Guidelines for the management of *Chlamydia trachomatis* genital infection

**Introduction**

This document is intended to give guidance to NHS staff in the South West of England on testing for and management of *Chlamydia trachomatis* genital infection. The aim is to develop a uniformly high standard of care throughout primary care, community clinics and secondary care. Appropriate local care pathways, which should also take account of the prevalence of other infections (such as gonorrhoea), should be developed. The guidelines have been updated since those of March 2005 as a result of the introduction of the National Chlamydia Screening Programme and new evidence about the safety and efficacy of the use of azithromycin in pregnancy.

**Testing for Chlamydia trachomatis**

**1. Whom to test**

The prevalence of chlamydia reduces significantly in those over the age of 25; testing should be targeted to the under 25s and those in the categories below.

**A. Opportunistic testing (under 25 years)**

All sexually active asymptomatic men and women under the age of 25, should be offered screening as part of the National Chlamydia Screening Programme, at least annually, and after a change of sexual partner.

**B. Those with symptoms or signs suggestive of chlamydia**

**Women**

- menstrual abnormalities (e.g. recent dysmenorrhoea or menorrhagia post-coital or intermenstrual bleeding)
- mucopurulent cervical discharge
- inflamed or friable cervix; bleeding on contact while taking swabs or cervical smear
- suspected or proven pelvic inflammatory disease (PID) (pelvic pain and tenderness)
- deep dyspareunia
- urethral syndrome (frequency and dysuria with negative mid-stream urine)
- tubal infertility, ectopic pregnancy
- reactive arthritis in the sexually active

**Men**

- dysuria (frequency suggests a urinary tract infection)
- urethral discharge
- urethritis
- epididymitis or epididymo-orchitis
- reactive arthritis in the sexually active

**C. Asymptomatic patients who may be at risk (irrespective of age)**

- sexual partners of those with proven or suspected chlamydia (including PID and epididymitis)
- men and women with a recent change of sexual partner

**2. How to test**

All samples should be tested using a nucleic acid amplification test (NAAT). Check with your local laboratory regarding collection, storage, and transport of specimens.

**Women**

- An endocervical swab is the first choice, if undergoing speculum examination. There is no need to take a urethral swab in addition.
- A self-taken vaginal swab is a suitable alternative if the woman is not undergoing speculum examination.
- A first void urine sample may be considered, especially if a woman has urinary symptoms. Check with your local laboratory as some NAATs have high rates of inhibition with female urines which may thus not be first choice samples.

**Men**

- First void urine sample is the first choice; best tested having held urine for at least 1 and preferably 2 hours.
- Urethral swabs are an alternative, but are uncomfortable and no more sensitive.

**3. Consider testing for other STIs**

Testing is recommended in

- Patients with proven chlamydia infection
- Symptomatic or high risk patients (e.g. high local prevalence of gonorrhoea, multiple sexual partners)
Management of *Chlamydia trachomatis*

1. **Give appropriate antibiotics**

   In patients with signs or symptoms strongly suggestive of chlamydia, start treatment without waiting for laboratory confirmation, and ensure that steps are taken to treat the sexual partner(s).

2. **When to refer or seek expert advice**

   - **Urgent referral to gynaecology:**
     - Acute, severe PID or lack of response to treatment in women
     - Pelvic pain in pregnant or possibly pregnant women
   - **Referral to GUM:**
     - Complicated upper genital tract infection (do not delay starting treatment)
     - Intolerance of treatment
     - Doubt about diagnosis (e.g. equivocal test results, atypical symptoms)
     - Persistent symptoms following treatment
     - Difficulty with partner notification
     - Pregnant women (if not referred to gynaecology)

3. **Partner notification**

   - All current sexual partners should be treated whether they are chlamydia positive or not.
   - Also attempt to contact any at risk partners within the last 6 months, or the most recent partner if over 6 months.
   - Support from a GUM trained health adviser or nurse, or from the Chlamydia screening office, is strongly recommended. If not available, or partners cannot attend a GUM clinic, make use of a partner notification slip (attached).
   - Treating partners without testing is not ideal as the opportunity for further partner notification is lost.

4. **Patient information / health promotion**

   - Provide verbal and written information about chlamydia, other STIs, and safer sex.
   - Advise abstaining from intercourse until both the patient and partner have completed treatment (and 7 days after taking azithromycin).
   - Provide condoms if appropriate.

5. **Follow-up**

   - To confirm adherence to treatment, resolution of symptoms, and outcome of partner notification. In uncomplicated infection, telephone follow-up is acceptable.
   - For complicated infection, follow-up should be at 2 weeks (or earlier if symptoms are severe). Further treatment or referral may be needed if symptoms persist (seek expert advice).
   - Re-treatment may be needed if patients have had unprotected sex with an untreated partner, or within 7 days of both being treated.
   - Treatment with doxycycline or azithromycin: national guidelines recommend that a test of cure is not necessary, providing the patient has completed the treatment and is not at risk of re-infection.
   - Treatment with erythromycin or amoxicillin: these are not reliable and a test of cure should be performed at least 5 weeks after completing treatment.

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**Treatment of uncomplicated infection**

**Women**

**First-line treatment:**

- Azithromycin 1g PO stat or
- Doxycycline 100mg bd PO for 7 days
- If pregnant or breast feeding:
  - Azithromycin 1g PO stat or
  - Erythromycin 500mg bd PO for 14 days or
  - Amoxicillin 500mg tds PO for 7 days

**Men**

- Azithromycin 1g PO stat or
- Doxycycline 100mg bd PO for 7 days

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**Treatment of complicated upper genital tract infection (PID, epididymitis)**

**Women**

**First-line treatment:**

- Doxycycline 100mg bd PO for 14 days +
- Metronidazole 400mg bd PO for 14 days +
- Ceftriaxone 250mg IM stat or Cefixime 400mg PO stat then 200mgs bd total 3 days
- Ofloxacin 400mg bd PO for 14 days +
- Metronidazole 400mg bd PO for 14 days
- If pregnant or breast feeding:
  - Erythromycin 500mg bd PO for 14 days or
  - Azithromycin 1g PO stat then 500mgs od for 4 days +
  - Metronidazole 400mg bd PO for 10-14 days +
  - Ceftriaxone 250mg IM stat

**Men**

- Doxycycline 100mg bd for 14 days or
- Ofloxacin 200mg bd for 14 days

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1. These may also be used in women who are not using adequate contraception, but whose period is not late.
2. Referral to GUM, and treatment by a doctor, rather than under a patient group direction, are recommended. This will depend on local circumstances and access to services.
3. Azithromycin is recommended by the WHO and USA CDC. The BNF recommends use only if there is no alternative available. Studies in non-pregnant women have shown that azithromycin is more effective than either erythromycin or amoxicillin, and there is no evidence of harm; however all drugs should be used with caution in pregnancy. Ensure that the discussion with patient regarding any off label use of a drug is documented.
4. Erythromycin is often poorly tolerated in pregnancy. Treatment is unreliable, and a test of cure is recommended.
5. Azithromycin may be discontinued earlier in mild to moderate disease if the patient is unable to tolerate it; they should be encouraged to take at least a week.
6. Cefixime is to cover gonorrhoea if patient declines referral and ceftriaxone is unavailable; although effective in the treatment of uncomplicated gonorrhoea, there has been no published research of its use in PID.
7. Ofloxacin should be avoided in patients at high risk of gonococcal PID – risk of resistance
8. This use of azithromycin is outside the scope of the licence and there is limited data on its efficacy in PID. Refer to note 4 regarding use in pregnancy, and ensure the discussion with patient is documented.
9. Consider the addition of ceftriaxone or cefixime if gonococcal infection is likely.
10. Doxycycline is to cover gonorrhoea if patient declines referral and ceftriaxone is unavailable; although effective in the treatment of uncomplicated gonorrhoea, there has been no published research of its use in PID.