RESULTS: Among 964 women with incident asymptomatic BV by Nugent score (mean 8.2), the mean age was 33 years; 98% had clue cells on saline microscopy, 85% had a pH ≥ 4.5, 32% had a positive whiff test, and 24% had abnormal vaginal discharge identified clinically during pelvic examination. With an average 112 days of follow-up, 578 (60%), women had resolution of incident asymptomatic BV, with an average of 93 days (range 33-128) until resolution; 83 (9%) women developed symptoms, with an average 100 days (range 42-147) till symptoms; and 303 (31%) women had no change in BV status, with an average 153 days (range 64-247) of follow-up. Women with a baseline Nugent score of 9 or 10 (adjusted hazard ratio [aHR]=0.59; 95% CI 0.46, 0.75), pH ≥4.5 (aHR 0.66; 95% CI 0.51, 0.87), or positive Whiff test (aHR 0.87; 95% CI 0.70, 1.08) had lower hazards of resolving BV compared to women who had no change in status. Women reporting use of depot medroxyprogesterone acetate (aHR 1.32; 95%CI 1.03, 1.70) or condoms (aHR 1.42; 95% CI 1.08, 1.87) as their current contraception had a higher hazard of resolving BV compared to women with no change. Among women who resolved BV, 4.7% later developed symptoms with an average of 103 days from resolution to symptomatic BV.

CONCLUSION: Over a year of follow-up, the majority of women with incident asymptomatic BV did not develop symptoms in the absence of treatment. However, almost a third of women remained asymptomatic with elevated Nugent scores. Baseline clinical factors may be useful in identifying these women who may remain at high risk for sequelae associated with asymptomatic BV.

LEARNING OBJECTIVES: Learners will be able to describe the natural history of incident asymptomatic BV and the proportion of women who resolve BV without treatment.

24 The effect of estimated blood loss on postpartum infection risk

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OBJECTIVES: Current guidelines for obstetric antimicrobial prophylaxis recommend additional intra-operative antibiotics for excessive blood loss defined as >1.5L. This recommendation is based on studies performed on patients undergoing spinal surgeries. Given the different risk profile of infection for patients undergoing Cesarean delivery, we aimed to evaluate rates of postpartum infection based on estimated blood loss(EBL).

METHODS: Retrospective cohort study of all women at a single institution undergoing Cesarean delivery from January-June 2014 and January-June 2016. Women with EBL<1.5L were compared with EBL ≥1.5L. Women were excluded only for vaginal birth and outcomes were tracked until 42 days postpartum. The primary outcome was composite postpartum infection characterized by a wound infection or endometritis. Secondary outcomes included the wound hematoma, seroma, or infection, endometritis, readmission for wound complications, wound debridement, outpatient visit for antibiotics or wound complication. Backwards-stepwise regression was used to estimate adjusted odds of primary outcome.

RESULTS: 2202 women met inclusion criteria; 104 (4.7%) women had an EBL ≥1.5L and 2098 (95.2%) had EBL <1.5L. Women with EBL ≥ 1.5L were more likely to be older, receive a blood transfusion, and receive postpartum antibiotics. Women with EBL ≥1.5L were less likely to have had an abdominal or vaginal surgical prep with chlorhexadine. There were also trends towards women with a larger EBL to have a multiple gestation, repeat Cesarean, Cesarean after labor, and chorioamnionitis although these failed to reach statistical significance. An EBL ≥ 1.5L was associated with a decreased risk of postpartum infection (aOR 0.26 95% CI 0.08-0.82) although rates of wound infection (aOR 0.31 95%CI 0.09-1.1), readmission (p=0.72) or outpatient treatment for a wound infection (p=>0.99) were not different between groups.

CONCLUSION: In this cohort, estimated blood loss greater than 1.5 liters with Cesarean delivery was associated with decreased risk of postpartum infectious morbidity related to endometritis or wound infections. However, women with higher EBL were treated differently in the intrapartum/postpartum period including receipt of additional antibiotics, which may explain their decreased infectious morbidity

LEARNING OBJECTIVES: 1. Learners will recognize the paucity of data on re-doing of antibiotics in the obstetric population and determine need for further research to determine the estimated blood loss associated with higher infection risk.

25 Prevalence of congenital CMV infection in Colombia

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OBJECTIVES: The prevalence of congenital cytomegalovirus (CMV) infection ranges from 0.6% to 3.2% in studies conducted in Brazil, Chile, Panama, and Mexico, but data from other Latin American countries are lacking. This study assessed the prevalence of congenital CMV infection among infants born to women in a prospective cohort study in Colombia.

METHODS: During October 2017-September 2018, urine samples were collected from infants born to women enrolled in the Zika en Embarazadas y Niños en Colombia cohort study in cities from three regions in Colombia. The first infant urine samples collected after birth were tested. Congenital CMV infection was defined as a positive result by quantitative polymerase chain reaction within 21 days of birth using the CMV R-gene kit (Argene) for detection of CMV DNA, and confirmatory testing was conducted in a second laboratory.

RESULTS: Among 657 infants with a urine sample collected within 21 days of birth (median=15 [interquartile range, IQR: 13-17] days), 8 infants (1.2%; 95% confidence interval [CI]=0.6-2.4%) were CMV-positive. The prevalence of congenital CMV infection was 1.6% (95% CI=0.6-4.7%) in Valle, 1.6% (95% CI=0.7-3.8%) in Barranquilla, and there were no cases of congenital CMV infection in Bucaramanga. The median viral load was 2.7*105 copies/mL [IQR: 9.16*103 − 1.02*107). Median maternal age was 22.2 years (IQR: 19.6-28.7) among mothers of CMV-positive infants compared to 25.3 (IQR: 21.0-30.0) years among mothers of CMV-negative infants (p=0.33).

CONCLUSION: Congenital CMV infection prevalence in our cohort was within the range reported from other studies in Latin America. Clinical follow-up is ongoing for CMV-positive infants. Studies including cohorts of pregnant women and infants offer an opportunity to understand the burden of congenital CMV infection and associated disabilities.