California Chlamydia Action Coalition

Diagnosis and Treatment of Chlamydia in Pregnancy

Clinical Significance

The reported prevalence of chlamydia infections in pregnancy range from 5-30% depending on age and other risk factors. Pregnant women infected with chlamydia, like non-pregnant women, are at risk for cervicitis, urethritis and pelvic inflammatory disease. Chlamydia infections during pregnancy can also cause chorioamnionitis and post-partum endometritis and may be associated with gestational bleeding, premature rupture of membranes and preterm labor and delivery.

Perinatal transmission and neonatal complications of chlamydia occur in up to 50% of newborns whose mothers were infected with chlamydia at delivery. Exposed infants are at risk for conjunctivitis (20-50% of exposed) and neonatal pneumonia (10-20% of exposed).

Screening recommendations in pregnancy

In the third trimester[1], screen:

- All women who are 25 years of age and under[2]
- Women at increased risk of chlamydia[3]

Treatment of chlamydia in pregnancy

Recommended:

- Azithromycin 1g p.o. x 1 [4]
- Amoxicillin 500 mg p.o. tid x 7 days
- Erythromycin base 500 mg p.o. qid x 7 days

Alternative:

- Erythromycin base 250 mg p.o. qid x 14 days
- Erythromycin ethylsuccinate 800 mg p.o. qid x 7 days
- Erythromycin ethylsuccinate 400 mg p.o. qid x 14 days

Test of cure should be routine 3-4 weeks post initiation of therapy[5]

Patient counseling and partner management

Patients should be told to abstain from sex for at least 7 days after single dose therapy or until completion of 7-day regimen and until 7 days after all sexual partners are treated and should be

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[1] The optimal timing of screening in pregnancy is unclear. Screening in the third trimester decreases the chance of post-partum and neonatal complications and reduces the chance of re-infection. Screening in the first trimester, however, may prevent adverse effects during the pregnancy, as well as an opportunity for prevention counseling to reduce future risks of chlamydia and other STDs, but allows a longer period for re-infection. The CDC and USPSTF all support third trimester screening with consideration of first trimester screening in high-risk patients. ACOG does not specify the timing.

[2] No major organization recommends universal screening of all pregnant women.

[3]Increased risk (definition highly variable) includes new or multiple partners or when partner has other partners.

[4] Region IX Infertility Prevention Project Advisory Committee recommends azithromycin as a first line treatment in pregnancy. The CDC lists azithromycin as an alternative treatment citing insufficient data for safety and efficacy.

[5] Test of cure recommended in pregnancy only because efficacy of amoxicillin and erythromycin is lower and because efficacy of azithromycin is not well documented. No need for test of cure in non-pregnant patients.

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warned about potential long term and neonatal complications. All sex partners within the previous 60 days should be evaluated, tested and treated.

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