VVS and rectal positive NAATs, the AC2 Reactive Light Units levels were equivalent, suggesting active infection at both sites.
Discussion/conclusion In this sample of women with no rectal symptoms, the rectum was the most prevalent site for chlamydia infection, and rectal swabs found significantly more infections than VVS. There was no association with reported anal sex indicating sexual risk history is unreliable for targeted screening in women.

0023 FEASIBILITY STUDY TO DETERMINE THE TIME TAKEN FOR NAATS TESTS TO BECOME NEGATIVE FOLLOWING TREATMENT FOR *CHLAMYDIA TRACHOMATIS* AND *NEISSERIA GONORRHOEAE* IN MEN AND WOMEN

[1,2]Binta Sultan*, [1]Clare Oakland, [1]Nataliya Brima, [3]Hemanti Patel, [1]Andrew Copas, [2]Paul Benn, [3]Cathy Ison, [4]Gabriel Schembri. *[1]University College London, London, UK; [2]Mortimer Market Centre, London, UK; [3]Public Health England, London, UK; [4]Manchester Centre for Sexual Health, Manchester, UK*

10.1136/sextrans-2016-052718.22

Background/introduction Few data are available to guide the best time to perform a test of cure using nucleic acid amplification tests (NAATs) following treatment for chlamydia (CT) and gonorrhoea (NG).
Aim(s)/objectives The association between the type of infection, organism load, site of infection and treatment were compared to the time for the NAAT to become negative after treatment.
Methods Individuals who had a positive NAAT test for CT and/or NG were eligible. Self-taken specimens from the site of infection were collected at 8 time points.The time to first negative test following treatment was examined using survival analysis techniques.
Results 102 men (87 MSM) and 52 women were recruited to the study (84 NG, 71 CT infections). 28 participants with NG and 16 with CT were lost to follow up. On day 0, 20 participants diagnosed with NG and 8 diagnosed with CT had negative tests. Median time to negativity for NG infection was 2 days (IQR 1–5) and for CT infection was 4 days (IQR 2–5). At day 14 after treatment 92% of participants were CT negative, and 84% NG negative.All tests were negative by day 35 for both infections.
Discussion/conclusion This study provides valuable data in determining the time to test of cure for CT and NG infections. Site of infection may have an effect on time to clearance of infection, with pharyngeal NG infections and vaginal CT infections taking longer to clear than other sites.The results of this study will help guide clinicians to the timing for test of cure.

0024 *TRICHOMONAS VAGINALIS* – TREATMENT AND TEST OF CURE ANALYSIS IN A GUM CLINIC POPULATION

Gabriella Bathgate*, Melissa Perry, John White. *Guy's & St Thomas' NHS Foundation Trust, London, UK*

10.1136/sextrans-2016-052718.23

Background/introduction *Trichomonas vaginalis* is prevalent in patients of black ethnicity in our south London population. Nucleic acid amplification testing (NAAT) is the diagnostic gold standard, and first-line treatment with metronidazole or tinidazole regimens thought to achieve comparable cure rates >90%. Test of cure (TOC) is recommended if symptoms persist following treatment, but this overlooks persistent asymptomatic infection and optimal timing and testing modality are uncertain.
Aim(s)/objectives To estimate clinical cure and TV eradication rates in a large cohort of *T. vaginalis* cases.
Methods All positive *T. vaginalis* NAAT results (TV TMA, Hologic) were identified between January 2013 and September 2015. Data were collected from our electronic patient record system, including clinical features, treatment regimen and TOC results, if performed.
Results 557 cases were identified in 500 patients (78.2% female; 82.2% Black African/Caribbean/mixed ethnicity; 8.8% HIV+). Infection was symptomatic in 47.3% (53.7% females, 24.5% males). Baseline wet mount microscopy was positive in 65.6%. TOC was performed in 72.4% (median time to TOC 4.1 weeks, IQR 2.3–7.6 weeks). 77.2% demonstrated parasitological clearance following a single treatment course. Cure rates were 70–80 for all regimens, significantly higher in males (85.5% vs 66.9%, $p < 0.01$).
Discussion/conclusion We see a significant asymptomatic, microscopy-negative burden of *T. vaginalis* infection. Lower clearance rates in women suggest azole-resistant strains may be prevalent. Based on NAAT results, cure rates are lower than expected, and relatively constant TMA positivity rate beyond 2 weeks suggests treatment failure is responsible rather than re-infection or timing of TOC. Further UK studies on treatment efficacy and molecular epidemiology are warranted.

0025 BEHAVIOURAL FACTORS ASSOCIATED WITH HPV VACCINE ACCEPTABILITY AMONGST MEN WHO HAVE SEX WITH MEN IN THE UNITED KINGDOM

[1]Tom Nadarzynski*, [1]Helen Smith, [1,2]Daniel Richardson, [1]Stephen Bremner, [1]Carrie Llewellyn. *[1]Brighton and Sussex Medical School, Brighton, UK; [2]Brighton and Sussex University NHS Trust, Brighton, UK*

10.1136/sextrans-2016-052718.24

Background Men who have sex with men (MSM) are selected for Human Papillomavirus (HPV) vaccination due to their higher risk of genital warts and anal cancer.
Aim To examine HPV vaccine acceptability amongst MSM in the UK.
Methods Using Facebook advertisements, MSM were recruited for an online survey measuring motivations for HPV vaccination. Logistic regression was performed to identify predictors of HPV vaccine acceptability at baseline, after receiving information about HPV vaccination, and four weeks later.
Results Out of 1508 MSM (median age = 22, range: 15–63) 19% knew about HPV. While only 55% of MSM would be willing to ask for the HPV vaccine, 89% would accept it if offered by a healthcare professional (HCP). Access to sexual health clinics [OR = 1.82, 95% CI 1.29–2.89], the disclosure of sexual orientation to an HCP [OR = 2.02, CI 1.39–3.14] and HIV-positive status [OR = 1.96, CI 1.09–3.53] positively predicted HPV vaccine acceptability. After receiving the information, perceptions of HPV risk [OR = 1.31, CI 1.05–1.63], HPV infection severity [OR = 1.89, CI 1.16–3.01), HPV vaccination benefits [OR = 1.61, CI 1.14–3.01], HPV vaccine effectiveness [OR = 1.54, CI 1.14–2.08], and the lack of perceived barriers to HPV vaccination [OR = 4.46, CI 2.95–6.73] were also associated with acceptability.
Discussion Although nearly half of MSM would not actively pursue HPV vaccination, the vast majority would accept the vaccine if recommended by HCPs. MSM need to be informed about