Aotearoa New Zealand STI Management Guidelines for Use in Primary Care

Sexual health check

Overview

A sexual health check involves taking a sexual history, and offering appropriate testing. A sexual history should include routine enquiry about intimate partner violence and sexual harm

Indications for testing

- Patient with possible signs or symptoms of a sexually transmitted infection (STI)
- Sexual contacts of people with STIs
- Pregnancy
- Before termination of pregnancy
- Before intrauterine device (IUD) insertion in persons with a risk for STIs
- In persons with a recent change in sexual contact, or multiple sexual contacts
- Sexually active patients aged under 30 years opportunistically when accessing health care
- Men who have sex with men (MSM)
- After a non-consenting sexual encounter
- At patient's request

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 for chlamydia**

and gonorrhoea testing, and 3 months for HIV and syphilis testing. If high risk exposure for HIV, an additional HIV test can be carried out at 6 weeks

- 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 periods

Recommended tests

Female (cisgender)

• Offer examination, including speculum, however self-collected swabs may be appropriate if asymptomatic • Examination is recommended if symptomatic with vaginal discharge, dysuria, lower abdominal pain, abnormal bleeding, anal pain or discharge, or a contact of gonorrhoea • Examine abdomen, inguinal lymph nodes, vulval and perianal skin, vestibule and introitus • Speculum examination of vagina and cervix	
Test	**Considerations**
Vulvovaginal NAAT swab for chlamydia, gonorrhoea +/- trichomoniasis	If examined, vaginal swab should be taken before speculum insertion Test for trichomonas in those who are symptomatic or at higher risk*
HIV and syphilis serology	
Consider:	
Endocervical culture swab for gonorrhoea (if available)	If suspected pelvic inflammatory disease (PID), profuse cervical discharge or a contact of gonorrhoea
Anorectal NAAT swab for chlamydia and gonorrhoea	If history of anal sex
High vaginal culture swab for candida and bacterial vaginosis (and trichomoniasis if NAAT not available)	Only if symptomatic Clinical details must be included on laboratory form
Herpes PCR swab	If genital ulceration
Hepatitis B serology	If hepatitis B immune status unknown, and risk factors present

Hepatitis C serology	If risk factors present, e.g. injecting drug use Repeat annually if risk factors present If history of treated hepatitis C, and ongoing risk, hepatitis C virus RNA should be requested instead of hepatitis C antibody

NAAT – nucleic acid amplification test

PCR – polymerase chain reaction

*Māori and Pacific women, social deprivation, history of incarceration, contact of trichomoniasis

Note: A first-void urine is not the specimen of choice as it has lower sensitivity than vaginal swabs, but may be useful if the patient declines a vaginal swab.

Men who have sex with women (cisgender)

• Offer examination • Examination is required if symptomatic with urethral discharge, dysuria, testicular pain or swelling, anal pain or discharge, or a contact of gonorrhoea • Examine inguinal lymph nodes, genital and perianal skin, penis, scrotum and testes	
Test	**Considerations**
First-pass urine for chlamydia and gonorrhoea	First 20-30 mL urine, preferably >1 hour after last void
HIV and syphilis serology	
Consider	
Urethral culture swab for gonorrhoea (if available)	Only indicated if frank urethral discharge is present It is not necessary to insert the swab into the urethra
Herpes PCR swab	If genital ulceration
Hepatitis B serology	If hepatitis B immune status unknown, and risk factors present

Hepatitis C serology	If risk factors present, e.g. injecting drug use Repeat annually if risk factors present If history of treated hepatitis C, and ongoing risk, hepatitis C virus RNA should be requested instead of hepatitis C antibody

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Men who have sex with men (cisgender)

All sexually active men who have sex with men (MSM) should be screened at least annually.

MSM in the following categories should be screened every 3 months:

- New partner or multiple sexual contacts
- Group sex
- Use of HIV pre-exposure prophylaxis (PrEP)
- Use of recreational drugs during sex (chemsex).

• Offer examination • Examination is required if symptomatic with urethral discharge, dysuria, testicular pain or swelling, anal pain or discharge, or a contact of gonorrhoea • Examine inguinal lymph nodes, genital and perianal skin, penis, scrotum and testes	
Test	**Considerations**
First-pass urine for chlamydia and gonorrhoea	First 20-30 mL urine, preferably > 1 hour after last void
Pharyngeal NAAT swab for chlamydia and gonorrhoea	Regardless of reported sexual practices or condom use as asymptomatic infection is common Can be self-collected
Anorectal NAAT swab for chlamydia and gonorrhoea	
HIV and syphilis serology	
Consider:	

Urethral culture swab for gonorrhoea (if available)	Only indicated if frank urethral discharge is present It is not necessary to insert the swab into the urethra
Herpes PCR swab	If genital ulceration
Hepatitis B serology	If immune status unknown Offer vaccination if not immune – may be free at sexual health services
Hepatitis A serology / vaccination	Hepatitis A is spread faeco-orally Outbreaks have occurred in MSM overseas Consider vaccination, however hepatitis A serology and vaccination are not funded for this indication in Aotearoa New Zealand
Hepatitis C serology	If risk factors present, e.g. injecting drug use, on PrEP, HIV positive Repeat annually if risk factors present If history of treated hepatitis C, and ongoing risk, hepatitis C virus RNA should be requested instead of hepatitis C antibody

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Transgender, non-binary and intersex people

See also transgender and non-binary people guideline

- Transgender, non-binary and intersex people should be offered sexual health screening based on anatomy, sexual practices and patient preference
- Consider self-collection of samples for testing. Examination is recommended if symptomatic
- People with a vagina may be offered self-collected vaginal, anal and pharyngeal swabs depending on sexual practices. A first-void urine might be preferable to the patient but may be a less sensitive test
- Testosterone can cause vaginal dryness; extra lubrication and a small speculum may increase comfort if an examination is needed. Oestrogen cream applied topically to the vagina for approximately two weeks prior to a speculum examination may also be helpful
- People with a neovagina (post genital gender affirmation surgery) should

be offered first-void urine testing in addition to a neovaginal swab. Colon-derived neovaginal tissue is inherently more susceptible to bacterial STIs than the penile inversion neovagina

- If examination of a person's neovagina is needed, consider an initial digital exam using a single digit to assess the length and path of the neovagina. Using an anoscope (instead of a speculum) may facilitate visual examination
- One way to ask about screening is to say, 'For an STI check up, we usually offer a blood test for HIV and syphilis and testing for chlamydia and gonorrhoea. People can get chlamydia and gonorrhoea in their urine, throat, bottom and cervix. You can do your own swabs of these sites if needed. Have you had sexual contact at any of these sites?'

Site	Test
Cervix / vagina	If examined, vaginal NAAT swab for chlamydia and gonorrhoea should be taken before speculum insertion Test for trichomonas in those who are symptomatic or at higher risk* If symptomatic, high vaginal culture swab for candida and bacterial vaginosis (and trichomoniasis if NAAT not available) Endocervical culture swab for gonorrhoea (if available) if suspected PID, profuse cervical discharge or a contact of gonorrhoea
Penile urethra	First-pass urine for chlamydia and gonorrhoea First 20-30 mL urine, preferably >1 hour after last void If frank urethral discharge is present, urethral culture swab for gonorrhoea (if available). It is not necessary to insert the swab into the urethra
Pharynx	Pharyngeal NAAT swab for chlamydia and gonorrhoea. Can be self-collected
Rectum	Anorectal NAAT swab for chlamydia and gonorrhoea. Can be self-collected
Serology	HIV and syphilis serology should be offered as a routine part of STI screening Consider: Hepatitis B serology if immune status is unknown and risk factors present. Offer vaccination if not immune – may be free at sexual health services Hepatitis C serology if risk factors present, e.g. injecting drug use, on PrEP, or HIV positive. Repeat annually if risk factors present. If history of treated hepatitis C, and ongoing risk, hepatitis C virus RNA should be requested instead of hepatitis C antibody Hepatitis A serology and vaccination if oral-anal sexual contact (rimming) or injecting drug use. Hepatitis A serology and vaccination are not funded for this indication in Aotearoa New Zealand

NAAT – nucleic acid amplification test

*Māori and Pacific people, social deprivation, history of incarceration, contact of trichomoniasis

Specimen collection

Specimen collection guidance
Clinician collected

Clinician collected for NAAT and culture

- **Urethral swabs** for gonorrhoea culture should be collected if the patient has frank urethral discharge, and ideally when the patient has not urinated for at least 1 hour. It is not necessary to insert the swab into the urethra
- **Vaginal swab** should be collected before speculum insertion. Wipe the swab around the vaginal entrance, then insert the swab 4 cm (thumb's length) into the vagina, count slowly to 5 and replace in the swab container
- **Rectal swabs** should be collected by inserting a sterile swab 2-4 cm into the anal canal and moving the swab gently side to side for 10-20 seconds
- **Pharyngeal swabs** should be collected from the tonsils and oropharynx

Self-collected

Self-collection of samples for NAAT testing

- **Vaginal swab**: instruct the patient to remove the swab from the container, wipe the swab around the vaginal entrance, then insert the swab 4 cm (thumb's length) into the vagina, count slowly to 5 and replace in the swab container
- **Rectal swab:** instruct the patient to insert the swab into the anal canal 2-4 cm and then remove and place into the transport tube
- **First pass urine:** Collect approximately 20-30 mL (1/3 of the standard urine jar) of the first part of the urine stream in a specimen jar, ideally >1 hour after last void
- **Pharyngeal swabs** should be collected from the tonsils and oropharynx

Click here for information on how to describe self-collection technique to a patient.

Endorsement: These guidelines have been endorsed by the Blood Borne Viruses

and Sexually Transmitted Infections Standing Committee (BBVSS).

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