

## 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 and lubricant:**

When taking swabs during speculum examination or proctoscopy, lubricant to be used sparingly to avoid contaminating the sample (certain lubricants can interfere with NAAT tests)

**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 an appropriately trained clinician with the support of sexual health advisers (SHA). 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, please note current MHRA restrictions on prescribing quinolones, please speak to GUM DoD (contra-indicated in pregnancy)

Uncomplicated genital infection is not an indication for removal of IUCD, however any infection should be treated prior to an IUCD insertion or change

**Pharyngeal Infection:**

Follow recommendations for genital chlamydia.

**Rectal Infection:**

Request an LGV test if patient symptomatic and/or HIV positive, the health advisors can contact the labs to add the test retrospectively .

**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 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 and symptomatic rectal infection in all patients**

Patients with symptomatic rectal infection 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. Due to the higher prevalence of LGV in this population, HIV patients with rectal chlamydia, even if they have no symptoms, should follow the same plan.

In all cases, the patient details should be handed into the SHA office to monitor the result and advise the patient as early as possible of a negative result in order to avoid unnecessary length of antibiotic treatment

**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.

<b>Prescription</b>			
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. BASHH CEG also note that doxycycline appears safe when used in the first trimester of pregnancy (all courses should be completed prior to 15 weeks' gestation), however the data is limited so a suitable alternative should be used wherever possible.

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 have a partner notification documented
  - Male index case with genital symptoms: **four weeks** prior to symptom onset
  - All other cases (all women, asymptomatic men and 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:**

Referral should be made to the Sexual Health Advisers to review the case and determine whether further follow up is necessary. All patients should be added to SC SHA Telephone at 2 weeks after treatment.

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). Patients should be added to SC SHA Re-Test for an automated text reminder at 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 (2024): BASHH position statement on doxycycline use in pregnancy Available at:

[https://www.bashh.org/resources/101/bashh\\_position\\_statement\\_on\\_doxycycline\\_use\\_in\\_pregnancy](https://www.bashh.org/resources/101/bashh_position_statement_on_doxycycline_use_in_pregnancy) [Access 12 June 2024]

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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]

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