Central and North West London NHS
NHS Foundation Trust

Genital Ulcer Disease BASHH September 2017

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UCL

Wellbeing for life

Objectives

To understand the epidemiology of GUD in the UK

To understand how to evaluate a patient presenting with GUD

To know how to manage primary syphilis and primary genital herpes

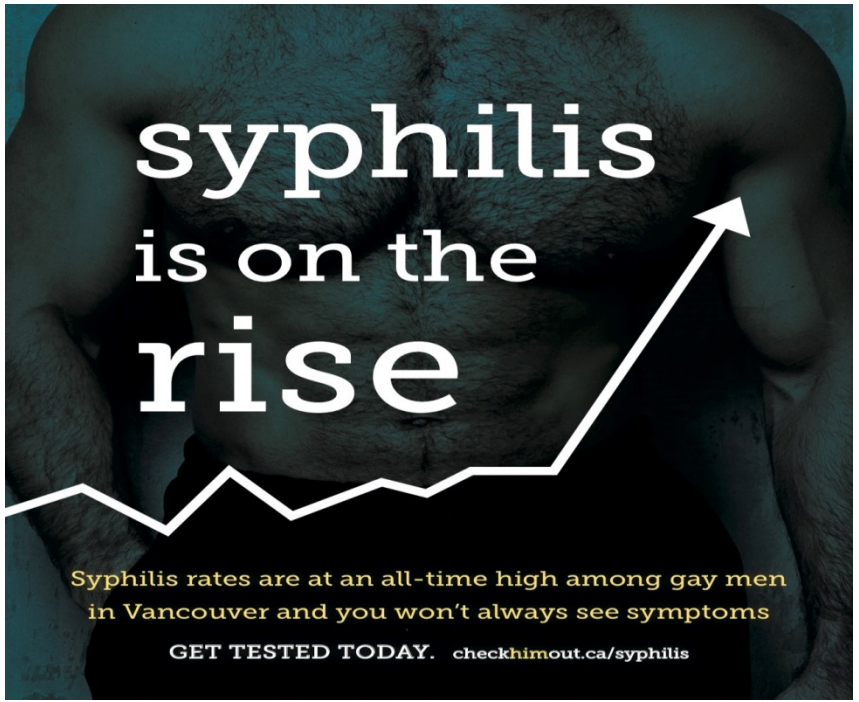
Session plan

- The epidemiology of HSV and early syphilis

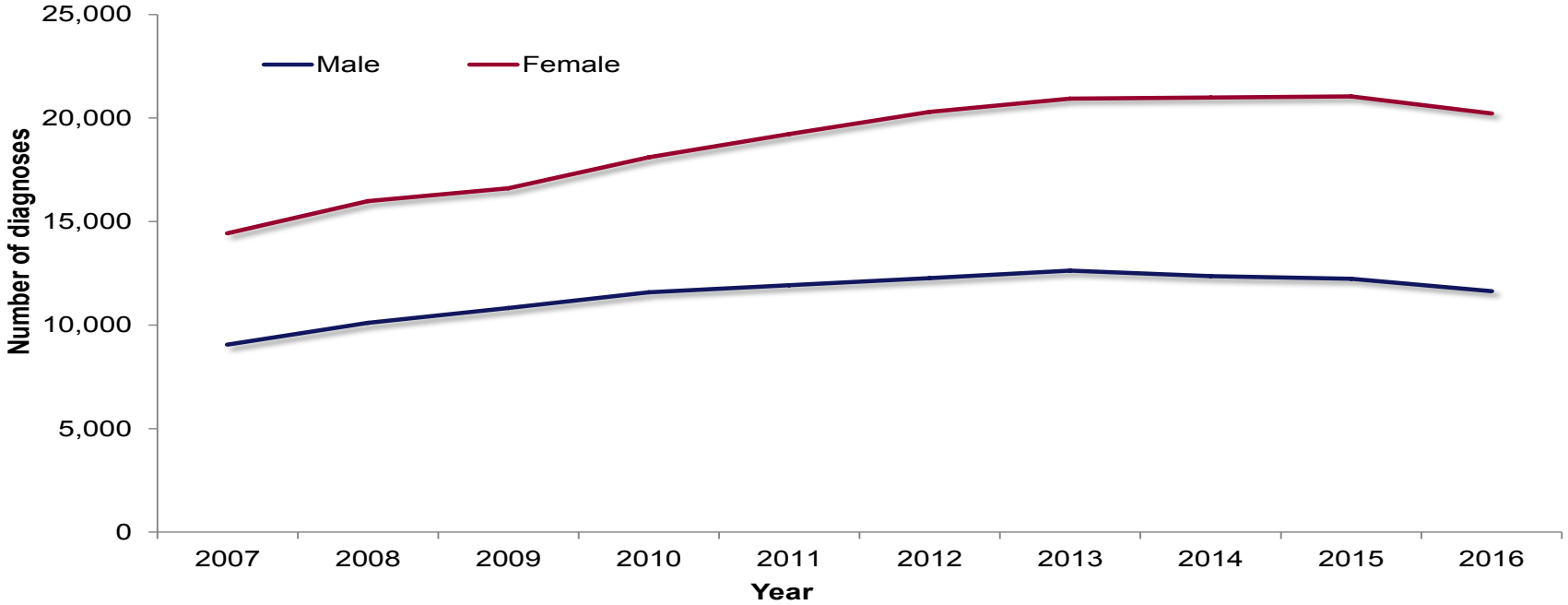
- The assessment of GUD

(N.B. “abrasions” / “fissures” / “sores” / “cuts” also = GUD)

- The management of primary syphilis and genital herpes

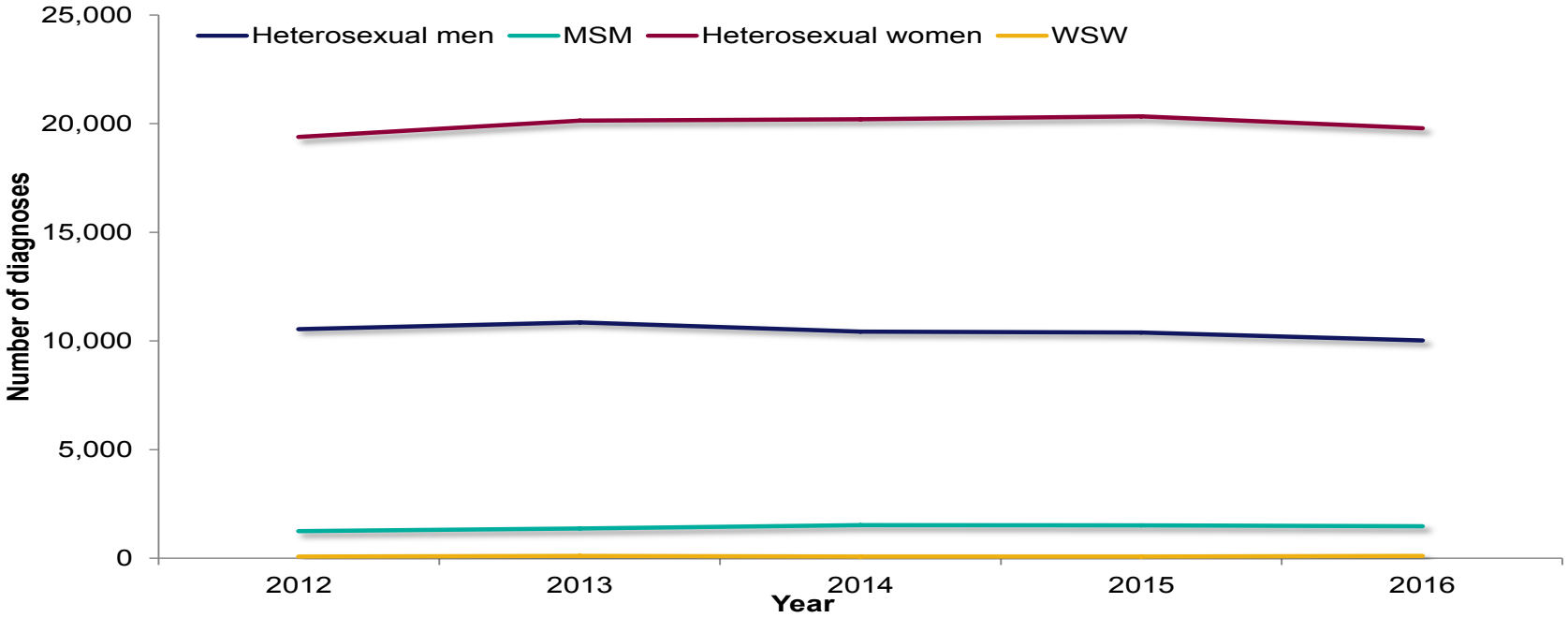


Number of anogenital herpes (first episode) diagnoses by gender: England, 2007–2016



- Data from specialist and non-specialist SHS (GUMCADv2 returns)
- Data type: service data

Number of anogenital herpes (first episode) diagnoses by sexual risk: England, 2012–2016



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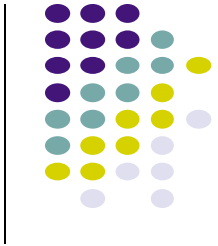
HSV 1 and 2 in the UK



Seroprevalance

- 4 - 8% HSV 2

(23% GUM Clinic)

- 45 – 55% HSV 1

(60% GUM clinic)

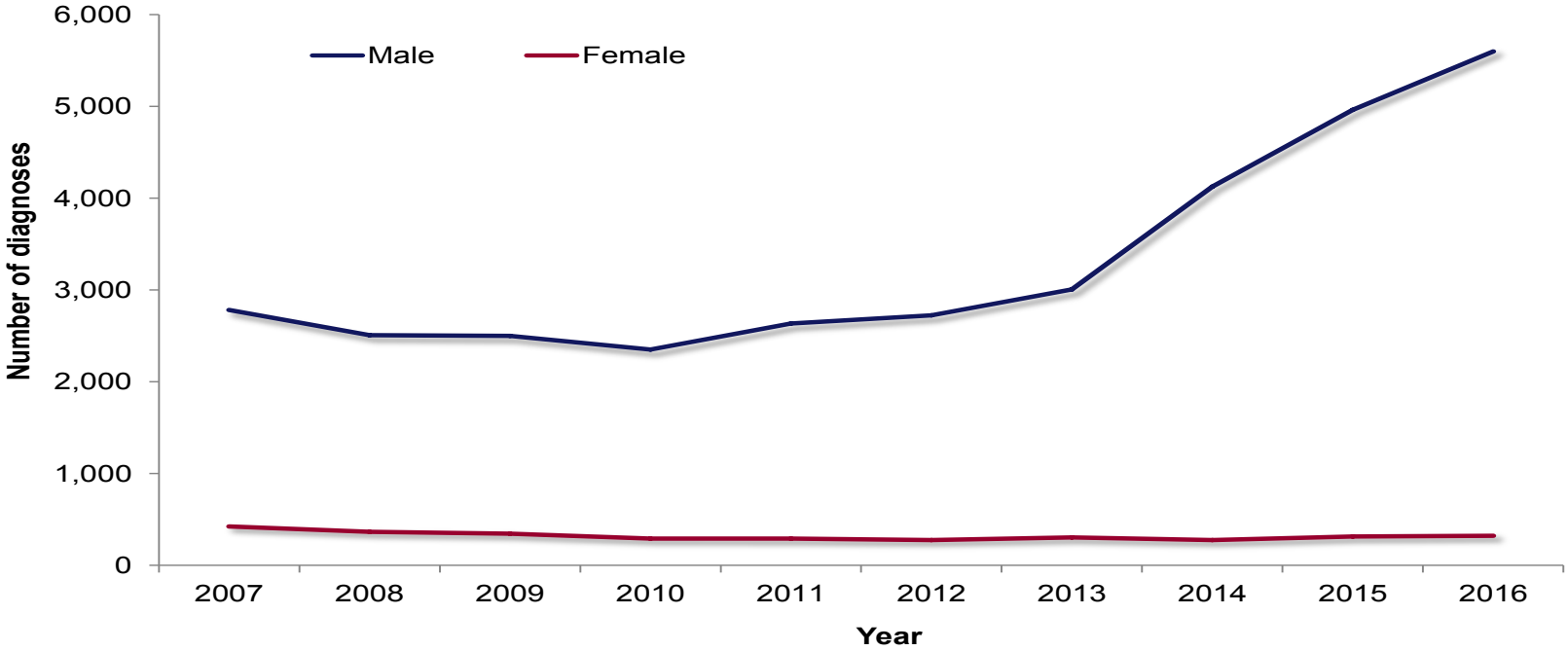
STIs 2004;80:185-191

- Most people (> 60 %) are asymptomatic. Most transmission is from asymptomatic “shedding”
- HSV 1 incidence is falling in the UK (35% 14 yr olds in 1980s 25% 1990s)

  STIs 2000;76:183-187
- Primary HSV caused by HSV1 is increasing (? 50-55% now)

  BMJ 2002; 324 :1366

Number of syphilis (primary, secondary & early latent) diagnoses by gender: England, 2007–2016



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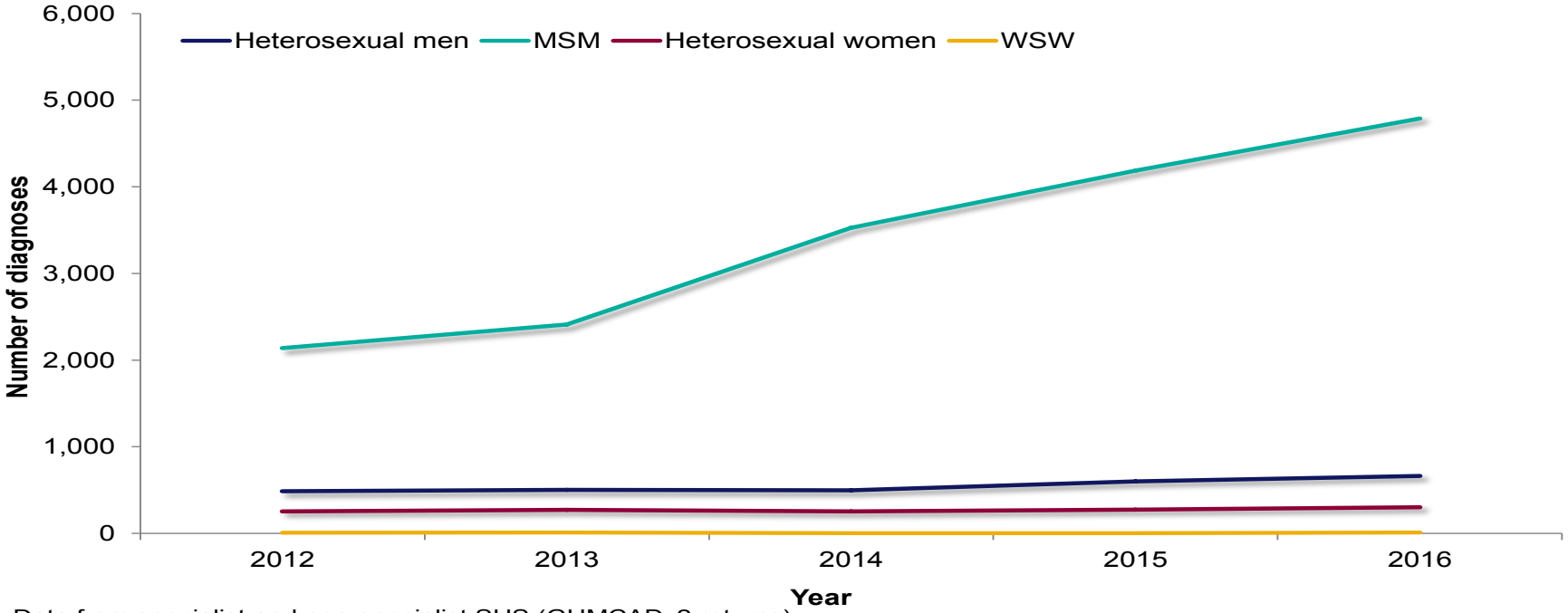
Number of syphilis (primary, secondary & early latent) diagnoses by sexual risk: England, 2012–2016



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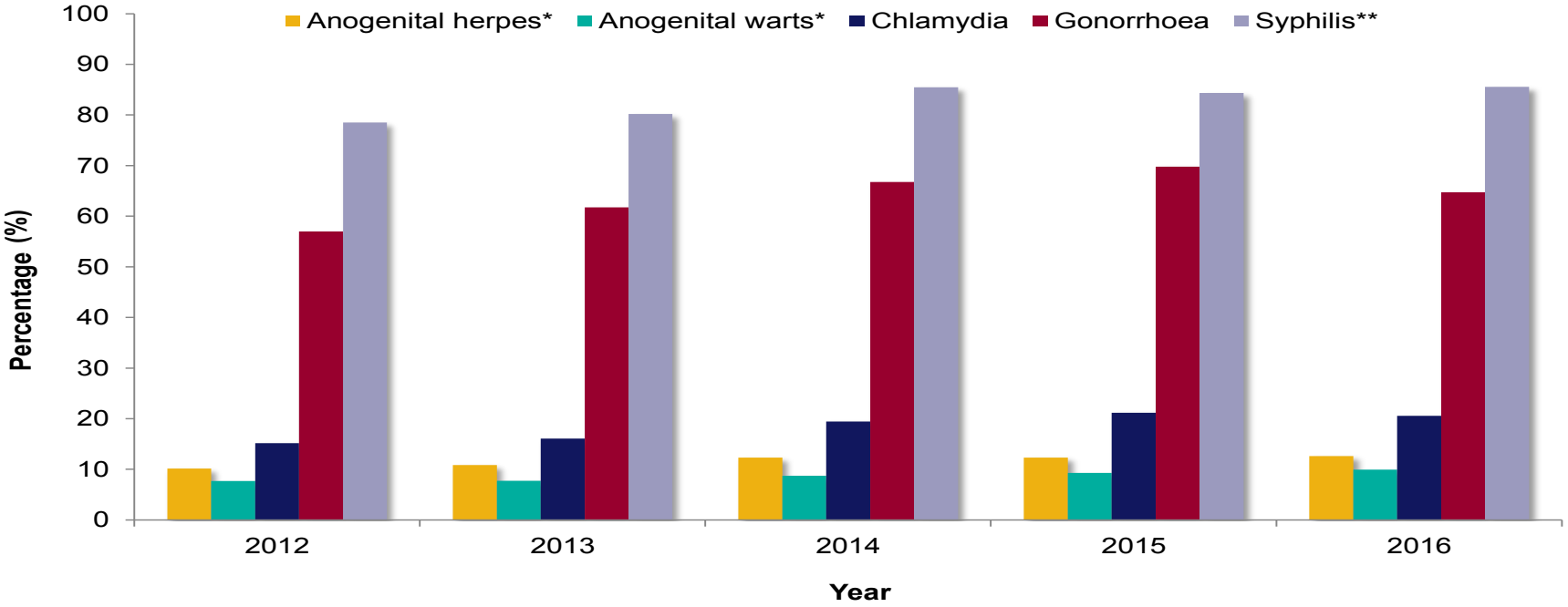
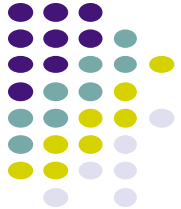
Percentage of all STI diagnoses in men which were among MSM: England, 2012-2016



- Data from specialist and non-specialist services
- * First episode; **Includes diagnoses of primary, secondary & early latent syphilis
- Chlamydia data from 2012 onwards are not comparable to data from previous years (please see 'Notes' slide for more details)
- Data type: service data

The Causes of GUD



- Syphilis
- Herpes simplex
- Chancroid
- Lymphogranuloma venereum
- Donovanosis
- Trauma
- Neoplasia
- Beçhets
- Erosive lichen planus
- Fixed drug eruption
- Crohn’s

Primary Syphilis

- Incubation period 2-3 weeks
- Primary syphilis – an ulcer or ulcers
- Heals after 3-4 weeks

- Secondary syphilis – generalised infection rash, lymphadenopathy 6-12wks
- Mucosal ulceration (including GUD)
- Rx Benzathine 2.4MIU IM x 1 or doxycycline 100mg BD 2 weeks

Primary syphilis – “painless single genital ulcer”

How common are “atypical” presentations?

- HIV pos vs. HIV neg
- 1/3 HIV neg multiple
- 2/3 HIV pos multiple
- Painful ulceration associated with HIV

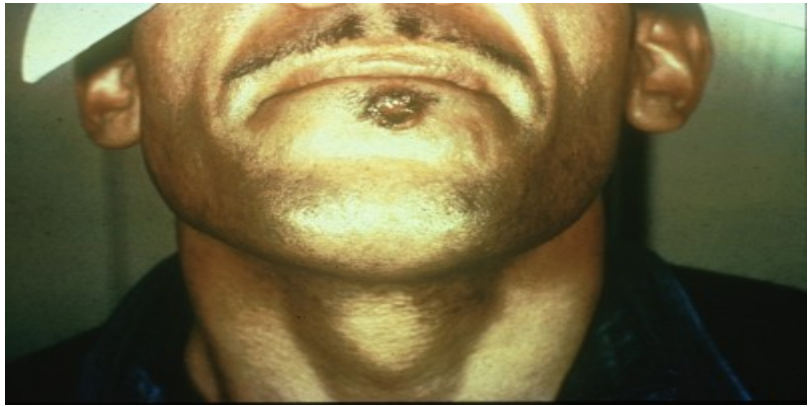
Sex Transm Dis. 2001 Mar;28(3):158-65

- N=183 Primary lesions were frequently painful (49%) or multiple (38%)
- Not associated with HIV infection

STIs 2016 Mar;92(2):110-5

Extragenital / non-perianal primary syphilis - oral

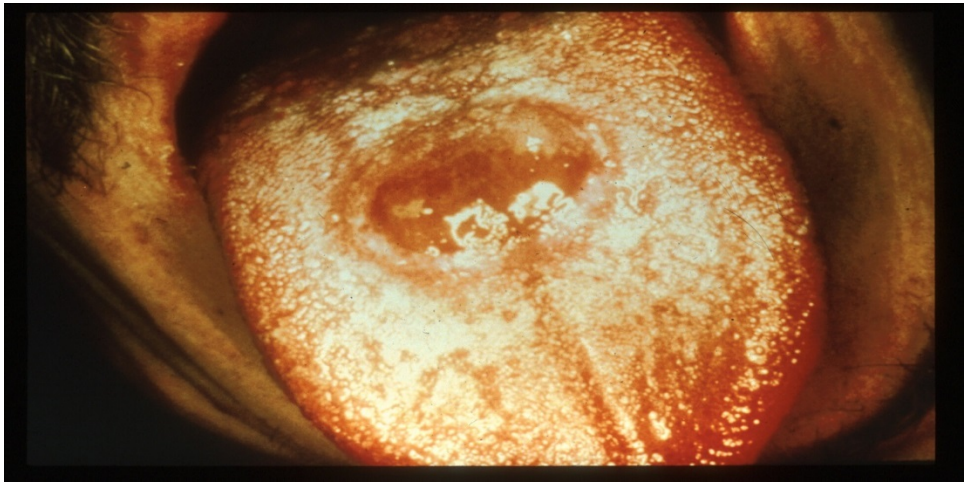
Ulcers at the site of inoculation



Images CDC

Oral sex is an important transmission route – 44% of infections in London, UK

Euro Surveill 2004; 9:21-25



Perianal / anal canal primary

“Anal Fissure” – low threshold for syphilis testing in MSM

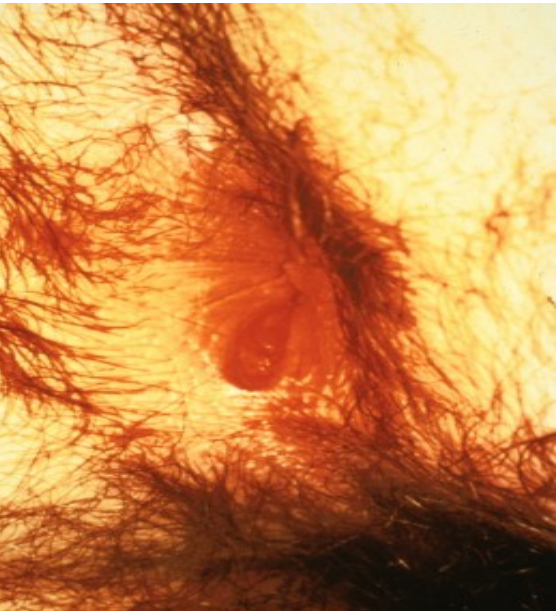


Image CDC

“Rectal Carcinoma”

Case Reports in Surgery
(2015), Article ID 434198 x 8 more recent cases

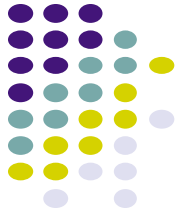
Image: Mass, a hard lump on palpation
Proc Baylor College 2016 Jul; 29(3): 327–328

Non ulcerative manifestations of primary syphilis

- Syphilitic balanitis of Follmann
- A diffuse balanitis with or without erosion
- Image. *Int J Derm* 2014; 53: 830

- Proctitis
- Ulceration, mass or diffuse proctitis
- *Proc (Bayl Univ Med Cent).* 2016 Jul; 29(3): 32

Primary syphilis – overlap with secondary syphilis and neurosyphilis



- Perseverance of the primary ulcer (s) in secondary syphilis
- HIV pos -24%
- HIV neg – 14%

- *Sex Transm Dis*. 2001 Mar;28(3):158-65

- Neurological symptoms in 24% of patients with primary syphilis (42% secondary)
- CNS invasion by *T.pallidum* in primary syphilis

- *Ann of Int Med.* 1988 1;109(11):855-62.

Primary HSV

- Similar distribution to primary syphilis
- Incubation 4 days (2-10 days)
- May have constitutional symptoms
- NB dissemination, neurological and urinary complications

Advice - immediate

- Major concern is urinary retention

- Pain
- Sacral radiculopathy

- Micturition in bath etc.

Medical Management

- Antivirals
- Aciclovir 400mg TDS for five days

BASHH Guideline 2015

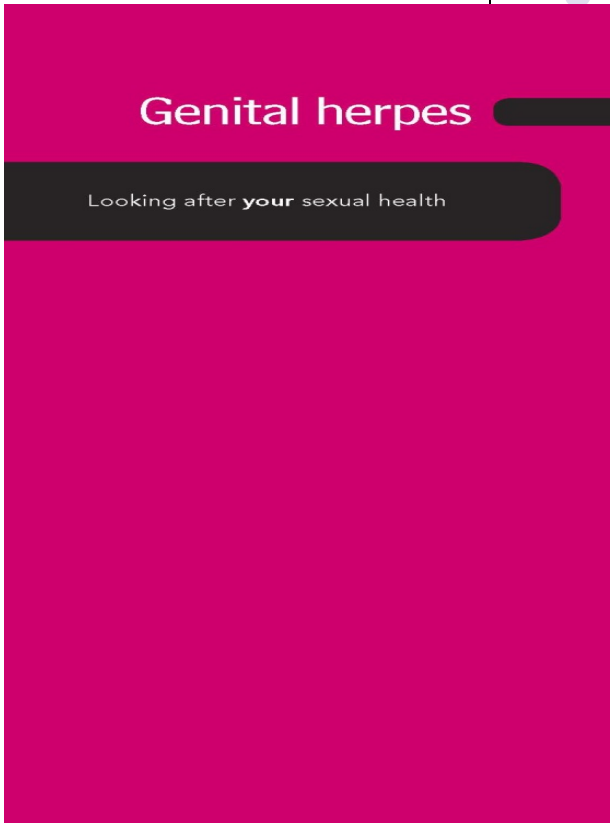
- Analgesia – NSAIDs / Paracetemol
- Topical analgesia – lidocaine 2% etc

Initial discussion at diagnosis

- Reassurance

- Discuss medical management and rationale.
- Mention auto-inoculation in first episode (and reassure about auto-inoculation subsequently)

- This will get better
- If it comes back it will not be like this
- Very common and not serious in long-term
- Most people with HSV have very few problems from it in long term
- Give leaflet, Herpes Viruses Association details and answer other questions
- Encourage to return for further discussion



Previous HSV

- ? Severe and prolonged
- ? > 5 / year

= consider suppression

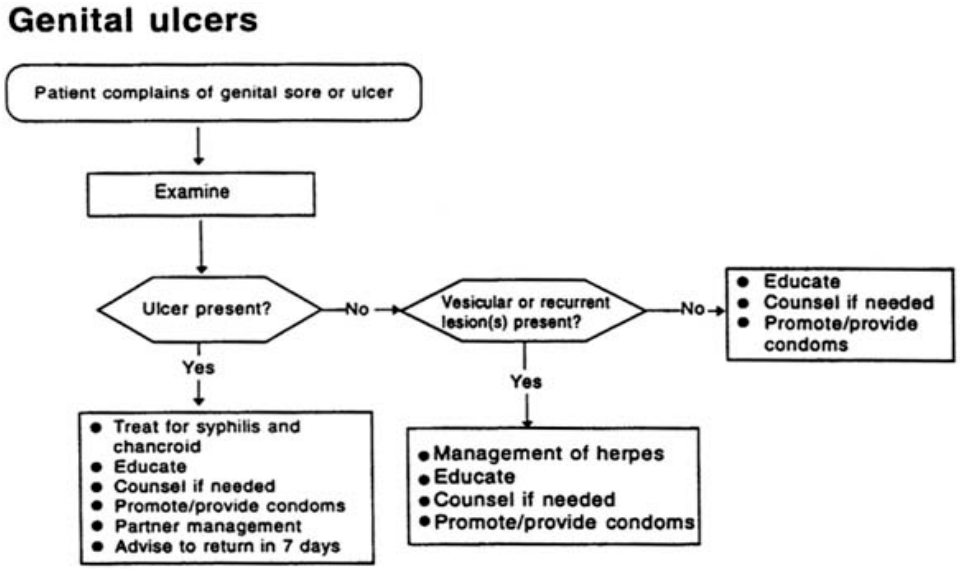
Discussion

Episodic treatment

Management of this episode

- Analgesia
- Warm water/salt water baths
- Aciclovir 800mg TDS for two days
- HIV test / STI screen including syphilis particularly if atypical features of ulcers

Simple algorithms have major limitations – but empirical Rx important



Clinical evaluation - history

- Is there a sexual risk?
- ? MSM (but GUM clinics should not miss syphilis)
- ? Travel
- ? Trauma
- Acute vs chronic (NB chronic ulceration in older people)
- 1st episode vs. recurrence
- Other associated symptoms

Clinical evaluation - examination

- Mouth
- Lymph nodes
- Skin

- Mucosal ulceration
- Lympadenopathy – local / generalised
- Is there a more generalised dermatosis?

What about the “tropical” STIs? – travel history

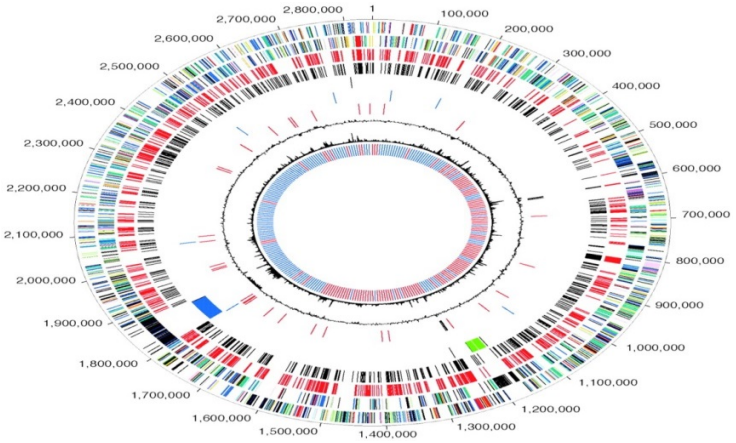
- Donovanosis – rare
- Lymphogranuloma venereum (small painless papule / ulcer) – LGV not uncommon – ulcer due to LGV - rare
- Chancroid – painful ulceration.
- Short incubation (3-7 days)
- NB *H.ducreyi* PCR test at PHE. Take swab – viral transport medium

Investigations

- Full STI screen
- HSV PCR
- *T.pallidum* PCR
- DGM - ? role now
- Syphilis serology – might be negative

+/- Add CT NAAT (small painless ulcer, MSM)

+/- *H.ducreyi* NAAT



Management – treatment / management

- Have a low threshold for HSV / syphilis treatment
- Pros and cons
- Aciclovir is cheap and very safe
- Benzathine is cheap, safe but potentially painful and has some risk – discuss chances of misdiagnosis and unnecessary treatment

Summary 1

- Herpes and Syphilis are the most important causes of GUD in the UK
- Most other causes can diagnosed by a careful clinical assessment

Summary 2

- Have a low threshold for giving antiviral therapy for suspected primary herpes

- *T.pallidum* PCR is a useful test in GUD