Concise clinician-oriented reference based primarily on the New Zealand STI Guidelines **(Sexual Wellbeing Aotearoa)**, with consistency with current NZ antimicrobial recommendations.

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STI	First-line NZ treatment	Alternative treatment	Important management pitfalls / notes
Chlamydia (C. trachomatis)	**Doxycycline 100 mg PO BD for 7 days**	Azithromycin 1 g PO stat **only** if doxycycline contraindicated (e.g. pregnancy) or adherence concerns	Doxycycline superior for rectal infection. Test all exposed sites (urine/vaginal, rectal, pharyngeal). Abstain from sex until 7 days after treatment completed and partners treated. Retest at **3 months** due to reinfection. Screen for HIV, syphilis and gonorrhoea. Pregnancy requires test of cure.
Gonorrhoea (N. gonorrhoeae)	**Ceftriaxone 500 mg IM stat** (increase dose in larger patients per guideline if applicable). Add doxycycline if chlamydia not excluded.	Specialist advice if severe cephalosporin allergy or resistance suspected.	Obtain culture (if possible) before antibiotics for susceptibility. NAAT alone cannot provide sensitivities. Mandatory partner notification. Test of cure required (especially pharyngeal infection). Rising antimicrobial resistance makes oral cefixime no longer routine first-line.
Syphilis	**Benzathine benzylpenicillin IM** (dose depends on stage: early = single dose; late latent = weekly ×3)	Doxycycline (non-pregnant penicillin-allergic patients) after specialist advice	Stage disease correctly. HIV testing essential. Follow quantitative RPR titres. Beware Jarisch–Herxheimer reaction. Pregnancy: penicillin is the only proven effective therapy—desensitise if allergic. Notify public health where required.
Genital herpes (HSV-1/HSV-2)	Valaciclovir 500 mg BD for 7 days (first episode)	Aciclovir or famciclovir	First episode often more severe than recurrence. Consider suppressive therapy for frequent recurrences. Swab lesions for PCR before treatment if feasible. Caesarean section may be indicated with primary infection near delivery.
Trichomoniasis	Metronidazole 400 mg BD for 7 days (preferred in women)	Metronidazole 2 g single dose (selected patients); tinidazole if available after specialist advice	Always treat sexual partners simultaneously. Avoid alcohol during treatment and for at least 24 hours after metronidazole. Test for other STIs. Higher prevalence in Māori and Pacific peoples.
Mycoplasma genitalium	Resistance-guided therapy where possible. Typically doxycycline 100 mg BD for 7 days followed by azithromycin **if macrolide susceptible**	Moxifloxacin for macrolide-resistant infection or treatment failure	Do **not** empirically give azithromycin 1 g stat—promotes resistance. Only test symptomatic patients or contacts where indicated. Test of cure usually recommended. Specialist advice if persistent.
Genital warts (HPV)	Patient-applied imiquimod or clinician-administered cryotherapy	Podophyllotoxin (not in pregnancy), surgical excision	Treatment removes warts—not HPV infection. Recurrence common. HPV vaccination still beneficial. Cervical screening recommendations unchanged.
Pubic lice / scabies	Permethrin 5% (scabies) or pyrethrin/permethrin preparations (lice)	Oral ivermectin (selected cases)	Treat close contacts simultaneously. Wash clothing/bedding appropriately. Persistent itch does not necessarily indicate treatment failure.

Common STI syndromes

Syndrome	Recommended empiric NZ treatment	Key pitfalls
Pelvic inflammatory disease (PID)	Ceftriaxone IM + doxycycline 14 days + metronidazole 14 days	Do not wait for swab results if clinical suspicion is high. Low threshold for treatment. Pregnancy, severe illness, tubo-ovarian abscess or diagnostic uncertainty require gynaecology review.
Epididymo-orchitis (likely STI)	Ceftriaxone 500 mg IM stat + doxycycline 100 mg BD for 14 days	Exclude testicular torsion urgently. Consider enteric organisms in insertive anal sex or older men. Scrotal support and analgesia important.
Non-gonococcal urethritis	Doxycycline 100 mg BD for 7 days	Persistent symptoms should prompt testing for *M. genitalium* rather than repeated empiric azithromycin.

High-yield NZ examination pearls

Situation	Recommendation
Routine STI screen	Offer HIV and syphilis serology plus NAAT testing from all exposed anatomical sites (urine/vaginal, rectal, pharyngeal as indicated). Self-collected vaginal and throat/rectal swabs are acceptable in many situations.
Gonorrhoea	Collect culture before antibiotics whenever possible if discharge is present or resistance is a concern.
Pregnancy	Syphilis, HIV and hepatitis B testing are essential. Avoid doxycycline. Penicillin remains the treatment of choice for syphilis.
Recent exposure	NAAT for chlamydia/gonorrhoea becomes reliable from approximately **2 weeks** after exposure; HIV and syphilis serology should be repeated at **3 months** if initially negative.

Common examination and prescribing pitfalls

- **Do not use azithromycin 1 g routinely for chlamydia**—doxycycline is now preferred because of superior efficacy, particularly for rectal infection.
- **Do not treat gonorrhoea with oral therapy alone** unless specifically advised by a sexual health or microbiology specialist.
- **Always consider infection at multiple anatomical sites**—a urine NAAT alone may miss pharyngeal or rectal infection.
- **Always offer HIV and syphilis testing** whenever another bacterial STI is diagnosed.
- **Partner notification and treatment** are as important as treating the index patient.
- **Retesting at 3 months** after chlamydia or gonorrhoea treatment is recommended because reinfection is common.
- **Pregnancy changes management**: avoid doxycycline; ensure test of cure where recommended.
- **Persistent urethritis after doxycycline** should prompt evaluation for *Mycoplasma genitalium* rather than repeated empiric antibiotic courses.

This format is suitable as a quick-reference guide for general practice or emergency department use in New Zealand and reflects current NZ STI guidance.

MSM-focused STI management table — Aotearoa New Zealand

Infection / presentation	Recommended NZ treatment	Alternative / specialist options	MSM-specific management priorities and pitfalls
Chlamydia — urethral, pharyngeal or asymptomatic rectal	**Doxycycline 100 mg PO twice daily for 7 days**	Azithromycin **1 g PO once** for genital/pharyngeal infection only when doxycycline is contraindicated or adherence is very unlikely. For anorectal infection: azithromycin **1 g PO, repeated after 1 week** under guideline criteria	Test **urine, pharynx and rectum**, not urine alone. Symptomatic anorectal infection may represent LGV or polymicrobial proctitis—examine and discuss with sexual health. Rectal chlamydia requires NAAT test of cure ≥4 weeks after treatment; retest all patients at 3 months. Notify sexual contacts from the previous 3 months. Patient-delivered partner therapy is not legal in NZ. Consider PrEP following rectal chlamydia.
Gonorrhoea — genital, pharyngeal or anorectal	**Ceftriaxone 500 mg IM once plus azithromycin 1 g PO once**	If azithromycin contraindicated: **ceftriaxone 1 g IM once**. Severe cephalosporin allergy or suspected resistance: seek sexual health/microbiology advice	Collect gonococcal culture before treatment when discharge or symptomatic rectal infection permits. Test all three sites. Pharyngeal infection requires NAAT test of cure ≥4 weeks after treatment; retest at 3 months. Gonorrhoea is notifiable. Persistent symptoms may indicate resistance or reinfection—not simply treatment failure. Consider PrEP following rectal gonorrhoea.
Concurrent gonorrhoea and chlamydia	**Ceftriaxone 1 g IM once plus doxycycline 100 mg PO twice daily for 7 days**	Seek specialist advice for allergy, symptomatic rectal co-infection or complicated disease	Do not use the lower ceftriaxone regimen when confirmed chlamydial co-infection is being treated according to the NZ guideline. Review at approximately 1 week and retest at 3 months.
Acute proctitis / suspected LGV	Where immediate syndromic treatment is required: **doxycycline 100 mg PO twice daily for 21 days plus ceftriaxone 500 mg IM once plus valaciclovir 500 mg PO twice daily for 7 days**	Rationalise therapy once results return; specialist sexual-health management is preferred	Take a careful history of receptive anal sex, pain, tenesmus, bleeding, discharge, ulcers and systemic symptoms. Perform perianal and digital rectal examination; proctoscopy is preferable. Collect rectal GC culture/NAAT, chlamydia NAAT, HSV swab and stool studies if diarrhoea. If rectal chlamydia is positive, request LGV typing through a sexual health physician or microbiologist. Do not manage severe rectal symptoms as uncomplicated chlamydia.
Syphilis — early	**Benzathine benzylpenicillin 2.4 million units IM once**	Penicillin allergy: obtain specialist advice; avoid substituting an unverified oral regimen	Establish stage from history, examination and previous serology. Examine oral cavity, skin, lymph nodes, genital and perianal areas; assess neurological, ocular and auditory symptoms. Obtain baseline quantitative RPR on the treatment day and repeat at 3, 6 and 12 months. Infectious syphilis is notifiable. Treat contacts exposed within the preceding 90 days empirically even if initial serology is negative. Actively offer PrEP.
Syphilis — late latent or unknown duration	**Benzathine benzylpenicillin 2.4 million units IM weekly for 3 doses**, on days 1, 8 and 15	Specialist advice for allergy or interrupted dosing	A previous positive treponemal test may remain positive lifelong. Use treatment documentation and RPR trends rather than treponemal serology to determine reinfection. Neurological, ocular or auditory features require urgent specialist assessment for neurosyphilis rather than routine IM therapy.

Infection / presentation	Recommended NZ treatment	Alternative / specialist options	MSM-specific management priorities and pitfalls
Mycoplasma genitalium	Macrolide susceptible: **doxycycline 100 mg twice daily for 7 days, immediately followed by azithromycin 1 g, then 500 mg daily for 3 days**	Macrolide resistant or no resistance result: **doxycycline 7 days followed by moxifloxacin 400 mg daily for 7 days**; specialist discussion strongly recommended	Do not screen asymptomatic MSM routinely. Test for persistent or recurrent urethritis, selected contacts or specialist-directed rectal disease. Do not give azithromycin 1 g alone—it promotes resistance and has a high failure risk. Rectal testing is mainly indicated for contacts who had receptive anal sex with the index case.
Genital or perianal herpes — initial episode	**Valaciclovir 500 mg PO twice daily for 7 days**, extended if lesions continue to develop or healing is incomplete	Aciclovir **400 mg PO three times daily for 7 days**	Swab the base of a fresh ulcer or deroofed vesicle for HSV NAAT, but do not delay treatment in a significant first episode. Also test for syphilis and HIV. Severe proctitis, urinary retention, neurological symptoms, HIV-associated severe disease or immunosuppression require specialist review. Do not use HSV serology for routine asymptomatic screening.
Recurrent genital herpes	Episodic: **valaciclovir 500 mg twice daily for 3 days**. Suppressive: **valaciclovir 500 mg daily**, usually reviewed every 6 months	Episodic aciclovir **800 mg three times daily for 2 days**; suppressive aciclovir **400 mg twice daily**	Provide a patient-held prescription so therapy can start during the prodrome. Suppression may be appropriate for frequent recurrences, significant distress or transmission concerns. HIV or immunosuppression may require altered dosing and specialist advice.
Genital or anal HPV warts	Lesion-directed treatment such as cryotherapy or patient-applied topical therapy according to lesion site and local availability	Surgical or specialist treatment for extensive, intra-anal, atypical or refractory lesions	Examine the perianal region and consider anoscopy where intra-anal lesions are suspected. Biopsy pigmented, indurated, ulcerated, bleeding or treatment-resistant lesions. Treatment removes visible lesions but does not eradicate HPV. Check HPV vaccination status. Routine anal cytology screening is not currently universally recommended in NZ.
Hepatitis A	Acute infection: supportive care and public-health management	—	Ask about oral–anal contact and travel. Consider hepatitis A vaccination for non-immune MSM, although vaccination and serology may be unfunded for this indication. Acute HAV is notifiable. Avoid sexual contact, particularly oral–anal contact, during the infectious period.
Hepatitis B	Acute or chronic infection: manage or refer according to HBV pathway	—	Check **HBsAg and anti-HBs** when immune status is unknown. Offer vaccination if susceptible; it may be available through sexual-health services. Chronic HBV affects PrEP choice: use daily rather than event-driven PrEP and do not stop tenofovir/emtricitabine abruptly because of possible hepatitis flare. Screen and vaccinate household and sexual contacts.
Hepatitis C	Confirm active infection with HCV RNA and refer/treat through the local hepatitis pathway	—	Test MSM with relevant risks, including HIV, PrEP use, injecting drug use, chemsex involving injection, traumatic sexual practices or prior HCV. Repeat at least annually with ongoing risk. After previous clearance or cure, use **HCV RNA**, not antibody, to detect reinfection.

Infection / presentation	Recommended NZ treatment	Alternative / specialist options	MSM-specific management priorities and pitfalls
HIV exposure within 72 hours	Urgent assessment for **HIV PEP** according to the NZ PEP guideline	—	Do not wait for baseline HIV results before arranging urgent PEP when the exposure is clinically significant. Document timing, receptive versus insertive exposure, condom use, source viral load and PrEP adherence. Transition directly from PEP to PrEP where ongoing risk exists.
HIV prevention with PrEP	**Tenofovir disoproxil 245 mg/emtricitabine 200 mg once daily** for eligible patients	Event-driven 2-1-1 PrEP may be used by eligible cisgender men and some people assigned male at birth who are not taking oestrogen-based gender-affirming therapy	Confirm HIV-negative status and assess for acute seroconversion before starting. Baseline assessment includes three-site STI testing, syphilis, HBV/HCV status and renal function. Review every 3 months. Do not use event-driven PrEP with chronic HBV. PrEP prevents HIV, not bacterial STIs.

Routine MSM sexual-health check

Component	NZ-oriented approach	Frequent pitfall
Frequency	At least annually for all sexually active MSM; **every 3 months** with new or multiple partners, group sex, PrEP use or chemsex	Restricting 3-month screening to people taking PrEP while overlooking comparable behavioural risk
Chlamydia and gonorrhoea	First-pass urine plus **pharyngeal and anorectal NAAT**, generally regardless of reported practices or condom use	Urine-only testing misses many asymptomatic infections
Blood tests	HIV and syphilis serology at each full screen; HBV immunity/infection assessment if unknown; HCV at least annually when indicated	Assuming a previous negative HIV or syphilis result covers subsequent exposures
Examination	Offer examination; it is required with discharge, dysuria, testicular symptoms, anal pain/discharge, ulcers or gonorrhoea contact	Treating proctitis solely from a self-collected rectal NAAT without examining for ulcers, masses, abscess or alternative pathology
Prevention	Actively assess PrEP/PEP eligibility, condom preferences, HPV/HBV vaccination, HAV vaccination, injecting safety and chemsex-related harms	Presenting prevention only as condom counselling rather than a combination-prevention discussion
HIV-positive MSM	Ensure engagement in treatment and viral-load monitoring; undetectable viral load prevents sexual HIV transmission	Continuing to counsel a person with sustained undetectable viral load as infectious; this undermines U=U and may increase stigma
Anal cancer risk	NZ STI guidance advises annual digital anorectal examination for HIV-positive MSM aged over 50 years	Confusing digital anorectal examination with a nationally established anal-cytology screening programme

Key practice point: An MSM sexual history should distinguish insertive and receptive anal sex, oral–anal contact, condom use by site, partner number and networks, group sex, overseas contacts, PrEP adherence, HIV viral suppression in partners, sex toys, fisting or traumatic practices, and recreational or injected drug use. Testing and examination should remain anatomy- and exposure-informed while avoiding assumptions about identity or behaviour.

Mpox (formerly monkeypox) — MSM-focused management in Aotearoa New Zealand

Mpox (formerly called **monkeypox**) is a **viral zoonotic infection** caused by the **monkeypox virus**, an **Orthopoxvirus** in the same family as the smallpox virus. It is usually a self-limiting illness but can cause severe disease in some people.

Key points

- **Transmission:** Close skin-to-skin contact with infectious lesions, body fluids, respiratory secretions during prolonged close contact, contaminated bedding or clothing, and sexual contact (although it is **not exclusively a sexually transmitted infection**).
- **Incubation period:** Typically **5–21 days**.
- **Symptoms:** Fever, headache, myalgia, lymphadenopathy, followed by a characteristic rash that progresses from macules → papules → vesicles → pustules → crusts. During recent outbreaks, some patients presented with isolated genital or perianal lesions and severe proctitis.
- **Diagnosis:** PCR testing of swabs taken from skin or mucosal lesions.
- **Treatment:** Mainly supportive (analgesia, hydration, wound care). Severe disease or high-risk patients may require specialist management and consideration of **tecovirimat** where available.
- **Prevention:** Avoid close contact with infected individuals, isolate until lesions have healed completely, and vaccinate eligible high-risk individuals with the **JYNNEOS** vaccine.

In New Zealand, **mpox is a notifiable disease**, and suspected cases should be discussed with the local Public Health Service.

Clinical issue	Recommended management	Alternatives / escalation	MSM-specific pitfalls and notes
When to suspect	Consider in any patient with new vesicles, pustules, ulcers or crusted lesions, particularly genital, perianal, rectal or oral lesions; systemic symptoms may include fever, lymphadenopathy, headache and myalgia	Maintain suspicion with a single lesion or isolated proctitis, even without fever	Do not dismiss lesions as herpes, folliculitis or syphilis solely because there are few lesions. Ask about close skin-to-skin or sexual contact, events, travel and known contacts without assuming sexual identity determines risk. Symptoms usually arise within **1–21 days** of exposure.
Examination	Examine skin, mouth, genital and perianal regions; assess for proctitis, urinary obstruction, ocular involvement and secondary bacterial infection	Consider proctoscopy or specialist review for severe rectal pain, bleeding or tenesmus	Internal rectal lesions may be missed on external inspection. Use appropriate PPE and avoid unnecessary lesion manipulation.
Diagnostic testing	Swab one or more active lesions firmly for **mpox PCR**, preferably sampling lesions at different sites or stages according to local laboratory instructions	Discuss atypical presentations or patients without accessible lesions with microbiology, sexual health or infectious diseases	Notify the laboratory before sending samples where locally required. A superficial swab may be falsely negative. Test simultaneously for HSV and syphilis, and perform three-site gonorrhoea/chlamydia testing where indicated.
Notification	Suspected and confirmed mpox should be discussed promptly with the local **Medical Officer of Health / Public Health Service**	In hospital, involve infectious diseases and infection prevention teams	Mpox is a **notifiable disease** in NZ. Do not defer notification until every result is available where clinical suspicion is substantial.
Uncomplicated disease	Usually supportive treatment: adequate analgesia, hydration, gentle lesion care and treatment of itch or secondary bacterial infection when present	Escalate analgesia early for genital or anorectal disease; severe pain may require admission	Most clade II disease resolves within **2–4 weeks**, but proctitis can cause disproportionate pain. Avoid prophylactic antibiotics without evidence of bacterial infection.

Clinical issue	Recommended management	Alternatives / escalation	MSM-specific pitfalls and notes
Severe or high-risk disease	Urgent specialist discussion for severe pain, extensive lesions, ocular disease, airway involvement, encephalitis, dehydration, urinary retention, significant proctitis, pregnancy, children or substantial immunocompromise	Antiviral therapy such as **tecovirimat** may be considered through infectious diseases/public-health pathways; availability and indications are specialist controlled	Advanced or uncontrolled HIV increases the risk of severe and prolonged disease. Arrange urgent HIV testing when status is unknown and assess current CD4 count and viral suppression in people living with HIV. Evidence for mpox-specific antivirals remains limited, so they are not routine primary-care prescriptions.
Transmission precautions	Avoid sex, intimate skin contact and contact with lesions until all lesions have crusted, scabs have separated and intact new skin has formed	Public health provides individualised advice about work, household contacts and high-risk settings	Formal home isolation may not always be required, but patients remain infectious while lesions are active. Cover lesions, avoid sharing bedding, towels, clothes and sex toys, and clean contaminated items carefully. Condoms alone do not prevent transmission because uncovered skin is involved.
After clinical recovery	NZ public-facing guidance recommends condoms during sexual activity involving semen for **12 weeks after recovery**	Discuss practical risk reduction and temporary reduction in partner number	This recommendation reflects uncertainty about persistence in semen; it does not replace avoidance of skin contact while active lesions remain.
Close contacts	Public health risk-assesses contacts; advise symptom monitoring for **21 days after the last exposure**	Post-exposure vaccination may be offered according to timing and eligibility	Contacts should promptly report rash, fever, lymphadenopathy or rectal symptoms. Current NZ advice also recommends avoiding sexual or intimate contact during the monitoring period.
Vaccination	NZ uses **JYNNEOS**, generally as **2 doses at least 28 days apart** for eligible people at increased risk	Post-exposure vaccination should be arranged urgently through public health or participating sexual-health services	Discuss vaccination proactively with eligible gay, bisexual and other MSM, their sexual partners, sex workers and others with relevant exposure risk. Previous smallpox vaccination does not necessarily remove the need for assessment. Protection is not immediate and vaccination does not treat established disease.
Broader sexual-health management	Offer HIV testing, syphilis serology and site-specific GC/CT testing; assess hepatitis vaccination, PrEP and PEP needs	Link to sexual-health services for partner notification and prevention planning	Mpox can coexist with another STI. Avoid framing it solely as an STI or solely as an MSM infection: transmission is predominantly through close physical contact, although sexual networks have been important in clade II outbreaks.

Important clinical red flags

- Severe anorectal pain, bleeding, inability to pass stool or suspected abscess.
- Ocular pain, visual change or periocular lesions.
- Dysphagia, airway symptoms or extensive oral lesions.
- Urinary retention from penile or vulval oedema.
- Rapidly progressive, necrotic or disseminated lesions.
- Pregnancy, marked immunosuppression, uncontrolled HIV or very low CD4 count.
- Inability to maintain hydration or control pain in the community.

Key pitfall: During the clade II outbreak, mpox may present as **one genital lesion, isolated anal pain or proctitis without a widespread rash**. A full sexual history and targeted examination are therefore more useful than relying on the classic “fever followed by diffuse rash” description.