarily imply multiple sexual partners or other partners outside the relationship. There is no need to alter sexual activity with a stable partner, as sharing of HPV would have occurred long before the clinical appearance of the cancer. Female partners are not known to be at higher risk of developing cancer (at any site) themselves, but should follow standard cervical screening guidelines. A useful guide to discussing these issues includes a printable patient information sheet.¹ At the time of writing there is no clear evidence for transmission of HPV through kissing.

HPV Vaccines FAQs

Can the vaccine be given to people who are already sexually active or already have HPV infection?

- Yes. HPV vaccine can be offered to people who have HPV and would like to use the vaccine to reduce the risk of further acquisition of new HPV or further disease. Vaccine protects against the HPV genotypes which a person has not previously encountered. Limited data in women shows that vaccination may help to prevent recurrence or reactivation of HPV infection.
- The decision to vaccinate older age groups or those already sexually active should be based on the individuals' assessment of potential benefit and future risk as vaccine efficacy decreases with age.

Are the HPV vaccines interchangeable?

- Yes. All HPV vaccines may be used interchangeably to complete a course.

Will cervical screening still be needed?

- Yes. Irrespective of whether a woman has been vaccinated, routine cervical screening will need to continue for the foreseeable future. This is because of possible prior infection with HPV types causing CIN, or new infection with other HPV types not covered by vaccination.

What if the vaccine is given to a pregnant woman?

- While the vaccines are not specifically recommended for use in pregnancy, enquiring about possible pregnancy is not required before vaccination. Completion of the vaccine course should be deferred if a woman is found to be pregnant. There are no safety concerns with the use of non-live vaccines in pregnant women and it is safe to use during breastfeeding.

Can the HPV vaccine be given with other vaccines?

- Yes, HPV vaccine can be co-administered with other non-live and live vaccines.

Is the vaccine safe in patients who are on biologic agents?

- Yes, as it is not a live vaccine.

How safe is the vaccine?

- Very safe. HPV vaccine has an excellent safety profile and is well tolerated in all age groups. HPV vaccine is the most monitored and researched vaccine in history. The HPV vaccine is no different from other routine vaccinations.

1. Fakhry C, D'Souza G. Discussing the diagnosis of HPV-OSCC: common questions and answers. Oral Oncol. 2013;49:863-71.

HPV: Key Information for Patients

There is a balance to be reached between 'over-normalising' a diagnosis of a viral STI and failing to empathise with the potential psychological impact of a diagnosis. It is important to address any concerns generated by the individual by the proactive provision of information and education, e.g. handouts, directing the individual to reputable sources of information (www.hpv.org.nz) and referral to a sexual health specialist if required.

- Vaccination against HPV has been available for many years and everyone who is eligible should have it.
- 80% of unvaccinated adults will pick up HPV at some point in their life. In most people, it causes no symptoms (you won't know you have it) so is therefore unavoidably shared mainly through sexual (including oral) skin-to-skin contact.
- In most people the virus is harmless and causes no symptoms and will not develop into warts, pre-cancer or cancer.
- In a few people, HPV causes genital warts which are harmless and different from the types of HPV that cause abnormal cells or cancer.
- In a few people, HPV can cause abnormal cells which can sometimes lead to cancers in both men and women, including cervical, vaginal, vulval, anal and head and neck cancers and penile cancers.
- Partners will inevitably share HPV. There is no way to know which partner it came from or how long ago. Having HPV does not mean that a person or his/her partner is having sex outside the relationship.
- There are treatments for genital warts and abnormal cells.
- There is no treatment to eliminate HPV itself. HPV is usually dealt with by your body's immune system.
- HPV does not affect fertility.
- HPV does not stop you having a normal sex life.
- There is no HPV test to check HPV status. This means there is no test that can help answer the questions "Do I have HPV?", "Does my partner have HPV?", "Has my HPV gone?", "Can I have the vaccine?"



NZSHS STI Management Guidelines – Summaries 2017

Taken from:

STI Management Guidelines for Use in Primary Care 2017

See: www.nzshs.org/guidelines

These STI Management Guidelines for Use in Primary Care have been produced by NZSHS.

Every effort has been taken to ensure that the information in these resources is correct at the time of publishing (July 2017).

Further guideline information – www.nzshs.org/guidelines or phone a sexual health specialist.

NB: These guidelines have been written at a time of change in laboratory testing in New Zealand, with an increase in the use of nucleic acid amplification testing (NAAT) methodology.

This increases the sensitivity of testing and ability to use self-collected specimens. However, these advantages need to be balanced against decreased specificity and, for gonorrhoea, a concern about reduced culture for monitoring of antimicrobial sensitivities.

Sexual Health Check

MANAGEMENT SUMMARY

Test all sexually active persons < 30 years and anyone at risk. See Express STI Testing Questionnaire www.nzshs.org/guidelines.
Be aware of the difference between a Nucleic Acid Amplification Test (NAAT) swab (e.g. PCR) and a culture swab.

Note: Most laboratories are automatically performing multiplex NAAT testing for chlamydia & gonorrhoea (+/-trichomoniasis). False positive gonorrhoea results are possible in low prevalence populations – see NZSHS Management of Gonorrhoea 2017, and Response to the Threat of Antimicrobial Resistance www.nzshs.org/guidelines.

Recommended tests – Females

Asymptomatic and/or opportunistic testing

- Offer examination including speculum.
- Vulvovaginal NAAT swab for chlamydia & gonorrhoea testing (self-collected if not examined).
- Anorectal NAAT swab for chlamydia & gonorrhoea testing if patient has anal sex or anorectal symptoms (self-collected if not examined).
- Serology: Universal HIV and syphilis.
- Targeted hepatitis B and C serology if hepatitis B immune status unknown and risk factors present e.g. Maori, Pasifika, areas of high endemicity, IDU or incarceration www.hepatitisfoundation.org.nz/

Symptomatic

Examination is required for clinical assessment if symptomatic of vaginal discharge, dysuria, lower abdominal pain, abnormal bleeding, anal pain or discharge, or a contact of gonorrhoea:

- Examine the inguinal nodes, vulval and perianal skin, vestibule and introitus.
- Vulvovaginal NAAT swab for chlamydia & gonorrhoea testing prior to speculum insertion.
- Insert speculum and examine vagina and cervix.
- Endocervical culture swab for gonorrhoea (if gonorrhoea culture available).
- High vaginal culture swab for candida & BV & trichomoniasis (if NAAT for trichomoniasis not available).
- Anorectal NAAT swab for chlamydia & gonorrhoea testing if patient has anal sex or anorectal symptoms.
- Serology: Universal HIV and syphilis.
- Targeted hepatitis B and C serology if hepatitis B immune status unknown and risk factors present e.g. Maori, Pasifika, areas of high endemicity, IDU or incarceration www.hepatitisfoundation.org.nz/

Recommended tests – Men who have sex with women (MSW)

Asymptomatic and/or opportunistic testing

- Offer examination, as below.
- First void urine for chlamydia & gonorrhoea NAAT testing (first 30ml), preferably ≥1 hour after last void.
- Serology: Universal HIV and syphilis.
- Targeted hepatitis B and C serology if hepatitis B immune status unknown and risk factors present e.g. Maori, Pasifika, areas of high endemicity, IDU or incarceration www.hepatitisfoundation.org.nz/

Symptomatic

Examination is required for clinical assessment if symptomatic of urethral discharge, dysuria, testicular pain or swelling, anal pain or discharge or a contact of gonorrhoea.

- Examine the genital and perianal skin, inguinal lymph nodes, penis, scrotum, and testes.
- Urethral culture swab for gonorrhoea (if gonorrhoea culture available) followed by:
- First void urine for chlamydia & gonorrhoea NAAT testing (first 30ml), preferably ≥1 hour after last void.
- Serology: Universal HIV and syphilis.
- Targeted hepatitis B and C serology if hepatitis B immune status unknown and risk factors present e.g. Maori, Pasifika, areas of high endemicity, IDU or incarceration www.hepatitisfoundation.org.nz/

Recommended tests – Men who have sex with men (MSM)

All MSM should be tested at least once a year.

- Extragenital (pharyngeal and anorectal) testing is required irrespective of reported sexual practices or condom use.
- Pharyngeal NAAT swab for chlamydia & gonorrhoea testing.
- Anorectal NAAT swab for chlamydia & gonorrhoea testing (self-collected if not examined).
- First void urine for chlamydia & gonorrhoea NAAT testing (first 30ml), preferably ≥1 hour after last void.
- If anorectal symptoms refer or discuss with a sexual health specialist
- Serology: Universal HIV, syphilis, hepatitis A and B (if hepatitis A and B immune status unknown).
- Targeted hepatitis C if HIV positive, IDU or incarceration.

MSM who fall into one or more categories below require testing up to 4 times a year:

- Any unprotected anal sex
- More than 10 sexual contacts in 6 months
- Participate in group sex
- Are HIV positive
- Use of PrEP or PEP
- Use recreational drugs during sex.

The Ministry of Health supports the use of these clinical guidelines, developed by clinical experts and professional associations to guide clinical care.

Further guideline information – www.nzshs.org/guidelines or phone a sexual health specialist.
This STI Management Guideline Summary has been produced by NZSHS. Every effort has been taken to ensure that the information in this guideline is correct at the time of publishing (July 2017).

Partner Notification/Contact Tracing

What is my role in Contact Tracing?

When making an STI diagnosis it is the diagnosing clinician's responsibility to initiate a discussion about contact tracing. As part of good clinical care this includes encouraging and supporting the patient in notifying their contacts. For more on difficult cases which may require public health action see the STI Notification Flow Chart www.nzshs.org/guidelines.

STI test results

Sexual contacts of chlamydia, gonorrhoea, trichomoniasis, syphilis, urethritis, PID and epididymo-orchitis need to be contacted and treated. Contact tracing is not required for genital warts or genital herpes. HIV, syphilis and gonorrhoea are automatic laboratory-notifiable infections under Infectious and Notifiable Diseases Regulations. Clinicians may receive a secure website link requesting additional anonymous information for national STI trend analysis. For all cases of syphilis and HIV refer or discuss with a sexual health specialist.

Introduce the reasons for partner notification/contact tracing as part of the STI treatment discussion

- 1-2 Framing sentences and personalise it:
 - Contact/s need treatment to avoid reinfecting the patient.
 - Most people with an STI don't have symptoms but could still have complications or pass the STI on.
 - The more times a person is re-infected the greater the risk of complications.

Identify who needs to be contacted based on routine sexual history

- Ask about number of sexual contacts in past 3 months.
- Are these contacts regular or casual? (Be mindful that the term partner may imply a relationship.)
- Are they able to contact these people? (Notifying all contacts may not be possible, e.g. if there insufficient information or a threat of violence.)
- The use of condoms does not affect the requirement for partner notification/contact tracing and treatment
- Document number of contacts clearly in the notes – you may not be the one following-up partner notification
- How many of these people does the patient have contact details for?
- What contact details do they have for these people?

Explain the methods and offer choice

PATIENT REFERRAL

(Patient informs sexual contact/s – preferred method if possible)

Discuss with client how they are going to notify contact/s

- Face-to-face
- Telephone
- SMS/Social media
- Treatment letter/s to be given to sexual contact/s, see www.nzshs.org/guidelines
- Email

Provide education, support and resources to assist patients, based on their chosen method:

- Factsheets on infection and partner notification with appropriate websites for further information.
- Treatment letter/s to be given to sexual contact/s, see www.nzshs.org/guidelines
- Role play telling their sexual contact/s, if appropriate.

Follow-up (phone or in person) 1 week later

- All notifiable contacts informed?
- If unable to notify contacts, ask why and offer support and appropriate resources.
- Check no unprotected sex with untreated contacts – will need re-treatment if re-exposed.
- Advise retest for infection in 3 months.
- Document in notes.

PROVIDER REFERRAL

(Clinician informs sexual contact/s with patient consent.)

Note: Patient safety takes priority, if risk of violence then don't notify contacts. Provider referral preferred if contact/s incarcerated or for repeated infections with doubt as to contact treatment.

Obtain details of contact/s to be notified

- Discuss confidentiality with index case, however explain that contacts may be able to identify them.

Consult with sexual health service if required

- Contact details of New Zealand sexual health services located at www.nzshs.org.

Notify contacts anonymously

- Advise they have been named as a contact of the specific infection.
- Do not give name of index client.
- Advise them to attend for sexual health check and treatment.
- Advise them where they can attend for this – GP, sexual health or family planning clinic.

The Ministry of Health supports the use of these clinical guidelines, developed by clinical experts and professional associations to guide clinical care.

Further guideline information – www.nzshs.org/guidelines or phone a sexual health specialist. This STI Management Guideline Summary has been produced by NZSHS. Every effort has been taken to ensure that the information in this guideline is correct at the time of publishing (July 2017).

Partner Notification/Contact Tracing

What is partner notification?

Partner notification is when you tell someone they have been in contact with an STI and advise them to get tested and treated for that STI, even if their test results are negative. This is also called contact tracing.

Why should we notify sexual contacts?

- To avoid getting an STI back again from an untreated sexual contact.
- The more times you get an STI, the higher the risk of getting serious problems in the future.
- It helps to stop the spread of STIs.
- Unless they get tested, people often don't know they have an STI and can spread it to others without knowing.

Who do I need to contact?

Usually anyone you have had sexual contact with (including oral, vaginal or anal sex) in the last 3 months, as advised by your doctor or nurse, even if you used condoms.

When should I do this?

- As soon as possible after finding out that you have an STI.
- Before you have sex with an untreated contact.

How am I going to do this?

There are many ways of telling sexual contacts:

- Face-to-face
- On the telephone
- SMS/Social media
- Give them a treatment letter for sexual contacts
- Give them an information sheet
- Email

Things to think about when deciding how best to tell your sexual contact/s

- How safe it is for you to tell your sexual contact/s. If you have concerns, please discuss this with your doctor or nurse.
- What contact details you have for your sexual contact/s.
- How you would like to be told yourself.

Many people prefer to inform people face-to-face and find that they have a positive response from their sexual contact/s.

Where can I go for help from a health professional?

- GP/practice nurse
- Local sexual health clinic
- Family Planning

Remember

- STIs are usually easy to test for and treat.
- Most STIs are passed on by people who don't know they have one, as they often don't have any signs or symptoms.
- Just because you were tested first doesn't mean that you had the infection first.
- Make sure you have the correct information (fact sheet or website) to answer any questions and correct any myths about the STI.
- If you use a condom every time you have sex, you are much less likely to get an STI.

Important information

- Partner notification/contact tracing has **health benefits to you as it can stop you getting re-infected**.
- Many people don't know they have an STI: notifying them can **help them get treated**.
- Partner notification/contact tracing helps stop the spread of STIs.
- Make sure the **information that you pass on is correct**. Health professionals can help you with this if you are unsure.

MANAGEMENT OF SEXUAL HEALTH CONDITIONS

Chlamydia

MANAGEMENT SUMMARY

TEST IF:

- Sexually active under 30 years
 - OR more than 2 sexual contacts in last year
 - OR has had an STI in past 12 months
 - OR has a sexual contact with an STI
- Pregnant
- Increased risk of complications of an STI, e.g. pre-termination of pregnancy (TOP)
- Signs or symptoms suggestive of chlamydia:
 - **Females: Vaginal discharge / dysuria / lower abdominal pain/ abnormal bleeding / anal pain or discharge**
 - **Males: Urethral discharge / dysuria / testicular pain or swelling / anal pain or discharge**
- Requesting a sexual health check

Note: Most laboratories are automatically performing multiplex NAAT testing for chlamydia & gonorrhoea (+/-trichomoniasis).

False positive gonorrhoea results are possible in low prevalence populations – see NZSHS Management of Gonorrhoea 2017, and Response to the Threat of Antimicrobial Resistance www.nzshs.org/guidelines.

RECOMMENDED TESTS

- It is recommended to test for co-existing STIs (see Sexual Health Check guideline www.nzshs.org/guidelines)
- **Females:**
 - A self-collected vulvovaginal NAAT swab if asymptomatic, examination declined and no other tests required
 - A vulvovaginal NAAT swab prior to a speculum examination and other STI swabs if symptomatic or needs examination
 - Additional anorectal NAAT swab as indicated based on sexual history
 - **Note:** A first void urine has lower sensitivity in females than cervical or vaginal swabs so is not specimen of choice
- **Males:**
 - A first void urine (first 30ml), preferably ≥ 1 hour after last void
- **Men who have Sex with Men:**
 - **Additional pharyngeal and anorectal NAAT swabs** irrespective of reported sexual practices or condom use, as asymptomatic pharyngeal and rectal infection is common

Treat immediately if high index of suspicion, e.g. symptoms and/or signs, or contact of index case.

- Start treatment for patient and sexual contact/s, without waiting for lab results

MANAGEMENT

- Azithromycin 1g po stat (pregnancy category B1) – for asymptomatic urogenital infection
- Doxycycline 100mg po twice daily for 7 days (**NOT in pregnancy**) – for symptomatic urethritis, rectal, pharyngeal or eye infection, or if patient is on QT-prolonging medication (www.medsafe.govt.nz/profs/PUArticles/DrugInducedQTProLongation.htm)
- If anorectal symptoms and a positive chlamydia test, refer or discuss with a sexual health specialist as LGV proctitis requires further testing and doxycycline 100mg po twice daily for 21 days
- Advise to abstain from sex or use condoms for 1 week from the start of treatment and until 1 week after sexual contact/s have been treated

PARTNER NOTIFICATION AND MANAGEMENT OF SEXUAL CONTACTS

- Be clear about language: 'partner' implies relationship – all sexual contacts in the last 3 months should be notified
- Contact/s should have a sexual health check and treatment for chlamydia with azithromycin 1g po stat, without waiting for test results
- If contacts test positive for an STI refer to specific guideline www.nzshs.org/guidelines
- Advise contact/s to abstain from sex or use condoms for 1 week from the start of treatment and until results of tests are available
- Most choose to tell contact/s themselves, giving written information is helpful
- Notifying all contacts may not be possible e.g. if there is insufficient information or a threat of violence

FOLLOW-UP

- By phone or in person, 1 week later
- No unprotected sex in the week post-treatment?
- Completed/tolerated medication?
- Notifiable contact/s informed?
- Any risk of re-infection? Re-treatment necessary if re-exposed to untreated contact
- Test of cure only needed if pregnant, extragenital infection or continuing symptoms
- Diagnostic tests can detect traces of dead organisms – wait at least 5 weeks before retesting
- Re-infection is common; offer repeat sexual health check in 3 months

The Ministry of Health supports the use of these clinical guidelines, developed by clinical experts and professional associations to guide clinical care.

Further guideline information – www.nzshs.org/guidelines or phone a sexual health specialist.

This STI Management Guideline Summary has been produced by NZSHS. Every effort has been taken to ensure that the information in this guideline is correct at the time of publishing (July 2017).

Chlamydia

PATIENT INFORMATION

What is chlamydia?

Chlamydia is a common sexually transmitted infection (STI) that is easy to treat. It is quite easy to catch and can cause serious problems if you don't get it treated. Untreated chlamydia infection can cause pelvic inflammatory disease and infertility in women, and testicle pain and swelling in men. It is very common in people aged less than 30.

How does someone get chlamydia?

- By having sex or sexual contact with another person with chlamydia.
- This includes oral, vaginal or anal sex and sex play or sharing toys.
- The other person may not know they have the infection.
- If you use a condom every time you have sex you are much less likely to get chlamydia.
- Chlamydia can also be passed from mother to baby during birth and may result in an eye or lung infection in the baby.

How do I know if I have chlamydia?

Many people don't notice any symptoms. If they do, symptoms could be:

Females

- There can be a discharge or fluid leaking from the vagina.
- There can be pain when urinating or low tummy pain, especially during sex.
- There can be unusual bleeding between periods or bleeding after sex.
- Chlamydia can cause an unusual discharge or bleeding from the anus if there has been anal sex.

Males

- There can be soreness, an unusual discharge or itching in the opening at the end of the penis (urethra).
- There can be pain when urinating.
- There can be unusual discharge or bleeding from the anus if there has been any anal sex with males.
- Very occasionally there can be pain or swelling in the testicles.

How do I get tested?

You need to see your doctor or nurse or sexual health clinic for a check-up. If you want, take along someone you trust, for support.

If you have symptoms you will need to be examined by a doctor or nurse to find the cause.

- **Females** will need a swab from the vagina. An anal swab might be required if you have anal sex. You may be able to do the swab/s yourself.
- **Males** need a urine test. Throat and anal swabs might be required if you have sex with males. You may be able to do the swabs yourself.

It may be embarrassing, but it is better to get checked than to have untreated chlamydia.

How do I get treated?

You will need to take some tablets – usually a single dose of an antibiotic cures chlamydia. Sometimes tablets may need to be taken for 2 weeks if the infection is more serious.

Important advice

- Finish all the tablets you have been given, even if you feel better.
- You need to tell anyone you have had sex with within the last 3 months to get a sexual health check and treatment for chlamydia even if their tests are normal.
- You should avoid sex for 1 week from the start of your treatment and until 1 week after your sexual contact/s have been treated. If this is not possible always use a condom, including for oral sex, until your treatment and your sexual contact/s treatment has been completed.
- We recommend you have another sexual health check in 3 months in case you get the infection again.

Important information

- Chlamydia is a **common sexually transmitted infection (STI)** that is **easy to treat** with antibiotics.
- Many people with chlamydia **don't notice symptoms**.
- You get chlamydia by having sexual contact with another person who has chlamydia.
- **Testing: Females** will need a swab from the vagina. **Males** need a urine test. Other tests might be required dependent on the type of sexual contact you have.
- **You need to tell** anyone you have had sex with in the last 3 months to get a sexual health check and treatment for chlamydia.
- You should **avoid sex** or use condoms for 1 week from the start of your treatment and until 1 week after your sexual contact/s have been treated, so you don't pass the infection on to someone else.

TEST IF:

- Person is a sexual contact of gonorrhoea
- Routine sexual health check in females
- Pre-termination of pregnancy (TOP)
- Pre-intrauterine device (IUD) insertion
- Routine sexual health check in man who has sex with other men (MSM)
- Signs or symptoms suggestive of gonorrhoea
 - **Females:** Vaginal discharge/dysuria/lower abdominal pain/abnormal bleeding/anal pain or discharge
 - **Males:** Urethral discharge/dysuria/testicular pain or swelling/anal pain or discharge

Note: Most laboratories are automatically performing multiplex NAAT testing for chlamydia & gonorrhoea (+/-trichomoniasis).

False positive gonorrhoea results are possible in low prevalence populations – see NZSHS Management of Gonorrhoea 2017, and Response to the Threat of Antimicrobial Resistance www.nzshs.org/guidelines.

RECOMMENDED TESTS

- It is recommended to test for co-existing STIs (see Sexual Health Check guideline www.nzshs.org/guidelines)
- **Asymptomatic Female** (or examination declined):
 - A vulvo-vaginal NAAT swab either clinician-taken or self-taken
 - Additional anorectal NAAT swab as indicated based on sexual history
- **Symptomatic Female:**
 - A speculum examination should be carried out. A vulvo-vaginal NAAT swab (prior to speculum insertion) plus an endocervical culture swab for gonorrhoea (if gonorrhoea culture available) plus a high vaginal culture swab for testing for candida, BV & trichomoniasis (if NAAT for trichomoniasis not available)
 - Additional anorectal NAAT swab as indicated based on sexual history
- **Symptomatic Male:**
 - Take a urethral culture swab for gonorrhoea (if gonorrhoea culture available), followed by first-void urine for gonorrhoea NAAT testing (first 30ml), preferably ≥1 hour after last void
- **Asymptomatic Male:**
 - Men do not require screening for urethral gonorrhoea if asymptomatic but gonorrhoea testing may be done if a first-void urine specimen is sent for chlamydia testing
- **Men who have Sex with Men:**
 - **Additional pharyngeal and anorectal NAAT swabs** irrespective of reported sexual practices or condom use, as asymptomatic rectal and pharyngeal infection is common

MANAGEMENT

- **Treat immediately if high index of suspicion** e.g. symptoms and/or signs, or contact of gonorrhoea
- Ceftriaxone 500mg im stat (make up with 2ml lignocaine 1% or as per data sheet) PLUS azithromycin 1g po stat (pregnancy category B1)
- If clinical PID or epididymo-orchitis, treat as per PID guideline www.nzshs.org/guidelines or Epididymo-orchitis guideline www.nzshs.org/guidelines
- Refer or discuss with a sexual health specialist if case has drug allergies or anti-microbial resistance is suspected or if anorectal symptoms or there are concerns with QT-prolonging medication (www.medsafe.govt.nz/profs/PUArticles/DrugInducedQTProlongation.htm)
- Advise to abstain from sex or use condoms for 1 week from the start of treatment and until 1 week after sexual contact/s have been treated

PARTNER NOTIFICATION AND MANAGEMENT OF SEXUAL CONTACTS

- Be clear about language: 'partner' implies relationship – all sexual contacts in the last 3 months should be notified
- Contact/s should have a sexual health check and treatment for gonorrhoea with ceftriaxone 500mg im stat (make up with 2ml lignocaine 1% or as per data sheet) plus azithromycin 1 gram po stat, without waiting for test results
- If contacts test positive for an STI refer to specific guideline www.nzshs.org/guidelines
- Advise contacts to abstain from sex or use condoms for 1 week from the start of treatment and until results of tests are available
- Most choose to tell contacts themselves; giving written information is helpful
- Notifying all contacts may not be possible, e.g. if there is insufficient information or a threat of violence

FOLLOW-UP

- By phone or in person, 1 week later
- No unprotected sex in the week post-treatment?
- Completed/tolerated medication?
- All notifiable contact/s informed?
- Any risk of re-infection? Re-treatment necessary if re-exposed to untreated contact
- Test of cure is only needed if symptoms don't resolve or if pharyngeal infection. Re-test by culture in 3 days for genital gonorrhoea, or by NAAT in 3 weeks for pharyngeal infection
- Reinfection is common; offer repeat sexual health check in 3 months

The Ministry of Health supports the use of these clinical guidelines, developed by clinical experts and professional associations to guide clinical care.

Further guideline information – www.nzshs.org/guidelines or phone a sexual health specialist.

This STI Management Guideline Summary has been produced by NZSHS. Every effort has been taken to ensure that the information in this guideline is correct at the time of publishing (July 2017).

Gonorrhoea

What is gonorrhoea?

Gonorrhoea is an STI (a sexually transmitted infection) that is more common in people aged less than 30 years. Gonorrhoea is very easy to catch and also very easy to treat. It may cause serious problems if you don't get it treated.

How does someone get gonorrhoea?

- By having sex or sexual contact with another person with gonorrhoea.
- This includes oral, vaginal or anal sex and sex play, particularly when saliva is used as a lubricant.
- The other person may not know they have the infection.
- **If you use a condom every time you have sex you are much less likely to get gonorrhoea.**
- Gonorrhoea can also be passed from mother to baby during birth and may result in an eye infection in the baby.

How do I know if I have gonorrhoea?

Males with gonorrhoea in the penis are more likely to be symptomatic than females.

Many people don't notice any symptoms. If they do, symptoms could be:

Females

- There can be a discharge or fluid leaking from the vagina.
- There can be pain when urinating or low tummy pain, especially during sex.
- There can be unusual bleeding between periods or bleeding after sex.
- Gonorrhoea can cause an unusual discharge or bleeding from the anus if there has been anal sex.

Males

- There can be soreness, an unusual discharge, or itching in the opening at the end of the penis (urethra).
- There can be pain when urinating.
- There can be unusual discharge or bleeding from the anus if there has been anal sex between males.
- Very occasionally there can be pain or swelling in the testicles.

How do I get tested?

You need to see your doctor, nurse or sexual health clinic for a check-up. If you want, take along someone you trust, for support.

If you have symptoms you will need to be examined by a doctor or nurse to find the cause.

- Females will need a swab test from the vagina. An anal swab might be required if you have had anal sex. You may be able to do the swab/s yourself.
- Males will need a urine test. Throat and anal swabs might be required if you have sex with males. You may be able to do the swabs yourself.

It may be embarrassing, but it is better to get checked than to have untreated gonorrhoea.

How do I get treated?

You will need an injection and to take some tablets. A single dose of the right treatment usually cures gonorrhoea. You may need to take tablets for up to 2 weeks if the infection is more serious.

Important advice

- Finish all the tablets you have been given, even if you feel better.
- You need to tell anyone you have had sex with in the last 3 months to get a sexual health check and treatment for gonorrhoea, even if their tests are normal.
- You should avoid sex for 1 week from the start of your treatment and until 1 week after your sexual contact/s have been treated. If this is not possible, always use a condom, including for oral sex, until your treatment and your sexual contact/s treatment has been completed.
- We recommend you have another sexual health check in 3 months in case you get the infection again.

PATIENT INFORMATION

Important information

- Gonorrhoea is a sexually transmitted infection (STI) that is easy to treat with antibiotics.
- Some people with gonorrhoea don't notice symptoms.
- You can get gonorrhoea by having sexual contact with another person who has gonorrhoea.
- Testing: Females will need a swab from the vagina. Males need a urine test. Other tests might be required dependent on the type of sexual contact you have.
- You need to tell anyone you have had sex with in the last 3 months to get a sexual health check and treatment for gonorrhoea..
- You should avoid sex or use condoms for 1 week from the start of your treatment and until 1 week after your sexual contact/s have been treated, so you don't pass the infection onto someone else.

Epididymo-orchitis

MANAGEMENT SUMMARY

EXCLUDE TORSION

Take history – age, sexual history, previous catheterisation or urinary tract infection (UTI)?
Examination – swollen scrotum, tender epididymis/testicle, urethral discharge?
Tests – urethral culture swab for gonorrhoea (if gonorrhoea culture available) if urethral discharge, plus in all cases first void urine for chlamydia & gonorrhoea NAAT testing (first 30ml), preferably ≥ 1 hour after last void, and mid-stream urine for urine dipstick and culture for urinary pathogens

STI-associated epididymo-orchitis more likely if

- < 35 years
- > 1 sexual contact in past 12 months
- Urethral discharge
- Men who have sex with men (MSM)

Management of epididymo-orchitis likely due to any STI

- Ceftriaxone 500mg im stat (make up with 2ml lignocaine 1% or as per data sheet) *plus* doxycycline 100mg po twice daily for 14 days
- Advise to abstain from sex or use condoms for 2 weeks after the start of treatment and until 1 week after all sexual contact/s have been treated
- Bed rest, scrotal support, analgesia

Urinary pathogen-associated epididymo-orchitis more likely if

- > 35 years
- Low risk sexual history
- Previous urological procedure or UTI
- No urethral discharge
- Positive urine dipstick for leucocytes + nitrites

Management of epididymo-orchitis likely due to enteric or urinary organisms

- Ciprofloxacin 500mg po bd 10 days (specialist approval may be required)
- Bed rest, scrotal support, analgesia

Follow-up

- Symptoms should be improving after 3 days
- Arrange further review at 1 week
- Check laboratory results

Symptoms and signs resolved/significantly improved

- Check compliance with treatment
- Check sexual abstinence
- Ensure partner notification/contact tracing complete

Discharge once symptoms and signs fully resolved
Offer repeat sexual health check in 3 months

MSU positive

- Consider renal tract ultra-sound scan (USS)
- Referral to urology

Symptoms and signs persist

- Check compliance with treatment
- Check no unprotected sex
- Ensure partner notification complete
- Review diagnosis
- Consider alternative aetiologies
- Consider testicular USS
- Consider urology referral

Partner notification and management of sexual contacts

If STI cause suspected:

- Be clear about language: 'partner' implies relationship
- All sexual contacts in the last 3 months should be notified
- Contact/s should have a sexual health check and treatment as an epididymitis contact, with azithromycin 1g po stat, without waiting for test results
 - If gonorrhoea suspected in index case, add ceftriaxone 500mg im stat
- If contacts test positive for an STI refer to specific guideline www.nzshs.org/guidelines
- Advise contacts to abstain from sex or use condoms for 1 week from the start of treatment and until results of tests are available
- Most choose to tell contacts themselves; giving written information is helpful
- Notifying all contacts may not be possible, e.g. if there is insufficient information or a threat of violence

The Ministry of Health supports the use of these clinical guidelines, developed by clinical experts and professional associations to guide clinical care.

Further guideline information – www.nzshs.org/guidelines or phone a sexual health specialist.

This STI Management Guideline Summary has been produced by NZSHS. Every effort has been taken to ensure that the information in this guideline is correct at the time of publishing (July 2017).

Epididymo-orchitis

PATIENT INFORMATION

What is epididymo-orchitis?

Epididymo-orchitis is an infection of the testicle and epididymis (tubes around the testicle).

How does someone get epididymo-orchitis?

- Epididymo-orchitis is usually due to a sexually transmitted infection (STI) such as chlamydia or gonorrhoea, which is caught from having unprotected sex with someone who has the STI. This can include oral, vaginal and anal sex, sex play or sharing sex toys.
- If you use a condom every time you have sex you are much less likely to get epididymo-orchitis.
- Sometimes epididymo-orchitis is due to a urinary infection – this is more common in men over 35.
- It can also be caused by a childhood infection known as mumps.

What are the symptoms?

These can include:

- Pain or swelling in the testicle or scrotum.
- Discharge or fluid leaking from the penis, especially if it is due to chlamydia or gonorrhoea.
- Sometimes there may be pain passing urine.
- Sudden severe pain in the testicle or scrotum can be due to a twisted testicle. This is serious and you will need to see a doctor straight away.

What do I do if I think I have epididymo-orchitis?

You should see a doctor urgently. You will need to have a sexual health check. You will need an examination and you will need to do a urine test. You may also need to have a swab taken from the penis.

How do I get treated?

You will usually need an injection and a 2 week course of tablets. You will be advised to wear supportive underwear until it gets better. You may need painkillers such as paracetamol or ibuprofen to manage pain.

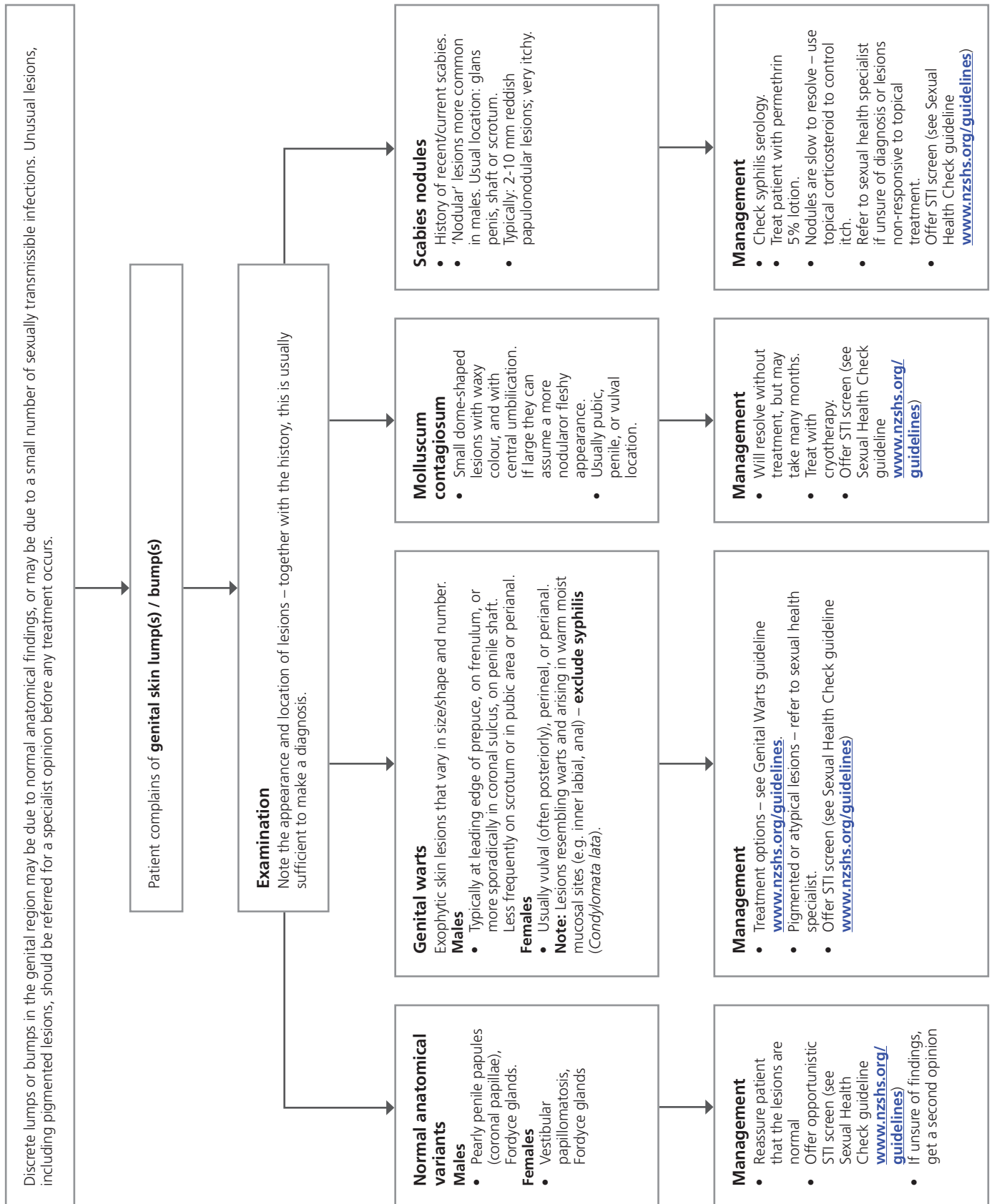
Important advice

- Finish all the tablets you have been given, even if you feel better.
- You should use a condom while on treatment, so you don't pass the infection on to someone else.
- You need to tell anyone you have had sex with in the last 3 months to get a sexual health check and treatment as a contact of epididymo-orchitis even if their tests are normal.
- You should avoid sex for 2 weeks from the start of your treatment and until 1 week after your sexual contact/s have been treated. If this is not possible always use a condom, including for oral sex, until your treatment and your sexual contact/s treatment has been completed.
- We recommend you have another sexual health check in 3 months in case you get the infection again.

Important information

- Epididymo-orchitis is an infection of a male's testicle and tubes.
- It is usually caused by an STI, but can sometimes be caused by a urinary infection or mumps.
- If you get pain or swelling in the testicle you need to see a doctor urgently.
- It is treated by antibiotics.
- You need to tell anyone you have had sex with in the last 3 months to get a sexual health check and treatment as a contact of epididymo-orchitis.
- You should avoid sex or use condoms for 2 weeks from the start of your treatment and until 1 week after your sexual contact/s have been treated, so you don't pass the infection onto someone else.

Genital Skin Lesions (Non-Ulcerative)



The Ministry of Health supports the use of these clinical guidelines, developed by clinical experts and professional associations to guide clinical care.

Further guideline information – www.nzshs.org/guidelines or phone a sexual health specialist.

This STI Management Guideline Summary has been produced by NZSHS. Every effort has been taken to ensure that the information in this guideline is correct at the time of publishing (July 2017).

Genital Ulcer Disease (GUD)

MANAGEMENT SUMMARY

In New Zealand, GUD due to STI is largely confined to herpes simplex virus (either HSV-2 or HSV-1), or syphilis. Tropical causes of GUD such as chancroid or lymphogranuloma venereum are RARE. Consider if there has been an overseas sexual contact in an endemic region or with someone from a high-prevalence population group. Some ulcerative lesions are due to non-sexually acquired dermatological conditions. However, it is important to remember that most breaks in the genital skin are due to micro-trauma to the epidermis.

Patient complains of genital sore(s) / ulcer(s)

Are the lesions on examination

- Multiple vesicles; or tender, shallow ulcerations; +/- inguinal adenopathy?

YES

Tests

- Viral swab for herpes simplex virus (HSV) testing from the base of the lesion (HSV PCR testing is the preferred test)
- Syphilis serology should be routinely requested

Management

- Valaciclovir 500mg po twice daily for 7 days OR
- Aciclovir 400mg po 3 times daily for 7 days
- +/- lignocaine gel and oral analgesia
- +/- salt baths

Follow-up

- Check HSV result and check for resolution of ulcers in 1 week
- If HSV result **positive**, discuss diagnosis with patient
- Partner notification is not necessary but diagnosis should be discussed with regular sexual contact/s
- Offer full sexual health check if not already done (see Sexual Health Check guideline www.nzshs.org/guidelines)
- If HSV result **negative** and the lesions have resolved, then arrange to repeat the HSV test promptly if problem recurs
- **Refer or discuss with a sexual health specialist if there are genital ulcers that are HSV-negative and have not resolved**

NO

- Larger typically solitary painless ulcers +/- unilateral non-tender enlarged rubbery lymph node is more typical of primary syphilis
- Other atypical lesions

- **Refer to or discuss with sexual health specialist for acute assessment**
- DO NOT give oral or topical treatments prior to specialist assessment

The Ministry of Health supports the use of these clinical guidelines, developed by clinical experts and professional associations to guide clinical care.

Further guideline information – www.nzshs.org/guidelines or phone a sexual health specialist.

This STI Management Guideline Summary has been produced by NZSHS. Every effort has been taken to ensure that the information in this guideline is correct at the time of publishing (July 2017).

TEST IF

- Woman at risk of STIs presents with lower abdominal/pelvic pain – see Express STI Testing Questionnaire www.nzshs.org/guidelines

Note: Most laboratories are automatically performing multiplex NAAT testing for chlamydia & gonorrhoea (+/-trichomoniasis).

False positive gonorrhoea results are possible in low prevalence populations – see NZSHS Management of Gonorrhoea 2017, and Response to the Threat of Antimicrobial Resistance www.nzshs.org/guidelines.

RECOMMENDED TESTS – see Sexual Health Check Guideline www.nzshs.org/guidelines

- Vulvovaginal NAAT swab for chlamydia & gonorrhoea testing prior to speculum insertion. Insert speculum, examine vagina and cervix.
- Endocervical culture swab for gonorrhoea (if gonorrhoea culture available)
- High vaginal culture swab for candida & BV & trichomoniasis (if NAAT for trichomoniasis not available)
- Additional anorectal NAAT swab for chlamydia & gonorrhoea testing as indicated based on sexual history
- Bimanual examination for pelvic masses or tenderness
- Urine pregnancy test and urinalysis dipstick
- Universal serology for HIV and syphilis
- Targeted hepatitis B and C serology if hepatitis B status unknown and risk factors present
- Full blood count (FBC) and C-reactive protein (CRP) in severe cases or diagnostic uncertainty
- Vital signs: Temperature, pulse, blood pressure
- Pain score: Mild PID = normal vital signs and pain score <5/10, moderate PID = normal vital signs and pain score ≥5/10

Treat immediately on the basis of symptoms of lower abdominal pain and EITHER uterine OR cervical OR adnexal tenderness.

SEVERITY ASSESSMENT

PID IS SEVERE IF:

- Acute abdomen
- Pregnant
- Fever, vomiting or systemically unwell
- Intolerant of oral therapy
- Clinical failure at review

REFER

- Severe PID
- Ectopic pregnancy suspected
- Severe drug allergies to usual regimen
- Persistent or repeat PID where reinfection is excluded as *Mycoplasma genitalium* testing may be required

MILD/MODERATE PID

- **Ceftriaxone 500mg** im stat (make up with 2ml lignocaine 1% or as per data sheet) PLUS
- **Doxycycline 100mg** po twice daily for 2 weeks PLUS
- **Metronidazole 400mg** po twice daily for 2 weeks. (*Metronidazole may be discontinued at review if not tolerated.*)
- For drug allergies refer to full guideline at www.nzshs.org/guidelines
- Advise treatment may take time to work
- Advise to abstain from sex until abdominal pain has settled and to use condoms for 2 weeks after initiation of treatment and until 1 week after sexual contact/s have been treated

PARTNER NOTIFICATION AND MANAGEMENT OF SEXUAL CONTACTS

- Be clear about language: 'partner' implies relationship – all sexual contacts in the last 3 months should be notified
- Contact/s should have a sexual health check and if asymptomatic be treated for chlamydia with azithromycin 1g po stat, without waiting for test results
- If sexual contact/s has symptoms of urethritis (see Urethritis in Males guideline www.nzshs.org/guidelines)
- If contacts test positive for an STI, refer to specific guideline www.nzshs.org/guidelines
- Advise contacts to abstain from sex or use condoms for 1 week from the start of treatment and until results of tests are available
- Most choose to tell contacts themselves; giving written information is helpful
- Notifying all contacts may not be possible, e.g. if there is insufficient information or a threat of violence

72 HOUR FOLLOW-UP FOR MODERATE/SEVERE PID

- Repeat bimanual exam to assess resolution of signs and refer if not improved
- No unprotected sex?
- Tolerated medication?
- Notifiable contacts informed?
- Any risk of reinfection? Will need further treatment if re-exposed to untreated contact

1 TO 2 WEEK FOLLOW-UP FOR MILD PID (PHONE OR IN PERSON)

- As above – bimanual where practical or where symptoms not improved
- Re-infection is common; offer repeat sexual health check in 3 months

The Ministry of Health supports the use of these clinical guidelines, developed by clinical experts and professional associations to guide clinical care.

Further guideline information – www.nzshs.org/guidelines or phone a sexual health specialist.

This STI Management Guideline Summary has been produced by NZSHS. Every effort has been taken to ensure that the information in this guideline is correct at the time of publishing (July 2017).

Pelvic Inflammatory Disease (PID)

PATIENT INFORMATION

What is pelvic inflammatory disease?

PID is the name given to infection in or around a woman's uterus (womb), fallopian tubes or ovaries. It is caused by bacteria spreading upwards into the uterus from the vagina or cervix (neck of the womb). It is commonly caused by sexually transmitted infections (STIs) such as chlamydia or gonorrhoea. Sometimes PID can occur after pelvic operations, a pregnancy, or in the first few weeks after an IUD is put in.

PID sometimes causes infertility (difficulty getting pregnant), ectopic pregnancy (a baby growing in a place outside the womb), or long term pelvic pain. These things are more likely to happen if the treatment is late, so it's important to get treated straight away.

How does someone get PID?

PID can develop after having sex or sexual contact with someone who has an STI.

PID is especially common if you are under 30 years old, have had a new sexual contact in the last 3 months, don't always use condoms for sex, or if you've had an STI such as chlamydia or gonorrhoea.

You can prevent PID by using a condom every time you have sex, especially when you have sex with a new sexual contact.

How do I know if I have PID?

In the early stages you might not notice anything wrong. Most women have mild symptoms such as:

- Lower tummy pain or aching – a bit like a period pain.
- Pain deep inside during sex.
- Bleeding inbetween periods or after sex.
- Abnormal vaginal discharge.

How do I get tested?

It's important to have a sexual health check if you have symptoms of PID. If you want, take along someone you trust, for support.

There is no one single test for PID. The doctor will rely on your symptoms and what is found on examination to decide if you have PID. Often the tests will not tell you the cause and you can still have PID even if the STI tests are negative.

How do I get treated?

If your doctor thinks you might have PID you will get a 2 week course of antibiotic tablets and an injection.

Important advice

- Finish all the tablets you have been given, even if you feel better and the tests are all normal.
- You need to tell anyone you have had sex with within the last 3 months to get a sexual health check and treatment as a contact of PID, even if their tests are normal.
- You should avoid sex for 2 weeks from the start of your treatment and until 1 week after your sexual contact/s have been treated. If this is not possible always use a condom, including for oral sex, until your treatment and your sexual contact/s treatment has been completed.
- The complications of PID get worse if you get it again, so preventing it by using condoms is important.
- We recommend you have another sexual health check in 3 months in case you get an infection again.

Important information

- PID is infection around a woman's uterus (womb), fallopian tubes or ovaries.
- It is commonly, but not always, caused by STIs such as chlamydia or gonorrhoea.
- Symptoms include abdominal (tummy) pain and abnormal bleeding or discharge.
- PID is treated with antibiotics. You should finish all the treatment you have been given.
- You need to tell anyone you have had sex with in the last 3 months to get a sexual health check and treatment as a contact of PID.
- You should avoid sex or use condoms for 2 weeks from the start of your treatment and until 1 week after your sexual contact/s have been treated, so you don't pass the infection on to someone else.

TEST IF

- MSM (at least annually, but ideally with every sexual health check)
- HIV positive (at least annually, but ideally with every sexual health check)
- Routine antenatal screen; consider rescreening in later pregnancy if partner change
- Routine immigration screen
- A sexual contact of a person with syphilis
- Routine sexual health check

Signs or symptoms of infectious syphilis:

- Genital ulcers (see Genital Ulcer Disease summary www.nzshs.org/guidelines)
- MSM with any genital symptoms or rash
- Any rash affecting the palms of the hands or soles of the feet, or that is persistent or unexplained
- Pyrexia of unknown origin, unexplained persistent lymphadenopathy, unexplained liver function disturbance, alopecia

RECOMMENDED TESTS

- Syphilis serology – if clinical suspicion of infectious syphilis specify on laboratory form
- HIV serology
- Routine STI tests (see Sexual Health Check guideline www.nzshs.org/guidelines)
- In MSM also request hepatitis A and B serology, unless known to be immune
- In persons with a history of IDU, incarceration, or who use recreational drugs during sex, request hepatitis C serology

Refer or discuss with a sexual health specialist if high index of suspicion of infectious syphilis (e.g. symptoms and/or signs, or contact of index case), or if pregnant.
It is recommended to discuss all positive syphilis serology with a sexual health specialist.

MANAGEMENT

- Advise to refrain from any sexual activity until assessed or discussed with a specialist service
- Do not use/prescribe any topical agents or oral antibiotics for genital ulcers
- Patients being treated for infectious syphilis should have syphilis serology repeated on the day treatment is commenced to provide an accurate baseline for monitoring treatment
- It is important that any intramuscular penicillin formulation used should be long-acting Bicillin LA (benzathine penicillin) 1.8g, as short-acting formulations are insufficient for syphilis treatment. Treatment should ideally be given at a sexual health service.

PARTNER NOTIFICATION AND MANAGEMENT OF SEXUAL CONTACTS

- **Referral or discussion with a sexual health specialist or service is strongly recommended**
- Be clear about language: 'partner' implies relationship
- All sexual contacts within the intervals below should be clinically and serologically evaluated

Infectious syphilis

- **Primary syphilis:** 3 months plus duration of symptoms. Empiric treatment for syphilis is recommended, as serology may be negative
- **Secondary syphilis:** 6 months plus duration of symptoms
- **Early latent syphilis and syphilis of unknown duration where RPR \geq 1:32:** 12 months

Late latent syphilis, syphilis of unknown duration with low RPR and tertiary syphilis

- Serologic evaluation of current or last sexual contact and/or serologic evaluation of children if index case is female

FOLLOW-UP

Infectious syphilis

- Repeat serology at 3, 6 and 12 months
- Serological cure is defined by consistent four-fold (2 dilutions) drop in RPR titre
- Failure of RPR titre to decrease fourfold (2 dilutions) within 12 months indicates treatment failure – re-evaluation is necessary
- A subsequent four-fold (2 dilution) rise in RPR titre is an indication of re-infection – re-evaluation is necessary

Late latent syphilis and tertiary syphilis (excluding neurosyphilis)

- Repeat serology at 6 and 12 months to ensure remains serofast
- Fourfold (2 dilutions) increase in titre indicates either treatment failure or re-infection – re-evaluation is necessary

The Ministry of Health supports the use of these clinical guidelines, developed by clinical experts and professional associations to guide clinical care.

Further guideline information – www.nzshs.org/guidelines or phone a sexual health specialist.
This STI Management Guideline Summary has been produced by NZSHS. Every effort has been taken to ensure that the information in this guideline is correct at the time of publishing (July 2017).

Syphilis

What is syphilis?

Syphilis is a sexually transmitted infection (STI). It is quite easy to catch and can cause serious problems if you don't get it treated. It has been increasing in New Zealand particularly in men having sex with men (MSM). Having untreated syphilis increases your chances of catching HIV infection.

How does someone get syphilis?

Syphilis is usually caught by having sexual contact with an infected person. This may include vaginal, anal or oral sex or just close skin-to-skin contact. The chances of catching syphilis are lower if you use condoms during sex. Syphilis can also be spread from mother to baby during pregnancy if the mother is infected. Syphilis can cause miscarriage or still-birth or infection in the baby if a pregnant woman is not treated.

How do I know if I have syphilis?

- **About 50% of people don't have any symptoms and would not know without having a blood test.**
- **People without symptoms can still get problems later on if they are not treated.**
- **At the infectious stage people without symptoms can still pass the infection to their sexual contacts.**

What are the symptoms of syphilis?

Early stages of syphilis (primary and secondary syphilis) are also called infectious syphilis.

Primary syphilis

- The first sign of syphilis is one or more sores on the penis, anus, mouth or cervix (neck of the womb).
- The sore may not be seen easily at these sites and because it is often painless it may go unnoticed.
- The sore will disappear on its own within a few weeks.
- **All genital sores must be examined by a doctor.**

Secondary syphilis

- The most common symptom of secondary syphilis is a rash.
- It may affect the palms of the hands or soles of the feet. It can be very mild or severe and will disappear on its own.
- There may also be other symptoms such as mouth ulcers, headaches, swollen glands, fever, hair loss, tiredness, or warty growths in the genitals or anus.

If untreated, the symptoms of primary and secondary syphilis disappear, but you can remain infectious for up to 2 years.

Late syphilis

- If not treated, a small number of people will get late stage syphilis (or tertiary syphilis), which can cause damage to the heart, brain, nerves, blood vessels, liver, bones and joints many years later.
- People with late syphilis (latent and tertiary) are not infectious to sexual contacts.

How do I get tested?

You need to see your doctor or nurse or sexual health clinic for a check-up. If you want, take along someone you trust, for support.

- Syphilis is usually diagnosed by a blood test.
- The tests can take up to 3 months after you get the infection to become positive.
- It may be negative if you test too soon, but treatment is usually recommended if you have had sexual contact with someone with syphilis, even if the test is negative.
- If you have symptoms, you may also need to have samples taken from the sores or body rash.
- Syphilis is one of the routine blood tests in pregnant women.

How do I get treated?

- You will need injections of an antibiotic called penicillin.
- If you are allergic to penicillin other antibiotics will be used.
- **Proper treatment of the mother during pregnancy will prevent the baby being born with syphilis.**
- **The blood tests can stay positive for months or years after the disease has been successfully treated, but this is nothing to worry about and does not mean that you are still infectious.**

Important advice

- You must finish all the treatment to be cured.
- If you have syphilis you will need to tell sexual contacts to get tested and treated.
- The doctor or nurse will tell you how far back to notify sexual contacts – usually anyone in the last 3 to 6 months.
- Do not have sex until any sores or rashes have completely gone away.
- After treatment, follow-up blood tests are essential for at least one year to make sure cure is complete.
- It is possible to get reinfected with syphilis again in the future, through sexual contact with someone who has syphilis.

PATIENT INFORMATION

Important information

- Syphilis is a sexually transmitted infection that is easily treated with antibiotics.
- It is most commonly diagnosed in men who have sex with men, but heterosexual infections are increasing.
- Many people with syphilis don't have symptoms.
- You get syphilis by having sexual contact, including oral sex, with another person with syphilis.
- Testing: You need a blood test, especially if you have a genital sore, a rash, or if you have had sexual contact with a person with syphilis.
- Condoms help prevent syphilis.
- You should avoid sex until any sores or rashes have completely gone.
- You will need follow-up blood tests.

TEST IF:

- Female with vaginal and vulval symptoms
- Female with evidence of vulvitis and/or vaginitis, "scalded skin" or napkin-distribution dermatitis on examination
- Sexual contacts of trichomoniasis
- Males with persistent urethritis

RECOMMENDED TESTS

Testing for trichomoniasis varies regionally with some laboratories offering NAAT (e.g. PCR) testing on the chlamydia & gonorrhoea swab

- It is recommended to test for co-existing STIs (see Sexual Health Check guideline www.nzshs.org/guidelines)

Female:

- If NAAT available, vulvovaginal NAAT swab for trichomoniasis, chlamydia & gonorrhoea testing
- If NAAT not available, high vaginal culture swab for testing for trichomoniasis plus vulvovaginal NAAT swab for chlamydia & gonorrhoea
- Additional anorectal NAAT swab for chlamydia & gonorrhoea testing as indicated based on sexual history

Asymptomatic male contacts:

- Full sexual health check (see Sexual Health Check guideline www.nzshs.org/guidelines) including first void urine (first 30ml), preferably ≥ 1 hour after last void for trichomoniasis testing by NAAT if available locally
- Treat empirically for trichomoniasis
- Male contacts with dysuria or discharge (see Urethritis in Males guideline www.nzshs.org/guidelines)

Symptomatic male contacts:

- See Urethritis in Men guideline www.nzshs.org/guidelines

Treat immediately if trichomoniasis is clinically suspected or if a sexual contact of trichomoniasis.

- Start treatment for patient and sexual contact/s, without waiting for lab results

MANAGEMENT

- Metronidazole 2g po stat (pregnancy category B2) OR
- Ornidazole 1.5g po stat (not recommended in pregnancy) OR
- Metronidazole 400mg po twice daily for 7 days
- Refer full guideline (www.nzshs.org/guidelines) if breastfeeding
- Advise to abstain from sex or use condoms for 1 week from the start of treatment and until 1 week after sexual contact/s have been treated
- Advise to abstain from alcohol for duration of treatment and for at least 24 hours after completion of treatment (72 hours for ornidazole)

PARTNER NOTIFICATION AND MANAGEMENT OF SEXUAL CONTACTS

- Be clear about language: 'partner' implies relationship – all sexual contacts in the last 3 months should be notified
- Male contacts should be treated empirically as testing for trichomoniasis is not available outside specialist services
- Contact/s should have a sexual health check and treatment for trichomoniasis, without waiting for test results
- If contacts test positive for an STI, refer to specific guideline www.nzshs.org/guidelines
- Advise contacts to abstain from sex or use condoms for 1 week from the start of treatment and until results of tests are available
- Most choose to tell contacts themselves; giving written information is helpful
- Notifying all contacts may not be possible, e.g. if there insufficient information or a threat of violence

FOLLOW-UP (PHONE OR IN PERSON) 1 WEEK LATER

- Any unprotected sex in last week?
- Completed/tolerated medication?
- All notifiable contacts informed?
- Any risk of re-infection? Re-treatment necessary if re-exposed to untreated contact
- Check other STI test results and treat if positive (refer to specific guidelines www.nzshs.org/guidelines)
- Test of cure only needed if symptoms don't resolve
- Refer suspected treatment failures to a sexual health specialist
- Offer repeat sexual health check in 3 months

The Ministry of Health supports the use of these clinical guidelines, developed by clinical experts and professional associations to guide clinical care.

Further guideline information – www.nzshs.org/guidelines or phone a sexual health specialist.

This STI Management Guideline Summary has been produced by NZSHS. Every effort has been taken to ensure that the information in this guideline is correct at the time of publishing (July 2017).

Trichomoniasis

PATIENT INFORMATION

What is trichomoniasis?

Trichomoniasis is a sexually transmitted infection (STI).

How does someone get trichomoniasis?

Trichomoniasis is passed on by having sex, sexual contact or sex play with another person with trichomoniasis. It can also be passed on by sharing sex toys, e.g. vibrators.

If you use a condom every time you have sex, you are much less likely to get trichomoniasis.

How do I know if have trichomoniasis?

Symptoms may develop after sexual contact with someone else with the infection. Symptoms include:

Females

- There can be a discharge or fluid leaking from the vagina.
- There can be a bad smell or odour in the genital area.
- You may feel itchy or sore in the genitals.
- Many women have no symptoms.

Males

- Most men do not have symptoms, however they can still pass trichomoniasis on.
- Some men may have discharge or fluid leaking from the penis and/or pain when passing urine.

How do I get tested?

- You need to see your doctor, nurse or sexual health clinic for a check-up. If you want, take along someone you trust, for support.
- Females will need a swab from the vagina. An anal swab might be required if you have anal sex. You may be able to do the swab/s yourself.
- Trichomoniasis is difficult to test for in men, so men are usually just treated if they have had sex with someone with trichomoniasis even if their tests are normal.
- It may be embarrassing, but it is better to get checked than to have untreated trichomoniasis.

How do I get treated?

A single dose of the right tablets usually cures it. The tablets sometimes make you feel a bit sick, but it helps if you take them with food. Don't drink alcohol for 24 hours after taking the tablets as it will make you feel really sick.

Important advice

- **Finish all the tablets you have been given, even if you feel better.**
- You need to tell **everyone** you have had sex with in the last 3 months to get a sexual health check and treatment for trichomoniasis.
- You should avoid sex for 1 week from the start of your treatment and until 1 week after your sexual contact/s have been treated. If this is not possible always use a condom, including for oral sex, until your treatment and your sexual contact/s treatment has been completed.
- We recommend you have another sexual health check in 3 months in case you get the infection again.

Important information

- Trichomoniasis is an STI that is **easy to treat**.
- It is more common for **females to show symptoms** than males.
- However, males can still pass it on.
- Women can get tested with a swab from the vagina.
- Men are usually just treated, but should have a sexual health check.
- You need to tell anyone you have had sex with in the last 3 months to get a sexual health check and treatment for trichomoniasis.
- You should avoid sex or use condoms for 1 week from the start of your treatment and until 1 week after your sexual contact/s have been treated, so you don't pass the infection on to someone else.

Patient complains of penile urethral discharge, discomfort, irritation or dysuria (without urge/frequency)

Recommended tests

- Full sexual health check including serology (see Sexual Health Check guideline www.nzshs.org/guidelines)
- Urethral culture swab for gonorrhoea (if gonorrhoea culture available) prior to urine test if discharge is present
- First void urine for chlamydia & gonorrhoea NAAT testing (first 30ml), preferably ≥ 1 hour after last void

Examination findings:

- Profuse purulent penile discharge?

YES

Presumptive gonorrhoea

OR if contact of gonorrhoea, treat with:

- Ceftriaxone 500mg stat im (make up with 2ml lignocaine 1% or as per data sheet) AND azithromycin 1g po stat

NO

Treat for **non-gonococcal urethritis** with:

- Doxycycline 100mg po twice daily for 7 days (recommended)* OR
- Azithromycin 1g po stat (alternative)

* Doxycycline is recommended because it has superior efficacy for symptomatic male urethritis and confirmed chlamydial urethritis, and azithromycin 1g is associated with resistance development in *Mycoplasma genitalium*. Azithromycin can be used as an alternative if compliance is a concern or doxycycline is contraindicated.

- If clinical epididymo-orchitis, see Epididymo-orchitis guideline www.nzshs.org/guidelines
- Refer to full guideline at www.nzshs.org/guidelines for drug allergies, suspected anti-microbial resistance, known contact with *Mycoplasma genitalium* or chlamydia and gonorrhoea co-infection
- Advise to abstain from sex or use condoms for 1 week from the start of treatment and until 1 week after sexual contact/s have been treated
- Reinfection is common; offer repeat sexual health check in 3 months

PARTNER NOTIFICATION AND MANAGEMENT OF SEXUAL CONTACTS

- Be clear about language: 'partner' implies relationship – all sexual contacts in the last 3 months should be notified
- Contact/s should have a sexual health check and treatment with doxycycline 100mg bd po 7 days or azithromycin 1g po stat, without waiting for test results
- If contacts test positive for an STI refer to specific guideline at www.nzshs.org/guidelines
- Advise contacts to abstain from sex or use condoms for 1 week from the start of treatment and until results of tests are available
- Most choose to tell contacts themselves; giving written information is helpful
- Notifying all contacts may not be possible, e.g. if there is insufficient information or a threat of violence
- Advise to use condoms or abstain from sex for 7 days after initiation of treatment and until results of tests are available

FOLLOW-UP

- By phone or in person 1 week later
- Check results. **If gonorrhoea positive and untreated** – treat with Ceftriaxone 500mg stat im (make up with 2ml lignocaine 1% or as per data sheet) AND azithromycin 1g po stat
- No unprotected sex for 1 week post-treatment?
- Completed/tolerated medication?
- All notifiable contacts informed?
- Any risk of re-infection? Re-treatment necessary if re-exposed to untreated contact
- Offer a repeat sexual health check in 3 months
- If ≥ 2 weeks after treatment the patient complains of persistent or recurrent urethral symptoms discuss or refer to a sexual health specialist for *Mycoplasma genitalium* testing

The Ministry of Health supports the use of these clinical guidelines, developed by clinical experts and professional associations to guide clinical care.

Further guideline information – www.nzshs.org/guidelines or phone a sexual health specialist.

This STI Management Guideline Summary has been produced by NZSHS. Every effort has been taken to ensure that the information in this guideline is correct at the time of publishing (July 2017).

Urethritis in Males

PATIENT INFORMATION

What is urethritis?

Urethritis means an inflammation of a male's urethra (the pee tube). It is often called NSU or NGU. It is usually due to a sexually transmitted infection (STI) such as chlamydia or gonorrhoea.

How does someone get urethritis?

Urethritis can be caught by having vaginal, anal or oral sex without a condom, or sex play.

If you use a condom every time you have sex you are much less likely to get urethritis.

How do I know if I have urethritis?

Symptoms can include:

- Discharge leaking from the urethra.
- Pain or discomfort when urinating.
- Itching in the urethra.

How do I get tested?

You need to see your doctor, nurse or sexual health clinic for a check-up. If you want, take along someone you trust, for support.

You will need to do a urine test, and you may need a swab test from the urethra. Throat and anal swabs might be required if you have sex with males. You may be able to do the swabs yourself.

It may be embarrassing, but it is better to get checked than to have untreated urethritis.

How do I get treated?

Urethritis is usually treated with tablets. Sometimes you may need an injection.

Important advice

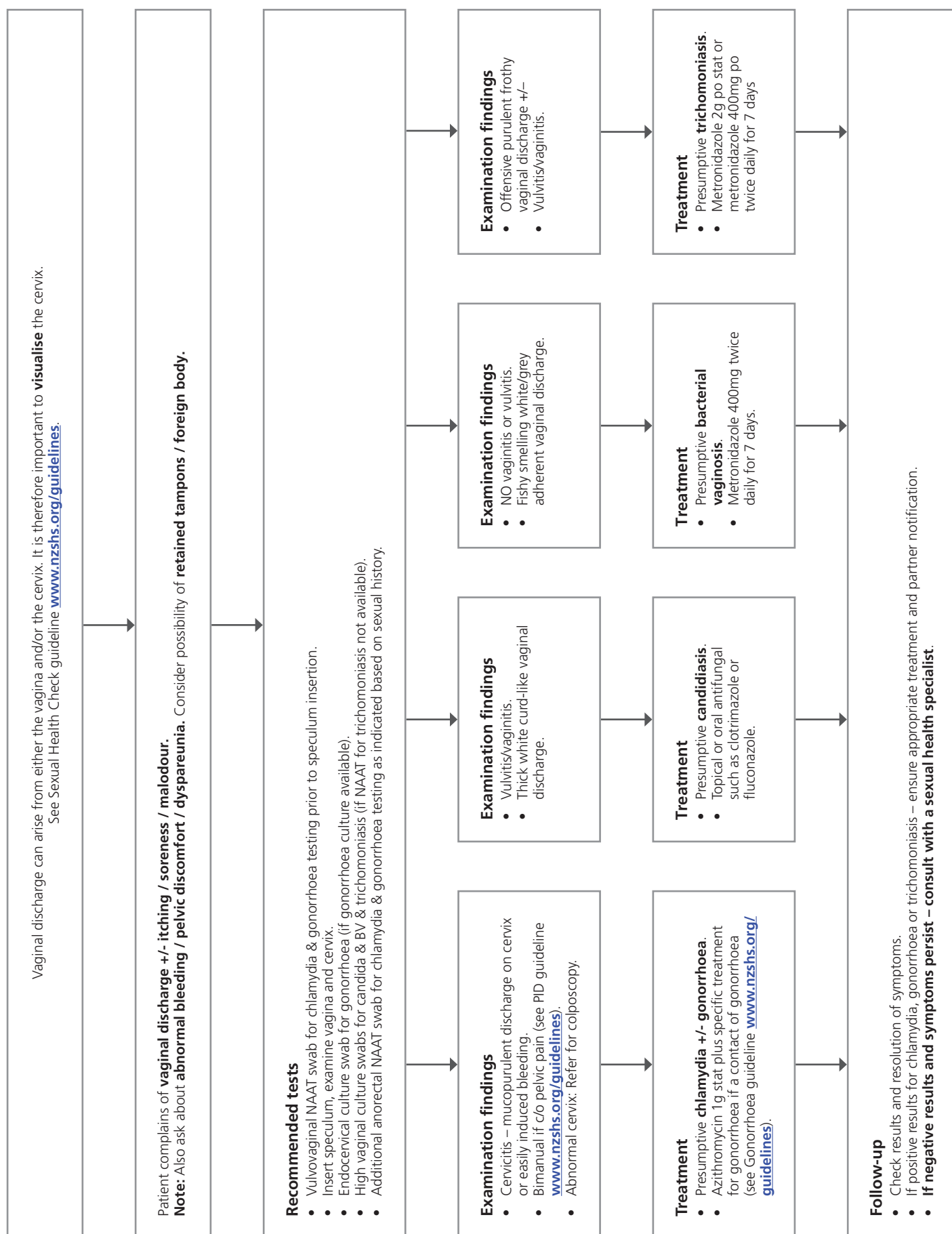
- **Finish all the tablets** you have been given, even if you feel better.
- You need to tell anyone you have had sex with in the last 3 months to get a sexual health check and treatment as a contact of urethritis even if their tests are normal.
- You should avoid sex for 1 week from the start of your treatment and until 1 week after all your sexual contact/s have been treated. If this is not possible, always use a condom, including for oral sex, until your treatment and your sexual contact/s treatment has been completed.
- We recommend you have another sexual health check in 3 months in case you get the infection again.

Important information

- Urethritis is an inflammation of the urethra (the pee tube).
- It is usually due to a sexually transmitted infection (STI) such as chlamydia or gonorrhoea.
- Symptoms can include discharge, pain when urinating, or itching.
- It is treated with antibiotics.
- You need to tell anyone you have had sex with in the last 3 months to get a sexual health check and treatment as a contact of urethritis.
- You should avoid sex or use condoms for 1 week from the start of your treatment and until 1 week after your sexual contact/s have been treated, so you don't pass the infection on to someone else.

Vaginal Discharge

MANAGEMENT SUMMARY



The Ministry of Health supports the use of these clinical guidelines, developed by clinical experts and professional associations to guide clinical care.

Further guideline information – www.nzshs.org/guidelines or phone a sexual health specialist.

This STI Management Guideline Summary has been produced by NZSHS. Every effort has been taken to ensure that the information in this guideline is correct at the time of publishing (July 2017).

Members of the Joint Sexually Transmitted Infections Education Foundation and New Zealand Sexual Health Society Professional Advisory Board 2017

Sexual Health Physicians

Dr Min Lo (Editor in Chief, HPV Guidelines)

Dr Edward Coughlan

Dr Jeannie Oliphant

Dr Heather Young

Infectious Disease and Sexual Health Physician

Dr Massimo Giola

NZ Dermatological Society

Dr Darion Rowan

NZ Committee of the Royal Australian and New Zealand College of Obstetrics and Gynaecology

Dr Anne Robertson

Paediatric Society of New Zealand

Dr Lesley Voss

NZ College of General Practitioners

Dr Phil Jacobs

Dr Andrew Miller

NZ Society of Otolaryngology, Head and Neck Surgery

Dr Julian White

Family Planning

Dr Christine Roke

Immunisation Advisory Centre (IMAC)

Dr Helen Petousis-Harris

Clinical Microbiologist

Dr Arlo Upton

Infectious Disease Pharmacist

Eamon Duffy

Counselling

Claire Hurst (Nurse Counsellor)

Nursing

Georgina McPherson (NZ HPV Project)

Midwife

Karen Upton

Patient Advocate

Peter

Project Manager

Hayley Samuel, PO Box 2437, Shortland Street, Auckland 1140

Tel: 09 433 6526 Email: info@stief.org.nz

New Zealand Sexual Health Society Guidelines Committee

Sexual Health Physicians

Dr Heather Young (Chair)

Dr Susan Bray

Dr Aideen Collins

Dr Rose Forster

Dr Massimo Giola

Dr Teena Mathew

Dr Jeannie Oliphant

Dr Anne Robertson

Dr Julia Scott

Project Co-ordinator

Hayley Samuel

Sexually Transmitted Infections Education Foundation

Secretariat:

PO Box 2437, Shortland Street, Auckland 1140, New Zealand

Phone: 09 433 6526

Email: info@stief.org.nz

To order more copies of this publication, email info@stief.org.nz

info@justthefacts.co.nz
www.justthefacts.co.nz



info@herpes.org.nz
www.herpes.org.nz



info@hpv.org.nz
www.hpv.org.nz



The New Zealand Sexual Health Society

www.nzshs.org



The Ministry of Health supports the use of these clinical guidelines,
developed by clinical experts and professional associations to guide clinical care.

Supported by an educational grant from New Zealand District Health Boards

© 2017 Sexually Transmitted Infections Education Foundation