**BASHH STI Revision Notes**

Last updated: 23 July 2025

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**1 Chlamydia trachomatis (2015)**

**1.1 Scope & Key Updates**

* Adults ≥ 16 y attending UK level‑3 sexual‑health services; principles adapt elsewhere.
* 2015 revision: universal NAAT use, emerging NAAT‑POCT, repeat‑testing rules, rectal infection guidance, azithro vs doxy debate, pregnancy/neonate advice.

**1.2 Epidemiology & Aetiology**

* Most common curable STI in UK – > 208 000 diagnoses (2013); 70 % aged 15–24.
* Prevalence 1.5–4.3 % in population surveys; risk ↑ in < 25 y, new/multiple partners, inconsistent condoms.
* Serovars D–K cause urogenital, L1–L3 cause LGV; ~75 % partner concordance; up to half clear spontaneously in 12 m.

**1.3 Clinical Presentation (summary)**

* Women: discharge, IMB/PCB, dysuria, pelvic pain → mucopurulent cervicitis, PID, infertility, ectopic, perihepatitis, SARA.
* Men: mild urethral discharge/dysuria → epididymo‑orchitis, SARA.
* Rectum: mostly asymptomatic; may discharge/tenesmus; can mimic proctitis.
* Pharynx / Conjunctiva: usually silent; chronic unilateral conjunctivitis possible.

**1.4 Diagnosis**

**Preferred Assay**

* First‑line NAATs – genital & extra‑genital; dual‑platform confirmation only for medico‑legal cases.

**Optimal Specimens**

| **Group** | **Best specimen** |
| --- | --- |
| Women | Self‑ or clinician‑taken vulvo‑vaginal swab (VVS) – highest sensitivity |
| Men | First‑catch urine (FCU) ≈ urethral swab |
| Rectal / Pharyngeal | Site‑specific swab for NAAT |
| LGV screen | Send CT‑positive samples to STBRL for LGV PCR |

**Practical Points**

* If exposure < 14 d: test now and repeat ≥ 2 wks.
* Self‑sampling (vaginal, rectal, pharyngeal) is acceptable & accurate – supports home testing.
* nvCT deletion resolved in modern assays.
* Medico‑legal cases: sample all penetrated sites, confirm positives on a second NAAT target.

**1.5 Management**

**General Measures**

* STI screen incl. HIV, syphilis, gonorrhoea; vaccinate/test for HBV.
* Abstain from sexual contact until both partners treated and 7 d have passed since azithro or completion of doxy.
* Do not remove IUD/IUS for uncomplicated CT.
* Provide written info, safer‑sex and partner‑notification counselling.

**Recommended Regimens**

| **Scenario** | **First‑line** | **Alternatives / notes** |
| --- | --- | --- |
| Uncomplicated genital / pharyngeal CT | Doxycycline 100 mg BD × 7 d or Azithromycin 1 g stat | Ofloxacin 200 mg BD 7 d; erythro 500 mg BD 10–14 d |
| Rectal CT (non‑LGV) | Doxy 100 mg BD 7 d | Azithro 1 g stat with TOC or longer doxy if LGV not excluded |
| Pregnancy / breast‑feeding | Azithro 1 g stat | Erythro 500 mg QDS 7 d, BD 14 d, or Amox 500 mg TDS 7 d |
| CT + Gonorrhoea | Standard GC Rx (ceftriaxone 500 mg IM + azithro 1 g) covers CT; add doxy 7–21 d if rectal CT/LGV risk |  |
| HIV‑positive | Same regimens; err on doxy 3 wks for rectal CT pending LGV PCR |  |

**Adverse‑Effect Pearls**

* Doxy: GI upset, photosensitivity, oesophagitis – take with water & stay upright.
* Azithro: GI upset, potential QT prolongation.
* Erythro: marked GI intolerance; avoid in cholestasis.

**1.6 Test of Cure (TOC) & Retesting**

* Routine TOC not required – except pregnancy, suspected non‑adherence, persistent symptoms, rectal CT treated with azithro, or LGV not excluded.
* If done, sample ≥ 3 wks post‑therapy to avoid residual DNA.
* Repeat screen at 3 months for all positives < 25 y (high reinfection risk).

**1.7 Partner Notification**

* Look‑back:
  + Symptomatic men (urethritis): partners since, plus 4 wks before onset.
  + All others: partners in previous 6 m.
* Offer epidemiological treatment to all contacts.
* Auditable standard: ≥ 97 % have documented partner‑action plan & correct SHHAPT coding.

**1.8 Pregnancy & Neonate**

* Vertical transmission → conjunctivitis (5–12 d) or pneumonia (1–3 m).
* Treat infant: Erythro 50 mg/kg/day PO ÷ 4 × 14 d.
* Test & treat mother and partners; perform maternal TOC ≥ 3 wks post‑therapy.

**1.9 Point‑of‑Care Testing**

* Older EIAs insensitive; new NAAT‑POCTs deliver comparable accuracy within < 2 h but extra‑genital validation ongoing.

**1.10 Exam Take‑Home Messages**

1. Doxy 7 d vs azithro 1 g – equal for genital CT; doxy better for rectal disease.
2. Vulvo‑vaginal swab outscores urine in women.
3. Always consider LGV in rectal CT, especially MSM/HIV‑positive – send to STBRL.
4. No routine TOC; if required, wait ≥ 3 wks.
5. Retest at 3 mths (< 25 y).
6. Azithro single‑dose safe in pregnancy; avoid tetracyclines/quinolones.
7. 97 % documentation of partner plan & coding is a BASHH KPI.

**2 Lymphogranuloma Venereum (LGV) – 2013**

**2.1 Scope & What’s New**

* Adults ≥ 16 y; UK level‑3 services.
* LGV now hyper‑endemic in UK MSM networks – majority HIV‑positive; serovar L2b dominates.
* Doxy 100 mg BD 21 d remains gold‑standard.

**2.2 Epidemiology & Risk Factors**

* 77 % of UK cases in London, Brighton, Manchester; sex‑party & chemsex scenes, HCV co‑infection common.

**2.3 Natural History & Clinical Presentation**

| **Stage** | **Typical findings** |
| --- | --- |
| Primary | Small transient genital/anal ulcer – often unnoticed |
| Secondary (inguinal / anorectal) | Painful bilateral inguinal nodes (buboes) or proctocolitis with bleeding, tenesmus, systemic upset; reactive arthritis possible |
| Tertiary | Fibrosis, strictures, fistulae, genital lymphoedema; now rare in outbreak era |

Rectal swab microscopy > 10–20 PMNL/HPF strongly predicts LGV in HIV‑positive MSM.

**2.4 Investigations & Diagnosis**

* Step 1 – Standard CT NAAT on ulcer exudate, bubo aspirate (through healthy skin), rectal/pharyngeal swab or FCU.
* Step 2 – LGV‑specific PCR confirmation at STBRL (required for definitive diagnosis).
* Additional tests: culture/NAAT for HSV & N. gonorrhoeae, syphilis serology, consider biopsy if malignancy.
* Serology (micro‑IF IgG > 1:128 or anti‑MOMP IgA) supports late disease but not sensitive early.

**2.5 Management**

**Recommended Regimens**

| **Scenario** | **First‑line** | **Alternatives / notes** |
| --- | --- | --- |
| All uncomplicated LGV | Doxycycline 100 mg BD × 21 d | Azithro 1 g weekly × 3 wk; erythro 500 mg QDS 21 d; tetracycline 2 g/day; minocycline 300 mg LD then 200 mg BD (specialist) |
| Pregnancy / tetracycline allergy | Erythro 500 mg QDS 21 d with mandatory TOC; extended‑course azithro if intolerant |  |
| HIV‑positive | Same regimens; no relevant ART interactions |  |

Fluctuant buboes → aspirate; avoid incision/drainage.

**Adverse‑Effect & Interaction Notes**

* Doxy – as per CT.
* Erythro – GI intolerance.
* No clinically significant interactions with standard antiretrovirals.

**2.6 Follow‑up & Test of Cure**

* Symptoms usually settle within 1–2 wk (may take 3–6 wk chronic).
* Routine NAAT TOC not required after fully‑adherent 21‑d doxy; if done, wait ≥ 2 wk post‑course.
* Confirm partner‑notification completion; repeat HIV, HCV, syphilis tests after window periods.

**2.7 Chronic/Tertiary Disease Management**

* Fibrosis, fistulae, strictures, genital lymphoedema require surgical referral – antibiotics ineffective.

**2.8 Patient Counselling & General Advice**

* Emphasise LGV is invasive but fully curable if treated early; untreated may cause permanent damage.
* Abstain from unprotected sex until all partners have completed therapy and follow‑up.
* Provide written information; discuss risk reduction for HIV/HCV (condoms, glove‑use, separate douching equipment, chemsex harms).
* Flag abnormal LFTs in HIV‑positive MSM – trigger HCV‑RNA testing (seroconversion delay).

**2.9 Partner Management & Public‑Health Measures**

* Look‑back period:
  + Symptomatic index – partners in 4 wk before onset.
  + Asymptomatic index – partners in last 3 m.
* Offer presumptive doxy 100 mg BD 21 d (or equivalent) to all contacts.
* Auditable 97 % standards: partner‑action plan, serovar confirmation, SHHAPT “C2” coding, repeat BBV testing plan.

**2.10 Exam Take‑Home Messages**

1. Proctitis in MSM → think LGV; send CT‑positive rectal swab for LGV PCR.
2. Diagnosis is two‑step (CT NAAT + LGV‑specific PCR).
3. 21‑day doxy is gold‑standard; any shorter regimen needs justification + TOC.
4. Partner look‑back: 4 wk symptomatic / 3 m asymptomatic.
5. Routine TOC only when alternative regimen, pregnancy, poor adherence or persistent symptoms.
6. Rectal PMNL > 10–20/HPF is a useful pointer.
7. Remember auditable 97 % KPIs, patient counselling and chronic‑stage surgical referral.

Rapid‑review tip: for essays/vivas, pair each guideline’s “clinical pathway” (diagnosis → treatment → follow‑up → PN → audit) with key numbers (dose, duration, time‑windows, 97 %) to score precision marks.