

CHLAMYDIA TRACHOMATIS V2.0

Comments from the Expert Advisory Group

1. Chlamydia, caused by *Chlamydia trachomatis*, is the most common STI reported in Ireland with almost half of cases diagnosed in those aged between 15 and 24 years.
2. Chlamydia is commonly asymptomatic in both males and females. Symptoms in males include dysuria and a urethral discharge. Symptoms in women include [vaginal discharge](#), intermenstrual bleeding and post coital bleeding.
3. Infection can lead to [epididymo-orchitis](#) in males.
4. Infection can lead to [pelvic inflammatory disease \(PID\)](#) in females. PID is associated with an increased risk of tubal factor infertility, ectopic pregnancy and chronic pelvic pain.
5. Diagnosis using NAAT (nucleic acid amplification technique), e.g. PCR (polymerase chain reaction), is the current diagnostic gold standard. This is frequently combined with a gonorrhoea NAAT in the same test.
6. Diagnosis can be made on first void urine in males and vulvovaginal or endocervical swab (less sensitive) in females. Vulvovaginal swabs can be provider or self-taken. The clinical utility of routine rectal and pharyngeal chlamydia testing is not yet established and therefore at this time it is not routinely recommended for all.
7. In sexually active gay, bisexual and other men who have sex with men (gbMSM), three site STI testing (first void urine, pharyngeal and rectal) is recommended for all, regardless of history or clinical picture. Rectal infection with invasive chlamydia types (Lymphogranuloma, LGV types - see note below for further information) can lead to severe proctitis presenting with rectal bleeding, anal pus, tenesmus and pain. gbMSM with severe proctitis symptoms should be referred promptly to GUM or ID specialist services.
8. Test of cure is not routinely required but is recommended in rectal infection, pregnancy and in women with an intrauterine device. If doing a test of cure, wait until at least 3 weeks post completion of treatment.
9. Individuals diagnosed with chlamydia should be offered testing for other STIs including HIV, hepatitis B, syphilis and gonorrhoea.
10. [Hepatitis C \(HCV\) testing](#) should be considered part of routine sexual health screening in the following circumstances: gbMSM; People living with HIV; Commercial sex workers; people who inject drugs (PWID). Partners of the above should also be considered for HCV testing.
11. A diagnosis of chlamydia in gbMSM should prompt a discussion about HIV prevention including [pre-exposure prophylaxis \(PrEP\)](#).
12. Sexual partners in the preceding 6 months should be informed of the need for testing and patients should be encouraged to inform their sexual partners. Sexual partners in the two week [window period](#) after last sexual contact may have a false negative result and should be empirically treated for chlamydia.
13. Advise no sexual contact until after completion of treatment or, where indicated (see above), after negative test of cure no sooner than 3 weeks after treatment.
14. Seek specialist (GUM Clinician / Infectious Diseases / Obstetrics / Microbiology) advice in cases of chlamydia in pregnant or breastfeeding patients.
15. Chlamydia is a [notifiable disease](#). Notification process is usually initiated by the testing laboratory.

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Notes:

Lymphogranuloma venereum (LGV) is caused by an invasive serovar of chlamydia (L1, L2, L3). L2 is the main serovar causing outbreaks in Ireland. LGV may be asymptomatic or may present with haemorrhagic proctitis, lymphadenopathy, or genital ulceration. Differential diagnosis such as herpes simplex and syphilis should be considered. Indications for LGV testing include gbMSM presenting with rectal symptoms and confirmed rectal chlamydia in gbMSM living with HIV. LGV testing is done on the same sample taken for chlamydia testing. Treatment is oral doxycycline 100 mg every 12 hours for three weeks. Patients should be referred to a sexual health service. Routine test of cure is no longer indicated if there has been full compliance with treatment and if symptoms have resolved.

Treatment

Azithromycin therapy should only be considered if doxycycline is contraindicated. Doxycycline is effective in treatment of *C. trachomatis* infections of urogenital, rectal, and oropharyngeal sites, whereas azithromycin is less efficacious than doxycycline in the treatment of pharyngeal and rectal chlamydia. Azithromycin therapy is also associated with macrolide resistance in *Mycoplasma genitalium* and high-level azithromycin resistance in gonorrhoea. If azithromycin therapy is indicated, single dose azithromycin is not recommended; a three day course is required.

UNCOMPLICATED CHLAMYDIA (GENITAL, RECTAL AND PHARYNGEAL) ANTIMICROBIAL TREATMENT TABLE

Drug	Dose	Duration	Notes
1st choice option			
Doxycycline	100 mg every 12 hours	7 days	Contraindicated in pregnancy. Risk of photosensitivity. Advise to take with a glass of water and sit upright for 30 minutes after taking. Absorption significantly impaired by antacids, iron/ calcium/ magnesium/zinc. Separate by at least 3 hours.
2nd choice option (if doxycycline contraindicated)			
Azithromycin	1 gram as a single dose on day 1, followed by 500 mg every 24 hours (day 2 & day 3)	3 days	Single dose Azithromycin is not recommended. See Macrolide warning and check drug interactions before prescribing. Tablets: Take with or without food. Take 1 hour before or 2 hours after antacids. Capsules: Take 1 hour before or 2 hours after food/ antacids.

Seek specialist (GUM Clinician / Infectious Diseases / Obstetrics / Microbiology) advice in cases of chlamydia in pregnant or breastfeeding patients.

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Patient Information

- [Chlamydia patient information leaflet](#)
- [Information on the free HSE home STI testing service.](#)