

# 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
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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
<b>Complications</b>	
Epididymitis or <u>epididymo-orchitis</u> <u>Pelvic inflammatory disease (PID)</u> , 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  <b>Only if doxycycline is contraindicated, or patient is highly likely to be non-adherent</b>
Anorectal infection	Doxycycline 100 mg orally twice daily for 7 days if asymptomatic  <b>Seek specialist advice if symptomatic, or refer to <u>anorectal syndromes guideline</u></b>	Azithromycin 1 g orally, and repeat in 1 week  <b>Only if doxycycline is contraindicated, or patient is highly likely to be non-adherent</b>

#### 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 3 <sup>rd</sup> trimester
Allergy or contraindications	If both treatment options unsuitable, seek specialist advice

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