Results From 35 patients with Ng positive NAAT, we obtained 34 (97%) Ng cultures from ESwab samples stored for 1 hour at RT. Storage for 24 hours at 4°C and RT resulted in 32 (91%) cultures. Storage for 48 hours at 4°C yielded 25 (71%), and at RT only 13 (37%, p = 0.007) cultures. Fourteen urine samples resulted in 13 (UR) respectively 14 (US) cultures after storage for 1 hour at RT. Storage for 24 hours at 4°C and RT resulted in 11 and 7 (UR), respectively 12 and 10 (US) cultures. Storage for 48 hours at 4°C and RT gave 3 and 1 (UR), respectively 5 and 2 (US) cultures.
Conclusion Delayed Ng cultivation from the ESwab system was successful after storage at 4°C for 24 hours in 91% and for 48 hours in 71% of cases. The ESwab system for NAAT diagnostics combined with delayed Ng cultivation of positive NAAT samples appears highly effective for future sustainable and essential gonococcal AMR surveillance. This approach is now being validated in routine practise.

P5.078 FALSE-POSITIVE *NEISSERIA GONORRHOEAE* RESULTS IN URINE SAMPLES USING A HIGHLY SENSITIVE NAAT TESTS: THE SAMPLING SITE AS A SOURCE OF CONTAMINATION?

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Introduction False-positive results due to contamination of NAATs have been described. Apart from the laboratory, also the area where samples from patients are collected can be the source of the contamination.
Methods and results: In a 46 days period, 62 (7.3%) of male patients visiting the STI outpatient clinic with a low risk for gonorrhoea showed a positive NAAT (AC 2, Hologic-GenProbe) for *Neisseria gonorrhoeae* (NG) in urine. This was only 0.8% in the previous 6 months. The prevalence of positive NAAT results for *Chlamydia trachomatis* (CT) remained unchanged. Culture was positive in only 2/24 NG-NAAT-positive patients whose cultures were available. The prevalence of NG among high-risk patients as determined by culturing, and the positive NG-NAAT results from vaginal, rectal and pharyngeal swabs from the STI clinic and from urines received from other practises remained unchanged.

All 5 environmental swabs from the male bathroom and all 4 swabs from transport trays were positive in NG-NAAT, but only 1 of these 9 was positive for CT. Swabs from trays from the laboratory, routinely cleaned with chlorine, were negative. An audit showed that some clients do not deliver their urine samples in a hygienic way and employees who transferred urine into Aptima tubes might have touched the seal of these tubes.

The pseudo-outbreak ended after daily cleaning of bathrooms and trays with chlorine and strictly following anti-contamination guidelines. Afterwards only 0.2% of low-risk male patients had a positive NG-NAAT in urine. Thirty-seven patients who had been treated for gonorrhoea were informed about the possible incorrect diagnosis.
Conclusion This pseudo-outbreak was most likely a consequence of external contamination of trays and test tubes with nucleic acids from the sampling site, in combination with inadequate handling of tubes during pipetting.

P5.079 LABORATORY DIAGNOSIS OF NEUROSYPHILIS IN PATIENTS CO-INFECTED WITH HUMAN IMMUNODEFICIENCY VIRUS (HIV) AND NEGATIVE-HIV PATIENTS IN MONTEVIDEO-URUGUAY

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Background Syphilis laboratory diagnosis, is made through the dosage of circulating antibodies in blood, but is not enough when neurological involvement is suspected.

A positive Venereal Disease Research Laboratory test (VDRL) result in cerebrospinal fluid (CSF) establishes the diagnosis of neurosyphilis, but it´s negativity does not rule it out, therefore the need to use other immunological tests arises. The aim of our study was to evaluate the immunological tests performance used for neurosyphilis diagnosis and compare them between HIV infected and uninfected patients.
Methods We studied 37 patients (17 positive HIV and 20 negative HIV) from 2005 to 2012. We selected patients with positive Treponema Pallidum Hemagglutination Assay (TPHA) result in serum and CSF. Those patients underwent VDRL and, IgG and Albumin dosage in serum and CSF. TPHA-index and ITpA-index were calculated, intrathecal IgG production and indemnity of the blood brain barrier were evaluated through "Reiber´s" diagram. Results:Neurosyphilis was diagnosed in 21 patients (6 positive HIV and 15 negative HIV): 18 reactive CSF VDRL, 13 TPHA in CSF > 1/320, 13 Index TPHA/Albumin > 70, 24 ITpA index ≥ 2, in 3 patients neurosyphilis diagnosis was established only by high TPHA titers and high TPHA-index (2 positive HIV and 1 negative HIV).14 patients had Intrathecal IgG synthesis and 10 had blood-brain barrier disruption.
Conclusions CSF VDRL made neurosyphilis diagnosis in 86% of patients, with a high concordance between CSF VDRL and CSF TPHA titer > 1/320 and TPHA-index > 70; the immunological tests performance was similar in HIV positive and HIV negative patients. Neurosyphilis diagnosis was established with the CSF/serum indexes and TPHA titers in 14% of the studied population. This highlights the importance of including the indexes in the routine diagnosis of neurosyphilis. Intrathecal IgG synthesis and disruption of the blood-brain barrier predominated in patients with neurosyphilis.

P5.080 COMPARISON OF AN IN-HOUSE POLYMERASE CHAIN REACTION AND DIRECT FLUORESCENT ANTIBODY ASSAY FOR DETECTION AND TYPING OF HERPES SIMPLEX VIRUS IN CLINICALLY SUSPECTED GENITAL HERPES

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Background Molecular assays based on PCR have become an important tool for the detection of herpes simplex virus-1&2 DNA in clinical specimens. Detection and typing of HSV can also be done by a monoclonal antibody based DFA. The present study was undertaken to standardise an in-house PCR for detection and typing of Herpes Simplex Virus (HSV) and compare it with Direct Fluorescent Antibody (DFA) test.
Methods 44 patients with genital herpes attending the STD clinic were studied. Specimens collected from genital lesions were placed in Viral transport medium (VTM) and stored at –70^{0}C till tested. DNA extraction was done using QiaAmp DNA mini kit (Qiagen, USA), PCR was carried out in GeneAmp PCR system 9700 (Applied BioSystems). Post PCR analysis of PCR product was done by electrophoresis using 2% agarose gel. DFA (BioRad) was also done for identification and typing of HSV-1& 2.
Results By DFA, 4 specimens were positive for HSV 1, 19 were positive for HSV 2 while 7 were positive for both. By PCR, 5 were HSV-1 positive, 18 were HSV-2 positive while 6 were positive for both HSV-1 & 2. (kappa for HSV-1 = 0.879, HSV-2 = 0.63,) One HSV- 1 and 3 HSV-2 cases was positive by PCR but not by DFA. Four specimens that were positive by DFA but negative by PCR