CHLAMYDIA

Key Points

- First-line treatment is doxycycline which should be used unless there are clear contra-indications.
- New dose amendments to second line and third line treatments
- Clarification around confirmed pregnancy.
- In those with ongoing pregnancy or rectal chlamydia, test of cure should be taken a minimum of three weeks after completion of treatment and then at 36 weeks gestation.

Diagnosis of Chlamydial Infection:

All Chlamydia tests in NHSGGC use the Abbott RealTime PCR which tests 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 additional relevant swabs.

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 is used primarily for GC testing but due to dual testing of testing pharynx chlamydia test is also performed. 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 and lubricant: When taking swabs during speculum examination or proctoscopy, lubricant to be used sparingly to avoid contaminating the sample (certain lubricants can interfere with NAAT tests)

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 an appropriately trained clinician with the support of sexual health advisers (SHA). Often this will be done via telephone.

Uncomplicated Genital Chlamydial Infection:

Doxycycline 100mg BD x SEVEN days (cure rate 98%) (contra-indicated in pregnancy, see pregnancy section)

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

QT prolongation: Certain medications including fluconazole, macrolide and quinolone antibiotics cause QT prolongation and should not be prescribed with interacting medications. This is unlikely to be of clinical significance for STAT doses but is important for longer courses. Please use BNF Interaction Checker to ensure these medications are safe to prescribe for your patient and discuss with a senior colleague if necessary.

Alternative regime (if azithromycin and doxycycline contraindicated): Erythromycin 500mg BD for 7 days; Levofloxacin 500mg once a day for 7 days; Ofloxacin 200mg BD/400mg OD 7 days. Please note current MHRA restrictions on prescribing quinolones, please speak to GUM DoD (contraindicated in pregnancy)

Uncomplicated genital infection is not an indication for removal of IUCD, however any infection should be treated prior to an IUCD insertion or change.

Pharyngeal Infection:
Follow recommendations for genital chlamydia.

Rectal Infection:
LGV testing: If **symptomatic** (**proctitis)** or known **HIV positive** please indicate on Sunquest clinical details and ask for 'LGV PCR if Chlamydia positive'. All positive rectal chlamydia in MSM with HIV should have an LGV request submitted. When supplying 3 weeks of doxycycline, please hand in the clinic number to the SHA office to check if chlamydia or LGV negative and advise patient to stop antibiotics accordingly. SHA to email lab when positive rectal Chlamydia reported to check LGV test requested.

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 negative patients:

- *If patient is returning for treatment after initial screening ensure that they have not developed symptoms in the intervening period.*
- *See separate GBMSM protocol for advice on symptomatic rectal Chlamydia/ LGV treatment*
- *Proctitis in women should be treated the same*

Doxycycline 100mg po BD x SEVEN days
(contra-indicated in pregnancy, see pregnancy section)

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 people living with HIV and symptomatic rectal infection in all patients

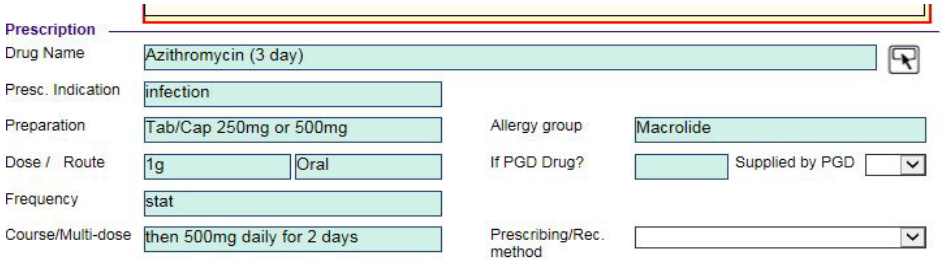
Doxycycline 100mg po BD x 21 days (or until LGV- negative result)
(contra-indicated in pregnancy, see pregnancy section)

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

People living with HIV with or without symptoms and those with symptoms of proctitis are more likely to have LGV infection. Treatment can be stopped if an LGV result returns as negative. If they don't wish to take 3 weeks of treatment, they must return for a ToC.

In all cases, the patient details should be passed to the SHA office to monitor the result and advise the patient as early as possible of a negative result in order to avoid unnecessary length of antibiotic treatment

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 (confirmed)
See 'Pregnancy and STIs' protocol. Doxycycline use remains contraindicated in confirmed pregnancy. If someone is at risk if pregnancy i.e. recent UPSI in absence of a confirmed test then a clinical judgment should be made as to risk. Women with an ongoing 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.

BASHH guideline notes that adverse outcomes are unlikely with the 2g azithromycin total dose but that women should be advised of lack of data. IUSTI Europe recommend: Azithromycin first line; Amoxicillin 500mg three times daily for 7 days or Erythromycin 500mg four times daily for 7 days second line; or doxycycline 100mg twice daily for 7 days third line. BASHH position statement notes that doxycycline appears safe when used in the first trimester of pregnancy (all courses should be completed prior to 15 weeks' gestation), however the data is limited so a suitable alternative should be used wherever possible. They also recommend practitioners report exposure to UKTIS at Reporting an exposure – UKTIS

Breastfeeding
First line treatment is with azithromycin. Doxycycline is contraindicated in breastfeeding- (BNF,SPC). Discuss treatment options if macrolides are contraindicated with GUM DoD.

Partner Notification:
- All patients diagnosed with chlamydia infection should have a partner notification documented
    - Male index case with genital symptoms: **four weeks** prior to symptom onset
    - All other cases (all women, asymptomatic men and men with extra-genital infection): **six months** prior to presentation.
- Contacts identified should be offered full STI screening including HIV testing, and vaccinations as indicated.
- All current partner(s) should be treated for chlamydia, irrespective of their test results to reduce risk of reinfection of the index case.
- Past contacts identified should be offered a test. Treatment could be considered based on how recent the exposure and the likelihood of re-attendance. 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:
Referral should be made to SHA to review the case and determine whether further follow up is necessary. All patients should be added to SC SHA Telephone at 2 weeks after treatment.

SHA will complete PN and contact the client either by phone or text to enquire about compliance.

If <25yrs encourage re-testing at three months (as 10-30% of young people are re-infected with Chlamydia within 3 months). Patients should be added to SC SHA Re-Test for an automated text reminder at 3 months.

Test of cure (ToC) is only indicated in rectal chlamydia or in ongoing pregnancy (retest at minimum 3 weeks after treatment and at 36 weeks' gestation). ToC may be considered with suspected poor compliance where retreatment is not preferred.

Patients with persistent symptoms not responding clinically to treatment need evaluation and discussion with GUM DoD.

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) and request 'Eye PCR screen' on ICE. 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. For infant index cases refer to SHA.

Management
Involve ophthalmology team if not already done (see SharePoint 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 first line; azithromycin second line (IUSTI). **It is essential that all clients with chlamydial conjunctivitis and their sexual partners are tested and treated for concomitant chlamydial genital tract infection**. Refer to SHA team as per genital Chlamydia guidelines.

DoxyPEP

Do not defer STI testing because someone has recently taken DoxyPEP.

Refer to DoxyPEP protocol for further guidance on prevention options once in place or discuss with GUM DoD.

References

BASHH Clinical Effectiveness Group (2024): BASHH position statement on doxycycline use in pregnancy [accessed June 2025]

BASHH Clinical Effectiveness Group (2018): Update on treatment of Chlamydia trachomatis infection Available at: https://www.bashh.org/guidelines [accessed June 2025]

BASHH Clinical Effectiveness Group (2015): UK national guideline for the management of infection with Chlamydia trachomatis. Available at: https://www.bashh.org/guidelines [accessed June 2025]

BASHH Clinical Effectiveness Group (2013): UK National Guideline for the management of lymphogranuloma venereum. Available at: https://www.bashh.org/guidelines [accessed June 2025]

IUSTI Europe (2025). European Guideline on the management of Chlamydia Trachomatis infection Available at: https://iusti.org/treatment-guidelines/ [accessed 17 June 2025]