

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 OR 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 PLUS 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. Seek local specialist advice
Uncomplicated pharyngeal infection	Ceftriaxone 500mg IMI, stat in 2mL 1% lignocaine PLUS 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 PLUS 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
<ul style="list-style-type: none"> • Syphilis serology • HIV antibody/antigen screening test: If not known to be HIV-positive • Hepatitis A antibody: Test if not vaccinated. Vaccinate if antibody negative • Hepatitis B core antibody, surface antigen: Test if not vaccinated. Vaccinate if no history or documentation of full vaccination course • Hepatitis C: Test one a year in people living with HIV, on PrEP or with history of injecting drug use 	<ul style="list-style-type: none"> • Oropharyngeal swab • First pass urine defines as the first part of the urine stream, not the first urine of the day • Anorectal swab (self-collected) <p>[^] NAAT-nucleic acid amplification test e.g. Transcription-Mediated Amplification (TMA), Strande Displacement Amplification (SDA), Polymerase Chain Reaction (PCR)</p>

* Men who have sex with men (MSM) who are not sexually active or in monogamous relationships may be tested 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



All GPSA resources are available [here](https://gpsupervisorsaustralia.org.au)

- 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

