GPSA
GENERAL PRACTICE SUPERVISION AUSTRALIA

Sexually transmitted infections

Screening for, and management of, sexually transmitted infections (STIs) is a common reason for encounter in general practice. It is important that registrars are skilled in taking an adequate and appropriate sexual history. Registrars need to be able to offer opportunistic screening and be aware of screening needs of specific populations. There are a suite of guidelines and resources available to guide practice.

TEACHING AND LEARNING AREAS

- Epidemiology of STIs – local and national
- Sexual history taking, using appropriate communication strategies
- Common STI presentations and key features of specific infections
- STI screening needs for different populations including heterosexual people, men who have sex with men (MSM), pregnant women, Aboriginal and Torres Strait Islander people, refugees and recent migrants, sex workers
- Management of common STIs and syndromes, including pelvic inflammatory disease (PID), urethritis, vaginal discharge, and genital lesions
- Pre exposure prophylaxis (PrEP) prescribing for MSM

PRE- SESSION ACTIVITIES

- RACGP Red Book chapter Sexually Transmissible Infections
- NSW STIPU STI/HIV testing tool

TEACHING TIPS AND TRAPS

- History taking should include recent sexual behaviours, risk factors, contraceptive history, presence of any symptoms, past STI history
- Taking an effective sexual history takes practice and it is important for registrars to spend time developing this skill - role-playing is a valuable teaching method
- Confidentiality and a non-judgemental approach are critical
- Symptomatic patients require examination
- When managing sexual health consultations with young people, there is a need to consider mandatory reporting requirements if there is risk of harm - consider capacity to consent
- Trauma informed sexual health care is essential, and consideration of a trauma informed approach is particularly essential in cases of sexual assault
- Never make assumptions about sexual orientation, gender identification or sexual behaviours
- Appropriate care for transgender patients is essential
- Consider offering a chaperone for genital examinations

RESOURCES

Read

- Australian STI Management Guidelines
- Therapeutic Guidelines: Sexual & Reproductive Health
- 2021 AJGP article New best practice guidance for general practice to reduce chlamydia-associated reproductive complications in women

FOLLOW UP/ EXTENSION ACTIVITIES

- Undertake further training through state-based Family Planning organisation - FPAA National Certificate in Sexual and Reproductive Health for Doctors
- Attend a session at a local sexual health clinic if available
- Consider completing education modules available on ASHM website, including PrEP prescribing

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Clinical Reasoning Challenge

Andrea, aged 24, attends with 3-4 week history of pelvic pain, more severe for the past one week, with some slightly offensive increased vaginal discharge. She also complains of dysuria and feeling tired and nauseate. She had a Mirena inserted 18 months ago and is amenorrhoeic. She had a current male sexual partner for the past five months and had a negative STI screen 8 months ago.

QUESTION 1. What is your differential diagnosis?

QUESTION 2. On speculum examination there is some mucoid discharge from an inflamed appearing cervix. There is uterine and adnexal tenderness on bimanual examination. UHCG is negative. What investigations would you request?

QUESTION 3. If you suspect PID clinically, what empirical antibiotic treatment would you commence?

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ANSWERS

QUESTION 1

What is your differential diagnosis?

- PID
- UTI
- Pregnancy – must exclude ectopic
- Ovarian pathology
- Appendicitis
- Endometriosis

QUESTION 2

On speculum examination there is some mucoid discharge from an inflamed appearing cervix. There is uterine and adnexal tenderness on bimanual examination. UHCG is negative. What investigations would you request?

- Endocervical swabs for chlamydia, gonorrhoea, mycoplasma PCR. Consider a laboratory which performs MG macrolide resistance testing.
- HVS M/C/S
- Could consider trichomonas if high risk setting/demographic (Aboriginal and Torres Strait Islander, rural/remote)
- MSU M/C/S
- Could consider pelvic USS if alternative diagnosis suspected – may be normal in PID. Transvaginal scan preferred.
- FBC/CRP may be normal in mild PID

QUESTION 3

If you suspect PID clinically, what empirical antibiotic treatment would you commence?

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

Reference: http://www.sti.guidelines.org.au/

Remember that in 60% of cases of PID no causative STI organism will be identified, and it may relate to vaginal microbiota. Negative swabs do not exclude PID.

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