Conclusion Analysis needs to account for study design, and we recommend cohort studies collect more information on partnership dynamics to inform more-accurate estimates of natural-history parameters. The cohorts’ clearance rates were probably similar, with the apparent difference due mostly to differences in sample handling in the studies, and perhaps partly due to the sex workers having more-frequent antibiotic treatment (for other infections), and in the London students some reinfection in stable partnerships causing some of the apparently-persistent infection.

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and treatment, if sensitivity is lower than conventional testing then there is potentially increased transmission from false-negative patients. The net effect depends upon characteristics of the particular PoCT.

**Conclusion** PoCT sensitivity and specificity are key determinants of whether replacing conventional testing is likely to reduce or increase the incidence of infection. Importantly, if the convenience of PoCT increases testing rates then diagnoses might initially increase even though incidence falls; interpretation of surveillance data needs to account for this. This work is the foundation of a user-friendly web-based tool assessing the (cost-) effectiveness of introducing PoCTs in different local settings.

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**P09.14 IMPLEMENTATION OF ORAL AND SELF-COLLECTED RECTAL SWABS FOR N. GONORRHOEAE AND C. TRACHOMATIS DETECTION AS A COMPONENT OF LOCAL HEALTH DEPARTMENT OUTREACH TESTING**

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**Introduction** The availability of extra-genital nucleic acid amplification testing (NAAT) for gonorrhoea (GC) and chlamydia (CT) is limited in many clinical and outreach settings. A recent initiative in Forsyth County, NC funded NAAT testing at oro-pharyngeal and rectal sites in both of these settings.

**Methods** A retrospective chart review was conducted for all males and females aged 12–80 who reported to an outreach site at STD clinic (MSM only) January 1, 2014 to February 28, 2015.

**Results** Clinic: 131 rectal, 163 pharyngeal, and 176 urethral NAAT tests were performed on 181 males. Twenty-five rectal (19.1%), 22 pharyngeal (13.5%), and 22 (12.5%) urethral specimens were GC positive. 24 rectal (18.3%) and 7 urethral (4.0%) were CT positive. 5 rectal GC (20.0%), 8 pharyngeal GC (36.4%), and 13 rectal CT (54.2%) infections would have been missed in the absence of extra-genital testing.

**Outreach** 47 rectal, 157 pharyngeal, and 162 urogenital NAATs were collected. For GC, 3 rectal (6.4%), 3 pharyngeal (1.9%), and 2 urogenital (1.2%) specimens were positive. Six (12.8%) and 9 (5.6%) individuals were positive for rectal and urogenital CT, respectively. 2 rectal GC (66.7%), 3 pharyngeal GC (100%), and 4 rectal CT (66.7%) infections would have been missed without extra-genital NAAT.

When NAAT and bacterial culture for GC were run on the same samples from clinic patients, culture detected 48% (12/25) of the rectal and 45.2% (10/22) of the pharyngeal infections detected by NAAT.

**Conclusion** A significant prevalence of extra-genital GC and CT infections were noted in both the clinic and outreach populations. In the absence of NAAT-based extra-genital testing approximately half of rectal and pharyngeal GC infections would have been missed with culture and more than half of the rectal CT infections would have been missed. Assurance of access of NAAT-based extra-genital testing is critical for STI control efforts.

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