Chlamydia Screening

May 2011

Screening Rationale:

Chlamydia infection is the most common sexually transmitted bacterial infection in the United States. Left untreated, cervical infections can lead to pelvic inflammatory disease (PID), fallopian tube scarring, ectopic pregnancy, and infertility. Screening of sexually active women under age 25, followed by appropriate treatment, has been shown to be effective in reducing the morbidity associated with chlamydia infection (number needed to screen to prevent one case of PID = 200, infertility = 1,000, ectopic pregnancy = 2,200, chronic pelvic pain = 1,500, any one sequelae = 150; cost to prevent any 1 sequelae = $1,000). Chlamydia during pregnancy is associated with adverse pregnancy outcomes, including miscarriage, premature rupture of membranes, preterm labor, low birth weight and increased infant mortality.

Detection:

Either urine testing or genprobe testing of endocervix can be used. In addition, consideration for testing of other STD is appropriate for symptomatic patients.

Recommendations for testing:

1. Nonpregnant women:
   - All sexually active women ages 16-25 should be screened for genito-urinary chlamydia infection at least once a calendar year. The optimal interval for testing is unknown.
   - Given the difficulty of determining which adolescent women are sexually active, all women under 25 may be offered Chlamydia screening.
   - Additional testing for chlamydia is appropriate at any visit where a woman has signs of cervicitis, or at the clinical discretion of the provider.
   - Starting at adolescence, all women should be asked about sexual activity at all health maintenance (“well teen”) exams and at other visits at the clinical discretion of the provider. Note that this information is confidential beginning at age 12 years according to Colorado statute.
   - Non-pregnant women at increased risk should also be tested.

2. Pregnant women:
   - All pregnant women should be tested, initially in the first trimester and, if newly at risk or with continued risk, in the third trimester.

Recommendations for low risk or optional testing:

1. Women who are not sexually active but are using oral contraceptives for reasons other than contraception, or have pregnancy tests for other reasons (such as prior to Accutane therapy) need not be tested.
2. Low risk women age 25 and older:
   There is no recommendation for testing in women who are not at increased risk, age 25 and older, although testing may be appropriate in some women.

3. Asymptomatic men:
   While the USPSTF makes no recommendation for or against screening asymptomatic men due to insufficient evidence, testing may be clinically beneficial in the at-risk population. Therefore, urine testing of sexually active males may be offered per provider discretion with shared decision making and appropriate counseling.

Additional recommendations for high risk women and positive tests:

1. GC:
   In 2007, the USPSTF also recommended that all high risk women should also be screened for asymptomatic GC. High risk status includes history of previous Chlamydia, GC or other STD, new or multiple partners, inconsistent condom use, sex work or drug use.

2. Positive Chlamydia test:
   - Anyone with a positive Chlamydia test should also be screened for GC or treated presumptively for both infections.
   - Per the CDC, routine "test of cure" exams are not needed after treatment for Chlamydia, but repeat screening in 3-4 months should be considered as re-infection rates are high.

3. There can be false positives if tested immediately after treatment. Consider waiting a 2-3 week period if member would like retesting after treatment.

Methods for Measuring Compliance: Number and type of tests ordered and completed AND HEDIS screening rates of females ages 16-24.


These guidelines are informational only and are not intended or designed to substitute the reasonable exercise of independent clinical judgment by providers in any particular set of circumstances for each patient encounter. The guidelines are flexible and are intended to be used as a resource for integration with a sound exercise of clinical judgment. They can be used to create an approach to care that is unique to the needs of each individual patient. The implementation of this guideline is not intended to conflict with any agreed upon health plan benefits nor is it intended to prevent access to care that the practitioner believes is warranted based on clinical judgment.