visit. A diagnosis of trichomoniasis was defined as a positive nucleic acid amplification test (NAAT) and/or motile trichomonads on wet mount microscopy, urinalysis, or cervical cytology. Women with abnormal vaginal discharge at the time of testing were considered symptomatic. A chi-squared test of proportions was used to compare the percentage of cases that received treatment and that had a TOR by testing modality. The Mann Whitney U test was used to compare time to treatment and TOR by mode of diagnosis.

RESULTS: Among 3,349 women, 390 (11.6%) women were diagnosed with 541 unique cases of trichomoniasis (1 case: 289 women, 2 cases: 61, 3 cases: 32; 4 cases: 6, 5 cases: 2). Of the 541 cases, 177 women were diagnosed by wet mount microscopy, 360 by NAAT, 39 by cytology, and 14 by urinalysis. Nearly 10% of women had more than one mode of diagnosis. There were 1,779 women (53.1%) that had NAAT screening for trichomoniasis at some point during pregnancy. Among women with a positive NAAT, 103 (28.6%) had wet mount microscopy done on the same day. Of these 103 women, 75 (72.8%) tested negative on wet mount. Of the 541 cases, 123 (22.7%) had abnormal vaginal discharge at time of testing. A Time to treatment ranged from 0 to 210 days, with 62 women (12.2%) waiting more than four weeks for treatment. Days to treatment was shorter for those who had a positive wet mount compared to those who were diagnosed by other modalities (median wet mount= 0 days, median other= 8 days, $p < 0.0001$). Time to TOR ranged from 14 to 260 days. The proportion tested for reinfection and time to TOR did not differ significantly by mode of diagnosis (wet mount= 73.6%, all others= 71.1%, X2= 0.4, p= 0.54; median wet mount= 37 days, median other= 38.5 days, p= 0.71).

CONCLUSION: Our results highlight that delays in treatment are common when point of care testing is not performed. Given the low sensitivity of wet mount, higher sensitivity point-of-care testing approaches should be explored. The high percentage of asymptomatic cases underscores the need for more structured guidelines for trichomoniasis testing and treatment in pregnancy. This need is even greater in high-risk populations, given the association of trichomoniasis infection with preterm delivery and increased HIV acquisition risk.

LEARNING OBJECTIVES: Learners will be able to identify the different patterns of testing, tests of reinfection, and treatment for trichomoniasis in pregnancy.

9 A comparison of 2 g single-dose versus 7-day 500 mg twice daily metronidazole for the treatment trichomoniasis in women by selected clinical factors

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OBJECTIVES: Trichomonias is the most common non-viral sexually transmitted infection (STI) among women worldwide and is associated with serious reproductive morbidity, poor birth outcomes, and amplified HIV transmission. Single-dose (2 g) metronidazole (MTZ) is the first line of treatment recommended by the Centers for Disease Control and Prevention and the World Health Organization with multi-dose MTZ as an alternative. Two multi-centered randomized trials and a meta-analysis found that women receiving multi-dose MTZ were nearly half as likely to retest positive to T. vaginalis post-treatment compared to women receiving single-dose MTZ, indicating that multi-dose MTZ should be recommended over single-dose. The purpose of this study was to examine if this effect was similar by selected clinical factors to determine if treatment recommendations should be nuanced.

METHODS: This is a secondary analysis of a previously published randomized, parallel, multi-site, open-label trial of single-dose (2 g one-time) versus multi-dose (500 mg twice daily for 7 days) MTZ for the treatment of trichomoniasis. The primary outcome was T. vaginalis infection at test-of-cure (TOC) 4 weeks after completion of treatment measured by nucleic acid amplification test or culture. Analyses were stratified by reported T. vaginalis history, genital symptoms, and bacterial vaginosis (BV) at baseline.

RESULTS: Women who returned for their TOC visit (n=540) were included. At baseline, 53.1% had a history of trichomoniasis, 80.6% had genital symptoms, and 45.9% had BV. At TOC, 15.0% rested positive. Stratified rates of T. vaginalis at TOC are in Table 1. In women who received single dose MTZ, those who were symptomatic and had a history of trichomoniasis had the highest rate of infection at TOC (26.7%) whereas those with neither factor had the lowest rate (4.3%). Among women receiving multi-dose MTZ, TOC+ rates were similar by these factors (range 9.3%-13.0%). There was a high rate of concomitant BV.

CONCLUSION: Multi-dose metronidazole should be recommended over single dose for all women, but it is particularly imperative that women who are symptomatic and/or who have a history of trichomoniasis receive multi-dose.

LEARNING OBJECTIVES: Multi-dose MTZ should be recommended over single dose for all women, but it is particularly imperative that women who are symptomatic and/or who have a history of trichomoniasis receive multi-dose.

10 Immunoglobulin A, immunoglobulin G, and neutralizing antibodies to respiratory syncytial virus increase in human milk following immunization with an RSV F protein vaccine

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OBJECTIVES: Maternal immunization with respiratory syncytial virus (RSV) F nanoparticle vaccine during pregnancy increases serum RSV antibodies. Our objective was to determine the effect of maternal immunization on the levels of RSV F-specific antibody levels in human breast milk.

METHODS: Prepare is a randomized, observer-blind, placebo-controlled trial of RSV F vaccination during the third trimester of pregnancy. It was conducted in the Northern and Southern hemispheres. As a sub-study to the parent trial, we evaluated breast milk in vaccinees and placebo recipients from 3 study sites in Bangladesh, New Zealand, and the United States. Maternal breast milk samples were obtained following delivery, and at 14 days, 35 days, 60 days, 90 days, 120 days, and 180 days. Maternal serum samples were obtained at 14 days, 60 days, 90 days, 120 days, and 180 days. Milk and serum specimens from 145 subjects were assayed using an enzyme-linked immunosorbent assay (ELISA) for RSV F-specific IgA and IgG, and using an RSV/A-specific microneutralization assay.