Aotearoa New Zealand STI Management Guidelines for Use in Primary Care

Trichomoniasis

Overview

- Infects vagina, urethra and para-urethral glands
- Co-infection with other STIs is common
- 60-80% of trichomoniasis cases have co-existent bacterial vaginosis
- **Transmission can occur between men and women and between women in same sex relationships** through:
    - Sexual contact with infected genital secretions
    - Sexual practices such as fingering which allow inoculation of infected secretions onto mucous membranes
    - From mother to baby at vaginal delivery (usually no adverse consequences)
    - Fomite transmission has been documented but is rare
- **Trichomoniasis is most commonly diagnosed in**
    - Women who test positive for other STIs
    - Māori and Pacific women
    - Women experiencing social deprivation
    - Women with a history of incarceration
- Trichomoniasis is less commonly diagnosed in males; tests are less sensitive, infection is usually asymptomatic, and of shorter duration

Clinical presentation

Site of infection	Signs and symptoms
Urethra	Usually asymptomatic Dysuria (uncommon) Urethral discharge (uncommon)
Vagina	May be asymptomatic Malodourous vaginal discharge - typically profuse and frothy Vulval itch or soreness Signs include vulval rash, vaginal and cervical inflammation Some women may have punctate haemorrhages on the vaginal walls and cervix (strawberry cervix)
Complications	
Adverse pregnancy outcomes including low birth weight, premature rupture of membranes and pre-term delivery. It is unclear whether treatment of asymptomatic infection in pregnancy reduces the risk of these outcomes. Rarely prostatitis	

Indications for testing

- Asymptomatic men do not need testing unless identified as a sexual contact of trichomoniasis
- Symptoms of vaginal discharge, odour, vulval irritation, dysuria or dyspareunia
- Symptoms or signs of vulvitis (vulval rash) or vaginitis
- Sexual contacts of trichomoniasis
- Women who test positive for other STIs
- Men with persistent urethritis who have not responded to standard empirical treatment for non-gonococcal urethritis
- Māori and Pacific women, as part of a sexual health check
- Women experiencing social deprivation, as part of a sexual health check
- Women with a history of incarceration

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

Recommended tests
Testing for trichomoniasis should occur as part of a complete sexual health check

- Nucleic acid amplification tests (NAAT) for *T.vaginalis* are the gold standard test for the diagnosis of trichomoniasis (vaginal swab for women, first void urine for men)
- Some laboratories in Aotearoa New Zealand do not offer NAAT for T.vaginalis. Non-molecular tests for trichomonas, such as wet microscopy and culture, have lower sensitivity
- Be familiar with the *T.vaginalis* test offered by your local laboratory

Management

- Trichomonas type organisms are sometimes reported on cervical cytology specimens but due to lack of specificity, these results must be confirmed by specific NAAT testing or culture as per your local laboratory before initiating treatment

Treatment options

Infection	Recommendation	Alternative Treatment
Uncomplicated infection	Metronidazole 400 mg orally with food, twice daily for 7 days OR Ornidazole 500 mg orally, twice daily for 5 days (not in pregnancy) Offer single-dose therapy if adherence is an issue	Metronidazole 2 g orally with food, as a single dose OR Ornidazole 1.5 g orally, as a single dose (not in pregnancy)

- Any nitroimidazole drug given as a single dose or over 7 days results in parasitological cure in 90% of cases. Single-dose therapy increases side-effects and is less effective, but improves adherence
- Ornidazole may be better tolerated than metronidazole but should NOT be used if pregnant or breastfeeding

Special Situations

Situation	Recommendation
Breastfeeding	• Metronidazole 400 mg orally, twice daily for 7 days • Breast milk during that time may have an altered taste Alternative regimen: • Metronidazole 2 g orally, as a single dose, and avoid breastfeeding for 24 hours following dose
Pregnancy	Metronidazole 400 mg orally, twice daily for 7 days (pregnancy category B2)
Allergy or contraindications	• Seek specialist advice • May require referral to immunology for desensitisation
Treatment failure	• Most treatment failure is due to sex with an untreated partner or non-adherence to treatment, however resistance or reduced susceptibility to metronidazole can occur in approximately 4-10% of cases • If treatment failure occurs without evidence of non-adherence or re-infection, try a repeat course for 1 week (40% respond to a repeat course of standard treatment) • All cases that have failed to respond to 2 full courses of metronidazole for 7 days should be referred to or discussed with a sexual health specialist for further management

- **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**
- If a patient has an intrauterine device (IUD), leave it in place and treat as recommended. Seek specialist advice as needed

Partner notification and management of sexual contacts

- 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

• Contacts should have a full sexual health check, and should be treated for trichomoniasis without waiting for test results
• 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
• Patient-delivered partner therapy is not legal in Aotearoa New Zealand

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 (TOC):
• Not routinely recommended, unless symptoms persist • Test of cure by nucleic acid amplification test (NAAT) in this situation should be performed **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:

- Screening and treatment of sexual contacts if clinician wishes
- Allergy to standard treatment options
- Suspected antibiotic resistance
- Males with recurrent or persisting urethritis that has not responded to empirical treatment
- Complicated clinical situations for further management

Auditable outcomes

- 100% of patients diagnosed with trichomoniasis are treated with an appropriate antibiotic regimen

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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