AUDIT OF THE TREATMENT AND FOLLOW UP OF GENITAL CHLAMYDIA IN 2016

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SHQ
Acknowledgement of country

I would like to acknowledge that this meeting is being held on Aboriginal land and recognise the strength, resilience and capacity of Noongar people in this land.
Chlamydia threatens the health of young Australians

• In 2008 Chlamydia was the most diagnosed STI in Australia

• Associated with
  – PID
  – Tubal infertility
  – Ectopic pregnancy
  – Epididymo-orchitis

• Despite being easily treatable with azithromycin or doxycycline.....
  – 10-14% of Australians are re-infected within a year
What are we doing wrong?

- Poor case finding
- Poor contact tracing
- Re-infection risk
What is being done?

1. Guidelines
   - ASHM
   - BASHH

2. Research
   - ACCEPT
   - This audit!
Aims of this audit

Assess the compliance of a metropolitan sexual health clinic (SHQ) with the guidelines created by ASHM and BASHH re: treatment and follow up of chlamydia diagnoses

1. 100% of patients diagnosed with Chlamydia are treated with an appropriate antibiotic regime (ASHM)

2. Contract tracing is attempted in 97% of patients (BASHH)

3. 50% of patients are re-tested at 3 months (ASHM)
Methods

- Retrospective audit of positive genital chlamydial cases in 2016
  - Any age
  - Any sex

- Excluded
  - Pregnant
  - PID / epididymoorchitis
  - Rectal, anal or pharyngeal chlamydia
  - HIV positive
Methods

• Retrospective audit from patient digital files (ZEDMED)

• Each recorded positive result had a file review to extract relevant data

• Descriptive analysis in Excel via pivot tables
Data collection

- Total positive chlamydial cases in 2016 = 223

- Excluded cases = 32
  - Anal, rectal, pharyngeal chlamydia
  - Suspected or diagnosed PID or epididymo-orchitis
  - Pregnant women or HIV positive patients

- Total included = 191
### Demographic analysis

<table>
<thead>
<tr>
<th>Demographic</th>
<th>Range</th>
<th>Median</th>
<th>Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>13-62</td>
<td>27.08</td>
<td>26</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Sex</th>
<th>n</th>
<th>% of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>104</td>
<td>54.45</td>
</tr>
<tr>
<td>Female</td>
<td>86</td>
<td>45.03</td>
</tr>
<tr>
<td>Missing data</td>
<td>1</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Symptoms</th>
<th>n</th>
<th>% of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Symptomatic</td>
<td>69</td>
<td>36.19</td>
</tr>
<tr>
<td>Asymptomatic</td>
<td>115</td>
<td>60.21</td>
</tr>
<tr>
<td>Missing data</td>
<td>7</td>
<td>3.66</td>
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</tbody>
</table>
### Standard 1 – antibiotic treatment

<table>
<thead>
<tr>
<th>Choice of antibiotic</th>
<th>n</th>
<th>%</th>
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</thead>
<tbody>
<tr>
<td>Azithromycin</td>
<td>175</td>
<td>91.1</td>
</tr>
<tr>
<td>Doxycycline</td>
<td>3</td>
<td>1.57</td>
</tr>
<tr>
<td>Missing data</td>
<td>2</td>
<td>1.04</td>
</tr>
<tr>
<td>Treated elsewhere</td>
<td>11</td>
<td>6.28</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>191</td>
<td>100</td>
</tr>
</tbody>
</table>

98.8% of patients treated at SHQ were documented as treated with an appropriate antibiotic regime.
Standard 2 – contact tracing

RESULTS
### Standard 3 – 3 month re-test

<table>
<thead>
<tr>
<th></th>
<th>Yes (n)</th>
<th>%</th>
<th>No (n)</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advice given to re-test</td>
<td>110</td>
<td>57.59%</td>
<td>81</td>
<td>42.41%</td>
</tr>
<tr>
<td>Returned for re-test</td>
<td>41</td>
<td>21.5%</td>
<td>150</td>
<td>78.5</td>
</tr>
</tbody>
</table>

Of patients advised to re-test (n=110), *only 37.2%* (n=41) did re-present at any stage.
So how did we do?

1. Choice of antibiotic – *almost* MET
   - 2 cases lost to follow up
2. Advice to contact trace – MET
   - Largely patient led
3. Repeat testing at three months – *NOT MET*
   - Low attrition rate in those advised to represent (37%)
   - ? Returned to different practice
   - ? Patient attitudes
Limitations

• Use of cases vs patients

• Patients attending different practices
  • Prescriptions & repeat testing

• Retrospective documentation
What next?

• Identifies the need for proactive strategies to increase the re-test rate
  • SMS contact identified as most successful in Cairns study

• Documentation & patient recall

• Repeat audit
Implications

• Benchmarks for sexual health clinics across Australia
  • BASHH vs ASHM auditable outcome
  • Other studies identified similar rates of contact tracing
  • USA studies identify low re-testing rates similar to SHQ
• Advocacy
• Education
  • Patients
  • Primary care practitioners
References


Questions?
Thank you!