Chlamydia

MANAGEMENT SUMMARY

TEST IF:

- Sexually active under 25 years
  - OR more than 2 partners in last year
  - OR has had an STI in past 12 months
  - OR has a sexual partner with an STI
- Pregnant
- Increased risk of complications of an STI, e.g. pre-termination of pregnancy (TOP) / intrauterine device (IUD) insertion
- Signs or symptoms suggestive of chlamydia
  - **Females:** Vaginal discharge / dysuria / pelvic pain / intermenstrual bleeding (IMB) / post-coital bleeding (PCB)
  - **Males:** Dysuria (urethritis) / urethral discharge / testicular pain / anal pain or discharge
- Requesting a sexual health check

Note: Most laboratories are automatically performing dual NAAT testing for chlamydia and gonorrhoea. False positive gonorrhoea results are possible in low prevalence populations – see NZSHS Management of Gonorrhoea 2014, and Response to the Threat of Antimicrobial Resistance.

RECOMMENDED TESTS by NAAT (e.g. PCR or SDA)

- It is recommended to test for co-existing STIs (see Sexual Health Check guideline www.nzshs.org/guidelines)
- **Females:**
  - A vulvovaginal NAAT swab prior to a speculum examination if symptomatic or needs examination
  - A self-collected vulvovaginal NAAT swab if asymptomatic, examination declined and no other tests required
  - Additional anorectal NAAT swab as indicated based on sexual history
  - **Note:** A first void urine has lower sensitivity in females than cervical or vaginal swabs so is not specimen of choice
- **Males:**
  - A first void urine (first 30ml of stream), preferably at least 1 hour after last passed urine
- **Men who have Sex with Men:**
  - **Additional anorectal and pharyngeal NAAT swabs** regardless of sexual practices as asymptomatic rectal and pharyngeal infection is common

Treat immediately if high index of suspicion, e.g. symptoms and/or signs, or contact of index case.

- Start treatment for patient and sexual partner(s) without waiting for lab results

MANAGEMENT

- Azithromycin 1g po stat (pregnancy category B1) – for uncomplicated urethral, cervical, pharyngeal infection and conjunctivitis
- Doxycycline 100mg po twice daily for 7 days **(NOT in pregnancy)** – for rectal infection, or as an alternative to azithromycin or highly symptomatic or on SSRI or QT-prolonging medication
- Amoxicillin 500mg po 3 times daily for 7 days (pregnancy category A) – alternative regimen in pregnancy if azithromycin contraindicated
- Advise to use condoms or abstain from sex for 7 days after initiation of treatment and until 7 days after all sexual contacts have been treated

PARTNER NOTIFICATION

- Be clear about language: 'partner' implies relationship – all sexual contacts in the last 2 months should be advised so they can have a sexual health check and treatment
- Contact(s) should have a sexual health check and if asymptomatic treat empirically for chlamydia with azithromycin 1g stat
- Contacts should be treated without waiting for their test results and advised to use condoms or abstain from sex for 7 days; if positive for an STI, refer to specific guideline
- Most choose to tell contacts themselves, giving written information is helpful
- Notifying all contacts may not be possible e.g. if there insufficient information or a threat of violence

FOLLOW-UP

- By phone or in person, 1 week later
- No unprotected sex in the week post-treatment?
- Completed/tolerated medication?
- Notifiable contacts informed?
- Any risk of re-infection?
- Test of cure only needed if pregnant, or if a second line treatment has been used, or if pharyngeal or rectal (extragenital) infection
- Diagnostic tests can detect traces of dead organisms – wait at least 5 weeks before retesting
- Re-infection is very common; offer repeat sexual health check in 3 months

Further guideline information – www.nzshs.org or phone local sexual health service.

This Best Practice Guide has been produced by NZSHS. Every effort has been taken to ensure that the information in this guideline is correct at the time of publishing (February 2015).

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