BC Centre for Disease Control
Provincial Health Services Authority

Clinical Prevention Services
Provincial STI Services
655 West 12th Avenue
Vancouver, BC V5Z 4R4
Tel : 604.707.5600
Fax: 604.707.5604
www.bccdc.ca

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

Provincial Health Services Authority
Province-wide solutions. Better health.

ACCREDITED • AGRÉÉ • CCHSA • CCASS

A research and teaching centre affiliated with UBC

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)
- 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 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.

Treatment	Notes
First Choice cefixime 800 mg PO in a single dose **AND** azithromycin 1 gm PO in a single dose	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 of HIV infection. 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: • 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: o has a history of congenital or documented QT prolongation o has a history of electrolyte disturbance in particular hypokalemia, hypomagnesaemia o has clinically relevant bradycardia or cardiac arrhythmia or cardiac insufficiency o is taking: ▪ Antipsychotics: pimozide (Orap®), ziprasidone (Zeldox®) ▪ Cardiac: dronedarone (Multaq®) ▪ Migraine: dihydroergotamine (Migranal®), ergotamine (Cafergot®)
ceftriaxone 250 mg IM in a single dose **AND** azithromycin 1 gm PO in a single dose	

Second Choice	
cefixime 800 mg PO in a single dose **AND** doxycycline 100 mg PO BID for 7 days	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 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.
ceftriaxone 250 mg IM in a single dose **AND** doxycycline 100 mg PO BID for 7 days	

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 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.
- Standard Client Education for Sexually Transmitted Infections and Blood-Borne Infections (STBBI)

REFERENCES

Ansari P. Merck Manuals – Proctitis. July 2018. Available from: https://www.merckmanuals.com/en-ca/professional/gastrointestinal-disorders/anorectal-disorders/proctitis.

Bissessor M, Fairley CK, Read T, Denham I, Bradshaw C, Chen M. The etiology of infectious proctitis in men who have sex with men differs according to HIV status. Sexually Transmitted Diseases. 2013;40(10):768-70.

Bissessor M, Tabrizi SN, Bradshaw CS, Fairley CK, Hocking JS, Garland SM, et al. The contribution of Mycoplasma genitalium to the aetiology of sexually acquired infectious proctitis in men who have sex with men. Clinical Microbiology And Infection: The Official Publication Of The European Society Of Clinical Microbiology And Infectious Diseases. 2016;22(3):260-5.

Boutin CA, Venne S, Fiset M, Fortin C, Murphy D, Severini A, et al. Lymphogranuloma venereum in Quebec: Re-emergence among men who have sex with men. Canada communicable disease report = Releve des maladies transmissibles au Canada. 2018 Feb 1;44(2):55–61.

Centers for Disease Control and Prevention (CDC). 2015 Sexually Transmitted Diseases Treatment Guidelines. Proctitis, Proctocolitis, and Enteritis. 2015. Available from: https://www.cdc.gov/std/tg2015/proctitis.htm.

Cole MJ, Field N, Pitt R, Amato-Gauci AJ, Begovac J, French PD, et al. Substantial underdiagnosis of lymphogranuloma venereum in men who have sex with men in Europe: preliminary findings from a multicentre surveillance pilot. Sexually transmitted infections. 2020 Mar;96(2):137–42.

de Vries HJC. Sexually transmitted infections in men who have sex with men. Clinics in dermatology. 2014 Mar;32(2):181–8.

de Vries HJC, Zingoni A, White JA, Ross JDC, Kreuter A. 2013 European Guideline on the management of proctitis, proctocolitis and enteritis caused by sexually transmissible pathogens. International journal of STD & AIDS. 2014 Jun;25(7):465–74.

Fanfair RN, Workowski KA. Clinical update in sexually transmitted diseases-2014. Cleveland Clinic journal of medicine. 2014 Feb;81(2):91–101.

Giesler DM, Casillas MA, Wilson DD, Nodit L. The Painful Diversity of Proctitis in the Modern Era. The American surgeon. 2015 Dec;81(12):E408–9.

Gopal P, Shah RB. Primary Anal Canal Syphilis in Men: The Clinicopathologic Spectrum of an Easily Overlooked Diagnosis. Archives of pathology & laboratory medicine. 2015 Sep;139(9):1156–60.

Groome M, Robinson EM, Mowat C, Morieux AML, Allstaff S. Are patients in the IBD clinic at risk of proctitis secondary to sexually transmitted infections? Frontline gastroenterology. 2017 Oct;8(4):267–71.

Horner PJ, Martin DH. Mycoplasma genitalium Infection in Men. The Journal of infectious diseases. 2017 Jul 15;216(suppl_2):S396–405.

Hughes G, Alexander S, Simms I, Conti S, Ward H, Powers C, et al. Lymphogranuloma venereum diagnoses among men who have sex with men in the U.K.: interpreting a cross-sectional study using an epidemic phase-specific framework. Sexually Transmitted Infections. 2013;89(7):542-7.

Irizarry L, Yarde I, Talavera F, Brenner BE, Beeson MS, O'Connor RE and Hardin E. Acute Proctitis. 2018. Available from: https://emedicine.medscape.com/article/775952-overview.

Khaw C, Richardson D, Matthews G, Read T. Looking at the positives: proactive management of STIs in people with HIV. AIDS research and therapy. 2018 Dec 21;15(1):28.

Klausner JD, Kohn R, Kent C. Etiology of clinical proctitis among men who have sex with men. Clinical infectious diseases : an official publication of the Infectious Diseases Society of America. 2004 Jan 15;38(2):300–2.

Lourtet Hascoet J, Dahoun M, Cohen M, Pommaret E, Pilmis B, Lemarchand N, et al. Clinical diagnostic and therapeutic aspects of 221 consecutive anorectal Chlamydia trachomatis and Neisseria gonorrhoeae sexually transmitted infections among men who have sex with men. International journal of infectious diseases : IJID : official publication of the International Society for Infectious Diseases. 2018 Jun;71:9–13.

Marrazzo J, Hynes NA, Bloom A. Clinical manifestations and diagnosis of Chlamydia trachomatis infections. UpToDate. 2019.

Patel R, Green J, Clarke E, Seneviratne K, Abbt N, Evans C, et al. 2014 UK national guideline for the management of anogenital herpes. International journal of STD & AIDS. 2015 Oct;26(11):763–76.

Public Health Agency of Canada (PHAC). Section 4-6: Canadian Guidelines on Sexually Transmitted Infections – Management and treatment of specific syndromes – Sexually transmitted intestinal and enteric infections. 2013. Available from: https://www.canada.ca/en/public-health/services/infectious-diseases/sexual-health-sexually-transmitted-infections/canadian-guidelines/sexually-transmitted-infections/canadian-guidelines-sexually-transmitted-infections-24.html.

Santos AL, Coelho R, Silva M, Rios E, Macedo G. Infectious proctitis: a necessary differential diagnosis in ulcerative colitis. International journal of colorectal disease. 2019 Feb;34(2):359–62.

U.S. Department of Health and Human Services. National Institutes of Health. National Institute of Diabetes and Digestive and Kidney Diseases. Proctitis. Available from: https://www.niddk.nih.gov/health-information/digestive-diseases/proctitis/all-content.

Voltaggio L, Montgomery EA, Ali MA, Singhi AD, Arnold CA. Sex, lies, and gastrointestinal tract biopsies: a review of selected sexually transmitted proctocolitides. Advances in anatomic pathology. 2014 Mar;21(2):83–93.