

Title: British Association for Sexual Health and HIV UK National guideline for the management of infection with *Chlamydia trachomatis*, 2026

Version No.: version 1.0 dated 20/07/2026

Title: British Association for Sexual Health and HIV **UK national guideline for the management of infection with *Chlamydia trachomatis*, 2026**

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Short Title: Chlamydia guideline

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Abstract: This guideline provides details on the pathology and clinical features of *Chlamydia trachomatis* infection and makes recommendations for diagnostic tests, treatment regimens and the health promotion principles needed for the effective management of infections, in people aged 16 years or older attending sexual health services. The guideline is primarily aimed at level 3 sexual health services in the UK, although it could also serve as a reference guide for sexually transmitted infection services at other levels. This guideline is an update of the previous one published in 2015.

Keywords: Chlamydia (*Chlamydia trachomatis*), bacterial disease, treatment, diagnosis

What is new in the 2026 guideline?

- Inclusion of considerations for people following genital reconstructive surgery (GRS).
- Doxycycline 100mg twice a day for seven days now sole first line recommended treatment (unless contraindicated).
- Inclusion of considerations for the management of chlamydia in people taking doxycycline post exposure prophylaxis.
- Recommended time for a retest changed to two - six months following treatment based on RCT evidence that positivity is similar across time points but statistically significantly more people retest at 2 months compared to other time points.

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Introduction and methodology

Scope and purpose

This guideline provides evidence-based recommendations for the diagnosis, treatment, and management of *Chlamydia trachomatis*.

The recommendations encompass diagnostic tests, treatment regimens, and health promotion principles essential for effectively managing *Chlamydia trachomatis* infections in individuals aged 16 years and older. For those under 16 years, the British Association for Sexual Health and HIV (BASHH) guideline on STI and Related Conditions in Children and Young People should be consulted.

The guideline is aimed primarily at patients aged 16 years or older presenting to healthcare professionals working in departments offering specialist level 3 care in sexually transmitted infections (STIs) management within the United Kingdom (UK). However, the principles of the recommendations are applicable across levels of STI care providers, and non-specialist services may need to develop, where appropriate, local referral pathways.

Search strategy and methods

This guideline was produced according to specifications set out in the CEG document '2020 Framework for guideline development and assessment' accessed at <https://www.bashhguidelines.org/media/1247/2020-guidelines-framework.pdf> and has been updated by reviewing the previous chlamydia guideline (2015) and medical literature since its publication. The Grading of Recommendations, Assessment, Development, and Evaluation (GRADE) system was used to assess the evidence and make recommendations as detailed in the guidance.

A search of published articles from January 2015 to August 2025 was conducted in MEDLINE, Embase, and the Cochrane Library using the same search strategy as the 2015 guideline (appendix). The writing group also formulated four 'PICO' questions addressing the patient problem or population (P), intervention (I) (or aetiology/diagnosis/frequency/prognosis), comparison (C) and outcome(s) (O), which formed the basis for more focused literature searches and article identification (appendix). Articles were limited to those in the English language, humans, randomised controlled trials, systematic reviews or observational studies.

Article titles and abstracts were reviewed and if relevant the full text article obtained. Abstracts from meetings in the relevant period were hand-searched and considered. Priority was given to randomised controlled trial and systematic review evidence, and recommendations made and graded based on the best available evidence.

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Equality impact assessment

An assessment of the guideline and its recommendations was undertaken to ensure the principles of equality and diversity were adhered to (appendix).

BASHH has adopted an anatomical approach without assuming gender in most guidelines and uses gender terminology in line with BASHH 'sexual health standards for trans, including non-binary, people'.

Stakeholder Involvement, Piloting and Feedback

The first draft was produced by the writing group and then circulated to the BASHH Clinical Effectiveness Group (CEG) for reviewing using the AGREE appraisal tool. The second draft of the guideline was posted on the BASHH website for wider consultation (2 months) and any comments received during the consultation period were reviewed by the authors and acted on appropriately. The document was also reviewed by a patient representative, target users and the public panel of BASHH, and their feedback was considered by the authors and used to inform the guideline. The final draft was presented to the CEG for review and piloting in sexual health clinics.

Once the guideline is published, the CEG will keep it under review should critical new evidence become available that affects the current recommendations. The guideline will be formally reviewed and updated, if necessary, every five years.

Aetiology

Genital chlamydial infection is caused by the obligate intracellular bacterium *Chlamydia trachomatis*. It is the most diagnosed bacterial STI in the UK.¹ Infection is associated with younger age, reporting a new partner and higher numbers of partners in the last year.² The primary sites of infection are the mucous membranes of the urethra, endocervix, rectum, pharynx and conjunctiva. Genovars D–K can cause urogenital, pharyngeal and ocular infection and are the focus for these guidelines. Genovars L1–L3 cause the disease Lymphogranuloma Venereum (LGV).³ The management of LGV is addressed in separate BASHH guidelines. A–C genovars infect the conjunctiva and cause the disease trachoma which is not covered in this guideline.

Clinical Features

Infection is primarily through penetrative sexual intercourse, although the organism can be detected in the conjunctiva and nasopharynx without concomitant genital infection and in the rectum in the absence of reporting anal sex.^{4–6}

If untreated, infection may persist or resolve spontaneously.^{7–16} Studies evaluating the natural history of untreated genital *C. trachomatis* infection have shown that clearance increases with

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the duration of untreated infection, with up to 50% of infections spontaneously resolving approximately 12 months from initial diagnosis.^{7,10,13,15}

Chlamydia infection can cause significant short- and long-term morbidity. Complications of untreated infection are experienced predominantly by women and other people with a womb and ovaries and include pelvic inflammatory disease (PID), tubal infertility and ectopic pregnancy which can have a significant impact on quality of life and substantial healthcare costs.¹⁷⁻¹⁹ In England, the National Chlamydia Screening Programme (NCSP) aims to reduce the harms of untreated chlamydia through opportunistic screening of sexually active women and other people with a womb and ovaries under 25 years of age.²⁰

Symptoms and Signs

A large proportion of individuals with chlamydial infection are asymptomatic.^{21,22}

Penile urethral infection in people assigned male at birth

Symptoms of urethral inflammation (urethral irritation and discomfort, discharge and dysuria) occur in approximately 50% of individuals, usually between 1-3 weeks after infection.²³ A cloudy urethral discharge may be present on examination.

Urethral infection in people assigned female at birth

Symptoms of urethral inflammation may be present but most individuals with infection at this site are asymptomatic.²³

Endocervical infection

Many individuals with infection at this site have no signs or symptoms. Symptoms may include increased vaginal discharge, post-coital and intermenstrual bleeding, lower abdominal pain, and deep dyspareunia. Mucopurulent cervicitis with or without contact bleeding, pelvic tenderness and cervical motion tenderness may be present on examination.

Rectal infection

Most cases are asymptomatic, but symptoms may include anorectal discomfort and discharge.²² ²⁴ The median time to clearance of untreated rectal chlamydia among men who have sex with men (MSM) is around 13 weeks.²⁵

The prevalence of rectal chlamydia in cisgender women attending sexual health services in high-income countries is estimated to be around 6% with around 68% of those testing positive for urogenital chlamydia also having rectal infection.⁶ Rectal infection in cisgender women is not associated with reporting anal sex.⁶ However, the clinical importance of rectal infection is not well understood nor the utility of targeted versus routine rectal sampling.

Pharyngeal infection

This is predominantly asymptomatic and not known to be associated with any significant morbidity.^{22,24,26} Diagnosis rates of chlamydia carriage in the throat are low.²⁶⁻²⁹ Spontaneous clearance occurs in up to 50% of individuals between testing and receiving treatment.^{26,30-32} In one study among women, of those with a persistent positive chlamydia test between baseline and treatment, three-quarters had non-viable infection.³¹ The median time to clearance of untreated pharyngeal chlamydia among MSM is around 6 weeks.^{25,26,33}

Ocular infection

Chlamydial conjunctivitis can occur following direct inoculation or autoinoculation of genital secretions infected with *C. trachomatis*. The presentation can be acute or chronic, bilateral or more typically, unilateral.³⁴ Rare cases assumed to be associated with non-sexual close contact have been reported.³⁵ A follicular conjunctivitis is the principal feature, but it can be difficult to distinguish from other forms of conjunctivitis, especially viral conjunctivitis. Reliable differentiation is only achieved through laboratory testing. In most cases there is clinical resolution following treatment without sequelae.³⁶

Complications

C. trachomatis infections may cause epididymo-orchitis, pelvic inflammatory disease (PID), peri-hepatitis (Fitz-Hugh-Curtis syndrome) and sexually acquired reactive arthritis (SARA).²³ It is estimated that epididymitis occurs in 2% of susceptible people with asymptomatic chlamydia.^{37,38}

The estimated risk of developing PID after genital *C. trachomatis* infection varies considerably in the literature because of different diagnostic techniques, clinical definitions and study populations. A multi parameter evidence synthesis of the prevalence and incidence of *C. trachomatis* in the UK and its complications suggests that following an untreated infection 17% and 7% of individuals will develop chlamydia related PID (symptomatic or asymptomatic) and salpingitis, respectively.¹⁴ Salpingitis is considered a necessary precondition for progression to infertility and ectopic pregnancy.³⁹ Estimated progression rates from chlamydia-related salpingitis to tubal factor infertility and ectopic pregnancy is 10.8% and 7.6%, respectively.⁴⁰

Exposure to *C. trachomatis*, either by persistent infection, or by re-infection is considered a major contributing factor for tubal tissue damage,^{41,42} and early diagnosis and treatment is important in reducing the risk of subsequent infertility.⁴³

Re-infection with chlamydia is common with around 10% to 15% of young adults diagnosed with chlamydia testing positive at a subsequent test and the percentage testing positive at a repeat test is up to three times higher in those with an initial positive test compared to those who test negative.⁴⁴⁻⁵¹

Diagnosis and specimen collection

Diagnostic Tests

The diagnosis of chlamydia is established by the detection of *C. trachomatis* at the sampled site by nucleic acid amplification tests (NAATs). NAATs are the standard of care for all cases, including medico-legal cases and extra-genital infections.⁵²⁻⁵⁶ Where diagnostic tests are available syndromic management of infection is not appropriate.

Although no test is 100% sensitive or specific, many highly sensitive and specific commercial NAAT assays are available.^{52, 57-64}

There remains debate as to whether a single reactive NAAT requires further confirmation by re-testing using a second NAAT with a different target/platform. Many authorities no longer recommend testing with a second platform (except for medico-legal cases) as the positive predictive value of a single positive result is high in the context of a high prevalence population (GRADE 1D).⁶⁵⁻⁶⁹ However, confirmation may be appropriate in low prevalence settings. Additionally, laboratories should be mindful of the potential for diagnostic escape through use of single target assays (please refer to Further Considerations, New Variant *Chlamydia trachomatis* (nvCT) for further information).

Historically, diagnosis of *C. trachomatis* infection utilised serology (enzyme immunoassay/EIA) and/or tissue culture in some settings. However, as NAATs are known to be significantly more sensitive and specific (compared to EIA) than these methods, neither is considered appropriate in the current diagnostic climate. Additionally, tissue culture for investigation of treatment failure is no longer available at the UKHSA reference laboratory.

Point-of-care testing (POCT)

Most chlamydia tests available in clinical practice are laboratory-based with a varying lag time between testing and diagnosis, depending on local clinical pathways.

Non-NAAT based point-of-care tests (POCTs) lack sensitivity⁷⁰⁻⁷³; however, POCTs using NAAT technologies have been developed with sensitivities approaching 100% when compared to traditional laboratory-based NAAT.^{72, 74-82} These are suitable for genital samples and considerably reduce the time from testing to diagnosis.⁸³ When testing extra-genital specimens, and as confirmatory tests using residual specimens from other commercial platforms, these tests require more validation.^{55, 84}

Window period

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The BASHH Bacterial STI Special Interest Group recommends that patients undergo testing for chlamydia when they first present, and that if there is concern about a sexual exposure within the last two weeks, that they return for a repeat NAAT test two weeks after the exposure (GRADE 1D).

Sites to be sampled

Female genital tract

A vulvo-vaginal swab (VVS) is the specimen of choice for detecting infection of the female genital tract (GRADE 1B).⁸⁵⁻⁸⁷

VVS has a sensitivity of 96–98% and can be either taken by the patient or a healthcare worker (HCW). Several studies indicate that VVS sensitivities are higher than those of endocervical swabs, as they pick up organisms in other parts of the genital tract.⁸⁸ Self-taken VVS are more acceptable to patients than urine or cervical specimens.⁸⁹

Variable sensitivities have been reported using first catch urine (FCU) specimens in cisgender women.⁸⁸ The lower sensitivity is attributed to the presence of fewer organisms in the female urethra compared to other parts of the female genital tract. As self-taken VVS have a high acceptance rate, and sensitivity, these are the recommended sample type (GRADE 1B).

Penile urethra

FCU in cisgender men is reported to be as, or more sensitive than urethral sampling.⁹⁰⁻⁹² Urine samples are easy to collect, do not cause discomfort and thus are preferable to urethral swabs (GRADE 1B).

Studies of self-taken penile-meatal swabs have yielded good results but may be less acceptable to patients compared to urine.^{93,94}

Rectal and oro-pharynx

NAATs are the assays of choice for extra-genital samples, though the sensitivities are variable (GRADE 1B).^{54,65,67,95,96}

Rectal swabs can be obtained via proctoscopy or taken 'blind' by the patient or a healthcare worker (GRADE 1B).^{65,97} Oro-pharyngeal swabs can also be clinician- or self-collected (GRADE 1B).^{65,97} Self-collected swabs have shown high sensitivity and acceptability.⁹⁷⁻⁹⁹

Conjunctiva

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NAATs are the assays of choice for ocular samples. The use of commercial PCR assays for the detection of *C. trachomatis* in ocular samples shows similar sensitivity (96%) and specificity (100%) to that of urogenital swabs (GRADE 1B).¹⁰⁰

Considerations for people following genital reconstructive surgery (GRS)

The susceptibility of a site to chlamydial infection is likely to be related to the nature of the reconstruction, with sites constructed from mucosal tissue (e.g., from the vaginal or bowel mucosa) being more susceptible than sites constructed from skin.

Chlamydial infections of the neovagina following penile-inversion and intestinal vaginoplasty surgery have been reported and cases resolved following treatment with a single dose of azithromycin 1g orally.¹⁰¹ We were unable to find any reports of chlamydial infection of the neopenis.

We recommend that optimal genital testing in transgender women, non-binary and other gender diverse people at risk of chlamydia should include swabs from the neovagina (if appropriate) and first-pass urine (Grade 1D).

We recommend first-pass urine as the specimen of choice from people with a neopenis (Grade 1D). Where the vagina is still present following GRS a vaginal swab should be considered as directed by the sexual history and symptoms.

Extragenital testing should be guided by sexual history and symptoms.

Further Considerations

New variant Chlamydia trachomatis (nvCT)

There have been two incidents where a variant of *C. trachomatis* has escaped molecular detection. In 2006, the Swedish new variant of CT (S-nvCT) harboured a 377 base pair deletion in the cryptic plasmid, a common NAAT target.^{102,103} Additionally, in 2019, the Finnish new variant (F-nvCT) escaped detection on the Hologic AC2 assay with a C1515T mutation in the 23S rRNA gene target region and was subsequently also detected in Sweden, Norway and Denmark.¹⁰⁴⁻¹⁰⁷ No cases of this F-nvCT were detected during a case-finding exercise by the UK Health Security Agency in England.^{108,109} However, four samples with two other CT variants escaping AC2 assay detection were identified; nvCT-C1514T and nvCT-G1523A. These, plus an additional variant (G1526A) were recently reported in a small number of samples during surveillance in Canada.¹¹⁰ The AC2 assay has been updated to detect these variants, as well as potential new variants arising due to mutations in that region of the 23S rRNA gene.

However, this experience, along with the emergence of SARS-CoV-2 escape variants, clearly shows the risk of using single-target NAATs for molecular diagnostics. Ideally all diagnostic platforms should employ more than one diagnostic target to prevent mutants from escaping

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detection. There are, however, financial advantages of using a single diagnostic assay, and the decision about which assay to use should be appropriately assessed when choosing the diagnostic pathway.

Pooling of specimens

To reduce testing costs, some centres combine samples by pooling urine, rectal and oro-pharyngeal swabs into a single sample. Centres can consider pooling specimens (GRADE 2D). If pooling is undertaken, we recommend local validation of this approach as the pooling may reduce sensitivity and in the event of a reactive result, the precise site of infection would be unknown (GRADE 1D).¹¹¹⁻¹¹⁶

Management

General advice

Patients should be given a detailed explanation on the natural history of chlamydia infection, as well as its transmission, treatment, complications, and implications for themselves and their sexual partner(s). This should be reinforced with the provision of clear and accurate written or web-based patient information (GRADE 1D). A patient information leaflet for *C. trachomatis* can be found on the guidelines page of the BASHH website.

Patients should be advised to abstain from sexual intercourse (including oral sex) until they have completed treatment (or wait seven days if treated with azithromycin) and symptoms have resolved (GRADE 1D).

Patients should be counselled appropriately on the antimicrobial given to them including adverse drug reactions and advice to discard any unnecessary medicines should an oversupply be given in line with antimicrobial stewardship best practices (GRADE 1D).¹¹⁷

Further Investigation

All patients diagnosed with *C. trachomatis* should be encouraged to have screening for other STIs, including HIV, and where indicated, hepatitis B screening and vaccination (GRADE 1D).

If the patient is within the window periods for HIV and syphilis, these should be repeated at an appropriate time interval. All contacts of *C. trachomatis* should be offered the same screening tests (GRADE 1D).

Treatments

Urogenital infection

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A meta-analysis of randomised controlled trials comparing doxycycline with azithromycin published in 2014 found a small (3%), but statistically significant increased benefit of doxycycline over azithromycin for urogenital chlamydia and a benefit of doxycycline over azithromycin of 7% in men with symptomatic urethral chlamydia. The quality of studies varied, and there were few double-blind, placebo-controlled trials.¹¹⁸

These findings are supported by a later randomised controlled trial demonstrating that doxycycline has a marginally higher cure rate (100% versus 97% for azithromycin) with noninferiority of azithromycin not being established.¹¹⁹ An association of azithromycin use with higher rates of treatment failure compared to doxycycline has been observed in multiple, more recent, studies.¹²⁰⁻¹²³

Given this evidence for elevated failure rates with azithromycin, doxycycline is recommended as first line treatment for urogenital chlamydial infection (GRADE 1A).

Rectal infection

There have been two systematic reviews and meta-analyses of the efficacy of doxycycline versus azithromycin for the treatment of rectal chlamydia.^{124,125} Fifteen unique studies are included across these meta-analyses including two randomised controlled trials.^{126,127} Both meta-analyses show that doxycycline achieves superior microbiological cure rates compared to azithromycin for rectal chlamydia.

Given this evidence for the superiority of doxycycline over azithromycin, doxycycline is recommended as first line treatment for rectal chlamydial infections (GRADE 1A).

Pharyngeal infection

There are no randomised controlled trials comparing the efficacy of doxycycline with azithromycin for the treatment of pharyngeal infection. In a recent prospective observational study, there was a non-significant greater cure rate with doxycycline versus azithromycin.³¹

Doxycycline is recommended as first line treatment for pharyngeal chlamydial infections (GRADE 1B).

Recommended and Alternative Regimens

Note on dose of azithromycin

In 2018, BASHH issued a statement to say single dose azithromycin (SDA) for the treatment of uncomplicated chlamydia infection at any site was no longer recommended. This decision was made based on two key points: firstly findings from the meta-analysis by Kong *et al.* showing that doxycycline was more effective than azithromycin for rectal chlamydia in GBMSM, and secondly, that SDA was selecting for macrolide resistance in *Mycoplasma genitalium*.¹²⁵

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However, the evidence base to support the use of extended doses of azithromycin to treat chlamydia is limited. We identified two observational studies using a 2g dose of azithromycin for the treatment of urogenital chlamydia: one study used a 2g single dose of azithromycin extended release and one other that used a 5-day course (500mg on day 1 and 250mg on the following 4 days).^{128, 129} Neither showed any additional benefit in terms of microbiological cure (91.5% and 98.8%, respectively), and neither uses the regimen recommended in the 2018 BASHH update (1g as a single dose followed by 500mg daily for 2 days). Diarrhoea was common among those receiving a 2g dose (35.2%). Therefore, the strongest existing trial evidence is for the 1g single dose, with no trial evidence for the 3-day dosing regimen identified. However, because of ongoing concerns about the potential for the single dose regimen to drive antimicrobial resistance, and to align with other BASHH guidelines, the stronger recommendation (based on expert opinion) is for the 3-day dosing regimen. We recommend *Mycoplasma genitalium* testing according to current BASHH guidelines (GRADE 1D) and that the single dose azithromycin dose is only used in individuals where *Mycoplasma genitalium* co-infection has been excluded (GRADE 1D).

Uncomplicated urogenital infection (GRADE 1A) and pharyngeal infection (GRADE 1B).

Preferred treatment:

- Doxycycline 100 mg orally twice a day for seven days (contraindicated in pregnancy)

Alternative regimens (if doxycycline is contraindicated or cannot be tolerated):

- Azithromycin 1g orally as a single dose followed by 500mg daily for 2 days (GRADE 1D)
- Azithromycin 1 g orally as a single dose (GRADE 2A)
- Erythromycin 500 mg bd for 10–14 days (GRADE 1C)
- Ofloxacin 200 mg bd or 400 mg od for seven days (GRADE 1A)

Rectal infection (non-LGV)

Preferred treatment:

- Doxycycline 100 mg orally twice a day for seven days (contraindicated in pregnancy) (GRADE 1A)

Alternative regimen:

- Azithromycin 1g orally as a single dose followed by 500mg daily for 2 days (see section on Test of Cure below) (GRADE 1D)
- Azithromycin 1 g orally as a single dose (see section on Test of Cure below) (GRADE 2A)

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Ocular infection

Given the high prevalence of concomitant genital infection (up to 80%), and possible colonisation at other sites, oral antibiotics are the recommended treatment for chlamydial conjunctivitis.^{4,130} There are no recent clinical trials on the management of chlamydia conjunctivitis but small, randomised trials have demonstrated non-inferiority between oral azithromycin and doxycycline.^{131,132} Contact lens wearers are advised to stop lens wear until symptoms are fully resolved. Referral to Ophthalmology is not required unless symptoms persist despite treatment or there is co-infection with *N. gonorrhoeae* (please refer to BASHH 2024 gonorrhoea guideline).

Doxycycline is recommended as first line treatment for ocular chlamydia infections based on ensuring adequate treatment at other sites (GRADE 1B). Oral treatment should be initiated at first diagnosis and not be delayed for sexual health review (if the patient is attending and diagnosed initially in a non-sexual health setting). Ophthalmologists commonly prescribe adjunctive topical antibiotics but there are no data to support the use of topical therapy in addition to systemic treatment.

Other antimicrobials

Evidence to support the use of antimicrobials other than doxycycline and azithromycin is less robust. A systematic review of non-standard treatments for uncomplicated urogenital infection found successful treatment with ofloxacin, levofloxacin, sitafloxacin, rifalazil, and amoxicillin. Pivmecillinam is not recommended due to higher levels of treatment failure.¹³³

Ofloxacin, levofloxacin, sitafloxacin (GRADE 1A)

These fluoroquinolones achieve comparable microbiological cure rates to doxycycline in limited studies but they carry increased risk of *Clostridium difficile* infection and tendon rupture.^{133,134} Fluoroquinolones have also been associated with adverse effects involving muscles, joints, nerves, or mental health which can be irreversible and the current advice from the Medicines and Healthcare products Regulatory Agency (MHRA) is to not prescribe fluoroquinolones for non-severe or self-limiting infections, or for mild to moderate infections unless other antibiotics that are commonly recommended for those infections are considered inappropriate.¹³⁵

Safety, cost, availability, concomitant medication, and frequency of dosing should all be considered before prescribing fluoroquinolones for chlamydia treatment.

Erythromycin (GRADE 1C)

A meta-analysis of azithromycin versus erythromycin for the treatment of chlamydia in pregnancy found erythromycin to have similar treatment success to azithromycin.¹³⁶ Erythromycin is associated with more side effects than azithromycin.¹³⁶ Erythromycin as a

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multiple-dose regimen is recommended but a superior regimen has not been established.¹³⁷

When taken four times daily, 20–25% of individuals may experience side-effects sufficient to cause discontinuation of treatment with erythromycin.¹³⁸ A 10–14 day-course appears to be more efficacious than a seven-day course of 500 mg twice a day, with a cure rate >95%.¹³⁸

Treatment of gonorrhoea co-infection

Individuals with gonorrhoea co-infection should be managed according to the most recent BASHH guideline for the management of gonorrhoea.

Considerations for people taking doxycycline pre- or post-exposure prophylaxis for STIs

Doxycycline post-exposure prophylaxis (doxyPEP) involves taking a single 200mg dose of doxycycline within 72 hours (ideally within 24 hours) of condomless sex. This has been shown to significantly reduce the incidence of chlamydia and syphilis among participants of three RCTs and gonorrhoea in two.¹³⁹⁻¹⁴¹ Currently, evidence to support the use of doxycycline pre-exposure prophylaxis (doxyPrEP) is more limited - it has been shown to reduce the incidence of bacterial STIs in a single, small and unpowered study and not currently a recommended regimen within the BASHH doxyPEP guideline.^{142,143}

For individuals diagnosed with chlamydia who report using doxyPEP, we recommend using the first line treatment outlined above (unless contraindicated) (GRADE 2D).

For the management of individuals using doxyPEP who attend as a sexual contact of chlamydia, healthcare professionals should follow recommendations in the current BASHH UK national guideline for the use of doxyPEP.¹⁴³

Pregnancy & Breastfeeding

Pregnancy

The BNF recommendation is to avoid tetracyclines at all stages of pregnancy. BASHH only supports the use of doxycycline in pregnant people when the full course of treatment can be completed prior to 15 weeks gestation and where no suitable alternative exists for treatment (GRADE 2D).¹⁴⁴

Recommended regimens

- Azithromycin 1g orally as a single dose followed by 500mg daily for 2 days (GRADE 1D)
- or
- Azithromycin 1 g orally as a single dose (GRADE 2A)
- or
- Erythromycin 500 mg four times daily for seven days (GRADE 1A)
- or
- Erythromycin 500 mg twice daily for 14 days (GRADE 1A)

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or

- Amoxicillin 500 mg three times a day for seven days (GRADE 1A)

Clinical experience and published studies suggest that azithromycin is safe and efficacious in pregnancy,^{138,145-148} and the World Health Organization (WHO) recommends its use in pregnancy although the British National Formulary (BNF) states that manufacturers advise use only if adequate alternatives are not available.

Erythromycin has a significant side-effect profile and is less than 95% effective.¹³⁶ A meta-analysis showed erythromycin has the same effectiveness for the treatment of chlamydia in pregnancy but its use is associated with significantly more gastrointestinal side effects and discontinuation.¹³⁶ This higher level of discontinuation may be a reason for lower microbiological cure rates seen in some studies.

Amoxicillin had a similar cure rate to erythromycin and a much better side effect profile.¹⁴⁶ However, penicillin in vitro has been shown to induce latency and re-emergence of infection at a later date is a theoretical concern of some experts.¹⁴⁹

It is recommended that individuals treated for chlamydia in pregnancy undergo a test of cure (TOC) which should be performed no earlier than three weeks after completing treatment (GRADE 2C).

Breastfeeding / Chestfeeding

NICE recommends the use of specialist resources for up-to-date information regarding medications in lactation such as UKDILAS or Lactmed.

Recommended regimens

- Azithromycin 1g orally as a single dose followed by 500mg daily for 2 days (GRADE 1D)
- or
- Azithromycin 1 g orally as a single dose (GRADE 2A)
- or
- Erythromycin 500 mg four times daily for seven days (GRADE 1A)
- or
- Erythromycin 500 mg twice daily for 14 days (GRADE 1A)
- or
- Amoxicillin 500 mg three times a day for seven days (GRADE 1A)

Alternative

- Doxycycline 100mg twice a day for seven days

When using antibiotics in breastfeeding/chestfeeding, it is recommended to monitor infants for side effects such as vomiting, diarrhoea and candida (GRADE 1D).

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Macrolide use in infants is associated with infantile hypertrophic pyloric stenosis (IHPS), and this association is strongest when administration occurs during the first two weeks of life.^[124] The majority of the infants included in this analysis were prescribed erythromycin. Erythromycin is excreted in breast milk although the quantity excreted is likely to be low.¹⁵⁰ There have been isolated reports of erythromycin excreted in breastmilk associated with IHPS.¹⁵¹ However, in a systematic review and meta-analysis, infantile exposure to macrolides including erythromycin during lactation was not significantly associated with IHPS.¹⁵² A discussion with the parent, considering the age of the infant, the low likelihood of IHPS occurring as a result of exposure through breastmilk and the benefits of treatment should be documented (GRADE 1D).

Doxycycline was previously not recommended during lactation due to risk of bone deposition or staining of tooth enamel. However, this is unlikely to occur with short courses (less than three weeks) and so can be considered if alternatives are not acceptable (GRADE 2D).

In People Living with HIV

People living with HIV with chlamydial infection should be managed in the same way as HIV-negative individuals (GRADE 1C).

Reactions to Treatment

Doxycycline may cause dysphagia, oesophageal irritation and photosensitivity. Patients should be advised to swallow capsules whole with plenty of fluid during meals while sitting or standing and should be advised to avoid sunlamps and direct sunshine.

Generally, all antibiotics may cause gastro-intestinal upset including nausea, vomiting, abdominal discomfort and diarrhoea. These side-effects are more common with erythromycin than with azithromycin. With all macrolides, hepatotoxicity (including cholestatic jaundice) and rash may occur but are infrequent.

Azithromycin may be associated with prolongation of the QT interval and should be used with caution or avoided in individuals with abnormalities of cardiac rhythm, increasing age, female sex, or on other QT-prolonging medicines.

Follow-up

Test of Cure (TOC)

TOC is not routinely recommended for uncomplicated chlamydia infection, because treatment success rates are high and residual, nonviable chlamydial DNA may be detected by NAAT for 3–5 weeks following treatment.^{153, 154} There are few data on the optimum time to perform a TOC; we recommend this should be deferred for at least three weeks after treatment is completed (GRADE 1C).¹⁵³⁻¹⁵⁵

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TOC is recommended in pregnancy, where poor compliance is suspected and where symptoms persist (GRADE 1C). A TOC may be considered if azithromycin was used to treat rectal infection (GRADE 1D).

Re-infection and repeat testing

TOC should be differentiated from testing for re-infection. Genital infection with chlamydia provides limited immunity to repeat infections.¹⁵⁶ Re-infection is common, with individuals testing positive for chlamydia being at higher risk of testing positive in subsequent tests compared to those who initially test negative.¹⁵⁷ Approximately 10% to 15% of young adults diagnosed with chlamydia test positive in their next test and the percentage of positive results in repeat tests is two to three times higher in individuals with an initial positive test compared to those with an initial negative test.⁴⁴⁻⁵⁰ Repeat diagnoses may arise for various reasons, including re-infection from untreated or new sexual partners, inadequate adherence to treatment, treatment failure or a false-positive result. In practice, it may be difficult to distinguish between treatment failure and rapid re-infection.

Modelling using US data from women aged 15 to 25 years suggests a peak in repeated infections between 2–5 months after treatment for an initial infection.¹⁵⁸ A single RCT of retesting 8, 16 or 26 weeks after treatment of urogenital chlamydia found similar positivity between the three groups (median age 23 years, interquartile range 21-26) but a statistically significant greater uptake of retesting in the 8-week group compared to the other groups.¹⁵⁹ We recommend retesting for chlamydia for those aged under 25 years between 2-6 months after treatment (GRADE 1B).

Several studies suggest that retesting rates can be improved with the use of SMS reminders.¹⁶⁰

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Tracing and Treatment of Contacts

Contact tracing for specific STIs should be performed according to BASHH guidelines (www.bashh.org/guidelines), with reference to look back periods. Patients should be informed of the importance of partner notification and supported to do this by appropriately trained professionals.

All patients identified with *C. trachomatis* should have partner notification (PN) discussed at the time of diagnosis by a trained healthcare professional. The method of PN for each partner/contact identified should be documented, as should PN outcomes. All sexual partners should be offered, and encouraged to take up, full STI screening, including HIV testing and if indicated, hepatitis B screening and vaccination (GRADE 1C).

Treatment for partners

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In keeping with good antimicrobial stewardship, the unnecessary use of antibiotics should be avoided. Between a third and two thirds of contacts will test negative for chlamydia and treating all contacts will result in overtreatment.¹⁶²⁻¹⁶⁴ The likelihood of a partner testing positive is a function of different variables including partner type (e.g. established partner versus one off partner), symptoms and bacterial load in the index, age, and use of condoms and doxyPEP. However, identifying which contacts of chlamydia are most likely to have the infection is challenging. Test and wait strategies are reliant on testing at an appropriate time point following sex and may be more costly because of additional visits for those who subsequently test positive.¹⁶⁵ It is important to note that there is no strong evidence to support the recommendations below which are based on expert opinion (GRADE 1D).

We recommend that:

- contacts with symptoms consistent with chlamydia should be offered epidemiological treatment alongside testing based on the assumption that these contacts are more likely to have chlamydial infection than asymptomatic partners and that empirical treatment may also help alleviate these symptoms

For those without symptoms presenting after 14 days of exposure, we recommend treatment only following a positive test for chlamydia

For those without symptoms presenting within 14 days of exposure, we recommend considering epidemiological treatment based on a clinical and psychological risk assessment and following a discussion with the individual. In particular, the following individuals should be considered for epidemiological treatment:

- individuals who are pregnant
- contacts of individuals who are pregnant
- Individuals living in geographically remote regions with limited access to clinics
- Individuals experiencing psychosocial barriers which include but are not limited to those who: are homeless, sell sex, are experiencing mental ill-health, misuse substances, are employed on zero-hour contracts, are unable to access childcare or are currently victims or survivors of domestic abuse.

For all other asymptomatic individuals, it may be appropriate to not give epidemiological treatment and to repeat testing 2 weeks after exposure.

We recommend that asymptomatic doxyPEP users who are contacts of chlamydia should be managed according to the BASHH doxyPEP guideline.

Look-back period

HCWs should refer to the BASHH statement on PN.¹⁶⁶ There are limited data regarding how far back to go when trying to identify sexual partners potentially at risk of infection. Any sexual partners in the look back periods below should be notified, if possible, that they have potentially been in contact with *C. trachomatis*.

Index cases with penile-urethral symptoms: all contacts since, and in the four weeks prior to, the onset of symptoms (GRADE 1C).

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All other index cases (i.e., all individuals with vaginal, rectal, throat and eye infections and those with asymptomatic penile-urethral infection): all contacts in the six months prior to presentation (GRADE 1C).

Auditable outcomes

- The percentage of cases offered a recommended treatment according to the type of chlamydial infection (performance standard 97%).
- Individuals provided with written information about their diagnosis and management (performance standard 97%).
- PN performed and documented according to BASHH Statement on PN for sexually transmissible infections (see www.bashh.org/guidelines) (performance standard 97%).

Recommendations for further research

- Clinical and microbiological cure with first line doxycycline treatment in patients who take doxyPEP
- Optimal time to test following sexual exposure
- Optimal time to TOC and re-testing
- Interventions to optimise partner notification and management outcomes

Qualifying Statement

The recommendations in this guideline may not be appropriate for use in all clinical situations. Decisions to follow these recommendations must be based on professional clinical judgement, consideration of individual patient circumstances and available resources.

All possible care has been undertaken to ensure specification of the correct dosage of medication and route of administration. However, it remains the responsibility of the prescribing clinician to ensure the accuracy and appropriateness of the medication they prescribe.

Review Arrangements

An author group will be invited by the BASHH CEG to review and revise the guideline in 2031 using the BASHH framework for guideline development. However, addenda may be issued sooner than 2031, particularly if relevant new data are available relating to testing or treatment options.

Disclosures

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APPENDIX 3: EQUALITY IMPACT ASSESSMENT TABLE

BASHH Guideline Equality Impact Assessment (based on NICE documentation shared with BASHH August 2019)				
Guidance title: UK national guideline for the management of infection with <i>Chlamydia trachomatis</i>		Completed by: JOHN SAUNDERS		Date: 27 Feb 2024
How relevant is the topic to equality?	Inequalities in health impact of the condition or public health issue	Potential of guidance to add value	Priority for NHS or other government department	Topic relevance; conclusions and outcomes
	• Prevalence and impact of condition or public health problem • Prevalence of risk factors	• Inequalities in access, uptake or impact • Timeliness • Equality issues identified by proposers of the topic • Equality issues identified by patient or lay organisations	• Department of Health or other centralised NHS bodies such as NHS England • Local authorities • Home Office • Other agencies	• If equality issues had impact on the guidance summarise these impacts
Sex/gender	Overall, chlamydia is most common in sexually active young women. The reproductive sequelae of chlamydia are only experienced directly by women and other people with a womb and ovaries.	The guideline highlights that the prevalence of chlamydia is greatest in young people and that reproductive sequelae of infection are not experienced equally by all genders. The guideline highlights criteria for screening	The guideline is referred to by the English National Chlamydia Screening Programme and supports the commissioning and delivery of this as well as sexual health services more broadly.	Recommendations for testing, retesting and PN

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		within the English National Chlamydia Screening Programme.		
Race	Rates of STIs, including chlamydia, are not equal across ethnicities. Particularly, those from black ethnicities are disproportionately affected.	N/A	N/A	N/A
Disability	Surveillance data does not tell us about any association between chlamydia and disability. Some people with physical and learning disabilities may be vulnerable to acquiring STIs including chlamydia. Departmental safeguarding procedures should be in place to identify and respond to any issues.	The guidelines are primarily for those working in level 3 specialist sexual health services and safeguarding concerns should be addressed by departmental policies. GU physicians receive level 3 safeguarding training.	Safeguarding concerns should be addressed.	Consideration of patients in these groups being at risk of sexual exploitation/abuse should be made as part of GUM departments safeguarding training.
Age	Chlamydia is most common among sexually active people under the age of 25 years. Some young	The guidelines are primarily for those working in level 3 specialist sexual health services and safeguarding	Safeguarding concerns should be addressed.	Consideration of patients in these groups being at risk of sexual exploitation/abuse should be made as part

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	people may be vulnerable to experiencing sexual coercion and violence. Departmental safeguarding procedures should be in place to identify and respond to any issues.	concerns should be addressed by departmental policies. GU physicians receive level 3 safeguarding training.		of GUM departments safeguarding training.
Sexual orientation	There are high rates of chlamydia (as with other bacterial STIs) among gay, bisexual and other men who have sex with men (although gonorrhoea is the most commonly diagnosed bacterial STI in this group). Overall, the majority of infections are diagnosed among heterosexual young people.	N/A	N/A	N/A
Gender reassignment	There is limited data about chlamydia in	The guideline addresses the potential	N/A	Specific guidance on considerations for

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	people following gender reassignment. The reproductive harms of untreated chlamydia can affect transgender men, non-binary (assigned female at birth) and other people who have not had a hysterectomy or bilateral oophorectomy.	harms of chlamydia for people following gender reassignment and provides recommendations for people following gender reassignment. We have removed, as far as possible, gendered language where this is not relevant to the information provided.		people following gender reassignment.
Religion/belief	Surveillance data does not tell us about any association between chlamydia and religion/belief.	N/A	N/A	N/A
Pregnancy & maternity	Chlamydia can lead to adverse reproductive and neonatal outcomes. Vertical transmission is discussed in the guideline as well as issues for pregnant and people who are breast/chest feeding. Some people may be vulnerable to experiencing sexual coercion and violence	The guidelines are primarily for those working in level 3 specialist sexual health services and safeguarding concerns should be addressed by departmental policies. GU physicians receive level 3 safeguarding training.	Safeguarding concerns should be addressed.	Specific guidance for management in pregnancy and for those who are breast or chest feeding. Consideration of patients in these groups being at risk of sexual exploitation/abuse should be made as part of GUM departments safeguarding training.

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	during pregnancy. Departmental safeguarding procedures should be in place to identify and respond to any issues.			
Other definable characteristics & socioeconomic factors that may be affected by protected characteristics, including: • Prisoners and young offenders • Refugees and asylum seekers • Migrant workers • Looked after children • Homeless people • Deprivation • Disadvantage associated with geographical distinctions	Rates of chlamydia are greatest among people residing in areas of greater deprivation. There are geographical variation in access to testing and treatment for STIs, including chlamydia. Surveillance data does not offer sufficient granularity to comment on how other inclusion populations may be more affected by chlamydia. Some people in this inclusion health populations may be vulnerable to additional adverse determinants of health including sexual coercion and violence. Departmental safeguarding procedures should be	The guidelines are primarily for those working in level 3 specialist sexual health services and safeguarding concerns should be addressed by departmental policies. GU physicians receive level 3 safeguarding training.	Safeguarding concerns should be addressed.	Consideration of patients in these groups being at risk of sexual exploitation/abuse should be made as part of GUM departments safeguarding training.

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	in place to identify and respond to any issues.			
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