



CLINICAL GUIDELINE

Chlamydia CEG

A guideline is intended to assist healthcare professionals in the choice of disease-specific treatments.

Clinical judgement should be exercised on the applicability of any guideline, influenced by individual patient characteristics. Clinicians should be mindful of the potential for harmful polypharmacy and increased susceptibility to adverse drug reactions in patients with multiple morbidities or frailty.

If, after discussion with the patient or carer, there are good reasons for not following a guideline, it is good practice to record these and communicate them to others involved in the care of the patient.

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Important Note:

The Intranet version of this document is the only version that is maintained. Any printed copies should therefore be viewed as 'Uncontrolled' and as such, may not necessarily contain the latest updates and amendments.

CHLAMYDIA

Key Points:

- BASHH first-line treatment is **Doxycycline** which should be used unless there are clear contra-indications.
- Where azithromycin must be used this should be a **3-day course totalling 2g**, not a single dose.
- In those with ongoing pregnancy or rectal chlamydia, test of cure should be taken a minimum of three weeks after completion of treatment.
- Current partners should be routinely offered epidemiological treatment. Previous partners should be offered testing only outwith window periods, however if exposure has been recent and it is felt they will struggle to come back quickly if testing is positive, epidemiological treatment should be considered.

Diagnosis of Chlamydial Infection:

All Chlamydia tests in NHSGGC use the Abbott RealTime PCR which tests for both *Chlamydia trachomatis* and *Neisseria gonorrhoeae* in the same sample.

Good sample collection technique improves sensitivity.

Men: Urine (ideally held for > 1 hour): NAAT – 10mls first catch urine in a plain universal container. Transfer to Abbott container as per local advice.
NB: Do not insert urinalysis dipsticks in the sample, as it may introduce contamination and adversely affect the amplification process.

Rectum: NAAT is used. Blind rectal swabs are fine – insert a dry cotton swab into the rectum and rotate for a few seconds. If symptomatic proctitis, will need proctoscopy: take a NAAT swab and additional relevant swabs.

LGV testing: If **symptomatic (proctitis)** or known **HIV positive** please indicate on request form and ask for 'LGV PCR if Chlamydia positive'. All positive rectal chlamydia in MSM with HIV should have an LGV request submitted.

Pharynx: NAAT testing is used primarily for GC testing but due to dual testing of testing pharynx chlamydia test is also performed. Chlamydia prevalence is low (<1-2%).

Women: Vulvovaginal swab: This may be self-taken by patient or by the clinician. Insert the dry swab approx 2 cm into the vagina and rotate six times. Hold in place for a count of 15 to 30 seconds. Bleeding may reduce sensitivity. **This is the preferred test for GC/CT NAAT in women.**

Urine (first pass urine): Unacceptably low sensitivity for the detection of gonorrhoea compared to a swab. Lower sensitivity for the detection of Chlamydia. **Urine sampling in women is NOT our preferred test.**

Genital swabs after Genital Reconstructive Surgery:

With neovagina (sigmoid or penile skin): NAAT neovaginal swab + first pass urine

With neo-penis: First pass urine (plus vaginal swab if vagina still present).

Treatment:

Ideally treatment should be administered following consultation with a sexual health adviser (SHA) or clinician with SHA competencies. Often this will be done via telephone.

Uncomplicated Genital Chlamydial Infection

Doxycycline 100mg BD x SEVEN days (cure rate 98%)
(contra-indicated in pregnancy)

2nd line: Azithromycin 1g immediately then 500mg OD on days 2 and 3.

QT prolongation: Certain medications including fluconazole, macrolide and quinolone antibiotics cause QT prolongation and should not be prescribed with interacting medications. This is unlikely to be of clinical significance for STAT doses but is important for longer courses. Please use BNF Interaction Checker to ensure these medications are safe to prescribe for your patient and discuss with a senior colleague if necessary.

Alternative regime (if Azithromycin and Doxycycline contraindicated): Erythromycin 500mg BD for 10-14 days; Ofloxacin 200mg BD/400mg OD 7 days (contraindicated in pregnancy)

Uncomplicated genital infection is not an indication for removal of IUCD.

Pharyngeal Infection:

Follow recommendations for genital chlamydia.

Rectal Infection:

Request an LGV test if patient symptomatic and/or HIV positive, the health advisors will also contact the labs to clarify test has been requested.

Management of asymptomatic rectal infection in HIV negative patients:

- *If patient is returning for treatment after initial screening ensure that they have not developed symptoms in the intervening period.*
- *See separate MSM protocol for advice on symptomatic rectal Chlamydia/ LGV treatment*
- *Proctitis in women should be treated the same*

Doxycycline 100mg po BD x SEVEN days
(contra-indicated in pregnancy)

2nd line: Azithromycin 1g immediately then 500mg OD on days 2 and 3.

Advice: Avoid sexual intercourse (including oral sex) until they and their partner(s) have completed treatment (or wait seven days if treated with Azithromycin).

Management of asymptomatic rectal infection in HIV positive patients


Due to the higher prevalence of LGV in this population, HIV patients with rectal chlamydia, even if they have no symptoms, should be treated with three weeks of doxycycline. This can be stopped if an LGV result returns as negative. If they don't wish to take 3 weeks of treatment, they must return for a ToC.

Doxycycline 100mg po BD x 21 days (or until LGV- negative result)
(contra-indicated in pregnancy)

2nd line: Azithromycin 1g immediately then 500mg OD on days 2 and 3.

Prescribing the 3-day course of azithromycin

Take care to choose the correct dose/regimen on NaSH: this is the '3-day' course. The patient can take the first 1g in the clinic but should be instructed to take 500mg on each of the subsequent days, 24h and 48h later.

Prescription			
Drug Name	Azithromycin (3 day)		
Presc. Indication	infection		
Preparation	Tab/Cap 250mg or 500mg	Allergy group	Macrolide
Dose / Route	1g	Oral	If PGD Drug? <input type="checkbox"/> Supplied by PGD <input type="checkbox"/>
Frequency	stat		
Course/Multi-dose	then 500mg daily for 2 days		Prescribing/Rec. method <input type="checkbox"/>

Avoiding sexual contact

All patients should be advised to abstain from any sexual contact including oral sex for the duration of the course of antibiotics or for seven days after treatment with azithromycin.

Pregnancy/breast feeding:

See 'Pregnancy and STIs' protocol. BASHH CEG state that adverse outcomes are unlikely with the 2g azithromycin total dose but that women should be advised of lack of data. Women with an ongoing pregnancy with chlamydia should return for test of cure a minimum of 3 weeks after completion of treatment. Repeat testing can be offered at 36 weeks for all pregnant women to exclude reinfection.

Partner Notification:

- All patients diagnosed with chlamydia infection should see a SHA or clinician with SHA competencies.
- Look back period:
 - Male index case with genital symptoms: **four weeks** prior to symptom onset
 - All other cases (all women, men with extra-genital infection): **six months** prior to presentation.
- Contacts identified should be offered full STI screening including HIV testing, and vaccinations as indicated.

- All current partner(s) should be treated for chlamydia, irrespective of their test results to reduce risk of reinfection of the index case.
- Treatment of past contacts identified should be considered based on how recent the exposure and the likelihood of re-attendance. The chlamydia test window period is two weeks.

Managing GC co-infection: stop presumptive treatment of chlamydia

There is no longer any need for Azithromycin co-treatment in gonorrhoea. If someone has both chlamydia and gonorrhoea they will usually be treated with ceftriaxone 1g IM along with oral doxycycline for 7 days (or 21 days if rectal infection).

Follow-up:

All patients treated for Chlamydia should be reviewed by a SHA or clinician with SHA competencies usually one week after treatment. If there are clinical complications then advise returning for review.

SHA will complete PN and contact the client either by phone or text to enquire about compliance.

If <25yrs encourage re-testing at three months (as 10-30% of young people are re-infected with Chlamydia within 3 months)

Test of cure (ToC) is only indicated in rectal chlamydia or in ongoing pregnancy. ToC should be taken a minimum of three weeks **after completion of treatment**.

ToC may be considered with suspected poor compliance where retreatment is not preferred.

Patients with persistent symptoms not responding clinically to treatment need evaluation and discussion with GU Dr of the Day. (DOD)

Chlamydial Conjunctivitis:

Uncommon presentation to GU settings, patient may be referred from Ophthalmology.

A chronic follicular conjunctivitis, usually unilateral, sub-acute onset.

Symptoms: foreign-body sensation, tearing, mucoid discharge, redness, photophobia, swelling of lids. Incubation usually 1 - 3 weeks.

Test: standard plain swab into viral PCR medium (as for HSV testing) and request 'Eye PCR screen' on our standard STI virus lab request form. Please note this does NOT cover gonorrhoea but includes adenovirus and HSV. If gonorrhoea suspected take a second swab with a standard Abbott Chlamydia/GC NAAT collection kit.

Management:

Involve ophthalmology team if not already done (see StaffNet for local ophthalmology referral details).

Inclusion conjunctivitis generally responds well to the type of regimens used for treating chlamydial genital tract infection (see above).

Doxycycline 100 mg BD for one week produces rapid clinical and microbiological cure.

It is essential that all clients with chlamydial conjunctivitis and their sexual partners are tested and treated for concomitant chlamydial genital tract infection.

Refer Health Advisor team as per genital Chlamydia guidelines.

References

BASHH Clinical Effectiveness Group (2018): Update on treatment of Chlamydia trachomatis infection Available at: <https://www.bashh.org/guidelines> [accessed 27 July 2023]

BASHH Clinical Effectiveness Group (2015): UK national guideline for the management of infection with Chlamydia trachomatis. Available at: <https://www.bashh.org/guidelines> [accessed 27 July 2023]

BASHH Clinical Effectiveness Group (2013): UK National Guideline for the management of lymphogranuloma venereum. Available at: <https://www.bashh.org/guidelines> [accessed 27 July 2023]

IUSTI Europe (2015). European Guideline on the management of Chlamydia Trachomatis infection Available at: <https://iusti.org/treatment-guidelines/> [accessed 27 July 2023]