SUMMARY

This study was aimed for detection of *C.trachomatis* by direct methods in non pregnant women of child bearing period by Giemsa stain &direct immunoflurescence.

This study was done during the period from November 2005 to May 2006 on 50 non pregnant women of child bearing age(15 to 49) years, suffering from vaginal discharge, irritation or soreness, cervicitis, cervical erosion. Cases were selected from the out patient clinics of Gynaecology and Obstetrics Department, Benha University Hospital.

All women were examined clinically for the presence of any cervical lesions, (cervicitis or cervical erosion).

Study groups were divided into subgroups according to symptoms, signs, age, residence, number of abortion(s), using of contraceptive method, week of menstrual cycle, and fertility condition.

The endocervical swabs were taken with care to avoid contamination by vaginal secretions. The swab was used for preparation of 2 smears, one for staining by Giemsa stain and the other for staining with fluorscein labeled monoclonal chlamydial antibodies.

The results of the study showed the following:

1- Eight women (16%) were positive for the presence of Chlamydia in their specimens, while 42 women (84%) were negative by Giemsa stain.

2- There were 15 women (30%) positive for the presence of Chlamydia in their specimens, while 35 women (70%) were negative by DFAtest.

3- Younger women were more positive for *C.trachomatis* infection.

4- Women from rural areas were more positive for *C.trachomatis* infection.

5- Women using contraceptive pills were more positive than those using other contraception methods.

6- Detection of *C.trachomatis* was more positive during second & third week of menstrual cycle.

7- Infertile women were more positive for *C.trachomatis* infection especially 2nd infertility.

8- Women had abnormal cervix were more positive *for C.trachomatis* infection.

RECOMMENDATIONS

1- Patient education is an essential tool for minimizing the silent infection of *chlamydia* and the infertility associated with it.

2-Promote behavioral changes that reduce the risk of acquiring or transmitting infection (e.g., delaying first intercourse until a later age, decreasing the number of sex partners, and using barrier contraception {condoms}.

3-Screening women at risk to identify and treat asymptomatic *chlamydial* infection

4-Recognizing clinical conditions such as Mucopurulent Cervicitis (MPC) and the urethral syndrome, and then applying or using appropriate *chlamydia* diagnostic tests and treatment.

5-It is better to use more than one methods fore diagnosis of *Chlamydial* infection to get the actual results about the disease, evaluate the magnitude of the problem, and then establish the ideal lines for eradication of this agent from the community.

6-Identify and treat persons with genital *chlamydial* infection before they infect their sex partners.

7-Treating the male partners of females with infection.

8- Prevent complications among persons infected with *chlamydia*. The most important complication to be prevented is salpingitis and its

potential sequelae (i.e., ectopic pregnancy, tubal infertility, and chronic pelvic pain) by early and proper treatment.

9-Treatment of pregnant women, before they infect their babies.

10- Further studies should be carried out to assess the *Chlamydial* role in genital infections in our community.