Male Dysuria / Discharge

Terminology of urethritis

- Depends on organism isolated
- Gonococcal urethritis
- Non-gonococcal urethritis (NGU)
- Non-Chlamydia NGU – non- specific urethritis (NSU)

Common causes of acute NGU

- Mainly caused by sexually transmitted pathogens
- *Chlamydia trachomatis* – 20-50%
- *Mycoplasma genitalium* – 10-30% (case – control study at ASHS 10% cases MG+)
- *Trichomonas vaginalis* -1-20%
- HSV type 1 and 2 - 2-3%
- Adenovirus 2-4%

Other possible causes

- *Ureaplasma urealyticum* (biovar 2) may account for 5-10% cases
- Pharyngeal organisms, Enteric bacteria
- *Gardnerella vaginalis*, Candida sp
- Pathogen not identified in 20-50% of cases

Complications

- Epididymitis
- SARA / reiters syndrome

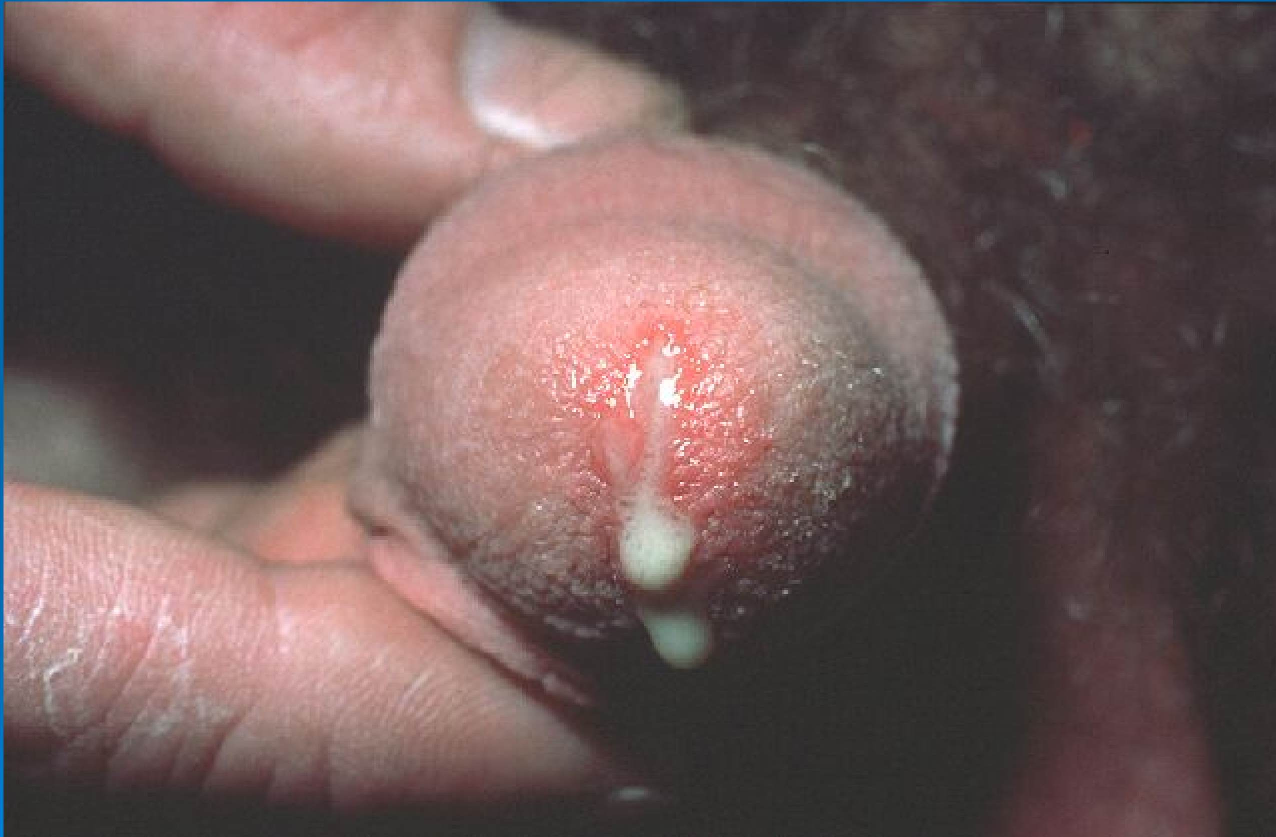
History

- Discharge – colour / type
- Dysuria
  - Not associated with frequency, haematuria and urgency
- Testicular pain
- Sexual history
  - Number of sexual partners last 2 months.
  - Sexual practices.
  - Use of condom.
- Previous STIs
- Past medical history

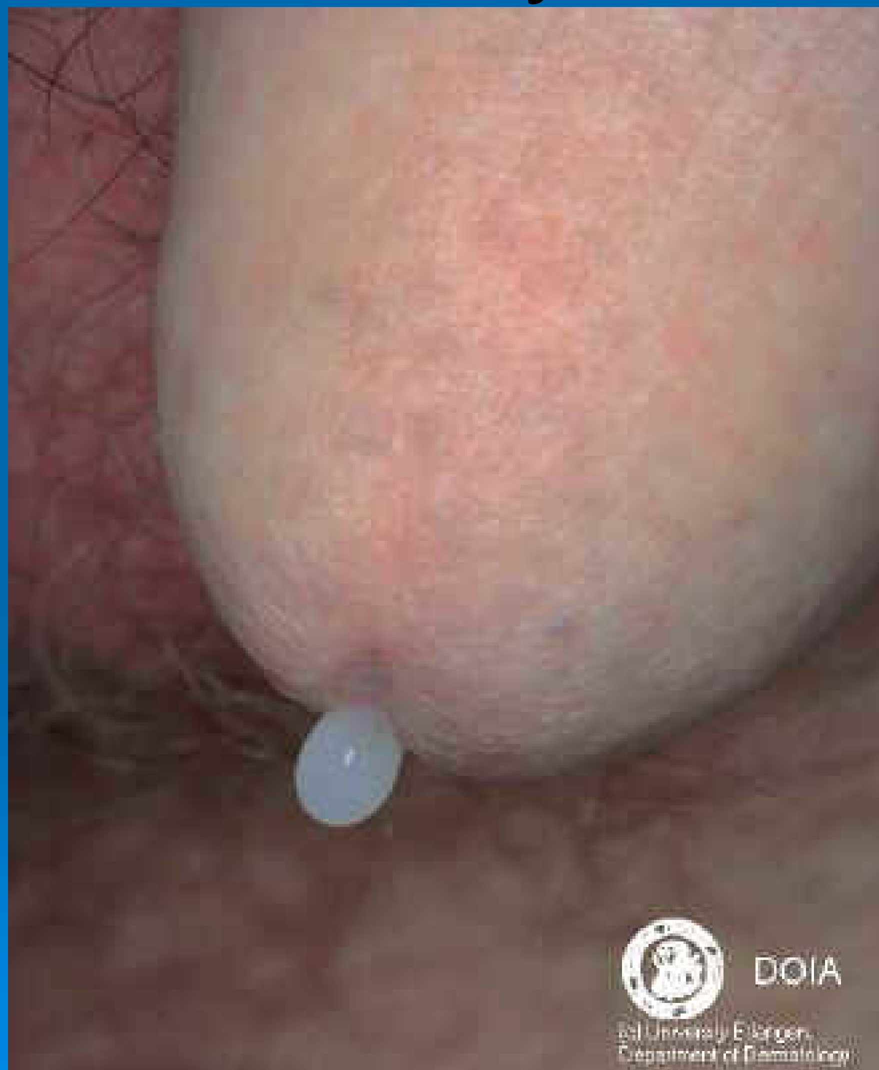
Examination

- General genital examination
- Inguinal lymph nodes
- Urethral meatus
- Skin
- Testes and epididymis
- Urethral massage looking for urethral discharge
- Other examination dependant on history

Gonococcal discharge



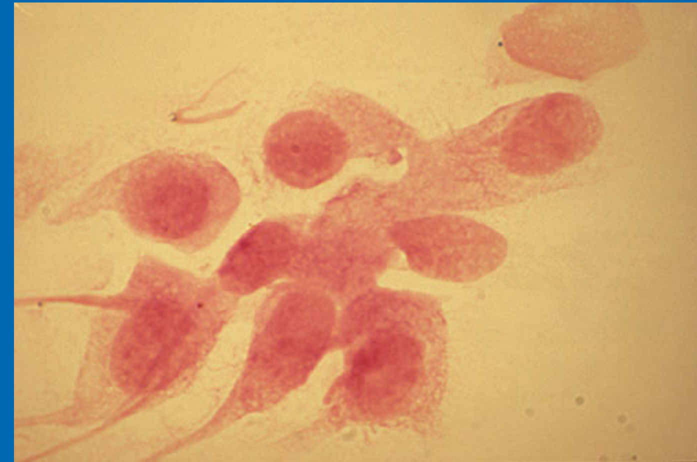
Discharge from urethritis caused by Chlamydia



Investigations in SHC

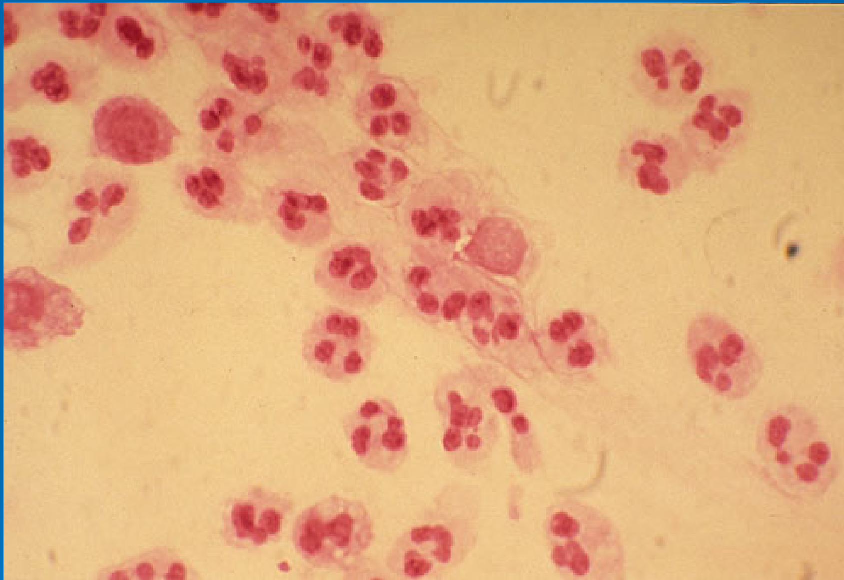
- Ideally no micturation in last 1-2 hours
- If microscopy available – 5mm plastic loop introduce 0.5cm into urethra – smear on glass slide – Gram stain
- Urethral swab for gonorrhoea culture (plate on selective artificial media)
- First void urine for Chlamydia NAAT testing
- If urinary symptoms prominent dipstick MSU (sensitivity 83%, specificity 90%)
- HSV swab if meatitis or ulceration present

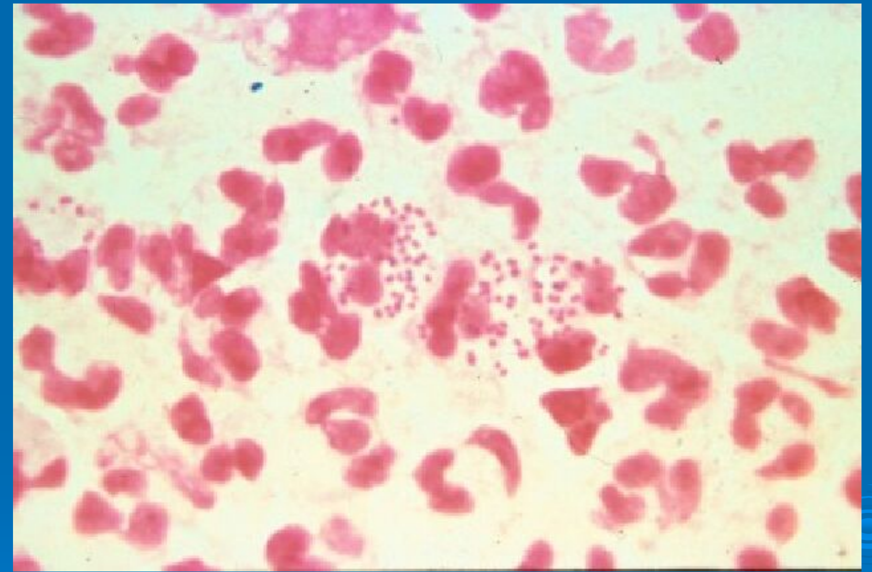
Gram stained slide



Images provided by the Seattle STD/HIV Prevention Training Center at the University of Washington, from the UW HSCER Slide Bank

Gram stain diagnosis of NGU and presumptive GC urethritis





Investigations in general practice

- Microscopy not available
- Urethral blue topped transwab for gonorrhoea culture (5-10% loss viability if gets to the lab within 24 hours, 50% loss if over 24 hours)
- First void urine for Chlamydia NAAT testing

Treatment

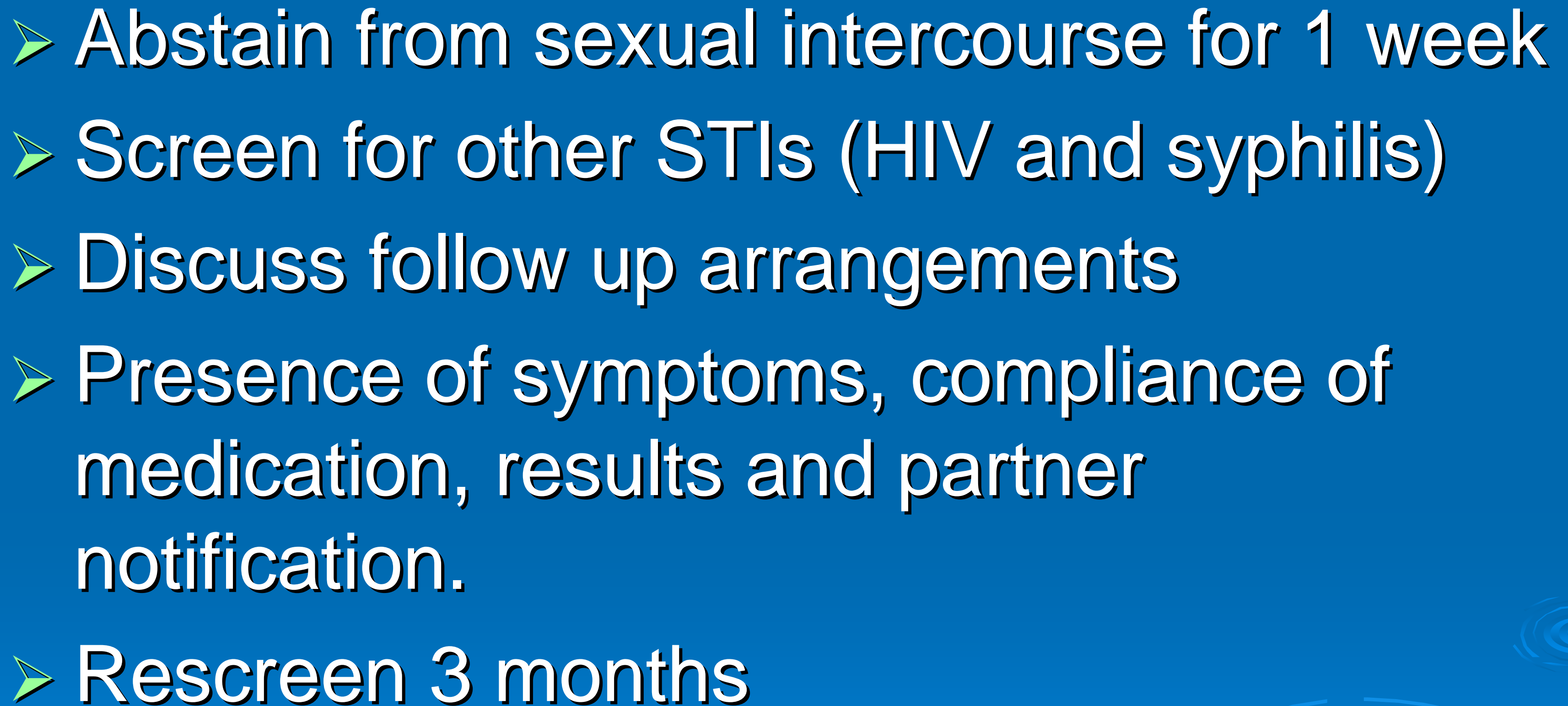
- If gram-negative intracellular diplococci on urethral Gram stain treat with ceftriaxone 500mg IM stat and azithromycin 1g stat (doxy 100mg bd 1 week)
- If >5 PMNLs treat azithromycin 1g stat
- If no microscopy available and symptoms and signs suggestive of urethritis treat presumptively for gonorrhoea and Chlamydia particularly in high prevalence populations

Management

- Explanation of causes of urethritis (written information -www.nzshs.org/pdf_2007/urethritis.pdf)
- Partner notification (PN) should be discussed at initial consultation
- Patient or provider PN
- Evaluation and treatment of sexual partners (2 month look back) for Chlamydia irrespective of results of investigations

Partner notification

- Partner notification is still recommended in gonorrhoea and Chlamydia negative urethritis – false negative results are possible, and evidence suggests that treatment of the female partner reduces the chance of recurrence for affected men



Abstain from sexual intercourse for 1 week
Screen for other STIs (HIV and syphilis)
Discuss follow up arrangements
Presence of symptoms, compliance of medication, results and partner notification.
Rescreen 3 months

Persistent / recurrent NGU

- Persistent – failure of symptoms to fully resolve 2 weeks after commencement of therapy
- Recurrent – past history of NGU with resolution of symptoms then recurrence of symptoms without any new exposure
- Need to check compliance and exclude re-infection or new infection
- Occurs in 10-20% of patients
- *M genitalium* present in 20-40% of cases
- (Resistance of *M genitalium* to azithromycin 1g and poor response to doxycycline)

Investigation and treatment for persistent / recurrent NGU

- Referral to sexual health clinic
- Urethral swab for *T vaginalis* culture (poor sensitivity)
- FVU for *M genitalium* PCR if available
- Treatment should cover *M genitalium* and *T vaginalis* (particularly in areas with high prevalence of this organism)