CHLAMYDIA

New in June 2019:

- Following updated guidance from BASHH first-line treatment is now **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.
- This aims to reduce the drive to macrolide resistance in *M. genitalium* and *N. gonorrhoeae*. Doxycycline is also more effective for rectal infection, with significant concomitant infection at this site in women irrespective of reported exposure.
- 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. A pragmatic approach should be taken for previous partners and treatment also offered if exposure has been recent and especially if they will struggle to come back quickly if testing is positive.

Diagnosis of Chlamydial Infection

All Chlamydia tests in NHSGGC use the Abbott RealTime PCR which test 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 a viral swab in addition.

DO NOT USE THE ABBOTT GC/CT KIT SWABS FOR BLIND RECTAL SAMPLING – RISK OF SWAB BREAKING OFF.

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 now first line to improve sensitivity of gonorrhoea culture. 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 nurse with SHA competencies unless the client refuses to remain or no staff member available. Document clearly in NaSH and give the notes or message the relevant staff member depending on where you are located**.**

Uncomplicated Genital Chlamydial Infection

Doxycycline 100mg BD x SEVEN days (cure rate 98%)

(contraindicated in pregnancy)

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

Alternative regime (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.

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

(contraindicated 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 once an LGV result returns as negative. If they don't wish to take 3 weeks of treatment, they must return for a TOC.

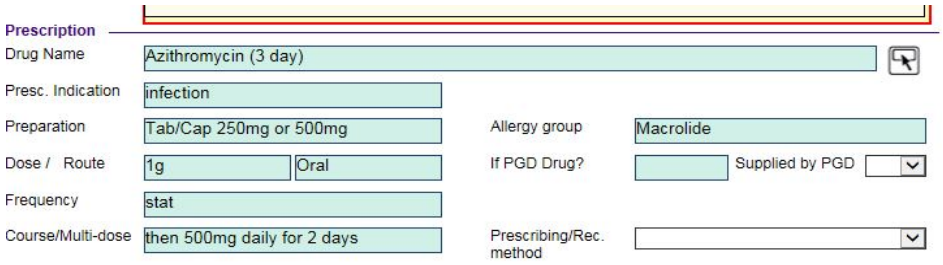
Doxycycline 100mg po BD x 21 days (or until LGV- negative result)

(contraindicated 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.



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 on going 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 nurse 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 extragenital infection): **six months** prior to presentation
- Contacts identified should be offered full STI screening including HIV testing, and hepatitis B vaccination if 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 the likelihood of reattendance, recency of exposure and availability for patient to return to if result positive. 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 given a follow up interview by a SHA or nurse with SHA competencies (in person or by telephone) usually one week after treatment. If there are clinical complications then advise returning for review.

Check:-

- Compliance with therapy
- No sex during the course of their treatment and with anyone untreated
- If asymptomatic, no further investigations are required
- If <25yrs encourage re-testing at three 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 not preferred

Patients with persistent symptoms not responding clinically to treatment need evaluation and discussion with a senior GUM clinician

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). 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 05 April 2019]

BASHH Clinical Effectiveness Group (2015): UK national guideline for the management of infection with Chlamydia trachomatis. Available at : https://www.bashh.org/guidelines [accessed 05 April 2019]

BASHH Clinical Effectiveness Group (2013): UK National Guideline for the management of lymphogranuloma venereum. Available at : https://www.bashh.org/guidelines [accessed 05 April 2019]

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