Issue 18, Autumn - Winter 2017

SEXUAL HEALTH Update

Provided by your Sexual Health Clinics

MYCOPLASMA GENITALIUM IN MEN WHO HAVE SEX WITH MEN (MSM)

Victoria Hounsfield
Senior CMO at Clinic 16, Northern Sydney LHD Sexual Health Service

Mycoplasma genitalium (Mg) is a sexually transmitted bacterium that is difficult to culture and detection relies on the use of nucleic acid amplification tests (NAAT). It causes urethritis in men, cervicitis and pelvic inflammatory disease in women, and rectal infection which is often asymptomatic.

There have been several articles in mainstream media in the last few months regarding Mg as a new "superbug" and as such there has been an anecdotal increase in clients requesting information and testing on Mg [1, 2].

Because evidence-based data is currently limited, resistance is common, and there are few effective treatment options, including antibiotics that are not on the PBS, treatment guidelines are difficult to develop and maintain, and can be inconsistent between locations. It is best to consult your local sexual health service or call NSW SHIL for help with managing Mg.

Melbourne Sexual Health Centre (MSHC) is a world leader in Mg research and here we summarise their current experimental treatment protocol supported by limited data[3]. MSHC is able to test for concurrent macrolide resistance and Mg NAAT which supports their current approach to treatment. Until resistance and Mg testing is more widely available and this approach has been assessed, it is difficult to provide specific recommendations for primary care.

INDICATIONS FOR MG TESTING IN MEN:

There is currently no evidence to support screening of asymptomatic individuals for Mg. However, testing is recommended for the following syndromes and situations:

1) **Urethritis:** all men with symptoms of urethral discharge, discomfort and dysuria: first void urine specimen for Mg NAAT.

2) **Proctitis**: MSM who present with symptoms of proctitis (e.g. rectal pain, discharge or bleeding) should be tested for rectal Mg NAAT using an anal swab.

3) **Sexual contacts of Mg**: should be tested including ano-rectal swabs in MSM. Throat swabs are not indicated as current evidence indicates pharyngeal infection is uncommon.

TREATMENT AND FOLLOW UP

Current Australian STI management guidelines advise treating uncomplicated Mg infections not known or suspected to be macrolide resistant with azithromycin 1g stat [4].

However, infections known to be susceptible to azithromycin will develop resistance in 10 – 20% of cases treated with azithromycin. A recent MSHC study detected macrolide-resistant mutations in Mg infections in approximately 80% of MSM and 50% of heterosexual men [3].

For Mg infections suspected to be macrolide resistant (Mg in MSM, persisting symptoms greater than 7 days after first line treatment, positive Mg result more than 21 days after azithromycin, or Mg resistance mutation detected) MSHC suggest using moxifloxacin 400mg daily orally for seven days.

Moxifloxacin is not TGA-approved for this infection and may cause diarrhoea or tendonitis. It is an option for GPs comfortable prescribing it privately, alternatively refer to your local Sexual Health clinic for further management. Pharmacies typically charge around $90 for seven tablets. There are limited efficacy data and no data for treatment courses of less than seven days.

TEST OF CURE (TOC)

TOC is essential in managing Mg infections because of the risk of persisting, asymptomatic, resistant infection. The ideal time is three weeks after starting antibiotics.

If treatment failure occurs, consider reinfection from an untreated partner. Testing and treating partners is recommended, but careful testing (including ano-rectal swabs in MSM) and observation of the index case may be sufficient. Infection rates in contacts are 40–50% in women and MSM and 30% in heterosexual men.

To reduce azithromycin use and the generation of macrolide resistance in Mg, MSHC is using 7 days oral doxycycline 100mg bd as first line treatment for NGU and proctitis. Patients who test positive to Mg are recalled while on doxycycline and prescribed azithromycin if macrolide susceptible and moxifloxacin if macrolide-resistant.

As information about Mg spreads through the community, you may notice an increase in anxiety in your patients. Remember there are a number of counselling services available for referrals.

There is an urgent need for new national data to bring consistency to Mg guidelines and new effective treatment options to become available.

References

1. http://www.smh.com.au/national/health/researchers-raise-concerns-over-sexually-transmitted-superbug-20170211-guao45.html
2. http://www.9news.com.au/health/2017/02/13/13/17/hundreds-of-thousands-of-aussies-could-have-drug-resistant-sti
3. http://mshc.org.au/HealthProfessional/MSHCTreatmentGuidelines/Mycoplasmagenitalium#.WK-3wNJ97cs
4. http://www.sti.guidelines.org.au/sexually-transmissible-infections/mycoplasma-genitalium#follow-up

SEXUAL TRANSMISSION OF HEPATITIS C VIRUS IN GAY AND BISEXUAL MEN

Gail Matthews, Andrew Grulich, and Fengyi Jin
Kirby Institute, UNSW

- There is some evidence the hepatitis C virus (HCV) can be sexually transmitted in gay and bisexual men (GBM), in the absence of HIV co-infection.
- HIV pre-exposure prophylaxis may increase rates of HCV sexual transmission due to reduced condom use and higher rates of ulcerative STIs.
- For HCV testing in GBM, GPs should refer to the STI Testing Guideline for Asymptomatic MSM or contact their local sexual health clinic.

The extent to which the hepatitis C virus (HCV) can be transmitted through sexual contact has been controversial. Gay and bisexual men (GBM) are particularly vulnerable to sexually transmitted infections (STI) due to higher exposure to new sexual partners.

Until recently, the higher incidence of HCV infection appears to be limited to HIV-positive GBM. However, this may change because of the implementation of Pre-Exposure Prophylaxis (PrEP) aimed at high-risk HIV-negative GBM as a means of biomedical HIV prevention. There are concerns that high-risk HIV-negative GBM might be at increased risk of HCV infection via sexual contact by having condom-less anal intercourse (CLAI) with HCV/HIV co-infected partners. A systematic review was conducted by researchers at the Kirby Institute, UNSW, to summarise evidence published since the year 2000 on the risk of HCV infection in GBM.

This review considered cross-sectional and cohort studies and case-series reports on HCV prevalence, incidence and risk factors among GBM.

Cross-sectional studies showed the pooled HCV prevalence was markedly higher in HIV-positive GBM than in their HIV-negative counterparts (8.3% vs 1.5%). Close to half of the studies reported a prevalence of above 10% in HIV-positive men. The difference was striking in pooled HCV prevalence between GBM who did and who did not report a history of injecting drug use (34.8% vs 3.5%). The majority of the 18 studies that had data in injecting drug users (IDUs) reported a prevalence of above 20%. Among those who did not report injecting drug use, the pooled prevalence was higher in HIV-positive than in HIV–negative GBM (7.1% vs 0.9%). In IDUs the pooled prevalence was similar between the HIV-positive and -negative (35.7% vs 23.5%).

Cohort studies showed a higher pooled HCV incidence in studies conducted in clinics than in the community (7.0 vs 1.4 per 1,000 person-years). The pooled incidence was also substantially higher in HIV-positive GBM (6.4 vs 0.4 per 1,000 person-years).

In both cross-sectional and cohort studies, the identified risk factors for HCV infection other than a history of injecting drug use included CLAI and a history of ulcerative STIs.

The authors also noted that case-series reports of acute HCV infection among mainly HIV-positive GBM began to surface since the early 2000s. The first report emerged in France, with five men presenting with infectious syphilis who also acquired acute HCV infection. All denied a history of injecting drug use but CLAI was identified as an important risk factor. Shortly afterwards, similar findings were echoed in other major cities in Europe, Australia, and the US. In 2015, McFaul et al summarised 42 cases of acute HCV infection cases diagnosed in Europe between 2010 and 2014 who were HIV-negative GBM. This report also noted that two cases were participants of a PrEP trial in the UK. In the same year, Volk et al also reported two cases of acute HCV infection among participants of a PrEP trial in the US who also denied a history of injecting drug use.

The authors concluded the risk for HCV infection in GBM who do not report a history of injecting drug use is generally low. Nevertheless, sexual transmission of HCV cannot be ruled out in this population. In HIV-negative GBM, HCV sexual transmission could be indirectly facilitated by PrEP, through reduced condom use and higher rates of ulcerative STIs.

For more information, contact your local sexual health clinic or the Sexual Health Info Link on 1800 451 624.

SEXUAL HEALTH SERVICES

NSW GOVERNMENT Health
South Eastern Sydney Local Health District

Sydney Sexual Health Centre
www.sshc.org.au
Sydney Hospital
Macquarie Street, Sydney
9382 7440

Short Street Centre
St George Hospital
Short Street, Kogarah
9113 2742

SouthZone Sexual Health Centre
430 The Kingsway, Caringbah
9113 2742

The Albion Centre
www.thealbioncentre.org.au
150 Albion Street, Surry Hills
9332 9600

Clinic 180
180 Victoria Street, Kings Cross
9357 1299

NSW GOVERNMENT Health
Sydney Local Health District

RPA Sexual Health
www.slhd.nsw.gov.au/communityhealth/sexualhealth.html
16 Marsden Street, Camperdown
9515 1200

NSW GOVERNMENT Health
Northern Sydney Local Health District

Clinic 16
www.clinic16.com.au
20 Herbert Street, St Leonards
9462 9500

SEXUAL HEALTH INFO link
1800 451 624

Play Safe
www.playsafe.health.nsw.gov.au

HIV TESTING WEEK 1-7 JUNE

1-7 June is NSW HIV Testing Week and aims to raise awareness of the importance of HIV testing. Increased testing improves the chance of early diagnosis, which leads to better individual health and reduced chance of onward transmission. HIV Testing Week was first held in 2013 in response to a 24% increase in HIV notifications from 2011 to 2012.

SUBSCRIBE

We extend an invitation to GPs, practice nurses and relevant clinicians to receive this free twice-yearly newsletter and updates on sexual health. To subscribe please email your name, job title and workplace to: **solomon.wong@sswahs.nsw.gov.au**

STIs in Gay Men Action Group

This newsletter is an initiative of the STIs in Gay Men Action group (STIGMA). It is written for general practitioners, practice nurses and relevant clinicians in inner Sydney.

Partners include:

South Eastern Sydney Local Health District, Sydney Local Health District, Northern Sydney Local Health District, Ministry of Health, ASHM, Central and Eastern Sydney Primary Health Network, Centre for Social Research in Health, The Kirby Institute, Australian Federation of AIDS Organisations (AFAO), Positive Life NSW and ACON.