GENITAL ULCERS

Also refer to separate protocols for Syphilis, Herpes and Lymphogranuloma venereum.

Notes

- Always take a good travel history from patient and any partner(s)
- Herpes simplex infection is still most likely to be the diagnosis but syphilis can present with multiple painful ulceration (30% in recent north London series)
- Infections with several different organisms are not uncommon
- Document inguinal lymphadenopathy
- There have been recent LGV outbreaks in gay men in Europe with several cases in Scotland – mostly presenting with proctitis in HIV+ MSM (but not exclusively)

Clinical Features

	Syphilis	**HSV**	**Chancroid**	**LGV**	**Granuloma inguinale**
Organism	*Treponema pallidum*	Herpes simplex	*Haemophilus ducreyi*	*Chlamydia trachomatis L1, L2, L3*	*Klebsiella granulomatis*
Geographical distibution	Worldwide	Worldwide	Africa, Asia, Latin America	Foci in tropics plus recent MSM outbreak mostly proctitis	All resource poor countries
Incubation period	1-12 weeks	2-7 days	4-7 days	3 days – 6 weeks	Up to 6 months
Primary lesion	Papule	Vesicle	Pustule	Papule	Papule
No of lesions	Usually one	Multiple, may coalesce	Multiple, may coalesce	Usually one, often cleared by time of lymphadeno pathy	Variable
Diameter (mm)	5-15	1-2	2-20	2-10	Variable
Edges	Elevated Round	Erythema	Ragged Undermined	Elevated Round	Elevated Irregular
Depth	Superficial or deep	Superficial	Excavated	Superficial Or deep	Elevated
Induration	Firm	None	Soft	Variable	Firm
Pain	Unusual	Common	Common	Variable	Uncommon
Lymphadenopathy	Firm Non-tender unless infected Unilateral	Firm Tender Bilateral	Soft Very tender May suppurate	Tender Loculated Unilateral “The Groove sign”	Uncommon Firm “Pseudobubo”

Initial Investigations

- Full sexual health screen.
- HSV / Syphilis PCR. Indicate genital ulcer and site on NAAT form.
- Dark ground microscopy to exclude syphilitic chancre.
- In a HUB if a patient presents with a possible chancre arrange for the patient to go directly to Sandyford Central for Dark Ground Microscopy (if appropriate reviewing staff available). Patients must be fast-tracked and the consultant or senior doctor on clinic must be notified.
- Request syphilis serology (indicate genital ulcer in additional information section of form)

Further Investigations

- Bacteriological culture of ulcer (MC&S, contact laboratory to request specific cultures if required),
- Aspirate any bubo through healthy skin, send sample in sterile container (contact laboratory to request specific cultures if required).

If LGV suspected:

- LGV :NAAT for *Chlamydia trachomatis* from lesion AND **urethral** sample for NAAT. LGV PCR available via West of Scotland Specialist Virology Centre (sent to STI ref lab in Edinburgh). LGV on request form.

If Chancroid suspected:

- Culture medium for *Haemophilus ducreyi* can be prepared by the laboratory if 2 working days' notice is given. Direct microscopy may show 'rail-road' bacilli. PCR for *H. ducreyi* is available through the West of Scotland Specialist Virology Centre (contact to discuss request)

If Donovonosis suspected:

If diagnosis I not established with above tests, consider biopsy and crush smear for *Klebsiella granulomatis* ("Donovan bodies").

- Consider dermatological conditions (Behcets, lichen planus, pemphigoid, bullous impetigo)

Treatment

If ulcer is clinically apparent as HSV, treat with Aciclovir (as per HSV protocol).

If ulcer is obviously infected, treat with Trimethoprim 400 mg bd for one week whilst awaiting results of investigations. This treats secondary bacterial infections, but will not inadvertently partially treat syphilis. If dark ground microscopy is positive, see syphilis protocol. **Therapeutic regimens:** (also refer to separate protocols for syphilis, HSV and LGV and BASHH Chancroid/Donovanosis Guidelines)

Chancroid

Azithromycin 1g orally single dose (if HIV negative)

Erythromycin 500mg orally, four times a day for 7 days (recommended if HIV positive). Ulcers should heal within 3 days to 2 weeks. Follow-up 1 week. Treat partners exposed within 10 days before lesions appear even if partner is asymptomatic.

Donovanosis

Azithromycin 1g weekly or 500 mg daily until lesions heal (minimum 3 weeks)

OR

Doxycycline 100 mg bd until lesions heal (minimum 3 weeks)

OR

Erythromycin 500 mg qid until lesions heal (minimum 3 weeks)

Partner notification: back 40 days before onset of lesions. Partner should be assessed clinically for signs of infection and offered treatment

*Some treatments are contraindicated in pregnancy – see STIs in pregnancy protocols

Follow up

All patients should be followed up clinically until signs and symptoms have resolved.

References

BASHH: UK National Guideline for the management of Chancoid 2014
https://www.bashhguidelines.org/media/1059/chancroid_2014-ijstda.pdf

BASHH: UK National Guideline for the management of Donavonosis 2018
https://www.bashhguidelines.org/media/1168/donovanosis-2018.pdf

BASHH: UK National guidelines on the management of syphilis, 2015 (updated 2017)
https://www.bashhguidelines.org/media/1148/uk-syphilis-guidelines-2015.pdf

BASHH: UK National guideline for the management of anogenital herpes 2014
https://www.bashhguidelines.org/media/1019/hsv_2014-ijstda.pdf

BASHH: UK National guideline for the management of lymphogranuloma venereum 2013
https://www.bashhguidelines.org/media/1054/2013-lgv-guideline.pdf