Figure. **Screening for chlamydial infection.**

Annals of Internal Medicine

Screening for Chlamydial Infection

	Nonpregnant Women			Pregnant Women			Men
Population	**Age 24 years or younger**	**Age 25 years or older**		**Age 24 years or younger**	**Age 25 years or older**		No recommendation due to insufficient evidence*
	Includes adolescents	**Not at increased risk**	**At increased risk**	**Includes adolescents**	**Not at increased risk**	**At increased risk**	
Recommendation	**A** **Screen if sexually active**	**C**	**A** **Screen if sexually active**	**B** **Screen**	**C**	**B** **Screen**	

Risk assessment	**Age:** Women and men age 24 years or younger are at greatest risk. **History of:** previous chlamydial infection or other sexually transmitted infections, new or multiple sexual partners, inconsistent condom use, sex work. **Demographics:** African-American and Hispanic women and men have higher prevalence rates than the general population in many communities.		
Screening tests	Nucleic acid amplification tests (NAATs) can identify chlamydial infection in asymptomatic women (nonpregnant and pregnant) and asymptomatic men. NAATs have high specificity and sensitivity and can be used with urine and vaginal swabs.		
Screening intervals	**Nonpregnant Women**	**Pregnant Women**	**Men**
	The optimal interval for screening is not known. The Centers for Disease Control and Prevention (CDC) recommends that women at increased risk be screened at least annually.†	Women 24 years or younger and older women at increased risk: Screen at the first prenatal visit. Patients at continuing risk or who are newly at risk: Screen in the third trimester.	Not applicable
Treatment	The CDC has outlined appropriate treatment: www.cdc.gov/STD/treatment. Test and/or treat partners of patients treated for chlamydial infection.		

For a summary of the evidence systematically reviewed in making these recommendations, the full recommendation statement, and supporting documents, please go to www.preventiveservices.ahrq.gov. *Chlamydial infection results in few sequelae in men. Therefore, the major benefit of screening men would be to reduce the likelihood that infected and untreated men would pass the infection to sexual partners. There is no evidence that screening men reduces the long-term consequences of chlamydial infection in women. Because of this lack of evidence, the USPSTF could not assess the balance of benefits and harms and concluded that the evidence is insufficient to recommend for or against routinely screening men. †Information from reference 1.

Table 1. **What the U.S. Preventive Services Task Force Grades Mean and Suggestions for Practice***

Grade	Definition	Suggestions for Practice
A	The USPSTF recommends the service. There is high certainty that the net benefit is substantial.	Offer or provide this service.
B	The USPSTF recommends the service. There is high certainty that the net benefit is moderate or there is moderate certainty that the net benefit is moderate to substantial.	Offer or provide this service.
C	The USPSTF recommends against routinely providing the service. There may be considerations that support providing the service in an individual patient. There is at least moderate certainty that the net benefit is small.	Offer or provide this service only if other considerations support offering or providing the service in an individual patient.
D	The USPSTF recommends against the service. There is moderate or high certainty that the service has no net benefit or that the harms outweigh the benefits.	Discourage the use of this service.
I statement	The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of the service. Evidence is lacking, of poor quality, or conflicting, and the balance of benefits and harms cannot be determined.	Read the clinical considerations section of USPSTF Recommendation Statement. If the service is offered, patients should understand the uncertainty about the balance of benefits and harms.

* The USPSTF defines *certainty* as "likelihood that the USPSTF assessment of the net benefit of a preventive service is correct." The net benefit is defined as benefit minus harm of the preventive service as implemented in a general, primary care population. The USPSTF assigns a certainty level based on the nature of the overall evidence available to assess the net benefit of a preventive service. USPSTF = U.S. Preventive Services Task Force.

Table 2. **U.S. Preventive Services Task Force Levels of Certainty Regarding Net Benefit**

Level of Certainty*	Description
High	The available evidence usually includes consistent results from well-designed, well-conducted studies in representative primary care populations. These studies assess the effects of the preventive service on health outcomes. This conclusion is therefore unlikely to be strongly affected by the results of future studies.
Moderate	The available evidence is sufficient to determine the effects of the preventive service on health outcomes, but confidence in the estimate is constrained by such factors as: the number, size, or quality of individual studies inconsistency of findings across individual studies limited generalizability of findings to routine primary care practice lack of coherence in the chain of evidence As more information becomes available, the magnitude or direction of the observed effect could change, and this change may be large enough to alter the conclusion.
Low	The available evidence is insufficient to assess effects on health outcomes. Evidence is insufficient because of: the limited number or size of studies important flaws in study design or methods inconsistency of findings across individual studies gaps in the chain of evidence findings not generalizable to routine primary care practice lack of information on important health outcomes More information may allow estimation of effects on health outcomes.

* The U.S. Preventive Services Task Force (USPSTF) defines *certainty* as "likelihood that the USPSTF assessment of the net benefit of a preventive service is correct." The net benefit is defined as benefit minus harm of the preventive service as implemented in a general, primary care population. The USPSTF assigns a certainty level based on the nature of the overall evidence available to assess the net benefit of a preventive service.