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GENERAL PRACTICE SUPERVISION AUSTRALIA

FAQ
FREQUENTLY ASKED QUESTIONS

PODCAST WEBINAR

# Teaching Your Registrar About STI Management - What's new?

## Where should we begin in teaching our registrars about taking a sexual history?

Firstly, you need to remember that …

A. This can be a steep learning curve for the registrar, particularly if they are new to community-based medicine or obstetrics and gynaecology.

B. The registrar brings their own cultural/gendered perspective to the consultation which may be overcome by role playing likely patient scenarios with you.

Use the following consultation strategies:

- Normalise the conversation.
- Introduce all questions as routine questions.
- Seek patient permission to proceed:

  *"I ask all of my patients these questions when offering cervical screening"*

  *"We offer routine STI screening to everyone under 30 – is it ok if I ask some specific questions about your sexual history?"*

  *"I ask everyone these questions"*
- Never make assumptions about sexual identity, orientation, or practices.
- Avoid value terms such as "*are you married?*"

  Alternatives to value terms:

  *"Do you have a regular partner?"*

  *"Are there any other partners for you?"*

  *"In the last 6 months, how many partners have there been for you?"*

  *"Have you ever had a male/female partner?"*

  *"What type of sex do you have?" [again, be sure to normalise the question]*

  *"Have you ever had an STI?"*

## What should be covered when taking a sexual history?

- Condom use.
- PrEP use in men who have sex with men (MSM).
- Contraceptive history.
- Current symptoms.
- Specific risk assessment for at risk target groups:
  - IV drug users, Prisoners, Sex workers. Pregnant women, Aboriginal and Torres Strait Islanders, Refugees, Recent migrants and people with tattoos.
- STI Vaccination status (HBV, HAV, HPV).
- **Always do a physical examination of a symptomatic patient!**
- Consider offering a chaperone during genital examination.

## What should a routine asymptomatic STI screen entail?

- Chlamydia
  - Self-collected LVS if not examined for women (more sensitive than First Pass Urine).
  - First Pass Urine test for men.
  - Consider ano-rectal swab if they have had anal sex.
  - Endocervical swab if examined.
  - Testing annually in 15-29 age group.
- Hepatitis B
  - Immunise if non already immunised.
- Syphilis
  - Test according to risk assessment.
  - Test annually if Aboriginal and Torres Strait Islander or IV drug user.
- HIV – offer test to anyone requesting testing.
- Gonorrhoea test according to risk assessment (done on same assay as CT).
- Trichomoniasis – test if rural/regional/remote Aboriginal and Torres Strait Islander.
- Do not screen for Mycoplasma Genitalium.

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## What should we focus on when teaching our registrars about STI examinations and investigations?

Advise registrars to:

- Always examine a symptomatic patient.
- Use speculum to search for signs of cervicitis or abnormality.
- Examine type of discharge, assess Ph.
- Consider bimanual.
- Use HVS MCS (gram stain if bedside micro available).
- Endocervical swab for chlamydia/gonorrhoea PCR.
- Consider HVS for Trichomonas PCR (regional, remote, ATSI).
- **Co-testing is not indicated in the vast majority of women** presenting with vaginal discharge.
- Only Co-test if unexplained, persistent, unusual discharge.

**Clinical screening guidelines:**

Cancer council cervical screening guidelines

Melbourne sexual health centre vaginal discharge treatment guidelines

## What should our registrars know about...

### CHLAMYDIA

- Most commonly reported communicable disease in Australia.
- Often asymptomatic, but implicated in urethritis, cervicitis and PID syndromes.
- Contact trace all partners from the past 6 months.
- Window period OF 6 days.
- Rescreen after 3 months; TOC in pregnant women and rectal infection.
- Legislation around PDPT (patient delivered partner therapy) differs by state - see article RACGP - Reducing chlamydia associated reproductive complications

### CHLAMYDIA: Principal Treatment Options

| Situation | Recommended | Alternative |
|---|---|---|
| Uncomplicated genital or pharyngeal infection | Doxycycline 100mg PO, BD 7 days<br>OR<br>Azithromycin 1g PO stat | |
| Ano-rectal infection | Doxycycline 100mg PO, BD 7 days if asymptomatic, but 21 days if symptomatic (see ano-rectal syndromes) | Azithromycin 1g PO, stat, and repeat in 1 week |

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## What should our registrars know about…

### GONORRHOEA

- More common in MSM and young heterosexual ATSI people
- Increasing antimicrobial resistance to first line treatments
- Contact trace for at least 2 months, TOC 2 weeks after treatment
- Take sample for M/C/S prior to antibiotic treatment

### GONORRHOEA: Principal Treatment Options

| Situation | Recommended | Alternative |
|---|---|---|
| Uncomplicated genital and ano-rectal infection | Ceftriaxone 500mg IMI, stat in 2mL 1% lignocaine<br>PLUS<br>Azithromycin 1g PO, stat | Alternative treatments are not recommended because of high levels of resistance, EXCEPT for some remote Australian locations and severe allergic reactions.<br>**Seek local specialist advice** |
| Uncomplicated pharyngeal infection | Ceftriaxone 500mg IMI, stat in 2mL 1% lignocaine<br>PLUS<br>Azithromycin 2g PO, stat* | Alternative treatments are not recommended because of high levels of resistance EXCEPT for some remote Australian locations and severe allergic reactions. |
| Adult gonococcal conjunctivitis | Ceftriaxone 500mg IMI, stat in 2mL 1% lignocaine<br>PLUS<br>Azithromycin 1g PO, stat | Alternative treatments are not recommended because of high levels of resistance. EXCEPT for some remote Australian locations and severe allergic reactions. |

## What are the screening requirements for men who have sex with men (MSM)?

- Consider PrEP prescribing www.ashm.org.au/HIV/PrEP

**After appropriate re-test discussion, all of the STI tests listed should be offered:**

**3 monthly testing for sexually transmitted infections in all men who have had any type of sex with another man in the previous 3 months***

| Blood tests | NAAT/PCR^ tests for gonorrhoea and chlamydia |
|---|---|
| • Syphillis serology<br>• HIV antibody/antigen screening test: If not known to be HIV-positive<br>• Hepatitis A antibody: Test if not vaccinated. Vaccinate if antibody negative<br>• Hepatitis B core antibody, surface antigen: Test if not vaccinated. Vaccinate if no history or documetnation of full vaccination course<br>• Hepatitis C: Test one a year in people living with HIV, on PrEP or with history of injecting drug use | • Oropharyngeal swab<br>• First pass urine defines as the first part of the urine stream, not the first urine of the day<br>• Anorectal swab (self-collected)<br><br>^ NAAT-nuceic acid amplification test e.g. Transcription-Mediated Amplification (TMA), Strande Displacement Amplification (SDA), Polyerase Chain Reaction (PCR) |

* Men who have sex with men (MSM) who are not sexually active or in monogamous relationships may be teested less frequently, but at least annually.

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## What are key features of Pelvic Inflammatory Disease (PID)?

- A clinical syndrome of ascending inflammation and infection.
- May involve the cervix, endometrium, fallopian tubes and peritoneum.
- Typically presents with recent history of pelvic pain and dyspareunia.
- Earlier treatment correlates with lower risk of sequelae and complications.
- Complications include ectopic pregnancy, tubal factor infertility, chronic pelvic pain.
- 60% of cases have no STI identified – negative swabs do not exclude PID.
- Polymicrobial, includes vaginal anaerobes.
- Diagnosis is clinical – maintain a low threshold for suspecting PID and commencing empirical treatment.

**PID treatment options**

- Ceftriaxone 500mg IMI in 2mL 1% lignocaine.
- Metronidazole 400mg BD 14 days.
- Doxycycline 100mg BD 14 days.

**STI Management guidelines:**
Australian STI management guidelines for use in primary care

## What are key features of Mycoplasma Genitalium (MG)?

- Sexually transmitted bacteria.
- Associated with NGU, cervicitis, PID and possibly proctitis. Asymptomatic rectal infection in MSM is common.
- Difficult to culture, emerging resistance is a major problem – significant macrolide resistance.
- Pharyngeal infection is rare.
- Screening asymptomatic individuals, other than ongoing sexual contacts of MG positive index patient, is currently not recommended.
- Use a laboratory with macrolide resistance assay where possible.

## What are key features of MG PID?

- Switch to moxifloxacin 400MG daily for 14 days.
  - Expensive.
  - Off label indication.
  - Black box warning for rare but significant tendinopathy.
- Test current ongoing sexual partner and treat if positive. If partner has asymptomatic macrolide resistant MG could use 7 days doxycycline then 7 days moxifloxacin.
- Test of cure at least 2 weeks after completing treatment.

**Clinical treatment guidelines**
Mycoplasma genitalium treatment guidelines - Melbourne Sexual Health Centre

## What are key features of Vaginal Discharge?

- Differential Diagnosis
  - Bacterial vaginosis.
  - Candida vulvovaginal infection.
  - Streptococcal or Haemophilus vaginal infections.
  - STI – NG, CT, MG, trichomonas.
  - Retained vaginal foreign body e.g. tampon.
  - Cervical pathology, cervical ectropion.
  - Atrophic vaginitis.
  - Inflammatory conditions of the vaginal mucosa – desquamative inflammatory vaginitis.
  - Vaginal pathology.
  - Fistula.

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## What are key features of Bacterial Vaginosis?

- Amsell's criteria
  - Homogenous vaginal discharge.
  - Positive whiff test.
  - Vaginal Ph >4.5.
  - Presence of clue cells on gram stain.

**Bacterial Vaginosis Treatment**

- Metronidazole 400mg PO BD 7 days.
- Clindamycin 2% intravaginal cream 7 nights.
- Metronidazole 0.75% gel intravaginally for 5 nights.
- Clindamycin 300mg PO BD for 5 days.
- Recurrent infection in 50% within 3-12 months.
  - Metronidazole 0.75% 5g vaginally twice weekly for 4 months; or Boric Acid vaginally.
  - No evidence for intravaginal lactic acid or probiotic products.

## What are key features of Syphilis?

- Relatively less painful ulcers.
- More likely if sexual exposure to MSM, remote Aboriginal populations and outside Australia.
- Lesions often indurated.
- May have non tender lymphadenopathy.
- Syphilis rates rising, including heterosexual women.
- Often not diagnosed until late – ocular syphilis.
- Congenital syphilis rates rising.
- Maintain low threshold for testing.

**Diagnostic support**
Syphilis Decision Making Tool

**Syphilis Testing (from Australian STI guidelines)**

- For men who have sex with men (MSM): at least annually, up to 4 times a year.
- For HIV positive MSM, up to 4 times per year or at least on each occasion of CD4/viral load monitoring.
- Routine antenatal testing –initial visit +/- 24-28/40.
- A sexual contact of a person with syphilis.
- Routine sexual health check.
- Presence of any signs and symptoms of infectious syphilis.
- Genital ulcers.
- MSM with any genital symptoms or rash.
- Any rash affecting the palms of the hands or soles of the feet, or that is persistent or unexplained.
- Pyrexia of unknown origin, unexplained persistent lymphadenopathy, unexplained liver function disturbance, alopecia.
- Include HIV and hepatitis B serology if performing EIA.
- Low threshold for including a viral swab for herpes if any genital ulceration present.

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## Resources

GPSA webinars

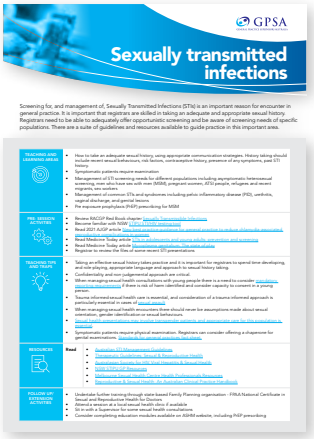

GPSA guides


GPSA teaching plans

GPSA FAQs

All GPSA resources are available here

- GPSA TEACHING PLAN: Sexually Transmitted Infections
  https://gpsupervisorsaustralia.org.au/download/13429/
- Australian STI Management Guidelines
- Reproductive & Sexual Health: An Australian Clinical Practice Handbook FPNSW 2020
- Therapeutic Guidelines: Sexual & Reproductive Health
- NSW STI Programs Unit (STIPU) General practice STI resources
- Australasian Society for HIV, Viral Hepatitis & Sexual Health Medicine (ASHM)
- Australian STI & HIV Testing guidelines for Asymptomatic MSM
- Patient Delivered Partner Therapy - article:
  Coombe J, Goller J, Vaisey A, et al. New best practice guidance for general practice to reduce chlamydia-associated reproductive complications in women. Australian Journal for General Practitioners. 01/21 2021;50:50-54. Accessed November 24, 2021
- Online notification tools:
  - https://letthemknow.org.au/
    Contact notification primarily for heterosexual patients
  - https://www.thedramadownunder.info/
    Contact notification primarily for MSM




Does this resource need to be updated? Contact GPSA: P: 03 9607 8590, E: admin@gpsa.org.au W: gpsa.org.au
GPSA is supported by funding from the Australian Government under the Australian General Practice Training Program 14/02/22