Aotearoa New Zealand STI Management Guidelines for Use in Primary Care

Gonorrhoea

Cause

- Gonorrhoea is a sexually transmitted infection (STI) caused by *Neisseria gonorrhoeae*

Overview

- Infects endocervix, urethra, rectum, pharynx and conjunctivae
- Reduced susceptibility to first-line treatment is emerging globally and is being monitored closely
- **Transmission** is through direct inoculation onto mucosal surfaces via:
    - Sexual contact (oral, vaginal or anal), particularly when saliva is used as a lubricant
    - Sexual practices such as fingering, or sharing of sex toys
    - From mother to baby at vaginal delivery (e.g. neonatal conjunctivitis)
- **Gonorrhoea is most commonly diagnosed in**
    - Young sexually active adults aged under 30 years
    - Sexual contacts of people with gonorrhoea
    - People who have multiple sexual contacts
    - People who have not consistently used condoms
    - Men who have sex with men (MSM)
    - Māori and Pacific Peoples
- Gonorrhoea is a notifiable infection

Clinical presentation

Site of infection	Signs and symptoms
Urethra	Approximately 90% of penile urethral infection is symptomatic Urethral discharge (penile urethra) Dysuria
Cervix	Up to 80% asymptomatic Vaginal discharge Dyspareunia Postcoital bleeding Intermenstrual bleeding
Anorectum	Usually asymptomatic Rectal discharge, irritation, painful defecation, disturbed bowel function
Pharynx	Usually asymptomatic
Eyes	Conjunctivitis – may be sight threatening
Complications	
Pelvic inflammatory disease (PID), subfertility, ectopic pregnancy, chronic pelvic pain Adverse pregnancy outcomes e.g. chorio-amnionitis, premature rupture of membranes, neonatal conjunctivitis Disseminated disease (rare) manifested by arthritis, skin lesions, endocarditis, meningitis Epididymitis or epididymo-orchitis Prostatitis (very rarely)	

Indications for testing

- Patients with possible signs or symptoms of gonorrhoea infection
- Sexual contacts of people with gonorrhoea or other STIs
- Before termination of pregnancy
- Before intrauterine device (IUD) insertion in people at risk of STIs
- Suspected epididymo-orchitis
- Suspected PID
- Sexually active patients aged under 30 years opportunistically when accessing health care
- Men who have sex with men (MSM)
- History of sexual assault or intimate partner violence
- If the patient requests a sexual health check

Note: If patient is asymptomatic and is concerned about a specific recent sexual event the recommended testing interval is 2 weeks from time of last unprotected sexual intercourse

If the patient is unlikely to return and has not been previously tested, then test opportunistically at the time of presentation and offer a re-test after the appropriate window period

Beware of false positive results in low prevalence populations – discuss with microbiologist or sexual health physician if unexpected positive result

Recommended tests
Symptomatic people should be examined

Testing for gonorrhoea should occur as part of a complete sexual health check

Management

- Reduced susceptibility to the first-line treatment of ceftriaxone and azithromycin is emerging globally, however is currently rare in Aotearoa New Zealand
- Dual antibiotic treatment is recommended to create a pharmacological barrier to the development of more widespread resistance to treatment

Treatment options

Infection	Recommendation	Alternative Treatment
Uncomplicated genital, pharyngeal or anorectal infection Adult gonococcal conjunctivitis	Ceftriaxone 500 mg in 2 mL 1% lignocaine, intramuscular injection, as a single dose PLUS Azithromycin 1 g orally, as a single dose	Alternative treatments are not recommended because of high levels of resistance, EXCEPT for severe allergic reactions Seek specialist advice

Special situations

Situation	Recommendation

Pregnancy	Ceftriaxone 500 mg in 2 mL 1% lignocaine, intramuscular injection, as a single dose PLUS Azithromycin 1 g orally, as a single dose Test of cure recommended 4 weeks after treatment completed Rescreen in 3rd trimester
Allergy or contraindications	If allergy or contraindication to azithromycin: Ceftriaxone 1 g in 3.5 mL 1% lignocaine, intramuscular injection, as a single dose Seek specialist advice if allergy to ceftriaxone
Co-infection with chlamydia	Ceftriaxone 1 g in 3.5 mL 1% lignocaine, intramuscular injection, as a single dose PLUS Doxycycline 100 mg orally twice daily for 7 days **Seek specialist advice if rectal co-infection and symptomatic, or refer to anorectal syndromes guideline**

- **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**
- **Gonorrhoea is a notifiable infection**
- If a patient has an IUD, leave it in place and treat as recommended. Seek specialist advice as needed
- Seek specialist advice if symptomatic anorectal infection, as further testing and extended treatment may be required
- Consider HIV pre-exposure prophylaxis (PrEP) if rectal gonorrhoea is diagnosed in a male or transgender person who has anal sex with men

Partner notification and management of sexual contacts

- 20-50% risk of transmission per act of unprotected intercourse
- Contact tracing is important to prevent re-infection and reduce transmission
- All sexual contacts in the last 3 months should be notified
- Most patients choose to tell contacts themselves; giving written information can be helpful
- Notifying all contacts may not be possible e.g. if there is insufficient

information or a threat of violence

Management of sexual contacts

- Where the last sexual contact with the index case was within the past 2 weeks, or the contact is symptomatic, or unlikely to return for treatment, perform a full sexual health check, and treat for gonorrhoea without waiting for test results
- Where the last sexual contact with the index case was over 2 weeks previously, and the contact is asymptomatic and likely to return for treatment, it would be reasonable to wait for test results, and treat only if positive
- Advise contacts to abstain from sex or use condoms until results are available, and for 1 week from the start of treatment
- If contacts test positive for an STI refer to specific guideline

Follow up

Review in **1 week** (in person or by phone): • Discuss test results • Check symptoms (if any) have resolved • Ask if any condomless sex in the week post-treatment • Check medication was completed and tolerated • Ensure notifiable contacts have been informed • Check if any risk of re-infection. Retreatment is necessary if re-exposed to an untreated contact
Test of cure Not routinely recommended, unless in the following situations: • Pregnancy • Pharyngeal gonorrhoea Test of cure by nucleic acid amplification test (NAAT) should be performed at least **4 weeks** after treatment is completed.
Retesting: • Re-infection is common • Retesting at **3 months** is recommended, to detect re-infection Consider testing for other STIs, if not undertaken at first presentation, or retesting after the window period

Indications for specialist referral

Referral to or discussion with a sexual health specialist is recommended

for:

- Suspected antibiotic resistance, e.g. persisting symptoms after correct management
- Screening and treatment of sexual contacts if clinician wishes
- Allergy or contraindication to standard treatment options
- Patients with anorectal symptoms that may be STI related
- Complicated clinical situations for further management

Auditable outcomes

- 100% of patients diagnosed with gonorrhoea are treated with an appropriate antibiotic regimen
- 100% of patients who test positive for gonorrhoea are notified to the Institute of Environmental Science and Research (ESR) New Zealand
- 100% of patient diagnosed with gonorrhoea have a recall for repeat testing in 3 months

Useful patient resources

Just the facts

Healthy Sex

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

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