

more MSM, PrEP users and clients notified for or with symptoms of STI were seen during- and post-lockdown compared to pre-lockdown. Chlamydia positivity was around 18% among heterosexual men and 15% among women from 2016–2019, and increased to 21.1% and 16.6% respectively in 2020. Positivity increased during lockdown, up to 32% among heterosexual men, followed by decreases post-lockdown to pre-lockdown levels. Among MSM, the increase during lockdown was smaller, only slightly affecting overall positivity in 2020. Gonorrhoea positivity also increased during lockdown, causing further increasing trends among heterosexuals from 1.8% in 2011 to 2.2% in 2020 and among MSM from 9.0% to 12.1%. Syphilis positivity among MSM fluctuated between 2.0% and 2.9% in 2011–2020. Positivity peaked (6.7%) during lockdown, while the number of diagnoses was similar to pre-lockdown. In contrast, HIV positivity continued to decrease from 2.0% to 0.3% among MSM in 2011–2020.

Conclusion Prioritising persons at highest risk caused decreases in diagnoses, especially chlamydia and gonorrhoea, but increases in positivity. More information is needed to understand transmission dynamics, including testing at GPs, self-testing and sexual behaviour during coronavirus pandemic.

P265 VALUE OF CLIA SEROCONVERSION WITH NEGATIVE RPR AND IMMUNOBLOT FOR THE DIAGNOSIS OF EARLY SYPHILIS

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Introduction An isolated CLIA seroconversion (i.e. CLIA-reactive, immunoblot non-reactive, RPR non-reactive, with a previous negative CLIA) could indicate a false positive result or early incubating syphilis. To confirm early syphilis, follow-up appointments are often needed. We wanted to evaluate the diagnostic value of such seroconversions.

Methods We included every patient with a positive CLIA (Liaison) and a negative RPR and immunoblot visiting the STI clinic (To) between January 2014 to April 2020, and a preceding visit with a negative CLIA in the 6 months prior to the initial consultation (T-1). If available, a follow-up appointment in the 2 months after the initial consultation (T1) was included. If darkfield microscopy (DFM) or PCR for *Treponema pallidum* was positive at T0, diagnosis of syphilis was confirmed. This also applied to a positive RPR and/or immunoblot in the T1 consultation.

Results We included 91 participants with an isolated CLIA seroconversion. The value of the CLIA seroconversion in 19/91 (21%) of the study population could not be established, since they had no positive PCR or DFM ulcer sample at To and had no T1 consultation. Of the remaining 72 patients, 54 (75%) the CLIA seroconversion was confirmed. 28/54 persons (52%) had a PCR or DFM confirmation in the initial consultation and 26/54 persons (48%) had a serologic confirmation in the follow-up appointment. In 18/72 (25%) persons the CLIA seroconversion was regarded as false positive reaction since no seroconversion in RPR or immunoblot was seen at T1.

Conclusion Of the evaluable patients with a CLIA seroconversion, 75% had an early incubating syphilis infection. 48% of these patients would benefit from presumptive treatment, since they had no signs of primary syphilis at the moment of the CLIA seroconversion. However, 25% had a false positive result, thus would receive unnecessary presumptive treatment.

P267 DISCORDANT CURES ARE ASSOCIATED WITH MYCOPLASMA GENITALIUM INFECTION IN MEN TREATED WITH AZITHROMYCIN FOR NONGONOCOCCAL URETHRITIS

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Background In men with nongonococcal urethritis (NGU), clinicians and patients rely on the resolution of urethritis signs and symptoms to determine the need for additional testing/treatment and when to resume sexual activity, respectively. Whether clinical NGU cure correlates with microbiological clearance across sexually transmitted infections (STI) remains unknown.

Methods Within the Idiopathic Urethritis Men's Project (IUMP), we identified men with mono-infection NGU due to *Chlamydia trachomatis*, *Mycoplasma genitalium*, or *Ureaplasma urealyticum*. Men had presented to the Bell Flower Clinic in Indianapolis, Indiana, and were diagnosed with NGU and enrolled in IUMP. Men provided a urine specimen for STI testing by NAAT, received azithromycin 1gm and returned for a 1-month test-of-cure visit. At the test-of-cure visit, men were asked about interval antibiotic use, sexual activity, interval urethritis signs and symptoms, and repeat STI testing was performed. Clinical cure was defined as resolution of urethritis signs and symptoms. Microbiological cure was defined as clearance of STI at the test-of-cure visit. Significance was evaluated by Fisher's exact test.

Results Seventy-five men were included in this analysis, 52 with CT, 16 with MG, and 7 with UU. Clinical cure occurred in 50–100% and microbiological cure occurred in 31–100% of men. Discordant cures were more common in men with MG than CT (44% vs 15%, $p = 0.102$); no UU discordant cures occurred. Men with MG-NGU were significantly more likely to have a clinical cure with microbiological failure compared to CT-NGU (31% vs 4%, $p = 0.0042$). Clinical failure with microbiological cure occurred in approximately 10% of men.

Conclusions Discordant NGU cure outcomes do occur and are more common in men with MG-NGU. The most common discordant cure outcome was clinical cure with microbiological failure. In men treated with azithromycin for NGU, MG testing should be included and a test-of-cure considered to ensure STI clearance.

P268 CLINICAL PERFORMANCE ASSESSMENT OF THE ALINITY M STI ASSAY

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Background It is estimated that everyday over 1 million individuals contract a curable sexually transmitted infection (STI) worldwide. For an appropriate STI treatment, it is necessary to have an accurate diagnosis. The Alinity m STI assay is a multiplex RT-PCR assay that identifies four STI pathogens: *Chlamydia trachomatis* (CT), *Neisseria gonorrhoeae* (NG), *Trichomonas vaginalis* (TV), and *Mycoplasma genitalium* (MG) in a single (115 min) reaction. The aim of this study was to evaluate the assay clinical performance.

Methods Clinical performance of Alinity m STI assay was assessed using 201 residual clinical samples [119 urine and 82 in gynecological specimens] and compared with Abbott Real-Time CT/NG assay and XGEN MULTI UP test (Mobius Life Science) for TV/MG. Precision and reproducibility were evaluated by testing panel members in contrived swab. Five panel members (PM) were tested in 12 replicates in two days: PM1=CT, PM2=NG, PM3=TV, PM4=MG and PM5=CT/NG/TV/MG at 2X claimed LoD.

Results For CT, the positive (PPA) agreement and negative (NPA) agreements were 95% and 100% respectively. For NG, the PPA was 94% for urine and 100% for gynecological specimens, and NPA was 99% and 100%, respectively. For MG, PPA and NPA were 100%. For TV, NPA was 100% (no positive result obtained). Co-infection with MG was observed in 5% of CT or NG positive samples. The overall agreement for both sample types and the four organisms was 98.5% (516/524). All panel members were detected and accurately identified, individually (PM1–4) or in the presence of the other three pathogens (PM5).

Conclusion The Alinity m STI assay showed excellent agreement (97–100%) between methods and streamlines laboratory workflow with simultaneous detection of 4 pathogens in a single reaction from the same sample. This assay allows rapid infection identification supporting clinicians to properly treat patients, especially when a co-infection is present.

P270 ACCEPTABILITY OF SELF-COLLECTED THROAT SWABS AMONG MEN WHO HAVE SEX WITH MEN ATTENDING A SEXUAL HEALTH CENTRE

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Background Due to the COVID-19 pandemic, sexual health clinics across Australia have switched from clinician-collected to self-collected swabs for oropharyngeal STI screening. The study aimed to determine the acceptability of self-collected throat swabs among 200 gay, bisexual and other men who have sex with men (GBMSM) attending a sexual health service.

Methods GBMSM aged ≥ 16 years old, had a throat swab taken at the Melbourne Sexual Health Centre (MSHC), and provided consent to participate in research, were invited to take this online survey by SMS. The survey collected data on how easy or difficult men found collecting their own throat swab.

Results 273 GBMSM completed the survey; 218 (79.9%) self-collected their throat swab and were included in the final analysis. Most participants found collecting their own throat

swabs very easy, easy, or were neutral (190; 87.2%; 95% confidence interval [95%CI]: 82.0% to 91.3%) and 28 (12.8%; 95%CI: 8.7% to 18.0%) found it difficult or very difficult. There were 85 (39.0%) who reported taking the swab by themselves was worse than previous experiences of clinician-collected swabs, compared to 110 (50.5%) who reported it was better taking the swab by themselves or found no difference to previous clinician-collected swabs. The two most commonly reported experiences during self-collection were gagging (155; 71.1%) and being worried they had not done it correctly (46 out of 95 who were asked this; 48.4%). Almost half of participants preferred to have a clinician take their throat swab (103; 47.5%; 95%CI: 40.5% to 54.1%); 66 (30.4%; CI: 24.3% to 36.8%) did not have a preference and 48 (22.1%; 95%CI: 16.7% to 28.1%) preferred to take the swab themselves.

Conclusion Most GBMSM did not find self-collecting throat swabs difficult, however almost half of participants preferred to have a clinician take the swab.

P271 SEXUAL HEALTH SERVICE ADAPTATIONS TO THE CORONAVIRUS DISEASE 2019 (COVID-19) PANDEMIC IN AUSTRALIA: A NATIONWIDE ONLINE SURVEY

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Background We aimed to examine the changes public sexual health services across Australia made during the national lockdown (March-May 2020) due to the COVID-19 pandemic.

Methods From July-August 2020, we emailed a link to an online survey to 21 sexual health clinic directors/managers who were part of the Australian Collaboration for Coordinated Enhanced Sentinel Surveillance of Sexually Transmissible Infections and Blood-borne Viruses (ACCESS) network.

Results All 20 participating clinics remained open but reported changes during the lockdown, including suspension of walk-in services in 8 clinics.

Some clinics stopped offering asymptomatic screening for heterosexuals (n=11), men who have sex with men (MSM) (n=3), or transgender persons (n=2). Most clinics offered a mix of telehealth and face-to-face consultations for asymptomatic MSM (n=11), asymptomatic transgender persons (n=12), post-exposure prophylaxis (PEP) prescription (n=13) or to initiate pre-exposure prophylaxis (PrEP) (n=14). People who were symptomatic for STIs and contacts of STIs were offered face-to-face and telehealth consultations across all clinics. Seven clinics suspended STI test-of-cure consultations and four clinics suspended hepatitis vaccinations for people not living with HIV. Nineteen clinics reported delays in testing and 13 reported limitations in testing during lockdown. Most clinics changed to phone consultations for HIV