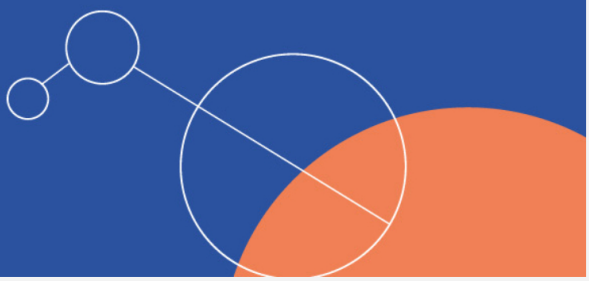
Chlamydia

Overview

- Chlamydia is the most commonly reported communicable disease in Australia.
- Those < 30 years are at greatest risk.
- Frequently asymptomatic.
- Simple to test and treat.
- Immunity to new infection is not provided by previous infection.



Cause

- *Chlamydia trachomatis* (See also *Lymphogranuloma venereum*)

Clinical presentation

Symptoms
85%-90% have no symptoms
• Dysuria • Penile urethral discharge • Vaginal discharge • Testicular pain • Pelvic Pain • Intermenstrual bleeding • Postcoital bleeding • Pain with sex - dyspareunia • Anorectal symptoms
Complications
• Epididymo-orchitis • Pelvic inflammatory disease (PID) • Infertility • Pregnancy - Ectopic pregnancy, Premature rupture of the membranes, preterm delivery, and low-birthweight infants • Reactive arthritis: arthritis, sometimes with concurrent rash and gastrointestinal symptoms • Cervicitis • Conjunctivitis • Perihepatitis

See STI Atlas for images.

Special considerations

May also infect the eye, anus and throat.

Diagnosis

Site/Specimen	Test	Consideration
Urethra First pass urine (FPU)	NAAT	In people who do not have a vagina or if endocervical swab/self-collected vaginal swab cannot be taken. Less sensitive than self-collected vaginal swab
Self-collected vaginal swab	NAAT	Best test if no speculum examination
Clinician-collected	NAAT	Best test if examined

endocervical swab		
Anorectal swab	NAAT	Any patient with anorectal symptoms All men who have sex with men Self-collection or during clinical examination
Pharyngeal swab	NAAT	All men who have sex with men.

NAAT – Nucleic acid amplification test

Specimen collection guidance

Clinician collected | Self-collection

Asymptomatic patients can collect most samples themselves, including vaginal swabs, anorectal and throat swabs.

Investigations

- NAATs are highly sensitive, can be used in non-clinical settings and are the only recommended test for chlamydia.
- For asymptomatic testing or where an examination is unable to be performed, encourage patient self-collection of vaginal swabs and anorectal swabs.
- Concurrent gonorrhoea testing should accompany chlamydia testing.

Management

Principal treatment options		
Infection	**Recommended**	**Alternative**
Uncomplicated genital or pharyngeal infection	Doxycycline 100 mg PO, BD 7 days	Azithromycin 1 g PO, stat.
Anorectal infection	Doxycycline 100 mg PO, BD for 7 days if asymptomatic, but 21 days if symptomatic (see anorectal syndromes)	Azithromycin 1 g PO, stat. and repeat in 12-24 hours

BD: twice a day

PO: orally

Stat.: immediately

Treatment advice

- See urethritis for immediate management of urethritis symptoms.
- Immediate treatment is not recommended for all sexual contacts of chlamydia but offer testing of exposed anatomical sites and await results.
- If contact treatment is initiated, use recommended treatment. Only use azithromycin if adherence likely to be poor or matches index case treatment. See Contact tracing below
- If a patient has an IUD, leave it in place and treat as recommended. Seek specialist advice as needed.

For symptomatic anorectal infection, see testing and treatment recommendations.

Other immediate management

- Advise no sexual contact for **7 days** after treatment is administered.
- Advise no sex with partners from the last **6 months** until the partners have been tested and treated if necessary.
- Contact tracing and patient delivered partner therapy (see contact tracing section for more information).
- Provide patient with factsheet.
- Notify the state or territory health department.

Special Treatment Situations

Special considerations

- Consider seeking specialist advice before treating any complicated presentation.

Situation	**Recommended**
Pregnant people	Azithromycin 1 g PO, stat.
Allergy to principal treatment choice	If both principal treatment options unsuitable, seek specialist advice.
Rectal co-infection	With gonorrhoea, treatment should be given for both infections i.e. ceftriaxone 500 mg IMI, stat. in 2 mL 1% lignocaine

	PLUS doxycycline 100 mg PO, BD 7 days if asymptomatic, but 21 days if symptomatic (see anorectal syndromes)

BD: twice a day

PO: orally

Stat.: immediately

IMI: intramuscular injection

Contact Tracing

- Notifiable condition
- Contact tracing is important to prevent re-infection and reduce transmission.
- All partners should be traced back for **6 months.**
- The diagnosing doctor is responsible for initiating and documenting a discussion about contact tracing.
- Offer testing of exposed anatomical sites to all sexual contacts.
- Consider presumptive treatment if there has been sexual contact within the past 2 weeks or when the person's individual circumstances mean later treatment may not occur.

Patient delivered partner therapy

- Patient delivered partner therapy is a partner notification and treatment method whereby antibiotic treatment is prescribed or supplied for the sexual partner/s of a patient diagnosed with chlamydia infection (index patient). The index patient delivers the prescription or treatment to their partner/s.
- Consider using patient delivered partner therapy which is approved in some jurisdictions for heterosexual index patients with anogenital or oropharyngeal chlamydia whose partners are unlikely to seek chlamydia testing or treatment, or with repeat infections whose partners have not been treated.
- Patient delivered partner therapy guidance is available in Victoria, NSW, and the NT.

See Australasian Contract Tracing Guideline– Chlamydia, for more information.

Follow Up

- To confirm patient adherence with treatment and assess for symptom resolution.
- To confirm contact tracing procedures have been undertaken or offer more contact tracing support.
- To provide further sexual health education and prevention counselling.

Test of cure

Not routinely recommended, except for:

- Pregnant people
- Anorectal infection treated with Azithromycin

Test of cure by nucleic acid amplification test (NAAT) in these situations should be performed no earlier than **4 weeks** after treatment is completed to prevent false positive result due to persistent chlamydia DNA.

Test for re-infection

- 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.

Auditable Outcomes

- 100% of patients diagnosed with chlamydia are treated with an appropriate antibiotic regimen.

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

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