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WHAT IS THE OPTIMAL TESTING STRATEGY FOR OROPHARYNGEAL *NEISSERIA GONORRHOEAE* IN MSM VISITING STI CLINICS?

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Background The majority of oropharyngeal *Neisseria gonorrhoeae* (*N. gonorrhoeae*) infections are asymptomatic, and many oropharyngeal *N. gonorrhoeae* infections could remain undetected, creating a reservoir for ongoing transmission and drug resistance. It is yet unknown what the optimal testing policy is for oropharyngeal *N. gonorrhoeae* infections in men who have sex with men (MSM), as data on routine universal screening are missing.

Methods Surveillance data from all Dutch STI clinics between 2008–2017 were used (n=271,242 consultations). Oropharyngeal testing policy was defined as routine universal screening, that is $\geq 85\%$ of MSM consultations included oropharyngeal testing per clinic per year, or as selective testing ($< 85\%$ tested). The proportion infections missed using selective testing was calculated by extrapolating positivity found by routine universal screening. Independent risk factors for oropharyngeal *N. gonorrhoeae* were assessed among MSM routinely universally screened between 2016–2017 using backward multivariable logistic regression analyses.

Results Routine universal screening was performed in 90% (n=238,619) of consultations. Oropharyngeal *N. gonorrhoeae* positivity was higher using routine universal screening (5.5%, 95%CI 5.4–5.6, n=12,769) compared to selective testing (4.7%, 95% CI 4.4–5.0, n=799, $P < 0.001$). When extrapolating, selective testing missed 45.2% of infections (95%CI 42.6%–47.8%, n=659). The proportion oropharyngeal-only among tested was 55% for routine universal screening and 47% for selective testing. Independent risk factors for oropharyngeal *N. gonorrhoeae* were age < 31 years (OR2.1, 95%CI 1.9–2.3) age 31–43 years (OR1.7, 95%CI 1.6–1.9, compared to ≥ 43 years), being notified for any STI (OR2.0, 95%CI 1.9–2.1), concurrent urogenital *N. gonorrhoeae* (OR2.4, 95%CI 2.1–2.7), and concurrent anorectal *N. gonorrhoeae* (OR11.4, 95%CI 10.6–12.3). When using any of the risk factors age, notified or oral sex as testing indicators, 98.4% of MSM would be tested, finding 99.5% of infections.

Conclusion Selective testing missed two fifth of oropharyngeal *N. gonorrhoeae* infections in MSM, of which more than half would be oropharyngeal-only. Using independent risk factors as testing indicator is not specific. Therefore, routine universal oropharyngeal screening in MSM is feasible and warranted, as is currently advised in the Dutch guidelines.

Disclosure No significant relationships.

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HIGH AWARENESS BUT LOW UPTAKE OF HPV VACCINE AMONG GBMSM IN ONTARIO, CANADA: RESULTS FROM THE #ICRUISE STUDY

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Background Gay, bisexual, and other men who have sex with men (gbMSM) are at higher risk for human papillomavirus (HPV) infection and HPV-associated anogenital warts and cancers. In the province of Ontario, a publicly-funded program was introduced in 09/2016 to provide the HPV vaccine at no cost to young gbMSM (≤ 26 years). We examined men's experiences with the HPV vaccine.

Methods #iCruise was an Ontario-wide study of gbMSM seeking sexual health information online. Men were recruited through websites and socio-sexual apps from 07/2017–01/2018. Men self-completed online questionnaires including items on HPV awareness and vaccination. We compared younger (≤ 26) to older (≥ 26) men using Pearson's chi-square tests and identified correlates of vaccination and willingness to get vaccinated using Poisson regression; results are reported as age-adjusted prevalence ratios (PR) with 95% confidence intervals (CI).

Results 975 participants were aged 14–89 years (34.7% aged ≤ 26); most had heard of HPV (94.0%) and the vaccine (79.2%). More younger men (25.5%) versus older men (14.3%; $p < 0.001$) had received 1+ doses. Vaccine initiation was associated with age (≤ 26 : PR=1.79; CI: 1.02–1.14; $p < 0.001$), being out to a doctor (PR=2.65; CI: 1.88–3.75; $p < 0.001$), living in Toronto (PR=1.53; CI: 1.18–2.00; $p < 0.001$ compared to elsewhere), identifying as gay (PR=2.46; CI: 1.45–4.16; $p = 0.001$) and having more than a high school education (PR=1.74; CI: 1.09–2.78; $p = 0.019$). Vaccine initiation was not associated with ethnicity, income, or having an HIV/STI test in the past year. Most men were willing to get the vaccine if it were free (79.6%) but fewer (9.4%) were willing if they had to pay out-of-pocket costs.

Conclusion Approximately one year since launching the publicly-funded program, more younger than older men had received it, reflecting vaccine availability at no cost. Nevertheless, 75% of younger men were not yet vaccinated, suggesting a need for improved awareness of the public program among patients and providers alike, and ensuring accessibility in non-stigmatizing and welcoming healthcare environments.

Disclosure No significant relationships.