included in the analysis. Logistic regression was used to calculate OR (95% CI) for the association of chlamydia with menstrual cycle adjusted by demographics and behavioural variables.

Results During the study period, there were 10,017 consultations with positive diagnoses in 417 of those with a valid recorded LNMP. Detection rates were 3.8% (233/6816) in the follicular and 4.8% (184/3831) in the luteal phase of the menstrual cycle (OR 1.29 95% CI 1.1 – 1.6, p = 0.01). Detection was significantly associated with the luteal phase (adjusted odds ratio (aOR) 1.4 (95% CI 1.1–1.8) when adjusted for age, number of male partners, symptoms, inconsistent use of condoms, site of sample and sexual partners overseas/ from overseas. Among women using hormonal contraception, there was no association with the luteal phase (aOR 1.3, 95% CI 0.9 – 1.8, p = 0.18; among women not using hormonal contraception, association with the luteal phase was significant (aOR 1.6, (95% CI 1.1 2.3, p = 0.007). The positive stored samples will undergo analysis to quantify bacterial load and determine if mean load differs across the cycle.

Conclusions Chlamydia detection rates are substantially and significantly higher in the luteal phase of the menstrual cycle. Hormonal and immune changes in the female reproductive tract may contribute to an increased burden of chlamydia infection in this phase, illustrated by the lack of association with the menstrual cycle in women using hormonal contraception.

P5.014 WHAT IS THE OPTIMAL TIME TO RESCREEN STI CLINIC VISITORS WITH A UROGENITAL CHLAMYDIA INFECTION?

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Background and Aim STI clinic visitors with a urogenital chlamydia infection (Ct) have a high re-infection rate. Retesting can be an effective strategy to prevent onward transmission and late sequelae. The optimal moment to offer a re-test is unknown.

Methods Between May 2012 and January 2013, all heterosexual visitors of the Amsterdam STI clinic, testing positive for urogenital Ct were offered retesting after receiving diagnosis, treatment and counselling. Participants were randomly assigned for re-testing after 2, 4 or 6 months. Participants were free to choose between two retest options; receive a home collection kit or an email/SMS invitation to return to the clinic for a self collected retest.

Results In total 1784 individuals were included of whom 47% were male, 74% were Dutch and the median age was 23 years (IQR 20–26). 779 (44%) opted for the home collection kit and 1005 (56%) for re-visiting the clinic. At this point, 795 are eligible to evaluate retesting; 265 home collection kits were returned (75%) and 237 individuals returned to the clinic for a retest (54%). Overall, the participation rate did not differ between the assigned time periods. A test result was available for 266, 126 and 49 individuals in the 2, 4 and 6 month group, respectively. The overall positivity rate at 2, 4 and 6 months was respectively 8%, 6% and 12%.

Conclusions Based on these preliminary data we found a high test uptake. Possibly because individuals were able to choose their preferred method of retesting. As the participation rate was not affected by the period of the retest and the positivity rate seemed to be highest after 6 months this might be an optimal time interval to offer a retest to STI clinic visitors. We conclude that retesting is feasible in identifying new Ct infections.

P5.015 CHLAMYDIA TRACHOMATIS SCREENING AND TREATMENT IN PREGNANT WOMEN IN LIMA, PERU

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Background Chlamydia trachomatis (CT), the most common bacterial STD and asymptomatic in most women, causes significant adverse outcomes in pregnancy but no programmes routinely conduct prenatal screening in Latin America. To prepare for a clinical trial of CT screening and treatment in pregnancy, we determined the feasibility and acceptability of routine chlamydia screening, patient and partner adherence to treatment, and chlamydia prevalence in pregnant women in Lima, Peru.

Methods We conducted a prospective study of pregnant women > 16 years of age at two large urban maternity hospitals in Lima. We offered chlamydia screening to pregnant women during their first prenatal visit using self-collected vaginal swabs with APTIMA Combo 2® Assay (Hologic Gen-Probe, San Diego, CA). CT positive patients were contacted within 14 days of testing and were asked to bring partner(s) for counselling and offered concurrent patient partner treatment (CPPT) with 1 gramme of oral azithromycin. Unaccompanied patients received counselling and treatment in the clinic and expedited partner therapy (EPT) for partners. We performed a test of cure > 3 weeks after treatment.

Results Over 2 months, we approached 646 women for the study and enrolled 603 (93.5%). The average (+/- standard deviation) age was 27.2 + 6.9 years with an average 2.3 + 2.5 lifetime partners and an average gestational age of 26.3 + 10.5 weeks. Chlamydia prevalence was 10.0% + 3.9%. Of 39 CT positive patients contacted so far, 35 (90%) have received treatment. Of those, 46% received CPPT, 49% EPT and 5% had no contactable partners. Treatment and test of cure are ongoing.

Conclusion Chlamydia screening in pregnancy was feasible and highly acceptable in two large urban maternity hospitals in Peru. The prevalence of CT infection was high. Our settings are optimal for a clinical trial of CT screening and treatment to prevent adverse pregnancy outcomes.

P5.016 WITHDRAWN BY AUTHOR

P5.017 THE AUSTRALIAN CHLAMYDIA CONTROL EFFECTIVENESS PILOT (ACCEPT): EARLY RESULTS FROM A RANDOMISED TRIAL OF ANNUAL CHLAMYDIA SCREENING IN GENERAL PRACTISE

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Background ACCEPt is a cluster randomised controlled trial to evaluate annual opportunistic chlamydia screening for 16–29 year olds in general practise (GP). Towns in which GP clinics are enrolled, are randomised to receive a multifaceted intervention to increase chlamydia testing or continue usual practise. The primary outcome is change in chlamydia prevalence amongst GP patients in each town. We report some early results on testing uptake, a secondary outcome.

Methods From July 2010-December 2011, we enrolled 787 GPs in 150 clinics (response rate > 80%) in 54 towns. Chlamydia testing rates (the proportion who consult a GP and have a test during 12 months) and re-testing rates (proportion who are re-tested within 12 (±3) months following a negative or within 3 months following a positive test) were calculated. We compared testing between intervention and control towns from July 2011 to Sept 2012. All analyses are adjusted for intracluster correlation within clinics.