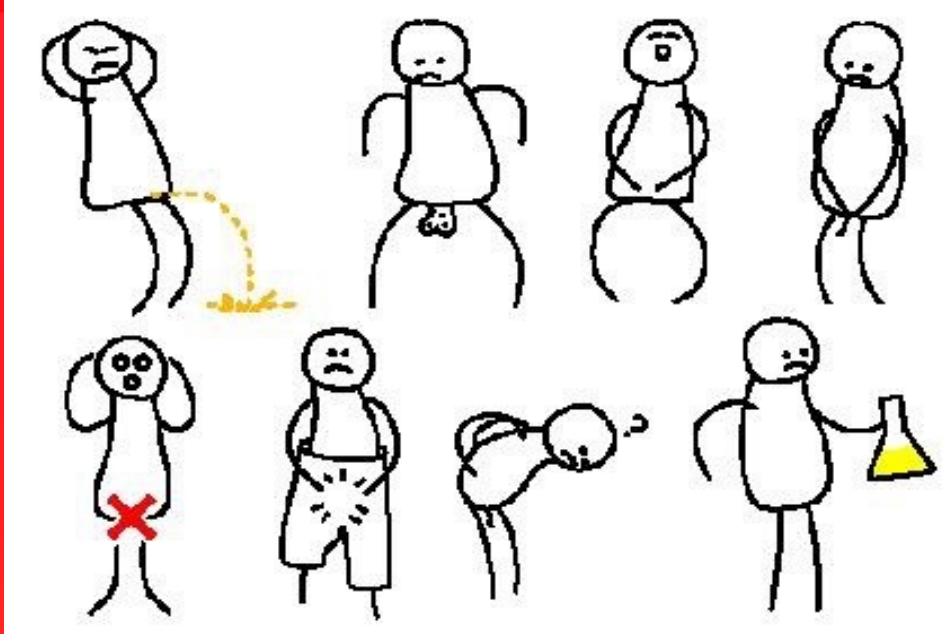
How do we know if we have an STI?



Case studies

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Part of AlfredHealth

Case studies

This presentation follows on from the MSHC GP Partnership Education video "How do we know we have an STI? – Nurses"

This presentation provides five case studies from Melbourne Sexual Health Centre

Following on from each case study presentation, we will pose a few questions and then provide the answers

Paul: presentation

Paul, a 27 year old male, attends your general practice for an STI screen. Paul states he has a male regular partner and as they have an 'open relationship' he also has other casual male partners. He was prompted to attend because one of these casual partners states he had gonorrhoea. Paul denies having any symptoms today.

What testing and/or treatment would you offer Paul today?

Testing for asymptomatic gay & other men who have sex with men (MSM)

STI testing:

- Testing for HIV, syphilis, chlamydia and gonorrhoea should be offered to all gay & other MSM **at least once a year**.

Hepatitis:

- If not already known, baseline testing for Hep A & B should be offered
- Vaccination should be offered if no immunity
- If at risk of Hep C, pre-test counselling and testing for Hep C should also be provided

All GMSM who fall into one or more of the following categories should be offered testing **up to 4 times a year**:

- Any unprotected anal sex
- More than 10 sexual partners in the last six months
- Participate in group sex
- Use recreational drugs during sex

Offer relevant information such as SSPs and NPEP/PrEP if applicable

Rachel: presentation

Rachel, a 21year old female, attends for contraceptive pill script renewal.

What other things might you consider?

Rachel: clinical considerations

- Chlamydia and gonorrhoea test (FPU or swab)
- Bloods – syphilis recommended and HIV if at risk
- CST – no longer necessary as starting age now 25 years
- Education around STI's and SSP's
- Is she using the OCP correctly?

Matthew: presentation

26 year old man presents with urethral discharge and dysuria, which started 2 days after having unprotected insertive anal sex with unknown male.

Nil other symptoms

On examination:

- Purulent discharge
- Redness at meatus/urethral tip
- Nil lesions/blisters/ulcers/rashes

What could it be?

Matthew: possible diagnosis and treatment

- Gonorrhoea, chlamydia, mycoplasma genitalium or NSU
- Test for above and treat at that time
- If high suspicion of gonorrhoea (i.e. purulent discharge, onset within a couple of days of possible exposure and in MSM or overseas traveler), treat with:

  Ceftriaxone 500mg IMI and **Azithromycin 1g PO** on the day
- If low index of suspicion of gonorrhoea treat as NSU with:

  Doxycycline 100mg PO BD for 7 days
- Await results

What would you advise your client?

Matthew: further advice

- No sex for 7 days
- Contact trace: inform all partners and advise them of the treatment needed. Refer to Let Them Know website for partner notification assistance

  https://letthemknow.org.au/
- If symptoms started 2 weeks after sexual contact, less likely to be gonorrhoea
- If he has had unprotected anal intercourse (UPAI) in the last 72 hours, may need PEP if partner's HIV status is unknown

Julie: presentation

30-year-old female presents with:

- White vaginal discharge, with an offensive smell
- No pain or vaginal/vulval itch
- Symptoms started 1 week ago, after sex with regular sexual partner (RSP)
- RSP (male) of 2 years – nil condoms
- Occasional casual sexual partners (CSP) – males, nil condoms
- No PCB or IMB
- LMP 3 weeks ago
- Cervical screening history: Up to date - last test 2 years ago NAD, no abnormal paps / CSTs in the past

What could it be?

What tests would you do?

Julie: examination

- On examination: white discharge at introitus
- Speculum inserted:
    - No inflammation
    - Nil thick white discharge present in vagina
- Raised pH
- Odour of amines

Julie: clinical advice

- Tests for vaginal micro, chlamydia and gonorrhoea
- Perform mycoplasma genitalium test if cervicitis present
- If bacterial vaginosis, treat with **metronidazole 400 bd for 7 days**
- If can't tolerate metronidazole, can use **vaginal dalacin** topically for 7 days

Simon: presentation

35 year old male presents with penile lesion for the last 2 days

- LSI 3/52 ago – UPOI R with an unknown male
- Occasional UPAI with other men – nil condoms

On examination:

- Non tender 1-2cm ulcer on shaft with indulated borders
- Bilateral inguinal lymphadenopathy present
- Nil urethral discharge or dysuria
- Nil rectal pain or bleeding

What tests will you do?

What do you think it may be and why?

Simon: clinical advice

- Swab of penile lesion for Syphilis and HSV
- Serology for syphilis and HIV
- Full STI screen – FPU, rectal swab, throat swab for gonorrhoea and chlamydia

Syphilis result...

General Clinic; on PrEP

Syphilis Serology

Date	Spec.Id	Specimen Type	Test	Result
23/11/17	17591587	Serum	CLIA Total AB	Reactive
			RPR	Non-Reactive
			TPPA	Reactive

Comments

Results consistent with effectively treated or inactive syphilis.

SYPHILIS CUMULATIVE REPORT

S. DATE	LAB ID	SPEC	TOTAL AB	RPR	TPPA	FTA-AB	IgM
04/09/14	14578648	Ser	Reactive	Non Reactive	Reactive		
10/12/14	14608464	Ser	Reactive	Non Reactive	Reactive		
05/03/15	15519934	Ser	Reactive	Non Reactive	Reactive		
05/11/15	15591013	Ser	Reactive	Non Reactive	Reactive		
09/05/16	16542039	Ser	Reactive	Non Reactive	Reactive		
20/06/16	16556302	Ser	Reactive	Non Reactive	Reactive		
01/02/17	17509426	SER	Reactive	Non-Reactive	Reactive		
19/05/17	17540616	SER	Reactive	Non-Reactive	Reactive		
23/11/17	17591587	Ser	Reactive	Non-Reactive	Reactive		

Validated by lsp 15:39 24 Nov 2017

NATA/RCPA accredation number: 2576

What would you advise your client?

Simon: clinical advice

- Bloods result is RPR negative, antibody positive – why?
  - Primary (early) syphilis
- Treatment?
  - **Benzathine Penicillin 1.8gm IMI**
- Follow up?
  - No sex 7/7
  - Contact trace
  - Re-test 1/52, make sure RPR neg

Summary and some tips

- STIs are often asymptomatic – always offer tests
- Treat on the day if you suspect an STI – don't let them out the door!
- Blood tests alone are inadequate
- Testing for Hepatitis C is not recommended unless patient has history of injecting drug use, unsafe tattoos/piercings or in men living with HIV
- Syphilis is endemic in gay men - never order HIV test without adding syphilis
- Avoid herpes serology as a screening test and be careful when interpreting results
- Most first presentations of herpes are recurrences of prior asymptomatic infection, rather than being recently acquired – keep in mind when counselling

Summary and some tips

- At risk populations should be screened for STIs prevalent in that community according to national screening guidelines
- Takes 2 to tango…partners of clients with infections need testing and treatment too!
- Test of cures or test of reinfections for some infections needed
- Ensure window period for HIV and Syphilis covered before giving the “all clear”
- Offer vaccines
- Do your part to reduce stigma

Resources

Victorian Department of Health & Human Services – Syphilis:
https://www2.health.vic.gov.au/about/news-and-events/healthalerts/rising-syphilis-cases-august-2018

Australian STI Management Guidelines for use in primary care:
http://www.sti.guidelines.org.au/

Australian STI & HIV testing guidelines: for asymptomatic MSM
http://stipu.nsw.gov.au/wp-content/uploads/STIGMA_Testing_Guidelines_Final_v5.pdf

ASHM sexual health resources
http://www.ashm.org.au/Resources

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Thank you