MEN WHO HAVE SEX WITH MEN

Practice Points On Particular STIs In MSM

HIV:

- HIV is more common in MSM (local seroprevalence study shows 3-4% of gay men attending Glasgow GUM services are HIV+, compared to 0.1-0.2% heterosexual men).
- HIV should be discussed with all MSM: history and examination taken with HIV in mind where appropriate, documenting previous negative HIV tests, testing intervals and risk events for transmission.

Syphilis:

- Syphilis is now endemic in MSM community, involving most major metropolitan areas in UK and Ireland and EU.. Many patients are asymptomatic. Unprotected sex including oral is implicated and chancres should be looked for at both anogenital and oral sites.
- May present as a single, tender, non-indurated ulcer at the anal margin, which may be confused with a traumatic anal fissure. Consider ulcer PCR for anal lesions and where also proctitis signs and symptoms.

Gonorrhoea:

- Pharyngeal gonorrhoea is very common, nearly always asymptomatic.
- Rectal gonorrhoea is frequently asymptomatic and may be acquired through oral-anal or digital-anal sex.
- Gram stain of rectal swab detects only 60% of cases and can be difficult to interpret.
- Urethritis may also be due to orally acquired *N. meningitidis*
- Co-infection with *C. trachomatis*.in one third cases.
- Antimicrobial resistance pressure on cephalosporins exists and is real threat to effective therapy.

NGU:

- *C. trachomatis* less common and *Mycoplasma genitalium* more common – think about appropriate therapy where persistent NGU.
- BE CAREFUL in interpreting results to patients in long-term relationships: NGU may not always imply acute STI nor recent infidelity

Rectal Chlamydia:

- Asymptomatic CTr: use doxycycline 100mg po bd for 7 days.
- Symptomatic proctitis (CT/LGV): treat with 3 weeks doxycycline 100mg po bd as if for LGV until routine typing/real-time PCR more widely available.
- LGV in asymptomatic form now more prevalent.

Prostatitis:

- Possibly more likely to be due to coliforms than traditional STIs

UTI:

- More common, often coliforms from the gut: a higher threshold for urological investigation may be appropriate (see SIGN 88 2012 at http://www.sign.ac.uk/pdf/sign88.pdf)

Herpes:

- Peri-anal herpes may present as fissuring or just erythema. Always consider a swab from any suspicious lesion. **Many HSV presentations are atypical**.
- Remember: the ulcer PCR tests for both HSV and syphilis.

Hepatitis A:

- Seroprevalence is no higher than rest of age-matched GU population. Epidemics in MSM reported from N America, Australasia and London and often linked to anonymous/group sex.
- Twinrix ® vaccination offered to all MSM because of the risk of sporadic outbreaks and better immunogenicity for Hep B.
- Hep A sero-testing is NOT required

Hepatitis B:

Serotesting and **vaccination** for Hepatitis B should be offered to all men who have sex with men

QIS Standard 7.3 – 70% target

- Close link with sexual activity. MSM regarded as high risk group, but frequent partner exchange confers risk, not sexual orientation per se.

Hepatitis C:

- Very weak correlation with sexual activity, although Hep C more common in MSM with HIV.
- Consider screening if IDU or partner is IDU.
- Note increase injecting drug use in MSM – crystal meth and mephedrone – in context of sex parties (Chem Sex)

Conditions Found Particularly In Men Who Have Sex With Men

Proctitis / Proctocolitis

Infections acquired anally	Infections acquired faecal-orally	Non-infectious causes
T. pallidum	*E. histolytica*	Trauma
N. gonorrhoeae	*Shigella* spp.	Chemical irritants
C. trachomatis (LGV and non-LGV)	*Campylobacter* spp.	Allergies
HSV	Cryptosporidium	Inflammatory bowel disease

N.B. Infections with multiple types of organisms are common

Symptoms

- Constipation or diarrhoea
- rectal discomfort
- tenesmus
- blood and/or mucus per rectum -often coats stool
- cramping abdominal pain
- abdominal tenderness
- fever

Investigations

- Clinical appearance by proctoscopy is a good guide
- Gram stain - **poor correlation** between pus cell count and histological evidence of inflammation. DO NOT TREAT +++ RECTAL PUS CELLS AS AN STI
- Swabs of mucopus for gonorrhoea (culture and NAAT), of rectal mucosa for Chlamydia (NAAT), HSV PCR (TP PCR)
- **If Clinical proctitis then indicate on Chlamydia test form and request LGV PCR**
- Stool specimens - at least 3 stool specimens on alternate days -for ova, cysts, culture and *C. difficile* toxin (if history of recent antibiotic use)
- Consider rectal charcoal requesting shigella, if clinical suspicion)
- Where enteric fever is suspected, take **blood** cultures as well. Unwell patients with enteric fever should be admitted to Brownlee under the ID team.
- If these fail to reveal cause refer to Ruth McKee @ GRI or Helen Dorrance @ Victoria for sigmoidoscopy and biopsy

Amoebiasis (*Entamoeba Histiolytica*)

- 90% of cyst excretors are asymptomatic. Symptoms include: diarrhoea, abdominal discomfort, flatulence, blood and mucus in stool, weight loss and anorexia

Diloxanide furoate 500 mg tid for 10 days is
drug of choice for asymptomatic cyst excretion (outside script on FP10)

Can pre-treat with **Metronidazole** 800 mg tid for 5 days if cysts persist

Enteric Fevers

- Caused by *Salmonella* spp, *Shigella* spp, and *Campylobacter*
- *Shigella flexneri* is more common in MSM, with more severe symptoms of watery diarrhoea which may be bloody, associated with fever, cramps and tenesmus. *Shigella* lesions in unusual sites e.g. (penile) cutaneous *shigella* have been reported in MSM
- Campylobacter may present as a cause of localised proctitis in MSM
- Antibiotics often prolong infectivity and may encourage *C.difficile.*
- However, HIV positive patients with salmonella are at risk of relapsing disease – seek advice re management from ID.

Treatment is usually supportive

All cases are notifiable

Salmonellosis/ Shigellosis: geographical variation in antimicrobial sensitivity patterns should prompt advice from local ID/microbiology team

Campylobacter: Azithromycin 500 mg po daily 3 days (increasing resistance reported in UK to quinolones such as ciprofloxacin)

Cryptosporidium

- Asymptomatic carriage is common. Orofaecal spread is a feature of sexual transmission
- Can present as a flu like illness with abdominal pain, diarrhoea – no blood or pus in stool.
- May occur in men of any orientation, but consider as a marker for possible HIV. Diarrhoea often persists longer (>14 days) in immunocompromised men
- Excretion may be episodic and repeat stool specimens may be necessary. ELISA test is around 90% accurate, but more expensive
- Treatment is with supportive measures including rehydration. No specific drug treatment if not immunocompromised.

Giardia Intestinalis

- Often asymptomatic. Can get foul smelling diarrhoea and flatulence, cramping epigastric pain and bloating, weight loss.
- Steatorrhoea-like stool with **no blood or pus**

Metronidazole 200 mg tid for 7 days (70% cure) (NB no alcohol)

Mepacrine 100 mg tid for 7 days (95% cure)

Strongyloides Stercoralis

- Larvae commonly infect upper GI tract, less commonly rectum is involved with eosinophilic chronic inflammation

Discuss with consultant: named patient drugs required

Enterobius Vermicularis (threadworm, pinworm)

Mebendazole 100 mg stat

May need second dose after 3 weeks if recurrence

- Remember partner may need treatment

Traumatic Anorectal Conditions

Traumatic Proctitis

Causes:

- rough penetrative sex (penis or fingering)
- chemical irritation as above for per-anal dermatitis, plus drugs
- foreign body damage e.g. dildos
- reactions to douching equipment and instillants.

Treatment:

- check for signs of systemic illness and/or perforation (see rectosigmoid injuries below)
- care if performing sigmoidoscopy/proctoscopy to avoid perforating a lacerated area
- observe, consider admission to a surgical unit if in doubt

Traumatic Klismaphilia

Features:

- caused by enema usage for sexual gratification
- allergic colitis
- chemical irritation leading to burns and water intoxication if high volume

Investigation:

- STI screen
- FBC, U&E, sigmoidoscopy and or barium enema

Treatment:

- supportive
- consider steroid enema (as for inflammatory bowel disease)
- may require admission if systemically unwell
- counselling on harm reduction is particularly important

Foreign Bodies

- Usually become impacted in the sacral hollow where rectum forms a sharp anteroposterior curve
- Can usually be palpated in lower/mid rectum
- Plain abdominal film helps locate number, size and position
- Peristalsis may expel the FB – if stable, patient may be observed for 24 hours
- Most can be manually removed with sedation and local anaesthesia: Valsalva manoeuvre may help. In Sandyford sedation is not practical and surgical help should be sought

Chronic Injury

Receptive anal intercourse is associated with reduced resting pressure in anal canal

There is no published evidence that anal incontinence is caused by anal intercourse, but it is more common in MSM than men who have sex with women, and women (even allowing for birth trauma and episiotomy damage), and anal trauma and anal fistulae are established causes which are also more common in MSM.

Rectosigmoid Trauma

	Laceration	**Full thickness injury**
Penis	30%	10%
Fisting	30%	30%
Foreign body	16%	60%
Unspecified	9%	-

Symptoms and findings:

- rectal pain and bleeding
- peritonism
- pelvic abscesses
- septic shock

Investigations:

- FBC
- Abdominal X-ray, Chest X-ray, water soluble barium enema
- Sigmoidoscopy

Management:

Admit if:

- Fever
- Unstable vital signs
- Peritonism
- Active bleeding
- Raised WCC

Ref: Irizarry E, Gottesman L. Rectal trauma including foreign bodies. Int J STD & AIDS 1996;7:166-9

Anal Sphincter Disruption

Symptoms:

- faecal leakage
- moist seepage
- not normally caused by anal sex unless fisting

Treatment:

- local measures – hygiene, incontinence aids
- various surgical procedures, results often disappointing

Peri-Anal Haematoma

Symptoms:

- painful swelling of anal margin may follow receptive anal intercourse
- dark blue-purple swelling about 2-4cm diameter observed at anal margin due to clot in vein

Treatment:

- lesions often regress or burst spontaneously
- small incision to vein can produce rapid relief: consider surgical referral if patient is distressed

Anal Fissures And Ulcers

- pain on defaecation

- bleeding
- erythematous /oedematous epithelium
- often lateral, rather than classical (non-traumatic) longitudinal fissures

Examination:

- STI screen especially HSV and syphilis
- Check for malignancy

Treatment:

- Hygiene
- Bulking agents
- Analgesia
- Second line: Glyceryl trinitrate 0.4% cream (Rectogesic 30g) apply 2.5 cm of cream (1.5 mg GTN) every 12 hours max 8 weeks; not if under 18 years old. NB costs £32.80 NON FORMULARY needs consultant signature.

Peri-Anal Dermatitis

- usually dry, erythematous, itchy rash
- poorly defined margin
- involvement of whole gluteal fold differentiates it from flexural eczema
- fungal tape/scrape may help, but negative findings do not exclude a fungal cause

Treatment:

- avoidance of possible irritants – lubricants, lotions, oils, perfumes and some condoms
- withdrawal of any self medication e.g. lanocaine
- simple water hygiene, pad dry and greasy emollient
- mild steroid such as 1% hydrocortisone
- if it persists trial of steroid + antifungal (Daktacort) or moderately potent steroid

Anorectal Malignancy

- Overall MSM have a higher relative risk of anorectal cancers, estimated in one study at 12.4%. Part of this increased risk is associated with HIV in which a wide variety of anal canal cancers has been reported.
- HPV has been found more commonly in rectal tumours in MSM. Risk factors generally for anorectal cancers are also more common in MSM, such as warts, fissures, fistulae and smoking

When these risks are controlled for, there is still an observed increased incidence of anorectal cancers, but with a relative risk of 2.8.

Screening

Routine cytological screening for HPV-associated anal intraepithelial neoplasia has been suggested but there is insufficient evidence to support its routine use in clinic. The management of AIN remains unclear. There is a developing debate regarding the use of the HPV vaccines for MSMs.

Clinical Points:

- Consider proctoscopy on MSM with perianal warts to exclude intranal lesions.
- Refer suspicious lesions to an appropriate recto-proctologist e.g. Ruth McKee at GRI
- In HIV positive patients be suspicious of unusual rectal appearances e.g. lymphoma, SCC
- In HIV positive patients remember to look for rectal Kaposi's sarcoma
- This means that you should do proctoscopy on all HIV positive men who give consent
- Health education for smokers