Submission to the Ministry of Health

Draft Chlamydia Management Guidelines: January 2008

The College of Nurses Aotearoa (NZ) welcomes the opportunity to respond to the Draft Chlamydia Management Guidelines circulated by the Ministry of Health. We thought the document was very good - clear, concise, and comprehensive.

We do have some minor suggestions relating to the document and these are as follows (with suggestions in red):

Page vi Recommendations

Add an additional recommendation:
9. Routine antenatal screening for 15-24 year olds.

Page 5 Biology and Pathology

Complications of repeated chlamydial infection include pelvic inflammatory disease (PID), ectopic pregnancy, tubal infertility, rarer complications such as Fitz-Hugh-Curtis Syndrome and proctitis.

Page 9 Asymptomatic women

- *Urine:* urine specimens can be used provided care is taken in collecting the sample. To achieve an adequate urine specimen, the urine must be the 'first catch' of urine (FCU, the first 10–20 ml of urine that is voided), and the patient must ideally should not have passed urine during the previous 1–2 hours. The sensitivity of urine (92%) is slightly lower than for vulvo-vaginal swabs or endocervical swabs (97%) (Skidmore et al 2006), but is more convenient to obtain and less intrusive to the patient.

Page 11 **Symptomatic individuals**

- **Women**
  - vaginal discharge
  - post-coital and/or intermenstrual bleeding and overdue periods

Page 12 Testing to prevent sequelae of untreated chlamydial infection

- *Pregnancy:* there is a 20–50% risk of neonatal transmission in women who have untreated chlamydial infection at delivery (see risk assessment). Possible neonatal complications include conjunctivitis and pneumonitis. A risk of prematurity from

early onset of labour is an additional neonatal complication. Mothers are prone to post natal infections.

Page 13 Summary

- men who have sex with men (offer test annually or when there has been a change in sexual contact).
- Long term partners but with a recent sexual contact outside of relationship, or a partner who has had sex outside the relationship.

Page 14 Selective testing and chlamydia risk factors

Receptionists (are a barrier to health services and are in a public area) and/or nurses could play a key role in identifying these women, who could then be offered a chlamydia test.

Page 15 Selective testing and chlamydia risk factors

- inconsistently used condoms if they are not in a stable monogamous relationship and if they have not been screened since starting this relationship.

Page 16 Treatment of uncomplicated infection

For uncomplicated infection the recommended treatment is azithromycin, 1 g stat, because it is the simplest regimen to administer and can act as a 'directly observed' form of therapy. To maximise compliance, medications for chlamydial infections should be dispensed *on site* wherever possible however there can be gastro-intestinal upset so it is often more practical to give the patient the medication to take after food in the evening. Primary care practitioners can order azithromycin on Medical Practitioner Supply Order (MPSO) to facilitate treatment on site.

Further Recommendation:

"All pregnant women should be routinely tested for *Chlamydia trachomatis* (see Chlamydia Infections, Diagnostic Considerations) at the first prenatal visit. Women aged < 25 years and those at increased risk for chlamydia (i.e. women who have a new or more than one sex partner) also should be retested during the third trimester to prevent maternal postnatal complications and chlamydial infection in the infant. Screening during the first trimester might prevent the adverse effects of chlamydia during pregnancy, but supportive evidence for this is lacking. If screening is performed only during the first trimester, a longer period exists for acquiring infection before delivery"

Taken from CDC Sexually Transmitted Diseases Treatment Guidelines 2006

Thank you for the opportunity to comment on these guidelines.