Aotearoa New Zealand STI Management Guidelines for Use in Primary Care

Urethritis

Overview

- Urethritis is an inflammation of the urethra, which may be due to many different aetiological agents
- Usually sexually transmitted, but may have other causes
- Consider urethritis in men presenting with dysuria and urethral discharge, irritation or discomfort
- Urinary frequency, urgency, haematuria or nocturia are more suggestive of urinary tract infection (UTI)
- UTIs are uncommon in men aged under 35 years, so a sexually transmitted infection (STI) should be suspected unless proven otherwise
- **Persistent or recurrent urethritis** is defined as symptoms persisting for longer than 2 weeks after initiation of treatment, or recurrence of symptoms within 90 days following treatment of acute urethritis

Cause

- **Gonococcal urethritis:** *Neisseria gonorrhoeae*
- **Non-gonococcal urethritis**
    - Often due to *Chlamydia trachomatis*
    - Sometimes due to genital mycoplasmas (e.g. *Mycoplasma genitalium*)
    - Other rarer causes include *Trichomonas vaginalis*, herpes simplex virus (HSV), adenovirus, enteric bacteria (insertive anal sex) and

pharyngeal organisms (oral sex)

Persistent or recurrent urethritis is due to *Mycoplasma genitalium* in over 40% of those who fail initial treatment with doxycycline

Ureaplasma urealyticum is considered part of the normal urethral flora, and generally does not require treatment

Clinical presentation

Symptoms	Comments/Considerations
Urethral discharge, dysuria, discomfort or irritation	Urethral discharge may be noted on examination, even if not reported
Complications	
Epididymo-orchitis Reactive arthritis	

Indications for testing

- Urethral discharge, dysuria, discomfort or irritation

Recommended tests

Examination is important, so that correct syndromic management can be initiated

Urethritis

- Screening for STIs as per sexual health check guideline
- Mid-stream urine for microscopy, culture and sensitivities if UTI suspected
- Consider swab of urethral meatus for HSV if inguinal lymphadenopathy, severe dysuria or meatitis

Persistent or recurrent urethritis

If adherent to treatment, and re-infection excluded:

- Repeat first-void urine for chlamydia and gonorrhoea nucleic acid amplification test (NAAT), add trichomonas NAAT (in men who have sex

with women)
- First-void urine for *Mycoplasma genitalium*

Management

Treatment options

Infection	Recommended
If discharge is profuse or purulent, or there has been known contact with gonorrhoea	Treat empirically for gonorrhoea: Ceftriaxone 500 mg in 2 mL of 1% lignocaine, intramuscular injection, as a single dose PLUS Azithromycin 1 g orally, as a single dose
If discharge is minimal, or none seen	Doxycycline 100 mg orally, twice daily for 7 days (recommended) Azithromycin 1 g orally, as a single dose can be used if contraindication to doxycycline, but is not recommended as first-line treatment due to inferior efficacy and concerns about antimicrobial resistance
Known chlamydia and gonorrhoea co-infection	Ceftriaxone 1g in 3.5 mL of 1% lignocaine, intramuscular injection, as a single dose PLUS Doxycycline 100 mg orally, twice daily for 7 days

- **Advise to abstain from sex or use condoms for 1 week from the start of treatment, and until partner(s) tested and treated.**

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 empirical treatment with **doxycycline 100 mg orally twice daily for 7 days**, assuming no

allergies or contraindications. If gonorrhoea is suspected in the index case, use **ceftriaxone 500 mg intramuscularly as a single dose, plus azithromycin 1 g orally**

- Advise contacts to abstain from sex or use condoms until results are available, and 1 week from start of treatment
- If index case or contacts test positive for an STI, see appropriate STI guideline for management
- 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 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 positive contact
Test of cure • Not routinely recommended for patients who are asymptomatic after completing treatment, unless urethritis due to *Mycoplasma genitalium* (see guideline for advice)
Retesting • Re-infection is common • Retesting at **3 months** is recommended, to detect re-infection

Indications for specialist referral

Referral to or discussion with a specialist is recommended for:

- Screening and treatment of sexual contacts if clinician wishes
- Allergy or contraindication to standard treatment options
- Males with recurrent or persisting urethritis that have not responded to empirical treatment
- All people testing positive for *Mycoplasma genitalium*

Auditable outcomes

- 100% of patients diagnosed with urethritis are treated with an appropriate

antibiotic regimen
- 100% of patients are advised to avoid sexual contact for **7 days** after treatment is commenced

Useful patient resources
Just the facts

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

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Funded by: The Australian Government Department of Health