GENITAL ULCERS

Also refer to separate protocols for Syphilis, Herpes and Lymphogranuloma venereum.

Notes

- Always take a good travel history from patient and any partner(s)
- Herpes simplex infection is by far the most common cause of genital ulcers in Sandyford but syphilis can present with multiple painful ulcers
- Examine for and document inguinal lymphadenopathy
- LGV is now well established in MSM globally but usually presents with proctitis. Be alert to genital ulcers in LGV contacts.

Clinical Features

	Syphilis	**HSV**	**Chancroid**	**LGV**	**Granuloma inguinale/ Donovanosis**
Organism	*Treponema pallidum*	Herpes simplex	*Haemophilus ducreyi*	*Chlamydia trachomatis L1, L2, L3*	*Klebsiella granulomatis*
Geographical distribution	Worldwide	Worldwide	Africa, Asia, Latin America	Foci in tropics plus recent MSM outbreak mostly proctitis	All resource poor countries
Incubation period	1-12 weeks	2-7 days	4-7 days	3 days – 6 weeks	Up to 6 months
Primary lesion	Papule	Vesicle	Pustule	Papule	Papule
No of lesions	Usually one	Multiple, may coalesce	Multiple, may coalesce	Usually one, often cleared by time of lymphadenopathy	Variable
Diameter (mm)	5-15	1-2	2-20	2-10	Variable
Edges	Elevated Round	Erythema	Ragged Undermined	Elevated Round	Elevated Irregular
Depth	Superficial or deep	Superficial	Excavated	Superficial Or deep	Elevated
Induration	Firm	None	Soft	Variable	Firm
Pain	Unusual	Common	Common	Variable	Uncommon
Lymphadenopathy	Firm Non-tender unless infected Unilateral	Firm Tender Bilateral	Soft Very tender May suppurate	Tender Loculated Unilateral "The Groove sign"	Uncommon Firm "Pseudobubo"

Initial Investigations

- Full sexual health screen including BBVs.
- HSV / Syphilis PCR. Indicate genital ulcer and site on NAAT form.
- Dark ground microscopy to exclude syphilitic chancre if lesion is moist.
- In a HUB if a patient presents with a possible chancre arrange for the patient to go directly to Sandyford Central for dark ground microscopy (if appropriate reviewing staff available). Patients must be fast-tracked and the GUM doctor of the day must be notified.
- Request syphilis serology (indicate 'genital ulcer' in additional information section of form)

Further Investigations

If clearly secondarily infected:

- Bacteriological culture of ulcer (charcoal swab)

If LGV ulcer suspected:

- NAAT for *Chlamydia trachomatis* from **lesion** AND **urethral** sample for CT NAAT. LGV PCR available via West of Scotland Specialist Virology Centre (sent to STI ref lab in Edinburgh). LGV on request form.

If Chancroid suspected:

- Culture medium for *Haemophilus ducreyi* can be prepared by the laboratory if 2 working days' notice is given. Direct microscopy may show 'rail-road' bacilli. PCR for *H. ducreyi* is available through the West of Scotland Specialist Virology Centre (contact to discuss request). Aim for bedside inoculation if possible.
- Aspirate any bubo through healthy skin, send sample in sterile container (contact laboratory to request specific cultures if required).

If Donovanosis suspected:

- A tissue 'rolling smear' can be stained with rapid Giemsa (or consider biopsy and crush smear) to look for *Klebsiella granulomatis* ("Donovan bodies").

If persistent symptoms:

- Consider dermatological conditions and malignancy (Behcet's, lichen planus, pemphigoid, bullous impetigo, squamous cell carcinoma)

Treatment

Have a low threshold for treating with Aciclovir as per HSV protocol as this has very few downsides. HSV can appear atypical.

Therapeutic regimens:
(also refer to separate protocols for syphilis, HSV and LGV and BASHH Chancroid/Donovanosis Guidelines)

Chancroid

Azithromycin 1g orally single dose (if HIV negative)

Ceftriaxone 250mg IM.

Follow-up 1 week. Treat partners exposed within 10 days of onset of symptoms even if partner is asymptomatic.

If symptomatic fluctuant buboes these can be aspirated to give relief.

Donovanosis

Azithromycin 1g weekly or 500 mg daily until lesions heal (minimum 3 weeks)
OR
Doxycycline 100 mg bd until lesions heal (minimum 3 weeks)

Partner notification: all contacts within 6 months should be assessed clinically for signs of infection and offered treatment

***Some treatments are contraindicated in pregnancy – see STIs in pregnancy protocols**

Follow up

All patients should be followed up clinically until signs and symptoms have resolved.

References

BASHH: UK National Guideline for the management of Chancroid 2014
https://www.bashhguidelines.org/media/1059/chancroid_2014-ijstda.pdf

2017 European guideline for the management of chancroid
https://iusti.org/wp-content/uploads/2019/12/chancroid.pdf

BASHH: UK National Guideline for the management of Donavonosis 2018
https://www.bashhguidelines.org/media/1168/donovanosis-2018.pdf

BASHH: UK National guidelines on the management of syphilis, 2015 (updated 2019)
https://www.bashhguidelines.org/media/1148/uk-syphilis-guidelines-2015.pdf

BASHH: UK National guideline for the management of anogenital herpes 2014
https://www.bashhguidelines.org/media/1019/hsv_2014-ijstda.pdf

BASHH: UK National guideline for the management of lymphogranuloma venereum 2013
https://www.bashhguidelines.org/media/1054/2013-lgv-guideline.pdf