



Global view

The management of *Chlamydia trachomatis*: combined community and hospital study

Demographic data

The study was performed in family planning clinics (FPC), general practices (GP), and a district general hospital (excluding STI clinic) in rural/semirural area of the United Kingdom.

Method

A review of the records of all patients diagnosed *Chlamydia trachomatis* positive by ELISA confirmed with MIF between June 1996 and May 1997 was performed. GP records were reviewed by questionnaires to GPs; hospital and family planning records were reviewed by audit coordinator or gynaecology senior house officers.

Statistics

Data were analysed by using Snap 4 Professional by Mercaptor. The χ^2 test was performed with Yates's correction when expected cell values were less than 5.

Results

Of the 3989 chlamydia tests requested (2237 GP, 537 FPC, and 115 hospital), 154 were positive (85 GP, 31 FPC, 38 hospital) giving prevalence rates in those tested of 3.6%, 5.8%, and 3.4% respectively.

Data were available for analysis on 127 patients: 68 GP (64 F, 4M), 21 FPC (21F), and 38 hospital (33F, 5M) (see table 1).

A doctor was more likely to give a positive result than another member of staff in a GP setting than FPC ($p < 0.05$) or hospital ($p < 0.03$). Many patients were not informed of their positive result and this was more likely in hospital ($p < 0.01$) than GP settings with a trend for FPCs ($p = 0.085$). Hospital patients were less likely to be referred to a GUM clinic than FPC attenders ($p < 0.05$), with a trend for GP patients ($p = 0.068$). Only one patient in the study refused referral.

For patients referred to GUM clinics, treatment was more likely to be given for patients from hospital ($p = 0.05$) or GP settings ($p < 0.01$) than from FPCs and was frequently inadequate.

None of the hospital patients referred were advised on abstinence from sexual intercourse.

Thirty seven patients were not referred to GUM clinics and drug therapy was inadequate or not documented in the majority. Similarly, the majority had no partner notification or treatment of partners.

Comment

Patients are diagnosed with chlamydia in numerous settings, but audits on their standard of care usually focus on a single settings¹⁻³ and assess intended rather than actual practice.⁴

The CMO's report recommends screening for *C trachomatis* in certain groups and advocates referral to GUM clinics for further management, including testing for other sexually transmitted diseases and partner notification.⁵

However, some have advocated that management of chlamydia should be by those who perform the tests, suggesting high referral rates are unachievable (because of distance or refusal to attend). We have shown patient refusal to be rare and high referral rates can be obtained, similar to results found in a large city where 94.5% of FPC and 52% GP cases were referred.⁶ The high level of inappropriate treatment is of concern, and consistent with GP studies where only 19-70% of patients would receive an adequate antibiotic regimen.^{4,7}

This is the only study, of which we are aware, that has covered chlamydia management across a whole district and indicates the need for a standardised policy across a whole health authority. As a result of this study, policies have been developed to standardise treatment and referral to GUM clinics across the whole health authority.

National clinical guidelines and standards for the management of genital chlamydia infection have been developed for use in genitourinary medicine⁸ and it is unethical that patients diagnosed in a non-GUM clinics setting do not have the same standards of care available to them. The most appropriate way to ensure this may be for all cases to be referred to GUM clinics, and the optimal management of chlamydia depends on close links between all healthcare services and the willingness to participate in collaborative audit to ensure standards are met.

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Table 1

| Prevalence | GP 3.6% | FPC 5.8% | Hospital 3.4% |
|---------------------------------|----------|----------|---------------|
| Reason for testing | n=68 (%) | n=21 (%) | n=38 (%) |
| Chlamydia associated symptoms | 46 (67) | 12 (57) | 21 (55) |
| Inflammatory cytology | 6 (9) | — | — |
| Pre instrumentation | 2 (3) | 6 (29) | 15 (39) |
| Opportunistic screening | 1 (1) | 3 (14) | 1 (3) |
| Other | 13 (19) | — | 1 (3) |
| Informing patient of result | | | |
| Doctor | 50 (73) | 9 (43) | 10 (26) |
| Nurse | 11 (16) | 8 (38) | 4 (11) |
| Receptionist/other | 3 (5) | — | 4 (10) |
| Letter | — | — | 1 (2) |
| No record | 4 (6) | 4 (20) | 19 (50) |
| Referral to GUM clinic | | | |
| Referred | 49 (72) | 19 (90) | 22 (58) |
| Not referred | 16 (24) | — | 13 (34) |
| No record | 3 (4) | 2 (10) | 3 (8) |
| Patients referred to GUM clinic | n=49 (%) | n=19 (%) | n=22 (%) |
| Letter | 9 (18) | 12 (63) | 1 (5) |
| Telephone | 8 (18) | 1 (5) | 16 (73) |
| Patient held letter | 10 (20) | 3 (16) | — |
| Patient no letter | 5 (12) | — | — |
| Patient refused | 1 (2) | — | — |
| No record | 14 (28) | 3 (16) | 5 (23) |
| Treatment given before referral | 37 (75) | 8 (42) | 16 (73) |
| Patients not referred | n=19 | n=2 | n=16 |
| Adequate treatment | 6 (32) | 0 | 4 (25) |
| Inadequate | 6 (32) | 0 | 6 (37) |
| No treatment | 7 (36) | 2 (100) | 6 (37) |
| Partner notification advised | 7 (37) | 0 | 6 (1) |
| Partner treated | 4 (20) | 0 | 0 |
| Follow up | 6 (32) | 0 | 2 (12) |

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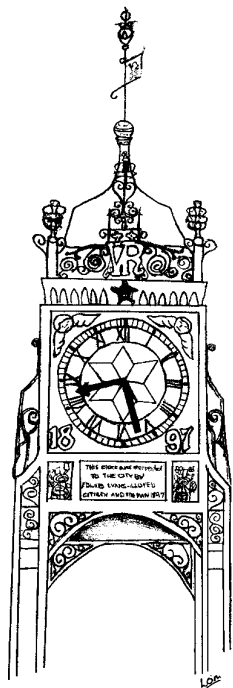
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EASTGATE CLOCK, CHESTER

Chester chronicles

Listening man—an oxymoron

"Will you listen to my chest?" "What, it's 3 am!" "I know, but it's sore and I feel I'm catching my breath." (So, no chance of sex then!) "Alright, alright, I'll get the stethoscope." After clearing several layers of dust off it (the stethoscope that is, not the chest) and listening for the second time, I was still uneasy that all was not well. There was a difference between right and left lung. However, the clouding effect of yet another alcoholic Christmas night out blurred my ability to work out which lung was not quite right, or left I opted for masterly inactivity and reassured my wife that "everything sounded fine, dear." I did fully intend to listen again in the morning (don't look at me like that, I did).

Three days later "You just won't listen when I've got a pain will you? I'm going to the GP. There is definitely something wrong." "Hold on, hold on, let me check again" (how could I have forgotten!). Now there was clearly a problem, absent movement, absent breath sounds, and a percussion note that Phil Collins would have been proud of. I even did the coin test,* as this was my wife and not a patient. On reflection, scrambling round for small change did little to inspire confidence in my increasingly sceptical, breathless wife. Lastly, where had the trachea gone! Tracheal deviation be damned, this was more like a detour. "I'll just phone Casualty and tell them I'll be in shortly with you." "Not before I've had a shower and washed my hair—it can't be that bad or you wouldn't have waited three days to listen to me?" "Let me turn on the water for you."

In A&E, Staff ask "where have you been until now?" "It's a long story" Chest x ray showed complete right lung collapse with mediastinal shift.

Gradually, it all started to become clear. Maybe the cause of that chronic intermittent right sided chest pain often around period time, since the prolonged traumatic twin delivery six years previously, was finally becoming clear. Endometriosis of the lung—catamenial pneumothorax—that is, collapsed lung pertaining to menstruation, virtually always right sided. Minute spontaneous collapses monthly over the next four months confirmed the diagnosis.

The cardiothoracic surgeon firmly commented that "if you were a normal patient, I would do it endoscopically, but you are a consultant's wife, so anything that can go wrong will. I will therefore just have to go and do it the old fashioned way—that is, open up the chest, strip off the pleura, a touch of a sander to rough up the surfaces and you'll be permanently adhered." I couldn't have agreed more. Evidenced based medicine is no substitute for common sense, experience, and sound intuition!

Nothing like a chest drain to dampen the Christmas spirit. Then again, even though "it only hurts when I laugh," there wasn't much to laugh about that Christmas.

Christmas shopping, however, still had to be done. I was determined to disprove the old adage: send a man to a supermarket for butter, milk, and eggs and he comes home with wine, jeans, and a tree! I therefore went forth diligently with an extensive list and, in my opinion, did magnificently. Failing only in the understandable misinterpretation of one item. The list said—buy at least £15 worth of crackers. It did cross my mind as being a somewhat unusual purchase, as I piled up the packets of *Jacob's Cream Crackers*, *Ritz*, *Carr's Water Biscuits*, etc. My successful expedition was greeted with thinly veiled sarcasm "Well, that's just grand! They're going to look really lovely on the Christmas tree! You men, you just won't listen."

Now where have I heard that before?

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*Coin test: Place coin on the back, tap it with another coin and listen at the front. Normal lung—you hear a dull thud. Pneumothorax—especially if pressure is increased, you hear high pitched tinkling sound, time to panic!