

BCCDC Non-certified Practice Decision Support Tool:

Proctitis

Scope

RN must consult and/or refer **all** clients who present with suspected proctitis to a physician (MD) or nurse practitioner (NP) for assessment and empiric treatment recommendations.

Etiology

Proctitis is inflammation of the rectal mucosa.

Infectious*

- *Neisseria gonorrhoeae* (GC)
- *Chlamydia trachomatis* (CT)
- *Chlamydia trachomatis* – *Lymphogranuloma Venereum* (LGV)
- *Treponema pallidum* (Syphilis)
- Herpes simplex virus (HSV)
- Mpox
- Gastrointestinal pathogens (e.g., *Campylobacter*, *Shigella*)

*There are other causative infectious processes specific to HIV infection, such as cytomegalovirus (CMV).

Non-infectious

- Inflammatory bowel disease (IBD), such as ulcerative colitis or Crohn's disease
- Foreign bodies (e.g., rectal instrumentation, sex toys)
- Use of chemicals (e.g., enemas, hydrogen peroxide, laxatives, unregulated substances taken rectally)
- Prior antibiotics
- Idiopathic
- Radiation treatment to pelvic area or lower abdomen

Epidemiology

Risk Factors

- Receptive anal intercourse (main cause)

- Oral-anal or genital-anal contact
- Receptive anal fisting/fingering
- Trauma
- Foreign bodies

Clinical Presentation

- Anorectal mucous discharge
- Anorectal itching and/or pain
- Constipation
- Tenesmus (cramping, feeling of incomplete defecation)
- Purulent and/or bloody stools, or bright red blood found on toilet paper, in the toilet, or in underwear
- Perianal lesions
- Fever

Proctocolitis (greater than 12cm above the anus) can present with signs and symptoms of proctitis, but also diarrhea and abdominal cramps. Enteritis (affects the duodenum, jejunum and/or ileum) presents with diarrhea, nausea, vomiting, general malaise and abdominal cramps, but generally no signs or symptoms of proctitis. Although difficult, it is important to try to distinguish between these presentations, as treatment recommendations differ.

Those with HIV infection may experience more severe symptoms.

Physical Assessment

- Inspect perianal region for lesions, fissures, hemorrhoids, exudate and erythema
- Palpate inguinal region for lymphadenopathy (buboes)
- Anoscopic examination is recommended by a practitioner who is trained and competent in performing anoscopy
- Perform abdominal exam as indicated per clinical presentation
- Assess temperature

A history or finding of hemorrhagic proctitis on physical assessment is suggestive of LGV (see [LGV DST](#)). Consult with or refer to a MD or NP or a BCCDC STI Clinic physician about presumptive LGV treatment.

Findings of painful perianal and/or mucosal ulcers are suggestive of HSV infection (see [HSV DST](#)).

Diagnostic and Screening Tests

If anoscopy is being performed, collect rectal specimens during examination. If not performed, collect via blind swab.

If enteric pathogens are suspected, consider stool specimen for culture for enteric pathogens, and ova and parasites (O&P).

Clinical presentation	Specimen	Tests
Rectal symptoms	Rectal swab	GC/CT nucleic acid amplification (NAAT)*
		GC culture & sensitivity (C&S) where available
		HSV PCR
External perianal lesions	Lesion swab	GC/CT NAAT**
		HSV PCR
		Syphilis PCR (also order syphilis serology)

* If CT positive, rectal specimens are automatically sent to the National Microbiology Lab (NML) for LGV testing (See [LGV DST](#)).

** On lab requisition, write: *"If lesion is CT positive, send for LGV testing"* to ensure that the CT positive lesion specimen is forwarded to the NML for LGV testing.

Management

Diagnosis and Clinical Evaluation

All suspect cases of proctitis must be referred to a MD or NP for evaluation and a client-specific order for empiric treatment.

Consultation and Referral

All suspect cases of proctitis must be referred to a MD or NP for evaluation and a client-specific order for empiric treatment.

Treatment

Recommended treatment options for gonorrhea reflect both current local antimicrobial resistance trends (see [BCCDC Laboratory Trends Newsletter](#)) and national STI guidelines.

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Treatment	Notes
First Choice Cefixime 800mg PO in a single dose AND Azithromycin 1gm PO in a single dose Ceftriaxone 250mg IM in a single dose AND Azithromycin 1gm PO in a single dose	<ol style="list-style-type: none"> 1. Treatment for proctitis in the absence of a diagnosis covers CT/GC infections. 2. If LGV is suspected, consider empiric treatment (see LGV DST). More likely in the presence and/or hemorrhagic proctitis. 3. If HSV is suspected, consider empiric treatment (see HSV DST). 4. If proctocolitis and/or enteritis is/are also suspected, additional empiric antibiotics may be required. 5. Review information on the BCCDC Medication Handouts and your agency's drug reference database, including: <ul style="list-style-type: none"> • Allergies, interactions and side effects • How to take the medication • After-care information
Second Choice Cefixime 800mg PO in a single dose AND Doxycycline 100mg PO BID for 7 days	<ol style="list-style-type: none"> 6. Azithromycin: <ul style="list-style-type: none"> • DO NOT USE if allergy to macrolides • Take with food/water to avoid potential adverse gastrointestinal effects • Although rare, QT prolongation is more significant in older populations, those with pre-existing heart conditions, arrhythmias or electrolyte disturbances. It is unclear if young to mid-age healthy adults consuming a one-time dose of azithromycin could be similarly affected. Consult with or refer to a MD or NP if the client: <ul style="list-style-type: none"> ○ has a history of congenital or documented QT prolongation ○ has a history of electrolyte disturbance in particular hypokalemia, hypomagnesaemia ○ has a clinically relevant bradycardia or cardiac arrhythmia or cardiac insufficiency
Ceftriaxone 250mg IM in a single dose AND Doxycycline 100mg PO BID for 7 days	

RNs must consult and/or refer **all** suspect cases of proctitis to a MD/NP for clinical evaluation and a client-specific order for empiric treatment.

○ is taking:

- Antipsychotics: pimozide (Orap®), ziprasidone (Zeldox®)
- Cardiac: dronedarone (Multaq®)
- Migraine: dihydroergotamine (Migranal®), ergotamine (Carergot®)

7. **Cefixime:**

- **DO NOT USE** if allergy to cephalosporins
- Consult with or refer to MD or NP if history of anaphylaxis or immediate reaction to penicillins

8. **Ceftriaxone:**

- **DO NOT USE** if allergy to cephalosporins
- To minimize discomfort, use 0.9 ml lidocaine 1% (without epinephrine) as the diluent for ceftriaxone IM
- Ventrogluteal site is preferred
- Review potential for side effects: pain, redness and swelling at the injection site, or diarrhea. If these persist or worsen, advise to contact a healthcare provider.

9. **Lidocaine:**

- **DO NOT USE** if allergy to local anaesthetics

10. **Doxycycline:**

- **DO NOT USE** if allergy to tetracyclines or if pregnant
- Take with food/water to avoid potential adverse gastrointestinal effects
- **RE-TREAT** if 2 consecutive doses are missed within the first 5 days of treatment, or if 5 days of treatment is not completed

Monitoring and Follow-up

- **Repeat testing:** No
- **Test-of-cure (TOC):** No
- **Follow-up:**

- If STI test results are positive, review treatment and follow-up plan with MD/NP, and confirm client received adequate treatment for the infection(s)
- Advise to seek urgent medical care if symptoms worsen (e.g., severe pain, signs of systemic infection)
- Return for re-assessment by MD or NP if symptoms have not improved within 3 to 7 days after the onset of treatment, for consideration of further STI testing and treatment, and possible GI referral

Partner Counselling and Referral

- **Reportable:** No
If STI infection(s) is/are confirmed, refer to appropriate DST for partner counselling and referral information
- **Trace-back period:** last 60 days. If no partners during this time, last sexual contact
- **Recommended partner follow-up:** empirically test and treat all contacts for CT/GC (see the [Treatment of Contacts DST](#))

Potential Complications

Depending on the causative agent(s), potential complications can include:

- Rectal stricture
- Fistula
- Secondary bacterial infection, abscess
- Perforation
- Stenosis
- Lymphatic obstruction
- Rectal and sigmoidal mucosa damage requiring surgical intervention
- Anemia
- Complications related to the etiology

Additional Education

- Avoid sexual contact until the client and their partner(s) have completed screening, treatment, and symptoms have resolved
- Regarding comfort measures (e.g., sitz baths, antispasmodic medications, stool softeners, low residue diet).

- Do not share douching materials or enemas
- [Standard Client Education for Sexually Transmitted Infections and Blood-Borne Infections \(STBBI\)](#)

References

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