

# 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

<b>Site of infection</b>	<b>Signs and symptoms</b>
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
<b>Complications</b>	
<p><u>Pelvic inflammatory disease (PID)</u>, subfertility, ectopic pregnancy, chronic pelvic pain Adverse pregnancy outcomes e.g. chorio-amnionitis, premature rupture of membranes, neonatal conjunctivitis</p> <p>Disseminated disease (rare) manifested by arthritis, skin lesions, endocarditis, meningitis <u>Epididymitis or epididymo-orchitis</u> Prostatitis (very rarely)</p>	

### **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**

<b>Infection</b>	<b>Recommendation</b>	<b>Alternative Treatment</b>
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**

<b>Situation</b>	<b>Recommendation</b>
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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 3 <sup>rd</sup> 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 <b>Seek specialist advice if rectal co-infection and symptomatic, or refer to <u>anorectal syndromes guideline</u></b>

- **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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