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Chlamydia Infection: A Main Role of Nursing Intervention Protocols and Laboratory Diagnosis

Amjad Ali Alqahtani[1], TAHANI HUWAYDI ALDHAFEERI[2], MASHAEL HUWAYDI ALDHAFEERI[3], BANDAR ABDALRAHMAN ALDABASI[4], Ahmad Hamoud ALMUTAIRI[5], ALMUTAIRI, ABDULALI NASSER S[6], Ahmed Mohammed Suliman Alshammari[7], AHMED MITHQAL ALSHAMMARI[8], DALAL FAHAD ALDHAFEERI[9], Khazim abdullah ali al- amri[10]

Abstract

Chlamydia trachomatis is the most prevalent bacterial sexually transmitted infection (STI) globally, with significant public health implications due to its frequent asymptomatic presentation and potential complications, including pelvic inflammatory disease (PID), infertility, and neonatal infections. Despite effective treatments, barriers to screening, diagnosis, and partner management perpetuate transmission.This article examines the critical role of nursing interventions and laboratory diagnostics in mitigating the burden of chlamydia infections, emphasizing evidence-based screening, treatment protocols, and patient education strategies.A comprehensive review of clinical guidelines and literature was conducted, focusing on nursing assessments, diagnostic approaches (notably NAAT testing), medical management (azithromycin/doxycycline), and interdisciplinary care coordination.Key findings highlight: (1) NAAT testing's superiority (95–99% accuracy) for urogenital and extragenital infections; (2) the efficacy of single-dose azithromycin for uncomplicated cases; (3) the necessity of annual screening for high-risk groups (e.g., women ≤25 years, MSM); and (4) nursing's pivotal role in patient education, partner notification, and adherence support. Expedited partner therapy (EPT) and follow-up testing at 3 months reduced reinfection rates.Multidisciplinary collaboration—integrating targeted screening, prompt treatment, and nursing-led health promotion—is essential to reduce chlamydia's sequelae and transmission.

Keywords: *Chlamydia Trachomatis, STI Screening, NAAT Testing, Nursing Interventions, Partner Management, Azithromycin.*

Introduction

Chlamydia is a prevalent sexually transmitted infection (STI) caused by the pathogenic bacterium *Chlamydia trachomatis*. In the United States, it holds the distinction of being the most frequently reported bacterial infection, while on a global scale, it ranks as the most widespread sexually transmitted disease (STD) [1]. This pathogen is also responsible for trachoma, a severe ocular infection that represents the primary infectious etiology of preventable blindness worldwide. Among female populations, infections caused by *Chlamydia trachomatis* are associated with significant reproductive health complications, including an elevated risk of infertility and ectopic pregnancies, which subsequently contribute to substantial healthcare expenditures [1]. Additionally, certain serovars of *Chlamydia trachomatis* can induce lymphogranuloma venereum (LGV), a less common but clinically significant condition characterized by manifestations such as lymphadenopathy or severe inflammatory processes affecting the rectal and colonic mucosa (proctocolitis) [2]. The multifaceted clinical presentations of *Chlamydia trachomatis* infections underscore

[1] Ksa, ministry of health, Prince Sultan Cardiac Center
[2] Ksa, ministry of health.
[3] Ksa, ministry of health, King khalid general hospital.
[4] BRANCH OF MINISTRY OF HEALTH IN RIYADH REGION.
[5] Ksa, ministry of health, Al-Qaisumah Hospital
[6] Ksa, ministry of health, Al-Qaisumah General Hospital
[7] Ksa, ministry of health, Qisumah general hospital- laboratory
[8] Ksa, ministry of health, King Khalid General Hospital, Hafar Al-Batin
[9] Ksa, ministry of health, King Khalid General Hospital, Hafar Al-Batin
[10] Ksa, ministry of health, Abha Health Sector - Inventory Control Department

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their considerable public health burden, necessitating ongoing research and targeted intervention strategies to mitigate their adverse outcomes.

Nursing Diagnoses Associated with Chlamydia trachomatis Infection

The management of *Chlamydia trachomatis* infection necessitates a comprehensive nursing assessment to identify potential health complications and psychosocial challenges. Key nursing diagnoses include ineffective healing, stemming from delayed treatment or recurrent infections, which may impair tissue repair and recovery. Deficient knowledge regarding disease transmission, prevention, and treatment adherence is common, requiring targeted patient education to reduce reinfection risks. Anxiety may arise due to the stigma associated with sexually transmitted infections (STIs), fear of complications (e.g., infertility), or concerns about partner notification. Additionally, ineffective body defense reflects the immune system's compromised ability to combat persistent or untreated infections, increasing susceptibility to secondary complications. Sexual dysfunction may develop due to physical discomfort, psychological distress, or relational strain. Acute or chronic pain can result from inflammatory processes, particularly in cases of pelvic inflammatory disease (PID) or lymphogranuloma venereum (LGV). Low self-esteem is frequently observed, linked to feelings of guilt, shame, or social isolation. Finally, risk for infection transmission remains a critical concern, emphasizing the need for safe-sex counseling and partner treatment to prevent further spread. These nursing diagnoses guide evidence-based interventions, including patient education, emotional support, pain management, and infection control strategies, to optimize health outcomes and reduce long-term sequelae.

Risk Factors for Urogenital Chlamydia Infections

Urogenital infections caused by *Chlamydia trachomatis* represent the most frequently reported bacterial sexually transmitted infection (STI) in the United States and the predominant cause of sexually transmitted disease globally [4]. Epidemiological data reveal significant demographic disparities in infection rates, with women in the U.S. exhibiting twice the prevalence of infection compared to men. This heightened susceptibility among women is particularly pronounced in adolescents and young adults aged 15–24 years, a demographic that accounts for the majority of reported cases. Conversely, men aged 20–24 years demonstrate the highest incidence rates, underscoring the role of age and sexual activity patterns in transmission dynamics [4]. Several behavioral and biological factors contribute to the elevated risk observed in these populations. Early sexual debut, multiple sexual partners, inconsistent condom use, and a history of prior STIs significantly increase susceptibility to infection. Additionally, asymptomatic presentation, particularly in women, often leads to delayed diagnosis and treatment, facilitating ongoing transmission. Structural and socioeconomic determinants, including limited access to sexual health education, stigma surrounding STI testing, and barriers to healthcare services, further exacerbate vulnerability, particularly among marginalized communities. The disproportionate burden of chlamydia among young women carries substantial public health implications, as untreated infections may result in pelvic inflammatory disease (PID), tubal factor infertility, and adverse pregnancy outcomes. Addressing these risk factors through targeted screening programs, comprehensive sexual education, and improved healthcare access remains critical to mitigating the individual and societal impact of this pervasive infection [4].

Clinical Assessment of Chlamydia trachomatis Infections

Chlamydia trachomatis infections present with a broad spectrum of clinical manifestations, ranging from asymptomatic carriage to severe inflammatory disease. The pathogen demonstrates a particular tropism for urogenital mucosa but can also cause infections at extragenital sites. A significant challenge in clinical management stems from the high prevalence of asymptomatic infections, which facilitates ongoing transmission while delaying diagnosis and treatment. When symptoms do occur, they vary considerably depending on the anatomical site of infection, necessitating a thorough clinical assessment to guide appropriate diagnostic testing and therapeutic interventions.

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Urogenital Manifestations

Cervicitis represents one of the most common clinical presentations in women, though approximately 70% of cases remain asymptomatic. Symptomatic patients may report nonspecific complaints including abnormal vaginal discharge, postcoital or intermenstrual bleeding, and mild dysuria. The classic findings of mucopurulent cervicitis - characterized by purulent endocervical exudate and cervical friability - occur in only a minority of cases. This subtle presentation frequently leads to underdiagnosis, allowing ascending infection to develop into pelvic inflammatory disease (PID). PID typically manifests with lower abdominal pain, often accompanied by abnormal vaginal bleeding, dyspareunia, and fever. Physical examination may reveal cervical motion tenderness, uterine tenderness, and adnexal fullness, though clinical findings can be remarkably variable in severity. In male patients, urethritis constitutes the most frequent symptomatic presentation of chlamydial infection. Clinical features include dysuria and a characteristic clear to mucoid urethral discharge that may be most evident upon awakening. The discharge often appears less purulent than that seen in gonococcal infections, though reliable clinical differentiation proves impossible without laboratory confirmation. Epididymitis represents a less common but important complication, typically presenting with unilateral testicular pain and swelling accompanied by palpable epididymal tenderness and occasionally fever. The insidious onset of symptoms helps distinguish chlamydial epididymitis from other acute scrotal pathologies.

Extragenital and Systemic Manifestations

Proctitis occurs primarily in individuals engaging in receptive anal intercourse and typically presents with rectal pain, tenesmus, mucopurulent discharge, and hematochezia. The clinical presentation often mimics inflammatory bowel disease, necessitating careful diagnostic evaluation. Lymphogranuloma venereum (LGV), caused by invasive L-serovars of *C. trachomatis*, follows a distinct clinical course characterized by initial genital ulceration followed by regional lymphadenopathy. The inguinal syndrome features painful, matted lymph nodes that may be suppurated, while the anorectal syndrome produces severe proctocolitis with systemic symptoms. Extragenital manifestations include conjunctivitis, which may occur through autoinoculation or perinatal transmission, presenting as eye redness, discharge, and photophobia. Perihepatitis (Fitz-Hugh-Curtis syndrome) manifests as right upper quadrant pain in the setting of PID, while reactive arthritis develops as a sterile inflammatory process weeks after genital infection. The triad of urethritis, conjunctivitis, and arthritis constitutes Reiter's syndrome, though incomplete forms frequently occur. Pharyngeal infections, though typically asymptomatic, may cause mild sore throat and are increasingly recognized as potential reservoirs for transmission.

Diagnostic Considerations

The frequent absence of specific symptoms creates significant challenges for clinical diagnosis. A high index of suspicion must be maintained for sexually active individuals, particularly adolescents and young adults. Physical examination should include careful inspection for mucopurulent discharge, cervical or urethral inflammation, and assessment for abdominal or pelvic tenderness. Given the limitations of clinical diagnosis alone, laboratory confirmation through nucleic acid amplification tests (NAATs) remains essential for accurate detection. The broad spectrum of potential manifestations underscores the importance of considering *C. trachomatis* infection in the differential diagnosis of various urogenital and systemic conditions, particularly in high-risk populations. Early recognition and treatment are crucial to prevent long-term sequelae and interrupt transmission chains within communities.

Diagnostic Evaluation of Chlamydia trachomatis Infections

The clinical diagnosis of *Chlamydia trachomatis* infections presents significant challenges due to their frequently asymptomatic nature and nonspecific presentations. Among the spectrum of chlamydial infections, only trachoma can be reliably diagnosed through clinical examination alone, characterized by its distinctive follicular conjunctivitis and corneal involvement in endemic regions. All other chlamydial infections, despite being associated with recognizable clinical syndromes, require laboratory confirmation for definitive diagnosis due to their overlapping presentations with other pathogens. Nucleic

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acid amplification testing (NAAT) represents the gold standard for diagnosing urogenital chlamydia infections due to its exceptional sensitivity (>95%) and specificity (>99%). For women, NAAT can be performed on self-collected or clinician-obtained vaginal swabs, while men are typically tested using first-catch urine specimens. Endocervical or urethral swabs remain alternative sampling methods, though they are more invasive. The non-invasive nature and high accuracy of NAAT have made it the preferred diagnostic approach in clinical practice. Alternative diagnostic methods include cell culture, which maintains importance for antibiotic resistance testing but suffers from low sensitivity (60-80%) and stringent transport requirements. Rapid antigen detection tests offer point-of-care convenience but demonstrate inferior accuracy compared to NAAT. Serological testing has limited utility in acute infections but may aid in diagnosing lymphogranuloma venereum (LGV) or neonatal pneumonia. In resource-limited settings where NAAT is unavailable, syndromic management based on clinical presentation remains a pragmatic approach, though this may lead to both overtreatment and missed asymptomatic cases. The selection of diagnostic method should consider clinical context, available resources, and the need for timely treatment to prevent complications and interrupt disease transmission.

Medical Management of Chlamydia trachomatis Infections

The primary objectives in treating *Chlamydia trachomatis* infections are threefold: preventing serious complications (such as pelvic inflammatory disease, infertility, and perihepatitis), reducing transmission rates, and achieving symptomatic relief. For uncomplicated urogenital infections, azithromycin (1 g single dose) remains the first-line treatment due to its convenience, high efficacy, and improved adherence compared to multi-dose regimens. Doxycycline (100 mg twice daily for 7 days) serves as an effective alternative, particularly in cases where azithromycin is contraindicated or in extragenital infections like lymphogranuloma venereum (LGV), which requires an extended 21-day course. However, azithromycin's single-dose administration makes it preferable for population-level control efforts. A critical consideration in management is the frequent coinfection with *Neisseria gonorrhoeae*, particularly in high-prevalence populations. For men, the decision to provide empiric gonorrhea co-treatment should be guided by either positive NAAT results or Gram stain findings of intracellular gram-negative diplococci in urethral secretions. In women, Gram stain interpretation is complicated by the presence of commensal *Neisseria* species in vaginal flora, making epidemiological risk assessment and local gonorrhea prevalence data more reliable indicators for dual therapy. Current guidelines recommend concurrent treatment with ceftriaxone for gonorrhea when risk factors are present or in regions with substantial coinfection rates. Partner management constitutes an essential component of treatment, requiring identification, testing, and presumptive treatment of all sexual contacts within the preceding 60 days. Patients should receive comprehensive counseling on sexual risk reduction, including consistent condom use, and must abstain from sexual activity for at least 7 days post-treatment to prevent reinfection or transmission. Concurrent HIV testing should be offered due to overlapping risk factors. Post-treatment follow-up includes test-of-cure via NAAT at 3 weeks after therapy completion for pregnant women or complicated infections, while repeat screening at 3 months is advised for all patients to detect reinfection. Persistent symptoms should prompt evaluation for treatment failure (rare with recommended regimens), reinfection (often due to untreated partners), or coinfections (e.g., *Trichomonas vaginalis*, bacterial vaginosis). In cases of recurrent infections, clinicians should reassess adherence, partner management, and behavioral risk factors while considering extended doxycycline courses for possible LGV serovars. This structured approach ensures microbiological eradication, reduces complications, and disrupts transmission chains within communities.

Nursing Management of Chlamydia trachomatis Infections

Nurses play a pivotal role in the comprehensive management of chlamydia infections, serving as educators, advocates, and facilitators of treatment adherence. The nursing management plan should encompass patient education, therapeutic interventions, and follow-up coordination to ensure optimal outcomes and prevent disease transmission.

Patient Education and Counseling: A cornerstone of nursing management involves providing thorough education about chlamydia infections. Nurses should explain the pathophysiology of the disease,

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emphasizing that many infections are asymptomatic yet still transmissible. Patients must understand potential complications such as pelvic inflammatory disease, infertility, and ectopic pregnancy to appreciate the importance of treatment. Education should be delivered in a non-judgmental manner using health literacy-appropriate language, with opportunities for questions and clarification.

Risk Reduction Strategies: Nurses should actively promote safe sex practices, including consistent and correct condom use. This counseling should include demonstrations of proper condom application and storage. Patients should be educated about the limitations of condoms in preventing all STIs and the importance of mutual monogamy or reduced partner numbers. For sexually active adolescents and young adults, nurses can provide guidance on negotiating safer sex practices with partners.

Medication Adherence and Monitoring: For patients prescribed azithromycin, nurses should verify understanding of the single-dose regimen. Those receiving doxycycline require detailed instructions about taking the medication with food to avoid nausea, completing the full 7-day course, and avoiding sun exposure. Nurses must review potential side effects and emphasize the dangers of sharing medications. Pregnancy testing is essential before doxycycline administration, and alternative regimens must be secured for pregnant patients.

Diagnostic Coordination and Treatment: Nurses facilitate the diagnostic process by ensuring proper specimen collection and timely processing. They administer prescribed antibiotics according to established protocols and document administration. Nurses should verify medication allergies and potential drug interactions before administration, particularly for patients receiving concurrent gonorrhea treatment.

Partner Notification and Follow-up: A critical nursing responsibility involves encouraging patients to notify partners while addressing potential fears or stigma. Nurses can provide anonymous notification resources or health department assistance. Patients should understand the rationale for partner treatment even in asymptomatic cases. Nurses schedule and reinforce the importance of follow-up testing at 3 months post-treatment, particularly for high-risk patients. They also coordinate referrals to specialized STD clinics when needed and document all education and interventions in the patient record.

Psychosocial Support: Recognizing the emotional impact of STI diagnosis, nurses provide supportive counseling to address feelings of shame or anxiety. They assess for intimate partner violence risks that may emerge during partner notification discussions and connect patients with appropriate resources. For patients with recurrent infections, nurses conduct motivational interviewing to identify and address barriers to safer sex practices. This comprehensive nursing approach addresses the biological, psychological, and social dimensions of chlamydia management, ultimately reducing complications and transmission rates in the community. By establishing therapeutic relationships and providing evidence-based care, nurses significantly contribute to public health efforts against this prevalent STI [5].

Coordination of Care for Chlamydia Trachomatis Infections

Effective management of *Chlamydia trachomatis* infections requires a coordinated, multidisciplinary approach that integrates screening protocols, treatment strategies, and preventive education. In the United States and other developed nations, prevention efforts primarily focus on routine screening of sexually active women aged ≤25 years, as this demographic bears the highest burden of infection. Current guidelines recommend annual screening for all non-pregnant sexually active women in this age group, while pregnant women should be screened during their first prenatal visit, with repeat testing in the third trimester for those at high risk. For women over 25, screening is advised when risk factors are present, including new or multiple sexual partners, inconsistent condom use, or a history of sexually transmitted infections (STIs). Although less emphasized, screening young men in high-prevalence settings (e.g., STI clinics, correctional facilities, and adolescent health centers) should be considered where feasible, as it may help reduce community transmission. Nucleic acid amplification tests (NAATs) serve as the gold standard for screening due to their high sensitivity and specificity. These tests can be performed on non-invasive specimens, including first-catch urine samples in men and self-collected vaginal swabs in women, which improve patient acceptability and screening compliance. The prognosis for chlamydial infections is excellent

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when treatment is initiated promptly and completed in full; first-line antibiotic regimens (azithromycin or doxycycline) demonstrate >95% efficacy in eradicating the infection. However, treatment success depends on patient adherence, making education and follow-up critical components of care [6].

Currently, no vaccine exists for either trachoma or genital chlamydia infections, underscoring the importance of behavioral interventions and regular screening as primary prevention strategies. A collaborative healthcare approach is essential to ensure optimal outcomes. Clinicians must accurately diagnose infections and prescribe appropriate therapy, while nurses play a key role in patient education, counseling on safe sex practices, and promoting medication adherence. Pharmacists contribute by ensuring proper antibiotic dispensing, reviewing potential drug interactions, and reinforcing the importance of completing the full course of treatment. Additionally, public health professionals are vital in contact tracing, partner notification, and monitoring local epidemiological trends to guide screening recommendations. To minimize reinfection and complications, patients should be counseled to abstain from sexual activity for 7 days post-treatment and to notify all sexual partners within the past 60 days for evaluation and presumptive treatment. Follow-up testing at 3 months post-treatment is recommended to detect reinfection, particularly in high-risk individuals. By fostering interprofessional collaboration and implementing evidence-based screening protocols, healthcare teams can effectively reduce the incidence of chlamydia, prevent long-term sequelae, and curb ongoing transmission in the community [6].

Health Teaching and Health Promotion for Chlamydia trachomatis Infections

Given the high prevalence of asymptomatic *Chlamydia trachomatis* infections and their potential long-term health consequences, comprehensive health education and promotion strategies are essential components of preventive care. The silent nature of many chlamydial infections means patients may unknowingly transmit the bacteria or develop complications before seeking treatment, making proactive screening initiatives critical. Current guidelines recommend targeted screening for specific populations based on age, sexual behaviors, and other risk factors to maximize early detection and treatment [6].

Screening Recommendations and Rationale: All pregnant women should undergo chlamydia screening during their initial prenatal visit, with repeat testing in the third trimester for those at ongoing risk, as untreated infections can lead to adverse pregnancy outcomes including preterm birth and neonatal conjunctivitis or pneumonia. Sexually active women under 25 years represent a high-priority group for annual screening due to biological susceptibility and higher prevalence rates in this demographic. For women over 25, screening should occur when risk factors are present, including having new or multiple partners, inconsistent condom use in non-monogamous relationships, a history of sex work, or previous/coexisting STIs. Men who have sex with men (MSM) require annual screening at all exposed anatomical sites (urethral, rectal, pharyngeal), with more frequent testing (every 3-6 months) for those at highest risk. HIV-positive individuals should be screened at initial HIV diagnosis and annually thereafter. Correctional facilities should implement screening protocols for women ≤35 years and men ≤30 years given the elevated prevalence in these populations [6].

Notification and Partner Management Strategies: As a nationally notifiable infection, healthcare providers must comply with state-specific reporting requirements for chlamydia cases. A critical component of prevention involves partner notification and treatment. Patients should be counseled to inform all sexual partners from the preceding 60 days about potential exposure. Expedited partner therapy (EPT), where permitted by state law, allows providers to prescribe medication to partners without an in-person evaluation, significantly improving treatment rates among contacts who might otherwise not seek care. Healthcare professionals should familiarize themselves with local EPT regulations and procedures to facilitate this evidence-based intervention [6].

Patient Education Approaches: Effective health teaching should emphasize several key messages: First, patients need to understand that chlamydia often causes no symptoms but can still lead to serious reproductive complications like infertility or chronic pelvic pain. Second, screening is simple and frequently requires only a urine sample, alleviating concerns about invasive pelvic exams. Third, all sexually active individuals should discuss STI testing with their providers, particularly when starting new relationships or

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experiencing partner changes. Education should be delivered using clear, non-stigmatizing language and should address common misconceptions about STI transmission and prevention.

Promoting Preventive Behaviors: Health promotion efforts should focus on encouraging consistent condom use, regular testing for those at risk, and open communication between sexual partners about STI status. Providers can distribute educational materials in waiting rooms and utilize brief counseling sessions during routine visits to reinforce these messages. Community-based interventions, including school health programs and outreach to high-risk populations, can further enhance prevention efforts. By combining targeted screening with comprehensive education and accessible treatment options, healthcare teams can significantly reduce the burden of chlamydial infections and their associated complications in the community [6].

Conclusion

The pervasive burden of *Chlamydia trachomatis* infections demands a multifaceted approach combining advanced diagnostics, evidence-based treatment, and proactive nursing interventions. As the leading bacterial STI globally, chlamydia's clinical impact stems not only from its high prevalence but also from its insidious asymptomatic course, which delays diagnosis and facilitates transmission. This review underscores the critical importance of routine NAAT screening for high-risk populations, particularly sexually active women under 25 and MSM, as the cornerstone of prevention. The non-invasive nature of urine and vaginal swab NAATs addresses patient hesitancy, while their high sensitivity ensures early detection, reducing complications like PID and infertility. Medical management relies on single-dose azithromycin or 7-day doxycycline, both achieving >95% efficacy when adhered to. However, treatment success hinges on nursing-led initiatives: medication counseling, partner notification support, and follow-up coordination. Nurses bridge gaps in care by addressing psychosocial barriers—stigma, poor health literacy, and fear of invasive exams—through tailored education. The integration of EPT in eligible regions further enhances outcomes by treating partners without clinic visits, breaking transmission chains. The absence of a vaccine elevates the role of behavioral interventions. Nurses promote preventive practices (condom use, mutual monogamy) and advocate for annual screenings in high-risk settings, including correctional facilities and adolescent clinics. For pregnant women, prenatal and third-trimester screening mitigates neonatal risks, exemplifying the need for risk-stratified protocols. Persistent challenges include resource disparities limiting NAAT access in low-income areas and reinfection rates linked to untreated partners. Future efforts must expand EPT adoption, leverage telehealth for education, and prioritize outreach to marginalized groups. In conclusion, combating chlamydia requires interprofessional synergy: clinicians prescribing accurately, nurses educating and empowering patients, and public health systems optimizing screening accessibility. By prioritizing these strategies, healthcare teams can curb the silent epidemic of chlamydia, safeguarding reproductive health and reducing long-term societal costs. Continued research into vaccines and point-of-care diagnostics remains vital to sustain progress.

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عدوى الكلاميديا: الدور الرئيسي لبروتوكولات التدخل التمريضي والتشخيص المخبري

الملخص

الخلفية: تُعد *Chlamydia trachomatis* العدوى البكتيرية المنقولة جنسيًا الأكثر انتشارًا عالميًا، ولها تأثيرات كبيرة على الصحة العامة بسبب طبيعتها اللاعرضية في كثير من الحالات ومضاعفاتها المحتملة، مثل مرض التهاب الحوض(PID) ، العقم، والعدوى الوليدية. على الرغم من توفر علاجات فعالة، لا تزال العوائق المتعلقة بالفحص والتشخيص وإدارة الشركاء تساهم في استمرار انتشار العدوى.

الهدف: يستعرض هذا المقال الدور الحاسم للتدخلات التمريضية والتشخيصات المخبرية في الحد من عبء عدوى الكلاميديا، مع التركيز على استراتيجيات الفحص، وبروتوكولات العلاج المستندة إلى الأدلة، وتعليم المرضى.

المنهجية: تمت مراجعة شاملة للإرشادات السريرية والأدبيات العلمية، مع التركيز على تقييمات التمريض، والنهج التشخيصية (خاصة اختبار التضخيم النووي *NAAT*)، والإدارة الطبية (الأزيثروميسين/الدوكسيسيكلين)، والتنسيق متعدد التخصصات في الرعاية.

النتائج: أبرزت النتائج ما يلي: تفوق اختبار *NAAT* بدقة تتراوح بين 95-99% في الكشف عن العدوى البولية والتناسلية وغير التناسلية، فعالية جرعة واحدة من الأزيثروميسين في الحالات غير المعقدة.، ضرورة إجراء الفحص السنوي للمجموعات عالية الخطورة، مثل النساء ≥ 25 عامًا والرجال المثليين جنسيًا.(*MSM*) ، الدور المحوري للتمريض في تثقيف المرضى، وإخطار الشركاء، ودعم الالتزام بالعلاج، انخفاض معدلات الإصابة المتكررة مع العلاج السريع للشركاء (*EPT*) وإعادة الفحص بعد 3 أشهر.

الخلاصة: يتطلب الحد من مضاعفات وانتشار الكلاميديا تعاونًا متعدد التخصصات، يشمل الفحص المستهدف، والعلاج الفوري، والتثقيف الصحي بقيادة التمريض.

الكلمات المفتاحية: فحص العدوى المنقولة جنسيًا، اختبار *NAAT*، التدخلات التمريضية، إدارة الشركاء، الأزيثروميسين.