

APPROACH TO AN STI CONSULTATION IN PRIMARY CARE V2.1

A glossary of abbreviations and acronyms used in this section is available at the end of this page.

Sexually transmitted infections (STIs) have a major negative impact on sexual and reproductive health worldwide. In addition to causing distressing symptoms in the short to medium term, they have the potential to cause significant morbidity in men and women, including infertility and ectopic pregnancy. Many individuals with an STI are asymptomatic. STIs are spread through intimate sexual contact, including vaginal, anal and oral sex, as well as through genital contact with an infected partner.

STIs are an ongoing public health issue and particular challenges worldwide (and in Ireland also) include:

- The largely silent nature of chlamydia infection and its potential to impact on fertility.
- The resurgence of syphilis, in particular, early infectious syphilis in gay, bisexual and other men who have sex with men (gbMSM). There have been concerns more recently regarding an increase in cases of syphilis among the heterosexual population. This may impact on congenital syphilis cases highlighting the importance of syphilis testing in pregnancy with prompt action of abnormal results. See syphilis guideline.
- The emergence of antibiotic resistance in *Neisseria gonorrhoea* and *Mycoplasma genitalium*, which calls for prudent antibiotic usage and robust antibiotic stewardship.
- The continuing prevalence of HIV.

Sexual health screening should be an integral component of any routine health check in order to prevent and treat STIs. It is an essential part of consultations for contraception, cervical screening, antenatal care and travel health. It is useful to start a conversation about sexual health testing during a routine appointment to help patients feel more comfortable in discussing their sexual health. Public sexual health clinics are also available throughout the country for testing and treatment for patients (by appointment or walk-in clinics in some areas) or for onward referral from primary care to a specialist centre.

Free home STI testing is now available across Ireland to asymptomatic individuals over 17 years of age. Test kits and further information is available from the [HSE home STI testing service linked here](#). In the event that an individual presents to your service with a positive chlamydia or gonorrhoea result there is no requirement to repeat this test prior to treatment. Where possible gonorrhoea culture is recommended to facilitate antimicrobial susceptibility testing and resistance surveillance. Individuals with reactive HIV, syphilis, hepatitis C or hepatitis B results on home testing require laboratory serum testing to confirm or refute the infection. In such circumstances individuals with positive or reactive test results are contacted by the SH:24 team and referred directly to a participating public STI clinic.

Minimum screening tests for STI consultation

| | |
|-------------|----------|
| Chlamydia | HIV |
| Gonorrhoea | Syphilis |
| Hepatitis B | |

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Quick reference guides for STI screening

- [FEMALE asymptomatic STI screen quick reference guide](#)
- [MALE \(heterosexual\) asymptomatic STI screen quick reference guide](#)
- [gbMSM asymptomatic STI screen quick reference guide](#)
- For STI testing in trans gender and non-binary individuals see STI tests, Table 4.

Vaginal discharge quick reference guide

Normal physiological discharge is the most common cause of vaginal discharge in females of reproductive age. Assurance may be required for the patient, and a [patient information leaflet on vaginal discharge](#) is available through www.healthpromotion.ie.

Abnormal vaginal discharge can have a number of possible causes including infections (non-STI), STIs and non-infectious causes. A full pelvic exam including speculum is advised to exclude any non-infectious cause of symptoms.

Three of the possible infections associated with abnormal vaginal discharge are outlined in the summary quick reference guide, namely bacterial vaginosis, vaginal candidiasis and trichomoniasis

| Feature | Bacterial vaginosis | Vulvovaginal candidiasis | Trichomoniasis |
|---|--|---|---|
| Normal vaginal discharge is usually white or clear, odourless and can vary with menstrual cycle (thick and sticky to slippery and wet) | | | |
| Symptoms | Thin white discharge Offensive fishy odour NO itch / irritation | Thick white discharge Non offensive odour Dyspareunia / Dysuria Vulval itch / discomfort | Frothy yellow-green discharge Offensive odour Dyspareunia / Dysuria Vulval itch / discomfort |
| Signs | No inflammation of vulva | Vulval erythema / fissuring Satellite lesions | Strawberry cervix Vulvitis / Vaginitis |
| Vaginal pH | > 4.5 | < 4.5 | > 4.5 |
| Swab to send | MC&S* swab if clinical uncertainty | MC&S* swab if clinical uncertainty | Aptima** swab (specify Trichomonas PCR on test request) |
| Microscopic findings | Clue cells | Yeasts | Motile trichomonas on wet prep |
| Test for STI? | Yes | Yes | Yes |
| Retest after treatment? | No | No | Yes (Window period applies) (If positive on retest refer to GUM clinic) |
| Consider empiric partner treatment | No | No | Yes (within 4 weeks prior to presentation) |
| Treatment | Refer to the treatment tables on https://healthservice.hse.ie/staff/information-healthcare-workers/antibiotic-prescribing/ | | |

*MC&S- Microscopy, Culture and Sensitivity (charcoal swab- check local laboratory / supplier)

** Aptima swab- NAAT/PCR test

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Sexual history

The British Association for Sexual Health and HIV (BASHH) UK National Guideline for consultations requiring sexual history taking contain detailed information on taking a sexual history. Adapted versions of the sexual health history tables are outlined below:

BASHH have also developed recommendations around provision of sexual health care to trans and non-binary people. In taking a sexual history it is important to sensitively establish an individual's gender identity and preferred pronouns. Additional information is available in the BASHH document [here](#). Advice around STI testing in trans and non-binary people is under STI testing, Table 4.

Table 1. Sexual health history adapted from [BASHH Guidelines](#)

| Sexual health history (* consider PrEP eligibility - see HSE Guidance) | |
|--|---|
| Reason for attendance | Establish reason(s) for attendance |
| Symptoms | Symptom review Duration of symptoms |
| Sexual history | Time since last sexual contact (LSC) (For gbMSM, ask about condomless anal sex in last 72 hours and document in terms of post-exposure prophylaxis - PEP) Time since previous sexual contact (PSC) (if within the last three months) Number of sexual partners in the last 3 months The gender of partner(s) The partnership type and whether the partner can be contacted The type of sexual contact/sites of exposure* Condom use/barrier use* Any symptoms or any risk factors for blood-borne viruses in the partner* |
| Past history | The diagnosis of previous STIs and the approximate date of diagnosis. Ask specifically about syphilis and if yes, then when and where treated and with what. For gbMSM, check if previous history of rectal STI infection* Past medical and surgical history Vaccination history: Hepatitis A; Hepatitis B; HPV Medication history and history of allergies (For gbMSM: ask about use of PEP and PrEP*) Alcohol and recreational drug history including previous or current IV drug use and Chemsex* Smoking history Identification of unmet needs with regards to difficulties with sexual performance and satisfaction Recognition of gender-based violence (GBV) or intimate partner violence (IPV) History of Female Genital Mutilation (FGM) |
| Risk of Pregnancy | Discuss pregnancy planning, contraceptive use, and unmet needs. History of unusual or altered vaginal bleeding Obstetric history, including outcomes and complications Assessment of other symptomatology such as pelvic pain, dysmenorrhoea or menorrhagia |

* For PrEP eligibility- see [HSE Guidance](#).

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Table 2 Minimum sexual history for asymptomatic patient requesting a STI screen adapted from [BASHH Guidelines](#)

Minimum sexual history for asymptomatic patient requesting a STI screen (* consider PrEP eligibility – see [HSE Guidance](#))

- Symptoms/reason for attendance
- Establish competency, safeguarding children/vulnerable adults
- Date of last sexual contact (LSC), partner's gender, anatomic sites of exposure, condom use and any suspected infection, infection risk or symptoms in this partner
- Previous sexual partner details, as for LSC, if in the last three months and a note of total number of partners in last three months if more than two
- Previous STIs
- For gbMSM: Ask specifically about syphilis and if yes, then when and where treated and with what. Ask about anal sex and if condom always/sometimes/never used.* Check if previous history of rectal STI infection*. Ask about use of PEP and PrEP*. Ask about recreational drug history including Chemsex*
- Last menstrual period (LMP) and menstrual pattern, contraceptive and cervical cytology history where indicated
- Pregnancy and gynaecological history where indicated
- Blood borne virus risk assessment and vaccination history for those at risk
- Recognition of gender-based violence/intimate partner violence
- Alcohol and recreational drug history
- Past medical and surgical history
- Medication history and history of drug allergies
- Agree the method of giving results

[The CDC Guide to Taking a Sexual History](#), propose the 5 P's of taking a sexual history: Partners; Prevention of Pregnancy; Protection from STIs; Practices; Past History of STIs.

Examples of questions to ask regarding sexual history are included in the Quick Reference Guides for Screening for asymptomatic males, females and gbMSM.

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STI tests



Minimum recommended tests when screening include: chlamydia, gonorrhoea, hepatitis B, HIV and syphilis and others as appropriate.

| | Bloods | Combined chlamydia and gonorrhoea NAAT/PCR ¹ |
|--|--|--|
| All females | HIV, Hepatitis B surface antigen, Syphilis, +/- Hepatitis C Ab ² | VulvoVaginal Swab ^{3,4} (VVS) +/- Rectal/ Pharyngeal |
| Heterosexual males | HIV, Hepatitis B surface antigen, Syphilis +/- Hepatitis C Ab ² | First Void Urine (FVU) ⁴ |
| Gay, bisexual and other men who have sex with men (gbMSM) | HIV, Hepatitis B surface antigen, Hepatitis C Ab ² /PCR, Syphilis | FVU, Pharyngeal, Rectal ⁴ |
| Transgender males, females and non-binary individuals | HIV, Hepatitis B surface antigen, Syphilis, +/- Hepatitis C Ab ² | Urine NAAT testing for chlamydia and gonorrhoea is appropriate for all trans people. Throat and rectal swabs should be guided by sexual history taking. Vaginal swabs are advised for any trans/ non binary person who has a vagina. |

¹ The Nucleic Acid Amplification Test (NAATs) / PCR is the gold standard for chlamydia and gonorrhoea testing. The type of test may vary for different laboratories. Most commercially available assays can test for both Chlamydia and Gonorrhoea on the same specimen. *Trichomonas vaginalis* PCR is available from some laboratories and can be done on the same swab as chlamydia and gonorrhoea. *Trichomonas vaginalis* should be specifically requested on the testing form. Currently available kits are licensed for use on urethral, urine, vulvovaginal and endocervical samples. For clinicians who do not have access to chlamydia/ gonorrhoea NAAT kits from their local laboratory, these can be ordered from the National Viral Reference Laboratory (NVRL) and will be posted to the practice free of charge. Further information on swab ordering is available on the [NVRL website](#).

² [Hepatitis C testing \(HCV\)](#) should be considered part of routine sexual health screening in the following circumstances: gbMSM; People living with HIV; Commercial sex workers; People who inject drugs (PWID). Partners of the above should also be considered for HCV testing.

³ Studies suggest that low vaginal swabs are more sensitive than endocervical swabs. A high vaginal swab (HVS) is required to assess for thrush and laboratory features of bacterial vaginosis.

⁴ A self-collected swab can also be used to test for STIs. Self-testing is appropriate for all asymptomatic patients. Vulvovaginal swab, first void urine, rectal and pharyngeal swabs are all suitable for self-collection. Information for the patient on how to perform a self-collected swab is usually included in the packaging for each kit.

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Window period, lookback period and partner notification

The window period is the time period between when a person comes in contact with a sexually transmitted infection and when a false negative result may occur in an STI screen. The window period can vary for the different STIs. Sexual partners may have a false negative test result in this period. Follow up testing should be discussed.

Partner notification (sometimes called contact tracing) is an integral part of the management and control of STIs. The look-back period is the time during which the index case may have been infectious and transmitted infection. Testing and treatment of sexual partners is important to prevent reinfection and onward transmission. Patients who have been diagnosed with an STI in primary care, should be encouraged to inform their sexual partners and of the need for testing. For complex cases that might require more expert help with partner notification, referral to a GUM clinic should be considered.

STI: *Chlamydia trachomatis*

Look back period:

For males with urethral symptoms: all contacts since symptom onset and in the 4 weeks prior to the symptoms.

For females, asymptomatic males/females or males with symptoms at other sites (rectal, throat or eye): all contacts in prior 6 months.

Window period: 2 weeks

Consider empiric partner treatment: Yes

STI: *Lymphogranuloma venereum* (LGV is an invasive serovar of chlamydia)

Look back period: Refer LGV cases to a GUM clinic.

Window period: Refer LGV cases to a GUM clinic.

Empiric partner treatment: Refer LGV cases to a GUM clinic.

STI: Gonorrhoea (*Neisseria gonorrhoea*)

Look back period: Males with urethral symptoms: all partners in past 2 weeks or last partner if longer than 2 weeks. All others including asymptomatic infection: 3 months.

Window period: 2 weeks

Consider empiric partner treatment: Yes

STI: Trichomoniasis (*Trichomonas vaginalis*)

Look back period: Sexual partners in the preceding 4 weeks prior to presentation

Window period: 4 weeks

Consider empiric partner treatment: Yes

STI: HIV

Look back period: Refer to GUM/HIV clinic

Window Period: 45 days

Consider empiric partner treatment: Refer to GUM/HIV clinic (Be mindful of new sexual partners who may require PEP)

STI: Anogenital warts (Human papilloma virus)

Look back period: N/A

Window period: N/A

Empiric partner treatment: N/A

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STI: Syphilis (*Treponema pallidum*)

Look back period: Refer syphilis cases to GUM clinic.

Window period: 12 weeks

Empiric partner treatment: Refer to GUM clinic

STI: Genital Herpes (Herpes simplex virus)

Look back period: N/A

Window period: N/A

Empiric partner treatment: No

Herpes simplex virus persists following primary infection. Defining lookback and window periods is not possible, as primary infection may have occurred in the remote past.

STI: Pelvic inflammatory disease

Look back period: Screen current male partners and refer to look back period if specific organism identified.

Window period: Dependent on organism.

Empiric partner treatment: N/A

STI: *Mycoplasma genitalium*

Look back period: Refer to GUM clinic

Window period: Refer to GUM clinic

Empiric partner treatment: Refer to GUM clinic

Sexual assault

Please see the National Guidelines on Referral and Forensic Clinical Examination Following Rape and Sexual Assault for information on referral and forensic examination.

Non-specific urethritis

Non-specific urethritis (NSU), also known as non-gonococcal urethritis (NGU), occurs in individuals who have inflammation of the penile urethra that is not the result of infection with *Neisseria gonorrhoeae*. Symptoms include urethral discharge and/or dysuria. NSU can have a number of causes, including irritation to the urethra by soaps, creams or an object, or sexually transmitted infections for example *Chlamydia trachomatis* and *Mycoplasma genitalium*. NSU can only be diagnosed by microscopy therefore it is not usually feasible to diagnose in a GP practice and a clinical suspicion of NSU usually requires referral to a specialist clinic. The diagnosis is made by demonstrating 5 or more PMNLs (pus cells) per high power (x1000) microscopic field on a urethral smear.

In men with urinary symptoms, an STI screen and MSU are required. If there is high clinical suspicion of an STI, then doxycycline 100mg every 12 hours x 7 days may be prescribed if empiric treatment required with STI testing as indicated by sexual history. It is recommended that all patients testing positive for *Mycoplasma genitalium* are referred to an STI clinic for management

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HIV pre-exposure prophylaxis (PrEP)

Pre-exposure prophylaxis (PrEP) is the pre-emptive use of oral antiretroviral therapy in HIV negative people to reduce the risk of HIV infection. NB: The window period for HIV is 45 days.

PrEP is available free of charge through the HSE to those who meet clinical eligibility criteria and are deemed to be at substantial risk of acquiring HIV. [A list of approved PrEP providers is available.](#)

PrEP should be provided as part of a combination HIV (and STI) prevention approach within services that meet national standards. Further information on the [guidelines and national standards for PrEP service providers is available.](#)

Shigellosis

Antimicrobial resistance in shigella species is a growing concern internationally.

Shigellosis is an acute diarrhoeal illness. In adult males shigellosis acquired in Ireland appears very strongly associated with gay or bisexual men who have sex with men (gbMSM). It is important to establish if adult males presenting with shigellosis are gbMSM and advise them to avail of screening for other STIs. Shigellosis is a [notifiable disease](#). Further information is available from the:

- [HPSC Recommendations on aspects of management of shigellosis in Ireland in the context of current antimicrobial resistant Shigella species associated with gay, bisexual and men who have sex with men \(gbMSM\)](#)
- Patient information leaflet on shigella in gbMSM (<https://www.healthpromotion.ie/products/a-guide-to-shigella-in-msm>)

Further resources for healthcare professionals

- [British Association of sexual health and HIV guidelines](#)
- [Hepatitis C Screening National Clinical Guideline](#)
- [Epidemiological reports on STIs in Ireland are available on the HPSC website](#)
- [Further information on notifiable diseases and the notification process is available on the HPSC website](#)
- [UK Faculty of Sexual and Reproductive Health](#)
- [HSE Foundation Programme in Sexual Health Promotion](#)
- [BASHH STI Foundation Theory Course](#) available in two locations in Dublin- [GUIDE clinic](#) and <https://www.stidoctor.com>; check Event calendar for details - open to GPs, Practice nurses, Pharmacists, AHPs
- [Community Gynaecology Course](#) Module 4 (sexual health, vaginal discharge, vulval dermatology) via ICGP website- open to GPs, Practice nurses, Pharmacists and AHPs.

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Patient resources

- Free home STI testing is now available across Ireland. Test kits and further information is available from the [HSE home STI testing service linked here](#).
- Your guide to STIs leaflet is available here <https://www.healthpromotion.ie/products?category=6&keyword=STI&page=1>
- There are information leaflets on individual STIs and genital conditions on <https://www.healthpromotion.ie/> - search under category 'sexual health' or search by keyword
- The [International Urogynecological Association](#) website has very useful patient information leaflets on disorders of the female pelvic floor.
- General advice on care of the male genital area is recommended. Examples of a patient information leaflet for penis care include the [Australian information leaflet on penis care](#).
- [Information for gbMSM on sexual health is available on the Man2Man website](#)
- Patient resources for specific genital conditions can be found in the individual sections.

Glossary of abbreviations and acronyms

| | |
|-----------------|---|
| FVU | First void urine |
| gbMSM | Gay, bisexual and other men who have sex with men |
| GUM | Genitourinary Medicine |
| HBV | Hepatitis B virus |
| HCV | Hepatitis C virus |
| HIV | Human immunodeficiency virus |
| HPV | Human Papilloma Virus |
| HVS | High vaginal swab |
| LGV | Lymphogranuloma venereum |
| LMP | Last menstrual period |
| LSC | Last sexual contact |
| MC&S | Microscopy, culture and sensitivity |
| MSU | Midstream specimen of urine |
| NAAT | Nucleic acid amplification test |
| NGU | Non-gonococcal urethritis |
| NSU | Non-specific urethritis |
| PCR | Polymerase chain reaction |
| PEP | HIV post exposure prophylaxis |
| PEPSE | Post-exposure prophylaxis following sexual exposure |
| PrEP | HIV pre-exposure prophylaxis |
| PSC | Previous sexual contact |
| PWID | People who inject drugs |
| STI | Sexually transmitted infection |
| U=U | Undetectable (viral load) = Untransmissible |
| VVS | Vulvovaginal swab |