# Perspectives

## Legislate for patient-delivered partner therapy for chlamydia

### Patient-delivered partner therapy requires legislative support to improve control of sexually transmitted infections

**Sarah E Huffam**
FAChSHM, MPH&TM, FRACP, Sexual Health Physician,[1] and Infectious Diseases Physician[2]

**Katherine M Brown**
MBBS, MSc, FAChSHM, Specialist in Sexual Health Medicine[3]

**Marcus Y Chen**
FRCP, FAChSHM, PhD, Sexual Health Physician,[1] and Clinical Associate Professor[4]

**Christopher K Fairley**
FRACP, PhD, Professor of Sexual Health,[4] and Director[1]

**1** Melbourne Sexual Health Centre, Alfred Health, Melbourne, VIC.
**2** Royal Darwin Hospital, Darwin, NT.
**3** Sydney Medical School, University of Sydney, Sydney, NSW.
**4** Melbourne School of Population and Global Health, University of Melbourne, Melbourne, VIC.

**shuffam@mshc.org.au**

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Genital *Chlamydia trachomatis* is Australia's most common reportable communicable infection. Despite considerable investment in screening programs, the National Notifiable Diseases Surveillance System reports notification rates steadily rising for more than a decade, from 87.2 per 100 000 in 2000, to 358.9 per 100 000 in 2012.

Effective control requires timely and appropriate antibiotic treatment of patients with confirmed infection as well as their sexual partners. However, in Australia, only a minority of partners currently receive treatment. If Australia is to reduce chlamydia prevalence, new effective approaches need to be incorporated into clinical care to ensure optimal testing and treatment of sexual partners. One potentially effective option in some cases, patient-delivered partner therapy (PDPT), is not specifically supported by legislation in most Australian states and territories.

PDPT, where the index patient with a sexually transmitted infection (STI) is given antibiotics to deliver to sexual partners, has been legalised in most states in the United States. While some clinicians do prescribe PDPT in Australia, in most Australian states PDPT is clearly illegal or its legal status is ambiguous. PDPT with single dose azithromycin is a safe and effective method of treating sexual partners of people with chlamydia and improves disclosure to partners. A meta-analysis of five published studies of PDPT showed reduced persistent or recurrent chlamydia or gonorrhoea infections (summary risk ratio of five trials, 0.73; 95% CI, 0.57–0.93).[1]

In Australia, specific PDPT guidelines are endorsed by the Australasian Chapter of Sexual Health Medicine (AChSHM), a Chapter of the Royal Australasian College of Physicians, and the Australasian Society for Infectious Diseases.[2]

In 2006 the US Centers for Disease Control and Prevention (CDC) recommended PDPT as an option for ensuring treatment of sex partners. PDPT was initially legally permissible in only a minority of states, but many states have since changed or clarified their laws and it is now explicitly legally permissible in 33 US states.[3] In Australia, only the Northern Territory has changed legislation to enable prescription of PDPT for chlamydia (*Medicines, Poisons and Therapeutic Goods Act 2012* [NT]) and implementation is pending drafting of regulations.

Legal status is the main barrier to implementing PDPT. Other concerns include acceptability within general practice, the risk of adverse reactions, and lack of opportunity to diagnose and manage complications of chlamydia or other STIs in partners receiving PDPT, a particular concern with men who have sex with men. In addition, partners who take PDPT without a clinical consultation may not be aware of the need to contact their other sexual partners. Consequently, the guidelines include an information sheet for sexual partners highlighting the need for a clinical consultation (particularly if there are symptoms), follow-up testing for reinfection in 3 months and the importance of contacting other sexual partners. The risks of missing other STIs in partners and their contacts are reduced if the intervention is confined to heterosexual people in the urban Australian context, who uncommonly have other STIs.[4]

Azithromycin is a safe and well tolerated antibiotic (pregnancy category B1). Although significant adverse reactions are rare, an observational cohort study in Tennessee, US, showed a small increase in cardiovascular deaths in patients taking a 5-day course of azithromycin compared with another antibiotic, the risk being most pronounced among patients with a high baseline risk of cardiovascular disease. Subsequently, the study design and conclusions were challenged and contrasted with the prior findings of six placebo-controlled trials of azithromycin in high-risk cardiovascular patients, in which there was no increase in mortality.[5] A recent nationwide Danish cohort study including over 1 million episodes of azithromycin use found no increased risk of death in patients taking azithromycin compared with penicillin.[6] No serious adverse effects have been reported from azithromycin associated with PDPT trials or subsequent surveillance in the US.[3]

The AChSHM and the CDC recommend PDPT because the benefits outweigh the risks. In the face of rising chlamydia prevalence, and no currently effective control strategy, we ask those Australian jurisdictions not actively planning to expressly endorse PDPT through laws permitting implementation of a proven effective strategy to do so as a matter of urgency.

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