and Cx NPM for the detection of GC in women, highlighting a need to perform targeted training, review the criteria for NPM and develop additional point of care tests for GC.

P74 EPIDEMIOLOGY OF AN *NEISSERIA GONORRHOEAE* OUTBREAK IN A LOW PREVALENCE AREA

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Background In January 2011, an increased number of gonococcal (GC) isolates was noted within the local bacteriology department. A "look back" exercise was initiated for all incidences of GC infections during the previous 13 months, while new episodes of GC infection were monitored to ascertain whether this increase represented an outbreak.
Aims To determine the epidemiology of GC infection observed during an outbreak of *Neisseria gonorrhoeae* within the local area.
Methods Cases of GC infection within our Health Board area were identified by culture or nucleic acid amplification test (NAAT) for the period December 2009 to April 2011. *N gonorrhoeae* multi-antigen sequence typing (NG-MAST) was performed on positive isolates or NAAT samples. Patient demographics were gathered at the local sexual and reproductive health (SRH) clinic.
Results 73 episodes of GC infection were recorded in one geographically distinct area of our Health Board between December 2010 and April 2011 (the outbreak). Nineteen cases were documented for the same period the previous year. No similar increase in GC diagnoses was observed in neighbouring areas. Chlamydia cases remained relatively stable. Patient demographics were available for 62 of the 67 cases diagnosed at the local SRH clinic. Of these, the majority of cases were male (66.1%) (of which 22% were MSM), under 25 years of age (71%), heterosexual (78.5%) and of White Scottish ethnicity (95.2%). 40 (64.5%) patients (29 male and 11 female) presented with symptoms of GC infection and 19 (29.2%) as GC contacts. The predominant NG-MAST sequence type was ST26.
Discussion The epidemiology of this outbreak is atypical, since GC infection and NG-MAST ST26 has been more commonly found in men who have sex with men in Scotland. Despite enhanced surveillance, no sexual networks or links to specific venues were identified. A gonorrhoea awareness campaign was launched in May 2011.

P75 DO CASH INCENTIVES INCREASE THE UPTAKE OF CHLAMYDIA TESTING IN PHARMACIES?

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Background Chlamydia screening uptake rates in Australian and overseas pharmacies vary widely (11% to 58%).
Aim To determine the effect on the uptake of chlamydia screening in community pharmacies when a cash reward is offered to young people and participating pharmacies.
Methods The study was advertised in print and electronic media. People aged 16–30 years requested, or were offered, chlamydia testing kits by pharmacy staff (assistants and pharmacists). Participants who provided a urine sample and completed a questionnaire received AUD$10; pharmacies received AUD$10 per person recruited. Urine specimens were tested in pools using PCR, with reflex testing of individual samples when the pool tested positive. Positive cases were notified by sexual health nurses and offered treatment.
Results Six urban community pharmacies took part in the study, each for 15 days. 979 testing kits were given out and 970 sample pots returned (99.1%); 66 (7%) did not contain urine. 74% (670/904) of the urine samples were determined to be from unique individuals, 65% of whom were male. 19 people (13 females and 6 males) tested positive; positivity rates were 5.2% (95% CI 2.8 to 8.8) for females and 1.4% for males. 11 (61%) of those testing positive were contacted and eight attended a local sexual health centre for treatment, three were treated elsewhere. Of the eight people treated at the sexual health centre, two females aged 15 and 20 years were diagnosed with pelvic inflammatory disease. Contact with the remaining eight positive individuals was not possible due to disconnected, incorrect or non-existent telephone numbers.
Conclusion The 68% specimen return rate found in this study significantly exceeds those reported elsewhere. Strategies to prevent repeat testing, non-urine specimens and incorrect contact numbers are needed to ensure good clinical care and optimum use of resources.

P76 EQUIVOCAL APTIMA COMBO 2 RESULTS: WHAT DO THEY MEAN IN CLINICAL PRACTICE?

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Background Molecular diagnostic tests have become standard of care for detection of gonococcal (GC) and chlamydial (CT) infections. The Aptima Combo 2 (AC2) test is widely used and is highly sensitive and specific, even for non-genital specimens. Equivocal results occur when the initial AC2 assay detects target RNA but the confirmatory Aptima GC or CT assay fails to detect a different RNA sequence in the same specimen.
Aim To determine whether equivocal AC2 (EAC2) results were predictive of subsequently confirmed infection in our GUM/HIV clinic population.
Methods Retrospective review of all EAC2 results for GC or CT at 3 urban UK GUM/HIV clinics from January to December 2011. Patients with EAC2 results were routinely recalled for repeat testing unless treated at the initial visit.
Results From a total of approximately 38 000 AC2 tests performed in 2011, 3118 (8.2%) were confirmed positive: 1189 GC and 1929 CT infections. There were 222 EAC2 results in 2011 (0.6% of total AC2 tests); 45 (20.3%) occurred in women, the majority (73%) of which were equivocal genital CT results. Of the 177 EAC2 results in men (mostly MSM), 70% were non-genital specimens. Equivocal pharyngeal GC was common, comprising one-third of all male EAC2. Of 34 EAC2 patients analysed in more detail, 5 were GC/CT contacts and 24/34 reported unprotected sex at the site of the EAC2. None with equivocal GC had GC positive culture results, at the time or subsequently. Of 19 men with EAC2 GC results, 6 (all MSM) had confirmed GC at another mucosal site at that visit. 30/34 patients had the AC2 test repeated (range 7–24 days after initial test); 29 were AC2-negative and one remained equivocal (see abstract P76 table 1).
Conclusions EAC2 results are uncommon but seem to occur in those at higher risk for infection; yet the vast majority does not have infection confirmed on subsequent testing. This suggests that these are spurious results, possibly from contamination, or low organism load infections that do not persist; thus routine treatment is not necessarily warranted.