

# SEXUALLY TRANSMITTED INFECTION TESTING GUIDELINES FOR MEN WHO HAVE SEX WITH MEN

Like other cities with large populations of men who have sex with men (MSM)<sup>1,2,3</sup>, rates of new cases of gonorrhoea, infectious syphilis<sup>4</sup> and chlamydia<sup>5</sup> remain high in some Sydney MSM. These sexually transmitted infections (STI) have been diagnosed in MSM with and without HIV infection in the context of changing patterns of unprotected anal sex.<sup>6</sup> Bacterial and viral STIs can fuel HIV transmission.

Along with other planned strategies, these guidelines have been developed to assist health care workers who care for MSM, including doctors providing HIV/AIDS care.

The following recommendations have been developed using evidence from clinic and outreach settings, population cohort and case control studies, expert opinion and guidelines from other countries (Level 3-4 NHMRC evidence<sup>7</sup>). Until there is higher-level evidence from studies including general practice settings in Australia, these recommendations provide guidance for STI testing of MSM.

MSM who do not have symptoms of STIs are the focus of these guidelines but they also apply to testing at anatomical sites other than the location of any current symptoms. Gonorrhoea, syphilis and chlamydia frequently do not produce symptoms regardless of the anatomical site of infection. Therefore, after behavioural risk assessment and appropriate counselling, it is important to offer comprehensive testing to all MSM.<sup>8,9</sup>

## 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 in the following ways:

- Pharyngeal swab                      Gonorrhoea culture<sup>10</sup>
- Anal swab                              Gonorrhoea culture/NAAT\* and chlamydia NAAT
- First catch urine                      Chlamydia NAAT<sup>11</sup>
- Serology                                HIV
- Syphilis
- Hepatitis A, if negative Immunise
- Hepatitis B, if negative Immunise
- Hepatitis C (if HIV+ or injecting drug use)<sup>12</sup>

**2. More frequent testing:** 3-6 monthly testing is recommended for men who

- have episodes of unprotected anal sex<sup>5</sup>
- have more than 10 partners in the past six months<sup>5</sup>
- attend sex-on-premises venues (SOPVs)
- use recreational drugs<sup>1</sup> or
- seek partners via the internet<sup>13</sup>

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

**4. Consider** Herpes simplex virus (HSV) type-specific serology.<sup>9</sup>

\* NAAT = Nucleic acid amplification test eg. PCR, LCR, SDA, TMA

# SOME EXPLANATIONS OF KEY STI TESTING RECOMMENDATIONS:

## **Anal STI testing**

Receptive anal sexual practices such as receptive fingering, toy insertion or oral-anal sex are independent risk factors for anal gonorrhoea and chlamydia, even in men who use condoms for receptive anal intercourse.<sup>5</sup> So, while any anal symptoms (eg bleeding, itching, discharge, pain) should prompt anal examination and testing, all MSM should have anal swabs. MSM with HIV are currently at high risk of anal STIs.<sup>14</sup>

Patient self collection of an anal swab has been shown to be acceptable and effective at detecting anal gonorrhoea and chlamydia.<sup>4</sup>

Anal screening for cytological abnormalities or HPV infection is not recommended until more data is available on the reliability of screening methods, the safety of and response to treatment, and programmatic considerations.<sup>9</sup>

## **Bacterial STI testing technology at the urethra, throat and anus**

NAAT are highly sensitive and robust tests, which have been validated for use in urethral, rectal and urine samples for gonorrhoea and chlamydia testing.<sup>15</sup> However, gonococcal NAAT are subject to cross reactions from non-*Neisseriae* and non-gonococcal *Neisseriae* species, so laboratory best practice recommends initially positive gonococcal NAAT samples undergo supplemental NAAT targeting different part(s) of the gonococcal genome before test results are issued.<sup>16</sup> Caution is advised when interpreting gonococcal NAAT results especially from non-genital sites.

The individual and public health significance of a positive chlamydia throat test has not been determined, so routine throat chlamydia testing is not recommended until there is further evidence.<sup>10</sup>

## **Herpes simplex (HSV) type-specific serology**<sup>9</sup>

HSV-1 and HSV-2 infections are highly prevalent in MSM, and, with or without symptoms, increase the risk of acquiring and transmitting HIV. People with HIV infection are at increased risk of chronic, disabling mucocutaneous ulcers and other complications. Therefore, some experts recommend routine HSV serological testing for MSM. Only type-specific HSV glycoprotein G antibody tests should be used; no other serological test accurately differentiates between HSV-1 & -2 antibodies. HSV-seropositive MSM, especially if antibody to HSV-2 is present, should be informed of the increased risk of acquiring or transmitting HIV and recognition of the symptoms of anogenital herpes, including prodrome and other mild and non-specific symptoms.

## **Repeat testing**<sup>9</sup>

Repeat testing at 3 months is recommended to detect reinfection, rather than as a 'test of cure'. Men recently infected with an STI often recommence sex within a network of men with high prevalence of infection and treatment of partners is often incomplete. Prevalence is higher amongst men who have had recent chlamydia and gonorrhoea infections.<sup>17</sup> Gonorrhoea and chlamydia DNA may persist for 4 - 6 weeks and the treatments are highly effective, so a 'test of cure' using a NAAT or culture test soon after treatment is not required.

## **Hepatitis C virus testing:**

Hepatitis C virus (HCV) testing is not recommended for HIV negative MSM who do not inject drugs because it is rare.<sup>18</sup> However, it is recommended for HIV positive MSM who appear to be at increased risk of HCV from some very specific sexual practices.<sup>12</sup>

## **IMMUNISATION TIPS FOR MSM**<sup>18</sup>

### **HIV negative MSM**

Once an immunocompetent patient has completed the primary immunisation schedule for HAV or HBV, further Hepatitis A or B serology and booster doses are not necessary.

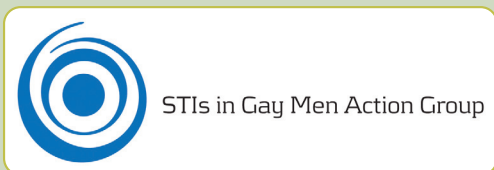
### **HIV positive MSM**

HBV surface antibody levels to guide the need for booster doses is indicated after double dose Hepatitis B immunisation in immunosuppressed MSM.

**STI CARE AND TREATMENT GUIDELINES** [www.stipu.nsw.gov.au/resources.html](http://www.stipu.nsw.gov.au/resources.html)

**STI INFORMATION FOR GAY MEN IN NSW** [www.whytest.org](http://www.whytest.org)

Endorsed by the Australasian Chapter of Sexual Health Medicine / Royal Australasian College of Physicians and the Royal Australian College Of General Practitioners



These guidelines are available at [www.stigma.net.au](http://www.stigma.net.au)

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