Urethritis in Men

MANAGEMENT SUMMARY

Patient complains of urethral discharge, or penile urethral irritation, or dysuria (without urge/frequency).

Recommended tests
- First catch urine (first 30ml of stream) for chlamydia
- Urethral swab for gonorrhoea

} Refer to respective guideline

Examination findings:
- Profuse purulent penile discharge?

YES

Presumptive gonorrhoea

OR if contact of gonorrhoea, treat with:
- Ceftriaxone 500mg stat im (make up with 2ml lignocaine 1% or as per data sheet) PLUS azithromycin 1g stat

NO

Treat for **non-gonococcal urethritis** with:
- Azithromycin 1g stat OR
- Doxycycline 100mg twice daily for 7 days

Follow-up and partner notification:
- Advise patient that all sexual contacts within past 60 days need testing and treatment.
- Advise no unprotected sex for at least 1 week (including until and 1 week after current partner(s) treated).
- Follow-up by phone or in person 1 week later.
- Check results.
- If **gonorrhoea positive and untreated** – treat accordingly with ceftriaxone or ciprofloxacin if isolate susceptible.
- RE-TREAT if any re-exposure from unprotected sex with untreated partner.
- Offer repeat sexual health checks in 3 months to all patients.
- **If ≥ 2 weeks after treatment the patient complains of persistent or recurrent urethral symptoms: consult with a sexual health specialist.**

Further guideline information – www.nzshs.org or phone the local sexual health service.

This Best Practice Guide has been produced by NZSHS, and is adapted from the CMDHB Best Practice Guideline.
Every effort has been taken to ensure that the information in this guideline is correct at the time of publishing (July 2012).

Produced with funding by the Ministry of Health

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Introduction

Urethritis is an inflammation of the urethra, which may be due to many different aetiological agents. Urethritis is usually sexually transmitted, but may have other causes.

Urethritis is

- Gonococcal when caused by *Neisseria gonorrhoeae*.
- Non-gonococcal (NGU) when *Neisseria gonorrhoeae* cannot be detected.

Non-gonococcal urethritis

- Often due to *Chlamydia trachomatis*.
- Sometimes due to genital mycoplasmas (e.g. *Mycoplasma genitalium*).
- Other rarer causes include *Trichomonas vaginalis*, herpes simplex virus, adenovirus, enteric bacteria (insertive anal sex), and pharyngeal organisms (oral sex).

Symptoms and signs

- Symptoms include urethral discharge, dysuria or irritation.
- Urethral discharge may be noted on examination.

Complications

- Epididymo-orchitis.
- Reactive arthritis.
- Reiter's Syndrome.

Diagnostic tests

- Patient should ideally not have passed urine for 1 hour prior to specimen collection (1 hour minimum).
- A urethral swab for gonorrhoea culture followed by a first catch urine (first 30ml stream) for chlamydia.
- A mid-stream urine (MSU) may be useful when a urinary tract infection is suspected.
- Consider testing for HSV if inguinal lympadenopathy, extreme dysuria or meatitis (see HSV guideline www.herpes.org.nz).

Management

If discharge is profuse and purulent, or there has been known contact with gonorrhoea, and where follow-up is unlikely:

- Empiric treatment for gonorrhoea with:
  Ceftriaxone 500mg im stat (make up with 2ml lignocaine 1% or as per data sheet) PLUS azithromycin 1g stat.

If discharge is minimal or no visible discharge treat with:

- Azithromycin 1g stat OR
- Doxycycline 100mg twice daily for 7 days.

Note: It is essential to check results – if gonorrhoea positive, correct treatment will need to be instituted (see guideline www.nzshs.org/guidelines/Gonorrhoea-guideline.pdf).

Partner notification and management of sexual partners

Partner notification

- Be clear about language: 'partner' implies relationship – all sexual contacts in the last 2 months should be advised so they can have a sexual health check and treatment.
- Contacts should be treated without waiting for their test results; if positive, then their recent contacts need to be informed.
- Most choose to tell contacts themselves.
- Giving written information is helpful.
- Notifying all contacts may not be possible, e.g. if there insufficient information or a threat of violence.

Note: Partner notification is still recommended in gonorrhoea and chlamydia negative urethritis – false negative results are possible, and evidence suggests that treatment of the female partner reduces the chance of recurrence for affected men.

Management of sexual partners/contacts

- Perform a full sexual health check.
- Do not wait for test results – treat empirically with azithromycin 1g stat.
- If gonococcal infection suspected or confirmed in index case, then add ceftriaxone 500mg im stat (make up with 2ml lignocaine 1% or as per data sheet).
- Advise them to use condoms or abstain from sex for 7 days until results of tests are available.

- If chlamydia or gonorrhoea positive – partner notification as above.

Follow-up

- The index case should be followed up by phone or in person 7 days after treatment to ensure symptom resolution, give results, check that all partners/contacts have been notified and to check compliance with treatment.
- Re-treatment is required if there has been any unprotected sex with untreated sexual contacts/partners during the follow-up interval.

Test of cure

- Not necessary.
- "Cure" is indicated by symptom resolution.

Persistent or recurrent urethritis (NGU)

- Symptoms persisting for longer than 2 weeks after initiation of treatment or recurrence of symptoms.
- Need to ensure treatment compliance, and that there has been no new exposure, or re-exposure to untreated contacts.
- Referral to a specialist sexual health service or urologist is recommended.

Referral guidelines

Referral to a specialist sexual health service or urologist is recommended for:

- Persistent or recurrent urethritis.
- Management of sexual partners if desired.

Further guideline information – www.nzshs.org or phone the local sexual health service.

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