Introduction Lymphogranuloma venereum (LGV) continues to be difficult to diagnose and can lead to significant sequelae. Since 2011, all rectal specimens testing positive for Chlamydia trachomatis were tested for LGV serovars, leading to a greater number of LGV cases (mean, 21 cases/year for 2011–2014). In 2015, case reports of LGV doubled to 42 cases. We sought to characterise LGV cases reported in BC since 2011, and assess possible reasons for the 2015 increase.

Methods Demographic and behavioural information about all LGV cases reported in BC from January 1, 2011 to December 31, 2015 were identified. Provincial laboratory data were reviewed for potentially missed cases. LGV cases were categorised by reporting year (i.e., 2011–2014 and 2015) and analysed using the chi-square test or Fisher’s exact test. LGV percent positivity was calculated as the number of LGV cases over the number of positive rectal chlamydia.

Results From 2011–2014, 83 cases were reported versus 42 in 2015. All were among men who have sex with men (MSM). The median age for cases was 46 years and 44 years for 2011–2014 and 2015, respectively (p=0.26). HIV co-infection was similar in both periods (54/83 in 2011–2014, 25/42 in 2015, p=0.61). Of those known to be co-infected with HIV, the majority had undetectable viral loads (34/54 in 2011–2014 and 18/25 in 2015). There was a decrease in the proportion of cases who identified as Caucasian from 2011–2014 to 2015 (p=0.004) and an increase in proportion of asymptomatic cases, although not statistically significant (p=0.06). Percent positivity was 7.1% and 7.2% in 2011–2014 and 2015, respectively.

Conclusion The similar case characteristics and percent positivity during both periods, and increase in proportion of asymptomatic cases, suggest that increased screening for rectal sexually transmitted infections may be the reason for the observed increase in LGV cases. Further evaluation is needed to understand LGV trends, particularly among HIV-positive MSM who are disproportionately affected by LGV.

P3.105 MATERNAL SYPHILIS IN BRITISH COLUMBIA, CANADA: 2010 TO 2016

Introduction From 2010 to 2016, syphilis rates have tripled among women in British Columbia (BC), Canada. We sought to characterise maternal syphilis cases in BC to identify areas to strengthen syphilis prevention programming.

Methods Virtually all syphilis tests in BC are performed at the provincial laboratory. Positive tests are reviewed by centrally-located expert clinicians who diagnose, stage, and recommend treatment. Demographic and treatment information of syphilis cases (primary, secondary, early and late latent) diagnosed in pregnant women (or within 90 days after delivery) from January 2010 to July 2016 were reviewed and descriptive analyses performed. We assessed prenatal syphilis screening based on the prenatal flag on the laboratory report, and compared the number of live births reported by BC Vital Statistics.

Results From 2010 to 2015, 2 83 168 syphilis tests were done as part of prenatal testing, compared with 2 64 496 live births. From 2010 to July 2016, there were 45 maternal syphilis cases reported (18 early latent, 27 late latent–of note, syphilis screening by EIA commenced July 2014). The majority of cases (38/45) lived in Greater Vancouver; median age 30 years (range: 20–46). 27, 13, and 3 cases were diagnosed in the first, second, and third trimester, respectively; 2 were diagnosed post-partum. Treatment information was available on 44/45 cases: 42 cases received ≥2 penicillin injections and 2 received doxycycline. Being born outside Canada or having a partner in a developing country was the most common risk factor identified (n=13). One case reported sex trade work, 4 reported having casual sex (>4 partners), and 4 reported substance use. Few cases (6/34) reported ≥2 partners in the last year.

Conclusion Most maternal syphilis cases are diagnosed by first trimester prenatal screening, but a few remain diagnosed post-partum. Increasing efforts to engage early for those born in high syphilis incidence countries (or whose partners remain in such countries) and repeat screening may be areas for focus.