**Chlamydia trachomatis Testing Guidelines**
Washington State Clinical Laboratory Advisory Council
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FOR EDUCATIONAL PURPOSES ONLY

The individual clinician is in the best position to determine which tests are most appropriate for a particular patient.

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**Specimen Source**

- Endocervical swab
- Urethral swab
- Urine
- Rectal swab
- Pharyngeal swab
- Conjunctival swab
- Medical/legal

**Test Method**

- NAAT
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- NAAT if validated by lab in-house
- DFA that is FDA-cleared for use with conjunctival specimens
- Culture

**Results/Interpretation**

- See reverse for who should be tested and frequency

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All positive screening tests should be considered presumptive evidence of infection.

Consider routinely performing an additional test if the positive predictive value of the screening test is less than 90%.

An additional test should be considered after a positive screening test if a false-positive screening test would result in substantial adverse medical, social or psychological impact for a patient.

Positive NAAT should only be retested using another NAAT

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**Abbreviations:**

- DFA = Direct Fluorescence Antibody
- NAAT = Nucleic Acid Amplification Test

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**Reference**

WHO SHOULD BE TESTED FOR CHLAMYDIA

- Women with mucopurulent cervicitis (defined as a purulent or mucopurulent cervical discharge, easily induced cervical bleeding, and sometimes inflammation in the zone of ectopy), pelvic inflammatory disease, and/or urethral syndrome (defined as acute dysuria and pyuria in the absence of bacteriuria).
- Sexually active women aged 25 years and under.
- Women over 25 with a new sex partner or more than one sex partner.
- Pregnant women.
- Women planning IUD insertion, depending on individual risk as defined by US Preventive Services Task Force guidelines and local Chlamydia trachomatis epidemiology.
- Sex partners of persons with chlamydial infection.
- Men with urethritis or epididymitis.
- Young sexually active men (aged 29 years and under) seeking routine health care should be evaluated for asymptomatic chlamydial infection in geographic areas of high prevalence (http://www.doh.wa.gov/cfh/ std/morbidity.htm).
- HIV-infected persons should be screened for asymptomatic urogenital infection annually or more frequently if at higher risk of infection. Patient reporting receptive anal sex should be tested for rectal chlamydial infection.4

FREQUENCY OF TESTING

- Sexually active adolescent women should be screened for chlamydial infection at least annually, even if symptoms are not present.
- All other women who meet the suggested screening criteria (listed above) should be tested for chlamydia annually unless a sexual risk assessment indicates more frequent screening.
- Routine test of cure is not recommended for persons treated with the recommended regimens unless therapeutic compliance is in question or symptoms persist or reinfection is suspected except in pregnant women. If a nucleic acid amplification test (NAAT) is used to determine if the patient is cured, the specimen should not be collected sooner than four weeks after completion of treatment.
- A test for C. trachomatis should be performed at the first prenatal visit. Women aged <25 years and those at increased risk for chlamydia (i.e., women who have a new or more than one sex partner) also should be tested during the third trimester to prevent maternal postnatal complications and chlamydial infection in the infant.