<table>
<thead>
<tr>
<th>Acronym</th>
<th>Definition</th>
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<tbody>
<tr>
<td>BBV</td>
<td>Blood Borne Virus</td>
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<tr>
<td>BV</td>
<td>Bacterial Vaginosis</td>
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<tr>
<td>FSRH</td>
<td>Faculty of Sexual and Reproductive Health</td>
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<tr>
<td>FVU</td>
<td>First Void Urine</td>
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<tr>
<td>GUM</td>
<td>Genito Urinary Medicine</td>
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<tr>
<td>HPV</td>
<td>Human papillomavirus</td>
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<tr>
<td>HSV</td>
<td>Herpes Simplex Virus</td>
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<tr>
<td>HVS</td>
<td>High Vaginal Swab</td>
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<tr>
<td>IUD</td>
<td>Intrauterine Device</td>
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<tr>
<td>IUS</td>
<td>Intrauterine System</td>
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<tr>
<td>MSM</td>
<td>Men who have Sex with Men</td>
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<tr>
<td>NAAT</td>
<td>Nucleic Acid Amplification Test</td>
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<tr>
<td>PID</td>
<td>Pelvic Inflammatory Disease</td>
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<td>PMS</td>
<td>Premenstrual Syndrome</td>
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<tr>
<td>PWID</td>
<td>People who Inject Drugs</td>
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<tr>
<td>STI</td>
<td>Sexually Transmitted Infection</td>
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<tr>
<td>TAF</td>
<td>Tayside Area Formulary</td>
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<tr>
<td>TV</td>
<td>Trichomonas Vaginalis</td>
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<tr>
<td>UPSI</td>
<td>Unprotected Sexual Intercourse</td>
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<tr>
<td>UTM</td>
<td>Universal Transfer Medium</td>
</tr>
<tr>
<td>VVS</td>
<td>Vulvovaginal Swab</td>
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This guidance is intended for use by those who undertake testing for Sexually Transmitted Infections. It highlights those STIs that cause harm and summarises the key points to consider when offering tests, or dealing with symptoms. It also provides guidance on how to access support or refer individuals to our specialist clinics (see details on last page).

Tayside Sexual and Reproductive Health Service (TSRHS) focuses on complex STI testing and management amongst high risk and vulnerable groups and will support partner notification for those diagnosed with an STI in primary care where patient consent is given.

For current service hours, visit: www.sexualhealthtayside.org

GPs and practice nurses can obtain support and advice via:
Phone: 07805 762572
Email: Tay-UHB.TSRH@nhs.net
The following questions are helpful in assessing risk of STIs and deciding when to undertake testing:

- When did you last have sex?
- Was this a regular or casual partner? If regular, how long have you been together? Are you using/did you use a condom.
- When did you last have sex with somebody else?
- In your lifetime have your sexual partners been male, female or both?
- Have any of your sexual partners been from Africa, the Caribbean, Asia or Eastern Europe?
- Any history of STIs (including hepatitis and HIV)?
- Any history of intravenous drug use (either themselves or their sexual partners)?

**Timing of tests**

Incubation periods for STIs vary. Confirm that sufficient time has elapsed post-exposure to ensure the validity of results. If ongoing sexual risk, do not defer testing: carry out a full baseline screen immediately and then arrange for repeat tests as necessary.

<table>
<thead>
<tr>
<th>Definitive results timing</th>
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<tbody>
<tr>
<td>Chlamydia/Gonorrhoea</td>
<td>2 weeks following risk</td>
</tr>
<tr>
<td>HIV</td>
<td>4 weeks following risk</td>
</tr>
<tr>
<td>Syphilis</td>
<td>3 months following risk</td>
</tr>
<tr>
<td>Hepatitis B/C</td>
<td>3 months following risk</td>
</tr>
</tbody>
</table>
Chlamydia and Gonorrhoea testing

KEY CHANGE TO GUIDANCE

Please confine testing for Chlamydia infection to the following symptomatic and specified groups of asymptomatic individuals. Avoid opportunistic testing in those attending for Smear tests or Intrauterine device insertion unless there is a clear clinical reason. Testing is NOT RECOMMENDED in women with vaginal discharge only as this is a poor predictor for CT infection. Please treat discharge empirically (see vaginal discharge section). Only discharge that persists despite treatment should prompt a Chlamydia test.

Test in the following symptomatic groups:
• Intermenstrual, post-coital or break-through bleeding
• Lower abdominal pain in those who are sexually active
• Cervicitis
• Urethritis
• Urethral discharge
• Reactive arthritis in those who are sexually active
• Epididymo-orchitis in those who are sexually active
• Conjunctivitis (Neonates or sexually active adults with persistent symptoms)

Provide targeted testing only in the following asymptomatic groups:

• Sexual partners of those diagnosed with Chlamydia
• Sexual partners of those with suspected Chlamydia (e.g. PID or epididymo-orchitis)
• Those who have been diagnosed with Chlamydia in the past year
• Individuals who are under 25 years
• Individuals post sexual assault
• Men who have sex with men
• Infertility
HIV - Many will be low risk but you are more likely to do harm by not offering an HIV test than by testing someone with their consent. Testing is recommended where any other STI has been diagnosed and in high risk patients as listed below.

Syphilis - This is more common in the high risk groups especially MSM although cases are rising in heterosexuals. Testing is recommended where any other STI has been diagnosed.

High risk patients

Men who have sex with men (MSM), sex workers, drug users, people from endemic areas or who have sex with someone from an endemic area or contacts of these cases.

- Offer HIV, Hep B and syphilis testing
- Offer Hepatitis C testing: main indication being drug use.

Whilst we would encourage GPs to test all high risk individuals all of the above high risk patients justify referral to specialist services.

Please note: there are other indicator illnesses which should prompt blood borne virus screening. NHS Tayside HIV testing guide and further information on BBV is available on Tayside Sexual Health and BBV MCN website www.sexualhealthtayside.org

Sexual health samples

<table>
<thead>
<tr>
<th></th>
<th>Male (heterosexual)</th>
<th>Male (MSM)</th>
<th>Female</th>
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</thead>
<tbody>
<tr>
<td>Chlamydia and Gonorrhoea NAAT</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>- First void urine (FVU)</td>
<td>- FVU</td>
<td>- Vulvovaginal swab (VVS) patient or clinician taken</td>
<td></td>
</tr>
<tr>
<td>(Not necessarily an early morning sample)</td>
<td>- Pharyngeal swab (if patient has oral sex)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(unless no history of anal contact during sex)</td>
<td>- Rectal swab</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Genital Herpes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- HSV swab to be taken from base of genital ulcer or a deroofed vesicle</td>
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</tbody>
</table>
Preferred samples for chlamydia/gonorrhoea and for herpes

Use this container for the following:
Chlamydia / Gonorrhoea testing; self taken Vulvovaginal swabs (women)
Throat and Rectal swabs (men who have sex with men). On ICE request 'swab for Chlamydia and Gonorrhoea PCR'. This container is 221394 from the National Distribution Centre, APTIMA MULTITEST KIT PRD-03456 HOLOGIC.

Use this container for the following:
Chlamydia/Gonorrhoea testing; urine (men).
The urine must fill the container to the level marked. On ICE request 'urine for Chlamydia and Gonorrhoea PCR'. This container is item 221387 from the National Distribution centre, APTIMA URINE SPECIMEN KIT 301040 HOLOGIC.

Use this container for suspected genital herpes
The preferred sample is a swab of the lesion. On ICE request ‘HSV (Herpes simplex) Swab’
This container is item 157167 from the National Distribution Centre, UNIVERSAL TRANSPORT MED1ML FLOCKED SWAB
How to take a vaginal swab for chlamydia/gonorrhoea

Gonorrhoea Culture Swabs

If a patient has a positive Gonorrhoea NAAT test please refer to a sexual health clinic for culture and sensitivity testing, treatment and contact tracing.

Sexual health serology: HIV, Syphilis and Hepatitis

A blood sample is sent in a single gold vacutainer. Hepatitis B screening is with core antibody (Hep B cAb).
Vaginal discharge

Vaginal discharge management exemplifies syndromic approach i.e. clinical assessment is more important than tests (see flowchart on next page).

The commonest causes of Vaginal discharge are not sexually transmitted. Candida and bacterial vaginosis are the most common cause of discharge; diagnosis can be based on symptoms, pH and signs.

Vaginal swabs (HVS) for culture are of limited value. Reporting of commensal bacteria can cause anxiety and lead to over treatment their use should be reserved for the following situations:

- Recurrent/persistant discharge after empiric treatment
- Symptoms, signs and/or pH are inconsistent with a specific diagnosis
- Related to problems in pregnancy, postpartum or gynaecological surgery/instrumentation

Vaginal discharge in post-menopausal women

The commonest cause of discharge in a post menopausal woman is due to lack of oestrogen. If there are no risk factors for STIs, examine and consider a trial of topical oestrogen.
History
Nature of discharge
Duration of discharge
Associated symptoms (itch/malodour/abd pain)
Cyclical symptoms
Any treatments tried

- Not sexually active or
- Low risk of STIs or
- None of the conditions listed on the right

Examination declined
Examination accepted

Rx based on clinical symptoms
Pt to return if Sx do not improve or if they recur

Consider examination and investigations based on clinical findings

pH > 4.5
pH ≤ 4.5

Malodour, no itch
Itch, no malodour

Rx for BV
See TAF
www.nhstayside.adtc.scot.nhs.uk

Rx for candida
See TAF
www.nhstayside.adtc.scot.nhs.uk

Examine and investigate
- Vaginal pH
- Vulvovaginal swab for Chlamydia and Gonorrhoea plus blood tests for HIV and Syphilis
- Consider HVS where outlined above
- Urinalysis where indicated
- Pregnancy test where indicated
- Bimanual examination if PID is suspected
- Exclude foreign body

- Manage as appropriate
- TV suspected refer
- Uncertain diagnosis refer
- Discharge persists or recurs refer

High risk of STIs
- <25
- 2 or more partners in past year
- History of STIs
- Upper reproductive tract Sx
- Bloody discharge
- Uncertain Sx
- Pregnant, post partum, post ToP, post instrumentation
- Recurrent Sx or failed Rx

Based on: Sexually Transmitted Infections in Primary Care 2013 (RCGP/BASHH)
by Lazaro N. available at www.rcgp.org and www.bashh.org/guidelines
Genital herpes simplex virus infection (HSV)

Clinical features suggestive of primary genital HSV infection include:
- Multiple painful vesicles or ulcerated lesions
- Systemic flu-like symptoms; fever, myalgia (only in primary infection)
- Inguinal or femoral tender lymphadenopathy
- Severe dysuria, particularly in women
- Retention of urine or constipation due to autonomic neuropathy

Diagnosis is often clinical but virological confirmation (HSV PCR) should always be attempted. Treat before you have results back. Please test for HIV and Syphilis and refer single/painless/atypical ulcers to rule out syphilis.

Management

Primary and recurrent genital herpes:
- Aciclovir 400mg 3 times daily for 5 days
- Encourage bathing in salty water to discourage the formation of labial adhesions
- Oral analgesia

Admit to hospital if there is:
- Urinary retention
- Intractable pain
- Aseptic meningitis
- Woman in second or third trimester of pregnancy who is systemically unwell

Follow up

Review at 2 weeks with virological results if first episode. Offer a full STI screen if deferred at first visit.

Suppressive treatment for confirmed recurrent genital herpes
Indication >6 recurrences per year
- Aciclovir 400mg BD for 12 months followed by treatment interruption

Await more than two recurrences before considering reintroducing suppressive therapy. Consider referral.
All women with primary herpes diagnosed in the third trimester should be referred to a GUM consultant and the obstetrician should be informed.
Genital warts (HPV)

Treatment options:

No treatment

One-third of visible warts disappear spontaneously within 6 months, therefore no treatment is an option for anogenital warts at any site (especially small, low volume warts).

Self-applied treatments

Self-Applied topical treatments cannot be used in pregnancy and are not licensed for use in children. If a self-applied treatment is chosen, show the person the location of the warts and where to apply topical treatment (to reduce treatment failure owing to under treatment)

Podophyllotoxin

Solution or 0.15% cream (Condyline® or Warticon®) is useful for soft, non-keratinized, external lesions but is not licensed for anal warts; cream may be easier to apply. Latex condoms may be weakened if in contact with podophyllotoxin.

Imiquimod

5% cream (Aldara®) may be suitable for both keratinized and non-keratinized, external genital and perianal warts but is not recommended for internal use. It is the first line for perianal warts. Latex condoms may be weakened if in contact with Imiquimod. Imiquimod has the lowest recurrence rate of all treatments.

Ablative methods

Cryotherapy, excision, and electrocautery: consider if appropriately trained and resourced. Follow up can be offered where complete response has not been achieved within 2 weeks or if new lesions appear. Consider referral for recalcitrant warts.
When to refer to specialist services

We can provide the following in our general clinics:

- STI testing - priority given to those in a high risk or vulnerable group.
- STI treatment.
- Contraception - priority given to those in a high risk or vulnerable group.
- IUS/IUD insertions or replacements if used for contraception or as part of HRT.
- SDI (Nexplanon®) insertions, replacements or removals.
- Emergency contraception, including emergency IUD insertion.
- Medical aftercare following sexual assault.

Specialist clinics

Complex SRH
A specialist clinic for individuals with the following;
Complex contraception issues, (medical problems, contraindication, side effects, bleeding problems on contraception, problems finding the right method, repeated termination of pregnancies or unplanned pregnancies, request for sterilization <30 years, diaphragms or perimenopause) and Pre-menstrual syndrome.
Refer through Trak to Genito-urinary contraception.
Please also refer to the Tayside Contraception Guidelines www.sexualhealthtayside.org/professionals/guidelines/guidelines-reproductive-health for advice, or email (see contact details below).

Complex Procedure
Failed IUD/IUS insertions or replacements.
Failed or deep implant removals.
Failed IUD/IUS removals.
Lost IUD/IUS threads (please ensure a TVUSS has been performed to confirm presence of device prior to referral)
Refer through Trak to Genito-urinary contraception.
Menopause
Patients with complex menopause problems can be referred to this clinic through Trak to Genito-urinary Menopause. Please also refer to the Tayside Menopause Guideline:

www-sexualhealthtayside-org-professionals-guidelines-guidelines-reproductive-health

for referral criteria or for advice please email (see contact details below).

GUM complex
A specialist clinic for individuals with the following:
• Atypical genital ulceration.
• Genital ulcers in individuals from endemic areas or who have had sex with someone from an endemic area.
• Recalcitrant warts.
• Recurrent bacterial vaginosis or vulvo-vaginal candida.
• Sexually acquired proctitis.
• Sexually acquired reactive arthritis.
Refer through Trak to Genito-urinary medicine.

HIV Pre exposure prophylaxis (PrEP)
Individuals wishing to start or continue with PrEP. Refer through Trak to Genito-urinary medicine.

YP drop-in
Sexual health clinic, Drumhar Health Centre only (age 18 and under, Monday 4-6 pm).
Young people are able to access all standard services
Please phone 01382 425542.

Sexual problems clinic
A specialist clinic for individuals with the following:
• Anorgasmia.
• Vaginismus/Superficial Dyspareunia.
• Lack of sex drive.
• Non consummation.
• Erectile dysfunction (after medical/organic causes excluded).
• Early and delayed ejaculation.
Refer through Trak to Genito-urinary medicine psychosexual.
Referral queries phone 01382 425533

For any non urgent clinical queries please email: Tay-UHB.TSRH@nhs.net.

Emails are checked by senior doctors and responded to within 48 working hours.

Where are our services

- Dundee Sexual Health Clinic
  Level 7 South Block
  Ninewells Hospital
  Dundee DD1 9SY

- Perth Sexual Health Clinic
  Drumhar Health Centre
  North Methven Street
  Perth PH1 5PD

- Angus Sexual Health Clinic
  Abbey Health Centre
  East Abbey Street
  Arbroath
  DD11 1EN

Opening hours can be found on our website
www.sexualhealthtayside.org

Useful resources

TSRH Hormonal contraception guide NHS Tayside Formulary
www.taysideformulary.scot.nhs.uk

Other useful websites

www.menonlytayside.org
www.sexualhealthscotland.co.uk
www.bashh.org
www.fsrh.org

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