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therapy (ART). Our hypothesis is that any association between STIs and VF would be confounded by drug use. **Methods** The OHTN Cohort Study follows people receiving HIV care in Ontario. STI results and viral load (VL) data were retrieved via linkage with the provincial laboratory. We restricted analyses to 2610 MSM who completed ≥1 annual questionnaire in 2008–2014 and had two consecutive VL <50 within a six-month period on ART. VF was defined as a single VL ≥1000 or two consecutive VLs ≥200. Periods of STI exposure were set around the diagnosis dates for each STI. We modelled STI diagnosis exposures and drug use as time-varying covariates on risk of VF using Cox regression adjustment for age, region and income as confounders. Our model allowed for repeat STI exposures and repeated VF events using the marginal means/rates model. **Results** There were 472 VFs with a 24 month cumulative incidence of 12.1% (95% CI 11.1, 13.1). VFs at time of a new chlamydia or gonorrhoea infection were close to nil. We did not observe an increased risk of VF at the time of a new syphilis infection (HR=1.2 95% CI 0.8, 2.0; aHR=1.1 95% CI 0.7, 1.7). Risk was higher among drug users (non-injection aHR=1.4 95% CI 1.1, 1.8; injection aHR=1.8 95% CI 1.1, 2.6). There was no significant interaction but some evidence of positive confounding between syphilis and VF by drug use. **Conclusion** Regardless of drug use, we did not find an association between a new STI diagnosis and increased risk of VF among men on suppressive ART. Our data are limited by possible misclassification of STI exposures, because not all men were tested, and among those diagnosed, exact dates of acquisition were unknown.

**P2.37** PRESENCE OF GENITAL CHLAMYDIA TRACHOMATIS SEROTYPE L2 INFECTION IN SOUTH AFRICAN WOMEN

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**Introduction:** Chlamydia trachomatis serotype-L, lymphogranuloma venereum (LGV), is a well-recognised infection among men who have sex with men in developed nations. In Africa, LGV is an uncommon but recognised cause of genital ulcer disease in men and women. The presence of genital infection in African women is unknown. **Methods** In this pilot study we evaluated the presence of C. trachomatis serotype-L in 55 vaginal specimens that tested positive for C. trachomatis. These specimens were obtained in several studies over the period 2012–2016 that recruited women visiting a mobile health clinic in rural Mopani District (n=25) and in various settings in Pretoria: a tertiary obstetrics and gynaecology clinic (n=14), an antiretroviral treatment (ART) clinic (n=10) and a sexually transmitted infections (STI) clinic (n=6). Presence of serovar type-L of C. trachomatis was assessed using a targeted PCR assay and confirmed by whole-genome sequencing (WGS) of DNA from the clinical specimen. **Results** We identified serotype-L C. trachomatis infection by targeted PCR in 8 cases. All of these women had presented with vaginal discharge at either the ART (n=5) or STI (n=3) clinic. Two women had co-infection with Neisseria gonorrhoeae, two with Mycoplasma genitalium and two with Trichomonas vaginalis. WGS of 5 specimens confirmed the presence of the L2 serovar. Also, one mixed infection of serovars L2 and E (minority) was observed. **Conclusion** This study demonstrates the presence of symptomatic cervical infection by C. trachomatis of serotype-L2 in African women. This confirms a report of (chronic) genital infection in African women from more than two decades ago. The significance of this observation is to be determined with regards to virulence, morbidity, distribution across the population and clinical management in the current context of the syndromic approach.