BCCDC Non-certified Practice Decision Support Tool

Proctitis

PROCTITIS

DEFINITION

Proctitis is an inflammation of the rectal mucosa that does not extend 10 cm beyond the anal verge.

*RNs (including certified practice RNs) must refer to a physician or nurse practitioner (NP) for all clients who present with suspected proctitis.*

POTENTIAL CAUSES

Infectious proctitis is more common than non-infectious proctitis.

**Bacterial:**

- *Neisseria gonorrhoeae* (GC)
- *Chlamydia trachomatis* (CT)
- *Chlamydia trachomatis* – *Lymphogranuloma Venereum* (LGV)
- *Treponema pallidum* (syphilis)

**Viral:**

- herpes simplex virus (HSV)

**Other:**

- tissue damage resulting from insertion of foreign bodies
- ulcerative colitis, Crohn’s disease
BCCDC Non-certified Practice Decision Support Tool

Proctitis

PREDISPOSING RISK FACTORS

- sexual contact
- receptive anal intercourse
- external and/or insertive anal contact (toys, mouth, body parts)

TYPICAL FINDINGS

Sexual Health History

- sexual contact
- sexual contact(s) diagnosed with a STI
- receptive anal intercourse

Physical Assessment

It is recommended that all cases of suspected proctitis receive an anoscopic examination as part of the overall STI assessment.

- tenesmus (urgent and ineffective need to empty the bowel associated with pain, cramping, and involuntary straining)
- anorectal pain
- mucous or blood on stools
- mucopurulent or blood-stained rectal discharge
- rectal or anal lesions
- anal erythema
- inflamed rectal mucosa, exudates, and ulceration

Note: If the client indicates hemorrhagic proctitis consult with the STI Clinic physician at the BCCDC Provincial STI/HIV Clinic for potential assessment/treatment for presumptive LGV.

Special Considerations

Symptoms of proctitis may resemble other serious gastrointestinal conditions and warrant further assessment by a physician or NP. RNs may initiate diagnostic test collection, including rectal swabs if consultation and referral are delayed.
Diagnostic Tests

It is recommended that all cases of suspected proctitis receive an anoscopic examination as part of the overall STI assessment. However, where anoscopy is not present or available, certain specimens can be collected via blind swab. The following diagnostic tests may be collected:

- rectal swab for smear for typical intracellular diplococci (TID) (if available and only collected during anoscopy, not by blind swab)

AND

- rectal swab for GC culture and sensitivity (C&S) (can be collected by blind swab)

AND

- rectal swab for GC/CT nucleic acid amplification test (NAAT) (can be collected by blind swab)

AND

- rectal swab for HSV polymerase chain reaction (PCR) (ideally collected during anoscopy but can be collected by blind swab if there are no external lesions present)

AND

- darkfield or direct florescent antibody (DFA) testing and/or PCR for syphilis (collected if kits are available and suspected lesion is present)

In addition to the diagnostic tests above, offer clients routine STI and HIV screening.

CLINICAL EVALUATION

Refer all clients who present with suspected proctitis to a physician or NP.

MANAGEMENT AND INTERVENTIONS

Goals of Treatment

- treat infection
- alleviate symptoms
- prevent complications
- prevent spread of infection
### TREATMENT OF CHOICE – USE ONLY IN CONSULTATION WITH A PHYSICIAN OR NP

<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 both gonorrhea and Chlamydia infections.</td>
</tr>
<tr>
<td>cefixime 800 mg PO in a single dose</td>
<td>2. <strong>DO NOT USE</strong> ceftriaxone or cefixime if history of allergy to cephalosporins or a history of anaphylaxis or immediate reaction to penicillins.</td>
</tr>
<tr>
<td>and</td>
<td>3. <strong>DO NOT USE</strong> azithromycin if history of allergy to macrolides.</td>
</tr>
<tr>
<td>azithromycin 1 gm PO in a single dose</td>
<td>4. <strong>DO NOT USE</strong> doxycycline if allergic to tetracycline.</td>
</tr>
<tr>
<td><strong>OR</strong></td>
<td>5. <strong>DO NOT USE</strong> lidocaine if history of allergy to lidocaine or other local anesthetics. Use cefixime PO as alternate treatment.</td>
</tr>
<tr>
<td>ceftriaxone 250 mg IM in a single dose</td>
<td>6. The preferred diluent for ceftriaxone IM is 0.9 ml lidocaine 1% (without epinephrine) to minimize discomfort.</td>
</tr>
<tr>
<td>and</td>
<td>7. For intramuscular injections (IM) of ceftriaxone the ventrogluteal site is preferred (See <a href="http://www.bccdc.ca/imm-vac/ForHealthProfessionals/ImmsCompetency.htm">http://www.bccdc.ca/imm-vac/ForHealthProfessionals/ImmsCompetency.htm</a>).</td>
</tr>
<tr>
<td>azithromycin 1 gm PO in a single dose</td>
<td>8. Advise the client to remain in the clinic for at least 15 minutes post IM injection in case of anaphylactic reaction to treatment. Provide anaphylaxis treatment as required, using the BCCDC Immunization Manual-Section V- Management of Anaphylaxis in a Non-Hospital Setting. BCCDC, available at: <a href="http://www.bccdc.ca/NR/rdonlyres/52EA275F-0791-4164-ABA9-07F0183FF103/0/SectionV_Anaphylaxis_Jan05.pdf">http://www.bccdc.ca/NR/rdonlyres/52EA275F-0791-4164-ABA9-07F0183FF103/0/SectionV_Anaphylaxis_Jan05.pdf</a>.</td>
</tr>
</tbody>
</table>

*continued on next page....*
Second Choice

cefixime 800 mg PO in a single dose

and
doxycycline 100 mg PO bid for 7 days

OR

ceftriaxone 250 mg IM in a single dose

and
doxycycline 100 mg PO bid for 7 days

Third Choice

azithromycin 2 gm PO in a single dose

9. If serious allergic reaction develops including difficulty breathing, severe itchiness, have the client inform clinic staff immediately. If symptoms develop after leaving the clinic, advise the client to seek immediate emergency care.

10. If the client has missed 2 consecutive doses of doxycycline within the first 5 days of treatment, or has not completed a full five day course of treatment then retreatment is indicated.

11. Advise the client about potential side effects of pain, redness and swelling at the injection site. If any of these effects persist or worsen, advise to contact health care provider.

12. Azithromycin is associated with gastrointestinal adverse effects. Taking the medication with food or administering a prophylactic antiemetic may minimize adverse effects.


14. In client populations who are MSM, the preferred co-treatment for Chlamydia coverage is azithromycin as it further potentiates treatment for gonorrhea.

15. The Canadian STI Treatment Guidelines (December, 2011) recommend ceftriaxone for the treatment of gonococcal infection in MSM and for all pharyngeal infection as a first choice; however, local BC data currently indicate treatment options (including oral therapies) outlined in this DST are equivalent.

PARTNER COUNSELLING AND REFERRAL

Counsel the client to notify sexual contact(s) within the previous 60 days (or the last sexual contact), that they require testing and treatment to cover Chlamydia and gonorrhea infections.

See the CRNBC Treatment of STI Contacts DST. Unless the client tests positive for a reportable STI (i.e., Chlamydia, gonorrhea), partner notification is completed by the client.

MONITORING AND FOLLOW-UP

- recommend the client return for re-assessment or seek medical care if symptoms have not resolved by 3 - 7 days after the onset of treatment
- advise the client to seek urgent medical care if symptoms worsen
- refer to a physician or NP at reassessment if the client’s symptoms are unresolved
- if test results are positive for gonorrhea and/or Chlamydia, refer to appropriate DST for follow-up

POTENTIAL COMPLICATIONS

- rectal stricture
- anal fistula

CLIENT EDUCATION

Counsel client:

- to return for re-assessment or seek medical care if symptoms have not resolved by 3-7 days after starting treatment.
- to seek urgent medical care if symptoms worsen.
- regarding the appropriate use of medications (dosage, side effects, and need for re-treatment if dosage not completed).
- to avoid sexual contact until the client and their partner(s) have completed screening and treatment.
- to inform all sexual contacts within the last 60 days (or the last sexual contact if no contacts in the previous 60 days) that they require testing and treatment.
- regarding harm reduction measures (condom use).
- regarding the complications from untreated proctitis.
**BCCDC Non-certified Practice Decision Support Tool**

**Proctitis**

- regarding the co-infection risk for HIV when another STI is present.
- regarding the asymptomatic nature of STI and HIV.

**CONSULTATION OR REFERRAL**

Refer all clients suspected of having proctitis to a physician or NP. Refer all clients who are pregnant or breastfeeding to a physician NP.

**DOCUMENTATION**

- proctitis is not reportable
- partner notification is required (e.g., completion of H208 form) if lab reportable infections are confirmed from diagnostic tests
- documentation as per agency guidelines
REFERENCES


BCCDC (2014). British Columbia Treatment Guidelines. Sexually Transmitted Infections in Adolescent and Adults. STI/HIV Prevention and Control Division, BC Centre for Disease Control.


