92
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# SEXUALLY TRANSMITTED INFECTIONS

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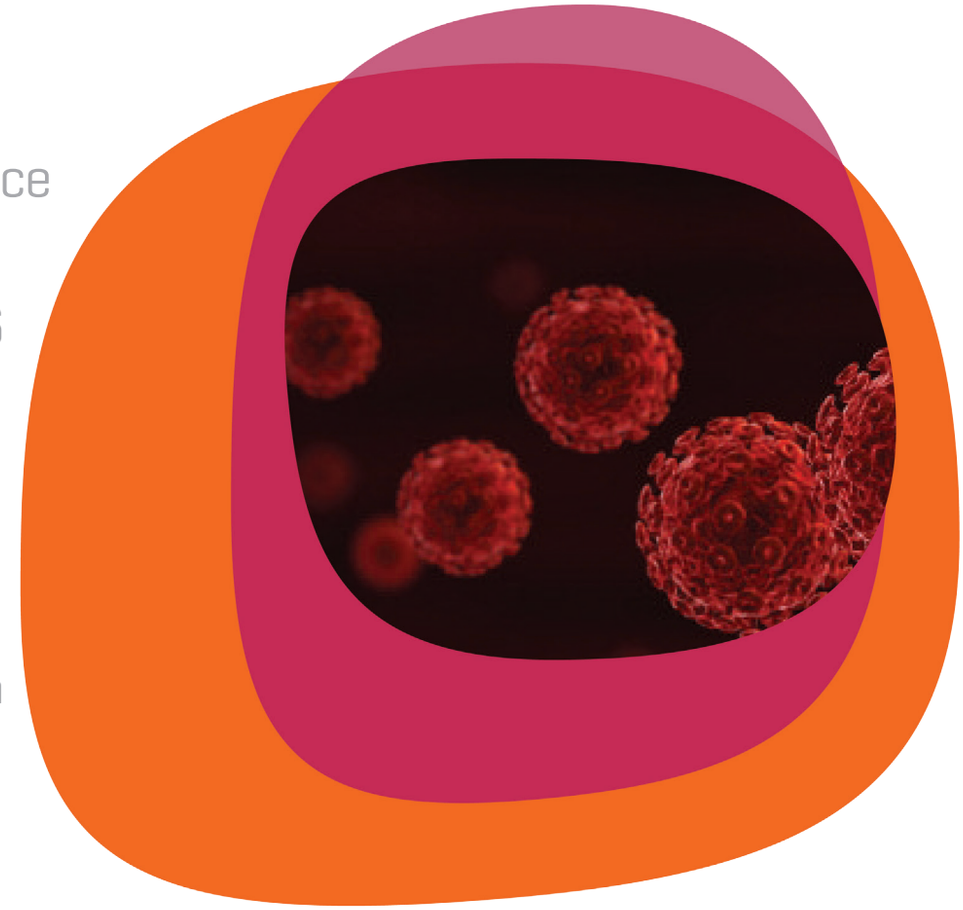
SEXUALLY TRANSMITTED INFECTIONS

## BASHH Conference OXFORD

## July 10–12 2016

## Abstract Presentations

Guest Editor
Dr Daniel Richardson



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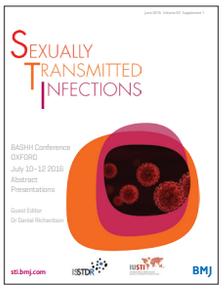


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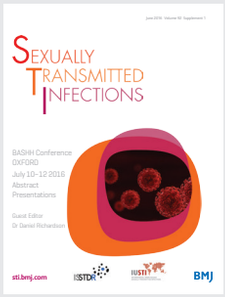



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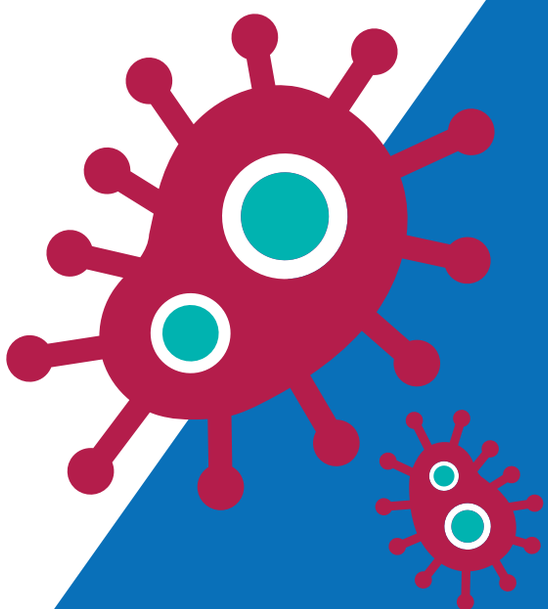

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# Section 1 Oral presentations

## O001 DIGITAL SEX AND THE CITY: PREVALENT USE OF DATING APPS AMONGST HETEROSEXUAL ATTENDEES OF GENITO-URINARY MEDICINE (GUM) CLINICS

Malika Mohabeer Hart*, Jey Zdravkov, Komal Plaha, Farhad Cooper, Katie Allen, Lisa Fuller, Rachael Jones, Sara Day. *Chelsea and Westminster Healthcare NHS Foundation Trust, London, UK*

10.1136/sextrans-2016-052718.1

**Background/introduction** Studies show that use of dating apps amongst men who have sex with men (MSM) is associated with an increased risk of sexually transmitted infections (STIs), including HIV. There is a paucity of research regarding the use of similar apps amongst the heterosexual population.
**Aim(s)/objectives** To quantify heterosexual use of dating apps and explore the sexual practices of app users.
**Methods** Anonymised questionnaires were offered to heterosexual attendees of two GUM clinics, throughout August 2015. Respondents self-completed information relating to purpose and frequency of app use, number of sexual partners, recreational drug use (RDU), condomless sex and STI diagnoses.
**Results** Questionnaires were returned by 539 attendees: 70% (377) women, 30% (162) men. Median age was 21–30 years.
**Discussion** A quarter of heterosexual GUM attendees frequent apps to find partners. This study identified high rates of STIs, condomless sex and RDU amongst app users, with rates mirroring those seen amongst MSM. Sexual health promotion and/or STI testing packages would be welcomed by most app users.
**conclusion** A quarter of heterosexual GUM attendees frequent apps to find partners. This study identified high rates of STIs, condomless sex and RDU amongst app users, with rates mirroring those seen amongst MSM. Sexual health promotion and/or STI testing packages would be welcomed by most app users.

**Abstract O001 Table 1** Use of mobile phone apps

| | Total | Men | Women |
|---|---|---|---|
| **Ever used dating app** | 132 (24%) | 45/132 (34%) | 87/132 (66%) |
| **Frequency of app use** | | | |
| Monthly | 34/132 (26%) | 14/45 (31%) | 20/87 (23%) |
| Every few months | 16/132 (12%) | 7/45 (16%) | 9/87 (10%) |
| **Reason for app use** | | | |
| Seeking long term relationship | 85 (64%) | 11 (24%) | 74 (85%) |
| Seeking casual sex | 13 (10%) | 9 (20%) | 4 (5%) |
| **Sex with app partner** | | | |
| Unprotected | 52 (39%) | 25 (56%) | 27 (31%) |
| Protected | 59 (45%) | 13 (29%) | 46 (53%) |
| **RDU with app partner** | 13 (10%) | 12 (26%) | 1 (1%) |
| **Diagnosed with STI after meeting app partner** | 6 (5%) | 2 (4%) | 4 (5%) |
| **Would request STI testing kit via app** | 62% | | |
| **Would value sexual health information via app** | 57% | | |

## O002 RATES OF ASYMPTOMATIC LYMPHOGRANULOMA VENEREUM (LGV) IN MEN WHO HAVE SEX WITH MEN (MSM)

Tristan Griffiths*, Nneka Nwokolo. *Chelsea and Westminster NHS Foundation Trust, London, UK*

10.1136/sextrans-2016-052718.2

**Background/introduction** The 2015 BASHH Chlamydia guidelines recommend LGV testing in asymptomatic HIV positive, but not HIV negative, MSM with rectal chlamydia. Despite evidence for serosorting among MSM having condomless sex, up to 16% are unaware of, or have different HIV status to their sex partners. HIV positive MSM may therefore transmit LGV to serodiscordent partners, resulting in higher than expected infection rates in HIV negative MSM.
**Aim(s)/objectives** To compare rates of asymptomatic and symptomatic LGV in HIV positive and negative MSM attending a sexual health service.
**Methods** Case notes of individuals with confirmed LGV from 8/6/2015–31/12/2015 were reviewed and data on demographics, symptoms, HIV status and presence of other STIs collected.
**Results** We identified 105 cases of LGV (79% White; median age 35.3 years). 48 (46%) were HIV negative. 73% of HIV negative and 56% of HIV positive individuals were asymptomatic. 50 patients (47.7%) had one or more other STIs at time of initial LGV diagnosis; 62% were HIV positive. At time of censor, 95% of individuals attending for test of cure had a negative result.
**Discussion/conclusion** Asymptomatic LGV was identified in 73% of HIV negative individuals which is likely to have been missed had they not been tested at initial chlamydia diagnosis. STIs facilitate onward transmission of HIV and our findings highlight the importance of continuing to recommend regular screening in all MSM regardless of HIV status to identify infections and offer timely treatment. We recommend LGV testing be extended to asymptomatic HIV negative MSM with rectal chlamydia.

## O003 SALIVA USE AS A LUBRICANT FOR ANAL SEX IS A RISK FACTOR FOR RECTAL GONORRHOEA AMONG MEN WHO HAVE SEX WITH MEN, A NEW PUBLIC HEALTH MESSAGE: A CROSS-SECTIONAL SURVEY

[1,2]Eric PF Chow, [2]Vincent J Cornelisse, [1,2]Tim RH Read, [1,3]David M Lee*, [2]Sandra Walker, [3]Jane S Hocking, [1,2]Marcus Y Chen, [1,2]Catriona S Bradshaw, [1,2]Christopher K Fairley. *[1]Melbourne Sexual Health Centre, Alfred Hospital, Melbourne, Australia; [2]Monash University, Central Clinical School, Faculty of Medicine, Nursing and Health Sciences, Melbourne, Australia; [3]University of Melbourne, Melbourne School of Population and Global Health, Melbourne, Australia*

10.1136/sextrans-2016-052718.3

**Background/introduction** Apart from penile–anal intercourse, other anal sexual practices (oral-anal contact or rimming, fingering and saliva use as a lubricant for anal sex) are common among men who have sex with men (MSM).
**Aim(s)/objectives** The aim of this study is to evaluate whether these anal sexual practices are risk factors for rectal gonorrhoea in MSM.
**Methods** A cross-sectional survey was conducted among MSM attending a large urban sexual health centre between July 2014 and June 2015. Rectal gonorrhoea cases were identified by culture.

**Results** Among 1312 MSM, 4.3% (n = 56) had rectal gonorrhoea. Anal sexual practices, other than anal-penile sex, were common among MSM: receptive oro-anal (rimming) (70.5%), receptive fingering or penile-perianal contact i.e dipping (84.3%) and using partner's saliva as a lubricant for anal sex (68.5%). Saliva as a lubricant (adjusted OR 2.17; 95% CI 1.00 to 4.71) was significantly associated with rectal gonorrhoea after adjusting for potential confounding factors. Receptive rimming and fingering or penis dipping were not statistically associated with rectal gonorrhoea. The crude population attributable fraction of rectal gonorrhoea associated with use of partner's saliva as a lubricant for anal sex was 48.9% (7.9% to 71.7%).
**Discussion/conclusion** Saliva use as a lubricant for anal sex is a common sexual practice in MSM, and may play an important role in gonorrhoea transmission. Almost half of rectal gonorrhoea cases may be eliminated if a message of prevention is included in not using partner's saliva for anal sex.

## 0004 INHIBITORY EFFECT OF AN ANTISEPTIC MOUTHWASH AGAINST *NEISSERIA GONORRHOEAE* IN THE PHARYNX (GONE) AMONG MEN WHO HAVE SEX WITH MEN: A RANDOMISED CONTROL TRIAL

[1,2]Eric Chow, [3]Benjamin Howden, [3]Kerrie Stevens, [1]Sandra Walker*, [1]David Lee, [1]Anthony Snow, [1]Stuart Cook, [1]Glenda Fehler, [1,2]Catriona Bradshaw, [1,2]Marcus Chen, [1,2]Christopher Fairley. *[1]Melbourne Sexual Health Centre, Alfred Health, Melbourne, VIC, Australia; [2]Central Clinical School, Faculty of Medicine, Nursing and Health Sciences, Melbourne, VIC, Australia; [3]Microbiological Diagnostic Unit Public Health Laboratory, Department of Microbiology and Immunology, The University of Melbourne, at the Peter Doherty Institute for Infection and Immunity, Melbourne, VIC, Australia*

10.1136/sextrans-2016-052718.4

**Background/introduction** Gonorrhoea prevalence is increasing among men who have sex with men (MSM) worldwide. Studies suggest pharyngeal infection may be central to transmission and is the site of acquisition of resistant genes. With condom use falling, other interventions to reduce the transmission of gonorrhoea are urgently required.
**Aim(s)/objectives** To determine whether Listerine, a commercial mouthwash product, has an inhibitory effect against *N. gonorrhoeae*.
**Methods** MSM who tested positive for pharyngeal gonorrhoea by nucleic acid amplification test between May-2015 and February-2016 and returned for treatment within 14 days, were enrolled in the study. They were randomised to gargle either Listerine or saline for 60 seconds. Pharyngeal swabs were taken before and after gargling, and tested by culture. Only men who tested positive by culture before gargling were included in the analysis. The proportions of men who tested positive for pharyngeal gonorrhoea after gargling in both groups were calculated.
**Results** Of the 197 MSM who enrolled, only 58 MSM (33 in Listerine arm and 25 in saline arm) tested positive by culture on the day of recruitment. 17 (52%) MSM in the Listerine arm remained culture positive versus 21 (84%) in the saline arm after gargling the solution ($p$ = 0.013). The odds of being culture positive were 4.4 (95% CI: 1.4–17.7) times higher among men who gargled saline compared to those gargled Listerine.
**Discussion/conclusion** This data suggest Listerine could reduce the viable numbers of *N. gonorrhoeae* on pharyngeal surface which may prevent transmission. Further trials to look at efficacy over time are warranted.

## 0005 SELF-TAKEN EXTRA-GENITAL SAMPLES COMPARED WITH CLINICIAN-TAKEN EXTRA-GENITAL SAMPLES FOR THE DIAGNOSIS OF GONORRHOEA AND CHLAMYDIA IN WOMEN AND MSM

[1]Janet Wilson*, [1]Harriet Wallace, [1]Michelle Loftus-Keeling, [2]Helen Ward, [3]Claire Hulme, [4]Mark Wilcox. *[1]Leeds Sexual Health, Leeds Teaching Hospitals NHS Trust, Leeds, UK; [2]Department of Infectious Disease Epidemiology, Imperial College, London, UK; [3]Academic Unit of Health Economics, University of Leeds, Leeds, UK; [4]Department of Clinical Microbiology, Leeds Teaching Hospitals NHS Trust, Leeds, UK*

10.1136/sextrans-2016-052718.5

**Background** Extra-genital tests for gonorrhoea and chlamydia are important in MSM and are increasingly important in women as vulvovaginal swabs (VVS) alone can miss infections. Self-sampling is frequently used but there has been no robust RCT against clinician-taken samples in MSM or women to assess its efficacy.
**Aim** To compare self-taken extra-genital samples in women and MSM with clinician-taken samples for diagnostic accuracy.
**Methods** Women and MSM attending a sexual health clinic were invited into a 'swab yourself' trial. Clinician and self-samples were taken from the pharynx and rectum (plus VVS in women and FCU in MSM) for gonorrhoea (NG) and chlamydia (CT) using NAATs. The sampling order was randomised. Patient infected status was defined as at least two positive confirmed samples.
**Results** 1251 women and MSM were recruited to January 2016. Overall prevalence: NG 5.7% (rectal 4.3%, pharyngeal 3.1%), CT 17.8% (rectal 16.5%, pharyngeal 4.0%). 9.4% of female NG cases and 13.8% of CT cases were VVS negative. 72% of MSM NG cases and 89.5% of CT cases were FCU negative.

Sensitivity, specificity, PPV and NPV are shown in the table:

**Abstract O005 Table 1** Sensitivity & specificity of extra genital samples

| | Sensitivity (95% CI) | Specificity (95% CI) | PPV (95% CI) | NPV (95% CI) |
|---|---|---|---|---|
| **NG rectal clinician** | 96.3 (87.3–99.6) | 100.0 (99,7–100.0) | 100.0 (93.2–100.0) | 99.8 (99.4–100.0 |
| **NG rectal self** | 98.2 (90.1–100.0) | 99.9 (99.5–100.0) | 98.2 (90.1–100.0) | 99.9 (99.5–100.0) |
| **NG pharynx clinician** | 95.1 (83.5–99.4) | 100.0 (99.7–100.0) | 100.0 (91.0–100.0) | 99.8 (99.4–100.0) |
| **NG pharnyx self** | 97.6 (87.4–99.9) | 100.0 (99.7–100.0) | 100.0 (91.4–100.0) | 99.9 (99.5–100.0) |
| **CT rectal clinician** | 96.6 (93.1–98.6) | 99.9 (99.5–100.0) | 99.5 (97.2–100.0) | 99.3 (98.6–99.7) |
| **CT rectal self** | 98.1 (95.1–99.5) | 99.8 (99.3–100.0) | 99.0 (96.5–99.9) | 99.6 (99.0–99.9) |
| **CT pharynx clinician** | 92.0 (80.8–97.8) | 99.9 (99.5–100.0) | 97.9 (88.7–100.0) | 99.7 (99.2–99.9) |
| **CT pharynx self** | 96.0 (86.3–99.5) | 99.9 (99.5–100.0) | 98.0 (89.2–100.0) | 99.8 (99.4–100.0) |

No statistical difference between self and clinician-taken rectal or pharyngeal samples by McNemar test.

**Conclusion** This on-going work is the first randomised study showing that self-taken extra-genital samples have high sensitivity and specificity and are comparable to clinician-taken samples. High levels of extra-genital infections were found. In women 9% of NG and 14% of CT infections would be missed using VVS alone demonstrating the benefit of extragenital sampling.

## O006 IS A SHORT COURSE OF AZITHROMYCIN EFFECTIVE IN THE TREATMENT OF MILD TO MODERATE PELVIC INFLAMMATORY DISEASE (PID)?

[1]Gillian Dean*, [1]Jennifer Whetham, [1]Suneeta Soni, [1]Louise Kerr, [2]Linda Greene, [3]Jonathan Ross, [4]Caroline Sabin. *[1]Brighton & Sussex University Hospitals NHS Trust, Brighton, UK; [2]St Mary's Hospital, Paddington, London, UK; [3]University Hospitals Birmingham NHS Foundation Trust, Birmingham, UK; [4]Research Department of Infection and Population Health, UCL, London, UK*

10.1136/sextrans-2016-052718.6

**Background/introduction** Crucial to treatment success in PID is adherence to therapy. All guidelines recommend 14-days of therapy although many women fail to complete 2-weeks, particularly if they experience side-effects. A shorter course of antibiotics may offer a valuable treatment alternative.
**Aim(s)/objectives** To compare clinical efficacy/acceptability of standard PID treatment 14-days with 5-day course of antibiotics for mild-moderate PID (pain for <30 days).
**Methods** A multicentre, open-label, non-inferiority RCT comparing arm-1 (ofloxacin/metronidazole) with arm-2 (azithromycin 1g day-1; 500mg od day-2–5, metronidazole/ceftriaxone). Efficacy was measured using standard pain-scores at baseline and 14–21 day follow-up looking for a 70% reduction; women who failed to complete treatment/return for follow-up were considered treatment failures.
**Results** N = 313 (152 arm-1, 162 arm-2 with similar baseline characteristics). Median age 25. Lower abdo-pain 95%, discharge 64%, dyspareunia 53%. Baseline pain-score median 8/36 (range 1–26); day 14–21 0/36 (range 0–18). Considering women who failed to complete therapy/return for follow-up as failures, the proportion with 70% pain reduction was 46.7% for arm-1; 42.2% for arm-2 (p = 0.49, difference in proportions (arm-2 minus arm-1) −4.5% (95% CI −15.5%, 6.5%)). For those women completing therapy the proportion with a 70% pain reduction was 68.9% for arm-1; 57.6% for arm-2 (p = 0.11, difference in proportions −11.3% (95% CI −23.9%, −1.3%). There were no significant differences in reported side effects except diarrhoea: 33.6% arm-1 vs 78.1% arm-2 (p = 0.0001).
**Discussion/conclusion** In terms of pain reduction we could not demonstrate that the shorter azithromycin course was non-inferior to the standard-of-care. Patients also experienced significantly more diarrhoea. This study highlights the importance of using evidence-based treatment regimens.

## O007 DIGITAL HEALTH AND REMOTE DIGITAL CONSULTATIONS: VIEWS AND EXPERIENCES IN SEXUAL HEALTH CLINIC ATTENDEES

Jake Bayley*, Marie McNulty, Michael O'Hanlon, Jennifer Hong. *Barts Health NHS Trust, London, UK*

10.1136/sextrans-2016-052718.7

**Background/introduction** Digital health is becoming increasingly important in the NHS. Use of apps and remote digital consultations (RDC) may improve patient access and satisfaction, but more data on attitudes in sexual health clinic attendees are needed.
**Aim(s)/objectives** Assess the views of using digital health in sexual health clinic attendees.
**Methods** Patient-directed questionnaires were completed by patients attending a sexual health service. Demographic data were collected, along with acceptability and use of apps, websites and RDC.
**Results** 231 surveys were returned. 85% (175/206) of participants would be happy to use a website for sexual health; 39% (82/208) find using an app acceptable. Education to A-level or above significantly improved acceptability of using digital health for RDC (see Table 1). A previous STI versus no STI in the last 12 months significantly improved acceptability of using an app for sexual health (22/40 versus 58/165, p = 0.02) and consenting for a recording of their RDC in clinic notes (17/38 versus 44/164, p = 0.02).

**Abstract O007 Table 1** Digital health

| | Overall | Educated to GCSE level or less | Educated to A-level or higher | p-value |
|---|---|---|---|---|
| Currently have a device for video consultation (i.e. Skype or FaceTime) | **84% (173/207)** | 67% (31/46) | 90% (137/152) | 0.001 |
| Give consent for face to face remote digital consultation | **51% (105/207)** | 37% (17/46) | 56% (85/152) | 0.01 |
| Find web cam use acceptable for remote appointments | **40% (81/202)** | 26% (12/46) | 46% (68/147) | 0.02 |

**Discussion/conclusion** Most participants find using a website acceptable, however the use of apps less so. RDC are acceptable for only one in two of all sexual health attendees, and less so for patients with lower educational attainment. Only four in ten would allow a recording of a digital consultation, with confidentiality stated as the main concern. Fewer responses were received from patients with a lower educational attainment, which may affect generalisability of these data. We should be mindful that a mixture of digital and traditional health is needed to accommodate all service users.

## O008 TRIAGE REVIEW: SHOULD THEY STAY, OR SHOULD THEY GO?

Susanna Currie*, Elizabeth Nicol, Gabriel Schembri. *Manchester Centre for Sexual Health, Manchester, UK*

10.1136/sextrans-2016-052718.8

**Background** BASHH guidance for GUM services advises access within 48 hours for all and on the day review for emergencies. GU services have varying policies for when capacity is reached, ranging from 'closed door' policies to triaging all, however, there are concerns that patients with significant infections may be turned away. Since 2010 our inner city clinic has used triage forms.
**Aims** To investigate the burden of STIs in individuals who were turned away after triage, and assess the efficacy of our triage system
**Methods** Review of all triaged patients between 5/1/15–24/3/15.
**Results** 698 patients triaged: 359M; 336F; 3 unknown. Median age 23 years (range 16–86). 488 (70%) were turned away: 255M; 230F; 3 unknown; median age 23 years (range 16–73). Warts/lumps/bumps (15%), urinary symptoms (15%) and

abnormal discharge (15%) were the most common presenting symptoms and most likely to be turned away.

**Abstract O008 Table 1** Triage review

| Diagnosis of all accepted and turned away re-attenders | Number diagnosed | Number initially turned away |
|---|---|---|
| Chlamydia | 33 | 16 (49%) |
| Gonorrhoea | 19 | 8 (42%) |
| Primary Syphilis | 2 | 1 (50%) |
| PID/epididymitis | 26 | 9 (35%) |
| Non-specific genital infection | 34 | 17 (50%) |

224 (46%) of those turned away, never returned.

**Conclusions** Turned away patients who re-attended had a significant number of STIs and BASHH concerns are justified. Patients who never return heighten these concerns. Management of excess demand in the current financial climate is challenging, but closer links between clinics in a region, central booking systems and social media could help to direct individuals to clinics with availability.

## O009 EVALUATION OF A PILOT OF INTERNET REQUESTED CHLAMYDIA TEST KITS IN 25 TO 34 YEAR OLDS

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10.1136/sextrans-2016-052718.9

**Background** In the UK, Chlamydia is most prevalent in those aged 16–24 years. However, 1.5% of women and 1.0% of men aged 25–34 years are estimated to be infected. Attending healthcare venues may be challenging in rural settings and internet-requested tests may help individuals to access testing. We report results from a pilot of internet-requested testing among 25 to 34 year-olds resident in a rural region of England.
**Aim(s)** To evaluate the pilot of internet-requested chlamydia test kits in 25 to 34 year-olds.
**Methods** Internet-requested test kits were made available to those aged 25 to 34 years through a dedicated website from 1st April to 31st December 2015. Number of test kit requests, returns, positivity (positive tests/number tested) and cost data were reviewed for those aged 15 to 24 and 25 to 34 years.
**Results** The proportion of kits that were returned was significantly higher among the older age group (Table 1). Positivity was similar in the two age groups. The average cost per test and per positive was £22.58 and £244.47, respectively, in the younger group and £22.08 and £303.45 for the older group.
**Discussion** The pilot shows that chlamydia internet tests were accessed by an older group who were at significant risk of infection as evidenced by the positivity in that group. Return rates were high. Provision of internet tests to older age groups may represent an attractive option for some local commissioners and providers.

## O010 USE AND PERCEPTIONS OF THE *ONLINE CHLAMYDIA PATHWAY (OCP)*: FINDINGS FROM QUALITATIVE INTERVIEWS AMONG PEOPLE TREATED FOR CHLAMYDIA

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10.1136/sextrans-2016-052718.10

**Introduction** Within the *e*STI[2] consortium, we conducted exploratory studies of an innovative *Online Chlamydia Pathway* (*OCP*: results service, automated clinical consultation, electronic prescription via community pharmacy, online partner management, with telephone helpline support). Access to traditional services was facilitated where appropriate.
**Objectives** To describe patients' use and perceptions of the *OCP*.
**Methods** In-depth qualitative interviews with 40 purposively-sampled *OCP* users (21/40 female, aged 18–35) analysed thematically.
**Results** Interviewees chose the *OCP* to obtain treatment rapidly, conveniently and inconspicuously, within busy lifestyles that impeded clinic access. They described completing the online consultation promptly and discreetly, often using smartphones. Many found the online information provided comprehensive, but those who completed the consultation in public locations

**Abstract O009 Table 1** Test requests, returns, tests and positivity by age group

| | 15 to 24 years | | 25 to 34 years | | Unadjusted OR (95%CI) | *p* value |
|---|---|---|---|---|---|---|
| | N | % | n | % | | |
| **Kits requested** | 2,203 | | 571 | | | |
| **Total test kits returned** | 1,548 | 70.3% | 426 | 75% | 1.24 (1.01 to 1.53) | 0.042 |
| **Suitable specimen returned for testing** | | | | | | |
| Total specimens | 1,508 | | 411 | | | |
| Specimens from women | 1,062 | | 252 | | | |
| Specimens from men | 446 | | 159 | | | |
| **Test positive for chlamydia** | | | | | | |
| Total | 139/1508 | 9.2% | 31/411 | 7.5% | 0.80 (0.54 to 1.21) | 0.29 |
| Women | 84/1062 | 7.9% | 14/252 | 5.6% | 0.68 (0.38 to 1.23) | 0.20 |
| Men | 55/446 | 12.3% | 17/159 | 10.7% | 0.85 (0.49 to 1.52) | 0.58 |

and proceeded immediately to the pharmacy, described lacking information (which they apparently overlooked). Treatment collection from pharmacies was acceptable, but sometimes pharmacy staff lacked knowledge of the *OCP* (despite training), causing delays and conversations which threatened patients' privacy – undermining the *OCP's* perceived benefits. For those routed to clinic (as opposed to choosing to attend), the *OCP's* anticipated benefits were also compromised. They described annoyance, anxiety, and did not always understand why a clinic visit was needed. The helpline was valued; users found it reassuring and informative.

**Conclusion** The *OCP* is a promising adjunct to traditional care, particularly when integrated into sexual health services. Critical points in users' journeys include the interface with pharmacies and clinics. Implementation issues in pharmacies need addressing. Management of users' expectations and tailored information may improve the experience when routed to clinic.

## O011 HITTING THE BULL'S-EYE: PARTNER NOTIFICATION REAL-TIME METRICS

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10.1136/sextrans-2016-052718.11

**Introduction** Partner notification (PN) is a key but challenging service to deliver. The gold standard for PN confirmation is health care worker (HCW) verification. A cloud-based anonymous tool was developed to inform partners, support them to find a testing service and record when the HCW uses a unique code to reveal the sexually transmitted infection (STI), timing of PN initiation and closing the PN loop.

**Objective** To test the impact of the new tool on PN delivery.

**Methods** A live pilot commenced on 27th January 2016 and analysis of all index patients using the PN tool over 49 days was performed using spreadsheet pivot tables and formulas.

**Results** A total of 259 index patients across nine providers with nine different STIs were analysed. These index patients declared 421 contactable contacts and 162 (38%) were informed using the tool. A total of 96 (59%) partners contacted opened the link embedded in their text message or email and 30 (31%) were seen and tested by a HCW. A total of 13 STI testing centres received partners and the median (range) distance & time from PN initiation to HCW verification was 2.1 (0.0–12.3) kilometres & 63.8 (1–189.5) hours respectively

**Discussion** The PN tool has demonstrated that it is able to support partners to find a service and get tested expeditiously. The limited number of partners being informed is the rate limiting step and more work is required to develop strategies to enable effective PN initiation.

## O013 UNDERSTANDING THE SEXUAL APPETITES OF MEN WHO HAVE SEX WITH MEN (MSM) TAKING PART IN A SEXUAL RISK REDUCTION INTERVENTION AFTER BEING PRESCRIBED POST EXPOSURE PROPHYLAXIS FOR HIV AFTER SEXUAL EXPOSURE (PEPSE)

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10.1136/sextrans-2016-052718.12

**Background/introduction** Risky sexual behaviours remain the drivers behind new HIV infections within MSM in the UK. Understanding reasons behind risk behaviour could inform HIV prevention strategies.

**Aim(s)/objectives** To document sexual appetite/libido among MSM taking PEPSE, and to examine the relations between libido and risk behaviours.

**Methods** Data were collected at enrolment, as part of an ongoing RCT evaluating a behavioural intervention to reduce HIV risk behaviour. Within this study, a 10-item measure of libido was included (possible range of scores 10–40). This assessed how much thoughts and feelings about sex were considered disruptive.

**Results** 171 MSM responded (mean age 34.5, SD 9.1, range 19–66 yrs). Mean (*SD*) libido score was 20.4 (7.7); median was 19 (range 30). Those with higher libido reported a higher number of sexual partners, both insertive ($r_s$ = 0.298; $p \leq 0.001$; n = 162) and receptive ($r_s$ = 0.329; $p \leq 0.001$; n = 164), and inconsistent condom use, both insertive ($r_s$ = 0.185; $p$ = 0.042; n = 121) and receptive ($r_s$ = 0.227; $p$ = 0.009; n = 132). Higher libido was associated with higher levels of loneliness ($r_s$ = 0.401; $p \leq 0.001$; n = 165); reduced self-efficacy ($r_s$ = −0.230; $p$ = 0.003; n = 165), action planning ($r_s$ = −0.182; $p$ = 0.019; n = 164), intentions ($r_s$ = −0.163; $p$ = 0.036; n = 165) and behavioural likelihood ($r_s$ = −0.228; $p$ = 0.003; n = 165) of performing safer sex strategies. Loneliness was related to inconsistent condom use, both insertive ($r_s$ = 0.191; $p$ = 0.021; n = 147) and receptive ($r_s$ = 0.165; $p$ = 0.036; n = 162), and a high number of sexual partners (receptive) ($r_s$ = 0.164; $p$ = 0.033; n = 171).

**Discussion/conclusion** Risky behaviours are related to stronger sexual appetites/libido and loneliness within this sample. The potential importance of libido and loneliness should be recognised within the context of future HIV prevention efforts.

## O014 INVESTIGATING ATTITUDES TOWARDS HIV PRE-EXPOSURE PROPHYLAXIS (PREP). A QUESTIONNAIRE STUDY IN MEN WHO HAVE SEX WITH MEN ATTENDING SEXUAL HEALTH CLINICS

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10.1136/sextrans-2016-052718.13

**Background/introduction** With the efficacy of HIV pre-exposure prophylaxis (PrEP) proven, provision of PrEP is currently being evaluated by commissioners. The question of who would wish to access PrEP, and where, is important in informing this process.

**Aim(s)/objectives** To establish potential users' attitudes towards, and experiences of, PrEP.

**Methods** Ethical approval was obtained to conduct a multicentre, prospective, anonymised questionnaire study of 1000 HIV negative MSM accessing sexual health clinics. Sexual behaviour, drug use, STI history and previous post exposure prophylaxis (PEP) use were collected. Opinions and attitudes towards PrEP and PrEP availability were assessed.

**Results** Of 386 analysed questionnaires the majority were British-born (203, 53%), white (300, 78%) men. 345 (89%) reported anal sex within the last month with 168 (43%) and 139 (36%) reporting unprotected insertive and receptive anal intercourse, respectively (103, (26%) and 64, (17%) with

multiple partners). 194 (50%) had recently used recreational drugs (within 3 months; 34% "Chemsex" substances). 157 (41%) reported a recent STI (6 months). 223 (58%) reported that they strongly believed they would benefit from PrEP. However, 42/223 (19%) reported no condomless sex. Concerns around taking PrEP were cited by 76 (20%). 167 (43%) expressed a preference for daily PrEP; 139 (38%) for coitally-driven. 311 (80%) supported PrEP delivery by sexual health clinics to MSM, and 233 (60%) to any-one who requests it. 112 (29%) agreed a prescription charge was appropriate. 17 respondents (4%) reported having already taken PrEP: 35% using medication acquired as PEP, and 30% acquiring PrEP privately. 7/17 (41%) reported decreased condom since commencing PrEP.

**Discussion/conclusion** This comprehensive questionnaire study demonstrates a high willingness to use PrEP in a cohort of at-risk MSM. These data should inform the commissioning process of this efficacious biological intervention.

## O015 ESTABLISHMENT OF A MONITORING SERVICE FOR MEN WHO HAVE SEX WITH MEN (MSM) TAKING GENERIC CO-FORMULATED TENOFOVIR DISOPROXIL FUMARATE (TDF)/EMTRICITABINE (FTC) AS PRE-EXPOSURE PROPHYLAXIS (PREP) AGAINST HIV INFECTION

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10.1136/sextrans-2016-052718.14

**Background/introduction** Truvada® (TDF/FTC) PrEP taken daily or intermittently reduces HIV acquisition by over 86%. However, PrEP is only available privately in the UK, costing upwards of £400 for 30 tablets. Online generic TDF/FTC is significantly cheaper at £35-£50 for 30 tablets. There are, however, authenticity concerns about online medicines. Additionally, HIV infection should be excluded in individuals taking PrEP and baseline assessments of hepatitis B and renal function performed which may not occur with online PrEP.

Since February 2016, we have provided assessment and therapeutic drug monitoring to individuals on generic TDF/FTC to ensure safety and medication integrity.

**Aim(s)/objectives** To review characteristics of individuals taking generic TDF/FTC.

**Methods** Service evaluation of individuals taking generic TDF/FTC attending a London sexual health service. Data on the first 44 patients were collected: demographics, HIV and renal function testing, hepatitis B status, baseline STIs, regimen, source of PrEP.

**Results** All MSM; mean age 41 years (28–73); 77% White; 33/44 (75%) on PrEP at time of attendance; all HIV antibody negative prior to commencement. Mean eGFR 81.5 ml/min, 65% had documented hepatitis B immunity. One STI (syphilis) was identified at baseline. 93% were taking daily PrEP and 86% obtained Cipla manufactured Tenvir-EM® from United Pharmacies. Tenofovir and FTC levels were measured in 18/44 (41%), all results demonstrating presence of adequate active compound.

**Discussion/conclusion** Numbers of individuals requiring monitoring on generic TDF/FTC are increasing. It is reassuring that so far, drug levels suggest appropriate quantities of tenofovir and FTC in Tenvir-EM®; however, more data are needed.

## O016 RENAL FUNCTION AT BASELINE AND MONTH 1 IN THE PROUD STUDY, A PRAGMATIC OPEN LABEL RANDOMISED TRIAL OF TRUVADA AS PRE-EXPOSURE PROPHYLAXIS

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10.1136/sextrans-2016-052718.15

**Background/introduction** Quarterly monitoring of creatinine is likely to be recommended by WHO for those on PrEP, even though there were no significant differences in creatinine in placebo-controlled trials. Establishing the appropriate level of monitoring of PrEP is important.

**Methods** PROUD is an open-label, randomised trial of Truvada as PrEP in MSM. HIV serology and serum creatinine was done at PrEP baseline ('start'). Clinics were advised to collect creatinine or urinary protein-creatinine ratio (UPCR) if there was $\geq$1+ protein on urinalysis at the month 1 visit (m1). Here we present the renal monitoring results at "start" and m1 with eGFR (ml/min/1.73m$^2$) calculated by the CKD-EPI equation.

**Results** 445 (93%) of 481 had baseline creatinine, 13 (3%) had UPCR, and 23 (5%) neither. The median eGFR was 106. Only one was <60 (eGFR = 49), probably due to dietary creatinine supplementation. 260 (59%) of 443 had a m1 creatinine, creating 246 paired results. On average, eGFR was 1.50 lower at m1. Seven (4%) of 194 with eGFR >90 dropped 20%, one to 59. He stopped PrEP and did not attend thereafter. Of the 7, none had abnormal urinalysis; 4 had UPCR – all normal. 41 (79%) of 52 with eGFR 60–90 at baseline remained at this level, the remainder increased to >90.

**Discussion/conclusion** The mean change in eGFR at month 1 is not clinically significant. Excepting one individual who could not be further evaluated, there were no clinically meaningful changes at m1. Further work will explore the relationships between eGFR and proteinuria.

## O017 CHEMSEX RELATED ADMISSIONS TO A CITY CENTRE HOSPITAL

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10.1136/sextrans-2016-052718.16

**Background/introduction** Recreational drug use (RDU), particularly the chemsex drugs mephedrone, crystal methamphetamine and gamma-hydroxybutyric acid (GHB) are associated with significant harms. Occasionally this has led to hospital admission with significant morbidity and mortality.

**Aim(s)/objectives** To review inpatient admissions from a large HIV service and look at RDU associations.

**Methods** A prospective analysis of admissions to an HIV inpatient service between April 2015 and March 2016 was conducted. Information was collected on demographics, admission details, complications and drug use.

**Results** From 194 admissions there were 19 (9.8%) related to RDU. Median age was 33.5 (range 23–65). All were male and 18 (94.7%) were men who have sex with men (MSM). 4 (21.1%) were Hepatitis C co-infected. 5 (26.3%) patients took

**Abstract O017 Table 1** Chemsex-related admissions

| Diagnosis | N (%) |
|---|---|
| Overdose | 9 (47.4%), 4 ITU admissions |
| Psychosis | 3 (15.8%) |
| Abscess | 2 (10.5%) |
| Arrhythmias | 2 (10.5%) |
| DVTs | 1 (5.3%) |
| Withdrawal | 1 (5.3%) |
| Rhabdomyalysis | 1 (5.3%) |

GHB, 5 (26.3%) mephedrone and 4 (21.1%) crystal meth. Cause of admission can be seen in Table 1. There were 3 deaths due to drug overdoses during the study period.

**Discussion/conclusion** RDU was responsible for 9.8% of admissions, with GHB, mephedrone and crystal meth responsible for 21–26%. This may underestimate the true effect of drug admissions as it only involves HIV positive MSM. We've developed a chemsex clinic and city-wide task and finish group, in liaison with Public Health to address the growing effect of chemsex. Clinicians need to ensure RDU is regularly reviewed and timely interventions are offered to limit harms.

## O018 COMMUNITY VIRAL LOAD: A NEW POPULATION-BASED BIOMARKER OF HIV DISEASE BURDEN IN SCOTLAND

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10.1136/sextrans-2016-052718.17

**Background/introduction** "Community viral load" (CVL) refers to an aggregate biological measure of viral load (VL) for a particular geographic location. Studies have suggested that CVL may be used as a population-based biomarker for HIV transmission, and that its reduction is associated with a decrease in HIV incidence. Currently, there is no published data on CVL in Scotland.

**Aim(s)/objectives** This study aims to measure CVL and to estimate the HIV transmission potential of communities in Scotland.

**Methods** HIV/AIDS surveillance data on patient demographics, first VL in 2014, and region of residence were analysed. Mean CVL was measured as the arithmetic average and total CVL the arithmetic sum of all VL in our data set respectively. Statistical analyses were performed using SPSS 23 at 95% significance level. Shapiro-Wilk test was performed for normality. Chi-square analysis and Kruskal-Wallis test were performed for differences in variables. Spearman's correlation was performed for correlations between CVL and HIV incidence.

**Results** 4126 non-duplicate cases were analysed. Mean CVL was highest in Central South-West (CSW) ($\mu$ = 20,469, 95% CI = 8146–32,933), followed by Central South-East (CSE) and North respectively. There was a significant difference in mean rank CVL between North-CSW and North-CSE. There was a positive correlation between mean CVL and HIV quarterly incidence for CSW (Spearman's rho = 0.062, p = 0.01) and CSE (Spearman's rho = 0.032, p = 0.196), whereas a negative correlation was seen in North (Spearman's rho = −0.047, p = 0.202).

**Discussion/conclusion** This study highlights the relationship between CVL and HIV quarterly incidence in Scotland in 2014. Further work using annual incidence data is needed to verify these conclusions and to determine factors influencing these results.

## O019 EXTRA-GENITAL SAMPLES FOR GONORRHOEA AND CHLAMYDIA IN WOMEN AND MSM: SELF-TAKEN SAMPLES ANALYSED SEPARATELY COMPARED WITH SELF-TAKEN POOLED SAMPLES

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10.1136/sextrans-2016-052718.18

**Background** Extra-genital infections are common in MSM and women and are frequently the sole sites of infection. However, analysing samples from the rectum and pharynx, in addition to the urogenital tract, trebles the diagnostic cost.

**Aim** Can samples from three sites be pooled into one NAAT container and still achieve the same sensitivity and specificity as the samples analysed separately?

**Methods** Women and MSM attending a sexual health clinic were invited into a 'swab yourself' trial. Two self-taken samples (one for separate analysis and one for pooling) were taken from the pharynx and rectum with VVS in women and FCU in MSM. The sampling order of the pooled or analysed separately swabs was randomised. Gonorrhoea (NG) and chlamydia (CT) were diagnosed using NAATs. Patient infected status was defined as at least two positive confirmed samples.

**Results** 1251 women and MSM were recruited to January 2016. Overall prevalence of infections was NG 5.7% and CT 17.8%. Sensitivity, specificity, PPV and NPV are shown in the table:

**Conclusion** This on-going study demonstrates that self-taken samples from the rectum, pharynx and urogenital tract are comparable in sensitivity and specificity if analysed separately or as a pooled sample. In MSM the diagnostic costs of three separate analyses are unaffordable for many health systems but a pooled sample has the same laboratory cost as a urogenital sample. These findings mean triple site testing could be expanded into women at no additional health service cost.

**Abstract O019 Table 1** Sensitivity & specificity of separate and pooled samples

| | Sensitivity (95% CI) | Specificity (95% CI) | PPV (95% CI) | NPV (95% CI) |
|---|---|---|---|---|
| **NG separate samples** | 98.6 (90.2–99.7) | 99.9 (99.5–100.0) | 98.6 (92.6–100.0) | 99.9 (99.5–100.0) |
| **NG pooled** | 97.2 (90.2–99.7) | 99.9 (99.5–100.0) | 98.6 (92.3–100.0) | 99.8 (99.4–100.0) |
| **CT separate samples** | 99.1 (96.8–99.4) | 99.7 (99.2–99.9) | 98.7 (96.1–99.7) | 99.8 (99.3–100.0) |
| **CT pooled** | 95.5 (91.9–97.8) | 99.5 (98.9–99.8) | 97.7 (94.7–99.3) | 99.0 (98.2–99.5) |

There was no difference between self-taken samples analysed separately or pooled by McNemar test.

## O020 PILOT STUDY COMPARING SELF-COLLECTED VAGINAL SWAB WITH CLINICIAN TAKEN VAGINAL SWAB FOR THE DETECTION OF CANDIDA AND BACTERIAL VAGINOSIS

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10.1136/sextrans-2016-052718.19

**Background/introduction** Vaginal discharge and vulvitis are common presenting symptoms in both sexual health services and general practice. Due to various constrains particularly in general practice, examination of a patient may not be possible. Syndromic management is often practiced but can be unreliable. Few studies to date have specifically looked at the validity of self-collected vulvovaginal swab for the diagnosis of bacterial vaginosis (BV) and vulvovaginal candidiasis (VVC)
**Aim(s)/objectives** To describe agreement between self-collected vulvovaginal swabs and clinician taken high vaginal swabs for the detection of BV and VVC.
**Design** Case controlled study with the patient acting as her own control.

Setting

An urban sexual health centre. Participants: Women aged 16–65 years attending with symptomatic vaginal discharge, vulval irritation or an offensive genital smell. Interventions: Participants took a vulvovaginal swab prior to speculum insertion and vaginal examination during which a clinician took a high vaginal swab. Main outcome measure: Diagnosis of BV or VVC infection with samples analysed in a microbiology department using both microscopy and culture.
**Results** 104 women were enrolled in the study. Of these 45 were diagnosed with VVC. 26 were diagnosed with BV. Using the reference standard of laboratory testing, the sensitivities of self-collected vulvovaginal swabs for BV and VVC were 88.5% and 95.5% respectively. The Cohen Kappa score showed strong agreement for the detection of both BV and VVC (k = 0.842 and k = 0.878 respectively).
**Discussion/conclusion** Self-collected vulvovaginal swabs appear to be a valid alternative to clinician taken high vaginal swabs for detecting BV and VVC infections.

## O021 A QUESTION OF STABILITY

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10.1136/sextrans-2016-052718.20

**Background/introduction** Urines to be tested by the APTIMA Combo 2 (AC2) are added to a collection tube containing preservatives to ensure stability of the nucleic acid for testing within 24 hours of collection. Home collected urines are often collected in containers without preservative to avoid the patient manipulating the sample.
**Aim(s)/objectives** An investigation was undertaken to determine the stability of gonococcal and chlamydial nucleic acids within neat urine stored in different conditions over a period of 25 days to provide evidence of the stability of the nucleic acid prior to testing.
**Methods** To mimic collection in a home setting and differing nucleic acid loads within clinical specimens, uninfected urine was inoculated with different concentrations of chlamydial (from cell culture) and gonococcal (from bacterial culture) nucleic acid. Aliquots of the urine were removed on eight occasions over 25 days, added to collection tubes and tested either on the Hologic Panther system to determine presence of RNA or, following DNA extraction, using in-house PCRs to determine DNA load.
**Results** Chlamydial RNA and DNA remained stable for over three weeks when either refrigerated or stored at room temperature. Gonococcal RNA was detectable up to three weeks if refrigerated and two weeks if stored at room temperature. GC DNA was detectable for 18 days if refrigerated and for 11 days if stored at room temperature.
**Discussion/conclusion** Chlamydial and gonococcal nucleic acids are stable in urine before addition to preservatives for longer than recommended by the manufacturer, enabling more flexibility for home collected samples.

## O022 RECTAL CHLAMYDIA INFECTION IN WOMEN – HAVE WE BEEN MISSING THE POINT?

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10.1136/sextrans-2016-052718.21

**Background/introduction** BASHH standards recommend rectal chlamydia sampling in women with increased risk. However, studies show high rates of rectal chlamydia in women, with concerns over treatment failures and risk of genital re-infection
**Aim(s)/objectives** To determine if rectal chlamydia screening in females should be universal.
**Methods** As part of a selfswab versus clinician trial we asked females about frequency of vaginal, receptive anal, and oral sex, and correlated this with chlamydia NAATs from these sites.
**Results** Recruitment to February 2016 included 1041 women. All consented to rectal sampling; none had rectal symptoms. 53% reported no prior receptive anal sex. 204 women had chlamydia (CT) positive NAATs at one or more sites: 176 (16.9%) VVS positive (86% of all CT positives); 190 (18.3%) rectal positive (93% of total CT positives); 49 (4.7%) pharyngeal positive. Rectal swabs were significantly more likely to detect CT than VVS: OR 2.75 (95% CI 1.22–6.18) p = 0.02 McNemar test. The table shows percentage women by positive site(s) reporting no anal sex. 92/190 (48.4%) of those with one site or combination rectal CT reported no previous anal sex. Of the 168 with

**Abstract O022 Table 1** Sites of chlamydia in women

| Site(s) of chlamydia positive NAATs | Number confirmed positive by site(s) [total 204] | Percentage women with infection at site(s) reporting never having had receptive anal sex (%) |
|---|---|---|
| VVS only | 7 | 43 |
| VVS and rectal | 132 | 50 |
| VVS, rectal, pharyngeal | 36 | 47 |
| Rectal only | 17 | 41 |
| Rectal and pharyngeal | 5 | 40 |
| Pharyngeal and VVS | 1 | 100 |
| Pharyngeal only | 6 | 0 |

VVS and rectal positive NAATs, the AC2 Reactive Light Units levels were equivalent, suggesting active infection at both sites.
**Discussion/conclusion** In this sample of women with no rectal symptoms, the rectum was the most prevalent site for chlamydia infection, and rectal swabs found significantly more infections than VVS. There was no association with reported anal sex indicating sexual risk history is unreliable for targeted screening in women.

## O023 FEASIBILITY STUDY TO DETERMINE THE TIME TAKEN FOR NAATS TESTS TO BECOME NEGATIVE FOLLOWING TREATMENT FOR *CHLAMYDIA TRACHOMATIS* AND *NEISSERIA GONORRHOEAE* IN MEN AND WOMEN

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10.1136/sextrans-2016-052718.22

**Background/introduction** Few data are available to guide the best time to perform a test of cure using nucleic acid amplification tests (NAATs) following treatment for chlamydia (CT) and gonorrhoea (NG).
**Aim(s)/objectives** The association between the type of infection, organism load, site of infection and treatment were compared to the time for the NAAT to become negative after treatment.
**Methods** Individuals who had a positive NAAT test for CT and/or NG were eligible. Self-taken specimens from the site of infection were collected at 8 time points.The time to first negative test following treatment was examined using survival analysis techniques.
**Results** 102 men (87 MSM) and 52 women were recruited to the study (84 NG, 71 CT infections). 28 participants with NG and 16 with CT were lost to follow up. On day 0, 20 participants diagnosed with NG and 8 diagnosed with CT had negative tests. Median time to negativity for NG infection was 2 days (IQR 1–5) and for CT infection was 4 days (IQR 2–5). At day 14 after treatment 92% of participants were CT negative, and 84% NG negative.All tests were negative by day 35 for both infections.
**Discussion/conclusion** This study provides valuable data in determining the time to test of cure for CT and NG infections. Site of infection may have an effect on time to clearance of infection, with pharyngeal NG infections and vaginal CT infections taking longer to clear than other sites.The results of this study will help guide clinicians to the timing for test of cure.

## O024 *TRICHOMONAS VAGINALIS* – TREATMENT AND TEST OF CURE ANALYSIS IN A GUM CLINIC POPULATION

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10.1136/sextrans-2016-052718.23

**Background/introduction** *Trichomonas vaginalis* is prevalent in patients of black ethnicity in our south London population. Nucleic acid amplification testing (NAAT) is the diagnostic gold standard, and first-line treatment with metronidazole or tinidazole regimens thought to achieve comparable cure rates >90%. Test of cure (TOC) is recommended if symptoms persist following treatment, but this overlooks persistent asymptomatic infection and optimal timing and testing modality are uncertain.
**Aim(s)/objectives** To estimate clinical cure and TV eradication rates in a large cohort of *T. vaginalis* cases.
**Methods** All positive *T. vaginalis* NAAT results (TV TMA, Hologic) were identified between January 2013 and September 2015. Data were collected from our electronic patient record system, including clinical features, treatment regimen and TOC results, if performed.
**Results** 557 cases were identified in 500 patients (78.2% female; 82.2% Black African/Caribbean/mixed ethnicity; 8.8% HIV+). Infection was symptomatic in 47.3% (53.7% females, 24.5% males). Baseline wet mount microscopy was positive in 65.6%. TOC was performed in 72.4% (median time to TOC 4.1 weeks, IQR 2.3–7.6 weeks). 77.2% demonstrated parasitological clearance following a single treatment course. Cure rates were 70–80 for all regimens, significantly higher in males (85.5% vs 66.9%, $p < 0.01$).
**Discussion/conclusion** We see a significant asymptomatic, microscopy-negative burden of *T. vaginalis* infection. Lower clearance rates in women suggest azole-resistant strains may be prevalent. Based on NAAT results, cure rates are lower than expected, and relatively constant TMA positivity rate beyond 2 weeks suggests treatment failure is responsible rather than re-infection or timing of TOC. Further UK studies on treatment efficacy and molecular epidemiology are warranted.

## O025 BEHAVIOURAL FACTORS ASSOCIATED WITH HPV VACCINE ACCEPTABILITY AMONGST MEN WHO HAVE SEX WITH MEN IN THE UNITED KINGDOM

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10.1136/sextrans-2016-052718.24

**Background** Men who have sex with men (MSM) are selected for Human Papillomavirus (HPV) vaccination due to their higher risk of genital warts and anal cancer.
**Aim** To examine HPV vaccine acceptability amongst MSM in the UK.
**Methods** Using Facebook advertisements, MSM were recruited for an online survey measuring motivations for HPV vaccination. Logistic regression was performed to identify predictors of HPV vaccine acceptability at baseline, after receiving information about HPV vaccination, and four weeks later.
**Results** Out of 1508 MSM (median age = 22, range: 15–63) 19% knew about HPV. While only 55% of MSM would be willing to ask for the HPV vaccine, 89% would accept it if offered by a healthcare professional (HCP). Access to sexual health clinics [OR = 1.82, 95% CI 1.29–2.89], the disclosure of sexual orientation to an HCP [OR = 2.02, CI 1.39–3.14] and HIV-positive status [OR = 1.96, CI 1.09–3.53] positively predicted HPV vaccine acceptability. After receiving the information, perceptions of HPV risk [OR = 1.31, CI 1.05–1.63], HPV infection severity [OR = 1.89, CI 1.16–3.01), HPV vaccination benefits [OR = 1.61, CI 1.14–3.01], HPV vaccine effectiveness [OR = 1.54, CI 1.14–2.08], and the lack of perceived barriers to HPV vaccination [OR = 4.46, CI 2.95–6.73] were also associated with acceptability.
**Discussion** Although nearly half of MSM would not actively pursue HPV vaccination, the vast majority would accept the vaccine if recommended by HCPs. MSM need to be informed about

HPV to appraise the benefits of HPV vaccination for their health. In order to achieve optimal uptake, vaccine promotion campaigns need to focus on MSM that do not access sexual health clinics and those unwilling to disclose their sexual orientation.

## O026 HUMAN PAPILLOMAVIRUS (HPV) VACCINATION AND STI SCREENING IN MEN WHO HAVE SEX WITH MEN (MSM). CLINICAL OUTCOMES AND FACTORS ASSOCIATED WITH COMPLETION OF A THREE DOSE SCHEDULE WITHIN ONE YEAR IN A CLINICAL COHORT

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10.1136/sextrans-2016-052718.25

**Background/introduction** We introduced HPV4 vaccination for younger MSM under 27 years into our sexual health services in 2012. We report on the attendance behaviour, clinical outcomes, completion rates and factors associated with vaccination completion in our cohort.

**Aims** (1) To deliver 3 dose HPV4 vaccination to younger MSM. (2) To increase engagement and STI testing by younger MSM at integrated sexual health services.

**Methods** HPV4 vaccine was offered at Time 0, 2–4 and 6–12 months, with STI testing, clinic call/recall, alongside care and support as appropriate. We conducted a retrospective electronic case note (EPR) review of all eligible MSM at end 2015. Completion rates are censored at 1 year.

**Results** 893/930 (96%) offered vaccine accepted 1st dose.

**Discussion/conclusion** We observed 3 dose completion rates commensurate with outcomes expected from a catch up vaccination programme. Completion was associated with older age, HIV infection, prior known HPV infection, self-identifying homosexual men and non- white british ethnicities. We observed high rates of STI testing and infection in this cohort. Delivering HPV vaccination within sexual health care services is an effective engagement strategy for young MSM.

## O027 RAPID FALL IN QUADRIVALENT VACCINE TARGETED HUMAN PAPILLOMAVIRUS GENOTYPES IN HETEROSEXUAL MEN FOLLOWING THE AUSTRALIAN FEMALE HPV VACCINATION PROGRAMME: AN OBSERVATIONAL STUDY FROM 2004 TO 2015

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10.1136/sextrans-2016-052718.26

**Background/introduction** Australia introduced the national quadrivalent human papillomavirus (4vHPV) vaccination programme in April 2007 in young women and included young boys in Feb 2013.

**Aim(s)/objectives** To examine the prevalence of 4vHPV and the nine-valent (9vHPV) targeted vaccines genotypes among predominantly unvaccinated heterosexual men in Australia in 2004–2015.

**Methods** 1,466 young heterosexual men tested positive for *Chlamydia trachomatis* were included. We calculated the prevalence of any HPV genotypes, genotypes 6/11/16/18 in the 4vHPV, and five additional genotypes 31/33/45/52/58 in the 9vHPV, detected in urine or urethral swab samples over each year stratified by country of birth.

**Results** The 4vHPV genotypes decreased from 20% in 2004/05 to 3% in 2014/15 ($p_{trend} < 0.001$) among Australian-born men; and a greater decline was observed in Australian-born men aged ≤21 (from 31% to 0%; $p_{trend} < 0.001$) in the last 11 years. No trends were observed in any HPV genotypes or in HPV 31/33/45/52/58. There was a decline in HPV 16/18 ($p = 0.004$) but not in HPV 6/11 ($p = 0.172$) in the post-vaccination period among men who recently arrived in Australia from countries with a bivalent vaccine programme. No change in 4vHPV in men from countries without any HPV vaccine programme.

**Discussion/conclusion** The marked reduction in prevalence of 4vHPV genotypes among unvaccinated Australian-born men, suggests herd protection from the female vaccination programme. The decline in HPV 16/18, but not in HPV 6/11

**Abstract O026 Table 1** HPV4 vaccination 3 dose completion within 1 year (2015 figures pro rata), STI testing and detection rates

| | 2013 No. (%) | 2014 No. (%) | 2015 No. (%) | STI screen/ Total No. (%) | STI +ve/ Total No. (%) | STI +ve/ No. Tested (%) |
|---|---|---|---|---|---|---|
| Dose 1 | 239 | 255 | 399 | 880/893(99) | 283/893(32) | 283/880(32) |
| Dose 2 | 187(78) | 194(76) | 243/324(75) | 556/658(84) | 77/658(12) | 77/556(14) |
| Dose 3 | 148(62) | 140(56) | 111/200(56) | 372/427(87) | 60/427(14) | 60/372(16) |
| **Factors associated with 3 doses in 1yr** | | **No.s/Total (%)** | | **No.s/Total (%)** | **p value** | **BOLD indicates higher completion** |
| Age | <21yrs | 57/119 (48) | >21yrs | 232/375 (62) | p = 0.008 | |
| HIV status | HIV -ve | 228/420 (54) | HIV +ve | 61/74 (82) | p = 0.0001 | |
| Prior HPV | Yes | 41/57 (72) | No | 248/438 (56) | p = 0.03 | |
| Orientation | H* | 231/379 (61) | Bis* | 38/77 (49) | p = 0.02 | |
| Ethnic Group | WB* | 81/172 (47) | WO* | 66/102 (65) | p = 0.006 | |
| | **Asian*** | **65/98 (66)** | **p = 0.003** | **Black* 54/80 (68)** | **p = 0.003** | |

*H = Homosexual, Bis = Bisexual, WB = white British, WO = white Other, Asian = All asian ethnicities, Black = All black ethnicities by UK Census Ethnicity categories

among overseas-born males predominantly from countries with a bivalent vaccine programme, suggests these men receive herd protection for 16/18 from their vaccinated female partners in their countries of origin.

## O028 LOW PROPORTION OF MEN WHO HAVE SEX WITH MEN (MSM) TESTED FOR HEPATITIS C DESPITE HIGH PREVALENCE IN 2 GENITO-URINARY MEDICINE (GUM) CLINICS

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**Background/introduction** Screening for HIV and hepatitis B (HBV) is recommended for MSM attending GUM clinics. Hepatitis C testing is recommended for all HIV positive MSM. However, the PROUD pilot study reported an HCV incidence of 3.1% in high-risk, HIV negative MSM.
**Aim(s)/objectives** To report on proportion tested and prevalence of blood-borne viruses (BBVs) amongst MSM attending GUM clinics
**Methods** We collected demographic data and numbers tested for BBVs in all MSM attending 2 GUM clinics between 01/07/14 and 30/06/15 from electronic records. We compared proportion tested and prevalence in high-risk vs low-risk MSM and in HIV + vs HIV- MSM. High-risk was defined as $\geq$1 sexually transmitted Infection (STI) i.e. Gonorrhoea, chlamydia and syphilis.
**Results** 4,415 patients were included. 3,289 (88.0%) were tested for HIV, 2,162 (49.1%) for HBV, 794 (18.1%) for HCV. Positives: 48 (1.5%) HIV, 11 (0.5%) HBV and 18 (2.3%) HCV [9/16 (56.3%) viraemic]. 1,003 (22.7%) were diagnosed with an STI: Syphilis 159 (3.6%), Gonorrhoea 640 (14.5%), Chlamydia 398 (9.0%). BBV prevalence was higher in high-risk vs low-risk MSM: HIV 23 (3.4%) vs 25 (1.0%); HBV 4 (0.7%) vs 7 (0.4%); HCV 10 (3.5%) vs 8 (1.6%).More HIV+ MSM were tested for HCV; 198 (27.8%) vs 587 (16.9%) HIV- (crude OR 1.9 (95% CI 1.6–2.3). HCV prevalence in those tested was 12 (6.1%) in HIV+ and 6 (1.0%) in HIV–.
**Discussion/conclusion** MSM were less likely to be tested for HCV than for HIV. Amongst those tested, HCV prevalence was 5x the national prevalence (0.4%). Prevalence of viral hepatitis was highest in HIV+ and in high-risk MSM suggesting that testing efforts should be increased.

## O029 SEXUAL FUNCTION PROBLEMS IN BRITISH 16–21 YEAR OLDS: CAUSE FOR CONCERN?

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**Background/introduction** Sexual function is largely absent from the policy discourse on young people's sexual health. The omission is troubling, given the link between low sexual function and indicators of risk (including higher partner numbers, paying for sex, non-consensual sex and STI diagnosis). An absence of data permits this silence.
**Aim(s)/objectives** To address the gap in empirical data on sexual function problems in young people aged 16 to 21 in Britain.
**Methods** Descriptive statistics from a national probability survey of 15,162 British men and women (Natsal-3), undertaken from 2010–2012 using computer-assisted self-interviews (CASI). Complex survey analyses of data from participants aged 16–21 (854 men and 1021 women sexually active in the last year; 262 men and 255 women sexually experienced but not active in the last year).
**Results** Distressing sexual function problems (>3months in last year) were reported by 9.1% of men and 13.4% of women. Most common among men was reaching a climax too quickly (4.5%) and among women, difficulty reaching climax at all (6.3%). The majority of young people experiencing problems did not seek help, and those that did rarely sought out professionals. Around 6% of those currently sexually active, and 10% of those not so, reported avoiding sex because of sexual function problems.
**Discussion/conclusion** Sexual function problems are common among young people and are largely unaddressed. Addressing these clear needs will have benefits for other aspects of sexual health. Reassurance in clinical settings and information/advice in educational settings are inexpensive and potentially effective strategies.

## O030 SEXUAL AND REPRODUCTIVE HEALTH CONSULTATIONS IN A NGO PRIMARY CARE FACILITY OVER A NINE WEEK PERIOD

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10.1136/sextrans-2016-052718.29

**Background/introduction** The emergence of the "jungle" camp in Calais has been described as a humanitarian emergency. There are internationally recognised minimum standards for provision (MISP) of sexual and reproductive health (SRH) care in a crisis situation. It has been reported that the Calais "jungle" camp has not met these.
**Methods** We reviewed clinic attendances/consultations during a 9 week period, from mid-December 2015 to February 2016, at a non-governmental organisation (NGO) primary care clinic in the Calais "jungle" staffed by volunteer clinicians
**Results** 394 women and 6118 men aged 15–44 attended the primary care clinic during the study period. Of these, 22 men (0.4%) and 39 women (10%) women sought a consultation regarding SRH. There were 17 requests for pregnancy tests (1.8 per week), 9 termination of pregnancy requests (1 per week) and 2 consultations where sexual violence in women was disclosed, (0.7 per week). 22/6118 men (0.4%) sought advice or treatment for a sexually transmitted infection during the study period.
**Discussion/Conclusion** Provision of (sexual) & reproductive health in Calais is limited, however our preliminary data shows that demand is high: men do not access the service leaving women particularly vulnerable to poor sexual health and possibly violence. The data is likely to represent the tip of an iceberg. Given the extent of the current refugee crisis and the increase in transit camps around Europe, lessons need to be learned from the Calais "jungle" camp.

## O031 PELVIC INFLAMMATORY DISEASE (PID), MYCOPLASMA GENITALIUM AND MACROLIDE RESISTANCE IN ENGLAND

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10.1136/sextrans-2016-052718.30

**Background/introduction** Mycoplasma genitalium (MG) is increasingly implicated in PID pathogenesis with many studies showing MG is as common as chlamydia in high-risk women. Current PID treatment guidelines specify antibiotics with low efficacy against MG. Increasing reports of macrolide resistance suggests first line treatment for MG (azithromycin) may have limitations.
**Aim(s)/objectives** To document rates of MG in a cohort of women with acute PID, and the proportion with baseline macrolide resistance.
**Methods** As part of a multicentre, open-label, non-inferiority RCT comparing ofloxacin/metronidazole (arm-1) with azithromycin 1g day-1; 500 mg od day 2–5, metronidazole/ceftriaxone (arm-2), samples were collected for baseline chlamydia, gonorrhoea and mycoplasma infection. Microbiological cure rates were documented at 6–8 weeks. Positive MG specimens were examined for macrolide resistance using a 23S rRNA PCR.
**Results** 313 women were recruited, median age 25. Preliminary results showed chlamydia was confirmed in 9.5%, MG in 8.2% and gonorrhoea in 0.4%. Of the 16 samples available for resistance testing, 9 (56%) had macrolide resistance mutations (A2058G/T, A2059G/C) at baseline. The reference laboratory received test-of-cure samples for only 8 patients with MG, of which 6 were negative, however 2 remained positive, both with A2059G nucleotide substitutions. Further results will be presented.
**Discussion/conclusion** MG infection was nearly as common as chlamydia in this cohort. Failure of patients to return at 6–8 weeks affected our ability to properly assess test-of-cure rates. Baseline macrolide resistance was unexpectedly high and impacted negatively on treatment success.

## O032 IMPLEMENTING A TEST AND TREAT PATHWAY FOR *MYCOPLASMA GENITALIUM* IN MEN WITH URETHRITIS ATTENDING A GUM CLINIC

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10.1136/sextrans-2016-052718.31

**Background/introduction** National guidelines recommend testing men with non-gonococcal urethritis(NGU) for *Mycoplasma genitalium*(MG) where testing is available. Recent studies have shown concerning levels of macrolide resistance and high rates of treatment failure with 1 g azithromycin. In response to this, we changed our standard treatment of NGU to doxycycline and implemented a test and treat pathway for MG in male NGU.
**Aim(s)/objectives** To determine the prevalence of MG and to measure clearance rates of infection post-treatment.
**Methods** From 1st September 2015 first void urine samples from men with NGU were routinely tested for MG using the Fast Track Diagnostics™ urethritis PCR. Men with confirmed MG were given 5days azithromycin and offered test of cure at 4 weeks.
**Results** 304 men had NGU over 5months. Mean age 33.2 years, 64.5% heterosexual, 77.6% white ethnicity and 8.2% HIV-positive. Tests for MG were performed in 230/304 (76%). 16.5% (38/230) were MG positive compared with 22.5% chlamydia. 6 (15.8%) men with MG were co-infected with chlamydia and 1 (2.6%) had urethral gonorrhoea. 20/38 men with MG (52.6%) were given azithromycin 5days, 8/38 (21.1%) had azithromycin 1g stat. 7/38 (18.4%) re-tested positive at 4 weeks, 6 of whom had initially had azithromycin 5days. All were given moxifloxacin 400mg for either 7, 10 or 14 days.
**Discussion/conclusion** The high rates of MG found support routine testing in men with NGU. Despite appropriate treatment, some men returned with positive TOC suggestive of macrolide failure. This demonstrates a need for more widely available MG diagnostics with resistance testing in the UK and attention to antimicrobial stewardship so that NGU can be better managed.

## O033 A QPCR ASSAY THAT SIMULTANEOUSLY DETECTS *MYCOPLASMA GENITALIUM* AND MUTATIONS ASSOCIATED WITH MACROLIDE RESISTANCE HAS THE POTENTIAL TO IMPROVE PATIENT MANAGEMENT

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10.1136/sextrans-2016-052718.32

**Background** Treatment of *M. genitalium* (Mg) infection with azithromycin, is routinely utilised in clinical practice. However, widespread use has been associated with the emergence of macrolide resistance and ineffective cure rates. A new qPCR assay, PlexPCR™ *M. genitalium* ResistancePlus™ kit, has been developed to simultaneously identify Mg and 5 mutations in the 23S rRNA gene (positions 2058 and 2059 (*E. coli* numbering)) associated with macrolide resistance.
**Aim** This study evaluates incorporating the assay into a diagnostic algorithm to direct faster and more appropriate clinical management and reduce the spread of antibiotic resistant.
**Methods** 1087 consecutive urogenital samples from symptomatic and asymptomatic patients were evaluated prospectively with the PlexPCR *M. genitalium* ResistancePlus kit. This was compared to an in-house test for Mg detection and sequencing of Mg positives to determine 23S rRNA mutation status. The PlexPCR *M. genitalium* ResistancePlus kit employs novel PlexPrime (amplifies mutants specifically) and PlexZyme (superior multiplexing) technology.
**Results** The prevalence of Mg was 6.0% and in the Mg positive samples 23S rRNA mutation prevalence was 63.1%. The PlexPCR *M. genitalium* ResistancePlus assay showed very high clinical performance compared to the reference methods with sensitivity and specificity for Mg detection of 98.5% and 100.0%, and 23S rRNA mutation detection of 92.7% and 95.7% respectively.
**Conclusion** The PlexPCR *M. genitalium* ResistancePlus kit demonstrated excellent clinical performance for the simultaneous detection of Mg and assessment of macrolide resistance. This test has the potential to be used in screening of Mg detection and macrolide resistance to allow more appropriate clinical management.

## O034 WHOLE GENOME SEQUENCING TO PREDICT *NEISSERIA GONORRHOEAE* ANTIBIOTIC SUSCEPTIBILITY: TOWARD TAILORED ANTIMICROBIAL THERAPY

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10.1136/sextrans-2016-052718.33

**Background/introduction** Absence of genotypic resistance-associated markers in *Neisseria gonorrhoeae* (NG) may predict antibiotic phenotypic susceptibility (APS). NG Whole genome sequencing (NG-WGS) on nucleic acid amplification test (NAAT) positive samples may allow for the avoidance and preservation of first line treatments such as ceftriaxone. However, NG-WGS predictive accuracy for APS should first be established.
**Aim(s)/objectives** To evaluate NG-WGS "wild-type" predictive value for tetracycline, ciprofloxacin and azithromycin APS.
**Methods** NG-WGS was performed on prospectively collected NG isolates from a London clinic in 2013, using Illumina MiSeq. Presence of 31 known single nucleotide polymorphisms (SNPs) and other resistance markers for tetracycline, ciprofloxacin, and azithromycin, were compared against a wild-type reference NG strain (FA1090).
**Results** Of 57 samples, APS to tetracycline, ciprofloxacin, and azithromycin was 14%, 72% and 87% respectively. Genotypic susceptibility (*GeSu*) was defined as absence of SNPs and other resistance-associated markers. For tetracyclines, ciprofloxacin and azithromycin, *GeSu-Tet*, *GeSu-Cip* and *GeSu-Azi*, accurately predicted APS in 7/8 (87.5%; 95% CI 52.9%–97.8%), 40/41 (97.6%; 95% CI 87.4%–99.6%) and 25/25 (100%; 95% CI 86.7%–100%) respectively. One phenotypically resistant *GeSu-Tet* isolate had "Intermediate" resistance. Of seven isolates, both genotypically and phenotypically susceptible to tetracyclines, all were also susceptible to ciprofloxacin, 24/25 isolates susceptible to azithromycin were also susceptible to ciprofloxacin.
**Discussion/conclusion** NG-WGS accurately predicted ciprofloxacin and azithromycin but not tetracycline APS. If validated on NG NAAT positive samples, this may allow for new precision ceftriaxone-sparing or ceftriaxone-adjunctive treatment combinations, for a substantial proportion of patients.

## O035 IS CEFIXIME BACK? TRENDS IN GONOCOCCAL RESISTANCE TO CURRENT AND PREVIOUS FRONT LINE THERAPIES IN ENGLAND AND WALES SINCE THE 2011 GUIDELINE CHANGE

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10.1136/sextrans-2016-052718.34

**Background/introduction** Antimicrobial resistance (AMR) in *Neisseria gonorrhoeae* threatens effective treatment and infection control. Treatment guidelines for gonorrhoea are revised when the prevalence of resistance to first-line therapy exceeds 5%; in the UK this last occurred in 2011, prompting a treatment guideline change from cefixime to dual therapy with ceftriaxone and azithromycin.
**Aim(s)/objectives** Describe emerging trends in gonococcal resistance to current and previous first-line therapies using data from the Gonococcal Resistance to Antimicrobials Surveillance Programme (GRASP).
**Methods** GRASP collects *N. gonorrhoeae* isolates from July–September annually from 27 genitourinary medicine clinics in England and Wales. The minimum inhibitory concentration (MIC) of each isolate to seven antimicrobials is determined, then linked to demographic, clinical and behavioural data. Data from 2011–2014 were considered in this analysis. For each antimicrobial, the test for trend in resistance was determined and MIC distributions were compared using the Kolmogorov–Smirnov test.
**Results** In 2014, there was no ceftriaxone resistance (MIC $\geq$ 0.125 mg/L), but the modal MIC drifted to 0.004 mg/L from 0.002 mg/L in 2011 ($p < 0.001$). Azithromycin resistance (MIC $\geq$ 1.0 mg/L) increased from 0.5% in 2011 to 1.0% in 2014 ($p = 0.09$). The prevalence of cefixime resistance (MIC $\geq$ 0.125 mg/L) declined below 5% for the first time since 2011, but the modal MIC drifted from 0.008 mg/L in 2011 to 0.015mg/L in 2014 ($p < 0.001$).
**Discussion/conclusion** Despite the decline in resistance in cefixime, the drifting MIC distribution suggests isolates are less susceptible than previous years. Ongoing monitoring of AMR with strong compliance with national treatment guidelines is essential to retain gonorrhoea as a treatable infection.

## O036 AN OUTBREAK OF HIGH LEVEL AZITHROMYCIN RESISTANT GONORRHOEA IN A UK CITY - ACTIONS TAKEN BY THE CLINICAL TEAM AND LESSONS LEARNT

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10.1136/sextrans-2016-052718.35

**Background** Between November 2014 and March 2015, eight high level azithromycin resistant *Neisseria gonorrhoeae* (NG) isolates (MIC > 256 mg/l) were identified by Sexually Transmitted Bacteria Reference Unit Microbiology Services (STBRU) from our clinic. An Outbreak Control Team was established to actively manage the outbreak. We report the actions and outcomes of the clinical team.
**Immediate actions** Clinicians reminded to take cultures from all exposed sites when NG suspected and before any treatment; first face-to-face contact is most effective in obtaining partner details; TOC at 2 weeks essential. Enhanced PN commenced. Where initial PN incomplete, or withheld, at least two further attempts of face-to-face interview or phone call. TOC non-attendees contacted by phone call and letter, giving further opportunity to pursue PN. Advice sought from STBRU about treating pharyngeal infections to avoid pressure on ceftriaxone by its use as monotherapy. Investigation of how the first eight cases were missed despite clinic systems in place for checking positive NG cultures.
**Outcomes** By December 2015: 16 infected people identified with whole genome sequencing suggesting clonal outbreak. All were heterosexual, most aged 16–20 years. No ethnic or geographic clustering. 12/16 attended for TOC which were negative. 28 contacts disclosed, 16 traceable all attended - 3 NG negative, 13 NG positive, (12/13 azithromycin resistant, 1 NAAT positive but culture negative). PN identified 1 cluster of 4 and 3 clusters of 2
**Lessons learned** NG cultures and sensitivities remain essential to detect antimicrobial resistance. Despite enhanced PN there are many untraceable contacts in young heterosexuals. Clinics need robust administrative systems for timely detection of antimicrobial resistance

## O037 PREDICTING STI RISK AMONG PEOPLE ATTENDING SEXUAL HEALTH SERVICES: DEVELOPMENT OF A TRIAGE TOOL TARGETING BEHAVIOURAL INTERVENTIONS AMONG YOUNG PEOPLE

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10.1136/sextrans-2016-052718.36

**Background/introduction** There are very limited resources for delivering sexual health promotion within sexual health services (SHS).
**Aim(s)/objectives** Santé, a feasibility study for a trial of sexual risk reduction interventions, is developing a triage tool embedded within the electronic patient record to target interventions by risk score among young people (16–25 years) attending SHS.
**Methods** We used GUMCADv2, the national mandatory STI surveillance dataset (2013–2014 – Model 1), and the GUMCADv3 pilot (July-October 2015 – Model 2). Predictive logistic regressions for acute STI diagnosis were run. Model 1 only considered demographic and clinical variables; Model 2 also included enhanced behavioural data (number of partners, new partners, and condom use in the past 3 months).
**Results** 936,251 and 619 patient-episodes were included in Models 1 and 2 respectively, of which 11% and 4% involved an STI diagnosis. In Model 1, predicted risk of STI diagnosis ranged between 1–47% (pseudo-$R^2$: 1.9%). Referring the riskiest (highest decile) patients to more intensive interventions gives a sensitivity and specificity of 70% and 45%, respectively, and a positive predictive value (PPV) of 13% for STI diagnosis. In Model 2 the predicted risk of STI was 0–53% (pseudo-$R^2$: 23%), and referring the riskiest patients demonstrated an improved sensitivity (76%), specificity (87%) and PPV (25%).
**Discussion/conclusion** Routinely collected surveillance data can be used to triage young people for targeted risk-reduction interventions, but this is more robust if behavioural data are taken into account. Addition of behavioural data to routine STI surveillance (GUMCADv3) is a powerful way to target sexual health promotion.

## O038 THE NATIONAL HIV SELF-SAMPLING SERVICE

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10.1136/sextrans-2016-052718.37

**Background/introduction** In November 2015, Public Health England, with the support of Local Authorities, launched a nationwide HIV self-sampling service free for populations most at-risk of HIV acquisition (www.freetesting.hiv). In February 2016 the service was devolved to participating local authorities who have taken responsibility for the service in their areas.
**Aim(s)/objectives** To determine who is accessing the service and whether it reached most at-risk groups (including MSM and Black African communities) and first-time testers.
**Methods** Disaggregated anonymised data from service users ordering kits from 18 November 2015 – 31 January 2016 were analysed, including: ethnicity, gender, sexual orientation, local authority residency and self-reported HIV testing information.
**Results** During this period there were 17,114 kits ordered of which 51% (n = 8,706) were returned with a 1.4% reactive rate (n = 122). 82% (n = 7149) of kits returned were from MSM with a 1.34% reactive rate (n = 96). 32% reported never testing and 40% testing over a year ago. 18% (n = 1537) of kits returned were from heterosexuals. Of those 42% (n = 649) were from Black African individuals with a 1.54% reactive rate (n = 10) and 31% reported never testing and 45% testing over a year ago. Manchester, Leeds and Birmingham are the local authorities presenting the highest service demand across England.
**Discussion/conclusion** The national self-sampling service has been successful at engaging most at-risk populations for HIV acquisition across the nation and those who had not tested for HIV as frequently as recommended in national guidelines; including many who have never tested before.

## O039 ROLE OF PRIMARY CARE IN THE DIAGNOSIS OF STIS IN ENGLAND

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10.1136/sextrans-2016-052718.38

**Background** Sexually transmitted infection (STI) diagnoses made in genitourinary medicine (GUM) clinics have been collected in England for many years, but little is known about the contribution of GPs to STI diagnoses.
**Objectives** To assess trends in diagnosis rates of selected STIs from GPs.
**Methods** Longitudinal analysis of age- and sex-standardised population diagnosis rates of selected STIs from GPs in England from 2005–2014 was performed using data from the Clinical Practice Research Datalink (CPRD).
**Results** The proportion STI diagnoses made by GPs varied by infection, ranging from 2% (gonorrhoea) to 34% (genital herpes), in 2014. From 2005–2014, diagnosis rates [95% CI] per 100,000 registered population decreased for chlamydia (51.4 [50.7–52.0] to 24.9 [24.5–25.3], p = 0.009), gonorrhoea (3.4 [3.2–3.5] to 1.8 [1.7–1.9], p = 0.02), genital warts (73.1 [72.4–73.9] to 38.4, [37.9–39.0], p = 0.004) and genital herpes (36.9 [36.4–37.4] to 26.1 [25.7–26.6], p = 0.02). Diagnosis rates for all four STIs were higher among women, particularly for chlamydia and genital herpes where respective 2014 rates were 38.3 [37.6–39.1] and 41.8 [41.0–42.5] compared to 11.1 [10.7–11.5] and 10.0 [9.7–10.4] in men.
**Conclusion** While the rates of STI diagnoses in GUM clinics in England have steadily risen in the past 10 years, particularly in men, diagnosis rates of these four STIs in GPs have decreased between 2005 and 2014. The high diagnosis rates seen in women in GPs, suggest that primary care has an important role in the diagnosis of STIs in women although their relative contribution may have declined in recent years.

## O040 A PARTNER NOTIFICATION BUREAU IN ACTION: OUTCOMES FOR CENTRALISED MANAGEMENT OF POSITIVE GONORRHOEA AND CHLAMYDIA RESULTS FROM PRIMARY CARE BY A SEXUAL HEALTH SERVICE

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10.1136/sextrans-2016-052718.39

**Background/introduction** Centralised management of positive results by a 'Partner Notification Bureau' has been suggested by the National Chlamydia Screening Programme. From September 2014 positive results for chlamydia and gonorrhoea from primary care were reported directly to the sexual health service in a UK city for management.
**Aim(s)/objectives** To evaluate the effectiveness of centralised management of treatment and partner notification (PN) by assessing outcomes for the first year and to estimate impact on health adviser workload.
**Methods** Health adviser records were reviewed retrospectively to assess outcomes in terms of : patients informed of their result, confirmed treated at any service, and offered PN discussion; partners attended.
**Results** Gonorrhoea: between September 2014 and August 2015 there were 46 positives reported (31 female). Forty five were informed, confirmed treated, and had a PN discussion by phone. The number of partners reported or verified attended per case was 0.8 (37/46). Chlamydia: Between September 2014–August 2015, 457 positives were reported (352 female). Of these, 440 (96%) were informed and had PN discussion, and 448 (98%) were confirmed treated. The number of partners reported or verified attended per case was 0.98 (450/457). Outcomes for both exceeded the national PN standard of 0.6 partners attending per case. Partner notification workload increased by approximately 10%.
**Conclusion** Centralised management of gonorrhoea and chlamydia positives from primary care resulted in excellent treatment rates and PN outcomes. However, additional health adviser resources are required to manage the extra workload.

# Section 2 Oral Case Presentations

## CC1 "PERSISTENT GENITAL AROUSAL DISORDER – THE EXPERIENCE OF A LONDON TEACHING HOSPITAL"

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10.1136/sextrans-2016-052718.40

**Background** Persistent genital arousal disorder (PGAD) is a condition seen mainly in women characterised by spontaneous and often unrelenting sensation of genital arousal in the absence of sexual desire or stimulation. These sensations typically do not fully remit with orgasm and are by definition intrusive and distressing. The condition overlaps in some cases with pudendal neuralgia but needs to be differentiated from hypersexuality. Patients may present preferentially to GUM clinics in the knowledge that sexual symptoms will not be trivialised. Different opinions exist as to triggers, causes and treatment. Taking this into consideration we analysed a cohort of patients with PGAD assessing whether they were any common themes in terms of precipitating and relieving factors.
**Aim** To describe our clinical experience and ascertain number of patients with diagnosis, common themes and treatment modalities.
**Methods** 57 patients were diagnosed with PGAD since departmental code was introduced in 2006 and 39 patients notes were located and reviewed.
**Results** Of these 69% were in a relationship and 64% had no history of past sexual abuse. Relieving factors were also varied among the cohort including masturbation and distraction. 95% were referred for mindfulness cognitive behavioural therapy and 51% were on medication such as amitriptyline, gabapentin, venlafaxine and nortriptyline. 72% were referred for pelvic floor physiotherapy.
**Discussion** PGAD is rarely seen estimates say 1–6% are affected by this hence it is important as sexual health clinicians to be aware of it to reduce delays in diagnosis. Overall management of PGAD requires a holistic approach with multidisciplinary team involvement.

## CC2 DOES MYCOPLASMA GENITALIUM CAUSE PROCTITIS? A CASE REPORT

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10.1136/sextrans-2016-052718.41

**Background/introduction** Mycoplasma genitalium is an emerging sexually transmitted pathogen implicated in urethritis in men and cervicitis and pelvic inflammatory disease in women. The overall prevalence of rectal mycoplasma genitalium was 4.4% in one study of MSM. However, symptomatic disease is not well reported.
**Aims/objectives** We describe a case of symptomatic rectal mycoplasma genitalium
**Methods** Retrospective case not review
**Results** A 19 year old MSM attended with a 2 week history of rectal bleeding, discharge and tenesmus. His last sexual contact was 6 weeks previously: condom-less receptive anal intercourse. On examination, he had no lymphadenopathy, no rash and no evidence of oral ulceration. On proctoscopy, he had erythematous mucosa and multiple small discrete rectal ulcers. Triple site swabs were taken including gonorrhoea culture, rectal swab for LGV and multiplex PCR (syphilis, HSV and mycoplasma genitalium). A full blood borne virus screen was performed. He was treated with ceftriaxone (500 g IM), azithromycin (1 g PO), doxycycline (100 mg PO BD for 7 days) and acyclovir (400 mg PO TDS for 5 days) but his symptoms did not resolve. All tests were negative except rectal multiplex PCR was positive for mycoplasma genitalium. He was diagnosed as having symptomatic mycoplasma genitalium infection and was treated with a prolonged course of azithromycin. His symptoms subsided.
**Discussion/conclusion** Mycoplasma genitalium has been found in the rectum of MSM and is usually asymptomatic. We describe a case of proctitis which seems to be related to Mycoplasma genitalium. MSM with unresolved proctitis should be tested for Mycoplasma genitalium.

## CC3 LYMPHOGRANULOMA VENEREUM PRESENTING AS A RECTAL TUMOUR

Maryam Alfa-Wali, Paul Toomey, Nalin Khosla, Essam Raweily, Ceri Slater*. *Epsom and St Helier Hospital, Surrey, UK*

10.1136/sextrans-2016-052718.42

**Background/introduction** Lymphogranuloma Venereum (LGV), due to an invasive serovar of Chlamydia Trachomatis, is endemic in the United Kingdom in men who have sex with men (MSM). It is associated with the human immunodeficiency virus (HIV) and other sexually transmitted infections including hepatitis C.
**Aim(s)/objectives** We present a case of LGV mimicking a rectal tumour in a heterosexual male.

**Methods** The diagnosis of LGV was made following molecular diagnostic testing of an anal swab.
**Results** The patient presented as an emergency with a history of change in bowel habit, tenesmus and rectal bleeding. He had a past medical history of duodenitis and a family history of Crohn's disease. Digital rectal exam revealed a circumferential rectal tumour, 2 cm from the anal verge. Features suggested a diagnosis of rectal cancer and radiological staging demonstrated extensive local infiltration and nodal involvement, supporting this diagnosis. Biopsies from colonoscopy however revealed severe proctitis with no evidence of malignancy. The local colorectal MDT meeting decided the patient would have neoadjuvant chemoradiotherapy and subsequent surgery based on response, after more biopsies. In the interim he presented with pending bowel obstruction resulting in a de-functioning colostomy and the patient tested positive for HIV prompting a referral to GUM physicians. Repeat MRIs captured the subsequent remarkable response to LGV treatment with Doxycycline.
**Discussion/conclusion** It is important for HIV testing to be incorporated as part of the management plan for colorectal malignancies.

## CC4 OCULAR SYPHILIS ON THE RISE: A CASE SERIES

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10.1136/sextrans-2016-052718.43

**Background** Ocular involvement of syphilis remains relatively rare, however our clinic has seen a recent flurry of cases with 13 new diagnoses in the last 2 years, compared with 11 seen in the proceeding 10 years. It can be difficult to diagnose with no pathognomonic signs and can affect any structure of the eye.
**Aim** To present a cluster of 13 new cases ocular syphilis diagnosed from 2013 until January 2016.
**Methods** A retrospective case review.
**Results** In conjunction with our tertiary eye hospital, our clinic saw 13 patients diagnosed with ocular syphilis between July 2013 and January 2016. All 13 patients were male: 6 heterosexual; 5 men who have sex with men (MSM) and 2 bisexual. 3 patients were HIV positive. Mean age 42 (range 22–75). Ocular involvement included uveitis (anterior, posterior and pan-), optic neuritis, papillitis and retinitis. Cases include both unilateral and bilateral symptoms. All were treated as per national guidelines for neurosyphilis with procaine penicillin plus probenecid, proceeded by oral steroids. The majority of these patients' symptoms resolved following treatment, however a few continue to have ongoing visual disturbances.
**Discussion** We present our 13 cases of ocular syphilis. They illustrate the diverse range of presentations of ocular syphilis and the importance of partnership between the GU clinic and specialist ophthalmology services.

## CC5 A CASE OF URTICARIAL VASCULITIS LEADING TO HIV DIAGNOSIS

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10.1136/sextrans-2016-052718.44

**Background/introduction** Urticarial Vasculitis (UV) is a form of cutaneous small vessel vasculitis characterised by urticaria-like weals. UV is most commonly precipitated by infections, drugs and connective tissue disorders.
**Aim(s)/objectives** UV is uncommon in the setting of HIV with very few cases reported in the literature. We present a case of UV leading to a diagnosis of HIV.
**Methods/Results** A 30 year old Malawian woman was referred to the dermatology clinic by her GP with an intermittent raised, itchy, burning rash on both legs over the last three years. Examination revealed multiple areas of flat postinflammatory hyperpigmentation on the legs and one oedematous/infiltrated area. Laboratory investigations revealed; raised eosinophil count (3.04 × 109/L), decreased C3 (0.35 g/L) and normal C4 (0.27 g/L), raised Rheumatoid factor antibody of 94 IU/ml. Autoimmune screen was negative. She was offered HIV testing which was positive for HIV-1 antibody. Other infection screen including hepatitis B and C was negative. Treponemal Antibody positive, TPPA positive and VDRL negative in keeping with late latent syphilis. Skin biopsy demonstrated a moderately dense perivascular inflammatory cell infiltrate within the dermis and subcutaneous tissue. This was neutrophil-rich with prominent eosinophils and nuclear debris associated with mild perivascular oedema. The changes were consistent with UV. She was commenced on fexofenadine hydrochloride 180 mg once daily with an improvement in her symptoms and was treated for late latent syphilis.
**Discussion/conclusion** HIV and Syphilis have both been cited as possible infective causes of UV. This case illustrates a less common cause of UV and highlights the importance of expanded HIV testing in other medical specialities.

## CC6 WARNINGS ARE NOT ENOUGH – A CASE SERIES OF RITONAVIR INDUCED CUSHING'S SYNDROME AND ADRENO-CORTICAL FAILURE

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10.1136/sextrans-2016-052718.45

**Background** Ritonavir is a potent inhibitor of the cytochrome P450 3A4 enzyme used to boost other protease inhibitors in the management of HIV infection. The metabolism of fluorinated steroids (eg fluticasone, triamcinolone), used for asthma, hay fever and arthritis, is inhibited by ritonavir causing increased exposure to corticosteroid. Cases of ritonavir induced Cushing's syndrome and subsequent adrenocortical suppression were first reported in 1999. Despite awareness of this interaction new cases continue to occur.

**Aim** To identify and describe patients in our cohort with iatrogenic Cushing's ± adrenocortical suppression, and to investigate whether there were missed opportunities for prevention.
**Methods** Cases were identified from laboratory and pharmacy records between January 2010 and December 2015. Data was collected on demographics, steroid use, presentation and outcome. GP and referral letters were reviewed.
**Results** 25 cases were identified. The steroids were prescribed in many different specialties, most commonly primary care and rheumatology, as well as being obtained OTC. Duration of steroid use ranged from a single dose to 3 injections over one year. The most common presentation was weight gain, facial swelling, fatigue and postural dizziness. Long-term sequelae included diabetes, osteoporosis and avascular necrosis as well as creating

anxiety and mistrust of the medical profession. Synacthen tests were performed in the majority of cases. The duration of adrenal suppression varied from 1 month to >4 years. Clinic letters first carried a postscript warning re the interaction in 2007.
**Discussion** Iatrogenic Cushings/adrenocortical suppression carries significant long-term morbidity. Innovative strategies to improve dissemination of information to healthcare professionals and patients are needed.

# Section 3: Nurses & Health advisors oral Presentations

## NH1 ARE WE MEETING THE NEEDS OF YOUNG PEOPLE?

[1]Justine Orme*, [1]Eleanor Morad, [1]Lauren Bignell, [1]Deborah Williams, [1,2]Daniel Richardson. *[2]Brighton and Sussex University Hospitals NHS Trust, Brighton, Sussex, UK*; *[1]Brighton and Sussex Medical School, Brighton, UK*

10.1136/sextrans-2016-052718.46

**Background/introduction** Research has shown that young people (YP) value services that provide easy access with confidential, prompt and comprehensive care. Healthcare professionals working in YP services need to be vigilant to vulnerabilities to child sexual exploitation (CSE) such as sexting: the sending of sexual images via mobile phone/social media.
**Methods** We carried out an anonymous patient survey based on the "You're Welcome" standards between November 2015 and March 2016
**Results** 54 surveys were included in the final analysis. Access: 16/54 (30%) were repeat attenders, 11/54 (20%) were referred by GP, 9/54 (17%) were recommended by a friend, 5/54 (9%) found the service via clinic website. Waiting time: 34/53 (63%) waited 30 minutes, 14/54 (26%) between 30–60 minutes. Confidentiality: 47/54 (87%) were made aware of the confidentiality policy. Services: 54/54 (100%) felt the clinic offered all the services they were expecting. 53/54 (98%) felt that the waiting room displayed information tailored to YP. Contraception was discussed in 33/54 (61%) of consultations and 22/54 (41%) were offered a local condom card. 54/54 (100%) of patients felt they would return to the clinic again in the future. Sexting: 25/54 (46%) had sent an image of themselves and 14/54 (26%) felt this had led to a negative outcome. Only 8/54 (14%), however, were asked about this during their consultation.
**Discussion/conclusion** Our YP clinic evaluated well. A high proportion of these YP had engaged in sexting and acknowledged a negative impact on their lives. Few were asked about this, however, illustrating the need for ongoing training and support of HCPs working with YP around asking non-clinical questions, and being up to date with the constantly evolving face of CSE.

## NH2 WHAT EFFECT DO PRACTICE VISITS HAVE UPON OPPORTUNISTIC CHLAMYDIA SCREENING TEST UPTAKE AND CASE DETECTION IN PRIMARY CARE? AN AUDIT OF 81 GENERAL PRACTICES IN OXFORDSHIRE

[1]Omotayo Adebanji*, [1]Leon R Maciocia, [1]Jackie Sherrard, [2]Adrian Smith. *[1]Oxford University Hospital NHS Foundation Trust, Oxford, UK*; *[2]University of Oxford, Oxford, UK*

10.1136/sextrans-2016-052718.47

**Background/Introduction** The National Chlamydia Screening Programme in England aims to reduce transmission and prevent complications through early diagnosis. The 'Value for Money' review proposed opportunistic screening in general practice supported by specialist services.
**Aims/Objectives** To evaluate the effect of practice visits upon chlamydia screening coverage and case identification in young people aged 15–24 in Oxfordshire, April 2012–March 2014.
**Methods** Quarterly counts of total screens and positive tests for general practices in Oxfordshire were linked to records of practice visits (date, attendance) and characteristics of practices (location, deprivation, practice size). Testing and positivity rates three months prior to screening officer visits (baseline) were compared to rates in the 0–3 and 4–6 months following a visit. Pre- and post-visit counts were compared using multivariate generalised estimating equation models, accounting for repeated measures by practices and confounders.
**Results** Practice screen counts were available for 136 periods before and after visits to 81 practices. Practices reported a median of 9 tests in the 3 months prior to visits or 3% screening coverage of registered 15–24 year olds. Screen counts were significantly higher following visits (Table 1), and positively associated with higher staff attendance at those visits. Also, there is an increase in number of positive cases diagnosed immediately after visits.
**Conclusion** Practice visits serve as a good reminder for staff in general practice to offer test opportunistically. However, there is a need for an enhanced intervention to sustain any increase in screening coverage and diagnoses following visit.

## NH3 PARTNERSHIP WORKING TO ACHIEVE SUCCESSFUL HEALTH BOARD-WIDE HEPATITIS B PARTNER NOTIFICATION OUTCOMES

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10.1136/sextrans-2016-052718.48

**Background/Introduction** The Sandyford Shared Care Support and failsafe (SSCS) service managed by the Sexual Health Advisers provides advice and support to NHS Greater Glasgow and Clyde Health Care Professionals in the management of individuals diagnosed with a sexually transmitted infection or blood borne virus. In relation to Hepatitis B infection their role is to make contact with testing clinicians by telephone to review the case, facilitate timely results giving and onward referral to appropriate specialist services, co-ordinate and assist with public health activities arising from each case, document and audit outcomes.
**Aims(s)/Objectives** To demonstrate the impact of SSCS support to promote partnership working to achieve effective and auditable partner notification outcomes for acute and chronic Hepatitis B cases.
**Methods** Acute or chronic Hepatitis B cases between 1 September 2012 and 31 December 2015 were reviewed. Partner notification outcomes documented for identified sexual partners, family and household contacts requiring testing and vaccination were examined.
**Results** A total of 710 cases of Hepatitis B were reported to SSCS during the audit period (675 chronic and 35 acute). 1278 contacts were identified, and 840 contacts (1.18 per index case) were reported (verified or unverified) to have attended a service

for assessment. 656 contacts were vaccinated, 113 had immunity and 62 found to have active infection.
**Discussion/Conclusion** This audit clearly demonstrates the value and importance of partnership working to achieve successful public health outcomes well above targets set by national standards.

### NH4 SERVICE DEVELOPMENT FOR PEOPLE WITH HIV WHO HAVE COMORBID CONDITIONS USING EXPERIENCE-BASED CO-DESIGN METHODOLOGY

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10.1136/sextrans-2016-052718.49

**Background/introduction** There is a need for evidence - based models of care to effectively manage the increasing numbers of the people with HIV (PWH) who have comorbid conditions. This study was part of an NIHR Programme Development Grant to inform the development of HIV services to meet the needs of an ageing population.
**Aim(s)/objectives** To explore the healthcare experiences of PWH who have comorbid conditions and the staff involved in their care to identify priorities for service improvement.
**Methods** Experience-based co-design methodology was used to understand the experiences of PWH accessing General Practice, HIV, Cardiology, Liver, Renal and Rheumatology services. Patients were recruited from the HIV clinic and staff purposively sampled from the service areas. Experiences were gathered through observation, diaries, audio and filmed interviews. Thematic analysis was undertaken and filmed patient interviews analysed for emotional touchpoints. Staff and patient feedback events were utilised to validate data and identify areas for service development. A joint staff and patient co-design event was held to agree shared priorities for future services.
**Results** 22 patients (with 110 comorbidities) and 18 staff were recruited. A composite film was produced from the patient interviews. Examples of touchpoints were communication, burden of appointments and repetition across services. Patients identified 6 areas for service improvement and staff identified 3. The agreed priorities for future service development were care co-ordination, shared medical records/results and systems to manage multiple appointments.
**Discussion/conclusion** Experience-based co-design methodology was effective in identifying future service models for PWH who have comorbid conditions.

## Section 4 Undergraduate oral Presentations

### UG1 DIGITAL ANO-RECTAL EXAMINATION (DARE) AS ANAL CANCER SCREENING IN HIV POSITIVE MEN WHO HAVE SEX WITH MEN (HMSM) – IS IT ACCEPTABLE TO PATIENTS?

[1]Tamara Lewis*, [2]Selvavelu Samraj, [1,2]Raj Patel, [2]Sangeetha Sundaram. *[1]School of Medicine, University of Southampton, Southampton, UK; [2]Dept. of Sexual Health, Solent NHS Trust, Royal South Hants Hospital, Southampton, UK*

10.1136/sextrans-2016-052718.50

**Background/introduction** Anal cancer is more common in HMSM than in HIV negative MSM or the general population. Tumours in HMSM tend to be larger and more advanced at diagnosis resulting in poorer prognosis. The European AIDS Clinical Society Guidelines recommend DARE with a screening interval of 1–3 years. However, this is only based on expert opinion. The benefit of such a strategy in a UK GUM managed HIV cohort is still unknown.
**Aim(s)/objectives** To assess acceptability of annual DARE to HMSM and establish patient experience of having DARE.
**Methods** From pre-published clinic lists covering the 8-week recruitment period, patients fitting the inclusion criteria (HMSM aged $\geq$ 35) were invited to participate in the study when they attended clinic. Patients were asked to complete a questionnaire and invited to have DARE as part of their consultation.
**Results** Of the 43 patients invited into the study, 29 [67%; 95% confidence interval (CI) 53–81] proceeded to DARE. Principal reason for refusal of DARE was 'lack of time' and 'not feeling clean'. Of the 29 having DARE, 12 [41%; 95% CI 23–59] were found to have a previously unrecorded clinical abnormality. 5 [17%; 95% CI 3–31] required colorectal referral - 3 [10%] for lesions suspicious of anal intraepithelial neoplasia. Outcomes of colorectal consultation are awaited. 100% of respondents said they would have DARE again.
**Discussion/conclusion** Annual DARE is an acceptable addition to the routine care of HMSM. Pre-warning patients to expect DARE at a routine visit when it is due may further improve acceptability.

### UG2 GRINDR© USE BY MEN WHO HAVE SEX WITH MEN (MSM) IS ASSOCIATED WITH HIGH RATES OF BACTERIAL SEXUALLY TRANSMITTED INFECTIONS

[1]Samuel Owen*, [1,2]Thomas Kurka, [1,2]Daniel Richardson. *[1]Brighton & Sussex Medical School, Brighton, UK; [2]Brighton & Sussex University Hospitals NHS Trust, Brighton, UK*

10.1136/sextrans-2016-052718.51

**Background/introduction** Mobile Phone 'apps' such as grindr© are becoming a more frequent and convenient way to meet sexual partners and may be a reason why sexually transmitted infections(STI) are increasing in MSM.
**Methods** From November 2015 to February 2016, a paper survey was distributed to MSM attending local sexual health services on acceptability of local service, including use of mobile phone applications to meet sexual partners. National Student Pride also used an online version of the survey.
**Results** 1186 MSM were included in the analysis of this survey. The median age was 26.8 years (18–89). 1026/1186 (86.5%) self-identified as gay, 108/1186 (9.1%) bisexual and 34/1186 (2.9%) straight. 918/1186 (77.4%) were HIV-negative, 42/1186 (3.5%) HIV-positive, 188/1186 (15.9%) never tested, and 38/1186 (3.2%) unknown status. 200/1186 (16.9%) of respondents reported a bacterial STI within the past 12 months: 116/1186 (9.8%) had gonorrhoea, 96/1186 (8.1%) chlamydia and 26/1186 (2.2%) syphilis. Reported use of grindr© was: 372/1186 (31.4%) more than once/day, 168/1186 (14.2%) more than once/week 124/1186 (10.5%) more than once/month. Those who used grindr© more than once per day reported having had gonorrhoea (62/372:16.7%), chlamydia (50/372:13.4%) and syphilis (16/372:4.3%) in the past 12 months. 80/116 (70.0%), 64/96 (67%) and 16/26 (62%) MSM who reported having gonorrhoea, chlamydia and syphilis in the past 12 months reported

using grindr© at least once a month. MSM were significantly more likely to report having gonorrhoea and chlamydia (but not syphilis) in the past 12 months using grindr© at least once per month compared to never using grindr(t-test = 2.79; p = 0.003), (t-test = 2.20; p = 0.028), (t-tst = 0.58; p = 0.565).
**Discussion/conclusion** Use of the mobile phone application grindr© is associated with acquisition of bacterial STIs. Public health interventions to reduce STI rates in MSM should include using appropriate social media.

## UG3 ARE GEOSOCIAL NETWORKING (GSN) APPS ASSOCIATED WITH INCREASED RISK OF STIS & HIV: A SYSTEMATIC REVIEW

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10.1136/sextrans-2016-052718.52

**Background/introduction** Geosocial networking (GSN) apps such as Tinder and Grindr provide new ways of finding sex partners. It is suggested that usage could be responsible for increased STI & HIV transmission.
**Aim(s)/objectives** To systematically review published literature to determine whether geosocial app use is associated with increased sexual risk behaviours, current and/or previous STIs & HIV.
**Methods** Search of PubMed, EMBASE and Google Scholar for studies involving women, men, men who have sex with men (MSM) and use of GSN apps for sex-seeking which reported risk factors for STIs & HIV transmission, published from 2009 to March 2016, in English. Search terms were associated using at least one regarding GSN apps and a second regarding STIs or sexual risk behaviours. Quality was assessed using Critical Appraisal Skills Programme criteria.
**Results** 13 studies met inclusion criteria: 12 cross-sectional studies, 1 review. All were in MSM from urban USA, China, Taiwan, UK and Ireland. In total there were 11924 subjects (range 92–7184). 7 studies reported app use to be associated with increased unprotected anal intercourse (UAI); 2 studies showed no association. 3 studies showed association with previous STI diagnoses, although association with HIV diagnoses had mixed results. 4 studies reported high response rate for app-based recruitment.
**Discussion/conclusion** Use of GSN apps is associated with factors known to facilitate STI & HIV transmission in MSM. Studies in heterosexuals are much needed. High uptake of some app-recruited studies suggests GSN apps could be useful platforms for sexual health promotion and targeted risk reduction strategies.

## UG4 NON-SPECIFIC URETHRITIS: CAN WE BE A LITTLE MORE SPECIFIC?

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10.1136/sextrans-2016-052718.53

**Background/introduction** The causes of non-specific urethritis (NSU) in men are many and in GUM clinics, evidence for *Chlamydia trachomatis* (CT) and *Neisseria gonorrhoeae* (GC) is routinely sought. *Mycoplasma genitalium* (MG) accounts for 5–33% of urethritis but is not routinely tested for in the UK. There is growing concern that widespread use of 1g Azithromycin is leading to macrolide resistance in many organisms including MG.
**Aim(s)/objectives** To describe the current management of men with confirmed urethritis and their outcomes.
**Methods** Men with diagnoses of NSU from January to July 2015 were identified. Data were collected from electronic patient records. p values were obtained using chi-square test.
**Results** 254 cases of NSU were identified, median age 30 (range 16–69 years). 181/254 (71%) heterosexual, 73/254 (29%) MSM, 21/254 (8%) HIV-positive. Rates of urethral CT and GC were 15% (n = 40) and 1% (n = 2) respectively. 21/254 (8%) had persistent dysuria or discharge; 15/21 of those were tested for MG; MG detected in 5/15 (33%). Pathogens were identified in 17% of cases and heterosexual men were more likely to have pathogen-positive urethritis than MSM (p = 0.02). First line treatment: 93% 1 g Azithromycin, 2.8% doxycycline 100 mg bd 7/7.
**Discussion/conclusion** For the majority of NSU cases, no bacterial cause was identified yet these men were all prescribed antibiotics. MG was detected in a third of persistent NSU cases but may account for more as 1g Azithromycin is enough to partially resolve symptoms but likely cause antimicrobial resistance. More effort should be made to determine the cause of urethritis in men so that appropriate antibiotics can be given where necessary.

## UG5 SH:24 – USER PERSPECTIVES ON AN ONLINE SEXUAL HEALTH SERVICE

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10.1136/sextrans-2016-052718.54

**Background/introduction** The London Boroughs of Lambeth and Southwark have high levels of sexual health need and services are overstretched. SH:24 offers online testing for chlamydia, gonorrhoea, HIV and syphillis in Lambeth and Southwark, and the 'GetTested' randomised controlled trial evaluates its effectiveness.
**Aim(s)/objectives** This study aimed to document user views on clinic-based and online services.
**Methods** We analysed qualitative data from a follow-up questionnaire of the GetTested trial of 1337 participants, which included the following question: 'In your opinion, how could we improve the experience of getting a test from a sexual health service?' This data was quantitatively analysed against baseline characteristics to generate descriptive statistics. A thematic analysis of the free text responses was performed.
**Results** Three key themes were identified: interaction with services; ease of use and experienced stigma. A subjective variable was developed to describe whether users needs were met. More participants reported the online service as meeting their needs than the clinic service. Areas needing improvement identified within the clinic arm were: Information prior to service use, Improved confidentiality & Waiting times. Areas needing improvement identified within the online arm were: Lack of personal contact, Difficulty with the self-sampling process, Confidence in ability to self-test.
**Discussion/conclusion** The problems identified with face-to-face services are overcome by online services and vice versa. In order

to be successful, both need to work in collaboration to provide accessible and acceptable services.

### UG6 PLEASE DON'T TELL MY GP: PATIENTS' CONCERNS ABOUT THE SHARING OF INFORMATION BETWEEN SEXUAL HEALTH CLINICS AND GENERAL PRACTITIONERS (GPS)

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10.1136/sextrans-2016-052718.55

**Background/introduction** At sexual health clinics, patients are asked for permission to contact them by a variety of methods. When patients who have opted-out of GP contact are found to have a sexually transmitted infection (STI) and cannot be contacted despite multiple attempts, a case-by-case decision is often made, regarding breaching the patient's permissions and contacting their GP.
**Aim(s)/objectives** To determine why some patients decline GP contact, and to assess their views on GP contact against their expressed wishes, in order to treat an STI, when a patient is unable to be contacted by other means.
**Methods** This was a prospective, qualitative, NRES-approved study involving 10 semi-structured interviews with patients attending a level 3 UK sexual health clinic who had declined GP contact.
**Results** Three key areas of concern were identified: potential negative implications of permanently recording sexual health problems on GP records, including the effect on future life insurance and job applications; concerns about receptionists in GP surgeries breaking confidentiality in the reception area and being judgmental; and patients' close relationship with their GP. However, 8/10 of those interviewed supported a breach of permissions by contacting their GP in order to treat an STI.
**Conclusion** With the increased involvement of GPs in delivering sexual health services in the UK, it is essential that action is taken to improve patients' confidence in confidentiality protections at their GP. Sexual health clinics should ensure they explain why GP contact may be required in order to potentially increase patients' willingness for this to occur.

## Section 5 Poster presentations

### P001 IN 2015, MSM ACCESSING PEPSE IS SIGNIFICANTLY MORE ASSOCIATED WITH CLUB DRUG USE THAN 2013/2014

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10.1136/sextrans-2016-052718.56

**Background/introduction** Recreational drug (RD) use is increasing in men who have sex with men (MSM) and increases sexual risk taking behaviour and possibly increasing attendances for PEPSE.
**Aim(s)/objectives** To identify Club drug use during PEPSE attendances in MSM in 2013/4 compared to 2015.
**Methods** Review PEPSE (MSM) attendance during two 4-month periods: November 2013 to February 2014 and March 2015 to June 2015.
**Results** 152 MSM attended for PEPSE: 51 in 2013/4 and 101 in 2015. The median age was 31 (18–79) years. Documentation of Club drug use during PEPSE episode increased significantly from 27/51 (53%) in 2013/14 to 100/101 (99%) during 2015 ($p < 0.001$). Club drug use during PEPSE episode increased significantly from 9/51 (18%) in 2013/4 to 41/101 (41%) in 2015 (OR 3.19, $p < 0.005$). There were no significant changes in the Club drugs being used: *gamma*-Butyrolactone(GBL), Mephedrone and Crystal Meth being the most frequent reported.
**Discussion/conclusion** Episodes of unsafe sex leading to access of PEPSE appear to be more associated with club drug use in 2015 than in 2013/4 and our documentation of this has improved. Identification of club drug use in MSM is an important harm intervention.

### P002 IS ENQUIRY REGARDING ALCOHOL CONSUMPTION AND ALCOHOL REDUCTION ADVICE ACCEPTABLE TO SEXUAL HEALTH SERVICE USERS? A CROSS-SECTIONAL STUDY OF CLINIC ATTENDEES

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10.1136/sextrans-2016-052718.57

**Background/introduction** Problem alcohol consumption is a major health problem in the UK. Alcohol assessment and behavioural advice or "brief interventions" are effective in decreasing alcohol intake in primary and secondary care but not in sexual health clinics.
**Aim(s)/objectives** We assessed sexual health service user views towards alcohol screening using a prospective cross-sectional survey to identify any themes, which limit acceptability of these methods.
**Methods** Age, gender, alcohol consumption measured by AUDIT-C score, and opinion towards 10 statements on alcohol screening within a sexual health clinic were assessed.
**Results** 462 surveys were returned. Respondents were 64% female, 36% male. Most, 53.7%, were aged $\geq$25 years, the highest number of responses was received from those aged 20–24 (32.2%), median age category was 25–29 years. The majority of respondents, 61.6% had hazardous alcohol consumption. Males had more positive AUDIT-C scores (indicating hazardous alcohol consumption) compared to females (75% vs 54%, $p < 0.001$). Those aged <30 had more positive AUDIT-C scores (67.9% vs 32.1%, $p < 0.001$). Attitudes to alcohol assessment performed by sexual health practitioners were positive (range 91.1%–74.5% favourable), responses were less favourable, becoming negative towards the appropriateness of the sexual health clinic as a screening venue (range 56.7%-33.6% favourable). Responses to 4 out of 10 opinion statements were related (multivariate regression model) to age or AUDIT-C score.
**Discussion/conclusion** Different strategies need to be explored within sexual health for alcohol consumption reduction

interventions as clinic users are younger, have higher rates of hazardous alcohol consumption and are potentially more resistant to standard brief interventions.

## P003 USING TRADITIONAL SEXUALITY DESCRIPTORS: ARE THEY USEFUL ANYMORE?

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10.1136/sextrans-2016-052718.58

**Introduction** Sexuality is a complex topic in sociology and healthcare. It is multifactorial; combining gender, sex, sexual orientation and erotic desires. Three sexuality descriptors are commonly used: heterosexual, bisexual and homosexual. Women who have sex with women (WSW) and men who have sex with men (MSM) are classified as homosexual. These three descriptors are sometimes used in sexual health clinics in the UK as part of the coding to understand the demographics of service users.
**Aims** We wished to review if these descriptors matched patients' described behaviours in an integrated sexual health clinic.
**Methods** We reviewed 300 patients presenting to a UK sexual health clinic between April 2013 and September 2013. 100 patients were randomly chosen based on their sexuality descriptor, which had been self-selected when booking in. Electronic patient records were used to access patient histories. Stated sexuality and sexual behaviour were compared.
**Results** Out of the 300 patients selected, 88 were excluded, leaving 212 for analysis. 18.1% of patients described behaviour outside of the stated sexuality descriptor. 50.1% of the bisexual cohort, 1.8% of the heterosexual cohort and 3.5% of the homosexual cohort described behaviour different from the descriptor.
**Conclusion** Our findings suggest that the current classifications of sexuality are inadequate to fully capture behaviours, although due to full sexual history taking clinical care is not compromised by this. Personal identity and choice of sexuality descriptors may bias epidemiological understanding of sexual behaviours if relying on these three traditional descriptors.

## P004 REGIONAL AUDIT OF THE MANAGEMENT OF SYPHILIS

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10.1136/sextrans-2016-052718.59

**Background/introduction** BASHH guidelines for syphilis management were revised in 2015 and are awaiting publication.
**Aim(s)/objectives** To review regional clinics' syphilis management and adherence to provisional BASHH audit standards.
**Methods** Regional sexual health clinics were asked to review cases of syphilis diagnosed the previous year with respect to gender, sexuality, HIV status, pregnancy, screening for other sexually transmitted infections, disease stage, whether non treponemal titres were measured, follow up, treatments given, discussion of the Jarisch Herxheimer (JH) reaction and partner notification (PN).
**Results** 13/15 (86%) clinics participated. 161 case notes were reviewed. 81% were male, 54% were classified as men having sex with men. 34/161 (21%) were HIV positive. 13/161 (19%) were pregnant (in 84% written communication had been made to obstetric/neonatal teams). 138/161 (86%) were screened for other STIs, 24% cases having concomitant STIs. 63% were early presentations. In 97% an RPR/VDRL was performed at commencement of therapy. 142/161 (88%) were treated with parenteral penicillin. The JH reaction was discussed in 49% of early STS cases. In 75% a four-fold reduction of titres in RPRs was achieved. In 37% the patient attended for follow up for 12 months (16% had no follow up). In 86% of cases PN was performed with 87/161 (54%) of contacts being verified as having attended clinics for screening and treatment.
**Discussion/conclusion** Areas for improvement regionally include discussion of JH reaction, demonstration of success of treatment, patient follow up and partner notification. A reaudit is planned in the future.

## P005 HEPATITIS C SCREENING BY COUNTRY OF BIRTH IN A GENITOURINARY MEDICINE CLINIC- HOW MUCH ARE WE MISSING?

Jennifer Murira*, Eric Monteiro. *Leeds Teaching Hospitals Trust, Leeds, UK*

10.1136/sextrans-2016-052718.60

**Background/introduction** Screening for Hepatitis C at GUM clinics is recommended by NICE (PH43) in high risk populations. One of these risk groups are people born/brought up in a country with a prevalence >2% of chronic hepatitis C.
**Aim(s)/objectives** To determine the rate of screening by country of birth in GUM clinic attendees before and after the introduction of a clinic specific guideline for Hep C screening.
**Methods** All GUM attendees who were seen between October 2013 and October 2014 and were born in a country of Hep C prevalence of >2% were included. This data was linked to whether a hepatitis C serology test had been performed with the results server. The rate of screening before and after the introduction of guidelines in April 2014 was compared. All HIV positive individuals were excluded.
**Results** During the audit time frame, 2,664 patients were identified as being born in a country with high Hep C prevalence. 1299 attended in the 6 months pre guidelines, 1365 attended 6 months after. Introducing clinic guidelines led to a 2.88 times increase in screening (4.7% vs 13.6%). During this period we diagnosed 3 cases of hepatitis C in people born in a high prevalence country.
**Discussion/conclusion** Introduction of guidelines improved screening in our clinic however the rate of screening remained low. Assuming 2% prevalence we 'missed' 50 cases of Hep C. Major factors identified were clinician knowledge of the countries that should be screened and asking the patient their country of birth within the sexual history.

## P006 WORKING WITH MARGINALISED GROUPS: HOMELESS ADULTS AND STREET BASED COMMERCIAL SEX WORKERS

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10.1136/sextrans-2016-052718.61

**Background/introduction** Homeless adults and street based sex workers are a highly vulnerable group of people with specific sexual and general health needs. A specialist outreach clinic was set up in 2010 to support these patients.
**Aim(s)/objectives** To evaluate the uptake of services used including contraception, immunisation, blood-borne virus testing, cytology, STI screening and evaluation of drug use.
**Methods** Data was retrospectively collected from May 2012 until March 2015.
**Results** 82 patients seen in total (female, 53; male, 29), with an average age of 28.6 (range 17–50.) 57% of patients were symptomatic. 57% patients (n = 47) were Hepatitis B immune, 26% (n = 21) received either boosters or full vaccination for HBV. 34% patients (n = 28) had STIs. Hepatitis C (36%) and Chlamydia (32%) were the most common infections. 57% patients (n = 47) were using drugs, the majority using heroin (57%). 3 females were pregnant at baseline review; of the remaining women, 78% (n = 39) were on contraception, LARCs being the most widely used. 34% of women (n = 18) were working as commercial sex workers. 35 of the women had given birth to a total of 97 children, with 70% of them (n = 68) either fostered or adopted. 33% smears taken (n = 10) were abnormal with 3 colposcopy referrals.
**Discussion/conclusion** This specialist outreach clinic facilitates sexual and reproductive healthcare for vulnerable patients who are otherwise hard to reach and often have poor experiences of healthcare. The high rate of sex work in this population emphasises the need for continued screening and treatment. LARC uptake rates are reassuring, but could be further improved.

## P007 TRIALS AND TRIBULATIONS-CREATING A SEXUAL HEALTH LEAFLET FOR PRISONERS

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10.1136/sextrans-2016-052718.62

**Background/introduction** Her Majesty's Inspectorate of Prisons recommends that prisoners are provided with sexual health information and condoms. Consensual sex rates for prisoners are reported between 1.6–10%, and they are considered high risk for STI's.
**Aim(s)/objectives** A request by a prison healthcare team for a sexual health leaflet prompted the creation of a pamphlet specific for prisoners.
**Methods** A working group was created between Genitourinary medicine, Public health England and prison healthcare. A literature review was conducted on sexual/prison healthcare leaflets. 30 prisoners were consulted informing content, length and language. A draft was given to a second focus group who completed a questionnaire to evaluate the impact of the leaflet. Approval of the content and look were required from the prison governor. Decisions were needed regarding dissemination and costs.
**Results** Literature review revealed no previous leaflet for prisoners on sexual health. Prisoners highlighted eye-catching language, pictures,'reference' style and a quiz being important points that would increase use of a leaflet. A second focus group questionnaire indicated the draft leaflet increased their knowledge about sexual health (90%) and would make them much more likely to wear a condom (52%). Difficulties arose around language used within the leaflet particularly the title acceptability to prison staff and who would fund printing costs. This impacted on distribution and reach of the leaflet.
**Discussion/conclusion** A simple request lead to a complex lengthy solution, many parties required consultation with differing views. Finally, we hope to have created a leaflet that is applicable for all prisons across England.

## P008 AN AUDIT OF TIME TO TREATMENT FOR BACTERIAL STIS, AND TIME TO PROVISION OF HIV DIAGNOSIS, IN A LARGE URBAN SEXUAL HEALTH CLINIC

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10.1136/sextrans-2016-052718.63

**Background** The time from testing to treatment of STIs, and the *provision of a new HIV diagnosis**, is a marker of quality of care. The follow-up of positive results is undertaken by nurses according to predetermined protocols. In April 2015 gonococcal NAAT superseded the relatively insensitive gonococcal culture test.
**Aims** The aims were to determine the time to treatment for HIV*, syphilis, gonorrhoea and chlamydia; and if the introduction of gonorrhoea NAAT affected the time to treatment.
**Methods** This observational study compared the median time (days) to treatment for HIV* and STIs in two time periods (P1: April-June 2014 and P2: April-June 2015). For gonorrhoea, the median time from testing to result complete and median follow-up time to treatment were also compared. The Mann-Whitney U Test for two independent samples was used to compare medians.
**Results** The median time to treatment for all STIs, including HIV*, was 8 days or less in P1 and P2 (all $p \geq 0.08$). The time to result complete for gonorrhoea was significantly less in P2 (n = 189, median = 3) compared to P1 (n = 50, median = 5) (p = 0.000). However, the median follow-up time to treatment was not significantly different between P1 (median = 3) and P2 (median = 4) (p = 0.4).
**Discussion/Conclusion** The median time to treatment for HIV*, syphilis, gonorrhoea and chlamydia was not significantly different between P1 and P2. Despite gonorrhoea NAAT results being available significantly earlier, the overall time to treatment was not different. This likely relates to the nearly fourfold increase in the detection of gonorrhoea and the additional burden of work for follow-up nurses.

## P009 A REVIEW OF SEXUAL HEALTH CARE ACCESS AND OUTCOMES AMONG WOMEN WHO HAVE SEX WITH WOMEN

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10.1136/sextrans-2016-052718.64

**Background/introduction** Women who have sex with women (WSW) are at risk of sexual ill-health, yet health professionals are ill-informed regarding the range of sexual health issues affecting these women. This ignorance may compound

misconceptions among WSW regarding their risk status and the services available to them. Sexually transmitted infections (STIs), abnormal cervical cytology, and unplanned pregnancy are conditions which are crucially exacerbated by barriers to engagement with health care.
**Aim(s)/objectives** To review the recent literature regarding access to sexual health care among WSW, and discuss some of the indicators of sexual ill-health adversely impacted by barriers to such engagement.
**Methods** Relevant databases (MEDLINE, Embase) were searched using MeSH terms related to sexual health, engagement with health serves, and WSW.
**Results** This review demonstrates that WSW experience several barriers to care, including the heteronormative expectations of health professionals. Studies suggest the prevalence of STIs among WSW is comparable to heterosexual women, while the use of barrier protection is limited. Screening uptake for cervical cancer among WSW remains poor. In addition, sexual minority, sexually active young women are more likely to experience an unplanned pregnancy than their heterosexual peers.
**Discussion/conclusion** The findings with regards to STI risk and unplanned pregnancy highlight the need for targeted interventions to address sexual risk taking behaviour among WSW. Further research should be conducted to examine the effectiveness of such interventions. Furthermore, greater understanding of the sexual health of WSW is urgently required among clinicians to improve care and engagement with healthcare among this population of women.

## P010 MAXIMISING DEPARTMENTAL INCOME; A QUALITY IMPROVEMENT PROJECT FOR IMPROVING HIV TESTING AND CODING

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10.1136/sextrans-2016-052718.65

**Background** BASHH standards recommend that 97% of 1st attenders to GUM services should be offered an HIV test to facilitate prompt diagnosis. This standard now features as a key performance indicator (KPI) in contracts where financial penalties are imposed for non-compliance.
**Aim** 97% of first GUM attendances will be offered an HIV test by August 2015.
**Methods** Quality improvement (QI) methodology was applied and key drivers were identified: 1) Staff: Timetabled administration sessions and training. 2) Communication: Weekly email reminders to staff regarding coding accuracy. 3) Timing: Timely upload of missed HIV codes by reception. 4) Measurement: Performance recorded/reviewed monthly.
**Plan-do-study-act cycles (PDSA) were used** PDSA 1: Computerised administration recall system launched resulting in all clinical administration tasks becoming computerised and accessible from any site across the Trust. Standard Operating Procedures (SOP) developed. Team training. PDSA 2: Reception team briefed/delegated task of uploading missed HIV codes. Weekly email reminders sent to staff. PDSA 3: Administration recall SOPs uploaded to intranet. New staff inductions delivered.
**Results** Prior to introduction of this project only 89% of new attenders were offered an HIV test (May 2014). We have exceeded our aim with 100% offered, avoiding a potential penalty of £19,165 per month, securing £229,980 income over the past 12 months.
**Discussion** Using QI methodology, robust systems can be implemented improving patient care and facilitating meeting KPIs.

## P011 IMPROVING TIME TO TREATMENT; A QUALITY IMPROVEMENT PROJECT FOR RESULTS HANDLING OF NON-STANDARD GUM TESTS

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10.1136/sextrans-2016-052718.66

**Background** Delays to treatment following late non-standard results (NSR) review (e.g. mid-stream urine or radiological tests) by a doctor can cause patient harm. There are on average 10 NSR per week in our department. Prior to this project there was limited governance around clinician review of results with most done in an adhoc way sometimes causing significant delays to treatment (2+ weeks). Verbal communication with staff often did not result in NSR being actioned faster. Patients would often make multiple calls to the results team resulting in poor patient experience.
**Aim** All NSR, once available, will be actioned within 7 days by August 2015.
**Methods** Quality improvement (QI) methodology applied and key drivers identified: 1) Staff: Training, timetabled administration sessions. 2) Communication: Clear roles/responsibilities identified, email communication. 3) Timing: Timely upload of NSR onto recall list by results team. 4) Measurement: Recall list checked daily, NSR remaining recorded.
**Plan-do-study-act cycles (PDSA) were used over six months** PDSA 1: Developed a computerised recall system. Standard Operating Procedures (SOP) written. Team training. PDSA 2: Results team briefed/delegated task of recording remaining NSR. PDSA 3: SOPs uploaded to intranet. Email communication with new staff. SHO induction briefing (every four months).
**Results** We now have on average only one outstanding NSR per week. Verbal communication from the results team has confirmed much improved patient satisfaction.
**Discussion** Through QI methodology and the development of a simple organised governance system, patient care and satisfaction can be improved. Additional PDSA cycles are planned to further service improvement.

## P012 MANAGING MYCOPLASMA GENITALIUM: ARE WE DOING ENOUGH?

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10.1136/sextrans-2016-052718.67

**Background** *Mycoplasma genitalium* (MG) caus+es urethritis in males and cervicitis and PID in females. MG prevalence in the UK is not well understood and frequent use of single dose macrolide antibiotics is driving antimicrobial resistance.
**Methods** From November 2011 to May 2015 selected men with persistent urethritis or proctitis and women with persistent PID

were tested for MG using the Fast-track Diagnostics™ urethritis PCR.

**Results** 461 patients were tested for MG. 30/461 (6.5%) were positive. Median age was 30 years(range 16–53) and more MG-positive males (26/30) than females (4/30) were identified. 1/4 females provided a cervical sample and 3/4 vaginal swabs. Of males, 1/26 provided a penile swab, 3/26 rectal swabs, and 22/26 (84.6%) gave urine samples. All females self-identified as heterosexual. 10/26 (38%) men self-identified as men who have sex with men (MSM); 6/30 (20%) patients were known to be HIV-positive, all of whom were male and 5/6 (83%) were MSM. 9/30 (30%) patients were treated with 1g single dose azithromycin and 5/30 (16.7%) received a regimen of azithromycin 500mg stat followed by 250mg od for 4 days. Tests of cure were done in 13/30 (43.3%). 4/13 (30.7%) remained positive and all received moxifloxacin, which was curative.

**Conclusion** We found MG in symptomatic patients attending our service. Many patients were treated with single dose azithromycin which may be insufficient to clear infection and lead to acquired resistance. Local protocols for persistent urethritis and PID should include routine testing for MG, and newer and better access to diagnostics are urgently needed to support this.

## P013 WHEN IS A HERNIA NOT A HERNIA AND LYMPHOMA NOT LYMPHOMA?

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**Background/introduction** Lymphogranuloma vereneum (LGV) is a relatively common cause of proctitis and other gastrointestinal symptoms in men who have sex with men (MSM). Other symptoms and signs may present and unless a careful sexual history is taken STI may not be considered in the differential diagnosis.

**Aim(s)/objectives** To illustrate the potential for mis/inaccurate diagnosis of groin swellings in sexually active MSM and provide a case that can be used for teaching primary care, surgical, oncology and histopathology colleagues.

**Methods** We present a case of a 55 year old HIV-infected MSM who presented to surgical colleagues with left groin swelling.

**Results** The patient underwent open surgery to repair an inguinal hernia. At surgery he was found to have significant inguinal lymphadenopathy. Histopathological analysis at the regional pathology centre identified a B cell lymphoma and referral was made to a haematologist to start anti-cancer therapy. In the interim the patient attended our GUM service, was diagnosed with rectal LGV and treated with antibiotics. His lymphadenopathy resolved and staging CT was negative.

**Discussion/conclusion** Careful consideration of the differential diagnosis of inguinal swelling should be undertaken and STI excluded prior to general anaesthesia and operative procedures whenever possible. Had this patient not attended his GUM clinic he may have undergone potentially toxic chemotherapy to treat LGV infection. This case serves to illustrate the need for open communication between GUM and other medical colleagues.

## P014 AN AUDIT OF PREVENTION OF MOTHER TO CHILD TRANSMISSION SERVICES WITHIN A ANTENATAL CARE FACILITY IN A RURAL HEALTH CLINIC IN SWAZILAND

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10.1136/sextrans-2016-052718.69

**Background/introduction** Swaziland is recorded to have the world's highest HIV prevalence amongst adults and pregnant women. To address this epidemic Swaziland's Ministry of Health (MOH) has adopted the WHO four pronged approach to reducing new HIV infections in women and children.

**Aim(s)/objectives** To audit whether prevention of mother to child transmission (PMTCT) services at a rural health clinic in Swaziland meets the 2010 MOH targets.

**Methods** Retrospective data was collected for all women accessing ANC services at the clinic from 1st Feb to 25th May 2015 analysis was performed using Microsoft Excel 2013

**Results** 29 women accessed ANC services in this time period, 11 (37.9%) were known HIV positive and a further 4 (22.2%) tested positive at presentation. The clinic achieved a HIV testing rate of 94.4% (target 100%) and a partner testing rate of 11.1% (target 50%). 93.3% (15) of HIV positive women received efficacious antiretroviral therapy (target 97%) and 93.3% (15) of exposed infants were initiated on appropriate prophylaxis (target 95%).

**Discussion/conclusion** This audit has identified areas where action is required for ANC services at the clinic to meet MOH targets. Early HIV diagnosis and partner testing must be prioritised to reduce new born infections. Access to necessary treatment should be improved by establishing links to antiretroviral clinics.

## P015 BASHH MSM SIG CLINIC SURVEY; TESTING AND VACCINATION

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10.1136/sextrans-2016-052718.70

**Background/introduction/Aim(s)/objectives** Our aim was to investigate practice across the UK in aspects of the clinical care of MSM who are HIV negative or of unknown status where evidence is absent, or guidance varies.

**Methods** An online questionnaire was drafted by the MSM SIG, tested by BASHH CGC members, revised and distributed to BASHH, FSRH members and CSP audit sites for one month to 31st October 2015.

**Results** There were 149 complete responses. Only 40% of respondents had a written protocol or policy on recall for HIV/STI testing of which 23% had an automated system to recall patients for testing. 50% routinely test for HIV at syphilis follow up. 90% of respondents report using both NAAT and culture for GC in contacts of gonorrhoea and 20% use both in asymptomatic men. 33% test anatomical sites according to sexual contact history. Self-taken throat (rectal) swabs for GC/Ct NAAT were used never by 26% (3%) and routinely in 18% (22.5%). 100% routinely test MSM for Hepatitis B exposure and over 50% for Hepatitis C. 78% routinely check HepB sAb levels

following vaccination. 79% routinely recall men for Hepatitis B vaccination.

**Discussion/conclusion** There is evidence of variation in clinical practice between clinics in the UK, not all of which can be explained by variations in local epidemiology and some of which has significant cost implications. Results have generated debate in the MSM SIG on the rationale for local policies.

## P016 BASHH MSM SIG CLINIC SURVEY; HOLISTIC AND INCLUSIVE CARE

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10.1136/sextrans-2016-052718.71

**Background/introduction** MSM experience a disproportionate burden of ill health in relation to sexual health, mental health and substance use.

**Aim(s)/objectives** Our aim was to investigate practice across the UK in aspects of the clinical care of MSM where evidence is absent, or guidance varies.

**Methods** An online questionnaire was distributed to BASHH, FSRH members and CSP audit sites for one month to 31st October 2015. Questions covered assessment of risk factors for STIs and HIV and other elements of holistic care.

**Results** There were 149 complete responses. A written policy on obtaining a history of alcohol or recreational drug use was reported by 62% and 66% of respondents respectively. 58% and 57% had a documented pathway for alcohol or drug use problems. 67% had dedicated services for behaviour change interventions, but only 20% had dedicated sexual dysfunction services. HPV vaccination and PrEP were provided in some form (including with charges, or by private prescription) by 13% of clinics, but 58% and 45% reported no local discussion yet on HPV vaccination or PrEP for MSM. Support for local CaSH & Youth services in providing care for MSM was given through a formal arrangement or MCN by 30% of respondents and informally by a further 47%.

**Discussion/conclusion** There is considerable variation in the breadth of clinical holistic care offered across the UK, suggesting missed opportunities to address the interrelated health inequalities experienced by MSM. GUM clinics may be under-utilised as a source of local expertise in the care of MSM.

## P017 ARE WE MISSING OPPORTUNITIES? — A RETROSPECTIVE AUDIT ON LATE DIAGNOSIS OF HIV

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10.1136/sextrans-2016-052718.72

**Introduction** 24% of deaths among HIV-positive adults in the UK are due to late diagnosis of HIV. Many 'late presenters' have previously been seen by healthcare professionals and the diagnosis missed. The study city also has a significantly higher late diagnoses rate (61%) compared to the national rate (45%).

**Aim** To identify: newly- diagnosed HIV positive patients between 2010- 2012; rates of 'late' diagnosis; missed opportunities for testing.

**Methods** Reviewing the case-notes of all newly diagnosed HIV positive residents in the study city, with a CD4 count <350 cells/μl.

National Testing guidelines were used to define the indicators for testing. The primary outcome was 'late' diagnosis (CD4 count <350 cells/μl). The secondary outcome was 'missed opportunity'(failure to diagnose HIV within one month) in the presence of an indicator for testing.

**Results** From 180 new HIV-positive cases reviewed 85 met the case definition of 'late' diagnosis, 38 of which had been diagnosed prior to 2010. Meaning the true number of late diagnosis cases during the audit period was 47 (26%). 14.8% of cases had pre-existing HIV indicators, and 46% of cases had missed opportunities for early diagnosis.

**Conclusions** This audit demonstrates that the actual late-diagnosis rate is lower than that reported previously. There is a high rate of missed opportunities, which warrants increasing the awareness of clinicians and the general population for early detection of HIV, the responsibility for which rests with both clinicians and commissioners.

## P018 EVOLVING CONTRACEPTIVE OPTIONS IN INDIGENOUS COMMUNITIES IN PANAMA

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10.1136/sextrans-2016-052718.73

**Background** Use of contraception in Panamanian indigenous groups is significantly lower than in the general population. Birth-rates in the Ng-be-Buglé group are the highest in the country. A large proportion of the Ng-be-Buglé live in isolated, rural communities with limited sanitation and education facilities and poor access to local health services. A non-governmental organisation (NGO) has been providing primary healthcare to these communities since 2011 and introduced the contraceptive injection in 2013.

**Aims** To assess the level and trends of contraceptive injection use and to identify associated challenges.

**Methods** An observational study of depot medroxyprogesterone acetate (DMPA) use in women attending the NGO clinics was carried out.

**Results** 143 women from 16 communities have used DMPA from the NGO; 46.9% started in the last 6 months. The most common reason for commencing is family completion. Average age at commencing is 27.6 years (range 12–46) and number of children is 4 (range 0–14). Since starting, 13.3% have discontinued use and 25.9% have missed their most recent dose. Missed doses are commonly due to clinic non-attendance. Influence from spouses and misconceptions regarding side-effects are key factors in discontinuation.

**Discussion** Ng-be-Buglé communities are experiencing unsustainable population growth. Contraceptive options available to these communities remain limited. Despite a recent surge in the uptake of DMPA from the NGO, major challenges regarding long-term use and compliance remain. Our ongoing work aims to broaden contraceptive options for these people and includes implementation of a pilot study introducing the contraceptive implant.

## P019 AUDIT ON THE MANAGEMENT OF SEXUAL HEALTH NEEDS OF YOUNG PEOPLE IN AN INTEGRATED COMMUNITY BASED SERVICE

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10.1136/sextrans-2016-052718.74

**Introduction** Our community based integrated service caters to a diverse population within the Slough area with pockets of high deprivation and rising rates of CSE. It is of paramount importance that clinicians are able to identify and risk assess those vulnerable have a valuable tool for documentation.
**Aims and Objectives** This audit was based on the BASHH standards on "Management of STIs and related conditions in children and young people (BASHH 2010)"
**Methods** Retrospective data collection of the first 100 new patients who accessed the service from July – Aug 2014 aged 18 and under from all three sites. The standards of the audit are: Offer of full STI screen (CT, GC, HIV, STS) to sexually active young people-100%. Offered an STI screen-90%. Completions of CSE risk assessment proforma- 100%. Documentation of decision for referral (100% of under 13s, 90% of those aged 16 and under)-100–90%.
**Results** 75% of the attendees were girls and had primarily contraception needs.STI screening was offered to all however the uptake of a full screen was less than 50%. Overall documentation was less than satisfactory and decision to refer was documented in only 15%.
**Conclusions** There are high rates of STI's among young people and risk taking behaviour was noticed in the attendances. Poor attendances among boys and MSM were identified. 50% refused to have screening for BBV and the need of alternative testing methods like the saliva testing was highlighted. A CSE proforma was introduced and all referrals are discussed with the safeguarding lead and audited on a regular basis.

## P020 EVALUATING PATIENT PERSPECTIVES ON CONFIDENTIALITY IN SEXUAL HEALTH CLINICS

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10.1136/sextrans-2016-052718.75

**Background/introduction** Since the introduction of the Venereal Diseases Act in 1917, confidentiality has been a key part of sexual health clinics in the UK. With the repealing of the VD Act, we devised a service evaluation to determine the patient's perspectives on confidentiality.
**Aim(s)/objectives** To determine patient understanding of the confidentiality process in a large inner city integrated sexual health (ISH) clinic.
**Methods** A patient questionnaire was designed and given to ISH clinic patients between 18th of May and 5th of June 2015.
**Results** 163 responses were obtained from the ISH clinic (49% female, 51% male). 89% patients reported confidentiality to be important or very important when attending the ISH clinic, with 97% patients reporting confidentiality to be important or very important in the diagnosis of STI's. With regards to ISH offering a non-judgmental service; 95% patients reporting this to be important or very important. 68% patients reported the importance of ISH clinic records being kept separate from GP and hospital records. 45% patients reported they would not attend their GP for STI testing due to a variety of reasons such as embarrassment, convenience and wanting to attend a specialised service.
**Discussion/conclusion** This study confirms that confidentiality in the diagnosis of STI's and the non-judgemental care that patients receive continues to be important to service users. These factors influence which services patients wish to access for sexual health needs. It is therefore essential that ISH services continue to provide this level of care.

## P021 ABSTRACT WITHDRAWN

## P022 IS INTRAVAGINAL BORIC ACID AN ALTERNATIVE THERAPEUTIC OPTION FOR VAGINAL TRICHOMONIASIS?

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10.1136/sextrans-2016-052718.76

**Background/introduction** Current national guidance recommends treating *Trichomonas vaginalis* (TV) infection with nitro-imidazole therapy. The high prevalence of TV, high rate of metronidazole resistance and limited tolerability to nitroimidazoles when treating TV, suggest that alternative treatment regimens are required. Intravaginal Boric acid (BA) pessaries are available and have been used to safely treat vulvo-vaginal candidiasis and bacterial vaginosis.
**Aim(s)/objectives** We aimed to review the evidence for the safety and efficacy of BA for the treatment of TV.
**Methods** We performed a systematic review, in accordance with Centre for Reviews and Dissemination methods, of the evidence for the use of BA as a topical treatment for TV.
**Results** No randomised controlled trials or case series were found. Case reports provided in vivo evidence that BA safely and effectively treated TV. These cases, in the setting of resistant TV or severe metronidazole allergy, were managed with combination treatment administered over a period of 4 weeks to 5 months using doses of boric acid ranging from 600 mg once a day to 600 mg twice a day. No studies assessed the efficacy of BA in uncomplicated TV infection. In vitro, low concentrations (0.2%) of BA reduced the growth rate of TV, whereas higher concentrations ($\geq$0.4%) were lethal to both laboratory TV strains and clinical isolates, providing evidence that the inhibitory effect of BA on TV is dose-dependent.
**Discussion/conclusion** BA is well-tolerated and has in vitro and in vivo activity against TV. There is limited evidence on the appropriate dosing schedule. There is need for further evaluation in a clinical trial.

## P023 'IT'S ALL ABOUT THE MONEY MONEY MONEY'? OPTIMISING BLOOD INVESTIGATION REQUESTS FOR HIV PATIENTS

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10.1136/sextrans-2016-052718.77

**Background/introduction** In 2010 Quality Innovation Productivity and Prevention (QIPP) was introduced to enable the NHS to provide cost efficient services. The 2013 BHIVA Standards of Care include the need to provide quality cost effective care.
**Aim(s)/objectives** Our aims were to assess whether unnecessary blood tests were undertaken during routine HIV assessments; to ensure minimal patient disruption and cost stewardship.
**Methods** Standards were established using current BHIVA and HIV CRG CD4 blood monitoring guidelines. A retrospective audit was carried out on patients attending for a routine review between the 1st of December 2014 and the 31st of January 2015 who had been on treatment for at least three months. Laboratory medicine cost data was ascertained.
**Results** 41 patient's notes and HARS entries were reviewed, 71%, 90%, and 83% had their CD4 count, full blood count and lipids, respectively, unnecessarily requested. 44%, 39%, 56% of the Syphilis, Hepatitis B and Hepatitis C blood tests respectively, were either not done as per the standards or inappropriately requested. There was a potential cost saving of over £1300 on blood tests where over 30% were unnecessarily requested.
**Discussion/conclusion** Blood monitoring should not be a tick box exercise. Requesting unnecessary blood tests is not only costly but minor changes in the results may lead to unnecessary patient intervention. Clinic proformas can be used as an aid to whether investigations are required. Testing for Syphilis, Hepatitis B and C outside of the recommended standards should be guided by sexual histories taken during consultation.

## P024 CLINICAL CHARACTERISTICS OF HERPES SIMPLEX VIRUS URETHRITIS COMPAERD WITH CHLAMYDIA URETHRITIS AMONG MEN: A CASE CONTROL STUDY

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10.1136/sextrans-2016-052718.78

**Background/introduction** Non-gonococcal urethritis (NGU) in males is a sexually transmitted infection commonly caused by Chlamydia trachomatis and Mycoplasma genitalium. Herpes simplex virus (HSV) has been reported as a causative agent in NGU; however, little is known about its clinical characteristics.
**Aim(s)/objectives** The study compared the clinical characteristics of men with HSV urethritis to those in men with chlamydial urethritis, and determined if there were any key differences.
**Methods** A retrospective case control study comparing the clinical and laboratory findings from men diagnosed with PCR confirmed HSV urethritis with those diagnosed with PCR confirmed chlamydial urethritis, was conducted between 2000 to 2015.
**Results** Eighty HSV urethritis cases were identified: 68% (95% CI 58–78) were HSV type 1 and 32% (95% CI 22–42) were HSV type 2. Compared with chlamydial urethritis, men with HSV urethritis were significantly more likely to report severe dysuria (20% vs 0%, $p < 0.01$) or constitutional symptoms (15% vs 0%, $p < 0.01$) and significantly less likely to report urethral discharge (19% vs 54%, $p < 0.01$). Men with HSV urethritis were significantly more likely to have meatitis (62% vs 23%, $p < 0.01$), genital ulceration (37% vs 0%, $p < 0.01$), and inguinal lymphadenopathy (30% vs 0%, $p < 0.01$).
**Discussion/conclusion** In our study men with HSV urethritis had distinctive clinical features, not usually associated with chlamydial urethritis: severe dysuria, constitutional symptoms, meatitis, genital ulceration and lymphadenopathy. Clinicians should consider HSV when these are present.

## P025 IMPROVING LOCAL SEXUAL HEALTH SERVICES FOR LESBIAN, GAY, BISEXUAL AND TRANS (LGBT) PEOPLE

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10.1136/sextrans-2016-052718.79

**Background/introduction** LGBT people have different care needs to other sexual health clinic attendees. Many STIs are known to disproportionately affect men who have sex with men (MSM). We wished to ascertain how to optimise LGBT, and in particular MSM, service provision by our urban sexual health clinic.
**Methods** 100 questionnaires were completed by attendees to the local Pride event.
**Results** 61 respondents self-defined as female, 34 male, 4 transman and 1 demifem. 27 (20 women, 4 men) stated their sexual partners were both male and female, 38 (12 women, 25 men) had same-sex partners, and 34 (28 women, 5 men) had opposite-sex partners only.

81 had not attended the local clinic. Reasons for this included previously living elsewhere (22), not feeling they required the service (15) or not knowing it existed (9). 67 reported they would like a specific LGBT sexual health clinic, with 63 requesting evening clinics. 9 did not want specific clinics, with 2 respondents citing concerns about discrimination. 61 felt more LGBT sexual health services outside the city centre are needed. Features they would like included web-based bookings (64), home-testing kits (49), pre-exposure prophylaxis (79) and HPV vaccination (69).
**Discussion/conclusion** The questionnaire was successful in capturing opinions of those who hadn't previously attended our service. However it is not possible to ascertain whether views expressed were representative of the local LGBT population as a whole and less than a third were MSM. We will consider developing a specific LGBT service in response to the survey's findings.

## P026 VALUE OF CONTINUING PHARYNGEAL GENPROBE APTIMA COMBO2 TRANSCRIPTION MEDIATED AMPLIFICATON (TMA) TESTING FOR CT/GC IN ADDITION TO UROGENITAL/RECTAL SWABS

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10.1136/sextrans-2016-052718.80

**Introduction** BASHH guidelines say 'consider' Throat swabs (TS)/rectal swabs (RS) in females where history suggests & to test in MSM. We were routinely testing females practicing fellatio & MSM on throat swabs (TS) for CT/GC in addition to the genital/rectal sites.
**Aim** To review testing practices to look at whether TS gave extra positivity & whether it was cost effective.

**Method** Retrospective extraction of data for all CT/GC TMA testing between 2011–2014, and analysis of selected records where TS & urogenital ± rectal sites sampled at the same visit.
**Results** CT was detected on TS from 1.2% of female (adding 8 extra cases), and from 0.76% of MSM (adding no extra cases) GC was detected on TS from 0.76% of females (adding 9 extra cases), and from 3.0% of males (adding 3 extra cases) In a subset of 251 females who had RS, GC was detected on TS from 3.6% adding 5 extra cases to the 4 urogenital/rectal diagnoses.
**Conclusions** In diagnosis of CT infection, TS find only a few extra male & female cases For GC infection TS did increase the number of diagnoses (females from 12 to 21, males from 17 to 20). Whilst GC testing by TMA adds no cost to a genital sample which is already being tested for CT, a throat swab which is an extra sample has to be charged at full price by the Laboratory. Perhaps full price testing of TS can only be justified for groups with higher than average GC diagnoses such as MSM (3.0%) or females with an indication for a rectal testing (3.6%).

## P027 A QUALITATIVE STUDY EXPLORING THE POTENTIAL INFLUENCES OF SEXUALITY, GENDER IDENTITY, AND OCCUPATION ON HEALTH STATES AND ENGAGEMENT WITH HEALTHCARE AMONG LGBTQIA$^+$ SEX WORKERS IN NEW ZEALAND

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10.1136/sextrans-2016-052718.81

**Background/introduction** The stigma an individual experiences in relation to their occupation, gender identity, or sexuality adversely influences health and well-being. There is however, limited literature which explores the joint influence of both sex work (a highly stigmatised occupation), and a sexual minority identity on health states and engagement with services. Preliminary work suggested that such individuals face greater risk of ill-health, and of experiencing barriers to care.
**Aim(s)/objectives** To explore how LGBTQIA$^+$ sex workers perceive their occupation, sexuality, and gender identities influence their health states and access to health care.
**Methods** Semi-structured phone interviews were conducted with sex workers who self-identified as LGBTQIA$^+$. Purposive sampling of participants ensured individuals were diverse in their sexuality, gender identity, and type and duration of sex work experience. The data collected during these interviews was analysed using a thematic approach.
**Results** Seven interviews were conducted. It was apparent that continuing social stigma directed towards sex workers and members of the LGBTQIA$^+$ community perpetuates occupational hazards and acts as a barrier to accessing healthcare. The positive influences of a community of stigmatised peers in promoting engagement with health services was explored, including community information sharing networks and providing specific services inclusive to the needs of LGBTQIA$^+$ sex workers.
**Discussion/conclusion** Whilst decriminalisation has reduced the stigma faced by many sex workers in New Zealand, disproportionate discrimination persists among those who identify as LGBTQIA$^+$, negatively impacting health states. The utilisation of peer networks promoting access to healthcare within this community is requiring of further research.

## P028 DO WE REALLY NEED TO SEND AN MSU?

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10.1136/sextrans-2016-052718.82

**Background/introduction** Midstream urine (MSU) results create a significant workload for our clinic. MSU can diagnose urinary tract infection (UTI), but detecting asymptomatic bacteriuria or contaminants confuses management. Lower UTI is common in non-pregnant women, but MSU is unnecessary as UTI can be diagnosed clinically. Local guidelines identified four indications for MSU: women with dysuria and loin pain, urinary symptoms in pregnancy, men with dysuria and frequency/urgency, and epididymo-orchitis.
**Aim(s)/objectives** To assess whether MSU is requested for appropriate indications, and to evaluate the usefulness of MSU in diagnosing and managing patients in a sexual health clinic.

**Abstract P026 Table 1** Throat swab results

| Urogenital/rectal diagnosis | Females: Throat swab results | | | | Males: Throat swab results | | | |
|---|---|---|---|---|---|---|---|---|
| | Neg | Pos | Total | % Positive | Neg | Pos | Total | % Positive |
| CT Negative | 2039 | 8 | 2047 | 0.39 | 240 | 0 | 240 | 0 |
| CT Positive | 133 | 18 | 151 | 11.9 | 21 | 2 | 23 | 8.6 |
| Total urogenital/rectal | 2172 | 26 | 2198 | 1.2 | 261 | 2 | 263 | 0.76 |
| % Positive | | | 6.9 | | | | | 8.8 |
| GC Negative | 2206 | 9 | 2215 | 0.41 | 246 | 3 | 249 | 1.2 |
| GC Positive | 4 | 8 | 12 | 67 | 12 | 5 | 17 | 29 |
| Total urogenital/rectal | 2210 | 17 | 2227 | 0.76 | 258 | 8 | 266 | 3.0 |
| % Positive | | | 0.53 | | | | | 6.4 |

**Methods** Retrospective case note review of 100 MSU requests at a sexual health clinic between 2014 and 2015. The associated clinical presentations and culture results were identified.
**Results** 14% of MSU were requested within guidelines. 29% (4/14) of those were positive, compared to 22% (19/86) not requested within guidelines. Indications outside guidelines associated with positive culture included: women with lower urinary tract symptoms (11), men with dysuria only (3), pelvic inflammatory disease (2), asymptomatic with positive urine dipstick (2), and vaginal discharge (1). 15/23 were sensitive and 8/23 were resistant to trimethoprim.
**Discussion/conclusion** MSU is often requested inappropriately. This generates positive results associated with clinical presentations unlikely to indicate UTI. Greater awareness amongst clinicians of appropriate indications for MSU will support optimal resource utilisation in sexual health clinics. Resistance to our first line antibiotic, trimethoprim, was identified. Resistance patterns should be monitored so clinicians can confidently prescribe empirical treatment for lower UTI in non-pregnant women.

## P029 HIS-UK CONDOM STUDY: AN INTERVENTION DEVELOPMENT STUDY WORKING WITH YOUNG MEN TO IMPROVE CONDOM USE SKILLS AND ENHANCE CONDOM USE EXPERIENCES

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10.1136/sextrans-2016-052718.83

**Background** The Kinsey Institute® Homework Intervention Strategy (KIHIS), designed to improve condom skills, enjoyment and self-efficacy, has demonstrated early evidence of efficacy in U.S. studies. The KIHIS places the impetus for change on the individual through solitary practice: experimenting with different condoms/lubricants; identifying best 'fit & feel'; and focusing on physical sensations.
**Aim(s)/objectives** To identify behaviour change techniques (BCTs) in KIHIS; to adapt and develop KIHIS for the UK context; to manualise and evaluate HIS-UK.
**Methods** Literature synthesis to identify additional BCT components and methods of delivery to address condom fit and feel. Stakeholder and user consultation through qualitative interviews (n = 15 men aged 16–25); advisory groups (e.g. consultants, commissioners); workshops (e.g. health promotion professionals)
**Results** Searches of online databases, July 2015, identified 1044 condom use intervention studies published since 2006; of these, 123 studies tested the effectiveness of behavioural interventions on condom use in high income countries – and only five targeted 'fit & feel' issues. In total 22 BCTs were identified, 16 of which were selected for inclusion in HIS-UK. Consultations have demonstrated enthusiasm for this 'fit & feel' approach, have enabled us to gauge UK preferences (e.g. condom kit contents) and have informed adaptation of the intervention.
**Discussion** This work ensures that the targeted outcomes, behaviour determinants and proposed mechanisms of action for HIS-UK are specified, so that future conclusions can be drawn about what works and why. An adapted and manualised intervention is currently being piloted for viability and operability among 50 men aged 16–25 years.

## P030 DEVELOPMENT, IMPLEMENTATION AND EARLY EVALUATION OF A PILOT CERVICAL SCREENING CLINIC FOR WOMEN WHO HAVE BEEN SEXUALLY ASSAULTED

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10.1136/sextrans-2016-052718.84

**Background** One in five women does not attend for cervical screening when invited. This includes those who have experienced sexual violence, putting them at increased risk of cervical cancer. A pilot clinic was set up in partnership with the My Body Back Project (MBB). MBB supports women who have been raped to regain confidence and control of their body and health. The clinic offers cervical screening and STI testing for these women with a multidisciplinary collaboration between doctor, nurse, psychologist and MBB advocate as facilitator. It aims to provide time, space, shared control and understanding of the particular difficulties faced.
**Aim** To evaluate acceptability and uptake of a pilot cervical screening clinic for women with a history of sexual assault.
**Methods** Questionnaires were collected from women attending between August and December 2015.
**Results** 30 women attended (median age 34.4years). 48.3% had never been screened and 72.4% were significantly overdue.

**Abstract P030 Table 1** Cytology results

| Cytology result | Cytology at visit 1 (N = 26*) | Cytology at visit 2 (N = 3) | Total (%) smears taken |
|---|---|---|---|
| Negative | 21 | 2 | 23 (79.3) |
| Unsatisfactory | 1 | 0 | 1 (3.4) |
| Borderline HPV+ | 1 | 0 | 1 (3.4) |
| Results pending | 3 | 1** | 4.13.8) |
| No cytology taken | 2*** | 0 | X |
| TOTAL | 26 | 3 | 29 (100) |

*1 women did not attend their appointments
**repeat smear for the unsatisfactory result at visit 1
***1 woman could not tolerate the examination and 1 was an inappropriate doctor's referral having been raped within the last month

Feedback showed 96.7% of women found the clinic very useful, the advocate helpful and felt understood. 86.2% found the smear taker and psychologist together helpful and 100% would recommend the service. Confidence in their ability to have a smear increased from slightly/in some situations before their examination to in some/most situations afterwards. Common qualitative themes included not feeling rushed, feeling in control and having needs understood.
**Discussion/conclusion** The uptake, waiting list and feedback from women suggest that this is a necessary and appreciated clinic. Further evaluation is required in order to improve and sustain the service.

## P031 ESTIMATING LOCAL CHLAMYDIA INCIDENCE AND PREVALENCE USING SURVEILLANCE DATA

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**Background/introduction** Understanding patterns of chlamydia prevalence is important for addressing inequalities and assessing interventions. Population-based surveys are expensive; the best UK data come from the Natsal national surveys which are only available once per decade and not powered to compare prevalence in different localities. Estimates at finer spatial and temporal scales are required.
**Aim(s)/objectives** We aimed to estimate chlamydia prevalence from numbers of tests and diagnoses reported in surveillance data.
**Methods** Our method is based on a simple model for the infection, testing and treatment processes and informed by the literature on infection natural history and treatment seeking behaviour. By combining this information with surveillance data we obtain estimates of chlamydia screening rates, incidence and prevalence. We validate and illustrate the method by application to national and local-level data from England.
**Results** Estimates of national prevalence by sex and age group agree with results from the Natsal-3 survey. They could be improved by additional information on the number of diagnoses that were symptomatic. There is substantial local-level variation in prevalence, with more infection in deprived areas. Incidence in each sex is strongly correlated with prevalence in the other. Importantly, we find that positivity (the proportion of tests which were positive) does not provide a reliable proxy for prevalence.
**Discussion/conclusion** This approach provides a powerful tool to identify prevalence trends with time and location, and understand the effects of control strategies. Estimates could be more accurate if surveillance systems recorded which patients were symptomatic and the duration of symptoms before care-seeking.

## P032 DEVELOPING A SECTOR LED IMPROVEMENT APPROACH TO SEXUAL HEALTH

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10.1136/sextrans-2016-052718.86

**Background** Sector-led improvement (SLI) is an approach where local authorities (LA) help each other to continuously improve. It is replacing more traditional performance frameworks, however, the approach lacks a clear methodology. We developed and piloted an evidence-based SLI approach to drive improvements in sexual health (SH) within LAs.
**Aim(s)** To develop and pilot an evidenced-based SLI toolkit
**Methods** Key components for effective SLI were identified following a review of the published literature. These were embedded within a co-produced, peer-review toolkit which was piloted by SH commissioners and key stakeholders from four local authorities. The pilot focussed on delivery of local chlamydia screening programmes.
**Results** Several key clinical and structural issues were identified through the SLI approach including low coverage, the potential to improve partner notification outcomes, low re-testing rates, threats from a reduction in spend and unclear governance. These have been put into a local action plan to focus and drive quality improvement activities. The impact of the action plans will be the focus of a follow up meeting planned for six months after the final peer review meeting involving wider stakeholders.
**Discussion** The SLI toolkit offers a systematic approach to evaluating complex programme activities. It was well received locally and helped key stakeholders to gain insight, catalyse self-reflection and prioritise areas for change in order to drive quality and improvement.

## P033 SAFETY FIRST: COMBINED ORAL CONTRACEPTIVE PRESCRIBING IN PRIMARY CARE

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10.1136/sextrans-2016-052718.87

**Background/introduction** 80% of contraceptive care occurs in the general practice (GP) setting. UK Medical Eligibility Criteria (UKMEC) provides clear guidelines for the safe provision of appropriate contraception. The Faculty of Sexual and Reproductive Health (FSRH) and the National Institute of Clinical Excellence (NICE) offer further recommendations for combined oral contraceptive pill (COCP) initiation and continuation.
**Aim(s)/objectives** To establish if primary care COCP prescribing was compliant with national safety and best practice guidelines.
**Methods** The EMIS database of an average size, inner city GP surgery was used to analyse COCP consultations between 11/10/2015 and 11/01/2016.
**Results** 56 women aged 14–39 years were prescribed the COCP. In 41% of consultations there was substandard documentation of medical eligibility.

**Abstract P033 Table 1** UKMEC

| UKMEC Condition | % Consultations Lacking Documentation |
|---|---|
| Venous thromboembolism | 28% |
| Smoking status | 25% |
| Blood pressure | 16% |
| Body mass index | 16% |

The COCP was prescribed without specialist input for three patients with a UKMEC 3 condition: systolic blood pressure 143, undiagnosed breast lump and first degree family history of venous thromboembolism. 87% patients did not receive advice about missed pill rules; and 21% of eligible women were not advised on the benefits of long acting reversible contraception (LARC). Only 8% of patients were risk assessed for sexually transmitted infections (STIs) and no women were offered HIV screening.

**Discussion/conclusion** The safety of COCP prescribing could be enhanced by improved application of UKMEC criteria. Promotion of safe sex was not undertaken despite high incidence of STIs and local availability of LARC options.

## P034 ACCESS TO SEXUAL AND REPRODUCTIVE HEALTH IN THE CALAIS "JUNGLE CAMP" FOR WOMEN. A VOLUNTEER PERSPECTIVE

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10.1136/sextrans-2016-052718.88

**Background/introduction** The number of women in the "jungle" camp in Calais, France increased in 2015 but definitive numbers are unknown. Health services report these women are a difficult to access population. Multiple small groups of grassroots volunteers support initiatives in the camp and have access to vulnerable groups.
**Aims/objectives** To survey volunteers opinions on access to sexual and reproductive health (SRH) care in the "jungle" camp

and protection against sexual and gender based violence (SGBV) for women.

**Methods** We designed an online survey and posted it on grassroots volunteer social media groups in November 2015.

**Results** 32 volunteers responded to our survey. Most 20/32 (63%) were short term volunteers working in a healthcare capacity n = 14/28 (50%). The average age of women reported by volunteers was 18-25 (65%). 19/28 (68%) of volunteers had encountered pregnant women and 4/29 (15%) said women disclosed sexual assault in the camp. 21/28 (75%) of the volunteers did not know how to refer women to sexual assault services. 100% of the volunteers reported inadequate protection and security measures against SGBV.

**Discussion/conclusion** There is inadequate security in the "jungle" camp and sexual violence has been described. As the number of makeshift transit camps continues to increase throughout Europe in the current refugee crisis, it is imperative that the minimum standards of SRH are met and that there is adequate security in place to protect against SGBV.

## P035 IMPROVING QUALITY OF PATIENT CARE IN A SRH SERVICE: INTRODUCTION OF ENDOMETRIAL BIOPSY FOR WOMEN WITH PERSISTENT BLEEDING PROBLEMS

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10.1136/sextrans-2016-052718.89

**Background/introduction** National Institutes of Clinical Excellence (NICE) recommends to undertake endometrial biopsy (EB) sample in cases of persistent intermenstrual bleeding and in woman aged 45 or over with failed or ineffective treatment of heavy menstrual bleeding. Since January 2015 we introduced EB in our sexual health clinics.

**Aim(s)/objectives** The aim was to perform a transvaginal ultrasound (TVS), undertake sexually transmitted infection (STI) screen and offer MIRENA®-IUS or other treatment options for persistent bleeding problems. This one-stop-service was meant to decrease referrals to the gynaecological service and improve a patient's journey.

**Methods** Retrospective analysis of all patients who underwent an EB over the past year was performed. Inclusion criteria were those specified by NICE. The exclusion criterion was postmenopausal bleeding.

**Results** Out of 300 patients who had a TVS (for bleeding or pain), 37 qualified for an EB. 8% of patients had additional risk factors for endometrial cancer. 2 patients had a positive STI screen and were treated. 11% of patients had chronic endometritis on EB and the rest of the biopsies were negative. 54% of patients had a MIRENA®-IUS inserted at the same visit. 78% of patients were discharged on the same day of consultation.

**Discussion/conclusion** Our study demonstrates that irregular bleeding problems in women presenting to sexual health clinics can be managed effectively in the same sitting. The clinician needs to be trained in TVS and EB procedures. This reduces the number of women referred to the gynaecological department for persistent bleeding problems.

## P036 AUDIT OF ORAL CONTRACEPTIVE PRESCRIBING IN PATIENTS WITH CARDIOVASCULAR RISK FACTORS

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10.1136/sextrans-2016-052718.90

**Background/introduction** Foundry Lane Surgery has a practice population of 6,564 serving a young population with the high levels of deprivation, smoking and obesity.

**Aim(s)/objectives** To determine if any patients fulfilling UKMEC 3 or 4 due cardiovascular risk factors or a combination of two or more cardiovascular risk factors were prescribed COCP during the 6 month period 11th July 2015 to 11st January 2016.

**Methods** Reports were run on practice software *SystemOne* producing lists of patients who were prescribed COCP in the study period and also fulfilled UKMEC 3 or 4 criteria based on cardiovascular risk factors.

**Results** 201 patients were prescribed COCP in the study period under analysis. 3 individual patients (1.49%) were identified who were prescribed COCP in this period despite fulfilling criteria for UKMEC 3 or 4. One patients who received COCP for reasons other than contraception was excluded along with one patient for whom POP was deemed unsuitable due to porphyria. Three patients were identified who received COCP in spite of UKMEC 3 or 4. Two fulfilled UK MEC 3, one due to BMI > 35, one due to a combination of smoking and age > 35. One patient fulfilled UKMEC4 (BMI > 35 & smoker).

**Discussion/conclusion** Three patients (1.49%) were prescribed COCP in spite of fulfilling UKMEC 3 or 4. In two out of three of these patients a combination of risk factors was responsible. Practice IT systems could be optimised to alert prescribers of contraindications such as BMI, hypertension and smoking.

## P037 MEN WHO HAVE SEX WITH MEN, WHO ARE DIAGNOSED WITH A SEXUALLY TRANSMITTED INFECTION, REPORT SIGNIFICANTLY MORE CHEM-SEX: A CASE CONTROL STUDY

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10.1136/sextrans-2016-052718.91

**Background/introduction** The sexualised use of recreational drugs (Mephedrone, GBL/GHB, Crystal Meth) is thought to be associated with STI acquisition however there is little data showing a direct relationship.

**Methods** We reviewed 130 cases of MSM with an STI attending our STI service and 130 controls (MSM attending the STI service who did not have an STI) between 5th May 2015 and 2nd Nov 2015 (6 months). We collected demographic data, sexual behaviour, drug use and STI diagnoses.

**Results** In the 6-month period there were 5,013 appointments with MSM. Reported condom-less anal sex was significantly higher in cases 90/121 (74%) compared with controls 65/122 (53%); ($X^2 = 11.71$, $p < 0.005$, OR 2.54). HIV prevalence was significantly higher in those with STIs: 71/130 (55%) compared to those without STIs 33/130 (25%); ($X^2 = 23.14$, $p < 0.001$, OR 3.53). Recreational drug use in the cases 38/122 (31%) was significantly greater than in controls 20/125 (16%); ($X^2 = 7.88$, $p < 0.005$, OR 2.37). In total Mephedrone was the most commonly used drug, followed by GBL/GHB.

**Discussion/conclusion** This data demonstrates a clear correlation between STI acquisition and recreational drug use in Men who have sex with men. Interventions to reduce party drug use should be implemented on an individual, local and national level to improve the sexual health of MSM, including reducing risk-taking behaviours.

## P038 HIV HOME/SELF-TESTING: A PILOT PROJECT AND SERVICE EVALUATION

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10.1136/sextrans-2016-052718.92

**Background/introduction** Early HIV diagnosis prevents morbidity, mortality and transmission. UK 2014 figures show 40% of new diagnoses were "late" and estimate an HIV positive population of 103,700, with 17% remaining undiagnosed. Innovative testing approaches may help. Home/self-testing kits became available for UK purchase in April 2015. We describe a free online HIV home/self-testing project.
**Aim(s)/objectives** To determine feasibility/acceptability of HIV home/self-testing
**Methods** OraQuick Advance HIV1/2 Rapid Antibody Tests (using oral fluid for immediate self-testing) were requested online by individuals who confirmed studying the testing information and demonstration video. Postal kits included a username/password to allow completion of a feedback form, plus an out-of-hours mobile number for immediate support. £282.28 was spent on targeted Facebook advertising. (OraQuick Advance is not a CE marked home/self-testing kit. The MHRA were consulted and due to particular specifics of our programme an additional CE mark/formal notification was not required.)
**Results** Between 21/05/2015–08/02/2016, 513 kits were posted [394 (77%) males, 119 (23%) females; 352 (72%) urban, 135 (28%) rural]. Two new HIV diagnoses were identified (2/513 = 3.9/1000, compared with 1.9/1000 overall UK HIV prevalence, 2014). Partner notification produced one further HIV diagnosis. Ninety-eight (19%) feedback forms were completed; 19 females/79 males. Of the 79 males, 58 (73%) were men who have sex with men (MSM). Forty-six (47%) had never tested previously; 25/58 (37%) MSM had never tested. When asked why they chose this test, 26 said fast result, five no blood required and 67 no appointment/consultation.
**Discussion/conclusion** HIV home/self-testing is highly acceptable to those choosing it and can reach previously untested individuals.

## P039 USING PSYCHOSOCIAL AND SOCIO-DEMOGRAPHIC CORRELATES OF SEXUAL RISK AMONG WOMEN IN BRITAIN, TO TARGET SERVICES IN PRIMARY CARE: EVIDENCE FROM NATSAL-3

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10.1136/sextrans-2016-052718.93

**Background** In primary care settings it can be difficult to identify which women would benefit from contraceptive advice and supply (CAS) and sexually transmitted infection (STI) testing without asking sensitive questions about sexual behaviour. Psychosocial and socio-demographic questions may offer an acceptable alternative.
**Aim** To identify psychosocial and socio-demographic factors associated with reporting key sexual risk behaviours among women aged 16–44 years in the British general population.
**Methods** We analysed data from 4,911 heterosexually-active women aged 16–44 years, who participated in Natsal-3, undertaken 2010–2012. Using multivariable regression we explored associations between the available psychosocial and socio-demographic variables and reporting of 3 key sexual behaviours indicative of clinical need: 2+ partners in the last year (2PP); non-use of condoms with 2+ partners in the last year (2PPNC); non-use of condoms at first sex with most recent partner (FSNC).
**Results** After adjustment, weekly binge drinking (6+ units on one occasion), early sexual debut (<16 years), younger age and renting (rather than owning) a home, remained associated with 2PP, 2PPNC and FSNC. Sexual identity and partner ethnicity were not associated with any of these behaviours. Current relationship status and reporting drug use (ever) were associated with 2PP and 2PPNC but not with FSNC.
**Discussion** These analyses indicate psychosocial factors and socio-demographic factors may be useful in targeting CAS and STI testing. A large cross-sectional survey is now underway determine the extent of sexual risk explained by these factors among women presenting in primary care and their acceptability in those settings.

## P040 REDUCING THE LATE DIAGNOSIS OF HIV – WHERE ARE WE? AN EXPERIENCE FROM A COUNTY PERSPECTIVE

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10.1136/sextrans-2016-052718.94

**Background/Introduction** HIV is a treatable medical condition, and death rates are similar to other long term conditions if the patient is diagnosed early enough for anti-retroviral therapy to have any meaningful effect and if the patient is adherent to their antiretroviral therapy. A late diagnosis is defined as a new HIV diagnosis with a CD4 count of <350 cells/mm$^3$, or an AIDS-defining illness.
**Aim(s)/objectives** Identify the numbers of late HIV diagnoses made over a five year period in a county with low prevalence. Educate hospital junior doctors & GPs about the consequences of a late diagnosis of and when to test for HIV.
**Methods** The numbers of positive HIV tests were obtained, plus the patients' CD4 count at the point of a positive HIV test over a five year period. Patients were included or excluded based on the following criteria. Included: over 18; new diagnosis of HIV within secondary care; CD4 count <350/AIDS defining illness. Excluded: antenatal testing, occupational health test; GP testing.
**Results** Fourteen patients identified. 12/14 were heterosexual white British males 11 of whom were diagnosed in hospital and mostly admitted under the acute medics. CD4 counts ranged from 0.01 to 475 with a mean count of 224 cells/mm$^3$.
**Discussion/conclusion** As a direct result of the talks delivered presenting the findings of the project, at the time of writing, two major changes in practice have occurred and there is closer collaboration between the hospital physicians, microbiology lab and the HIV consultants. A poster has been designed and is now found in numerous hospital sites.

## P041 2 PAEDIATRIC CASES OF HIV RELATED COMPLICATIONS IN SOUTHERN AFRICA

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10.1136/sextrans-2016-052718.95

**Background/introduction** Southern Africa has some of the highest rates of HIV with a prevalence of over 10% in the adult population. As we enter the second decade of the epidemic over 17.1 million people in southern and eastern Africa live with the disease. In Zambia around 100,000 children under the age of 14 and in Malawi an estimated 170, 000 children have HIV.
**Aim(s)/objectives** Case study of 2 paediatric patients in Southern Africa with diagnosis of HIV related complications.
**Methods** Individual cases were examined and followed up.
**Results** An 8 year old girl, is seen in rural Zambia with new diagnosis of HIV, moderate malnutrition, septic wounds and cough. She lives far from a rural hospital and during wet season is unable to cross the river to attend follow up. A 14 year old boy in rural Malawi is seen with severe malnutrition, HIV treatment failure after late diagnosis, chronic abdominal pain due to 3TC pancreatitis and new neurology. The family refuse to attend the palliative care team at central hospital.
**Discussion/conclusion** Zambia currently has an estimated ART coverage of 72%. Whilst this seems like excellent progress the child vs adult breakdown shows that only 26% of children with HIV have access to treatment compared to 84% of adults. In Malawi 51% of adults with HIV are on ART but only 30% of children receive therapy and 30% of paediatric cases receive a diagnosis of HIV within first 2 months of life. These cases explore the inequalities that children face with late diagnosis of HIV.

## P042 MSM SCREENING IN SAUNAS – IS IT WORTH IT?

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10.1136/sextrans-2016-052718.96

**Background** Commissioners requested STI screening for MSMs attending male-only saunas in an effort to reduce HIV late diagnosis and engage hard-to-reach clients. Similar schemes have been successfully described elsewhere.
**Aim** Examine success of sexual health screening (SHS) and health promotion for 'high risk' MSM in saunas. We examined infection rate and proportion of individuals who were not accessing services elsewhere.
**Methods** Two saunas were visited monthly over 16 months by senior nursing staff. All attendees were offered a full SHS (HIV, STS, Hep B, GC, CT) and safer sex advice. Symptomatic individuals were signposted to main GUM clinic. We collected demographics and data on previous clinic attendance.
**Results** Results are outlined in Table 1. One symptomatic patient was signposted to the GUM clinic. Health promotion was provided to all.

**Abstract P042 Table 1** MAM screening in saunas

| Total Screened | Age range (yrs) | Accessed mainstream services | Sexuality | HIV/STS testing | Positive results | |
|---|---|---|---|---|---|---|
| 30 | 22–76 (mean 50) | 19 (63%) | 26 Gay (87%) 4 Bisexual (13%) | 26 (87%) | Chlamydia | 0 |
| | | | | | Gonorrhoea | 3 (10%) |
| | | | | | HIV | 0 |
| | | | | | Syphilis | 0 |

**Discussion** 64 hours of staff time were used (total cost £2,632 – not including lab costs). Small numbers were seen, with an overall 10% positivity rate for STIs and no new HIV diagnoses. Many regular attendees declined repeat screening as they perceived themselves to be at low risk. We concluded that supplying condoms/lubrication and prominently displaying health promotion literature was a more effective way of engaging with this group in terms of both time & cost.

## P043 FLOW CYTOMETRIC CELL COUNTS: NOT PERFECT? (HOW GETTING A CALCULATOR OUT CAN SUGGEST AN ANOMALOUS RESULT)

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10.1136/sextrans-2016-052718.97

**Background/introduction** HIV patients have their CD4 counts measured regularly using flow cytometry, 'single platform' measurement being the current standard. Recently, two HIV patients attending for routine follow up blood tests showed unexpectedly low CD4 counts compared to previous results. Using the patients' total lymphocyte counts (obtained from contemporaneous testing on a haematology analyser) and CD4% (from the flow cytometry report), we calculated a more expected result. This prompted a review of our CD4 counts comparing single and dual platform results.
**Aim(s)/objectives** To identify any anomalous results when comparing flow to calculated CD4s.
**Methods** Fifty-nine CD4 counts from 38 HIV patients (27 males and 11 females) attending clinic for routine bloods from 18/01/2015 to 09/02/2016 were reviewed.
**Results** The table shows the comparison between the dual platform CD4 and the single platform CD4. The two patients that triggered the query are in green (male) and red (female). The sequential before/after CD4 counts for the male patient (pale green) and the female patient (pale pink) are also highlighted on the table.
**Discussion/conclusion** Reassuringly, statistical analysis showed very close correlation between the two methods, apart from the two odd results. Previous and subsequent counts in these two patients were normal, as expected. Twenty years ago only the percentage was available so absolute number was calculated using the simple method: lymphocyte count × CD4%. As usual in medicine, no methodology is perfect. Unexpected results should be questioned and, if necessary, repeated, especially if important therapeutic decisions depend on them.

## P044 PEP/PEPSE REAUDIT - WHOSE NOTES ARE THEY ANYWAY? – THE DATA PROTECTION ACT RESTRICTING CLINICAL AUDIT

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10.1136/sextrans-2016-052718.98

**Background/introduction** Post Exposure Prophylaxis (PEP) is prescribed to patients presenting with a history of occupational or sexual exposure to HIV infection. The British Association for Sexual Health and HIV (BASHH) published new clinical guidelines on PEP following Sexual Exposure (PEPSE) in 2015.

**Aim(s)/objectives** To audit occupational PEP/PEPSE related attendances in a sexual health clinic (SHC) in 2015 and compare to a previous audit (2011–2013).
**Methods** A retrospective case note review of patients attending in 2015 for PEP/PEPSE. Clinical records were unavailable for patients attending prior to April 2015 due to the SHC contract transferring to a new provider.
**Results** A total of 8 patients attended for PEPSE, two were initiated in A&E, 1 in a Sexual Assault Referral Centre (SARC) and 4 in the SHC. All patients attended after sexual exposure, with none attending after needle stick injury. All patients were started on PEPSE within 72 hours, had baseline HIV test and STI screen. All had PEPSE prescribed within the recommended indications compared to 88% previously. Fifty percent finished PEP course whilst 25% had a documented HIV test 4–6 weeks post PEP.
**Discussion/conclusion** Issues around clinical record ownership have been interpreted differently across trusts. Locally, when the provider for the SHC changed, minimal patient record information was transferred to the new trust. This limited access contributed to small audit numbers. Compared to previous audit smaller numbers of patients finished the PEP course and attended for follow up HIV test but clinicians have a greater understanding of recommended indications for PEPSE.

## P045 SWITCHING FROM BOOSTED ATAZANAVIR (ATV) PLUS FTC/TDF TO A TAF-BASED SINGLE TABLET REGIMEN (STR): WEEK 48 DATA IN VIROLOGICALLY SUPPRESSED ADULTS

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10.1136/sextrans-2016-052718.99

**Background/introduction** Tenofovir alafenamide (TAF) is a tenofovir prodrug that contains elvitegravir 150mg/cobicistat 150mg/FTC 200mg/TAF 10mg (E/C/F/TAF).
**Aim(s)/objectives** This study assessed efficacy and possible bone and renal safety advantages in patients who switched from a TDF-based regimen to E/C/F/TAF.
**Methods** Virologically suppressed (HIV-1 RNA < 50 copies/ml) adults on a TDF-based regimen for at least 96 weeks were randomised 2:1 to switch to open label E/C/F/TAF or to continue their prior regimen. At baseline, the median CD4 count was 658 cells/uL, the median eGFR(Cockcroft-Gault) was 103.8 mL/min and 10.6% of patients had baseline proteinuria of at least 1+ on dipstick analysis.
**Results** At Week 48, 390/402 (97.0%) of those who switched to E/C/F/TAF and 183/199 (92.0%) of those continuing boosted ATV plus FTC/TDF had HIV-1 RNA < 50 c/mL (difference, 5.1%; 95% CI: 0.9% to 9.2%). No patients had virologic failure with resistance. In patients who switched, hip and spine bone mineral density (BMD) improved significantly, and proteinuria and specific tubular proteinuria also improved significantly Serum creatinine mean change (µmol/L) from baseline: E/C/F/TAF, +0.88; ATV+ FTC/TDF, +3.54 (p = 0.003). E/C/F/TAF patients had statistically higher changes from baseline in fasted lipid tests; the median change in total cholesterol: HDL ratio was: E/C/F/TAF, +0.2; boosted ATV+FTC/TDF, +0.0 (p = 0.001).
**Discussion/conclusion** At Week 48, patients who switched from a boosted ATV+FTC/TDF regimen to E/C/F/TAF had a significantly higher rate of virologic control, had significant improvements in hip BMD, spine BMD and in serum creatinine, and also had significantly less proteinuria than those continuing on their TDF-based regimen.

## P046 A NEW APPROACH TO QUANTIFYING HEALTH ADVISER INPUT IN A RE-COMMISSIONED SEXUAL HEALTH SERVICE

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10.1136/sextrans-2016-052718.100

**Background/introduction** With sexual health services going out to tender, commissioning intentions have prioritised health promotion and prevention strategies. Whilst these activities are currently performed they have been difficult to quantify. Consequently, new codes have been devised to register face to face and telephone input for a) counselling/support/safeguarding issues face to face (HCSF) b) counselling/support/safeguarding via telephone interaction (HCST), c) Health education/health promotion or advice face to face (HEF) d) Health education/health promotion or advice via telephone interaction (HET) e) partner notification face to face (HPNF) and e) partner notification via telephone interaction(HPNT)
**Aim(s)/objectives** To ascertain whether the newly devised codes have been integrated into routine service
**Methods** Case notes were analysed over a 3 month period to ascertain, the frequency of use of such codes
**Results** 37 case notes had input as regards counselling/support/safeguarding face to face (HCSF). 14 had such input via telephone. 75 case notes had input as regards health education/health promotion (HET) face to face, 94 had such input via telephone. 66 case notes had input as regards partner notification face to face, 43 had this via telephone.
**Discussion/conclusion** It has been established that the codes have been easy to apply and have already given a quantitative view as regards health promotion/education/safeguarding, which has supported discussions with commissioners. It is envisaged that use of the codes will enable of health adviser interventions to be measured time wise. This work will also be presented.

## P047 HEALTH CARE NEEDS OF WOMEN AGED 40 AND OVER ATTENDING AN INNER CITY INTEGRATED SEXUAL HEALTH CLINIC

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10.1136/sextrans-2016-052718.101

**Background/introduction** Sexual health policy is targeted towards younger adults, with national screening programmes and research studies excluding individuals over the age of 44. UK surveillance data demonstrated that rates of sexually

transmitted infections (STIs) doubled in older people between 1996 and 2003, the fastest rise in all age groups.
**Aim(s)/objectives** To assess the health care needs of women aged 40 and over attending an integrated sexual health clinic in South London.
**Methods** Retrospective case notes review of 200 randomly selected female patients aged 40 and over attending between 2nd June 2014 and 30th May 2015.
**Results** 1728 out of 5039 women (34%) who attended the sexual health clinic were aged 40 and over. In the sample of 200, mean age was 46.6 years (range: 40–73 years). Ethnicity: Black 111 (55%), White 57 (29%), Other 32 (16%). 110 women (55%) attended for STI-related reasons (symptoms/partner notification/possible exposure/treatment). 41% attended for contraception and 10.5% for asymptomatic screen. Of 150 tested, 29 (19.3%) had STIs. STIs were: genital herpes 8 (5.3%), trichomoniasis 7 (4.7%), genital warts 5 (3.3%), chlamydia 2 (1.3%) and gonorrhoea 1 (0.7%). Overall condom use was 22.9%.
**Discussion/conclusion** A significant proportion of women accessing sexual health services were aged 40 and over. 1 in 5 women were diagnosed with an STI. Under a quarter of women used condoms, indicating sexual risk taking behaviour. The sexual health needs of older people will continue to increase, given our rapidly ageing population. There is therefore a need to develop age-specific health promotion strategies and to challenge assumptions regarding sexuality in older age.

## P048 WHAT FACTORS CAUSE DELAY IN TERMINATION OF PREGNANCY? A LITERATURE REVIEW OF THE EVIDENCE

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10.1136/sextrans-2016-052718.102

**Background/introduction** Although abortions performed at earlier gestations are relatively medically safer and less costly, nonetheless in many settings there exists a small minority of women who receive abortions in the second trimester. The difficult circumstances faced by women seeking later abortions have been highlighted, but it is not always clear what factors lead to abortions being performed later in pregnancy.
**Aim(s)/objectives** To identify the causative factors of later (second trimester) abortion, analyse the impact of service provision on timing of abortion and highlight other factors relevant to delay in seeking or obtaining abortion.
**Methods** A literature search was conducted using Medline and Embase databases, and results were limited to English language studies from the last 20 years in settings where termination of pregnancy was legally available.
**Results** Most delays tended to act on one or more of three periods: identification of pregnancy, decision-making, and obtaining an abortion having made a decision. Delays in suspecting or confirming the pregnancy were key drivers in later termination and were particularly pronounced in young people; service-related delays were common, though small, and were often compounded by logistical factors such as financial difficulties.
**Discussion/conclusion** The causes of later abortion are many and complex, and very commonly overlap; more research is needed to analyse how these factors interact to cause delay. The association of low socioeconomic status with increased abortion delay suggests more must be done to ensure the accessibility of abortion services.

**Abstract P049 Table 1** HIV+ MSM

| ASPECT OF ASSESSMENT | Number (%) n = 85 |
|---|---|
| Sexual history taken | 77 (91) |
| If sexual history taken, Sexually active in past 12 months | 60 (78) |
| Of those who are sexually active, STI screen offered | 58 (97) |
| Of those with screen offered, STI screen done | 53 (91) |
| STI detected: | 10 (19) |
| 1. Chlamydia trachomatis | 1 (10) |
| 2. Neisseria gonorrheae | 8 (80) |
| 3. Syphilis | 1 (10) |
| 4. Warts | 2 (20) |
| 5. Acute Hepatitis C | 2 (20) |
| Recreational drug history | 63 (74) |
| If recreational drug history taken, recreational drugs use disclosed | 17 (27) |
| If recreational drug history taken, chemsex specifically disclosed | 3 (5) |

## P049 AUDIT: RATES OF SEXUAL HISTORY TAKING AND SCREENING IN HIV POSITIVE MEN WHO HAVE SEX WITH MEN (MSM)

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10.1136/sextrans-2016-052718.103

**Background/introduction** Increased rates of STIs in MSM may in part be due to the emergence of 'chemsex'; use of recreational drugs in the context of high-risk sex. BASHH has set a target of 97% of MSM attending for a new episode being offered a screen (80% acceptance). BASHH/BHIVA guidance recommends HIV-positive patients have 6 monthly sexual histories and annual STI screens.
**Aim(s)/objectives** To evaluate whether HIV positive MSM patients were asked about recreational drug use, including chemsex and assessed and screened for STIs during consultations.
**Methods** The notes of 142 HIV positive men seen in 2015 were available, of whom 85 were MSM. Information was collected regarding sexual history, recreational drug use documentation, STI screen offer and test results.
**Results** 77 (91%) of the MSM had a sexual history documented, of whom 60 (78%) were sexually active. STI screens were offered to 58/60 (97%) of those who were sexually active and accepted by 53 (91%) 10 (19%) of these had an STI. A recreational drug history was taken in 63 (74%) with 17 (27%) admitting to use and 3 (5%) to chemsex (Table 1).
**Discussion/conclusion** Sexual history documentation was below recommended levels. 19% men tested had an STI highlighting that frequent screening in this group is essential. A quarter of patients admitted to recreational drug use, although how many were explicitly asked about chemsex is unclear. Given the increasing concern around this practice, questions about chemsex should be incorporated into the sexual history proforma.

## P050 IMPROVING MANAGEMENT AND PARTNER NOTIFICATION OUTCOMES OF WOMEN TREATED FOR PELVIC INFLAMMATORY DISEASE (PID) BY INNOVATIVE YET SIMPLE BESPOKE MEASURES

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10.1136/sextrans-2016-052718.104

**Background** PID is a common condition seen at genitourinary clinics. BASHH published NICE approved guidelines in 2011. To improve consistency amongst clinicians we designed a simple *aide memoire* tick-box sticker. To improve health adviser (HA) contact and reduce "did-not-attend" (DNA) rates we established a HA staffed telephone follow-up clinic
**Methods** We regularly audit both management of PID and follow-up and so were able to compare data (2011–2015) to demonstrate improvements in practice with these changes
**Outcome** Partner notification rates improved from 50% to 67% helped mainly by the telephone clinic as HA documented in all cases whether partners had been screened/treated. 82% had a recording of symptom change, previously 77%. For those followed-up using the telephone clinic proforma this was 100%. Results for the number of named male contacts screened for infection and/or treated have improved (2011 = 0.21; 2014 = 0.38; 2015 = 0.48) and we now achieve above the BASHH target (0.4 – large city centre clinic). Over the past five years introducing these measures into clinic has improved all outcomes except DNA rate which remains stubborn (33% vs 27%). For a large city centre clinic the reasons behind this are complex and varied
**Conclusions** Innovative yet simple measures can be easily introduced which have a positive impact on guideline adherence and also make audit an easier task. With the advent of EPR in many clinics these initiatives should be transferable and aid standardising management across the GU network particularly during this time of change and service integration

## P051 AN AUDIT OF BLOODBORNE VIRUS SCREENING AND SAFER SEX ADVICE FOR SEX WORKERS

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10.1136/sextrans-2016-052718.105

**Background/introduction** Commercial Sex Workers (CSW) are at increased risk of STIs including Hepatitis B virus (HBV) and, for some, Hepatitis C virus (HCV) and sexual assault. These risks can be reduced by vaccination, post-exposure prophylaxis (PEP) awareness and condoms.

**Aim(s)/objectives** To audit management against clinic policy with respect to documentation of: HBV status; offering vaccination (vacc.) to HBV negative; HCV test; HIV test; PEP information/awareness and offer of condoms. Additional data was collected on new/prior STIs, recreational drugs, and same sex contact.
**Methods** Casenotes of all attenders between 01/01/12 and 30/09/15 with a SW code were reviewed and additional data collected regarding vaccine uptake.
**Results** 56 (7 males (12.5%), 49 females (87.5%)) individuals with a total of 243 episodes, with a median of 3 (1–17) visits, were identified. Median age of 30 (range 18–63) with 51 (91%) of white British ethnicity. 38 (67.9%) reported an STI diagnosis prior to the period audited and 13 (23.2%) had ≥1 new STI during this period, median 1 (1–3). 21 (37.5%) reported current/recent use of recreational drugs and 31/54 (57.4%) documented same sex contact, (including MSM contact for females). PEPSE was issued at 2/243 (0.8%) of episodes.
**Discussion/conclusion** The main limitation of the audit was dependence on SW code. Performance was good (>95%) for HBV documentation at first/subsequent visits, offer of HIV test, whilst HCV testing and documentation re. condoms and PEPSE awareness were suboptimal (45–80%). None were IVDU, and policy re. HCV testing in CSW will be reviewed given the low positivity rate.

**Abstract P051 Table 1** Blood borne viruses in sex workers

| | Test offered | Test accepted | Tested positive |
|---|---|---|---|
| **HBV at first visit (*n* = 56)** | 55 (98.2%) | 55 (98.2%) | 1 (eAb + sAg) |
| **HCV test (episode, *n* = 243)** | 193 (79.4%) | 176 (91%) | 0 |
| **HIV test (episode, *n* = 243)** | 239 (98.4%) | 222 (92.9%) | 0 |
| | **Documented** | **HBV status at first visit (*n* = 56)** | **Outcome of those with unknown status at first visit (*n* = 33)** |
| **HBV status (episode, 243)** | 239 (98.4%) | 1 past infection (1.8%) | 4 immune (12.1%) |
| | | 1 chronic HBV (1.8%) | 7 undergoing vacc. (21.2%) |
| | | 20 immune post vac (35.7%) | 10 vacc. at first visit (30.3%) |
| | | 1 not tested (1.8%) | 7 vacc. at later visit (21.2%) |
| | | 33 status unknown (58.9%) | 3 declined vacc, (9.1%) |
| | | | 2 did not attend vacc. (6.1%) |
| | **Documented** | **Not documented** | |
| **PEPSE info/awareness (episode, 243)** | 111 (45.7%) | 132 (54.3%) | |
| **Offered condoms (episode, 243)** | 174 (71.6%) | 69 (28.4%) | |

## P052 MEN WHO HAVE SEX WITH MEN (MSM) PRESENTING WITH REPEAT BACTERIAL SEXUALLY TRANSMITTED INFECTIONS (STI) REPORT HIGH USE OF ALCOHOL AND PARTY DRUGS

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10.1136/sextrans-2016-052718.106

**Background/introduction** Bacterial sexually transmitted infections (Chlamydia, Gonorrhoea and Syphilis) are increasing in men who have sex with men in the UK. The reasons for this include alcohol and recreational drug use, availability of PrEP and awareness of HIV treatment as prevention, and social media.

**Aim(s)/objectives** Our aim was to investigate the factors associated with recurrent bacterial STIs in MSM in Brighton, focusing specifically on drug and alcohol use.
**Methods** We reviewed MSM presenting to our service between September 2014-September 2015 who had had 3 or more repeat attendances with a bacterial STI. We included infectious Syphilis, pharyngeal, rectal and urethral Chlamydia and Gonorrhoea. We collected data on alcohol and recreational drug use.
**Results** An estimated 11,000 MSM attended during the study period. Of these, 46 MSM had 3 or more bacterial STIs. The median age was 34.5 years 21–57). 26/46 (57%) were HIV positive. 32/46 (70%) had 3 STIs; 10/46 (22%) had 4 STIs, 3/46 (7%) had 5 STIs and 1/46 (2%) had 6 STIs. 14/46 (30%) reported hazardous drinking, 31/46 (67%) reported use of party drugs (including Mephedrone, Crystal Meth, Ecstasy and GHB) and 7/46 (15%) reported 'slamming'.
**Discussion/conclusion** MSM attending multiple times with recurrent bacterial STIs also report high use of alcohol and recreational drug use including slamming. Public health interventions to reduce incidence of STIs should include focusing on drug and alcohol use in MSM.

## P053 HIV SCREENING IN THE HIV NEGATIVE POPULATION – A REGIONAL HIV NETWORK AUDIT OF SCREENING OFFER, UPTAKE AND TURN-AROUND TIMES

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10.1136/sextrans-2016-052718.107

**Background** New BHIVA Standards of care for people living with HIV were published in 2013 for proportion of people newly attending sexual health services offered an HIV test in and time from HIV testing to lab reporting and sharing result with patient
**Aims** Baseline regional audit to assess HIV screening offer, uptake and turn-around times within sexual health services to feedback to commissioners.
**Method** Standards set from the 'Management of Sexually transmitted Infections' MEDFASH 2014. Retrospective audit of first 30 attendances between 01/09/14 and 30/11/14. Services reviewed notes coded as either HIV testing performed, inappropriate or declined. Information collected included documentation of offer, reason given for decline or deemed inappropriate. For those tested, times taken for lab reporting and sending patient result text was collected.
**Results** 8 services took part. 0.1% HIV positivity rate. 70% overall had documented reason for HIV test decline. 13% were coded as declined with no documented offer. Percentage of people with needs relating to STI's who had an HIV test at first attendance 97% offered (achieved in 84%, range 59 to 100%), 80% uptake (achieved in 70%, range 47 to 87%). 3/8 of services met both standards for turn-around times. Overall 92% of services received report from laboratory within 5 working days, range 1 to 20 days (standard 97%) and 90% of patients received their result within 10 working days, range 3 to 30 days (standard 95%).
**Discussion** Not all patients appropriate to be tested were offered HIV test, training as to when HIV testing is not appropriate in Sexual health was recommended. Patients in a long term relationship were most likely not to be offered screening, regardless of previous screening history. There was a large variation between processing times in both laboratories and sexual health services. Good practices for those meeting standards were shared with the network.

## P054 PELVIC INFLAMMATORY DISEASE (PID) – IS TELEPHONE FOLLOW-UP FEASIBLE, SAFE AND EFFECTIVE?

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10.1136/sextrans-2016-052718.108

**Background** BASHH guidelines recommend follow up after PID treatment. A previous clinic audit highlighted high DNA rates for such appointments. In October 2013 we introduced a telephone follow-up protocol for PID to reduce unattended appointments without compromising patient safety and satisfaction. Patients diagnosed with PID were referred to the Health Advisor (HA) at the first consultation to commence the Partner Notification (PN) process. HA's then conducted a telephone follow-up appointment 2 weeks later to ensure treatment compliance and review symptoms.
**Aim** To audit the performance of the new PID telephone follow-up protocol and estimate number of appointments saved.
**Method** A 3 months retrospective electronic case note and PN record review of female patients diagnosed with C5A attending between 1/7/14 and 30/9/14.
**Results** 59 eligible case notes reviewed. Mean age = 25.8 years. 66% (39/59) patients received telephone follow-up. 71% (28/39) patients contacted on first attempt and all were happy to be telephoned. As per PID protocol 23% (14/59) patients with positive Chlamydia, gonorrhoea test or IUD in situ were advised to attend for doctor review. Of these 36% DNA'd their clinic follow up appointment. PN rates 0.8%.
**Discussion** PID follow up performed by HA telephone consultation is acceptable to patients and HCP's. We saved 39 doctors appointments over 3 months and there was no impact on PN rates or patient safety. Since this audit we now include patients with Chlamydia and IUD's in the telephone follow-up protocol, and men with Epididymo- orchitis. We estimate we could save 280 follow-up appointments a year.

## P055 IMPROVING CLINICAL STANDARDS IN GU MEDICINE: A RETROSPECTIVE AUDIT OF NEISSERIA GONORRHOEA 2007 - 2015

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10.1136/sextrans-2016-052718.109

**Background/introduction** This was a retrospective analysis of clinic performance in the management and treatment of *Neisseria gonorrhoeae* (GC) according to the current British Association of Sexual Health and HIV (BASHH) guidelines.
**Methods** All cases of GC diagnosed in our clinic between 1st January and 30th June 2015 were identified. The case notes were reviewed and assessed against current BASHH criteria. This was compared to data collected at the same clinic for the

same six months in 2007 to 2014. The total number of cases identified in 2015 were 151.

**Results**

**Abstract P055 Table 1**

| | 2007 | 2008 | 2009 | 2011 | 2012 | 2013 | 2014 | 2015 |
|---|---|---|---|---|---|---|---|---|
| TOC (%) (Had TOC%) | | | | – (36) | 91 (66) | 84.6 (53) | 91 (60) | 91 (60) |
| C4 Treatment (%) | 100 | 100 | 100 | 98.60 | 100 | 100 | 100 | 99.3 |
| PN (%) | 82 | 95 | 92 | 98.60 | 100 | 100 | 100 | 96.7 |
| PIL (%) | 32 | 64 | 81 | 61 | 50 | 66 | 27 | 74 |
| 1st line (%) | 77 | 96 | 100 | 97 | 88 | 100 | 97 | 93.4 |

**Discussion/conclusion** To my knowledge, this is the longest continuous audit of the management of *N.gonorrhoea* in the UK. I have seen continuous improvements in the performance of all five domains. We introduced an electronic reminder to provide patients with an information leaflet at the end of 2014. This has shown a marked improved from 27% to 74%. We aim to achieve full BASHH compliance in 2016.

## P056 INFLUENCE OF COUNTRY OF BIRTH ON RISK OF STI DIAGNOSIS AMONG BLACK CARIBBEANS IN ENGLAND IN 2014

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10.1136/sextrans-2016-052718.110

**Background/introduction** In England, people of Black Caribbean (BC) ethnicity are disproportionately affected by sexually transmitted infections (STIs), but it is unclear whether this is associated with their country of birth.

**Aim(s)/objectives** To examine differences in STI diagnoses among UK- and Caribbean-born BC people.

**Methods** Data on STI diagnoses in BC people attending genitourinary medicine (GUM) clinics and living in England were obtained from the GUM Clinic Activity Dataset (GUMCADv2). Associations between being UK- or Caribbean-born and diagnosis with an STI were derived using univariate and multivariable multilevel logistic regression models adjusted for age, gender/sexual-orientation, residence, and HIV status.

**Results** BC people made 231,719 attendances in 2014; 81.9% were UK-born. The median age (years) was 25 for UK-born and 34 for Caribbean-born people ($p \leq 0.001$). Chlamydia, non-specific genital infection and gonorrhoea were the most commonly diagnosed STIs among UK- (37.4%, 19.5% and 13.7%) and Caribbean-born attendees (32.1%, 25.2% and 13.1%). From the multilevel analysis, UK-born attendees were less likely to be diagnosed with chlamydia (aOR 0.87 [95%C.I. 0.81–0.94]) and trichomoniasis (0.83 [0.71–0.97]), and more likely to be diagnosed with genital warts (1.24 [1.07–1.45]) than Caribbean-born attendees. The adjusted odds of a gonorrhoea diagnosis did not vary by country of birth.

**Discussion/conclusion** STI rates among black Caribbeans attending GUM clinics in England are high and might be influenced by STI epidemiology in their country of birth. Studies on the effectiveness of interventions aimed at reducing the burden of STIs in all black Caribbeans are urgently needed.

## P057 NEISSERIA GONORRHOEA (GC): PERSISTENCE OF DNA DETECTION AFTER SUCCESSFUL THERAPY AND CHANGING PATTERN OF ANTIBIOTIC SENSITIVITY, 2007–2015

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10.1136/sextrans-2016-052718.111

**Background/introduction** Nucleic acid amplification testing (NAAT) is widely used in GUM clinics to diagnose GC infection; its in-built high sensitivity may potentially detect DNA from non-viable organisms following successful treatment. The BASHH national guidelines stipulate that test-of-cure (TOC) with NAAT should take place 2 weeks post-treatment. The purpose of this study was to determine whether this is an adequate time interval to perform TOC. We also analysed the changing pattern of antibiotic sensitivity between 2007–2015.

**Aim(s)/objectives** All GC cases at our clinic between 1st January and 30th June in 2007–2015 were identified and assessed for antibiotic sensitivity and TOC.

**Methods** In 2015 there were 151 cases; culture and sensitivity results were available for 99 cases. TOC with NAAT was done in 81 cases. There were 10 cases where the NAAT was SDA positive but PCR negative. Overall a TOC with NAAT was performed between 7 and 50 days post-treatment with a mean, median and mode of 17, 14 and 14 days respectively.

**Abstract P057 Table 1** Gonorrhoea 2007–2015

| | 2007 | 2009 | 2011 | 2012 | 2013 | 2014 | 2015 |
|---|---|---|---|---|---|---|---|
| % fully sensitive | 46 | 67 | 59 | 49 | 79 | 59 | 43 |
| Resistance to 1 antibiotic group | 27 | 15 | 20 | 38 | 10 | 20 | 23 |
| Resistance to 2 antibiotic groups | 15 | 10 | 16 | 8 | 6 | 13 | 21 |
| Resistance to 3 antibiotic groups | 12 | 2 | 5 | 3 | 2 | 8 | 5 |

**Conclusion** None of the cultures were resistant to ceftriaxone. However prevalence of multi-drug resistance in N.gonorrhoea has shown gradual decline from 27% in 2007 to 8% in 2013. The trend has reversed in 2014 with increasing multi-drug resistance to 26% in 2015. Since 2013 I have also looked at the persistence of DNA detection following successful therapy and this supports the BASHH Guidelines of TOC 2 weeks post treatment.

## P058 TWO CASES OF DELIBERATE ANTIRETROVIRAL OVERDOSE: RALTEGRAVIR AND TENOFOVIR DISAPROXIL FUMARATE/EMTRICITABINE

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10.1136/sextrans-2016-052718.112

**Background/introduction** There is a high incidence of psychiatric illness amongst those living with HIV. This is associated with a risk of deliberate self harm including overdose with antiretrovirals. There are a small number of publications describing overdose with antiretrovirals but none describing overdose with raltegravir.

**Aim(s)/objectives** In this report we aim to describe two cases of overdose with antiretrovirals: the management, investigations and resultant complications.

**Methods** The patient case notes and laboratory test results were reviewed.

**Results** Case 1: A 28 year old HIV-positive man presented 96 hours after taking a deliberate overdose of 40 x 400mg raltegravir tablets. He developed mild symptoms of diarrhoea, abdominal cramps and a sore chest. Results post-overdose: electrolytes and renal function: normal; liver function tests: ALT 58, others normal; creatinine kinase 67; haematology: normal; therapeutic drug monitoring (TDM) results: raltegravir not detected 96 hours post overdose. There were no serious complications. Case 2: A 52 year old HIV-positive man presented 24 hours after taking a deliberate overdose of 18 × Truvada (tenofovir disaproxil fumarate/emtricitabine). He had no symptoms related to the overdose. Results post-overdose: urinalysis: normal; electrolytes and renal: phosphate 0.75, creatinine 94; TDM: 24 hours: 207 ng/ml; 48 hours: 80 ng/ml; 72 hours: 16 ng/ml; 192 hours: 2 ng/ml. There were no serious complications.
**Discussion/conclusion** The patients in our case series showed few side effects and no serious sequelae as a result of their overdose. There seems to be little guidance available to guide management of such cases.

## P059 A REVIEW OF SEXUALLY ACQUIRED PROCTITIS: AN ARRAY OF SYMPTOMS, INVESTIGATIONS AND TREATMENTS

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10.1136/sextrans-2016-052718.113

**Introduction** With recent lymphogranuloma veneruem (LGV) and Shigella outbreaks amongst men-who-have-sex-with-men (MSM), proctitis has become a prominent clinical issue. There is no UK guideline regarding proctitis management but guidance is available from IUSTI and CDC.
**Objectives** To review our proctitis cases and generate a clinic policy to standardise practice.
**Methods** Casenotes coded C4NR between 01/01/14–31/12/15 were reviewed with data collated and analysed via Microsoft Excel.
**Results** 100 care episodes were reviewed (92 patients, 6 attended twice and 1 thrice). All patients were male; 83 homosexual, 8 bisexual and 1 heterosexual. 67 patients were White British, 31 were HIV positive. Median age was 29 years (range = 18–62). Presenting symptoms were varied with rectal pain (58), discharge (54), and bleeding (44) most common. Proctoscopy in 82 cases found varying signs (32 discharge, 24 oedema, 25 contact bleeding, 10 ulceration). Microscopy was diagnostic of proctitis in 39/84 (46.4%) patients. Physician-requested investigations were:

**Abstract P059 Table 1** Sexually acquired proctitis

| Test | Performed | Positive results |
|---|---|---|
| *Chlamydia trachomatis* TMA | 100 | 14 (including 6 LGV) |
| *Neisseria gonorrhoea* TMA | 100 | 28 |
| Gonococcal culture | 98 | 24 |
| Herpes Simplex PCR | 30 | 9 |
| *Treponema pallidum* PCR | 27 | 1 |
| Treponemal serology | 93 | 5 |
| Stool culture | 13 | 4 |

Treatment at initial visit was predominantly doxycycline-based (99/100), with course length varying from 7–21 days. Concurrent therapies were influenced by clinical findings and reported contacts; predominantly ceftriaxone (53), azithromycin (31), and aciclovir (19).
**Conclusions** Gonorrhoea incidence was high (28%), as was herpes when requested (30%). Updated clinic policy for all proctitis patients includes requesting Herpes Simplex PCR and presumptive treatment for gonorrhoea.

## P060 ARE WE 'SPOTTING THE SIGNS?'

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10.1136/sextrans-2016-052718.114

**Background/introduction** In 2014, BASHH/Brook piloted a pro-forma for identifying risks of child sexual exploitation in sexual health settings in the light of cases of child sexual exploitation identified nationally. Use of the pro-forma was promoted. The form was introduced in our unit in October 2014 following discussion. This replaced the 'under-16's risk-assessment,' used previously.
**Aim(s)/objectives** To assess as to whether the pro-forma was being used overall, with in-depth analysis of key components of the document.
**Methods** Retrospective note audit between 01/04/15–30/09/215 conducted. 44 attendees under 18, identified (17 male, 27 female)
**Results** The form was used in 39/44 (88.6%). Assessment of Fraser competence was documented in 34/42 (81%); 2 attendees were over 16. There was documentation that 'confidentiality clause' was discussed in 37/44 (84.1%). Age of partner was documented in 35/42 (83.3%); 2 patients had never had sex and hence were excluded. Name of social worker was documented in 7/13 (53.8%) attendees who had indicated they had one. 31 attendees had no social worker. Professional analysis was completed in 16/44 (36.4%). However, a further 10 notes had comments documented, which increased completion rate to 59.09%.
**Discussion/conclusion** After initial concerns raised by Staff about time taken to complete the form and the qualitative nature of information included in the form, this was incorporated into most consultations including under-18 attendees. Documentation on most key aspects of the pro-forma was generally good, with room for improvement. A feed-back session for staff combined with a further dedicated teaching session on safe-guarding is organised to improve this.

## P061 SAFETY OF SINGLE DOSE GENTAMICIN COMPARED WITH MULTIPLE DOSE REGIMENS

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10.1136/sextrans-2016-052718.115

**Background** Traditionally, gentamicin is given eight hourly, guided by drug levels. Several studies have shown that single-daily dosing of gentamicin offers an equal, if not improved, toxicity profile compared to traditional dosing. Single one-off dose gentamicin has been suggested as treatment for gonorrhoea, but its safety has not been reviewed.
**Aim** Systematically review the frequency and type of adverse events associated with a single dose of intravenous or

intramuscular gentamicin in adults, for any indication, in studies where a comparator was available.

**Methods** A review protocol was developed and registered (PROSPERO: CRD42013003229). Studies were eligible for review if they; recruited participants ≥16 years old, used gentamicin intramuscularly or intravenously as a single one-off dose, compared gentamicin to another medication or placebo, and if adverse events were monitored. We searched MEDLINE, EMBASE and other relevant databases. Risk of bias was assessed in included studies.

**Results** 12,116 records were identified. After removal of duplicates, screening of title/abstracts for relevance and independent selection of full texts by two reviewers, 20 studies were included. 3589 participants were analysed across all studies, 2042 received a single one-off dose of gentamicin (doses ranged from 1 mg/kg - 280 mg). Reversible nephrotoxicity/creatinine rise was reported in 37 cases, with one case of irreversible renal impairment. There were three cases of ototoxicity, with similar frequency reported in the comparator group. A meta-analysis was not possible due to heterogeneity. Reporting of adverse events was poor in the majority of studies.

**Discussion** Adverse events with single dose gentamicin are infrequent.

## P062 A RETROSPECTIVE AUDIT OF HEPATITIS B MANAGEMENT IN THE GU CLINIC

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10.1136/sextrans-2016-052718.116

**Background/introduction** Background/introduction: Hepatitis B (HBV) is a sexually transmitted infection commonly diagnosed in GU settings. We routinely test for HBV in high risk patients such as men who have sex with men, sex workers and those from high prevalence areas.

**Aim(s)/objectives** A retrospective audit was undertaken assessing whether patients diagnosed with HBV are being managed in accordance with BASHH guidance and whether changes made following a previous audit were implemented successfully.

**Methods** Patients newly diagnosed with HBV over an 18 month period up to 31/8/15 had their records reviewed. Data was collected on demographics, investigations, initial management and follow up.

**Results** 31 patients were included in the audit and their care compared to the 2008 national auditable standards. Median age was 28(range 16–46). 20 (64.5%) were male and 11 (35.5%) female. 29 (93.5%) identified as heterosexual, 2 (6.5%) as homosexual. 11 (35.5%) were of African descent. Only 6% of patients were provided with written information on HBV transmission and outcomes and 68% had documented partner notification. 95% had liver function tests performed post diagnosis, 97% had clear long term management plans documented and 87% were offered appointments with hepatology(compared to 67% in the previous audit).

**Conclusion** Clinicians were failing to provide written information about HBV following diagnosis as information leaflets were not available in clinic. 87% of patients received verbal health advice but this still falls short of national standards. A scheme giving cards with QR codes linking to approved patient information is being trialled. Improved referral pathways have resulted in more patients having specialist review.

## P063 STAFF, ASSOCIATE SPECIALIST AND SPECIALTY (SAS) DOCTORS' NATIONAL AUDIT ON THE MANAGEMENT OF GONORRHOEA IN THE UK

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10.1136/sextrans-2016-052718.117

**Background/introduction** The British Society for Sexual Health and HIV (BASHH) revised United Kingdom national guideline for the management of gonorrhoea in adults, 2011, identified five auditable outcome measures. The UK National Guideline for Gonorrhoea Testing, Clinical Effectiveness Group, BASHH, 2012, suggested a further three.

**Aim(s)/objectives** The aim was to audit national management of gonorrhoea against the standards recommended in these two documents. Only SAS doctors were eligible to participate.

**Methods** SAS doctors, whose details were registered on the SAS database, were invited to contribute. All clinics were asked to designate a Local Co-ordinator who would register that clinic and allocate patients to the other participating doctors. Results for the individual clinics were sent to the Local Co-ordinator for dissemination. All information was submitted via a secure online link. Data from forty patients was requested.

**Results** 3233 cases were submitted from 78 centres by 168 doctors. 68% cases were male and 44% were MSM. 83% received first line treatment. 97% were tested or treated for CT. 41% offered written information on GC. Culture attempted in 86% of those GC NAAT positive. Sensitivity testing performed on 94% culture positive. Supplementary testing performed on 61% throat and 60% rectal NAAT reactive. TOC performed on 61%; 41% of these within 2 weeks. Partner notification was done in 92% cases.

**Discussion/conclusion** 83% patients received first-line treatment. A reason was provided for 11% treated with other regimens. The number offered written information was low at 41%. Results about supplementary testing were inconsistent. The results for the other outcomes were satisfactory.

## P064 DELIVERY OF SEXUAL HEALTH INTERVENTIONS FOR MEN WHO HAVE SEX WITH MEN (HPV VACCINATION AND PREP) MAY BE HINDERED BY THE LACK OF SEXUALITY DISCLOSURE IN PRIMARY CARE

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10.1136/sextrans-2016-052718.118

**Background/introduction** Large scale new sexual heath interventions for MSM (HPV vaccination, PrEP) will potentially need to be delivered in primary care as well as sexual health. It is important these services are acceptable to MSM and MSM feel confident to disclose their sexuality.

**Methods** From November 2015 to February 2016, a paper survey was distributed to MSM attending local sexual health services on acceptability of local services and initial disclosure of sexuality to a healthcare setting. National Student Pride also used an online version of the survey.

**Results** 1186 MSM were included in the analysis of this survey. The median age was 26.8 years (18–89). 1026/1186 (86.5%) self-identified as gay, 108/1186 (9.1%) bisexual and 34/1186

(2.9%) straight. 918/1186 (77.4%) were HIV-negative, 42/1186 (3.5%) HIV-positive, 188/1186 (15.9%) never tested, and 38/1186 (3.2%) unknown status. The median age of first sexual behaviour with another man was 17.6 years (6–41). The median age of disclosure of sexuality to: family is 18 years (8–45) and friends 17 years (11–41); sexual health services 892/1186 (66.6%) = 19.0 years (14–54); and to primary care 522/1186 (44%) = 21.2years (13–54). There is a difference between age of first sexual experience and disclosure to primary care of 3.6 years.

**Discussion/conclusion** Delayed disclosure to healthcare professionals of sexuality by MSM is likely to impede the uptake of important health interventions in MSM.

## P065 LACK OF EXPOSURE TO GENITOURINARY MEDICINE (GUM) IS LEADING TO A RECRUITMENT CRISIS

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10.1136/sextrans-2016-052718.119

**Background** In 2015, genitourinary medicine (GUM) filled 46% of its national training numbers. Reasons for low recruitment are unclear. In February, GUM exhibited at the Royal College of Physicians (RCP) Medical Careers Day attended by undergraduates (UGs) and junior doctors (JDs).

**Aim** We aimed to assess the factors that attract and deter delegates from choosing a career in GUM.

**Methods** A survey was conducted amongst delegates who visited the GUM stall at the Careers Day.

**Results** 93% (25/27) of delegates who visited the stall completed the survey (14 UGs, 8 foundation year (FY) doctors, 3 other). 33% (8/24) would like a career in GUM (54% (13/24) not sure; 13% (3/24) were not interested in GUM). 92% (23/25) would like/have liked a rotation in GUM as a JD. 76% (19/25) were exposed to GUM in medical school (86% FYs, 50% UGS). One delegate had done a rotation in GUM as a FY. The table shows the main factors that attract delegates to or deter them from a career in GUM:

**Abstract P065 Table 1**

| Attracts | Number of delegates | Deters | Number of delegates |
|---|---|---|---|
| "Variety/interesting speciality" | 11 | Lack of exposure to GUM | 5 |
| Work-life balance | 7 | Lack of inpatient work | 3 |
| Research opportunities | 4 | | |
| HIV | 4 | | |

**Conclusion** This survey shows that there is interest in GUM at UG/JD level. A variety of factors appealed to delegates, with fewer deterrents, of which "lack of exposure" predominated. Delegates would like GUM rotations as JDs. Optimising exposure to GUM within medical schools and JD rotations should be a priority in order to attract trainees to GUM.

## P066 TRANSMISSION OF *NEISSERIA GONORRHOEAE* AMONG MEN WHO HAVE SEX WITH MEN: AN ANATOMICAL SITE-SPECIFIC MATHEMATICAL MODEL AND IMPACT OF MOUTHWASH

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10.1136/sextrans-2016-052718.120

**Background/introduction** Epidemiological data suggest that kissing may play a significant role in gonorrhoea transmission.

**Aim(s)/objectives** We developed a transmission model to explain anatomical site-specific prevalence of gonorrhoea among Australian men who have sex with men (MSM) and evaluate the population-level impacts of screening and the use of mouthwash as interventions in reducing its transmission.

**Methods** We constructed a gonorrhoea transmission model to estimate the per-act transmission probability. Using Monte-Carlo simulations, we constructed hypothetical scenarios to evaluate its population-level impacts.

**Results** We have previously reported the prevalence of pharyngeal, anal and urethral gonorrhoea as being 10.6% (95%CI 8.1–12.2%), 8.6% (6.7–10.4%) and 0.17% (0.02–0.24%), respectively, in Australian MSM. Calibrated to these data, the model-estimated per-act transmission probability for gonorrhoea was high for transmission from urethra-to-anus (46.0% [41.7–52.6%]) and from-urethra to-pharynx (49.6% [46.7–53.8%]). Although pharynx-to-pharynx transmission through kissing has only a transmission probability of 17.4% (16.0–21.0%), it accounts for nearly three quarters of the annual incident cases (74.6% [70.0–82.4%]). A substantial increase in gonorrhoea screening from the current 40% to 100% may only halve gonorrhoea prevalence in MSM. In contrast, the use of mouthwash with moderate efficacy (extra 1% bacterial load reduction/use) would further reduce the corresponding site prevalence to 2.4% (1.8%–3.7%), 2.2% (1.6–3.2%) and 0.02% (0.01–0.03%), whereas a high efficacy (extra 1.5% reduction/use) may achieve a scenario of close to elimination.

**Discussion/conclusion** Our results suggests that kissing may be the key driver of community prevalence. If antibacterial mouthwash is effective and widely used, it may contribute to controlling the gonorrhoea epidemic.

## P067 WHY DON'T PEOPLE WITH GENITO-URINARY SYMPTOMS GO TO SEXUAL HEALTH CLINICS? A MIXED METHODS STUDY ABOUT MEANINGS OF SYMPTOMS AND CARE-SEEKING USING THE THIRD NATIONAL SURVEY OF SEXUAL ATTITUDES AND LIFESTYLES (NATSAL-3)

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10.1136/sextrans-2016-052718.121

**Background/introduction** There are both individual and public health benefits in people responding to genito-urinary symptoms effectively. Sexual health clinics are best equipped for managing symptoms but not everyone with symptoms chooses to attend.

**Aim(s)/objectives** To examine the prevalence and meanings of genito-urinary symptoms and the impact on non-attendance at sexual health clinics among people in Britain.
**Methods** An explanatory sequential mixed methods study design was used to estimate symptom and clinic non-attendance prevalences using data from 8,947 sexually-experienced women and men aged 16–44 years who participated in Britain's third National Survey of Sexual Attitudes and Lifestyles (Natsal-3). We conducted follow-up semi-structured interviews with Natsal-3 participants (n = 27) who reported current or recent symptoms and had never attended a clinic, in order to explore STI perceptions, symptom meanings and care-seeking behaviour.
**Results** Prevalence of experiencing symptom(s) in the last month was 21.6% (95% CI 20.4–22.9%) among women and 5.6% (95% CI 4.9–6.6%) among men, of whom 86.3% (95% CI 84.2–88.1) reported not having attended a sexual health clinic in the past year. Bodily changes were not always viewed as symptoms and perceived potential causes were diverse, causing strong emotional responses. Individuals normalised, concealed and/or distanced their experiences from STIs. GPs were the preferred service provider although not all participants perceived a need for care.
**Discussion/conclusion** Symptoms are more commonly reported by women although both women and men may benefit from interventions targeting symptom normalisation and concealment. Good links between services will facilitate efficient and appropriate care-seeking and service delivery.

## P068 INEQUALITIES IN SEXUALLY TRANSMITTED INFECTION RISK AMONG BLACK AND MINORITY ETHNIC MEN WHO HAVE SEX WITH MEN IN ENGLAND

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10.1136/sextrans-2016-052718.122

**Background/introduction** Sexually transmitted infection (STI) diagnoses are increasing in men who have sex with men (MSM) in England. While black and minority ethnic (BME) populations bear a disproportionate burden of STIs overall, it is unclear whether this inequality persists among MSM.
**Aim(s)/objectives** To assess the likelihood of an STI diagnosis among BME MSM relative to other MSM attending genitourinary medicine (GUM) clinics in England.
**Methods** We included data from the GUM clinic activity dataset (GUMCADv2), the national STI surveillance system in England. All attendances by MSM in 2014 were analysed using univariate and multivariable generalised estimating equations logistic regression. Separate models, adjusted for age, sexual orientation (homosexual/bisexual), residence (London/non-London), area-level deprivation, HIV positivity and history of HIV testing in the past year, were run for each STI.
**Results** BME men accounted for 5.6% of the 326,820 attendances by MSM in 2014. An STI was diagnosed at 12.5% of attendances by MSM, ranging from 11.1% in Asian non-Indian/Pakistani/Bangladeshi to 17.7% in mixed white and black African MSM. Compared to white British MSM, black Caribbean MSM were most likely to be diagnosed with chlamydia (aOR [95% CI]:1.34 [1.18–1.52]) and rectal gonorrhoea (1.31 [1.08–1.60]), while those of mixed white and black African ethnicity were most likely to be newly diagnosed with HIV (1.90 [1.14–3.17]).
**Discussion/conclusion** Among MSM attending GUM services, BME MSM are most likely to be diagnosed with bacterial STIs and HIV. Culturally appropriate prevention messages must be developed to address this inequality and reduce the higher burden of STIs among BME MSM.

## P069 WHAT IMPACT HAS TENDERING HAD ON TRAINEES? THE RESULTS OF A NATIONAL SURVEY OF TRAINEES AND NEWLY APPOINTED CONSULTANTS BY BASHH TRAINEES COLLABORATIVE FOR AUDIT, RESEARCH AND QUALITY IMPROVEMENT PROJECTS

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10.1136/sextrans-2016-052718.123

**Background/introduction** In April 2013, local authorities gained responsibility for commissioning services for sexual health in England. With many services going to tender and resultant change in services or service provider, there is anecdotal evidence that this has impacted on the education, training and morale of genitourinary medicine (GUM) trainees.
**Aim(s)/objectives** To evaluate the impact of tendering on GUM trainees.
**Methods** An electronic survey designed by the British Association for Sexual Health and HIV Trainees' Collaborative for Audit, Research and Quality Improvement Projects (T-CARQ) was distributed to GUM trainees and newly appointed consultants.
**Results** 82 individuals responded, (74% GUM trainees, 25% newly appointed consultants, 1% Locum appointed for Service). 63% (45/72) had experience of training within a service which was being tendered. Of these, 59% (24/41) felt their training was not considered and 20% (8/41) felt that it was. 44% (18/41) felt adequately supported. 30% (12/40) reported active participation in the tendering process. On a scale of 0 (no impact) to 5 (major impact), the median score for impact of tendering on training was 2. The positive/negative impact of tendering on different training elements was rated; other than management experience the overall impact on all parameters was negative namely morale, senior support and education.
**Discussion/conclusion** This survey describes the variable impact of service tendering on GUM training. Our recommendations for maintaining training standards despite tendering include: actively involving trainees and education partners, inclusion of specialist GUM training in service specifications, development of guidance for commissioners and services for the management of GUM training within tendering.

## P070 'CHEMSEX' WITHIN MEN WHO HAVE SEX WITH MEN (MSM): HOW BIG IS THE PROBLEM OUTSIDE MAJOR CONURBATIONS?

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10.1136/sextrans-2016-052718.124

**Abstract P070 Table 1** Frequency of chemsex consultations reported by English clinics split into urban/rural category (n = number of clinics):

| Frequency of Chemsex Consultations | Group A clinics (urban conurbation) n(%) | Group B clinics (Urban + city/town) n(%) | Group C Clinics (Urban + rural) n(%) | Group D clinics (Non-urban) n(%) | Total n | P value |
|---|---|---|---|---|---|---|
| Never | 7 (19%) | 5 (12.5%) | 3 (30%) | 4 (27%) | 19 | |
| Monthly or less | 16 (44%) | 28 (70%) | 5 (50%) | 8 (53%) | 57 | |
| Weekly | 10 (28%) | 5 (12.5%) | 2 (20%) | 3 (20%) | 20 | |
| At least daily | 3 (8%) | 2 (5%) | 0 | 0 | 5 | |
| Total | 36 | 40 | 10 | 15 | 101 | 0.851 |

**Background/introduction** Sexualised substance use (chemsex) amongst men who have sex with men is well documented in some areas (London, Brighton, Manchester), and associated with high-risk sexual practices and acquisition of sexually transmitted infections.
**Aim(s)/objectives** To explore demand for chemsex services in UK GUM clinics, including outside major conurbations
**Methods** An online survey was distributed to clinical staff in GUM clinics across the UK. Analysis at clinic level was undertaken for England, with clinics split into 4 categories: (A) urban conurbation, (B) urban with city/town, (C) urban with significant rural, and (D) non-urban.
**Results** 357 individuals responded from 152 clinics, 90% were from England. Country–specific clinic response rates were 63% (135/214) in England, 80% (4/5) Northern Ireland (NI), 8% (3/39) Scotland and 83% (10/12) Wales. 82% (227/278) of respondents reported seeing patients who disclosed chemsex (82% England (205/251), 83% NI (5/6), 75% Scotland (6/8), 85% Wales (11/13)), and there was broad consensus that chemsex services (86%) and training were needed (98%). 64% (68/106) of clinics reported routinely asking selected patients about chemsex, 10% (11/106) asked all patients, and the remainder did not ask. Although the proportion of clinics seeing chemsex and the frequency of chemsex consultations was reported to be higher in more urban settings, differences were not significant and many clinics in rural areas reported chemsex consultations (Table 1).
**Discussion/conclusion** Chemsex consultations occur in most GUM clinics across the UK albeit to varying degrees. These data suggest a widespread need for specialist chemsex services and training.

## P071 COST EFFICACY SAVINGS ON SEROLOGICAL FOLLOW UP FOR SYPHILIS AT AN URBAN SEXUAL HEALTH CLINIC

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10.1136/sextrans-2016-052718.125

**Background/introduction** General Practitioners (GPs) in Lothian are requesting syphilis serology in 65% of individuals being tested for HIV. Adding syphilis to the remaining 35% would cost around £7000. In Edinburgh full serology (IgG, RPR, TPPA, IgM) is performed in all with a previous syphilis diagnosis. HIV positive individuals are tested 6 monthly. BASHH 2015 Syphilis Guidelines recommend RPR follow up and annual monitoring in HIV positive individuals. The aim was to evaluate if full serological screening was appropriate and whether cost savings could be made.
**Methods** One hundred individuals with full serological testing for syphilis, 30/9/15 to 29/10/15. Age, risk group, HIV status, stage of infection, PCR, treatment, symptoms, follow up and infection risks were collated.
**Results** 88 male, 12 female. Twenty one early infection (all positive RPR), 4 re infection (all rise in RPR), 7 late latent and 54 treated infection. Forty seven HIV positive. Of these 14 (21%) had no ongoing risks and 16 (34%) had ongoing risks, longstanding RPR 0. Forty HIV negative. Twenty four (60%) were MSM with treated STS, and a longstanding RPR 0.
**Recommendations** Testing should be annual RPR in HIV positive individuals with no ongoing risks. In those with ongoing risks RPR alone sufficient for monitoring. All with re infection would have been picked up on RPR. In HIV negative individuals, most had ongoing risks but a longstanding RPR 0. Monitoring with RPR only would have diagnosed all re infections.
**Discussion** It was difficult to vary testing based on risk assessment and concerns that RPR only may miss prozone. However, there was agreement that IgM should no longer be performed. At £3.77/test approximately £377/month would be saved in this group alone. This would apply to all other testing with considerable cost savings

## P072 EQUITY OF ACCESS TO ONLINE SEXUALLY TRANSMITTED INFECTION SELF-SAMPLING SERVICES IN LAMBETH AND SOUTHWARK: AN EARLY VIEW OF THE DATA

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**Background** In 2015, free access to online services for STI self-sampling was made available to residents in Lambeth and Southwark. Little is known about who accesses online services within these boroughs and whether access is equitable between demographic groups.

**Aims** To describe the demographic factors associated with use of online services for STI self-sampling.

**Methods** A cross-sectional analysis of routinely collected data from April to October 2015 for online and sexual health clinics in Lambeth and Southwark. We included residents who attended sexual health clinics or used online sexual health services for basic STI testing and were over the age of 16. Data were analysed by means of logistic regression.

**Results** A total of 9,496 basic STI testing services were delivered, 6,697 (70.52%) were delivered in clinics while 2,799 (29.48%) were delivered online. Descriptive data for service use by demographic group is available in Table 1. When compared to residents aged 16–20 years old, residents aged 21–24 (OR = 1.93, $p \leq 0.001$), and 25–30 (OR = 2.17, $p \leq 0.001$)

were more likely to use online services than clinic services. Females were more likely to use online services than clinic services when compared to males (OR = 1.55, p ≤ 0.001). When compared to residents of white ethnicity, residents who identified as Asian (OR = 0.74, p = 0.04), Black (OR = 0.43, p ≤ 0.001) or Other (OR = 0.48, p ≤ 0.001) were less likely to use online services than clinic services. When compared with heterosexuals, homosexuals (OR = 1.46, p ≤ 0.001) and bisexuals (OR = 3.10, p ≤ 0.001) were more likely to use online services than clinic services.

**Conclusion** There are demographic differences between residents that access online services and those that access clinic services. These data and more up to date data will be presented at the conference.

**Abstract P072 Table 1** Online STI sampling

| Demographic variable | Clinic users n (%) | Online users n (%) | Total n | p value ($X^2$) |
|---|---|---|---|---|
| Ethnicity | | | | |
| White | 3,285 (62.88) | 1,939 (37.12) | 5,224 | <0.001 |
| Mixed | 369 (59.23) | 254 (40.77) | 623 | |
| Asian | 172 (71.07) | 70 (28.93) | 242 | |
| Black | 1,991 (81.83) | 442 (18.17) | 2,433 | |
| Other | 360 (79.30) | 94 (20.70) | 454 | |
| Not Known | 516 (100.00) | 0 (0.00) | 516 | |
| Age group | | | | |
| 16–20 | 717 (80.02) | 179 (19.98) | 896 | <0.001 |
| 21–25 | 1,664 (66.06) | 855 (33.94) | 2,519 | |
| 26–30 | 1,726 (63.29) | 1,001 (36.71) | 2,727 | |
| 31–35 | 1,067 (72.34) | 408 (27.66) | 1,475 | |
| 36+ | 1,523 (81.05) | 356 (18.95) | 1,879 | |
| Gender | | | | |
| Male | 3,107 (74.99) | 1,036 (25.01) | 4143 | <0.001 |
| Female | 3,590 (67.07) | 1,763 (32.93) | 5,353 | |
| Sexual orientation | | | | |
| Heterosexual | 5,439 (70.57) | 2,268 (29.43) | 7,707 | <0.001 |
| Homosexual | 927 (70.28) | 392 (29.72) | 1,319 | |
| Bisexual | 109 (43.95) | 139 (56.05) | 248 | |
| Unknown | 222 (100.00) | 0 (0.00) | 222 | |
| Total | 6,697 (70.52) | 2,799 (29.48) | 9,496 | |

## P073 IF HIV-PREP IS MADE AVAILABLE IN ENGLAND, WHAT ARE THE RESOURCE IMPLICATIONS FOR GUM CLINIC SERVICE PROVIDERS?

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**Background** Under plausible assumptions, HIV-pre-exposure prophylaxis (HIV-PrEP) is cost-effective for high-risk MSM in England. There is consensus that HIV-PrEP should be delivered via quarterly GUM clinic attendances. BASHH recommends quarterly STI screening for high-risk MSM. An HIV-PrEP policy would have direct (extra consultation time and renal function tests) and indirect (additional STI/HIV screening) GUM clinic resource implications, as well as drug costs.
**Aims** To explore clinic costs if HIV-PrEP is introduced.
**Methods** Indirect clinic costs per person per year (PPPY) used the draft 2016/17 National Tariff (£104/follow-up GUM visit). Direct HIV-PrEP-specific clinic costs were estimated by micro-costing. Direct tenofovir/emtricitabine costs used BNF prices (£12/tablet), assuming 50%/50% daily/intermittent dosing. GUMCADv2 provided numbers of eligible MSM and likely additional clinic attendances.
**Results** MSM, clinically assessed as high-risk, currently attend GUM services twice/year (median); for those given PrEP, two additional attendances would be required annually with indirect costs of £208 PPPY. In year one, the direct cost of starting HIV-PrEP would be £176 PPPY, including an additional month-1 follow-up. Clinical risk-assessment should result in offering HIV-PrEP to 8,000 high-risk MSM annually. There is considerable turnover in this group, with <10% remaining high-risk after two years. Assuming steady increases in coverage (from 2,000 in year one to 5,000 by year four), direct and indirect clinic costs would be £0.8M–£2M/year and drug costs £8M–£20M/year.
**Discussion** A national HIV-PrEP programme is likely to incur large drug costs but limited clinic costs. A substantially reduced drug price will be needed to enable wide coverage and maximise population impact.

## P074 BARRIERS ASSOCIATED WITH THE IMPLEMENTATION OF PROGRAMS FOR THE PREVENTION OF VERTICAL TRANSMISSION OF HIV

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**Background** Implementation of programs for the Prevention of Vertical Transmission of HIV(PVTHIV)/PMTCT faces higher degree of barriers and challenges at different levels.
**Objective** This pilot study is to examine the potential barriers that might affect the acceptability of interventions for in rural estate health care settings in Sri Lanka.
**Methodology** This is a cross-sectional study conducted among pregnant women in tea plantations where there are no programs for PVTHIV.
**Results** Of the 404 participants, 81% (324/404) were tea estate workers, while 80 (19%) were from nearby villages. Literacy rate among the respondents was high (88%). Only 16% knew about HIV/AIDS, 381 (95%) did not know that a mother with HIV can pass the virus to her child and 390 (97%) did not aware that HIV can transmit through breast milk. More than 95% of participants agreed that they have enough access to basic antenatal care, including institutional delivery plan but none were aware of PMTCT services. Acceptability of a HIV test was high with 87% (337/404). Out of the women living with their marital partners (398/404,98%), 68% (264/398) preferred to

consult their partners before having an HIV test. Availability and accessibility of PMTCT service facilities, associated stigma, shame and fear, confidentiality of reports and concerns over risk to the foetus due to lack of knowledge are some of the potential barriers identified with future PMTCT programs.
**Conclusion** Lack of knowledge, stigma and fear and confidentiality issues need to be overcome with extensive universal awareness programs on HIV/AIDS and PMTCT.

## P075 DISCRIMINATORY ATTITUDES TOWARDS PEOPLE LIVING WITH HIV/AIDS, A POPULATION BASED STUDY IN SRI LANKA

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10.1136/sextrans-2016-052718.129

**Background** People living with HIV/AIDS(PLWHA) are vulnerable to discrimination because of the stigma associated with the disease.
**Aim(s)/objectives** To examine the level of disease awareness, discriminatory attitudes towards PLWHA and factors in association with such attitudes.
**Methods** A cross sectional survey was conducted by using a semi-structured validated telephone questionnaire of a random sample from the Sri Lankan telephone directory. The questionnaire consisted questions regarding awareness of the modes of transmission and questions to assess the attitude toward PLWHA.
**Results** Around 92% (120/130) of the respondents reported discriminatory attitudes in at least five out of the 20 relevant items, about 98% would avoid making physical contact with PLWHA, hesitating to sit next in the public transport (98%), divorcing the infected spouse (85%) and dismissing a HIV positive maid (100%). A sizeable proportion of the respondents exhibit negative perceptions; PLWHA are merely receiving the punishment they deserve (92%) and believe that they are purposefully infect others (94%). Also 89% concluded that the majority of PLWHA are promiscuous. Multiple regression analysis found that age, HIV related knowledge, above mentioned negative perceptions about PLWHA and fear associated with AIDS are independent predictors of discriminatory attitudes towards PLWHA. About 90% would give PLWHA the lowest priority in resource allocation among five groups of chronic diseases.
**Conclusion** Stigma among this study sample of general public was mostly due to fear of contracting the HIV/AIDS. Therefore, steps need to take increase public awareness and dissemination of information regarding HIV/AIDS to reduce the stigma associated with HIV.

## P076 THE CHARLIE SHEEN AFFAIR: HIV NARRATIVES IN THE UK MEDIA IN 2015 – DOES REPORTING MEET THE NATIONAL AIDS TRUST STANDARDS?

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10.1136/sextrans-2016-052718.130

**Background/introduction** Despite media guidance from the National Aids Trust (NAT), there is evidence to suggest the UK media are continuing to portray HIV infection in a negative fashion. The "Charlie Sheen effect" has been described with a reported 400% increase in Google related HIV searches just after Charlie Sheen's diagnosis.
**Aim(s)/objectives** Our aim was to identify themes of discussion about HIV in the media following the publication of Charlie Sheen's diagnosis, focussing specifically on language used.
**Methods** Articles were selected using the term "Charlie Sheen HIV" in Google search engine. Fourteen articles dating from 17th November 2015 to 27th November 2015 were reviewed and common themes identified. We compared the language used to NAT guidelines.
**Results** 9/14 articles were negative in their overall discussion about HIV and three contained factually incorrect information. There were a large number of sensationalist headlines and quotes including "HIV monster". 6/7 articles from 17th November referred to Sheen's drug use, wealth and sexual preferences. Three speculated about sexual contact with "prostitutes" and transgender men. Two articles commented on racism and domestic violence despite no association with article content.
**Discussion/conclusion** The media continue to associate HIV infection with negative personality traits, which have no impact on HIV transmission. The media has a key role in reducing stigma associated with HIV. With a quarter of people living with HIV in the UK unaware of their status, it is imperative that barriers to testing and treatment (including pervasive stigma) are tackled urgently.

## P077 MANAGING AN OUTBREAK OF INFECTIOUS SYPHILIS AMONG UNIVERSITY STUDENTS

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10.1136/sextrans-2016-052718.131

**Background/introduction** In November 2015 we were surprised by 5 cases of infectious syphilis among university students, including two bisexual males and one female. Mindful of the potential for onward transmission bridging both homosexual and heterosexual networks in this atypical group, we alerted Public Health to a potential outbreak.
**Aim(s)/objectives** To report on management of an outbreak.
**Methods** A pre-existing Outbreak Control Team (OCT) liaised by telephone to discuss preliminary control strategies. Student Health services were alerted immediately by telephone and email. Partner notification (PN) for syphilis cases was prioritised and intensified: additional information was collected (descriptions, where/how met, where studying); provider referral was encouraged, and home visits undertaken to reach contacts before the Christmas vacation. Targeted screening and on-line health promotion via student bulletins and social network sites was introduced.
**Results** From November 2015 – January 2016, a linked network of 37 individuals was identified, of whom 29 (78%) attended. Most contacts attended following provider referral (25/29; 86%). Repeated efforts were required to secure the attendance of several contacts. In all, 7 student cases of infectious syphilis were identified (1 female; 2 heterosexual males, 2 bisexual males, 2 MSM). The last 2 cases, identified in January, had initially tested negative 2–3 weeks after exposure.

**Conclusion** A swift response, using a range of case finding and health promotion strategies successfully curtailed a nascent outbreak of infectious syphilis among university students. An intensive approach to PN, with an emphasis on provider referral, ensured the majority of partners attended with minimal delay.

## P078 CLOSING THE AUDIT CYCLE IN THE MANAGEMENT OF PELVIC INFLAMMATORY DISEASE (PID): UPDATING TRUST GUIDELINES LEADS TO A HUGE IMPROVEMENT IN PID TREATMENT

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10.1136/sextrans-2016-052718.132

**Background** Correct management of Pelvic Inflammatory Disease (PID) is important to reduce complications but often varies widely. An audit of PID management in our trust's GUM clinics was undertaken in 2014 which led to trust guidelines being updated in early 2015. The main finding was antibiotic regimes were varied; only 12% received a BASHH recommended regime. We re-audited the management of PID in 2015.
**Aim** To compare PID management across our trust's GUM clinics in 2014 and 2015.
**Methods** Electronic patient records of 141 female patients with C5A codes in 2014 and 100 in 2015 were reviewed and compared.
**Results** In both audits 98% of patients had Chlamydia/Gonorrhoea NAATs sent; 93% had vaginal microscopy in 2014 and 92% in 2015, but cervical microscopy improved from 13% in 2014 to 45% in 2015. Pregnancy tests were inconsistently done, 83% in 2014 and 75% in 2015. Those with chlamydia, gonorrhoea or trichomonas vaginalis increased from 8% to 13% but bacterial vaginosis was the most common finding, 28% in 2014 and 46% in 2015. Antibiotic regimes were BASHH recommended in 12% (2014) and 88% (2015), due to updated 2015 trust guidelines being in line with BASHH.
**Discussion** Improvements have occurred since 2014 but cervical microscopy and pregnancy tests are still not consistently being done. Low levels of STIs detected may represent incorrect diagnosis in some. Antibiotic prescription has improved significantly, however we are still below the BASHH target of 95% (currently 88% compliance). We will re-present findings of this re-audit to clinics to improve standardisation of PID management.

## P079 HIV SERVICES IN A CHANGING PROVIDER LANDSCAPE: PATIENT EXPERIENCES AND PERCEIVED NEEDS

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10.1136/sextrans-2016-052718.133

**Background/introduction** With recent commissioning changes, non NHS providers are increasingly being awarded contracts to manage services including HIV care. There is little data on patient views and experiences around this change.
**Aim(s)/objectives** To obtain service user view of the aspects of the HIV service which they consider important in the landscape of commissioning changes.
**Methods** A patient survey was carried out in a community-based HIV service managed by a non-NHS provider. Questions were created to cover the most affected areas of the service due to the changes of HIV service provision.
**Results** A representative sample of 44 attenders over 2 months undertook the survey; 34 men and 10 women. All were satisfied with the service. However some expressed concerns since change of provider, such as "services are being stripped off", "not enough staff", "standards have fallen", "staff are under severe stress". The proportion that rated the following aspects of the service as very important or important to patients are as follows: 24hour on-call service (98%), clinician access to investigation (95%), HIV team involvement in teaching wider NHS (98%) and current location (95%), HIV team involvement in their inpatient care (98%) and co-location of HIV and Sexual Health service (100%). The majority (86%) wanted an NHS provider, while 7% had no preference.
**Discussion/conclusion** The majority of patients preferred an NHS provider, with co-located Sexual Health services. They rated links with acute trust and the wider NHS as important aspects of their care. This needs to be considered while commissioning, planning and delivering future services.

## P080 AUDIT OF THE MANAGEMENT OF SEXUAL ASSAULT COMPLAINANTS ATTENDING GENITOURINARY MEDICINE AGAINST THE BRITISH ASSOCIATION FOR SEXUAL HEALTH AND HIV UK NATIONAL GUIDELINES ON THE MANAGEMENT OF ADULT AND ADOLESCENT COMPLAINANTS OF SEXUAL ASSAULT 2011

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10.1136/sextrans-2016-052718.134

**Background/introduction** Patients attending clinic following an alleged sexual assault (SA) involve a complex history and management plan. The regional Sexual Assault Referral Centre (SARC) is on site and so the clinic receives significant numbers of SA referrals. As a clinic we felt that the proforma for documenting such histories was not fit for purpose.
**Aim(s)/objectives** To compare the documentation and management of SA complainants against standards set out by The British Association for Sexual Health and HIV UK National Guidelines on the Management of Adult and Adolescent Complainants of Sexual Assault 2011.
**Methods** A retrospective case note review of notes coded for SA between 1/1/13 and 31/3/14. 36 case notes were identified for inclusion.
**Results** 32/36 patients were female, 29/36 were heterosexual. 30/36 were of white British origin. 26/36 were referred from the local SARC. Age range 13–79 yrs. Areas which performed well in relation to the auditable outcomes were documentation in relation to: when the assault took place (100%), child protection needs (100%),who the assailant was (94%), if baseline testing occurred (94%), follow up advice (91%), what type of assault (87%). Areas which performed less well included documentation in relation to: bleeding at time of assault (8%), physical injuries (12.5%), ejaculation (24%), self harm (16%), mental state assessment (33%).
**Discussion/conclusion** Documentation of a number of standards requires significant improvement. Safeguarding was well managed, particularly in those under 18. As a result of gaps in documentation a SA proforma has been devised to capture all the detailed information required when assessing SA patients.

## P081 AN AUDIT OF THE MANAGEMENT AND AETIOLOGY OF PROCTITIS IN MEN WHO HAVE SEX WITH MEN (MSM)

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10.1136/sextrans-2016-052718.135

**Background** Proctitis remains an important presentation of MSM to sexual health clinics. It causes significant morbidity and facilitates the transmission of other infections including HIV.
**Aims** To audit the management and aetiology of proctitis in a UK sexual health clinic and determine the pattern of STIs presenting with rectal symptoms.
**Methods** 100 consecutive notes of MSM presenting with rectal symptoms were examined (December 2014 – March 2015). The local clinical management standard is proctoscopy and Gram stain for gonorrhoea; gonorrhoea culture; gonorrhoea/chlamydia NAAT; HSV1/HSV2/*T.pallidum* PCR; syphilis serology. Positive chlamydia NAATs are tested for LGV-associated serovars.
**Results** 88/100 had proctoscopy performed. The tests undertaken and test results are summarised in the table below.

**Abstract P081 Table 1** Proctitis in MSM

| Investigation | No. undertaken | No. positive | % positive |
|---|---|---|---|
| Gram stain for gonorrhoea | 63 | 7 | 11.1 |
| Culture for gonorrhoea | 69 | 13 | 18.8 |
| NAAT for gonorrhoea | 97 | 24 | 24.7 |
| NAAT for chlamydia – non-LGV serovar | 97 | 11 | 11.3 |
| NAAT for chlamydia – LGV serovar | 97 | 10 | 10.3 |
| HSV1 PCR | 66 | 4 | 6.2 |
| HSV2 PCR | 66 | 10 | 15.1 |
| *T.pallidum* PCR | 66 | 3 | 4.5 |
| Syphilis serology | 94 | 7 (active infection) | 7.4 |

43 patients had all the recommended tests. 66 infections were diagnosed in 53 patients. 42 patients had one infection, 9 had two infections and 2 had three infections. 35 patients were diagnosed HIV positive before presentation, 64 patients tested HIV negative at presentation and one patient declined testing.
**Discussion** This audit confirms that the majority of MSM presenting with rectal symptoms had proctoscopy but there is room for improvement in practice as only a minority had all tests undertaken. STIs are a common cause of anal symptoms in MSM and this data strongly supports a low threshold for STI screening. Routine HSV testing in MSM with rectal symptoms is useful.

## P082 EVALUATION OF A NEW LGBTI SERVICE TO COMPLEMENT A BUSY INNER CITY GUM CLINIC

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10.1136/sextrans-2016-052718.136

**Background/introduction** LGBTI individuals are at significantly increased risk of STI's and HIV, as well as sexual violence and discrimination. The need for specialist LGBTI services in level 3 GUM settings is increasingly recognised and also subscribes to BASHH equality and diversity standards. We established a new LGBTI specialist clinic and present here a service evaluation of its first 8 months.
**Aim(s)/objectives** To evaluate a new LGBTI service.
**Methods** Coding for all patients who accessed the service over an 8 month period was collated and used to garner basic information about diagnoses. A 4 week period was then chosen at random and individual patient notes were accessed to get more detailed information.
**Results** There were 526 attendances for 450 individual patients. The rates of STI's compared to our general clinics are tabled below.

**Abstract P082 Table 1** LGBTI Diagnoses

| | LGBTI clinic | General GUM |
|---|---|---|
| Gonorrhoea | 14.0% | 3.8% |
| Chlamydia | 6.4% | 5.0% |
| NSU | 5.3% | 2.9% |
| Syphilis | 3.8% | 1.2% |
| Warts | 4.8% | 6.3% |
| HSV | 2.0% | 4.0% |
| Treated as contact | 20.0% | 6.9% |

In the 4 week period there were 104 booked attendances. The age range was 19 – 75 (mean: 37.1). Of the 92 patients who attended 59% had at least one diagnosis with 13% having multiple diagnoses. 26% were HIV positive.
**Discussion/conclusion** The high STI and HIV rates in this group suggest they will benefit from a specialist service. This involves a reconfiguration of staff compared to general clinics to account for increased requirements for treatments, injections and counselling. An additional qualitative assessment demonstrated that the clinic was also extremely well received by patients.

## P083 PSYCHOLOGICAL IMPACT DUE TO GENITAL HERPES AMONG CENTRAL STD CLINIC ATTENDEES IN SRI-LANKA

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10.1136/sextrans-2016-052718.137

**Background/introduction** Genital herpes is becoming the most prevalent STI throughout the world. Patients with genital herpes are more susceptible to psychological distress, possibly due to its natural history of incurability, asymptomatic viral shedding, recurrences, painful ulcers and risk of transmission to the partner and to the baby.
**Aim(s)/objectives** To study the psycho-social impact among patients with genital herpes.
**Methods** Study design was cross sectional comparative study using HSV infected and non-infected group attending central STD clinic Colombo. Study group was having genital herpes and a comparative group was asymptomatic and did not have genital herpes but having any other STI. Interviewer administered questionnaire was used for 85 from each group. General Health

Questionnaire (GHQ 30), Hospital Anxiety and Depression Questionnaire (HADQ) and the questionnaire related to socio-demographic variables were used.
**Results** The demographic differences were not statistically significant. Social stigmatisation and the fear of transmitting to their partners were high among herpes. This difference is statistically significant at $p < 0.001$. The psychological distress among herpes group 66% (56/85) was significantly higher at $p < 0.001$ than the non herpes group 29% (25/85).The level of anxiety and depression among herpes group was 35% (30/85) and 23.5% (20/85) respectively. For non herpes patients 15% (13/85) and 9% (8/85).The difference in the level of anxiety and depression among two groups was statistically significant at $p < 0.05$.
**Discussion/conclusion** Patients with genital herpes had more psychological distress, anxiety and depression compared to non herpes patients.

## P084 AN UNUSUAL CASE OF INTRADERMAL "KISSING" NAEVUS PRESENTING AS PENILE WARTS

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10.1136/sextrans-2016-052718.138

**Background/introduction** We describe a case of a 38 yr old white heterosexual male with Crohns disease presenting with warty lesions of the penis which were found on histological diagnosis to be benign intradermal naevi. The differential diagnosis included papular warts, skin tags, and in this case Crohns and pyoderma gangrenosum.
**Aim(s)/objectives** Initially presented with two smooth papular warty type lesions on the prepuce and glans adjacent to the coronal sulcus,which had been present for several months causing discomfort during sexual activity and unsightly appearance. Currently taking oral prednisolone and mesalazine for longstanding Crohns disease,with no other cutaneous manifestations, and had regular female partner.
**Results** Initially treated with Liquid Nitrogen application but with minimal resolution and in light of his medical history to exclude "metastatic" Crohns and associated pyoderma gangrenosum a punch biopsy was carried out. Histological appearances were that of a benign intradermal naevus with characteristic nests of naevus cells within the dermis only, there was no atypia present. He was subsequently referred to the urologist for surgical excision of the lesions.
**Discussion/Conclusion** Benign intradermal naevi or "kissing naevi" of Penis such as this are extremely rare there being only a handful previously reported. Due to the dermal location of naevus cells they usually present as skin coloured or slightly pigmented papules and may be confused with warts, skin tags or dermatofibroma. Treatment with surgical excision or laser therapy results in satisfactory functional and aesthetic outcomes.

## P085 A RE-AUDIT LOOKING AT CHAPERONING IN AN INTEGRATED SEXUAL HEALTH CLINIC

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10.1136/sextrans-2016-052718.139

**Background** According to the General Medical Council (GMC) intimate examination guidelines 2013, the British Association of Sexual Health and HIV and the Royal College of Nursing guidelines, a chaperone should be offered when conducting an intimate examination. The GMC guidance supports clinicians who do not want to perform an intimate examination unchaperoned. The presence of a chaperone is considered essential in The Royal College of Obstetricians & Gynaecologists clinical governance advice, January 2015.
**Aim** A retrospective audit was conducted in our integrated sexual health clinic to see if a chaperone was being used for intimate examinations according to the GMC guidelines. Method: 100 cases were identified in January 2015 and a re-audit was conducted in July 2015.
**Results** In January 2015, 70% of patients accepted an examination. In 9% of these cases the offer of a chaperone was not documented. 44% declined a chaperone and 54% accepted. In July 2015: 63% of patients accepted an examination. In 14% of these cases the offer of a chaperone was not documented. 54% declined a chaperone, 40% accepted.
**Conclusion** Documentation of the offer of a chaperone has worsened. In July 2015, the majority of staff are performing an intimate examination unchaperoned, as patients decline the offer. In order to reduce the risk of false accusation against clinicians and nurses during an intimate examination, it is essential we follow the GMC guidance and ensure a chaperone is present for all intimate examinations.

## P086 AN AUDIT OF THE MANAGEMENT OF PERSISTENT AND RECURRENT NON-GONOCOCCAL URETHRITIS (PNGU) IN A LARGE LONDON TEACHING HOSPITAL

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10.1136/sextrans-2016-052718.140

**Background/introduction** The British Association of Sexual Health and HIV (BASHH) released a new national guideline on the management of non-gonococcal urethritis (NGU) in 2015. This audit was completed to assess compliance and identify areas for service improvement.
**Aim(s)/objectives** To compare the management of pNGU against national guidelines.
**Methods** A retrospective case note review was performed for all patients having two or more NGU code (C4N) over a 12-month period from 1st April 2014. We collected demographic details, presenting symptoms, signs, investigations, management and number of visits.
**Results** 130 patients were identified from three different clinics within the same Trust. A total of 282 visits were recorded. 35.4% of visits were diagnosed as NGU and 66.2% as pNGU. We achieved 100% compliance with all four of BASHH auditable out comes (i.e. screening for C. trachomatis (CT) and gonorrhoea, documented offer of written information, delivery of first-line therapy and partner notification). Only one patient was diagnosed with CT. In recurrent visits, only 31.0% of further investigations were done and 12.6% of them were treated as pNGU according to the guideline. 55.2% of the patients had 4 or more visits.
**Discussion/conclusion** We demonstrated high levels of compliance with national guidelines for managing NGU. However, management of patients with pNGU was sub-optimal with a lack of appropriate investigations and incorrect treatment regimes.

Low levels of CT positivity in this cohort demonstrate the importance of further investigations. Correct pNGU treatment may also lead to fewer visits and reduced burden on the service.

## P087 WHERE HAS ALL THE MYCOPLASMA GONE?

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10.1136/sextrans-2016-052718.141

**Background** Non gonococcal urethritis (NGU) is thought to be most often due to *Chlamydia trachomatis* (CT), *Mycoplasma genitalium* (MG) and *Ureaplasma urealyticum*. Standard doses of Azithromycin 1g stat may be insufficient to clear MG and may induce resistance to macrolides while doxycycline is not sufficient to clear MG. Doxycycline has been advocated as first line therapy for NGU allowing extended dosage with Azithromycin in those that do not clear with first line therapies.
**Aim** To look at the current pathways for managing NGU and assess how often patients who have first line Doxycycline return for further therapy.
**Methods** A retrospective review of all patients initially treated for NGU in August and September 2015 across a sexual health trust.
**Results** Of the 208 cases reviewed, 26.4% were due to CT. 99.5% of all cases were treated with a first line antibiotic; with 95.2% receiving Doxycycline 100mg bd for 7 days compared to 4.3% receiving Azithromycin 1g stat. In both the CT and non-CT groups 9%, returned within 90 days after experiencing symptoms despite treatment. Of these, only 15.8% were diagnosed with persistent NGU and treated with extended Azithromycin.
**Conclusion** Current pathways designed to preserve macrolide therapy using Doxycycline initially result in few patients reattending with persistent symptoms than would be anticipated. The impact of Doxycycline on reducing MG load and related symptoms should be factored into advice given to patients who may dismiss mild symptoms or be reassured by negative CT/NG NAATs often communicated to them by text.

## P088 SEXUAL CONTACT IS THE TRIGGER! WOMEN'S VIEWS AND EXPERIENCES OF THE TRIGGERS FOR THE ONSET OF BACTERIAL VAGINOSIS AND EXACERBATING FACTORS ASSOCIATED WITH RECURRENCE

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10.1136/sextrans-2016-052718.142

**Background/introduction** Bacterial vaginosis (BV) is the most common vaginal infection affecting women of childbearing age. While the aetiology and transmissibility of BV remain unclear, there is strong evidence to suggest an association between BV and sexual activity.
**Aim(s)/objectives** This study aimed to explore women's views and experiences of the triggers for BV onset and factors associated with recurrence
**Methods** A descriptive, social constructionist approach was chosen as the framework for the study. Thirty five women of varying sexual orientation who had experienced recurrent BV in the past five years took part in semi-structured interviews.
**Results** The majority of women predominantly reported sexual contact triggered the onset of BV and sexual and non-sexual factors precipitated recurrence. Recurrence was most commonly referred to in terms of a 'flare-up' of symptoms. The majority of women did not think BV was an STI however many reported being informed this by their clinician. Single women who attributed BV onset to sex with casual partners were most likely to display self-blame tendencies and to consider changing their future sexual behaviour. Women who have sex with women (WSW) were more inclined to believe their partner was responsible for the transmission of or reinfection with BV and seek partner treatment or change their sexual practices.
**Discussion/conclusion** Findings from this study strongly suggest women believe that BV onset is associated with sexual activity, concurring with epidemiological data which increasingly suggest sexual contact is associated with the development of BV. There was some evidence to suggest possible transmission among WSW reinforcing the need for new approaches to treatment and management strategies.

## P089 DETECTION OF *NEISSERIA GONORRHOEAE* BACTERIAL LOADS IN THE PHARYNX AND SALIVA AMONG MEN WHO HAVE SEX WITH MEN

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10.1136/sextrans-2016-052718.143

**Background/introduction** Studies have shown that *N. gonorrhoeae* can be cultured in human saliva among individuals with pharyngeal gonorrhoea. As saliva could potentially act as a carrier for gonorrhoea transmission during sex, the bacterial load of *N. gonorrhoeae* in saliva may influence the transmissibility of gonorrhoea.
**Aim(s)/objectives** To quantify the gonococcal bacterial load in the pharynx and saliva among men who have sex with men (MSM) with untreated pharyngeal gonorrhoea.
**Methods** MSM who tested positive for pharyngeal gonorrhoea by culture were recalled for antibiotic treatment within 14 days between October 2014 and March 2015. The gonococcal bacterial load was estimated using real-time quantitative PCR (qPCR) by interpolating against a standard curve generated with known gonococcal DNA copy numbers. The median of gonococcal bacterial load in the pharynx and saliva was calculated and compared between culture positivity using Mann-Whitney *U* test.
**Results** A total of 33 men were included in this study. At the time of treatment, the median gonococcal bacterial load in the pharynx was similar in men who were culture-positive ($2.5 \times 10^5$ copies/swab) and culture-negative ($2.9 \times 10^4$ copies/swab) ($p = 0.166$), and similar in the saliva in culture-positive: $2.2 \times$

$10^5$ copies/ml compared to culture-negative: $2.7 \times 10^5$ copies/ml samples ($p = 0.499$).

**Discussion/conclusion** The gonococcal bacterial loads were similar between saliva and the pharynx and not influenced by culture status. Saliva could be important in the transmission of gonorrhoea such as oral-anal sex and saliva use as a lubricant for anal sex.

## P090 ASSORTATIVE SEXUAL MIXING PATTERNS IN MALE-FEMALE AND MALE-MALE PARTNERSHIPS IN MELBOURNE, AUSTRALIA: IMPLICATIONS FOR HIV AND STI TRANSMISSION

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10.1136/sextrans-2016-052718.144

**Background/introduction** Assortative (like-with-like) mixing pattern has become a new and important focus in HIV/STI research in recent years in order to understand the mixed sexual network. There are very limited data on sexual mixing patterns, particularly in an Australian population.

**Aim(s)/objectives** To understand the assortative sexual mixing patterns for age, number of partners, and condom use in male-female and male-male partnerships in Melbourne between 2011 and 2014.

**Methods** 1165 male-female and 610 male-male partnerships were included. Correlation between age of partners was examined by the Spearman's rank correlation. The Newman's assortativity coefficient was used as an aggregate quantitative measurement of sexual mixing of number of partners and condom use.

**Results** There was a strong positive correlation between age of partners in both male-female (rho = 0.709; $p < 0.001$), and male-male partnerships (rho = 0.553; $p < 0.001$). The assortative mixing pattern for number of partners was similar in male-female ($r = 0.255$), and male-male partnerships ($r = 0.264$). This pattern decreased over time in male-male (p = 0.034) but not in male-female ($p = 0.718$) partnerships. There was a stronger assortative mixing pattern for condom use in male-male ($r = 0.517$) compared to male-female ($r = 0.382$) partnerships.

**Discussion/conclusion** Male-female and male-male partnerships have a high assortativity mixing patterns with respects for age, number of partners, and condom use. Individuals are more likely to connect with partners with of similar age and sexual experience. The sexual mixing pattern is not purely assortative; and hence it may lead to increased HIV and STI transmission in certain risk groups.

## P091 EVALUATION OF THE CURRENT AND PROSPECTIVE ROLE OF POOLED SAMPLING FOR SEXUALLY TRANSMITTED INFECTION TESTING: A WEB-BASED SURVEY OF GENITOURINARY MEDICINE SERVICES IN ENGLAND

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10.1136/sextrans-2016-052718.145

**Introduction** *Chlamydia trachomatis* and *Neisseria gonorrhoeae* testing guidance recommends extragenital screening with locally validated nucleic acid amplification tests for patients reporting receptive oral and/or anal sex, with anatomical sites sampled and tested separately. Within-patient pooled sampling (PS) could be more cost effective for triple -site (genital/oral/anal) testing, but may require establishment of complex management pathways and loss of information to guide risk assessments and treatment.

**Objectives** We reviewed the evidence on the cost effectiveness of PS and explored current opinion and practice among genitourinary medicine (GUM) clinics in England.

**Methods** Global literature on PS was reviewed. A web-based survey was distributed to GUM clinical leads throughout England on 11/02/16.

**Results** Published evidence supports multi-patient combined aliquot PS for population screening, however evidence for within-patient PS is sparse. 44/223 (19.7%) services responded to the web survey. One service (2.3%) reported current PS and 2 (4.5%) were awaiting implementation. Of the 41 services not pooling, 4 (9.8%) were considering future implementation. Commonly reported barriers to implementation of PS were: loss of infection site information (30/44, 68.2%), absence of national guidance (26/44, 59.1%), and decreases in assay sensitivity/specificity (17/44, 38.6%). Only 6/44 (13.6%) considered the current level of evidence sufficient to support PS, with 35/44 (79.5%) requesting further validation studies, 34/44 (77.3%) national guidance, and 23/44 (52.3%) more cost effectiveness data.

**Conclusion** PS is currently uncommon in GUM services across England. Best practice evidence-based guidance on the appropriate use of PS will be needed if PS is introduced more widely as part of cost-saving measures.

## P092 PELVIC INFLAMMATORY DISEASE: A REVIEW OF PRESENTATIONS TO OUR SERVICE

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10.1136/sextrans-2016-052718.146

**Background/introduction** Pelvic inflammatory disease (PID) is an important complication of the sexually transmitted infections *Chlamydia trachomatis* and *Neisseria gonorrhoea*.

**Aim(s)/objectives** We sought to review the presentation and management of women treated for PID attending our service.

**Methods** We used the SHHAPT code C5A to identify women diagnosed with PID between 01/06/2015–30/11/2015. We performed a retrospective case note review of all women, collecting demographic data and details of their presentation and management.

**Results** 50 cases were identified. The women ranged from ages 17–40 years, median 23.5 years. Presenting complaints were pelvic pain (38/50), discharge (21/50), dyspareunia (14/50) and bleeding irregularities (14/50). The majority of women (40/50) reported having a regular male partner, and most (42/50) had had one partner only in the preceding 3 months. 4/50 (8.0%) women tested positive for chlamydia, all of whom were aged less than 25 years. No other sexually transmitted infections were identified. The rate of chlamydia amongst women less than 25 treated for PID was 4/31 (12.9%). Less than half of women (19/50) attended for follow up, and there was documentation of the regular partner attending for treatment in only 14/40 cases.

**Discussion/conclusion** Our project reflects Chlamydia as an important cause of PID in younger women. This supports the latest guidance recommending repeat Chlamydia screening in under 25s to identify reinfections and reduce the risk of complications such as PID.

## P093 AUDIT ON THE MANAGEMENT OF EPIDIDYMO-ORCHITIS IN A LONDON-BASED LEVEL 3 SEXUAL HEALTH CLINIC

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10.1136/sextrans-2016-052718.147

**Background/introduction** The aetiology of epididymo-orchitis is largely related to a patient's age with sexually transmitted pathogens being the common aetiological agents in those under 35 years of age. In individuals aged over 35 uropathogens represent the commonest cause. National guidelines exist for the appropriate management of this condition.
**Aim(s)/objectives** To assess the management of epididymo-orchitis in our clinic with reference to the BASHH guidelines.
**Methods** A case note review of all men with epididymo-orchitis attending our clinic between January and June 2015. Age at time of diagnosis, investigations and treatment decisions were recorded.
**Results** A total of 59 patients were identified ranging from age 16 to 67. Only 66% of patients had all four recommended microbiological investigations performed (target 90%). Nineteen patients did not have an MSU microscopy/culture performed and 7 had no urethral smear. All patients were tested for chlamydia and gonorrhoea. All 59 patients were prescribed an appropriate antibiotic regimen. The 5 patients who did not respond clinically had a documented plan for further clinical action.

**Abstract P093 Table 1** Epididymo-orchitis

| | Age ≤ 35 years | Age > 35 years | Total |
|---|---|---|---|
| No. of patients | 38 | 21 | 59 |
| CT positive | 5 | 0 | 5 |
| GC positive | 0 | 0 | 0 |
| MSU positive | 1 | 1 | 2 |

**Discussion/conclusions** This audit demonstrated that patients attending our clinic were treated in concordance with national guidelines and the vast majority showed a good clinical response. However, lack of routine urine sampling for microscopy/culture was evident. Although a urine dipstick was performed in most cases, guidelines do stipulate that this only serves as a useful adjunct. As a result of this audit our department intends to obtain an MSU for culture in all cases of epididymo-orchitis.

## P094 *CHLAMYDIA TRACHOMATIS* (CT) POSITIVITY RATE AT 2 WEEK *NEISSERIA GONORRHOEAE* (NG) TEST OF CURE (TOC)

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10.1136/sextrans-2016-052718.148

**Background/introduction** Whilst guidelines recommend NG TOC 2 weeks after treatment, there is little data on the optimum time to perform a TOC for CT in those for whom this is indicated. Current BASHH guidelines recommend deferring TOC for at least 3 weeks after treatment because residual chlamydial DNA may persist.
**Aim(s)/objectives** Patients who are treated for NG and CT co-infection re-attending for subsequent NG TOC are tested for both infections by NAAT providing the opportunity to evaluate the CT positivity rate at re-attendance.
**Methods** A retrospective case review of co-infected GC/CT positive (analysed with Cepheid GeneXpert) patients tested in a London sexual health clinic over 12 consecutive months was performed. TOC details were evaluated, and appropriate antibiotic treatment according to BASHH guidelines was assessed.
**Results** 480 patients tested positive for both infections and 132 attended for TOC within 21 days of treatment (median 15 days, IQR 14–17). Of these 131 were male, of whom 126 MSM; median age was 35 y and median number of sexual partners in previous 3 months was 5. Site of CT infection was rectal (94), urethral (49), throat (11), vulvovaginal (1). At TOC, 6 (4.5%) had a persistent positive CT NAAT: rectum (3), urethra (3). One patient with persistent rectal CT had received treatment with azithromycin; the other 5 received BASHH preferred treatment. By comparison, 3 (2.3%) had a positive NG NAAT at TOC.
**Discussion** CT positivity 15 days after treatment is low, suggesting that TOC at 2 weeks may be a possible management strategy.

## P095 GETTING HIGH AND HAVING SEX- ARE YOUNG WOMEN JOINING THE PARTY?

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10.1136/sextrans-2016-052718.149

**Background** Use of 'chems' by MSM (men who have sex with men) is reported widely and is associated with poor sexual health outcomes but less is known for the general GU clinic population.
**Aims** To determine the proportion of men and women reporting recreational drug use and identify sexual risk taking and health outcomes.
**Methods** Patients attending GUM from 1–21st December 2015 were invited to complete an anonymous paper questionnaire. Age, sexual orientation, sexual partners, STIs, smoking, drug and alcohol use were collected.
**Results** 128 men (32.8% MSM) and 101 women responded. 19% women, 36% heterosexual men (HM) and 52% MSM reported recreational drug use in the past 12 months. Women users were younger (age range 19–42, median 23) and their preferred drug was Cocaine (12%). Men were older (age range 19–67, median 28), cocaine was a preferred drug (28% HM, 19% MSM) but MSM also used Mephadrone, Ecstasy and Viagra equally (19%). Users reported UPSI with multiple partners in the last 3 months more often (68% MSM, 50% HM, 53% females) compared with non users (30% MSM, 26% HM and 17% females). Female users reported the highest recent STI rates, 68% (MSM 55%) and non-consensual sex (21%).
**Discussion** We found significant drug use and risky sexual behaviour amongst heterosexuals, although MSM remain the highest

users. Drug use by young women is of particular concern and may lead to sexual health morbidity. We believe this group is currently under-recognised and opportunities for risk reduction are being missed.

## P096 CONCORDANCE OF CHLAMYDIA INFECTIONS OF THE RECTUM AND URETHRA IN SAME-SEX MALE PARTNERSHIPS: A CROSS-SECTIONAL ANALYSIS

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10.1136/sextrans-2016-052718.150

**Background**

Sexual health services should ask all high risk attenders about drug and alcohol use. However, the impact of drug and alcohol use on STI epidemiology remains uncertain.

**Aims** To audit drug and alcohol history taking after introduction of a screening tool and to describe the patterns of use and associations with STI diagnoses.

**Methods** An anonymised database of all clients attending in 2015 was constructed including basic demographics, reported drug and alcohol history, HIV status and STI diagnoses.

**Results** 48,654 clients were seen in 2015. 26,429 (54%) were asked about drug and/or alcohol use at least once. Use of any drug or excess alcohol was reported by 16% and was associated with higher rates of STIs (24 vs 10%, $p < 0.001$). Amongst MSM, 62% had a drug and/or alcohol history taken, compared with 47% and 55% in heterosexual men (MSW) and women, respectively ($p < 0.0001$). STIs diagnoses were significantly higher in drug users compared to non-users (27 vs 11%), but were not different comparing alcohol excess vs no excess (14 vs 13%). STI diagnoses were significantly higher in drug users compared to non-users in all sub-groups – MSM (41 vs 20%) MSW (26 vs 18%) women (12 vs 7%) – all $p < 0.0001$.

**Conclusions** The audit showed room for improvement in history taking. Chemsex drugs are associated with the highest risk of STIs. This relationship might not be causal. Party drug use was associated with some STIs. The audit supports drug and alcohol histories for all MSM as well as heterosexual men and women attending with STIs.

## P097 ARE PATIENTS IN RURAL COMMUNITIES INTERESTED IN ONLINE SEXUAL HEALTH SERVICES?

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10.1136/sextrans-2016-052718.151

**Background/introduction** People do not attend Genitourinary Medicine (GUM) services for reasons including cultural beliefs and stigma. In Cornwall geographical isolation, poor transport and local Council budgetary cuts to peripheral clinics also limit access.

**Aim(s)/objectives** To ascertain whether patients would use online services to book appointments and/or order home testing kits.

**Methods** An anonymised questionnaire survey of GUM patients. Data was recorded into an Excel spreadsheet and analysed using SPSS.

**Results** 248 questionnaires were returned from women(59.7%) and men(40.3%) aged 13–72 years. 154 (62.3%) were previous

**Abstract P096 Table 1** Association of reported drug and alcohol use and STI diagnosis in 2015

| | | [1]Chems Yes, % N = 26,429 asked | [4]p-value | [2]Party Yes, % N = 26,429 asked | [4]p-value | [3]Alcohol excess, % N = 20,406 asked | [4]p-value |
|---|---|---|---|---|---|---|---|
| Total | | 4.4% n = 1046 | | 12% n = 2891 | | 6% n = 1225 | |
| Gender/ | MSM | 16.5 | **<0.0001** | 15.9 | **<0.0001** | 8.7 | **<0.0001** |
| Sexual orientation (MSW-heterosexual men) | MSW | 0.9 | | 18.2 | | 9.1 | |
| | Women | 0.3 | | 7.1 | | 3.9 | |
| New STI this year | Yes | 17.0 | **<0.0001** | 19.6 | **<0.0001** | 6.6 | 0.156 |
| | No | 2.4 | | 10.9 | | 5.9 | |
| Chlamydia | Yes | 14.0 | **<0.0001** | 19.1 | 0.435 | 7.1 | 0.257 |
| | No | 20.6 | | 20.2 | | 6.0 | |
| Gonorrhoea | Yes | 33.2 | **<0.0001** | 23.8 | **<0.0001** | 6.8 | 0.753 |
| | No | 7.8 | | 17.2 | | 6.5 | |
| Syphilis | Yes | 40.1 | **<0.0001** | 21.7 | 0.320 | 4.7 | 0.191 |
| | No | 14.5 | | 19.3 | | 6.8 | |
| HSV | Yes | 8.0 | **<0.0001** | 17.4 | 0.190 | 5.3 | 0.205 |
| | No | 18.6 | | 20.0 | | 6.9 | |
| Hepatitis B | Yes | 17.1 | **<0.006** | 9.7 | 0.252 | 6.7 | 1.000 |
| | No | 0 | | 19.7 | | 6.6 | |
| Hepatitis C | Yes | 65.7 | **<0.0001** | 45.7 | **<0.0001** | 0 | 0.166 |
| | No | 16.4 | | 19.3 | | 6.7 | |

[1]"Chemsex drugs" (mephedrone, gamma-Hydroxybutyric acid, methamphetamine)
[2]"Party drugs" (cannabis, ecstasy/MDMA, cocaine, ketamine)
[3]Excess alcohol use was >14 units for women and >21 units for men.
[4]p-values calculated using Chi squared or Fisher exact test as appropriate.

attendees and 234 (94.7%) had internet access. Confidentiality was more important than face-to-face consultations or 24 hr access to testing (p = *0.036*). Previous GUM attendees were more likely to book appointments compared to new users who would attend a drop-in clinic (p = *0.011*).

**Abstract P097 Table 1** Rural communities' sexual health services

| | Yes (%) | No (%) | P-Value |
|---|---|---|---|
| **Car Access** | 63.7 | 26.3 | |
| <18 | 67.6 | 32.4 | ***0.000*** |
| 18–25 | 58.2 | 41.8 | |
| >25 | 86.9 | 13.1 | |
| **Interested in Online Booking** | 71.8 | 28.2 | |
| <18 | 54.3 | 45.7 | ***0.023*** |
| 18–25 | 78.9 | 21.1 | |
| >25 | 71.7 | 28.3 | |
| **Would take finger prick blood test (FPBT)** | 71.7 | 28.3 | |
| Men | 75.6 | 24.4 | 0.366 |
| Women | 69.6 | 30.4 | |
| <18 | 58.8 | 41.2 | 0.354 |
| 18–25 | 70.0 | 30.0 | |
| >25 | 74.8 | 25.2 | |
| **Would take Chlamydia (CT) and Gonorrhoea (GC) samples** | 86.3 | 13.7 | |
| Men | 90.0 | 10.0 | 0.237 |
| Women | 83.8 | 16.2 | |
| <18 | 73.3 | 26.7 | 0.060 |
| 18–25 | 92.2 | 7.8 | |
| >25 | 83.5 | 16.5 | |

**Discussion/conclusion** Patients would be willing to consider online services. Home testing could reach those who struggle to access clinics through lack of transport and appealed most to patients >18years, a group that should be targeted.

## P098 ADHERENCE TO AND ACCEPTABILITY OF MOUTHWASH AS A POTENTIAL PREVENTIVE INTERVENTION FOR PHARYNGEAL GONORRHOEA AMONG MEN WHO HAVE SEX WITH MEN IN AUSTRALIA – AN OBSERVATIONAL STUDY

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**Background/Introduction** Gonorrhoea infections amongst men who have sex with men (MSM) are at a 20-year high, and antibiotic resistance is also increasing. Pharyngeal gonorrhoea is an important contributor to gonorrhoea transmission, and gonorrhoea acquires genes that confer antibiotic resistance from other pharyngeal bacteria.

**Aim(s)/Objective(s)** This study assessed whether MSM would adhere to a regimen of daily mouthwash use, as a new intervention to prevent pharyngeal gonorrhoea.

**Methods** Ten MSM at were invited to use Listerine® alcohol-containing mouthwash daily for 14 days in August 2015. Participants were asked to complete baseline and follow-up questionnaires about their experience of mouthwash use, and a daily diary to record mouthwash use over the 14-day study period.

**Results** The participants' mean age was 28 years (SD 7.2). Mouthwash was used at least once daily for 133 of 140 days (95% of days; 95% CI 90% to 98%). All ten men reported willingness to use mouthwash on a daily basis, and nine men were willing to use mouthwash after oral sex.

**Conclusion:;** This study showed a high adherence to daily use of mouthwash and that it is an acceptable intervention to reduce the risk of pharyngeal gonorrhoea in MSM. Further studies are required to assess whether Listerine® mouthwash is effective against pharyngeal gonorrhoea *in vitro* and *in vivo*. If this is confirmed, then this will be a novel strategy to reduce transmission of gonorrhoea amongst MSM and may potentially also reduce rates of antimicrobial resistance.

## P099 RENAL SAFETY OF TENOFOVIR ALAFENAMIDE IN PATIENTS AT HIGH RISK OF KIDNEY DISEASE

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10.1136/sextrans-2016-052718.153

**Background/introduction** Compared with tenofovir disoproxil fumarate (TDF), tenofovir alafenamide (TAF) results in significantly reduced plasma tenofovir (TFV) and has demonstrated less impact on surrogate markers of renal and bone health in multiple populations, but renal outcomes in treatment-naïve subjects at risk for chronic kidney disease (CKD) have not been characterised.

**Aim(s)/objectives** Renal outcomes in treatment-naïve subjects at risk for chronic kidney disease (CKD) were investigated.

**Methods** Treatment naïve HIV-1+ adults were randomised 1:1 to a single tablet regimen of elvitegravir, cobicistat, emtricitabine, with TAF (E/C/F/TAF) or (E/C/F/TDF) once daily in two double blind studies. Assessments of renal function including markers of proximal renal tubulopathy were carried out. A post-hoc analysis of renal function by group with high risk vs low risk for development of CKD is described.

**Results** Of 1,733 participants, those with high CKD risk was similar by treatment arm (E/C/F/TAF 28%, E/C/F/TDF 32%). Among high CKD risk participants, significantly fewer subjects on E/C/F/TAF experienced a decline in eGFR to below 60 mL/min compared to E/C/F/TDF: 4.9% vs 9.6% (p = 0.044). Participants with high CKD risk who initiated E/C/F/TAF also had significant declines in multiple measures of quantitative proteinuria. Within the low CKD risk group, significantly fewer participants receiving E/C/F/TAF experienced a decline in eGFR by ≥25% (11.5% vs 24.9%, p < 0.001). High rates of virologic suppression at week 48 were observed in both treatment groups in the high CKD risk category.

**Discussion/conclusion** Among participants with both low and high CKD risk, participants receiving E/C/F/TAF had more favourable renal outcomes compared with those treated with E/C/F/TDF. These data support the improved renal safety profile of TAF.

## P100 EXPLORING WHY A COMPLEX INTERVENTION PILOTED IN GENERAL PRACTICES DID NOT RESULT IN AN INCREASE IN CHLAMYDIA SCREENING AND DIAGNOSIS: A QUALITATIVE EVALUATION USING THE FIDELITY OF IMPLEMENTATION MODEL

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10.1136/sextrans-2016-052718.154

**Background** To facilitate opportunistic chlamydia screening in general practices, a complex intervention (3Cs and HIV), based on the previously successful CIRT trial, was implemented across England. The intervention, to encourage practice staff to routinely offer chlamydia testing, only increased chlamydia screening in larger practices or in those offered incentives.
**Aims** a) Explore why the modified intervention did not increase screening across all general practices. b) Suggest recommendations for future intervention implementation.
**Methods** Phone interviews were carried out with 26 GP staff exploring their opinions on the workshops and intervention implementation in practice. Interview transcripts were thematically analysed and further examined using the fidelity of implementation model.
**Results** Participants were positive about the workshops but attendee numbers were low. Often, the intervention content was not adhered to: practice staff were unaware of any on-going trainer support; computer prompts were only added to the female contraception template; patients were not encouraged to complete the test immediately; and videos and posters were not utilised, as suggested. Staff reported that financial incentives, themselves, were not a motivator; competing priorities and time were identified as major barriers.
**Conclusions** Not adhering to the exact intervention model may explain the lack of significant increases in chlamydia screening. To increase fidelity of implementation and consequently improve likelihood of increased screening, the intervention needs to have: more specific action planning; computer prompts added to systems and used; all staff attend the workshop; and on-going practice staff support.

## P101 LATE PRESENTATION OF HIV (HUMAN IMMUNODEFICIENCY VIRUS) INFECTION AT A DISTRICT GENERAL HOSPITAL

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10.1136/sextrans-2016-052718.155

**Background/introduction** A significant proportion of patients (390/6360 (6.1%) in 2012 nationally) present with an AIDS defining illness yearly despite increasing awareness and recognition of HIV. In 2012 the British HIV Association (BHIVA) suggested newly diagnosed patients should commence Anti-Retroviral Therapy (ART) if their CD4 count <350 cells/mm$^3$, they have an AIDS defining illness or a neurological complication.
**Aim(s)/objectives** A re-audit was performed following previous audits in 2006/07 and 2011/2012 to ascertain whether late presentation has improved.
**Methods** A retrospective study compiled data from case notes of the newly diagnosed between 01/01/2014 and 31/12/2015. Defining late presenters as a CD4 count <350 cells/mm$^3$ or an AIDS defining illness.
**Results** 100 patients were identified, 33 were transfers and excluded. 67 remained of which 82.1% were male and 17.9% female. 52.2% were late presenters and 25.4% had an AIDS defining illness of which 9 had PCP, 6 had oesophageal candidiasis, 1 had cryptococcal meningitis and 1 had OHL. Overall 35.8% had a CD4 <200 cells/mm$^3$ (42.9% in 2011/2012 audit) and 68% of the late presenters.
**Discussion/conclusion** An improvement was identified in patients presenting with a CD4 count <350 cells/mm$^3$ (52.2%) compared with 2011/12 audit (55.7%). A high proportion continue to present with AIDS defining illnesses or depleted CD4 levels despite growing awareness of HIV and accessibility to health care. Poor prognosis, increasing morbidity and mortality is associated with late presentation. Atypical and opportunistic infections should prompt HIV testing amongst clinicians in both primary and secondary care along with improving patient education and contact tracing to minimise late presentation.

## P102 PRIMARY CARE SUPPORTED BY LEVEL 3 SEXUAL HEALTH CAN PROVIDE A HIGHLY ACCEPTABLE STI SERVICE TO MEN WHO HAVE SEX WITH MEN (MSM)

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10.1136/sextrans-2016-052718.156

**Background/introduction** Future health interventions for MSM (HPV vaccination & HIV-PrEP) may need to be delivered in primary care: services need to be acceptable to MSM and aware of patient's sexuality. We are a walk in primary care and level 2 sexual health service in a city with a large MSM population supported by the local level 3 integrated sexual health service.
**Aim(s)/objectives** To measure the acceptability of an STI service in primary care.
**Methods** We offered an anonymous patient survey in the service between January and February 2016.
**Results** 93/120 (83%) surveys were completed. 62/93 (67%) of participants were male: 45/93 (48%) identified as MSM. 91/93 (98%) were satisfied with the clinical environment, 92/93 (99%) said the service was accessible, 92/93 (99%) would use the service again and 90/9% (97%) would recommend the service to family and friends. 24/45 (53%) MSM and 23/48 (48%) non-MSM had previously used primary care for STI screening. 19/45 (42%) MSM and 12/48 (25%) non-MSM previously had Chlamydia. 27/45 (60%) MSM, 7/48 (15%) non-MSM previously had Gonorrhoea. 7/45 (16%) MSM and 2/48 (4%) of non-MSM were previously diagnosed with Syphilis. 5/45 (11%) of MSM and 8/48 (17%) of non-MSM said their GP was not aware of their sexuality. 9/45 (20%) MSM and 7/38 (18%) non-MSM voluntarily informed their GP of their sexuality. 15/45 (33%) of MSM and 13/48 (27%) of non-MSM were asked about their sexuality by their GP.
**Discussion/conclusion** Our primary care STI service is acceptable to patients who appear to attend primary care for sexual health including MSM with high rates of STIs. Systems to determine sexuality in primary care will be necessary for implementation of HPV vaccination and other health interventions in MSM

## P103 INCREASING STI DIAGNOSIS, TREATMENT AND AWARENESS AT THE WORLD'S LARGEST ANNUAL SEXUALITY AND LIFESTYLE CONVENTION WITH THE AID OF POINT-OF-CARE TESTING

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**Background** Sexpo is the largest sexual health and lifestyle exhibition in the world. It launched in the UK (London) in November 2015.
**Aim** Raise sexual health awareness and offer STI screening to attendees identifying whether these clients attend mainstream GUM services.
**Methods** A health bus was stationed inside the exhibition where attendees and exhibitors received a sexual health consultation and free STI testing (including HIV point of care tests), condoms and contraceptive information. Interactive seminars, covering common sexual health and contraceptive themes, were delivered by our team of five nurses, two health advisers, one doctor and one event co-ordinator.
**Results** 205 patient consultations occurred. These were 56% (114) male, 44% (89) female and a median age 33 years. Most clients were white British, 51% (104), or white Other, 23% (47). 77% (156) identified as heterosexual, 10.8% (22) bisexual women, 9.9% (20) MSM, 0.5% (1) WSW and 2% (4) declined to answer. 5% (12) identified as swingers. 100% were offered an HIV test, 188 (94%) accepted. 31.5% (64) clients had never tested for HIV before. 199 clients accepted either HIV or STI testing: of these 5% (10) were diagnosed with an STI. All patients with an STI were offered treatment. 3% (6) clients reported hazardous use of drugs.

**Abstract P103 Table 1** STI diagnoses at Sexpo

| STI | % (N) |
|---|---|
| Syphilis | 0.5% (1) |
| Hepatitis B | 0.5% (1) |
| Hepatitis C | 0.5% (1) |
| Chlamydia | 3.5% (7) |

**Discussion** Visitors to this exhibition found our opportunistic sexual health screening acceptable. Up to 15% of our clients were amongst high risk groups and 1 in 20 clients were diagnosed with an STI. 31.5% (64) clients had not accessed mainstream GUM services before.

## P104 MANAGEMENT OF CHRONIC PROSTATITIS IN AN INNER LONDON SEXUAL HEALTH CLINIC

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10.1136/sextrans-2016-052718.158

**Introduction** Chronic prostatitis is a distressing condition with significant impact of quality of life. Chronic prostatitis (CP) symptoms include pain, urinary symptoms and sexual dysfunction. The prevalence of prostatitis is approximately 5- 9% in the general population. This retrospective case study evaluated the management of this condition using the NIH –Prostatitis symptoms index (NIH-CPSI) and UPOINT involving 6 domains (urinary, psychological, organic-specific, infection, neurological/systemic, tenderness) to stratify patient into specific symptoms-led phenotypes.
**Method** The symptoms of patients were captured using the NIH- CPSI scores and the UPOINT diagnostic algorithm addressing CP phenotypic domains according to the likely aetiology mechanism (3). NIH-CPSI is used to measure the severity of CP symptoms, encompassing 13 items grouped into three domains: pain, urinary symptoms and quality of life (QOL). The highest score is 43; a high score indicates a worse outcome. A reduction of 6 points after treatment is considered a good response.
**Results** 28 patients were seen over 6 months. 57% (16) were new diagnoses and 43% (12) were recurrent. All patients were treated with ciprofloxacin except when gram positive bacteria were detected and Co-Amoxiclav was prescribed. The average reduction in NIH-CPSI score after treatment was 11.5.
**Conclusion;** In our cohort a significant proportion of men responded to antibiotic because of positive bacterial culture in the semen. A quarter of patients had a combination of antibiotics and anti-inflammatories. Patient with voiding difficulties were referred to the urology team, those with psychological problems, were referred to the psychology team.

## P105 A BESPOKE SEXUAL HEALTH SERVICE FOR TRANSGENDER PEOPLE IS HIGHLY ACCEPTABLE AND MEETS THE BROADER HEALTH NEEDS OF THIS POPULATION

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**Background/introduction** As part of a local health inequalities study Clinic-T was established in the summer of 2012 in partnership with Brighton LGBT Health Inclusion Project and Terence Higgins Trust to meet the sexual health and broader needs of transgender (trans) patients. Services provided include STI testing and treating, contraception advice, post-exposure prophylaxis, and supporting psychological and medical aspects of transitioning.
**Aim(s)/objectives** To evaluate the current service within Clinic-T, specifically relating to the care and management of trans patients.
**Methods** Patients attending Clinic-T on 25th November 2015 and 4th February 2016 were asked to complete a fifteen-question satisfaction survey.
**Results** 14 patients returned surveys. Median age 32 (IQR 25–42). All participants were White British. The self-reported gender identities were: Non-binary 6/14 (43%), Trans - not specified 3/14 (21%), Male (including trans male) 3/14 (21%), and Female 2/14 (14%). 50% of respondents were new patients. 50% of patients had discussed their trans health concerns with their GP: 72% were satisfied with the GP consultation. 11/14 (78%) included sexual health as a reason for attending. 5/11 patients also attended for their general health/psychological issues/hormonal treatment. 7 aspects of patient satisfaction were assessed with all but 1 of those who responded giving the maximum rating. 14/14 recommended the service to family or friends (FFT).
**Discussion/conclusion** Clinic-T appears to be addressing the needs and expectations of the trans community and scored

highly on the FFT. Working in partnership with local charitable organisations underpins working with difficult to reach groups.

## P106 ENSURING STAFF TRAINING IN INTEGRATED GUM SERVICES IN TRANSGENDER HEALTH ISSUES IS IMPORTANT: SEXUAL HEALTHCARE PROFESSIONALS (HCP) WANT SMALL GROUP TEACHING

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10.1136/sextrans-2016-052718.160

**Background/introduction** Locally there is a large transgender (trans) population. As part of a health inequalities initiative in 2012 a bespoke sexual health service for trans patients (Clinic-T) was set up. This included HCP training.
**Aim(s)/objectives** To evaluate the current service relating to care and management of trans patients within the Claude Nicol Centre.
**Methods** Online survey - emailed to all staff between February and March 2016.
**Results** 45 HCP completed the survey. Job roles were: Doctor 21/45 (47%), Nurse 17/45 (38%), Health Advisor 3/45 (7%), HCA 1/45 (2%), Admin/Reception staff 3/45 (7%). 31/45 (69%) of the respondents had been working in sexual health for at least 6 years. The majority of respondents, 36/44 (82%), do not see patients during Clinic-T. However, 16/45 (36%) see trans patients at least three monthly and 29/45 (64%) see trans patients less frequently than every 6 months. 33/43 (77%) of HCP did not feel confident about seeing trans patients in a clinical setting - specific aspects include: 21/42 (50%) understanding sexual health needs, 35/43 (81%) where to seek gender reassignment advice, 40/43 (93%) seeking hormonal replacement therapy advice, 32/43 (74%) addressing psychological issues, and 34/43 (79%) providing additional support in the community. The majority of HCP 26/45 (58%) would like further training to be delivered through small group teaching.
**Discussion/conclusion** The majority of HCP are not confident when approaching trans patients at work. With a significant number of HCP seeing trans patients in general clinics it is important to ensure that broader sexual health services are acceptable to the local trans population. Programmes of education are needed to underpin quality improvement.

## P107 IDENTIFYING ABUSE IN SEXUAL HEALTH SETTINGS – HOW WELL ARE WE DOING?

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10.1136/sextrans-2016-052718.161

**Background/introduction** There is increasing evidence to suggest that individuals, who have encountered abuse of any nature, may present in a variety of health care settings and with a multiplicity of symptoms without disclosing the fact that the underlying reason for their presentation is abuse. In 2015 we introduced a prompt in our template to encourage professionals to raise the issue of abuse with all attendees to our unit.
**Aim(s)/objectives** Our aim was to assess how often abuse was disclosed, identify the nature of the abuse and offer support when this was requested.
**Methods** Retrospective review of all attendees to the Walk-in sessions over the course of a month in February 2016. A total of 106 notes were reviewed.
**Results** Of the 106 attendees interviewed, 8 (13.25%) reported abuse. Of these, 6 were women and 2 were men. In all cases the abuse was disclosed, only on direct questioning. All 8 cases reported historical abuse. Physical and emotional abuse, were commonly reported. 3 of the women were aged between 21–30 years and 2 between 51–60 years. The men were aged 21 and 41. All attendees were offered the option of referral for further support, but all declined as all felt that they had either received support previously or had the opportunity to get over the trauma of what they had encountered.
**Discussion/conclusion** This audit demonstrates that abuse is common among attendees to Sexual health. This may not be disclosed unless raised as a matter of routine.

## P108 CAN INTEGRATED SEXUAL HEALTH SERVICES FUNCTION EFFECTIVELY WITHOUT A HEALTH ADVISOR?

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10.1136/sextrans-2016-052718.162

**Background/introduction** Four services merged to create one integrated sexual health service. The service is operating without a health advisor. Basic health advising duties are carried out by nursing staff.
**Aim(s)/objectives** Assess the effectiveness of current practice in relation to adherence to BASHH PN standards and consider changing practice and/or service provision if adherence is found to be poor.
**Methods** The inclusion criteria is any patients attending the service 01/08/2015–30/09/2015 who had a C4 diagnosis. The notes were reviewed retrospectively and the level of PN was checked against BASHH standards.
**Results** 90 patients were in the sample. 96% of patients had PN discussed at the time of treatment. 57% had PN agreed for each contact and PN outcomes documented, 0.66 contacts per index patient were reported as attended, 0.3 contacts per index patient were verified at attended, 79% of patients had a follow-up compliance check.
**Discussion/conclusion** Adherence to BASHH PN standards was better than expected. Measures were taken to improve adherence including prompts on the new EPR system to initiate and review PN. The recalls policy was updated and a compliance check proforma was introduced. The audit demonstrated the need for a health advisor within an integrated sexual health service. Recruitment of a new health advisor for the service has commenced.

## P109 THE SANTÉ PROJECT: ATTITUDE TOWARDS STI RISK ASSESSMENT, PREFERENCES FOR STI BEHAVIOURAL RISK REDUCTION INTERVENTIONS: SERVICE USERS PERSPECTIVES

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10.1136/sextrans-2016-052718.163

**Background/introduction** A variety of risk-reduction interventions may be suitable for sexual health clinic attendees.
**Aim(s)/objectives** In the SANTE project, we explored service users' (SU) perceptions of their STI risk, and experiences and preferences for risk reduction interventions.
**Methods** Semi-structured interviews were conducted with 15 young people (YP) (16–25 years) and 20 MSM (≥16 years) from two SH clinics. Data were analysed thematically. Based on these, a Discrete Choice Experiment (DCE) to quantitatively assess YP and MSM preferences for interventions was designed and conducted in three clinics (n = 371).
**Results** Most participants, despite presenting with symptoms or concerned about STIs, did not perceive themselves to be at risk. Most reported receiving SH promotion but felt access to accurate information was lacking. While short advert-like videos were acceptable, onscreen material in waiting rooms was deemed inappropriate by some SUs. Opinions on group sessions were mixed. 1:1 sessions were favoured, with talking therapies acceptable if needed. Privacy around mobile apps was a concern while online materials from a reputable source were acceptable. DCE results demonstrated preferences for 'talking interventions', while all interventions were generally preferred to 'nothing'. People strongly disliked peer-led interventions compared to others, and preferred 1:1 to group sessions. Latent class analysis identified three respondent groups, those that preferred talking (56%), email/text (29%) or nothing (15%).
**Discussion/conclusion** Young people and MSM welcome SH promotion offered through SH clinics. Triangulation demonstrated strong preferences for 1:1 talking interventions. Awareness of sexual risk was not commensurate with actual risk, suggesting that providers need to direct service users to appropriate interventions.

## P110 THE SANTÉ PROJECT: A MIXED-METHODS ASSESSMENT OF OPPORTUNITIES AND CHALLENGES FOR THE DELIVERY OF BRIEF RISK REDUCTION INTERVENTIONS IN SEXUAL HEALTH CLINICS IN ENGLAND - A HEALTHCARE PROVIDER'S PERSPECTIVE

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10.1136/sextrans-2016-052718.164

**Background/introduction** Sante is a study to improve targeted sexual health promotion in UK sexual health (SH) clinics.
**Aim(s)/objectives** We explored opportunities and challenges for delivering interventions including 1:1 and group sessions, digital and video interventions.
**Methods** Semi-structured interviews were conducted by telephone with healthcare providers (HCPs) from a range of clinics, by location, size, and patient mix. Data were analysed thematically using a framework approach. A web-survey was sent to key HCP contacts in SH services in England.
**Results** Interviews (n = 26) showed that digital interventions were viewed as logistically and financially feasible; some clinics reported already using them. All clinics provided brief 1:1 sessions, but challenges to delivery were identified as: lack of evidence for effectiveness on behaviours; costs and staff resourcing; and patient motivation. Videos received mixed opinions, they were seen as a practical option for providing STI information while patients wait, but issues about appropriateness were raised. HCPs had concerns about the feasibility of group sessions within clinic-based settings, while acknowledging their usefulness for outreach. The web-survey is ongoing; preliminary data indicates that clinics would like to be able to offer mobile apps, online education and videos (Table 1).
**Discussion/conclusion** Staff time, costs and logistics were universal challenges, while group sessions and videos raised issues of privacy in particular. Brief 1:1 interventions are currently widely delivered, and can be tailored to the patient's needs, but are resource-intensive while digital methods despite being uncommon were seen as desirable.

**Abstract P110 Table 1** Overview of web-survey responses about interventions (current and desired)

| | Level 3 (n=36) | | | Level 2 (n=8) | | |
|---|---|---|---|---|---|---|
| | Currently offer | Currently not offered* | | Currently offer | Currently not offered* | |
| | | Would like | Would not like | | Would like | Would not like |
| Educational videos | 0 (0%) | 19 (53%) | 9 (25%) | 0 (0%) | 4 (50%) | 1 (13%) |
| Online education | 4 (11%) | 20 (63%) | 5 (16%) | 4 (50%) | 4 (100%) | 0 (0%) |
| Mobile 'app' | 1 (3%) | 21 (60%) | 3 (9%) | 0 (0%) | 4 (50%) | 0 (0%) |
| Single 1:1 sessions | 26 (74%) | 4 (40%) | 2 (20%) | 6 (75%) | 2 (100%) | 0 (0%) |
| Multiple 1:1 sessions | 17 (49%) | 9 (47%) | 2 (11%) | 3 (38%) | 1 (20%) | 1 (20%) |
| Group sessions | 3 (9%) | 6 (18%) | 18 (55%) | 3 (38%) | | 2 (40%) |

*Percentages are calculated based on the number of clinics not already providing this service. One clinic reported not providing any interventions.

## P111 PERCEPTIONS OF CHLAMYDIA SCREENING, CONTRACEPTION AND HIV TESTING AMONG 16–24 YEAR OLD PATIENTS VISITING A GP SURGERY

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10.1136/sextrans-2016-052718.165

**Background** A complex intervention based on the Theory of Planned Behaviour significantly increased chlamydia screening in general practice (McNulty et al 2014). It may be more beneficial to extend this intervention to a broader sexual health offer including chlamydia testing, contraception advice and when appropriate, HIV testing (3Cs and HIV).
**Aim** To determine young adults' opinions of having a broader sexual health offer (3Cs and HIV) at their GP practice.
**Methods** Thirty interviews were conducted with 9 male and 21 female patients, 16–24 years in English GP practices. Participants were interviewed immediately before or after a routine practice attendance of any type. Data was analysed using a thematic framework and using QSR Nvivo 10.
**Results** Participants indicated that method of testing, timing and staff member approach were important aspects to chlamydia screening and contraception discussions. Participants displayed a clear preference for the GP practice over other sexual health

service locations. Items most important to participants were convenience, reassurance, and that the sexual health discussion is appropriate and routine. Barriers identified were embarrassment, unease, lack of time, religion and concern of causing offence. Suggested facilitators include raising awareness, reassuring confidentiality, ensuring the discussion is facilitated by trust and professionalism at the end of the consultation.

**Conclusion** The majority of participants are happy to be offered 3Cs and HIV at their GP surgery. Therefore, it is important for GP staff to recognise these preferences and ensure that the full 3Cs and HIV services are made available and offered to appropriate patients.

## P112 X FACTOR MAKEOVER FOR 4TH YEAR MEDICAL STUDENT LECTURES

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10.1136/sextrans-2016-052718.166

**Background/introduction** Traditionally Year 4 Medical students at Bristol University receive 4 hours of didactic lecture based teaching on sexual health topics. Overall, the feedback is satisfactory but student evaluations consistently denounce the volume of information contained in the lectures.

**Aim(s)/objectives** To support learner diversity and increase student participation, we decided to revamp the delivery of the sexual health curriculum.

**Methods** We made the lectures available on the student intranet for background reading and signposted the students towards additional sources of information such as BASHH guidelines. During a study day, 60 students in groups of 5 or 6 were asked to teach their peers using case studies on topics such as vaginal discharge, genital ulcers and sexual assault. Teaching methods included game shows, a rap about syphilis and role-play. There were prizes for the top three presentations (through peer grading) and a prize for the most innovative. A questionnaire, and open discussion were used to obtain feedback on both the old and new teaching formats.

**Results** Overwhelmingly the students preferred and gained more from the student led case based presentations. They felt more engaged and would recommend it for future groups. Some students felt it was also important to have an opportunity to ask questions about the online lectures in future.

**Discussion/conclusion** Through this alternative approach to learning new information, we have catered for different learning styles and created a positive learning environment. Peer teaching can be very effective in encouraging critical thinking and producing deeper learning outcomes.

## P113 HIV IN SOCIAL MEDIA: WHAT DO YOUTUBE USERS WATCH?

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10.1136/sextrans-2016-052718.167

**Background/introduction** Increased risk-taking behaviour, sexual networks, and sexually transmitted infections have been attributed to the rapid increase in social media use. YouTube is a video sharing, revenue generating website that's content is not scientifically vetted, and any registered user can post media content.

**Aim(s)/objectives** The objective of this study was to determine how HIV related issues are portrayed on YouTube.

**Methods** A YouTube account was created using 'worldwide' and 'English UK' settings. The search engine was cleared, Flash Player cache emptied, and cookies removed. Each of the following search terms was used: 'HIV', 'AIDS', 'PrEP' and 'HIV home testing'. Inclusion criteria: first 60 videos. Exclusion criteria: >10 minute duration, exclusively non-HIV content, not in English. Each video was scored by 2 investigators.

**Results**

**Abstract P113 Table 1** HIV in social media

| | No. of YouTube hits | Views/ Day | Engagement/ view (%) | Any advert (n) | | Factual Inaccuracies (n) | | | Contained gossip/ media (n) | |
|---|---|---|---|---|---|---|---|---|---|---|
| Search Category | (n) | (Median) | (Median) | Yes | (%) | Major | Minor | No | Yes | (%) |
| AIDS (n = 30) | 2,240,000 | 585 | 0.34 | 16 | (41) | 2 | 5 | 23 | 12 | 40 |
| Home Testing (n = 55) | 212,000 | 3 | 0.17 | 29 | (51) | 1 | 1 | 53 | 0 | 0 |
| HIV (n = 39) | 1,250,000 | 1153 | 0.8 | 21 | (54) | 3 | 0 | 36 | 16 | 41 |
| PrEP (n = 29) | 2,190 | 334 | 0.62 | 16 | (55) | 1 | 3 | 25 | 2 | 7 |

M: Median Engagement/view: Number of likes, dislikes, and comments/by number of views (% value)

**Discussion/conclusion** Social media is an accessible source of information to the general public and healthcare professionals. When four search terms were compared, "HIV" and "AIDS" were most popular. "HIV" generated the most viewer-engagement. Following Charlie Sheen's HIV disclosure and publication of PrEP studies (November 2015), there was a massively increased use of "HIV" and "PrEP" search terms. 10% (15/149) of videos contained factual inaccuracies with 40% (6/15) potentially causing significant harm. Due to high rate of embedded advertisements, inaccurate material, and material which could stigmatise PLWHA, it is vital that Public Health/HIV clinicians harness the potential of social media, are aware of the associated risks and strive to promote accurate information to patients.

## P114 CONCORDANCE OF CHLAMYDIA INFECTIONS OF THE RECTUM AND URETHRA IN SAME-SEX MALE PARTNERSHIPS: A CROSS-SECTIONAL ANALYSIS

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**Background** Sexual health services should ask all high risk attenders about drug and alcohol use. However, the impact of drug and alcohol use on STI epidemiology remains uncertain.

**Aims** To audit drug and alcohol history taking after introduction of a screening tool and to describe the patterns of use and associations with STI diagnoses.

**Abstract P114 Table 1** Association of reported drug and alcohol use and STI diagnosis in 2015

| | | [1]Chems Yes, % N = 26,429 asked | [4]p-value | [2]Party Yes, % N = 26,429 asked | [4]p-value | [3]Alcohol excess, % N = 20,406 asked | [4]p-value |
|---|---|---|---|---|---|---|---|
| Total | | 4.4% n = 1046 | | 12% n = 2891 | | 6% n = 1225 | |
| Gender/ | MSM | 16.5 | **<0.0001** | 15.9 | **<0.0001** | 8.7 | **<0.0001** |
| Sexual orientation | MSW | 0.9 | | 18.2 | | 9.1 | |
| (MSW-heterosexual men) | Women | 0.3 | | 7.1 | | 3.9 | |
| New STI this year | Yes | 17.0 | **<0.0001** | 19.6 | **<0.0001** | 6.6 | 0.156 |
| | No | 2.4 | | 10.9 | | 5.9 | |
| Chlamydia | Yes | 14.0 | **<0.0001** | 19.1 | 0.435 | 7.1 | 0.257 |
| | No | 20.6 | | 20.2 | | 6.0 | |
| Gonorrhoea | Yes | 33.2 | **<0.0001** | 23.8 | **<0.0001** | 6.8 | 0.753 |
| | No | 7.8 | | 17.2 | | 6.5 | |
| Syphilis | Yes | 40.1 | **<0.0001** | 21.7 | 0.320 | 4.7 | 0.191 |
| | No | 14.5 | | 19.3 | | 6.8 | |
| HSV | Yes | 8.0 | | 17.4 | 0.190 | 5.3 | 0.205 |
| | No | 18.6 | | 20.0 | | 6.9 | |
| Hepatitis B | Yes | 17.1 | **0.006** | 9.7 | 0.252 | 6.7 | 1.000 |
| | No | 0 | | 19.7 | | 6.6 | |
| Hepatitis C | Yes | 65.7 | **<0.0001** | 45.7 | **<0.0001** | 0 | 0.166 |
| | No | 16.4 | | 19.3 | | 6.7 | |

[1]"Chemsex drugs" (mephedrone, gamma-Hydroxybutyric acid, methamphetamine).
[2]"Party drugs" (cannabis, ecstasy/MDMA, cocaine, ketamine).
[3]Excess alcohol use was >14 units for women and >21 units for men.
[4]p-values calculated using Chi squared or Fisher exact test as appropriate.

**Methods** An anonymised database of all clients attending in 2015 was constructed including basic demographics, reported drug and alcohol history, HIV status and STI diagnoses.
**Results** 48,654 clients were seen in 2015. 26,429 (54%) were asked about drug and/or alcohol use at least once. Use of any drug or excess alcohol was reported by 16% and was associated with higher rates of STIs (24 vs 10%, $p < 0.001$). Amongst MSM, 62% had a drug and/or alcohol history taken, compared with 47% and 55% in heterosexual men (MSW) and women, respectively ($p < 0.0001$). STIs diagnoses were significantly higher in drug users compared to non-users (27 vs 11%), but were not different comparing alcohol excess vs no excess (14 vs 13%). STI diagnoses were significantly higher in drug users compared to non-users in all sub-groups – MSM (41 vs 20%) MSW (26 vs 18%) women (12 vs 7%) – all $p < 0.0001$.
**Conclusions** The audit showed room for improvement in history taking. Chemsex drugs are associated with the highest risk of STIs. This relationship might not be causal. Party drug use was associated with some STIs. The audit supports drug and alcohol histories for all MSM as well as heterosexual men and women attending with STIs.

## P115 IS GENITAL HERPES SIMPLEX VIRUS TYPE 1 (HSV-1) ASSOCIATED WITH HIGH RISK SEXUAL BEHAVIOURS?

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**Background/introduction** HSV-1 is the primary cause of genital herpes in the UK. Genital HSV has been linked with early sexual debut as well as men-who-have-sex-with-men (MSM), but previous studies do not differentiate between genital HSV-1 and HSV-2. A diagnosis of genital herpes is often distressing to patients due to stigma surrounding herpes, and receiving a sexually transmitted infection (STI) diagnosis.
**Aim(s)/objectives** To assess whether genital HSV-1 is associated with high risk sexual behaviours in comparison with HSV-2, chlamydia, or asymptomatic patients with no STI diagnosis.
**Methods** An NRES approved questionnaire assessing sexual behaviour - based on NATSAL questions and other recognised risk taking behaviours - was completed by 125 patients attending a UK level 3 sexual health service, with a diagnosis of first episode genital HSV-1 or HSV-2, or a diagnosis of chlamydia or asymptomatic with no STI diagnosis.
**Results** Preliminary results show that the chlamydia group is the highest risk takers; in comparison, the HSV-1 group have lower risk sexual histories.
**Discussion/conclusion** Provisional results have shown that HSV-1 genital herpes may not be associated with high risk sexual

**Abstract P115 Table 1** HSV and sexual behaviour

| | Age at first vaginal sex (years) | Condom usage (%) | Condom usage at most recent vaginal sex (%) | Age at first receptive oral sex (years) | Age at giving first oral sex (years) | Number of new partners in the last year |
|---|---|---|---|---|---|---|
| HSV-1 (10) | 16.8 | 75 | 37.5 | 17.5 | 17.1 | 1.8 |
| HSV-2 (15) | 16.1 | 66.7 | 38.1 | 16.5 | 16.5 | 2.7 |
| Chlamydia (50) | 16 | 67.4 | 22.5 | 16.8 | 16.8 | 4.2 |
| Asymptomatic (50) | 17 | 60.4 | 33.3 | 16.7 | 17 | 2.6 |

behaviour. In order to challenge the stigma surrounding genital herpes, further research is required.

## P116 HOW COMMON IS RECTAL *CHLAMYDIA TRACHOMATIS* INFECTION IN WOMEN? A SYSTEMATIC REVIEW, 1997 TO 2015

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**Background** *Chlamydia trachomatis* is the most commonly diagnosed STI in the UK. While men-who-have-sex-with-men are known to be at-risk of rectal chlamydia infection (ReCT), the prevalence and risk-factors in women are incompletely-understood. This may have important implications for testing and treatment approaches since azithromycin and doxycycline are considered first-line regimens for uncomplicated urogenital infections, whereas doxycycline is the preferred treatment for ReCT.
**Objectives** Undertake a systematic review to: 1) calculate ReCT positivity (number ReCT positive/number tested) among women in different testing settings; 2) determine the proportion of women diagnosed with ReCT with: a) concurrent urogenital infections and; b) a history of anal-intercourse.
**Methods** Medline, Embase, CINAHL, PsychINFO and the Cochrane Database were searched for articles published January 1997-September 2015. Studies reporting ReCT positivity in women aged ≥15 years in high-income countries were included and relevant data extracted.
**Results** Fifteen studies were included (14 among women attending sexual health services). Populations tested varied e.g. 4/15 studies included only women with a history of anal-intercourse. Among all studies, ReCT positivity ranged from 0.5%–77% (median 13%). Among women with ReCT, 7%–100% had a concurrent urogenital infection; 16%–100% reported anal-intercourse (where data were available; Table 1)

**Abstract P116 Table 1** Key findings from studies (n = 15) reporting rectal chlamydia test positivity among women.

| | Number of studies where data reported | Range (%) | | Median (%) |
|---|---|---|---|---|
| | | Minimum | Maximum | |
| Percentage testing positive for Rectal chlamydia (positivity) | 15 | 0.5 | 77 | 13 |
| Site of infection among women testing positive for chlamydia: | 12 | | | |
| Rectal only | | 0 | 31 | 7 |
| Rectal and urogenital | | 7 | 100 | 68 |
| Urogenital only | | 0 | 86 | 18 |
| Percentage reporting history of anal-intercourse among women testing positive for rectal chlamydia | 9 | 16 | 100 | 44 |

**Conclusion** ReCT infections have been found in a substantial proportion of women in the populations tested. In these studies, urogenital testing alone would have missed up to 31% of chlamydia infections. Further work to establish need, criteria and feasibility for routine ReCT testing in women is needed to ensure chlamydia infections are not missed or inadequately treated.

## P117 ARE WOMEN PRESCRIBED LARC LESS LIKELY TO HAVE AN ABORTION?

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**Background/introduction** Almost half of pregnancies in England were estimated to be unplanned or ambivalent, and a fifth resulted in abortions. Uptake of non-injectable long-acting reversible contraception (NI-LARC) methods is recommended to reduce the risk of unplanned pregnancies and abortions.
**Aim(s)/objectives** To determine if NI-LARC usage reduces the risk of abortion.
**Methods** Attendances at Sexual and Reproductive Health (SRH) services which provided more than 10 abortions during 1/1/2013–31/12/2014, recorded in the SRH Activity Dataset, were considered. The risk of abortion by contraceptive method (NI-LARC, other methods) used at least once or no method during the study period, was estimated using the Kaplan-Meier method. Cox Proportional Hazards Models were used to estimate hazard ratios for risk of abortion by contraceptive method used, adjusted for age, ethnicity, area-level deprivation and rural/urban residence.
**Results** 42,210 women used NI-LARC (26.2%), 79,380 women used other contraceptive methods (49.3%), 39,403 women had no method (24.5%); 2,339 women had an abortion (1.5%). The highest proportion of women who had an abortion was reached within first month of exposure: 0.08% of women using NI-LARC, 1.34% of those using other contraceptive methods and 2.63% of those not on contraception. The adjusted hazard ratios for risk of abortions were 17.5 (CI 13.1–23.4) times higher in women who were not on contraception and 12.6 (9.5–16.9) times higher in women using other contraceptive methods, compared to those who used NI- LARC.
**Discussion/conclusion** NI-LARC use is strongly associated with reduced risk of abortion in women attending SRH services because it is independent of compliance.

## P118 "LARCING ABOUT" WITH INTEGRATED SERVICES: OUR GENITOURINARY MEDICINE (GUM) SERVICE USERS' VIEWS ON THE PROVISION OF SHORT & LONG ACTING REVERSIBLE CONTRACEPTION (LARC)

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10.1136/sextrans-2016-052718.172

**Background** Integrated models are promoted as the ideal way for women to receive sexual health and contraception. Commissioners advocate shifting contraceptive provision away from GUM to general practice and community settings. Given our boroughs have the lowest GP LARC prescribing rates in

England, we are concerned about compromised access to contraception and a consequent rise in unplanned pregnancy/abortion rates.
**Aim** To explore our service users' preferences and experiences of accessing contraception.
**Methods** Between January and February 2016, an anonymised questionnaire was offered to all patients requesting contraception from four integrated GUM clinics.
**Results** 329 patients (median age 20–30 years) returned their questionnaire. 52%, 19% and 28% of users attended short-acting contraception, sub-dermal implant or intrauterine device (IUD) appointments respectively. 83% respondents found our service easy/very easy to access. Median LARC waiting time was 1–2 weeks. 33/86 (38%) of non-LARC and 29/109 (27%) of LARC (34% IUD, 21% implant) users experienced problems obtaining contraception elsewhere with 88% citing their GP had no suitable appointment or didn't offer their chosen method. 77% (126/164) of respondents prefer to have their sexual health and contraceptive needs met together, whilst 6% prefer separate settings. Patients prefer obtaining contraception from: GUM (46%); GP(19%); community clinics(16%); private establishments/online(6%); no clear preference(13%). 34% of users would consider accessing LARC privately.
**Conclusion** Two fifths of patients had difficulty accessing any form of contraception outside of GUM, most appreciate a one-stop shop approach and half prefer GUM to be their contraceptive provider. This survey demonstrates the need to preserve GUM as a contraceptive provider.

## P119 THEORY OF CHANGE MODEL FOR CLINIC-BASED PREP PROGRAMME EVALUATION

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10.1136/sextrans-2016-052718.173

**Background** A national programme to provide Truvada HIV pre-exposure prophylaxis (PrEP) is currently being considered in England. Some men already access PrEP and some sexual health clinics already offer PrEP monitoring.
**Aim(s)/objectives** We created a Theory of Change (ToC) to define the key components of a clinic-based PrEP programme to reduce HIV incidence. We identified indicators, outputs and outcomes to aid programme evaluation for a large London sexual health clinic.
**Methods** We used a ToC approach to define necessary pre-conditions, indicators, outputs and outcomes for our PrEP delivery programme.
**Results** The aim of our PrEP programme is to prevent HIV seroconversion in those at greatest risk. There are three broad areas: 1) identifying those eligible; 2) engaging eligibles to initiate PrEP and other HIV prevention activities; 3) maintaining effective adherence in those at continuing risk while advising therapy cessation for those no longer at risk. We estimate that approximately 1,200 men attending our service annually could be eligible for PrEP. Assuming a high level of uptake, these men would require 1,000 follow-up appointments annually in order to fulfil quality measures of three monthly HIV and STI testing in those on PrEP.
**Discussion** Using a ToC approach we have defined what a clinic-based PrEP programme might look like against our current service specification to enable us to collect meaningful evaluation data. This ToC might be used by other clinics to evaluate PrEP programmes, and allow comparison across programmes to build understanding of PrEP delivery and enhance new national PrEP surveillance systems.

## P120 SELF TAKEN EXTRAGENITAL SAMPLING – WHAT DO WOMEN AND MSM THINK? FEEDBACK FROM A SELF-SWAB AND CLINICIAN SWAB TRIAL

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10.1136/sextrans-2016-052718.174

**Background/introduction** Extragenital sampling for chlamydia and gonorrhoea is standard practice in MSM and is increasingly important in women. Some UK clinics offer self-swabbing from these sites, but little has been published about its acceptability, particularly in women. We explored this as part of a clinician versus self-swab study.
**Methods** Women and MSM attending a sexual health clinic were invited to take part in a 'swab yourself' study. Clinician and self-swab samples for chlamydia and gonorrhoea NAATs were taken from the rectum and pharynx. Participants then completed a questionnaire.
**Results** See table. Response rates were >99% in both women (958/968) and MSM (197/210). MSM were not significantly more likely to feel confident taking their own swabs (83% vs 77%, p = 0.53). Of those who agreed/strongly agreed they 'felt uncomfortable taking their own swabs', sexual naivety of the site was not a common factor (53% of women agreeing stated they had never had anal sex; 70% of men agreeing reported receptive anal sex in the preceding 3 months). Free comments included 'more confidence if had clinician samples taken before', 'concerns if self-swabbing would give accurate results' and concerns about being not able to speak to a healthcare professional with home sampling. 10 women commented specifically on discomfort but only 1/10 disagreed with the statement 'I would feel happy to take my own swabs in a non-clinic environment'.

**Abstract P120 Table 1** Extra genital sampling in MSM and women

| Survey responses | Women (n = 958) | MSM (n = 197) |
|---|---|---|
| Strongly agree/agree "I felt confident taking my own swabs" | 77% | 83% |
| Strongly agree/agree "I felt uncomfortable taking my own swabs" | 25% | 23% |
| Strongly agree/agree "I would prefer to take my own samples | 40% | 48% |
| Strongly agree/agree 'I would prefer a clinician to take my samples" | 33% | 35% |
| Strongly agree/agree "I would be happy to take my own swabs in a non-clinic environment" | 64% | 61% |

**Discussion/conclusion** Extragenital self-swabbing was highly acceptable in both groups, with high levels of confidence and low reports of discomfort. This has positive implications for expanding future use.

## P121 PROSPECTIVE COMPARISON OF CHARCOAL SWABS VERSUS NEAR-PATIENT DIRECT CULTURE PLATE INOCULATION FOR THE CULTURE OF GONORRHOEA IN HIGH-RISK PATIENTS

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10.1136/sextrans-2016-052718.175

**Background/introduction** Gonorrhoea culture is required to monitor antibiotic resistance and is recommended for all patients known or suspected to be infected. In July 2015 our laboratory service requested us to switch from near-patient direct plating of high-risk swabs to sending charcoal swabs urgently to the lab.
**Aim(s)/objectives** To compare the efficacy of direct plating versus charcoal swabs for GC culture.
**Methods** Between July and November 2015 all patients who had a positive GC NAAT or where otherwise at high risk and had not received antibiotics had two culture swab specimens taken from the infected site: 1. a charcoal swab sent urgently to the laboratory for plating there and 2. a plastic loop specimen which was directly plated onto VCAT GC selective agar.
**Results** 61 patients had both specimen types taken. 41/61 (67%) directly plated specimens and 31/61 (51%) specimens transported on charcoal swabs were culture +ve ($P < 0.05$). For male urethral samples, plate versus charcoal, the results were 29/34 (85%) vs 22/34 (65%) ($P < 0.05$) and for endocervical specimens 7/14 (50%) vs 6/14 (43%) (n.s.). Numbers were too small for comparison for rectal and pharyngeal swabs.
**Discussion/conclusion** Despite sending the charcoal swabs urgently to the laboratory, the culture-positive rate was 24% lower than for directly plated specimens. This could not be explained through order of swabbing. Near-patient direct plating of specimens has to comply with UKAS accreditation but none the less, our results showed that this was superior to charcoal swabs transported to the lab for GC culture.

## P122 ARE PHARYNGEAL SWABS FOR CT/GC OF VALUE IN HETEROSEXUAL MEN? A RETROSPECTIVE REVIEW OF A CLINIC COHORT

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10.1136/sextrans-2016-052718.176

**Background/introduction** Pharyngeal testing for CT/GC is generally not recommended for heterosexual men whose only sexual exposure is cunilingus. However, some clinicians in this service also started sending self-taken swabs from heterosexual men when self-taken swabs became routine practice for MSM in 2014.
**Aim(s)/objectives** To measure the utility of pharyngeal CT/GC swabs in heterosexual men
**Methods** A retrospective case-note review of all heterosexual men who had been coded as having had a pharyngeal swab for CT/GC NAAT between July 2014 and August 2015.
**Results** 1374 eligible patients were identified. 25/1374 (1.8%) of these were GC NAAT +ve of which 4/25 (16%) were +ve in the pharynx, the others being +ve in the urine. 3/4 pharyngeal +ve specimens were GC NAAT +ve in the pharynx only, 1 was positive in the urine also. 110/1374 (8%) patients were CT NAAT +ve of which 1/110 (0.9%) was in the pharynx only, the rest being from urine specimens
**Discussion/conclusion** Out of 1374 pharyngeal swabs sent, only 5 (0.4%) were CT or GC +ve, of which 1 was also +ve in the urine. The 3 lone +ve pharyngeal GC NAAT specimens could be false-positive e.g. due to a cross-reaction with non-pathogenic Neisseria sp. Similarly the single CT+ve may be a false +ve assay. Alternatively, some of those patients with a +ve test may be MSM who had not revealed their status. Whatever the explanation, the very low pick-up rate does not justify taking pharyngeal CT/GC swabs in men who identify as being exclusively heterosexual.

## P123 DRUG AND ALCOHOL USE IN GU MEDICINE ATTENDEES – WHAT IS THE IMPACT ON SEXUAL HEALTH?

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**Background/Introduction** Patients attending sexual health services report higher rates of drug and alcohol use. This may lead them to ignore safer sex messages putting them at greater risk of STIs. 'Chemsex' has been recognised as an additional risk factor in MSMs, but it is unclear how widespread this is in heterosexual individuals or outside large conurbations.
**Aims/Objectives** This service evaluation aimed to assess the extent of the alcohol and drug use in all patients attending a GU clinic and its impact on sexual behaviour.
**Methods** Self-completed detailed questionnaires were incorporated into the clinic dataset for 600 consecutive patients during February 2016. Data was anonymised and analysed using SPSS v23.
**Results** Results show 70% of women and 75% of men reported alcohol use in the last month, however fewer than 1/3 reported drug use. Men were more likely to have taken recreational drugs (37% v 25%). Fewer women than men reported engaging in chemsex (2% v 5% respectively). 25% of women and 30% of men regretted sex they had had in the last year with men more likely to attribute this to alcohol. Women reported alcohol use contributing to worse partner choice but better sex, with the converse for men. There was no association between drug and alcohol use and STI rates.
**Discussion/conclusion** Alcohol does not appear to impact as much upon sexual behaviour as previously suggested. Chemsex is prevalent amongst heterosexuals as well as MSMs and questions on this should be incorporated into standard data collection in clinic.

## P124 CONFIDENTIALITY IN SEXUAL HEALTH CLINICS: A SERVICE EVALUATION OF PATIENTS' UNDERSTANDINGS AND ATTITUDES TO ADDITIONAL CONFIDENTIALITY PROTECTIONS

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10.1136/sextrans-2016-052718.178

**Background/introduction** UK sexual health clinics provide patients with additional confidentiality by having separate patient records systems, and by not routinely communicating with General Practitioners (GPs). However, research into patients' awareness of these policies is limited.
**Aim(s)/objectives** To assess patients' knowledge and perceptions of additional confidentiality protections in sexual health clinics.
**Methods** A self-administered anonymous questionnaire (approved by Trust Clinical Governance Committee) was distributed prospectively to 200 patients attending two level 3 UK sexual health clinics.
**Results** Response rate was 178/200 (89.0%). 46/178 (25.8%) patients were aware that sexual health records are kept separately from other medical records, and 89/178 (50.0%) had never been told how their notes are handled. After learning more about confidentiality protections in sexual health clinics, 47/178 (26.4%) reported that they would be more likely to give GP details, 67/178 (37.6%) to give updated contact details, and 58/178 (32.6%) to disclose an accurate sexual history to clinicians. Patients were less confident that their information is kept confidential in the reception area compared to the treatment area (46.9% vs 77.3% feel definitely confident). 16/17 free-text comments received complained about personal information being overheard when registering at the reception.
**Discussion/conclusion** Sexual health clinics should ensure they provide basic information on additional confidentiality protections, in order to increase the likelihood of patients disclosing intimate information, and ensuring they can be contacted. Efforts to improve patients' perception of confidentiality in reception areas are vital and need to be considered carefully when designing units.

## P125 "I GOOGLED IT…": WHAT IS RECOMMENDED ONLINE FOR THE MANAGEMENT OF VULVOVAGINAL CANDIDIASIS?

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**Background** Recently our centre encountered women reporting self-treatment of candidiasis with intravaginal applications of foodstuffs including garlic, vinegar and yoghurt. All patients had a unifying factor of reporting "googling" their therapy.
**Aim** To establish which candidiasis management strategies female patients are most likely to encounter when searching via Google.
**Method** Search history data was collated from Google Trends to identify the ten most popular search terms related to candidiasis in the UK between 15/03/15–06/03/16. These terms, along with term "thrush", were assessed totalling 11 Google searches. All websites on the initial results page for each search term were accessed to review recommended therapies. Click-through data suggests the vast majority of Google users (>90%) select their chosen website from this first results page.
**Results** 116 search results included 97 (83.6%) advising women about vulvovaginal candidiasis. 96/97 (99%) recommended imidazole therapy first line, all reassuringly advising against oral therapy in pregnancy. Patients were recommended to seek treatment via a pharmacy (72, 74.2%) or their GP (54, 55.7%) rather than attending a genitourinary service (12, 12.2%). The recommendation of natural yoghurt for symptomatic relief was frequent (40, 41.2%), more than using emollients or soap substitutes (27, 27.8%). Unfounded treatments including eating probiotic yoghurts (9, 9.3%), vinegar (8, 8.2%), and treatment of sexual partners (8, 8.2%) were encountered.
**Conclusions** Sensible evidence-based advice is the most prevalent online for vulvovaginal candidiasis. However a number of poorly evidenced therapies are encouraged. This information should be discussed and appropriately challenged during routine management of vulvovaginal candidiasis.

## P126 "WE CARE ABOUT YOUR CARE": A CLIENT DELIVERED REAL TIME AUDIT AND FEEDBACK TOOL OF HOLISTIC CARE FOR MEN WHO HAVE SEX WITH MEN (MSM) ATTENDING SEXUAL HEALTH SERVICES. AN AUDIT AND REAUDIT

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10.1136/sextrans-2016-052718.180

**Background** In 2014 Public Health England produced an action plan to improve the health and well-being of MSM in the UK. We mapped key domains to create a "Checklist for holistic care of MSM" for staff and audited performance (Audit 1). We redesigned the "Checklist" to enable client led audit and feedback in real time, either named or anonymously and re-audited (Audit 2).
**Aims** To assess the acceptability and impact of a client led real-time audit and feedback tool on the delivery of holistic care to MSM presenting for STI testing within generic sexual health services.
**Methods** A retrospective electronic patient record (EPR) case note review of consecutive MSM under 27yrs new to the service between January and May 2015 was performed. (Audit 1). We introduced the Client Checklist in August 2015 and re-audited all MSM attendances to February 2016.
**Results**

**Abstract P126 Table 1** Client delivered real time audit in MSM

| | Audit 1 : HCW Checklist + Standard EPR | Audit 2 : Patient held Checklist + HCW Checklist + Standard EPR | Probability Value |
|---|---|---|---|
| Demographics | 41 MSM <27yrs. 1st visit | 207 MSM 15–63 yrs. New visit | |
| Mobile phone number confirmed | 33/41 (80%) | 205/207 (99%) | p = 0.0001 |
| Email address given | 29/41 (70%) | 197/207 (95%) | p = 0.0001 |
| How are you? Answer recorded | 0 | 195/207 (94%) | |
| Family aware of sexuality? | 0 | 199/207 (96%) | |
| Vaccines offered? | 41/41 (100%) | 198/207 (96%) | p = 0.04 |
| Alcohol & Drug history? | 37/41 (90%) | 186/207 (90%) | p = 1 |
| PEP/PREP awareness recorded? | 26/41 (63%) | 183/207 (88%) | p = 0.0002 |
| STI & HIV retesting organised? | 20/41 (49%) | 193/207 (93%) | p = 0.0001 |
| Smoking & Exercise recorded? | 0 | 133/207 (64%) | |
| MSM pack given (website and support access information) | 11/41 (27%) | 179/207 (86%) | p = 0.0001 |
| Named feedback given | 0 | 206/207 (99%) | |

**Conclusion** A client led real time audit of care was highly acceptable to clients and staff and was effective in improving the

content of client and healthcare worker interactions and documentation. The checklist complemented STI care focussed EPR proformas, significantly improved communication modalities and was especially valued by staff and clients new to the service.

## P127 HIV TESTING: ARE THE TARGETS OFF TARGET?

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10.1136/sextrans-2016-052718.181

**Background/introduction** The British Association for Sexual Health and HIV (BASHH) standards provide clear targets for HIV testing in genitourinary medicine (GUM). BASHH state that 97% of people with 'needs relating to STIs' are offered an HIV test at first attendance; and that 80% are recorded to have an HIV test. Public Health England place testing figures for our fully integrated sexual and reproductive health service consistently below recommended standards.
**Aim(s)/objectives** To establish true HIV testing rates within an urban sexual health clinic, and to explore factors contributing to our performance.
**Methods** Electronic patient records from all attendances to GUM or contraception and sexual health clinics between 02/03/2015 and 06/03/2015 were analysed to establish rates and patterns of HIV testing.
**Results** 282 patients were included in analysis; 253 (89.7%) were offered an HIV test, and 176 (62.3%) had a test. 77 patients refused an HIV test; the most common documented reason was self/clinician perceived low risk (22). Within the 'high risk' cohort (52) only four refused and the reason was clearly noted. If patients attending primarily for contraceptive care were excluded from analysis, 225 patients remained; of these 211 (93.7%) were offered an HIV test and 164 (72.9%) had a test.
**Discussion/conclusion** We suggest that our lower testing rates, in part, reflect the inclusion of patients attending primarily for contraceptive care. In all sexual health/contraceptive clinics it remains important to risk assess patients, and offer HIV testing where appropriate, but our analysis begs the question: should the targets be amended for fully integrated services?

## P128 HUMAN PAPILLOMAVIRUS (HPV) VACCINATION IN YOUNG MEN WHO HAVE SEX WITH MEN (MSM) IN THE UK. AN ONLINE SURVEY OF ATTITUDES, INTENTIONS AND OPINIONS AMONG MSM OFFERED VACCINATION WITHIN INTEGRATED SEXUAL HEALTH SERVICES

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10.1136/sextrans-2016-052718.182

**Background** We have offered quadrivalent HPV vaccine (HPV4) to MSM under 27 years since 2012. We have observed a 60% 3 dose completion rate within 1 year.
**Aims** (1) To identify motivating factors or barriers influencing HPV4 completion in a cohort of MSM receiving at least one dose of HPV vaccine. (2) To identify factors influencing survey response rates.
**Methods** An email and reminder and an SMS text weblink to an online survey was sent to all MSM who received at least 1 dose of HPV4 vaccine.
**Results** Of 893 eligible, 688 (77%) had an email address, 257 (29%) opened the survey, and 228 (26%) completed the survey. 89% respondents learned of the vaccine at offer. 87% were happy with the information received and 97% with their decision to accept vaccine. A reminder strategy utilising SMS text for 1 year was preferred. Prevention of genital warts and anogenital cancers were equally highly important in motivation. Trusted healthcare workers were important influences in decision making

**Abstract P128 Table 1** Sample questions and summary responses

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **What's important for Prevention? Score/5** | GW* Me 4.2/5 | GW* My partner 4.1/5 | GW* Population 3.8/5 | AIN/AC* Me 4.2/5 | AIN/AC* My partner 4.1/5 | AIN/AC* Population 3.8/5 | Agreeing with HCW* 2/5 |
| **GW before?** | Yes 22% | No 73% | Not sure 4% | **GW since?** | Yes 4% | No 95% | Not sure 2% |
| **AIN/AC before?** | Yes 3% | No 96% | Not sure 1% | **AIN/AC since?** | Yes 0.3% | No 99% | Not sure 1% |
| **Who could influence MSM?** | Sexual Health 80% | Friend thro' Facebook 74% | Primary Care Team 65% | Schools Campaign 53% | Twitter Campaign 51% | Youtube Campaign 40% | LGBT+ Media 40% |

*GW = genital warts, AIN/AC = anal intra-epithelial neoplasia/anogenital cancer HCW = Health Care Worker

Survey respondents were more likely to be older (>21 yrs), HIV positive, homosexual and of non-white british ethnicity than the cohort of vaccine recipients.
**Discussion** MSM HPV vaccine recipients express high levels of satisfaction with vaccination despite little a priori awareness. Trusted public service providers & friends are influential. Completion should be supported through a multifaceted approach involving a range of agencies and media and expansion of access to vaccine.

## P129 HOW COMMON IS MYCOPLASMA GENITALIUM? SYSTEMATIC REVIEW AND META-ANALYSIS

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10.1136/sextrans-2016-052718.183

**Background** *Mycoplasma genitalium* is a common cause of non-gonococcal non-chlamydial urethritis but prevalence rates in asymptomatic populations are not well-established.
**Objectives** To estimate the prevalence of *M. genitalium* in adult women and men in general population and clinic based samples.
**Methods** We searched Embase, Medline, IndMED, AIM and LILACS. We examined eligible studies in forest plots and conducted random effects meta-analysis if appropriate. Between study heterogeneity was examined by use of the $I^2$ statistic.
**Results** Of 4355 screened abstracts, 55 studies were eligible. In high income countries that described samples from the general population, prevalence estimates ranged from 0.5 to 3.3% (pooled prevalence 1.4% (95% confidence intervals, CI 0.9 to 1.9%, $I^2$ 72.2%). In three studies with population-based random sampling prevalence was 1.2% (95% CI 0.9 to 1.6%, $I^2$ 30.1%).

Pooled estimates of prevalence in other populations were: pregnant women 1.2% (95% CI 0.4 to 1.9%, $I^2$ 85.1%, 4 studies); men who have sex (MSM) in the general population 2.3% (95% CI 1.6 to 3.1, $I^2$ 0%, 3 studies); and clinic-based samples of MSM 5.2% (95% CI 4.2% to 6.1%, $I^2$ 0%, 2 studies). In female sex workers in low income countries, prevalence estimates ranged from 13.2 to 26.3% (4 studies).
**Discussion** Prevalence rates of *M. genitalium* in the overall general population, population-based samples of MSM and pregnant women in high income countries are low. Estimates of prevalence are higher in MSM in clinic-based samples and in female sex workers in low income countries.

## P130 NATURAL HISTORY OF *MYCOPLASMA GENITALIUM*: INCIDENCE, PERSISTENCE, TRANSMISSIBILITY AND PROGRESSION TO PELVIC INFLAMMATORY DISEASE: SYSTEMATIC REVIEW AND META-ANALYSIS

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**Background** *Mycoplasma genitalium* causes urethritis in men and cervicitis in women but characteristics of the infection have not been systematically reviewed.
**Objectives** To determine the incidence, persistence and transmissibility of *M. genitalium* and its role in pelvic inflammatory disease (PID).
**Methods** We searched Medline, EMBASE, LILACS, IndMed and African Index Medicus. Two investigators selected studies and extracted data independently. We examined the findings in forest plots and assessed heterogeneity using the $I^2$ statistic. We conducted meta-analysis if appropriate.
**Results** Of 4355 abstracts we included 6, 5, 9 and 3 studies about incidence, persistence, transmissibility and PID respectively. Study designs were heterogeneous. In high income countries the pooled incidence was 1.1 per 100 person-years (95% CI, 0.5 to 1.7, $I^2$ 28.3%, 3 studies). The proportion of infected people who cleared infection were 50% after 2.5 months and <90% after 8 months but in one study 25.9% had persistent infection after a median of 16 months. In studies of people with *M. genitalium* the proportion of sexual partners also infected was 55% (95% CI 40 to 70%, $I^2$ 61.5%) and in cross-sectional studies 1 to 22% of couples were concordantly infected. Two cohort studies found PID more commonly in women with *M. genitalium* than in uninfected women (risk ratios 2.4, 95% CI 0.7 to 7.5 and 1.6, 95% CI 0.8 to 3.1).
**Discussion** Further studies of the natural history of *M. genitalium* are warranted. These estimates can be used in mathematical modelling studies of *M. genitalium* dynamics.

## P131 LESSONS LEARNT FROM PATIENT PUBLIC INVOLVEMENT

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**Background/introduction** NHS England are clear that patients and carers should supported in their involvement to help shape NHS services. Patient public involvement (PPI) groups to determine patients' views can be used to plan and improve services.
**Aim(s)/objectives** To hold a patient focus group discussing expectations of an integrated GUM clinic and explore patient views regarding engagement with our service.
**Methods** A survey given to all patients assessed views on PPI. Interested patients were requested to complete contact details. 12 mixed sex patients confirmed to attend a 90 minute session at a local venue, facilitated by an independent lead. Topics were decided in advance. Responses were documented by clinicians.
**Results** 306 completed the survey: 89% agreed patient involvement is important. 65 left contact details. 5/12 confirmed participants attended the session; all were male. All stated they would participate in future PPI sessions, and would be agreeable if held within our clinic.
**Discussion/conclusion** The survey demonstrated that patients agree public involvement is beneficial. However, only a fifth agreed to be contacted for this project. The focus group provided valuable development suggestions including increasing bookable appointments and introducing online triage. Acceptability of holding groups within our clinic enables a financial saving compared to external venues. Adequate participant numbers remains a challenge, with further sessions achieving a similar 50% attendance. Suggestions include reducing time between survey and date of focus group. Increasing invited numbers would allow for high drop-out rates. Trialling targeted focus groups e.g. single sex or telephone interviews may improve patient acceptability.

## P132 REVIEW OF SMOKING, ALCOHOL AND DRUG USE WITHIN AN INNER-CITY INTEGRATED GUM SERVICE

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**Background/introduction** Evidence suggests alcohol and drug use correspond to poorer sexual health outcomes. NICE recommend routine screening for alcohol use disorders, with adults and young people regularly attending GUM services identified as a high risk group. Assessment for drug and alcohol misuse enables health promotion through brief intervention.
**Aim(s)/objectives** To assess the prevalence of cigarette, alcohol and drug use within our GUM clinic population.
**Methods** Patients were requested to complete a questionnaire as part of the clinic triage form, including data on smoking status, alcohol use using AUDIT-C and recreational drug use. Cases were randomly selected for retrospective review over two week-long periods in June-July 2015.
**Results** 493 patients were reviewed: 261 (52.9%) female vs 232 (47.1%) male. Ages ranged from 14–79 (median = 28). 27.9% were current smokers (F = 26.8%, M = 29.2%). 391 (79.3%) patients completed questions to allow adequate assessment of their alcohol use. 220 (56.3%) scored ≥5 using the AUDIT-C screening tool, indicating need for further discussion. 317/409 (77.5%) disclosed binge drinking. Of the 418 patients (84.8%) who responded, 73 (17.5%) admitted recreational drug use. The most common method of use disclosed was smoking (71.2%),

followed by snorting (49.3%) and pills (30.1%). (31 reported more than 1 method.)
**Discussion/conclusion** Over half of patients attending our clinic warranted further assessment or brief intervention regarding their alcohol use. Recreational drug use and smoking was higher than that of the general population. Further staff training and developing links with local support services will improve the holistic management of our patients.

## P133 INTER-SPECIALITY WORKING TO PROVIDE COMPETENCIES IN GENITAL DERMATOLOGY FOR GUM TRAINEES

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**Background** The Health and Social Care Act (2012) led to decommissioning of genital dermatology services in our sexual health clinic, creating a training deficiency in this aspect of the GUM curriculum.
**Objective** To develop a service for patients with vulval pathology whilst also providing competencies in genital dermatology for GUM trainees.
**Methods** Training concerns were discussed with the local Health Education England board. A dermatology consultant with considerable experience in vulval disorders agreed to supervise a weekly vulval clinic, held within the dermatology department, to which GUM trainees would be seconded. Women were seen by a GUM trainee under the supervision of the dermatology consultant. Details of patient outcomes were prospectively recorded.
**Results** Over 10 months 84 women were seen in a total of 165 visits. The patients had a median age of 57 (range 19–94) years. 34 (40.5%) were follow-up dermatology patients. Of the 50 remaining patients, 10 (20%) were referred from other dermatology consultants, 3 (6%) from gynaecology, 8 (16%) from genitourinary medicine, and 29 (58%) from general practice. Diagnoses are tabulated below.

**Abstract P133 Table 1** Genital dermatology

| Diagnosis | Number of patients |
|---|---|
| Lichen sclerosus | 30 |
| Lichen planus | 15 |
| Dermatitis | 15 |
| Vulvodynia | 5 |
| Atrophic vaginitis | 4 |
| Lichen sclerosus/lichen planus | 3 |
| Psoriasis | 2 |
| Tinea | 2 |
| Vulval melanoma | 1 |
| Vulval Crohn's disease | 1 |
| Other | 6 |

**Discussion** Inter-speciality working has allowed GUM trainees to develop expertise in genital dermatology whilst the presence of a GUM doctor facilitates exploration of psychosexual issues in these patients. We recommend that other centres consider this model for training and service provision.

## P134 MAINTAINING CONFIDENTIALITY IN SEXUAL HEALTH CLINICS; A LOCAL AND NATIONAL SERVICE EVALUATION

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**Background/introduction** The need for confidentiality is of particular importance in sexual health clinics, as patients are sometimes reluctant to give personal contact information due to fears of disclosure to other parties. This can cause difficulties for clinicians when trying to issues results or advise patients of the need to attend for follow up.
**Aim(s)/objectives** To review the proportion of patients with *Chlamydia Trachomatis* who had their confidentiality/permissions (CP) breached in order to issue results, or who never received their results. To review UK wide policy in sexual health clinics on these issues.
**Methods** The EPRs of those attending a large provincial Sexual Health Department with a new diagnosis of *Chlamydia Trachomatis* between July 2014 and June 2015 were reviewed. A nationwide policy survey regarding breaches in CP in order to provide patients with results was disseminated to Lead Clinicians.
**Results** The records of 605 patients were reviewed. 4% had their CP breached, of whom 18 (69%) required follow up only, and 31% for the issue of positive results post treatment. 5% did not receive their results. 62 (25%) of sexual health clinics returned surveys, of whom 16 (26%) had a policy for issuing results when breaches were required.
**Discussion/conclusion** Breaching CP in order to issue results or ask patients to attend for follow up, or failing to give results, was common, affecting nearly 1 in 10 patients. The survey showed that a minority of UK clinics have formal policies addressing this issue. A BASHH national guideline would be helpful.

## P135 DO HIV SERVICES MEET THE NEEDS OF ADULTS DIAGNOSED WITH HIV AT AN OLDER AGE? A UK BASED, MULTI-CENTRE QUALITATIVE STUDY

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**Background/introduction** As the number of new HIV diagnoses in adults aged ≥50 years is increasing, the effectiveness of HIV services in meeting the needs of this group warrants exploration.
**Aim(s)/objectives** Exploring HIV service provision for adults diagnosed with HIV at age ≥50 years, from the perspectives of service users and healthcare professionals (HCP).
**Methods** Qualitative interviews with nine adults (age range 50–67 years) diagnosed with HIV at age ≥50 years and 12 sexual health/HIV HCP.
**Results** Service users reported a generally outstanding level of care delivery, and considered themselves to have a greater control of their health following diagnosis, primarily due to an increased level of support and general health monitoring (e.g. frequent blood pressure checks, blood tests, and regular follow-ups). Some service users believed their life-expectancy may have improved after diagnosis. Perceived advantages were identified

for older service users with HIV compared with the general older population, including earlier detection of general health problems. However, services in low HIV prevalence areas were commonly considered to be youth-orientated. The targeting of sexual health/HIV resources towards younger people was identified as a key contributor to the high proportion of older adults diagnosed at a late stage of disease. Late HIV diagnosis was associated with a lack of awareness or acknowledgement of personal risk.

**Discussion/conclusion** Once diagnosed, older adults report receiving exceptional HIV care and support. However, to promote early HIV detection, HIV awareness needs to increase across all age groups.

## P136 IS 7 DAYS OF DOXYCYCLINE ENOUGH FOR THE TREATMENT OF LGV?

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**Background** Current treatment recommendations for lymphogranuloma venereum (LGV) are for 21 days of doxycycline but the evidence is limited.

**Aims** To describe clinical outcomes in MSM treated with short-course doxycycline for rectal Chlamydia, subsequently proven to be LGV.

**Methods** We reviewed all MSM who received 7–14 days of doxycycline but tested positive for LGV between Dec 2012 – Jan 2016. Clinical features and test of cure (TOC) results were tabulated.

**Results** Thirty-three MSM with LGV were included. Median age was 35 (range 25–57), 88% were HIV positive and all tested positive for LGV-specific DNA in the rectum. Only 18/33 (55%) had ano-rectal symptoms including pain, bleeding, tenesmus, discharge, constipation, diarrhoea and ulceration. The remainder were asymptomatic or had genital symptoms. 24/33 (73%) were treated with 7 days of doxycycline, 8 (25%) with 14 days, and 1 patient received azithromycin 1g stat; 20 patients also received ceftriaxone 500mg. 100% (32/32) of patients treated with doxycycline had a negative TOC at a median 28 days (range 14–200). Of these, 1 patient had an initial positive rectal chlamydia TOC but this was LGV negative. The patient treated with azithromycin had a positive TOC at 24 days and remained symptomatic, representing treatment failure.

**Discussion/conclusion** This case series suggests efficacy for short-course doxycycline for both symptomatic and asymptomatic rectal LGV with no treatment failures seen. Current BASHH Chlamydia guidelines suggest 21 days of doxycycline should be considered if no LGV test is done. Our data suggest this is not warranted but further prospective studies are needed.

## P137 IS THE MANAGEMENT OF HIV POSITIVE LYMPHOMA PATIENTS WITHIN SMALL COHORT CENTRES IN LINE WITH CURRENT BEST PRACTICE GUIDELINES?

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**Background** As the incidence of opportunistic infections accounting for HIV-related deaths has declined significantly, malignancies now account for approximately a third of HIV related death with the majority of these being lymphoma related.

**Aims** To determine whether management of HIV positive patients within small centres is in line with current best practice guidelines.

**Methods** All HIV positive patients diagnosed with lymphoma or relapsing with lymphoma, from 2010 to 2015, in the BASHH Wessex region were eligible for inclusion. On review of previous studies and current BHIVA guidelines, a data collection tool was designed to accumulate relevant patient information to review care. Data collection was conducted at three centres across Wessex.

**Results** The total sample size of the study was 25 patients, all of which received the recommended diagnostic and staging procedures. Of the patients with documented staging, 73% were diagnosed with stage 4 lymphoma and 50% had an International Prognostic Index score of 3 or more. The mean follow up time of each patient was 19 months (from 1 to 64 months). Within the follow up time, the overall survival rate was 72%. In those followed up for a minimum of 2 years, the progression free survival rate was 100%.

**Conclusions** Although the small sample size does not allow comparison with larger cohorts, current findings suggest that management of HIV positive lymphoma patients within these smaller centres is in line with best care guidelines. The formation of a national registry would allow for closer monitoring of this in the future.

## P138 IDENTIFYING THE PREVALENCE OF RECREATIONAL DRUG USE IN MEN WHO HAVE SEX WITH MEN ATTENDING SEXUAL HEALTH CLINICS IN GREATER MANCHESTER

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**Background/introduction** Recreational drug use has been reported to be disproportionately higher in men who have sex with men (MSM) when compared to their heterosexual counterparts. There are indications that increased recreational drug use may lead to risky sexual behaviour. Patterns of recreational drug use are subject to spatial and temporal variations and as such, regular assessment of these changes is essential in understanding service user behaviour.

**Aim(s)/objectives** To identify commonly used recreational drugs, routes of administration and frequency of use for MSM service users attending sexual health clinics in Greater Manchester.

**Methods** A retrospective case note review was conducted using a random, powered sample of MSM attending three sexual health clinics across Greater Manchester during 2014. Details of risky sexual practices, sexually transmitted infection diagnoses and number of sexual partners were also recorded.

**Results** 357 case notes were reviewed from across three sites. In total, 18% of service users reported recreational drug use. The most commonly reported substances were cannabis (7%) and

cocaine (6%). 3.7% of service users reported using at least one of the three main drugs typically associated with chemsex.
**Discussion/conclusion** Our study identified that substance misuse is common in MSM attending sexual health clinics in Greater Manchester. It highlights the need for the robust collection of data during consultation in order to better understand service user requirements.

## P139 SCREENING FOR CHILD EXPLOITATION IN ONLINE SEXUAL HEALTH SERVICES: AN EXPLORATORY STUDY OF EXPERT VIEWS

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**Background/introduction** Sexual health services routinely screen for child sexual exploitation. Although, sexual health services are increasingly provided online there has been no research on translation of the safeguarding function to online services. We studied expert views on safeguarding in this context.
**Aim(s)/objectives** To explore expert views on safeguarding within online sexual health services and their implications for service development.
**Methods** We conducted semi-structured interviews with local, regional and national experts purposively sampled to represent a wide range of organisations that have direct influence over CSE protocols, child protection policies and sexual health services. Interviews were analysed by three researchers using a matrix based analytic method.
**Results** Our respondents described two different approaches to safeguarding. The 'information providing' approach considers that young people, at risk of CSE, will ask for help, when they are ready from someone they trust. The primary function of the service is to provide information, generate trust and respond reliably to disclosure. The approach values online services as an anonymous space to test out disclosure without commitment. The 'information gathering' approach considers that young people may withhold information about exploitation. Services should therefore seek out information to assess risk and initiate disclosure. This approach values face-to-face opportunities for individualised questioning and immediate referral.
**Discussion/conclusion** The 'information providing' approach is associated with confidential telephone support lines and the 'information gathering' approach with clinical services. The approach adopted online will depend on ethos and the range of services provided. Effective transition from online to clinic services after disclosure is an essential element of this process and further research is needed to understand and support this transition.

## P140 THE USE OF PELVIC ULTRASOUND IN AN INTEGRATED SEXUAL HEALTH SERVICE

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**Background** Clients presenting to integrated sexual health services may have gynaecological and contraceptive problems requiring ultrasound assessment. This would usually need referral to radiology causing delays in diagnosis and engendering patient worry and anxiety. To address this we have developed an in-house ultrasound service.
**Aim** To analyse if the use of pelvic ultrasound improves the patient journey, avoids referrals to radiology and saves time and potentially money.
**Methods** Over a 6-month period, 180 transvaginal pelvic ultrasounds were performed. So far we have reviewed 50 case notes. Information collated includes the indication for the scan, the findings and diagnosis. Further analysis of the rest is on going.
**Results** Preliminary results show that 96% of patients had their ultrasound on the day of initial presentation. Some of the indications for scanning included pelvic pain (36%), confirmation of position of IUC (30%) and abnormal bleeding (10%). 88% of patients were managed within the sexual health service and did not require onward referral. The majority of these had normal scans. Abnormal findings on scanning included fibroids, partial uterine perforation, adenomysosis and polycystic ovaries. 6 patients required referrals; one for a urological problem and 5 for appropriate gynaecological problems such as endometriosis and pelvic congestion syndrome. No radiology departmental ultrasound scans were required.
**Conclusion** Use of ultrasound in an integrated sexual health service provides patients with a streamlined experience, effectively providing a 'one stop shop' for most sexual health presentations. In the long run it could provide a value-based local service.

## P141 A SERVICE EVALUATION FOR AND ON BEHALF OF THE EUROPEAN CLINICAL COLLABORATIVE GROUP (ECCG) - THE MANAGEMENT OF GONORRHOEA ACROSS EUROPE

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**Background/introduction** Gonorrhoea (GC) cases appear to be rising as well as increasing problems with resistance to many antibiotic groups. With open boundaries and free movement of populations and doctors, a consistent standard of care is important across Europe. Regular evaluation is crucial in controlling the emergent spread of resistant GC.
**Aim(s)/objectives** To evaluate current clinical practice amongst sexual health physicians across Europe against the current European guidelines. Also, key areas of controversy will be explored with to help inform further guideline development.
**Methods** The ECCG is a network of 120 sexual health specialists across 38 countries, who conduct questionnaire-based research across the European region. An expert panel consisting of six ECCG members was established then interviewed to help identify areas of controversy. Subsequently, a clinical scenario based questionnaire was developed then disseminated to all ECCG members.
**Results** Provisional results demonstrate variation in clinical practice across Europe. This is discernable from the choice of treatment for a patient with a history of anaphylaxis to penicillin and

treatment for confirmed pharyngeal infection. In addition, data showed a lack of consensus to guidelines regarding choices of look back period for sexual contacts.
**Discussion/conclusion** Management of GC varies across Europe and is not always in line with current European guidelines. Although there are minor variations between guidelines, there are vast discrepancies amongst European clinicians regarding clinical practice. There is a need for on-going Europe wide education to ensure that patients are receiving safe evidence based care.

## P142 CHALLENGES AND OPPORTUNITIES OF A 'LOOK BACK' EXERCISE ON CHILD TESTING

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**Background/introduction** The consensus document 'Don't forget the children' 2009 recommends that all HIV units perform a 'look back' exercise to establish the HIV status of children whose HIV positive parents attend that service, as a standard of care.
**Aim(s)/objectives** To perform a 'look back' to identify children born to HIV positive females in our unit. Determine their HIV testing status and establish a robust pathway for testing and recording outcome.
**Methods** A retrospective notes review of all HIV positive women registered with the Sexual Health Clinic.
**Results** 76 women identified, 66 had 149 children. Ethnicity was predominantly African (38/76). 48/76 women acquired infection abroad. Children at risk of vertical HIV transmission recognised in 53/66 women. Child testing identified and documented in 29/53 women (65 children); 8 were HIV positive. 10/53 had children resident abroad (23 children). Parental discussions on-going in 6/53 women. A further 3/53 women declined testing. In 3/53 records were incomplete and 2/53 testing in progress.
**Discussion/conclusion** Challenges of retrospectively identifying children at risk of undiagnosed HIV highlighted particularly in parents that have not disclosed their status to children. We identified a reliance on verbally reported documentation as evidence of child testing, the challenges of testing older children and the need for robust reporting between paediatric and adult services. Clinicians should continue to ask about children abroad who subsequently join parents in the UK to avoid missed opportunities for testing.

## P143 AN AUDIT OF THE MANAGEMENT OF CHLAMYDIA TRACHOMATIS

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**Background/introduction** Chlamydia trachomatis (CT) is the most commonly reported bacterial STI in the UK.
**Aim(s)/objectives** We aimed to evaluate our overall management of CT.
**Methods** All patients with a positive CT NAATs result over a 2month period (August–September 2014) were identified from our electronic patient records; clinical data was collated and analysed using an Excel spreadsheet
**Results** 180 patients were identified; 54% female, 72.6% aged <25 years, 41.6% of Black Afro-Caribbean/UK ethnicity. 96.6% were heterosexual. 97 infections were from LVS and 1 urine (females); males 82 urine and 2 rectal swabs. Both rectal swabs were negative for LGV. 39% (70/180) were symptomatic; 19 males and 24 females had microscopy performed. 25.5% (46/180) had co-infections. 69% (125/180) had an HIV test; all negative. All contactable patients (174/180) were treated for CT and any co-infections. Three patients were treated elsewhere, and three were uncontactable. The median time from result to treatment was 2 (IQ (0–6) weeks. 36% (65/180) attended for a test of cure. One patient tested positive for CT due to re-infection. 8 patients had HIV tests repeated at their follow up attendance, all negative.
**Discussion/conclusion** Our centre meets the BASHH 2015 standards. Areas for improvement are HIV testing and performing microscopy in all symptomatic men to enable earlier treatment. We now offer repeat testing at three months only to patients aged <25 years and all MSM via a recall text reminder. This will enable better use of clinic resources through targeting higher risk patients and detecting re-infections as well as treatment failure.

## P144 STAFF ENGAGEMENT SURVEY PRE- AND 6-MONTHS POST INTRODUCTION OF ROUTINE DOMESTIC ABUSE ENQUIRY

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**Background/introduction** In July 2015, routine domestic abuse (DA) enquiry was introduced in a busy, walk-in, inner-London, genitourinary medicine (GUM) clinic. Guidelines, proforma and management pathway were devised. Tiered training was/is provided (basic level for all staff, in-depth for Sexual Health Information Protection team and DA champions). A separate audit demonstrated 91% of walk-in GUM patients were asked about DA, following routine enquiry introduction.
**Aim(s)/objectives** To assess staff engagement with routine DA enquiry.
**Methods** On-line survey disseminated to GUM healthcare professionals, two weeks prior to, and 6 months post-introduction of, routine DA enquiry.
**Results** 27 vs 20 staff completed the surveys. The majority were female [70 vs 90%]. Respondents were doctors [48.1% vs 42.1%], nurses [44.4% vs 57.9%] and healthcare assistants [7.4% vs 0%]. 3.7% vs 20% had worked in GUM < 1 year. 87.5% vs 89.5% had received training, 85.0% vs 100% of these respectively had rated this good-excellent. 4.8% vs 66.7% of respondents reported having managed patients disclosing DA at least once/week. 14.3% pre-introduction vs 0% post-introduction respondents had never managed a patient disclosing DA. Respondents reported feeling 'very confident' asking about DA [16.7% vs 63.2%] and managing disclosures [8.3% vs 26.3%]. 45.8% vs 63.2% thought 'Routine DA enquiry was a great idea…why hadn't we introduced earlier?' 8.3% pre-introduction respondents had some reservations vs 0% post-introduction.
**Discussion/conclusion** Staff engagement in routine DA enquiry was high from the outset and improved over 6 months. Levels

of experience and confidence in DA enquiry and disclosure management improved dramatically over this period.

## P145 AUSTRALIAN MSM'S VIEWS AND KNOWLEDGE OF PHARYNGEAL GONORRHOEA, WILLINGNESS TO CHANGE CURRENT SEXUAL PRACTICES AND THE ACCEPTABILITY OF USING MOUTHWASH TO REDUCE THE RISK OF PHARYNGEAL GONORRHOEA: A QUALITATIVE STUDY

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**Background/introduction** The pharynx is the most common site of gonorrhoea among men who have sex with men (MSM) and may serve as a reservoir for infection, with saliva implicated in transmission possibly through oral sex, kissing, and rimming. Reducing sexual activities involving saliva may reduce pharyngeal gonorrhoea however strategies that target the oral cavity warrant investigation.
**Aim(s)/objectives** This study aimed to explore MSM's views and knowledge of pharyngeal gonorrhoea, their willingness to change saliva transmitting sexual practices and the acceptability of using mouthwash to reduce transmission.
**Methods** 30 MSM, recruited from a sexual health clinic in Melbourne, Australia, were interviewed face to face or by telephone.
**Results** Most men considered pharyngeal gonorrhoea non-serious and attributed transmission to saliva and oral ejaculate. Most men would not stop kissing (n = 25), oral sex (n = 26), or consider using condoms for oral sex (n = 25) to reduce their risk of gonorrhoea. Kissing and oral sex were common and considered enjoyable but regarded as low risk sexual activities. Men were more likely to consider stopping sexual activities they did not enjoy or practice often including rimming (n = 21) and using saliva as a lubricant for anal sex (n = 28). If proven effective, most men reported they would use a mouthwash to reduce or prevent their risk of pharyngeal gonorrhoea.
**Discussion/conclusion** MSM are unlikely to stop sexual practices they enjoy and consider low risk. The findings from this study highlight the need for further exploration of innovative strategies such as mouthwash to reduce their risk of pharyngeal gonorrhoea.

## P146 DIAGNOSING GONORRHOEA – HOW DO DOCTORS AND NURSES COMPARE? AN AUDIT OF GONORRHOEA MANAGEMENT IN A LARGE PROVINCIAL NHS TRUST

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**Background/introduction** Although gonorrhoea rates are rising, incidence of urethral and cervical infection remain low in comparison to historic data. There is therefore concern that expertise in microscopic diagnosis of gonorrhoea may be falling. Additionally, in light of emerging resistance of gonorrhoea to extended-spectrum cephalosporins, multiple guidelines highlight the importance of taking cultures from NAAT positive sites prior to antibiotic treatment.
**Aim(s)/objectives** To evaluate the sensitivity of urethral microscopy performed by doctors/nurses and the frequency with which cultures are taken from all NAAT positive sites prior to treatment.
**Methods** A retrospective case note review of 100 patients with a gonorrhoea diagnosis and all gonorrhoea contacts in the same time period.
**Results** 16 men with genitourinary symptoms had positive urethral cultures on initial visit. 16/16 (100%) had positive microscopy. 32 men with genitourinary symptoms had a positive urethral/urine NAAT, of which 30 had microscopy. In 25/30 (83%), microscopy was positive. When performed by doctors, this was 7/8 (88%), and by nurses was 18/22 (82%)(p = 0.46). 64 patients with a positive NAAT were consulted by exclusively doctors or nurses before treatment. 11/15 (73%) of doctors' patients and 30/49 (61%) of nurses' patients had cultures taken from all NAAT positive sites before treatment (p = 0.12).
**Discussion/conclusion** Microscopy in men with genitourinary symptoms remains sensitive in comparison with culture. However, there may be a case for a new auditable standard comparing microscopy with NAATs. Doctors and nurses are inconsistent in taking cultures from all NAAT positive sites prior to treatment and training in both groups should be addressed.

## P147 ADDING A DOMESTIC ABUSE ROUTINE PROMPT TO THE GUM PROFORMA: BUT ARE WE ASKING THE QUESTION?

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10.1136/sextrans-2016-052718.201

**Background/introduction** In July 2015, a routine domestic abuse (DA) prompt was introduced in a busy, walk-in, inner-London, genitourinary medicine (GUM) clinic. DA guidelines, proforma and management flowchart were devised. Tiered training was/is provided at a basic level for all staff and in-depth for Sexual Health Information Protection team (SHIP) and DA champions. Auditable outcomes: DA question asked where safe (Target 100%), (SAFE: quiet/confidential space, seen alone, no child > 18 months present, professional interpreter if necessary), Complete DA proforma if DA disclosed (100%), Patient information leaflet (PIL) given if DA > 3/12 ago/no on-going risk (100%), Offered SHIP referral for risk assessment if DA < 3/12 or on-going risk (100%), DA disclosures correctly coded (100%).
**Aim(s)/objectives** Audit whether DA routine prompt asked, proforma completed, initial management pathway followed and disclosures coded.
**Methods** Data collected (notes review) on 100 consecutive, new, walk-in, GUM patients > 18 years-old, from 1st October 2015.
**Results** 59 female, 41 male. 91% patients asked about DA. 9 not asked: 5/41 (12.1%) male, 4/59 (6.8%) female. 9/9: no reason documented explaining omission. 5/91 (5%) disclosed DA (all female). DA proforma completed in 3/5 (60%) (1 patient declined further discussion). 1/4 (25%) had current/on-going risk and referred to SHIP. 3/4 DA occurred > 3/12 ago/no on-going risk: 1 accepted, 1 declined, 1 not offered PIL. 2/5 (40%) DA disclosures coded correctly (using in-house code).
**Discussion/conclusion** High enquiry rate (male patients less likely to be asked). DA protocol/flow chart followed in the

majority of cases (proforma completion and referral to SHIP). There were low levels of accurate coding.

## P148 AN AUDIT ON MANAGEMENT OF AFTERCARE FOR VICTIMS OF SEXUAL ASSAULT ATTENDING A DEDICATED AFTERCARE CLINIC

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10.1136/sextrans-2016-052718.202

**Background/introduction** A dedicated sexual assault aftercare clinic was set up at the integrated sexual health service to provide care for the victims of sexual assault. British Association for Sexual Health and HIV (BASHH) guidelines provide auditable measures to compare standard of care provided by services. We wanted to assess and improve the service offered to victims by the dedicated clinic.
**Aim(s)/objectives** To evaluate current clinical practice in the management of victims of sexual assault against the auditable outcome measures in the guidelines and improve the quality of care provided by communicating the findings, recommendations and action plans to team members.
**Methods** Retrospective review of all victims who attended the clinic between January 2015 and 31st September 2015 was performed. Cases were identified from coding used in the clinic. A standard data collection sheet developed on the basis of the BASHH guidelines was used.
**Results** Of the 53 victims identified, 96% were women, 83% were white, 13% were alcohol/drug related and 25% were under 18 years of age. 57% were referred by the sexual assault referral centre.96% reported one assailant and 55% were known to the victim. 100% had HIV risk assessment and were offered PEPSE if indicated. 98% were offered forensic examination if applicable, 93% emergency contraception if needed. Offer of prophylaxis against sexually transmitted infections: chlamydia 74%, gonorrhoea 62%, Trichomonas 49%. Offer of baseline testing for chlamydia 98%, gonorrhoea 100%, trichomonas 64%, syphilis HIV and hepatitis B & C 100%. Documentation of a plan for repeat STI testing 93%, documentation of offer of vaccination against hepatitis B 94% and assessment of child protection needs if under 18 years 77%.
**Discussion/conclusion** Areas to improve: documentation of a self-harm risk assessment, offer of emergency contraception, recording of a discussion of need for pregnancy test in 3 weeks after emergency contraception, documentation of offer of prophylactic treatment for chlamydia, gonorrhoea and trichomonas and documentation of an assessment of child protection needs if the victim was under 18 years of age. This will be re-audited in 6 months.

## P149 PATTERNS OF SEXUAL BEHAVIOUR AMONG TRANSGENDER INDIVIDUALS IN MELBOURNE, AUSTRALIA 2011–2014

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10.1136/sextrans-2016-052718.203

**Background/introduction** Literature on the healthcare needs of transgender individuals is limited in Australia.
**Aim(s)/objectives** The aim of this study was to investigate the demographic characteristics, risk behaviours and STI/HIV positivity among male-to-female (MTF) and female-to-male (FTM) transgender individuals attending a sexual health clinic in Melbourne, Australia, between 2011 and 2014.
**Methods** A retrospective cohort analysis among 133 transgender individuals was conducted based on the first visit of the study period. Demographic characteristics, sexual behaviours, and HIV/STI positivity were examined.
**Results** 77 MTF, 28 FTM, and 28 unreported transgender status, attended 558 consultations with a median of two [IQR 1–5] visits. 70% percent attended for their first ever visit. Reassignment hormone use was 63% and surgery 27%. 11% had a history of injecting drug use, 74% were single/never married. In the last 12 months, 21% had sex overseas and 11% attended for counselling. Low median male sexual partners 1 [IQR 1–5] and female sexual partners 2 [1–4] were reported. MTF were more likely to be overseas born, older and work currently as a sex worker than FTM. STI positivity was 7% (n = 8) chlamydia; 5% (n = 6) gonorrhoea and 5% (n = 6) syphilis and HIV 3% (n = 1). There were no differences in positivity between MTF and FTM.
**Discussion/conclusion** In the Australian context STIs, HIV and sexual risk behaviours may differ to other developing and first world countries and therefore the healthcare needs may differ. Attention to differences in MTF and FTM transgender persons must be considered in health care.

## P152 RECOGNITION OF LGV LYMPHADENITIS IN MSM

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**Background** There is a sustained high rate of lymphogranuloma venereum (LGV) amongst men who have sex with men (MSM) in the UK, with the highest annual number of diagnoses reported in 2015, yet prompt diagnosis of LGV, particularly from non-rectal sites, eludes clinicians.
**Aims** We present 4 cases highlighting the ongoing challenge of recognition of LGV lymphadenitis, particularly outside GUM settings, and challenges with diagnosis and management.
**Case reports** 4 MSM (3 with well-controlled HIV on antiretroviral therapy, 1 HIV negative) presented to their GPs with unilateral groin swellings, and were referred to haematology or surgical teams for investigation. Investigations included ultrasound, CT/MRI of the groin as well as fine needle aspiration, and in 2 cases surgical exploration followed by node excision. None of the patients had symptomatic proctitis, and triple-site NAAT swabs for *Chlamydia trachomatis* (CT) were negative, although 1 patient had previously diagnosed but untreated urethral CT one month prior. In 1 case, CT serology (WIF) showed a high L2 titre of >1:4000. In all cases, a 21-day course of doxycycline was commenced between 10–45 days from initial presentation. There was slow resolution of the lymphadenitis in 2 patients, necessitating a prolonged course of doxycycline (5 weeks), and addition of 7days of azithromycin 500mg once daily, respectively.
**Conclusion** Early recognition and management, including prompt aspiration/drainage of buboes and appropriate antibiotic treatment are key to management of LGV lymphadenitis. Poor

penetration of antibiotics into abscesses and residual inflammation may delay clinical resolution compared to proctitis cases.

## P155 TRANSDERMAL OESTROGEN PREVENTS CYCLICALLY-RECURRENT GENITAL HERPES

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10.1136/sextrans-2016-052718.205

**Background** Some women suffer cyclical recurrences of genital herpes (c-RGH) immediately prior to menstruation, which are effectively prevented using aciclovir in the luteal phase only. This is more likely to occur in perimenopausal women whose immunity is diminished by premenstrual dysphoric disorder (PMDD), which is treatable with transdermal estradiol.
**Aim** To observe the frequency of herpes recurrences in women commencing estradiol treatment for perimenopausal PMDD.
**Methods** 12 perimenopausal women median age 41 years (range 36–45) presented between 2006–15, each meeting the criteria for PMDD subsequently defined in DSM-5. Each had at least 4 consecutive monthly episodes of c-RGH (culture-proven HSV2) before some took luteal-phase aciclovir, then all switched to transdermal 17-beta estradiol gel 0.5mg daily for 14 days in the luteal phase or continuously for those using Mirena. Subjects self-reported mood with a modified daily symptom chart and herpetic symptoms over 9 months follow-up during which no aciclovir was taken pre-emptively. Intention-to-treat analysis included 10 cycles where treatment was omitted in error and both conditions recurred.
**Results** All women experienced substantial or complete relief of PMDD in all but three treated cycles. Only 13 symptomatic c-RGH episodes occurred on treatment in 108 woman-months' observation.

**Abstract P155 Table 1** Estradiol for PMDD

| | PMDD | Herpes |
|---|---|---|
| Total episodes observed in 9 months (I.T.T.) | 13 | 23 |
| Mean episodes per month Observed/Expected (1.0) | 0.12 | 0.21 |
| Probability (Student's t-Test) | <0.001 | <0.01 |

**Conclusion** Transdermal estradiol treatment is a novel and biologically plausible method of preventing cyclically-recurrent genital herpes as it stabilises the hormonal milieu and diminishes immune suppression caused by PMDD.

## P156 A RARE CASE OF LYMPHANGIOMA CIRCUMSCRIPTUM OF THE PENIS

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10.1136/sextrans-2016-052718.206

**Introduction** Lymphangioma Circumscriptum (LC) is a vascular malformation resulting from a developmental anomaly of the lymphatic system. The common sites for the anomaly include trunk, axilla, thigh, buttock area and the oral cavity. It is a rare for LC to occur on the penis.
**Aim** To increase awareness of this rare condition which may mimic sexually transmitted infections such as genital warts.
**Methods** Review of clinical notes and case presentation.
**Results** Description of the case: A 47 years old Afro-Caribbean man presented with a long-standing wart-like lesion on the dorsal aspect of his penis. Treatment in the past included cryotherapy and podophyllotoxin. There were no symptoms of itching, bleeding, change in size or pigmentation. The initial clinical impression was a genital wart. However on examination it was smooth to palpation despite its warty appearance. An excision biopsy was performed for both diagnostic and therapeutic purposes. Histology results showed penile LC.
**Discussion** LC is the commonest superficial type of lymphangiomas. Penile LC is rare and it maybe congenital or acquired. There was no identifiable predisposing factor in our case. LC presents with varying sizes of persistent vesicles, which are saccular dilations arising from underlying lymphatic vessels. Incidence of LC is high soon after birth. The vesicles may undergo verrucous changes and give the appearance of warts and therefore they may be mistaken for genital warts or molluscum contagiosum. Surgical treatment is the mainstay of treatment for LC.

## P157 SEXUAL HEALTH & CONTRACEPTION: DEVELOPING A ONE STOP SHOP SERVICE USING A COLLABORATIVE APPROACH BETWEEN A LOCAL AUTHORITY, ACUTE AND COMMUNITY TRUSTS

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10.1136/sextrans-2016-052718.207

**Background/introduction** This city on the South East coast has a high proportion of young people/LGBT with some of the highest STI/HIV rates in England (2013 gonorrhoea 162.1/100,000; HIV prevalence 8/1,000). GUM & contraception services were historically provided by two separate NHS Trusts. Transfer of public health responsibility to the Local Authority (LA) in 2013 led to service review.
**Aim(s)/objectives** To deliver an efficient and accessible multi-disciplinary sexual health and contraception service.
**Methods** City-wide public consultation favoured a one-stop-shop integrated service. Pathway Analytics© sexual health tariff was accepted by LA/providers as a transparent & fair payment mechanism. Following legal advice LA gave the commissioner permission to negotiate a new contract with existing providers, moving to a competitive tender process if unsuccessful.
**Results** The contract was awarded to existing providers in April 2015. The local Sexual Health Programme Board ensured all stakeholders were engaged in service review. A staged approach was followed to deliver an integrated service. The tariff was introduced allowing fair remuneration for combined services at diverse sites across the city. Trusts have established a steering group to ensure safe governance across legal, financial & clinical frameworks & robust risk management processes across both organisations.
**Discussion/conclusion** Innovative thinking by the LA allowed service re-design by negotiation with existing providers avoiding a competitive tender process. Good working relationships within the sexual health network allowed a collaborative approach to service improvement. Despite the challenges of two Trusts working together with different organisational accountabilities, a 'one-stop-shop model' has been successfully introduced without destabilising HIV services.

## P158 EVALUATION OF SEXUAL HEALTH SERVICE USE AT BASELINE (2014) IN SOUTH EAST LONDON

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10.1136/sextrans-2016-052718.208

**Background/introduction** Lambeth and Southwark have poor sexual health outcomes compared with the rest of England. We wished to evaluate an intervention to improve access to sexual health services through online STI testing and contraceptive provision.
**Aim(s)/objectives** This study describes baseline service use in Lambeth and Southwark in 2014 prior to the introduction of online services. We present our methodology for evaluating service use across the boroughs.
**Methods** We collated baseline demographic and clinical data from all sexual health service providers (genitourinary medicine and community sexual health clinics) in Lambeth/Southwark, South East London, for one calendar year (2014). Individual level clinic data were merged, together with Office for National Statistics (ONS) on index of multiple deprivation for area (LSOA) of residence. We summarise the main type of service used and define each attendance as possible to be provided "online" (basic STI test, repeat oral contraception) or requiring "offline" services (e.g. clinical exam, surgical intervention, symptoms, long-acting contraception).
**Results** We collected over 127,000 attendance records for sexual health services in Lambeth and Southwark during 2014. All clinics reported consistent levels of activity during each quarter. Up to 40% of attendances could potentially be provided online based on clinic coding.
**Discussion/conclusion** The low monthly variation in attendances suggests that current services are operating at capacity. Understanding current service use will enable evaluation of online services to assess whether providing online services 1) increases capacity, 2) reaches new population groups 3) improves access for high risk groups.

## P159 INCREASING USER INVOLVEMENT AND DIVERSITY IN HIV RESEARCH. A PATIENT QUESTIONNAIRE SURVEY

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10.1136/sextrans-2016-052718.209

**Background/introduction** Engaging people living with HIV in developing and participating in research is essential for improving quality of care and evidence based practice. Women and black and minority ethnic groups (BME) remain underrepresented in HIV research. Barriers to HIV research participation are underexplored.
**Aim(s)/objectives** To explore: i) barriers to participation ii) research preferences in our HIV clinic population- majority female and set in a socioeconomically vulnerable and diverse population.
**Methods** We developed a self-administered paper questionnaire which was reviewed by two patient representative organisations by email and group discussion. Questionnaires were completed in clinic November 2015 – March 2016.
**Results** From a cohort of approximately 1000 patients, 765 attended in the study period and 157 (20.5%) participated: 79 (50.3%) female; 81 (51.6%) black ethnicity, 41 (26.1%) white. Research participation: 74 (47.1%) had previously participated in at least one study; 118 (75.1%) would consider future participation. Research preferences: 66 (42.0%) patients expressed interest in both medical and social research, 60 (38.2%) medical and 17 (10.8%) social. Incentives: 69 (43.9%) were more likely to participate if incentives available; 62 (39.5%) were unsure whether incentives would influence participation; 21 (13.4%) said it would not. Travel: 60 (38.2%) patients were unsure whether they would travel to another clinic for research, 36 (22.9%) would travel and 33 (21.0%) would not. For 22 (14.0%) respondents, clinic location would influence a decision to participate. Barriers to participation: 51 (32.4%) fear of HIV disclosure; 52 (33.1%) fear of something going wrong; 45 (28.7%) time constraints.
**Discussion/conclusion** Our survey suggests that raising research awareness and disseminating information addressing fears and barriers could potentially increase research participation in our clinic.

## P160 IDENTIFICATION AND CHARACTERISTICS OF WOMEN WITH FEMALE GENITAL MUTILATION PRESENTING TO SEXUAL HEALTH SERVICES

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10.1136/sextrans-2016-052718.210

**Background/introduction** Female Genital Mutilation (FGM) is illegal in the UK. When identified, it is mandatory to record FGM in a patient's health care record and to report under 18s to the police.
**Aim(s)/objectives** To investigate characteristics and management of patients with FGM attending an inner city sexual health service.
**Methods** Retrospective case note review of patients recorded as having had FGM between February 2014 and November 2015.
**Results** 65 patients were identified; 52 attended the walk-in GUM clinic and 13 attended the HIV clinic. Median age was 33 years (range 17–54 years). Common countries of origin were Sierra Leone, Somalia and Nigeria in 38%, 20% and 12%, respectively. Most FGM took place in childhood (aged 0–4 years in 17%, aged 5–10 years in 37%, aged 10–15 years in 11%). FGM was self-reported in 13 (20%) and identified during examination in 52 (80%) patients. Type 1 and 2 FGM were the most common forms in 21 (32%) and 29 (45%), respectively. Of 52 cases presenting to GUM, 28 (54%) were first attendances. Of the remaining, 15/24 (63%) cases of FGM had not been identified on previous visits despite a previous documented examination in 11/15 (73%). One patient was under 18 at presentation and 18 (28%) had daughters or sisters aged < 18 years. Immediate safeguarding concerns were raised in 4 cases.
**Discussion/conclusion** FGM is common yet frequently missed by health care professionals even during examination. Training in the recognition and management of FGM is essential for staff working in Sexual Health.

## P161 MANAGING SEXUAL ASSAULT IN AN INTEGRATED SEXUAL HEALTH SERVICE: ENSURING QUALITY AND PATHWAYS INTO CARE

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10.1136/sextrans-2016-052718.211

**Background/introduction** Reported sexual assaults have increased in England & Wales since operation Yewtree. Sexual health services are ideally placed to manage and support victims of sexual assault. Clear patient pathways underpin the quality of care victims of sexual assault receive.
**Aim(s)/objectives** To assess our outcomes against the 2011 BASHH guidelines on the management of complainants of sexual assault.
**Methods** We undertook a case note review of all SA attendances to the CNC between August 2014 and July 2015
**Results** 114 sexual assault patients were seen, 87% (99/114) were female, the median age was 23 years (13–66) and 96% (110/114) were white British or white other. 41% (47/114) were referred by the Sexual Assault Referral Centre (SARC), 49% (56/114) self-referred. 24% (27/114) reported being assaulted in an outside area, 16% (18/114) at a public venue and 20% (23/114) at the accused's home. 35% (40/114) attended within 72 hours of the assault, 22% (2/114) within 7 days, 17% (19/114) within 2 weeks, 21% (24/114) within 3 months and 4% (5/114) within a year. 99% (43/44) were appropriately assessed for PEPSE, 89% (64/72) were offered prophylactic antibiotics, 50/51 (99%) of women were assessed for emergency contraception. 63% (72/114) reported the assault to the police, 37% (9/28) who didn't report were offered third Party Reporting. STI infection rate was 6/114 (5%).
**Discussion/conclusion** Our results suggest that our current management is in keeping with BASHH guidelines and that local referral pathways support patient care.

## P162 WHY ARE CORE MEDICAL TRAINEES NOT APPLYING FOR GENITOURINARY MEDICINE?

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10.1136/sextrans-2016-052718.212

**Background/introduction** Applications for higher speciality training in genitourinary medicine (GUM) have decreased dramatically in recent years leaving a number of unfilled posts. The reasons for this are unknown.
**Methods** We produced an anonymous electronic survey for CMTs which was distributed to all deaneries in the UK. Survey questions included the advantages/disadvantages of a career in GUM and main barriers to application. A specific question was asked regarding the impact that the Shape of Training review (SOT) would have on the perceived attractiveness of a career in GUM.
**Results** 100 CMTs responded, 51 CT1s and 49 CT2s. 35/100 were considering or applying for GUM and 17/100 may be. 61/100 gave reasons as to why they were not applying: 28% (17/61) interested in another speciality, 33% (20/61) no previous exposure, 21% (13/61) no interest, 20% (12/61) too specialist, and 3% (2/61) were uncertain of speciality future. The main advantage of GUM was an attractive work/life balance 44% (32/73). When specifically asked about the SOT implementation and likelihood of applying for GUM, 94/100 responded. 27% (25/94) were more likely to apply and for 36% (34/94) it made no difference. However of those applying/considering or maybe considering GUM (n = 52); 31% (16/52) would be less likely to apply and 27% (14/52) would apply but not if SOT is implemented.
**Discussion/conclusion** This survey demonstrates that a significant proportion of CMTs are not considering GUM due to lack of exposure to the specialty. The SOT review is likely to significantly impact on GUM training, possibly deterring trainees currently considering applying but potentially also attracting other trainees who may not previously have considered it.

## P163 A QUALITATIVE EVALUATION OF THE PATIENTS KNOW BEST® (PKB) PATIENT-CONTROLLED ELECTRONIC MEDICAL RECORD AND COMMUNICATION PLATFORM IN UK HIV SERVICES

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10.1136/sextrans-2016-052718.213

**Background/introduction** Patients Know Best® (PKB) is an innovative, patient-controlled, medical record and communication platform aiming to facilitate patient centred care.
**Aim(s)/objectives** This qualitative service evaluation aimed to gain insight into the utility of PKB and experiences of users: specialist doctors, nurses and people living with HIV (PLWHIV).
**Methods** Participants were from 7 UK HIV centres that use PKB, 2 with PKB integrated with lab systems allowing automatic upload of blood results. Six doctors, 5 nurses and 4 PLWHIV took part in focus groups or individual interviews, which were audio-recorded and transcribed verbatim. Transcripts were systematically coded using a thematic analysis approach.
**Results** Participants had on average 1.5–2 years' experience of using PKB. PKB was mainly used to send/access lab results (automatically, or via secure messaging) or for other secure messaging e.g. clinicians uploaded clinic communications to GPs, care plans, letters for employment/sick notes, PLWHIV requested new/repeat prescriptions, booked appointments, queried results, symptoms and medication issues. Participants reported that PKB enabled different models of care (e.g. nurse-led, remote-monitoring) and use resulted in efficiencies and increased capacity, improved patient experience and self-management. Communication with GPs, pharmacists and clinicians in other departments via PKB was an area of unmet potential. Participants suggested lack of IT systems integration and resistance to PKB by some colleagues/PLWHIV were barriers to wider uptake.
**Discussion/conclusion** Varied benefits and value of PKB were reported. Overall experiences with PKB in UK HIV services were positive with all supporting continued use, greater uptake and integration.

## P164 MANAGEMENT OF PRIMARY AND SECONDARY SYPHILIS IN A LARGE LONDON TEACHING HOSPITAL

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10.1136/sextrans-2016-052718.214

**Background/introduction** Acute syphilis is on the increase and prompt treatment is vitally important to prevent onward transmission.
**Aim(s)/objectives** To ensure compliance with BASHH audit outcomes for the management of acute syphilis.
**Methods** We collected all patients who had been coded as primary or secondary syphilis (A1 or A2) for 12 months from May

2014. Demographics, symptoms at presentation and subsequent management were collected.
**Results** 132 records were returned with 89% (117/131) identifying as men who have sex with men (MSM). 55% (72/132) were HIV positive, with 3 new HIV diagnoses. 70% (89/128) had symptoms of acute syphilis; with an ulcer, 87% (41/47) had herpes simplex virus (HSV) PCR which was positive in 7% of cases. Dark ground microscopy was performed in 38% (20/52) with one third being positive. 42% (56/131) were treated for syphilis on their initial visit (14% if seen by a technician, 31% if seen by a nurse and 51% if seen by a medic, p = 0.006). 90% had been treated by 2 weeks.
**Discussion/conclusion** MSM comprised the majority of acute syphilis with high rates of new HIV diagnoses, reinforcing the importance of routine HIV testing. There was a high co-infection prevalence of HSV. Dark ground microscopy was positive in a third of samples, perhaps due to technical difficulties in the clinic. Only 4 in 10 patients were treated at the first visit indicating a lack of awareness of symptoms of acute syphilis. More education on recognising and treating acute syphilis, especially in high risk groups, is needed.

## P165 SURVEY OF HEALTHCARE PROFESSIONALS' KNOWLEDGE AND ADHERENCE TO NATIONAL CHLAMYDIA SCREENING PROGRAMME GUIDANCE

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10.1136/sextrans-2016-052718.215

**Background** The National Chlamydia Screening Programme (NCSP) aims to prevent and control chlamydia through detection and treatment of infection. The NCSP recommends that under 25 year-olds test annually, upon change of partner and re-test three months after treatment. Healthcare professionals' (HCP) knowledge of and adherence to NCSP guidance is unknown.
**Aims** To establish HCPs' knowledge of and adherence to NCSP testing guidance, among those working in genitourinary medicine (GUM) and sexual and reproductive health (SRH) in England.
**Methods** Participants were invited through the BASHH newsletter and snowball sampling to complete an online survey (December 2015 to February 2016).
**Results** One hundred HCPs responded (82 medics, 17 nurses, 1 health adviser). Twelve percent knew the NCSP age limits (15–24 years). Among respondents, 25% identified screening criteria for annual testing, 70% for testing on change of partner, 59% for re-test following a positive and 16% identified all three screening criteria. Of those who correctly identified screening criteria, 75% would always do it in practice, 19% sometimes and 2% never. Of those who did not recognise screening criteria, 41% would still always screen appropriately in practice; 34% sometimes; 10% never.
**Discussion** Knowledge of NCSP testing guidelines among healthcare providers was variable. While knowledge of NCSP was associated with testing in accordance with recommendations, knowledge did not automatically lead to adherence to testing recommendations. These findings will help to inform future development and dissemination of NCSP guidance.

## P166 SERVICE EVALUATION OF PERCEIVED NEEDS OF WOMEN LIVING WITH HIV IN THE OUTPATIENT SETTING

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10.1136/sextrans-2016-052718.216

**Background/introduction** Gender plays an important role in determining vulnerability and ability to access appropriate HIV care. Services must adapt to meet the needs of their population. Our HIV outpatient service provides care for 2400 people: <15% are women
**Methods** A pilot plus follow up patient survey of the women attending the HIV outpatients.
**Results** 16 women completed the pilot questionnaire; 5/16 (31.2%) aged 17–45 years, 11/16 (68.75%) aged > 46. 4/16 (25%) disclosed a disability. 16/16 (100%) had no difficulty accessing our service. 3/16 (18.8%) of households had children living in them <16 years of age which 2/3 (66%) attended with mother: 2/2/(100% ) were comfortable bringing their children into clinic. 1/3 ( 33.4%) had an option to leave children someone else. 10/16 (62.5%) thought a service for women only would be useful: only 7/16 (43.2%) were aware of the nurse led Women only HIV service. Women found the following services most useful: counselling support/psychology 9/16 (56%), cervical cytology 9/16 (56%), menopausal advice 6/16 (37.5%), benefits-support 6/16 (38%), sexual health screening 3/16 (19%), fertility advice 3/16 (18.8%), contraception advice 1/16 (6%), and pregnancy advice 2/16 (13%).8/16 (50%) preferred a female HCP. 2/16 (13%) reported violence or abuse from a partner or family member: 1/2 (50%) of those discussed with a HCP.
**Discussion/conclusion** Preliminary results suggest that that the women attending our clinic have no issues with child care, language barriers or disabilities. Women over 45 years were more likely to take part in our study (70% response). Of concern is a reported lack of knowledge about services already available which we are pursuing.

## P167 MANAGING RECTAL GC : ROOM FOR IMPROVEMENT

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10.1136/sextrans-2016-052718.217

**Background/introduction** Most (~60%) rectal gonorrhoea (GC) occur in MSM with 25% symptomatic at presentation. Those with rectal GC are at increased risk of other STIs. BASHH provide guidelines on GC management and targets to be achieved in testing, treatment and partner notification.
**Aim(s)/objectives** To compare our clinic's performance in managing rectal GC compared to the national recommendations.
**Methods** Retrospective case-note review of confirmed cases of rectal GC on NAAT between 1st November 2011 and 31st March 2015. Data were obtained from clinic notes, the clinic database and laboratory results. Audit standards were based on BASHH guidelines in managing GC.
**Results** 184 cases from 156 men: 61% White, 12% Black, median age 31 (IQR 26,37) years, 71% MSM 29% bisexual, 58% symptomatic. Triple site testing was done in 91%. Rectal GC cultures were taken in 55%. Adequate treatment was given to 94%. Quinolone resistance occurred in 31%. Partner notification was done in 43%. 14% had other STIs (syphilis, LGV,

chlamydia and HSV). There were 2 new diagnoses of HIV at the time of GC diagnosis, and 2 further cases at 3 months follow-up.
**Discussion/conclusion** Management of rectal GC did not reach the BASHH targets on any recommendation, suggesting that improvements in managing rectal GC are needed within our clinic. Re-testing and re-attendance were poor. Staff has received further training and a re-audit in 2017 will assess improvement. We have established a robust call/recall system to enable early diagnosis of HIV which was significant in our cohort of men with rectal GC.

## P168 CHEMSEX: A HEALTH NEEDS ASSESSMENT FOR AN EMERGING PUBLIC HEALTH CONCERN

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10.1136/sextrans-2016-052718.218

**Background/introduction** Reports of sexualised drug taking (chemsex) have increased significantly in recent years. To establish the risks associated with chemsex and the services required by participants in Greater Manchester, a health needs assessment was undertaken.
**Aim(s)/objectives** To identify links between chemsex and adverse health outcomes, and to determine the perceived barriers seeking support.
**Methods** An online survey was devised, and then promoted with the support of local voluntary organisations and sexual health clinics. Data were analysed on acute Hepatitis C diagnoses for the previous 5 years using data collected by PHE. Interviews were conducted with key stakeholders.
**Results** In total, 54 participants completed the anonymous online survey, of which 52 were men who have sex with men (MSM). 76% were HIV positive and 20% were Hepatitis C positive. The most commonly used recreational drugs were Mephedrone (81%) and GHB/GBL (79%). Of respondents, 78% felt they would prefer to access support in a specialist clinic within a sexual health service. Qualitative data on barriers to accessing support were determined. Using PHE Acute Hepatitis C data, 46% of the 57 patients diagnosed via Greater Manchester sexual health clinics between 2009 – 2015 had used at least one chemsex drugs in the past 12 months. Stakeholder interviews gave insight into perceived barriers to accessing care.
**Discussion/conclusion** We identify demographic factors of chemsex users and the perceived barriers to accessing support. These findings will be useful in guiding commissioning and tailoring specialist services.

## P169 COMPARISON OF THE FTD™ URETHRITIS PLUS (7-PLEX) DETECTION KIT WITH ROUTINE SEXUAL HEALTH CLINIC NUCLEIC ACID AMPLIFICATION TESTING FOR DETECTION OF *NEISSERIA GONORRHOEAE* AND *CHLAMYDIA TRACHOMATIS* IN URINE, VAGINAL, PHARYNGEAL AND RECTAL SAMPLES

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10.1136/sextrans-2016-052718.219

**Background/introduction** The FTD™ Urethritis Plus (FTDU) nucleic acid amplification test (NAAT) detects seven pathogens associated with urethritis, including *Chlamydia trachomatis* (CT), *Neisseria gonorrhoeae* (NG), *Mycoplasma genitalium, Trichomonas vaginalis, Mycoplasma hominis, Ureaplasma urealyticum and Ureaplasma parvum*.
**Aim(s)/objectives** To perform an initial diagnostic evaluation of FTDU performance for NG and CT, compared to routine clinic NAAT (BD Viper), in prospectively collected genital samples from symptomatic patients.
**Methods** Alongside routine clinical samples, additional samples (n = 684) were taken from symptomatic patients: females (vulvovaginal swabs; VVS), men-who-have-sex-with-women (MSW) (urine) and men-who-have-sex-with-men (MSM) (rectal and pharyngeal swabs; urine).
**Results** The prevalence of CT was 9.38% across sample sites tested (24 Female, 21 Male, 3 MSM Urine, 1 MSM Pharynx and 5 MSM Rectal positives). The prevalence of NG was 9.74% across sample sites tested (5 Female, 6 Male, 10 MSM Urine, 17 MSM Pharynx and 19 MSM Rectal positives).
**Discussion/conclusion** FTDU was accurate for detecting CT from genital sites only and had poor sensitivity for NG at all sampling sites. This test could not be used for NG testing for urine or extra genital testing without supplementary testing according to the BASHH guidelines as the PPV is below 90%.

**Abstract P169 Table 1** FTD™ Urethritis Plus (7-Plex) detection kit

| | CT | | | | | NG | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Sample type (n)** | **Females (287)** | **Males (98)** | **MSM Urine (56)** | **MSM Rectal (67)** | **MSM Pharynx (71)** | **Females (291)** | **Males (98)** | **MSM Urine (57)** | **MSM Rectal (67)** | **MSM Pharynx (72)** |
| Sensitivity% (95% CI[a]) | 100 (85.7–100[b]) | 100 (83.2–100[b]) | 66.7 (9.4–99.2) | 21.9 (14.7–94.7) | 50.0 (1.3–98.7) | 80.0 (28.4–99.5) | 83.3 (35.9–99.6) | 50.0 (18.7–81.3) | 78.9 (54.4–93.9) | 64.7 (38.3–85.8) |
| Specificity% (95% CI[a]) | 99.6 (97.8–100.0) | 97.4 (90.9–99.7) | 98.1 (89.9–100) | 96.8 (88.8–99.6) | 100 (94.4–100[b]) | 99.6 (98.0–100.0) | 100 (96.1–100[b]) | 100 (92.3–100[b]) | 83.3 (69.8–92.5) | 96.4 (87.5–99.6) |
| PPV (97.5% CI[a]) | 96.0 (79.6–99.9) | 91.3 (71.9–98.9) | 66.7 (9.4–99.2) | 21.9 (14.8–94.7) | 100 (2.5–100[b]) | 80 (28.4–99.5) | 100 (47.8–100[b]) | 100 (47.8–100[b]) | 65.2 (42.7–83.6) | 84.6 (54.6–98.1) |
| NPV (95% CI[a]) | 100 (98.6–100[b]) | 100 (95.2–100[b]) | 98.1 (89.9–100) | 96.8 (88.8–99.6) | 97.2 (90.2–99.7) | 99.6 (98.0–100.0) | 98.9 (94.1–100) | 90.2 (78.6–96.7) | 90.9 (78.3–97.5) | 89.8 (79.2–96.2) |

[a]Binomial Exact
[b]one sided, 97.5% Confidence Interval

Further work is required to establish its suitability for detecting the other organisms claimed.

## P170 RISK FACTORS FOR *MYCOPLASMA GENITALIUM* INFECTION IN SYMPTOMATIC MALES, FEMALES AND MEN WHO HAVE SEX WITH MEN FROM THREE CLINICAL SETTINGS IN LONDON

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**Background/introduction** *Mycoplasma genitalium* (MG), a sexually transmitted infection (STI), is increasingly recognised as a cause of major reproductive health sequelae. Treatment has become increasingly difficult due to macrolide and fluoroquinolone antibiotic resistance. MG is not routinely tested for in most UK genitourinary medicine (GUM) clinics, and limited risk-factor data exist for infection in at-risk populations and in different anatomical sites.
**Aim(s)/objectives** To determine risk factors for MG infection in symptomatic male and female patients accessing three London GUM clinics.
**Methods** Patients aged ≥16 years, symptomatic of an STI (or Chlamydia, Gonorrhoea, *Trichomonas vaginalis*, or non-specific urethritis contact) were consented. Additional-to-routine samples provided were vulvovaginal swab (VVS) (females), first void urine (FVU) (men-who-have-sex-with-women (MSW), (men-who-have-sex-with-men (MSM)), pharyngeal and rectal swabs (MSM). Samples were tested using the FTD Urethritis Plus Test kit and positives confirmed by Polymerase Chain Reaction. Risk factors were analysed using univariate and multivariate logistic regression.
**Results** MG was detected in: 10.7% (95% CI 7.9%–13.5%) patients; 7.9% (95% CI 4.86%–10.94%) VVS; 19.4% (95% CI 11.76%–27.04%) MSW urine; 1.6% (95% CI 0%–4.72%) MSM urine; 0% MSM pharynx; 8.1% (95% CI 1.31%–14.89%) MSM rectum.

**Abstract P170 Table 1** Risk factors associated with MG infection

| Risk | Male | Odds Ratios (95% Confidence interval) Univariate MSW | Odds Ratios (95% Confidence interval) Univariate Females |
|---|---|---|---|
| **Age** | 16–19 | 1* | 1* |
| | 20–24 | 0.06 (0.01–0.61) | 0.46 (0.15–1.40) |
| | 25–34 | 0.16 (0.02–1.08) | 0.26 (0.08–0.79) |
| | 34–44 | 0.24 (0.03–2.03) | 0.08 (0.01–0.68) |
| **Ethnicity** | White | 1 | 1 |
| | Mixed | 10.00 (0.61–162.66) | 2.98 (0.88–10.13) |
| | Asian | 7.00 (0.46–96.44) | 2.13 (0.24–18.76) |
| | Black | 8.33 (1.78–38.97) | 1.58 (0.60–4.19) |
| **Symptoms** | Discharge | 1 | - |
| | Pain | 0.68 (0.24–1.89) | - |
| **Gonorrhoea Contact** | No | - | - |
| | Yes | - | 11.5 (1.54–85.64) |

*Only ages 16–19 remained a risk factor in the multivariate analysis

**Discussion/conclusion** MG positivity was highest in MSW compared to the other patient groups, with younger age being the only risk factor for infection, remaining after multivariate analysis. The presence of rectal MG despite a lack of urogenital infection in MSMs warrants further investigation with a larger cohort. Overall the results indicate high MG positivity across symptomatic male and female populations.

## P171 RAPID RELIABLE HIV POINT OF CARE TESTING

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10.1136/sextrans-2016-052718.221

**Background** Our outreach HIV Point of care testing (POCT) programme changed from 4th generation testing to 3rd generation POCT kits in August 2014, which led to a significantly quicker turnaround time for results and greater convenience for both outreach staff and patients. We continued to confirm all POCT serology by conventional laboratory testing.
**Aims** To compare 3rd and 4th generation POCT in clinical practice and review the need for laboratory confirmation of all samples.
**Methods** The INSTI™ HIV-1/HIV-2 Antibody Test was used for POCT testing at a city centre outreach service from August 2014 until July 2015. All samples were also tested in parallel, in real-time, by standard laboratory tests for HIV. Results were compared retrospectively.
**Results** POCT was provided for 399 patients. 31 patients were excluded. Of the remaining 368 patients, there were 6 true positive results (1.6%) and no false-negatives or false-positives. By contrast, our previous evaluation of Alere Determine™ 4th generation testing, with a sample size of 367, found 3 true positives (0.8%); 2 false positives (0.6%); and 3 false negatives (0.8%), leading to negative predictive value 99.2%; positive predictive value 60%; sensitivity 50%; specificity 99.4%. This was a significant underperformance in clinical practice compared with advertised values.
**Discussion** INSTI™ is outperforming Alere Determine™ in our local experience. We intend to continue using 3rd generation POCT in our outreach programme. Given INSTI™'s performance, the question now raised is can we consider moving away from carrying out backup serology in all cases?

## P172 HIGH HIV INCIDENCE IN MSM DIAGNOSED WITH EARLY SYPHILIS: A ROLE FOR PREP?

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10.1136/sextrans-2016-052718.222

**Background.** Understanding the risk factors for HIV acquisition allows targeted interventions to reduce HIV transmission such as PrEP.
**Aims/Objectives.** To evaluate HIV incidence in HIV-negative MSM with early syphilis infection.
**Methods.** A retrospective case-note review of MSM who were diagnosed with early syphilis between January and June 2014 at a London sexual health clinic.
**Results.** 206 MSM were diagnosed with early syphilis: 110 HIV-negative; 96 HIV-positive. For 110 HIV-negative MSM, median

age was 32 y, median number of sexual partners in last 3 months was 4. Reported drug use in the previous month was 38%; 19% had injected drugs. Syphilis stage was primary (31%), secondary (25%), early latent (45%).Up to February 2016, total follow-up was 144 person-years. 12 (11%) were newly diagnosed HIV-positive. HIV incidence was 8.3 (95% confidence interval, CI 4.2–14) per 100 person-years follow-up (HPYFU). Incidence of rectal STIs was: rectal chlamydia, 27 HPYFU (CI 19–36); rectal gonorrhoea, 33 HPYFU (CI 25–44); syphilis re-infection, 10 HPYFU (CI 5.7–17).

**Conclusions.** The significant risk of HIV seroconversion following a diagnosis of early syphilis suggests that this group may particularly benefit from the use of pre-exposure prophylaxis. The high levels of subsequent rectal infections support the inclusion of regular STI screening in PrEP management guidelines.

## P173 MULTI-DRUG USE, AND ASSOCIATED FACTORS, WITHIN A COMMUNITY BASED SAMPLE OF GAY AND BISEXUAL MEN IN SCOTLAND

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10.1136/sextrans-2016-052718.223

**Background/introduction** Research suggests that drug use may be higher among men who have sex with men (MSM), and links between drug use and risky sexual behaviours are well established. Evidence suggests that MSM who report 'ever using' drugs may report using a variety of drug types.

**Aim(s)/objectives** To explore multi-drug use and associated sexual risk behaviours within a community sample of MSM in Scotland.

**Methods** Analysis of data from 1292 MSM participating in bar-based surveys in Scotland in 2014. Factors related to 'ever using' and multi-drug use within the previous 12 months were examined. Multi-drug use was calculated using those who reported more than one type of drug use in the previous 12 months (injecting, snorting or psychoactive drugs).

**Results** The mean age of men sampled was 34.72 years (range 18–82, SD = 11.23). Most men identified as gay (92.3%) and reported being educated post 16 (85.8%). 42.6% of men reported 'ever using' drugs and of those, 55.3% had used within the last 12 months. 47.8% of men using within the last 12 months reported multi-drug use. Men who had used drugs within the last 12 months and those reporting multi-drug use were more likely to report more risky sex, specifically group sex. However, they also reported higher rates of both HIV and STI testing.

**Discussion/conclusion** The percentage of men reporting multi-drug use is consistent with previous research. Although men reported more risky sexual behaviours, testing rates would suggest they understand and respond to these risks. HIV/STI screening may present opportunities to identify and address potentially problematic drug use with attendees.

## P174 MANCHESTER CHEMSEX – INJECTING STRAIGHT UP THE M6

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10.1136/sextrans-2016-052718.224

**Background/introduction** Chemsex involves sex under the influence of psychoactive drugs such as gamma-hydroxybutyric acid (GHB), mephedrone and crystal methamphetamine. There's been an increasing trend of chemsex use among UK men who have sex with men (MSM) requiring services to tackle this growing problem.

**Aim(s)/objectives** To review the first year's progress of a newly developed chemsex clinic co-commissioned by sexual health and drugs and alcohol commissioners.

**Methods** Prospective data collection of patients attending clinic from April 2015 to March 2016. Data was collected on demographics, risk taking, sexually transmitted infections (STIs) and drug use.

**Results** 43 patients were seen. 34 (79.1%) were White British, and 42 (97.7%) were MSM. 19 (44.2%) were referred through genitourinary medicine (GUM) clinics, of which 10 (52.6%) were for post-exposure prophylaxis, 9 (20.9%) through HIV services, and 7 (16.3%) self-referrals. 24 (55.8%) were HIV positive, and 10 (23.3%) had Hepatitis C. 32 (74.4%) reported episodes of condomless sex, 21 (48.8%) engaged regularly in group sex and 5 (11.9%) participated in fisting, highlighting high rates of sexual risk taking. 36 (83.7%) patients reported taking mephedrone, 29 (67.4%) GHB, and 12 (27.9%) crystal meth. 23 (53.5%) patients injected. 21 STIs were found in 16 (37.2%) patients, with 10 (47.6%) Gonorrhoea infections, 4 (19.0%) chlamydia, 3 (14.3%) syphilis and 3 (14.3%) Hepatitis C.

**Discussion/conclusion** Our data shows high rates of risk taking among chemsex participants with resultant high rates of STIs. Targeted harm reduction interventions need to be developed in GUM clinics to continue to address this issue.

## P175 SERVICE EVALUATION OF THE USE OF THE YOUNG PERSON'S PROFORMA IN RELATION TO CENTRAL AND COMMUNITY SEXUAL HEALTH CLINICS

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10.1136/sextrans-2016-052718.225

**Background/introduction** The prevalence of non-consensual sex is higher in those with a sexual debut before the age of 16. BASHH therefore advocates the use of a Young Person's Proforma (YPP) in sexual health clinics to detect signs of, and concurrent risk factors for, child sexual exploitation (CSE), intending to safeguard this vulnerable group of attendees.

**Aim(s)/objectives** To investigate the adherence to BASHH guidelines relating to the care of young people accessing sexual health services, specifically the use of the YPP.

**Methods** A retrospective review analysing 150 case notes of patients under 16yrs, attending between 1st July 2014 and 1st June 2015. Notes were extracted from a central clinic (n = 50), and 4 community sexual health clinics (n = 100).

**Results** Centrally, all patients had a proforma completed, compared with 81% of community patients. Proformas were completed in 67% of male community patients. 19 patients had experienced involuntary sexual activity. 19% of patients had 1 or more significant risk factor for CSE. In total, 83 further referrals (57% safeguarding) were made. Risk factors were reassessed in 79% of patients. 71% attended primarily for contraception (central = 46%, community = 83%), with 79% offered STI screening.

**Discussion/conclusion** The central clinic achieved all BASHH targets, whereas the community clinics failed to do so, highlighting the need for a consistent approach to assessment of safeguarding concerns across all sites. Proforma completion is pivotal in safeguarding patients, however consistency between sexes is needed. Extending proforma use for reassessment and 16–17 year olds may also be beneficial. Improvements to ensure an equitable service are needed.

## P176 ARE SEXUALLY TRANSMITTED INFECTIONS ASSOCIATED WITH CHILD SEXUAL EXPLOITATION IN UNDER 16 YEAR OLDS ATTENDING GENITOURINARY MEDICINE CLINICS IN THE UK?

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10.1136/sextrans-2016-052718.226

**Background** Child sexual exploitation (CSE) is a challenging diagnosis to make, with few clinical signs or symptoms, and little evidence that markers such as sexually transmitted infections (STIs) are CSE predictors.
**Aim** To investigate associations between STIs and CSE risk factors.
**Methods** The genitourinary medicine clinic activity dataset (GUMCAD) was used to identify clinics with >18 STI diagnoses in 13–15 year-olds in 2012. Cases with confirmed bacterial or protozoal STIs were matched by age, gender and clinic with non-STI controls. Clinics provided details of CSE-related risk factors irrespective of STI presence through an on-line questionnaire. Associations between STI outcome and CSE-related risk factors were analysed using logistic regression.
**Results** 18/44 (40.9%) clinics contacted provided data on 466 13–15 year-olds; 414 (88.8%) were female, and 52 (11.2%) male. 98.6% were heterosexual, and 66.7% white British. There were 18 (3.9%) 13, 108 (23.2%) 14 and 340 (80.0%) 15 year-olds. In univariate analysis an STI diagnosis was significantly associated with: 'highly-likely' CSE (OR 9.00, p = 0.037), >1 partner (OR 5.50, p = 0.000), >1 attendance in 2012 (OR 3.79, p = 0.0000), safeguarding referral (OR 1.94, p = 0.022), other service involvement (OR 1.72, p = 0.031) and vulnerability (OR 1.64, p = 0.026). After adjustment, STI diagnosis was significantly associated with: Health Advisor review (OR 6.78, p = 0.000), >1 partner (OR 5.82, p = 0.002), >1 attendance (OR 3.72, p = 0.000) and looked after child (OR 3.43, p = 0.039).
**Discussion** The presence of a bacterial or protozoal STI is only weakly associated with CSE and should not be used to infer CSE in the absence of more compelling evidence.

## P177 THE ROLE OF SYPHILIS POINT-OF-CARE TESTING IN THE MANAGEMENT OF PATIENTS WITH GENITAL ULCERATION

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10.1136/sextrans-2016-052718.227

**Background/introduction** Within the United Kingdom (UK) there has been an increase in infectious syphilis in the last decade, particularly amongst white men who have sex with men (MSM) aged 25–34 years old. Syphilis Point-of-Care (POC) tests were originally designed for resource-limited settings; however they can play a role in sexual health clinics in the UK.
**Aim(s)/objectives** Review the use of syphilis POC testing in the management of patients with genital ulceration.
**Methods** A search of Electronic Patient Records identified all patients who were offered a syphilis POC test between 1st October 2014 and 31st March 2015 at Whittall Street Clinic. Using a previously tested audit data collection tool, information about patient demographics, indication for syphilis POC test and clinical diagnosis were collected from each patient record and anonymised.
**Results** During six months, 111 records were identified as having offered a syphilis POC test. 13 records were excluded; 3 duplicate records and 10 patients were offered a syphilis POC test, but it was not performed. Of the remaining 98 records, 20 patients had a syphilis POC test performed due to genital ulceration. Eight patients had confirmed syphilis on serology testing, of which four had a reactive syphilis POC test on the day of presentation and subsequently had treatment the same day.
**Discussion/conclusion** Syphilis POC test remains an important diagnostic tool in settings which have no on-site laboratory facilities. Syphilis POC can also add strength to clinical judgement and diagnostic tests in well-resourced settings.

## P178 DOING IT THE FIRST TIME? AN AUDIT OF MEN REFUSING HIV TESTING AT FIRST CLINIC VISIT

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10.1136/sextrans-2016-052718.228

**Background/introduction** South East London has the UK highest rates of heterosexual HIV acquisition and also significant numbers of HIV positive MSM. Our current uptake of HIV testing is 84%. Risk assessment is the subject of the current BASHH national audit.
**Aim(s)/objectives** Trying to achieve highest possible uptake of HIV testing by GUM attenders we examined a group of new male attenders who refused HIV tests looking at their risk and reasons for refusal.
**Methods** A review of clinic notes of 50 consecutive male patients who refused an HIV test at first ever clinic visit comparing to the preceding new male patient accepting an HIV test.
**Results**

**Abstract P178 Table 1** Men refusing HIV testing

| | REFUSED N = 50 | TESTED N = 50 | |
|---|---|---|---|
| MEDIAN AGE | 27 | 27 | |
| MSM | 5 (**10%**) | 7 ( 14%) | NS |
| GU SYMPTOMS | 23 (46%) | 23 (46%) | |
| STI DIAGNOSED | 30 (60%) | 13 (26%) | P 0.001 |
| NON-WHITE ETHNICITY | 11 (22%) | 24 (48%) | P 0.012 |
| PREVIOUS HIV TEST | 22 (44% ) | 19 (38%) | NS |

Of 5 MSM refusing HIV test all had a reason documented 4 reporting recent test and 1 very recent exposure; only 21/45 (47%) heterosexual men had documented reason for refusal.

**Discussion** MSM in our centre who decline HIV testing are more likely to report recent/ever testing and around 40% of all new attendees report a previous HIV test. It is of concern that patients who refuse testing have higher rate of STI diagnoses increasing their likelihood of HIV acquisition. The outcome of this audit is to re-visit our documentation of reasons for declining HIV testing and re-inforce strategies to improve uptake in this group

## P179 CHARACTERISTICS OF MSM ATTENDEES AND RATE OF STI RE-TESTING IN A DEDICATED MSM SERVICE VERSUS THE GENERAL WALK IN GU CLINIC

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10.1136/sextrans-2016-052718.229

**Background** Men who have sex with men (MSM) in London experience inequalities in sexual health despite bearing the highest burden of sexually transmitted infections (STIs). Annual STI screening in MSM is recommended in the UK. Our London based clinic has a dedicated service for MSM to foster rapport with patients, promote safer sex and normalise regular STI screening.
**Aims** To describe characteristics of MSM attending a general walk in clinic (GWI) versus a dedicated MSM service (MSMS), and rate of STI retesting between the two clinics.
**Methods** A case-note review of MSM and bisexual male attendees between October and December 2014 in the GWI and MSMS and new episode attendances up to January 2016.
**Results** Information on 101 MSM (50 GWI, 51 MSMS) was collected; median age was 32 (range 25–59) and 29 (22–49) years respectively, and they were of white ethnicity in 33/50, 66%, and 40/51, 78% in GWI and MSMS respectively. There were no differences in HIV status or new STI/HIV diagnoses between clinic attendees. There were 82 and 104 further new episode attendances amongst these GWI and MSMS attendees respectively; the latter mostly re-attended the MSMS (69/101, 68%). There was no differences in number of non-reattenders (18, 36%; 19, 37% respectively).
**Conclusion** Patients in our MSMS tended to re-attend more for repeat screening and within the same service, in comparison to GWI. Similar numbers of patients never re-attended in both clinics, suggesting that further strategies are needed to embed a culture of regular screening in this group.

## P180 AN UNUSUAL CAUSE OF PHARYNGO-TONSILLAR ULCERATION

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10.1136/sextrans-2016-052718.230

**Background/introduction** Herpes Simplex 1 virus has historically been known to cause oral and genital symptoms, whereas Herpes Simplex 2 virus is mostly associated with genital symptoms. We present the first case in the UK, to our knowledge, of primary Herpes Simplex 2 virus causing genital and pharyngo-tonsillar ulceration in a sexually active female patient.
**Case** A 33 year old female patient attended the GUM clinic reporting 2 day history of genital sores associated with dysuria. She has recently completed a 3 day course of Nitrofurantoin for presumed UTI with no effect, and is currently taking a course of Penicillin for tonsillitis. She has a new male partner of 1 month duration. Genital examination revealed bilateral inguinal lymphadenopathy with multiple herpetic lesions on the labia majora and minora. Pharyngeal examination revealed pustular looking tonsils with ulceration bilaterally, more marked on the left. Cervical chain lymphadenopathy was also present. HSV PCR swabs taken from both the tonsillar and genital ulcers came back positive for HSV-2. She was initially treated with a 10 day course of Aciclovir and returned for follow up 1 week later. Repeat examination revealed fully healed vulval ulcers and normal tonsillar appearance.
**Discussion/conclusion** This is the first UK reported case of primary HSV-2 causing pharyngo-tonsillar ulceration in addition to genital symptoms. The patient made a full and rapid recovery following prompt treatment with Aciclovir. This case highlights the importance of recognising less common causes for tonsillitis such as HSV-2, which responds very quickly to antiviral treatment.

## P181 DO WE NEED TO ROUTINELY RE-SCREEN HETEROSEXUAL PATIENTS FOR HIV AND SYPHILIS WHEN THEY REATTEND GUM/SRH CLINICS? (IMPROVING CLINICAL PRACTICE AND SERVICE DELIVERY)

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10.1136/sextrans-2016-052718.231

**Background/introduction** In the current financial climate we need to ensure that scarce resources are used efficiently. Heterosexual patients re-attending GUM/SRH services after an initial negative screen for HIV may be at low risk for acquiring new HIV and/or Syphilis and routine testing may not be cost-effective.
**Aim(s)/objectives** Determine the incidence of HIV and Syphilis in heterosexuals re-attending GUM/SRH services after previous negative HIV testing. Establish potential savings.
**Methods** Case note review of heterosexual patients attending a mixture of Inner London Integrated and Sexual Health clinics in 2014 and re-testing for HIV and/or Syphilis within 12 months. Data extracted includes patient demographics, tests performed and outcomes. Cost of HIV POCT £2.64, HIV serology £18.75, Syphilis screen £10.35.
**Results** Of 31,469 patients who tested for HIV in 2014, 4,584 (14.6%) were retested within 12 months. 69% were female and 31% male. The age range was 16–81 years with 27% <25 years, 33% White British, 20% White Other, 18% Black African/Black British/Caribbean/Other Black and others from a diverse range of ethnicities. 89% tested for HIV (82% POCT, 18% Antigen/Antibody) and 88% for Syphilis. Results showed one newly diagnosed HIV infection (male seroconverter with recent high-risk activity) and no new Syphilis infections. 25 patients found with positive Syphilis Serology were all either previously treated or had a false positive result. Potential savings if we had not tested for: HIV POCT- £8,886, HIV Antigen/Antibody- £13,763, Syphilis- £42,083.

**Discussion/conclusion** These results suggest that we need to review our current testing policy.

## P182 HIV FILM CLUB: AN INNOVATIVE METHOD FOR HIV MEDICAL EDUCATION IS ACCEPTABLE AND EFFECTIVE

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10.1136/sextrans-2016-052718.232

**Background/introduction** Training and continuing professional development in HIV medicine requires knowledge of the history of HIV. Locally we have instigated an HIV film club. There is no literature on the impact of HIV medical education using film. To date, we have had 2 educational events using "How to Survive a Plague" [Producer: D.France, 2013] and "We were Here", [Producers: D. Weissman & B.Weberdate, 2011].
**Methods** An anonymous electronic survey was sent to 13 participants exploring what they had learnt, influence on practice and their opinion on the importance of the history for trainees.
**Results** 10/13 completed the survey. 10/10 (100%) had learnt something new: appreciating HIV stigma in greater depth, recognition of the role of HIV negative MSM support and the importance in mechanisms for licensing new HIV drugs. 4/10 (40%) reported a change in practice such as a greater awareness of the psychological impact on long term survivors. 3/10 (30%) said that the films had underpinned and increased their understanding of the importance of Pre- exposure Prophylaxis (PrEP) and Direct Acting Antivirals provision in hepatitis C for patients currently. 10/10 (100%) felt it was important to have an comprehension of the history and stigma of HIV. Additional film recommendations included: "And the Band Played On" [Spelling, 1994], "Philadelphia" [J.Demme, 1993] and "Angels in America" [C.Costas, 2003].
**Discussion/conclusion** Innovation and progress in HIV medical education requires exploring new models of teaching: using the medium of film is ideal for HIV medicine where the field has transformed beyond recognition. Film nights were useful and interesting.

## P183 MULTICENTRE AUDIT ON THE DIAGNOSIS AND MANAGEMENT OF TRICHOMONAS VAGINALIS

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10.1136/sextrans-2016-052718.233

**Background/introduction** *Trichomonas vaginalis* (TV) is a sexually transmitted parasitic infection. It is commonly found in patients of non-white ethnicity and in females is usually symptomatic though may be asymptomatic in up to 50%. Untreated infection can lead to complications such as pelvic inflammatory disease, preterm delivery and increased risk of transmission of HIV.
**Aim(s)/objectives** To compare the management of TV in five GUM clinics across Essex to the BASHH 2014 TV guidelines
**Methods** Audit of 30 case notes of patients diagnosed with TV (SHHAPT code C6A) between January and December 2014
**Results**

**Abstract P183 Table 1** Audit of *Trichomonas Vaginalis* in Essex

| | |
|---|---|
| Total Number of patients | 146 (100%) |
| Age – median (range) | 27 (15 – 57) years |
| Sex – females | 98% |
| Ethnicity – White British | 79% |
| Black African | 5% |
| others | 16% |
| Diagnosis – Wet mount (range) | 57 (27–87)% |
| Culture (range) | 57.1 (38–71)% |
| HVS | 78% |
| Symptomatic | 71% |
| Asymptomatic | 12% |
| Cervical smear TV + | 17% |
| Contact CT/GC | 17% |
| BASHH Auditable outcomes | 99% |
| - 1st line treatment | 74% |
| - Written information given | 95% |
| - PN carried out | |

**Discussion/conclusion** In Essex 79% of patients diagnosed with TV were of white British ethnicity, reflecting local demographics. Nearly all were female and the majority were symptomatic. All clinics performed wet mount to diagnosed TV. It is cheap and gives an immediate result but the sensitivity is skill dependent. The regional audit group felt PCR testing should be used in the future. Written information on TV should also be improved by using approved websites and patients given BASHH leaflets.

## P184 WHAT'S IN A NAME? ESTABLISHING BRAND VALUES FOR A NEW SEXUAL HEALTH SERVICE

Joelle Turner*, Bernie Rigoulay, Tom Joyce. *Luton & Dunstable University Hospital NHS Foundation Trust, Luton, UK*

10.1136/sextrans-2016-052718.234

**Background/introduction** Award of a new contract for an integrated sexual health service requires a fresh brand identity for service launch.
**Aim(s)/objectives** To establish from service users and stakeholders the important brand values for a sexual health service.
**Methods** An online survey was designed to investigate public opinion about naming and brand values. This was distributed via email to all hospital and local council employees and through local stakeholder and youth networks.
**Results** In February 2016, 103 online surveys were completed by service users and 256 by potential service users. Of 359 respondents, 56% were young people (<25), 76% were female, 86% identified as heterosexual and 50% were White British. The most important values for a sexual service were confidentiality (27%), professional and knowledgeable staff (16%) and friendly and approachable staff (14%). The most common reasons for difficulty using a sexual health service were embarrassment (50%), unsuitable opening hours (40%) and not knowing where to find services (25%). Regarding staff uniforms, 58% of respondents preferred 'uniform but not too formal', 37% preferred 'formal wear (traditional uniform)' and 5% 'something else'. 'A name that clearly states what the service is' was preferred overall, though differences were marginal (see Table 1).

**Discussion/conclusion** Online surveys are an effective method of establishing important brand values for a sexual health service. Overall, respondents preferred a distinct identity for the service, exhibited through uniforms and a transparent naming convention. Though traditional barriers to accessing services persist, so also do the core values of confidentiality and professionalism.

**Abstract P184 Table 1** Online survey of brand values for new service

| Naming convention | Total | Age | | | Gender | | Service user? | |
|---|---|---|---|---|---|---|---|---|
| | | <25 | 25–44 | 45+ | Female | Male | Yes | No |
| Clearly states what the service is | 36% | 39% | 40% | 24% | 32% | | 24% | 40% |
| Name linked to the building | 34% | 31% | 32% | 29% | 33% | 17% | 38% | 28% |
| No reference to what/where service is | 31% | 30% | 28% | | 34% | 33% | 38% | 32% |

## P185 THE SEXUAL HEALTH OF TRANSGENDER WOMEN IN EAST LONDON

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10.1136/sextrans-2016-052718.235

**Background** Previous studies into the sexual health of transgender women (TGW) report high rates of STI and HIV positivity.
**Aim** To evaluate the sexual health of TGW attending routine GUM clinics in a London Trust.
**Methods** Retrospective case-note review of TGW attendances from May 2013 to November 2015. Clinical records and laboratory results assessed.
**Results** 52 attendances were made by 17 TGW with a median age of 31 years (IQR 27–36). 41.2% were European, 52.9% were White and 29.4% were Asian. All had sex with men however 23.5% also had sex with women. 17.6% report sex work in the last year but no unprotected anal intercourse (UAI) with clients. 64.7% report UAI with male partners in the preceding 3 months (90.9% receptive). 64.7% had a history of any STI including 14.3% with Hepatitis B (naturally immune) and 6.7% with HIV. There were no diagnoses of Hepatitis C. The most common diagnosis made during the study period was Syphilis at 26.7% (of which 50% early infection) followed by HPV (23.5%), Chlamydia trachomatis (18.8%), Neisseria gonorrhoea (18.8%) and HSV (17.6%). 35.3% report drug or harmful alcohol use, 5.9% IVDU and 23.5% a history of physical or sexual assault.
**Discussion** Very high rates of UAI and STIs in TGW are comparable to those seen in previous studies. The prevalence of HIV infection is lower than expected from previous studies, perhaps due to variation in the cohort of TGW seen at our clinics. There remain significant challenges in identifying and providing tailored sexual health services to this at-risk population.

## P186 IMPROVING DIAGNOSIS OF GONORRHOEA: A SERVICE IMPROVEMENT PROJECT

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10.1136/sextrans-2016-052718.236

**Background** With rising rates of gonorrhoea and increasing resistance, accurate diagnosis and appropriate use of antibiotics has become increasingly important. In response to this, we have focussed service improvement in our sexual health service (site 1 = GUM clinic, site 2 = integrated clinic) over the past 5 years on gonorrhoea. Our main focus has been on the high level of NAAT positive, culture negative samples- was this related to false positive tests or failed culture or both. This prompted a review of how samples were handled and, in particular, the time period between sample taking for culture and arriving within the lab. We have refined procedures to improve uptake of culture testing, culture positivity and finally the addition of supplementary testing for all positive NAAT testing in 2015.
**Aim** To review gonorrhoea diagnosis over a 5 year period, exploring the issue of NAAT positive, culture negative samples.
**Methods** yearly audit of gonorrhoea diagnoses
**Results**

**Abstract P186 Table 1** Diagnoses of gonorrhoea

| Year | 2011 | | 2013 | | 2014 | | 2015 |
|---|---|---|---|---|---|---|---|
| Number of cases | 195 | | 342 | | 342 | | 189 |
| Rate of GC/100000 | 46.1 (site1) | 47.5 (site2) | 51.4 (site1) | 59.1 (site2) | 50.4 (site1) | 61.1 (site2) | not available |
| % cultures performed | 91 (site 1+ 2) | | 60 (site 1) | | 73 (site 1+2) | | 93 (site 1+2) |
| % culture positive | 63 ( site 1+ 2) | | 52 (site 1) | | 75 (site 1+2) | | 80 ( site 1+2) |

**Discussion** Gonorrhoea diagnoses have dramatically declined between 2014 and 2015 due to the introduction of supplementary testing to remove the issue of false positive results. We have improved the uptake of culture testing in the era of self-taken NAAT testing and improved culture positivity rate with simple changes in the processing of samples.

## P187 ESTIMATING COST SAVINGS BY INTRODUCING A REFLEX HEPATITIS B VIRUS SCREENING ALGORITHM IN A SEXUAL HEALTH SERVICE

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10.1136/sextrans-2016-052718.237

**Background/introduction** BASHH recommends that screening for HBV infection may be with HBcAb, with reflex HBsAg testing in HBcAb-positive patients. False negative HBcAb (eg in acute HBV infection or with low assay sensitivity) is rare. At the time our laboratory did not routinely perform reflex HBsAg testing, placing the onus on clinicians, many of whom therefore requested both tests simultaneously (with redundant sAg tests being performed in the presence of a negative cAb). We wished to audit the extent of this practice and estimate cost savings by introducing reflex testing.
**Aim(s)/objectives** This was a retrospective case notes review of patients for whom HBcAb had been requested between 01/01/15 and 01/05/15. The cost of performing HBsAg testing was estimated at £3.60 per test.
**Methods** There were two hundred patients with HBcAb results: 110 (55%) male; median age 32 (IQR 26–39) years; 9 (4.5%) HIV-infected. Twenty-two (11%) tested HBcAb-positive of whom 5 (2.5%) were HBsAg-positive, 16 (8.0%) HBsAg-

negative and 1 (0.5%) not tested for HBsAg. Of the HBcAb-positive individuals, requesting details were available for 10 cases: for 8/10 both HBsAg and HBcAb were requested initially.. Of 178 (89.0%) HBcAb-negative individuals, HBsAg was performed for 49 (24.5%); all were HBsAg-negative. Across the Trust, 11,500 HBcAb tests were requested in 12 months. Assuming 89.0% HBcAb-negativity, the cost of testing 24.5% of these patients for HBsAg would almost reach £10,000.
**Results** Reducing HBsAg testing in HBcAb-negative individuals would provide savings. Reflex laboratory HBsAg should be implemented for HBcAb-positive patients.

## P188 SAFEGUARDING ADULTS ATTENDING AN INNER CITY SEXUAL HEALTH SERVICE

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10.1136/sextrans-2016-052718.238

**Background/introduction** Adult safeguarding is the process of protecting vulnerable adults from harm or exploitation. In 2014 our sexual health clinic introduced an adult safeguarding proforma and a regular adult safeguarding meeting.
**Aim(s)/objectives** To evaluate the impact of a new safeguarding pathway.
**Methods** Retrospective case note review of patients entered onto the safeguarding database from April-December 2015.
**Results** Of 14833 adult attendances, 148 patients were identified as vulnerable (1.0% vs 0.3% in 2013, $p < 0.0001$). Notes were available for 135/148. Median age was 30 years (range 18–70); 74% female; 17% homosexual or bisexual. Main reasons for attendance were STI screening (69%) and contraception (11%). 13% of females were pregnant. Vulnerability was identified by the clinician in 64% and disclosed by the patient or carer in 27%. Mental health problems were reported in 60%; a violent or pressurised relationship in 53%; drug or alcohol consumption in 55%. 13% were asylum seekers; 7% were victims of trafficking. 7% had learning disabilities. 4% reported sex with a person in a position of trust. Two or more vulnerability factors were identified in 86%. 2% lacked capacity. 70% were discussed at the Adult safeguarding meeting, 27% were referred to the Trust safeguarding team. Other referrals included social services (7%), mental health services (5%) and police (3%). 14% had responsibility for children aged <18 years; 5% required child safeguarding input.
**Discussion/conclusion** A large number of vulnerable adults attend our service, highlighting the importance of robust safeguarding procedures. Greater numbers were identified following introduction of a new safeguarding pathway.

## P190 SEXUAL HEALTH APPOINTMENTS BY TEXT ONLY: SPEED, SAVINGS AND SATISFACTION

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10.1136/sextrans-2016-052718.239

**Background/introduction** When setting up an appointment-based specialist GUM service within our walk-in community sexual and reproductive health service we took the opportunity to send patients their appointment details by text message rather than letters. We also send reminder texts prior to the appointment, in an attempt to reduce "Did not attend" (DNA) rates.
**Aim(s)/objectives** To estimate associated cost savings and patient satisfaction with the use of texts instead of appointment letters.
**Methods** Cost saving calculations considered costs of sending texts relative to stationery and postage and a time and motion study to estimate relative staff costs. DNA rates 6 months before and after the implementation of the text reminder service were compared using Fisher's exact test. A satisfaction survey of a random sample of patients attending the booked GUM clinics included basic demographic questions and questions about the use of appointment and reminder texts.
**Results** There was an estimated cost saving of 88p per appointment.

**Abstract P190 Table 1** Impact of text reminders on DNA rates

| | May–Nov 2013 | Dec 13 – Jun 2014 | |
|---|---|---|---|
| GUM Appointments | 2118 | 1683 | |
| GUM DNAs | 589 | 355 | |
| DNA Rate | 27.81% | 21.09% | P =< 0.001 |

28 satisfaction surveys were completed. 82% preferred to get their appointments solely by text.

**Discussion/conclusion** The use of text messages instead of letters has saved the clinic money and time, and is popular with patients. Our Trust offers 500,000 outpatient appointments per year. If only half of those were booked by text instead of letter, the trust could save more than £220,000 per year.

## P191 ESTABLISHING AN INTEGRATED LEVEL 2 SEXUAL HEALTH SERVICE FOR PEOPLE WITH LEARNING DIFFICUTIES

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10.1136/sextrans-2016-052718.240

**Background/introduction** A local needs assessment by Public Health in 2013 identified an unmet need for sexual health services for young people (13–25 years) with learning difficulties. Public Health identified funding and developed a service specification for a local level 2 sexual service that was tendered for a pilot period of 15months. We were successful in bidding for the service.
**Aim(s)/objectives** We describe our journey in establishing a bespoke sexual health service for people with learning difficulties as part of our level 3 Sexual Health and HIV service. We outline the difficulties we encountered, how we overcame them and highlight learning points for other providers wishing to establish similar services.
**Methods** A descriptive analysis of the clinic history, service provision, staff training, clinic activity and STI and contraception diagnoses. The complexity of individual cases is captured by brief case histories.
**Results** The service delivery model is multidisciplinary and was developed in collaboration with all key stakeholders including the users themselves. An initial survey identified a community site co-located with the community paediatric service for disability and a Friday afternoon after school as the preferred options. We advertised the service widely including all schools for children with special education needs, social services and carers and

GPs. The service opened in March 2014 as a monthly service (Friday 2–6 pm) and was provided by an experienced dual trained speciality doctor, band 6 nurse and band 2 technician together with the community nurse specialist for children with learning difficulties. The service provided STI/HIV screening and management, a full range of contraception choices and sexual health advice. New patient appointments were 1hr and involved time with both the Dr and nurse in order to meet the complex needs of the patients. After 14 months we relocated the service to our level 3 Sexual Health centre located on the main hospital site due to practical difficulties with providing a remote service to a complex group of patients. We changed the clinic session to a regular weekly session on a Wednesday afternoon (3–6 pm). From March 2014 to Dec 2015 there have been 60 attendances by 18 patients (13F, 5M; 17 heterosexual, 1 MSM; 90% white British). 50% patients were under 25 years with a range from 16 to 40 years. Number of STI screens: GC, chlamydia and HIV = 15; GC and chlamydia only = 10; HIV only = 3. STIs diagnosed: chlamydia = 3, TV = 1, PID = 2, 1st episode HSV = 1. Contraception services provided: implant 3, IUS 1, depo 2, COCP 2, EMC 2, PT 6. Historic child sexual abuse was disclosed by three patients.

**Discussion/conclusion** We successfully established a dedicated sexual health service for people with learning difficulties. Although numbers of attendances are small the patients present with complex needs and require long appointment times. 38% of our patients were diagnosed with an STI. The service team benefited from additional training in learning difficulties and capacity assessments and support from senior staff in the level 3 clinic.

## P192 ACUTE HEPATITIS C INFECTION: ARE WE DOING ENOUGH?

Elizabeth Okecha*, Caroline Oswald, Thomas Clayton, Vincent Lee, Chris Ward. *Central Manchester University Hospitals NHS Foundation Trust, Manchester, UK*

10.1136/sextrans-2016-052718.241

**Background/introduction** Hepatitis C (HCV) is an important blood-borne virus in the UK with high morbidity/mortality. Injecting drug use has traditionally been seen as the most important risk factor for transmission in Britain, but since 2000 there has been an emergent rise in infection rates amongst HIV-positive men who have sex with men (MSM). This is thought to be driven by risky sexual/drug taking behaviours.

**Aim(s)/objectives** Review viral response of acute HCV infections after treatment with current NICE approved therapy.

**Methods** A prospective case note review was performed of patients diagnosed with acute HCV between 2004–2015.

**Abstract P192 Table 1** Data for acute HCV treated within 6 months of diagnosis

| Response | SVR | No SVR | Predictive value(%) |
|---|---|---|---|
| RVR | 4 | 0 | PPV = 100 |
| No RVR | 7 | 1 | NPV = 12.5 |
| EVR | 6 | 1 | PPV = 85.7 |
| No EVR | 1 | 0 | NPV = 0 |

RVR = Rapid viral response, EVR = Early viral response, SVR = Sustained viral response, PPV = Positive predictive value, NPV = Negative predictive value.

**Results** There were 102 acute HCV infections. Median age 37, (range 20–61), all cases were male and MSM. 91 (89%) patients had Genotype 1 infection, and 98 (96%) were co-infected with HIV. 36 (35%) patients had a history of injecting drug use. 20 patients were initiated on pegylated interferon/ribavirin within 6 months of diagnosis.

**Discussion/conclusion** Only 4 (20%) acute HCV patients achieved simultaneous RVR/SVR within 6 months of diagnosis (PPV = 100%). Novel direct acting antivirals (DAAs) have SVR rates above 90%; this alone is a compelling reason to promote DAAs in managing the burden of HCV infection thus reducing propensity for onward transmission.

## P193 MANAGEMENT OF PATIENTS WITH HIV AND HEPATITIS C CO-INFECTION AT A SMALL TEACHING HOSPITAL; AN AUDIT AGAINST 2013 BHIVA GUIDELINES

Jessica Gaddie*, Iain Reeves, Adam Croucher. *Homerton University Hospital, London, UK*

10.1136/sextrans-2016-052718.242

**Background/introduction** HIV positive patients with Hepatitis C (HCV) progress to cirrhosis faster than patients without HIV. BHIVA guidelines 2013 recommend surveillance for cirrhosis and hepatocellular carcinoma.

**Aim(s)/objectives** To evaluate the management of patients with HCV and HIV co-infection against current guidelines for surveillance for liver disease, including with Liver Transient Elastography (TE).

**Methods** The clinical records of all patients with HIV and HCV co-infection in the last 10 years were reviewed.

**Results** 41 patients had co-infection; 6 patients spontaneously cleared HCV. 100% (41/41) of all new diagnoses of HCV received HCV RNA measurement. Genotyping carried out in 86% (30/35) of patients and not possible in 6 cases. Annual HCV RNA was carried out in 76% (29/38). Only 8% (3/36) cases had initial TE result. In 17/36 the result was not recorded, and there was no evidence that the TE had been carried out. In 14/36 the patient did not attend the tertiary centre. Two of the initial TEs were reported as normal (less than 7 kPa). For annual TE assessments, 5/36 were reported.

**Discussion/conclusion** Most patients reviewed did not have assessment for liver disease per national guidelines. Our monitoring of patients with HCV and HIV co-infection particularly with liver TE is poor. The main barrier to co-infected patients receiving care is non-attendance at the tertiary centre. The Trust is now a "spoke" in a hepatitis C network and has local TE, which may improve monitoring of co-infected patients. We will re-audit after this programme has been running for one year.

## P194 SEXUALLY TRANSMITTED INFECTION (STI) SCREENING IN MEN WHO HAVE SEX WITH MEN (MSM)

Helen Bradshaw, Nicola Lomax*, Rachel Drayton. *Cardiff and Vale University Healthboard, Cardiff, UK*

10.1136/sextrans-2016-052718.243

**Background/introduction** MSM are at increased STI risk. Easily accessible and thorough STI screening should be available to all MSM. BASHH recommendations for MSM STI screening include guidance about which tests to offer and to whom, and suggested frequency of testing.

**Aim(s)/objectives** To ascertain if our service is following the 2014 BASHH recommendations for MSM STI screening.
**Methods** 97 MSM attending December 2014 to July 2015 coded T2 and T4, (Chlamydia and Gonorrhoea screening performed and Chlamydia, Gonorrhoea, HIV and Syphilis screening performed respectively), and MSM requesting post exposure prophylaxis (PEP) were included.
**Results** 3% met Hepatitis C screening recommendations but were not offered testing. Hepatitis C risk factors were not always documented so it is likely more patients should have been offered Hepatitis C screening. Some tests were not indicated for every patient, for example Chlamydia and Gonorrhoea screening is not routinely offered until the 2 week visit for patients attending for PEP due to the 2 week window period for these infections.
**Discussion/conclusion** BASHH recommend 97% of MSM attending a sexual health service with a new episode of care should be offered STI screening with 80% uptake. Targets for offering HIV and Syphilis screening were achieved but targets for offering Chlamydia, Gonorrhoea and Hepatitis B screening were not met and need to be improved upon. The results also highlighted screening for Hepatitis C risk factors (such as chemsex) needs to be routinely undertaken. The target for STI screening uptake in all areas was achieved. Repeat STI testing needs to be routinely offered to MSM.

## P195 DIAGNOSING RECENT HIV INFECTION IN AN URBAN SEXUAL HEALTH CENTRE: COULD MORE HAVE BE DONE TO PREVENT ACQUISITION?

Eliza Walker*, Rebecca Gilson, Imali Fernando. *NHS Lothian, Edinburgh, UK*

10.1136/sextrans-2016-052718.244

**Background/introduction** There are a number of strategies that may be employed by sexual health services to prevent HIV transmission, including motivational interviewing and Pre-Exposure Prophylaxis (PrEP). In order to utilise resources effectively, prevention strategies need to target those at high risk of acquiring HIV such as those having unprotected anal sex or who had known rectal infections.
**Aim(s)/objectives** We aimed to identify individuals in our cohort diagnosed with recently acquired HIV infection, review whether they had previously been accurately identified as high risk and what strategies had been employed to attempt reduce their risk.
**Methods** Electronic records of patients diagnosed HIV positive at an urban sexual health centre over a two year period were reviewed for timing of acquiring infection and previous engagement with sexual health services. Recently acquired infections were determined by: positive avidity, a negative test or a history of seroconversion symptoms in the 6-months prior to positive result.
**Results** 68 patients were diagnosed with HIV; 30 (44.1%) were recently acquired infections. Of these, 13 (43.3%) had attended a sexual health service in the year prior, 12 (92%) of whom had been identified as at risk and had risks discussed by a healthcare professional.
**Discussion/conclusion** Almost half of our patients with recently acquired HIV had had contact with sexual health services in the year before their diagnosis, and the vast majority were identified at high risk. Being able to correctly identify patients at high risk of HIV has implications for using strategies such as PrEP in the future.

## P197 EVALUATION OF THE CLINICAL UTILITY OF THE BECTON DICKINSON PROBETEC QX (BDQ) *TRICHOMONAS VAGINALIS* MOLECULAR DETECTION TEST IN TWO LARGE, URBAN GU MEDICINE SERVICES

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10.1136/sextrans-2016-052718.245

**Background** BASHH guidelines recommend molecular tests to aid diagnosis of *Trichomonas vaginalis* (TV), but many clinics use relatively insensitive techniques (pH, wet-prep microscopy (WPM) and culture).
**Objectives** To establish a laboratory pathway for TV testing with the BDQ assay, determine TV prevalence, and identify variables associated with TV detection.
**Methods** A prospective study of 900 women attending clinics for STI testing was undertaken. All were offered TV BDQ tests. Data collected: demographics, symptoms, results of near-patient tests and BDQ for TV, *Chlamydia trachomatis* (CT) and *Neisseria gonorrhoeae* (GC). Women with any positive TV result were treated and invited to attend for test of cure (TOC). Data were collected in Excel and analysed in SPSS.
**Results** 891 women had a TV BDQ test. 472 (53%) were white, 143 (16%) black; median age 28yrs. 499 (55%) were symptomatic. Infections detected by BDQ: 11 TV (1.2%), 3 GC (0.3%) and 44 CT (4.9%). Of BDQ+ TV infections: 8 (73%) black, 7 (64%) symptomatic, 4/7 (57%) WPM+, 4/4 (100%) pH > 4.5, 7/7 (100%) Hay-Ison Grade 2, and 1/3 (33%) TV culture+. Mean BDQ turn-around time: 3.44 days. All received treatment. 9/9 (100%) were BDQ negative at TOC (mean time to TOC 15 days (range: 7–42). In univariate analysis, only black ethnicity was associated with likelihood of TV BDQ+ (RR 10.2 [95%CI 2.15–48.4]).
**Discussion** The use of the BDQ enhanced detection of TV in asymptomatic and symptomatic populations. Cost effective implementation of the test will rely upon further work to reliably detect demographic and clinical variables that predict positivity.

## P198 COMPARISON OF RECREATIONAL DRUG USE (RDU) AND SEXUALLY TRANSMITTED INFECTIONS (STIS) IN HIV POSITIVE MEN WHO HAVE SEX WITH MEN (MSM) AND HIV NEGATIVE MSM RECEIVING POST EXPOSURE PROPHYLAXIS (PEP)

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10.1136/sextrans-2016-052718.246

**Introduction** Recreational drug use (RDU) in a sexualised context ("chemsex") is increasing amongst MSM regardless of HIV status and is associated with poor sexual health outcomes. National guidelines for both PEP and HIV management suggest regular sexual health screens (SHS) and screening for RDU and alcohol use.
**Aim(s)/objectives** To audit the documentation of SHS and RDU history from HIV positive MSM attending routine outpatient clinics compared to HIV negative MSM accessing PEP.

**Methods** Retrospective review of 45 randomly selected MSM attending routine HIV care (HIV+ group) OR receiving PEP (PEP group) at each of 2 London clinics during 2014/15.
**Results**

**Abstract P198 Table 1** RDU use in HIV+ and HIV negative MSM

| | HIV+ group (*n* = 90) | PEP group (*n* = 81) |
|---|---|---|
| Aged <45 | 29 (32%) | 67 (83%) |
| Offered SHS | 47 (52%) | 73 (90%) |
| Accepted SHS | 33 (70%) | 68 (93%) |
| Positive for STI | 8 (24%) | 25 (37%) |
| Asked about RDU | 40 (44%) | 78 (96%) |
| Ever used RDU | 18 (45%) | 38 (48%) |
| Used RDU in last 6 months | 8 (44%) | 37 (97%) |
| RDU considered problematic | 2 (25%) | 14 (37%) |

The most commonly used drug was mephedrone (81% in PEP group vs 38% in HIV+ group) followed by crystal methamphetamine (54% vs 12.5%). 2/81 (2.4%) in the PEP group tested HIV positive within 3 months of follow up.

**Discussion** High levels of STIs and RDU were seen in both groups but most significantly in the PEP group. This highlights the importance of identifying RDU/chemsex in PEP patients, which may be an opportunity for intervention to reduce risk of acquisition of HIV through risky sex.

## P199 ANALYSIS OF TRAINING NEEDS IN A NEWLY INTEGRATED SEXUAL HEALTH SERVICE (SHS)

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10.1136/sextrans-2016-052718.247

**Background** The Integrated Sexual Health Services: National Service Specification 2013, includes; Patients to receive their care in a "one stop shop." Staff training should include accredited courses facilitated by BASHH and the FRSH. Key Performance Indicators that relate to the number of staff who are dual qualified.
**Method** Nurses were identified by their nursing role, band, original speciality and their training needs. The Band 6 (B6) nurses are the initial first training focus. Training for B6 nurses was considered as Essential; (that required to meet service specification) and Non Essential (that required in order to deliver a truly "one stop" holistic care package, or provide training to others).
**Aim** To identify the training needs of a newly integrated service in order to formulate a strategy which meets the training requirements of the team, whilst retaining high quality service delivery.
**Conclusion** Integration causes a significant training burden on SHS from a financial, organisational and workforce perspective. Meeting integration training demands is likely to cause disruption to services and staff; resulting in additional stress, increasing sickness and staff turnover rates. Training approach is based upon "quick wins" first targeting those B6 nurses with contraception and Level 2 sexual health experience. B6 Nurses were targeted first as most of their time is spent in clinic; thus improving access, and useful in upskilling others. B6 nurses considered "early adopters" were selected, as likely to have a positive effect on others.

## P200 EARLY DETECTION OF SEXUALLY TRANSMITTED INFECTIONS - WERE THERE MISSED OPPORTUNITIES? A QUALITATIVE STUDY IN THE UK

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10.1136/sextrans-2016-052718.248

**Background/introduction** The early recognition and investigation of outbreaks of sexually transmitted infections (STIs) is vital for preventing onward transmission.
**Aim(s)/objectives** We sought to understand the facilitators and barriers to outbreak recognition in order to improve early detection. To review the recognition and management of a series of recent outbreaks of sexually transmitted infections in the United Kingdom (UK). To formulate guidance that will enable early recognition of outbreaks.
**Methods** We interviewed clinicians and public health professionals who had been recently involved in identifying and managing STI outbreaks in the UK. Interviews were audio-recorded and transcribed verbatim. Transcripts were analysed using thematic analysis.
**Results** Ten STI outbreaks were reviewed, generally by interviewing both a clinician and public health professional. Health advisers and sexual health consultants often noticed increases in cases with smaller clinics often identifying outbreaks more quickly than larger centres through "soft" signals such as increased partner notification, contacts named multiple times or cases with similar geographical location. Sometimes changing demographics first alerted staff. In two centres, increased ceftriaxone use prompted data review. Public Health England (PHE) regional teams identified two outbreaks: one through analysis of the national dataset (GUMCAD); and one via the formal Infectious Diseases Notifications process.
**Discussion/conclusion** "Soft" signals, picked up in smaller clinics were less readily noticed in larger services. Although quarterly retrospective collation of electronic data by PHE currently limits their role, electronic records should be better exploited locally within services.

## P201 EVALUATION OF *CHLAMYDIA TRACHOMATIS* (CT) AND *NEISSERIA GONORRHOEAE* (GC) INFECTIONS IN FEMALE SEX WORKERS (FSW) ATTENDING A DEDICATED SEX WORKER CLINIC

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10.1136/sextrans-2016-052718.249

**Background/introduction** Previous research shows that female sex workers (FSW) are at high risk of certain sexually transmitted infections (STIs), and that migrant FSW appear to be at even higher risk.
**Aim(s)/objectives** To evaluate the characteristics of FSW managed by our dedicated sex worker clinics who tested positive for either CT or GC, including information about sexual partners outside of work.
**Methods** Retrospective case note review of patients identified by the Sexual Health and HIV Activity Property Type (SHHAPT) code 'SW' who also had either CT or GC in 2012–2014.

**Results** 129 episodes of infection were seen in 114 women. Age range 18–56; 76% (87/114) were ≤30 yrs. 103/114 (90%) were born outside of the UK; 77/103 (75%) were from Eastern Europe. 83/129 (64%) were vaginal infections (CT, GC or both); 40/120 (31%) pharyngeal and 26/129 (20%) rectal. 21/114 (18%) reported unprotected vaginal sex (UPVI) with clients. Where recorded 71/93 (76%) had a partner outside of work; of these 77% reported UPVI. 86/114 (75%) were HIV negative; 16% had never tested. 58/114 (51%) were deemed to have at least one vulnerability.

**Abstract P201 Table 1**

| | 2012 | 2013 | 2014 |
|---|---|---|---|
| Total number FSW seen | 560 | 538 | 517 |
| *Number of CT infections | 16 | 28 | 47 |
| *Number of GC infections | 8 | 18 | 22 |
| Prevalence CT (%) | 2.8 | 5.2 | 9.1 |
| Prevalence GC (%) | 1.4 | 3.3 | 4.2 |

*10 patients had both CT and GC

**Discussion/conclusion** Prevalence of both CT and GC is high and increasing in FSW, highlighting the importance outreach and testing in this vulnerable patient group.

## P202 THE ACCEPTABILITY OF SELF-SAMPLING AT HOME FOR *CHLAMYDIA TRACHOMATIS* AND *NEISSERIA GONORRHOEAE* IN MEN AND WOMEN; RESULTS FROM THE FEASIBILITY STUDY TO DETERMINE THE TIME TAKEN FOR NAATS TESTS TO BECOME NEGATIVE FOLLOWING TREATMENT FOR *CHLAMYDIA TRACHOMATIS* AND *NEISSERIA GONORRHOEAE* IN MEN AND WOMEN

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10.1136/sextrans-2016-052718.250

**Background/introduction** Self-sampling with nucleic acid amplification tests(NAATs) for detection of chlamydia(CT) and gonorrhoea(NG) is increasingly being used in clinics, with much success. There is some data to suggest that it is acceptable to patients.
**Aim(s)/objectives** To assess symptoms, sexual behaviour and the acceptability of self-taken swabs for CT and NG, among participants in the 'Time to test of cure study for CT and NG'.
**Methods** Individuals who had a positive NAAT test for CT and/or NG were eligible. Self-taken specimens from the site of infection were collected at home. Data about sexual behaviour, symptoms and acceptability of home testing with self-taken samples was collected from questionnaires.
**Results** 102 men (87 MSM) and 52 women were recruited to the study, 84 had NG infection and 71 had CT infection. The median age was 28 years. Unprotected sexual intercourse in the last month was reported by 68% of MSM, 56% of heterosexual men and 51% of women. Symptoms were reported by 25% of MSMs, 50% of heterosexual men and 51% of women. 86% of participants found the information clear and easily understandable. 85% felt confident taking their own samples. 58% found the samples easy to take, 75% were happy to take their own swabs and 78% were happy to take samples at home.
**Discussion/conclusion** This data highlights the need for screening of asymptomatic patients and provides data to support that self-taken sampling is acceptable to patients. It also provides evidence to support home testing for CT and NG. Therefore allowing for greater access to testing and treatment and reducing the burden of infection in the community.

## P203 HIV-TESTING AFRICAN SERVICE USERS WITHIN A NEWLY INTEGRATED SEXUAL HEALTH SERVICE - OUR EXPERIENCE

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10.1136/sextrans-2016-052718.251

**Background/introduction** HIV testing is recommended for all sexual health clinic attendees, and in generic health services for high risk groups including BME communities, especially in areas of high HIV prevalence such as Leeds (2.51/1000).
**Aim(s)/objectives** In July 2015 an integrated contraception and STI service, Leeds Sexual Health, began following commissioning by Leeds local Authority wherein the routine offer of HIV testing was extended to all attending service sites across the city, 4 out of 5 of which had previously seen patients for contraception and sexual health (CASH) services only.
**Methods** We prospectively examined data in those of African ethnicity regarding offer and uptake of HIV testing in these new settings.
**Results** Interim data indicates a much higher number of African patients accessing the integrated service but with a lower overall uptake of HIV testing, a significant disparity in HIV testing uptake between men and women, with significant numbers of patients choosing not to disclose their known HIV status at a community setting where they are accustomed to only sharing contraception information.
**Discussion/conclusion** Staff used to achieving HIV testing rates of over 80% in a GUM clinic setting have found patients reluctant to test when they have come expecting the previous service. We are therefore trying to assess genuine missed opportunities for testing and considering reframing HIV testing as a positive and routine intervention e.g. along with postpartum contraception, when trying to embed HIV testing as part of a standard, integrated sexual health care offer.

## P204 IDENTIFYING PROBLEM DRUG USE IN MSM ATTENDING A DEDICATED SEXUAL HEALTH CLINIC

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10.1136/sextrans-2016-052718.252

**Background/introduction** There has been increasing recognition of the sexualised use of drugs (Chemsex) by MSM in recent years. Associations with sexual risk behaviour, HIV and other STIs are well described.
**Aim(s)/objectives** Our objective was to evaluate self-reported problem drug use in MSM attending a dedicated clinic.
**Methods** Patients attending the dedicated MSM clinic were given a simple questionnaire at registration, asking about: I) recent

drug use; ii) negative effects in general; iii) problems with drugs and sex. Patients were offered the opportunity to see a drug worker in the clinic, who collected more information about drugs used. Questionnaires completed between July 2014 and August 2015 were analysed.
**Results** 335 questionnaires were completed, but 59 excluded because of lack of patient identifiers. 170 of 276 (62%) reported recreational drug use. Of these 170, 38 (22%) reported negative effects in general, 31 (18%) reported problems with drugs and sex. However, these two groups were not identical and 14 reporting problems with sex answered "no" to the question about general problems. Excluding alcohol, 66 had drug details recorded: 16 had not reported problem use. Drugs associated with Chemsex such as GBL, Mephedrone, Ketamine and Crystal Methamphetamine were frequently identified.
**Discussion/conclusions** A simple questionnaire can identify problem drug use in a substantial proportion of MSM attending sexual health services. Asking specifically about problems relating to sex as well as general negative effects appears to offer a complementary approach. However, not all MSM who use "chems" will self-identify as having problem use, requiring vigilance on the part of clinicians.

## P205 MANAGEMENT OF STI OUTBREAKS. WHAT CAN WE LEARN FROM EACH OTHER? A QUALITATIVE STUDY IN THE UK

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10.1136/sextrans-2016-052718.253

**Background/introduction** When outbreaks of sexually transmitted infections (STIs) are identified, effective management in a timely manner is essential for bringing the outbreak under control. Challenges to achieving this may vary, needing different approaches.
**Aim(s)/objectives** To review the management of outbreaks contrasting by setting and sexual orientation in order to inform responsive guidance.
**Methods** We interviewed clinicians and public health professionals who had recently been involved in identifying and managing STI outbreaks in the United Kingdom. Transcripts were analysed using thematic analysis.
**Results** Ten outbreaks were reviewed. The combination of public health teams' wider outbreak expertise and clinic staff's knowledge of the local population was essential when developing management strategies. Partner notification, mainly by health advisers, was very achievable in smaller heterosexual outbreaks but proved challenging in MSM focussed outbreaks where use of mobile apps or anonymous sex was common. Publicity campaigns via social media platforms and third sector organisations were employed although quantifying their impact was difficult. Education of local physicians resulted in syphilis referrals to sexual health services via ophthalmology, gastroenterology, oral and maxillofacial surgery and general practice. Enhanced surveillance enabled venue identification but was time consuming for clinic staff. In gonorrhoea outbreaks, the use of dual NAAT testing as part of the chlamydia screening programme enabled case finding.
**Discussion/conclusion** Traditional management strategies remain important but as the use of social media increases, novel strategies for managing outbreaks are needed. Education of other professionals is essential to maximise case finding.

## P206 'DOCTOR, I THINK I'M ALLERGIC TO PENICILLIN' - PRIMARY SYPHILIS IN THE THIRD TRIMESTER

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10.1136/sextrans-2016-052718.254

**Case Report** We present a case of primary syphilis in the third trimester of pregnancy requiring penicillin desensitisation. A 34-year old woman was contacted by provider referral as a syphilis contact. She was 30 weeks pregnant. Both HIV and syphilis serology were negative at booking. She had presented to a community clinic with a sore vulva one week before and had empirical aciclovir for possible genital herpes. In our clinic, examination showed a small, non-indurated ulcer. Dark-ground microscopy was not done. A syphilis antibody screen was requested and reported positive six days later. On recall, repeat examination showed a larger, indurated ulcer. Treatment for primary syphilis was advised before confirmatory testing. However, the patient reported a possible reaction to penicillin. This was also documented by her general practitioner but the reaction was unknown. The next day she was admitted for penicillin desensitisation and the first dose of benzathine penicillin. Urgent referral to foetal medicine was made. Treponema pallidum was later detected by PCR on a vulval swab. Syphilis serology was reported as RPR 1:8 and TPPA 1:80. HIV serology and HSV PCR were negative. A second dose of benzathine penicillin was administered a week later, followed by 45 minutes of observation. After delivery at term, the neonate received 10 days of benzyl penicillin.
**Discussion** Learning points: 1. Exclude syphilis in anyone with genital ulceration, particularly in pregnancy. 2. Consult Immunology for advice on desensitisation regimen. 3. Write a syphilis birth plan as recommended by new BASHH guidelines

## P207 CHLAMYDIA AND OUR 'BEST FRIENDS FOREVER' POLICY

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10.1136/sextrans-2016-052718.255

**Background/introduction** Our chlamydia screening target was challenging.
**Aim(s)/Objectives** To test more under 25 year olds in our area. To assess the number of new positives from the intervention and the potential impact on our target.
**Methods** We implemented a policy that all <25 yo's were offered kits for their friends. We developed kits with a 'site code' BFF (Best Friend Forever) enabling laboratory tracking. We developed a local code to determine if the offer was made and accepted/declined.
**Results** From Dec to Feb 2016 we saw 3072 <25 yo patients. We recorded that we offered BFF kits to 32% (989). They were accepted by 28% (277) who took 415 kits (average 1.5 kits each). Of these 15% (62) were returned and the chlamydia positivity in these kits was 11.2% (7). From these 7 positives via contact tracing 5 additional positives were identified. On average there are 0.6 chlamydia positives/case identified. If we extrapolate this we expect 6 additional chlamydia positives. From our intervention 7 cases, 5 chlamydia positive partners and an

estimated 6 additional chlamydia positive partners would have been identified totalling 18.
**Discussion/Conclusion** Only 1/3rd of our target group were offered, we calculate 54 new chlamydia positives (18% of target) if offered to all. Kits costs £1.30, we distributed 415 costing £539. We identified 12 patients (7 + 5) and estimate an extra 6 would have been found so each chlamydia positive costs £30 - £45 (test kit only).

## P208 AUDIT OF THE MANAGEMENT OF HIV POSITIVE PREGNANT WOMEN IN A LOW PREVALENCE SETTING

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10.1136/sextrans-2016-052718.256

**Background/introduction** HIV Maternal to child transmission (MTCT) has reduced from 25% in 1993 to 0.57% in 2007 due to increased intervention in pregnancy. Compliance with BHIVA guidelines requires multidisciplinary care, which could be a challenge in areas with low HIV prevalence.
**Aim(s)/objectives** To audit the management of HIV positive pregnant women in a large district general hospital (DGH) against BHIVA guidelines.
**Methods** Retrospective audit of all HIV positive women giving birth at this DGH between September 2010 and October 2015.
**Results** 21 women identified. *Diagnosis*: 100% screened for STI, hepatitis C, VZV and HIV. *Treatment*: 81% on HAART at start of pregnancy, 100% of the four women not on HAART were started on treatment during pregnancy. At start of pregnancy 61% (n = 13) had a viral load <50RNA copies/ml, by the end of pregnancy this increased to 86% (n = 18). 100% (n = 21) had MDT management. *Delivery:* 43%: vaginal delivery. 38%: elective Caesarean section. 19% emergency Caesarean section. *Post-partum care*: 100% babies had post exposure prophylaxis started within 4 hours. No babies contracted HIV. 100% babies exclusively bottle-fed. 57% mothers given carbegoline.
**Discussion/conclusion** There was good compliance with guidelines. All women received HAART and the MTCT rate was 0%. 43% of women had a vaginal birth. Inclusion of the importance of carbergoline in departmental training may improve compliance in this area. In a low prevalence centre a specialist HIV antenatal clinic cannot be justified. The centre has introduced bimonthly MDT meetings to discuss these cases and these results suggest that communication and standards of care are high.

## P209 OUTCOMES OF PARTNER NOTIFICATION (PN) FOR SEX PARTNERS OF PEOPLE WITH CHLAMYDIA, MANAGED VIA THE *ONLINE CHLAMYDIA PATHWAY.*

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10.1136/sextrans-2016-052718.257

**Background/introduction** Within the *e*STI[2] consortium, we conducted exploratory studies of an innovative *Online Chlamydia Pathway* (*OCP*: results service, automated clinical consultation, electronic prescription via community pharmacy, with telephone helpline support), which included optional online partner management.
**Aim(s)/objectives** To evaluate PN outcomes and sex partner uptake of online management.
**Methods** *Participants:* untreated GUM clinic attenders (two London services) and people tested through six London NCSP online postal testing areas: 21.07.14–13.3.15. The *OCP* offered index patients an SMS/email containing a unique code and link to forward to partners permitting them to access online care via *OCP* (patient referral). Outcomes were captured by *OCP* and index-reported at telephone follow-up (2 weeks post diagnosis)
**Results** *Outcomes*: 221 index patients consented to the study and 172 (78%) were followed up by telephone (median age 23, 62% female). These 172 index patients reported 371 partners; 317/371 (85%) were contactable and 256/317 (81%) of these were notified. Index patients reported 120/317 (38%) as treated. *Online outcomes:* 154 index patients reached PN stage of *OCP* (some had already been routed to clinic). 94/154 (61%) requested online partner access. They reported 280 partners: 28 went online; 19 received treatment at their chosen pharmacy; and 4 were treated elsewhere.
**Discussion/conclusion** 38% of partners treated compares favourably with outcomes for routine PN within similar studies. Online management of sex partners through patient referral is feasible but uptake was low and most successful PN was achieved offline. Pathway optimisation could include anonymised sex-partner PN messaging and provision of partner STI self-sampling kits.

## P210 THE PREVALENCE OF CHLAMYDIA IN PREGNANT WOMEN COMPARED WITH NON-PREGNANT WOMEN IN A BUSY SEXUAL HEALTH CLINIC IN THE UK: MAKING THE CASE FOR SYSTEMATIC CHLAMYDIA SCREENING IN PREGNANCY?

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10.1136/sextrans-2016-052718.258

**Background** *Chlamydia trachomatis* (CT) is the commonest STI in the UK with high prevalence in pregnancy. CT testing is not

**Abstract P210 Table 1** Prevalence of chlamydia in pregnant women

| Characteristics | Negative or no pregnancy test | Positive pregnancy test | P for difference | All |
|---|---|---|---|---|
| | N = 20,629 | N = 837 | | N = 21,466 |
| N visits per person | 2.5 (2.27) | 3.6 (3.02) | *<0.001* | 2.5 (2.22) |
| Positive CT at least once | 1,761 (5%) | 177 (12%) | *<0.001* | 1,938 (5%) |
| Positive GC at least once | 332 (1%) | 47 (3%) | *<0.001* | 379 (2%) |
| Positive TV* | 333 (1%) | 27 (2%) | *0.003* | 360 (1%) |
| Tested for HIV/syphilis | 9,618 (28%) | 430 (28%) | *0.93* | 20,271 (51%) |
| Positive HIV serology | 2 (0%) | 0 (0%)* | *0.076* | 2 (0%) |
| Positive Syphilis serology | 57 (0%) | 0 (0%)* | *0.60* | 59 (0%) |
| Known HIV positive | 10 (0%) | 0 (0%) | *0.87* | 10 (0%) |
| Did not return for treatment | | | | |
| CT | 140 (8%)* | 24 (14%)* | *<0.001* | 164 (8%) |
| GC | 19 (6%)* | 3 (6%)* | *<0.001* | 22 (6%) |

*percentage of people diagnosed

routinely recommended for pregnant women in the UK despite adverse effects on pregnancy, neonate and mother. Countries with recommended CT screening in pregnancy have good results despite suboptimal uptake.
**Aim(s)** To determine the prevalence of CT and treatment uptake in pregnant and non-pregnant women who have attended a large, busy urban integrated sexual health service.
**Methods** Retrospective observational cohort study of all patient encounters with women of child bearing age (15 to 49) between 2012 and 2015 who were tested for CT. Women with a positive pregnancy and STI testing 2 weeks prior and 9 months post STI test were included (n = 837). Women with terminations were excluded. Socio-demographic factors and clinical factors were compared to 20,629 women who had a CT test but no pregnancy.
**Results:** Pregnant women were on average younger (25 vs 28) and had higher CT prevalence across all age groups (12 vs 5%), peaking between 15 and 25 years (21 vs 10%). Being pregnant doubled the odds of having CT after controlling for age (adjusted OR 1.96; CI 1.64–2.30).
**Discussion** The national opportunistic screening programme is deemed to cover CT detection in an age group where both STIs and pregnancy rates are high. However, the results of our study support additional targeted CT screening during pregnancy, particularly in the youngest age group.

## P211 BASHH ON TWITTER: SOCIAL MEDIA FOR SEXUAL HEALTH

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10.1136/sextrans-2016-052718.259

**Background/introduction** Twitter is a free, online social networking service through which users can read and send brief messages of up to 140-characters called "Tweets." BASHH (@BASHH_UK) currently has 3479 followers on Twitter. These include professionals working in sexual health, sexual health services with their own Twitter accounts and members of the public. Twitter disseminates messages instantly and can influence a wide audience. It can be used to keep health professionals and patients informed about relevant research and headline news. For example, recent Twitter themes have included discussions about PrEP and gonorrhoea resistance. Twitter is also used for sharing practical information such as conference deadlines.
**Aim(s)/objectives** To evaluate the reach of BASHH on Twitter by reporting BASHH's Twitter activity.
**Methods** Using Twitter Analytics, data was obtained on the number of Tweets and Tweet Impressions for each of the last 4 months. Tweet Impressions are counted as the number of times each Tweet is seen. The number of visits to BASHH's Twitter profile, mentions by other Twitter users and number of new followers are also recorded. This is presented below:
**Results**

**Abstract P211 Table 1** BASHH on Twitter

| Month | Tweets | Tweet Impressions | Profile Visits | Mentions | New followers |
|---|---|---|---|---|---|
| November 2015 | 18 | 19200 | 1122 | 105 | 120 |
| December 2015 | 31 | 36600 | 1548 | 83 | 67 |
| January 2016 | 49 | 45500 | 2398 | 222 | 120 |
| February 2016 | 33 | 28100 | 2394 | 125 | 108 |

**Discussion/conclusion** BASHH's Twitter activity is reaching a large audience and increasing. All individuals working in sexual health and HIV should consider using Twitter to support wider engagement with their professional network.

## P212 WHICH PATIENTS MAY BE ELIGIBLE FOR PRE-EXPOSURE PROPHYLAXIS (PREP) FOR HIV?

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10.1136/sextrans-2016-052718.260

**Background/introduction** HIV diagnoses remain high among men who have sex with men (MSM). Recent studies show promising results with reducing MSM HIV transmission. The PROUD and IPERGAY studies, using daily or 'on demand' Truvada as PrEP respectively, showed an 86% HIV transmission reduction. Clinical guidance and funding arrangements for PrEP are in development. We assessed PrEP eligibility amongst MSM attending our sexual health service.
**Aim(s)/objectives** To ascertain the proportion of MSM attending our service eligible for PrEP on clinical grounds and estimate the service and cost implications of introducing PrEP.
**Methods** 97 MSM attending from December 2014 to July 2015 were reviewed, including patients who had attended for post-exposure prophylaxis and STI screening. Patients were assessed against the PROUD study inclusion criteria to identify those who would benefit from PrEP.
**Results**

**Abstract P212 Table 1** Eligible for PrEP

| Inclusion criteria | Percentage of patients who fit the criteria |
|---|---|
| Born male | 100% |
| Completed HIV and STI screen | 84% |
| HIV negative within previous 4 weeks | 95% |
| Unprotected anal intercourse (UPAI) on > one occasion in the previous 90 days | 16% |
| All criteria fulfilled (Having attended at least once previously was not considered as this was felt unnecessary) | 14% |

No patients met any of the PROUD exclusion criteria. In a further 21% of notes, the exact number of episodes of UPAI, if any, was unclear although all other criteria were met. This suggests a range of 14–35% eligible for PrEP. We assumed all patients would continue having UPAI, were willing to comply with additional visits and were able to provide consent. The annual cost of Truvada is £356 per year. Further service cost analyses will be described.
**Discussion/conclusion** At least 14–35% of MSM attending our service may benefit from PrEP provision. Additional costs include STI screening, monitoring and care pathways will need to be introduced. However, the overall impact of PrEP may be to reduce new HIV diagnoses and the resultant care costs.

**Abstract P213 Table 1** Self sampling in sexual health

| Characteristics | Clinic only | PUP only | Mixed visits | P for diff | All |
|---|---|---|---|---|---|
| | N = 34,712 | N = 1,691 | N = 3,220 | | N = 39,623 |
| N visits per person | 2.6 (2.36) | 1.2 (0.66) | 5.4 (3.69) | *<0.001* | **2.7 (2.58)** |
| Positive CT at least once | 3,107 (9%) | 50 (3%) | 943 (29%) | *<0.001* | **4,100 (10%)** |
| Positive GC at least once | 746 (2%) | 7 (0%) | 230 (7%) | *<0.001* | **983 (2%)** |
| Positive TV* | 351 (1%) | 0 (0%) | 55 (2%) | *0.002* | **406 (1%)** |
| Tested for HIV/syphilis | 18,498 (53%) | 27 (2%)* | 1,694 (53%) | *<0.001* | **20,271 (51%)** |
| Positive HIV serology | 68 (0%) | 0 (0%)* | 2 (0%) | *0.045*** | **70 (0%)** |
| Positive Syphilis serology | 57 (0%) | 0 (0%)* | 2 (0%) | *0.60*** | **59 (0%)** |
| Known HIV positive | 27 (0%) | 0 (0%) | 0 (%) | *0.87* | **27 (0%)** |
| Did not return for treatment | | | | | |
| CT | 279 (9%) | 19 (38%) | 69 (7%) | *<0.001* | **367 (9%)[$]** |
| GC | 73 (10%) | 3 (43%) | 20 (9%) | *<0.001* | **96 (0%)[$]** |

*not recorded with PUP or tested by PUP unless returned to clinic for treatment
**comparing clinic and mixed cohorts only
[$]percentage of pts not treated out of all diagnosed

## P213 SELF-SAMPLING IN SEXUAL REPRODUCTIVE HEALTH: WHO USES THIS SERVICE AND ARE WE MISSING THE OPPORTUNITY TO SCREEN FOR OTHER SEXUALLY TRANSMITTED INFECTIONS?

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10.1136/sextrans-2016-052718.261

**Background** Self-sampling kits (called Pick-up packs or PUPs in our service) have been introduced to increase STI screening in difficult to engage groups with high prevalence rates, such as male adolescents. There has been little focus on characterisation of its users.
**Aim(s)** To examine PUP uptake rates and describe the socio-demographic and clinical characteristics of their users compared with those attending face-to-face clinics in a large, inner city, Sexual and Reproductive Health (SRH) service in London.
**Methods** Retrospective study from 2012 to 2015 comparing 3 service user groups: (1) face-to-face attendances only (2) PUPs screening only (3) 'mixed attenders' using both. We compared: demographics, number of visits, STI diagnosis, treatment and HIV and syphilis testing.
**Results** PUP users are younger (29 yrs vs 25 yrs, $p < 0.001$). More men use PUP only (69% vs 32%). More heterosexual patients use face-to-face only (95%) compared with mixed attenders (89%), sexual orientation is not recorded for PUP users. No difference in ethnicity was found. Mixed attenders have the highest average number of visits and incidence of CT, GC and TV (Table 1). Incidence is lowest in the PUP only group. Nearly 40% with a CT/GC diagnosis on PUP did not return for treatment vs 10% in the other groups and only 77% had an HIV/Syphillis test.
**Discussion** There is satisfactory uptake but uncertainty as to whether we reach the right target group. The treatment rate for STIs diagnosed using these kits is inadequate. Mixed attenders demonstrated more risk-taking behaviours.

## P214 HOW EASY IS IT TO DISCUSS PARTY DRUG USE IN MEN WHO HAVE SEX WITH MEN? A CLINIC SURVEY

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10.1136/sextrans-2016-052718.262

**Background/introduction** Party drug use is associated with poor health outcomes particularly in men who have sex with men (MSM). We have shown high and increasing rates of party drug use in MSM locally including injecting drug use (Slamming).
**Aim(s)/objectives** To ascertain staff confidence in discussing party drug use in MSM and to identify challenges and training needs.
**Methods** We designed an eight-question electronic survey for health care professionals working in sexual health locally. Questions related to confidence and training required in asking MSM about party drug use.
**Results** 93 professionals responded (19 doctors, 26 nurses and 48 allied health care professionals including health advisers, health care assistants and pharmacists). 54/92 (59%) of respondents felt happy with their current knowledge and 54/81 (65%) of respondents had had specific training in party drug use. 75/81 (93%) felt they would benefit from further training. 49/91 (54%) felt confident discussing party drug use with MSM but respondents felt less confident discussing slamming – 36/89 (41%) felt confident, 34/89 (38%) felt sometimes confident and 19/89 (21%) did not feel confident at all. Reported challenges included keeping up to date with new party drugs and legal highs and knowledge of the modes of administration. Small group teaching was the preferred mode of teaching.
**Discussion/conclusion** Even in centres where recreational drug use in MSM is high and staff receive training on drug use, it is an ever-changing landscape, and training needs to be regular and up to date preferably in a small group setting.

## P215 PATIENT TELEPHONE CONSULTATIONS IN A SEXUAL HEALTH SERVICE. WHAT DO THEY TELL US ABOUT SERVICE EFFICIENCY AND PATIENT NEED?

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10.1136/sextrans-2016-052718.263

**Background/introduction** With an ever decreasing financial envelope, sexual health services are being tasked with developing more cost effective ways of managing patients without impacting on quality of care. Centralised patient management systems have reduced the need for face to face contact, using virtual systems, based upon Health and Social Care information Centre (HSCI)

definitions, to manage ongoing care for patients including partner notification.
**Aim(s)/objectives** Analyse virtual management undertaken with patients following new attendance for episodes of STI care. To ascertain and categorise the number of virtual contacts that prevented a face to face follow up attendance.
**Methods** Thematic analysis was performed on a randomised sample of telephone consultations definitions between 04/15 and 01/16
**Results** 82,994 calls were made to automated results systems. 13,373 calls were transferred from the automated system.

**Abstract P215 Table 1** Telephone consultations

| | |
|---|---|
| calls were analysed | 2719 |
| No follow up required | 969 (35.6%) |
| Information, support or reassurance only | 640 (23.5%) |
| Previously undiagnosed infections requiring follow up | 1054 (38.8%) |
| Initiation or verification of PN | 1150 (42.9%) |
| Referral to Level 1/2 or other services | 68 (2.5%) |

**Discussion/Conclusion** The automated system manages 82% of calls without patients opting to speak with clinicians. Significant numbers of patients opted for telephone consultation upon notification of an infection, giving opportunity for initiation of PN alongside management of further testing and treatment. Approaching ¼ of consultations analysed, showed no additional testing or treatment was indicated, but advice and reassurance was the primary reason for speaking with staff. Virtual consultations can provide a high quality alternative to face to face follow-up visits.

## P216 COMMUNITY PHARMACY-DELIVERED CHLAMYDIA TESTING AND MANAGEMENT IN THE UK - A COMPREHENSIVE REVIEW

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10.1136/sextrans-2016-052718.264

**Background/introduction** Provision of sexual health services in community pharmacies is perceived to be a desirable strategy for increasing access to STI testing and care.
**Aim(s)/objectives** To comprehensively review the literature on chlamydia services in community pharmacies in the UK
**Methods** Eight electronic databases (Medline, AMED, BNI, CINAHL, EMBASE, HBE, HMC, PsychInfo) were searched by two researchers independently, until 4.3.16. Search terms were: (1) chlamydia, AND (2) pharmac*. Studies with qualitative or quantitative evidence on community pharmacy-based chlamydia care including screening, testing, treatment, partner notification and training were included.
**Results** 8 studies, published 2007–2015, met inclusion criteria. They were disparate in terms of subjects: (4 focused on pharmacy staff, 2 on clients), methodology: (2 surveys, 1 qualitative, 1 mixed methods, 1 RCT, 2 cross-sectional and 1 cost-consequence study). Focus varied: treatment 7, screening/testing 5, partner notification 4, training 1, studies respectively. Main findings: pharmacists appear willing to offer chlamydia services if appropriately trained and supported. Barriers to offering opportunistic screening were highlighted. Two studies reported acceptability of screening/treatment but uptake by men in one study was very low (6%). The largest study (1131 people tested positive through pharmacy) reported 47% treated in pharmacy. Preliminary feasibility and acceptability of accelerated partner therapy and expedited partner therapy were shown (2 studies).
**Discussion/conclusion** Despite considerable policy appetite and pharmacist support for pharmacy-delivered chlamydia care, very little robust evaluation of any element of chlamydia testing and/or management has occurred. Well implemented studies of clinical efficacy, assessing quality of care and cost-effectiveness are warranted.

## P217 THE DEMAND AND PROVISION OF INTERPRETATION SERVICES IN AN INNER CITY LONDON INTEGRATED SEXUAL HEALTH CENTRE

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10.1136/sextrans-2016-052718.265

**Background/introduction** Our centre serves a typical linguistically diverse inner city area. The General Medical Council (GMC) states we must provide our patients with information in a way they understand and, where possible, make arrangements to meet language needs. The trust has its own policy, in line with NHS England, relying exclusively on commercial medical interpretation services.
**Aim(s)/objectives** To ensure we are responding to the communication and language needs of our clients in line with GMC guidance and trust policy.
**Methods** A retrospective case note review of patients attending between January 2014 and August 2015 coded as requiring an interpreter. A systematic sample of 100 out of 604 cases was taken.
**Results** 88 notes were identified as appropriately coded. Place of birth comprised 23 countries with the most common being Ecuador (15, 17%), Spain (15, 17%) and Colombia (11, 12.5%). The most common language recorded was Spanish (32, 36%). The type of interpreter used was documented in 76 (85%) cases with 48% of episodes using telephone Language Line. Other sources of interpretation included friend (9%), family (3.3%), partner (5.5%), clinician (4.4%) and Google Translate (11%) with, at times, multiple sources. Average consultation time was increased by 12.7 minutes. The majority of results (80.3%) were delivered by text in English.
**Discussion/conclusion** Although the trust recommends exclusive use of commercial interpretation services we are using this in only 48% of episodes. Other sources are utilised but these are not recommended by the trust. It may be that clarified departmental protocol will change practice.

## P218 A FULL STOP : PROVIDING A FULLY INTEGRATED SEXUAL HEALTH SERVICE FOR WOMEN ATTENDING TERMINATION SERVICES

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10.1136/sextrans-2016-052718.266

**Background/introduction** Traditionally Pregnancy Advice Services (PAS) stood apart from Family Planning and Genito-Urinary

Medicine services. Since 2011 Abertawe Bro Morgannwg Health Board deliver an Integrated Sexual Health service.
**Aim(s)/objectives** To demonstrate the benefits of integrated an service
**Methods** A case note review of all women attending PAS from 1st to 29th February 2016.
**Results** 145 case notes of women accessing PAS were reviewed; median age was 25 years (16–43). 137/145 (94%) had a termination procedure, 1 found not be pregnant, 1 miscarried, 3 transferred to BPAS as >18 weeks pregnant, 3 decided to continue pregnancy. At time of initial consultation, 89/145 (61%) had no form of contraception, 30/145 (21%) used condoms only, 20/145 (14%) were using the Combined Oral Contraception (COC) and 6/145 (4%) the Progesterone Only Pill (POP). At the time of discharge, 77/139 (55%) started a new method of Long Acting Reversible Contraception (LARC). 16/139 (11.5%) were prescribed COC, 25/139 (18%) POP and 1/139 (0.5%), contraceptive patch. 5/139 (4%) declined contraception, 15/139 (11%) wanted to access their GP for future contraception. 144/145 (99%) were offered Sexually Transmitted Infections (STIs) screening, 133/144 (92%) accepted dual Nucleic Amplification Assay Tests (NAATs), 7/133 (5%) had chlamydia, 1/133 (0.8%) had gonorrhoea. All 74/144 (51%) tested negative for syphilis and HIV.
**Discussion/conclusion** This holistic model of care provides women a more immediate opportunity to address their future contraceptive and sexual health needs, with a 55% increase in uptake of LARC and >5% identification of untreated STIs.

## P219 RESPONDING TO THE LGV EPIDEMIC: ARE THE RIGHT PATIENTS BEING TESTED FOR LGV?

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10.1136/sextrans-2016-052718.267

**Background** UK national guidelines will recommend that samples from all *Chlamydia trachomatis* (CT)-positive men who have sex with men (MSM) with proctitis and all asymptomatic CT-positive MSM with HIV should be tested for Lymphogranuloma venereum (LGV).
**Aim** To investigate case characteristics and test outcomes of samples referred to the Sexually Transmitted Bacterial Reference Unit (STBRU) for LGV testing.
**Methods** STBRU and GUMCADv2 data for 2014 in England were matched. Test numbers and outcomes for patients in different risk categories were compared to understand targeting of LGV testing.
**Results** In 2014, 3,782 CT samples were tested for LGV, and 2,426 (64%) were matched to GUMCADv2. MSM accounted for 77% (1876/2426), heterosexual men 7% (178/2426) and women 11% (277/2426) of LGV tests (Table 1). Overall, LGV prevalence was 15% (366/2426), and was highest among HIV-positive MSM (33%; 230/692) and lowest in women (0.4%; 1/277). MSM accounted for 93% (342/366) of all positive samples, and 67% (230/342) of MSM with LGV were HIV-positive. In 2014, there were 3,434 CT diagnoses reported by GUM clinics in HIV-positive MSM, but we found only 692 HIV positive MSM had a CT sample tested for LGV, while 1,639 CT samples were from MSM without HIV, heterosexual men, or women, suggesting inadequate testing of CT samples from HIV-positive MSM.
**Conclusion** Although miscoding in GUMCADv2 may partially explain some LGV testing in heterosexual men and women and HIV negative MSM, these data still suggest that LGV testing might be targeted more effectively to conserve resources and maximise identification of LGV.

**Abstract Table 1** The distribution of LGV tests and test outcomes by sexual orientation and HIV status for patients whose CT samples were referred for LGV testing in England in 2014

| | LGV Positive | LGV Negative | Total | % of all LGV tests done in group | % of all positive LGV test results in group | LGV prevalence in group (%) |
|---|---|---|---|---|---|---|
| Total | 366 | 2060 | 2426 | 100 | 100 | 15.1 |
| **MSM** | **342** | **1534** | **1876** | **77.3** | **93.4** | **18.2** |
| HIV positive | 230 | 462 | 692 | 28.5 | 62.8 | 33.2 |
| HIV negative | 112 | 1,072 | 1,184 | 48.8 | 30.4 | 9.5 |
| **Heterosexual** | **14** | **164** | **178** | **7.3** | **3.8** | **7.9** |
| **men** | 7 | 29 | 36 | 1.5 | 1.9 | 19.4 |
| HIV positive | 7 | 135 | 142 | 5.8 | 1.9 | 4.9 |
| HIV negative | | | | | | |
| **Women** | **1** | **276** | **277** | **11.4** | **<0.1** | **0.4** |
| HIV positive | 0 | 1 | 1 | <0.1 | 0 | 0 |
| HIV negative | 1 | 275 | 276 | 11.4 | <0.1 | 0.4 |
| **Unknown** | **9** | **86** | **95** | **3.9** | **2.5** | **9.5** |
| HIV positive | 6 | 19 | 25 | 1.0 | 1.6 | 24.0 |
| HIV negative | 3 | 67 | 70 | 2.9 | 0.8 | 4.3 |

## P220 THE UPTAKE OF HIV SCREENING AMONG PREGNANT WOMEN AT A GRENADIAN CLINIC

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**Background/introduction** In Grenada, almost 70% of patients diagnosed with HIV are of reproductive age, however this group is often the least educated about the disease. To prevent vertical transmission, access to testing and treatment is free. Screening for HIV occurs at booking and at 32 weeks gestation. Awareness of HIV status is not only important for the mother and child but also for healthcare professionals involved in her care. Despite this, women continue to opt out of HIV screening. This audit will seek to determine the uptake of HIV screening among pregnant women at a Grenadian clinic and discuss potential barriers to screening.
**Aim(s)/objectives** Determine the uptake of HIV screening among pregnant women. Explore possible barriers to screening.
**Methods** Optimal adherence to the screening programme was set at 100%. Retrospective data from women attending the antenatal clinic between 01/06/14 and 01/06/15 were included. Screening status was obtained from the visiting book. Data was then analysed against the set standard.
**Results** 140 women attended the clinic. 110/140 had opted in for HIV screening giving a screening rate of 79%. Reasons why women opted out of screening were discussed and included: Denial, Ignorance to susceptibility, Fear of discrimination, Confidentiality concerns, Screening at separate location and being unable to breastfeed with HIV-positive status.

**Discussion/conclusion** Education is key to increase awareness about the importance of HIV screening. Healthcare professionals should be aware of and address barriers to screening during consultations. An educational poster has been produced for the clinic with the intention of increasing awareness of HIV among the pregnant population.

## P221 A SURVEY EXAMINING HEALTH SEEKING BEHAVIOURS OF THOSE ACCESSING SEXUAL HEALTH SERVICES IN LONDON

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10.1136/sextrans-2016-052718.269

**Background/introduction** Open access to sexual health services reduces STI's and onwards transmission. Given cuts to Public Health budgets, a better understanding of how patients access care is vital to rationalise services.
**Aim(s)/objectives** Assessing demographics and health behaviours of sexual health clinic attendees to improve service delivery.
**Methods** Patient-directed questionnaires were completed on registration in a London Trust. Information including demographics, travel times and whether patients sought help before attending were collected.
**Results** 231 surveys were returned with respondents 48% white, 23% black and 13% Asian. 62% of patients walked-in, 34% booked online. 52/217 (24%) sought advice from elsewhere before attending (primarily GP - 26/52, 50%) with 50% finding it useful. Of 107 responses, 41 (38%) tried self-treating before attendance. Symptomatic patients were more likely then asymptomatic patients to seek help elsewhere (40/113 versus 12/99, $p < 0.05$). No significant differences in behaviour were observed given age, ethnicity or employment, or previous STI < 12 months ago. No patients with qualifications less than GCSE sought prior to attendance. 80% of patients travelled under 30 minutes to clinic, 58% attended their closest clinic.
**Discussion/conclusion** Our data demonstrates the clinics surveyed serving a very local population. However a significant proportion of patients, particularly those with symptoms, seek help elsewhere before attending, with only 50% finding this useful. This highlights the importance of specialist services addressing local patients' health needs. Overall socio-demographic factors did not appear to influence health seeking behaviour, although those with a lower education status appeared to access services more directly.

## P222 DOES HIV INFECTION INCREASE COMPLICATIONS AFTER INTRA UTERINE CONTRACEPTION (IUC)?

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10.1136/sextrans-2016-052718.270

**Background** As estimated by World Health Organisation about 50% of all HIV infected individuals are women. Comparison data for complications after IUC in HIV positive and negative women are lacking.
**Aims** The aim of our study is to compare short-term complications and side-effects after IUC in the above two groups.
**Methods** Retrospective notes review of 76 patient records of HIV negative women who attended in 2013, for IUC and followed up for 3 months was carried out. All HIV positive women, who attended between 2012–2015, for IUC and followed up within 3 months were included. Data including demographics and complications were collected in addition to HIV related parameters.
**Results** Among the 49 HIV positive women 46 were on treatment and was undetectable at the time of IUC insertion. Mean CD4 count was 589 cells/μL. Mean age was 38 years, and 30 in the negative women. Black ethnicity was common among both groups. Pelvic pain was reported in 6% of the HIV group vs 17% of the non-HIV group (P value = 0.034). Incidence of lost threads was also significantly high in HIV negative women (P value = 0.018). 31% of the HIV group reported heavy or prolonged bleeding vs 37% of the negative group.
**Discussion** In HIV negative women, pelvic pain and incidence of lost threads were significantly high. Occurrence of any complication or side effect was also significantly high in HIV negative women (P value = 0.022).

## P223 PROVISION OF MENTAL HELATH CARE IN HIV POSITIVE HOSPITAL INPATIENTS EVALUATED AGAINST BRITISH PSYCHOLOGICAL SOCIETY (BPS) STANDARDS

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10.1136/sextrans-2016-052718.271

**Background** The prevalence of mental health problems (MHP) in PLWH is significantly higher than in the general population. Little is known of the prevalence of MHP and experience of patients of MH services locally.
**Aim** This study aimed to audit the provision of MH care in HIV-positive inpatients locally against 2011 BPS standards.
**Methods** We undertook a retrospective notes review of HIV-positive inpatients between 15/07/2015 – 30/11/2015. The following data were collected: demographics, HIV parameters, substance misuse, and MH history. Phone interviews were held to obtain feedback on patients' experiences of MH care. Statistical analysis was undertaken using chi-square or Fisher's exact test.
**Results** Of seventy-three patients 86% were male (n = 63) and 80% UK-born Caucasian (n = 58). Median CD4 was 495 cells/mm3 (range: 8–1847); HIV-1 viral load was undetectable in 78% (n = 57); 8% were HCV antibody positive (n = 6); 3% homeless (n = 2), 26% reported alcohol excess (n = 19), 4% injection drug use (IDU) (n = 3), 32% (n = 23) active and 38% (n = 28) previous MHP. Only IDU was significantly associated with active MHP, (p = 0.01). Of 15 patients reporting MHP who provided feedback, 6 (40%) felt healthcare professionals (HCPs) had not given them sufficient opportunity to discuss their psychological wellbeing and 40% (n = 6) reported experiencing stigma from HCPs.
**Conclusion** Results suggest a high prevalence of MHP in this cohort. Many reported difficulties discussing MHPs with HCPs. We have therefore initiated a pilot joint HIV/Psychiatric clinic to improve access to MH services.

## P224 MISSED OPPORTUNITIES AND COST IMPLICATIONS IN A HIV LOW PREVALENCE REGION IN THE UK

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10.1136/sextrans-2016-052718.272

**Background/introduction** Missed opportunities is a leading cause for late presentation in HIV.
**Aim(s)/objectives** We analysed missed opportunities, clinical outcomes and associated cost in a HIV low prevalence region in UK.
**Methods** A retrospective review of case notes and pathology system of new HIV diagnosis from 2010 to 2013 was undertaken. Clinical summary preceding 12 months of diagnosis collected from GPs with patient's consent. Data analysed using Excel workbook.
**Results** Out of 25 new HIV diagnosis,17 males, 21 white ethnicity, 10 heterosexual and 6 bisexual. One third > 40 years. Sixteen (64%) were late diagnosis with CD4 < 350. 13/16 had CD4 < 200 and 9/16 (56%) had an AIDS defining illness. 19/25 (76%) had atleast one missed opportunity (range 1–16). 11/19 in primary care and remaining at different levels.There was no difference in VL between early and late diagnosis. 10/16 had a blood test in the preceding 12 months. In the first 12 months post diagnosis, early group had 51 clinical consultation compared to 147 in late group. Three patients had extended inpatient stay in the late group.One died. Using Reference costs of around £385, late diagnosis costed £ 56595 compared to £19635 for early excluding inpatients cost, excess bed days, additional outpatient investigations, medications including ARVS and other specialty referral costs.
**Discussion/conclusion** Our study shows increased missed opportunities in apparently non high-risk groups resulting in poor outcomes and significant costs. Higher HIV awareness and national testing policy tailored to HIV low prevalence region is required.

## P225 LYMPHOGRANULOMA VENEREUM: CASE REPORT OF SIMULTANEOUS PENILE ULCERATION AND BUBO FORMATION

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10.1136/sextrans-2016-052718.273

**Background/introduction** Lymphogranuloma venereum (LGV) has become an important UK public health issue since 2003. HIV positive men who have sex with men (MSM) continue to be the predominant risk group for contracting LGV in the UK.
**Aim(s)/objectives** LGV commonly presents as proctitis alone; we present an unusual case of a patient who presented with simultaneous rectal symptoms, penile ulceration and bubo.
**Methods** A 25 year old HIV (CD4 996 (43%)/viral load undetectable) and Hepatitis C co-infected MSM presented to A&E with a 2 week history of painful left inguinal swelling. Additional history revealed episodes of bloody diarrhoea which the patient related to a previous diagnosis of Inflammatory Bowel disease. Examination revealed a left inguinal bubo and 3 areas of penile ulceration (2 painful, one indurated/painless). Proctoscopy was normal. Empirical treatment with Doxycycline and Aciclovir was commenced.
**Results** Nucleic acid amplification testing (NAAT) was performed on pharynx, rectum, urine and penile ulcers. Urine NAAT was positive for *Chlamydia trachomatis;* penile ulcer NAAT was positive for LGV specific DNA. Herpes simplex and Treponemal PCR from the ulcers were negative. Rectal NAAT was negative for *Chlamydia trachomatis*. An Ultrasound of the left inguinal bubo revealed abscess formation with frank pus seen on aspiration.
**Discussion/conclusion** LGV is commonly associated with proctitis and genital ulcers of LGV are evanescent. Persistence of LGV ulceration until bubo formation has not been reported to-date. The negative Rectal NAAT for Chlamydia was unusual however the diarrhoeal symptoms settled with Doxycycline.

## P226 REATTENDANCE, RETESTING AND TEST POSITIVITY AMONG PATIENTS INITIALLY TREATED FOR CHLAMYDIA OR GONORRHOEA IN A LARGE INNER CITY CLINIC

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10.1136/sextrans-2016-052718.274

**Background/introduction** Reinfection with a bacterial sexually transmitted infection following treatment is common. National guidelines recommend retesting for chlamydia three to six months after treatment in <25 year olds.
**Aim(s)/objectives** To review reattendance, retest and positivity rates in patients with chlamydia or gonorrhoea at a large inner-city clinic.
**Methods** Patients diagnosed with chlamydia or gonorrhoea were identified in our electronic patient records (March-September 2015). Proportion reattending, retesting and test positivity two to four months after treatment of the initial infection were recorded.
**Results** The minority of patients treated for chlamydia and gonorrhoea reattended and retested for infection (Table 1). Positivity was high in those who retested, especially in MSM. Two HIV diagnoses and 89 syphilis serology positive results were found in those retesting.

**Abstract P226 Table 1** Reattendance, retesting and test positivity among patients initially treated for chlamydia or gonorrhoea, by age and risk group

| | <25 years (n = 584) | | ≥25 years (n = 1,713) | |
|---|---|---|---|---|
| | Heterosexual (n = 442) | MSM (n = 142) | Heterosexual (n = 647) | MSM (n = 1066) |
| **Total: Chlamydia ± Gonorrhoea (n = 2297)** | | | | |
| Reattended | 97 (22%) | 42 (30%) | 148 (23%) | 481 (45%) |
| Retested | 76 (78%) | 25 (60%) | 96 (65%) | 258 (54%) |
| Positivity | 11 (14%) | 9 (36%) | 11 (11%) | 92 (36%) |

**Discussion/conclusion** Retesting rates following treatment for chlamydia and gonorrhoea are low. Those who did reattend and retest experienced high rates of infections and represent an important group to target for active recall.

## P227 PATIENT SATISFACTION – NEW LGBTQ (LESBIAN, GAY, BISEXUAL AND QUEER) SEXUAL HEALTH CLINIC

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10.1136/sextrans-2016-052718.275

**Background/introduction** This clinic opened in 2015 offering a weekly specialist sexual health service for our LGBTQ community. Burden of pathology is high, suggesting a potentially more

stressful environment for patients. All medical and non-medical staff were trained on LGBTQ sexual health issues and some on Club Drug related issues.
**Aim** To assess patient satisfaction with the new service, a questionnaire was undertaken seven months after service commencement.
**Methods** Over a four-week period, questionnaires were handed to patients by reception at booking. Thirty-six questionnaires were returned.
**Results** Patients rated the service as excellent 81% (26/32) very good 14% (5/32) or good 3% (1/32). All patients who answered said they would attend again 100% (32/32). Most would recommend it to a friend 97% (32/33). Patient staff satisfaction was high, with 96% (29/30) stating they felt listened to. Patients felt treated with respect and dignity always 97% (31/32) or sometimes 3% (1/32). 83% (30/36) of patients attended specifically with LGBTQ concerns, of these 93% (28/30) felt confident in discussing concerns with staff, 7% (2/30) to some extent. 77% (24/31) indicated that drugs or alcohol were related to their visit. Only 21% (5/24) felt they could raise this topic with staff and 79% (19/24) stated they couldn't.
**Discussion** Staff training on managing vulnerable clients' health needs enables confidant and approachable health care. This provides patients with opportunities to verbalise health anxieties, facilitating opportunistic healthcare interventions. Drug and Alcohol training for all staff will enhance the patient care package.

## P228 EVALUATING THE USE OF EXTRA-GENITAL CHLAMYDIA TRACHOMATIS (CT) AND NEISSERIA GONORRHOEA (GC) NUCLEIC ACID AMPLIFICATION TESTS (NAATS) IN NON-MSM POPULATIONS

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10.1136/sextrans-2016-052718.276

**Background/introduction** Our clinic performs routine oral and anal CT and GC NAATs following disclosure during sexual history of oral or receptive anal sex. Specimens are analysed using the Abbott M2000 assay, costing £4.50 per dual NAAT.
**Aim(s)/objectives** We report the findings of this practice, focusing on clinical and partner notification outcomes, and the cost per diagnosis.
**Methods** We included all non-MSM patients with isolated extra-genital CT or GC infection from 1/8/14 to 31/7/15. We excluded contacts of either infection, plus those without GC confirmed by culture or second NAAT platform. Retrospective case note review was performed for identified cases.
**Results** In total 8796 NAATs were processed in non-MSM patients, of which 3813 (43%) were extra-genital. In heterosexual men we identified 3 pharyngeal GC cases and one contact, and one pharyngeal CT case with one contact. In women there were 2 pharyngeal GC cases, one pharyngeal CT case and one rectal CT case with no additional contacts. The spend per pharyngeal diagnosis was £1519 in males and £3138 in women. The spend per rectal diagnosis in women was £1665.
**Discussion/conclusion** Our screening practice has picked up only a small number of cases which would otherwise have been missed. 25% (2/8) of those cases had verified contacts identified. The cost implication of such screening is high, meaning that ongoing routine screening is not viable. In our relatively low-prevalence setting we now intend to target our screening in line with BASHH CEG guidance which will provide significant cost savings.

## P229 CLINICIAN AND COMMUNITY COLLABORATION ON PREP IN THE UK – A NARRATIVE

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10.1136/sextrans-2016-052718.277

**Background** The PROUD study showed that PrEP can be successfully provided via sexual health clinics in the UK. The delay in widespread availability of PrEP has seen renewed grassroots activism from the community sector.
**Methods** We document the timeline and benefits of a close relationship between community activists and clinicians in advancing the PrEP agenda.
**Results** Community engagement during the PROUD trial led on to increased advocacy and activism from October 2014 when interim results were published. Launch of the websites IWantPrEPNow.co.uk (with a click to buy generic PrEP) and PrEPster.info in October 2015 further galvanised clinicians and community advocates into greater joined up action. The benefits of this included: 1) Mutual social media support; advancing the PrEP agenda amongst potential PrEP users and clinicians, 2) Obtaining GMC input on providing clinical advice regarding generics, 3) Pushing for free monitoring for current generic PrEP users, 4) Sharing of therapeutic drug monitoring data, 5) Community input into staff training and service development such as production and review of patient information, and 6) Two way learning; sharing PrEP users perspective and evidence based research.
**Discussion/conclusion** The lack of availability of PrEP in the UK is proving a challenge to both community advocates and clinicians. We wish to celebrate the achievements made within the confines of the current political climate, in particular working to ensure patient safety. There is a history of successful clinician/community collaboration in GUM/HIV medicine; with an NHS England PrEP roll out we need to reflect this to drive uptake. If NHS England decides against PrEP funding, we suggest that continued collaboration, support and innovation will be paramount.

## P230 REVIEW OF SYPHILIS MANAGEMENT AT A BUSY URBAN STI CLINIC

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10.1136/sextrans-2016-052718.278

**Background/introduction** Appropriate management of syphilis is vital in order to avoid late complications. A retrospective cohort study of patients with positive serology at an urban STI clinic where the BASHH guidelines are followed was undertaken.

**Aim(s)/objectives** Evaluate:: Documentation of syphilis stage, Treatment, Interval between treatment and first follow-up RPR, RPR 12 months post treatment -determine those with negative RPR; fourfold reduction in RPR or documented as "serofast".
**Methods** A list of positive serology between April 2013 and March 2014 was generated. Patients managed at clinic were identified and their electronic record reviewed. Descriptive column statistics were used for data analysis.
**Results** 93 cases of syphilis were managed. Median age 35 years (range 20–74); 82 (88%) cases male; 47 (51%) HIV positive. Stage was documented in 45 (48%). Of those with undocumented stage, RPR >/=1:8 in 29, 25 were treated with single benzathine-penicillin. 85 received penicillin- based treatment, 48 (52%) received single dose benzathine penicillin. 8 received doxycycline. Median interval from treatment to subsequent RPR 40 days (range14- 219). 12 months post treatment, 48 (52%) had negative or "neat" RPR. 58 (62%) a fourfold reduction. In those with a positive RPR, 4 were deemed to be "serofast".
**Discussion/conclusion** Syphilis continues to be a common infection in men. The majority of patients were treated with penicillin as per BASHH guidelines. There is room for improvement in documenting stage of infection and outcome in those who fail to have a fourfold reduction in RPR at 12 months.

## P231 SERVICE IMPROVEMENT REVIEW OF SEXUAL HEALTH SERVICE DNA RATES

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10.1136/sextrans-2016-052718.279

**Background/introduction** Reductions in sexual health budgets have occurred across England. There is significant focus on the Public Health Outcomes framework and requirements to deliver improved services for less. Sexual health services are examining ways to be more efficient. In 2015 we set out to examine aspects of inefficiency within our service. We highlighted a high 'Did Not Attend' (DNA) rate for Follow up patients as a significant inefficiency. We describe a service review undertaken as part of service improvement plan looking at the reasons and triggers for patients not attending or cancelling their appointments.
**Aim(s)/objectives** To describe associated factors with not attending appointments when a follow up (FU) appointment has been arranged. To identify solutions to reduce DNA rates to release extra capacity for new appointments.
**Methods** Focused initial data collection on Doctor follow up stream for November 2015. Aimed to look at whether the following impacted on DNA rate: SMS reminders, Time between booking & appointment and Reason for follow up
**Results** The overall DNA rate for Doctor Follow up appointments is 23.7%. Median time from appointment made to appointment either attended or not was the same, 18 days. Patients re-attending for Gonorrhoea and chlamydia treatment, Post exposure Prophylaxis FU, Herpes FU and patients with ongoing symptoms attended well. Patients attending for hepatitis B vaccination, window period testing, FU for Pelvic inflammatory disease and Chlamydia Test of cure were significantly more likely to DNA. A survey was conducted to ask patients what were the acceptable means of avoiding DNAs.
**Discussion/conclusion** A total of 165 appointments were missed in November 2015, equivalent to 10 appointments every day. Introducing additional text reminders, using social influence models to increase patient cancellation, were all likely to reduce DNA rate and increase capacity for new appointments.

## P232 KEEPING ON TOP OF BV – AN AUDIT OF BACTERIAL VAGINOSIS AND STI SCREENING IN GUM CLINIC ATTENDEES REQUESTING A TERMINATION OF PREGNANCY

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10.1136/sextrans-2016-052718.280

**Background/introduction** BASHH guidelines currently recommend universal testing for all GUM clinic attendees and all those undergoing termination of pregnancy (TOP). Screening for and treating bacterial vaginosis (BV) is recommended by BASHH in order to reduce the incidence of post TOP endometritis and PID.
**Aim(s)/objectives** To audit whether STI screening, to include testing for BV, is being carried out in patients attending a GUM service requesting TOP referral.
**Methods** Retrospective case note review of 100 consecutive patients seen requesting TOP referral in an Inner London GUM clinic 1/1/15–1/2/15.
**Results** Case notes of 100 were reviewed. Median age was 25yrs (range 16–49 yrs). 21% of patients (n = 21) were of Black ethnicity. 28/50 (56%) reported previous pregnancy and 19/43 (44%) previous TOP. Sexual histories were documented in 53% (n = 53) of cases. 43% (43/100) of patients were documented to be asymptomatic. 38/100 patients had an STI screen and of the remainder 37% were documented to have declined. STI screening included serology testing for HIV/STS in 68% (n = 26) of cases and microscopy for BV/TV in 42% (n = 16). No asymptomatic patients were screened for BV. STI prevalence in those screened was BV 50% (8/16), Chlamydia 8% (3/37), Gonorrhoea 5% (2/37).
**Discussion/conclusion** Adherence to BASHH guidelines was inconsistent particularly in relation to STI screening and BV screening in asymptomatic women seeking TOP. STI prevalence was relatively high in those screened. A designated clinical proforma may improve documentation and testing rates.

## P233 A CASE OF CMV (CANCER MIMICKING VIRULENCE)

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10.1136/sextrans-2016-052718.281

**Background/introduction** Generalised lymphadenopathy and fatigue have a broad differential diagnosis ranging from curable infections to lymphoma. Certain diagnoses can be delayed or missed altogether when patients do not present to sexual health clinics.
**Aim(s)/objectives** Highlight secondary syphilis as a cause of lymphadenopathy amongst non-sexual health colleagues. Expand syphilis testing beyond sexual health clinics, even in the absence of classical risk factors.
**Methods** Case report of secondary syphilis which was misdiagnosed despite numerous investigations in primary and secondary care.

**Results** A 23 year Caucasian lady was referred to lymphoma clinic by her GP with a three month history of lymphadenopathy and fatigue. She was diagnosed with a primary CMV infection and lost to follow up after her symptoms resolved. One year later she attempted to donate blood. Positive syphilis serology with a low RPR was detected on routine blood screening by the transfusion service. The patient was referred to Bristol Sexual Health Centre where sexual history taking revealed she had a bi sexual partner at the time of her illness who also tested positive for syphilis. An archived blood sample from the time of her illness revealed active syphilis infection with a high RPR.
**Discussion/conclusion** Secondary syphilis can mimic numerous illnesses. However syphilis testing remains uncommon outside of sexual health clinics for a variety of reasons. A change of culture is required to ensure medical professionals are prepared for routine sexual enquiry and consider syphilis as a potential cause for lymphadenopathy.

## P234 EXPLORING SERVICE USER NEEDS AND STREAMLINING DELIVERY THROUGH TRIAGE BY SENIOR CLINICIANS IN AN INTEGRATED SEXUAL HEALTH WALK-IN

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10.1136/sextrans-2016-052718.282

**Background/introduction** On-going procurement exercises in Sexual Health inevitably require that efficiencies are sought whilst maintaining high quality and equity of access.
**Aim(s)/objectives** This test of change aimed to inform a streamlining of a city centre walk-in service and to test the feasibility of delivering an integrated service using staff with mixed skill sets. Means were sought to reduce re-attendances to the co-located Contraception and GU Medicine services.
**Methods** For two weeks in January 2016 patients attending the walk-in service were triaged by a senior dual trained clinician. Triage notes were made and patients were subsequently seen by another clinician who could meet all of their needs. Data was collected regarding staff skillsets, waiting times, patient-perceived versus clinician-assessed needs as well as services actually delivered and staff feedback.
**Results** 324 patients were seen (236 females, 88 male). Approximately 40% of women had mixed (GU and contraception) needs, whilst of those believing themselves to have a solely contraception need, half were identified as also having a GU need. A third of patients were symptomatic Two thirds had a sexual health screen. Nursing staff saw 66% of patients. 80% of staff reported similar or increased job satisfaction (qualitative data are available).
**Discussion/conclusion** Service users perceived needs are often less than those assessed by experienced clinicians. Delivering an integrated walk-in service whilst maintaining specialist skills is feasible if triage is effective; missed opportunities are minimised. Work to assess the utility and cost-effectiveness of different types of triage is required

## P236 A REVIEW OF A YEAR OF NEW HIV DIAGNOSES AT A SINGLE CENTRE – WHAT CAN WE LEARN? HOW PEOPLE TEST, PRIMARY INFECTION AND HOSPITALISATION

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10.1136/sextrans-2016-052718.283

**Introduction** A large proportion of new HIV diagnoses are incident and hospitalised. HIV testing can be accessed by various means. HIV incidence in UK men who have sex with men (MSM) continues to increase. HIV testing is an important public health intervention to reduce incidence. Locally we have a high prevalence (8:1000) and an HIV cohort of 2300 mainly MSM.
**Methods** New diagnoses from January- December 2015 were identified from our local database, clinical records were examined. Data was collected on patient characteristics, medical history, results, the method and location of testing.
**Results** There were 57 new diagnoses; 50 (88%) MSM, 4 (7%) heterosexual females and 3 (5%) heterosexual males. 24 (42%) had tested negative in the previous year, 24 (42%) more than 1 year ago and 9 (16%) had never tested. Testing locations included: 27 (47%) GUM clinic, 14 (25%) GP, 5 (9%) home test kits, 4 (7%) THT, 3 (5%) inpatient, 2 (3.5%) hospital outpatients, 1 (1.75%) sauna and 1 (1.75%) private clinic. Reasons for testing encompassed: 17 (30%) GUM screening, 10 (18%) HIV symptoms, 2 (4%) post exposure prophylaxis, 2 (4%) partner notification, 2 (4%) malignancy, 1 (2%) assault, 1 (2%) condom break, 1 (2%) intravenous drug use and 1 (2%) insurance. 12/49 (24%) avidity results were incident. 10/57 (18%) were hospitalised within 3 months of diagnosis; 3 malignancies, 2 opportunistic infections (Pneumocystis, Mycobacterium avium complex), 1 STI (Shigella), 1 abscess, 1 seroconversion, 1 treatment toxicity and 1 for investigations.
**Discussion/conclusion** Locally a large proportion of new HIV diagnoses are incident, MSM and hospitalised. Continued innovation is vital in community and hospital admission testing to reduce undiagnosed HIV and incidence.

## P237 ASSESSING THE IMPACT OF A HIV TESTING POLICY

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10.1136/sextrans-2016-052718.284

**Background/introduction** Mirroring national data, HIV testing in our local board is failing to reduce the high proportion of late diagnoses. Healthcare Improvement Scotland (HIS) HIV standards 2011 recommended the development and promotion of a written HIV testing policy. A local HIV testing policy was introduced in 2013 based on the UK National testing guideline (BHIVA), recommending routine testing in certain clinical areas, in high risk groups and all individuals with "clinical indicator conditions" regardless of perceived risk. The introduction of the policy was supported by staff training.
**Aim(s)/objectives** Review the impact of a HIV testing policy on staff knowledge and levels of HIV testing.
**Methods** In November 2015 a survey was undertaken to question staff awareness of the policy, understanding of HIV testing and levels of HIV testing. The survey was advertised on local websites to healthcare, social work, third sector and substance misuse staff.
**Results** The survey had 120 respondents, with the largest proportion from Consultant and GP staff. Over 70% of respondents were aware of the policy. 25% reported that the policy had changed their clinical practice by increasing their confidence in testing. There has been a corresponding increase in HIV testing figures. Interestingly over 70% responded that a detailed HIV risk assessment was required even in the presence of a clinical indicator condition.

**Discussion/conclusion** The survey has demonstrated that the HIV testing policy has increased staff awareness and confidence in HIV testing. Late diagnosis rates continue to be monitored and misconceptions regarding HIV testing challenged.

## P239 DON'T ASK, DON'T TELL: INTRODUCTION OF ROUTINE DOMESTIC ABUSE PROMPT IN GENITOURINARY WALK-IN CLINIC

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10.1136/sextrans-2016-052718.285

**Background/introduction** Domestic abuse (DA) is common and spontaneous disclosure rare. In July 2015, routine DA enquiry was introduced in a busy, inner London, walk-in genitourinary medicine clinic. All DA disclosures prompted completion of a proforma identifying ongoing risk/<3/12 (=current DA) with clear management pathway. Patients disclosing current DA were seen by Sexual Health Information Protection (SHIP) team for detailed risk assessment and referrals, as needed. Those with previous DA were offered information/referrals if indicated.
**Aim(s)/objectives** To review DA disclosure management following DA routine prompt introduction.
**Methods** A retrospective case-notes review of patients' notes (coded DA) for 3 months from 14/07/2015.
**Results** 137 patients (111 women,26 men): age-range 17–75 years old(mean 33), 7% (10/137) commercial sex workers, 11% (15/137) MSM/bisexual. 72% of patients had never disclosed to professionals previously. Ex-regular and current partners most common perpetrators (62%, 15% respectively). 25% (34/137) disclosed current DA. Of these, 94% (32/34) were offered SHIP referral, 88% (28/32) accepted, 75% (21/28) were seen. Referrals were made to DA services 48% (10/21), refuges 10% (2/21), MARAC 19% (4/21). 52% (11/21) had a standardised risk assessment; those who did not, 60% (6/10) were already engaged in services, 20% (2/10) didn't attend follow-up and 20% (2/10) referred to psychology. 44% (14/34) patients were discussed at Vulnerable Adults MDT. No escalation of violence was recorded.
**Discussion/conclusion** Patients with significant risk from DA were identified who may not have disclosed without routine prompt. This is suggested as the majority were first disclosures. Interventions to reduce the negative consequences of DA for these patients have been performed.

## P240 WHAT IS THE HEPATITIS B VACCINATION COVERAGE IN MSM IN SOUTH WEST LONDON? AN AUDIT OF HEPATITIS B VACCINATION COVERAGE IN 'FIRST ATTENDEE' MSM IN A BUSY TEACHING HOSPITAL GUM CLINIC

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10.1136/sextrans-2016-052718.286

**Background** The 2001 National Strategy for Sexual Health and HIV recommended 90% uptake of Hepatitis B (HBV) vaccine in non-immune MSM at first GUM clinic attendance. The HepB3 Survey reported 95% uptake in 2008 but recent surveillance using GUM Clinic Activity Dataset-v2 (GUMCADv2) coding shows <20% uptake. A detailed regional audit was designed to investigate this apparent drop in coverage.
**Aim** To determine HBV vaccination coverage in 'first-attendee' MSMs.
**Methods** All MSM 'first-attendees' at our service between January-March 2014 were identified. Patient records were reviewed for HBV screening, vaccine-offer, vaccine-uptake, HIV testing and coding accuracy up to 18 months from first-attendance. MSM were deemed '*immune*' if surface antibody (sAb) >10 mIU/ml, core antibody positive, or self-reported vaccination-status was 'Fully-vaccinated' and no serology was done; and *eligible* for vaccination if sAb ≤10 mIU/ml, or if they reported 'Partially-vaccinated', 'Never-vaccinated', or 'Don't know' and no serology was done.
**Results** We identified 115 MSM 'first-attendees' (13 HIV+). 41% only attended once. Regarding vaccination-status: 41/95 (43%) reported 'Fully-vaccinated', 29/95 (30%) 'Partially-vaccinated', 12/95 (13%)'Never-vaccinated', 11/95 (12%) 'Don't-know', 1/95 (1%) 'Chronic-HBV' and 1/95 (1%) 'Cleared-HBV'. 48/103 (47%) were deemed *immune* and 46/103 (45%) *eligible*. 36/46 (76%) of *eligibles* were offered vaccination; 2/36 (6%) declined, reporting 'not at risk'. 3/32 (9%) who accepted vaccination pending sAb levels did not return for it. 31/46 (67%) of *eligibles* received ≥1 dose of vaccine, 28/46 (61%) within 42 days of first-attendance. Reasons for non-offer were not recorded. 75% of first-doses were coded. Only 15% of '*immune*' patients were coded as such (P2I). HIV-test uptake was 99% and coding accuracy was 97%.
**Discussion** We found below-target levels of HBV vaccination-coverage and incomplete coding of immunity/vaccination. Failure to code P2I for '*immunes*' will increase the apparent '*eligibles*' denominator in GUMCADv2 algorithms, generating incorrectly low vaccination-coverage figures. Reduced offer-rate may contribute to low vaccination-coverage and should be reviewed locally. Further regional audits may be required. Significant improvements in coding are essential for accurate surveillance of HBV vaccination-coverage using GUMCADv2.

## P241 DO MEN ATTENDING A GENITOURINARY MEDICINE SERVICE KNOW IF THEIR MOST RECENT SEXUAL PARTNER WAS USING CONTRACEPTION?

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10.1136/sextrans-2016-052718.287

**Background/introduction** Unintended pregnancy is a significant problem. In 2014 in England and Wales 184,571 abortions were performed. Contraceptive methods generally focus on females. Males have the potential to contribute significantly to the contraceptive decisions in their relationships.
**Aim(s)/objectives** To demonstrate what knowledge male patients have of their partner's contraception status.
**Methods** Electronic proformas for male GUM patients in the region studied were amended to include a question that assessed whether or not the attending patient was aware if their most recent sexual partner (MRSP) was using contraception. After this was in place, notes of all male patients classified "new"/"rebook" who attended in January 2016 were studied. Those coded MSM (men who have sex with men) were excluded. An Excel workbook was created from the data of the 396 patients. Patients assessed on alternative proformas were excluded, as were those

of practitioners not engaging in the study. 159 of the remaining 201 patients had the appropriate proforma section completed.
**Results** 125/159 (78.6%) had performed unprotected sexual intercourse (UPSI) with their MRSP. 120/159 (75.4%) stated that they knew whether or not their MRSP was using contraception. Of the 39 (24.6%) who didn't know, 10 had performed only protected sex with their MRSP and a further two had vasectomies. Of the remaining 27 (17%), 19/27 (70.4%) classed their partner as "Casual" and 8/27 (29.6%) "Regular". 19/37 (51.3%) men having UPSI with a casual partner didn't know if they were on contraception.
**Discussion/conclusion** Poor knowledge of partner's contraceptive status is demonstrated. This may highlight a potential area for future intervention.

## P242 ARE POINT OF CARE TESTS PRICKING POSITIVE PEOPLE?

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10.1136/sextrans-2016-052718.288

**Background/introduction/Aims** To establish whether point of care testing is being carried out in the appropriate populations. We endeavoured to see if our rapid HIV testing met the guideline specificity of 99.4%
**Methods** We carried out a retrospective analysis of 674 patients who received point of care tests (POCTs) after attending the sexual health clinic at the Royal Liverpool Hospital between October 2014 and May 2015. We reviewed the point of care tests based upon the indication, age and sex of the patient. The outcome measures included whether the test was reactive or not and the final result of the laboratory HIV test. Indications were defined by individual staff members logging the information and if multiple indications were given, the aspect deemed to be higher risk was used
**Results** Of the 674 patients 499 were female and 175 were male. The four most common indications were for testing were MSM (36%), Worried/Anxious (15%), PEP (11.5%) and HIV positive partner (9%). 31 tests (4.8%) were reactive and 23 tests (3.4%) produced a corresponding positive final laboratory result. This equated to a specificity of 98.77%. Positivity of indications varied remarkably-MSM, 3.7% versus Worried,0%.
**Discussion/conclusion** The study developed our understanding of the uptake of POCTs. A larger sample could have increased the specificity to the national guidance. The variability in documentation made it difficult to categorise risk in different indications. For example, indications of "high risk" and "worried" are vague and potentially misleading.

## P243 CHARACTERISING NEW HIV DIAGNOSES IN NORTH WEST NORTHERN IRELAND

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10.1136/sextrans-2016-052718.289

**Background/introduction** North West Northern Ireland is a predominately rural population. New HIV diagnoses in Northern Ireland are rising.
**Aim** We sought to characterise the new diagnoses being made in this region.
**Methods** The service became a consultant-led service on a daily basis in November 2015 and since this date has been offering ongoing care for PLWH. We analysised demographic details of new HIV diagnoses including sex, age and sexual identity. Details regarding the health location of the first positive test and surrogate markers at diagnosis were also recorded.
**Results** Since November 2015 there have been 7 new HIV diagnoses. Two tested positive within the GU service; external referrals with a new positive test included 1 from General Practice, 1 from Oral Surgery and 3 from Gastroenterology. Of the 7 new diagnoses 6 were in men. All were of white Northern Irish ethnicity. 3 men were MSM and 3 were heterosexual. 6 of the 7 are thought to have acquired their HIV within NI. Age range at diagnosis was 27–64 years old, but 6/7 were 44 years old or over. One patient disengaged from care following diagnosis and no surrogate markers were obtained as a result of patient's refusal for further blood tests. Of the 6 that have remained in care only 1 patient had a baseline CD4 count of greater than 350 cells/mm$^3$; 2 patients had a CD4 < 200 cells/mm$^3$ at diagnosis.
**Conclusion** Although small numbers so far, this analysis suggests that new HIV diagnoses in this region are of an older age with advanced HIV.

## P244 HSV SEROTYPES IN FIRST EPISODE GENITAL HERPES IN NORTH WEST NORTHERN IRELAND

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10.1136/sextrans-2016-052718.290

**Background/introduction** Most populations have observed an increase in the role of HSV-1 as a cause of genital herpes simplex virus (HSV)
**Aims** To analyse HSV serotypes in first episode genital herpes in North West Northern Ireland.
**Methods** All patients who tested positive for HSV and were coded as C10A from 01/03/2015 – 01/03/2016 were included. Demographic details including sex, age, ethnicity and sexual identity were recorded. The confirmed serotype (HSV-1 vs HSV-2) was noted.
**Results** A total of 36 cases of first episode genital HSV was seen. 100% were white Caucasian (35/36 White UK); 29 were female and 7 were male. All females self-reported as heterosexual and of the 2/7 men were MSM. Overall median age at diagnosis was 23 years old (range 16–40). Of the 36 positive PCR tests 83.3% (30) were HSV-1 and 6.7% (6) were HSV-2. The median age at diagnosis for HSV-1 was also 23 years (range 16–32); 26 were female and 4 male. Of the 6 positive who tested positive for HSV-2, 3 each were male and female.
**Conclusion** It is well documented that HSV-1 is increasingly prevalent as a cause of first episode genital HSV, our rate of 83% for HSV-1 infection is notably high. Although not a significant diagnostic or management challenge this may reflect a lower prevalence of HSV-2 infection within the local sexually-active population or an increasing level of sexual risk behaviour capable of transmitting HSV-1 infection. Local clinicians need to be aware of the differences in prognosis for HSV-1 infection such that accurate information and advice can be given to help reduce stigma traditionally attached to HSV-2 infection.

## P245 GETTING HERPES SIMPLEX: DIAGNOSIS, TREATMENTS AND ATTITUDES OF PATIENTS AND PARTNERS

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**Background/introduction** In 2003, a survey summary taken from patients with genital herpes, based on 198 responses was presented to BASHH. In 2015 similar questions were asked, with 548 replies.
**Aim(s)/objectives** Answers related to place of diagnosis (GP, GUM, etc.), treatments and psychological implications for patients and potential partners. Where the same question was asked in 2003, comparisons with before and after 2003 are made; also male/female. Neuropathic pain resulting from herpes simplex is not widely recognised. Questions re long-term pain have been included in 2015 questionnaire to assess the problem in this self-selected group.
**Methods** A SurveyMonkey to 800+ patients: diagnosed 1976–2015. Questions include where diagnosed, treatment used (e.g. suppression), have symptoms relocated, is there pain? Also level of psycho-sexual burden felt, telling partners and outcome?
**Results** Diagnosis: 2003, 26.8% by GPs; 53.5% direct to GUM. 2015, 25.5% going to GPs, 68.1% direct to GUM. Access to antivirals: 2003, 21% (n.42) – mixed episodic/suppressive treatment. 2015, greater usage: episodic treatment 33% (n.161), suppression 25.4% (n.139). 11.3% buy antivirals online. 22.6% get antivirals from GUM, 34.9% from GPs. 8.4% have been refused antivirals by GPs, 8.1% refused by GUMs. Most also use complementary therapy including 59.5% making dietary changes. Itching, shooting, aching and other pains before outbreaks 61%, at any time 32% 57.7% actively seek changed mental attitude. 81.8% have told partner(s) with 82.5% success rate.
**Discussion/conclusion** There are limited opportunities for following herpes simplex patients long-term. As well more patients using antivirals, there is a high level of self-help, physical and psychological. Associated neuropathy is high.

## P246 PERSISTENCE OF CHLAMYDIAL GENITAL INFECTION – HOW COMMON IS IT?

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**Background/introduction** We present a case of long term persistence of urethral chlamydia in a patient for over 1year, despite multiple treatments. We have not found any such case documented in the literature.
**Aims/Objective** This case raises certain questions? Could this be happening more often in patients? If yes, what is the significance? May this also explain why CT-positive patients are more likely to re-test positive within 2 yrs?
**Methods** In Jan 2015 a Slovakian man and his Czech female partner attend for asymptomatic sexual health screen. They were diagnosed with urethral and cervical Chlamydial infection respectively and were treated with a stat dose of Azithryomycin1gm. The only history of note is the female had had treatment for UTI requiring prolonged Nitrofurantion and the male CSW contact 3yrs ago. No other sexual partners were reported. Rescreen in March 2015 showed persistence of chlamydial urethral infection in the man while the female partner was negative.

**Results**

**Abstract P246 Table 1**

| Case | Date | Site tested | Result | A/B used |
|---|---|---|---|---|
| Male Female | 20.03.15 | Urine Vaginal swab | Positive Negative | Doxycycline 100mg bd x 1/52 Doxycycline 100mg bd x 1/52 |
| Male Female | 25.07.15 | Urine Vaginal swab | Positive Negative | |
| Male | 25.09.15 | Urine | Positive | |
| Male Female | 14.10.15 | Urine* Urethral swab* (*STBRL PHE) vaginal/oral/rectal | Positive - LGV DNA not detected Negative Negative | Azithromycin 1gm stat, 500mg BD x 4/7 |
| Male | 04.12.15 | Urine | Positive | Cinnamon and ginger!!! |
| Male | 18.01.16 | Urine Cell culture (PHE) Urethral swab | Equivocal first extraction low positive, repeat negative Negative Negative | |
| Male | 29.02.16 | Urine Urethal swab | Negative Negative | |

**Conclusion** Whilst untreated cases of chlamydial infection can resolve, to our knowledge this is the first case of persistent low load infection in a treated case and so is intriguing. It is unlikely to represent residual DNA after such a long period as in this case. The clinical significance of this is uncertain as he remained asymptomatic. The female partner was cured suggesting its not related to genotype and rectal carriage was excluded.

## P247 CAN TEXT MESSAGES INCREASE SAFER SEX BEHAVIOURS IN YOUNG PEOPLE: INTERVENTION DEVELOPMENT AND PILOT RANDOMISED CONTROLLED TRIAL

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**Background/introduction** Younger people bear the heaviest burden of sexually transmitted infections (STIs). The acceptability and feasibility of conducting a randomised controlled trial of safer sex support delivered by text message are not known.
**Aim(s)/objectives** To develop a safer sex intervention delivered by text messages for people aged 16–24. To assess the acceptability and feasibility of a randomised controlled trial.
**Methods** The intervention was developed based on evidence, behavioural theory, and user views. It was designed to reduce STIs by increasing correct treatment of STI, partner notification, condom use and STI testing. We conducted a pilot, randomised controlled trial with people aged 16–24 diagnosed with chlamydia or reporting unprotected sex with more than one partner in the last year. We conducted qualitative interviews.
**Results** Two hundred participants were randomised. We fully recruited early and achieved 81% follow up for our proposed primary outcome cumulative incidence of chlamydia at 12 months. Ninety-seven percent of messages sent were successfully delivered to participants' phones. Recipients reported that the

tone, language, content, and frequency of messages was appropriate. Messages reportedly increased knowledge and confidence in how to use and negotiate condom use, and reduced stigma enabling participants to tell a partner about a STI.

**Discussion/conclusion** The intervention is acceptable and a main trial is feasible. The NIHR have funded a randomised controlled trial to establish the effects of the intervention on sexually transmitted infections at 12 months.

***The number next to the author indicates the page number, not the abstract number.***

# Author index

# Author index