

URETHRITIS IN MEN

February 2009

Symptoms of urethritis include: urethral discomfort, discharge and dysuria. Some men will report only dysuria or discomfort.

It is useful to divide urethritis into gonococcal and non-gonococcal urethritis (NGU). The latter caused by (in order of frequency) Chlamydia trachomatis, Mycoplasma genitalium, Herpes simplex virus, Adenovirus and rarely Trichomonas vaginalis, but often no pathogen is found.

Urethral gonorrhoea is typically a purulent urethral discharge beginning less than a week after infection. In Victoria it is largely confined to men reporting sex with other men, or overseas or occasionally with street sex workers or some Aboriginal populations. NGU generally presents after a week or more and may be subtle or purulent.

Suspect Herpes simplex in cases with severe dysuria and no discharge: look for meatal lesions or a tender inguinal node. Adenovirus urethritis is suggested by a bright red meatus or a red eye.

Recommended tests

1. Urethral smear for Gram stain
2. urethral gonococcal culture (PCR more sensitive if delay in transport to lab, but gives no antibiotic susceptibilities)
3. Nucleic acid amplification (eg PCR, SDA) testing of swab or first-catch urine for Chlamydia (and if available, M. genitalium)
4. Depending on the presentation, consider tests for urethral Trichomonas* (culture or PCR), Adenovirus* (PCR) and Herpes (PCR). *Discuss with laboratory.

The urethral Gram stain enables detection of gonococci,

requiring confirmation by culture. Finding 5 or more polymorphs per average high-power field on the urethral smear (“++ polymorphs”) is a surrogate marker for infection, but is neither sensitive nor specific. Urethral polymorphs may add weight to a diagnosis of urethritis in doubtful cases.

NON-GONOCOCCAL URETHRITIS

Treatment

- Single dose azithromycin 1gm is the preferred treatment.
- Alternatives: doxycycline 100mg bd for one week, but this is unreliable in treating Mycoplasma genitalium.

Add ceftriaxone 500mg IM if gonorrhoea is suspected eg purulent with risk factors.

Review

NGU should improve within a week but may require 2-3 weeks to resolve completely. Repeat Chlamydia testing is not recommended until after 3 weeks because of the risk of a false positive and is only necessary in those patients who have not responded. Test responders for reinfection at 3 months instead. Consider reinfection and other causes of NGU (eg M genitalium in non-responders).

Treat contacts and test for HIV and syphilis*.

Urethritis due to Mycoplasma genitalium

It is not possible to clinically distinguish urethritis due to M. genitalium from other causes of NGU. PCR testing in Victoria is performed by the department of Molecular Microbiology at the Royal Women’s Hospital. Discuss the availability of this test with your pathology lab.

Disclaimer

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Treatment

- Single dose azithromycin 1gm is the preferred treatment.
- If persistent symptoms occur and reinfection is not likely then Azithromycin-resistant *M. genitalium* should be considered. Treat with 400mg daily of moxifloxacin for 10 days. Advise the patient that this is based on expert opinion and is off-label use of moxifloxacin. *M. genitalium* testing is strongly recommended before prescribing moxifloxacin. A test of cure at one month is recommended after both azithromycin and moxifloxacin.

Treat contacts and test for HIV and syphilis*.

Recurrent or persistent NGU

Dysuria or urethral discomfort often persists for some time after treatment of NGU, with or without urethral polymorphs, even when causative organisms are thought to have been treated. Symptoms usually settle without further treatment, though many men are anxious that they are still infected. Where there has been subsequent sex with an inadequately treated partner, reinfection should be considered. Consider less common causes of NGU such as resistant *M. genitalium*, HSV, Adenovirus or trichomoniasis..

Antiviral therapy is appropriate for herpes urethritis, but not effective for adenovirus. If an antibiotic must be used for persistent urethritis, a course of doxycycline sometimes helps but the mechanism is unknown.

URETHRAL GONORRHOEA

Gonococcal urethritis may be indistinguishable from other causes of urethral infection on examination. But there is usually a purulent discharge and dysuria within a few days of exposure..

Treatment

- Intramuscular ceftriaxone 500 mg IMI (mix with lignocaine).
- Resistance to ciprofloxacin is widespread in Asia and urban Australia.
- Accompanying chlamydial infection is common in heterosexually acquired gonorrhoea (usually imported) so these men should receive azithromycin 1g. Consider this in all patients if reattendance is uncertain.

Review

Test of cure is recommended where resistance might be suspected. Testing for HIV and syphilis at least six weeks after infection is recommended in all cases because gonorrhoea tends to be found in populations at increased risk of these infections.

*Treating contacts.

As a general rule all contacts exposed to a bacterial STI should be treated. The sexual history often reveals a high-risk exposure so this and subsequent partners should be treated.

Gonococcal urethritis typically appears within a week of infection so oral, anal, vaginal sexual contacts within the two weeks prior to symptoms, need treatment and testing. Gonococcal infection in the throat, cervix and rectum is often asymptomatic.

NGU may develop up to a month after exposure, suggesting a need to treat and test contacts from the two months prior to symptoms.