Lambeth Sexually Transmitted Infections quick reference treatment guideline for primary care

Principles of Treatment

1. Please refer to the most up to date BNF and Summary of Product Characteristics for full drug monographs which include further dosing and interaction information. ALWAYS check for hypersensitivity/allergy.
2. This is a quick reference guide. Please refer to the Public Health England, National Institute for Health and Care Excellence (NICE) Summary of antimicrobial prescribing guidance – managing common infections (July 2021) and relevant British Association for Sexual Health and HIV (BASHH) guidelines for further information.
3. This guideline is for uncomplicated cases. For complicated cases (e.g. treatment failure/recurrent episodes/clinician concern) consider discussing or referring to Sexual and Reproductive Health (SRH) services.
4. This guideline is based on the best available evidence at the time of development. Its application must be modified by professional judgement, based on knowledge about individual patient co-morbidities, potential for drug interactions and involve patients in management decisions.
5. The majority of this guideline provides dose and duration of treatment for adults. Doses may need modification for age, weight and renal function.
6. If diarrhoea or vomiting occurs due to an antibiotic or the illness being treated, the efficacy of hormonal contraception may be impaired and additional precautions should be recommended. Also see NICE Clinical Knowledge Summaries: Diarrhoea - antibiotic associated
7. Sexually Transmitted Infections (STI) may co-exist therefore consider screening for other STIs if positive for one or more STIs. Screening should include: Chlamydia, Gonorrhoea, HIV, Syphilis (and Trichomonas Vaginalis if patients or their partner are Black African/Caribbean). Hepatitis B and Hepatitis C only need to be tested in high risk groups.

Approved by the Lambeth Together Medicines & Clinical Pathways Group: December 2022. Review date: December 2024 (or sooner if evidence changes)

These guidelines have been developed by the Lambeth Medicines & Long Term Conditions team, Consultant in Sexual Health - Guy's and St Thomas' NHS Foundation Trust (GSTFT) and Lambeth Public Health. The guideline is based on the Public Health England and NICE – Summary of antimicrobial prescribing guidance – managing common infections (July 2021), the British Association for Sexual Health and HIV (BASHH) guidelines and input from a specialist in sexual health.

Please direct any comments or queries to the Lambeth Medicines & Long Term Conditions team (email: Lambethmedicines@selondonics.nhs.uk

Lambeth together

NHS South East London

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STIs may co-exist therefore consider screening for other STIs if positive for one or more STIs. Screening should include: Chlamydia, Gonorrhoea, HIV, Syphilis (and Trichomonas Vaginalis if patients or their partner are Black African/Caribbean). Hepatitis B and C only need to be tested in high risk groups.					
Gonorrhoea PHE & NICE BASHH	**Prerequisite (if unable to complete the following refer to SRH services):** ➢ **Bacterial culture should be taken in addition to Nucleic Acid Amplification Test (NAAT) before treatment** ➢ **Partner notification should be pursued in all patients** ➢ **Test of cure is needed in all patients**			Refer to SRH services for culture and treatment.	If persisting symptoms/signs, then culture at least 72 hours after treatment and look for other co-infection. If asymptomatic, test two weeks after treatment. Antibiotic resistance is now very high, and this concerns all antibiotic used to treat Gonorrhoea. Take advice/refer to SRH services in treatment failure. SRH must report all treatment failures to Public Health England,
	Intramuscular (IM) ceftriaxone 1g Stat	If cannot provide 1st line treatment refer to SRH services for culture and treatment.			
Chlamydia PHE & NICE BASHH	**Prerequisite (if unable to complete the following refer to SRH services):** ➢ **Partner notification should be pursued in all patients.** ➢ **Treat partners or refer partners to SRH services.** ➢ **Test for reinfection at 3-6 months following treatment if under 25 years and consider if over 25years and at high risk of re-infection.**			Due to lower cure rate in pregnancy, test of cure at least three weeks after end of treatment. Azithromycin is the most effective option in pregnancy or breastfeeding. Oral azithromycin 1g Stat then 500mg OD for 2 days (total 3 days treatment) (off-label use).	Opportunistically screen all aged 15-24 years. Risk factors for infection include age under 25 years, a new sexual partner or more than one sexual partner in the past year and lack of consistent condom use. Patients should be advised to avoid sexual intercourse (including oral sex) until they and their partner (s) have completed treatment (or wait seven days if treated with azithromycin). Test of cure for non-pregnant patients is not routinely recommended for uncomplicated genital chlamydia infection, because residual, non-viable chlamydial DNA may be detected by NAAT for 3–5 weeks following treatment.
	Oral doxycycline 100mg BD 7 days	Azithromycin 1g stat on day 1 and then 500mg OD on days 2 and 3.			

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Epididymo-orchitis or Epididymitis
 	
BASHH
 	
PHE & NICE
	Prerequisite (if unable to complete the following refer to SRH services):
	• **If Gonorrhoea suspected take bacterial culture in addition to NAAT at presentation due to high rates of antibiotic resistance.**
	• **If the patient is Gonorrhoea positive, perform test of cure:**
	  • **If by culture, perform at least 72 hours after completion of treatment.**
	  • **If by NAAT, perform 3 weeks after completing treatment.**
					If no improvement after 3 days, reassess diagnosis and therapy.
					
					Further follow-up is recommended at 2 weeks after the initiation of treatment to assess compliance with treatment, partner notification and improvement of symptoms.
					
					Usually due to Gram-negative enteric bacteria in men over 35 years with low risk of STI.
					
					Patients should be advised to abstain from sexual intercourse until they and their partner have completed treatment and follow up in those with confirmed and suspected sexually transmitted infection.

	If STI suspected: Intramuscular (IM) ceftriaxone 1g stat, plus oral doxycycline 100mg BD for 10-14 days If suspect urinary tract infection (UTI) treat as per Lambeth Antibiotic Guideline for Primary Care 2022.	If cannot provide 1st line treatment refer to SRH services for culture and treatment.			
Likely Non-Gonococcal Urethritis (NGU) BASHH	**Prerequisite (if unable to complete the following refer to SRH services):** ➢ **Urethral microscopy to rule out gonorrhoea and to diagnose urethritis** ➢ **Perform STI screening and culture before treatment.**				If no improvement or recurrent NGU refer to SRH services. Patients should be advised to avoid sexual intercourse (including oral sex) until they and their partner (s) have completed treatment.
	Oral doxycycline 100mg BD for 7 days	If cannot provide 1st line treatment refer to SRH services for culture and treatment			

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Pelvic Inflammatory Disease (PID) PHE & NICE BASHH	**Refer woman and contacts to SRH services for cervical microscopy and treatment.** **If prefer to treat in GP practice, see 2nd line option** ➔	**Prerequisite (if unable to complete the following refer to SRH services):** ➢ **Always test for gonorrhoea and chlamydia** ➢ **Offer pregnancy test to exclude ectopic pregnancy** Intramuscular Ceftriaxone 1g STAT PLUS Oral metronidazole 400mg BD for 14 days PLUS Oral doxycycline 100mg BD for 14 days		Refer to gynaecology.	Cervical microscopy is a sensitive test to rule out PID. If gonorrhoea likely (partner has it, sex abroad, severe symptoms), use regimen with ceftriaxone, as resistance to quinolones is high. Review within 3 days of initiating treatment, if no improvement, review diagnosis and treatment, consider referral. Further review at end of treatment may be useful to check symptoms and compliance with all advice. Patients should be advised to avoid oral or genital intercourse until they, and their partner(s), have completed their treatment.
Trichomonas Vaginalis BASHH	Oral metronidazole 400mg BD for 7 days			High rates of treatment failure so advised treatment under care of sexual health team*. **AVOID** 2g single dose metronidazole **local decision*	Treat partner(s) or refer partner(s) to SRH services. Complete test of cure only if still symptomatic following treatment or if symptoms recur. If treatment fails (on-going discharge or repeat positive test at four weeks) refer to SRH services. Advise to abstain from sex for at least one week until patient and partner(s) have completed treatment and follow-up. **Note although BASHH guidance states 2g single dose metronidazole can be used as an alternative in treatment, this dose may not be as effective as metronidazole 400mg BD for 5-7 days** – for further information see BASHH guidance on trichomonas vaginalis

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Genital Herpes BASHH PHE & NICE	Oral aciclovir 400 mg TDS for 5 days		Suppressive treatment (if more than six episodes per year): Oral aciclovir 400 mg BD. Discontinue after a maximum of 12 months to reassess recurrence frequency.	Seek SRH advice.	First episode: treat within five days while new lesions are still forming, or if systemic symptoms persist and refer to SRH services. Review after 5 days and continue treatment if new lesions still appearing and/or complex disease. Refer to SRH services in 2 to 3 weeks if symptoms are not improving. Recurrent: self-care if mild, or short course antiviral treatment (1st line agent) if five or less episodes per year, or suppressive therapy can be initiated if there are six or more episodes per year. Self-care: saline bathing, analgesia, Petroleum jelly or Topical anaesthetic agents, e.g. over the counter (OTC) 5% lidocaine ointment may be useful to apply especially prior to micturition. Discuss transmission.
Genital Warts BASHH CKS	Self-application of podophyllotoxin cream (0.15%) or solution (0.5%) twice daily for 3 days followed by 4 days of no application, for 4 cycles. If ineffective after 4 cycles (i.e.: 4 weeks) try a different method. Unlicensed for extra-genital (i.e.: anal) warts.	Self-application of imiquimod 5% cream 3 nights a week (usually Mon / Wed / Fri) and then wash off each morning, for up to 16 weeks.	Cryotherapy - repeat at weekly intervals for 4 weeks. OR Refer to SRH services.	Refer to SRH services	Review at the end of a treatment course to monitor response and assess the need for further therapy. Ensure that all female patients are on a robust method of contraception for the duration of treatment. See Summary of Product Characteristics (SPC) for selected preparation.

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Molluscum Contagiosum BASHH	**For immunocompetent patients** – *no treatment as can resolve naturally.* Self-application of podophyllotoxin 0.5% solution twice daily for 3 days followed by 4 days of no application. Cycles can be repeated, if necessary, for up to 4 cycles (unlicensed use).	Cryotherapy		*Cryotherapy and other destructive methods are safe. AVOID podophyllotoxin*	Ensure that all female patients are on a robust method of contraception for the duration of treatment. See Summary of Product Characteristics (SPC) for selected preparation. Advise against shaving, electrolysis or waxing genital regions to prevent further spread of lesions
Bacterial Vaginosis (BV) BASHH PHE & NICE CKS	Oral metronidazole 400 mg BD for 5 – 7 days	Dequalinium* 10mg vaginal tablet OD at night for 6 days as a single treatment course **where oral metronidazole has failed or is not well tolerated** **local decision in line with SEL IMOC guidance*	Metronidazole 0.75% vaginal gel. 5g applicator PV at night for 5 nights OR Clindamycin 2% vaginal cream 5g applicator PV at night, for 7 nights	Routine treatment of asymptomatic pregnant women not recommended Treat if symptomatic Women with additional risk factors for preterm birth may benefit from treatment before 20 weeks gestation 1st line oral metronidazole 400 mg BD for 7 days. AVOID 2g single dose oral metronidazole Alternatives are: Metronidazole 0.75% vaginal gel. 5g applicator PV at night for 5 nights OR Clindamycin 2% vaginal cream 5g applicator PV at night for 7 nights	Treating partners does not reduce relapse. A test of cure is not needed if symptoms resolve. Women with BV should be screened for Trichomonas Vaginalis if at risk of STI. For persistent BV in women with an intrauterine contraceptive device, consider removing the device and advising the use of an alternative form of contraception. Treatment is indicated for symptomatic women. If asymptomatic can opt not to treat. **Note although BASHH guidance states 2g single dose metronidazole can be used in treatment in adults, evidence suggests this dose may not be as effective as metronidazole 400mg BD for 5-7 days** – for further information see BASHH guidance on bacterial vaginosis

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Vulvo-vaginal candidiasis PHE & NICE BASHH	Purchase OTC clotrimazole pessaries/ cream or fluconazole oral capsule, if non-recurrent (≤ 2 episodes in 6 months) For further information see: • NHS South East London CCG: 'Prescribing of over the counter medicines is changing' leaflet • Self-Care Forum website • NHS Choices website		Recurrent (>4 episodes per year): 150mg oral fluconazole every 72 hours for three doses induction, followed by 150mg once a week for six months maintenance	Treat if symptomatic, no evidence that asymptomatic women need treatment. OTC clotrimazole 100mg pessary PV at night for 6 nights. AVOID oral antifungal treatment	Follow-up is unnecessary if symptoms resolve. Test of cure is unnecessary. There is no evidence to support treatment of asymptomatic male partners in either episodic or recurrent vulvo-vaginal Candidiasis. OTC topical antifungal creams may be used in addition to oral / vaginal treatment if there are vulval symptoms. All topical and oral azoles give over 80% cure. Be aware of oral azole antifungal medicine related interactions.
Syphilis	Refer to SRH services				
Mycoplasma Genitalium	Refer to SRH services in GSTT only (King's do not test for Mycoplasma Genitalium)				

Sexual and Reproductive Health (SRH) services contact details	
Guy's and St Thomas' NHS Foundation Trust	If your patient has a **positive diagnosis** and requires additional testing, treatment or partner notification you can book an appointment at Burrell Street for the following day here To book the appointment you need to add the patients name, their mobile number and there is a box where you can add notes for the clinic. Referrals from health professionals can be sent to: • Email: gst-tr.referralsrsh@nhs.net • Address: Sexual and reproductive health Business Support Team Burrell Street 4-6 Railway Arches Burrell Street London SE1 0UN https://www.guysandstthomas.nhs.uk/our-services/sexual-health/referrals.aspx Telephone advice from senior clinician: 020 7188 6666
King's College Hospital NHS Foundation Trust	**GP Referral form** should be emailed to kch-tr.outpatientofficer@nhs.net. For emergency referrals, contact the department on Tel: 020 3299 5000 to be put through to the relevant person. Or bleep the HIV/Sexual Health on-call doctor via switchboard Tel: 020 3299 9000 For general enquiries about walk-in clinics and appointments, contact the department on Tel:020 3299 5000 https://www.kch.nhs.uk/service/a-z/sexual-health
Lewisham and Greenwich NHS Trust	Main office for Sexual Health Tel: 0203 049 3516 https://www.nhs.uk/Services/Trusts/Services/Service/DefaultView.aspx?id=104110
Consultant Connect	Consultant Connect enables GPs to access rapid specialist telephone and photo advice and guidance. For South East London user guide https://selondonccg.nhs.uk/wp-content/uploads/2022/03/Primary-care-user-guide.pdf Please note specialties available differ by borough/locality

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