O020 PILOT STUDY COMPARING SELF-COLLECTED VAGINAL SWAB WITH CLINICIAN TAKEN VAGINAL SWAB FOR THE DETECTION OF CANDIDA AND BACTERIAL VAGINOSIS

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10.1136/sextrans-2016-052718.19

Background/introduction Vaginal discharge and vulvitis are common presenting symptoms in both sexual health services and general practice. Due to various constrains particularly in general practice, examination of a patient may not be possible. Syndromic management is often practiced but can be unreliable. Few studies to date have specifically looked at the validity of self-collected vulvovaginal swab for the diagnosis of bacterial vaginosis (BV) and vulvovaginal candidiasis (VVC)
Aim(s)/objectives To describe agreement between self-collected vulvovaginal swabs and clinician taken high vaginal swabs for the detection of BV and VVC.
Design Case controlled study with the patient acting as her own control.

Setting

An urban sexual health centre. Participants: Women aged 16–65 years attending with symptomatic vaginal discharge, vulval irritation or an offensive genital smell. Interventions: Participants took a vulvovaginal swab prior to speculum insertion and vaginal examination during which a clinician took a high vaginal swab. Main outcome measure: Diagnosis of BV or VVC infection with samples analysed in a microbiology department using both microscopy and culture.
Results 104 women were enrolled in the study. Of these 45 were diagnosed with VVC. 26 were diagnosed with BV. Using the reference standard of laboratory testing, the sensitivities of self-collected vulvovaginal swabs for BV and VVC were 88.5% and 95.5% respectively. The Cohen Kappa score showed strong agreement for the detection of both BV and VVC (k = 0.842 and k = 0.878 respectively).
Discussion/conclusion Self-collected vulvovaginal swabs appear to be a valid alternative to clinician taken high vaginal swabs for detecting BV and VVC infections.

O021 A QUESTION OF STABILITY

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10.1136/sextrans-2016-052718.20

Background/introduction Urines to be tested by the APTIMA Combo 2 (AC2) are added to a collection tube containing preservatives to ensure stability of the nucleic acid for testing within 24 hours of collection. Home collected urines are often collected in containers without preservative to avoid the patient manipulating the sample.
Aim(s)/objectives An investigation was undertaken to determine the stability of gonococcal and chlamydial nucleic acids within neat urine stored in different conditions over a period of 25 days to provide evidence of the stability of the nucleic acid prior to testing.
Methods To mimic collection in a home setting and differing nucleic acid loads within clinical specimens, uninfected urine was inoculated with different concentrations of chlamydial (from cell culture) and gonococcal (from bacterial culture) nucleic acid. Aliquots of the urine were removed on eight occasions over 25 days, added to collection tubes and tested either on the Hologic Panther system to determine presence of RNA or, following DNA extraction, using in-house PCRs to determine DNA load.
Results Chlamydial RNA and DNA remained stable for over three weeks when either refrigerated or stored at room temperature. Gonococcal RNA was detectable up to three weeks if refrigerated and two weeks if stored at room temperature. GC DNA was detectable for 18 days if refrigerated and for 11 days if stored at room temperature.
Discussion/conclusion Chlamydial and gonococcal nucleic acids are stable in urine before addition to preservatives for longer than recommended by the manufacturer, enabling more flexibility for home collected samples.

O022 RECTAL CHLAMYDIA INFECTION IN WOMEN – HAVE WE BEEN MISSING THE POINT?

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10.1136/sextrans-2016-052718.21

Background/introduction BASHH standards recommend rectal chlamydia sampling in women with increased risk. However, studies show high rates of rectal chlamydia in women, with concerns over treatment failures and risk of genital re-infection
Aim(s)/objectives To determine if rectal chlamydia screening in females should be universal.
Methods As part of a selfswab versus clinician trial we asked females about frequency of vaginal, receptive anal, and oral sex, and correlated this with chlamydia NAATs from these sites.
Results Recruitment to February 2016 included 1041 women. All consented to rectal sampling; none had rectal symptoms. 53% reported no prior receptive anal sex. 204 women had chlamydia (CT) positive NAATs at one or more sites: 176 (16.9%) VVS positive (86% of all CT positives); 190 (18.3%) rectal positive (93% of total CT positives); 49 (4.7%) pharyngeal positive. Rectal swabs were significantly more likely to detect CT than VVS: OR 2.75 (95% CI 1.22–6.18) p = 0.02 McNemar test. The table shows percentage women by positive site(s) reporting no anal sex. 92/190 (48.4%) of those with one site or combination rectal CT reported no previous anal sex. Of the 168 with

Abstract O022 Table 1 Sites of chlamydia in women

Site(s) of chlamydia positive NAATs	Number confirmed positive by site(s) [total 204]	Percentage women with infection at site(s) reporting never having had receptive anal sex (%)
VVS only	7	43
VVS and rectal	132	50
VVS, rectal, pharyngeal	36	47
Rectal only	17	41
Rectal and pharyngeal	5	40
Pharyngeal and VVS	1	100
Pharyngeal only	6	0