NEWSLETTER #9
APRIL 2012

STIs in Gay Men Action Group

Gonorrhoea Notifications Rising

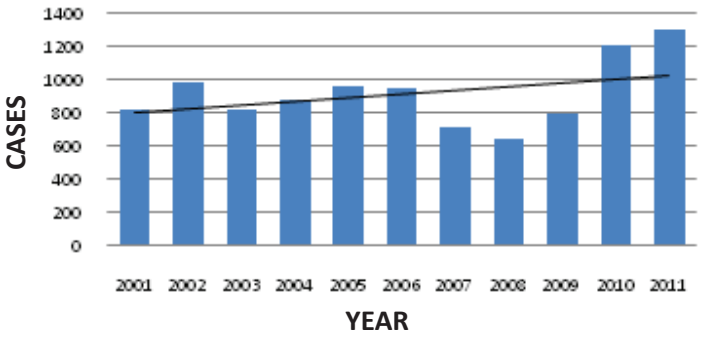
2012 has brought with it a substantial increase in gonorrhoea cases detected in men in the Sydney and South Eastern Sydney Local Health Districts.

This followed a 10% increase from 2010 figures to over 1200 cases of gonorrhoea detected in 2011.

The proportion of all gonorrhoea infections affecting non-genital sites also increased between 2010 and 2011. In 2011, almost half of reported gonorrhoea cases were rectal and throat infections compared with one-third of all cases in 2010.

This highlights the importance of gonorrhoea screening at non-genital sites in MSM where, in contrast to urethral infections, symptoms are often absent.

GONORRHOEA NOTIFICATIONS IN MALE RESIDENTS OF SYDNEY AND SOUTH EASTERN SYDNEY LOCAL HEALTH DISTRICTS, 2001-2011



Gonorrhoea Screening and Surveillance

In the pre-antibiotic era, urethral irrigation was used as a treatment for infection in the urethra. Potassium permanganate was used in World War 1 (the soldiers' nick-named this treatment "pinky panky"). Sulphonamides were used, then penicillin when it was discovered.

Initially, these antibiotics were very effective. Penicillin was successful for decades as a single-dose treatment, but gonorrhoea has shown remarkable capacity to develop resistance to the antibiotics used to treat it.

Resistance has developed to penicillins, quinolones and tetracyclines, and is mediated by either a single-step plasmid mutation which produces a major resistance, or a chromosomal mutation which produces a step-wise more gradual resistance over time.

The 3rd generation **cepahlosporin ceftriaxone,** used as a single intramuscular injection, has been very effective in treating gonorrhoea at all mucosal sites (urethra, rectum, cervix and throat). So it is alarming to experts that the first true high-resistant case to ceftriaxone was reported recently in Japan.

Ceftriaxone 500mg IMI stat is still the treatment of choice for gonorrhoea. Recent sexual partners must be tested and presumptively treated.

Antibiotic Sensitivity Surveillance is critical.

To assist with surveillance, doctors diagnosing gonorrhoea based on a PCR test should take a swab for culture because PCR tests cannot be used for antimicrobial sensitivity testing.

In Sydney most gonorrhoea is occurring among MSM. It is important to take swabs from all mucosal sites at risk of infection - for MSM this usually means a rectal and throat swab, in addition to urine PCR testing.

Infections at the rectum or throat usually do **NOT** cause any symptoms, so regular screening is the only way to detect infections. Infection with gonorrhoea in the urethra nearly always causes a urethral discharge.

Key Points:

- When doing an STI screen in MSM, take a throat swab to test for gonorrhoea, a rectal swab to test for gonorrhoea and chlamydia, and a urine test for chlamydia and gonorrhoea
- If urethral discharge is present, take a urethral swab for gonorrhoea culture in transport medium
- To treat gonorrhoea, use ceftriaxone 500 mg IMI stat
- Get recent sexual partners (those from the previous 2-6 months) tested AND presumptively treated
- Retest for gonorrhoea in line with the MSM testing guidelines

HPV vaccination to prevent cancers in gay men

A 2011 study by Palefsky et al[1] on the efficacy of Gardasil in 602 MSM, demonstrated 77.5% efficacy at preventing HPV 6, 11, 16, and 18-related anal intraepithelial neoplasia (AIN grades 1-3) and anal cancer in HPV naïve individuals.

Analysis of all randomised MSM individuals in the study group (irrespective of HPV status at enrolment) demonstrated vaccine efficacy for prevention of HPV 6, 11, 16 and 18-related intraepithelial neoplasia of 50.3%.

In response to this and other ongoing research in males, the TGA has extended the indication for Gardasil to include the prevention of anal disease.

GARDASIL is indicated in males 9 through 26 years of age for the prevention of anal cancer, precancerous or dysplastic lesions, external genital lesions and infection caused by HPV types 6, 11, 16, and 18 (which are included in the vaccine)[2].

For full article click here

STIGMA:
Addressing STIs in Gay Men for Over 10 Years.

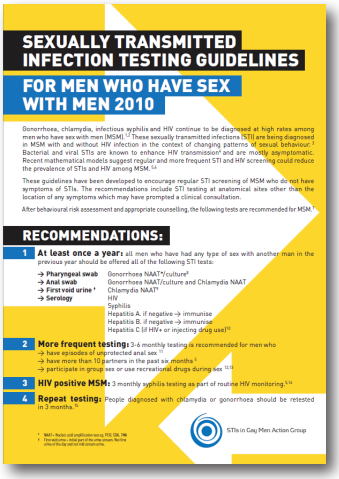
STIGMA was formed in 2000 out of initial concerns that there would be an outbreak of syphilis among Sydney gay men, as had occurred among gay communities in the UK, USA and Netherlands. During that time a small number of syphilis cases had already been identified in homosexually active men who had sexual contacts from the east coast of the United States.

The STIGMA partnership works collaboratively to address STIs in gay men in inner-Sydney. The STIGMA collaboration has grown from 10 members at the first meeting to 20 members at present.

The membership includes Local Health Districts (public health units, sexual health services, HIV/sexual health promotion programs), community-based organisations, research centres, general practitioners, Ministry of Health and divisions of general practice.

STIGMA achievements:

- The development of the 'Clinical guidelines for STI testing of men who have sex with men'. Most recent edition: 2010.
- The promotion of the Drama Down Under STI testing website.
- The development of STI testing resources.
- The implementation of a hepatitis A & B vaccination campaign.
- The implementation of a syphilis reduction initiative including awareness raising and enhanced surveillance.
- The coordination of accredited GP education.
- Biannual development and distribution of the STIGMA newsletter.


SEXUALLY TRANSMITTED INFECTION TESTING GUIDELINES

FOR MEN WHO HAVE SEX WITH MEN 2010

Gonorrhoea, chlamydia, infectious syphilis and HIV continue to be diagnosed at high rates among men who have sex with men (MSM).[1,2] These sexually transmitted infections (STI) are being diagnosed in MSM with and without HIV infection in the context of changing patterns of sexual behaviour.[3] Bacterial and viral STIs are known to enhance HIV transmission[4] and are mostly asymptomatic. Recent mathematical models suggest regular and more frequent STI and HIV screening could reduce the prevalence of STIs and HIV among MSM.[5,6]

These guidelines have been developed to encourage regular STI screening of MSM who do not have symptoms of STIs. The recommendations include STI testing at anatomical sites other than the location of any symptoms which may have prompted a clinical consultation.

After behavioural risk assessment and appropriate counselling, the following tests are recommended for MSM.[7]

RECOMMENDATIONS:

1 **At least once a year:** all men who have had any type of sex with another man in the previous year should be offered all of the following STI tests:

→ Pharyngeal swab	Gonorrhoea NAAT*/culture[8]
→ Anal swab	Gonorrhoea NAAT/culture and Chlamydia NAAT
→ First void urine †	Chlamydia NAAT†
→ Serology	HIV
	Syphilis
	Hepatitis A, if negative → immunise
	Hepatitis B, if negative → immunise
	Hepatitis C [if HIV+ or injecting drug use][10]

2 **More frequent testing:** 3-6 monthly testing is recommended for men who
→ have episodes of unprotected anal sex [11]
→ have more than 10 partners in the past six months [6]
→ participate in group sex or use recreational drugs during sex [12,6]

3 **HIV positive MSM:** 3 monthly syphilis testing as part of routine HIV monitoring.[6,13]

4 **Repeat testing:** People diagnosed with chlamydia or gonorrhoea should be retested in 3 months.[14]

STIs in Gay Men Action Group

The STIGMA partnership aims to provide relevant, high quality responses to local epidemiology.

Currently, STIGMA is evaluating this newsletter.

We would appreciate any feedback you could provide to assist us in ensuring we are the newsletter best meets your needs.

A 2 page fax-back survey is attached for your completion.

Alternatively, you can complete an online version of the survey at: www.surveymonkey.com/s/SurveySTI

The STIGMA partnership would like to thank you in advance for your feedback.

References

1. Donovan B, Franklin N, Guy R, Grulich AE, Regan DG, Ali H, et al. Quadrivalent human papillomavirus vaccination and trends in genital warts in Australia: analysis of national sentinel surveillance data. LancetInfect Dis 2001; 11: 39-44
2. Future I/II Study Group; Dillner J, Kjaer SK, Wheeler CM, Sigurdsson K, Iversen OE, Hernandez-Avila M, et al. Four year efficacy of prophylactic human papillomavirus quadrivalent vaccine against low grade cervical, vulvar, and vaginal intraepithelial neoplasia and anogenital warts: randomised controlled trial. BMJ 2012; 341: c3493

This newsletter is produced by the STIGMA GP/Clinicians Communication Project and is written for general practitioners in metropolitan Sydney. For further information on STIGMA visit: www.stigma.net.au

This working group focuses on informing GPs of issues relating to gay men and STIs and includes GP representatives, health promotion and education specialists in consultation with sexual health specialists.

Feedback or suggestions to: **Jeffrey Dabbhadatta,** Jeffrey.Dabbhadatta@sesiahs.health.nsw.gov.au

STIs in Gay Men Action Group members:

South Eastern Sydney Local Health District, Sydney Local Health District, Northern Sydney Local Health District, Eastern Sydney Division of General Practice, Central Sydney GP Network, The National Centre in HIV Social Research, The Kirby Institute, Positive Life NSW and ACON