CST-III. These two CSTs are known to be associated with rapidly fluctuating dysbiotic states. When comparing the population structure of all urine and vaginal samples, no statistical differences were observed (PERMANOVA: $F_{1,148}=1.0815$, $p=0.31$).

Conclusion Vaginal and random catch urine samples from the same participant showed substantial agreement on bacterial composition. Random catch urine samples could present another sampling option to assess the vaginal and urogenital microbiota.

O10.5 TESTING OF BD MAX™ VAGINAL PANEL RESIDUAL SPECIMENS USING THE BD MAX™ CT/GC/TV ASSAY

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Introduction Vaginitis is a common problem in women's health globally. Sexually Transmitted Infections (STI) are also highly prevalent and often have symptoms similar to vaginitis. *Trichomonas vaginalis* (TV) is a causative agent of vaginitis that is exclusively sexually transmitted and thus falls into both of these diagnostic categories. To better understand co-infection rates for STI and vaginitis, we used the BD MAX- CT/GC/TV (MCGT) assay for detection of *Chlamydia trachomatis* (CT), *Neisseria gonorrhoeae* (GC) and TV on samples previously tested with BD MAX- Vaginal Panel (MVP).

Methods Women who reported vaginitis symptoms were enrolled in a study that evaluated the performance of MVP. A subset of the vaginal swabs collected and frozen was tested using MCGT. The presence of CT, GC or TV was assessed in women with Bacterial Vaginosis (BV) only, *Candida spp*. only (Ca), BV+Ca, or negative for vaginitis as determined by the MVP. This last category included women with all negative results as well as women with TV only, since for this analysis TV was classified as an STI.

Results Self-collected samples gave reportable results for 528 women to date. 210 (39.8%), 62 (11.7%), 95 (18.0%) and 161 (30.5%) were diagnosed with BV, Ca, BV+Ca or no vaginitis, respectively. TV, CT and GC were present in samples from 62 (11.7%), 32 (6.1%) and 8 (1.5%), respectively. STI positivity rates among those with BV, Ca, BV+Ca and vaginitis negative women were 23.3, 9.7, 25.3% and 8.7%. Of the 62 TV results obtained with MCGT, 61 were detected with MVP, with an overall agreement of 99.8% (527/528).

Conclusion STI rates were high among women seeking care for vaginitis and co-infection was common. While treatment for vaginitis may include appropriate management for TV, CT and GC management requires appropriate diagnostics in order to prescribe the appropriate treatment. Testing of the same vaginal specimen on the BD MAX instrument for both vaginitis and STI diagnostics is an efficient solution which maximises the number of results available to effectively guide patient management.

O10.6 CLEARANCE OF *MYCOPLASMA GENITALIUM* AND *TRICHOMONAS VAGINALIS* AMONG ADOLESCENTS AND YOUNG ADULTS WITH PELVIC INFLAMMATORY DISEASE: RESULTS FROM THE TECH-N STUDY

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Introduction While the broad-spectrum antibiotics recommended for treatment of pelvic inflammatory disease (PID) effectively treats *Neisseria gonorrhoeae* (GC) and *Chlamydia trachomatis* (CT), coverage may be inadequate for Mycoplasma *genitalium* (MG) and *Trichomonas vaginalis* (TV). Untreated MG and TV may result in vaginal dysbiosis, increasing the risk for recurrent STIs and HIV. The objective of this study is to evaluate longitudinal MG and TV outcomes compared with GC/CT outcomes over the 90 day following treatment.

Methods 259 Female AYA aged 13–25 years with mild-moderate PID enrolled in a randomised trial of a technology enhanced community health nursing study designed to prevent STIs after PID. Participants completed audio computer-assisted self-interviews and provided vaginal specimens at baseline, 30 days and 90 days and were notified and referred for treatment for positive results. Generalised estimating equations were used to measure changes in the prevalence of MG and TV compared with GC/CT over time.

Results At baseline, 29% were positive for CT or GC at baseline (25% CT and 8% GC), 19% for MG, and 16% for TV. Ninety-four percent of the effective sample was retained at 90 days and 44% reported completing all medication doses. At 30 days, 17 (8%) of women were positive for CT or GC, while 36 (17%) were MG positive, and 22 (10%) were positive for TV. At 90 days, 13 (6%) were positive for CT or GC, 39 (18%) for MG, and 30 (14%) for TV. GC/CT infection was declining on average over time (odds ratio 0.48, 95% CI 0.36 to 0.63 per additional month). MG was not significantly changing over time (odds ratio 0.94, 95% CI 0.84 to 1.05), at a different rate than GC/CT ($p<0.001$). TV was also consistent over time (odds ratio 0.92, 95% CI 0.78 to 1.09), also at a different rate than GC/CT ($p<0.001$).

Conclusion Youth treated with the recommended syndromic management protocols clear infection with GC/CT, but often have recurrent, persistent, and/or new MG/TV infections during the 90 day post-PID follow-up period.

Oral Presentation Session 11

STI Diagnosis and Clinical Observations

O11.1 DECLINE IN GENITAL SHEDDING IN THE YEAR AFTER FIRST CLINICAL EPISODE GENITAL HERPES SIMPLEX VIRUS TYPE 1

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