**Sexually Transmitted Infection Education Foundation resources**

**HERPES**

**Helpline**
Tollfree 0508 11 12 13

**Website**
www.herpes.org.nz

**Resources**

Health professionals’ resources
2. STI – Summary of Guidelines 2013

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 Fact

**HPV**

**Helpline**
Tollfree 0508 11 12 13

**Website**
www.hpv.org.nz

**Resources**

Health professionals’ resources
2. STI – Summary of Guidelines 2013

Patient information pamphlets
1. Some Questions and Answers about HPV and Genital Warts
2. A Patient Guide: HPV in Perspective
3. Cervical Smears and Human Papilloma Virus Infection (HPV)
4. What everyone should know about Genital HPV (Human Papilloma Virus) Infection and the Cervical Cancer Vaccines

**New Zealand Sexual Health Society (NZSHS) resources**

Comprehensive Sexually Transmitted Infection (STI) Management Guidelines and Patient Information handouts are available on www.nzshs.org/guidelines.html
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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.
- Confirm diagnosis with HSV PCR or viral culture. HSV serology is NOT recommended as a routine diagnostic tool.
- Oral antiviral treatment of the first clinical episode 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. Many patients prefer suppressive antiviral therapy. It is particularly recommended for those with frequent and/or severe recurrences or associated psychosocial morbidity. For those choosing episodic antiviral therapy, it is more effective when patients start therapy themselves at the first signs of a recurrence; this requires anticipatory prescribing.
- 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 – changes since the 2009 Guidelines

Treatment of first episode genital herpes
- Oral aciclovir 400mg 3 times daily (8 hourly) for 7 days.

Treatment of recurrent genital herpes

Episodic treatment
- Oral aciclovir 800mg (2 x 400mg) 3 times daily for 2 days.
  Prescribe 48 x 400mg tablets for patients to be able to self-initiate treatment at onset of symptoms.

Suppressive therapy
- Oral aciclovir 400mg twice daily.
- Valaciclovir (Valtrex™) 500mg daily is listed for suppressive treatment of recurrent genital herpes, subject to a Special Authority restriction, in the pharmaceutical schedule.
  - Initial application: From any practitioner. Approvals valid for 12 months where the patient has genital herpes with two or more breakthrough episodes in any 6 month period while treated with aciclovir 400mg twice daily.
  - Renewal: From any practitioner. Approvals valid for 12 months where the treatment remains appropriate and the patient is benefiting from treatment.

Epidemiology

- As many as one in five adults in New Zealand have genital herpes due to HSV-2, but 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

1. In cases of immunocompromised patients or herpes proctitis, refer to specialist.
2. Serology may be useful in some clinical situations. See full Guidelines on [www.herpes.org.nz](http://www.herpes.org.nz)
3. Use in pregnancy requires specialist consultation.
4. Recommend early presentation for viral swab if recurrence.

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1. In cases of immunocompromised patients or herpes proctitis, refer to specialist.
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3. Use in pregnancy requires specialist consultation.
4. Recommend early presentation for viral swab if recurrence.
Management of Recurrent Episodes of Genital Herpes

Patient presents with recurrent episodes of genital herpes

Virology confirmed (see footnote 1)

Other cause(s) of recurrent genital lesions diagnosed (see footnote 2)

Refer for specialist consultation

YES

NO

Treat as appropriate

Frequent/severe or problematic in any way

Suppressive therapy required (see footnote 3)

NO

YES

Oral antiviral for 1 year:
- aciclovir 400mg bd (if aciclovir not tolerated, see footnote 4)

After 1 year negotiate withdrawal for minimum of either 2 recurrences or 3 months to monitor recurrence pattern

Problematic recurrences

NO

YES

Offer further suppressive therapy

Aciclovir 800mg (2 x 400mg) 3 times daily for 2 days
Prescribe 48 x 400mg tabs so patient can self-initiate treatment at onset of symptoms

Assess psychological status

Provide patient information:
- written information
- Helpline tollfree 0508 11 12 13
- Website www.herpes.org.nz

NO

Offer referral to support system or sexual health clinic if appropriate

YES

Consider pre-emptive prescribing to allow patient to start therapy as soon as symptoms begin

Other psychological problems unmasked

Treat as appropriate. Consider referral for specialist counselling

NO

Offer episodic therapy (see footnote 3)

YES

Offer episodic therapy (see footnote 3)

1. In cases of immunocompromised patients or herpes proctitis, refer to specialist.
2. Recommend self-applied swab or early presentation for viral swab if recurrence.
3. Use in pregnancy requires specialist consultation.
4. Valaciclovir (Valtrex™) 500mg daily is available for suppressive treatment of recurrent genital herpes subject to a Special Authority restriction.
Management of women with suspected/possible genital herpes in pregnancy (in consultation with a specialist)

Consider testing for syphilis on basis of history and clinical assessment

Genital ulceration ? genital herpes

Previous history of genital herpes

YES

See management of recurrent genital herpes (see footnote 1)

NO

Treat with IV or oral aciclovir according to clinical condition

Do HSV PCR test (see footnote 2)

Stage of pregnancy

Less than 34 weeks (NB: see footnote 3)

Consider aciclovir treatment from 36 weeks

• aciclovir 400mg TDS (see footnote 4)

Recurrence at delivery

YES

NO

Manage as recurrent genital herpes

Deliver vaginally

• If possible, avoid instrumental delivery/scalp clips
• Mark history of HSV on chart
• Educate parents on neonatal herpes

Deliver baby by elective caesarean section

If baby inadvertently delivered vaginally or membranes ruptured more than 4 hours before delivery

Take specimens from baby for HSV culture immediately after delivery

Take blood and CSF for viral culture/PCR prior to starting aciclovir treatment

Are culture results positive in baby after 5 days?

YES

Aciclovir for 14 days in SEM (see footnote 5) disease, 21 days in CNS or disseminated neonatal HSV

NO

Stop aciclovir if baby looking well

Greater than 34 weeks

Consider testing for syphilis on basis of history and clinical assessment

NB: A diagnosis of herpes in pregnancy may be very distressing. Specialist counselling and education is available via the Herpes Helpline Tollfree 0508 11 12 13 or www.herpes.org.nz

1. If atypical presentation, confirm with HSV PCR test.
2. If HSV PCR negative, discuss with specialist.
3. If onset of labour or need for delivery is less than 6 weeks after first clinical episode, deliver by caesarean section.
4. For first or second trimester acquisition, suppressive aciclovir therapy may be used from 36 weeks to reduce recurrences at term and hence the need for caesarean section. The available data on the effect on the neonate is reassuring, although study numbers have been small.
5. SEM – skin, eye and/or mouth lesions only.
Management of women with history of recurrent genital herpes and women with first clinical episode more than 6 weeks prior to delivery (in consultation with a specialist)

1. For women with recurrences during pregnancy, suppressive aciclovir therapy can be considered to reduce recurrence at term and hence the need for caesarean section. The available data on the effect on the neonate is reassuring, although study numbers have been small.
Key Information to provide patients on diagnosis – available on www.herpes.org.nz - 3 minute PowerPoint tool home page

- 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. If this happens there is effective 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.

- 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 Tollfree 0508 11 12 13 or visit www.herpes.org.nz
THE NEW ZEALAND HPV PROJECT

Genital Human Papilloma Virus (HPV)
Key Information Summary

Taken from:
Guidelines for the Management of Genital HPV Infection in New Zealand
7th Edition - 2013

Introduction

Genital Human Papilloma Virus (HPV)
More than 40 genital types, subcategorised as:

- Low risk HPV (LrHPV) – not associated with pre-cancer or cancer of the lower genital tract.
- High risk HPV (HrHPV) – associated with pre-cancer and cancer of the lower genital tract.

Presents as:
- Genital warts – always due to LrHPV.
- Latent and/or subclinical (as detected on cervical smear, not visible to the naked eye) – may be either HrHPV or LrHPV.

Epidemiology

- A common infection with a prevalence of 20% in 20-year-olds.
- Lifetime risk of HPV infection > 80%.
- The majority of infections are transient with 80-90% clearance within 2 years.

Acquisition

- Genital HPV infection is often found in people who have recently become sexually active.
- Most genital HPV infections are subclinical.
- On average, 80% of sexually active adults will have had some form of HPV infection during their lives.
- HPV infection increases in incidence in proportion to the number of sexual partners.
- For most people, infection with each HPV type is transient and clears spontaneously within the first 6 to 12 months, but in some cases HPV infection persists or remains latent and may reactivate years or decades later.

Transmission

- HPV is highly infectious and is transmitted by skin-to-skin contact.
- If one member of a stable partnership has genital HPV infection, the other is likely to be either infected or immune to that infection.
- Condoms provide limited protection against HPV infection, but their use is recommended to prevent other sexually transmitted infections.
- Because of variable latency, HPV infection may develop during a long-term relationship and does not necessarily imply infidelity.

HPV and Pregnancy

- Genital HPV is common in pregnant women.
- It is extremely rare for babies to develop clinical HPV. Where it does occur it usually manifests as recurrent respiratory papillomatosis and this may cause serious illness in the neonate.
- Transient HPV colonisation in the neonate is common, but persistent infection is unusual.
- Ablative methods, e.g. cryotherapy or diathermy, should be used for treatment of genital warts in pregnancy.
- Caesarean section has not been shown to significantly reduce maternal-fetal transmission.
Genital Warts

Clinical Presentation and Diagnosis

- Genital warts vary widely in appearance and distribution in the anogenital area.
- The differential diagnosis includes normal anatomical findings such as vestibular papillomatosis and pearly penile papules, dermatoses, and intraepithelial neoplasia.
- Diagnosis is generally made on clinical grounds.
- Genital warts which are atypical in appearance should be biopsied to exclude alternate diagnoses, particularly intraepithelial neoplasia.

Treatment

- The primary goal of treatment is to eliminate warts that cause physical or psychological symptoms. Non-treatment is an option for asymptomatic warts and the cure should not be worse than the disease.
- There is no definitive evidence that any one treatment is superior to the others and no single treatment is suitable for all patients or all warts.
- The method of treatment should be determined by patient preference, available resources and the experience of the practitioner. Other factors include the size, number and site of the warts, the age of the patient and whether the patient is pregnant.
- Commonly used treatments in primary care are self-administered podophyllotoxin (recommended for males only) or imiquimod, and practitioner administered cryotherapy repeated weekly until warts have disappeared.
- If there is no significant response within 4 to 6 weeks, an alternative diagnosis, change of treatment modality, or onward referral should be considered.
- Patients should be given information about all the treatment options in order for them to make an informed decision.
- Continuing lack of response to therapy should be referred to a relevant specialist to review diagnosis and management options.

Genital Warts – Summary of Treatment

<table>
<thead>
<tr>
<th>Site</th>
<th>Treatment</th>
<th>Use in Pregnancy</th>
</tr>
</thead>
<tbody>
<tr>
<td>External genital warts</td>
<td>Patient applied&lt;br&gt; Imiquimod (Aldara 5% cream); OR Podophyllotoxin solution (males only).&lt;br&gt; Provider administered&lt;br&gt; Cryotherapy; OR Trichloracetic acid; OR Surgical removal; OR Laser; OR Diathermy.</td>
<td>No&lt;br&gt; Yes</td>
</tr>
<tr>
<td>Cervical warts (high grade CIN excluded)</td>
<td>Cryotherapy with liquid nitrogen&lt;br&gt; Cryoprobe not recommended in vagina because of risk of vaginal perforation/fistula formation. However, the experienced operator can use a bent cryoprobe with protective sleeve (to stop sticking to the vaginal wall); OR Trichloracetic acid.</td>
<td>Yes</td>
</tr>
<tr>
<td>Vaginal warts</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urethral meatal warts</td>
<td>Cryotherapy with cryoprobe (technically difficult with liquid nitrogen).&lt;br&gt; N.B. Risk of stenosis if overzealous treatment.&lt;br&gt; Note: Podophyllotoxin and imiquimod have been used, but limited data.</td>
<td>Yes&lt;br&gt; No</td>
</tr>
<tr>
<td>Anal warts</td>
<td>Cryotherapy. Special open-sided anoscopes and bent probes are available to permit treatment laterally; OR Surgical removal.</td>
<td>Yes</td>
</tr>
<tr>
<td>Oral</td>
<td>Cryotherapy; OR Surgical removal.</td>
<td>Yes</td>
</tr>
</tbody>
</table>
HrHPV

Genital HPV and Cancer

- HrHPV needs to be present for cancer of the cervix to develop but other factors may play a role.
- The presence of HrHPV increases the risk of developing cervical cancer.
- Women who have HrHPV need more frequent monitoring because of the increased risk.
- Most women with HrHPV will not develop cervical cancer and in many the HrHPV will resolve spontaneously.
- The presence of HrHPV increases the risk of developing pre-cancerous states – cervical intraepithelial neoplasia (CIN).
- HrHPV also plays a significant role in other lower genital tract pre-cancers and cancers: (Cervical 100%), vaginal 90%, anal 80%, penile 50%, vulval 40%, head and neck 26% (oral cavity and pharynx).

HPV Vaccines

- Gardasil vaccine is safe and highly effective in preventing the four important HPV types – 6, 11, 16 and 18.
  - HPV 16 and 18 are associated with cervical cancer and precursor lesions, as well as some other genital pre-cancers and cancers.
  - HPV 6 and 11 cause the majority of genital warts.
- HPV immunisation (with the quadrivalent vaccine Gardasil) is part of the National Immunisation Schedule for girls as a school-based programme in Year 8 (except in the Canterbury region).
  - Girls who are not vaccinated at school can receive Gardasil from their local medical clinic.
  - Gardasil is FREE for girls and young women up to their 20th birthday.
- Bivalent vaccine Cervarix is available, but not funded in New Zealand.
- Ideally, individuals should be vaccinated prior to sexual exposure.
- Gardasil induces a higher immune response when given between 9-15 years than in women aged 16-26 years.
- To date, protection has been demonstrated to be stable for up to 10 years (limited to the length of time the vaccine has been in use) and projections suggest the primary 3-dose course of Gardasil offers lifelong protection.
- The vaccine shows effectiveness even with a previous history of CIN or genital warts through its ability to prevent infection with other HPV serotypes.
- The vaccine is also indicated for males aged between 9-26 years, but is not funded. Currently a funding submission is being considered to have boys aged 12-14 years included as part of the National HPV Immunisation programme.

Clinical Presentation and Diagnosis

- Mostly latent and/or subclinical.
- Usually detected via cervical smear in women deemed at higher risk according to the guidelines of the national cervical screening programme.
- HrHPV molecular diagnostic techniques are not used for routine diagnostic purposes, but are used according to national guidelines in the triage and management of patients with abnormal cervical smears.
  

Management of HrHPV

- Goal – early detection and management of pre-cancer cell changes to prevent development of cervical cancer.
- Regular cervical screening and HPV testing as per the National Cervical Screening Programme (NCSP).
- Colposcopy/treatment of cervical cells affected by pre-cancerous changes.
- Treatment and follow-up as prescribed by the National Cervical Screening Programme.

The full NCSP Guidelines can be accessed on http://www.nsu.govt.nz/Health-Professionals/2747.aspx
Genital HPV – Key Information for Patients

- Genital HPV (Human Papilloma Virus) is a common virus that is carried by a large percentage of sexually active people.
- Genital HPV is highly infectious and is transmitted by skin-to-skin contact.
- There are different strains (types) of genital HPV – some cause visible genital warts and some are subclinical (invisible to the naked eye).
- Some subclinical HPV infections are due to High Risk HPV types and if these remain undetected and untreated may lead to pre-cancer changes and/or cancer of the lower genital tract.
- Genital warts are Low Risk HPV and are not associated with the development of cervical cancer.
- It is possible to be infected by more than one type of HPV.
- Developing a genital HPV infection whilst in a long-term monogamous relationship need not imply infidelity. It is possible that one or even both were exposed to the virus months or years previously and have carried it without their knowledge.
- Most genital warts disappear even if left untreated. Treatment is usually for cosmetic and comfort reasons.
- After successful treatment, genital warts may recur – this usually happens in about 1 in 3 people.
- Many people who have genital HPV have neither symptoms nor signs and will be unaware of they have the infection.
- Regular cervical screening is essential to ensure early detection and treatment of infected cells, to prevent the development of cervical cancer.
- HPV vaccine (Gardasil) immunises against four types of genital HPV: Types 16 and 18 which cause 70% of cervical cancers and types 6 and 11 which cause 90% of genital warts.
- Currently there are no tests available to detect whether clearance of HPV has occurred.
- Condoms have some use in the reduction of transmission of genital HPV.
- Genital HPV does not affect fertility.
- Genital HPV does not stop you having sex.
- Cervical cancer can be prevented by HPV vaccination and having regular smears.

Management of Sexually Transmitted Infections – Summary of Guidelines

Taken from:
NZSHS Best Practice Guidelines
2012
See: www.nzshs.org.nz/guidelines

These Best Practice Guides have been produced by NZSHS, and are adapted from the CBDHB Best Practice Guidelines.

Every effort has been taken to ensure that the information in these resources is correct at the time of publishing (July 2012).

Produced with funding by the Ministry of Health.

Further guideline information – www.nzshs.org or phone the local sexual health service.

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.
Recommended tests

**Females**
Symptoms or contact of STI requires speculum examination
- Endocervical swab for chlamydia.
- Endocervical culture swab for gonorrhoea.
- High vaginal swab for trichomoniasis/candida/BV.

Asymptomatic, opportunistic testing or declines speculum examination
- Self-collected vaginal swab for chlamydia.

Plus serology: HIV, syphilis, hepatitis B.

**Males**

Symptoms or contact of gonorrhoea
- Urethral swab for gonorrhoea culture.
- First catch urine for chlamydia (Note: after urethral swab).

Asymptomatic or opportunistic testing
- First catch urine for chlamydia.

Plus serology: HIV, syphilis, hepatitis B.

**Men who have sex with men**

As for male testing +/-
- Pharyngeal swab for gonorrhoea.
- Anorectal swab for gonorrhoea.
- Anorectal swab for chlamydia.

Plus serology: HIV, syphilis, hepatitis A and B.

**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.
Partner Notification – Management Summary

**Sexual history**
- Introduce concept of partner notification by asking about number of sexual contacts in past 2 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 is insufficient information or a threat of violence.)
- Document number of contacts clearly in the notes – you may not be the one following-up partner notification.

**Positive test result**
For chlamydia, gonorrhoea, trichomoniasis and syphilis, or contact of non-specific urethritis, pelvic inflammatory disease (PID) or epididymo-orchitis [partner notification (PN) not required for herpes simplex virus (HSV) and human papilloma virus (HPV)].
**Note:** Consultation with sexual health or infectious diseases physicians is required for the management of all cases of syphilis.

**Identify who needs to be contacted based on sexual history**
- How many of these people does the patient have contact details for?
- What contact details do they have for these people?

**Simple case**
- Safety or confidentiality issues?

**NO:** PATIENT REFERRAL
(Patient informs sexual contacts – recommended method.)

**YES:** PROVIDER REFERRAL
(Clinician informs sexual contacts with patient consent.)
**Note:** If violence is likely then may be better not to notify contacts.

**Discuss with client how they are going to notify contact(s)**
- Face-to-face (this is the most popular method)
- Telephone
- Text
- Partner notification card
- 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.
- Partner notification cards.
- Role play telling their partner 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.

**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](http://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.

Further guideline information – [www.nzshs.org](http://www.nzshs.org) or phone the local sexual health service.
This Best Practice Guide has been produced by NZSHS, and is adapted from the CMDHB Best Practice Guideline.
Every effort has been taken to ensure that the information in this guideline is correct at the time of publishing (July 2012).
Produced with funding by the Ministry of Health.
Partner Notification – Patient Information

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.

Why should we notify partners?
- It helps to stop the spread of STIs.
- To avoid getting an STI back again from an untreated sexual partner.
- The more times you get an STI, the higher the risk of getting serious problems in the future.
- 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 2 months (or as advised by your doctor or nurse).

When should I do this?
- As soon as possible after finding out that you have an STI.
- Before you have sex with an untreated partner(s).

How am I going to do this?
There are many ways of telling partners/sex contacts:
- Face-to-face.
- On the telephone.
- Text message.
- Give them a partner notification card (ask your doctor or nurse).
- Email.

Things to think about when deciding how best to tell your partner(s)
- How safe it is for you to tell your partner(s). If you have concerns, please discuss this with your doctor or nurse.
- What contact details you have for your sexual partner(s) / sex 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 partner(s) / sex contact(s).

Where can I go for help?
- GP/practice nurse.
- Local sexual health clinic.
- Website.
- 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 helps stop the spread of STIs.
- Many people don’t know they have an STI; notifying them can help them get treated.
- This can also stop you getting re-infected.
- Make sure the information that you pass on is correct. Health professionals can help you with this if you are unsure.

To download or print the patient information leaflet on partner notification, go to www.nzshs.org.nz/guidelines
Chlamydia – Management Summary

**TEST IF:**
- Sexually active under 25 years
  - OR more than 2 partners in last year
  - OR have had an STI in past 12 months
  - OR a sexual partner with an STI.
- At increased risk of complications of an STI, e.g. pre-termination of pregnancy (TOP) / intrauterine device (IUD) insertion.
- Has signs or symptoms suggestive of chlamydia:
  - **Females:** Vaginal discharge / dysuria / pelvic pain / intermenstrual bleeding (IMB) / post coital bleeding (PCB).
  - **Males:** Dysuria (urethritis) / urethral or anal discharge / testicular pain.
- Requests a sexual health check.

**RECOMMENDED TESTS**
- **Females:** A cervical swab if undertaking a speculum examination (symptoms or clinical scenario dictates).
  - Self-collected vaginal swab if asymptomatic, examination declined and no other tests required.
  - **Note:** A first catch urine has lower sensitivity in females than cervical or vaginal swabs.
- **Males:** A first catch urine (first 30ml of stream), preferably at least 1 hour after last passed urine, but if the patient is unlikely to come back then it is still worthwhile to obtain a sample at the time.
- **MSM:** An additional ano-rectal swab if receptive anal intercourse.

**TREATMENT**
- Azithromycin 1g stat – pregnancy category B1.
- OR doxycycline 100mg twice daily for 7 days *(NOT in pregnancy).*
- OR amoxicillin 500mg 3 times daily for 7 days – alternative in pregnancy.
- Advise to use condoms or abstain from sex for 7 days after initiation of treatment or until 7 days after all sexual contacts have been treated.

**PARTNER NOTIFICATION**
- Be clear about language: ‘partner’ implies relationship – all sexual contacts in the last 2 months should be advised so they can have a sexual health check and treatment.
- Contact(s) should have a sexual health check and if asymptomatic treat empirically for chlamydia with azithromycin 1g stat.
- Contacts should be treated without waiting for their test results; if positive, then refer to specific guideline.
- 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**
- By phone or in person, 1 week later.
- No unprotected sex in the week post treatment?
- Completed/tolerated medication?
- Notifiable contacts informed?
- Any risk of re-infection?
- Test of cure only needed if pregnant or if a second line treatment has been used.
- Diagnostic tests can detect traces of dead organisms – wait at least 5 weeks before retesting.
- Re-infection is very common; offer repeat sexual health check in 3 months.

*Further guideline information – [www.nzshs.org](http://www.nzshs.org) or phone the local sexual health service.*
*This Best Practice Guide has been produced by NZSHS, and is adapted from the CMDHB Best Practice Guideline.*
*Every effort has been taken to ensure that the information in this guideline is correct at the time of publishing (July 2012).*
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. It is very common in people aged less than 25.

How do I know if I have chlamydia?
Many people don’t notice any symptoms. If they do, symptoms could be:

Females
• Sometimes there can be pain when urinating or low tummy pain, especially during sex.
• There can be unusual bleeding between periods or bleeding after sex.
• Sometimes chlamydia can cause an unusual discharge or bleeding from the anus if there has been anal sex.

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

How does someone get chlamydia?
By having sex or sexual contact with another person who has chlamydia. The other person may not know they have the infection. Types of sexual contact include vaginal and anal sex, and sometimes oral sex, sharing sex toys, or sex play. If you use condoms every time you have a 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 get checked for chlamydia?
You need to see your doctor or nurse or sexual health clinic for a check-up. Take along someone you trust if you want, for support.

• Females will need a swab from the vagina. If you don’t have any symptoms you may be able to do the swab yourself.
  If you have symptoms you will need to be examined by a doctor or nurse in case there are other things causing your symptoms.
• Males need a urine test.
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 2 months to get tested and treated for chlamydia.
• You should use condoms or avoid sex for 7 days after you have been treated, so you don’t pass the infection on to someone else.
• You will also need to use condoms or avoid sex for 7 days after your partner(s) have been treated or you may get chlamydia back again.
• We recommend you have another sexual health check in 3 months in case you get chlamydia again.

To download or print the patient information leaflet on chlamydia, go to www.nzshs.org.nz/guidelines
Gonorrhoea – Management Summary

TEST IF:
- Has signs or symptoms of gonorrhoea, e.g. urethritis in males.
- A sexual contact of gonorrhoea.
- Routine sexual health check in asymptomatic women.
- Antenatal screening for STIs.
- Pre-termination of pregnancy (TOP) or pre-intrauterine device (IUD) insertion.
- Suspected pelvic inflammatory disease (PID).
- Suspected epididymo-orchitis.

RECOMMENDED TESTS
- **Female**: A cervical swab if undertaking a speculum examination (culture/NAAT) or a self-taken vaginal swab if asymptomatic (or examination declined) and no other tests required (NAAT testing only).
- **Male**: Take urethral swab with smallest possible swab, e.g. pernasal (for culture).
- **Both sexes**: Anorectal or pharyngeal swab if indicated.

Treat immediately if high index of suspicion e.g. symptoms and/or signs, or contact of gonorrhoea.
- Start treatment for patient and sexual partner(s) without waiting for lab results.

MANAGEMENT
- **If antimicrobial susceptibilities not available** or Ciprofloxacin resistant or pregnant or breastfeeding:
  - Ceftriaxone 500mg im stat (make up with 2ml lignocaine 1% or as per data sheet) PLUS azithromycin 1g stat (both drugs category B1).
- **If isolate is Ciprofloxacin sensitive**:
  - Ciprofloxacin 500mg po stat PLUS azithromycin 1g stat.
  - If clinical PID, treat as per PID guideline.
  - Refer to full guideline if case has drug allergies.
  - Advise to abstain from sex until abdominal pain has settled and to abstain or use condoms until 7 days after all sexual contacts have been treated.

PARTNER NOTIFICATION
- Be clear about language: ‘partner’ implies relationship – all sexual contacts in the last 2 months should be advised so they can be tested and treated.
- Contact(s) should have a sexual health check and if asymptomatic treat empirically for gonorrhoea with ceftriaxone 500mg im stat (make up with 2ml lignocaine 1% or as per data sheet).
- Contacts should be treated without waiting for their test results; if positive, refer to specific guideline.
- 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 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.
- Test of cure is only needed if symptoms don’t resolve. Re-test by culture in 3 days.
- Re-infection is very common; offer repeat sexual health check in 3 months.

Further guideline information – [www.nzshs.org](http://www.nzshs.org) or phone the local sexual health service.
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Produced with funding by the Ministry of Health.
Gonorrhoea – Patient Information

What is gonorrhoea?
Gonorrhoea is an STI (a sexually transmitted infection) that is very common in people aged less than 25 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 do I know if I have gonorrhoea?

Symptoms
Females
• Women often have no symptoms.
• Sometimes there might be a discharge or fluid leaking from the vagina.
• Sometimes there may be pain when passing urine, bleeding between periods, or tummy pain.
• Sometimes there can be discharge or bleeding from the anus if a person has had anal sex.

Males
• Men are more likely to have symptoms.
• There can be discharge or fluid leaking from the penis.
• Or pain when passing urine.
• Sometimes there may be pain or swelling in the testicles.
• Sometimes there can be discharge or bleeding from the anus if a person has had anal sex.

How does someone get gonorrhoea?
• You get gonorrhoea by having sex or sexual contact with another person with gonorrhoea.
• This includes oral, vaginal or anal sex and sex play.
• 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.

How do I get tested?
You need to see your doctor, nurse or sexual health clinic for a check-up.
• Females will need a swab test from the vagina.
• Males will need a swab test from the urethra (opening in the penis).

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 by the doctor or nurse, even if you feel better.
• You should use a condom for 7 days after treatment, so you don’t pass the infection onto someone else.
• You need to tell anyone you have had sex with in the last 2 months to get tested and treated for gonorrhoea.
• Also use a condom when you have sex with your partner(s) until 7 days after they have been treated, or you may get gonorrhoea again.
• We recommend you have another sexual health check in 3 months in case you get gonorrhoea again.

Important information
• Gonorrhoea is a common 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 and a swab.
• You need to tell anyone you have had sex with within the last 2 months to get tested and treated for gonorrhoea.
• You should use condoms or avoid sex for 7 days after you and your partner(s) have been treated so you don’t pass the infection on to someone else.

To download or print the patient information leaflet on gonorrhoea, go to www.nzshs.org.nz/guidelines
Epididymo-orchitis – Management Summary

**EXCLUDE TORSION**

Take history – age, sexual history, previous catheterisation or urine tract infection (UTI)?
Examination – urethral discharge?
Tests – urethral swab for gonorrhoea culture, first catch urine for chlamydia and gonorrhoea testing, AND mid-stream urine (MSU) for urinary pathogens.

**STI-associated epididymo-orchitis more likely if**
- < 35 years
- > 1 partner in past 12 months
- Urethral discharge present

**Management**
- Ceftriaxone 500mg im stat (make up with 2ml lignocaine 1% or as per data sheet) **plus**
  doxycycline 100mg twice daily for 14 days
- Advise to use condoms or abstain from sex for 7 days after initiation of treatment or until 7 days after all sexual contacts have been treated
- Bed rest, scrotal support, analgesia

**Follow-up**
- Symptoms should be improving after 3 days
- Further review at 1 week
- Check laboratory results

**Symptoms and signs resolved/significantly improved**
- Check compliance with treatment
- Check sexual abstinence
- Ensure partner notification complete

Discharge once symptoms and signs fully resolved

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

**MSU positive**
- Renal tract ultra-sound scan (USS)
- Referral to urology

**Partner notification**
If STI cause suspected:
- Be clear about language; ‘partner’ implies relationship – all sexual contacts in the last 2 months should be advised so they can have a sexual health check and treatment.
- Contact(s) should have a sexual health check and if asymptomatic treat empirically for chlamydia with azithromycin 1g stat.
  - If gonorrhoea suspected in index case, add ceftriaxone 500mg im.
- Contacts should be treated without waiting for their test results; if positive, then refer to specific guideline.
- 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.

**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

Further guideline information – [www.nzshs.org](http://www.nzshs.org) or phone the local sexual health service.
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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 2 months to get tested and treated for STIs.
- Use a condom when you have sex with your partner(s) until 7 days after they have been treated, or you may 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.
- It is important to get your partner(s) tested and treated as well.

To download or print the patient information leaflet on epididymo-orchitis, go to www.nzshs.org.nz/guidelines
Discrete lumps or bumps in the genital region may be due to normal anatomical findings, or may be due to a small number of sexually transmissible infections. Unusual lesions should be referred for a specialist opinion before any treatment occurs.

Patient complains of **genital skin lump(s) / bump(s)**

**Examination**
Note the appearance and location of lesions – together with the history, this is usually sufficient to make a diagnosis.

### Normal anatomical variants

**Males**
- Pearly penile papules (coronal papillae), Fordyce glands.

**Females**
- Vestibular papillomatosis, Fordyce glands

### Genital warts
Exophytic skin lesions that typically vary in size/shape and number.

**Males**
- Typically at leading edge of prepuce, on frenulum, or more sporadically in coronal sulcus, on penile shaft. Less frequently on scrotum or in pubic area. May occasionally be perianal.

**Females**
- Usually vulval (often posteriorly), perineal, or perianal.
**Note:** Fleshy lesions resembling warts and arising in warm moist mucosal sites (e.g. inner labial, anal) – **exclude syphilis** *(Condylomata lata).*

### Molluscum contagiosum
- Lesions that are dome shaped, waxy colour, and with central umbilication. Usually small. If large they can assume a more nodular appearance.
- Typically pubic, penile, or vulval location.

### Scabies nodules
- History of recent/current scabies.
- ‘Nodular’ lesions more common in males. Usual location: glans penis, or possibly scrotum.
- Typically: 2-10 mm reddish papulonodular lesions; very itchy.

### Treatment
- **Reassure** patient that normal.
- **If unsure** of findings, get a second opinion.

### Treatment
- Pigmented or atypical lesions – refer to sexual health specialist.

### Treatment
- **Will resolve without** treatment, but may take many months.
- **Treat** with cryotherapy.
- **Genital Molluscum contagiosum** can be acquired from or spread to sexual partners.

### Treatment
- **Check** syphilis serology.
- **Treat** patient with permethrin 5% lotion (unless contraindicated).
- Nodules are slow to resolve – use topical corticosteroid to control itch.
- Refer to sexual health specialist if unsure of diagnosis or lesion non-responsive to topical treatment.
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 and are typified by an overseas sexual contact in an endemic region or 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
• Multiple vesicles; or tender, shallow ulcerations; +/- inguinal adenopathy?

YES

Tests
• Viral swab for HSV test (rub base of lesion firmly to obtain adequate sample).
• Syphilis serology should be routinely done in men who have sex with men.

Treatment
• Aciclovir 400mg 3 times daily for 7 days
• +/- lignocaine gel
• +/- salt baths

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.

Follow-up
• Check HSV result and check for resolution of ulcers.
• If result positive, discuss diagnosis with patient.
• Partner notification is not necessary.
• Offer full sexual health check (including syphilis serology) if not already done.
• If result negative and the lesions have resolved, then arrange to repeat the HSV test promptly if problem recurs.
• If result negative and the lesions have not resolved, refer to or discuss with a sexual health specialist.

Further guideline information – www.nzshs.org or phone the local sexual health service.
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Pelvic Inflammatory Disease (PID) – Management Summary

TEST IF:
- Woman at risk of STIs presents with lower abdominal or pelvic pain.

RECOMMENDED TESTS
- High vaginal swab for bacterial vaginosis and trichomoniasis.
- Bimanual examination.
- Urine pregnancy test and urinalysis dipstick.
- Serology for HIV and syphilis.
- Full blood count (FBC) and C-reactive protein (CRP) (for severe cases or diagnostic uncertainty).
- Vital signs: Temperature, pulse, blood pressure.

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

MANAGEMENT
- Ceftriaxone 500mg im stat (make up with 2ml lignocaine 1% or as per data sheet) PLUS
- Doxycycline 100mg twice daily for 2 weeks PLUS
- Metronidazole 400mg twice daily for 2 weeks.
  (Metronidazole may be discontinued at review if not tolerated.)
- Advise treatment may take time to work.
- Advise to abstain from sex until abdominal pain has settled and to use condoms until 7 days after all sexual contacts have been treated.

REFER IF
- Pregnant
- Severe PID
- Severe drug allergies

PARTNER NOTIFICATION
- Be clear about language: ‘partner’ implies relationship – all sexual contacts in the last 2 months should be advised so they can have a sexual health check and treatment.
- Contact(s) should have a sexual health check and if asymptomatic treat empirically for chlamydia with azithromycin 1g stat.
- If sexual contact(s) has symptoms of urethritis, manage as per urethritis guideline [www.nzshs.org/guidelines/Urethritis-in-Men-guideline.pdf].
- Contacts should be treated without waiting for their test results; if positive, then refer to specific guideline.
- 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 STI check in 3-6 months.
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 (womb neck). The most common cause is sexually transmitted infections (STIs) such as chlamydia or gonorrhea. Sometimes PID can occur after pelvic operations, a pregnancy, or in the first few weeks after an IUD is put in.

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

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 checked for it?
It’s important to have a sexual health check if you have symptoms of PID.

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.

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 your tablets, even if you feel better and the tests are all fine.
• You need to tell anyone you have had sex with in the last 2 months to get a sexual health check and treatment.
• All partners from the last 2 months need treatment, even if their tests are negative.
• Use condoms or avoid sex for 7 days after your partner(s) have been treated or you may get PID back again.
• Return to see your doctor if you are asked to, but also have a repeat sexual health check in 3 months to make sure everything is okay.
• The complications of PID get worse if you get it again, so preventing it is important.
• You can prevent PID by using a condom every time you have sex, especially when you have sex with a new partner.

To download or print the patient information leaflet on PID, go to www.nzshs.org.nz/guidelines
### Syphilis – Management Summary

**TEST IF:**
- MSM (at least annually).
- HIV positive (at least annually).
- Routine antenatal screen.
- Routine immigration screen.
- A sexual contact of a person with syphilis.
- Routine sexual health check.

**Signs or symptoms of infectious syphilis:**
- Genital ulcers (refer to Genital Ulcer Disease Summary).
- 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.

<table>
<thead>
<tr>
<th>RECOMMENDED TESTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Syphilis serology – if clinical suspicion of infectious syphilis specify on laboratory form.</td>
</tr>
<tr>
<td>HIV and hepatitis B serology.</td>
</tr>
<tr>
<td>Routine STI swabs (see sexual health check guideline).</td>
</tr>
<tr>
<td>In MSM also request hepatitis A serology.</td>
</tr>
<tr>
<td>In persons with a history of IDU, incarceration, or who have received blood products, request hepatitis C serology.</td>
</tr>
</tbody>
</table>

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
- Referral or discussion with a sexual health specialist or service is strongly recommended.
- 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.

It is imperative that any intramuscular penicillin formulation used should be long-acting Bicillin LA (benzathine penicillin G) 1.8g, as short-acting formulations provide insufficient treatment duration.

### PARTNER NOTIFICATION AND MANAGEMENT OF SEXUAL PARTNERS
- 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:** 90 days plus empirical treatment for syphilis is recommended, as serology may be negative.
- **Secondary syphilis:** 6 months.
- **Early latent syphilis and syphilis of unknown duration where RPR ≥ 1:32:** 12 months.
- **Late latent syphilis, syphilis of unknown duration with low RPR and tertiary syphilis**
  - Serologic evaluation of current or last sexual partner 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.

Further guideline information – [www.nzshs.org](http://www.nzshs.org) or phone the local sexual health service.  
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Syphilis – Patient Information

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 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 partners.

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 usually 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 partners.

How do I get tested for syphilis?
You need to see your doctor or nurse or sexual health clinic for a check-up. Take along someone you trust if you want, 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.

Important advice
• You must finish all the treatment to be cured.
• If you have syphilis you will need to tell sexual partners to get tested and treated.
• The doctor or nurse will tell you how far back to notify partners – 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.

To download or print the patient information leaflet on syphilis, go to www.nzshs.org.nz/guidelines
**Trichomoniasis – Management Summary**

**TEST IF:**
- Woman with vaginal discharge or vulval irritation.
- Woman requesting full sexual health check.

**RECOMMENDED TESTS**
- Female: High vaginal swab.
- Male contacts: Sexual health check and treat empirically (no reliable tests available for trichomoniasis).

**MANAGEMENT**
- Metronidazole 2g stat (pregnancy category B2) OR
- Ornidazole 1.5g stat (not recommended in pregnancy) OR
- Metronidazole 400mg twice daily for 7 days if GI intolerance to stat dose.
- Refer full guideline if breastfeeding.
- Advise to use condoms or abstain from sex for 7 days after initiation of treatment or until 7 days after all sexual contacts have been treated.

**PARTNER NOTIFICATION**
- Be clear about language: ‘partner’ implies relationship – all sexual contacts in the last 2 months should be advised so they can be treated.
- Male contacts should be treated empirically without testing for trichomoniasis.
- 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? If yes – re-treat.
- Test of cure only needed if symptoms don’t resolve (females).
- Refer suspected treatment failures to specialist sexual health clinic.

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Further guideline information – [www.nzshs.org](http://www.nzshs.org) or phone the local sexual health service.
This Best Practice Guide has been produced by NZSHS, and is adapted from the CMDHB Best Practice Guideline.
Every effort has been taken to ensure that the information in this guideline is correct at the time of publishing (July 2012).
Produced with funding by the Ministry of Health.
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 I have trichomoniasis?
Symptoms may develop after sexual contact with someone else with the infection. Symptoms include:

Females
- Sometimes you may notice a discharge or fluid leaking from the vagina.
- There is sometimes 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.
- Women will need a swab test from the vagina.
- Trichomoniasis is difficult to test for in men, so men are usually just treated if they have had sex with someone with trichomoniasis.
- 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
- You should use a condom for 7 days after treatment, so you don’t pass the infection on to someone else.
- You need to tell everyone you have had sex with in the last 2 months to get treated for trichomoniasis and have a sexual health check.
- Don’t have unprotected sex with your partner(s) until 7 days after they have been treated, or you may get trichomoniasis 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 2 months to get tested and treated.
- You should use condoms or avoid sex for 7 days after you have been treated, so you don’t pass the infection on to someone else.

To download or print the patient information leaflet on trichomoniasis, go to www.nzshs.org.nz/guidelines
Urethritis in Men – Management Summary

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

Recommended tests
• First catch urine (first 30ml of stream) for chlamydia.
• Urethral swab for gonorrhoea.

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) PLUS azithromycin 1g stat

NO
Treat for non-gonococcal urethritis with:
• Azithromycin 1g stat OR
• Doxycycline 100mg twice daily for 7 days

Follow-up and partner notification:
• All sexual contacts in last 2 months should be advised so they can have a sexual health check and treatment.
• Advise to use condoms or abstain from sex for 7 days after initiation of treatment or until 7 days after all sexual contacts have been treated.
• Follow-up by phone or in person 1 week later.
• Check results.
• If gonorrhoea positive and untreated – treat accordingly with ceftriaxone or ciprofloxacin if isolate susceptible.
• RE-TREAT if any re-exposure from unprotected sex with untreated partner.
• Offer repeat sexual health checks in 3 months to all patients.
• If ≥ 2 weeks after treatment the patient complains of persistent or recurrent urethral symptoms: consult with a sexual health specialist.

Further guideline information – www.nzshs.org or phone the local sexual health service.
This Best Practice Guide has been produced by NZSHS, and is adapted from the CMDHB Best Practice Guideline.
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Produced with funding by the Ministry of Health.
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. You will need a swab test from the urethra and will need to do a urine test.
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, even if you feel better.
• You should use condoms for 7 days after treatment, so you don’t pass the infection onto someone else.
• You need to tell anyone you have had sex with in the last 2 months to get a sexual health check and treatment. Use a condom if you have sex with your partner(s) until 7 days after they have been treated, or you may get urethritis back again.
• We recommend you have another sexual health check in 3 months, just to make sure you are all clear.

To download or print the patient information leaflet on urethritis in men, go to www.nzshs.org.nz/guidelines
Vaginal discharge can arise from either the vagina and/or the cervix. It is therefore important to **visualise** the cervix.

Patient complains of **vaginal discharge +/- itching / soreness / malodour.**
**Note:** Also ask about abnormal bleeding / pelvic discomfort / dyspareunia.
Consider possibility of **retained tampons / foreign body.**

**Recommended tests**
- Endo-cervical swab for chlamydia.
- Endo-cervical swab for gonorrhoea.
- High vaginal swab for candida, bacterial vaginosis and trichomoniasis.

**Examination findings**
- Cervicitis – mucopurulent discharge on cervix or easily induced bleeding.
- Bimanual if c/o pelvic pain (see **PID guideline**).
- Abnormal cervix: Refer for colposcopy.

**Treatment**
- Presumptive **chlamydia +/- gonorrhoea.**
- Azithromycin 1g stat plus specific treatment for gonorrhoea if a contact of gonorrhoea (see **gonorrhoea guideline**).

**Follow-up**
- Check results and resolution of symptoms.
- If positive results for chlamydia, gonorrhoea or trichomoniasis – ensure appropriate treatment and partner notification.
- If negative results and symptoms persist – consult with a sexual health specialist.
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**Youth Consultation**
Auckland Peer Sexuality Support Program Students – for feedback on the Patient Information sheets

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