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Sexually transmitted infection proctitis, Inflammatory bowel disease and Sexual History.

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WINNING POSTER 2013 DISCOVERING RESEARCH EVENT ABSTRACT & IMPLICATIONS FOR CLINICAL CARE

Background: In the UK and many other western countries there has been a sustained annual increase in the incidence of sexually transmitted infections (STIs) over the past decade[1]. Gonorrhea, chlamydia, syphilis and herpes infection can present with rectal symptoms and endoscopic features that can mimic inflammatory bowel disease (IBD). Traditionally patients who disclose having anal sexual intercourse and present with rectal symptoms are referred to the genitourinary service where a sexual history is taken and STI proctitis considered. Patients who do not disclose anal sex to the primary referrer are usually sent to a gastroenterology clinic where sexually transmitted causes are usually not considered and a sexual history is not routinely taken. The aim of this project was to assess the prevalence of anal sex in a population referred to an IBD clinic with rectal symptoms; and to determine if there were associations between sexual practice and rectal symptoms reported.

Methods: Prospectively a sexual health questionnaire was distributed to patients attending the IBD Clinics in a tertiary Teaching Hospital setting over a 6-week period. The questionnaire recorded age, sexual orientation, number of sexual partners, sexual sites, STI and rectal symptoms. Results were compared to the Scottish figures from The National Survey of Sexual Attitudes and Lifestyles 2 (NATSAL2) [2].

Results: Only 2 men disclosed having sex with men so analysis was limited to female patients. 170 females completed a questionnaire (age range 16-81). The incidence of

receptive anal sex with men within the age group 17-44 (the age range in NATSAL2) was 23.5% compared with 13.4% in NATSAL2. Regarding chronic symptoms: Rectal pain was reported in 41.6% of those having anal sex versus 15% in those not ($p<0.002$), rectal bleeding was reported in 29.2% of those having anal sex versus 28% in those not (p=NS) and rectal discharge was reported in 25% of those having anal sex versus 11.6% in those not ($p=0.076$). These symptoms were reported on a chronic basis and were not related to discrete episodes of anal sex. Past STI rates were shown as 29.2% in those having anal sex versus 4.8% in those not ($p<0.0001$).

Conclusion: The prevalence of anal sex is higher in this cohort than the general population. A lack of routine sexual health questioning in an IBD clinic will fail to identify those at risk of rectal STIs. Chronic rectal pain was strongly associated with a history of anal sex and should trigger a thorough sexual history. When receptive anal sex is disclosed STI screening should be offered to this cohort. Further studies are planned in this high-risk group.

Key Words: sexual history, inflammatory bowel disease, sexually transmitted infections

Implications of the Study

This research shows that there may be a connection between anal sex incidence and IBD clinic attendance, which leads to the idea that anal sex is causing symptoms which are leading to clinic attendance. These symptoms could be due STI proctitis. This is of particular importance due to rising rates of sexually transmitted diseases as well as risky sexual behaviour as reported in the National Survey of Sexual Attitudes and Lifestlyes (NATSAL)[2].

It also shows that in particular, chronic rectal pain is associated with anal sex, with significant results. Finally, it shows a very significant correlation between past STI rates and anal sex. This leads to the idea that if someone has an STI and has engaged in anal sex, it is possible the STI has also been transmitted through anal sex to cause STI proctitis.

STI proctitis can be difficult to pick up, particularly due to the fact that its symptoms and signs are very similar to those of inflammatory bowel disease. The first point at which the differentiation between those patients at risk of having STI proctitis and those who aren't, would be at the first history taking, by taking a full sexual history. However, this is often not done, as the symptoms of rectal pain, discharge and bleeding are often not ones we

associate with STIs. In addition to this, it is awkward, especially as these are not questions the patient may expect in response to these symptoms. The patient is therefore often referred straight to gastroenetreology. Here, a GI clinician, who is more used to diagnosing IBD, may not think of STI proctitis. The patient will end up being incorrectly diagnosed and mistreated. However, if a patient were picked up initially as being at risk of STI proctitis, they could be referred to both GI and genitourinary (GUM) services, to ensure the correct diagnosis is made.

This research therefore leads us to recommend that a full sexual history be taken when patients present with the symptoms of chronic rectal pain and discharge.

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