The Shrewsbury and Telford Hospital NHS Trust

Screening for Chlamydia and Gonorrhoea in Pregnancy

Version 6

Lead Person(s)	**:**	Jan Baker, Antenatal Screening Coordinator
Centre	**:**	Women and Children's
First Implemented	**:**	July 2008
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Keywords	**:**	Chlamydia, Gonorrhoea, Screening.
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Comments	**:**	References to SaTH Guidelines in the text pertain to the latest version of the Guideline on the intranet. Printed copies may not be the most up to date version.

For Triennial Review

Version	Implementation Date	History	Ratified by	Full Review Date
1	July 2008	New Guideline	MGG & MG	July 2010
2	January 2011	Reviewed and revised	MGG	January 2014
3	18th March	Full Review and amendments to the process for requesting and treatment	MGG Maternity Governance	February 2017
4.0	25th October 2017	Full version review	MGG Maternity Governance	October 2022
5.0	March 2021	Full version review	MGG Maternity Governance	March 2024
5.1	November 2022	Audit & Monitoring paragraph updated to reflect new process		March 2024
5.2	March 2023	Auditable Standards added- Appendix 4		March 2024
6	23rd February 2024	Full version review	Maternity Governance	February 2027

In this guideline we use the terms ‘woman’ or ‘mother’ throughout. These should be taken to include people who do not identify as women but are pregnant or have given birth.

1.0 Introduction

Genital Chlamydia trachomatis is the **most common** sexually transmitted infection in England (10% of sexually active 16 to 24 year olds). Department of Health statistics state that this sexually transmitted infection is responsible for 40% of ectopic pregnancies and is the primary cause for 30% of women who develop Pelvic Inflammatory Disease (PID). Some women who develop PID will go on to have fertility problems.

70% of women with Chlamydia infection will be asymptomatic.

Chlamydia is thought to be linked to first trimester spontaneous abortion, premature labour, premature rupture of membranes and intrauterine growth restriction. If mother to neonate transmission should occur during delivery it can cause neonatal conjunctivitis or pneumonia.

Gonorrhoea is caused by the bacterium Neisseria gonorrhoeae and is the **second most common** bacterial sexually transmitted infection in the UK.

Symptoms that some women may experience include:

- discharge of yellow mucus and pus from the vagina
- painful urination
- abnormal menstrual bleeding
- Rectal pain and swelling may occur if the infection spreads to that area

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Approximately half of women don’t show symptoms and infections often go untreated. If that happens, the infection can spread from the cervix to the upper genital tract and infect the uterus. The infection can also spread to the fallopian tubes, which is known as salpingitis, or pelvic inflammatory disease (PID). Women with PID due to gonorrhoea typically get a fever and have abdominal and pelvic pain. Bacteria that cause PID can damage the fallopian tubes, which can cause infertility, ectopic pregnancy, and chronic pelvic pain.

Additionally, gonorrhoea infection may make it easier to contract HIV. This happens because gonorrhoea inflames your tissues and weakens your immune system.

Gonorrhoea has been associated with risk of preterm rupture of membranes, preterm birth, low birth weight. As well as this, pregnant women with gonorrhoea can transmit the infection to their babies during vaginal delivery. This happens because the baby comes into contact with the mother’s genital secretions. Symptoms in infected infants usually appear two to five days after delivery. The perinatal transmission rate is between 30 to 40% where cervical infection is present. Once membranes have ruptured, there is a risk of intrauterine infection.

Infected infants may develop scalp infections, upper respiratory infections, urethritis, or vaginitis. They can also develop a serious eye infection resulting in permanent blindness.

Both Chlamydia and Gonorrhoea are sexually transmitted infections; transmitted through unprotected vaginal, oral or anal intercourse or genital contact with an infected partner. An infected person may have no symptoms but still transmit the infection.

Offering screening to women between the ages of 16 and 24 during pregnancy will help to reduce the risk of the infection and its consequences.

2.0 Aim

To meet the National Guidelines regarding antenatal screening and the care of women with Chlamydia and or gonorrhoea infection to improve the diagnosis and treatment of infection and reduce the serious complications for a woman and her baby.

3.0 Objective

To offer all pregnant women in Shropshire between 16 and 24 years of age Chlamydia and gonorrhoea screening in pregnancy.

To ensure care pathways are in place to ensure prompt and effective treatment of confirmed infection.

4.0 Definition

4.1 **Chlamydia** is an obligate, intracellular, bacterial pathogen, which means that it can only live within a cell.

Clinical features:

- 70% of cases are asymptomatic
- Postcoital bleeding or inter-menstrual bleeding
- Lower abdominal pain
- Mucopurulent cervicitis and/or contact bleeding
- Dysuria

4.2 **Chlamydia screening coordinator**, Designated Sexual Health nurse

4.3 **MIS – Maternity Information System**

4.4 **PID,** A general term for the infection of the upper genital tract. Infection spreads upwards from the endocervix causing one or more of the following; endometriosis, salpingitits, parametritis, oophoritis, tubo-ovarian abscess, pelvic peritonitis.

4.5 **Gonorrhoea** is a common bacterial sexually transmitted infection caused by the bacterium Neisseria gonorrhoeae.

5.0 Process – see appendix 1

A **national** screening programme is not recommended for chlamydia in pregnancy as there is little evidence to show:

- That having chlamydia in pregnancy will have a negative outcome on the pregnancy
- That screening in pregnancy will benefit the pregnancy or baby
- The effect of antibiotic treatment during pregnancy.

However, as per national guidance, women between 16 and 24 years of age should be informed of the high prevalence within their age group and offered screening.

5.1 Consent for Screening

Screening is discussed at the booking appointment with all women who are 16 to 24 years old.

It is important to ensure the woman is fully informed about the infections they are being tested for and what the test involves. Consent to test for both infections should be explicitly obtained; but is particularly important where individuals are being screened opportunistically.

The midwife will document that the woman has been offered screening for each infection and the woman's decision to accept or decline screening.

If the woman declines screening this should be documented on the MIS. The woman should also be advised how screening can be accessed if she wishes screening at a later date,

through her GP, Midwife or Sexual Health Services. Service users in Shropshire, age 16+ can order free STI testing vis OpenClinic online.

5.2 Requesting Screening – see appendix 2

To request a Chlamydia/gonorrhoea screening sample, go onto the Review system and go into 'Test Search' and select 'Urine – Chlamydia/N.gonorrhoea (including Antenatal Booking).

You will be asked for the woman's contact number, so that if the result is positive the woman will be contacted by that number.

You will also be asked if the woman consents to sharing her contact details. This consent is important to enable the result to be passed onto Sexual Health for appropriate management.

The woman must be aware of the purpose of these questions.

5.3 Taking the sample

The woman should not have urinated for at least 1 hour prior to taking the sample and cleansing is not recommended prior to sampling.

The first 10-50mls of the void should be collected and immediately transferred into the 'Cobas ® PCR Media' tube (see Appendix 3 for manufacture instructions) using the disposal pipette provided in the pack and then invert the sample 5 times to mix with the stabilising solution. The sample is stable at 2-30ºC for up to 24 hours therefore does not need to be refrigerated**.**

The sample should be labelled with the electronic sticker generated from the request form and bagged with the request form.

5.4 Documenting Screening

The Midwife will document on the MIS that screening for both chlamydia and gonorrhoea has been offered and undertaken.

5.5 Reporting Results.

5.5.1 Negative results

For negative screening results the result will be available via the electronic results reporting system and a paper copy sent to the requestor. Results to be documented on MIS.

5.5.2 Positive or equivocal results

The positive/equivocal result is reported to the requestor. The result is available to view on the results reporting system and a paper copy sent to the requestor.

A neonatal alert referral is required, this should be completed on the MIS by the requestor for actioning by the neonatal team.

If the woman **has consented** to her information being shared, then **the requestor contacts the local GUM (Genito-Urinary Medicine/ Open Clinic)** for treatment and partner contact tracing.

The contact details for Shropshire and Telford and Wrekin local Sexual Health services are found via:

www.openclinic.org.uk
Telephone: 0300 123 0994

If the woman **has not** consented to her information being shared the requestor will need to inform the woman's GP to request treatment. **The GP will be responsible for treating the woman but is not responsible for contact tracing of the partner.**

5.6 Treatment

The optimum management and treatment for women with Chlamydia and or gonorrhoea infection is through GUM/Open Clinic.

Gonorrhoea infection

Clinicians treating a woman with gonorrhoea should follow the latest evidence-based guidelines developed by BASHH and the Royal College of General Practitioners.

Gonorrhoea can be easily treated with a single dose combination of antibiotics – one is usually given by injection. Occasionally a second course of antibiotics is needed if a resistant strain of gonorrhoea is found.

Pregnant and breastfeeding individuals should not be treated with quinolone or tetracycline antimicrobials.

Pregnancy does not diminish treatment efficacy.

Chlamydia

The treatment consists of erythromycin 500 mg b.d. for 14 days. Erythromycin is less effective than azithromycin or doxycycline, but these are contraindicated in pregnancy and breastfeeding. If the woman is allergic to erythromycin then the alternative is amoxycillin 500 mg t.d.s. for 7 days. Erythromycin has been reported as 73% to 95% effective if taken only for one week. In order to achieve a >95% success rate in treatment, a two-week course of erythromycin must be prescribed.

Women must be encouraged to complete the course of antibiotics to ensure that the infection is eradicated.

Women with Chlamydia infection will be advised by the health adviser in sexual Health /RISQ to abstain from sexual contact or use condoms until treatment has been completed and the partner's result is negative, or the partner has also completed treatment.

Testing for eradication of Chlamydia infection is not routinely recommended, except in the case of women who are pregnant and there is a suspicion of non-compliance with treatment. This will be undertaken by Sexual Health /RISQ in the **third trimester**

All women must be offered a repeat Chlamydia screen if they change their partner during the pregnancy or are concerned about re-infection.

5.7 Documentation

At the next contact the Midwife will discuss and document the result and any treatment that the woman has received on the MIS.

6.0 Training

6.1 Midwives are responsible for updating their own practice and knowledge base by using the resources available from:

www.dh.gov.uk/Policyandguidance/Healthandsocialcaretopics/sexualhealth and by ensuring they are familiar with the Chlamydia resource pack provided by the Chlamydia Screening Coordinator in each community/clinic area.

6.2 All Midwives will attend mandatory updates which will include a session on Antenatal screening. This covers, different aspects of antenatal screening, including Chlamydia.

6.3 Training will be in accordance with SaTH Training Needs Analysis

7.0 Monitoring and audit

Compliance with this guideline / SOP will be audited as part of the Shrewsbury and Telford Hospital NHS Trust's five-year rolling programme of NICE and local guideline audits, unless circumstances require an earlier or more frequent audit. The audit will be carried out against the auditable standards and the results of the audit will be reported and acted on in accordance with the Trust Clinical Audit Policy (CG25).

8.0 References

Chlamydia Screening Programme information available from: https://www.gov.uk/government/publications/ncsp-patient-information-leaflets

BASHH (2014) Standards and Management of Sexual Transmitted Infections

DoH, (2006), UK National Guideline for the management of Genital Tract Infections with Chlamydia Trachomatis, Department of Health.

NCSP (2018), The National Chlamydia Screening Programme Standards, available from: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/759846/NCSP_Standards_7th_edition_update_November_2018.pdf

Gov.UK 2018. UK National Screening Committee: Antenatal screening programme, Chlamydia (pregnancy) [Online: Accessed at Chlamydia (pregnancy) - UK National Screening Committee (UK NSC) - GOV.UK (view-health-screening-recommendations.service.gov.uk)

Randall, S. (2007) Antenatal Screening to the under 25's –the current position prepared by Sarah Randall, Medical Adviser to the National Chlamydia Screening Programme available from: www.nelnet.nhs.uk/files/documents/235_antenatalscreeningtotheunder25smay07.pd

PHE Guidance for the detection of gonorrhoea in England 2015

Appendix 1 - **Chlamydia Screening Pathway - for women under 25yrs**

Woman is 16-24 years old and books with midwife.
Chlamydia screening discussed and written information given

Woman consents to screening

Woman declines screening.

Requesting screening
Go onto Review
Go into Test Search and select
Urine –Chlamydia/N.gonorrhoea (including Antenatal Booking).
It is important to complete the next questions.

- Q1 Enter the woman's contact number, so that if the result is positive the woman will be contacted by that number.
- -Q2 Answer whether the woman consents to sharing her contact details. Yes / No

It is important that the woman is aware of the purpose of these questions

Document that screening has been discussed and offered, but that screening has been declined on the MIS. The woman should also be advised how screening can be accessed if she wishes screening at a later date through:
GP,
Midwife
Sexual Health Services

Taking the sample
The woman should not have urinated for at least 1 hour.
Cleansing before sampling is not recommended.
The first 10-50mls of the sample should be collected
Immediately transfer the sample into the 'Cobas PCR Media' tube using the disposal pipette provided and invert the sample 5 times to mix.
The sample is stable at 2^{o}C-30^{o}C for up to 24 hours

Documenting Screening
Document on the MIS that screening has been offered, accepted and taken and whether the woman consents to her details being passed to sexual health services

Screening result is Negative

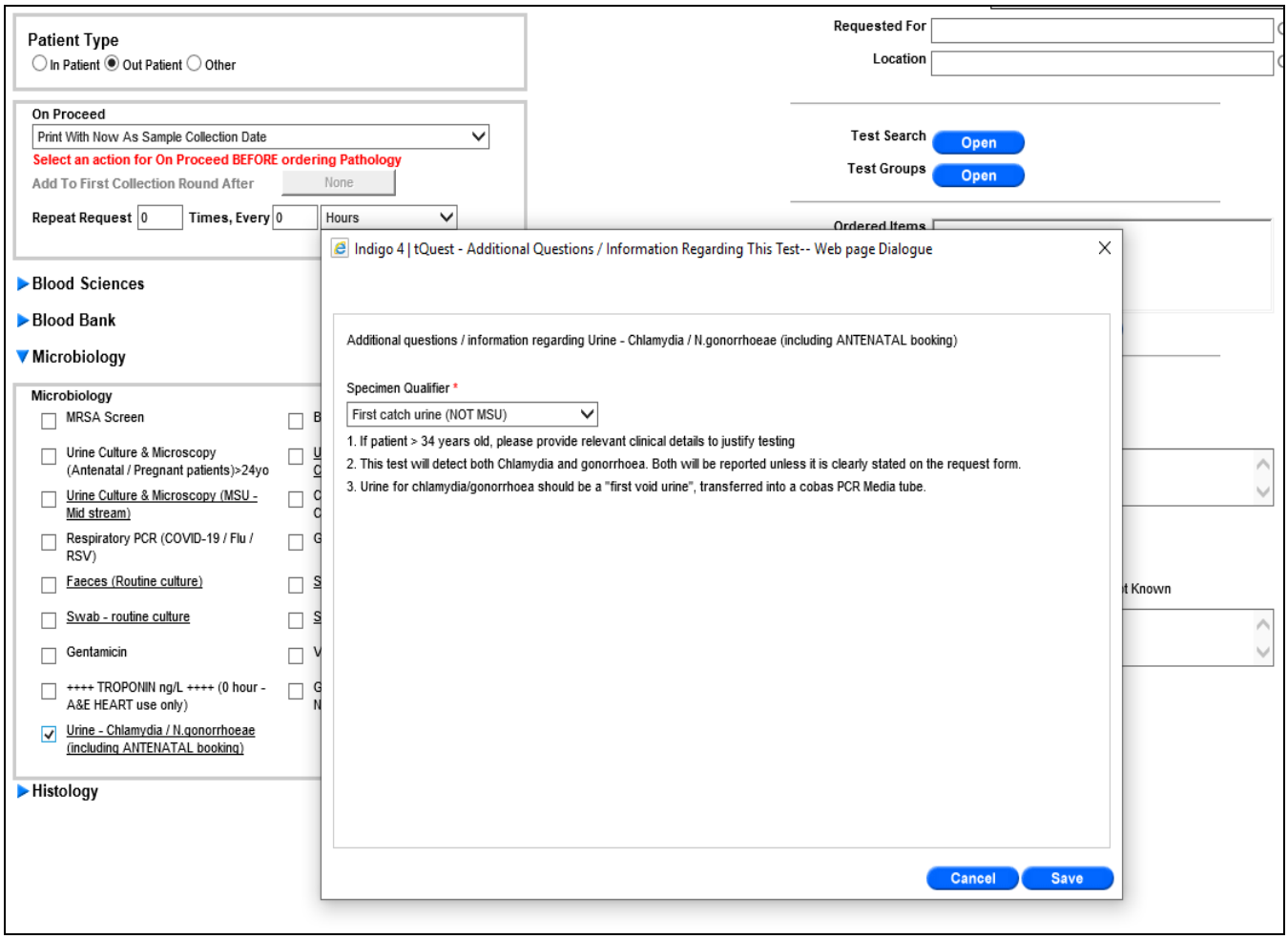
Woman informed of result at next antenatal visit and documented on MIS

Positive Screening Result
The requestor only is informed

The Woman consents to her information being shared
The Requestor contacts Sexual Health Services and information regarding the lady's result is shared.
Contacting the woman and her management will be undertaken by them.
Sexual Health Services will contact the woman's partner for screening and possible treatment.
FU regarding effective management will also be completed by sexual health

The woman has not consented to her information being shared
The requestor will need to inform the woman's GP and request treatment for the woman only.
The GP will treat the woman but will not be responsible for contact tracing and management of her partner.

Appendix 2.


Patient Type
In Patient Out Patient Other
On Proceed
Print With Now As Sample Collection Date
Select an action for On Proceed BEFORE ordering Pathology
Add To First Collection Round After
None
Repeat Request 0 Times, Every 0 Hours
Requested For
Location
Test Search Open
Test Groups Open
Ordered Items
Blood Sciences
Blood Bank
Microbiology
Microbiology
MRSA Screen
Urine Culture & Microscopy (Antenatal / Pregnant patients)>24yo
Urine Culture & Microscopy (MSU - Mid stream)
Respiratory PCR (COVID-19 / Flu / RSV)
Faeces (Routine culture)
Swab - routine culture
Gentamicin
++++ TROPONIN ng/L ++++ (0 hour - A&E HEART use only)
Urine - Chlamydia / N.gonorrhoeae (including ANTENATAL booking)
Histology
Indigo 4 | tQuest - Additional Questions / Information Regarding This Test-- Web page Dialogue
Additional questions / information regarding Urine - Chlamydia / N.gonorrhoeae (including ANTENATAL booking)
Specimen Qualifier *
First catch urine (NOT MSU)
1. If patient > 34 years old, please provide relevant clinical details to justify testing
2. This test will detect both Chlamydia and gonorrhoea. Both will be reported unless it is clearly stated on the request form.
3. Urine for chlamydia/gonorrhoea should be a "first void urine", transferred into a cobas PCR Media tube.
Cancel
Save

Appendix 3

1 Collecting male and female urine

1 COLLECT: Prior to sampling, the patient should not have urinated for at least one hour. Given that collection of larger volumes of urine may reduce test sensitivity, please direct patient to provide first-catch urine (approximately 10 to 50 mL of the initial urine stream) into a urine collection cup (not provided).

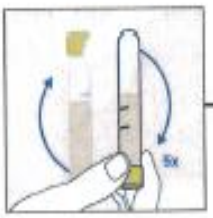
Note: For best results, female patients should not cleanse the labial area prior to collection.

2 PIPETTE: Immediately transfer urine into the **cobas®** PCR Media tube using the provided disposable pipette.

Note: If the urine specimen cannot be transferred immediately, it can be stored at 2°C to 30°C for up to 24 hours.

3 TRANSFER: The correct volume of urine has been added when the fluid level is between the two black lines on the tube label.

4 CAP: Tightly re-cap the **cobas®** PCR Media tube.



5 MIX: Invert the tube 5 times to mix. The specimen is now ready for transport.

Handling precautions:

- Female patients should not cleanse the labial area prior to providing specimens
- **Do NOT** collect specimen from patients who are menstruating
- Female and male patients should not have urinated for at least one hour prior to sampling
- Use care to avoid splashing of contents

Document development, ratification and dissemination form

Document title:	***Chlamydia and Gonorrhoea Screening***
Version:	2

Checklist	Yes	No	N/A	Comments/Actions required/Dates*
Trust logo	✓			
Title page complete	✓			
Key words appropriate	✓			
Footer complete	✓			
Text complete	✓			
Local and national guidance identified	✓			
Cross references included	✓			
Consultation complete	✓			
Draft watermark	✓			
References checked	✓			
Key points checked	✓			
CNST compliance				
Training issues				
Cost issues				
Implementation issues				
Training needs identified				
M & A requirements discussed				
Ratified by MGG				
Ratified by Maternity Governance				
Final check and 'Draft' removed				
Uploaded to intranet				
Copy on labour ward				
Copy to archive				
Old version removed from labour ward				
Email/memo to all relevant staff				
Information for Governance Newsletter				
Added to monitoring/audit programme				

*Please make any further notes or comments below:

Signature.....Date..... (Guidelines Coordinator or CNST Midwife)

Signature.....Date..... (Head of Midwifery or Centre Chief)

Appendix 4 – Auditable Standards

Screening for Chlamydia and Gonorrhoea in Pregnancy

3.0 Objective

To offer all pregnant women in Shropshire between 16 and 24 years of age Chlamydia and gonorrhoea screening in pregnancy

6.0 Process

5.1 **Consent for Screening**

Screening is discussed at the booking appointment with all women who are 16 to 24 years old.

It is important to ensure the woman is fully informed about the infections they are being tested for and what the test involves. Consent to test for both infections should be explicitly obtained; but is particularly important where individuals are being screened opportunistically.

The midwife will document that the woman has been offered screening for each infection and the woman's decision to accept or decline screening.

If the woman declines screening this should be documented in the woman's maternity notes and on the MIS. The woman should also be advised how screening can be accessed if she wishes screening at a later date, through her GP, Midwife or Sexual Health Services.

5.3 **Taking the sample**

N/A

5.4 **Documenting Screening**

The Midwife will document on the MIS that screening for both chlamydia and gonorrhoea has been offered and undertaken. This will be recorded on the MIS.

5.7 Treatment

Gonorrhoea infection

Gonorrhoea can be easily treated with a single dose combination of antibiotics – one is usually given by injection. Occasionally a second course of antibiotics is needed if a resistant strain of gonorrhoea is found.

Pregnant and breastfeeding individuals should not be treated with quinolone or tetracycline antimicrobials.

Chlamydia

The treatment consists of erythromycin 500 mg b.d. for 14 days. Erythromycin is less effective than azithromycin or doxycycline, but these are contraindicated in pregnancy and breastfeeding. If the woman is allergic to erythromycin then the alternative is amoxycillin 500 mg t.d.s. for 7 days. Erythromycin has been reported as 73% to 95% effective if taken only for one week. In order to achieve a >95% success rate in treatment, a two-week course of erythromycin must be prescribed.

Women must be encouraged to complete the course of antibiotics to ensure that the infection is eradicated.
All women must be offered a repeat Chlamydia screen if they change their partner during the pregnancy or are concerned about re-infection.

5.7 Documentation

At the next contact the Midwife will discuss and document the result and any treatment that the woman has received on the MIS.