A review of sexually acquired proctitis: an array of symptoms, investigations and treatments

E Nicol, J Shaw, C Ward

The Hathersage Integrated Contraception, Sexual Health and HIV Service, Central Manchester University Hospitals NHS Foundation Trust, UK
Contact email: jonathan.shaw2@cmft.nhs.uk

Background

With recent lymphogranuloma veneruem (LGV) and Shigella outbreaks amongst men-who-have-sex-with-men (MSM), proctitis has become a prominent clinical issue. There is no UK guideline regarding proctitis management but guidance is available from IUSTI¹ and CDC². We have summarised this guidance as an appendix to this poster (please contact us via email to request this). IUSTI states “A presumptive clinical diagnosis of proctitis can be made when there are symptoms and signs, and a definitive diagnosis when the results of laboratory tests are available”¹. Our service follows IUSTI recommendations that focussed syndromic management is recommended if there are signs of proctitis and/or >10 PMNLs on gram-stained rectal microscopy¹.

Objectives

We aimed to review our proctitis cases to generate an evidence-based clinic policy. We also considered this an opportunity to standardise practice within a large inner-city sexual health clinic.

Methods

All casenotes coded C4NR between 01/01/14-31/12/15 were reviewed with data collated on demographics, presenting complaint[s], requested investigations, initial management, subsequent follow up and further treatment. This data was analysed via a bespoke Microsoft Excel spreadsheet. Current guidance and themes from this analysis were combined to generate a clinical pathway for proctitis within our service.

Results

Demographics: Of 114 C4NR codes during the review period, 100 care episodes had notes accessible for retrospective review. This cohort comprised 92 patients, with 6 patients attended twice and 1 thrice. All patients were male; 83 homosexual, 8 bisexual and 1 heterosexual. 67 patients were White British, 31 were HIV positive. Median age was 29 years (range=18-62).

Clinical assessment: Presenting symptoms were varied:

Proctoscopy in 82 cases found varying combinations of clinical signs:

32 - rectal discharge
24 - rectal oedema
25 - contact bleeding
10 - rectal and/or anal ulceration
19 - normal findings

Microscopy was diagnostic of proctitis in 39/84 (46.4%) patients.

PMNL per field	N=
<1	4
1-5	14
5-10	27
>10	39

Table 1: Microscopy findings

Physician-requested investigations were:

LGV was prevalent amongst the chlamydia infections identified with 43% (6/14) from the L1-L3 serovars; 4 of the 6 (67%) patients with LGV infection were HIV positive.

Treatment: All patients were treated at their initial visit. Treatment at the initial visit was predominantly doxycycline-based (99/100), with course length varying from 7-21 days. Concurrent therapies were influenced by clinical findings and reported contacts; predominantly ceftriaxone (53), azithromycin (31), and aciclovir (19).

With the variety in diagnoses and therapies we were concerned about patient re-attendance rates. During the assessed period 32 patients re-attended the service within one month. The reasons were varied:

Table 2: Reattendances		
Re-attendance reason	N=	
Treatment following positive results from baseline visit	10	(5x gonorrhoea, 3X syphilis, 1x LGV, 1x shigella)
Test of Cure	7	
Clinical review of symptoms	13	
Retreatment (failure of abstinence)	1	
No improvement in symptoms	1	(GP follow up recommended)

Conclusions

The following key themes were identified:

- Gonorrhoea incidence was high (28%), with 86% (24/28) of these cases also culture positive.
- Herpes simplex was also common when tested for (9/30, 30%).
- 43% of CT infections identified were of LGV serovars, the majority of whom were amongst HIV-positive MSM
- All patients diagnosed with proctitis were male, and 99% were MSM

With regards to a clinic policy the following decisions were made for all patients with symptomatic proctitis:

- All patients should have a gonococcal culture taken and receive presumptive treatment for gonorrhoea.
- All patients will be tested for Herpes, with a future retrospective review of the cost effectiveness of this universal testing approach.
- All patients should receive sufficient doxycycline to allow time for an LGV result to be returned (in our service this is 14 days initial therapy) with an extension to 21 days if the result is positive

We would suggest that other services retrospectively review their cases of proctitis to generate clinical pathways for proctitis management within local populations.

We also are intrigued by the absence of women in this cohort. We postulate that there may be under-reporting of symptoms or presentation to other [non-GU] services. More work assessing female proctitis would be of interest.

References

- HJC de Vries, A Zingoni, J White, et al. 2013 European Guideline on the management of proctitis, proctocolitis and enteritis caused by sexually transmissible pathogens. Int Journal STD & AIDS 2014, Vol. 25(7) 465–474
- KA Workowski, GA Bolan. Centers for Disease Control and Prevention. Sexually Transmitted Diseases Treatment Guidelines, 2015. MMWR R&R, 64 (3), June, 2015, pp 100-101