



## Another year and still going strong

**Over three years since the first clinic signed on to ACCEPT, the project is still leading the charge on chlamydia testing in Australian general practices.**

The end of the year is a time for reflection and when I reflect on how far ACCEPT has come, I am humbled by how many GPs, practice nurses and practice managers have helped us get here.

So far over 150 GP clinics and Aboriginal Medical Services have enrolled in ACCEPT. Six clinics have closed since recruitment, and seven new clinics have opened in ACCEPT areas and been recruited into the study.

Over 900 GPs have signed on to the project – an incredible show of support from the general practice community. Many of the GPs have moved on from ACCEPT clinics and new GPs are continually being recruited at a rate of about 20 per month.

Many GPs and practice nurses have also taken the time to speak with ACCEPT researchers in qualitative interviews, crucial for the evaluation of ACCEPT.

For all of these contributions, ACCEPT staff and investigators are immensely grateful.

*Associate Professor Jane Hocking*

*Principal Investigator, ACCEPT*

## Showcasing ACCEPT

The 2013 Australasian Sexual Health Conference was held in Darwin on October 23–25. ACCEPT staff gave four great presentations at the conference:

- Associate Professor Jane Hocking (Principal Investigator): plenary speech titled “Can chlamydia testing become standard in general practice?”
- Alaina Vaisey (Project Officer, University of Melbourne): speech titled “‘Yeah, why not?’ Evaluating the acceptability of chlamydia testing in general practice to young people living in rural Australia: a mixed method approach.
- Anna Wood (Project Officer, University of Melbourne): speech titled “Increasing chlamydia testing in general practice is achievable: an update from the Australian Chlamydia Control Effectiveness Pilot (ACCEPT)”
- Rebecca Lorch (PhD student and Project Officer, Kirby Institute, UNSW): speech titled “‘I think it is better for practice nurses to do that’ Findings from the Australian Chlamydia Control Effectiveness Pilot (ACCEPT)”

## Travellers bring STIs back home

Young Australians are travelling overseas more than ever before and often take greater risks while travelling than at home. General practitioners can help keep their young patients healthy by giving them pre-travel advice and post-travel health and STI checks.

In 2012–13, Australians aged 15–29 years took 1.7 million short-term overseas trips, more than 2.5 times the number of a decade earlier. High rates of casual sex with locals or fellow travellers, travel for sex tourism



and low rates of condom use place young travellers at increased risk of catching HIV and other STIs.

Australian data show that:

- Sex overseas can increase the risk of chlamydia among young heterosexuals by 30–50%.
- STIs that are rare in heterosexuals (gonorrhoea, syphilis, HIV) are more common in returned travellers.
- Travellers visiting Asia are at increased risk of acquiring the new superbug, drug resistant gonorrhoea.
- Over 85% of heterosexual men and 56% of heterosexual women recently diagnosed with HIV in Western Australia acquired the infection overseas.

Making young patients aware of the risks of unprotected sex while travelling and importance of post travel STI checks will ensure that they take precautions and remain safe.

Since many of the most common STIs have few symptoms to prompt young people to seek an STI check after travelling, a thorough STI screen (including HIV test) is a vital way of detecting and treating infections early to prevent long-term health complications and transmission to future sexual partners.

## Pelvic Inflammatory Disease – easy to miss

Pelvic inflammatory disease (PID) is a challenging condition to diagnose. It can vary from a virtually asymptomatic condition to a severe one requiring hospitalisation. Inflammation of the endometrium or fallopian tubes from PID leads to an increased risk of ectopic pregnancy and infertility. A high degree of suspicion is therefore necessary when treating young, sexually active patients, so that a PID diagnosis is not missed. The following is a brief guide on the diagnosis and management of PID.

### Risk factors for PID

- Sexually active young women under 30 years
- Past history of chlamydia or gonorrhoea infection or PID
- High frequency of partner change
- Intrauterine device (IUD) insertion or termination of pregnancy

### Signs and symptoms

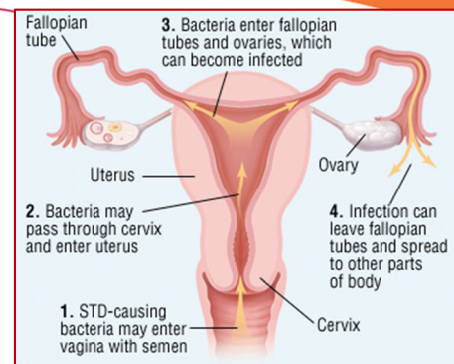
- Lower abdominal pain/discomfort
- Vaginal discharge
- Post-coital or intermenstrual bleeding
- Deep dyspareunia
- Lower abdominal tenderness
- Adnexal tenderness – unilateral or bilateral
- Cervical motion tenderness
- Uterine tenderness
- Fever (only if severe)

### Diagnosing PID

The Centers for Disease Control and Prevention guidelines suggest treatment for PID when any one of the following signs are present: uterine tenderness, adnexal tenderness or cervical motion tenderness in sexually active young women at risk of STIs where no other cause is identified.

### Investigations

- Chlamydia PCR (self-collected vaginal swab/first void urine/endocervical swab).
- Gonorrhoea culture (endocervical) or gonorrhoea PCR (vaginal/cervical/urine).
- High vaginal swab and gram stain for polymorphs and bacterial vaginosis.
- Vaginal pH and 'whiff' test for bacterial vaginosis
- Full blood count plus erythrocyte sedimentation rate or C-reactive protein measure for severity.
- Pregnancy test, mid-stream urine and pelvic ultrasound can rule out other causes of symptoms.



### Outpatient treatment for PID

- In cases of moderate or severe PID, pelvic mass, or if the woman is pregnant, consider admission to hospital.
- In young sexually active women with no predisposing factors:

Azithromycin 1 g orally stat

+

Doxycycline 100 mg twice per day for 14 days

+

Metronidazole 400 mg twice per day for 14 days

+

(if gonorrhoea is suspected or proven)

Ceftriaxone 500 mg IM stat

- Post-procedural PID:

Doxycycline 100 mg twice per day for 2–4 weeks

**Or**

Amoxicillin 500 mg three times per day for 2–4 weeks

+

Metronidazole 400 mg three times per day for 2–4 weeks

Please note: If the patient is pregnant or breastfeeding, substitute Doxycycline with Roxithromycin 300 mg orally, daily for 14 days.

Advise patients to abstain from sexual activity (oral, vaginal and anal sex) for 7 days after they and their partner have received treatment

### Follow-up

- Review treatment after 48–72 hours.
- Treatment duration depends on disease severity and response to therapy.
- Continue treatment until symptoms and cervical tenderness have resolved, for a minimum of 14 days.
- If PID is STI-related, test for re-infection and partner notification and treatment 3 months after treatment.

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