Melbourne Sexual Health Centre
A service within The Alfred, a member of Bayside Health

CPG M3
CLINICAL MANAGEMENT OF PROCTITIS IN MEN

GUIDELINE STATUS: FINAL 21/05/2008
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SCOPE OF PRACTICE

TARGET POPULATION

- Male clients presenting with rectal (PR) pain, bleeding, discharge, tenesmus, diarrhoea, abdominal symptoms suggestive of proctitis
- Clients who present as asymptomatic with subsequent abnormal PR discharge or inflammation on clinical examination

EXCLUSION CRITERIA

- Clients with ongoing gastrointestinal or autoimmune conditions including Irritable Bowel Syndrome (IBS), Chrons Disease and or ulcerative colitis
- Clients presenting with persistent symptoms post treatment
- HIV positive clients who present with PR symptoms

GUIDELINE OBJECTIVES AND ANTICIPATED OUTCOMES

- Determine cause of symptoms and identify probable aetiology
- Provide treatment for clients with a confirmed diagnosed infection or presumptive treatment for symptomatic clients
- Identification of individual STI risk and provision of appropriate screening
- Identify public health risks to control infections by:
    - Provision of STI education and information
    - Identification and exploration of sexual risk taking behaviours
    - Partner notification and treatment
    - Test of reinfection/test of cure where appropriate
    - Monitoring antimicrobial resistance

BACKGROUND

CONDITION DESCRIPTION- PROCTITIS

Proctitis is defined as an inflammation of the anus and the lining of the rectum, affecting the distal 10-12 cm of the rectum. [1,2]
Symptoms of acute proctitis include one or more of the following: [1,2,3,4]

- Rectal discharge (mucoid or purulent discharge)
- Rectal pain or discomfort (with or without PR bleeding)
- Tenesmus (sensation of incomplete defecation)
- Bleeding on defecation

Proctitis occurs predominantly among clients who participate in receptive anal intercourse, men who have sex with men (MSM) and is commonly caused by the following sexually transmitted infections (STIs): *Chlamydia trachomatis* (CT), *Neisseria gonorrhea* (GC), *Treponema pallidum* (Syphilis) and Herpes Simplex Virus (HSV). [1,2,3,5] Proctitis may also be caused by auto-immune conditions (Crohn's disease and ulcerative colitis), harmful physical agents, chemicals, foreign objects and trauma to the anorectal area. [5] Rarer causes include damage from radiotherapy. It may also occur independently (idiopathic proctitis).[5]

PROCTOCOLITIS

Proctocolitis is associated with symptoms of proctitis with diarrhorea or abdominal cramps and inflammation of the colonic mucosa (extending to 12 cm above the anus).[1,2,5] Proctocolitis is acquired through anilingus or when a causitive agent is ingested orally during sexual activity.[5,6] Faecal leukocytes may be detected on stool examination.

Pathogenic organisms which may cause proctocolitis include: [1,2,5,6]

- *Campylobacter spp.*
- *Shigella spp.*
- *Entamoeba histolytica*
- *C. trachomatis* Lymphogranuloma venereum serovars (LGV)

STI CAUSES	NON STI CAUSES

Acute Proctitis
• *N. gonorrhoea*
• *C. trachomatis*
• *T. pallidum*
• HSV 1 and 2
 	
Acute Proctocolitis
• *Camphylobacter spp.*
• *Shigella spp.*
• *Entamoeba histolytica*
• *C. trachomatis* (LGV)
	• Autoimmune disorders
	  • Crohn's disease
	  • Ulcerative colitis
	• Radiotherapy
	• Chemical irritation
	• Chemotherapy
	• Foreign object
	• Trauma

Table M3.1: Causes of acute proctitis, proctocolitis and enteritis in MSM [1,2,6,7]

EPIDEMIOLOGY

Sexually transmitted anorectal infections in MSM are facilitated by specific sexual practices such as unprotected anal intercourse, insertion of contaminated sex toys and by oral anal contact. [6,8] GC and CT are the most common infections in MSM with clinical proctitis (20% GC; 11% CT and 7% both GC and CT). [3] Herpes and syphilis are less common with clients presenting with clinical proctitis. [1,2] Recent surveillance has further reported LGV as an emerging anorectal STI amongst gay communities worldwide. [5,9]

SEQUELAE

Untreated LGV proctitis/proctocolitis may lead to tissue destruction with fistula or stricture formation. [1,7,9] Untreated anal CT and GC increase the risk of HIV acquisition and transmission [1,2,

	GONORRHOEA	CHLAMYDIA	HSV 1 AND 2	SYPHILIS
Aetiological agent	Neisseria gonorrhoeae	C.trachomatis	Herpes Simplex Virus Type 1 or 2	T.pallidum
Incubation period	2-5 days	1-21 days	5-10 days	10-90 days avg 21 days
Symptoms	Purulent discharge And dysuria	Muciod watery or mucopurulent discharge dysuria Often asymptomatic	Ulcer, severe discharge and dysuria	Chancre firm, non tender non purulent, non vascular
Investigations	Th/An/Ur Culture	FPU NAAT	Ur swab PCR	DGI/PCR/serology

Table M3.2: Common aetiological causes of acute proctitis [1,2,6,7]

INVESTIGATION AND DIAGNOSIS

The sexual history of the client is of value in determining the aetiology of genital ulcers. Laboratory testing is required to confirm the diagnosis and to identify the infecting organism. HSV and syphilis have specific characteristics and have prevalence within specific population groups. The visual inspection of the area will help inform the diagnosis. Genital ulcers will require collection of direct microbiological specimens. [9,10,11] Proctoscopy is indicated when inspection for lumps, ulcers, source of discharge and or bleeding is required.

MICROSCOPY

A smear of secretion or discharge is prepared and Gram stained. A typical positive gram-stained smear of rectal discharge may shows a large number of characteristic kidney shaped Gram-negative diplococci (GNDC). This enables presumptive diagnosis at point of presentation. [9,10]
General Investigations

- Microscopy of ulcer or area of inflammation
- Culture of ulcer or area of inflammation
    - HBA plate for bacteria culture
    - Gonococcal culture
- NAAT for Chlamydia
- PCR for gonorrhea is available for specific circumstances (e.g. Recent antibiotic use)

TARGETED TESTING

Investigations for non STI causes of ulcers include: [9,11]

- VZV PCR swab of lesion

Investigations for HSV include [9]

- HSV PCR type specific swab of lesion

Investigations for Syphilis include [11]

- Dark field examination (DGI) of anal lesions can be complicated by the presence of other treponemes and material
- Treponema pallidum PCR
- Syphilis serology

TREATMENT AND MANAGEMENT

TREATMENT INDICATORS

After the identification of a specific aetiology, appropriate therapy for proctitis can be commenced

- Clinical diagnosis based on examination findings
- Laboratory confirmed diagnosis (CT/LGV/GC/HSV/Syphilis)

ACUTE PROCTITIS OF UNCERTAIN ORIGIN [11,12,13,14,15]

- In the absence of a specific aetiology, treatment of suspected proctitis will be empirical and should be commenced prior to test results which may take several days to return
- Joint treatment for Chlamydia and gonorrhoeae is considered appropriate especially in clients who are MSM.
- If there is clinical suspicion of HSV infection, HSV antivirals are also recommended.

TREATMENT- CHLAMYDIA

- **Azithromycin 1 gm single dose**

Refer to Clinical management of uncomplicated Chlamydia infection (CPG C1)

TREATMENT- GONORRHOEA

- **Ceftriaxone 250mg IM**

Refer to Clinical management of uncomplicated Gonococcal infection (CPG C2)

TREATMENT- HERPES SIMPLEX VIRUS

- **Famciclovir 125mg bd for 5 days**

Refer to Clinical management of uncomplicated Herpes Simplex Virus infection (CPG C4)

TREATMENT- 1° & 2° SYPHILIS

- **Benzathine penicillin G 1.8gm IM single dose**

Refer to Clinical management of Syphilis infection (CPG C5)

TREATMENT FOR LGV

All men who have sex with men (MSM) presenting with symptoms of proctitis will be initially tested for CT. If the result is positive, further sequencing of the omp1 gene to identify LGV is required. Suspected LGV should be discussed with a Medical Officer.

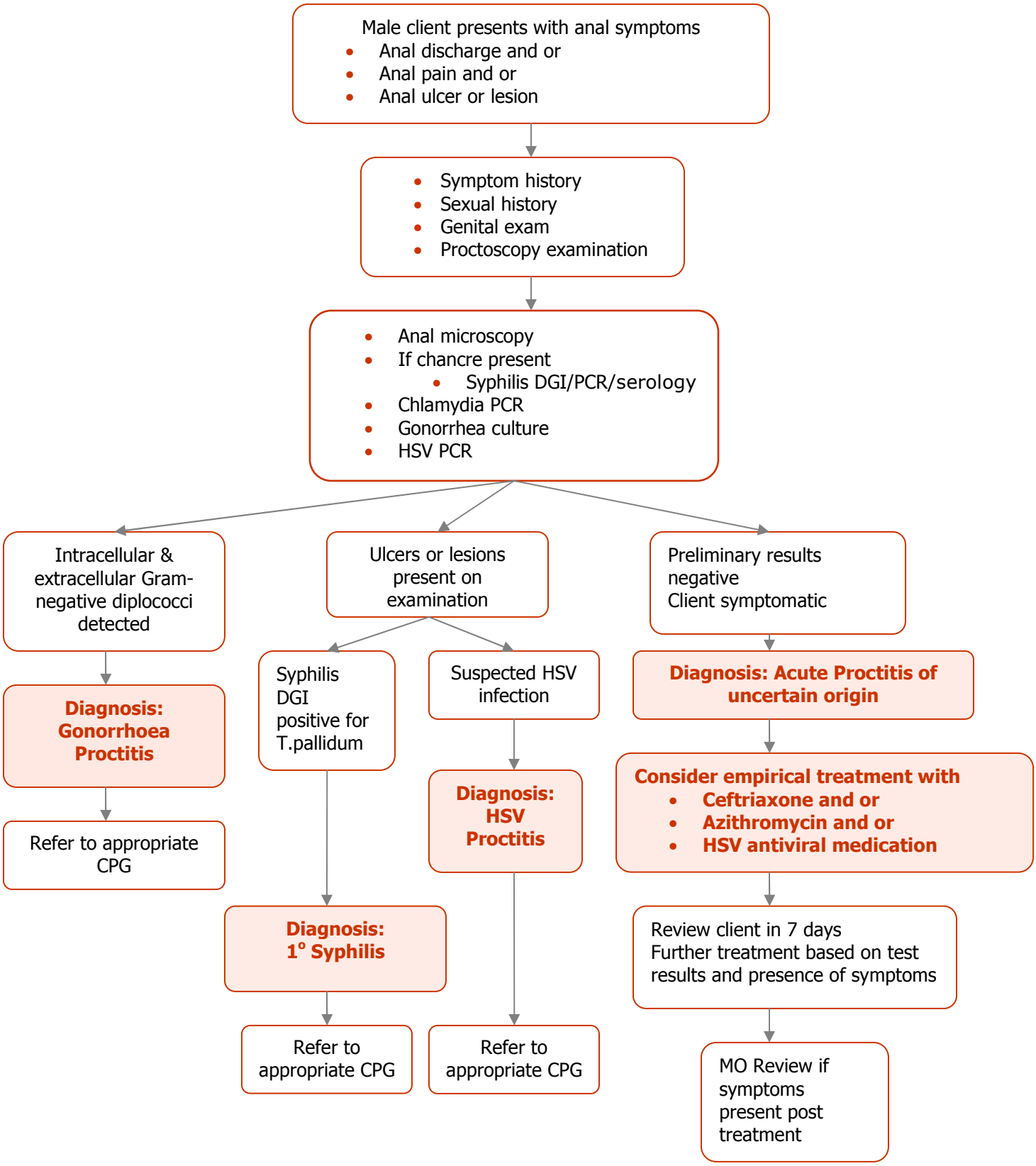
GENERAL MANAGEMENT	SYMPTOM MANAGEMENT
• STI information and safe sex counselling • Review compliance, adverse effects and side effects of prescribed medication • Advise no sexual contact for seven days post treatment • Contact tracing and partner notification is required • MO review if symptoms persist post treatment	• Stool softener • Analgesia • High fibre diet • Promote hydration • Genital skin care

Table M3.4: General Management [1,15]

PUBLIC HEALTH CONSIDERATIONS-FOLLOW UP AND REVIEW

- Clients are advised to contact trace all sexual contacts for past 6 months.
- A test of cure is required if the organisms were resistant to the prescribed antibiotic
- All clients with positive results will undergo follow up according to MSHC follow up procedures including recall for treatment and results, serological monitoring, test of re-infection, test of cure, Department of Human Services (DHS) notification and surveillance forms, partner notification and assistance in contact tracing

CLINICAL ALGORITHM



REFERENCES

1. Russell D. Anorectal symptoms. In: Russell D, Bradford D, and Fairley C, editors. Sexual health medicine. Melbourne: IP Communications; 2005. p. 184-195.

2. McMillan A. Prostatitis, orchitis and epididymitis. In: McMillan A, Young H, Ogilvie MM, Scott G R, editors. Clinical practice in sexually transmissible infections. London: Saunders; 2002. p. 369-378.

3. Verley JR, Quinn TC. Sexually transmitted intestinal syndromes. In: Holmes KK, Frederick Sparling P, Mardh PA, et.al, editors. Sexually Transmitted Diseases. 3rd ed. New York: McGraw-Hill, 1999. p. 937-960.

4. Denham I, Bowden F. Genital and sexually transmitted infections. In: Yung A , McDonald M, Spelmen D, Street A, Johnson P, Sorrell T, McCormack J, editors. Infectious diseases a clinical approach. 2nd ed. Melbourne: IP Communications; 2005. p. 372-387.

5. Klausner JD, Kohn R, Kent C. Etiology of clinical proctitis among men who have sex with men. Clinical Infectious Diseases. 2004;38: 300-302.

6. Krieger JN. Prostatitis syndromes In: Holmes K K, Sparling P F, Mardh P A, Lemon S M, Stamm W E, et al, editors. Sexually transmitted diseases. 3rd ed. New York: McGraw Hill; 1999. p. 859-870.

7. Lister NA, Smith A, Fairley, CK et.al Testing men who have sex with men for Neisseria gonorrhoeae and Chlamydia trachomatis prior to the introduction of guidelines at an STD clinic in Melbourne. Sexual Health. 2006; 1(1): 47-50.

8. Morton AN, Fairley CK, Zaia AM, Chen MY. Anorectal lymphogranuloma venereum in a Melbourne man. Sexual Health. 2006; 3(3): 189-190.

9. Marrazzo J, Ocbamichael N, Meegan A, Stamm WE, editors. The practitioners handbook for the management of STD's. 4th ed. Washington: University of Washington; 2007.

10. Melbourne Sexual Health Centre. Treatment guidelines: chlamydia. Melbourne: Bayside Health; 2005.

11. Melbourne Sexual Health Centre. Treatment guidelines: gonococcal infections. Melbourne: Bayside Health; 2005.

12. Melbourne Sexual Health Centre. Treatment guidelines: herpes. Melbourne: Bayside Health; 2005.

13. Melbourne Sexual Health Centre. Treatment guidelines: lymphogranuloma venereum (LGV) in MSM. Melbourne: Bayside Health; 2005.

14. Melbourne Sexual Health Centre. Treatment guidelines: syphilis in HIV negative patients. Melbourne: Bayside Health; 2005.

15. Venereology Society of Victoria. National management guidelines for sexually transmissible infections. Melbourne: Venereology Society of Victoria; 2002.

16. Therapeutic Guidelines Limited. Therapeutic guidelines antibiotic version 13. Melbourne: Therapeutic Guidelines Limited; 2006

17. Queensland Health. Queensland clinical practice guidelines for advanced sexual and reproductive health nursing officers. Public Health Service Branch. Queensland Government. 2007.