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.

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**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.

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**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 Urthritis 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.

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**P268** CLINICAL PERFORMANCE ASSESSMENT OF THE ALINITY M STI ASSAY

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**Background** Among the many urogenital pathogens, Mycoplasma genitalium (MG) appears to be the most prevalent. Diagnosis of MG requires culture or PCR, which often results in delayed treatment and may lead to persistent or recurrent infections. The ALINITY M STI Assay (Abbott Molecular Inc.) is an ultrasensitive PCR assay that is able to detect MG directly from genital samples.

**Methods** A multicentre study including 300 patients from 10 laboratories across the United States and Brazil was conducted. Each participant was asked to provide genital samples for the ALINITY M STI Assay. A 1-month follow-up was performed.

**Results** In this study, the ALINITY M STI Assay detected 27/300 (9%) positive samples for MG. At follow-up, 23/27 (86%) of the positive samples remained positive indicating that the assay is able to detect persistent infections.

**Conclusions** The ALINITY M STI Assay is a sensitive and specific assay for the diagnosis of MG. It is recommended for the detection of MG in clinical settings to improve patient care and reduce the transmission of this common STI.
Acceptability of self-collected throat swabs among men who have sex with men attending a sexual health centre

**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.

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

**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...