

Screening for Chlamydia and Gonorrhoea in abortion services – an opportunity not to be missed.

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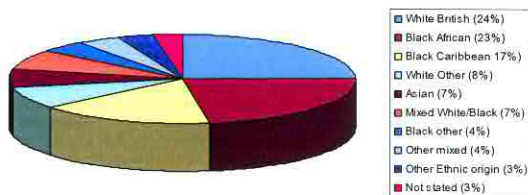
Introduction

Bacterial sexually transmitted infections (STIs) are risk factors for post-abortion infection. We report the preliminary outcomes of a partnership between charity abortion organisation BPAS (British Pregnancy Advisory Service) and an NHS genito-urinary medicine (GUM) provider to introduce routine screening for *Chlamydia trachomatis* (CT) and *Neisseria gonorrhoea* (GC) into termination of pregnancy (TOP) services.

Methods

- From 16.08.09, women < 25 years old from Lambeth, Southwark or Lewisham Primary Care Trusts attending BPAS TOP services were offered GC and CT screening.
- Self-taken vulvo-vaginal swabs were analysed using nucleic acid amplification tests (NAATs; Roche Diagnostics).
- Women having TOPs were treated prophylactically with 1g azithromycin (plus 1g metronidazole if surgical). Those with GC were also given 400mg cefixime.
- Partner notification was performed by telephone.
- Demographic and obstetric history was extracted from an electronic database.
- Those accepting/declining tests were compared.

Fig 1. Baseline Ethnicity.



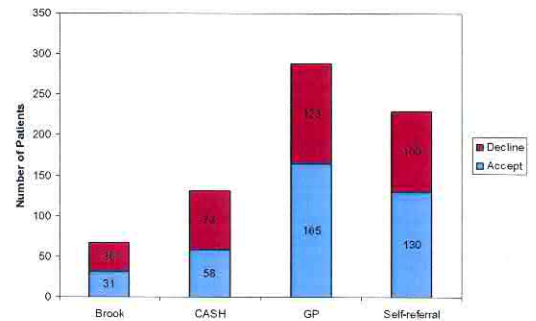
Results

- 16.08/09- 16.02.10: 722 eligible women, mean age 20.5 years.
- Those of non-white ethnicity were more likely to accept STI screening: 54% Asian clients, 56.3% of those who were Black African/Caribbean, 67.5% of mixed race versus 47% of Caucasians (Chi-squared test, p=0.03).
- There was no difference in age or obstetric history between those accepting/declining screening. GP/self-referred clients were more likely to accept testing. (Chi-squared test, p=0.05).
- The proportion of those offered screening increased over time, 56.6% in August to 95.7% in February (correlation coefficient 0.64).
- 32 samples equivocal for CT and 40 for GC (excluded from analysis).
- 18/241 (7.5%) samples CT positive.
- 9/235 (3.8%) samples GC positive; 3 cases were CT co-infected.
- Partner notification was successful in 20/24 cases.

References

1. NCSP Data Presentations Q1-3 2009-10.
http://www.chlamydia-screening.nhs.uk/ps/data/data_tables.html

Fig. 2. Source of referral and uptake of STI screening

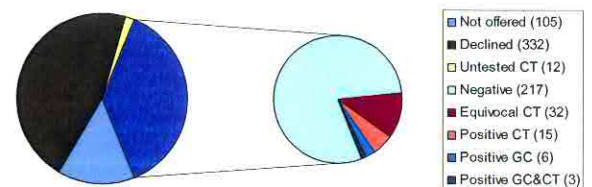


Limitations

Ongoing training is needed to increase the proportion of eligible clients who are offered screening and identify/address the reasons why clients are refusing screening. A proportion of clients may have been tested elsewhere which could account for the differences in uptake between different referral routes.

A significant number of tests were equivocal because of the presence of inhibitory substances, eg β -HCG, preventing nucleic acid amplification. This incidence has been reduced by freezing samples prior to analysis. Larger numbers of cases are needed to look at further risk factors associated with an STI diagnosis.

Fig. 3. Outcome of STI screening, 16.08.09-16.02.10 (n=722)



Conclusion

The contribution of TOP services to non-GUM CT screening is 0.3% in London.¹ Routine screening for CT has been demonstrated as feasible in inner-London termination clinics. The prevalence of CT is similar to that reported by London TOP clinics contributing to the National Chlamydia Screening Programme (6.2%).¹ However, GC is not routinely screened for. Our data demonstrates that the prevalence of GC in this setting is also significant.

Key Points

1. Increased collaboration between independent and NHS agencies can facilitate improved screening for STIs.
2. The opportunity to screen and ensure partner notification for *Chlamydia trachomatis* and *Neisseria gonorrhoea* in TOP services should not be missed.