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Editorial

Aim to treat a sexually transmitted disease (STD) or eradication of its pathogen(s)?

Very often, many of our clients have the general belief that it is quite straight forward and simple to treat uncomplicated sexually transmitted urethritis in male patients. Identify the pathogen and eradicate that from the body will cure the disease and heal the involved person. Indeed, dermato-venereologists should have the experience that it is not so simple from their daily clinical encounters. It is indeed not always easy when we are addressing to our patients or colleagues on the management of some types of sexually transmitted disease (STD) nowadays. The article on "Genital infections with Mycoplasma genitalium" by Dr. Robin Su is a good example to illustrate the above-mentioned personal observation.

Non-gonococcal urethritis (NGU) is a well described clinical entity in the male attendees of the sexually transmitted disease clinics. This disease is however not that simple as it is not caused by only one pathogen. *Chlamydia trachomatis, Ureaplasma parvum* and *urealyticum, Mycoplasma genitalium, Adenoviruses, Trichomonas Vaginalis* and *Herpes simplex virus* have been detected from patients suffering from NGU. Many pathogens have been identified to have some causal roles in sexually transmitted urethritis in men, with the well established ones like *Neisseria gonorrhoeae* and *Chlamydia trachomatis*. However, for the non-Chlamydia Non-gonococcal urethritis, there are still a lot of on-going studies worldwide to document the roles of other potential pathogens. *Mycoplasma genitalium* has gained cumulative evidence to substantiate its role in leading to NGU and Dr. Su has described a local study that may be useful to apply for the local scenario.

Some knowledgeable anxious patients will be keen to know whether more STD tests are needed for screening in view of more and more validated and invalidated tests available in the market. It may also confuse doctors for proper interpretation of these tests when patients do bring them for consultation. Microbiological tests have possessed both edges of the sword applying to our clinical management of STD patients. Inappropriately prescribed tests may generate unnecessary anxiety for patients without proper counseling and explanation for the nature of tests whereas a timely and well prescribed test will help to assist early prompt treatment.

I have often been asked by colleagues for giving expert opinion on how to manage some difficult or persistent NGU cases. Sometimes, patients will present with persistent positive molecular tests for other potential pathogens for NGU (e.g. *Ureaplasma urealyticum*). Clinical correlation including the more genuine sexual history, elaboration of clinical symptoms and signs of urethritis (if microscopic examination is not readily available) and the compliance of past treatment history will be very important in this situation. The emphasis should not be based solely on the results of the repeated positive molecular tests. Actually, the World Health Organization has promulgated the Syndromic case management approach for management of sexually transmitted infections in not only the developing regions but some settings in

developed region where microscopic and other microbiological tests are not readily available (e.g. in the private sector locally).

In the conclusion of the article by Dr. Su, I fully agree with the recommendation of having a good clinical management protocol for the Chlamydia negative persistent NGU for our male clients and not to rely too much on the molecular testing at the present juncture. Taking reference from the most updated overseas guideline may shed lights on the management of persistent recurrent NGU. An empirical prescription of first line treatment for persistent symptomatic NGU is Azithromycin 500 mg stat then 250 mg for the next four days Plus metronidazole 500 mg twice daily for five days when validated microbiological tests not available. Some newer medications e.g. Moxifloxacin 400 mg for 7-10 days may be tried but we should be aware of its potential hepatotoxicity and other adverse effects. The most important thing is for the clinician to familiarize himself/herself with the most recent guideline regularly. It will certainly be a better approach than to confronting the intriguing and not fully accredited molecular tests that may be self-tested or self-requested by patient.

Test for NGU is just one of the many examples that requires the proper interpretation and advice by doctor. There may be even more confusion for other STD tests to identify pathogens e.g. human papilloma viral (HPV) infection. The development on the newer microbiological and molecular tests has reached such a rapid pace that we must regularly upkeep ourselves with the newest development in this aspect. The appropriate clinical applications of these molecular tests should assist our clinical judgment but not to intimidate our patients or to cause unwanted anxiety or confusion. We should educate our clients that we should treat and manage the disease but not the equivalence of eradication of pathogens or rendering all tests negative as a consequence of treatment.

Reference

1. Shahmanesh M, Moi H, Lassau F, Jaier M. European guideline on the management of male non-gonococcal urethritis. Int J STD AIDS 2009;20:458-64.

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