The problem of chlamydia in the UK

In the past decade, the UK has witnessed a dramatic rise in the number of cases of uncomplicated *Chlamydia trachomatis*.1 Increasingly, this is being managed in general practice and community and hospital gynaecological settings as well as in genitourinary medicine (GUM) clinics.2 Treatment of patients is usually straightforward with a single dose of azithromycin. However, ensuring that sexual partners are treated is often challenging. Timely treatment of partners is important to prevent the index patient from becoming re-infected. This is particularly important for women because repeat infection is more likely to lead to complications such as tubal infertility.3 Partner notification has been the traditional means for arranging partner treatment. This usually involves ‘patient-referral’, whereby the patients themselves inform their sexual partners of the possibility of infection and of the need to attend a clinic for treatment and testing. Usually this involves partners attending a GUM clinic where specialised staff offer testing, advice and education and often give empirical treatment at the same time.4 However, partners may be reluctant to undergo testing and treatment for an asymptomatic condition and may be deterred from attending GUM clinics in view of the stigma associated with having a sexually transmitted infection (STI).5 In many parts of the UK, patients may wait several weeks for an appointment to be seen at a GUM clinic.5 Resumption of sexual intercourse with an untreated partner during this time period to be seen can thus result in re-infection in the index woman, increasing the likelihood of infective sequelae. Furthermore, sex with an untreated partner necessitates repeat treatment that may result in a labour-intensive cycle for health professionals of treating index patient, testing and treating partner and then re-testing and re-retreating index patient.

Clearly, partner notification with a consultation with specially trained staff may be the ‘gold standard’ of care. However, this is no longer a realistic option for all partners, given the number of people infected (the majority asymptomatic) and the fact that existing GUM services are struggling to cope with increasing workloads. Given the importance of preventing tubal infertility in women as a result of re-infection, novel partner interventions are now necessary.

An obvious solution to prevent re-infection is to expedite partner treatment. Patient-delivered partner therapy (PDPT) is an example of such a strategy. This involves the index patient delivering a dose of antichlamydial therapy (usually azithromycin) to each sexual partner. This approach has been used in Sweden and is currently in use in some parts of the USA.7,8 Large randomised controlled trials conducted in the USA have shown that it is as least as effective as patient referral, both in terms of re-infection rates in index patients and in proportion of sexual contacts treated.9,10 Clearly, this is a controversial practice because it involves the clinician providing antibiotics for an individual they have neither laid eyes on nor been able to assess clinically. In the UK, the practice of PDPT would encounter legislative difficulties because it is in conflict with the General Medical Council guidelines on good prescribing and Medicines Act.11 Legislative change has been possible in the USA, so that PDPT is now legal in 14 states for treating partners of women with uncomplicated chlamydia.7 In the USA, PDPT is supplied with a comprehensive datasheet clearly listing the contraindications to its use and instructions on when and how to seek medical advice.12 Fortunately, azithromycin is a well-tolerated antibiotic and with a good safety record and low incidence of allergic reactions. Increased use of PDPT has raised concerns about possible increased antibiotic resistance. However, this strategy involves single dose treatment only and so may not carry the same risk of resistance from failure to complete a course of antibiotics. Indeed, a greater threat to antibiotic resistance is likely to come from veterinary medicine and animal husbandry, which account for more than half of the worldwide
use of antibiotics. Although clinicians may also have concerns about ‘over-treatment’ with PDPT (treating partners who might have a negative test result), many GUM clinics in the UK already practice ‘epidemiological treatment’ for partners, which involves giving antibiotic treatment at the same time as testing on the assumption that the test will be positive. A possible disadvantage of failure to test partners and thus confirm chlamydia positivity is that it may reduce the likelihood that other sexual contacts that the partner may have had will be notified and treated. Conversely, if partners are not tested then this removes the difficulty that may arise in explaining discordant results among couples and the suspicion of infidelity that may develop in such situations. A further concern is that use of PDPT would remove the opportunity to test partners for other STIs. Clearly, however, the value of this will depend on the local prevalence of other STIs. A recent survey of health professionals (general practitioners, gynaecologists, family planning doctors and practice nurses) in the UK who are increasingly involved in managing women with chlamydia revealed an overwhelming openness of using PDPT in this way. Furthermore, one in four doctors surveyed in this study admitted that they had previously used PDPT. For the health service, PDPT is an inexpensive option because it involves the cost of antibiotic therapy only.

In the current issue of the journal, Melvin et al. report the preferences of men and women towards different partner interventions for chlamydia. Most women stated that they would prefer PDPT for a partner and for themselves in the reverse situation where a partner was first to test positive. Men, however, seemed to prefer (at least in theory) to be tested before being treated for reasons which are discussed in the paper.

There is a growing realisation that given many societal changes (shift work, single parent families and childcare difficulties), patients require greater choice in how, where and when, health care is delivered to them. Given the difficulty of access to GP surgeries and GUM clinics, especially at weekends and evenings, surely partners require greater flexibility in how they can access treatment for uncomplicated chlamydial infection? Expediting partner treatment by using PDPT would seem to offer an alternative flexible approach to treatment. Partners who prefer to have a test result before treatment (or to be tested for other STIs) could still choose to attend a healthcare setting for this or be treated with PDPT and subsequently attend for testing (nucleic acid amplification test for chlamydia may remain positive for up to 6 weeks after treatment).4

Conclusion

PDPT for treating partners of women with uncomplicated chlamydia is a realistic, inexpensive public health measure in the UK. It has been shown to be effective, acceptable to relevant health professionals and (in this issue of the journal) acceptable to patients. The only barrier to its implementation would appear to be legislative change to enable health professionals to use it in this way. Legislative change has been possible in 14 states of the USA, so surely now the time has come for us in the UK to follow suit.

Disclosure of interests

The author has no financial, personal, political, intellectual or religious conflicts of interest.

References

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