

## Poster presentation

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?**

doi:10.1136/sextrans-2012-050601c.72

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)**

doi:10.1136/sextrans-2012-050601c.73

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 be 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%

and Cx NPM for the detection of GC in women, highlighting a need to perform targeted training, review the criteria for NPM and develop additional point of care tests for GC.

# P74 EPIDEMIOLOGY OF AN *NEISSERIA GONORRHOEA* OUTBREAK IN A LOW PREVALENCE AREA

doi:10.1136/sextrans-2012-050601c.74

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

**Background** In January 2011, an increased number of gonococcal (GC) isolates was noted within the local bacteriology department. A "look back" exercise was initiated for all incidences of GC infections during the previous 13 months, while new episodes of GC infection were monitored to ascertain whether this increase represented an outbreak.

**Aims** To determine the epidemiology of GC infection observed during an outbreak of *Neisseria gonorrhoeae* within the local area.

**Methods** Cases of GC infection within our Health Board area were identified by culture or nucleic acid amplification test (NAAT) for the period December 2009 to April 2011. *N. gonorrhoeae* multi-antigen sequence typing (NG-MAST) was performed on positive isolates or NAAT samples. Patient demographics were gathered at the local sexual and reproductive health (SRH) clinic.

**Results** 73 episodes of GC infection were recorded in one geographically distinct area of our Health Board between December 2010 and April 2011 (the outbreak). Nineteen cases were documented for the same period the previous year. No similar increase in GC diagnoses was observed in neighbouring areas. Chlamydia cases remained relatively stable. Patient demographics were available for 62 of the 67 cases diagnosed at the local SRH clinic. Of these, the majority of cases were male (66.1%) (of which 22% were MSM), under 25 years of age (71%), heterosexual (78.5%) and of White Scottish ethnicity (95.2%). 40 (64.5%) patients (29 male and 11 female) presented with symptoms of GC infection and 19 (29.2%) as GC contacts. The predominant NG-MAST sequence type was ST26.

**Discussion** The epidemiology of this outbreak is atypical, since GC infection and NG-MAST ST26 has been more commonly found in men who have sex with men in Scotland. Despite enhanced surveillance, no sexual networks or links to specific venues were identified. A gonorrhoea awareness campaign was launched in May 2011.

# P75 DO CASH INCENTIVES INCREASE THE UPTAKE OF CHLAMYDIA TESTING IN PHARMACIES?

doi:10.1136/sextrans-2012-050601c.75

<sup>1</sup>S J Martin, \* <sup>2</sup>M J Currie, <sup>2</sup>L S Deeks, <sup>3</sup>G M Cooper, <sup>4</sup>R M Parker, <sup>5</sup>R Del Rosario, <sup>6</sup>J S Hocking, <sup>2</sup>F J Bowden. <sup>1</sup>Canberra Sexual Health Centre, Academic Unit of Internal Medicine, Australian National University Medical School, Canberra, Australia; <sup>2</sup>Academic Unit of Internal Medicine, Australian National University Medical School, Canberra, Australia; <sup>3</sup>Faculty of Health, University of Canberra, Canberra, Australia; <sup>4</sup>Australian Primary Health Care Research Institute, Australian National University, Canberra, Australia; <sup>5</sup>Canberra Sexual Health Centre, Canberra Hospital, Garran, Australia; <sup>6</sup>Centre for Women's Health, Gender and Society, Melbourne School of Population Health, University of Melbourne, Melbourne, Australia

**Background** Chlamydia screening uptake rates in Australian and overseas pharmacies vary widely (11% to 58%).

**Aim** To determine the effect on the uptake of chlamydia screening in community pharmacies when a cash reward is offered to young people and participating pharmacies.

**Methods** The study was advertised in print and electronic media. People aged 16–30 years requested, or were offered, chlamydia testing kits by pharmacy staff (assistants and pharmacists). Participants who provided a urine sample and completed a questionnaire received AUD\$10; pharmacies received AUD\$10 per person recruited. Urine specimens were tested in pools using PCR, with reflex testing of individual samples when the pool tested positive. Positive cases were notified by sexual health nurses and offered treatment.

**Results** Six urban community pharmacies took part in the study, each for 15 days. 979 testing kits were given out and 970 sample pots returned (99.1%); 66 (7%) did not contain urine. 74% (670/904) of the urine samples were determined to be from unique individuals, 65% of whom were male. 19 people (13 females and 6 males) tested positive; positivity rates were 5.2% (95% CI 2.8 to 8.8) for females and 1.4% for males. 11 (61%) of those testing positive were contacted and eight attended a local sexual health centre for treatment, three were treated elsewhere. Of the eight people treated at the sexual health centre, two females aged 15 and 20 years were diagnosed with pelvic inflammatory disease. Contact with the remaining eight positive individuals was not possible due to disconnected, incorrect or non-existent telephone numbers.

**Conclusion** The 68% specimen return rate found in this study significantly exceeds those reported elsewhere. Strategies to prevent repeat testing, non-urine specimens and incorrect contact numbers are needed to ensure good clinical care and optimum use of resources.

# P76 EQUIVOCAL APTIMA COMBO 2 RESULTS: WHAT DO THEY MEAN IN CLINICAL PRACTICE?

doi:10.1136/sextrans-2012-050601c.76

S Cassidy, \* R Artykov, J White. Guy's and St Thomas' NHS Trust, London, UK

**Background** Molecular diagnostic tests have become standard of care for detection of gonococcal (GC) and chlamydial (CT) infections. The Aptima Combo 2 (AC2) test is widely used and is highly sensitive and specific, even for non-genital specimens. Equivocal results occur when the initial AC2 assay detects target RNA but the confirmatory Aptima GC or CT assay fails to detect a different RNA sequence in the same specimen.

**Aim** To determine whether equivocal AC2 (EAC2) results were predictive of subsequently confirmed infection in our GUM/HIV clinic population.

**Methods** Retrospective review of all EAC2 results for GC or CT at 3 urban UK GUM/HIV clinics from January to December 2011. Patients with EAC2 results were routinely recalled for repeat testing unless treated at the initial visit.

**Results** From a total of approximately 38 000 AC2 tests performed in 2011, 3118 (8.2%) were confirmed positive: 1189 GC and 1929 CT infections. There were 222 EAC2 results in 2011 (0.6% of total AC2 tests); 45 (20.3%) occurred in women, the majority (73%) of which were equivocal genital CT results. Of the 177 EAC2 results in men (mostly MSM), 70% were non-genital specimens. Equivocal pharyngeal GC was common, comprising one-third of all male EAC2. Of 34 EAC2 patients analysed in more detail, 5 were GC/CT contacts and 24/34 reported unprotected sex at the site of the EAC2. None with equivocal GC had GC positive culture results, at the time or subsequently. Of 19 men with EAC2 GC results, 6 (all MSM) had confirmed GC at another mucosal site at that visit. 30/34 patients had the AC2 test repeated (range 7–24 days after initial test); 29 were AC2-negative and one remained equivocal (see abstract P76 table 1).

**Conclusions** EAC2 results are uncommon but seem to occur in those at higher risk for infection; yet the vast majority does not have infection confirmed on subsequent testing. This suggests that these are spurious results, possibly from contamination, or low organism load infections that do not persist; thus routine treatment is not necessarily warranted.