Complete Summary

GUIDELINE TITLE

2006 UK national guideline for the management of genital tract infection with *Chlamydia trachomatis*.

BIBLIOGRAPHIC SOURCE(S)

Horner PJ, Boag F. 2006 UK national guideline for the management of genital tract infection with Chlamydia trachomatis. London (UK): British Association of Sexual Health and HIV (BASHH); 2006. 24 p. [76 references]

GUIDELINE STATUS

This is the current release of the guideline.

This guideline updates a previous version: Association for Genitourinary Medicine (AGUM), Medical Society for the Study of Venereal Disease (MSSVD). 2002 national guideline for the management of *Chlamydia trachomatis* genital tract infection. London: Association for Genitourinary Medicine (AGUM), Medical Society for the Study of Venereal Disease (MSSVD); 2002. Various p.

** REGULATORY ALERT **

FDA WARNING/REGULATORY ALERT

Note from the National Guideline Clearinghouse (NGC): This guideline references a drug(s) for which important revised regulatory and/or warning information has been released.

- July 08, 2008, Fluoroquinolones (ciprofloxacin, norfloxacin, ofloxacin, levofloxacin, moxifloxacin, gemifloxacin): A BOXED WARNING and Medication Guide are to be added to the prescribing information to strengthen existing warnings about the increased risk of developing tendinitis and tendon rupture in patients taking fluoroquinolones for systemic use.

COMPLETE SUMMARY CONTENT

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SCOPE

DISEASE/CONDITION(S)

Chlamydia trachomatis genital tract infection

GUIDELINE CATEGORY

Diagnosis
Evaluation
Management
Prevention
Treatment

CLINICAL SPECIALTY

Infectious Diseases
Obstetrics and Gynecology
Urology

INTENDED USERS

Physicians

GUIDELINE OBJECTIVE(S)

- To reduce the number of sexually transmitted infections and complications of *Chlamydia trachomatis* genital tract infection
- To offer recommendations on the diagnostic tests, treatment regimens, and health promotion principles needed for the effective management of *Chlamydia trachomatis*

TARGET POPULATION

Men and women in the United Kingdom aged 16 year or older either presenting with signs and symptoms of a sexually transmitted infection or undergoing investigation for possible *Chlamydia trachomatis* genital tract infection

INTERVENTIONS AND PRACTICES CONSIDERED

Diagnosis

1. Nucleic acid amplification techniques (NAAT)
2. Cell culture (routine use not recommended)

3. Direct fluorescent antibody (DFA) (not recommended routinely)
4. Enzyme immunoassays (EIA) (not recommended routinely)

Treatment/Management

1. Antibiotics including doxycycline, azithromycin, erythromycin, ofloxacin, Deteclo, oxytetracycline, amoxicillin
2. Patient education
3. Partner notification
4. Follow-up, including test of cure in pregnant women or if noncompliance or re-exposure is suspected

MAJOR OUTCOMES CONSIDERED

- Sensitivity and specificity of diagnostic tests
- Microbiological cure rate
- Partner notification rate

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

An extensive literature review was carried out using Medline searches for the years 1970 to 2001 using keywords "Chlamydia trachomatis" in association with "polymerase chain reaction" or "PCR" or "ligase chain reaction" or "lcr" or "lcx" and "immunoenzyme techniques" or "enzyme linked immunosorbent assay." "Chlamydia trachomatis" combined with the following keywords: "detection," "diagnosis," "treatment." The Cochrane Library: "Chlamydia trachomatis." This literature search was updated in 2005 and included "nucleic acid amplification technique," "Aptima," "Probetec" and "SDA".

NUMBER OF SOURCE DOCUMENTS

Not stated

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Weighting According to a Rating Scheme (Scheme Given)

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Levels of Evidence

Ia

- Evidence obtained from meta-analysis of randomised controlled trials

Ib

- Evidence obtained from at least one randomised controlled trial

IIa

- Evidence obtained from at least one well designed controlled study without randomisation

IIb

- Evidence obtained from at least one type of well designed quasi-experimental study

III

- Evidence obtained from well designed, non-experimental descriptive studies, such as comparative studies, correlation studies, and case control studies

IV

- Evidence obtained from expert committee reports or opinions and/or clinical experience of respected authorities

METHODS USED TO ANALYZE THE EVIDENCE

Review of Published Meta-Analyses
Systematic Review

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Not stated

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

This guideline has been produced by medical specialists from relevant disciplines with input from patients attending United Kingdom genitourinary medicine (GUM) clinics.

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Grading of Recommendations

A (Evidence Levels Ia, Ib)

- Requires at least one randomised controlled trial as part of the body of literature of overall good quality and consistency addressing the specific recommendation

B (Evidence Levels IIa, IIb, III)

- Requires availability of well conducted clinical studies but no randomised clinical trials on the topic of recommendation

C (Evidence Level IV)

- Requires evidence from expert committee reports or opinions and/or clinical experience of respected authorities
- Indicates absence of directly applicable studies of good quality

COST ANALYSIS

Published cost analyses were reviewed.

It is estimated that complications cost at least 100 million pounds sterling annually in the United Kingdom. The majority of health economic valuations demonstrate that chlamydia screening is cost effective.

METHOD OF GUIDELINE VALIDATION

External Peer Review
Internal Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

The initial versions of the guidelines were sent to the following for review:

- Clinical Effectiveness Group (CEG) members
- Chairs of UK Regional GU Medicine Audit Committees who had responded to an invitation to comment on the guidelines
- Chair of the Genitourinary Nurses Association (GUNA)
- President of the Society of Health Advisers in Sexually Transmitted Diseases (SHASTD)
- Clinical Effectiveness Committee of the Faculty of Family Planning and Reproductive Health Care (FFP)

Successive drafts have been reviewed by Genitourinary Medicine (GUM) patients, GUM physicians, nurses, health advisers, and key professional organisations.

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

Levels of evidence (I-IV) and grades of recommendation (A-C) are defined at the end of the "Major Recommendations" field.

Diagnosis

- Although the technology for diagnosing *Chlamydia trachomatis* continues to be a rapidly developing field, the standard of care for all cases, including medico legal cases, is a nucleic acid amplification technique (NAAT).
- NAATs are more sensitive and specific than enzyme immunoassays (EIAs) and the Department of Health has recently advised that the use of sub-optimal EIAs is no longer appropriate and has provided funding to support laboratories moving from EIAs to NAATs (Department of Health, 2003). However no test is 100% sensitive or specific (Skidmore, Horner, & Mallinson, 2006).
- Reactive tests should be confirmed in the laboratory either using the same NAAT platform but if possible a second platform is to be preferred (Skidmore, Horner, & Mallinson, 2006; Health Protection Agency, 2004). This improves specificity by countering processing errors but at the expense, which is usually judged acceptable, of a small reduction in sensitivity caused by specimens with a low organism load being missed at re-test (Skidmore, Horner, & Mallinson, 2006). Thus therapy should be offered to all patients with unconfirmed reactive NAAT results but the significance of this result must be discussed with them (Johnson et al., 2002). The laboratory report should request an additional specimen for further testing when reporting an unconfirmed reactive test, but this may be not be possible (Skidmore, Horner, & Mallinson, 2006; Health Protection Agency, 2004).
- An inhibitory control should be used for each specimen (Skidmore, Horner, & Mallinson, 2006; Health Protection Agency, 2004) as substances may be present in biological fluids which can inhibit NAATs. Failure to use an inhibitory control with each specimen will lead to false negative results (Horner et al., 2005; Mahony et al., 1998; Chong et al., 2003). The Gen-Probe APTIMA system includes a nucleic acid extraction stage which removes the majority of inhibitors and thus the manufacturers state that no inhibitory control is needed (Chong et al., 2003).
- In general NAATs are 90 to 95% sensitive with the majority of studies indicating that as either the number of sites sampled increases, or the number of different NAAT used increases, the greater the detection of *C. trachomatis* in any given population.

Sites to Be Sampled

Women

- A cervical swab (Grade of Recommendation B) or vulvo-vaginal swab (Grade of Recommendation C) are specimens of choice. To collect cervical specimens, a speculum examination is performed and as the sample must contain cervical columnar cells (Loeffelholz et al., 2001; Welsh, Quinn, & Gaydos, 1997), swabs should be inserted inside the cervical os and firmly rotated against the endocervix. Inadequate specimens reduce the sensitivity of NAATs.
- The vulvo-vaginal swab has a sensitivity of 90 to 95% (Carder et al., 1999; Macmillan et al., 2000; Wiesenfeld et al., 1996; Gaydos et al., 2003) and can

be either taken by the patient or health care worker (Schachter et al., 2003). Studies indicate that sensitivities similar to a cervical swab are obtainable. Currently, only the APTIMA system (Gen-Probe Inc., San Diego, CA) has U.S. Food and Drug Administration (FDA) approval for this specimen type.

- If a speculum examination is not possible then urine (Grade of Recommendation B) samples can be utilized.
- Variable sensitivities (65 to 100%) have been reported using the first catch urine (FCU) specimen (McCartney, Walker, & Scoular, 2001; Schachter et al., 2003; Van Der Pol et al., 2001; Jensen, Thorsen, & Moller, 1997; Moncada et al., 2004). When processed by inexperienced staff it may perform with sensitivity <90% (Schachter et al., 2003). Patients should hold their urine for at least 1 hour (Johnson et al., 2002) (maybe 2 hours with some kits, check manufacturer's instructions) before providing a FCU specimen.

Men

- First voided urine sample is reported to be as good as a urethral swab. (Van Der Pol et al., 2001; Chernesky et al., 2005; Crotchfelt et al, 1997; Young et al, 1998; Sugunendran et al., 2001) Urine samples are easy to collect, do not cause discomfort and thus are preferable to urethral swabs. Urethral swabs should be inserted 2 to 4 cm inside the urethra and rotated once before removal (Grade of Recommendation C).
- Patients should hold their urine at least 1 hour before being tested (Johnson et al., 2002), (maybe 2 hours with some kits, check manufacturer's instructions).

Rectal, Pharyngeal and Conjunctival Specimens, Men and Women

- Currently none of the NAATs have FDA approval for these sites. Only culture or direct fluorescent antibody (DFA) are recommended (Grade of Recommendation A). However, in the absence of culture or DFA tests, NAATs may be used (Grade of Recommendation C).

  Rectal swabs should be obtained via proctoscopy in symptomatic patients, but can be taken blind from the rectal mucosa in asymptomatics.

- Due to the emergence of rectal Lymphogranuloma venereum (LGV) infection in men who have sex with men (French, Ison, & Macdonald, 2005), the current (2006) recommended method of detecting rectal LGV infection is to perform a rectal NAAT which, if positive, is sent to the Health Protection Authority for confirmation.

Medico Legal Cases

For medico legal cases a NAAT should be taken from all the sites where penetration has occurred. This guideline recommends NAAT rather than culture due to the low sensitivity (60 to 80%) of culture and its lack of availability in many centres (Grade of Recommendation D).

- A reactive NAAT result must be confirmed using a different NAAT (Johnson et al., 2002). Ideally, two swabs should be taken from each site, one for testing

and one for confirmation if the initial test is positive. This avoids potential compatibility problems when retesting specimens using a different platform (Skidmore, Horner, & Mallinson, 2006). There is evidence that the Becton Dickinson ProbeTec ET strand displacement amplification (SDA) assay has a lower analytical sensitivity than Roche Cobas Amplicor PCR (Chalker et al., 2005) for some serotypes, which means that SDA may not be suitable for the confirmation of PCR results. There are also data to suggest that Gen-Probe APTIMA system has a higher sensitivity than the other two assays discussed (Schacter et al., 2005). Although, this system does have its own confirmatory assay with matching sensitivity it uses the same methodology, on the same specimen, thus theoretically some causes of false positives may not be eliminated (Johnson et al., 2002).

Cell Culture

- Sensitivity 60 to 80%
- 100% specificity
- Expertise essential
- Expensive—and only limited availability nationally
- Can be used on all specimen types
- Routine use is not recommended due to high cost and low sensitivity.

Enzyme Immunoassays (EIAs)

- The sensitivity of the majority of EIAs is probably only 40 to 70% and their use is not recommended. This guideline recommends laboratories to move to the use of NAATs utilizing Department of Health dedicated funding (Westrom, 1994).
- Should be not used on non-invasive specimens in women, nor on rectal or throat specimens in women or men.

Direct Fluorescent Antibody (DFA)

- Routine use is not recommended.
- Labour intensive, and although a >80% sensitivity is achievable, this requires skilled personnel using a cut off of 2 elementary bodies.
- Unsuitable for large numbers of specimens (>30/day).
- Will accommodate all specimen types including rectal and pharyngeal

Management

General Advice

Ideally, treatment should be effective (microbiological cure rate >95%), easy to take (not more than twice daily), with a low side effect profile, and cause minimal interference with daily lifestyle (Grade of Recommendation C). Uncomplicated genital tract infection with *C. trachomatis* is not an indication for removal of an intrauterine system (IUS) or intrauterine device (IUD).

Patients should be advised to avoid sexual intercourse (including oral sex) until they and their partner(s) have completed treatment (or wait 7 days if treated with

azithromycin). Advice regarding appropriate action if using hormonal contraceptives is also required.

Patients should be given detailed explanation of their condition with particular emphasis on the long–term implications for them and their partner(s). This should be reinforced by giving them clear, accurate written information.

Further Investigation

All patients diagnosed with *C .trachomatis* should be encouraged to have screening for other sexually transmitted infections (STIs), including a human immunodeficiency virus (HIV) test and, where indicated, hepatitis B screening and vaccination (Grade of Recommendation C). If the patient is within the window period for HIV and syphilis, these should be repeated at an appropriate time interval. All contacts of *C. trachomatis* should be offered the same screening tests.

Treatment of Genital, Rectal and Pharyngeal Uncomplicated Infection (see appropriate guidelines for treatment of complications) and Epidemiological Treatment

Recommended Regimens (Grade of Recommendation A)

- Doxycycline 100 mg twice a day (bd) for 7 days (contraindicated in pregnancy)

  or

- Azithromycin 1 g orally in a single dose

Alternative Regimens (Grade of Recommendation A)

- Erythromycin 500 mg bd for 10 to 14 days

  or

- Ofloxacin 200 mg bd or 400 mg once a day for 7 days

Studies of Anti-Microbial Efficacy

Doxycycline and Azithromycin

For information on the studies of the efficacy of azithromycin and doxycycline, see the original guideline document.

Other Anti-Microbials

The information from published studies on efficacy of other anti-microbials is considerably less than that available for azithromycin and doxycycline. It should not be assumed that these are more efficacious than either doxycycline or azithromycin.

Ofloxacin (Grade of Recommendation B)

- It is unknown whether 200 mg twice a day is superior to 400 mg once a day (Kitchen et al., 1990).
- Ofloxacin has similar efficacy to doxycycline and a better side-effect profile but is considerably more expensive, so is not recommended as first-line treatment.
- Resistance to ofloxacin has been demonstrated in vivo and in vitro, but appears to be rare (64).
- No long term follow up (>6 weeks) data.

Erythromycin (Grade of Recommendation A)

- Erythromycin is less efficacious than either azithromycin or doxycycline.
- When taken four times a day, 20 to 25% may experience side effects sufficient to cause the patient to discontinue treatment (Linneman, Heaton, & Ritchey, 1987).
- There are only limited data on erythromycin 500 mg twice a day, with efficacy reported to be between 73 and 95%. A 10 to 14 day course appears to be more efficacious than a 1-week course of 500 mg twice a day, with a cure rate >95% (Tobin, Harindra, & Mani, 2004; Ross, Crean, & McMillan, 1996).
- Resistance to erythromycin has been demonstrated in vivo and appears to be rare. It has not been documented to be significant in vivo.

Other Tetracyclines (Grade of Recommendation A)

- "Deteclo" (registered trademark) is probably as efficacious as doxycycline (Munday et al., 1995). However, photosensitivity occurs more frequently and there are insufficient data on efficacy if compliance is poor.
- Oxytetracycline 500 mg bd 10 days has also been shown to be effective (Tobin, Harindra, & Mani, 2004)

Pregnancy and Breast Feeding

Recommended Regimens (Grade of Recommendation A)

- Erythromycin 500 mg four times a day for 7 days

  or

- Erythromycin 500 mg twice a day for 14 days

  or

- Amoxicillin 500 mg three times a day for 7 days

  or

- Azithromycin 1 g stat (see caution below from the British National Formulary [BNF])

Due to higher positive chlamydia tests after treatment in pregnancy, attributed to either less efficacious treatment regime, non compliance, or re-infection, it is recommended that pregnant woman must have a test of cure 5 weeks after completing therapy, 6 weeks later if given azithromycin.

- Doxycycline and ofloxacin are contraindicated in pregnancy
- Azithromycin is probably less than 95% effective (Jacobson et al., 2001; Kacmar et al., 2001; Brocklehurst & Rooney, 2000). The safety of azithromycin in pregnancy and lactating mothers has not yet been fully assessed, although available data indicate that it is safe (Brocklehurst & Rooney, 2000). World Health Organization (WHO) Guidelines recommend 1 g stat to treat *C. trachomatis* in pregnancy; the BNF recommends its use in pregnancy and lactation only if no alternative is available.
- Erythromycin has a significant side effect profile and is less than 95% effective. There are no trials of erythromycin 500 mg twice a day for 14 days, which would be better tolerated than four times a day although the follow-up data from the Portsmouth pilot study suggests it is efficacious (Tobin, Harindra, & Mani, 2004).
- Amoxycillin had a similar cure rate to erythromycin in a meta-analysis and had a much better side effect profile (Brocklehurst & Rooney, 2000). However, penicillin in vitro has been shown to induce latency and re-emergence of infection at a later date is a theoretical concern of some experts.

Compliance with Therapy

In general, compliance with therapy is improved if there is a positive therapeutic relationship between the patient and the doctor (Sanson-Fisher, Bowman, & Armstrong, 1992) and/or nurse.

This can probably be improved if the following are applied (Grade of Recommendation C):

Discuss with patient and provide clear written information on:

- What *C. trachomatis* is and how it is transmitted
    - It is primarily sexually transmitted.
    - If asymptomatic there is evidence that it could have persisted for months or years.
- The diagnosis of *C. trachomatis*, particularly
    - It is often asymptomatic in both men and women.
    - Whilst tests are accurate, no test is absolutely so.
- The complications of untreated *C. trachomatis*
- Side effects and importance of complying fully with treatment and what to do if a dose is missed
- Advice regarding antibiotics and hormonal contraception
- The importance of their sexual partner(s) being evaluated and treated
- Advice to abstain from sexual intercourse until they and their partner(s) have completed therapy (and waited 7 days if treated with azithromycin)
- Advice on safer sexual practices, including advice on correct, consistent condom use

Reducing the Risk of Individuals Retesting Chlamydia-Positive Following Treatment

Recommendations

- Advise (and document that advice given) no genital, oral, or anal sex, even with a condom, until both index patient and their partner(s) have completed treatment or if the partner(s) choose testing only until the partner(s) have a negative test.
- Abstain as above from sexual activity, for one week after azithromycin 1 g stat.

Management of Sexual Partners

- All patients identified with *C. trachomatis* should have partner notification discussed at treatment by a health care professional.
- The method of partner notification agreed for each partner/contact identified should be documented, as should partner notification outcomes.
- All sexual partners should be offered, and encouraged to take up a full STI screen, including HIV test and if indicated hepatitis B screening +/- vaccination.
- Epidemiological treatment for *C. trachomatis* should be offered. If declined, patients must be advised to abstain from sex until they have received a negative result. If found to be positive, any other potentially exposed partner(s) needs screening and the offer of epidemiological treatment.

Look Back Period

Only limited evaluation has taken place of the incubation period following exposure to the development of symptoms. In the United Kingdom a cut-off of 4 weeks is used to identify those sexual partner(s) potentially at risk if the index patient is symptomatic. If the index case is asymptomatic, an arbitrary cut off of 6 months, or until the last previous sexual partner (whichever is the longer time period), is used. Common sense needs to be used in assessing which sexual partner(s) may have been at risk in these situations.

Those at risk should be informed and invited to attend for evaluation and epidemiological treatment even if tests are negative. This may be patient led or provider led.

Follow Up

Follow up by phone may be both more efficacious and cost effective than by re-attendance.

This is an important part of the management of chlamydial infection and it has a number of objectives including:

- Following up partner notification
- Reinforcing health education

- Ensuring compliance with treatment and abstinence from sexual intercourse until partner(s) have completed antibiotics (if treated with azithromycin waiting seven days)
- There is evidence to suggest that follow-up by phone may be more efficacious than asking the patient to re-attend. It is therefore likely that the former method is more cost effective (Apoola, Boothby, & Radcliffe, 2004).
- Re-treat non-compliant and/or re-exposed individuals

Test of Cure

A test of cure is not routinely recommended but should be performed in pregnancy or if non-compliance or re-exposure is suspected. It should be deferred for 5 weeks (6 weeks if azithromycin given) after treatment is completed.

Definitions:

Grading of Recommendations

A (Evidence Levels Ia, Ib)

- Requires at least one randomised controlled trial as part of the body of literature of overall good quality and consistency addressing the specific recommendation

B (Evidence Levels IIa, IIb, III)

- Requires availability of well conducted clinical studies but no randomised clinical trials on the topic of recommendation

C (Evidence Level IV)

- Requires evidence from expert committee reports or opinions and/or clinical experience of respected authorities
- Indicates absence of directly applicable studies of good quality

Levels of Evidence

Ia

- Evidence obtained from meta-analysis of randomised controlled trials

Ib

- Evidence obtained from at least one randomised controlled trial

IIa

- Evidence obtained from at least one well designed controlled study without randomisation

IIb

- Evidence obtained from at least one type of well designed quasi-experimental study

III

- Evidence obtained from well designed, non-experimental descriptive studies, such as comparative studies, correlation studies, and case control studies

IV

- Evidence obtained from expert committee reports or opinions and/or clinical experience of respected authorities

CLINICAL ALGORITHM(S)

None provided

EVIDENCE SUPPORTING THE RECOMMENDATIONS

REFERENCES SUPPORTING THE RECOMMENDATIONS

References open in a new window

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of supporting evidence is graded and identified for selected recommendations (see "Major Recommendations").

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

Appropriate diagnosis, treatment, and management of patients with *Chlamydia trachomatis* genital tract infection and prevention of *C. trachomatis* infection in sexual partners

POTENTIAL HARMS

- Erythromycin is less efficacious than either azithromycin or doxycycline. When taken four times a day, 20 to 25% may experience side-effects sufficient to cause the patient to discontinue treatment.
- Amoxycillin had a similar cure rate to erythromycin in a meta-analysis and had a much better side effect profile. However, penicillin in vitro has been shown to induce latency, and re-emergence of infection at a later date is a theoretical concern of some experts.

CONTRAINDICATIONS

CONTRAINDICATIONS

Doxycycline and ofloxacin are contraindicated in pregnancy.

QUALIFYING STATEMENTS

QUALIFYING STATEMENTS

The recommendations in this guideline may not be appropriate for use in all clinical situations. Decisions to follow these recommendations must be based on the professional judgement of the clinician and consideration of individual patient circumstances and available resources. All possible care has been undertaken to ensure the publication of the correct dosage of medication and route of administration. However, it remains the responsibility of the prescribing physician to ensure the accuracy and appropriateness of the medication they prescribe.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

The following auditable outcome measures are provided:

- Compliance with clinical standards of care
- Partner notification

IMPLEMENTATION TOOLS

Audit Criteria/Indicators

For information about availability, see the "Availability of Companion Documents" and "Patient Resources" fields below.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Getting Better
Staying Healthy

IOM DOMAIN

Effectiveness
Patient-centeredness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

Horner PJ, Boag F. 2006 UK national guideline for the management of genital tract infection with Chlamydia trachomatis. London (UK): British Association of Sexual Health and HIV (BASHH); 2006. 24 p. [76 references]

ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

1999 Aug (revised 2006)

GUIDELINE DEVELOPER(S)

British Association for Sexual Health and HIV - Medical Specialty Society

SOURCE(S) OF FUNDING

No specific or external funding was sought or provided in the development of this guideline.

GUIDELINE COMMITTEE

Clinical Effectiveness Group (CEG) and British Association for Sexual Health and HIV (BASHH)

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

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Clinical Effectiveness Group (CEG) Members: Keith Radcliffe (Chair); Imtyaz Ahmed-Jushuf; David Daniels; Mark FitzGerald; Neil Lazaro; Gillian McCarthy; Guy Rooney

FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

P. Horner - none.
F. Boag - none.

GUIDELINE STATUS

This is the current release of the guideline.

This guideline updates a previous version: Association for Genitourinary Medicine (AGUM), Medical Society for the Study of Venereal Disease (MSSVD). 2002 national guideline for the management of *Chlamydia trachomatis* genital tract infection. London: Association for Genitourinary Medicine (AGUM), Medical Society for the Study of Venereal Disease (MSSVD); 2002. Various p.

GUIDELINE AVAILABILITY

Electronic copies: Available from the British Association for Sexual Health and HIV Web site.

AVAILABILITY OF COMPANION DOCUMENTS

The following are available:

- Specifications for the development of UK guidelines on the management of sexually transmitted infections (STIs) and closely related conditions 2005. London (UK): British Association of Sexual Health and HIV (BASHH); 2005. 14 p. Electronic copies: Available in Portable Document Format (PDF) from the British Association for Sexual Health and HIV Web site.

Additionally, auditable outcome measures can be found in the original guideline document.

PATIENT RESOURCES

None available

NGC STATUS

This summary was completed by ECRI on June 15, 2000. The information was verified by the guideline developer on October 13, 2000. This summary was updated by ECRI on June 24, 2002. The updated information was verified by the guideline developer on February 6, 2007. This summary was updated by ECRI Institute on July 28, 2008 following the U.S. Food and Drug Administration advisory on fluoroquinolone antimicrobial drugs.

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Date Modified: 9/22/2008