**Proctitis and Proctocolitis**

I. **DEFINITION:**

Proctitis is inflammation of the rectum (the distal 10-12 cm) that can be associated with anorectal pain, tenesmus, or rectal discharge. The most common sexually transmitted pathogens associated with proctitis include N. gonorrhoea, C. trachomatis, T. pallidum and HSV. Proctitis occurs predominantly among persons who participate in receptive anal intercourse.

Proctocolitis is associated with symptoms of proctitis, bloody discharge/diarrhea, or abdominal cramps and inflammation of the colonic mucosa extending to 12 cm above the anus. Proctocolitis can be acquired through receptive anal intercourse or by oral-anal (analingus) contact, depending on the pathogen.

II. **CLINICAL FEATURES:**

A. **Subjective**

1. History of anal intercourse.

2. Symptoms of acute **Proctitis** include any combination of:
   - a. tenesmus (frequent or continuous urge to defecate without significant production of feces)
   - b. anorectal pain or discomfort
   - c. mucoid, purulent or blood-stained anal discharge
   - d. mild diarrhea
   - e. constipation in severe cases
   - f. perianal itching

3. Symptoms of **Proctocolitis** include acute proctitis symptoms **plus** any of the following:
   - a. diarrhea, sometimes bloody
   - b. abdominal pain and/or cramping
   - c. bloating
   - d. fever

B. **Objective**

1. Exam findings for **Proctitis** include:
   - a. perianal tenderness or pain
   - b. perianal erythema and/or swelling
   - c. mucoid, purulent or blood-stained rectal discharge
   - d. perianal ulcers/lesions (seen with HSV and syphilis)
   - e. inguinal lymphadenopathy (seen with LGV)

2. Exam findings for **Proctocolitis** include proctitis findings **plus any of the following**:
   - a. bloody anorectal discharge
   - b. diffuse or localized abdominal tenderness
   - c. fever

III. **MANAGEMENT PLAN:**

A. **Physical Examination:** A physical exam is recommended for both males and females that includes:
   - vital signs, visual inspection and palpation of the perianal area and abdomen.

B. **Laboratory Studies:**

1. Collect rectal swab for *N. gonorrhoea* and *C. trachomatis* by NAAT. If rectal swab for *N.
gonorrhea and C. trachomatis by NAAT is not available, refer to urgent care or primary care provider (preferred option, if patient has one) for rectal swab testing as instructed under H. Consultation/Referral.

2. If rectal swab for N. gonorrhea and C. trachomatis by NAAT is not available, collect specimens for C. trachomatis and N. gonorrhoeae per instructions below.

a. Females: appropriate testing: **Vaginal swab is the preferred specimen collection method when and where available.**

   1) **Collect vaginal swab if product is available.** Refer to vaginal swab specimen collection procedure for instructions. If vaginal swab testing is not available, collect urine specimen as mentioned under laboratory option 2.a.2).

   2) **Collect urine for C. trachomatis and N. gonorrhoeae. Ensure client waits 1 hour after last voiding before giving urine sample.**

b. Males: **Collect urine for C. trachomatis and N. gonorrhoeae. Ensure client waits 1 hour after last voiding before giving urine sample.**

c. Obtain blood tests for HIV and Syphilis.

C. **Criteria to Presumptively Treat (Gonorrhea and/or Chlamydia):**

   History of receptive anal intercourse; symptoms of any combination of rectal discharge, anorectal pain, tenesmus, anal pruritis, or constipation in severe cases; and exam findings of external anal erythema, rectal discharge alone or in conjunction with either perianal ulcers or lesions, inguinal adenopathy, and/or proctocolitis symptoms/findings.

D. **Treatment (these treatment options cover gonorrhea and chlamydia):**

   **Option #1**  
   Ceftriaxone#2 250 mg IM in a single dose  
   Given with  
   Doxycycline 100 mg orally twice a day for 7 days  
   **Doxycycline cannot be given to pregnant clients** (See treatment note # 7)

**Treatment Notes:**

1. **#Ceftriaxone:**

   Must be given with 1% lidocaine solution as a diluent to lessen injection pain unless the client reports hypersensitivity or allergic reaction to local anesthetic agents or severe liver disease. See package insert for amounts and a complete discussion of lidocaine.

2. Dual therapy is the recommended treatment (option 1, 2, or 3). Ceftriaxone must be administered with or doxycycline. Ceftriaxone works by keeping bacteria from making and maintaining their cell walls and doxycycline prevents protein production and replication. They must be administered at the same time to achieve the desired effect.

3. To maximize adherence for multi-dose regimens, the first dose should be dispensed on site and directly observed.

4. Clients with an unknown reactions to PCN that occurred >10 years ago can be safely given ceftriaxone. Less than 1% will have allergic reactions and they are extremely unlikely to have anaphylaxis. Ceftriaxone is safe for clients with ampicillin or
amoxicillin specific allergies due to these medications not sharing the same side chains ceftriaxone.

5. Ceftriaxone is contraindicated in clients who report true IgE mediated reaction to PCN or cephalosporins. Characteristics of IgE mediated reaction include:
   a. **Reactions that occur immediately or usually within one hour after taking medication.** True hypersensitivity reactions include: generalized flushing of the skin, urticaria, rash (hives) anywhere on the body; angioedema, swelling of face, throat or mouth, bronchospasm, wheeze and shortness of breath, sensation of throat closure or intense throat itch, nausea and vomiting; alterations in heart rate, cardiovascular collapse, hypotension, vasodilatation, sudden feeling of weakness, sense of impending doom, collapse and unconsciousness.
   b. **Anaphylaxis-** Requires signs and symptoms in at least two of the following body systems: Skin, respiratory, cardiovascular, gastrointestinal.
   c. **Stevens - Johnson Syndrome**
   d. **Toxic epidermal necrolysis**
   e. Clients (+GC, Urethritis, or contact) with well-documented hypersensitivity to PCN, (including documentation of patient stated adverse effects of penicillin, cephalosporins, or ceftriaxone) are to be referred to their private physician for evaluation and treatment.

6. Doxycycline is contraindicated in clients who report a known hypersensitivity to doxycycline, minocycline, or tetracycline. Clients allergic to doxycycline must be referred to a primary care physician for treatment using ODH 399 Referral Form.

7. Treatment in Pregnancy: Doxycycline **cannot** be given to pregnant clients. Pregnant clients with symptoms of proctitis must be referred to a primary care physician or their OB-GYN physician for evaluation using ODH 399 Referral Form.

E. **Special Consideration:**

1. The public health nurse must ensure that another employee, preferably CPR certified, is present who can assist if an emergency occurs before any injections can be administered.
2. Notify HIV/STD Nurse and DNM and consult with Medical Director, if available, regarding:
   a. Presumptive treatment and referral of clients for rectal tests for *N. gonnorhea* and *C. trachomatis* by NAAT.
   b. Presumptive treatment and referral of clients with symptoms of proctitis in conjunction with perianal ulcers or lesions, inguinal adenopathy, and/or signs and symptoms of proctocolitis.

F. **Client Education:**

1. Take prescribed oral medication appropriately
2. All sex partner(s) from the past 60 days clients treated for proctitis should be referred for testing and treatment of the identified or suspected STD and serologically screened for HIV and syphilis.
3. Abstain from sex:
   a. until client and partner(s) have completed a 7-day regimen, or
b. until 7 days after client and partner(s) take a single dose regimen

4. For clients presumptively treated for uncomplicated proctitis, instruct client to follow up with a higher level of care (primary care provider, FQHC or urgent care facility) if symptoms have not improved within 3-5 days.

4. Prevention measures (e.g., condoms) to prevent future infections.

G. Follow up:

1. If client presents to the county health department symptomatic after 1-2 weeks post-treatment, they should be reassessed (completion of medication regimen, abstaining from partner, evaluating if partner was treated) in STD clinic, examined, screened and referred to higher level of care (primary care provider, urgent care facility and or emergent care facility) for further evaluation based upon level of severity of client’s condition and availability of care.

2. Clients who are presumptively treated for acute uncomplicated proctitis should be followed up through a higher level of care (primary care physician or urgent care facility) for rescreening in 3 months if proctitis was associated with documented gonorrhea or chlamydia.

H. Consultation/Referral:

1. Clients who report medication allergies which would prevent them from being able to take the medications (dual therapy) listed in the treatment options listed above must be referred to a higher level of care (primary care provider, FQHC, urgent care facility, and/or emergency facility) using ODH 399 Referral form for evaluation and treatment.

2. If rectal swab for *N. gonorrhea* and *C. trachomatis* by NAAT is not available, clients presumptively treated for proctitis and/or proctocolitis are to be referred directly to a higher level of care (primary care provider, FQHC or urgent care facility) using ODH 399 Referral form for obtaining rectal tests for *N. gonorrhoeae* and *C. trachomatis*.

3. Clients presumptively treated for acute proctitis in conjunction with perianal ulcers or lesions, inguinal adenopathy, and/or signs and symptoms of proctocolitis should be referred directly to a higher level of care (primary care provider, FQHC, urgent care facility, and/or emergent care facility) using ODH 399 Referral form for further evaluation and, as indicated, treatment.

4. MSM presumptively treated for proctitis and/or proctocolitis symptoms should be referred to a higher level of care (primary care provider, urgent care facility, and/or emergent care facility) for evaluation for lymphogranuloma venereum (LGV).

5. Any client who has an HIV diagnosis who presents with symptoms of proctitis and/or proctocolitis needs to be presumptively treated and directly referred to a higher level of care (primary care provider, urgent care facility, and/or emergent care facility) using ODH 399 Referral form for further evaluation and, as indicated, treatment.

6. In making a referral to a higher level of care (primary care provider, FQHC, urgent care facility, and/or emergent care facility), the nurse needs to explain the importance of the need for additional testing or further evaluation, as indicated, to the client, assess the client’s ability to access higher a level care (do they have a PCP, OB, insurance or ability to pay…), and fax a copy of the referral form to the clinic or facility.

7. Referrals for acute proctitis should use the ODH 399 Referral Form and include:
   a. Reason for referral (e.g., obtaining rectal tests for *N. gonorrhoeae* and *C.
trachomatis and, as indicated, further evaluation of perianal ulcers or lesions, inguinal adenopathy, and/or signs and symptoms of proctocolitis).

b. List of laboratory tests obtained (urine or vaginal tests for gonorrhea and chlamydia)
c. List and dosage of medications administered for presumptive treatment of proctitis.

I. Management of Sex Partners:

All sex partner(s) of clients presumptively treated for proctitis (gonorrhea and chlamydia) within the 60 days before the onset of the clients symptoms should be notified, examined, and treated as follows:

1. Partners of clients treated presumptively should receive testing and the treatment at the time of the visit.

2. If client’s test results are known, partner(s) should be tested and treated for STD(s) identified.

3. Instruct the sex partners to abstain from sexual intercourse until both they and their partner(s) are adequately treated to avoid reinfection.

REFERENCES:


Centers for Disease Control and Prevention (2016), Evaluation and Diagnosis of Penicillin Allergy for Healthcare Professionals.


STD Counseling and Treatment Guide: American Social Health Association.