SUPPLEMENTARY STATEMENT

for recommendations related to the diagnosis, management, and follow-up of

EPIDIDYMITIS

March 2014

Canadian Guidelines on Sexually Transmitted Infections

KEY ISSUE

The *Gonococcal Infections* chapter has been revised in response to emerging antimicrobial resistance. As a result, the 2010 print and online versions of the *Epididymitis* chapter of the *Canadian Guidelines on Sexually Transmitted Infections* also require updates.

This statement is intended to inform clinicians of **key changes in the management of epididymitis most likely caused by a sexually transmitted pathogen** until such time as the full chapter revision is available.

The following recommendations apply only to men presenting with symptoms of epididymitis and not prepubertal children. Clinicians should refer to the full chapter for special considerations, management and treatment for children presenting with symptoms of epididymitis.

DIAGNOSIS

- Gonococcal and/or chlamydial infections should be considered as the etiology of acute epididymitis in all sexually active men, especially in those under age 35. For a full discussion of the other possible microbial etiologies and predisposing factors for acute epididymitis, clinicians should refer to the full chapter.
- Coliforms are a frequent cause of acute epididymitis in sexually active men in all age groups who practice unprotected insertive anal intercourse. For recommendations related to epididymitis likely caused by enteric organisms, refer to *Table 2* in the full chapter.
- **Testicular torsion should be included in the differential diagnosis in all cases, as testicular viability may be compromised. If diagnosis is questionable, a specialist should be consulted immediately, as testicular torsion is a surgical emergency.**
- Evaluation and specimen collection for epididymitis should include the following:
  - A urethral swab for Gram stain.
  - Collection of specimens for identification of *N. gonorrhoeae* and *C. trachomatis* (intraurethral exudate or urine according to available laboratory techniques). Depending on the clinical situation, consideration should be given to collection of samples for *N. gonorrhoeae* for both culture and NAAT. This is strongly recommended in symptomatic men who have sex with men (MSM) or in situations where there is increased probability of treatment failure.
  - Microscopy and culture of mid-stream urine.

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TREATMENT

- The recommended treatment for epididymitis that is likely due to a sexually transmitted pathogen now consists of **ceftriaxone** 250 mg IM in a single dose PLUS **doxycycline** 100 mg orally twice a day for 10 to 14 days.
- Due to the rapid increase in quinolone-resistant *N. gonorrhoeae*, quinolones such as ciprofloxacin are no longer recommended for treating gonococcal infections in Canada, unless local resistance rates are known to be under 5%. Ciprofloxacin will be removed as a treatment option from ***Table 2*** in the current Epididymitis chapter.
- Refer to the *Gonococcal Infections* chapter for detailed information on antimicrobial resistance in *N. Gonorrhoeae*.
- **If an enteric organism is suspected, the recommended treatment is ofloxacin 200 mg PO bid for 14 days.**
- **Consultation with an experienced colleague** is recommended for patients who have suspected or confirmed gonococcal epididymitis and contraindications to treatment with cephalosporins.

FOLLOW-UP

- All patients treated for epididymitis should improve within 48 hours of initiation of treatment; those that do not should be reassessed to evaluate the initial diagnosis and treatment.
- Those who have confirmed gonococcal epididymitis should be reported to local public health and followed up as per the recommendations in the *Partner notification* and *Follow-up* sections of the *Gonococcal Infections* chapter.

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