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British Association of Sexual Health and HIV (BASHH) United Kingdom national guideline for the management of sexually transmitted enteric infections 2023

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Abstract

This is the first British Association of Sexual Health and HIV (BASHH) national guideline for the management of sexually transmitted enteric infections (STEI). This guideline is primarily aimed for level 3 sexual health clinics; however, it may also be applicable to other settings such as primary care or other hospital departments where individuals with STEI may present. This guideline makes recommendations on testing, management, partner notification and public health control of STEI.

Keywords

Sexually transmitted enteric infections, men who have sex with men, *Shigella* spp., *Giardia duodenalis*, *Entamoeba histolytica*, proctocolitis, enteritis, hepatitis, proctitis, antimicrobial resistance, public health, guideline

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Introduction

There are increasing rates of sexually transmitted enteric infections (STEI) particularly amongst men who have sex with men (MSM), including heterosexual identifying MSM and some groups of gender diverse people.[1–3] This guideline is intended to provide evidence-based guidance on the management of both suspected and confirmed STEI in adults. This guideline focuses on STEI organisms for which there exists robust evidence for sexual transmission.

Search strategy

PICO (Population, Intervention, Comparator, Outcome) questions were generated and used for database searches conducted from Pubmed, Medline, Embase and the Cochrane library. (Supplemental Appendix 1) The search terms were kept broad to include all the guideline questions. Only publications in the English language were reviewed. Manuscript titles, abstracts, and then selected full texts manuscripts were reviewed and included in the review; further manuscripts identified from key manuscript references were also included. The Grading of Recommendations Assessment Development and Evaluation (GRADE) system was applied to assess the grade of the evidence.

Methods

The multidisciplinary writing group reviewed the evidence for transmission, investigation, management, antimicrobial

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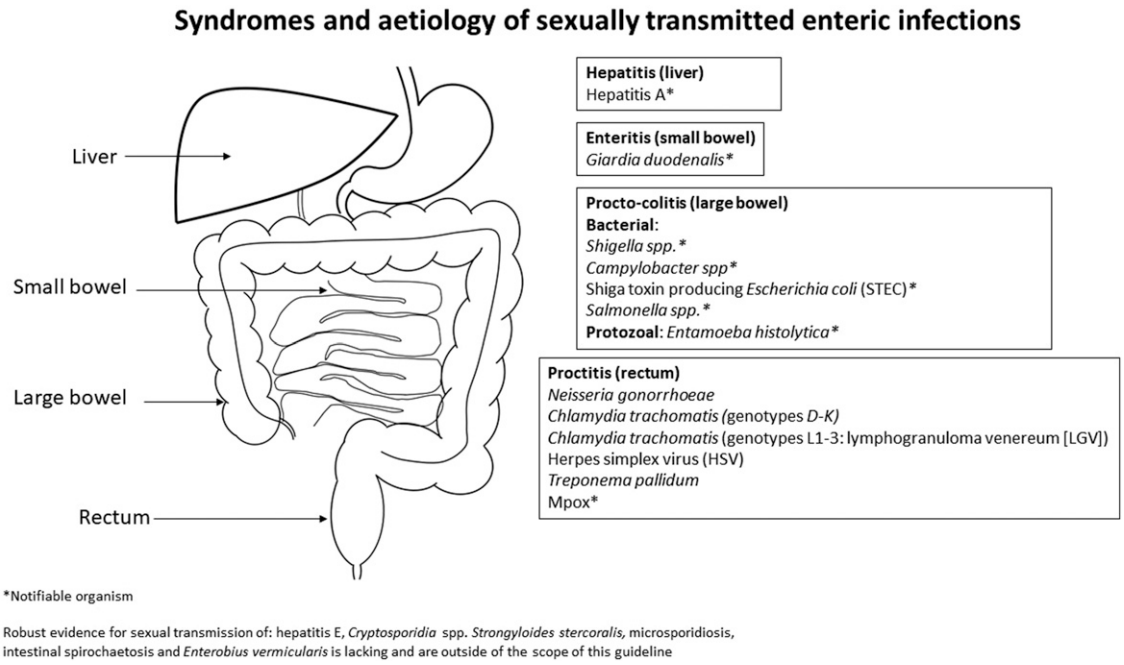

Figure 1. Syndromes and aetiology of sexually trasmitted enteric infections.

stewardship, and public health control for STEI. We aimed to provide guidance for specific populations, e.g., people who are pregnant, and considered scenarios where treatment may need to be altered due to availability or cost.

Piloting & feedback

Following public panel and professional review (Clinical Effectiveness Group (CEG) and BASHH membership web consultation), the guideline was piloted for validation by several BASHH pilot sites.

Equality impact assessment

An assessment of the guideline recommendations was made according to the principals of the NICE equality policy.

Patient & public involvement

Three community members contributed to the design and content of the draft guidelines and the patient information leaflet. The guideline was also reviewed by the BASHH patient and public panel.

Aetiology

STEI can cause ill health characterised by diarrhoea, sepsis, jaundice (in the case of Hepatitis A) and rectal symptoms.[4–6] STEIs can be categorised by syndrome: hepatitis, enteritis (small bowel), procto-colitis (large bowel), and proctitis (rectum). Most of the causative agents of STEI are notifiable and are subject to specific health protection regulations. (Figure 1) During the development of this guideline there has been a global outbreak of Mpox in MSM which can cause proctitis.[1]

General management of sexually transmitted enteric infections

Clinical history

Clinical history should include a comprehensive sexual history (including recent chemsex or recent use of sex on premises venues), information about travel to endemic areas or sexual contact with someone returning from an area of high endemicity.[5,7,8] The occupation (e.g. food handlers) of suspected or confirmed cases should also be considered.[9,10] Bacterial STEI should be considered in sexually active MSM and other individuals who may be part of sexual networks where there is an outbreak of STEI (e.g. *Shigella sonnei*).[5,7,8] (Figure 2)

Recommendations

- Adults (particularly MSM) presenting with gastro-enteritis, or a suspected or confirmed STEI should have a documented sexual history as per BASHH guidelines. **(1C)**
- Occupation history should be taken in patients with suspected or confirmed STEI. **(1B)**

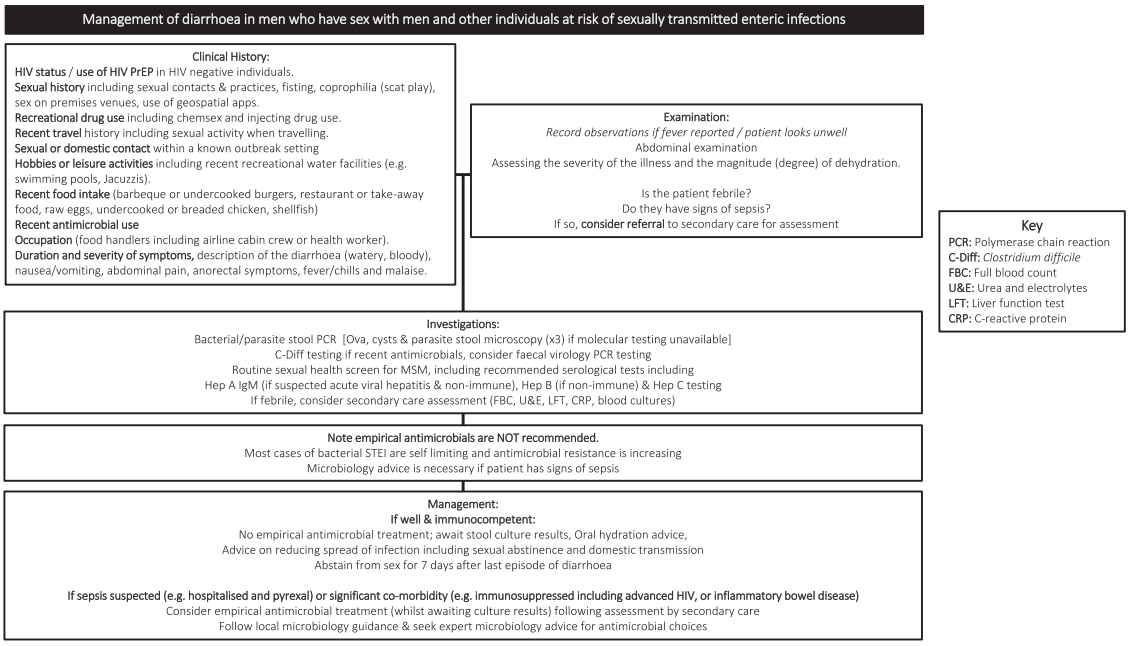

Figure 2. Management of diarrhoea in men who have sex with men and other individuals at risk of sexually transmitted enteric infections.

Clinical examination

Clinical examination and assessment should include an abdominal and ano-genital examination, consideration for the possibility of extra-intestinal disease (e.g. liver abscess), and an assessment of disease severity and sepsis (measurement of relevant vital signs: blood pressure, pulse, temperature).[11–13] Proctoscopic examination findings may include: mucosal erythema, ulceration, muco-purulent pus, bleeding (including contact bleeding).[14–16] Some patients may be unable to tolerate proctoscopy and blind rectal specimens for microbiological investigations may be necessary.[15]

Recommendations

- Clinical examination should include relevant vital signs, an abdominal examination, ano-genital examination, and rectal examination using proctoscopy where tolerated. **(1C)**
- Blind rectal specimens for microbiological investigation (without visualisation of the rectal mucosa with a proctoscope) should be taken in cases where proctoscopy is not tolerated. **(1D)**

Investigations

Stool specimens for microbiological testing are recommended in all patients presenting with a suspected STEI. Comprehensive STI testing should be performed including for *C. trachomatis, N gonorrhoeae, T. pallidum*, HIV and viral hepatitis.[13,17–20] In cases where hepatitis A is suspected, hepatitis A IgM testing should be performed (as per BASHH guidelines). *Clostridium difficile* testing may be necessary in patient presenting with diarrhoea who have recently used antimicrobials. Following assessment, febrile unwell patients, or those with severe diarrhoea who require hospital admission may require further investigations (e.g. blood cultures, full blood count, urea & electrolytes, C-reactive protein, coagulation screen, abdominal X-ray) to identify and manage cases of severe dehydration, renal impairment, haemolytic uraemic syndrome (HUS), or toxic dilatation of the colon.[12] (Figure 2)

Recommendations

- Patients presenting with possible STEI should have stool PCR testing for bacteria and parasites. **(1D)**
- Direct microscopy of stool samples for ova, cysts and parasites is unreliable and we recommend a minimum three separate sequential samples if this is the only diagnostic method available. **(1D)**
- Comprehensive sexually transmitted infection testing including genital, rectal, oropharyngeal and serological samples should be performed on all patients with an STEI as per current BASHH guidelines and standards. **(1B)**

Hospital admission

Admission to hospital should be based on NICE guidelines.[21] Hospital assessment is advised if: the patient is systemically unwell with severe dehydration, and if there is intractable vomiting or high output diarrhoea or if there is a suspected serious complication such as sepsis or acute kidney injury.[21]

Oral rehydration

Oral rehydration consisting of oral rehydration salts may be required, taken after every loose stool passed for up to 48 h[12,22,23]

Anti-motility agents

The use of anti-motility agents such as loperamide is controversial for the management of infectious diarrhoea and should be avoided.[12,22,24,25]

Contact tracing & partner management

Partner management for proctitis depends on underlying cause: see current BASHH guidance on causes of proctitis. As *E. histolytica* symptoms can develop after a period of asymptomatic colonisation, the sexual partner look-back period is less clear.[26–32] There is no requirement for stool specimen testing of asymptomatic contacts of STEI unless *E. histolytica* is diagnosed or in cases of refractory giardiasis where reinfection from an asymptomatic sexual contact is suspected.

Recommendations

- Contact tracing should include a look back period of 4 weeks (since onset of symptoms) for sexual contacts of patients with STEI (not proctitis or *E. histolytica*) **(1D)**
- Both asymptomatic and symptomatic sexual contacts of *E. histolytica* should be tested and treated if stool sample is positive. **(1C)**
- Symptomatic sexual contacts of other STEI should be treated with the same agent(s) as index cases. **(1D)** (except for the causes of proctitis which should be managed according to the relevant BASHH guideline)

Prevention

Patients with a confirmed or suspected STEI should be given clear verbal and written information on their condition, with particular emphasis on the implications for their own, their partners and the wider public health. Advice regarding hand washing particularly after using the toilet, when preparing food and avoiding sex until 7 days after the diarrhoea has resolved.[33,34]

Recommendations

- Patients with STEI should be given advice on hand washing particularly after using the toilet, preparing food, and avoidance of sexual contact until 7 days after diarrhoea resolution. **(1C)**

Other sexual health interventions (HIV pre-exposure prophylaxis and vaccination)

Patients with STEI are at increased risk of other STIs and HIV and may benefit from other sexual health interventions including: HIV post-exposure prophylaxis (HIV-PEP), HIV pre-exposure prophylaxis (HIV-PrEP), hepatitis A, B and HPV vaccinations, and vaccination relevant to outbreaks e.g. Mpox.[6,18,35–37] Patients who are having issues with chemsex use including dependence should be supported using local guidelines.

Recommendations

- HIV pre-exposure prophylaxis should be discussed with HIV negative individuals diagnosed with a STEI. **(1A)**
- Hepatitis A & B, HPV, and possibly Mpox vaccination should be offered to patients diagnosed with a STEI if not already vaccinated **(1D)** (Table 1).

Public health

Registered medical practitioners have a statutory duty to report notifiable diseases to their local public health team under the respective Health Protection (Notification) Regulations or Public Health Acts in each country of the United Kingdom (see Supplemental Appendix 2 for country specific guidance). Individuals with diarrhoea and occupations which include the care of children or vulnerable adults, healthcare, food handling or recreational water facilities should be advised to follow local public health protection guidance for the purposes of infection control or outbreak management.[13] Patients should be informed of the need for notification to local public health teams as local health protection or environmental health officers may need to contact them for contact tracing or as part of outbreak management. Where clinics use GUM identification numbers ('GUM IDs'; instead of first name and surname) for specimen identification on laboratory request forms, the local public health teams will require notification of infection using name, date of birth and contact details (e.g. home address, phone number).[38] This sharing of direct identifiers such as first name and surname with local public health teams should be clearly discussed with patients.

Hepatitis

Hepatitis A virus

Hepatitis A can be sexually transmitted.[4,39–44] Acute hepatitis A generally causes a self-limiting illness characterised by nausea, vomiting, diarrhoea, dark urine, jaundice, fever, headache, weight loss, and abdominal pain.[45]

Recommendations. See BASHH hepatitis guidelines for testing, management, and vaccination for hepatitis A.

Enteritis

Giardia duodenalis

Background & clinical features. *Giardia duodenalis* (also known as *Giardia lamblia* and *Giardia intestinalis*) is

Table 1. General management of STEIs: summary of recommendations.

Adults (particularly MSM) presenting with gastro-enteritis or a suspected or confirmed STEI should have a documented sexual history as per BASHH guidelines	1C
Occupation and food history should be taken in patients with suspected or confirmed STEI	1B
Clinical examination should include relevant vital signs, an abdominal examination, ano-genital examination and rectal examination using proctoscopy where tolerated	1C
Blind rectal specimens for microbiological investigation (without visualisation of the rectal mucosa with a proctoscope) should be taken in cases where proctoscopy is not tolerated	1D
Patients presenting with possible STEI should have stool PCR testing for bacteria and parasites	1D
Direct microscopy of stool samples for ova, cysts and parasites is unreliable and we recommend a minimum three separate sequential samples if this is the only diagnostic method available	1D
If an initial diagnosis of bacterial proctocolitis (*Shigella* spp., *Campylobacter* spp., STEC or *Salmonella* spp.) is made with a culture-independent diagnostic test (e.g. PCR), reflex stool culture and antimicrobial susceptibility testing should be performed	1C
Comprehensive sexually transmitted infection testing including genital, rectal, oropharyngeal and serological samples should be performed on all patients with an STEI as per current BASHH guidelines and standards	1B
Contact tracing should include a look back period for of 4 weeks (since onset of symptoms of the index) for sexual contacts of patients with STEI (not proctitis or *E. histolytica*)	1D
Both asymptomatic and symptomatic contacts of *E. histolytica* should be tested and treated if stool sample is positive	1C
Symptomatic sexual contacts of other STEI should be treated with the same agent(s) as index cases. (1D) (except for the causes of proctitis which should be managed according to the relevant BASHH guideline)	1D
Patients with STEI should be given advice on hand washing particularly after using the toilet, preparing food, and avoidance of sexual contact until 7 days after diarrhoea resolution	1C
HIV pre-exposure prophylaxis should be discussed with HIV negative individuals diagnosed with a STEI	1A
Hepatitis A & B, HPV, and possibly Mpox vaccination should be offered to patients diagnosed with a STEI if not already vaccinated/non-immune	1D

sexually transmitted amongst MSM.[46–51] Individuals can be asymptomatic (up to 40%); or may experience mild, self-limiting diarrhoea; or have profuse watery diarrhoea including greasy, foul-smelling stools with abdominal cramping, bloating, flatulence, and weight loss.[48,52–57] The incubation period is 1–25 days (average 1 week), but can be longer.[58,59] The median duration of illness is 6 weeks, with symptoms seldom lasting less than 1 week [59,60] Antimicrobial treatment shortens the course of disease, reduces complications and limits onward transmission.[61–63]

Clinical history

Giardiasis should be considered in patients presenting with profuse watery diarrhoea associated with bloating, nausea, malaise, flatulence, smelly stools, steatorrhoea and weight loss.[52,56,64]

Investigations for giardiasis

Stool PCR is the most sensitive assay for detection.[65,66] *Giardia* spp. may be detected by microscopy or serology.[57] As cysts are shed sporadically during infection, microscopic detection requires several stool samples for accurate diagnosis.

Antimicrobial treatment

Antimicrobial treatment of confirmed cases cures symptoms, shortens the course of the disease, reduces post infectious complications, and limits onward transmission.[61–63] Tinidazole and metronidazole are the most effective agents to treat giardiasis. Other 5-nitroimidazole drugs such as secnidazole or ornidazole have milder side effects than metronidazole, but are unlicensed in the UK and harder to obtain.[62,63,67] Nitroimidazole monotherapy offers 45–95% cure, however cases refractory to treatment are increasing.[62,67,68] (Table 2) Refractory Giardiasis is seen in up to 70% of patients with travel associated diarrhoea returning from the Indian subcontinent.[69,70] Parasites are cleared from stool at 3–5 days if successfully treated with symptom resolution in 5–7 days.[71–73] Lactose intolerance due to villous atrophy may follow; a lactose free or low FODMAP (fermentable oligosaccharides, disaccharides, monosaccharides and polyols: short-chain carbohydrates that the small intestine absorbs poorly) diet can relieve the irritable bowel-like sequelae (Table 2).[74,75]

Recommendations

- Anti-microbial treatment is necessary in microbiologically proven (confirmed) cases of giardiasis **(1B)**
- Tinidazole is the first line treatment for giardiasis (or metronidazole if tinidazole is unavailable) **(1A)**
- A lactose free or low FODMAP diet is recommended relieve irritable bowel like symptoms **(2C)**
- Specialist advice from a parasitologist should be sought for the management of laboratory confirmed refractory giardiasis **(1B)** (Table 3).

Table 2. Treatment recommendations for confirmed or suspected sexually transmitted *Giardia duodenalis*.

First line (1A)	Tinidazole 2g PO stat (unlicensed in the UK) Alternative agents Metronidazole 2g PO OD for 3 days Or 400 mg PO TDS for 5–7 days Secnidazole 2 g PO stat (though unavailable at time of writing in the UK)
Alternative agents (2C)	Paromomycin 500 mg PO TDS for 5-days (unlicensed, suitable in pregnancy) Nitazoxanide 500 mg PO TDS for 3 days (unlicensed, caution in pregnancy and should be avoided in breastfeeding)
Refractory Giardia (confirmed on microscopy/PCR following treatment failure of 1st treatment and reinfection excluded)	Discuss with microbiology or parasitology

The guideline writing group recognise that the availability and the cost of some of these medicines may limit accessibility. Discussion with parasitology/infectious diseases/microbiology should guide treatment

Table 3. Enteritis: summary of recommendations.

Anti-microbial treatment is necessary in microbiologically proven (confirmed) cases of giardiasis	1B
Tinidazole is the first line treatment for giardiasis (or metronidazole if tinidazole is unavailable)	1A
A lactose free or low FODMAP diet is recommended to relieve irritable bowel like symptoms	2C
Specialist advice from a parasitologist should be sought for the management of laboratory confirmed refractory giardiasis	1B

Empirical treatment

The role of empirical treatment is unknown, and not recommended as highly sensitive PCR testing is now widely available.

Pregnancy & breastfeeding

Tinidazole should not be used in the first trimester of pregnancy and should only be used in the second and third trimester if the benefit outweighs the risk. Breastfeeding should be withheld during tinidazole treatment and for 72-h after.[76] There is no evidence for teratogenicity with the use of metronidazole, however, high dose metronidazole (2g) should be avoided in pregnancy and breastfeeding due to limited data.[77,78] Secnidazole has been shown to have a positive impact in reducing birth complications in women with bacterial vaginosis however the manufacturers make no recommendation regarding use during pregnancy, and it is unlicensed in the UK. Paromomycin is not absorbed systemically following oral administration but data in pregnancy and breastfeeding is limited: the manufacturers make no recommendation regarding pregnancy and advise caution in breastfeeding.[79] Nitazoxanide is unlicensed for Giardiasis and should only be used during pregnancy if the benefit outweighs the risk. It should be avoided during the first trimester and in breast feeding.

Procto-colitis

Bacterial procto-colitis

Background. *S. flexneri, S. sonnei, C. jejuni, C. coli*, STEC and *S. Typhi* can be sexually transmitted[1,80–82] The protozoan infection, *E. histolytica* can cause proctocolitis and is sexually transmissible.[29,32,51,83–87] Most cases of sexually transmitted proctocolitis are self-limiting but some may develop severe dysentery, and sepsis.[88]

Clinical features of sexually transmitted procto-colitis. *Shigella* spp., STEC, *Campylobacter* spp. and *S. Typhi* share similar short incubation periods between 1-10 days.[8,82,89] MSM with bacterial procto-colitis have symptoms lasting 4–30 days, with an average of 10 days.[8] Patients present with watery diarrhoea (or less frequently bloody diarrhoea), abdominal pain, fever (including night sweats), rectal symptoms (including urgency, tenesmus, passing mucus and blood) nausea, vomiting and fatigue.[8,90]

Complications

Hospitalisation for severe colitis, bacteraemia and sepsis, dehydration, acute kidney injury and intestinal perforation is not uncommon.[82,88] Reactive arthritis can be triggered by sexually acquired *S.flexneri* or *S.sonnei* and *Campylobacter* spp.[91,92] Toxin mediated encephalitis has been described in an adult MSM with *S.flexneri.*[93] Acute demyelinating peripheral

neuropathies (Guillain Barre syndrome) is associated with *Campylobacter* spp.[94,95] HUS is a rare complication of STEC and *S. flexneri*.[96]

Shigella spp. There are frequent outbreaks of sexually transmitted *S. sonnei* and *S. flexneri* in MSM.[8,18,34,35,80,81,88,97–110] Extensively resistant sexually transmitted shigella has been reported in MSM, including antimicrobial resistance to azithromycin, quinolones, aminoglycosides, co-trimoxazole and ceftriaxone.[111–120]

Campylobacter spp. Sporadic outbreaks of sexually transmitted *C. coli* and *C. jejuni* are reported in MSM.[81,121–126] Macrolide and ciprofloxacin antimicrobial resistant *Campylobacter coli* and *jejuni* outbreaks amongst MSM have been reported.[127–129]

Shiga toxin-producing E.coli *(STEC).* An outbreak of STEC (O117:H7 VT1) was reported amongst MSM in the UK.[130] Antimicrobials can up-regulate toxin release in some strains of *E.coli* (and *Shigella* spp.), triggering the HUS, making the role of empirical antibiotics uncertain in patients presenting with bloody diarrhoea.[96,131,132]

Salmonella spp. Outbreaks of sexually transmitted *S. Typhi* have been reported in small clusters of MSM in the United States, however, their role in sexually transmited proctocolitis is likely to be small.[81,109,133–135]

Management

The use of empirical antibiotics is NOT recommended where diarrhoea is mild and of unknown aetiology, as treatment is likely to be of minimal benefit particularly in the context of increasing antimicrobial resistance [12,22,111,117,118,136–138]

Recommendations

- Patients with suspected or confirmed bacterial sexually transmitted proctocolitis (shigellosis, campylobacteriosis, STEC or enteric fever) should usually be managed conservatively, without empirical or susceptibility testing guided antimicrobials. **(1B)**

Antimicrobials

Extensively drug resistant sexually transmitted *Shigella* spp., *Campylobacter* spp., and STEC have been reported and antimicrobials will have a limited effect.[12,82,111–114,116,118–120,139] Additionally, there is concern over the use of empirical antimicrobial for cases of STEC and the potential to increase toxin release and HUS.[140–142]

Recommendations

- Empirical (presumptive) or susceptibility testing guided antimicrobials for patients with suspected or proven sexually transmitted proctocolitis should only be considered when: the patient is hospitalised, pyrexial, the diarrhoea has been present for at least 7 days and/or there are significant comorbidities (frailty, inflammatory bowel disease, immunocompromised, including advanced HIV). **(1B)**

Pregnancy & breastfeeding

The effects of antimicrobials in pregnancy and breastfeeding should be considered and discussed with microbiology before any antimicrobial treatment.

Protozoal procto-colitis

Entamoeba histolytica

Background. *E. histolytica* can be sexually transmitted in MSM (particularly in MSM living with HIV), and in heterosexual men and women.[27,29,31,32,51,83–87,143–146] *E. histolytica* causes a procto-colitis (and rarely distal ileitis) and can be complicated by liver abscess formation.[26,147,148]

Clinical features

Most patients (up to 90%) are asymptomatic.[29,51,147] Those who become symptomatic may develop amoebic dysentery (procto-colitis) or extra-luminal disease (including liver abscesses). The incubation period for procto-colitis is generally 1–3 weeks, but can be several months.[26,32]

Investigations

PCR testing offers the most accurate diagnostic tool.[149,150] Microscopy alone cannot distinguish between cysts of non-pathogenic species and pathogenic *E. histolytica*.[26,151] Repeating microscopy of separate stool samples may be required over a period of 10 days to improve diagnostic yield (as cysts may only be intermittently shed).

Recommendations

- PCR assays for *Entamoeba histolytica* on stool samples is the diagnostic method of choice. **(1C)**

Antimicrobial treatment

Metronidazole may be less effective than tinidazole at reducing clinical symptoms, but as effective at clearing parasites.[28] Metronidazole may be more likely than tinidazole to cause adverse effects such as nausea.[28] Alcohol should be avoided because of the risk of disulfiram-like effect associated with 5-Nitroimidazoles.[147,152] Paromomycin is currently the only available luminal agent.[30,147,153–155] (Table 4)

Recommendations

- All patients with confirmed *E. histolytica* should be treated, including asymptomatic sexual contacts. **(1C)**
- Patients with *E. histolytica* require sequential treatment with two agents: an amoebicidal tissue active agent

followed by a luminal agent to prevent invasion and transmission of cysts. **(1C)**
- First line treatment for patients with *E. histolytica* is Tinidazole 2g orally once/day for 3 days or metronidazole orally 800mg TDS for 5 days followed by paromomycin 500 mg TDS PO for 7 days with meals. **(1C)** (Table 5)

E. dispar, *E. moshkovskii, Blastocyctis hominis* and *Dientamobea fragilis, E Bangladeshi*, *Entamoeba coli*, *E. hartmanni*, *E. polecki*, *Endolimax nana*, *Iodamoeba bütschlii* are generally not thought to be pathogenic, expert guidance should be sought if these species are identified in symptomatic patients where no other cause for symptoms is found.[147,156]

Follow-up: Entamoeba histolytica. Repeat stool examination is not necessary if there is symptom resolution after completion of treatment, however *E. histolytica* is a notifiable infection in the UK and subject to public health processes.[157]

Pregnancy and breastfeeding. See section on Giardia: pregnancy and breastfeeding.

Proctitis

Background

N. gonorrhoeae, HSV, *C. trachomatis* [D-K genotypes], *C. trachomatis* [L1-3 genotypes] (LGV), *T. pallidum* and Mpox are all causes of symptomatic proctitis and polymicrobial infection is not uncommon.[13,14,17,158–169] The role of *M. genitalium* in symptomatic proctitis is currently unclear.[170–172] Recently, there has been an outbreak of Mpox amongst MSM globally (including the UK) including a proctitis syndrome.[173] We have not included any specific management recommendations regarding Mpox, as these are likely to be covered in a new Mpox guideline (Table 6).

Investigations

Direct microscopy can be useful for the diagnosis of *N. gonorrhoeae* and *T. Pallidum*.[14,162,174,175] Patients with proctitis should be tested for HIV, hepatitis C, and hepatitis A & B if non-immune, as per BASHH guidelines. Individuals with ongoing symptomatic proctitis with negative microbiology who remain symptomatic following antimicrobial testing and treatment require further investigation by specialist gastroenterology teams[176,177] (Figure 3).

Recommendations

- Comprehensive sexually transmitted infection testing should be performed in patients with proctitis (as per BASHH guidelines) including rectal testing for *N. gonorrhoeae*, HSV, *C. trachomatis* (including the L genotype: lymphogranuloma venereum), *T. pallidum* (serology and direct molecular testing) **(1C)**

Empirical treatment

Recommendations

- Patients with a possible sexually transmitted proctitis should be considered for empirical treatment for

Table 4. Sequential antimicrobial treatment of *Entamoeba histolytica*.

Amoebicidal agent	Tinidazole 2 g OD for 3 days Or Metronidazole 800 mg PO TDS for 5 days
Followed by Luminal/Cysticidal eradication agent	Paromomycin 500 mg PO TDS for 7 days

The guideline writing group recognise that the availability and cost of some medicines may limit their use in practice. Discussion with parasitology/infectious diseases/microbiology should guide treatment

Table 5. Proctocolitis: summary of recommendations.

Patients with suspected or confirmed sexually transmitted proctocolitis should usually managed conservatively without empirical or susceptibility testing guided antimicrobials	1B
Empirical (presumptive) or susceptibility testing guided antimicrobials for patients with suspected or proven sexually transmitted proctocolitis should only be considered when: the patient is hospitalised, pyrexial, the diarrhoea has been present for at least 7 days and/or there are significant comorbidities (frailty, inflammatory bowel disease, immunocompromised, including advanced HIV)	1B
PCR assays for *Entamoeba histolytica* on stool samples is the diagnostic method of choice	1C
All patients with confirmed *E. histolytica* procto-colitis should be treated, including asymptomatic sexual contacts	1C
Patients with *E. histolytica* require sequential treatment with two agents: An amoebicidal tissue active agent followed by a luminal agent to prevent invasion and transmission of cysts	1C
First line treatment for symptomatic patients with *E. histolytica* is Tinidazole 2 g orally once/day for 3 days or metronidazole orally 800 mg TDS for 5 days followed by paromomycin 500 mg TDS PO for 7 days with meals	1C

C. trachomatis (including Lymphogranuloma venereum) **(1D),** *N. gonorrhoeae* **(1C)** and HSV **(1D).** (Table 7)

Pregnancy & breastfeeding

See relevant BASHH guidelines for management of *N. gonorrhoeae, C. trachomatis* (including LGV) and HSV.

Follow up

Patients with severe proctitis should have a clinical review after 7 days. If microbiology tests are negative and the patient with proctitis remains symptomatic, rectal *M. genitalium* testing and referral to gastroenterology should be considered.[171,172,178] If the symptoms of proctitis have resolved and *C. trachomatis* NAAT testing is negative,

Table 6. Investigations in patients with symptomatic proctitis.

Microscopy	Gram stain of rectal sample
	Dark field microscopy (DFM) from anal ulcer(s)
N. gonorrhoeae	Using NAAT and culture
C. trachomatis	Using NAAT including LGV genotype
Herpes simplex virus	Using PCR
T. pallidum	Using DFM, PCR and serology
Mpox	(See BASHH/UKHSA guidance)
Other sexually transmitted infections	HIV
	Hepatitis A (if non-immune)
	Hepatitis B (if non-immune)
	Hepatitis C

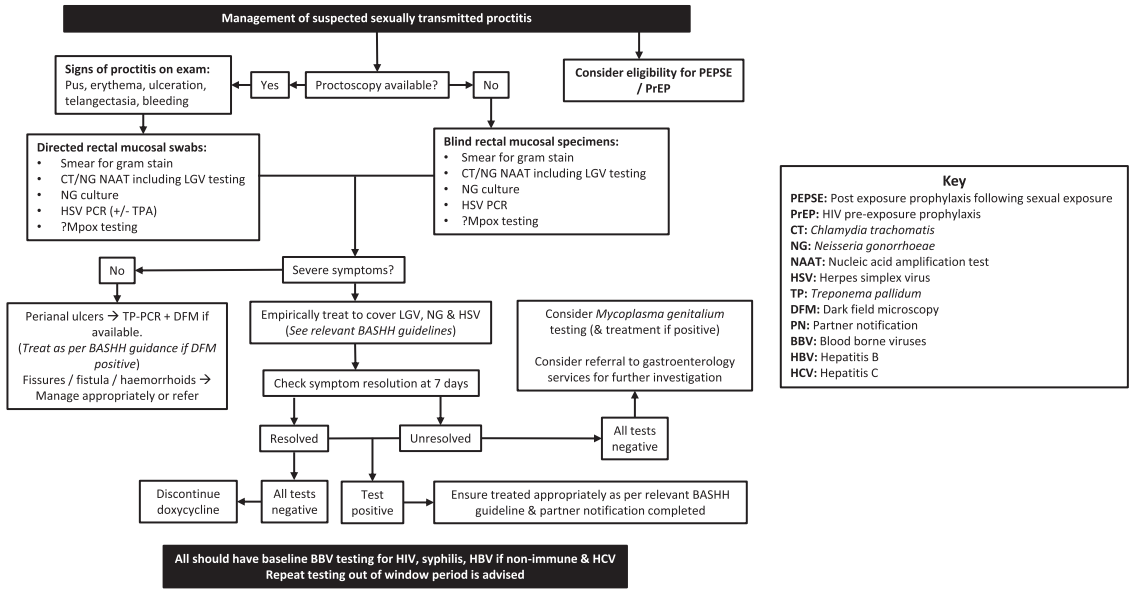

Figure 3. Management of suspected sexually transmitted proctitis.

Table 7. Proctitis; summary of recommendations.

Comprehensive sexually transmitted infection testing should be performed in patients with proctitis (as per BASHH guidelines) including rectal testing for *N. gonorrhoeae*, HSV, *C. trachomatis* (including the L genotype: Lymphogranuloma venereum) and *T. pallidum* (serology and direct molecular testing)	1C
Patients with a possible sexually transmitted proctitis should be considered for empirical treatment for *C. trachomatis* (including lymphogranuloma venereum)	1D
Patients with a possible sexually transmitted proctitis should be considered for empirical treatment for *N. gonorrhoeae*	1C
Patients with a possible sexually transmitted proctitis should be considered for empirical treatment for HSV	1D

doxycycline therapy can be discontinued after 1 week. If a pathogen has been isolated, then follow up and test of cure (where indicated) should follow the relevant BASHH guideline.

Auditable outcomes

- All patients with suspected or confirmed STEI (not proctitis) should have a documented sexual history, travel history, recreational drug history (including chemsex) and occupational history. (performance standard 97%)
- All patients presenting with suspected or confirmed STEI should have a documented discussion on transmission prevention including handwashing, avoidance of sexual activity and contact tracing. (performance standard 97%)
- All patients with suspected or confirmed STEI should have at least one stool sample sent to the laboratory PCR testing at first attendance (or 3 separate sequential samples if microscopy being used). (performance standard 97%)
- All patients with suspected or confirmed STEI should have sexually transmitted infection testing for HIV, *T. pallidum, C. trachomatis, N. gonorrhoeae*, hepatitis A and B (if non immune) and C (as per BASHH guidelines). (performance standard 97%)
- All patients with suspected or confirmed STEI should have a documented discussion about HIV PrEP. (performance standard 97%)
- All patients with a PCR positive bacterial sexually transmitted procto-colitis should have stool samples sent for (reflex) culture and sensitivity testing (prior to any antimicrobials, if used). (performance standard 97%)
- All patients with suspected or confirmed sexually transmitted enteric infection should receive verbal and online/written information about STEIs including advice on prevention of sexual and non-sexual transmission (performance standard 97%)

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