Aotearoa New Zealand STI Management Guidelines for Use in Primary Care

CHLAMYDIA

Cause

- Chlamydia is a sexually transmitted infection (STI) caused by *Chlamydia trachomatis*
- Serovars D-K cause urogenital infection, while serovars L1-L3 cause lymphogranuloma venereum (LGV)

Overview

- Infects endocervix, urethra, rectum and occasionally pharynx and conjunctivae
- **Transmission** is through
    - Contact with infected genital secretions
    - Sexual practices such as fingering which allow inoculation of infected secretions onto mucous membranes
    - Mother to baby at vaginal delivery
- **Chlamydia is most commonly diagnosed in**
    - Adolescents and young sexually active adults aged under 30 years
    - Sexual contacts of people with chlamydia
    - People who have multiple sexual contacts or a new sexual contact
    - People who have not consistently used condoms
    - Māori and Pacific Peoples

Clinical presentation

Site of infection	Signs and symptoms

Urethra	Approximately 50% are asymptomatic Dysuria Discharge (penile urethra)
Cervix	Approximately 75% are asymptomatic Vaginal discharge Post coital bleeding Intermenstrual bleeding
Anorectum	Often asymptomatic Discharge
Pharynx	Usually asymptomatic
Complications	
Epididymitis or epididymo-orchitis Pelvic inflammatory disease (PID), subfertility, chronic pelvic pain, ectopic pregnancy Reactive arthritis	

Indications for testing

- Patients with possible signs or symptoms of a chlamydia infection
- Sexual contacts of people with chlamydia or other STIs
- Pregnancy
- Before termination of pregnancy
- Before intrauterine device (IUD) insertion in people at risk of STIs
- Suspected epididymo-orchitis
- Suspected PID
- Sexually active patients aged under 30 years opportunistically when accessing health care
- Men who have sex with men (MSM)
- History of sexual assault or intimate partner violence
- If the patient requests a sexual health check

Note: If patient is asymptomatic and is concerned about a specific recent sexual event the recommended testing interval is 2 weeks from time of last unprotected sexual intercourse

If the patient is unlikely to return and has not been previously tested, then test opportunistically at the time of presentation and offer a re-test after the appropriate window period

Chlamydia is a common infection, however false positive results may occur in low prevalence populations – discuss with microbiologist or sexual health physician if unexpected positive result

Recommended tests
Symptomatic people should be examined

Testing for chlamydia should occur as part of a complete sexual health check

Management
Treatment options

Infection	Recommendation	Alternative
Uncomplicated genital or pharyngeal infection	Doxycycline 100 mg orally twice daily for 7 days	Azithromycin 1 g orally, as a single dose **Only if doxycycline is contraindicated, or patient is highly likely to be non-adherent**
Anorectal infection	Doxycycline 100 mg orally twice daily for 7 days if asymptomatic **Seek specialist advice if symptomatic, or refer to anorectal syndromes guideline**	Azithromycin 1 g orally, and repeat in 1 week **Only if doxycycline is contraindicated, or patient is highly likely to be non-adherent**

Special situations

Situation	Recommendations
Breastfeeding	Azithromycin 1 g orally, as a single dose
Pregnancy	Azithromycin 1 g orally, as a single dose Test of cure recommended 4 weeks after treatment completed Rescreen in 3rd trimester
Allergy or contraindications	If both treatment options unsuitable, seek specialist advice

Co-infection with gonorrhoea	Ceftriaxone 1g in 3.5 mL 1% lignocaine, intramuscular injection, as a single dose PLUS Doxycycline 100 mg orally twice daily for 7 days **Seek specialist advice if rectal co-infection and symptomatic, or refer to anorectal syndromes guideline**

- **Advise to abstain from sex or use condoms for 1 week from the start of treatment and until 1 week after sexual contact/s have been treated**
- If a patient has an IUD, leave it in place and treat as recommended. Seek specialist advice as needed
- Seek specialist advice if symptomatic anorectal infection, as further testing and extended treatment may be required
- Consider HIV pre-exposure prophylaxis (PrEP) if rectal chlamydia is diagnosed in a male or transgender person who has anal sex with men

Partner notification and management of sexual contacts

- 30-50% risk of transmission per act of unprotected intercourse
- Contact tracing is important to prevent re-infection and reduce transmission
- All sexual contacts in the last 3 months should be notified
- Most patients choose to tell contacts themselves; giving written information can be helpful
- Notifying all contacts may not be possible e.g. if there is insufficient information or a threat of violence

Management of sexual contacts

- Where the last sexual contact with the index case was within the past 2 weeks, or the contact is symptomatic, or unlikely to return for treatment, perform a full sexual health check, and treat for chlamydia without waiting for test results
- Where the last sexual contact with the index case was more than 2 weeks previously, and the contact is asymptomatic and likely to return for treatment, it would be reasonable to wait for test results, and treat only if

positive
- Advise contacts to abstain from sex or use condoms until results are available, and for 1 week from the start of treatment
- If contacts test positive for an STI refer to specific guideline
- Patient-delivered partner therapy is not legal in Aotearoa New Zealand

Follow up

Review in **1 week** (in person or by phone): • Discuss test results • Check symptoms (if any) have resolved • Ask if any condomless sex in the week post-treatment • Check medication was completed and tolerated • Ensure notifiable contacts have been informed • Check if any risk of re-infection. Retreatment is necessary if re-exposed to an untreated contact
Test of cure Not routinely recommended, unless in the following situations: • Pregnancy • Rectal chlamydia Test of cure by nucleic acid amplification test (NAAT) in these situations should be performed at least **4 weeks** after treatment is completed. An earlier test of cure could yield a false-positive result due to the presence of chlamydia DNA remnants
Retesting • Re-infection is common • Retesting at **3 months** is recommended, to detect re-infection Consider testing for other STIs, if not undertaken at first presentation, or retesting after the window period

Indications for specialist referral

Referral to or discussion with a sexual health specialist is recommended for:

- Screening and treatment of sexual contacts if clinician wishes
- Allergy or contraindication to standard treatment options
- Patients with anorectal symptoms that may be STI-related
- Complicated clinical situations for further management

Auditable outcomes

- 100% of patients diagnosed with chlamydia are treated with an appropriate antibiotic regimen
- 100% of patients are advised to avoid sexual contact for 7 days after treatment is commenced
- 100% of patient diagnosed with chlamydia have a recall for repeat testing in 3 months

Useful patient resources
Just the facts

Healthy Sex

Endorsement: These guidelines have been endorsed by the Blood Borne Viruses and Sexually Transmitted Infections Standing Committee (BBVSS).

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Funded by: The Australian Government Department of Health