Abstract P68 Table 1 Management of chlamydia positive patients

Year	Site 1/2 (%)	Age: median (range) years	CT positive (%)	PN complete (%)	Untreated (%)
2008	80/20	22 (19–40)	13/647 (2)	4/13 (31)	5/13 (38)
2011/2012	79/22	33 (14–84)	16/889 (1.8)	12/16 (75)	3/16 (18.7)

P69 IN THOSE WITH HIGH WHITE CELL COUNTS PER HIGH POWERED FIELD DOES EXTENDED AZITHROMYCIN AFFECT PERSISTENCE/RECURRENCE

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A de Burgh-Thomas,* A Ross Russell, K Maple, I Karunaratne. *Gloucestershire Care Services, Gloucestershire Royal Hospital, Gloucester, UK*

Aims We will compare the effect of an extended azithromycin (2 g of over several days) vs 1 g stat for those where >50 WCs per hi power field were found.
Methods We have reviewed all cases of NSU over a 3-month period following the introduction of extended treatment with azithromycin for those with hi levels of WCs per hpf. We will review the records of those patients diagnosed with NSU in previous years (over the same months) who were treated with regimes of either doxycycline 100 mg twice daily for 7 days or azithromycin 1 g stat.
Results Following the change in policy half of all patients treated for NSU received an extended course. In the group who had hi levels of WC's 13% were subsequently found to be chlamydia positive by PCR and 87% were chlamydia negative. In the group with low levels of WC's 10% were chlamydia PCR positive and 90% were chlamydia negative. Of those with hi levels of WCs per HPF treated with a total of 2 g of azithromycin 18% returned to clinic complaining of continuing symptoms. This compares to 20% with low levels of WCs per hi powered treated with the standard 1 g of azithromycin who suffered persistence/recurrence following treatment We will present data on those patient treated in previous years with both doxycycline and azithromycin at a dose of 1 g.
Discussion So far we have analysed only those cases following the change in policy. We will present data that will demonstrate any change in response to extended azithromycin. The results will demonstrate whether the extended course has any benefits and at what cost.

P70 *NEISSERIA GONORRHOEAE* ST26; EMERGENCE OF AN MSM ASSOCIATED STRAIN WITHIN A HETEROSEXUAL POPULATION DURING AN OUTBREAK

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[1]J Shone,* [1]G Orange, [1]S Allstaff, [1]C Cunningham, [1]D Yirrell, [2]K Eastick. *[1]Ninewells Hospital & Medical School, Dundee, UK; [2]Scottish Bacterial Sexually Transmitted Infections Reference Laboratory, RIE, Edinburgh, UK*

Background *Neisseria gonorrhoeae* sequence type (ST) 26 has been documented across Scotland since the introduction of *N gonorrhoeae* multi-antigen sequence typing (NG-MAST) in 2004. Scottish incidents of ST26 have historically been associated with men who have sex with men (MSM). In November 2010, it was noted that an increased proportion of ST26 isolates were documented among women within our local Health Board area.
Aims To explore the epidemiology of Scottish *N gonorrhoeae* ST26 strains, with reference to a rising incidence of gonococcal (GC) diagnoses within our local area.
Methods All Scottish GC isolates (2004–2011), and nucleic acid amplification positive specimens where no isolate was available (2009–2011), were analysed by NG-MAST.

Results

Abstract P70 Table 1 Scottish incidences of *Neisseria gonorrhoeae* ST26 strains

	Local health board	Local health board	Non-local health boards	Non-local health boards
Time period	Total isolates	Male isolates (%)	Total isolates	Male isolates (%)
2004–2007	0	–	45	91.1
2008	0	–	0	–
2009	20	100	6	100
January 2010–April 2010	3	100	6	83.3
May 2010–October 2010	0	–	0	–
November 2010–September 2011	32	56.3	2	50
Total	55		59	

Discussion These data describe that up until November 2010, *N gonorrhoeae* ST26 in Scotland was predominantly found in men, indicating its association with MSM networks. The spike of ST26 strains in 2010/2011 in both men and women within our local Health Board area imply its introduction to a heterosexual network. These data demonstrate the utility of NG-MAST for the epidemiological study of GC infection. In particular, the data describe the manner in which gonococcal STs can become established and transferred between different regions and population groups, which may be assumed to have separate sexual networks.

P71 VALIDATION OF AN IN HOUSE NUCLEIC ACID AMPLIFICATION (NAATS) PCR TEST FOR *TRICHOMONAS VAGINALIS*

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[1]J Appiah,* [2]P Saunders, [3]M Yapa, [3]C Y W Tong, [3]J White, [2]C Ison, [2]S Alexander. *[1]Sexually Transmitted Bacteria Reference Laboratory, Health Protection Agency, London, UK; [2]Health Protection Agency; [3]Guys and St. Thomas Hospital NHS Trust, London, UK*

Background *Trichomonas vaginalis*, a flagellated protozoan, is transmitted through sexual contact that commonly manifests itself as symptomatic in more women than men. However, the true prevalence of infection and the proportion that is asymptomatic is not known because of the lack of good diagnostic tests. Microscopy is the most common method of detection used but this is known to have a low sensitivity. Other methods include culture, which is considered the gold standard, a point of care test and molecular methods, which have increased sensitivity but are more time consuming or expensive.
Aim To validate an in-house nucleic acid amplification test (NAAT) test for the detection of *T vaginalis*.
Method Two methods were established In-house. The first NAATs detected *T vaginalis* by amplification of a 92 bp segment of the *T vaginalis*-specific repeat DNA fragment and the second amplified a segment of the â-tubulin gene, and was used to confirm the positive results. A further control ran alongside the first NAATs to identify inhibition by targeting the ribonuclease P gene. Sensitivity was initially validated with a positive control *T vaginalis* strain S1 and then validated against anonimised clinical samples previously tested using the APTIMA *T vaginalis* (ATV) transcription mediated amplification (TMA) kit and an in-house real-time TV PCR (see abstract P71 table 1).
Results A total of 96 samples were tested. 17 (17.9%) of the specimens tested resulted in positive *T vaginalis* NAATs using both *T vaginalis* real-time PCR and the TV confirmatory real-time PCR.
Conclusions These in house NAATs gave good concordance with the commercial assay. It would be useful to further compare detection between this and other methods including the culture and POCT in

asymptomatic patients. The methods established could also be used in comparisons in clinical studies.

Abstract P71 Table 1 TV diagnosed according to test

Assay	Aptima ATV TMA	WT In-house PCR	TV RT PCR	TV confirmation PCR
Number of positives	18 (18.75%)	17 (17.9%)*	17 (17.9%)	17 (17.9%)

*One sample was a low level positive/negative, but this was also positive on Aptima.

P72 MICROSCOPY AND CULTURE FOR *TRICHOMONAS VAGINALIS* (TV): ARE BOTH TESTS REQUIRED AND SHOULD TEST OF CURES (TOC) BE PERFORMED ROUTINELY?

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C Gilmour,* L Jones, R Jones, C E Cohen. *Chelsea and Westminster NHS Foundation Trust, London, UK*

Background Testing for TV has changed locally in recent years dependant upon whether the woman has symptoms. Microscopy and culture are now only performed in symptomatic women or in contacts of TV. All patients diagnosed with TV must be seen by the Health Advisers to discuss partner notification and to arrange a TOC within 2 weeks.
Aim To ascertain if both microscopy and culture remain warranted for symptomatic women and those attending for TOC or whether microscopy alone is sufficient for diagnosis. To compare audit findings with previous audits using BASHH auditable standards.
Method Case notes of patients diagnosed with a KC60 code of C6A between 1 October 2009 and 31 October 2010 were reviewed.
Results A total of 58 patients were included in the audit pertaining to 65 episodes. Largest ethnic group was Black/Black British Caribbean (34%). The majority (93%) were symptomatic. Nine (14%) patients had positive microscopy and negative culture, 10 (15%) had negative microscopy and positive culture and 46 (71%) had positive microscopy and culture results. The majority (97%) received Metronidazole therapy. 43 (74%) saw a Health Adviser after initial diagnosis. Almost all (88%) had documented partner notification and 27 contacts attended for treatment. 46 (79%) attended for TOC and of these 36 (78%) attended within 2 weeks. Of the 46 attending for TOC, 42 (91%) were symptomatic but only five (12%) were TV positive on TOC. Auditable standards comparison (see abstract P72 table 1).
Discussion Overall the results from this audit have demonstrated an improvement in respect to previous audits in line with BASHH auditable standards. Findings related to microscopy and culture results do not appear to demonstrate a significant risk in missed diagnoses and those who were microscopy negative (subsequently culture positive) had Hay and Ison Grade 2/3 and treatment with Metronidazole. In skilled hands, microscopy alone may be sufficient to diagnose TV in those attending with symptoms.

P73 A REVIEW OF DIAGNOSTIC TOOLS USED IN THE DETECTION OF *NEISSERIA GONORRHOEAE* (GC) IN WOMEN ATTENDING A LONDON SEXUAL HEALTH CLINIC (SHC)

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M Rosenvinge,* N Storrar. *St. George's Hospital, London, UK*

Background Near-patient microscopy (NPM) has poor sensitivity in the identification of GC in women, with NPM of urethral (Ur) smears no longer recommended by BASHH.
Aim To review the diagnosis of GC in women attending a London SHC and assess the relative merits of NPM, culture and Nucleic acid amplification tests (NAATs) in detecting GC.
Method Female GC diagnoses from 1 January 2008 to 30 June 2011 were identified from the GU Medicine Clinic Activity Dataset and case notes reviewed. The results and sites of GC tests taken, were recorded. Slides stated as "suspicious" for GC on NPM were counted as positive. GC was cultured on selective medium. The Beckton Dickinson Probe Tec Strand Displacement Assay (dual NAAT for GC/CT) was used for endocervical (Cx) specimens from 22 June 2009.
Results Notes were available in 334/369 (91%) of cases (317 women): median age 20 years (range 13–53); 92/334 (28%) White British; 87/334 (26%) Black Caribbean; 219/313 (70%) symptomatic; 160/321 (50%) had a previous STI; 42/317 (13%) had a history of GC; 58/334 (17%) were GC contacts. 289 cases had Ur/Cx cultures taken: 30 (10%) were positive on Ur culture; 148 (51%) on Ur and Cx culture; 88 (30%) on Cx culture. 11/142 (8%) Cx NAATs performed were negative for GC: 6/11 were positive on Ur culture; 5/11 on pharyngeal culture/NAAT; 1/11 on Cx culture. 104/125 (83%) with positive Cx NAATs were positive on Cx culture. 42 were diagnosed with GC on vaginal NAATs. 135/330 (41%) were also diagnosed with *Chlamydia trachomatis* (CT) (see abstract P73 table 1).
Conclusion Cx NAAT was more sensitive than culture in detecting GC; supplementing Cx NAAT with Ur culture will reduce the potential for missed cases. Our data shows a poor sensitivity of Ur

Abstract P73 Table 1 Results of NPM for culture positives

	Urethral	Endocervical
NPM positive	29 (12 Cx NPM negative)	29 (12 Ur NPM negative)
NPM negative	99	138
NPM not done	49	69
Sensitivity NPM	29/128 (23%)	29/167 (17%)
False positives*	3	13

*NPM was positive for GC but samples were culture negative

Abstract P72 Table 1 Comparison of auditable standards and rate

Auditable standards	BASHH	Local	Audit 2011 n=58	Audit 2006 n=94
Patients diagnosed with TV should receive treatment with Metronidazole—either 400 mg twice daily 5/7 or 2 g stat	100%	–	97%	96%
Symptomatic female patients at presentation should have a TV wet mount and culture	–	100%	100%	98%
Those diagnosed with TV infection should have contact tracing performed	100%	–	88%	71%
One or more traceable contacts should treated within 1 month	60%	–	47%	33%
Women with TV on cervical cytology should be offered confirmation of diagnosis with a vaginal swab before treatment and offered	100%	–	100%	–
Patients should return for a TOC within 2 weeks of treatment	–	50%	78%	71%