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LABORATORY TESTS

CHOICE OF TEST

C Aptima Combo 2 (TMA) and BD Probetec (SDA) are recommended tests for chlamydial infection.

D Real time PCR can be used as an alternative to TMA and SDA.

C Either single or dual (combined with gonorrhoea) tests can be used to test for chlamydial infection.

CHOICE OF SPECIMEN

D If the patient is having a speculum examination either an endocervical or vaginal swab can be used to test for chlamydia.

D Women not undergoing speculum examination should be offered the choice between self obtained low vaginal swab or first void urine.

D In men, first void urine is the specimen of choice.

TESTING FOR GENITAL CHLAMYDIAL INFECTION

In the absence of data to support a complication rate of 10% or more in women with untreated chlamydial infection, there is no evidence that screening for chlamydia is cost effective with regard to reducing morbidity.

The reason for, implications of, and results of any test carried out should be explained to the individual being tested.

PATIENTS WITH SYMPTOMS/SIGNS

Testing for chlamydia should be performed in women and men with any of the following symptoms and signs:

Women

- vaginal discharge
- post-coital/intermenstrual/breakthrough bleeding
- inflamed/friable cervix (which may bleed on contact)
- urethritis
- pelvic inflammatory disease
- lower abdominal pain in the sexually active
- reactive arthritis in the sexually active.

Men

- urethral discharge
- dysuria
- urethritis
- epididymo-orchitis in the sexually active
- reactive arthritis in the sexually active.

ASYMPTOMATIC GROUPS

C Sexual partners of chlamydia-positive individuals should be tested.

D Sexual partners of those with suspected but undiagnosed chlamydial infection (with PID or epididymo-orchitis) should be tested.

D Those who have been diagnosed with chlamydia in the previous 12 months should be tested.

D All patients attending GUM clinics should be tested for chlamydia.

D In healthcare settings other than GUM, testing should be most strongly advised for those who have had two or more partners in the past 12 months.

D Resources for chlamydia testing in women should be targeted where prevalence is known to be highest, ie first those aged 15-19 and then those aged 20-24.

A All women undergoing termination of pregnancy should be tested for chlamydial infection.

D Resources for chlamydia testing in men should be targeted where prevalence is known to be highest, ie those aged under 25.

B Postal testing kits should be used to increase chlamydia testing among young men.

B All MSM attending GUM clinics, including those who are HIV-positive, should be offered chlamydia testing, including rectal swabs.

TESTING FOR STIS

D Men who have sex with men (MSM) should be offered a full sexual health screen, including HIV, syphilis, gonorrhoea, and rectal chlamydia testing, depending on their individual risk.

Consultations for chlamydia testing or treatment should include an assessment of the patient's risk factors for blood borne virus infection.

D Heterosexual patients whose partners include intravenous drug users, bisexual men, or people who have had unprotected sex in high-risk geographical areas abroad should be offered tests for other STIs, depending on their individual risk.

D Asymptomatic heterosexual patients requesting an STI screen can be offered a chlamydia test alone in the absence of other risk factors.

ANTIMICROBIAL TREATMENT

Patients with symptomatic or confirmed asymptomatic chlamydial infection should be advised to abstain from having sex (including oral and anal) until they and their current partners have been treated and for one week thereafter even when treated at the same time.

INITIATION OF TREATMENT

C Initiate treatment without waiting for laboratory confirmation of infection in patients with symptoms and signs of chlamydial infection and their sexual partners.

UNCOMPLICATED INFECTION

A Uncomplicated genital chlamydial infection may be treated with either azithromycin 1 g as a single oral dose or doxycycline 100 mg twice daily for seven days.

B Taking compliance with therapy into account, uncomplicated genital chlamydial infection should be treated with azithromycin 1 g as a single oral dose.

UNCOMPLICATED INFECTION IN PREGNANCY

A Uncomplicated genital chlamydial infection in pregnancy should be treated with

- azithromycin 1 g as a single oral dose *or*
- erythromycin 500 mg four times daily orally for seven days *or*
- amoxicillin 500 mg three times daily orally for seven days.

B Taking compliance, tolerability, and efficacy into account, azithromycin 1 g as a single oral dose is recommended for uncomplicated genital chlamydial infection in pregnancy following discussion of the balance of benefits and risks with the patient.

When women have been treated with amoxicillin in pregnancy, practitioners should maintain a high index of suspicion should symptoms suggestive of chlamydial infection develop in the infant.

RECTAL INFECTION IN MEN

D Rectal infection may be treated with either azithromycin 1 g as a single oral dose or doxycycline 100 mg twice daily for seven days.

D If LGV is diagnosed, or suspected on clinical grounds, the recommended regimen is doxycycline 100 mg twice daily for three weeks.

Primary care health professionals should refer patients with rectal infection to GUM.

PARTNER NOTIFICATION

C Patients diagnosed with chlamydia must receive a partner notification interview.

B Patients should be given a choice of patient or provider referral.

B Patients diagnosed with chlamydia in general practice should be offered a choice of provider for initial partner notification – either trained practice nurses with support from health advisers in GUM, or referral to GUM. practice nurses with support from health advisers in GUM, or referral to GUM.

In GUM settings, health advisers should continue to provide partner notification.

Healthcare workers providing partner notification in non-GUM settings should be trained and supported by GUM sexual health advisers.

C Patients with chlamydia should be offered additional written information for partners, with accompanying guidance for healthcare professionals.

D In men with symptomatic chlamydial infection, all partners from the four weeks prior to onset of symptoms should be contacted.

D In women and asymptomatic men, all partners from the last six months or the most recent sexual partner (if outwith that time period) should be contacted.

FOLLOW UP AND TEST OF CURE

D All patients treated for chlamydia should be given a follow-up interview within 2-4 weeks of treatment.

D Adherence with therapy and risk of re-infection should be discussed with patients at follow-up interviews.

D A test of cure need not be performed in patients who have adhered to therapy and in whom there is no risk of re-infection.

D Test of cure should be routine during pregnancy.

D Test of cure/re-infection established by NAAT should be performed a minimum of five weeks after the initiation of therapy (six weeks after azithromycin), to avoid false positive results.



D Test for re-infection should be recommended at 3-12 months, or sooner if there is a change of partner.

PRIMARY PREVENTION

B Client centred, risk reduction focused, one to one counselling involving behavioural goal setting should be considered during consultations for sexual and reproductive health issues.

Where one to one counselling is not feasible, the provision of sexual health information should be integral to consultations for contraception, STI testing or other sexual and reproductive health issues.

C For prevention of STIs, including chlamydia, condom use should be promoted in all settings where sexual health care is provided.

ABBREVIATIONS



GUM	genitourinary medicine
LGV	lymphogranuloma venereum
MSM	men who have sex with men
NAAT	nucleic acid amplification test
PCR	polymerase chain reaction
PID	pelvic inflammatory disease
SDA	strand displacement amplification
STI	sexually transmitted infection
TMA	transcription mediated amplification

