Gonorrhoea

MANAGEMENT SUMMARY

TEST IF:
- Person has signs or symptoms of gonorrhoea, e.g. urethritis in males
- Person is a sexual contact of gonorrhoea
- Routine sexual health check in women
- Pre-termination of pregnancy (TOP)
- Pre-intrauterine device (IUD) insertion
- Suspected pelvic inflammatory disease (PID)
- Routine sexual health check in man who has sex with other men (MSM)
- Suspected epididymo-orchitis

Note: Most laboratories are automatically performing dual NAAT testing for chlamydia and gonorrhoea. False positive gonorrhoea results are possible in low prevalence populations – see NZSHS Management of Gonorrhoea 2014, and Response to the Threat of Antimicrobial Resistance.

RECOMMENDED TESTS by NAAT (e.g. PCR or SDA)
- It is recommended to test for co-existing STIs (see Sexual Health Check guideline www.nzshs.org/guidelines)
- **Asymptomatic Female** (or examination declined):
  - A vulvo-vaginal NAAT swab either clinician-taken or self-taken
  - Additional anorectal NAAT swab as indicated based on sexual history
- **Symptomatic Female** (vaginal discharge, abnormal bleeding or pelvic pain):
  - A speculum examination should be carried out. A vulvo-vaginal swab for NAAT testing (prior to speculum insertion) plus an endocervical swab for gonorrhoea culture plus a vaginal culture swab for testing for trichomoniasis, bacterial vaginosis and candida
  - Additional anorectal NAAT swab as indicated based on sexual history
- **Symptomatic Male** (dysuria or discharge):
  - Take a urethral swab for gonorrhoea culture followed by first-void urine for NAAT testing
- **Asymptomatic Male**:
  - Men do not require screening for urethral gonorrhoea if asymptomatic but gonorrhoea testing may be done if a urine specimen is sent for chlamydia testing
- **Men who have Sex with Men:**
  - **Additional anorectal and pharyngeal NAAT swabs** regardless of sexual practices as asymptomatic rectal and pharyngeal infection is common

MANAGEMENT
- **Treat immediately if high index of suspicion** e.g. symptoms and/or signs, or contact of gonorrhoea
- **If antimicrobial susceptibilities are not available** or isolate is ciprofloxacin resistant or pregnant or breastfeeding or pharyngeal infection:
  - Ceftriaxone 500mg im stat (make up with 2ml lignocaine 1% or as per data sheet) PLUS azithromycin 1g po stat (pregnancy category B1) is preferred first line therapy regardless of sensitivities
- **If isolate is Ciprofloxacin susceptible and it is not practical to given an im injection, or severe penicillin or cephalosporin allergy is present:**
  - Ciprofloxacin 500mg po stat PLUS azithromycin 1g po stat. (not in pregnancy, lactation, or pharyngeal infection)
- If clinical PID or epididymo-orchitis, treat as per PID guideline www.nzshs.org/guidelines or Epididymo-orchitis guideline www.nzshs.org/guidelines
- Refer to full guideline if case has drug allergies or anti-microbial resistance is suspected or if anorectal symptoms
- Advise to use condoms or abstain from sex for 7 days after the initiation of treatment and until 7 days after all sexual contacts have been treated

PARTNER NOTIFICATION
- Be clear about language: 'partner' implies relationship – all sexual contacts in the last 2 months should be advised so they can be tested and treated
- Contact(s) should have a sexual health check and if asymptomatic treat empirically for gonorrhoea with ceftriaxone 500mg im stat (make up with 2ml lignocaine 1% or as per data sheet) plus azithromycin 1 gram po stat
- Contacts should be treated without waiting for their test results and advised to use condoms or abstain from sex for 7 days; if positive for other STIs, refer to specific guideline
- Most choose to tell contacts themselves; giving written information is helpful
- Notifying all contacts may not be possible, e.g. if there is insufficient information or a threat of violence

FOLLOW-UP
- By phone or in person, 1 week later
- No unprotected sex for 1 week post treatment?
- Completed/tolerated medication?
- All notifiable contacts informed?
- Any risk of re-infection? Re-treatment necessary if re-exposed to untreated contact
- Test of cure is only needed if symptoms don't resolve or if pharyngeal infection. Re-test by culture in 3 days or by NAAT in 2 weeks (pharyngeal infection)
- Patient should be asked to re-attend for a sexual health check-up in 3 months (test of re-infection)

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

This Best Practice Guide has been produced by NZSHS. Every effort has been taken to ensure that the information in this guideline is correct at the time of publishing (February 2015).

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