BCCDC Non-certified Practice Decision Support Tool
Proctitis

PROCTITIS

SCOPE

RNs 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)

*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)
- 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
- trauma
- foreign bodies

**CLINICAL PRESENTATION**
- anorectal itching and/or pain
- tenesmus (cramping, feeling of incomplete defecation)
- mucous, purulent and/or bloody stools
- perianal lesions
- fever

Proctocolitis (greater than 12 cm 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)
- anoscopy 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).

<table>
<thead>
<tr>
<th>Clinical presentation</th>
<th>Specimen</th>
<th>Tests</th>
</tr>
</thead>
<tbody>
<tr>
<td>rectal symptoms</td>
<td>rectal swab</td>
<td>GC/CT nucleic acid amplification (NAAT)*</td>
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<tr>
<td></td>
<td></td>
<td>GC culture &amp; sensitivity (C&amp;S) where available</td>
</tr>
<tr>
<td></td>
<td></td>
<td>HSV PCR</td>
</tr>
<tr>
<td>external perianal lesions</td>
<td>lesion swab</td>
<td>GC/CT NAAT**</td>
</tr>
<tr>
<td></td>
<td></td>
<td>HSV PCR</td>
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<tr>
<td></td>
<td></td>
<td>Syphilis PCR (also order syphilis serology)</td>
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</tbody>
</table>

*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 and 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 Newsletters](#)) and national STI guidelines.

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.

<table>
<thead>
<tr>
<th>Treatment</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>First Choice</strong></td>
<td>1. Treatment for proctitis covers CT/GC infections.</td>
</tr>
<tr>
<td>cefixime 800 mg PO in a</td>
<td>2. If <strong>LGV</strong> is suspected, consider empiric treatment (see <a href="#">LGV DST</a>). More likely in the presence of HIV infection.</td>
</tr>
<tr>
<td>single dose</td>
<td>3. If <strong>HSV</strong> is suspected, consider empiric treatment (see <a href="#">HSV DST</a>).</td>
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<tr>
<td><strong>AND</strong></td>
<td>4. If proctocolitis and/or enteritis is/are also suspected, additional empiric antibiotics may be required.</td>
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<tr>
<td>azithromycin 1 gm PO in a</td>
<td>5. Review information on the <a href="#">BCCDC Medication Handouts</a> and your</td>
</tr>
<tr>
<td>single dose</td>
<td></td>
</tr>
<tr>
<td>Condition</td>
<td>Treatment Options</td>
</tr>
<tr>
<td>-----------</td>
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</tr>
<tr>
<td>Proctitis</td>
<td>Ceftriaxone 250 mg IM in a single dose AND Azithromycin 1 gm PO in a single dose</td>
</tr>
<tr>
<td>Second Choice</td>
<td>Cefixime 800 mg PO in a single dose AND Doxycycline 100 mg PO BID for 7 days</td>
</tr>
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<td>Proctitis</td>
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</tr>
</tbody>
</table>

The agency’s drug reference database, including:
- Allergies, interactions and side effects
- How to take the medication
- After-care information

6. **Azithromycin:**
- **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:
  - has a history of congenital or documented QT prolongation
  - has a history of electrolyte disturbance in particular hypokalemia, hypomagnesaemia
  - has clinically relevant bradycardia or cardiac arrhythmia or cardiac insufficiency
  - is taking:
    - Antipsychotics: pimozide (Orap®), ziprasidone (Zeldox®)
    - Cardiac: dronedarone (Multaq®)
    - Migraine: dihydroergotamine (Migranal®), ergotamine (Cafergot®)

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 health care provider.

9. **Lidocaine:**
- **DO NOT USE** if allergy to local anaesthetics.

10. **Doxycycline:**
- **DO NOT USE** if allergy to doxycycline or other 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 test results are positive for CT/GC, review MD or NP treatment and follow-up plan, 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 CT/GC, LGV and/or syphilis infection is 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, LGV and/or syphilis (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 Client Education

Counsel client:

- to 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).
- to not share douching materials or enemas.
REFERENCES


