

# GONORRHOEA V3.0

## Comments from the Expert Advisory Group

- Referral to a dedicated Genitourinary Medicine (GUM), Infectious Diseases (ID) or sexual health clinic for treatment is recommended for all patients where first line treatment with ceftriaxone cannot be administered.
- There was a very marked increase in the number of cases of gonorrhoea reported in Ireland in 2022 and early 2023. Since then the number of cases reduced in 2024 and 2025 to date. However, rates remain much higher than rates reported up to 2019. The majority of cases occur in young heterosexual men and women and gay, bisexual and other men who have sex with men (gbMSM).
- Genitourinary tract infection can be asymptomatic in both males (less than 10%) and females (approximately 50%). Symptoms in males include dysuria and a urethral discharge. Urethral infection may present with dysuria without urinary frequency. Symptoms in women include [vaginal discharge](#), intermenstrual bleeding, post-coital bleeding, and/or lower abdominal pain. Most rectal infections are asymptomatic but symptoms may include anal discharge and perianal /anal pain or discomfort. Pharyngeal infections are predominantly asymptomatic, but some may report a sore throat.
- Infection can lead to epididymo-orchitis, prostatitis and infertility in males. Infection can lead to pelvic inflammatory disease (PID) in females. PID is associated with an increased risk of tubal factor infertility, ectopic pregnancy and chronic pelvic pain. Rectal infection can lead to proctitis.

## Guidance on diagnostic sampling

- Diagnosis using NAAT (nucleic acid amplification technique), e.g. PCR (polymerase chain reaction), is the current diagnostic gold standard. This is frequently combined with a chlamydia NAAT in the same test.
- Infection can occur at multiple anatomical sites. Below is a guide to testing sites for diagnosing gonorrhoea using NAAT.
  - People with a penis: First void urine.
  - People with a vagina: Vulvo-vaginal swab.
  - See [British Association for Sexual Health and HIV \(BASHH\) guidelines](#) for considerations in people following gender affirming surgery.
  - Rectal site testing is recommended for sexually active gbMSM, transgender women (TGW) and sex workers. Rectal site testing should be guided by assessment of risk and symptoms in all others.
  - Pharyngeal testing is recommended for sexually active gbMSM, TGW, sex workers, all people who have been diagnosed with urogenital infection and all those who are sexual contacts of gonorrhoea.
- Vulvovaginal, pharyngeal and rectal sampling can be provider or self-taken. Clear instructions around self-taken swabs should be provided to all individuals.
- Pharyngeal testing is not currently recommended in heterosexual men and women as part of an asymptomatic routine screen. Those who would like more detail on this can refer to the [British Association for Sexual Health and HIV \(BASHH\) guidelines](#).

# GONORRHOEA V3.0

## Importance of Antimicrobial Susceptibility Testing

- Increasing resistance to antimicrobials is a major concern with gonorrhoea. For example, ciprofloxacin resistance was seen in 1 in 2 isolates tested at the National Gonococcal Reference Laboratory in 2023 as part of the European Gonococcal Antimicrobial Surveillance Programme.
- NAAT testing does not currently give information on gonorrhoea antimicrobial susceptibility. Wherever possible, specimens for culture should be taken from each positive site in all gonorrhoea cases diagnosed by NAAT prior to antibiotics being given so that susceptibility testing can be performed and resistant strains identified. This is ideally carried out with gonorrhoea specific culture plates but can be performed in general practice with a transport swab, sent without delay, and with clear information that gonorrhoea culture and sensitivity is requested. Liaison with local laboratories to confirm the most appropriate transport arrangement for gonorrhoea cultures is recommended. Ceftriaxone treatment should be initiated, as outlined in the table below, without waiting for sensitivity results.
- Empiric treatment with cefixime, azithromycin or ciprofloxacin is inappropriate. These agents should only be used where ceftriaxone is unsuitable and where antimicrobial susceptibility results are available.

## Test of cure

- Test of cure is no longer recommended for anogenital infections treated with ceftriaxone 1g if isolate is known to be susceptible to ceftriaxone.
- Test of cure is recommended 2-3 weeks post completion of treatment for: persistent symptoms (review earlier than 2-3 weeks if symptoms are ongoing); pharyngeal infection; where sensitivities are unknown; treatment with anything other than ceftriaxone; pregnancy.

## Other considerations

- Individuals diagnosed with gonorrhoea should be offered testing for other STIs including HIV, Hepatitis B, syphilis and chlamydia.
- [Hepatitis C \(HCV\) testing](#) 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.
- A diagnosis of gonorrhoea in gbMSM and TGW should prompt a discussion about HIV prevention including [pre-exposure prophylaxis PrEP](#).
- Sexual partners of the following should be informed of the need for testing:
  - Individuals with symptomatic penile urethral infection: all partners within the preceding 2 weeks (or the last partner if longer than two weeks ago).
  - All others with infection at other sites or asymptomatic infection: all partners within the preceding 3 months.

## GONORRHOEA V3.0

- ◊ All sexual partners should have genital and pharyngeal testing. Rectal site testing is recommended for sexually active gbMSM, transgender women (TGW) and sex workers. Rectal site testing should be guided by assessment of risk and symptoms in all others.
- Sexual partners in the two week [window period](#) after last sexual contact may have a false negative result. Epidemiological treatment with ceftriaxone 1g can be considered, particularly in those who are pregnant, contacts of those who are pregnant and those experiencing barriers to re-attending for care. For other contacts repeat testing can be done after two weeks if initially negative.
- Sexual partners outside the two week period do not need epidemiological treatment and testing results should be awaited.
- Advise no sexual contact until negative on test of cure for gonorrhoea. If test of cure not indicated then should abstain for 2 weeks.
- Seek specialist (GUM/ Infectious Diseases (ID)/ Obstetrics/ Microbiology) advice in cases of gonorrhoea in pregnant or breastfeeding patients.
- Gonorrhoea is a [notifiable disease](#). Notification process is usually initiated by the testing laboratory.

Treatment table is outlined on the next page.

# GONORRHOEA V3.0

## Treatment

### UNCOMPLICATED ANOGENITAL AND PHARYNGEAL GONORRHOEA ANTIMICROBIAL TREATMENT TABLE

Drug	Dose	Duration	Notes
<b>1st choice options</b>			
Ceftriaxone	1g deep intramuscular (IM) injection	Single dose	Avoid if history of severe allergy to penicillin or any beta-lactam. Dissolve 1g ceftriaxone in 3.5ml of 1% lidocaine injection for IM injection. Not for intravenous (IV) injection.
<p><b>Cephalosporin allergy or severe hypersensitivity to penicillin or other beta-lactam</b></p> <ul style="list-style-type: none"> <li>➤ Refer to dedicated GUM/ID service. Where not possible, discuss with a specialist in GUM/ID.</li> <li>➤ Some treatment options are outlined in the table below. Other options may be available in GUM/ID/sexual health clinics.</li> <li>➤ A test of cure is particularly important where first choice option (Ceftriaxone) has not been used.</li> </ul> <p><b>Alternative choices may be given because of allergy, needle phobia or other absolute or relative contraindications.</b></p> <p>Empiric treatment with cefixime, azithromycin or ciprofloxacin is inappropriate. These agents should only be used where ceftriaxone is unsuitable and where antimicrobial susceptibility results for alternative antibiotic choices are available.</p>			
Drug	Dose	Duration	Notes
Cefixime	400 mg oral	2 doses (taken 6-12 hours apart)	Cephalosporins should be avoided if history of severe allergy to penicillin or any beta-lactam.
<b>PLUS</b>			
Azithromycin (only when known to be susceptible to cefixime and macrolides)	1 g oral	2 doses (taken 6-12 hours apart)	Alternatively Azithromycin 2 g as a single dose. Note: divided dose may improve GI tolerability. Tablets: Take with or without food. Take 1 hr before or 2 hrs after antacids. Capsules: Take 1 hour before or 2 hours after food / antacids.
<b>OR</b>			
Azithromycin (only when known to be susceptible to macrolides)	2 g oral	Single dose	The azithromycin dose can be divided as two 1 g doses taken 6-12 hours apart to improve GI tolerability. Tablets: Take with or without food. Take 1hr before or 2hrs after antacids. Capsules: Take 1 hour before or 2 hours after food / antacids
<b>OR</b>			
Ciprofloxacin (only when known to be susceptible to quinolones)	500 mg oral	Single dose	<a href="#">Multiple adverse effects associated with ciprofloxacin</a> Avoid ciprofloxacin in pregnancy.

Seek specialist (GUM Clinician / Infectious Diseases / Obstetrics / Microbiology) advice in cases of gonorrhoea in pregnant or breastfeeding patients.

HSE Antimicrobial Resistance and Infection Control Programme  
Version 3.0 Reviewed: February 2026

Document uploaded onto the HSE.ie site in February 2026. This information is valid only on the day of printing, for any updates please check [www.antibioticprescribing.ie](http://www.antibioticprescribing.ie)

## GONORRHOEA V3.0

### Other information:

[National guidelines for the prevention and control of gonorrhoea and for minimising the impact of antimicrobial resistance in Neisseria gonorrhoea](#)

### Patient Information

- [Gonorrhoea patient information leaflet.](#)
- [Information for gbMSM on sexual health is available on the Man2Man website](#)
- [Information on the free HSE home STI testing service.](#)