Painful perianal lumps in a man with male sexual partners

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Case

A man in his early 20s presented with perianal lesions. Two general practitioners (GPs) had previously diagnosed haemorrhoids and provided treatment advice. However, the patient described worsening symptoms over six months and was now struggling to walk or sit comfortably. He was otherwise well. His sexual partners were male. Sexually transmissible infection (STI) screening 16 months earlier was unremarkable. He had no regular medications or allergies.

On examination, there were multiple tender, flesh-coloured perianal papules/plaques up to 15 mm in diameter (Figure 1). Other skin areas, mucous membranes and hair were unremarkable.

Question 1

What STI screening is appropriate for men who have sex with men (MSM)?

Question 2

What are the main differential diagnoses in this case?

Question 3

What investigations are appropriate?

Answer 1

The Australian STI management guidelines[1] (www.sti.guidelines.org.au) and STIGMA guidelines[2] recommendations for MSM are:

- gonorrhoea nucleic acid amplification testing (NAAT) of the throat and rectum
- chlamydia NAAT of urine, throat and rectum
- serology for human immunodeficiency virus (HIV), syphilis and, if immunity has not been previously demonstrated, hepatitis A and B
- serology for hepatitis C if the patient is HIV-positive or has a history of injecting drug use.

STI screening should be conducted three-monthly to yearly, depending on the risk.[1,2]

Answer 2

The lesions are most consistent with condylomata lata (secondary syphilis), with a differential of condylomata accuminata (warts).[3] Broad differentials for perianal lumps are shown in Table 1.

Answer 3

Testing should include syphilis serology and a swab from the lesions for syphilis NAAT (flocked swab). NAAT may be positive before positive serology develops. A suspicion of syphilis with negative serology should prompt re-testing in two

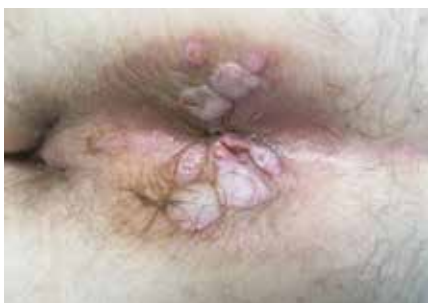

Figure 1. Perianal lesions

These had been increasing in number/size over months and the patient had been applying witch-hazel ointment

Table 1. Common and important causes of perianal lumps[1,9]

Viral infections
• Condylomata accuminata (warts: human papilloma virus)
• Molluscum contagiosum
• Herpes simplex virus (HSV)
Bacterial infections
• Condymomata lata (syphilis)
• Perianal abscess (multiple causes including gonorrhoea)
• Folliculitis (multiple causes)
Other
• Haemorrhoids
• Fibroepithelial polyps
• Perianal neoplasia (anal intraepithelial neoplasia [AIN]/squamous cell carcinoma [SCC])

weeks[1] or consideration of treatment with same-day rapid plasma reagin (RPR).

Warts are generally diagnosed clinically but can be confirmed histologically. Anogenital ulcers or fissures may be swabbed for herpes simplex virus (HSV) NAAT.[1]

As the patient has a probable STI, he should also be offered chlamydia, gonorrhoea, HIV, and hepatitis A and B testing as per Answer 1.

Case continued

Treatment for secondary syphilis was offered presumptively and the patient's symptoms improved dramatically post-treatment. Baseline syphilis serology on the day of treatment was positive, with an RPR of 64. Perianal swab for syphilis NAAT was also positive.

Question 4

What is the appropriate treatment for syphilis? What specific warnings need to be given regarding that treatment?

Question 5

What follow-up does this patient need?

Answer 4

The recommended treatment for syphilis is long-acting parenteral benzathine penicillin. For infections within two years, a single 1.8 g intramuscular (IM) dose is recommended, but for infections longer than two years, or where the duration is uncertain, 1.8 g IM weekly for three weeks is recommended.[1] In patients with a penicillin allergy, oral doxycycline 100 mg twice daily for 14 days (infections under two years) or 28 days (infections longer than two years) may be given, but it is less efficacious than benzathine penicillin.[1]

Tertiary syphilis and neurosyphilis require intravenous therapy,[4] so it is important to exclude these and refer if suspected.[1] Sexual health clinics can assist with the interpretation of serology, treatment decisions and treatment provision. To find your nearest service, see Table 2.

Benzathine penicillin syphilis treatment can cause a Jarisch–Herxheimer (JH) reaction[1], a flu-like syndrome, within hours of treatment. This is self-limiting, typically lasting under 24 hours.[5] It can be managed with simple anagesia (eg paracetamol) and rest.[1]

Answer 5

The patient should not have any sex for seven days post-treatment and not have sex with recent sexual contacts until they have been tested and treated.[1] Contact tracing for secondary syphilis covers the past six months (three months for primary syphilis),[6] but given this patient's symptom duration, a nine-month timeframe is more realistic. If he opts to contact partners himself, he should be followed up after a few weeks to see if he has been successful and to offer him support. Helpful contact-tracing resources for patients include Let Them Know (www.letthemknow.org.au) and The Drama Downunder (www.thedramadownunder.info/introduction). The local public health department will need to be notified.

RPR or venereal disease research laboratory (VDRL) should be collected on the day of treatment, and at three, six and, if necessary, 12 months, to monitor response (a four-fold drop in titre is expected).[1] The patient should be warned that his syphilis serology will remain positive for the rest of his life, and only RPR/VDRL will be useful for screening from now on. In addition to the management of his syphilis and STI screening, this patient needs:

- education about harm reduction strategies,[1] including use of condoms, post-exposure prophylaxis (PEP)[7] and pre-exposure prophylaxis (PrEP)[8] for HIV

Table 2. State-based resources

Australian Capital Territory	
Canberra Sexual Health Centre	02 6244 2184
New South Wales	
NSW Sexual Health Infolink	1800 451 624
PEP Hotline	1800 737 669
Northern Territory	
Clinic 34 Darwin	08 8999 2678
Queensland	
Healthline	134 325 84
South Australia	
Clinic 275 Royal Adelaide Hospital	08 9222 5075
PEP Hotline	1800 022 226
Tasmania	
Tasmanian Sexual Health Service	1800 675 859
PEP Hotline	1800 889 887
Victoria	
Melbourne Sexual Health Centre clinician advice line	1800 009 903
PEP Hotline	1800 889 887
Western Australia	
WA Sexual Health Helpline	08 9772 6178 or 1800 198 205 (country callers)
PEP Line	1300 767 161

- to consider PEP[7] if his last condomless anal sex was within 72 hours. PEP is available from sexual health centres or emergency departments. To find the nearest provider, see Table 2 or check online resources (eg www.getpep.info/where.html).
- to be offered hepatitis A, hepatitis B and/or HPV immunisation, depending on his vaccination status and serology.[1]

Key points

- Secondary syphilis can cause lesions that closely resemble warts.
- A sexual history is part of assessment of anogenital lesions.
- Treatment for syphilis depends on the duration of infection.
- Diagnosis with one STI should prompt testing for others. The Australian STI management guidelines provide free online recommendations for testing and treatment.
- Sexual health centres can help with interpretation of syphilis testing and provide treatment.

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References

1. Australian Sexual Health Alliance. Australian STI management guidelines. Darlinghurst, NSW: ASHA, 2015. Available at www.sti.guidelines.org.au [Accessed 24 August 2015].
2. STIGMA. Australian sexually transmitted infection and HIV testing guidelines 2014 – STIs in gay men action group. Sydney: STIGMA, 2014. Available at http://stipu.nsw.gov.au/wp-content/uploads/STIGMA_Testing_Guidelines_Final_v5.pdf [Accessed 24 August 2015].
3. Bruins FG, van Deudekom FJA and deVries HJ. Syphilitic condylomata lata mimicking anogenital warts. BMJ;2015;350:h1259.
4. Therapeutic Guidelines. Syphilis. Melbourne: Therapeutic Guidelines, 2014.
5. Belum GR, Belum VR, Chaitanya Arudra SK, Reddy BS. The Jarisch–Herxheimer reaction: Revisited. Travel Med Infect Dis 2013;11:231–37.
6. Australasian Society for HIV, Viral Hepatitis and Sexual Health Medicine. Australasian contact tracing manual 2010. Darlinghurst, NSW: ASHM, 2010. Available at http://ctm.ashm.org.au/Default.asp?PublicationID=6 [Accessed 3 May 2015].
7. Australasian Society for HIV, Viral Hepatitis and Sexual Health Medicine. Post-exposure prophylaxis after non-occupational and occupational exposure to HIV: National guidelines 2013. Darlinghurst, NSW: ASHM, 2013. Available at www.ashm.org.au/Documents/Guide for the Management of Occupational and Non-Occupational Post-Exposure Prophylaxis.pdf [Accessed 3 May 2015].
8. Australasian Society for HIV, Viral Hepatitis and Sexual Health Medicine. Australian national PrEP guidelines 2015. Darlinghurst, NSW: ASHM, 2015. Available at http://arv.ashm.org.au/images/Australian_National_PrEP_Guidelines.PDF [Accessed 3 May 2015].
9. Daniel WJ. Anorectal pain, bleeding and lumps. Aust Fam Physician 2010;39:376–81.